Health Care Appropriations Subcommittee

Meeting Packet

January 15, 2013
2:00 PM—4:00 PM
Webster Hall

Will Weatherford
Speaker

Matt Hudson
Chair

AGENDA

Health Care Appropriations Subcommittee
January 15, 2013
2:00 p.m. – 4:00 p.m.
212 Knott

I. Call to Order/Roll Call

II. Opening Remarks

III. Briefing and Status Update by the Agency for Health Care Administration

- Departmental Overview: Elizabeth Dudek, Secretary, Agency for Health Care Administration
- Medicaid: Justin Senior, Deputy Secretary for Division of Medicaid, Agency for Health Care Administration
- Medicaid Reform: Justin Senior, Deputy Secretary for Division of Medicaid and Marcy Hajdukiewicz, Division Director, Statewide Community Based Services, Department of Elder Affairs

IV. Closing Remarks/Adjournment

AHCA

Florida Medicaid: An Overview

Elizabeth Dudek
Secretary, Agency for Health Care Administration

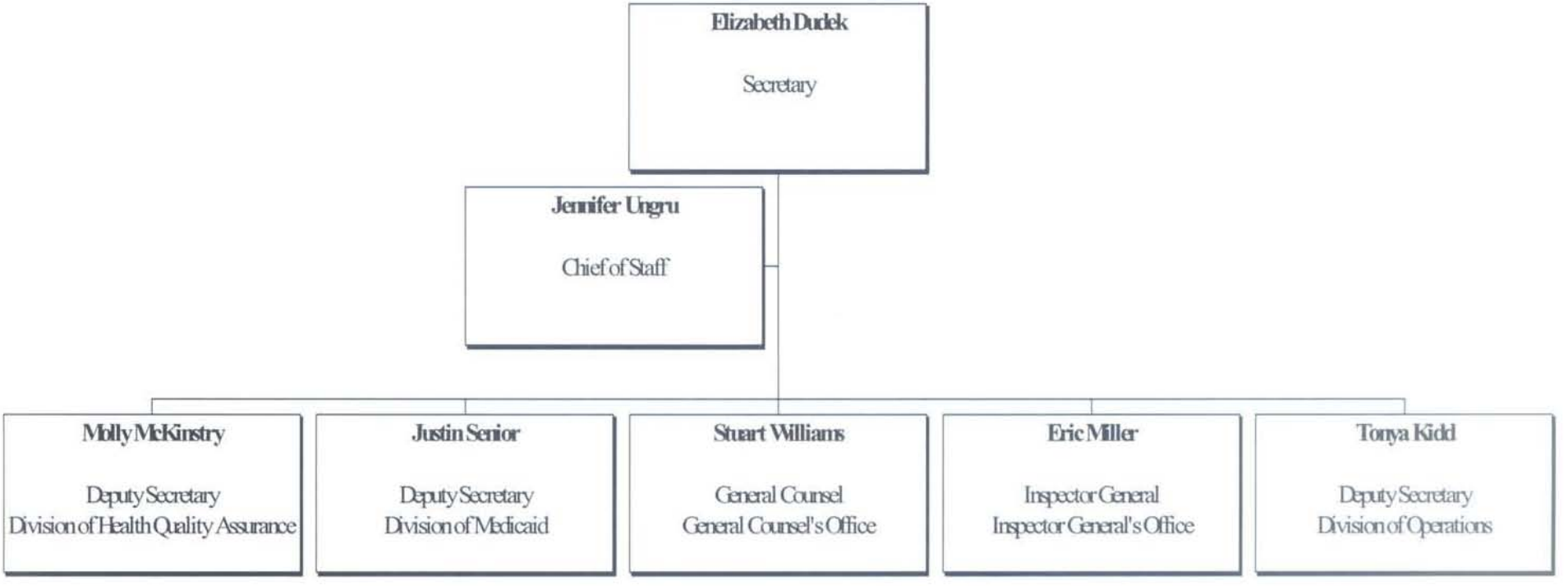
House Health Care Appropriations Subcommittee

January 15, 2013

AHCA Overview

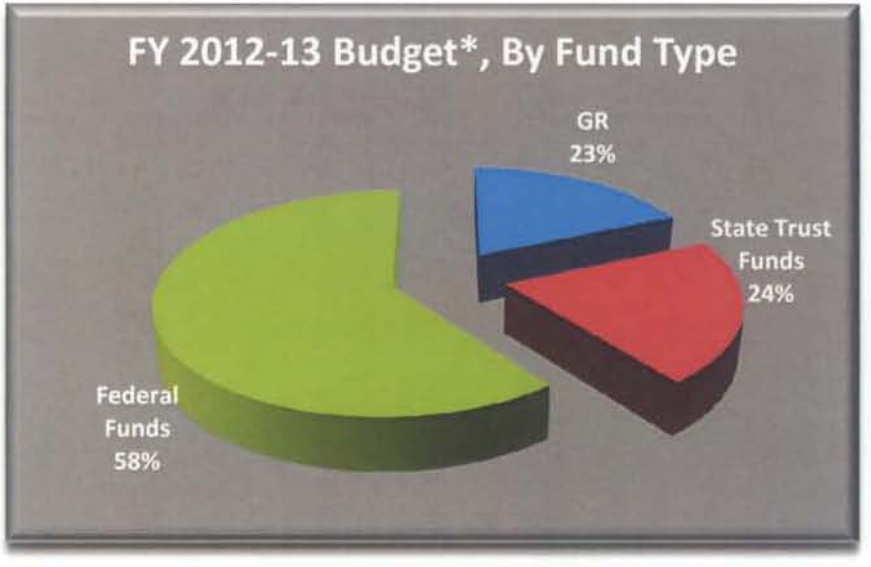
- The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state.
- Our mission is *Better Health Care for All Floridians*.
- There are 1,655 employees at the Agency.
- The Agency has three major divisions: Medicaid, Health Quality Assurance, and Administration/Support.
- The Agency's total budget for FY 2012-13 is $22,280,592,196.

