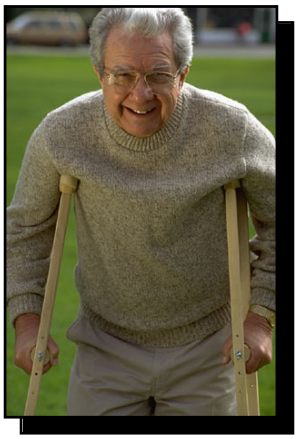
# *Senior Health Choices: A Managed, Integrated Long Term Care Plan*



**Agency for**
**Health Care Administration**
**Division of Medicaid**

**Submitted to the**
**Legislative Budget Commission**

**December 31, 2004**

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

FLORIDA MEDICAID

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# Executive Summary

This proposal is the result of a mandate by the 2004 Florida Legislature to create a plan for an "integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 65 and older." This comprehensive health and long-term care service system is to be piloted with the goal of creating a care management model designed to serve consumers in their community. Called Senior Health Choices (SHC), this will be a managed care program for all individuals age 65 and older who enroll in Medicaid in the pilot areas. The plan to deliver services using managed care organizations is designed to accomplish both an integrated service delivery model and fixed payment financing. The creation of a capitated payment structure will give the managed care organization flexibility to expend resources on the care that is most needed.

The need for a flexible, integrated approach to health and long term care for elders is critical, as Florida has the largest proportion of elderly in the United States. With the aging process comes, for many, the need for long term care services to assist with basic daily activities such as bathing and eating. Although family members provide the vast majority of long term care, individuals who do not have family available, or whose needs exceed the abilities and resources of their caregivers, seek long term care from formal, paid service providers. Since this care is expensive and is not paid for by the major health care insurer of the elderly, Medicare, large numbers of individuals seek assistance from Medicaid to pay for long term care needs.

Traditionally, nursing facilities have been the major providers of Medicaid long term care, but over the last twenty years, home based alternatives have developed. Over the years the Florida Medicaid program has developed twelve such programs through approved waivers of federal Medicaid rules. These home and community based services (HCBS) waiver programs are preferred by elders over nursing home care, but the availability of services is limited by budget allocations. Unlike nursing home care, which Medicaid is required to supply to all who qualify, HCBS waivers are optional services, and thus their scope can be limited by the Medicaid program. This leads to waiting lists for HCBS programs.

In addition to the fact that a limited number of persons can access HCBS waiver services instead of nursing facility care, the proliferation of waiver programs leads to confusion among consumers and providers, making it difficult to understand care options. Most waivers do not attempt to coordinate primary and acute care with long term care services, leading to fragmentation of information and even conflicting types of care. An example would be multiple specialist physicians prescribing medications for an elder without knowing what each was prescribing. This could cause a side effect such as dizziness, which could lead to a fall and broken hip, thus causing a need for long term care services.

The proposed pilot would provide some remedy to this fragmentation and lack of service coordination by having one managed care organization provide all Medicaid services for a recipient age 65 or older, including long term care, if needed. This includes physician services, hospitalization, prescription drugs, durable medical equipment, transportation, mental health services, and more. HCBS waiver services would still be limited as they are now, but the MCO could choose to provide additional HCBS services beyond those required in order to help prevent the need for more expensive nursing facility care. This flexibility in the service menu is one of the key benefits of the Senior Health Choices plan.

The following are the major components of the Senior Health Choices plan.

**Eligibility:** All individuals age 65 or older who are enrolled in Medicaid in the pilot areas must choose a Senior Health Choices provider. If they do not choose a provider, they will be assigned one. Some limited exceptions to mandatory enrollment are being proposed. There are currently over 300,000 Florida Medicaid recipients age 65 or older. Recipients will continue to enter the Medicaid program through financial eligibility determination by the Department of Children and Families Offices of Economic Self Sufficiency. Medical eligibility for long term care services will continue to be determined by the Department of Elder Affairs' CARES unit.

**Providers:** At least two managed care organizations, licensed under Chapter 641, Florida Statutes, will be selected through competitive procurement for each pilot area. Each must be able to demonstrate that it has a comprehensive network of qualified providers for each service that must be provided under the plan.

**Services:** All Medicaid services will be available to SHC enrollees including primary, acute, and long term care, and prescription medications. Each enrollee will have a care manager who assists in planning and coordinating the enrollee's care and in navigating the SHC program. The majority of enrollees, 87 percent, are also eligible for Medicare. These "dual eligibles" will continue to receive Medicare services as they do now, but the SHC care manager will also assist with coordinating, as much as possible, Medicare and Medicaid services.

**Financing:** Funding for the Senior Health Choices program will come from individual Medicaid services line items in the budget, as appropriated by the Florida Legislature. These funds will be taken in proportion to the population 65 and older served in the pilot areas. Service funds will be pooled in order to make fixed monthly payments to SHC plans for each individual enrolled. These capitated payments will be developed based on the current cost to Medicaid to provide services for this population. Additional funds of over $600,000 per year will be needed for program administration, including staff, an enrollment broker, and program evaluation.

**Pilot Areas:** Two pilot areas will be chosen to test the program concept. The areas will be chosen to represent both rural and urban areas and will encompass two of the eleven Agency for Health Care Administration / Department of Elder Affairs service areas. Priority will also be given to areas that have fewer HCBS waiver programs, as this will simplify implementation of the pilot and potentially bring increased access to services to recipients in the pilot areas.

**Program Administration:** The Agency for Health Care Administration will procure the providers and administer their contracts. All program decisions will be made in partnership with the Department of Elder Affairs.

**Implementation:** Implementation is expected to take a minimum of twelve months. The timeline could be much longer depending on the length of time it takes to receive approval of a waiver from the federal Centers for Medicare and Medicaid Services.

**Evaluation:** An independent evaluation of the pilots will be conducted. If the pilots meet the goals of creating seamless, integrated care for elders with an emphasis on community based care options and is able to prove that it is not more costly than traditional service models, then the Agency and Department will recommend expanding SHC statewide.

# Introduction

The 2004 Florida Legislature passed HB 1837 which states in part, "…the Agency for Health Care Administration, in partnership with the Department of Elder Affairs, shall develop a plan which identifies funding necessary for an integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 65 and older." The legislation further defines this as a comprehensive health and long-term care service system that serves persons aged 65 years and older who are in need of services and meet Medicaid and Medicare eligibility requirements. (Please see Appendix A for the full text of the legislation.)

Consistent with this mandate, the Agency for Health Care Administration and the Department of Elder Affairs are proposing a new Medicaid program, called Senior Health Choices (SHC), a managed integrated long-term care program. The program will provide services for Medicaid recipients age 65 and older. The Senior Health Choices program will include all primary, acute, and long-term care services. The program will initially be piloted, with a goal of expanding it statewide if it is successful.

The need to restructure Florida's current long-term care system is due to existing fragmentation in the state's health care delivery system; a mandate to deliver long-term care services in the least restrictive setting appropriate to individuals' needs; and the escalating cost of long-term care, which is a primary component of Medicaid spending growth.

The project strives to promote home and community based services; streamline long term care eligibility determinations; develop and integrate new quality management systems; create integrated networks of care at the local level; and develop an appropriate risk-adjusted reimbursement method that will include incentives for community living arrangements.

The Senior Health Choices program is intended to achieve the following outcomes:

- Promote community-based long-term care services. Over the last few years, Medicaid has expanded home and community based services through 1915(c) and 1915(b) waivers. These services, however, are only available to a limited number of enrollees under specific conditions and limitations. A new model of delivering services can create flexibility to offer cost-effective community services to a greater percentage of Medicaid beneficiaries. Financial incentives to develop alternatives to nursing home care will help support these objectives, expand the array of services available to people who need long term care, and expand opportunities for consumer direction.

- Manage all health costs. The current system pays providers for providing specific services. There are few financial incentives for providers to help people stay healthy and independent. By changing the financing of services, the State can create incentives to promote health, prevent the need for hospitalization and nursing facility placements, and use the most cost effective means of care.

- Coordinate care and establish accountability. By integrating the financing of health care services, managed care organizations (MCOs) can help Medicaid recipients and their

families navigate the maze of services, linking primary, acute, and long term care with social support services. Each MCO will be accountable for delivering high-quality services.

This plan has been developed consistent with Legislative guidance to date. Elements of the plan may change in the future due to actions of the Legislature. In addition, since broad Medicaid reform is being proposed and will likely be considered by the Legislature in 2005, this plan may need to be reevaluated in the context of any reform proposals.

## Current and Proposed Medicaid Long Term Care Systems

This section describes the current Medicaid long term care system and how the proposed pilots will differ from the current system.

