Long-term Care Managed Care program
Frequently Asked Questions

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Posted May 23, 2012

Question: Are there true limits on the amount of Medicaid providers within region? Although the legislation states there are limits to Medicaid Providers in each region (i.e. 10 in Miami Dade), is that countered by the part of the legislation that allows companies to avoid the procurement process?

Answer: In regard to the Long term Care Managed Care program, according to section 409.981(2), F.S., relating to Eligible Plan Selection, the Agency for Health Care Administration (Agency) shall select eligible plans through the procurement process described in s. 409.966, F.S. The Agency will provide notice of invitations to negotiate by July 1, 2012 and procure:

(a) Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(b) Two plans for Region 2. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(c) At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.
(e) At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(g) At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.
(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

Section 409.981(4) , F.S., relates to the Program of All-Inclusive Care for the Elderly (PACE). Participation by the Program of All-inclusive Care for the Elderly (PACE) shall be pursuant to a contract with the agency and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

In addition, s. 409.981(5), F.S., relates to Medicare Advantage Special Needs Plans. Participation by a Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with the Medicare Improvement for Patients and Providers Act of 2008, Pub. L. No. 110-275. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued. Otherwise, Medicare Advantage Special Needs Plans are subject to all procurement requirements.

Question: What happens, if a major insurer (with an advantage plan), currently has Medicaid LTC patient in Waiver or Diversion, and they do not win in the procurement process. Do they get to keep their patients? If so for how long?

Answer: Current providers that do not win a contract through the procurement or who do not choose to participate through non-bidding will keep their enrollees until the program goes live in their region.

Question: HB 7107 line 1686 seems to confirm that if a company has dually eligible's in Medicaid, it can avoid the procurement requirements. Does the state know how many companies fall into this category, Does the state know how many beneficiaries fall into that category?

Answer: Currently there are 20 plans that fall into this category. There are approximately 40,000 Medicaid recipients enrolled in a Medicare Advantage Special Needs Plan. Approximately, 4,000 of these Medicaid recipients meet long term care eligibility requirements. The Agency does not currently have contracts with Medicare Advantage Preferred Provider Organizations or Medicare Advantage Provider-Sponsored Organizations.

Question: If a provider does not currently have Medicaid patients, but only has an advantage plan, and is recruiting these patients today, how long must the patient be qualified for Medicaid prior to the implementation of the reform or its application, must the patient be in service to establish the provider has the experience to care for that population group.

Answer: It appears this question relates to how many months of experience a plan would need to have in order for it to count as "experience" in the procurement. The Agency cannot respond specifically to this question to ensure the integrity of the competitive bid process. Per statutory requirements experience must be considered in awarding the bids.

Question: Patients are required to sign up for a new health plan within 30 days of the Medicaid reform. If a patient has not signed up for a health plan within the time frame, how will the state confirm they have not made a choice? Will the patients confirm in writing to AHCA that they have not chosen? How will the state prevent the "slamming" of patients into plans?

Answer: Section 409.969(1), F.S., relating to enrollment, requires all Medicaid recipients to be enrolled in a managed care plan unless specifically exempted. Each recipient has a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans.

Section 409.984(1), F.S., relating to enrollment in a long-term care managed care plan, the Agency will automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan

Further, according to section 409.969(2), F.S., relating to disenrollment and grievances, after a Medicaid recipient has enrolled in a managed care plan, the recipient will have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause.

Question: The new bill S 730 is a 2012 amendment to the Medicaid Reform Law, which has passed both chambers and is destined to become law. It specifies those companies that can avoid the LTC procurement. The questions such an amendment generate are:

- How will those companies that avoid the procurement be paid, (will it be fee for services)?
- Will they be subject to the new rates established by the procurement?

Answer: Per section 409.981(5), Florida Statues, the Agency must allow certain types of Medicare Advantage Plans to participate outside of the procurement in the SMMC LTC program.