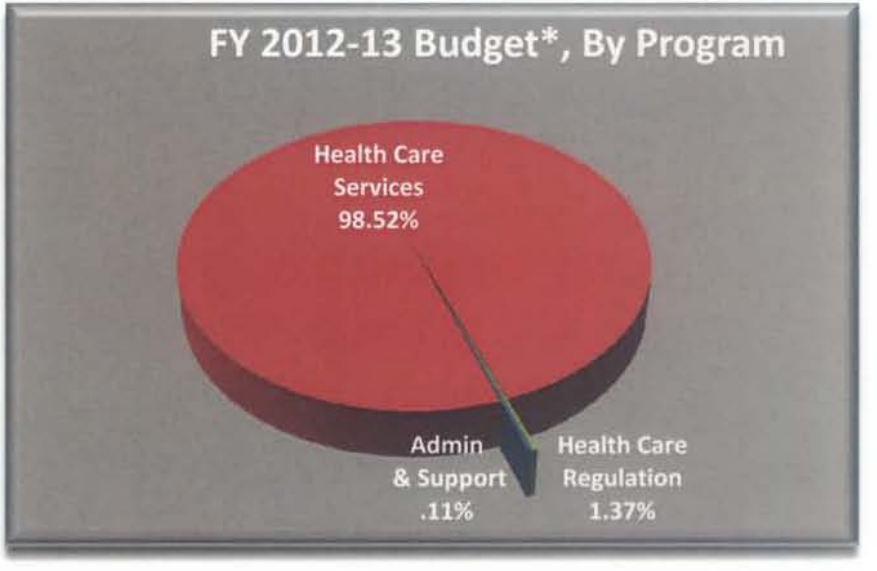
Agency for Health Care Administration Organizational Chart



Fiscal Year 2012-13 General Appropriations Act

#	Program	FTE	General Revenue	State Trust Funds	Federal Funds	Total
1	Administration & Support	249	3,468,242	12,667,941	8,462,181	24,598,364
2	Health Care Services	747	5,069,720,512	4,310,597,339	12,570,587,275	21,950,905,126
3	Health Care Regulation	659	131,019	36,001,634	268,956,053	305,088,706
4	**Total**	**1,655**	**5,073,319,773**	**4,359,266,914**	**12,848,005,509**	**22,280,592,196**





Total $22,280,592,196 includes reappropriations.

Inspector General

- The Office of the Inspector General is comprised of the Bureau of Medicaid Program Integrity (MPI), the Bureau of Internal Audit and the Investigations Unit.
- The Bureau of Medicaid Program Integrity is responsible for overseeing the activities of Medicaid recipients, and Medicaid providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible and for recovering overpayments and imposing sanctions as appropriate.
- MPI has field offices located in Miami, Jacksonville, Orlando and Tampa.
- Personnel in these offices are responsible for performing Medicaid provider site visits, coordinating special investigations, coordinating state-wide initiatives and working with other investigative agencies such as the Medicaid Fraud Control Unit (MFCU) on local projects that support the integrity of the Medicaid program.

Inspector General

MPI Recovery Activities (Millions)				
	FY 07-08	FY 08-09	FY 09-10	FY 10-11
MPI Audits (Overpayments Collected)	$14.9	$15.4	$16.4	$38.8
Costs (Collected by F&A)				1.5
Fines				1.0
Paid Claims Reversals	0.5	0.3	1.5	1.0
Contractual Assessments				10.8
TPL Contractor-Assisted Claims Adjustments	12.8	34.6	40.6	30.0
Total	$28.2	$50.3	$58.5	$83.1

MPI Prevention of Overpayments ($ Millions)								
	FY 2007-08		FY 2008-09		FY 2009-10		FY 2010-11	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	156	$4.2	99	$5.8	116	$4.8	272	$3.4
Termination of Providers	255	5.4	152	3.2	68	1.8	99	$1.8
Focused Projects	3	9.8	3	2.6	7	5.1		$1.2
Denial of Reimbursement for Prescription Drugs	40	0.5	3	0.3	-	-	-	-
Policy Changes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Site Visits	229	1.8	481	6.5	410	7.4	-	$12.1
Sanctioned Providers	-	-	-	-	-	-	525	$3.6
Total		$21.7		$18.40		$19.10		$22.1

Division of Health Quality Assurance

- The Division of Health Quality Assurance protects the citizens of Florida through oversight of health care service providers.
- The Division is divided into six bureaus:
  - Health Facility Regulation
  - Field Operations
  - Managed Health Care
  - Plans and Construction
  - Central Services
  - Florida Center for Health Information and Policy Analysis

Division of Health Quality Assurance

FY 2011/12 Volume Statistics:

- 22,082 applications
- 9,549 complaints
- 1,864 adverse incidents
- 189,756 background screenings
- 21,643 surveys and investigations
- 1,079 CON reviews
- 2,364 financial reviews
- 4,869 plans and construction reviews
- 406 subscriber assistance program cases
- 3,744 public information requests

