BY U.S. MAIL & E-MAIL

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Dear Ms Brown-Woofter:

Thank you very much for the opportunity to comment on the proposed contract between the Agency for Health Care Administration (AHCA) and managed care plans (MCPs), regarding the recently-approved Section 1915(b)/(c) waiver program to provide Medicaid long-term services and supports (LTSS) through managed care. This letter is written on behalf of Florida Legal Services, the Academy of Florida Elder Law Attorneys and the Florida Bar Elder Law Section.

It is important to recognize the vulnerability of the persons included in this program —these are persons of very limited financial means who need nursing facility care or an equivalent level of services. Strong consumer protections must be established so that services truly are provided in an appropriate and individualized way. We have read the approved waiver applications, and believe that the consumer protections in those applications are important but not sufficient. It is vital for the state's Medicaid beneficiaries that the AHCA/MCP contract both implement the consumer protections from the approved applications, but also enunciate additional protections to fill in the gaps left by the applications.

1) Person-Centered Care Planning
(Exhibits to Attachment II, pp. 59-61 (within Exhibit 5))

The draft contract states on page 61 that "together" the enrollee and case manager develop goals for the enrollee. On the other hand, on pages 59 and 60, the draft contract says that the case manager develops the person-centered care plan after consulting with the enrollee or the enrollee's representative. Consultation is not enough to create a person-centered system: if the person is in the center, he or she is making decisions, and not merely being consulted.

A recently-approved New York Medicaid waiver for managed long-term services and supports describes a care plan as being "*developed by the participant* with the assistance of the MCP/PIHP, provider, and those individuals the participant chooses to include." *See* CMS, Special Terms and Conditions, New York Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration, p. 14 (emphasis added). This is the type of model that also should be implemented in Florida, as it properly places the enrollee in the center of the decision-making process.

We include recommended language in an attachment to this letter.

2) Definition of Person-Centered Planning
(Attachment II, p. 25)

The definition of person-centered planning also needs to be revised to reflect the fact that the enrollee should be at the center of the process. The current draft definition (see immediately below) is a very generic care planning definition, with little to identify the process as being particularly person-centered:

> Person Centered Planning (PCP) — A process to produce a plan of care that includes an enrollee's care needs and includes the enrollee's service needs, personal goals and community activities.

We recommend that this draft definition be replaced with a definition of "person-centered planning process" adapted from the CMS regulations for the Community First Choice Option (CFCO). Unlike the current draft definition, the CFCO definition properly puts the enrollee in the center of the decision-making process. We have included the CFCO definition in the attachment to this letter.

3) Appeals of Care Plans
(Exhibits to Attachment II, pp. 62-63 (within Exhibit 5))

The draft contract requires that the plan of care "document that the process for enrollee grievance and appeals was clearly explained" and, "[i]f the enrollee disagrees with the assessment and/or authorization of placement/services," provides for the enrollee to be notified about the right to appeal a plan of care or a placement. This process is inadequate — the right to receive a notice should not be dependent upon the enrollee first expressing his or her disagreement, because disagreement may seem futile to the enrollee unless he or she first is aware of available appeal rights.

Recommended language is included in the attachment to this letter.

4) Importance of Private Occupancy in Assisted Living
(Exhibits to Attachment II, p. 15 (within Exhibit 5))

The proposed contract language states that an assisted living unit "may include dual occupied units when both occupants consent to the arrangement." We support that requirement, but recommend additionally a more specific requirement that beneficiaries not share *bedrooms* unless they are spouses, partners, or other family members.

Currently, in many residential facilities certified to accept Medicaid reimbursement, unrelated beneficiaries share bedrooms because the state Medicaid program and its reimbursement rate offer no real alternative. A beneficiary "chooses" to share but it is not really a choice, given the lack of alternatives. This type of shared occupancy is not faithful to the principles of community-based services and, accordingly, we recommend that only spouses, partners, or other

family members be allowed to share a bedroom in Medicaid-funded assisted living. The draft contract places an admirable emphasis on home-like environments in assisted living, but all that emphasis could be undermined if beneficiaries are sharing bedrooms with unrelated persons.

