

Proposed Medicaid Long-Term Care Changes Raise Host of Questions About Impact

Florida is proposing to make significant changes in its Medicaid Long-Term Care program. To assess the possible consequences, certain aspects of the proposal deserve careful consideration:

- » Time and resources allocated for program implementation may not be sufficient to accomplish the goals set for the program and particularly to assure smooth transitions for a very vulnerable population.
- » The popular goal of shifting services from institutional to community-based settings may be difficult to accomplish given certain program design features.
- » Independent sources of information and counseling for consumers as well as strong independent oversight of plans will be essential. These program elements need to be strengthened.
- » The potential impact of the proposal on costs is unclear.

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INTRODUCTION

Florida's 2011 Managed Care Legislation, HB 7107, established "Medicaid Managed Care," a new statewide managed care program for all covered services. The program is expected to control Medicaid program costs by using a capitated rather than fee-for-service payment model⁽¹⁾. Two separate components are anticipated for the new program: the Florida Long-Term Care Managed Care program, slated for implementation first, and the Florida Managed Medical Assistance program, an expansion of the Medicaid pilot program currently operating in five counties.

The new Long-Term Care Managed Care program, which will cover adults 65 and older and younger adults with disabilities, will affect as many as 84,000 current Florida Medicaid beneficiaries as well as another 27,000 eligible individuals who are on various waiting lists for services.

In addition to controlling costs, specific goals of the Long-Term Care Managed Care program, as described by Florida's Agency for Health Care Administration (AHCA), are to provide:

- » Access to cost-effective community-based long-term care services;
- » Coordinated long-term care across different health care settings;
- » Long-term care plans with the ability to offer more services;
- » A choice of the best long-term care plans for program participants' needs⁽²⁾.

This brief describes the Long-Term Care Managed Care program as it is outlined in the legislation and in Florida's waiver submission to the federal government. Drawing on experience from other states, the brief also examines how various aspects of the program may affect the state's ability to achieve the program's ambitious goals.

BACKGROUND

Long-term care services primarily provide help with essential tasks of daily living – such as bathing, dressing or eating – for people who need assistance on a prolonged basis because of chronic physical or mental conditions or disabilities.

The long-term care population is diverse and can include, for example, an older person living with chronic conditions and dementia or a younger person with a spinal cord injury. Individuals may receive services in institutions or in the community.

People who need long-term care services also need medical services for preventing, diagnosing and treating health conditions (see Exhibit 1 on Page 2).

Most of the older adults and younger adults with disabilities who receive long-term care services through Medicaid – approximately 94 percent in Florida – also are eligible for Medicare. Medicare is the primary payer, but Medicare covers only limited post-acute care services or home health for rehabilitation after a hospital stay. More prolonged assistance is covered by Medicaid, which is also a secondary payer for dually eligible beneficiaries' medical services.

**EXHIBIT 1: Medical and Long-Term Services And Supports
For Individuals 65+ and Younger Adults with Disabilities**

	Medical Services	Long-Term Services and Supports
Type of Service	Acute and Chronic Conditions: Prevention Diagnosis Treatment	Assistance with activities such as bathing, dressing, eating, medication management Assistive devices and home modifications
Service Setting	Hospital Doctor's Office or Clinic Other Medical Settings	Nursing facility Community-based setting such as private home or assisted living facility
Public Coverage	Medicare Medicaid	Medicare only for short-term post-acute care Medicaid for prolonged care

Currently in Florida, most dually eligible beneficiaries who qualify receive long-term care services through Medicaid on a fee-for-service basis and medical services through Medicare either on a fee-for-service basis or through a managed Medicare Advantage Plan. Most beneficiaries who have only Medicaid coverage receive both long-term and medical services on a fee-for-service basis. Among Medicaid beneficiaries receiving long-term care services, about one-quarter are enrolled in the Nursing Home Diversion program, a managed long-term care program.

To qualify for long-term care services financed by Medicaid, applicants must meet functional as well as financial eligibility requirements. Florida uses the Comprehensive Assessment and Review for Long-Term Care Services (CARES) process to assess each applicant's needs and to help develop individual service plans. Only applicants who require the constant availability of medical and nursing treatment and care on a routine basis qualify.

The 2011 managed care legislation directs AHCA to use a capitated managed care approach for medical and long-term care services for most Medicaid beneficiaries.

Before Florida can use a new approach to providing services, however, the federal Centers for Medicare & Medicaid Services (CMS) must grant a waiver of existing federal rules.

The state has submitted an 1115 waiver request to expand the current pilot program that provides medical services on a managed care basis in five counties.

In addition, for authorization of the Long-Term Care Managed Care program, Florida submitted 1915(b) and (c) waivers, relying on a waiver combination approach that has been used historically to provide managed long-term services and supports.

CMS has determined in the past that waivers to section 1915(b) of the Social Security Act permit states to mandatorily enroll beneficiaries in Medicaid managed care plans and to selectively contract with certain service providers. Waivers to section 1915(c), sometimes called home and community-based service (HCBS) waivers, allow states to provide services in a community-based setting to select groups of individuals who otherwise would require institutional services reimbursable by Medicaid.