### Current Medicaid Long Term Care System

Medicaid's current long term care system is a collection of distinct services, each with its own eligibility criteria. Services are considered either institutional or home and community based. Institutional services are mandatory for the Medicaid program, meaning that in order to receive federal matching Medicaid funds, these services must be available to any Medicaid eligible recipient who meets the criteria to receive the service. There are two types of mandatory institutional long term care services:

- Nursing Facility: 24-hour nursing and rehabilitation services (room and board, nursing services, therapies, supplies and other essential care) in licensed and certified nursing facilities and hospitals with nursing units. Nursing facility services include skilled and intermediate care services; special care for AIDS patients and medically fragile children; swing bed services provided by a rural acute care hospital; and skilled nursing services provided in a hospital-based, skilled nursing unit. Nursing facilities are paid a daily rate for each Medicaid resident.

- Intermediate Care Facility for the Developmentally Disabled (ICF/DD): Services are provided by licensed intermediate care facilities for the developmentally disabled, providing coverage for room and board, therapies, nursing services, training with daily living skills, and rehabilitative care to individuals with developmental disabilities. ICFs/DD are paid a daily rate for each Medicaid resident.

Home and community based long term care services are optional for Medicaid, meaning that a state may choose to provide the service. The goal of these services is to help frail elders and individuals with disabilities continue living in their home or a community setting such as an assisted living facility or an apartment with services. Without these services, these individuals would likely require permanent placement in an institutional setting. Florida Medicaid reimburses two major types of optional home and community based long term care services:

- Home and Community-Based Services Waivers: Medicaid is permitted under section 1915(c) of the Social Security Act to waive certain federal requirements in order to

provide home and community-based services to persons who would require institutionalization without community supports. Services vary by waiver but typical waiver programs include services such as personal care, homemaker, companion, chore, respite care, and adult day health care. Most services are provided directly in a recipient's home. Florida has twelve approved HCBS waivers. Each waiver has specific eligibility criteria such as age, type and level of disability, and service area covered. All waivers provide case management services to assess individual needs and work with recipients to develop a plan for their care, including which services will be provided, by which provider, and at what frequency. Unlike other long term care services, the state can, and does, limit the number of individuals served in each waiver program. There are waiting lists for most waiver programs due to this limit. Most waivers reimburse providers on a fee-for-service basis.

- Assistive Care Services: Assistive care provided to residents of congregate living facilities, such as assisted living facilities or adult family care homes, who have functional deterioration that makes it medically necessary for them to live in the facility and receive services on a 24-hour scheduled and unscheduled basis. Assistive care services may include health support and assistance with activities of daily living, instrumental activities of daily living, and medications. ACS providers are paid a daily rate per Medicaid resident.

Long term care is a major expense for Medicaid. In state fiscal year 2002-2003, Medicaid reimbursed $3.2 billion in long term care services. This represented 28% of the Medicaid budget, the largest single expenditure category. Table 1 below details these expenditures.

**Table 1: Medicaid Long Term Care Expenditures in State Fiscal Year 2002-2003**

| Long Term Care Service | Expenditures in SFY 2002-03 | Percentage of Total Medicaid Expenditures in SFY 2002-03 |
|---|---|---|
| Nursing Facility | $2,091,099,715 | 18% |
| Intermediate Care Facility for the Developmentally Disabled | $316,540,833 | 3% |
| Home & Community Based Services Waivers | $760,205,124 | 7% |
| Assistive Care Service | $ 35,457,223 | <1% |
| **Total Medicaid Long-Term Care** | **$ 3,203,302,895** | **28%** |

Nursing facility costs are by far the largest expense, primarily due to the cost of delivering care to 70,000 frail individuals with multiple health conditions in a highly regulated, residential environment. Long term care costs are expected to continue rising due to demographic trends towards an aging population, especially in Florida, which has the highest proportion of individuals age 65 and older of any state in the nation.[1]

Given these trends of rising costs and population growth it is imperative that Florida improve the manner in which it delivers long term care in order to control costs while still providing high quality care. Since home and community based services (HCBS) are generally less expensive than institutional services, it seems logical to continue shifting resources from institutional to HCBS. Many residents of nursing facilities, although by no means all, could be served in the community if given appropriate supports. This is especially true if individuals are prevented from being placed in a facility by supplementing the care given by family and other informal caregivers. A gradual shift over time to supporting a greater percentage of individuals needing long term care in the community could help level rising costs. This shift will be difficult to achieve in the current environment, however, because institutional care is an entitlement for those who qualify, while HCBS services are not.

In addition to the requirement that individuals receiving Medicaid-funded long term care meet the nursing facility level of care criteria defined in 59G-4.290 and 59G-4.180, Florida Administrative Code, there are two other types of restraints that control utilization. Access to HCBS waiver services is limited by absolute caps on budget authority and numbers of individuals who may enroll. Nursing facility utilization is restrained by consumer's reluctance to use the service. Individuals show a marked preference for remaining in their own home or in a less restrictive setting such as an assisted living facility. They choose nursing facility placement only as a last resort when their service needs are too great to remain independent.

Thus, there are many individuals who qualify for Medicaid long term care services because they meet the criteria for level of care, but who do not access services because HCBS programs have limited enrollment, and because they prefer to "make do" with only informal care rather than enter a nursing facility. The "woodwork effect" theory recognizes this phenomenon and theorizes that if access to HCBS programs were unlimited, people in need of services, but who were not accessing services, would "come out of the woodwork," and the system would be overwhelmed by individuals seeking services. An integrated system that pools funding for nursing facility and HCBS must control for the woodwork effect.

## Overview of Managed Integrated Long Term Care Pilot

The Senior Health Choices pilot will differ from the current Medicaid long term care system in many ways, although the services offered and the recipients enrolled will not change significantly. Instead, the program will shift from distinct long term care services and numerous home and community services programs, each with individualized eligibility criteria, service packages, and even different service areas, to a single, unified long term care program. This section will give a brief overview of the major components of the plan, and the remainder of the plan will explore each area in greater depth.

[1] U.S. Census Bureau, Census 2000.

Program Administration**:** The program will be operated by the Agency for Health Care Administration, in partnership and consultation with the Department of Elder Affairs.

Eligibility**:** Individuals age 65 and older who receive full benefits from Medicaid will be enrolled in Senior Health Choices. Some limited exceptions are being proposed.

Services Provided**:** All Medicaid services currently provided under the Medicaid state plan will be available to SHC enrollees. Recipients who seek long term care services and who meet nursing facility level of care criteria will have the choice of nursing facility care or an opportunity to enroll in home and community based long term care services.

As with the current system, access to home and community based long term care services will be limited. Individuals who qualify for long term care, but who do not choose to reside in a nursing facility may be placed on a waiting list for services. A major advantage of the pilot program, however, is that the managed care organization may choose to provide home and community based services as a substitution for nursing facility services. The managed care organization's incentive to do so is to prevent the individual's needs from growing to the point that nursing facility care is the only option. Since nursing facility care is the most expensive form of long term care, each provider will be motivated to avoid paying for that level of care by providing alternative services.

Service Providers**:** Service providers will be managed care organizations (MCOs) licensed under Chapter 641, Florida Statutes. MCOs will be chosen through a competitive procurement process, and at least two MCOs will be chosen for each pilot area. MCOs must provide directly, or subcontract for, all services included in Senior Health Choices. Credentialing standards will be developed for each provider type, and the MCO will be responsible for developing a credentialing system that ensures compliance with the standards.

Service Area**:** Two areas of the state will be chosen to pilot the program. Within the pilot areas, services for Medicaid recipients age 65 or older will be offered only through Senior Health Choices.

## Impact on Home and Community-Based Services (HCBS) Waivers

There are eleven Medicaid home and community based waivers in Florida that serve individuals age 65 and older. This plan is recommending excluding four of these waivers from inclusion in the pilot. The remaining waiver programs, if operational in the pilot area chosen, will be modified to exclude individuals age 65 and older. The individuals age 65 and older will receive HCBS through Senior Health Choices. Table 2 lists the waivers that will be merged into SHC for individuals age 65 and older and some details about age criteria, area of operation and number of services included.

**Table 2: Waivers Included in Senior Health Choices for Individuals 65+**

| Waiver Name | Age | Area of Operation | Number of Services Included |
|---|---|---|---|
| Adult Cystic Fibrosis | 18+ | Statewide | 19 |
| Adult Day Health Care | 75+ | Lee, Palm Beach | 1 |
| Aged/Disabled Adult | 18+ | Statewide | 25 |
| Alzheimer's Disease | 60+ | Broward, Dade, Palm Beach, Pinellas | 11 |
| Assisted Living for the Elderly | 60+ | Statewide | 3 |
| Channeling | 65+ | Broward, Dade | 19 |
| Nursing Home Diversion | 65+ | 26 counties | 21 HCBS; all other Medicaid services |

## Program Administration

This section describes the administration of the program and how the current Medicaid administrative infrastructure will adapt to meet the challenges of managed integrated long-term care.