This recommended language is included in the attachment to this letter.

5) Services Available in Assisted Living
(Exhibits to Attachment II, p. 15 (within Exhibit 5))

In the approved Section 1915(c) application, the definition of "assisted living" includes the statement that "[a]ssisted living services may also include medication administration, periodic nursing evaluations and respite." *See* Section 1915(c) application, p. 98. These specified services, however, are not included in the definition of assisted living in the draft Contract; instead, comparable language has been deleted, as follows: "~~Assisted living services may also include: physical therapy, occupational therapy, speech therapy, medication administration and periodic nursing evaluations.~~"

We request that the Contract be modified to be consistent with the Section 1915(c) application, in order to give beneficiaries access to services at the level promised in the application. A revised definition of "assisted living" is included in the attachment to this letter.

6) Home-Like Environment and Community Inclusion
(Exhibits to Attachment II, p. 47 (within Exhibit 5))

We appreciate the attention placed in the draft contract on a home-like environment in assisted living facilities and adult family care homes. The draft contract provisions, however, are not sufficient, and we recommend additional provisions to ensure a home-like environment.

For one, the contract should be revised to ensure that facility residents are protected from precipitous evictions. Existing Florida law is entirely deficient in this respect, as the existing statute for assisted living allows a resident's tenancy to be terminated *without cause* upon the mere service of a 45-day notice, requiring good cause for termination and a court order only when adequate notice is not provided. Fla. Stat. § 429.28(1) (k). The comparable provision for adult family care homes allows discharge if the facility first provides "30 days' written notice stating reasons for the move or transfer," with no mention of a good-cause requirement or appeal rights. Fla. Stat. § 58A-14.0061(7).

We also recommend that the contact be revised to require that enrollees can furnish and decorate their sleeping or living units, and that the setting is physically accessible. These protections are taken from CMS's proposed regulations on standards for community-based settings. *See* 77 Fed. Reg. 26,362, 26,400 (2012) (proposed 42 C.F.R. § 441.530(a) (1) (vi) (B) (3), (E)).

Also, we note that the draft contract currently contains a broad exception allowing protections to be eliminated or restricted by "medical, physical, or cognitive impairments." This type of broad exception seems entirely unwarranted, since many of these protections — a choice of a private room, for example — would be important regardless of an enrollee's impairment. We

understand that a lockable door might be inappropriate for a person with a cognitive impairment but, otherwise, recommend against a broad exception based on an enrollee's impairments.

Proposed revisions are included in the attachment to this letter.

7) Room and Board Charges in Assisted Living Facilities
(Exhibits to Attachment II, p. 82 (within Exhibit 7))

Under the draft contract, an assisted living facility must accept MCP payment as payment in full for services, but may charge separately for room and board as set forth in a resident contract. An additional protection is needed, however, to assure that room and board charges are consistent with Medicaid income allowances. If an assisted living facility is a participating provider under a Medicaid MCP, charges for room and board should not be allowed to exceed the amount remaining from the resident's income after deduction of a personal needs allowance. Otherwise, the payment-in-full restriction would be of little significance, since a facility simply could charge an inordinate amount for room and board, regardless of not being allowed to charge extra for assisted living services.

We have included our suggested language in the attachment to this letter.

8) Performance Measures
(Exhibits to Attachment II, p. 98-99 (within Exhibit 8)

The draft contract specifies only 12 performance measures, although AHCA explicitly reserves the right to add additional quality measures based on state and federal quality initiatives. The twelve measures have little specific relevance to home and community-based services (HCBS), with the limited exception of the CAHPS satisfaction measures relating to long-term care plans, care managers, and quality of services.