Health Quality Assurance Field Offices

Area 1/2 – Donah Heiberg
2727 Mahan Drive
Tallahassee, FL, 32308
850-412-4540 phone
850-922-9162 fax
Donah.Heiberg@ahca.myflorida.com

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Area 8 – Harold Williams
2295 Victoria Ave. Room 340
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Area 11 – Arlene Mayo-Davis
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Miami, FL 33166
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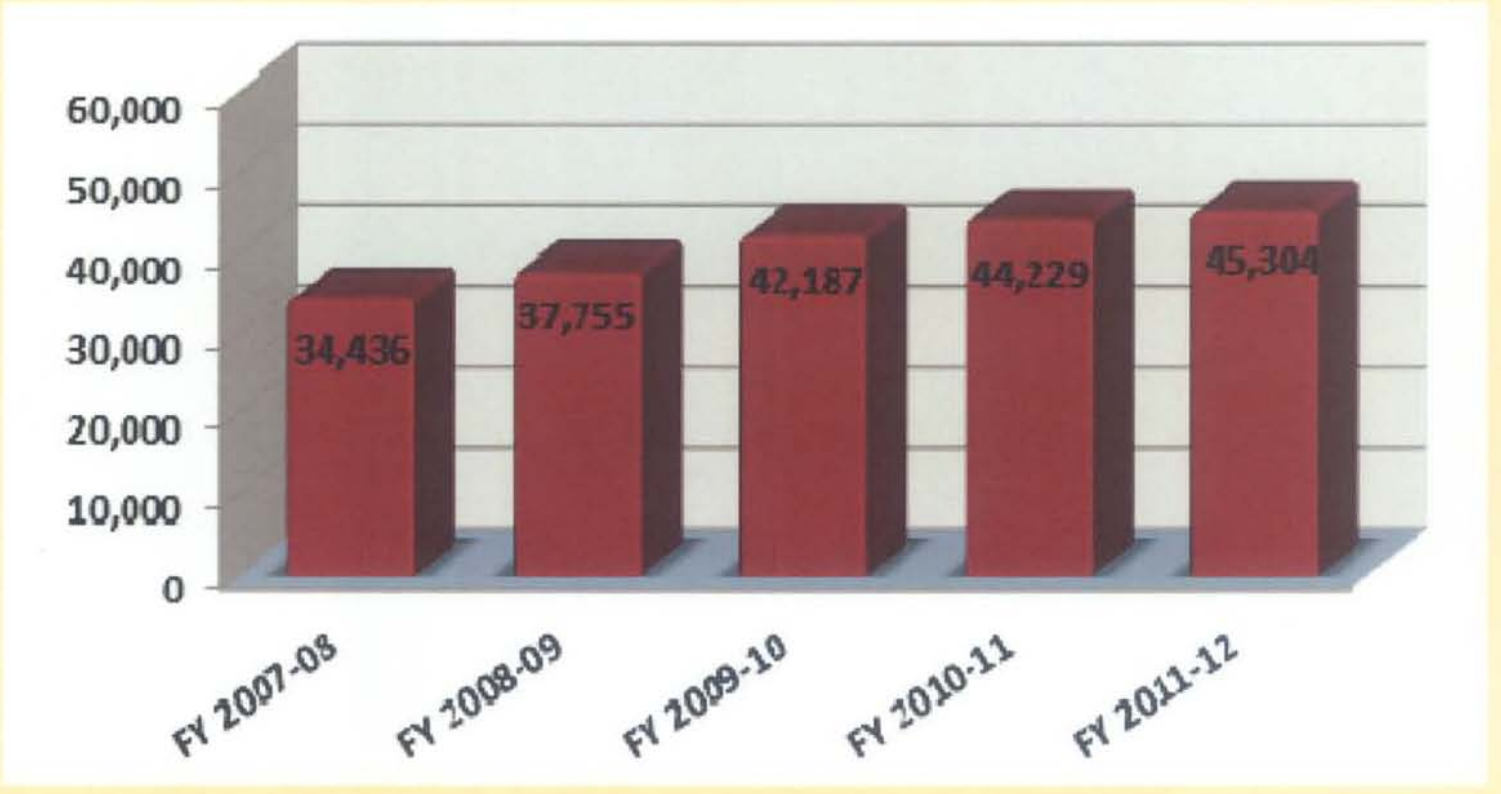
305-593-3121 fax
Arlene.Mayo-Davis@ahca.myflorida.com

Revised 12-1-2012

Number of Regulated Providers



Florida Center for Health Information and Policy Analysis

About Us | Data Submission/Online Reporting | Consumers | Researchers | Committees and Councils | Health Information Technology

Florida Center for Health Information and Policy Analysis

The Florida Center for Health Information and Policy Analysis (Florida Center) performs several important functions to improve the effectiveness and efficiency of health care services in the state and to support consumers in health care decision making. The Florida Center is responsible for collecting, compiling, coordinating, analyzing, and disseminating health related data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through www.FloridaHealthFinder.gov. These data provide accurate and timely health care information to consumers, policy analysts, administrators, and researchers in order to evaluate cost, quality, and access to care.

The Florida Center also promotes the exchange of secure, privacy-protected health care information, the adoption of electronic health records among providers, and the use of personal health records by all consumers. The Florida Center is actively promoting the adoption of electronic health record systems through health information exchange, electronic prescribing and personal health records software in partnership with health care stakeholders statewide.

