NSCLC
National Senior Citizens Law Center

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LTSS Through Managed Care: Looking at Florida's New Program

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Webinar Logistics

- All attendees are on mute.
  - For technical questions, use chat box.
  - For substantive questions, use questions box.
- E-mail trainings@nsclc.org if unable to access webinar.
- Link for slides will be sent to all attendees. Slides and recording will be at nsclc.org.

Acknowledgement

NSCLC thanks The Retirement Research Foundation for its support in advocating for the rights of LTSS consumers in Florida and nationwide.

Our Focus Today

- Immediate issues
  - Enrollment
  - Service planning
  - Transitions/continuity of care
  - Communicating with consumers

The Landscape

- 2011 state legislation
  - Florida Statutes, Chapter 409
- Two components
  - Long-Term Care (persons with need for nursing facility care or equivalent)
    - Began roll-out in August 2013
  - Managed Medical Assistance
    - Scheduled to begin Fall 2014

Who's Participating?

Nursing Facility Residents

Recipients of Services Under Waivers for Older Persons

Also Optional Enrollees

PACE enrollees

Recipients of services under waivers for younger populations

Good Cause Exemption from Enrollment

- Approved on case-by-case basis
  - e.g., Receiving services from nursing facility or hospice that is not part of network
    - (although continuity of care requirements should avoid this problem for time being)

Rebalancing?

- Incorporating 4 existing HCBS waivers:
  - Aged and Disabled Adult Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver, Frail Elder Option

- Enrollment as of Dec. 2012 – 35,852
- Same limit going forward; no more than 35,852 at any one time
  – No more than 36,795 annually

Includes Nursing Facility Care and Various HCBS

- e.g., Adult day care
- Assisted living
- Behavior management
- Home accessibility adaptations
- Nutritional assessment; risk reduction
- Personal emergency response system
- Respite care

Gradual Roll-Out Through Eleven Regions

- Effective Dates August 2013 through March 2014
  - August 2013 – Orlando region
  - September 2013 – Fort Myers, Palm Beach
  - November 2013 – Fort Lauderdale, Tallahassee
  - December 2013 – Miami
  - February 2014 – St. Petersburg, Tampa
  - March 2014 – Gainesville, Jacksonville, Pensacola

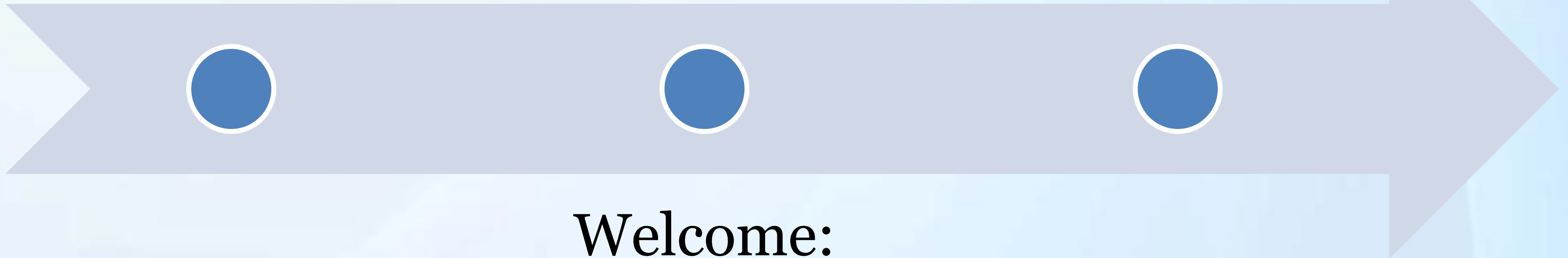
Seven MCOs

- Two to seven MCOs per region. Most common are:
  - American ElderCare (being purchased by Humana)
    - All eleven regions
  - Sunshine State Health Plan (Centene)
    - 10 regions
  - United Healthcare
    - 9 regions

Notices to Current Recipients

Pre-Welcome: Four Months Before Effective Date

Reminder: 1 ½ Months Before



Welcome: Two-plus Months Before

Enrollment Processes

Choice Counselors

- Over the phone
- In person

On-Line

- www.flmedicaidmanagedcare.com

Select a text size that is comfortable for you. A A A

Google™ Custom Search Search

Statewide Medicaid Managed Care

Click Here to download the "Authorized Representative Form"

Click Here to ENROLL ONLINE

Home

Choose Your Language

Welcome!
Click here to learn more about the program.

