

Questions and Answers from Carol Gormley
FCCF meeting on November 22, 2010

Ms. Gormley made some general comments. She stated that the legislature passed the resolution to indicate its intent to seriously look at the Medicaid program. The legislature is looking at controlling cost but also looking at quality of services. Medicaid is performing at less than an optimal fashion. In the system now people can't get access to the services they need. The House leadership goal is to manage the cost and improve the value. It is a 20 billion dollar program.

The waiver program for persons with developmental disabilities has had both cost issues and access issues. There continues to be individuals on a wait list that the legislature has not been able to serve.

Q: What are the 6 regions that are being proposed?

A: The 2010 House legislative proposal and the map in the presentation made at the FARF conference on managed care defines the six regions. However there is room for debate about whether those same regions need to be exactly the same for the waiver program. That issue can be revisited and even the number of regions could be debated. The desire was to have a small number of very large plans that would be capable of getting systemic efficiencies out of the size of the regions. Then within those large geographic areas there would be specific access standards as well as specific standards of provider availability.

Q: In the original proposal last year it started out with 15% for overhead and then it got knocked down to 8%. However APD overhead is at 4% so why spend extra on something that is working pretty well?

A: 15% is kind of the rule of thumb for a medical loss ratio. It is not known if 8% for a medical loss ratio is the correct number. APD at 4% may not be including all the overhead in the DD program because a provider participating in the program would have some administrative overhead for complying with the Agency's regulations. You have to ask: Are you getting the outcome you want? Do you have in every instance quality providers who meet the needs of people enrolled in the program? By having providers that do both the medical care and the HCBS the thought was that any savings in the medical care would be put into the HCBS.

Q: How will the wait list be addressed if the program goes to managed care? Will people be taken off the wait list?

A: Serving people on the wait list require an appropriation from the legislature. It is an issue of additional funding or savings within the existing program. People

are also served from the waitlist when space becomes available in the program through attrition.

Q: What may happen to independent waiver support coordinators or solo providers if something isn't put into place to protect their jobs? Managed care companies may go with the larger agencies.

A: First think about the services these individuals supply. The case management, the care coordination and specialized knowledge of community resources and how to meet the needs of the people with developmental disabilities are absolutely qualities and services that any system of care would have to have. The current practice of independent, solo and small companies continuing in the new system is a question that can be debated through the process. Last year's proposal did not have provisions for independent support coordinators. Since then, support coordinators have met with us and made suggestions as to how that independent nature could be protected in a managed care environment. That will be up to the legislature to debate and decide. Certainly the service itself, the relationship families have with an individual who knows how the system is structured and can find the resources that are needed is a very necessary service.

Q: Most Medicaid patients are medical and most can pretty much think for themselves and as a result they can defend themselves and they can complain about when they don't get good services. Most of our folks can't. Who in this scheme is going to represent those individuals that can't advocate for themselves and do not have family to speak for them?

A: That was one of the changes in the proposal last year in the role of APD. APD would have the time to be the oversight quality monitors, the quality improvement stimulators and the advocate for the individuals they are serving. Also, there was specific requirement in the proposal for managed care organizations to have methods of accepting input and advice from family member. There may be other assurances or methods to ensure that the individual being served has a voice because clearly they need to.

Q: So part of the overhead is a watchdog agency in addition to the managed care organization?

A: APD would continue to exist under last year's proposal. Their work and their efforts would be redirected to make sure the system functioned appropriately.

Q: If this all goes through and legislation is passed, it (waiver) needs to be approved by CMS. What happens if CMS does not approve whatever happens to the waivers? Is there a mechanism in place to address that?

A: Yes, the portion of the program that relates to persons with developmental disabilities would need federal approval. A five year time line was anticipated in the statewide implementation of last year's proposed legislation. The changes that would affect persons with disabilities was postponed until the end of that five year time frame with the idea that if it was not approved or if in the process of making the changes problems came up you could pull back and readjust and go in some different direction if needed. Medical assistance services was done earlier in the timeline because there is already federal permission to do statewide managed care for these services.

Q: We spent a number of years empowering families to manage themselves in the CDC+ program. It is effective and it gives families choices. The comment is that CDC+ should be kept because it takes out the middle man.

A: In last year's proposal they tried to emphasize that they should keep CDC+ and make that a priority for the competitive bid process. It was not made mandatory though. It was encouraged. However it could be made mandatory that any managed care organization would have to offer and CDC+ like program.

Q: Would the legislature consider contracting case management separately from the managed care plan?

A: In Last year's proposal, independent support coordination services would have been provided by the case managers and coordinators within the managed care organization. Over the summer some Waiver Support Coordinators contended that they needed to keep their independent nature and that will need to be debated by the legislature.

Q: What happens to the FCCs?

A: They would continue to remain a valuable way to gather input and comments from families and hopefully use that input to adapt and modify the program as time goes on. The House proposal last year required the families and consumers to have input as to how the plans were structured. That would be a likely role for FCC.

Q: Provider Service Networks and CDC+. Right now CDC+ hires their own workers and they do not need to be in the Medicaid system as it is now.

A: It could operate as it does now and the managed care plan would be the 3rd party payer. In last years proposed legislation they referred to CDC+ as it is in statute (the Consumer Directed Care Act, s.409.221, Florida Statutes) and would have given priority to those plans who included the consumer directed care piece.

Q: Parent has died-- Do you have any evidence as to the future financial impact to the government of folks on the wait list?