Quick Links

- FloridaHealthFinder.gov
- Florida Health Information Network (FHIN)
- Order Patient Data
- Submit Adverse Incident Reports
- Patient Data Upload Portal

General Counsel

- The General Counsel's Office provides legal advice and representation for the Agency on all legal matters, including licensure and regulation of health care facilities and regulation of managed care plans; administration of the Medicaid plan and recovery of Medicaid overpayments due to abuse or third party liability; and civil litigation related to various Agency programs.

- The office of the Agency Clerk and the Public Records Office are housed in the General Counsel's Office.

For fiscal year 11-12:

- Final Orders: 4,208
- Public records requests: 5,226
- Total hearings: 240
- Total HQA cases: 3,281
- Total Medicaid cases: 274

- The General Counsel has field offices in: St Petersburg, Ft. Myers and Miami.

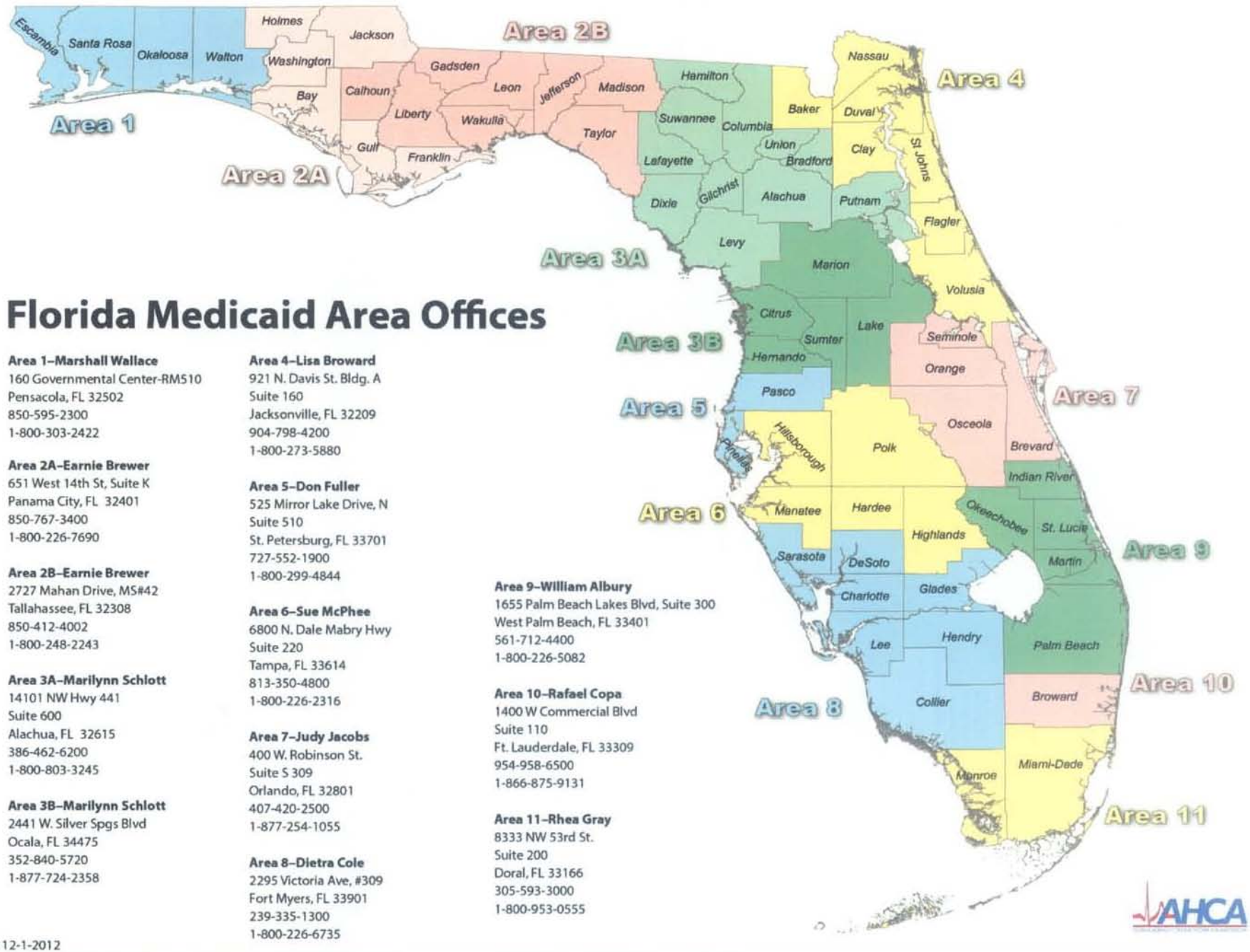
Division of Medicaid

- The Florida Medicaid program is a $21,950,905,126 billion state and federal partnership that provides health care to more than 3.3 million beneficiaries.
- The operation of the program is conducted by Medicaid bureaus that include:
  - Medicaid Finance
  - Medicaid Program Analysis
  - Contact Management
  - Health Systems Development
  - Medicaid Services
  - Pharmacy Services
  - Medicaid Area Offices

Division of Medicaid

- Medicaid serves the most vulnerable in Florida:
  - 59% of nursing home days are covered by Medicaid
  - 27% of children are covered by Medicaid
  - 1,450,543 adults - parents, aged and disabled. Over age 21 as of November 30, 2012
  - 49.5% of deliveries

- Medicaid processed more than 523,410 claim lines each day.
- There are more than 76,000 active Medicaid providers in Florida.
- Medicaid processes an average of 650 Medicaid provider enrollment applications each week.
- Medicaid call centers handle more than 7,500 calls per day.