A 90-day timeline is specified for review of these waiver applications, although CMS can stop the clock to request information.

Florida submitted the two waiver applications to CMS on August 1, 2011. The state submitted a formal response to questions posed by CMS on November 22, 2011 for the 1915(b) waiver. A new 90-day review period began when Florida submitted the response to questions about the (c) waiver on December 8, 2011.

The more comprehensive 1115 waiver is not subject to a 90-day timeline.

FLORIDA'S NEW LONG-TERM CARE PROGRAM

Florida's new long-term care program will be administered by AHCA in partnership with the Department of Elder Affairs.

If approved, the program will divide Florida into 11 regions (See Exhibit 2 on Page 3) and the state will use a competitive procurement process to select long-term care Managed Care Organizations, also called plans, for each region. Several types of managed care organizations, such as Health Maintenance Organizations, Provider Service Networks, or similar organizations⁽³⁾ are eligible to participate. Enrollees in each region will have a choice of at least two plans⁽⁴⁾.

Timeline for implementation

The initial waiver request indicated that implementation of the Long-Term Care Managed Care program would begin July 1, 2012, and enrollment of program participants, by region, would span a nine-month period beginning January 2013.

However, the most recent response to CMS from the state says that Florida expects to award contracts by June 2013, which suggests that enrollment would not begin until later in the year.

The implementation timeline for the Managed Medical Assistance program is on a parallel track, but is expected to begin later.

Who must enroll?

Individuals who are 65 years of age or older, or who are 18 years of age or older and are eligible for Medicaid by reason of a disability, must enroll in the new Long-Term Care Managed Care program if they now participate in any of five of the Elder and Disabled waiver programs that Florida currently operates, or if they receive nursing facility or hospice services⁽⁵⁾.

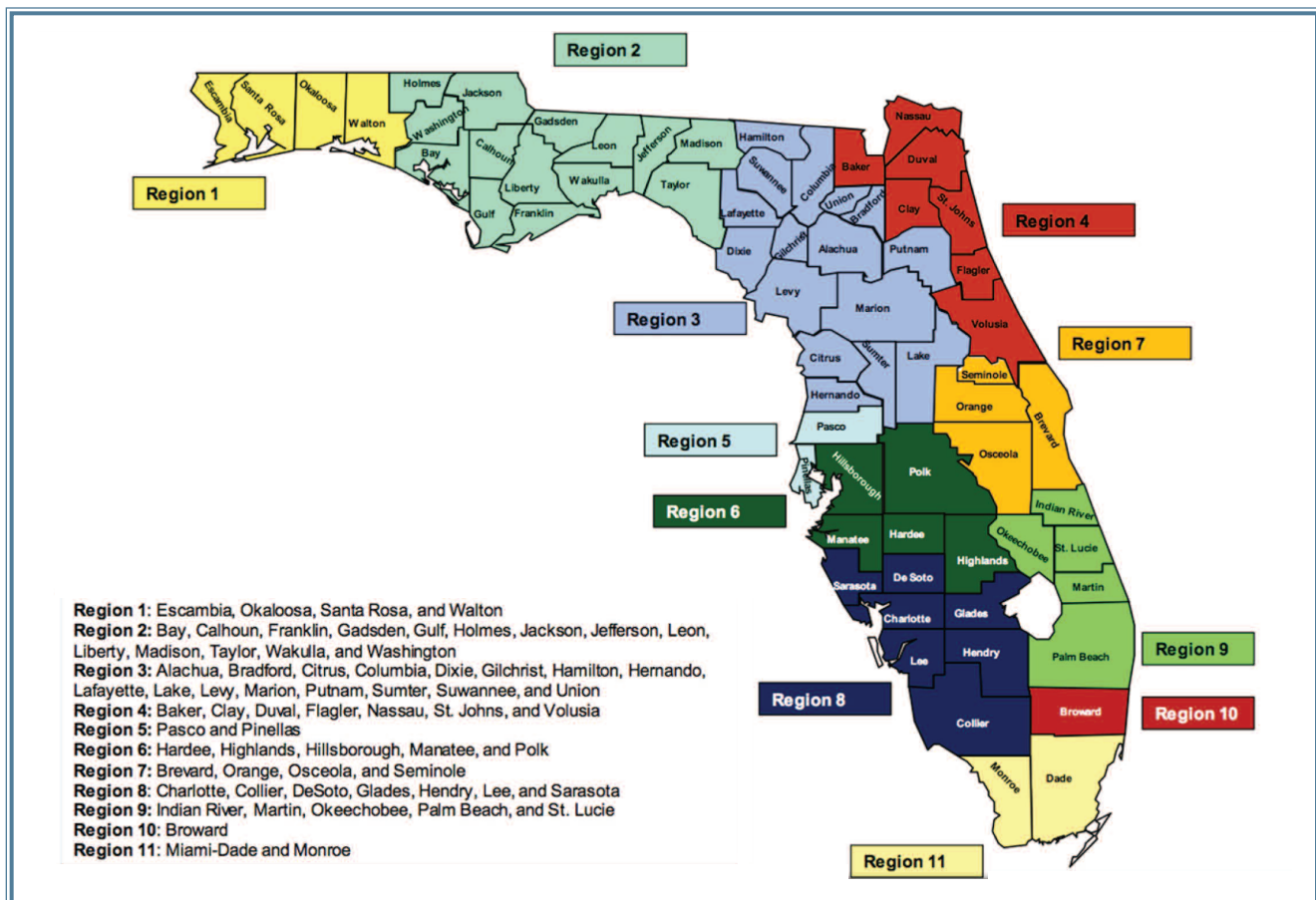
Almost 42,000 are enrolled in the waiver programs; almost 27,000 are on waitlists for services. (See Exhibit 3, Page 4) In addition to those receiving services through the Elder and Disabled waiver programs, another 42,230 people who receive nursing facility services will be included in the new Long-Term Care Managed Care program⁽⁶⁾.