¡Bienvenidos!
Haga 'clic' aquí para obtener más información sobre el programa.

Bienvini!
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Deadline – Two Weeks b/4 Effective Date

- If no affirmative choice, state assigns based on:
  - Plan capacity
  - Whether consumer's HCBS providers are in plan
  - Geographical access to HCBS providers
    - Fla. Stat. 409.984
- Default plan listed in "Welcome" letter

Right to Change MCO

- Follows federal law (42 CFR 438.56(c))
  - During first 90 days
  - Annually
  - Good cause
    - Predictable reasons – can't provide covered services; enrollment in error
    - Some reasons involve more subjectivity
      - Poor quality of care
      - Lack of access to providers experienced with consumer's health care needs

Services b/4 Financial Eligibility Is Determined

- Nursing facility services:
  - Receive services under Medicaid fee-for-service; no enrollment in MCO until financial eligibility determined
- HCBS:
  - Receive MCO services prior to financial eligibility determination
- In either case, consumer liable if ultimately does not qualify financially

Level of Care Assessments

- Performed by state
  – Department of Elder Affairs
    - CARES Unit -- Comprehensive Assessment and Review of Long-Term Care Services

Assessment for Service Planning

- Performed by MCO case manager
  - Health status
  - Physical and cognitive functioning
  - Environment
  - Social supports
  - Personal goals

Service Plans -- Timing

- For HCBS, within 5 business days of enrollment
- For nursing facility care, within 7 days of enrollment

Consumer Involvement in Service Planning

- Consumer "directs" service planning
  - Assisted by case manager, and others that consumer wants to include

- *But* service planning development listed as one responsibility of case manager

Case Manager Contacts

- Monthly over the phone
- Face-to-face meeting every three months

Service Plan Specifics

- Measurable goals, with plans to reach those goals
- Encourage integration of formal and informal supports
  - Development of informal volunteer network

What If Consumer Objects to Service Plan?

- Service planning form must inform about right to fair hearing if:
  – Denial or reduction of services
  – No choice of qualified provider

- Case manager assists with filing of appeal

Additional Review of Service Reductions

- Audit by Department of Elder Affairs.

Any Other Service Planning Oversight?

- MCO must:
  - Develop internal safeguards for service planning development
  - Audit representative sample of service plans
- State must:
  - Review random samples of service plans
  - Use service planning performance measures
    - e.g., % of service plans meeting assessed needs.

Transition & Continuity of Care Consumer Protections Goals

- Preserve patient-provider relationships;
- Maintain necessary treatments & services;
- Prevent ER visits, hospitalizations and/or nursing home placements triggered by disruptions in care.

Times When Individuals Are at High Risk for Service Disruptions

- Initial enrollment into an LTC plan
- Implementation of a new care plan
- Changing LTC plans
- Moving from hospital/nursing home to a community setting
- Provider leaves the plan's network
- Temporary loss of Medicaid eligibility

Florida Consumer Protections on Paper

- Florida statutes, waiver applications and plan contracts include important consumer legal protections;
  - http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA (**Waiver applications**)
  - http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#ltcplans (**Model Contract**)

Initial Enrollment – Will Consumers Be Able to Keep Their Current Providers?

- Persons in nursing homes and hospices will be able to keep their current providers, at least for 12 months. § 409.982(2), Fla. Stat.
  - After the 12 month period providers can be excluded from a plan for failing to meet quality or performance standards.
- From Oct. 1, 2013-Sept. 30, 2014 each plan must ***offer*** network contracts to all aging network service providers in their region. § 409.982(2), Fla. Stat.