Florida Medicaid Area Offices

Area 1–Marshall Wallace
160 Governmental Center-RM510
Pensacola, FL 32502
850-595-2300
1-800-303-2422

Area 2A–Earnie Brewer
651 West 14th St, Suite K
Panama City, FL 32401
850-767-3400
1-800-226-7690

Area 2B–Earnie Brewer
2727 Mahan Drive, MS#42
Tallahassee, FL 32308
850-412-4002
1-800-248-2243

Area 3A–Marilynn Schlott
14101 NW Hwy 441
Suite 600
Alachua, FL 32615
386-462-6200
1-800-803-3245

Area 3B–Marilynn Schlott
2441 W. Silver Spgs Blvd
Ocala, FL 34475
352-840-5720
1-877-724-2358

Area 4–Lisa Broward
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Suite 160
Jacksonville, FL 32209
904-798-4200
1-800-273-5880

Area 5–Don Fuller
525 Mirror Lake Drive, N
Suite 510
St. Petersburg, FL 33701
727-552-1900
1-800-299-4844

Area 6–Sue McPhee
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Tampa, FL 33614
813-350-4800
1-800-226-2316

Area 7–Judy Jacobs
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Orlando, FL 32801
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1-877-254-1055

Area 8–Dietra Cole
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Fort Myers, FL 33901
239-335-1300
1-800-226-6735

Area 9–William Albury
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West Palm Beach, FL 33401
561-712-4400
1-800-226-5082

Area 10–Rafael Copa
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Ft. Lauderdale, FL 33309
954-958-6500
1-866-875-9131

Area 11–Rhea Gray
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Doral, FL 33166
305-593-3000
1-800-953-0555

Revised 12-1-2012

Medicaid
A State and Federal Partnership

- In 1965, the federal Social Security Act was amended to establish two major national health care programs:
  - Title XVIII (Medicare)
  - Title XIX (Medicaid)
- Medicaid is jointly financed by state and federal funds.
- States administer their programs under federally approved State Plans.

The Medicaid Program
Major Federal Requirements

- States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS).
  - Mandatory eligibility groups and services must be covered.
  - Services must be available statewide in the same amount, duration and scope.
- In order for states to implement programs which deviate from their State Plan (to vary by geographic areas, amount, duration and scope), the state must request a waiver.
  - A waiver is a program requested by a state and approved by federal CMS that waives certain provisions of the Social Security Act.

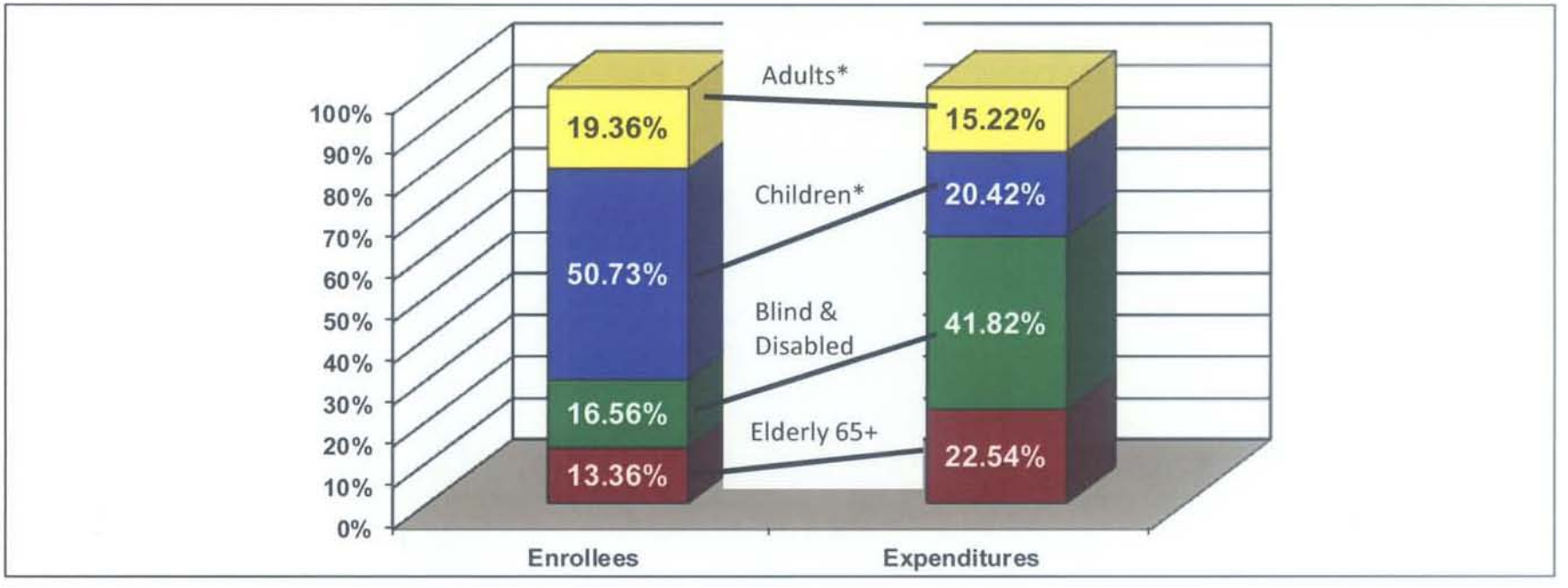
Types of Waivers

- There are three major types of waivers.
  - 1915(b)
    - Waive the requirement that "any willing qualified provider" can enroll and provide Medicaid reimbursable services.
  - 1915(c)
    - Cover services traditionally viewed as "long-term care" and provide them in a community setting instead of nursing facilities or Intermediate Care Facilities for the Developmentally Disabled.
  - 1115
    - To test or pilot a unique program or method of service delivery.

