

FCCF OBSERVATIONS/QUESTIONS ON MANAGED CARE

1. It is hard to argue that something needs to be done, especially in light of the rampant fraud abuse.
 - *Fraud has been a persistent problem, despite numerous efforts to stop it. Most fraud occurs in the fee-for-service system where claims are paid and later determined to be fraudulent. In these circumstances, the state must “chase” the fraud and try to recoup it. In contrast when the state contracts with managed care organizations, these organizations have a financial interest in preventing fraud. That does not mean that fraud cannot occur in a managed care environment, but historically such fraud has been less frequent. It is easier to prevent fraud in managed care with adequate agency oversight and enforcement of contract obligations.*
2. In slide #12 of the FARF presentation you mention that ALL medicaid recipients are enrolled. This begs the question of the current medicaid waiver wait list. It appears that there will be no wait list in Florida. Is the legislature in a position to "swallow" this \$1 billion pill?
 - *During the 2010 session, HB 7223 proposed 3 types of managed care plans:*
 - *Medical assistance plans which provide only primary and acute care medical services;*
 - *Long-term care plans that only provide home and community based services;*
 - *Comprehensive plans that provide both medical assistance and home and community based services.*
 - *Under this proposed legislation, all Medicaid recipients (not specifically excluded or made optional) would be enrolled into a medical assistance plan to receive their primary and acute care services.*
 - *Enrollment into a plan providing home and community based services (either a long-term care or comprehensive plan) is limited to individuals eligible for and currently enrolled in one of the tier waivers or a resident of a private ICFDD facility (see section 28 of HB 7223).*
 - *Persons with developmental disabilities on the Medicaid waiver wait list could be included when they receive an offer for enrollment. Offered placements would be possible when vacancies occurred or additional funds were appropriated.*
3. In slide #13 you mention that there will be no carve-outs. why is this?
 - *Carve-outs are exceptions to the rules. Numerous special deals are currently authorized in statute and they tend to favor particular plans/vendors who have lobbied the legislature to secure some singular arrangement.*
 - *The House proposed to eliminate these favors to special interests.*
 - *At the same time, the proposed legislation recognized the need for the Medicaid program to serve unique needs of specific people. Therefore, it is possible under the House proposal to establish specialty plans that only enroll people with certain conditions or diseases.*
4. In slide #23 you mention

- Medicaid for medical coverage (State Plan services) and home and community based care (waiver services)
- Medicaid coverage as supplement to Medicare; may include nursing home or other long term care services (dually eligible)
- Medicaid only for medical coverage
- Medicaid only for home and community based services
- No Medicaid for medical services and on waitlist

Are these legislative choices? are they options that we can pick? I am sorry that I missed the presentation and have to ask but these are important points, I think.

- *The list on the slide was intended to describe the various ways in which people with developmental disabilities are involved with the Medicaid program.*
5. The slides appear to be a good summary but it is very hard for a family to figure out what the impact on their lives will be. Perhaps a description of some typical family situations and how their lives would change (or stay the same) would be helpful.

Scenario #1

An 11 year old child with autism is currently enrolled in the Tier 3 home and community based services Medicaid waiver where she receives behavior analysis services, respite, companion services and support coordination. She also receives primary and acute care services through the Medicaid state plan program.

She could be enrolled into a comprehensive managed care plan that would arrange and pay for both medical and home and community based services. The managed care plan would likely contract with many existing developmental disabilities Medicaid providers to provide the home and community based services so the child and her family may see little difference as a result of the enrollment in managed care.

The plan would also offer a choice of health care professionals and facilities to choose from for primary and acute care medical needs. Access to a coordinated array of medical services may be easier following managed care enrollment. All of the medical and home and community services currently offered under state plan and the waiver would be available through the managed care plan.

The plan might also offer additional services to the child. The plans are incentivized to offer these additional benefits due to the competitive procurement.

A care coordinator working for the plan would help arrange and schedule the services needed and provide coordination between medical assistance and home and community based services.

Scenario #2

A 36 year old man with a developmental disability is currently enrolled in the Tier 1 home and community based Medicaid waiver. The man currently lives in an intensive behavior group home where he receives intensive behavior residential habilitation, behavior analysis

services, adult day training, and transportation services. He also receives primary and acute care services through the Medicaid state plan program.

Under this scenario, a comprehensive managed care plan is not available in his service area, therefore, the man would be enrolled into two managed care plans to meet his medical and long-term care service needs. Perhaps his long-term care plan might be owned and operated by a provider services network, made up of developmental disability residential providers. This plan would contract with a variety of service providers to provide all of the individual's long-term care needs.

The second plan would be a medical assistance plan which offers health care professionals and facilities for primary and acute care medical needs. The man could stay in his current group home because the managed long-term care plan must offer a contract to all current residential service providers at the beginning of the plan.

