

**FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL HEALTH CARE TASK FORCE
PLANNING MEETING ON MEDICAID MANAGED CARE EXPANSION:
SUMMARY AND RECOMMENDATIONS FOR STRATEGIC ACTION**

MEETING PARTICIPANTS

The following individuals attended and participated in the meeting, either in person or via conference call:

- Melanie Brown-Wolfler, AHCA HMO unit
- Karen Clay, FDDC Policy and Advocacy Committee
- Christopher Drummond, FDDC Consumer Advocate
- Margaret Hooper, FDDC Director of Legislative Policy and Advocacy
- Beth Kidder, AHCA
- Susan Redmon, FDDC Family Advocate
- Debbie Richards, FDDC Program Manager
- Phyllis Sloyer, Florida Children Medical Services (CMS)
- Ernest Smith, FDDC Consumer Advocate
- Sandra Sroka, FDDC Consumer Advocate
- Jarrett Stone, AHCA Home and Community-Based Services Waiver Unit
- Charm Thometz, FDDC Family Advocate
- David Wood, Chair of FDDC HCTF
- Celeste Putnam, FDDC Consultant on Medical Necessity
- Mari-Lynn Drainoni, Boston University School of Public Health, Facilitator

SUMMARY AND BACKGROUND

On October 8, 2007, the Florida Developmental Disabilities Council (FDDC) Health Care Task Force (HCTF) hosted a planning meeting to address key issues related to the expansion of managed care in Florida. The goals of this meeting were to build consensus related to managed care expansion, to identify responsible and inclusive planning components necessary for successful managed care for persons with developmental disabilities (including those with complex health care needs), and to build a platform that will be used to guide the FDDC legislative planning efforts.

As part of Florida's Medicaid Reform initiative, a large proportion of persons with developmental disabilities in Florida are expected to be enrolled in managed care. While currently the state has enacted managed care pilot projects for Medicaid state plan services, there is also consideration of building a managed care model for Medicaid long-term care and other waiver services, now provided and managed through the Agency for Persons with Disabilities (APD). In addition, ARC Florida commissioned a consultant organization Health Management Associates (HMA) to assist them in identifying key practices and requirements for enrolling persons with developmental disabilities in Medicaid managed care programs. It is important to note that the group working with HMA included representatives from at least one HMO that hopes to be a key player in Medicaid managed care in Florida, and also represented primarily large provider agencies.

ROLE OF FDDC AND THE HCTF

The HCTF within the FDDC serves as a key advocacy and planning group for persons with developmental disabilities in Florida. There is a broad range of participants, but the group

involved in this initiative does not represent providers. Although representatives from the Agency for Health Care Administration (AHCA) participate on the HCTF, AHCA is a state agency and does not represent specific provider interests. As a group with no financial investment in this initiative, the FDDC, and specifically its the HCTF, is in an ideal position to develop a platform that should be acceptable to and can be used widely within the developmental disability community.

MEETING GOALS

Goals of this meeting were to ensure that a knowledgeable group composed of consumers, family members, FDDC staff and state policymakers:

- Review the status of legislative proposals related to managed care in Florida and their potential impact on persons with developmental disabilities
- Discuss the status of Medicaid state plan services and waiver services and separate out the impact of movement toward long care in both arenas, as well as managed care experience with each
- Determine the importance of assessing differences between persons with developmental disabilities receiving APD services/on the APD waiting list and other persons with developmental disabilities in Florida, and the differential impact of Medicaid managed care on both groups
- Review the status of managed care for persons with disabilities and persons with developmental disabilities, both in Florida and nationally
- Identify strengths and barriers encountered in current managed care initiatives
- Review the HMA report commissioned and discuss its implications
- Review recommendations from the previous FDDC-funded report
- Develop a broad recommendations regarding whether to support or oppose managed care initiatives for Medicaid state plan services and/or for Medicaid waiver services for persons with developmental disabilities
- Identify key elements and mandatory safeguards for implementation should there be support for including individuals with developmental disabilities in mandatory managed care.

