FAMILY CARE COUNCIL FLORIDA

Mary Smith, Chairperson

Family Centered Care Options Panel Report -- January 20, 2017

Embassy Suites, Orlando Airport

Members: Mary Smith, FCCF Chair -- FCC4; Patty Houghland, FCCF Vice Chair -- FCC1; Pauline Lipps, FCCF Past Chair -- Suncoast East; Betsy Hill, FCC3; Paula James, Suncoast West; Dan Bayley, FCC7; Patricia Oglesby, FCC8; Martha Stuart, FCC9; Marty Norris, FCC10; Sandy Ames, FCC11; Karen Huscher, FCC13; Tosha Littles, FCC14; Lisa Lupi, FCC15; **APD FCCF Liaison:** Stephanie Rogers, **Guest Speakers:** Karen Hagan, Chief of Staff, Agency for Persons with Disabilities: Mike Carroll, Secretary, Florida Department of Children and Families; Justin M. Senior, Secretary, Agency for Health Care Administration; **Guests:** Connie Stuart, Patricia Bell Kennealy, Terese Cavanagh, Sharron Koors, Margie Garlin, Bryan Garlin, Anayre Mitchell, Diane Ciccarelli, Susan Andersen Moore, Howard Fetes, Megan Coccia, Wendy Hawkins, Suzanne Lane, Melody Hearn, Stephanie Weis, Reshawna Johnson, Sheryl Soukup, Eva Soukup, Kely Monblack, Tim Smith and Leah Smith

Karen Hagan introduced herself and fellow panelists Secretary of AHCA, Justin Senior and Secretary of DCF, Mike Carroll, to discuss key issues and answer questions involving their agencies.

- Can experts from each agency help navigate the system of services and are there suggestions for improvement in agency relationships? Individuals start with Medicaid application at DCF or Social Security Administration for eligibility prior to AHCA and APD involvement. Agencies also engage others whose services can be coordinated to resolve issues. *FCCF will send these contacts to FCC Chairs. Panelist noted communication/cooperation between agencies has improved and are considered an ongoing obligation.*
- A solution to disparity of funding between agencies that affects provider turnover and availability? AHCA contracts with managed care health plans that provide services to 3.3 million of their enrollees. The majority of the remainder are dual eligibles, receiving services from Medicare and Medicaid, and the small, fee-for-service group consists of those on the Medicaid Waiver and waitlist for the Waiver who participate voluntarily. Medicaid managed care plans are required by Florida statute to pay physicians at least Medicare rates, about 40% higher than fee-for-service Medicaid rates, accomplished through savings achieved by diversion from more expensive services. Managed care is allowed to set their fees to a percentage over fee-for-service rates by contract. The provider shortage has caused an increase in Waiver participants seeking managed care. *AHCA pays more for LPNs than APD. A legislative budget request by APD this session was proposed to address this difference in payments.*
- Can the six-month reauthorization required for EQ Health personal care and therapy services be changed to a less frequent process? Can the funding that now follows a provider's prior authorization instead follow the child when changing providers to avoid service level issues? *Can agency employees be covered under the Medicaid authorization number assigned to their agency as APD did in the past as it is now more cumbersome to apply for personal care services? Can AHCA and managed care entities work with APD to address this issue? ACHA understands that APD works on annual authorizations, and is discussing internally the areas where they can become more consistent with APD scheduling for service reapplication. AHCA will also consider allowing the child to hold the prior authorization to avoid service complications when changing providers. AHCA will have a discussion with APD about the requirement for authorization numbers for agency personnel. AHCA now allows directly hiring nurses at fee-for-service rates for Medicaid clients. Nurses can hold their own Medicaid number and be hired independent of a home health agency.*
- How can we move to a Medicaid buy-in for people with disabilities? *Consider supporting a legislative initiative for an increased financial threshold for Medicaid participation, currently at 222% of poverty level.*
- Do children with developmental disabilities mainly enter the foster care system because of lack of services or family breakdown? *It was a certain percentage in the past, but deterioration of the home through substance abuse, mental health and domestic violence, with an overlay of poverty, can cause out-of-home care even before children are identified with developmental disabilities. Previously the focus was on what*

the family did or did not do to cause the removal of a child. Improved assessments are focusing on the child's trauma and their needs, to help break the cycle of abuse/neglect.

- How can we promote and publicize children's issues and recruit foster families? DCF cannot fix generational societal issues alone, but needs community support. Without foster family homes, children are removed from the positive experiences of childhood that shape their lives. *Finding families to support a child with developmental disabilities is often initiated by current foster families. Partnerships with community organizations that focus on children such as Family Care Councils can promote the message, potentially through videos produced to assist in foster family recruitment.*
- At this time there are two types of therapeutic homes, medical and mental illness models. Can behavioral homes be included in the DCF therapeutic foster care model? What parent training could be coordinated with APD for foster families? DCF's critical challenge is with behavioral issues, whether children have disabilities or not. The greatest current need are therapeutic foster homes, different than medical foster homes, and also needed are short-term therapeutic care in a group home, providing more intensive case management and therapy. Foster parents all receive 21 hours of training, and are required to receive ongoing yearly training. Medical foster parents receive additional training for complex medical issues. Therapeutic foster parents train in substance abuse/mental health. *DCF acknowledges that medical foster homes also need behavioral services. The community based care agency servicing the child writes a services plan identifying medical necessity to provide for the child's medical needs that may include behavioral services, which require preauthorization. APD has IFS funding independent of Waiver funding.*
- Should families call their managed care entity or AHCA when they have a grievance about refusal of a prior authorization for doctor approved medically necessary services? *You can call either, they both have grievance processes, and you can ask for a fair hearing. DCF currently does these hearings, but AHCA will be taking over later this year for Medicaid services. Under the Waiver, you don't have to use the grievance procedure first.*
- If a abuse report comes in through the school system and involves DCF regarding an improper restraint according to school policy and the case was closed, what is the family's recourse? And how does this work in group homes? Police determine if it is a criminal act, but it could also be abuse. There should be two aligned investigations, law enforcement and DCF. *Ms. Rogers will get contact information to the family.*
- How do we keep coordinating agency information flowing to FCCF? *APD will gather the information from continuing joint agency meetings and pass it on to the Council.*
- MAPP classes provide great information, but paperwork was challenging. Are there any changes in the paperwork to lighten this load for families? *Some has been eliminated, but some remains. The relicensing process has been streamlined, and instead of every year, some can be done every three years. Most community based care foster care liaisons are available 24/7 currently.*
- Nursing providers in some areas are not available. How can we get nursing providers to accept the Waiver rates? How can families advocate to increase the number of nursing agencies? *These issues come to AHCA through the Department of Health, families and the providers themselves. An increase in provider rates will still involve the inherent gap in what managed care receives. CMS is a managed care plan that cannot deviate from AHCA's fees at this time. They can explore structural options in the future, to allow rate increases above fee-for service. Direct hiring of nurses has improved the situation for CMS families.*
- Is there a streamlined way to get providers and anesthesia for dental care for individuals with disabilities. *AHCA has changed the network adequacy requirements for managed care to require the service be available with appropriate staffing for need.*

Contact information for APD, DCF and AHCA available as attached.

Submitted as the Family Centered Options Panel Report, Ruth Wingate, FCCF Secretary