### Responsibilities of State Agencies

Agency for Health Care Administration (AHCA). As the single state Medicaid agency, AHCA will have lead responsibility, with the Department of Elder Affairs, for development, maintenance and accountability for the provisions of the Medicaid waiver, development of capitated payments, and for procurement of and contracting with the managed care organizations. AHCA will serve as the primary contact with the Centers for Medicare and Medicaid Services (CMS) and the Medicaid fiscal agent. AHCA's Division of Health Quality Assurance will monitor quarterly reports from managed care organizations to ensure the organizations meet Medicaid surplus requirements.

Department of Children and Family Services (DCF). The DCF and its local offices establish eligibility of Medicaid recipients under agreement with AHCA.

Department of Elder Affairs (DOEA). The DOEA will partner on waiver and procurement development and consult on all aspects of project design. The DOEA will perform CARES nursing facility level of care assessments and coordinate outreach, information and referral, and ombudsman activities for older adults through Florida's network of Area Agencies on Aging and the planned Aging Resource Centers. If there is an Aging Resource Center in an SHC pilot area, the ARC will serve as the enrollment broker for the pilot.

Department of Financial Services, Office of Insurance Regulation (OIR). OIR will determine whether managed care organizations seeking to be Senior Health Choices providers meet financial solvency standards and will review quarterly reports from the managed care organizations to ensure that solvency standards are maintained.

## Contractual Relationships

It may be necessary to contract with outside entities when a task requires resources or expertise the AHCA or DOEA do not possess internally. Examples include:

- Actuarial analysis and rate setting;
- Data warehousing;
- Decision support system;
- Enrollment broker;
- Analyses of encounter data for performance measures; and
- Program evaluation.

## Type of Medicaid Waiver Needed

AHCA will seek a Medicaid 1115 Research & Demonstration waiver. This type of waiver allows maximum flexibility to institute managed care and flexible services, and it is the only waiver type that will allow individuals who are dually eligible for Medicare and Medicaid to be mandatorily enrolled. AHCA and DOEA believe that this is a critical step if Senior Health Choices is to be a success. The reasons for this are discussed below.

### *Reasons an 1115 Waiver is Required*

- **Ensure adequate numbers of enrollees.** Successful managed care programs require risk to be spread across an adequate pool of enrollees. Dual eligibles generally do not volunteer to participate in managed care models, as evidenced by the low numbers of Florida Medicaid recipients enrolled in Medicaid managed care plans. In addition, research by AARP[2] found that other states' Medicaid managed long term care programs, such as Minnesota Senior Health Options and Texas Star+ Plus, had little success in voluntarily enrolling Medicare beneficiaries. In particular, Minnesota's program found difficulties in attracting older persons living in the community into a voluntary integrated plan, especially if they had substantial care needs. Since 87 percent of Medicaid recipients age 65 and older are also receiving Medicare, it may be difficult to voluntarily enroll enough elders to create an adequate risk pool.

- **Expand beyond current models**. Florida has had for six years a voluntary managed long term care program for dually eligible recipients age 65 and older. The long term care community diversion pilot project, also known as the Nursing Home Diversion waiver, currently serves over 5,600 frail elders in twenty-six counties. The program is fully capitated for almost all Medicaid services, including prescription drugs, Medicare copays and deductibles, home and community based services and, if needed, nursing

[2] Capitated Payment of Medicaid Long-Term Care for Older Americans: An Analysis of Current Methods (2001)

home care. The program is considered successful in providing integrated care with a focus on community based long term care. There are, however, limitations to the model, including the fact that recipients must meet high frailty criteria to enter the program. This ensures that the program serves only the most needy individuals, but it also increases the financial risk to the managed care plan and denies the plan the opportunity to provide preventative services before frailty advances and caregivers burn out from their care duties. In addition, even though the managed care plans are capitated for and are "at risk" for the cost of nursing home placement, it is common for recipients to disenroll from the program if they choose a nursing facility that is out of the plan's network. Thus, the risk of nursing facility cost is not fully shifted to the managed care entity.

Senior Health Choices affords the State the opportunity to extend the benefits of coordinated care to all elders, even before they are in crisis and seek formal long term care services. Examples of this type of care include preventative health care and respite for caregivers that assists them in continuing to provide services. The inclusion of all elders, rather than just those who are frail and in need of formal long term care services allows managed care organizations to spread their risk by incorporating more healthy individuals into their plan, and by having greater numbers of enrollees. By enrolling all dual eligibles in Senior Health Choices, there will be an opportunity to expand on the lessons learned in the existing Nursing Home Diversion waiver and evolve the long term care system towards greater integration.

### *Approval Process for 1115 Waivers*

The disadvantage of the 1115 waiver is that there is no set timeframe for the Centers for Medicare and Medicaid Services (CMS) to respond to an 1115 waiver application. Thus, the timeframes for approval can be lengthy and make program planning challenging. Despite this, the recommendation remains that the state should seek an 1115 waiver.

### *Other Waiver Options*

The other possible waiver option would be to apply for a 1915(b) waiver. This would allow capitation of services and limitation of the number of managed care organizations that would be allowed to participate. CMS has 90 days to respond to a request for a 1915(b) waiver with approval, denial, or a request for additional information. If additional information is requested, CMS has 90 days from receipt of the state's response to make a final determination on approval. The disadvantage of the 1915(b) is that dual eligibles could not be required to enroll; that is, enrollment would be voluntary. If they did enroll voluntarily, they would not be required to use the provider's service network. This seriously diminishes the managed care organization's ability to coordinate and manage individuals' care.

### *Requirement for Home and Community Based Services Waiver*

In order to provide home and community based long term care services, the state may also need a 1915(c) Medicaid waiver in addition to the 1115 waiver in order to continue providing home and community based services. Currently the state has eleven such waivers that serve individuals age 65 and older, some of which would likely need to be modified in order to implement Senior

Health Choices. Waivers operating in the pilot areas could be amended to integrate all waiver services for individuals age 65 and older. A new 1915(c) waiver could be sought to specifically provide home and community based services to those populations in the pilot areas. 1915(c) waivers are relatively simple and the approval process follows the same 90 day timeframe described above in reference to 1915(b) waivers. A 1915(c) waiver would also allow the state to control the number of individuals who receive home and community based services under SHC. This is critical because of the financial impact of the woodwork effect described the section on the current Medicaid system. Further discussions with the Centers for Medicare and Medicaid Services will be needed to determine the structure of any needed waivers.

## Recipient Eligibility

This section addresses SHC program participation criteria, including Medicaid eligibility and program exemption criteria, and the administrative responsibilities for SHC eligibility determination.

The SHC will coordinate services for Medicaid beneficiaries age 65 and older. Therefore, the State will enroll into SHC most Medicaid eligible individuals age 65 and older who qualify under Medicaid's "aged, blind and disabled" criteria. The process for enrolling in SHC once determined eligible is described in the section on eligibility determination.

### Program Participation Criteria

Individuals age 65 and older who qualify for full Medicaid benefits and live in the pilot areas will be enrolled in the program. Eligibility categories that do not meet these requirements include:

- Individuals eligible under the "medically needy" program, which requires a specific monthly expenditure on medical expenses in order to gain Medicaid benefits for the month;
- Individuals under a penalty for disposal of assets; or
- Individuals certified for a retroactive eligibility period.

Medicaid categorical and financial eligibility criteria will not change as a result of this program. Individuals participating in home and community based waivers at the beginning of Senior Health Choices, excluding the exceptions proposed in the section on eligibility, will continue Medicaid eligibility and receiving waiver services.

### Recommended Eligibility Exemptions

AHCA is recommending that individuals participating in the following programs initially be exempted from participation in the SHC. Once the pilot has been demonstrated, these populations could be considered for integration.

***Exception: Individuals with Developmental Disabilities***

Individuals included in this category are individuals age 65 or older who are enrolled in the Developmental Disabilities or Family and Supported Living home and community based services waivers, or who reside in an intermediate care facility for the developmentally disabled (ICF/DD). By definition developmental disabilities (DD) are lifelong disabilities, and thus individuals will have been receiving services under the DD system of care for the majority of their life. It is not productive to remove them from this system towards the latter part of their life. Currently there are 703 individuals who are age 65 and older in these waivers and in ICFs/DD out of a total population of over 23,000.

***Exception: Individuals in Specialized Managed Care Programs***

Individuals included in this category are age 65 and older and enrolled in the Project AIDS Care home and community based services waiver or in the Program of All-inclusive Care for the Elderly (PACE). AHCA is currently developing a specialty managed care organization for individuals with HIV or AIDS that is mandated by the Legislature. Thus the individuals in the PAC waiver will have access to coordinated, managed care through a program designed specifically to treat their disease and disabilities. There are 230 individuals age 65 or older out of 6,676 enrolled in the PAC waiver.