> *(5) MEDICARE ADVANTAGE SPECIAL NEEDS PLANS.—Participation by a Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with Medicare Improvement for Patients and Providers Act of 2008, P.L. 110-275. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued. Medicare Advantage Special Needs Plans are subject to all procurement requirements.*

Pursuant to this language, the Agency will provide for participation in the Statewide Medicaid Managed Long Term Care Program as described below.

Medicare Advantage Special Needs Plans (SNPs) that wish to contract with the Agency to provide managed long term care services must choose one of these three options for participation:

1. Submit a bid in response to the Statewide Medicaid Managed Long Term Care Invitation to Negotiate (ITN). If the SNP receives a contract award as a result of the ITN, the SNP can participate as a managed long term plan open to all enrollees. Plans would be able to receive voluntary enrollment and mandatory assignments of new enrollees.

2. If the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued, contract with the Agency outside of the procurement and sign a contract to provide full Medicaid LTC services to those enrollees in their Medicare Advantage plan as of the date of the release of the ITN. Plans will be limited to serving the enrollees in their plan as of the contract date and will not receive new enrollees.

    - If a SNP submits a bid in response to the ITN, but does not win a contract, it will not have the option to then contract with the Agency outside of the procurement.

    - The contract terms under this option will be the same as for those plans being awarded a bid as a result of the ITN. Contracts outside of the procurement process will not be offered at any other time during the five year contract cycle.

    - Applications for a SNP to participate under a LTC contract outside of the procurement must be submitted at the same time as responses are due for the LTC ITN.

3. If a SNP does not wish to provide managed long term care services, it may contract with the Agency as a Medicare Advantage SNP to provide wrap-around Medicaid services (standard contract) or coordination of those wrap-around Medicaid services (coordination of benefits agreement).

Question: The language specifies that if there is a health plan in which only some of the current Medicare enrollees are dual eligible, not all, those plans will be excluded from the provision that entitles them to avoid procurement. Is that an accurate statement? If a plan has a mix of dual and non-dual enrollees, do they have to go through procurement?

Answer: Section 409.981(5), F.S., relates to Medicare Advantage Special Needs Plans. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued. Otherwise, Medicare Advantage Special Needs Plans are subject to all procurement requirements.

Question: IN HB 7109, Line 2523 A Demonstration project is mentioned which will be allowed prior to 2014.

Answer: This is an exception, rather than an exemption, to Certificate of Need (CON) requirements for a new geriatric psychiatric hospital to be located at what used to be Victoria Hospital in Miami. This is existing language from nearly 10 years ago that was set up for Select Specialty Long Term Care Hospital.

The Agency has not received an application for this project and would only act if one was submitted.

If you have any more questions, please contact Mr. Jeffrey Gregg, Division of Health Quality Assurance, Agency for Health Care Administration at Jeffrey.Gregg@ahca.myflorida.com or 850-412-4402.

Question: Are there any current plans to craft this demonstration project? Is it being crafted now, and who would be the possible applicants and benefiting patients.

Answer: Please see response to #8.

Question: Does the State of Florida Waiver to create LTC Managed Care reform require Registries to be Medicare Certified or Medicaid Certified (both or either) to service Dual enrollment patients.

Answer: The Long-Term Care Managed Care 1915(c) home and community-based waiver document specifies that Nurse Registries licensed under Chapter 400.506, Florida Statutes can be qualified providers in Florida's Long-Term Care Managed Care program. Nurse Registries are currently identified as qualified providers for dually eligible recipients in our existing home and community-based waiver programs. This requirement is consistent with provider qualifications for Florida's current home and community-based waiver programs serving this same population.

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Question: Will dual eligibles be handled under the statewide expansion by a special program, or will they be directed to specialty plans such as United Evercare, or will they be absorbed with the rest of the Medicaid population?

Answer: There is not a separate program for dual eligibles. Duals eligible for the Long-term Care (LTC) program must choose a LTC plan. Those not eligible for LTC, will choose a Managed Medical Assistance (MMA) plan when one becomes available in their area. In both the LTC and MMA programs, if a dual eligible does not make a choice of plan, he or she will be assigned to a plan.