We understand that to a certain extent the development of performance measures for HCBS is still a work in progress. However, even with that in-progress status taken into account, the measures currently identified in the draft contract are inadequate. We note that the Measure Applications Partnership, in a recent report to the federal HHS, listed a number of promising measures for HCBS. *See* Measure Applications Partnership, Measuring Healthcare Quality for the Dual Eligible Beneficiary Population, Appendix H (June 2012). (available at: http://www.qualityforum.org/Publications/2012/06/Measuring_Healthcare_Quality_for_the_Dual_Eligible_Beneficiary_Population.aspx). We note, for example, potential measures relating to changes in an enrollee's daily activity function, the availability of support with activities of daily living, and community integration. The performance measure system would be improved by adding those measures or other measures focusing on HCBS.

9) Access to Reports
(Exhibit 12 to Attachment II)

The draft Contract requires MCPs to develop and submit numerous reports, but does not specify how that information is available to the public. Access to this information is crucial for proper

evaluation of the program and, therefore, the reports should be broadly available. We note that Fla. Stat. § 409.967(2) (e) (2) requires that an MCP publish its HEDIS performance measure data on the MCP's website "in a manner that allows recipients to reliably compare the performance of plans." We also note that the enrollee handbook must explain how enrollees can obtain information regarding the MCP's performance measures (Attachment II, p. 57); if such a handbook provision is to be meaningful, MCPs must be required to make information easily accessible to enrollees and the general public.

Our recommended language is set forth in the attachment to this letter.

10) Cultural Competency Plan
(Attachment II, pp. 98-99)

We strongly support the contractual requirement that each MCP develop a comprehensive written cultural competency plan, and that such a plan be submitted to AHCA for approval by each June 1 for implementation by September 1. We recommend, however, that this requirement be modified by requiring that such plans be made available for public comment before they are submitted to AHCA. The point of the plans is for the MCPs to provide services in a culturally competent manner and, since cultural competency varies from population to population, public comment would help MCPs and AHCA to better understand the pros and cons of certain methods of care provision.

Recommended revised language is in provided in the attachment to this letter.

11) Network Adequacy
(Exhibits to Attachment II, pp. 80, 84, 86-88 (within Exhibit 7))

In the draft contract, Table 1-A lists minimum network adequacy standards for long-term services and supports. For every provider type, an MCP will be required to have at least two providers per county. In addition, for adult day health care only, at least one provider will be required to be at least within a 30-minute drive in urban counties, and within a 60-minute drive for rural counties.

These minimum standards truly are minimal, and we recommend that they be revised to better account for the size of the county and the type of service. For example, under the current draft contract, an MCP in Region 11 (comprised of Miami-Dade and Monroe counties) would be required to contract with only two providers of adult companion services, and two assisted living facilities, even though it is estimated (according to AHCA's webinar of February 27, 2013, for potential network providers) that 17,257 persons will be eligible in Region 11. For enrollees in Region 11, as well as enrollees in other regions, the two-provider minimum will do little to ensure decent choice and access. We understand that more populated regions will have the greater number of MCPs, but the existence of additional MCPs will not improve access for an individual MCP enrollee who is choosing among potentially only two providers within a heavily populated urban region, or in a rural region where enrollees may be widely dispersed.

12) Physical Accessibility
(Attachment II, Section VII; Exhibit 7 to Attachment II (Provider Network))

The draft contract should be revised to include a clear requirement that service providers' facilities and offices be physically accessible.

13) Payment for Background Checks
(Exhibits to Attachment II, p. 23 (within Exhibit 5))

The draft Contract states that the "Managed Care Plan shall pay for Level 2 background screening for ... at least one direct service worker for each service per enrollee per Contract year." This language is unduly limiting, however, since an enrollee who needs assistance at home may well need more than one worker for a particular service, in order to provide necessary care at various times during a day, each day, 365 days per year. It is unrealistic to expect that one person alone would be able to provide a necessary service to an enrollee throughout a year. Therefore, we recommend a revision that would obligate an MCP to pay for background screening for "~~at least one~~ any direct service worker who wishes to provide ~~for each~~ service ~~per~~ to an enrollee ~~per Contract year~~."