While the total of approximately 84,000 represents a small portion of the 3.1 million Medicaid beneficiaries in Florida, they are a particularly vulnerable and costly group:

- » Having qualified for Medicaid, they have little income and few resources⁽⁷⁾.
- » They report that they are in fair or poor health, according to the Florida Department of Elder Affairs⁽⁸⁾.
- » About half of older people receiving assistance – 51 percent – have been diagnosed with dementia, according to The Florida Council on Aging⁽⁹⁾.

Moreover, significant growth in the population eligible for long-term care services is expected. A 127 percent increase in the population age 65 and older is anticipated between 2010 and 2030 in Florida⁽¹⁰⁾.

EXHIBIT 2: Statewide Medicaid Managed Care Regions



Source: Florida Agency for Health Care Administration, September 2011

EXHIBIT 3: Waiver Programs to Be Included in Long-Term Care Managed Care Program

Waiver Program	Population	Enrollees SFY 2010/2011	Waitlist as of March 2011
Aged and Disabled Adult	18-59 and 60+	12,449	4,475 Adults with Disabilities 13,239 Older Adults
Adult Day Health	60+	39	0
Assisted Living for the Elderly	60+	4,756	856
"Channeling" Home & Community Based Care*	65+	1,554	87
Nursing Home Diversion	65+	22,939	8,330
Total	NA	41,737	26,987

* Name derives from a pilot program. Source: Agency for Health Care Administration, December 2011.

What services will be provided?

The legislation specifies a range of long-term care services that Managed Care Organizations must provide.

Enrollees will have access to most of the services now offered through the five existing waivers, but certain services that have not been heavily used historically, such as case aide, chore, counseling, escort or physical risk reduction services, are not included in the list of required services for the new program. AHCA has indicated that these services can be provided as a component of other covered services and notes that Managed Care Organizations have the flexibility to offer services beyond those that are required. How broadly or narrowly Managed Care Organizations interpret service requirements can have consequences for enrollees.

Case managers employed by Managed Care Organizations will develop a plan of care with each enrollee that specifies the type and amount of services to be provided. It will be important to develop safeguards to ensure objectivity when the same entity that is at risk financially is also responsible for developing service plans.

Who will provide services?

Managed Care Organizations must offer network contracts to certain providers that have previously participated in Home and Community-Based Service waiver programs, such as nursing facilities, hospices and aging network service providers. These providers are obligated to participate in the plans.

Managed Care Organizations may negotiate contracts with other types of providers – such as Centers for Independent Living and organizations that assist with community-based services, particularly for younger people with disabilities – but they are not obligated to do so.

KEY ISSUES

Moving to managed long-term care is a complex and difficult undertaking, particularly given the broad program changes proposed and the short time frame. Among the key questions about the Long-Term Care Managed Care program:

Are the time and resources allocated for implementation sufficient?

Past research found that the goal of providing better-integrated high quality services in a more cost-effective manner is not likely to be achieved if the timelines for program design and implementation are short and hasty decisions are made as a result. Planning and start-up periods must be sufficient to allow state agencies to collaborate and make complex program design choices, to work with CMS to obtain the authority to operate new programs, and to consult with stakeholders. Experts note that these activities are time and resource intensive⁽¹¹⁾.

A recent review of Medicaid managed long-term care programs concluded that successful implementation depends on working with a variety of stakeholders, including consumer groups, providers and plans, both during the early stages of program design and on a continuing basis⁽¹²⁾. Consumer involvement has not been a prominent feature of the planning process for Florida's Long-Term Care Managed Care program.⁽¹³⁾

Florida has some experience with managed long-term care, but the new program is more expansive and comprehensive than the current Nursing Home Diversion Program. AHCA and the Department of Elder Affairs staff not only must continue to oversee current programs, but also must be involved in waiver negotiations with

LEARNING FROM OTHER STATES

Experience and evidence related to Medicaid managed long-term care is very limited.

Across the country, only 10 other states operate capitated managed long-term care programs for the elderly or individuals with disabilities and only four of those are statewide programs with mandatory enrollment⁽¹⁴⁾.

Managed care payments account for only 6 percent of spending for Medicaid beneficiaries using any long-term services or supports⁽¹⁵⁾.