Question: Just to make sure I'm looking at the right figures: the AHCA shows 275,289 dual eligibles in the state as of April 2012, correct? The Kaiser Family Foundation claims that there were 601,276 dual eligibles in the state as of 2008, but they included what they considered partial eligibles. Does the AHCA anticipate enrolling a significantly higher number of dual eligibles in managed care than the population currently in the system?

Answer: The Agency would only enroll those known to our system. We are not aware of an expected increase.

Question: Does the AHCA have an estimate of how many dual eligibles will enroll in the Long-term Care expansion, or what percentage of that population they will make up?

Answer: The Agency currently serves approximately 85,000 Medicaid recipients in nursing facilities and the home and community-based waiver programs identified in the authorizing legislation for the long-term care managed care program. Approximately 95% of these recipients are dually eligible for both Medicare and Medicaid.

Question: In one of the waiver request documents on the website, I read that qualified Medicare Advantage plans that serve only dual eligibles can participate in the long-term care plan without participating in the competitive procurement process. Is this still the case, and if so, what is the process?

Answer: The Agency has received direction from the following language contained in 409.974(5), Florida Statutes that was passed by the 2012 Florida Legislature. This authorizing legislation outlines the process for participation in the long-term care managed care program by Medicare Advantage Plans:

Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with the Medicare Improvements for Patients and Providers act of 2008, Pub. L. No. 110-275. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible

recipients who are enrolled in the plan in order to receive Medicare benefits as of the date that the invitation to negotiate is issued. Otherwise, such plans are subject to all procurement requirements.

Question: What will a Medicaid certified nursing home be required to do as the state transitions to managed care in the way of credentialing professional staff, reminding Medicaid qualified residents & their families of the change and whatever they have to do to select a plan, etc.? We are assuming that the transition would not be automatic.

Answer: Medicaid certified nursing homes will continue to be licensed through the Agency for Health Care Administration and will still be required to meet all state licensure and certification requirements.

The Agency for Health Care Administration, in cooperation with the Department of Elder Affairs, will provide outreach and education materials to Medicaid providers and recipients, including nursing home residents, prior to implementation of the Long-term Care Managed Care program. Approximately 60 days prior to implementation of the program in each region of the state, Medicaid will mail plan selection materials to residents or their designated representatives. Individuals from the Medicaid Enrollment Broker and the local Aging and Disability Resource Centers will be available to respond to questions and assist individuals in securing the information they need to select a plan that best meets their needs.

Question: Will nursing home providers be required to contact the plans selected by AHCA to become a network provider or will it occur automatically because of the safeguard in the law that no nursing home can be denied participation initially?

Answer: As specified in s. 409.982, F.S., managed care plans must offer a network contract to all nursing homes in each region of the state. Although the managed care plans will be contacting the nursing homes in the regions of the state where they are establishing their provider networks, nursing homes may wish to contact the managed care plans that have expressed an interest in the Long-term Care Managed Care program. A list of organizations that submitted a non-binding letter of intent to bid to become a Managed LTC plan is posted on the Agency for Health Care Administration's Statewide Medicaid Managed Care website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/LTC_Non-Binding_Letters_of_Intent_041912.pdf

Question: Will care coordinators contact current Medicaid nursing home and ALF residents before the transition and explain what they must do to select a plan? If so, what type of coordination, if any, will occur with providers?

Answer: The Agency for Health Care Administration in cooperation with the Department of Elder Affairs will provide outreach and education materials to Medicaid providers and recipients, including nursing home residents, prior to implementation of the Long-term Care Managed Care Program. Approximately 60 days prior to implementation of the program in each region of the state, Medicaid will mail plan selection materials to residents or their designated representatives. Individuals

from the Medicaid Enrollment Broker and the local Aging and Disability Resource Centers will be available to respond to questions and assist individuals in securing the information they need to select a plan that best meets their needs.