A: Not at this time. I have heard the number a billion dollars as what it would take to serve everyone on the wait list. However, I have not seen a comprehensive analysis to support that amount. It is a very important issue. It will only get addressed when the legislature authorizes more money and approve more slots for people to be served under the Medicaid waiver.

Q: Is there any information on the cost to society because individuals with DD are not receiving services and end up in jail or homeless or mental hospital or institutions

A: It is an important point. I have not seen a study that evaluates that. I would be interested in seeing a study done on that impact. If anyone has some studies along that line please forward them to us.

Q: How will continuity between the regions be assured?

A: On the point of people moving from one side of the region to the other side you wouldn't have to change provider networks. The network must serve the entire region. Now, changing from region to region was not addressed in the legislation last year. It may be necessary to look at that. I would expect the Agency for Health Care Administration contract to require each network and managed care organization to automatically accept transfers from other regions.

Q: CDC+ needs to be a requirement. Shouldn't all regions offer the same services?

A: In the House proposal last year, consumer directed care was a preference and priority for selecting plans through competitive bidding. The Legislature may want to consider if it needs to be a requirement.

Q: On this issue of regions—you know that someone will live right on the boundary of a region and will they be restricted to get services in the region they live in?

A: For the most part it is expected that you get services in the region where you reside. Any region border is going to be somewhat arbitrary and so there will be somebody that the line does not make sense for. This issue was not addressed in 2010 proposed legislation but I would hope that the contract would specify some type of inter-regional cooperative possibilities that would cover this issue. It may be something that will need legislation.

Q: Provider Service Networks—How does this work? Would a person have to use one agency provider?

A: A provider does not equal a provider service network (PSN). The PSN is made up of a bunch of providers that organized themselves to have the capabilities to provide every type of service that is in the list of services offered by the network- In this case, the PSN is the managed care organization. Consumer choice and information is very important. The concept of a provider service network is that some providers are in and some providers are out. The proposed legislation last year required the networks to post who the providers are and all the services they were offering on line. If a family became dissatisfied with the provider service network within the first 90 days after enrollment they could opt out for no reason at all. After that you can still opt out for cause.

Q: How many providers would there be to choose from in each region?

A: In the 2010 proposed legislation, the number of managed care organization providers for developmental disabilities plans was varied for each region. However, there was a minimum of 1 Provider Service Network required for each region. The number of service providers who may contract with each managed care organization (including provider service networks) is unlimited. At a minimum, there must be sufficient providers to give access to services throughout the region.

Q: What do you envision for the independent group homes?

A: The 2010 proposed legislation, required the PSN or other type of managed care organization to contract with all residential providers (group homes, foster homes, ICF/DDs, etc) who were currently serving anyone in the waiver. After the first 12 months of participation in the plan network, the only way a residential provider could be excluded is for specific quality or performance violations.

Q: So what will happen if the managed care organization takes too much for overhead and the independent group home cannot stay in business with what the managed care organization is going to reimburse them for the service?

A: The 2010 proposed legislation was not intending to change what residential providers are paid. In the proposal, for ICF/DD and Intensive Behavioral Group Homes the state would establish the rates and that would be passed through to the managed care organization to the service provider. A suggestion was given that the present residential rates could be the starting point for negotiations and the Legislature could consider if that should be put into law.

The savings and the overhead for a managed care organization should be supported by the improvements and efficiencies in the system rather than the change in provider rate. This works well in the medical assistance managed care but is unknown in the home and community based service system. However, in the 2010 proposed legislation, HMO's can only participate if they do both the medical assistance and the home and community based waiver services.

Q: What would be the role of Delmarva in this new system?

A: There is a need for ongoing evaluation of the managed care organizations in this model. Whether APD might be inclined and able to do that or have a contract with an entity would be a decision of APD because it was not addressed in the proposed legislation.

Q: In order to form a PSN isn't there some capital necessary and if so how much?

A: There is some capital necessary and it is prescribed in state and federal law (s.641.2261 and 42CFR subpart H).

Q: The competitive bidding: Who writes the bid and then who does the contract with the managed care organization.

A: The proposed legislation had AHCA offering the bid. APD has a role in defining the qualifications and criteria and participates in the selection process.

Q: What percentage of the bidding amount goes into the winning bidder?

A: It isn't automatically going to the lowest bidder. The bid process was specified as an invitation to negotiate which would include many competitive factors such as quality, access and bidder experience which are used in determining the successful bidder.

Q: How long are the managed care organizations contracts for?

A: The proposal from last session was a 5 year time frame with no automatic renewal.

Q: In that 5 year bid period could the managed care organization raise their rates?

A: What we would anticipate is that the bid process would be for a base rate and some schedule of increases. Whether or not that schedule of increase would be funded by the legislature or not would need to be addressed.

Q: Where will iBudget fit in?

A. I think the components of the iBudget system can be integrated into a managed care system in a variety of ways. Assessment process and the algorithm would be used as part of setting needs based or risk adjusted capitation rates. With iBudget now, the consumer either spends all the funds or less than their amount. They may not spend more. If they spend less then, the unspent funds would revert to general revenue. The application of the iBudget concepts to a managed care approach uses all those steps to set a rate and that rate is paid to a managed care organization. However, funds paid to the managed care organization do not revert if unspent and the organization is on the hook and obligated by contract to meet the needs of that individual. So as circumstances change the managed care organization has the obligation to find the resources to meet those changed needs.