SMMC: LTC and MMA

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Why should you care about SMMC

- Florida has 7M+ people 50 y/o +
- 4M+ Social Security beneficiaries
- 3.5M+ Medicare beneficiaries
- More than 29,000 Floridians remain on waiting lists for home and community based services

What is Managed Care?

- Managed care is when health care organizations manage how their enrollees receive health care services
- Managed Care Organizations (MCO's) work with different providers to offer qualify health care services
- MCO's work to make sure enrollees have access to all needed doctors and other health care providers for covered services
- People enrolled in managed care receive their services from providers that have a contract with the managed care plan

AHCA: Agency for Health Care Administration, SMMC

- Long-Term Care Program implemented August 2013- March 2014
- Managed Medical Assistance Program implemented May 2014 – August 2014
- SMMC does not limit medically necessary services
- SMMC is not linked to changes in the Medicare program and does not change Medicare benefits or choices
- SMMC is not linked to National Health Care Reform or the Affordable Care Act passed by Congress
  - No mandates for individuals or employers
  - It does not expand Medicaid coverage or cost the state or federal government any additional money

SMMC
Long Term Care Managed Care

- Fully implemented as March 2014
- Provides LTC services, including nursing facility services and home and community based services, to recipients eligible for enrollment

LTC Minimum Covered Services

- Adult companion care
- Intermittent and skilled nursing
- Adult day health care
- Medical equipment and supplies
- Assisted living
- Medication administration
- Assistive care services
- Medication management
- Attendant care
- Nursing facility
- Behavioral management
- Nutritional assessment/ risk reduction

LTC Minimum Covered Services

- Care coordination/ Case management
- Personal care
- Caregiver training
- Personal emergency response system
- Home accessibility adaptation
- Respite care
- Home-delivered meals
- Therapies, occupational, physical, respiratory and speech
- Homemaker
- Transportation, Non-emergency
- Hospice

Eligibility

- Financial Requirements have stayed the same: Need to file for Medicaid benefits online at Medicaid ACCESS website- http://www.myflorida.com/accessflorida/
- Level of Care still needs to be met:
  - ADRC (Aging and Disability Resource Center) to get on waiting list (701S), once slot received, CARES completes LOC
  - If in hospital and/or Skilled nursing facility, 3008 completed by Dr and medical team, sent to CARES to initiate evaluation for LOC
  - If in SNF, can apply for Medicaid, and after 60 day stay with Medicaid approval can transition to HCBS at ALF/Home

Pinellas/Pasco Region 5 Providers

- Sunshine Health www.sunshinehealth.com
- United Healthcare http://www.uhccommunityplan.com/fl/medicaid/health-home-connection.html
- Molina Healthcare http://www.molinahealthcare.com/
- American Eldercare http://providerportal.americaneldercare.com/ExternalWeb/

Contracts with the state of Florida are for 5 years – there are penalties assessed against company for early withdrawal

Recipients of SMMC LTC are mandatory for enrollment if:

- 65 years of age or older AND need nursing facility level of care
- 18 years of age or older AND are eligible for Medicaid by reason of a disability, AND need nursing facility level of care

Recipients must enroll in SMMC LTC if they are 18 and older and enrolled in the following:

- Assisted Living Waiver
- Aged and Disabled Adult Waiver
- Consumer-Directed Care Plus Program (CDC+)
- Channeling Services Waiver
- Frail and Elder Program
- Long-term Care Community Diversion Waiver.
- Or, if they live in a nursing facility and have Medicaid as
- the primary payer.

Recipients cannot be enrolled to receive home and community based services until they have:

- Received nursing facility level of care from CARES
- Been released from the wait list
- Filed a Medicaid application

SMMC Managed Medical Assistance (MMA)

- Implemented May 2014 – August 2014
- Provides primary care, acute care and behavioral health care services to recipients eligible for enrollment
- Goals include:
  - Recipients maintaining primary care provider
  - Recipients keeping current prescriptions
  - Maintaining ongoing treatments - uninterrupted
- Plans must have ability to pay providers fully and promptly to ensure no provider cash flow or payroll issues
- Plans must have sufficient provider networks in place