Once a Medicaid recipient selects a managed care plan and is enrolled into the program, the plan will assign a care coordinator/case manager who will meet with the enrollee to perform an assessment, develop a plan of care, and assist the enrollee in obtaining appropriate care. All Medicaid recipients, including individuals in nursing homes and assisted living facilities, will have access to care coordination/case management services.

Question: What is the role of assisted living in managed care? As private pay residents exhaust their funds and become eligible for Medicaid, will they be permitted to remain in ALF if the ALF is willing to continue to serve them or will that depend on the availability of a "slots," much like occurs now? We anticipate that the demand for ALF care will increase if government assistance through Medicaid is more available.

Answer: As specified in s. 409.98, F.S., long-term care plans will be required to cover services provided to enrollees in assisted living facilities.

The Agency anticipates that the Long-term Care Managed Care Program will receive the same amount of funding for home and community-based service (HCBS) as is currently appropriated for the existing HCBS programs. Therefore, there will need to be a state-wide waiting list for HCBS, including services in assisted living facilities. For individuals transitioning from nursing homes, the Agency does not anticipate that there will be a waiting list for HCBS, including services in assisted living facilities.

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Question: Will there still be a wait list for home and community based (HCBS) services?

Answer: The Statewide Medicaid Managed Care program does not provide additional funding or create additional "slots" for recipients to receive home and community based services, thus it doesn't eliminate the wait list.

The Statewide Medicaid Managed Care program provides that the Department of Elder Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before making enrollment offers, DOEA is required to determine that sufficient funds exist to support additional enrollment into plans.

Once a recipient enrolls in a Long-term Care Managed Care plan, the plan is responsible for providing appropriate services, whether in an institutional setting or in a home or community based setting.

Question: Will plans be able to force a recipient to move out of their nursing home?

Answer: No, a recipient residing in a nursing facility can always choose to remain in that facility, if this is the least restrictive setting that can provide the appropriate level of care for that individual.

Question: Will Medicaid funding for nursing home services be limited based on available slots and funding? If an individual meets the technical and financial criteria for the Institutional Care Program and meets a nursing home level of care as determined by the CARES unit, can the individual be denied Medicaid funding to pay for nursing facility services based on slots and funding availability? Who will determine what level of care a recipient qualifies for? Will it still be CARES?

Answer: There will be no wait list for nursing facility services under the Statewide Medicaid Managed Care program.

Individuals who meet the financial eligibility criteria for Medicaid as determined by the Department of Children and Families and who meet nursing home level of care criteria as determined by CARES (Comprehensive Assessment and Review for Long Term Care Services) will be eligible to receive all medically necessary services through a Long-term Care Managed Care plan in their nursing home of choice.

Question: Which home and community based waivers are included in the Long-term Care Managed Care program, and will those waivers go away once this is implemented?

Answer: The following are eligible for enrollment and may re-enroll for 12 months without reevaluation:

- The Assisted Living for the Frail Elderly Waiver
- The Aged and Disabled Adult Waiver
- The Adult Day Health Care Waiver
- The Consumer-Directed Care Plus Program as described in s. 409.221
- The Program of All-inclusive Care for the Elderly. (f) The long-term care community-based diversion pilot project as described in s. 430.705
- The Channeling Services Waiver for Frail Elders.

Recipients enrolled in the DD waivers are specifically excluded from mandatory enrollment in the Long-term Care or Managed Medical Assistance programs.

Recipients enrolled in other waivers that are not specifically mentioned in the legislation will be voluntary for enrollment. This means that they can choose to enroll in a Long-term Care or Managed Medical Assistance plan if they wish, but will not be required to do so.

Question: Will CARES or the plan assess people's need for long term care services?

Answer: CARES will still determine who is eligible for Medicaid nursing facility and home and community based waiver programs.

Under the SMMC program, the Agency is directed to continue to operate the CARES program through an interagency agreement with the Department of Elder Affairs. In order to be eligible for enrollment into the Long Term Care Managed Care program, a recipient must be determined by the CARES program to require nursing facility care.

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