Research to date indicates that relative to fee-for-service programs, managed long-term care programs reduce the use of institutional services and increase access to home and community-based services, but there is little definitive evidence about whether the model saves money or how it affects outcomes for consumers. Little detailed evaluation has been conducted.

Furthermore, because evaluations have been specific to particular types of beneficiaries or to certain counties or states – and because program design differs significantly from state to state – results are not generalizable.

CMS and preparations for the new program. Although state officials can prepare for program changes, they cannot make changes – such as executing contracts with Managed Care Organizations – until waiver approvals occur. As negotiations continue, the timeline for implementation must change and could, perhaps be expanded. Not only is the proposed timeframe short, but also the legislation did not provide additional resources to cover most start-up costs.

Will the dual-program design complicate efforts to coordinate services across settings?

Better integration and coordination of services are potential advantages of managed care arrangements. Plans have more opportunities and incentives to manage services when they are responsible and at risk for the full continuum of health and long-term services. The coverage and service delivery systems also tend to be simpler to understand and use.

However, given that AHCA is planning to negotiate two sets of contracts at separate times – one for long-term care and another for other medical services – the advantages associated with integrated services may be difficult to realize.

Beneficiaries will have to choose Managed Care Organizations for long-term care first and for medical services at a later date. Thus, it appears that at first, providers in a managed care network will deliver long-term care services, but other services may be delivered on a fee-for-service basis or through another network⁽¹⁶⁾.

Subsequently, when the Managed Medical Assistance program is implemented, all types of services may be available from one Managed Care Organization, but that is not assured because each set of contracts will be bid competitively. The state may contract with different groups of plans for long-term and other medical services.

Whether beneficiaries will be required or encouraged to enroll with one plan that provides both types of services is unclear. Efforts to coordinate care could be difficult, administratively complex and confusing for program participants⁽¹⁷⁾.

How will transitions be accomplished?

Medicaid beneficiaries who must enroll in the Long-Term Care Managed Care program will receive letters that describe the program and inform them that they have 30 days to choose a managed care plan. AHCA will automatically enroll those who do not make a selection. Program participants will have 90 days after enrollment to choose a different Managed Care Organization.

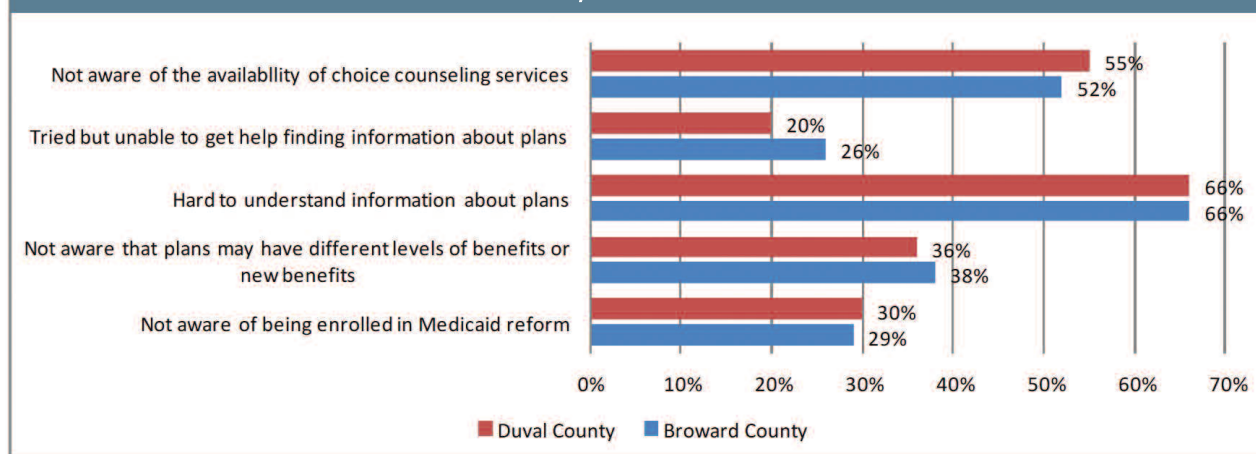
An initial concern is what type of assistance program participants will have to help with plan choice and enrollment.

Outreach activities to increase awareness of the program are planned, including the development of strategic partnerships with community agencies.

But in order to make the best choices, program participants and new applicants may require individual face-to-face counseling in addition to information.

Research regarding Florida's 2006 Medicaid Reform pilot program, which used the same enrollment process as the one proposed for the Long-Term Care Managed Care program, found considerable confusion among enrollees, particularly adults with disabilities⁽¹⁸⁾. (See Exhibit 4 on Page 6) A similar population will be enrolled in the Long-Term Care Managed Care program.

Currently, Aging and Disability Resource Centers provide information, counseling, referrals and help with applications for individuals who have questions related to long-term care. The centers in Florida have been cited as being among the most effective in the country⁽¹⁹⁾. They do not have a designated set of responsibilities or additional resources associated with the new program, however.