Florida Medicaid – A Snapshot

Expenditures	• $20.8 billion estimated spending in Fiscal Year 2012-13 • Federal-state matching program – 57.73% federal, 42.27% state. • Florida will spend approximately $6,208 per eligible in Fiscal Year 2012-2013. • 42% of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's); Low Income Pool and Disproportionate Share Payments. • 10% of all Medicaid expenditures cover drugs. • Fifth largest nationwide in Medicaid expenditures.
Eligibles	• 3.35 million eligibles. • Elders, disabled, families, pregnant women, children in families below poverty. • Fourth largest Medicaid population in the nation.
Providers/Plans	• Approximately 76,000 Fee-For-Service providers; 28 Medicaid Managed Care plans (19 HMOs and 9 PSNs).

Florida Medicaid Budget - How it was Spent
Fiscal Year 2011-12



* Adults and children refers to non disabled adults and children.

Florida Medicaid Enrollment Today

- The Florida Medicaid program is continuing to grow with enrollment anticipated to reach more than 3.35 million enrollees during 2013-2014.
  - Note: October 31, 2007, enrollment was 2,117,174. Increase of 52% over 5 year period (ending October 31, 2012).
- Medicaid recipients in Florida receive services through several different delivery systems, each with a different level of care coordination.

The Evolution of Florida Medicaid Delivery Systems

1970 - 1983 → Fee-for-Service

1984 - 1996 →
HMOs – Since 1984
MediPass (PCCM) – Since 1991
Prepaid Mental Health Plans – Since 1996

1997 -2003 →
Fee-for-service Provider Service Network - Since 2000
Disease Management
Nursing Home Diversion
Prepaid Dental Plans – Since 2004

2004 - Present →
Improvements in:
- Integrated Care Management/ Care Coordination
- Outcomes Management/Improved Clinical Decision Making
- Quality Assurance
- Enhancements to Fraud and Abuse Controls

New:
- Medicaid Reform Pilot (2006)
- Specialty Plan (HIV/AIDS)
- Capitated Provider Service Networks (Since 2008)

Florida's Current Medicaid Enrollment
December 1, 2012

Medicaid Enrollment As of December 2012		% of total Enrollment
HMO	1,226,484	38.2%
PSN	263,406	8.2%
MediPass (PCCM)	594,314	18.5%
Fee-For-Service	1,110,123	34.5%
Nursing Home Diversion	20,089	.62%
Total	**3,214,416**	

Note: 46.9% of recipients receive their care through a managed care plan today.

Florida's Medicaid Managed Care Programs

- Enrollment into:
  - Health Maintenance Organizations (HMO) since 1984 and MediPass since 1991
  - Addition of Provider Service Networks (PSN) in 2000
- Medicaid Managed Care Reform Pilot Program
  - July 1, 2006 through June 30, 2014
- Statewide Medicaid Managed Care Program
  - Beginning 2013/2014

Florida's Medicaid Managed Care Program: Goals

- Improve access to health care services.
- Provide more choices (plans and services) for Medicaid recipients.
- Provide opportunities for recipients to take a more active role in their health care decisions.
- Reduce the administrative complexity of managing the Florida Medicaid Program.
- Slow the rate of growth of expenditures:
  - Better care coordination
  - Reduction of over-utilization
  - Reduction of fraud and abuse

Medicaid Managed Care Pilot Program
(July 1, 2006 – June 30, 2014)

The Agency for Health Care Administration (Agency) was directed by the 2005 Florida Legislature, through Section 409.91211, Florida Statutes, to implement the Medicaid Managed Care Pilot Program.

~ 1115 Demonstration Waiver

Medicaid Managed Care Pilot Program (2006-2014): Choice of Plan Types

- HMO
  - HMO: Agency contracts with HMOs on a prepaid fixed monthly rate per member (e.g. capitation rate) for which the HMO assumes all risk for providing covered services to their enrollees.
- PSN
  - Provider Service Network (PSN) is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers.
- Specialty Plans
  - The Agency currently contracts with two HIV/AIDS specialty plans.

Medicaid Managed Care Pilot Program (2006-2014): Choice of Benefit Packages

- Expanded Benefits: Health plans may provide benefits in addition to the state plan benefit package.
  - over the counter drug benefits
  - preventative dental care for adults
  - adult eyeglass upgrades
  - circumcision
  - respite care
  - nutrition therapy
  - health and wellness benefit
  - Meals on Wheels for families of newborns
- Flexible Benefits: Plans may vary some benefits within an actuarially sound range.

Medicaid Managed Care Pilot Program (2006-2014): Choice Counseling

- Choice Counseling is designed to assist Medicaid recipients to choose a health care plan that meets their needs.
- Features unique to Pilot:
  - Online enrollment
  - Comprehensive plan comparison information
  - Home visits available upon request
  - Services available in many languages
  - Plan prescription drug formulary comparison tool
  - Special Needs Unit staffed with nurses to assist the medically complex

Medicaid Managed Care Pilot Program (2006-2014): Enhanced Benefits

- Participation in healthy behaviors that have positive outcomes and can improve one's health status are rewarded.
- Rewards are in the form of credit dollars that may be used to purchase health related products and supplies.
- Recipients may earn up to a maximum of $125 per year in credit dollars.
- Recipients may use credits for up three years after losing Medicaid eligibility if the credits were earned before January 1, 2012, or for up to 1 year after losing Medicaid eligibility if the credits were earned after January 1, 2012.