Choice Counseling & Auto Assignment

- Consumers who access choice counseling can find out which providers are included in each plan's network;
  - Consumers can then select a plan that includes their current providers
- Consumers not making a choice will be assigned to a plan by AHCA. In making assignments, AHCA must consider:
  - what plan(s) include home and community based service providers that have previously served this consumer. § 409.984, Fla. Stat.

Continuation of Services for New Plan Enrollees

- Plans must continue a new enrollee's services for up to **60 days** or until the plan completes assessments, develops a new care plan and makes provision for services with providers.

- ***"Plans are required to provide medically necessary services by any means."***
  - If a plan does not have a suitable provider for a medically necessary service in its network, it must arrange for a recipient to receive care by an out-of-network provider.

Consumer Disagrees with the New Care Plan

- Consumers have the right, through a ***Fair Hearing***, to challenge a new care plan, including any denials or reductions in services.

- Plans must continue an enrollee's services at the current level until the end of the Fair Hearing process.

Transitioning Between LTC Plans

- The LTC plan is responsible for coordination of care for enrollees transitioning to another plan;
  - Records and information must be shared with the new plan within thirty (30) days.
- The new plan is required to cover the costs of any ongoing prior authorized treatment until an assessment and new care plan is developed, for up to 60 days.

Continuity of Care Across Different Health Care Settings

- All plans must have policies and procedures that address all "transitional care management requirements" including:
  - Referral and scheduling assistance for consumers to access specialty health care & transportation;
  - Identification of consumers with hospitalizations, including ER visits and documentation of appropriate follow-up to reduce avoidable hospitalizations;
  - Coordinating hospital/institutional discharge planning and post-discharge care.

Provider Leaves a Plan

- If a consumer's provider leaves the plan, the consumer may select another provider, or request a plan change.
- A consumer wishing to switch plans in order to retain their service provider is grounds for good cause disenrollment.
  - An enrollee may change plans within 90 days of enrollment for any reason, and ***for cause*** thereafter.
  - The state considers these requests on a case-by-case basis.

Provider Contract Is Terminated

- Plans must "provide for continuity of treatment" if a provider's contract ends in the middle of treatment by that provider.
- The consumer must continue to receive services from that provider until they choose another provider, up to 60 days after the provider's contract ends.
  - Exceptions: provider terminated for cause; or provider refuses to continue care for a consumer who is "abusive or noncompliant."