PACE is requested for exclusion because it is already a fully capitated, integrated long-term care program. The PACE model includes all Medicaid and Medicare services and integrates funding from both programs. It is, therefore, an even more advanced model than the Senior Health Choices proposed in this plan. There is currently one Florida PACE site operating in Miami-Dade County. Two additional sites are proposed for Lee and Martin Counties. There are 62 individuals age 65 or older out of 85 currently enrolled in PACE.

***Exception: Individuals in the Traumatic Brain Injury/Spinal Cord Injury Waiver***

Individuals enrolled in the Traumatic Brain Injury/Spinal Cord Injury home and community based services waiver are receiving services tailored to their specific disabilities. In addition, most brain and spinal cord injuries occur when individuals are young adults, so they will have been handling their disabilities for some time by the time they reach age 65. Thus, it is recommended that they be allowed to continue receiving services under their current program. None of the 285 individuals currently enrolled in the TBI/SCI waiver are age 65 or older.

***Exception: Individuals in the Consumer-Directed Care Waiver***

The Consumer-Directed Care (CDC) program is an 1115 Research and Demonstration waiver that allows individuals receiving home and community based services to exchange their traditional service plan for a "cash" option. This budget allows them to purchase services from non-traditional providers, such as family members and neighbors. The federal requirements for 1115 programs are stringent, and thus it is recommended that this program be kept separate until the demonstration period expires in 2008. Principles of consumer direction, however, will be

integrated into the SHC pilot. There are currently 128 individuals age 65 or older participating in Consumer-Directed Care out of 899 enrolled.

## Service Provision

This section will describe the services to be provided to SHC enrollees. The flexibility to provide services from each of these categories as needed by the enrollee is a major advantage of Senior Health Choices.

### Services to be Provided

#### *Medicaid State Plan Services*

For all enrollees, MCOs will be responsible for providing services equivalent to the services required in the Florida Medicaid State Plan. This includes, but is not limited to, primary care, acute care, prescription drugs, nursing facility, and copays and deductibles for individuals eligible for Medicare. Since 87 percent of Medicaid recipients 65 and older are eligible for Medicare, many of the primary and acute care services will be covered by Medicare. The SHC plans will, however, be required to provide those services for the individuals enrolled who are only eligible for Medicaid. (Please see Appendix B for a list of Medicaid State Plan Services.)

#### *Home and Community Based Services*

Home and community-based long-term care services will be defined by a 1915(c) waiver which will be targeted to individuals 65 and older in the pilot SHC areas. Eligibility for these services will be limited to the number currently receiving home and community based services from waivers in the pilot area prior to implementation of SHC. Individuals age 65 and older who are receiving waiver services prior to implementation of SHC will continue to receive HCBS services. As these individuals leave the program, or move to a nursing facility, individuals on a waiting list for HCBS services will be allowed to enroll.

An MCO may not require that an enrollee move into an assisted living facility solely because the costs of serving the enrollee in his or her own home would exceed the cost of the assisted living services for that individual. For enrollees who require nursing facility level of care, the MCO will not be required to provide community based long term care services if the cost of serving the enrollee in the community would exceed the cost of nursing facility services for that individual.

#### *Substitution Services*

The MCOs will have the option of providing an enrollee with any services in addition to state plan services, including home and community based services. These services are considered a "substitution" for other, generally more expensive, services. They can be used to prevent hospitalization or institutionalization or to improve the satisfaction or quality of life for enrollees. An example of a substitution service would be providing respite care to an older spouse caring for her husband who is on the waiting list for home and community based services. This

flexibility to provide services not normally covered by Medicaid is one of the most important benefits of Senior Health Choices.

**Cost Sharing**

The AHCA will allow MCOs to charge limited co-payments and other cost sharing for enrollees, in accordance with federal rules.

**Continuity of Care**

Some Medicaid beneficiaries will be receiving on-going services from providers such as personal care aides, medical day care centers, or assisted living facilities at the time they enroll with an MCO. To ensure that these beneficiaries transition smoothly into the new program, the AHCA will require that MCOs continue to reimburse existing providers for any medically necessary and appropriate services received by an enrollee before a care plan is developed and implemented.

The enrollment broker will also promote continuity of care by helping potential SHC enrollees identify which MCOs include individuals' current Medicaid providers in their network.

**Coordination of Care**

Each MCO is responsible for coordinating the services under SHC, and coordinating those services with services covered under Medicare, services covered by other third party payers, and other community supports. Each MCO must assign a care coordinator for enrollees. A care coordinator is a person who must have a Bachelor's degree in Social Work, Sociology, Psychology, Gerontology or related field, or be a Registered Nurse, licensed to practice in Florida. Care coordination ratios will be specified.

Care coordinators must conduct a comprehensive face-to-face assessment and develop an individualized written plan of care for every new enrollee. Care coordinators will be required to conduct on-site placement and service reviews at specified intervals and more frequently if needed based on the social and clinical needs of individuals.

**Incorporating Principles of Consumer Direction**

The Senior Health Choices pilots will be developed to incorporate principles of consumer-directed care, which have been successfully piloted in Florida over the past four years. Medicaid recipients enrolled in the Consumer-Directed Care 1115 research and demonstration waiver are allowed to exchange their traditional long term care home and community based services for a budget equivalent to the value of the services they had been receiving. With the support of a trained consultant and a bookkeeping and tax service, consumers develop plans of care and hire their own workers.

A significant benefit of the program is that consumers are allowed to hire non-Medicaid enrolled providers, including family members, friends, and neighbors. This greatly increases the comfort level of consumers with the individuals providing hands-on personal care assistance in their homes, improves continuity of care, and gives improved service in terms of flexibility in times of

day services are provided. Independent, validated evaluations have shown that allowing consumers flexibility among services and service providers greatly increases consumer satisfaction while maintaining, and sometimes improving, quality of care. Consumer direction also offers increased access to care in rural areas where it is not cost effective for traditional providers such as home health agencies to provide service due to long travel distances for aides and nurses.

The waiver submitted to the federal Centers for Medicare and Medicaid Services will include a request that family members be allowed to provide direct, paid care to enrollees and that the MCOs be allowed to give consumers a budget option similar to the current Consumer-Directed Care program. MCOs participating in SHC will be encouraged to offer consumer directed service options and to allow non-traditional providers in an effort to improve access to care, quality, and consumer satisfaction.

## Service Providers

This section describes the types of organizations that can participate in this program, the process by which entities will qualify, and how historic Medicaid providers will be integrated into this program.

### Managed Care Organizations

Care under this plan will be provided by capitated managed care organizations (MCOs). All eligible recipients will be served by MCOs that accept risk and provide the full range of services through a comprehensive delivery system. MCOs will provide Medicaid services as described in section on service provision. MCOs may subcontract specified required services to a provider that meets Medicaid standards to provide those services.

Providers will have to meet standards before being allowed to participate in the program. For example, the State will review:

- Experience in providing long term care and acute care services;
- Network capacity, adequacy and quality;
- Information technology and data systems;
- Financial and administrative systems;
- Solvency/risk reserves;
- Claims payment systems that are compliant with Health Insurance Portability and Accountability Act (HIPAA) standards; and
- Quality assurance systems.

### Qualifications for Managed Care Organizations

Managed care organizations must be licensed under Chapter 641, Florida Statutes. Under this program, possession of MCO licensure does not assure that an entity may become a Senior Health Choices provider. Any MCO wishing to serve this population must be selected through a competitive procurement process.

**Competitive Procurement of Providers**

MCOs will be chosen through competitive procurement by pilot area. To ensure healthy competition and consumer choice, a minimum of two MCOs will be selected for each service area.

**Quality Standards for MCOs**

During the competitive procurement process and prior to being permitted to enroll any Medicaid recipients, each organization will undergo a rigorous qualifications review by AHCA. Each potential provider's capability will be evaluated in a number of areas, including:

- Provider network capacity and patient access;
- HIPAA compliant quality assurance and data systems;
- Solvency standards.

**Provider Network and Capacity Standards**

MCOs that participate in SHC will be required to develop a provider credentialing system, and monitor and maintain an adequate network of providers for all covered services. MCOs will be encouraged to use long term care providers from the current networks of aging services providers. MCOs will promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency. In establishing and maintaining provider networks, each MCO must consider the following:

- The plan's anticipated enrollment;
- The expected utilization of services;
- The number and types of providers necessary to furnish SHC services;
- The capacity of network providers to accept new Medicaid patients; and
- The geographic location of providers and SHC enrollees.

The MCO will maintain and regularly update a listing of available providers, their locations, and whether the practice site is open or closed for new patients. AHCA will perform an initial evaluation of the MCO's provider network prior to the implementation of the SHC and periodic re-evaluation thereafter.