Medicaid Managed Care Pilot Program (2006-2014): Risk Adjusted Rates

- Risk Adjusted Rates:
  - A process to predict health care expenses based on chronic diagnoses.
  - Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.
  - Captures adverse selection without using experience rating (health status, not health use).
  - Rate allocation, not rate setting; are budget neutral
- Risk Adjustment Process:
  - Better matches payment to risk.
  - Pay for the risk associated with each plan's enrolled population.

Low Income Pool (LIP) Program

- The Low-Income Pool (LIP) program provides $1 billion annually to certain Florida Medicaid providers.
- Per Special Term and Condition (STC) #51 of the 1115 Wavier:
  - "The Low Income Pool provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or enhances existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations."

Statewide Medicaid Managed Care
(Beginning 2013/2014)

During the 2011 Florida Legislative Session, the House and Senate passed House Bill 7107 and HB 7109, which require the state Medicaid program to implement a Statewide Medicaid Managed Care Program.

- *~ 1915 (b)(c) Waiver*
- *~ 1115 Demonstration Waiver*
- *~ State Plan Amendment*

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for All Floridians
AHCA.MyFlorida.com

Statewide Medicaid Managed Care (2013/2014): Maintains Elements from Pilot

- Plan Choice
- Choice of Benefit Package
- Choice Counseling
- Healthy Behaviors
- Risk Adjusted Rates
- Low Income Pool

Statewide Medicaid Managed Care (2013/2014): Program Improvements

- Integrates long-term care for a more comprehensive and coordinated delivery system
  - Long-term care managed care program component
    - Will begin in the fall of 2013
  - Managed Medical Assistance program component
    - Will begin in mid-2014
- Comprehensive Plans
  - Ensure comprehensive care for recipients receiving both long-term care and managed medical assistance services

Statewide Medicaid Managed Care (2013/2014): Program Improvements

- Achieved Savings Rebate
  - Ensures appropriate medical services expenditures
- Access to Care Partnership
  - Ensures appropriate distribution of local funds (intergovernmental transfers) and Low Income Pool funds
- Florida Medical Schools Quality Network
  - Ensures continued involvement of medical schools and graduate medical education programs to improve clinical outcomes of managed care plans

Statewide Medicaid Managed Care Program: Program Improvements

- Increased access to quality providers:
  - Plan selection based on the Agency's 11 regions in the state
  - Selection of the most qualified plans through competitive procurement
  - Expanding services available in rural areas.
- Increased access to quality services:
  - Increased access to participant direction
  - Plans can offer expanded benefits
  - Increased opportunity for integration between Medicaid and Medicare through enhanced care coordination

Statewide Medicaid Managed Care Program: Program Improvements

- Increased predictability for recipients and providers:
  - Five year contracting period - less confusion for providers and recipients
  - Penalties for plan withdrawals
  - Maintenance of role of critical community-based providers
  - Parameters for payments to certain providers (nursing facilities, hospice)
  - Limited number of plans ensures adequate market share for plan stability

Statewide Medicaid Managed Care Program: Program Improvements

- Increased accountability:
  - Enhanced quality measures
  - Enhanced access to encounter data for long-term care services and other services
  - Enhanced contract compliance tools, including liquidated damages, sanctions, and statutory penalties and terminations
  - Additional integrity functions and activities to reduce the incidence of fraud and abuse

Statewide Medicaid Managed Care (2013/2014): Status of Federal Approval

- **Long-term Care Managed Care Program:**
  - The Agency submitted the 1915b/c application for the Long-term Care Managed Care waiver program on August 1, 2011.
  - On July 24, 2012, the Centers for Medicare and Medicaid Services (CMS) directed the Agency to submit a Transition Plan, Quality Measure Crosswalk, and Action Plan. The Agency initially submitted the Transition Plan, Quality Measures Crosswalk and Action Plan to CMS on August 30, 2012. Updated versions of these same documents were submitted to CMS on October 5, 2012, based on feedback received from CMS.
  - The LTC SMMC waiver went "back on the clock" for the final 90 day review period on November 9, 2012.
  - After much negotiation/ conversation/ provision of additional information, we anticipate approval by early February, 2013.

- **The Long-term Care Managed Care Invitation to Negotiate (ITN):**
  - The Long-term Care Managed Care Invitation to Negotiate (ITN) was released June 29, 2012, and the deadline for receipt of responses was August 28, 2012.
  - We are in the statutorily mandated black-out period for this ITN (section 287.057(3), F.S.).

Statewide Medicaid Managed Care (2013/2014): Status of Federal Approval

- **Managed Medical Assistance Program:**
  - The Agency submitted a request to amend the 1115 Medicaid Reform Demonstration Waiver for implementation of the Managed Medical Assistance Managed Care waiver program on August 1, 2011.
  - On January 3, 2012, CMS sent the Agency informal questions relating to this request and the Agency submitted responses on April 13, 2012.
  - On September / October, 2012, the Agency submitted Florida's Medicaid Managed Care Quality Assessment and Improvement Strategies (QAIS) and draft implementation plan for the MMA program to Federal CMS. The draft implementation plan summarizes the key implementation activities the Agency has undertaken or will undertake to implement the MMA program.
  - The Managed Medical Assistance ITN was released December 28, 2012
  - We are in the statutorily mandated black-out period for this ITN (section 287.057(3), F.S.).