Discontinued Programs due to MMA implementation

- Medipass
- Prepaid Mental Health Plans
- Prepaid Dental Health Plans

SMMC MMA Providers
Pinellas/Pasco

- Amerigroup https://www.myamerigroup.com/FL/Pages/smmc-mma.aspx
- Prestige Health Choice http://www.prestigehealthchoice.com/
- Sunshine Health www.sunshinehealth.com
- Staywell Health https://florida.wellcare.com/member/florida_staywell#

Specialty MMA Plans Available

- HIV/AIDS: Clear Health Alliance http://www.clearhealthalliance.com/
- Children with Chronic Conditions: Children's Medical Services Network http://www.floridahealth.gov/alternatesites/cms-kids/families/health_services/cms_network_home.html
- Serious mental illness: Magellan Complete Care http://www.magellancompletecareoffl.com/fl-site/about-complete-care/welcome.aspx
- Child Welfare: Sunshine Health Plan http://www.sunshinehealth.com/
- Cardiovascular Dx, COPD, CHF, and Diabetes: Freedom Health (dual eligibles only) https://www.freedomhealth.com/

Which Medicaid Recipients Have Enrolled in MMA?

- SSI (Aged, Blind and Disabled)
- Hospice
- Temporary Assistance to Needy Families (TANF)
- Institutional Care
- MEDS-AD
- Protected Medicaid
- Dual Eligibles (Medicare and Medicaid)
- Dual Eligibles (Part C – Medicare Advantage Plans Only) (will enroll 1/2015)

Populations who MAY choose to Enroll in MMA

- Recipients with Third Party Liability coverage excluding Medicare
- Recipients residing in ICF for Individual with Intellectual Disabilities
- Individuals receiving refugee assistance
- Recipients ages 65 or older residing in a State Mental Health Hospital
- Recipients enrolled in iBudget home (developmental disabilities) and community based services waivers & recipients on the iBudget home and community based services waiver wait list (must be fully eligible)
- Children receiving services in a prescribed pediatric extended care facility
- Medicaid recipients in group home licensed under Chapter 393

Populations who will NOT participate in the SMMC MMA

- Individuals eligible for emergency services only due to immigration status
- Women only eligible for family planning services
- Women who are eligible through the breast and cervical cancer program
- Emergency shelter/Department of Juvenile Justice residential
- Recipients only enrolled in the Qualified Individuals 1, QMB, and SLMB
- Recipients in the Health Insurance Premium Payment program
- Presumptively eligible pregnant women
- Medically Needy individuals

Continuity of Care Requirements for MMA Plans

- MMA plans are responsible for coordination of care for new enrollees transitioning into the plan
- MMA plans are required to cover any ongoing course of treatment with the recipient's provider during the 60 day continuity of care period, even if that provider is not enrolled in the plan's network
- No additional authorization required for course of treatment during transition
- The following services may extend longer to ensure continuity of care:
  - Prenatal and postpartum care up to six weeks after birth
  - Transplant services (through the first year)
  - Radiation and/or chemotherapy services (for the current round of treatment)

How to Choose a Plan (LTC or MMA) and Enroll

- Information is available online at www.flmedicaidmanagedcare.com
- May speak with a CHOICE counselor by calling 1.877.711.3662 or 1.866.467.4970 (TTY) and speak with a CHOICE Counselor or Interactive Voice Response System
- Choice Counseling is offered through contracted broker to help recipients understand:
  - Managed care
  - Available plan choices and the differences
  - The Enrollment process and Plan change process
- Counseling is unbiased and objective

Choice Counseling Cycle

- Recipient determined eligible for enrollment
- Recipient receives communication informing him of choices
- Recipient may enroll or change via phone, online on in person
- Enrollment or change is processed during monthly processing and becomes effective the following month
- Newly eligible recipients are allowed 90 days to try the plan out, before becoming locked-in

Considerations when choosing a plan…

- What services do I think I need?
- What plan do my doctors take?
- What extra benefits may meet my needs?
- Basic benefits are required and all companies provide the required core benefits
- Review online the Plan Information tab to see what extra services are offered by each plan
- Word of mouth reputation of company
- For LTC, case manager is the gate keeper and authorizer of services

Mixed Services
Available under LTC and MMA

- Assistive Services
- Case Management
- Home Health
- Hospice
- DME and supplies
- Therapy Services
- Non-emergency transportation