EXHIBIT 4: Consumer Experience with Enrollment, Florida Medicaid Reform Waiver, 2006-2007, Adult SSI Case Load


Source: Kaiser Family Foundation Survey of Florida Medicaid Beneficiaries, 2006-2007, reported in: T. A. Coughlin et al., "Florida's Medicaid Reform: Informed Consumer Choice?" *Health Affairs* 27, no.6 (2008w): w523-w532.

The waiver proposal indicates that an independent enrollment broker will be hired to help with administrative functions related to transitions. AHCA assumes that funds to pay for enrollment broker services as well as other administrative tasks – external quality review, an independent assessment of the program and actuarial development of capitated rates – will be available from savings of 0.2 percent achieved through more effective management of nursing facility services. This funding is not assured, however.

Another factor that may affect efforts to educate and assist program participants is that Managed Care Organizations are permitted to conduct marketing campaigns for the new program. The campaigns will be a source of information for enrollees, though not an objective source, and there is a need for particular vigilance, given past experience in Florida and other states.

In the enrollment period, state officials are tasked not only with assuring that information is available to program participants but also with monitoring marketing activities. Plans will be responsible for logging and resolving marketing complaints in the new program. More real-time monitoring on the part of the state could potentially avoid confusion or problems associated with enrollment.

Ensuring that services continue uninterrupted is an essential feature of the transition process. The need to make a change if current providers are not in a new plan's network has been a major concern for program participants in other states.

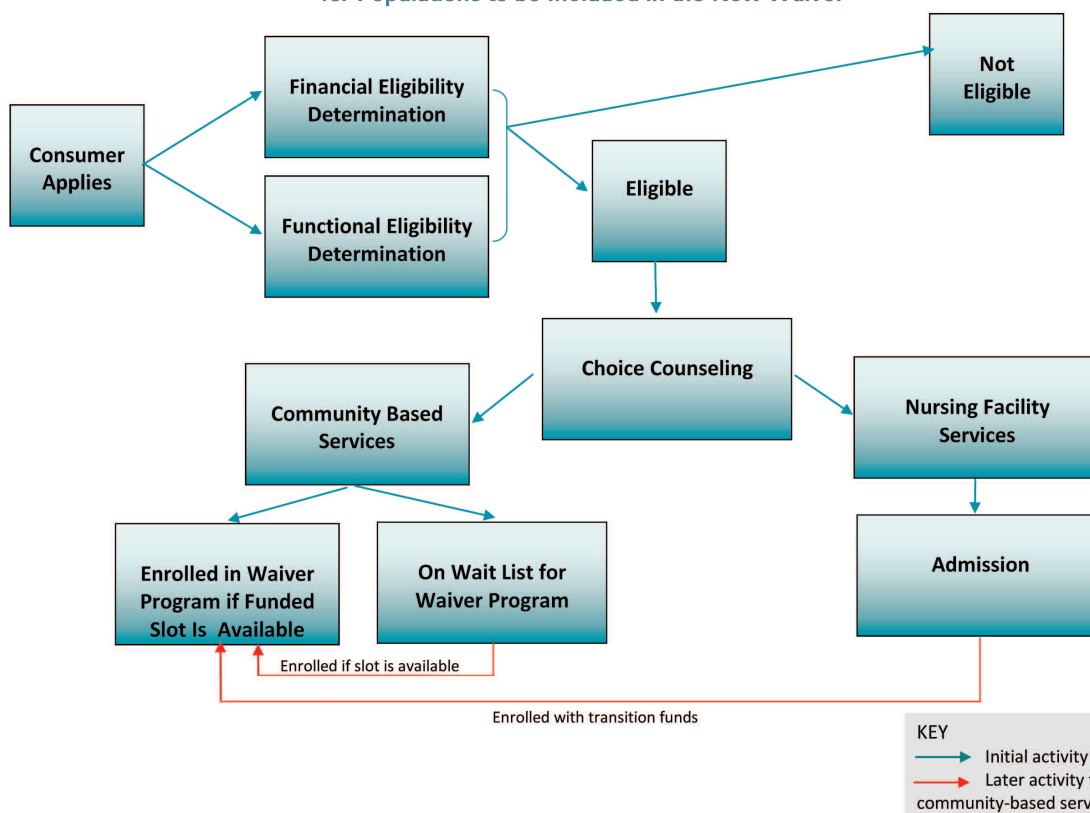
In Florida, experience with the Nursing Home Diversion waiver program suggests that forming provider networks may be challenging in certain areas of the state where providers are not present or decline to participate in networks. The Nursing Home Diversion program is authorized to operate statewide, but in more than 20 counties no service providers have contracted with Managed Care Organizations and the program has not been operational ⁽²⁰⁾.

The waiver submission anticipates that some program participants will have to change providers, noting that Managed Care Organizations must pay for the use of out-of-network services until case managers have developed and implemented an appropriate written plan of care for transitioned individuals. There will also be instances where services that participants currently use are no longer covered or are denied initially. In both cases, individual counseling or troubleshooting capabilities independent from plans may be needed ⁽²¹⁾.

How will program design features affect access to community-based services or plans to shift services to the community?