Sample standards for access to each provider type are detailed in Appendix C.

## Pilot Areas

Legislation authorizing a managed integrated long term care plan references the need for pilot areas. This plan recommends two pilot sites to allow the state to test the Senior Health Choices concept in two varied communities. Criteria under consideration for choosing pilot areas include the following:

- Choose entire AHCA geographic service areas, which mirror the Department of Elder Affairs' Planning and Service Areas. This eases administration of the program, as eligibility and level of care determination and service delivery are typically organized by area rather than by county or city. (Please see Appendix D for a map delineating AHCA and DOEA areas.)

- Test the pilot in both rural and urban areas. If Senior Health Choices is successful in integrating care and shifting resources to community based care, it should be expanded statewide. Since, however, Florida has both urban and rural areas, the concept should be piloted in both so that it can be determined whether this is a viable option for statewide expansion. This may mean choosing one rural area and one urban area, or choosing pilot sites that encompass both urban and rural areas.

- Choose areas that have fewer home and community based services pilots and programs (see Table 3 below). There are two reasons for this criterion. First, areas with fewer pilots have a greater need for a program that is designed to shift long term care delivery towards home and community based services. Second, having fewer programs to integrate will simplify the design of the Senior Health Choices pilot, allowing for smoother implementation. The areas that have the fewest home and community based Medicaid programs are AHCA areas 1 and 2, which encompass the Florida panhandle. The areas with the next fewest number of home and community based services programs are Areas 4 (including Jacksonville), Area 6 (including Tampa), and Area 7 (including Orlando).

**Table 3: Presence of Medicaid Home and Community Based Services Programs by AHCA/DOEA Area**

| AHCA/ DOEA Area | Medicaid Eligible Recipients Age 65 and Over | Adult Cystic Fibrosis | Adult Day Health Care | Aged & Disabled Adult | Alzheimer's Disease | Assisted Living for the Elderly | Channeling | Nursing Home Diversion | Project AIDS Care | Consumer Directed Care | Traumatic Brain/Spinal Cord Injury | Program of All-inclusive Care for the Elderly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 8,032 | X | | X | | X | | | X | X | X | |
| 2 | 13,822 | X | | X | | X | | | X | X | X | |
| 3 | 22,420 | X | | X | | X | | X | X | X | X | |
| 4 | 21,983 | X | | X | | X | | X | X | X | X | |
| 5 | 20,782 | X | | X | X | X | | X | X | X | X | |
| 6 | 30,696 | X | | X | | X | | X | X | X | X | |
| 7 | 27,168 | X | | X | | X | | X | X | X | X | |
| 8 | 14,948 | X | X | X | | X | | X | X | X | X | * |
| 9 | 21,379 | X | X | X | | X | | X | X | X | X | * |
| 10 | 23,972 | X | | X | X | X | X | X | X | X | X | |
| 11 | 111,298 | X | | X | X | X | X | X | X | X | X | X |
| **Total** | **316,500** | * Proposed PACE expansion sites | | | | | | | | | | |

# Eligibility, Enrollment, and Disenrollment

This section describes the process by which enrollees and potential enrollees are determined eligible for Senior Health Choices and informed about the State's managed care program and processes for MCO enrollment and disenrollment. This section also addresses how recipients will be provided with sufficient information on which to base their enrollment decisions.

## Eligibility Process

Eligibility for SHC will be determined much as it is for Medicaid currently. Any individual age 65 or older who wishes to apply for Medicaid will do so through the Department of Children and Families' Economic Self Sufficiency offices. This is the current Medicaid eligibility process. If Aging Resource Centers are established in the SHC pilot areas, the ARC can be the point of application for Medicaid eligibility. If an elder meets the financial criteria for Medicaid's aged, blind, and disabled category, he will be made eligible and his information referred to the enrollment broker, described below, to receive assistance in choosing and enrolling in a SHC provider plan.

An elder who has income and assets above the limit to qualify for Medicaid under the aged, blind, and disabled category may still qualify if he meets nursing facility level of care, since there is a higher income and asset limit for individuals needing long term care services. If an individual seeks to qualify for Medicaid under these higher limits, known as the Institutional Care Program (ICP), he must be seeking placement in a nursing facility or have been determined eligible for an available space in a home and community based services waiver. If these conditions apply, the Department of Elder Affairs' CARES unit will conduct a thorough assessment of functional capacity and long term care assistance need and determine if the individual satisfies the nursing facility level of care criteria. If these criteria are met, then DCF will determine whether the elder meets ICP financial eligibility criteria. If all these conditions are satisfied, the individual will be enrolled in Medicaid and his information referred to the enrollment broker to receive assistance in choosing and enrolling in a SHC provider plan.

If individuals will only qualify for Medicaid under ICP eligibility, but do not wish to enter a nursing facility and there is no space available in the home and community based services portion of the SHC, they will be placed on a waiting list for services. When services become available, their eligibility will be determined.

## Principles of Enrollment

The enrollment and disenrollment processes are central to a properly functioning managed care system. The enrollment process must promote informed recipient choice through the provision of timely, accurate, and understandable information about MCO network providers.

The agency will use several means to achieve these goals, including intensive outreach and education efforts preceding the program's implementation; the prohibition of direct marketing by MCOs; and establishment of an enrollment process that is independent from the MCOs participating in the program.

Each MCO will have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

For existing Medicaid beneficiaries, enrollment will be phased in during the first year of implementation. During this phase-in period, all individuals newly eligible for Medicaid who are also SHC eligible will enroll with an MCO.

## Pre-implementation Outreach and Education

For individuals age 65 or older who are Medicaid recipients at the time Senior Health Choices is implemented, there will be a major outreach and education effort. Pre-implementation outreach and education will have three goals:

- Notify current recipients and potential recipients regarding the upcoming changes to the Medicaid system;
- Inform recipients of the effect those changes may have on how they access care; and
- Instruct recipients on their rights and responsibilities in a managed care system.

## Enrollment Broker

AHCA will contract with an independent enrollment broker to enroll Medicaid recipients into the program. In areas where the Department of Elder Affairs has established an Aging Resource Center, the ARC will serve as the enrollment broker. Through the enrollment broker, when an individual is notified of their eligibility for Medicaid, they will be provided an enrollment packet, including necessary forms for enrollment. The enrollment packet will include information on:

- The basic features of managed care;
- The fact that enrollment is mandatory, and that auto-assignment will occur for those who do not choose an MCO;
- MCO responsibilities; and
- Benefits covered.

If the enrollment broker for this pilot is different from the current AHCA contracted managed care enrollment broker, the two entities will be required to coordinate communications to enrollees.

### *Information Provided by the Enrollment Broker*

The enrollment broker will also include summary information specific to each MCO on:

- Cost sharing, if applicable;
- Service areas;
- Names, locations, telephone numbers of current network providers; and
- To the extent available, quality and performance indicators, including enrollee satisfaction.

The enrollment broker will provide outreach in the most effective manner, including face-to-face enrollment when necessary. MCOs must accept all individuals who enroll or who are assigned by the enrollment broker.

***Auto-assignment of Enrollees***

Auto-assignment to MCOs for individuals who do not choose an MCO will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients, and will follow the following criteria:

- If a recipient is enrolled in a Medicare Advantage plan which also participates as a Medicaid MCO, the recipient will be assigned to that MCO.
- If the above does not apply and the recipient was previously eligible and enrolled in a Medicaid HMO that is certified to participate as a SHC MCO, he/she will be assigned to that MCO.
- If, neither of the above applies, he/she will be randomly assigned to an MCO in the service area with available capacity.

***Enrollment Broker Performance***

The AHCA will monitor the performance of the enrollment broker. Specific attention will be paid to the following:

- Automatic assignments;
- Timeliness of enrollment;
- MCO disenrollment rates; and
- Enrollment related complaints.

**MCO Responsibilities Upon Enrollment**

After the recipient has chosen or been assigned to an MCO, the MCO will assign a case manager, administer a health risk assessment, and develop a plan of care with the enrollee. During the assessment, the MCO will also be responsible for providing the following information:

- How to request and obtain information;
- Grievance, appeal, and fair hearing procedures;
- Advance directives policies;
- Procedures for obtaining benefits, including authorization requests;
- Procedures for developing plans of care.

**Re-enrollment and Annual Right of Change**

Upon the annual anniversary of enrollment in an MCO, each enrollee will be given an opportunity to choose a new MCO, or remain with the current MCO. Recipients will have the

month of the anniversary date of their enrollment in an MCO in which to make any changes. Individuals who are disenrolled from an MCO due to loss of Medicaid eligibility will be automatically re-enrolled into the same MCO if they regain Medicaid eligibility within two months.

**Disenrollment**

As stated above, the recipient disenrollment rate will be tracked as a possible sign that recipients are receiving inadequate information during the enrollment process.