Both of the managed care plans would offer all of the services currently available through the State plan and the waiver and may offer additional services to encourage healthy behavior and add value to the plan benefit schedule. The plans are incentivized to offer these additional benefits due to the competitive procurement.

Care coordinators working for each plan would help arrange and schedule the services needed and provide coordination between medical assistance and long-term care services delivered.

ADDITIONAL QUESTIONS 1

6. Have individuals with developmental disabilities or their families (not agencies or providers or medical professionals) been involved in the proposed House legislation put forth last year? Will they be invited to the table? Especially members of the Family Care Council since it was created by the legislature to represent families of those with developmental disabilities.

- *The legislation developed last session resulted from extensive study of the Medicaid program by the Select Council on Strategic and Economic Planning that include almost 80 hours of hearings. All people were invited to participate. Several people (providers and families) testified regarding services for persons with developmental disabilities.*
- *Committee meetings, workshops, and hearings on Medicaid are likely to be extensive leading up to and during the 2011 session. The input of the Family Care Council would be welcomed and greatly appreciated.*

7. How does the iBudget legislation of last session and the managed care model being considered not cancel the need for the other out. Could iBudget be considered not as a carve out that will not be considered, but a managed care system designed for those with DD?

- *The iBudget algorithm has the potential to be a useful tool for setting capitation rates based on individual needs. The QSI can continue to be the method for*

gathering information for the purpose of determining individual needs. Once set, these rates would be the capitation payments made to the managed care plans.

- *The iBudget is neither a carve-out nor a managed care system. It is a system for analyzing need and allocating resources based on relative need within a population.*
 - *It is possible for the aspects of the iBudget—such as the QSI and the algorithm—to work in conjunction with a managed care system.*
 - *One difference between the iBudget and a managed care system relates to the overall financing arrangement. With the iBudget, the algorithm produces a strict cap for each individual. APD reserves a small amount to respond to unexpected changes in circumstances. When individuals do not spend their entire allocation, the unspent funds are reverted to the State's general fund. In contrast, contracted managed care organizations must bear risk for delivering services and meeting the needs of their enrollees. The capitation rate does not constitute a firm cap on spending. Specific needs of each patient must be met regardless of the capitation rate received by the managed care organization. The MCO will have flexibility to use available resources for additional needs. These available funds will not automatically revert to the general fund and the requirements for the MCO to achieve a 92% medical loss ratio will ensure that available funds are reinvested in patient services.*
 - *The legislative process will include many opportunities for input and people who want to recommend iBudget as an alternative to managed care will have the chance to have those ideas considered.*
8. Individuals with DD need assistance related to the unique (non medical) needs that have been identified in order to keep them from being institutionalized i.e., (HCBS Waiver). Who would assist the individual with this vulnerability to navigate this system or to manage their services, namely would there be case management with reasonable caseloads?
- *Case management is a critical component of any managed care system which must to be tailored to meet the unique needs of persons with developmental disabilities.*
 - *Preventing unnecessary institutionalization and providing needed services in the least restrictive setting possible will continue to be primary goals and managed care plans will need to provide evidence that they are capable of meeting these goals in order to be selected in the procurement process.*
 - *Case management/care coordination can be provided in a variety of ways. Last year's legislation required plans to provide this service. They may employ coordinators or contract with qualified coordinators.*
9. How does the House Bill address who administers the HCBS waiver based on experience with those services? Would the current plan consider retaining APD as the administrator?
- *Federal law requires each state to designate a single state agency to administer the Medicaid program. In Florida, that agency is AHCA although various functions and responsibilities are delegated to Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. These agencies are given various responsibilities because of their expertise in certain areas.*

- *The delegation of certain duties does not diminish the authority of AHCA as the single state Medicaid agency. However, in practice, AHCA gives its partners considerable discretion to carry out their respective functions.*
- *This similar arrangement is proposed in the House legislation. AHCA is the single state Medicaid agency. Specific functions and responsibilities are delegated to various other state agencies. To the extent that some management/contracting responsibilities are more limited, it is expected that APD will be able to enhance their work to assure quality care and to advocate for persons with disabilities.*

ADDITIONAL QUESTIONS 2

10. Where do mental health issues fit into the managed care system? It seems to be left out completely. Half of people receiving services in PBC need these services too.

- *Mental health services are provided as part of the medical assistance benefits available to all Medicaid beneficiaries.*

11. What does LTC (plan procedure) mean?

- *LTC refers to long term care. The House legislation defined three types of managed care programs. 1) "Medical assistance" refers to primary and acute care services. 2) "Long term care" refers to home and community based services for elderly and disabled persons. 3) Long term care for persons with developmental disabilities refer to the specialized home and community based services needed by people with specific developmental conditions.*

12. What does IFC mean?

- *I am unable to find any reference or use of the term "IFC". ICF/DD is identified on slide 17 of the FARF presentation and refers to intermediate care facilities for persons with developmental disabilities.*

ADDITIONAL QUESTIONS 3 – From a family on the med waiver.