Policies intended to provide more community-based rather than institutional long-term care services are popular among states as they seek to control costs and respond to consumer preferences. Institutional care is an entitlement or required Medicaid service, but community-based services are not. Thus, states design waiver programs, which if

EXHIBIT 5: Current Routes to Medicaid Community-Based Long-term Care Services for Populations to be Included in the New Waiver



approved, allow them to provide services in a community-based setting to a limited number of individuals who otherwise would require institutional services reimbursable by Medicaid. Each waiver has a specified number of “slots” that can be filled, providing that funds are available.

Nationally, 36 percent of Medicaid and state-funded spending for long-term care for older people and adults with physical disabilities goes to home and community-based care. In Florida, 21 percent of such spending goes to home and community-based care, ranking the state 37th in the nation⁽²²⁾.

An explicit goal of shifting services from institutional to community-based settings is stated in the Florida Medicaid legislation, with financial incentives available to Managed Care Organizations that facilitate this transition. The legislation directs AHCA to adjust payment rates to account for changes in each plan’s “level of care” profile, though details regarding how the profile will be developed have not yet been determined⁽²³⁾.

Currently, consumers who are eligible for Medicaid long-term care services choose between nursing facility and community-based services, but they may be put on waitlists until a community-based slot is available. Transitions from nursing

facilities are another route to community-based services. (See Exhibit 5) Proviso funding authorized by the 2009, 2010 and 2011 Florida Legislatures has been used by the Medicaid program to transfer nursing home funds to certain Home and Community-Based Service waiver programs in order to transition eligible Medicaid recipients from institutions to the community. Between January 2009 and November 2011, more than 2,700 individuals were so transitioned⁽²⁴⁾.

Substantial shifts from institutional to the community settings may be difficult to achieve, and access to community-based services will likely continue to be limited under the new program for several reasons:

- » **Waitlists for community-based services will be retained.** With almost 27,000 people on waitlists for the five waiver programs that are slated to be part of the Long-Term Care Managed Care program, the demand for services already exceeds waiver program capacity in Florida. AHCA has indicated that the new program does not provide additional funding or create additional slots for home and community-based services and that, therefore, those on current waitlists will not be eligible to enroll in the Long-Term Care Managed Care program unless program funds become available.

- » AHCA is proposing that the number of home and community-based waiver slots remain constant over the course of the five-year program, despite the expected growth in the population eligible for long-term care services.
- » Nursing facility placement will remain an entitlement service. Therefore, it appears that the initial choice for many people who newly qualify for long-term care services will continue to be between nursing facility services or a waitlist for community-based services.
- » The shift to community-based services will rely heavily on transitions from nursing facilities to the community. States that have succeeded in changing the balance of institutional and community-based long-term services and supports generally have relied on policies that encourage the immediate provision of community-based services as well as policies that foster transition.
- » Only 8 percent of nursing facility residents in Florida have low-care needs, compared with a national average of almost 13 percent,⁽²⁵⁾ a reflection of the relatively strict eligibility criteria for long-term care established in Florida. Although community-based services can be arranged for all levels of care, the composition of the nursing facility population, along with the fact that transitions already occur routinely, suggests that it may be difficult to achieve a large increase in the number of people in nursing facilities who move to the community when the new program is implemented.
- » Across the country, a shortage of affordable accessible housing and qualified workers has hampered efforts to move people to the community. The supply of home care aides and assisted living units relative to the older population is lower in Florida than in many other states (See Exhibit 6). Investments and training may be required to increase community capacity.
- » Money Follows the Person, a demonstration program sponsored by CMS, has been a source of funds for many states to help individuals residing in nursing facilities make the transition back to the community. Florida received a five-year Money Follows the Person grant in February 2011, but the state budget did not give AHCA the authority to accept the funds.

The retention of waitlists raises questions regarding who will have priority for community-based services in the new program.

What will the waitlist policy be for new applicants who choose community-based services relative to those already on the list?

Will enrollees in nursing facilities have priority for waiver slots over those currently on waitlists?

Will applicants who choose nursing facilities have quicker access to community-based services than those who choose home and community-based services initially?

If so, will the new program create a “back-door entitlement” to waiver services – one that could be more costly than simply serving people in the community first?

The prospect of combining separate lists for current waiver programs and the change from maintaining regional waitlists for some of the programs to maintaining a statewide waitlist also raises questions about who will have priority for community-based services.

Members of the Long Term Care Managed Care Technical Advisory Workgroup have noted a lack of clarity regarding whether applicants will be on a waitlist to get into Managed Care Organizations or if they will remain on a waitlist for specific services once they are enrolled in a plan⁽²⁶⁾.

EXHIBIT 6: Home and Community-Based Service Provider Supply

	Home Health & Personal Care Aides Per 1,000 Pop. Age 65+ (2009)	Assisted Living & Residential Care Units Per 1,000 Pop. Age 65+ (2010)
Florida	14	26
U.S.	40	31
Florida's Rank (among 50 states & D.C.)	49th	30th

Source: Reinhard, S., E. Kassner, A. Houser, and R. Mollica, “Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,” AARP, The Commonwealth Fund, The Scan Foundation, September 2011.