***Disenrollment Without Cause***

Individuals may disenroll from their MCO and choose a different Senior Health Choices MCO without cause during the 90 days following the date of the recipient's initial enrollment. During the first 12 months of an individual's enrollment in SHC, enrollees who are auto-assigned will be permitted one disenrollment from an MCO and enrollment in another SHC MCO.

***Disenrollment for Cause***

Individuals may disenroll from a current MCO and enroll in another SHC MCO if they enroll in a Medicare Advantage plan that also participates as a SHC MCO. Enrollees may also request a change of MCO at any time upon showing a good cause.

Circumstances under which an enrollee will be disenrolled from SHC include:

- Loss of Medicaid eligibility;
- Moving out of the pilot area; and
- Death.

## Quality Assurance and Ongoing Evaluation

This section outlines various methods AHCA will use to ensure the delivery of high quality health care by all MCOs to SHC enrollees. The goal of the SHC quality strategy is to promote the health and well being of enrollees by 1) assuring enrollee access to services; 2) holding MCOs accountable for outcomes; and 3) promoting quality and cost-effective delivery of services.

**Quality Strategy**

Oversight will exist on two levels: at AHCA and at individual MCOs. AHCA will have a written strategy for assessing and improving the quality and appropriateness of care delivered by all MCOs to their enrollees. The SHC quality strategy includes:

- Systems performance review;
- Clinical outcome measures;
- Care coordination;

- Enrollee satisfaction;
- Provider satisfaction;
- Network adequacy;
- MCO performance improvement projects;
- Implementing a care plan within established timeframes;
- Timeliness of handling complaints and grievances; and
- Focused studies using chart reviews in areas that cannot be evaluated using encounter data.

Each MCO will also be required to have an active consumer advisory board.

MCO performance on the requirements included throughout this plan will be part of the quality strategy, including but not limited to:

- Enrollment and disenrollment;
- Enrollee information;
- Provider access and timeliness of care;
- Coverage and authorization of services; and
- Care coordination and continuity of care.

**Evaluation**

Program evaluation is essential in order to assure enrollees are accessing high quality personal care providers. AHCA will contract for a baseline and ongoing evaluation to determine the effectiveness of services in meeting enrollees' needs. The contracted evaluator will assess SHC on an ongoing basis by reviewing a range of areas, including health outcomes, access to care, utilization of services, MCO networks, enrollee and provider satisfaction, and MCO systems performance to determine how well SHC goals are being met. The evaluation will focus on measures such as the percent of enrollees using community versus institutional long-term care services, rates of hospitalizations, emergency room utilization, and hospice services. AHCA, DOEA, and the contracted evaluator will establish baseline performance on key measures in order to compare performance prior to the implementation of SHC with performance under SHC.

**Data for Evaluation**

MCOs will be required to provide certified, complete, accurate encounter data in standard formats for every enrollee. MCOs will use automated systems to submit encounter data on a regular basis. AHCA will specify minimum acceptable capabilities of an MCO's automated system, including compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy and standard transactions standards. MCOs will be required to demonstrate capability to comply with all data requirements prior to the implementation of SHC. Part of this demonstration of capability will be the timely, accurate submission of data.

AHCA, at a minimum annually, will conduct focused medical record reviews to supplement encounter data in the early years of SHC as the encounter data set is developing. AHCA will

analyze other quantitative or qualitative data as appropriate (e.g., fee-for-service or Medicare claims data, surveys, complaints/grievances) to complement MCO encounter data.

**Reporting**

AHCA will prepare a variety of regular reports on the implementation and effectiveness on SHC comprehensive quality strategy to ensure continuous improvement. Reports will take into account the following dimensions:

- Evaluation of enrollees' access to care and utilization of services (e.g., through encounter data analyses);
- Enrollee centered service planning and delivery, including evaluations of MCOs' adherence to care plan standards and quality of care standards;
- Provider capacity and capabilities, based on MCOs' compliance with access and credentialing standards;
- Outcomes measurements to ensure appropriate enrollee safeguards are taken (e.g., monitoring of incidence of pressure-induced bed sores, falls, etc.);
- Results of consumer satisfaction surveys;
- Results of provider satisfaction surveys;
- System performance review;
- Summary of complaints, grievances and appeals; and
- MCO internal performance improvement project reports.

MCOs will regularly submit financial reports, including a quarterly financial monitoring report card, and an annual financial filing with the Florida Department of Financial Services.

## Additional Consumer Protections

Protection of consumer rights is a critical component of any managed care plan, but particularly a plan that requires enrollment. This section outlines a number of the consumer protections that will be part of the Senior Health Choices design.

**Enrollee Rights and Responsibilities**

Section 381.026, Florida Statutes, requires that a health care provider or health care facility recognize the following rights while an enrollee is receiving medical care and that the enrollee respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. A summary of enrollee rights and responsibilities follow.

***Enrollee Rights***

An individual has the right to:

- Be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.
- A prompt and reasonable response to questions and requests.

- Know who is providing medical services and who is responsible for his care.
- Know what support services are available, including whether an interpreter is available if he does not speak English.
- Know what rules and regulations apply to his conduct.
- Express grievances regarding any violation of his rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him and to the appropriate state licensing agency.
- Be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Treatment for any emergency medical condition that shall deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

***Enrollee Responsibilities***

An enrollee is responsible for:

- Keeping appointments and, when he is unable to do so for any reason, for notifying the health care provider or health care facility.
- Providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health.
- Reporting unexpected changes in his condition to his health care provider.
- Reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.
- Following the treatment plan recommended by his health care provider.
- His actions if he refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his health care are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting patient care and conduct.

## Complaints and Appeals

Enrollees, their representatives, or their providers acting on their behalf who are dissatisfied with their MCO will have avenues through which they can voice complaints and access the complaint/grievance, appeal, and fair hearing processes.

In case of a denial, termination, or reduction of benefits, an enrollee, the enrollee's representative, or the enrollee's provider may file a complaint, grievance or an appeal with the MCO and may request a Medicaid fair hearing. An enrollee, the enrollee's representative, or the enrollee's provider may also file a complaint or grievance to express dissatisfaction about any matter other than a denial, termination, or reduction of benefits.

The MCO will have an internal dispute resolution unit to handle enrollee and provider complaints that require extensive investigation or clinical expertise. An enrollee who accesses the MCO's complaint or grievance process will still have a right to a Medicaid fair hearing.

## Provider Access and Credentialing Standards

Access standards, described in more detail in Appendix C, will be developed for each network provider type to ensure that enrollees are able to access providers in a timely manner at a reasonable distance from their residence. AHCA and DOEA will also develop minimum qualifications that providers of each service must meet in order to be eligible to contract with an MCO under the SHC program. These access and credentialing standards add an additional layer of consumer protection to ensure high quality services in appropriate, accessible settings.

## Services Provided During the Initial Transition Period

For all recipients who were enrolled by Medicaid on a fee-for-services basis prior to enrollment in SHC, MCOs will be responsible for care provided by out-of-network providers. This means that MCOs are responsible for out-of-network services received by all enrollees who are in the middle of treatment plans until a care plan has been developed and a care manager is coordinating the enrollee's care. Additionally, those recipients residing in an out-of-network nursing facility will be allowed to remain in that facility. MCOs must negotiate a reimbursement agreement with that nursing facility or pay the current Medicaid per diem rate.

**Marketing**

MCO marketing activities will be carefully structured to ensure that enrollees receive clear, unbiased information about plans and are not pressured or coerced to choose a specific plan. MCOs will be permitted to engage in general marketing activities, but may not directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities (defined as any unsolicited personal contact) with any recipient who is not an enrollee of the MCO. The following rules will also apply to MCO marketing activities:

- Individuals will be able to contact MCOs directly prior to enrolling.
- MCOs cannot distribute marketing materials without first obtaining approval from AHCA.
- MCOs must assure that marketing materials are accurate and do not mislead, confuse, or defraud recipients.
- MCOs will be required to provide information in a format to be prescribed by the state, including writing materials to a grade level of understanding prescribed by AHCA.
- Any marketing materials distributed by MCOs must be distributed to their entire service area.
- MCOs cannot seek to influence enrollment in conjunction with the sale or offering of any private insurance.

## Financing

The financial goals of this program are as follows:

- Achieve more predictable budgets for the Medicaid program.
- Transfer financial risk through fixed, prospective payments. MCOs will assume more financial risk and in turn be given greater flexibility in how funds may be spent.
- Reduce the rate of growth in expenditures compared to the current system while promoting a coordinated network of providers responsible for the health of a defined population.

**Rate Setting and Adjustments**

Rates paid to MCOs will be initially based on the amounts being paid for covered benefits to the covered population under the existing payment system. This is known as the "fee-for-service equivalency rate" (FFSER). There will need to be special adjustments for the population that is dually eligible for both Medicare and Medicaid services, since Medicare is responsible for certain services.