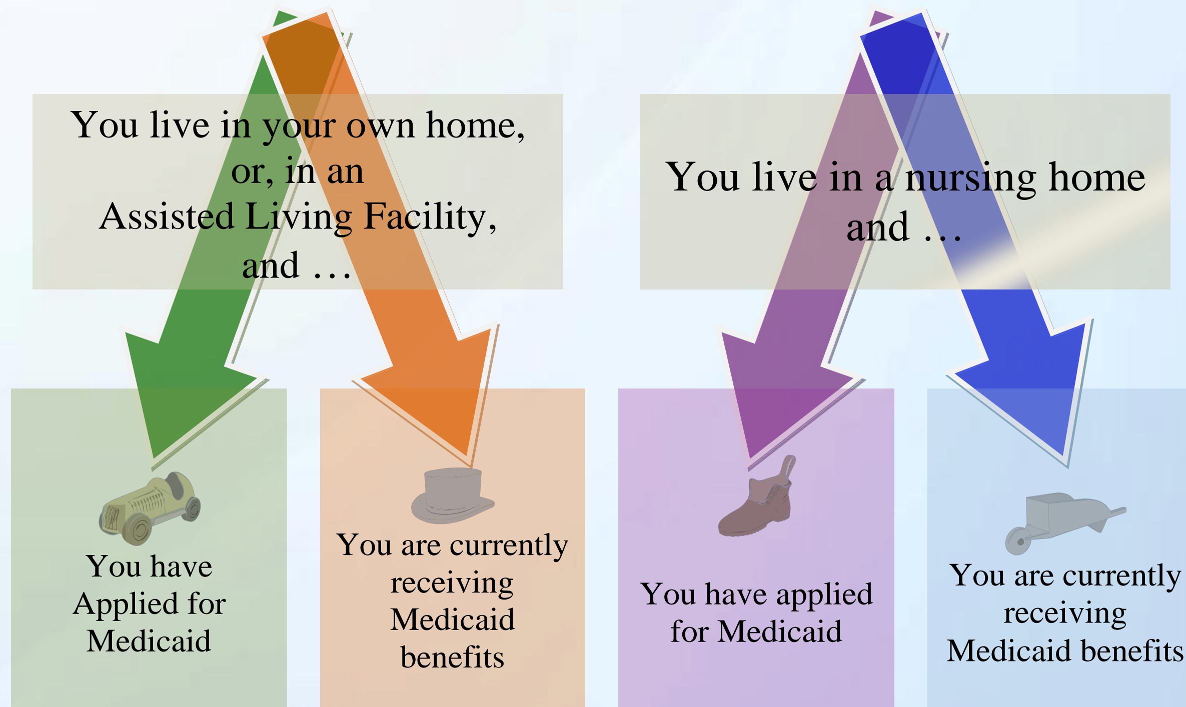
Temporary Loss of Medicaid Eligibility

- The plan must provide services to consumers who lose eligibility for up to sixty (60) calendar days.
  - This includes case management services.
- The plans must develop a process for tracking eligibility redeterminations and documenting the assistance provided by the plan to ensure continuous Medicaid eligibility.

"Street Level" Advocacy Issues

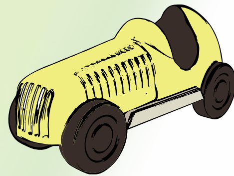
- At the street level (from the POV of an elder law attorney)
  - Program is very complex
  - Frail, sick, poor elder population; unsophisticated decision-maker
  - ELAs around the State are sharing experiences
- Unique positioning of elder law attorney as client advocate
  - Attorney-client relationships already in existence
  - Serving as Designated Representative for many; receiving notices
  - Explaining enrollment process, Plan choices, HCB options
    - Conflict free advocacy
    - Consequences within choice selection
    - Alerting to "glitches" which may occur
    - Timelines, deadlines, and rights
    - Ready to file grievances and Fair Hearings
- Information is available, yet difficult to comprehend or access w/out help
  - Example: "Decision Tree" for consumer enrollment choices (created by Foundation for LTC Solutions LLC)

Do You Know What Choices the State Requires from You?



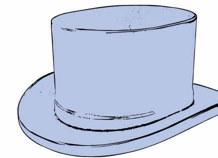
If you do not fit into one of these 4 categories, you should consult with a qualified elder law attorney.

If You Are Living in your Home or an Assisted Living Facility



If you are living in your own home or an assisted living facility AND you have applied for Medicaid …

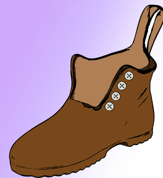
- Must get CARES LOC determining medical eligibility
- Must file application with DCF for financial approval
- Wait to enroll until financial approval; or enroll with a Plan through the State and become "Medicaid Pending" to begin services BEFORE financial approval
- While "Medicaid Pending", you cannot change Plans
- Upon financial approval, the process is the same as the HAT



If you are living in your own home or an assisted living facility AND you are currently receiving Medicaid …

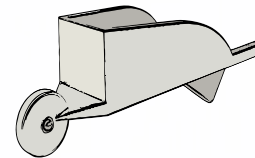
- Contact the State's Enrollment Broker to choose your Plan within 30 days or be automatically enrolled in a Plan the State chooses for you
- Change your Plan within 90 days, or stay with the Plan until 60 days prior to anniversary date; or have "good cause"
- Receive a new plan of care within 5 days
- If your ALF Provider doesn't have a contract with the Plan, you may have to move
- If you live in the home, Participant Direction Option must be discussed with you