Our son, Cameron, age 31, began receiving Medwaiver services through CDC+ this month. He started receiving Medwaiver services in 2004 after applying in 1999. First he was assigned to the limited funding waiver, moved up to the large waiver in late 2005 with a budget of over \$30,000 and 3 years ago he was reassigned to Tier 4 with a budget of less than \$15,000 that carried over to the CDC+ program, minus participation costs. After reading the staff analysis of the Medicaid Managed Care HB7223 by Ms. Gormley my concerns are:

13. On pages 6 and 7 the document states "After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next 9 months. Cameron is enrolled in Medicare Part D for prescription drugs. Medicare allows people with disabilities to change drug plans any time during the year. CDC+ also allows the same flexibility to change any of your employees at will. Keeping people in plans that are not meeting needs for any reason unless approved by the agency for good cause doesn't allow client choice. Why not allow this choice.

- *Continuous open enrollment/disenrollment increases the difficulty of system management and care coordination. The intent of the legislation is to offer participants/families a significant, but defined window for choosing the right plan. Even after 90 days, plan changes can be made for good cause.*
14. On page 10, does reference to “uninsured” in low Income Pool information and the bulleted points include illegal aliens? This would not be my choice for expenditure of tax dollars.
- *The low income funds are not paid as claims for specific individuals. Some of the facilities that receive LIP funding do provide services to all people regardless of their immigration status. In fact, hospitals are required to provide emergency care and treatment to anyone that seeks such care. Most providers that receive LIP funding provide sufficient amounts of uncompensated care to justify the receipt of this amount of funding based on care provided to legal residents.*
15. On page 11 – Reform Objective 1 “To ensure there is an increase in the number of plans from which an individual may choose and an increase in the different type of plans”. We chose CDC+ because there are the least plan and provider restrictions regarding choice. Right now at any time Cameron’s needs aren’t met he can change doctors, providers, and even what they refer to as “case managers”, that we know as support coordinators or consultants. A greater number of more restrictive plans is not an improvement in quality or choice for our son.
- *The intent is to maintain CDC+ as a choice for families of persons with developmental disabilities. . The House proposal in HB 7223 encourages plans to offer a CDC program based on the consumer directed care act already in statute (s.409.221, F.S.)*
16. On page 13 – Objective 5, 3rd paragraph, it says 85% can easily get physician appointments and 50% can easily get specialist appointments. We have no problem accessing physicians or specialists, except for Medicaid dentists, when Cameron still had that service. Cameron has earned enough employment credits to qualify for SSDI, and consequently Medicare and can access a wide choice of medical personnel. However I attended a meeting where dually-enrolled clients were referred to in a derogatory fashion as “double-dippers” and I find the term inaccurate and offensive. Use of this term, then logically should also apply to families who couple private insurance with Medicaid. Either of these dually-eligible scenarios saves the Florida and U.S. Medicaid system money, by coordinating, not duplicating benefits.
- *Agree. Dually eligible persons are not “double dippers”; they receive different benefits under each program. This coordination of benefits is not disrupted by the House proposal for managed care.*
17. On page 14 referring to Arizona and Georgia comparisons are a concern. They refer to care for the developmentally disabled without defining the population. In 2005 we investigated moving to Alabama. In that state only intellectually disabled people were considered developmentally disabled. You could have secondary/tertiary diagnoses, but you needed a primary diagnosis of intellectual disability to access their waiver. The director of Decatur, Alabama’s ARC was not

even sure if Cameron would qualify for Medicaid medical services with a diagnosis of autism.

- *Last year, the House contracted with a consultant who provided information on several other states. The purpose is not to duplicate any particular state, but simply to learn about other ways of providing services.*

18. Before modelling other states I'd like assurance that Florida's definition of developmental disabilities that includes intellectual disabilities, autism, Prader-Willi, Spina Bifida and Cerebral Palsy were also populations served through Medicaid Reform in those states. Programs or reforms look promising until you connect with families in other states who let you know the true status of implementation. This may be reflected in the acknowledgement in the Arizona comparison that "75% of applicants are denied".

- *The study of other state Medicaid programs did not include an examination of other definitions of developmental disabilities. The House proposed legislation did not change the Florida definition of developmental disabilities.*

19. On page 21 under Plan Accountability/Contract Requirements "AHCA shall establish a 5-year non-renewable contract with each plan". Non-renewable contracts disrupt continuity for clients happy with their providers, doctors or case workers multiple times throughout their lifespan. Non-renewable contracts offer no incentive for plans to maintain high quality standards so they're competitive in the next round of contract bids after their 5-year contract expires.