A person-level database will be created that contains recipient demographic information and health care cost information by type of service, including all claims expenditures. In this file each recipient has a yearly total payment for each service type, i.e., physician, inpatient, outpatient, personal care, pharmacy, home health, and nursing home care, etc. These total payment variables are based on date of for inpatient episodes, date of dispensing of the pharmacy type, and date of service for all other services.

Records of recipients who are not eligible for enrollment in the program will be excluded from the analysis. Populations may be further segmented on eligibility categories, level of care, age, gender, diagnosis, or other factors that may predict financial risk.

Over time, the goal is to evaluate whether it is appropriate to also segment the population, for rate-setting purposes, based on indicators of functional status such as scores from CARES long-term care assessments, which include assessment of individuals' ability to perform activities of daily living and instrumental activities of daily living. The AHCA will work with its actuary in developing this methodology. This methodology will not be immediately available, since the measurements of functionality must be directly linked to historical data on individuals and payments.

Actuarial models will be used to calculate rates for different groups such as those eligible for Medicare and those only eligible for Medicaid. Base year fee-for-service gross payment rates will be adjusted and trended forward to derive the capitation rates for SHC enrollment years. The factors will include adjustments for:

- Claims submission lag;
- An annual inflation factor; and,
- Adjustments for third party collections.

Reimbursement rates must be certified actuarially sound each year and approved by the federal Centers for Medicare and Medicaid Services. Adjustments will be made for major policy and program changes. An example of a major programmatic change that would require a rate adjustment would be the projected January 1, 2006, implementation of Medicare Part D coverage, which will initiate prescription drug coverage for Medicare recipients.

**Payments and Funding**

MCOs will be paid a monthly capitation rate, which will be paid prospectively on or around the first of the month. Payments for those individuals whose eligibility is cancelled will be recovered. The Federal Financial Participation rate is assumed to remain the same for this population as it currently is for the fee-for-service Medicaid program.

**Budget Neutrality**

This program must demonstrate that is budget neutral; that is, that it does not cost more than it would have cost to serve these individuals under the traditional Medicaid program. The requirements for proving budget neutrality vary depending on the type of waiver granted by the federal Centers for Medicare and Medicaid Services.

**Financing**

Table 4 below identifies all state fiscal year 2003-2004 expenditures for Medicaid eligible individuals age 65 and older in the eleven AHCA service areas, excluding individuals enrolled in

the waivers identified in the section on exclusions from the pilot. These data reflect spending for Medicaid services as a guide to anticipated costs for the program. Funds from the areas chosen for the pilots will be combined to form the basis for the capitated rates.

**Table 4: Medicaid Recipients Age 65 and Older and Expenditures by Area for SFY 2003-2004**

| AHCA/DOEA Area | Number of Medicaid Recipients Aged 65+ Served | Total Medicaid Expenditures |
|---|---|---|
| 1 | 9,184 | $112,902,577 |
| 2 | 15,947 | $175,748,265 |
| 3 | 24,398 | $275,230,084 |
| 4 | 23,474 | $318,397,789 |
| 5 | 21,288 | $318,076,405 |
| 6 | 33,118 | $339,368,888 |
| 7 | 29,322 | $343,189,355 |
| 8 | 16,538 | $223,329,292 |
| 9 | 22,599 | $301,253,155 |
| 10 | 22,452 | $186,658,914 |
| 11 | 103,327 | $816,983,600 |
| **Total** | **321,647** | **$3,411,138,324** |

## Administrative Costs

Total administrative costs per year are estimated at a maximum of $671,024. The federal Medicaid match rate for administrative services would be fifty percent, so General Revenue needs are $335,512 per year.

This program will require contract managers skilled in managed care, Medicaid, and utilization management and outcomes measurements. Existing staff will need to maintain the current waiver programs in the non-pilot areas and for the population under age 65, thus the workload of maintaining and administering those programs will not decrease. It is therefore recommended that funding be provided to allow for two additional full-time equivalent (FTE) contract managers to assist with critical workload increases to Medicaid.

| | |
|---|---|
| $39,509 | Base Salary for Medical/Health Care Program Analyst - Pay grade 24 |
| x 27.85% | Benefit Rate |
| $50,512 | per FTE |

The use of an independent enrollment broker is estimated to cost $500,000, which includes development and implementation costs as well as one year of service provision as outlined in the section on eligibility.

An independent evaluation of the program is anticipated to cost $70,000 per year. If a state university is contracted to conduct the evaluation, it is possible that the university will provide in

kind match of staff and administrative resources, eliminating the need for state General Revenue match in order to draw federal Medicaid matching funds.

## Implementation Steps and Timeline

This section outlines the major implementation steps and the timeline for completion of the steps. A significant factor in the timing of implementation is the federal waiver review process. Unlike 1915 waiver applications, there are no deadlines for the Centers for Medicare and Medicaid Services (CMS) to review and comment on 1115 waiver applications. Historically, the timeframes for approval of 1115 waivers have varied, ranging from six to eighteen months. Given the uncertainty of the timeframes, the chart below estimates the time to complete each step following approval of the waiver. Based on the steps outlined, development and start-up will take a minimum of twelve months, even if CMS rapidly approves the waiver application.

| Implementation Step | Timeframe for Completion |
|---|---|
| Develop and submit managed integrated long term care plan to Legislative Budget Commission | July 1, 2004, to December 31, 2004 |
| Legislative Budget Commission meeting | January/February 2005 |
| Assuming approval by LBC, develop and submit waiver to CMS for approval. Waiver must include:<br>• Eligibility<br>• Service packages<br>• Provider standards<br>• Rate setting methodology and proposed rates (actuarially sound)<br>• Budget neutrality calculations<br>• Operating procedures<br>Hold stakeholder meetings in each pilot area during waiver development. | January/February 2005 to June 2005 |
| CMS review of waiver application | June 2005 to unknown |
| Seek legislation to continue authority for pilot program | March 2005 to May 2005 |
| Develop competitive procurement document | June 2005 to August 2005 |
| • Continue public education: stakeholder and advocate meeting in each pilot area; education of AHCA, CARES and Department of Children and Families Medicaid eligibility staff<br>• Develop draft operating procedures<br>• Begin Florida Medicaid Management Information System (FMMIS) modifications | During CMS review period |
| • Issue competitive procurement documents for managed care organizations and, if necessary, enrollment broker<br>• Continue public education: stakeholder and advocate meeting in each pilot area; notification letters to providers and eligible recipients; policies and procedures training of AHCA, CARES and Department of Children and Families Medicaid eligibility staff | Upon CMS approval of waiver |
| Review provider bids and award contracts | 3 months after posting of procurement document |
| Notify first group of enrollees of the enrollment process | Upon award of contracts |
| • On-site readiness review and certification of providers<br>• Final notice to enrollees | 2 months after award of contract |
| Begin first phase of enrollment | Upon certification of provider readiness |
| • Phase in enrollment of all current recipients over six month period<br>• New Medicaid recipients would be enrolled upon receiving eligibility | Six months |

# Appendix A: Legislative Authority

From House Bill 1837:

Section 19. In order to implement Specific Appropriations 228-237 of the 2004-2005 General Appropriations Act, the proviso immediately preceding Specific Appropriation 227 of the 2004-2005 General Appropriations Act, is amended to read:

From the funds in Specific Appropriations 228 through 237, the Agency for Health Care Administration, in partnership with the Department of Elder Affairs, shall develop a plan which identifies funding necessary for an integrated, long-term care, fixed payment, delivery system for Medicaid beneficiaries age 65 and older. Identified funds shall include funds for Medicaid Home and Community-Based waiver services, all Medicaid services authorized in sections 409.905 and 409.906, Florida Statutes, including Medicaid nursing home services and funds paid for Medicare premiums, coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in section 409.908(13), Florida Statutes. The plan shall provide for the transition of all Medicaid services for eligible elderly individuals into an integrated care management model designed to serve consumers in their community. The agency and the department shall consult with the appropriations committees and the appropriate substantive committees of the Legislature during the development of the plan. The plan shall include specific pilot project sites and may include strategies for the phase-in of statewide coverage. The plan to implement the pilot project and any necessary budget amendments shall be presented to the Legislative Budget Commission no later than December 31, 2004, for approval. The plan shall provide for integration of all funding for Medicaid services provided to individuals over the age of 65 into the integrated system. The agency is authorized to seek federal waivers as necessary to implement this project.