14) Compliance with Existing Medicaid Standards
(Attachment II, pp. 42-43, 80)

We strongly support the requirement that bed holds be available in nursing facilities and hospices under managed care to the same extent that they are available in fee-for-service Medicaid.

We also commend AHCA for the draft contractual requirements that require MCPs to comply with current Medicaid handbooks, and provide services in an amount, duration and scope consistent with that provided under fee-for-service Medicaid. However, we are concerned that some of the existing Medicaid standards provide hard caps on services which cannot be exceeded even if medically necessary. (e.g., a limit of 12 hours of attendant care per day under the Aged and Disabled Waiver). We urge the Agency to adopt contract language authorizing the MCPs to provide services over and above existing Medicaid standards when the services are medically necessary.

15) Case Manager Ratios

We are concerned that the case manager caseload standards set out in the draft Contract are too high. (*See* Exhibits to Attachment II, p. 54, providing 1 case manager for 60 enrollees in the community, and 1 case manager for 100 nursing facility residents?) How did the Agency determine that these standards will sufficient to meet the needs of the beneficiaries?

Conclusion

Thank you again for this opportunity to comment on the draft contract. Please feel free to contact us at any time with any questions or suggestions pertaining to this letter, or with any

other inquiries relating to the development or implementation of Statewide Medicaid Managed Care program.

Sincerely,

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ATTACHMENT TO COMMENT LETTER

RECOMMENDED REVISIONS
(longer revisions, moved from text of letter for easier reference; see text of letter for shorter recommended revisions)

1) Person-Centered Care Planning
(Exhibits to Attachment II, pp. 59-61 (within Exhibit 5))

The enrollee (or legal guardian, guardian advocate or other enrollee-authorized representative, as appropriate), in consultation with the case manager, shall develop a single, comprehensive, person-centered plan of care specific to the enrollee's needs and goals that are identified using, at a minimum, the assessment form(s) provided to the Managed Care Plan by the Agency and the Managed Care Plan's assessment tool, if applicable. The ~~enrollee or legal guardian and the guardian advocate,~~ caregiver~~,~~ or primary care provider ~~or other enrollee-authorized representative~~ must be consulted in the development of the plan of care.

2) Definition of Person-Centered Planning
(Attachment II, p. 25)

Our recommended language is drawn from the Community First Choice Option, as explained in the body of this letter (*see* 42 C.F.R. § 441.540(a)):

> Person-centered planning is driven by the enrollee. The process --
>
> (1) Includes people chosen by the enrollee.
>
> (2) Provides necessary information and support to ensure that the enrollee directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
>
> (3) Is timely and occurs at times and locations of convenience to the enrollee.
>
> (4) Reflects cultural considerations of the enrollee.
>
> (5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
>
> (6) Offers choices to the enrollee regarding the services and supports he or she receives and from whom.
>
> (7) Includes a method for the enrollee to request updates to the plan.

3) Appeals of Care Plans
(Exhibits to Attachment II, pp. 62-63 (within Exhibit 5))

(p. 62) The plan of care must document that the process for enrollee grievance and appeals was clearly explained. It must be noted for each service whether the frequency/quantity of the service has changed since the previous plan of care. The enrollee or representative must indicate whether he or she ~~they~~ agrees or disagrees with each service authorization and sign the plan of care at initial development and when there are changes in services. The plan of care must notify the enrollee of the right to file a grievance or appeal on any disagreement regarding the plan of care. The case manager must provide a copy of the plan of care to the enrollee or representative and maintain a copy in the case file.