- *By "non-renewable", the legislation means no automatic renewals; every plan would have to compete for to win a contract with the state every 5 years. A plan previously selected can be selected again, but only if by being the best plan with the most satisfied participants. This arrangement enhances incentives to achieve high quality.*

20. Also page 21 – Plan Accountability Language should be included to prevent national companies from spinning off independent Florida subsidiaries that can declare bankruptcy to avoid penalties and fulfilling contracts without substantially affecting the parent company. All national companies, whether home insurance or Medicaid plans should be held accountable for how they do business in Florida.

- *You make a good point. We will look at ways to address that issue in the legislation.*

21. On page 28 – Eligibility – CDC+ recipients are grouped with the geriatric categories of:

- Assisted Living for the Frail Elderly Waiver
- Aged and Disabled Adult Waiver
- Adult Day Health Care Waiver
- 4 CDC+ Waiver
- Program of All-inclusive Care for the Elderly (PACE)
- Long-Term Care Community-Based Diversion Pilot
- The Channeling Services Waiver for Frail Elderly

Services offered for this geriatric group are not those CDC+ or the Developmental Disabilities waiver clients currently receive or that are proposed for DD waiver clients upon implementation of Medicaid Reform. They are tailored for the elderly.

- *There is a CDC waiver for elders as well as persons with developmental disabilities. This section referred to the CDC program for elders.*
22. On page 29 – these elderly focused plans will require controlling interest held by nursing homes, Assisted Living Facilities, home health agencies, elderly care agencies or hospices. The Long-Term Care plans for persons with developmental disabilities that CDC+ has been severed from in this Bill would require controlling interest by an individual (on page 32) that has 10 years of experience with people having developmental disabilities. Also, the geriatric group will be fully implemented by October, 2012. The Developmental Disabilities group, where CDC+ would logically be included will be implemented in October 2015. Placing CDC+ with the geriatric-focused group must have been a misunderstanding of the needs of CDC+ participants. Proposed services listed on page 28 for the geriatric group do not resemble the services currently received by CDC+ participants listed on pages 31-32, especially as CDC+ also includes children. Services for CDC+ clients should continue to mirror those of other individuals with developmental disabilities. “Grandfathering” clients to allow waiving age or level of care requirements does not make the lack of appropriate services for CDC+ clients acceptable. Regarding the difference in timing of implementation of these two groups, the CDC+ families should not be required to be the pilot for managed care for the rest of Medwaiver families with an inappropriate list of service choices. They should not be phased in years before the rest of the waiver recipients, however both CDC+ and waiver clients should be “grandfathered” in to automatically qualify for services in the Long-Term Managed Care group for Developmental Disabilities. The difference in background experience required by these two long-term plans should point to the category CDC+ participants would best be served.
- *There is a CDC waiver for elders as well as persons with developmental disabilities. This section referred to the CDC program for elders.*
23. On page 33 – Plan Payment – Once CDC+ gets either carved out of Medicaid Reform, as in my opinion it should be, or joined with the Developmental Disability Long-Term group where it will at least be offered services tailored to the developmentally disabled, how will CDC+ savings accounts co-exist with AHCA paying 5 different levels of care identified through the QSI?
- *CDC plus is not currently a mandatory offering for DD or elder recipients in the House proposal(HB 7223). However, plans were encouraged to offer this service; in the proposed competitive procurement, offering CDC programs is a priority in plan quality selection criteria. A CDC program offered by a managed care plan would not necessarily be identical to the current CDC+ program. In the HB 7223 proposal, plans would need to offer the program in accordance with the consumer directed care act already in statute (s.409.221) which does not specifically mention savings accounts. However, while not required, nothing precludes a plan from offering the savings account option as part of a CDC program within the plan. The ability for a consumer to retain and use savings as they do now in CDC+ would depend on how the plan structures this option.*

The 5 level of care payments were proposed in HB 7223 as a needs-based adjustment to the capitation rates paid to the managed care plans. If a plan offers the CDC type budget to the consumer, a separate budget amount would be calculated and this may be unrelated to the capitation rates adjusted by level of service needs.

24. And speaking about Medicaid, why is yearly recertification needed for people with developmental disabilities? It's a burden to families and a waste of time and money for the state. These recertifications imply that individuals with developmental disabilities will become "restored" at some point (and perhaps make way for the next person on the wait list?). Families, people with disabilities, and yes, even professionals know that lifelong needs may be somewhat ameliorated, but not cured. Lets rethink why people with developmental disabilities should be subjected to this unnecessary exercise

- *Good points. Federal law requires yearly recertification of eligibility for circumstances that may change. You are correct that the developmental disability diagnosis for a person is not likely to change. However, some of the eligibility criteria for DD long term care services require the participant to have deficits in 3 major life activities. These deficits in life activities could change from year to year. Also, financial eligibility for Medicaid could change if someone acquired assets.*