The plan shall provide for a competitive procurement to operate the project. The agency shall insure that rates proposed in the plan are actuarially sound and reflect the intent of the project to provide quality care in the least restrictive setting. The agency shall also insure that the plan provides for organizations to develop a service provider credentialing system and to contract with all Gold Seal nursing homes and exclude, where feasible, chronically poor performing nursing homes. In the absence of a contract between the organization and the nursing home, the plan shall provide that current Medicaid rates shall prevail. The plan shall provide that if the consumer resides in a non-contracted nursing home at the time the program is initiated, the consumer shall be permitted to continue to reside in the non-contracted home for not less than twelve months. The agency and the Department of Elder Affairs shall jointly develop procedures to manage the services provided through this project to ensure quality and consumer choice.

# Appendix B: Medicaid State Plan Services

Adult Health Screening
Adult Emergency Dental Services
Ambulatory Surgical Centers
Assistive Care Services
Birth Center Services
Chiropractic Services
Community Mental Health
County Health Department Clinic Services
Dialysis Facility Services
Durable Medical Equipment
Family Planning
Home Health Care
Hospice Services
Hospital (inpatient and outpatient)
Independent Lab
Intermediate Care Facility for Developmentally Disabled
Nurse Midwife
Nurse Practitioner
Physician
Physician Assistant Services
Podiatry Services
Portable X-ray
Prescribed Drugs
Primary Care Case Management
Rural health
Skilled Nursing Home
State Mental Hospital (Age 65+)
Targeted Case Management
Transplant Services
Transportation

**For Children Only:**

Dental Services
Child Health Check-Up
Early Intervention Services
Hearing Services
Medical Foster Care
Visual Services
Prescribed Pediatric Extended Care
School-Based Health Services
Private Duty Nursing
Subacute Inpatient Psychiatric Program
Physical Therapy
Occupational Therapy
Respiratory Therapy
Speech Therapy

# Appendix C: Standards for Access to Service Providers

This section will discuss access standards that AHCA will employ to ensure that every MCO can effectively provide the benefits covered under the SHC. These standards will apply where Medicaid is the primary payer. Medicaid will be the primary payer for long term care services for all recipients covered under SHC.

**Access to a Choice of Providers**

Each participating MCO will be required to maintain a network that includes an adequate number of service providers to ensure timely access. At all times the MCO must maintain a minimum of at least two contracted providers of each service type. Additional providers may be required based on criteria such as those described below.

**Geographic Access**

MCOs will ensure that all enrollees have reasonable travel times to receive Medicaid covered services. Examples of potential geographic access standards include:

- Enrollees in urban areas must be able to access covered primary care services within 30 minutes travel time or within a 10-mile radius of the provider's office, and covered pharmacy services within 10 minutes travel time or within a 5-mile radius.
- Enrollees in a rural area must be able to access covered primary care services and medical day care within 30 minutes travel time or within a 30-mile radius.

**Primary Care Provider Access Standards**

Each SHC enrollee for whom Medicaid is the primary payer will have a primary care provider (PCP) to serve as the enrollee's medical home. The MCO will be required to meet a primary care capacity standard. The enrollee's PCP assignment will be based on:

- The enrollee's selection of a PCP from the MCO's panel of qualified providers; or
- The MCO's assignment of a PCP from its panel of qualified providers if the enrollee does not select a PCP.

**Care Coordination Access Standards**

All SHC enrollees will be assigned a care coordinator by the MCO. Care coordinators will be responsible for developing and monitoring care plans to ensure that enrollees' needs are met. Care coordinators must be part of the MCO's staff. Examples of care coordination access standards for individuals receiving long term care services include: a care coordinator to enrollee ratio of no less than 1:50 for individuals utilizing SHC services in the community and a ratio of no less than 1:120 for those in nursing facilities.

**Specialty Provider Access Standards**

AHCA will use the current specialty provider network standards in place for its Medicaid HMO program. AHCA will require every MCO to have a core network of specialty providers consistent with its current HMO standards, except SHC MCOs will also be required to include a gerontologist. The MCO will provide for a second opinion for enrollees for whom Medicaid is the primary payer.

For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

**Home And Community-Based Services Access Standards**

AHCA will utilize current home and community-based long-term care provider network standards to ensure access to home and community-based providers. Additionally, MCOs will be required to make good faith efforts to contract with existing home and community-based services providers.

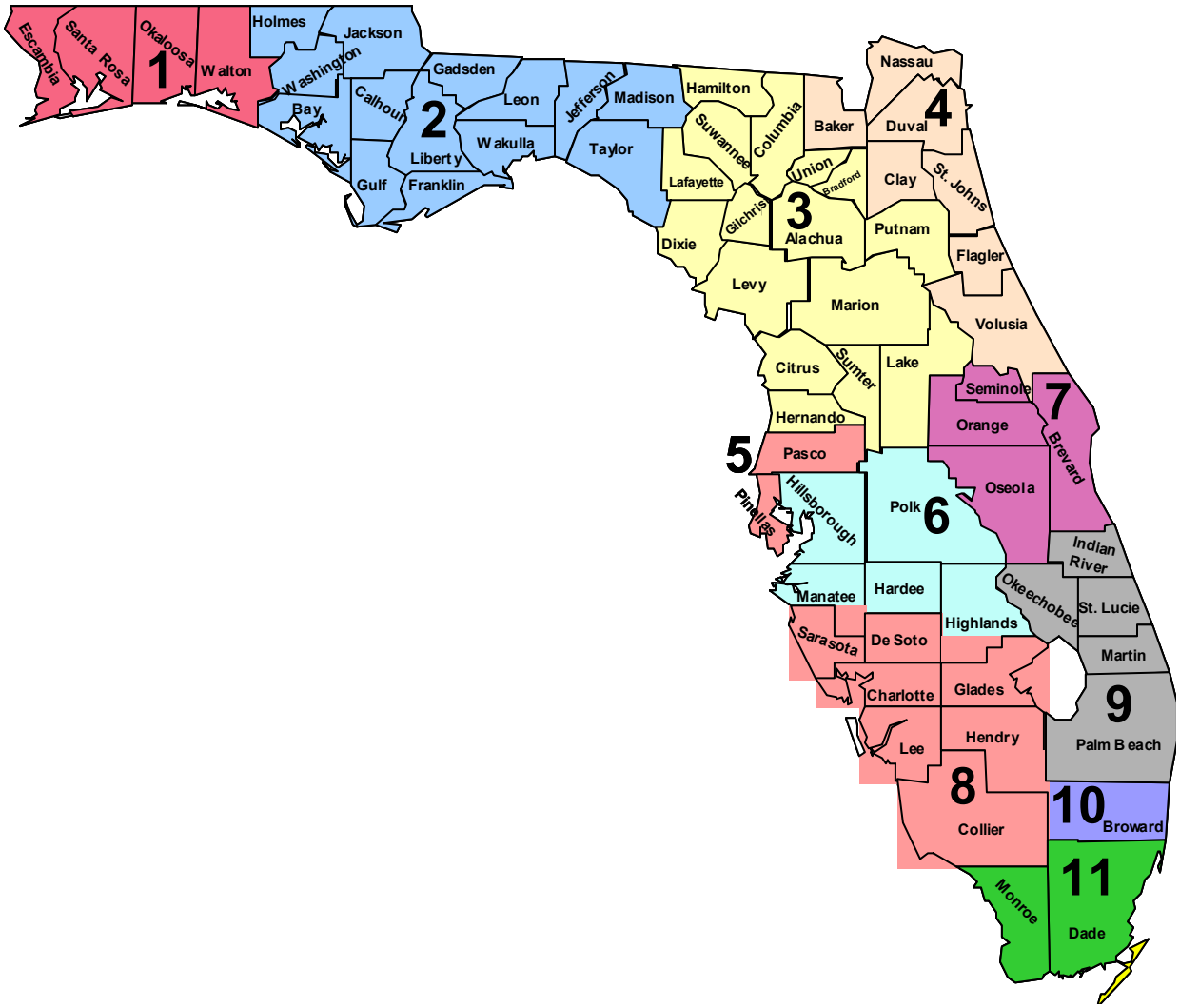
**Nursing Facility Access Standards**

AHCA will require MCOs to reimburse any licensed nursing facility that participates in Medicaid at no less than the current Medicaid rate. MCOs will be required to contract with all Gold Seal nursing homes and exclude, where feasible, chronically poor performing nursing homes. An individual who resides in a nursing facility at the time of enrollment in SHC will be allowed to remain in that facility until he chooses to leave, moves out of the pilot service area, or dies.

**Out-Of-Network Access and Referral Standards**

If the MCO network is unable to provide necessary covered services, the MCO must arrange for these services outside of the network. MCOs will coordinate with out-of-network providers with respect to payment. MCOs will be financially responsible for medically necessary and appropriate covered services delivered outside the MCO's service area.

# Appendix D: AHCA And DOEA Geographic Regions

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***Mission Statement***

*The Agency for Health Care Administration champions accessible, affordable, quality health care for all Floridians.*