4) Importance of Private Occupancy in Assisted Living
(Exhibits to Attachment II, p. 15 (within Exhibit 5))

… Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. A bedroom may be shared only with a spouse, partner, or family member. The resident has a right to privacy. …

5) Services Available in Assisted Living
(Exhibits to Attachment II, p. 15(within Exhibit 5))

Assisted living — A service comprising personal care, homemaker, chore, attendant care, companion care, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility, licensed pursuant to Chapter 429 Part I, F.S., in conjunction with living in the facility. Assisted living services may also include medication administration, periodic nursing evaluations, and respite. Service providers must ensure …

6) Home-Like Environment and Community Inclusion
(Exhibits to Attachment II, p. 47 (within Exhibit 5))

Our proposed revisions could be implemented as follows:

> The Managed Care Plan shall ensure enrollees who reside in assisted living facilities and adult family care homes reside in a home-like environment, and are integrated into their community as much as possible.~~, unless medical, physical, or cognitive impairments restrict or limit exercise of these options which,~~ An enrollee's rights at a minimum~~,~~ includes~~:~~

Choice of: Private or semi-private rooms; roommate for semi-private rooms; locking door to living unit; access to telephone and length of use; eating schedule; and participation in facility and community activities.

Freedom to furnish and decorate living unit, which must be physically accessible.

Ability to have unlimited visitation; and snacks as desired.

Ability to prepare snacks as desired; and maintain personal sleeping schedule.

Freedom from involuntary termination of residence unless the residence has obtained a court order authorizing the involuntary termination of the enrollee's residence, based on nonpayment or a finding that the enrollee's continued residence would endanger the health or safety of other persons in the assisted living facility or adult family care home.

The choice of a locked door to a living unit may be modified to the extent necessary to protect the enrollee's safety or health, but only if any such modification is supported by a specific assessed need and documented in the person-centered service plan.

For consistency, similar revisions should be made to the language used in subcontracts between MCPs and assisted living facilities and adult family care homes, as set forth on page 82 of the draft Contract. We recommend the following language:

Enrollees residing in (insert ALC/AFCH identifier) must be offered services with the following options ~~unless medical, physical, or cognitive impairments restrict or limit exercise of these options~~.

Choice of:

- Private or semi-private rooms;
- Roommate for semi-private rooms;
- Locking door to living unit (unless a locked door would endanger the enrollee's safety or health, as documented in the service plan);
- Access to telephone and length of use;
- Eating schedule; and
- Participation in facility and community activities.

Ability to have:

- Unlimited visitation; and
- Snacks as desired.

Ability to:

- Prepare snacks as desired;

- Furnish and decorate living unit, which must be physically accessible; ~~and~~
- Maintain personal sleeping schedule; and
- Be free from involuntary termination of residence unless the residence has obtained a court order authorizing the involuntary termination of the enrollee's residence, based on nonpayment or a finding that the enrollee's continued residence would endanger the health or safety of other persons in the assisted living facility or adult family care home.

7) Room and Board Charges in Assisted Living Facilities
(Exhibits to Attachment II, p. 82 (within Exhibit 7))

(insert ALF identifier) hereby agrees to accept monthly payments from (insert plan identifier) for enrollee services as full and final payment for all long-term care services detailed in the enrollee's plan of care which are to be provided by (insert ALF identified). Enrollees remain responsible for the separate ALF room and board costs as detailed in their resident contract, provided that the room and board cost must not exceed the difference between the enrollee's monthly income, and his or her monthly Medicaid income allocation. As enrollees age in place and require more intense or additional long-term care services, (insert ALF identifier) may not request payment for new or additional services from an enrollee, their family members or personal representative. (Insert ALF identifier) may only negotiate payment terms for services pursuant to this agreement with (insert plan identifier).

8) See body of letter for recommendations.

9) Access to Reports
(Exhibit 12 to Attachment II)

Managed Care Plan reports required by the Agency are as follows as indicated by plan type. These reports must be submitted as indicated in the Summary of Reporting Requirements table (below) and as specified in the LTC Report Guide. All reports are shall be made available to the public, and shall be considered "public records" as defined by Fla. Stat. 119.011. The Agency shall post all reports on the Agency website in an accessible, prominent way.

10) Cultural Competency Plan
(Attachment II, pp. 98-99)

… The CCP shall be updated annually and submitted to the Agency by June 1st for approval for implementation by September 1st of each Contract year. The MCP shall make a draft CCP available on its website by March 1 of each year, accept comments from the public through April 15 and, as considered appropriate by the MCP, incorporate those comments into the CCP submitted to the Agency.