If You Are Living in a Nursing Home



If you are living in a nursing home AND you have applied for Medicaid …

- Must get CARES LOC determining medical eligibility
- Must file application with DCF for financial approval
- You do NOT have to enroll in a Plan until financial approval.
- Upon financial approval, the process is the same as the WHEELBARROW
- If you select a Plan before financial approval, then you are "pending choice"
- No services will begin during "pending choice"



If you are living in a nursing home AND you are currently receiving Medicaid …

- Contact the State's Enrollment Broker to choose your Plan within 30 days or be automatically enrolled in a Plan the State chooses for you
- If your nursing home doesn't have a contract with the Plan you selected, you may be placed into a new Plan
- Change your Plan within 90 days, or stay with the Plan until 60 days prior to anniversary date; or have "good cause"
- Receive a new plan of care within 7 days
- You should NOT have to move to a new NH

A Few “Glitches”

Decision-making -
- AHCA Form allows only competent enrollees to designate
- http://www.flmedicaidreform.com/SharedFiles/english/Designation%20of%20Authorized%20Representative%20For%20Selection%20of%20Managed%20Care%20Plan_EN.pdf
- All others must fax authority to (850) # and wait . . . ?

Premature Enrollment in wrong Region
- Faulty data exists on enrollees, who have never lived in any other Region
- Notified; not corrected
- Disrupts NH payment

Developing care plan without friend or representative present
- Presuming competency and ability to participate
- Fear of fines emphasized over enrollee participation

Acquisition of Enrollee Information
- Enrollee (medical) information being requested from Provider’s records
- Enrollee (financial) information being requested from friend or representative
- Attorney-client relationship not respected

Patient Choice & Plan “Switch-a-Roo”
- Plan selected, yet enrolled in different Plan
- Requires attention to detail; Plan RE-selection w/in 90

A Few "Glitches" (cont'd) . . .

Informational brochures affecting preference of enrollees

- Info presented so that one Plan appears to offer significantly more services
- Occam's razor – more enrollees in this Plan

Premature Enrollment before financial approval

- Routinely auto enrolled into Plan while pending ICP
- Brochures are confusing to this group; includes reference to all services
- May interfere with FFS NH payment
- Suggestion: Create distinct process

Choice Counseling Script "biased" against MedP

- After choosing to enroll, potential for denial and financial liability is not appropriately balanced against the benefits of beginning services and reduction in private pay (ALF) for HCBS applications

Participant Direction Option (PDO) not offered

- Lack of confirmation for any Plans in Regions 7,8,9 offering PDO to in-home enrollees

Achieved Savings Rebate v. Medical Loss Ratio

- Measurement upon quantity/quality of services?
- Need understanding as to ASR calculation, the audit, and access to the audit results

Rebalancing

- A future concern to be monitored closely for appropriateness and adequate supports
- Tied to compensation; timing of compensation

Need for Targeted Outreach

- Isolated and vulnerable population
- May not be part of your program's traditional client population
- Systemic & structural changes to a vital program
- Provides opportunity to learn more about what is happening locally

Outreach Strategies

- Client Based
  - Family Support Groups
  - Churches

- Healthcare Providers
  - Nursing Homes
  - ALF's
  - Home Health Agencies

- Social Service Agencies & Govt.
  - Long-Term Care Ombudsmen Program - http://ombudsman.myflorida.com/DistrictsList.php
  - Area Agency on Aging - http://elderaffairs.state.fl.us/doea/arc.php
  - Elected Officials (constituent services)

Resources for Consumers & Advocates

- For Consumers:
  - Consumer Tips for Enrolling in Long-Term Managed Care
  - What Long-Term Care Services Must a Managed Care Plan Offer?
- For Advocates:
  - Choosing a Managed Care Plan for Medicaid Long-Term Care
  - Appeals and Fair Hearings in Florida's Managed Long-Term Care

These resources were created through a collaboration of the Academy of Florida Elder Law Attorneys, Florida Legal Services, Inc. and the National Senior Citizens Law Center and are available at *http://floridalawhelp.org/issues/health/long-term-care*.

Additionally, for information on legal assistance for low-income individuals please visit *www.floridalawhelp.org*.

Contact Information

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