Statewide Medicaid Managed Care (2013/2014): Status of Federal Approval

- **Medically Needy Program: Seeking Section 1115 Research and Demonstration Waiver**
  - The Agency submitted a concept paper to federal CMS on August 1, 2011, and submitted the final waiver application on November 21, 2012.
- **State Plan Amendment**
  - To authorize the Health Insurance Premium Payment Program
  - Approved by federal CMS September 2011
  - Rulemaking is in process

Public input and Program Improvements

- Florida Medicaid is open to feedback from any stakeholder, including recipients, providers, advocates and researchers.
- Based on this feedback, the program has taken advantage of opportunities to adapt and improve components of the Reform Pilot, including:
  - Focus groups and public meetings
  - Revision of publications and call center scripts
  - Choice Counseling Special Needs Unit
  - Choice Counseling Navigator System
  - Centralized Complaint Tracking System
- Email your comments and suggestions to FLMedicaidManagedCare@AHCA.myflorida.com.

Questions?

DOEA

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

DOEA'S ROLE:

MEDICAID MANAGED CARE LONG-TERM CARE IN FLORIDA

House Health Care Appropriations Committee

January 15, 2013, 2:00 p.m. – 4:00 p.m.

212 Knott Building

Rick Scott, Governor
Charles T. Corley, DOEA Secretary

Marcy Hajdukiewicz, Division Director, Statewide Community-Based Services
Florida Department of Elder Affairs (DOEA)

Knowledge and Expertise

- Florida Department of Elder Affairs (DOEA): Florida's designated State Unit on Aging
  - **Contributes 28 years of experience** operating Florida's primary Medicaid long-term care programs
    - Since the mid 1980s: administered the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program
    - Since 1985: administered the fee-for-service long-term care waivers (current Aged Disabled Adult and Assisted Living Waivers)
    - Since 1996: designed/administered Florida's Medicaid managed long-term care programs [Nursing Home Diversion, Program of All Inclusive Care for the Elderly (PACE), Channeling]

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

Knowledge and Expertise

- Partnerships:
  - AHCA, DCF, and other agencies
  - Aging and Disability Resource Centers (ADRCs)
  - Aging network service providers

- DOEA contributed to the following:
  - Development of the SMMCLTC Program design
  - Participated in various interagency workgroups
  - Contract development
  - Invitation to Negotiate (ITN) specifications
  - Evaluation of ITNs and negotiations
  - Managed care plan readiness and implementation

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

Responsibilities of DOEA

- Assist with development of specifications for use in the Invitation to Negotiate (ITN) and the model contract
- Develop a transition plan
- Determine medical eligibility for enrollment in managed long-term care plans through CARES
- Monitor managed care plan performance and measure quality of service delivery
- Enrollment management (fiscal management of waitlist)
- Facilitate working relationships between managed care plans and providers serving elders and adults with disabilities

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Responsibilities of ADRCs

- Program Education/Referral
- Intake/Screening
- Placement on waitlist
- Annual re-screening and contact upon release from waitlist
- Assistance with Medicaid specific eligibility forms
- Assistance with grievance and appeals

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Transition Plan

- The Legislature directed DOEA to develop a plan to seamlessly transition approximately 89,000 elders and adults with disabilities who are currently enrolled in various Medicaid HCBS Waivers and Medicaid residents of nursing facilities to the SMMCLTC Program.

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Transition from Current Operations to SMMCLTC Program

- Education of the aging network stakeholders, e.g.:
  - ADRCs
  - Aging Service Providers, including Nursing Facilities (NF) and Assisted Living Facilities
  - Long-Term Care Ombudsman Program
  - SHINE (Serving Health Insurance Needs of Elders)
  - Other stakeholders
- Initial notification of current recipients and individuals on the waitlist

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SMMCLTC Program Transition Population

- As each region implements the SMMCLTC Program, there will be two categories of recipients:
  - Recipients actively receiving NF services
  - Recipients receiving services through DOEA's or DCF's existing Medicaid programs

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Enrollment Process into SMMCLTC Program

- Recipients are encouraged to choose the long-term care managed care plan that best meets their needs.
- If a recipient who is required to enroll does not choose a plan within 30 days, AHCA will automatically assign the recipient to a long-term care managed care plan.

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Transition Plan

- As part of this seamless transition, the new SMMCLTC managed care plan is required to continue existing services without question and without interruption for up to 60 days, until the enrollee receives a comprehensive assessment and a new plan of care is developed.

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Regional Enrollment Schedule

Region(s)	Plan Readiness Deadline	Enrollment Effective Date
7	May 1, 2013	August 1, 2013
8, 9	June 1, 2013	September 1, 2013
1, 2, 10	August 1, 2013	November 1, 2013
11	September 1, 2013	December 1, 2013
5, 6	November 1, 2013	February 1, 2014
3, 4	December 1, 2013	March 1, 2014

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Closing Summary

- DOEA's experience designing and operating managed LTC in Florida has guided the SMMCLTC Program design, lessons learned, and the inclusion of best practices.

- DOEA's transition plan ensures contact with each frail elder and disabled adult. This seamless process will avoid or minimize confusion about the service delivery change for these populations.

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