What is the potential impact on program costs?

Cost control is one of the main goals for the new program. A capitated managed care approach does have the potential to control costs, but certain design features of the Long-Term Care Managed Care program may be problematic.

For example, since Managed Care Organizations will only be at risk for long-term care services, the potential to deliver services more efficiently and achieve savings in the broader Medicaid program will be more limited than in a system that fully integrates long-term care and other health services. Cost shifting between acute and long-term care programs may occur.

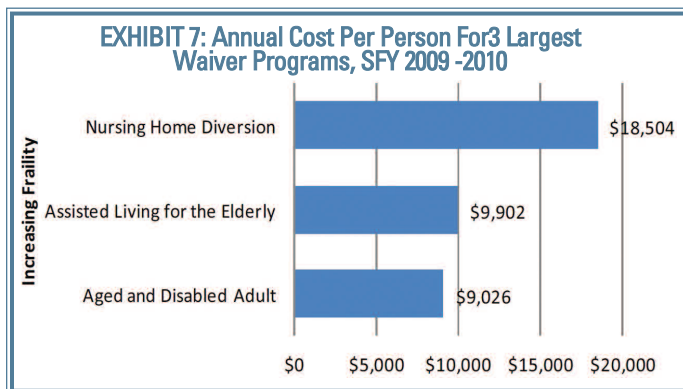
The ability of Managed Care Organizations to negotiate with providers for more favorable payment rates is another aspect of managed care that has the potential to control program costs, but the Legislature has said that the state will set minimum nursing facility and hospice payment rates, limiting plans' ability to negotiate with these providers.

The shift from nursing facility to community-based services is associated with lower per capita costs, but as noted above,

the shift may be difficult to achieve if the program relies heavily on transitions from nursing facilities.

If waitlists for community-based services remain and individuals are admitted to nursing facilities before they transition to the community, initial per capita costs would be higher than if community-based services were available immediately.

Experience in Florida indicates that managed care programs are not necessarily less costly than fee-for-service programs. The cost per person is substantially higher for the Nursing Home Diversion program – the only one of the five Elder and Disabled waiver programs that uses a managed care approach – than for the other waiver programs. The higher frailty level for Diversion program participants is likely one reason for the higher costs. (See Exhibit 7) Administrative activities and profits are other probable contributing factors.



Source: Reinhard, S., E. Kassner, A. Houser, and R. Mollica, "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," AARP, The Commonwealth Fund, The Scan Foundation, September 2011.

Much will depend on the payment rates the state negotiates with Managed Care Organizations. The Legislature has mandated that for the first year of the first contract term, negotiated rates must reflect an aggregate savings of 5 percent. At the same time, there will be new program costs for start-up activities and some margin of profit for plans.

Finally, the potential for savings in Florida may not be as great as in other states because spending is already relatively low. Florida ranks 34th in Medicaid nursing facility expenditures per person served. For older people and adults with physical disabilities, Florida ranks 32nd in Medicaid Home and Community Based Services expenditures per person served⁽²⁷⁾. And, it is important to note that achieving the goal of controlling costs is not desirable unless it is accompanied by better or at least equivalent outcomes.

How will quality services for program participants be assured?

Managed care plans have administrative and organizational capabilities that can augment states' capacity to deliver services effectively, but even when states delegate functions to Managed Care Organizations, they retain responsibility for management and quality assurance. Significant components of effective oversight that have been cited by officials in other states include explicit contract language about plans' responsibilities, safeguards to ensure that conflicts of interest do not occur – for example when Managed Care Organizations develop service plans or evaluate providers – and early attention on the part of states to determining how performance and outcomes will be measured.

In questions about the waiver request, CMS has pressed Florida for additional information regarding activities related to ensuring the health and welfare of participants, improving quality and conducting oversight and contract compliance monitoring.

The state is working with a consultant from the National HCBS Quality Enterprise, an initiative sponsored by CMS, to develop strategies and procedures, which CMS has indicated must be well defined and in place before the waiver can be approved.

CONCLUSION

Florida is proposing to make substantial changes in the financing and delivery of Medicaid long-term care services in a short period of time. But many questions about the design and operational aspects of the new program remain.

In order to better understand what the implications of the changes will be for service delivery and program costs, more detail is needed, particularly about who will have access to community-based services, how transitions and service coordination will be achieved, and how the adequacy and quality of services will be assured.