Care Coordination

- Plans must coordinate to ensure services are not duplicated
- LTC case manager is primary
- Plans must coordinate with any other third party payor
- Plans must ensure services are provided in most efficient and effective manner

LTC and MMA Coordination

- Medicare is primary payor – and pays first if covered service
- MMA and LTC responsible for services not covered by Medicare
- If enrollee is enrolled in MMA and LTC, the LTC plan is responsible for paying for the mixed services
- LTC plans must pay hospice providers through a prospective system for each enrollee an amount equal to the rate set by AHCA
- LTC must provide non-emergency transportation to all LTC covered services
- LTC must offer all DME providers network contract during first 12 months if they were an aging network service and had participated HCBS programs

Comprehensive Plans

- Managed care plans that offer BOTH LTC and MMA serices
- Pinellas/Pasco: Sunshine Health Services
- Advantage of joining a comprehensive plan – increased ability of the managed care plan to coordinate care
- Medicaid comprehensive plan will cover Medicare co-payments
- In 2015, recipients enrolled in Medicare Advantage plans will have the ability to choose a comprehensive Medicaid plan where the Medicare and Medicaid plans are the same entity
- Except for ***patient responsibility*** for LTC services, the plan members should have no costs to pay

Drugs (Legally Prescribed Medications)

- Need to evaluate clients medications and confirm Medicare Advantage Plan or Part D or Medicaid MCO – has medication on their formulary
- Medicaid always pays last
- Individual could have Medicare A & B, Supplemental Ins, Part D, SMMC LTC, and SMMC MA coverage

Open Enrollment

- Medicare Open Enrollment – October 15, 2014- December 7, 2014
- Can change MCO during first 90 days of enrollment
- Medicaid Open Enrollment- This is the 60 day period when recipients can change managed care plans without a State Approved "Cause" (See definition). Open enrollment occurs yearly on the recipient's anniversary of their first enrollment into a plan.
- Cause - Also known as "For Cause" or "Good Cause", these are State approved reasons to change care plans during the lock-in period

Good Cause

- The enrollee moves out of the county, or the enrollee's address is incorrect and the enrollee does not live in a county where the plan is authorized to provide services.
- The provider is no longer with the health plan.
- A substantiated marketing or community outreach violation has occurred. The enrollee is excluded from enrollment.
- The enrollee is prevented from participating in the development of his/her treatment plan.
- The enrollee has an active relationship with a provider who is not on the health plan's panel, but is on the panel of another health plan.
- The enrollee is in the wrong health plan as determined by the Agency.
- The health plan no longer participates in the county.
- The state has imposed intermediate sanctions upon the health plan, as specified in 42 CFR 438.702(a)(3).

Good Cause

- The enrollee needs related services to be performed concurrently, but not all related services are available within the health plan network or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- The health plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for non-Reform populations and 180 calendar days or less for Reform populations.
- (Other reasons per 42 CFR 438.56(d)(2), including, but not limited to, poor quality of care; lack of access to services covered under the contract; inordinate or inappropriate

Good Cause

- Changes of PCPs; service access impairments due to significant changes in the geographic location of services; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.
- Voluntary enrollees may disenroll from the health plan at any time.

Advocacy

- Work with your client to assess their situation, needs, ADL's, IADL's, medications, treatments, etc….
- Ensure you know how the process works and have what is needed for program eligibility, don't miss key dates, know your client's rights
- Research plans, get specific information on how the plan will work with your diagnosis/prognosis
- Know the complaint and appeal process, know when and how to make changes
- Understand the Continuity of Care requirements
- Understand the potential claim(s) against their estate

Rights and Complaints

- http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml
- Post a complaint online or Call Justin Senior, Deputy Secretary for Medicaid, Phone: (850) 412-4000
- When there has been a "denial, reduction, suspension or termination of services …."
  - Enrollee has 2 choices upon receipt of a Notice of Action
- 1. File an appeal with the Plan w/in 30 days OR
- 2. File a request for Fair Hearing with DCF w/ in 90 days
- Enrollee must request an appeal with the Plan within 10 business days of the mailing date of the Notice or the intended effective date of the action, whichever is later. OR Request Fair Hearing within 10 days of the date of notice of action.
- KEY: Enrollee must request extension of benefits