ENDNOTES

- (1) In capitated managed care arrangements, states contract with Managed Care Organizations to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries. The state pays a per-member-per-month premium to the Managed Care Organizations, which establish provider networks and pay providers. The more traditional fee-for-service arrangement relies on direct payments from Medicaid to service providers.
- (2) Agency for Health Care Administration, Florida Long-Term Care Managed Care Program: Program Overview, August 1, 2011.
- (3) Participating plans may include: Health Maintenance Organizations, Provider Service Networks, Exclusive Provider Organizations, Accountable Care Organizations, Medicare Advantage Preferred Provider Organizations, Provider-Sponsored Organizations and Special Needs Plans.
- (4) A minimum number of 3 plans will be required in 3 regions: regions 3, 4, and 7. A minimum of 4 will be required in region 6, and a minimum of 5 will be required in region 11.
- (5) The Adult Day Health Care waiver is scheduled to expire March 31, 2012. Rather than renew the waiver, AHCA plans to transfer enrollees to the other four waiver programs.
- (6) Florida Department of Elder Affairs, Summary of Programs and Services, February 2011.
- (7) The monthly income limit for an individual is \$2,022 and the asset limit is up to \$5,000, although it is as low as \$2,000 for some applicants. The value of the individual's home is not counted in calculating assets values.
- (8) Florida Department of Elder Affairs, Summary of Programs and Services, February 2011.
- (9) Florida Council on Aging, 2012 Legislative Priorities, available at <http://www.fcoa.org>.
- (10) U.S. Census Bureau, U.S. Population Projections, Ranking of states by projected percent of population age 65 and over: 2000, 2010, and 2030. Available at: <http://www.census.gov/population/www/projections/projectionsagesex.html>
- (11) Summer, L., Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider, Kaiser Commission on Medicaid and the Uninsured, October 2011.
- (12) Lind, A., S. Gore, L. Barnette, S. Somers, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services, Center for Health Care Strategies, November 2010.
- (13) Consumers have had opportunities to comment on the legislative and waiver proposals, but they do not appear to have been included to a great extent in program design efforts. For example, the legislation specified that a Long-Term Care Managed Care Technical Advisory Workgroup be established and while representation was not limited to providers and plans, they are the only groups specified for inclusion and are strongly represented. In other states, consumers or their representatives have been key members of advisory boards that meet for more than a year prior to and following program implementation; strong ombudsman programs have been established; and contracts with managed care organizations require that the organizations establish consumer advisory boards that meet frequently.
- (14) Gifford, K., V. Smith, D. Snipes, J. Paradise, A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, Kaiser Commission on Medicaid and the Uninsured, September 2011.
- (15) Medicaid and CHIP Payment Access Commission, The Evolution of Managed Care in Medicaid, Report to the Congress, MACPAC, June 2011.
- (16) Dually eligible beneficiaries may receive medical services on a fee-for-service basis or through a Medicare Advantage managed care plan.
- (17) The legislation does specify that if dually eligible program participants do not enroll in a Long-Term Care Managed Care plan, but are already enrolled in a Medicare Advantage plan, they will automatically be enrolled in the Medicare Advantage plan for long-term care services. The waiver proposal notes that when the anticipated change to the Managed Medical Assistance program occurs individuals enrolled in both the Managed Medical Assistance program and Long-Term Care Managed Care program will be identified as "individuals with special health care needs," but it does not specify whether particular services or benefits will accompany that distinction.
- (18) Coughlin, T, S. Long, T. Triplett, S. Artiga, B. Lyons, R. Duncan, and A. Hall, Florida's Medicaid Reform: Informed Consumer Choice? Health Affairs, Web Exclusive, October 14, 2008.
- (19) Reinhard, S.C, E. Kassner, A. Houser, and R. Mollica, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, AARP, The Commonwealth Fund, The Scan Foundation, September 2011.
- (20) Office of Program Policy Analysis and Government Accountability, Profile of Florida's Medicaid Home and Community-Based Services Waivers, Report No. 11-03, January 2011.
- (21) The transition for people participating in the Nursing Home Diversion program, which already contracts with Managed Care Organizations, could be relatively easy if their current plans are chosen for the new program. If not, there could be significant disruption for these participants during the period between the award of contracts and enrollment for the new program when the market is in flux.
- (22) Eiken, S., K. Sredl, B. Burwell, L. Gold, Medicaid Expenditures for Long-Term Services and Supports: 2011 Update, Thomson Reuters, October 31, 2011.
- (23) The legislation states that incentives will be available to each plan until no more than 35 percent of the plan's enrollees are placed in institutional settings.
- (24) Florida Agency for Health Care Administration, December 2011.
- (25) Reinhard et al, September 2011.
- (26) The Long-Term Care Managed Care Technical Advisory Workgroup, established by the legislation, is charged with making recommendations regarding five administrative issues. The legislation specified that providers and plans be represented on the Workgroup. The group began meeting in July 2011. Members were appointed for a period of up to one year.
- (27) Houser, A., W. Fox-Grage, Gibson, MJ, Across the States, Profiles of Long-Term Care and Independent Living, Florida, AARP, 2009.

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AUTHORS

Laura Summer
Health Policy Institute
Georgetown University
Box 571444
3300 Whitehaven Street NW
Washington, D.C. 20057
202-687-0880



Sherry P. Magill
PRESIDENT

Jessie Ball duPont Fund
One Independent Drive
Suite 1400
Jacksonville, Florida 32202
904-353-0890
www.dupontfund.org



WINTER PARK
HEALTH FOUNDATION

Patricia Maddox
PRESIDENT

Winter Park
Health Foundation
220 Edinburgh Drive
Winter Park, Florida 32792
407-644-2300
www.wphf.org