ACCOMPLISHMENTS

During the full-day meeting, several activities were accomplished:

- A review of legislature's plan for managed care and potential for including persons with developmental disabilities as a mandatory population
- A discussion of other states' level of experience with Medicaid managed care for state plan services and for wavier services and consensus building related to considering them separately in further discussions
- A brief review of the current status of the Medicaid Reform pilot projects currently underway in Florida
- Development of general recommendations and a legislative platform
- Identification of key activities that are not managed care organization-specific, but that are the responsibility of AHCA prior to RFP development and instituting mandatory managed care for persons with developmental disabilities
- Identification of important mandatory elements and safeguards considered necessary for AHCA to include in an RFP that must be documented by the managed care organization if they will be considered certified to enroll persons with disabilities for Medicaid state plan services

The items that achieved consensus, including general recommendations and legislative platform, the key activities that need to be implemented by AHCA prior to RFP development, and the suggestions for mandatory elements and safeguards to be included in the RFP for state plan services are discussed in Document I. Document II includes the issues that were discussed but require ongoing discussion to come to consensus. Document III includes items that are important but that we not addressed due to time constraints, but that will necessitate further research and/or discussion.

I. ITEMS ON WHICH THE GROUP ACHIEVED CONSENSUS

General Recommendations and Legislative Platform

1. Specific planning within AHCA regarding managed care for persons with developmental disabilities is necessary. Although there is some language in SB #836 that specifies the needs of persons with developmental disabilities in managed care planning, AHCA's current "Set of Principles" for managed care makes no mention persons with developmental disabilities.
2. Managed care for waiver services is unacceptable at this time. There is little to no experience with this model in other states; states with managed long-term care programs primarily serve elders and some persons with physical disabilities receiving both Medicare and Medicaid benefits. HMOs and other managed care organizations serving Florida residents have little experience providing state plan services to persons with developmental disabilities and no expertise in waiver services. A reasonable period of successful managed care experience with state plan services is needed prior to considering managed waiver services. Other models of care management for waiver services, such as CDC-Plus, should be fully evaluated before new initiatives are implemented.
3. Managed care planning should be equitable and non-discriminatory, and developed by a group that does not include potential contractors or service providers. Planning for implementation and for RFP and contract language must be developed without the input of potential managed care contractors or providers. The present approach that allows potential contractors and service providers to develop the concepts and language encourages managed care organizations and larger, well-funded providers to drive the system without specific safeguards or input regarding consumer needs and leads to the appearance of conflict of interest. Contract specifications should be written by AHCA. AHCA should establish an Advisory Group consisting of consumers, family members and advocates for persons with developmental disabilities who have no formal affiliations with potential contractors or service providers to review the standards and contract language.

Key Activities for AHCA Implementation Prior to RFP Development and Mandatory Managed Care

4. A screening procedure to needs to identify all persons with developmental disabilities should be put into place prior to instituting mandatory managed care. The state's only mechanism for identifying persons with developmental disabilities is based on enrollment in APD services. However, the large majority of persons with developmental disabilities in Florida are not enrolled with APD. To avoid having these individuals enroll in a managed care plan

that cannot meet their needs, these individuals must be identified prior to implementing mandatory managed care.

5. Proposed process: Screen all SSI beneficiaries and all Medicaid enrollees at enrollment and renewal using a brief 2-3 question screening questionnaire. A positive screen should then trigger a telephone assessment by a trained individual to clarify whether a person has a developmental disability. A working group should be assembled to develop the initial screening questions and the telephone assessment procedure.
6. Evaluate the experience of persons with developmental disabilities enrolled in the pilot managed care programs under Medicaid Reform. AHCA should contract out – to an organization outside of Florida - consumer satisfaction surveys that specifically targeting persons with developmental disabilities and persons in their support networks to assess their experience with managed care. The evaluation should also include a component that assesses the managed care plans' experiences serving enrollees with developmental disabilities.
7. Develop a plan for sufficient training and assistance to enable consumers to make the most appropriate choice of a managed care plan. Persons with developmental disabilities will require assistance when selecting a managed care option. It is clear from experience in other states that there is a lack of knowledge about Medicaid managed care among community-based staff providing waiver services and state developmental disability agencies. There needs to be a plan for training these individuals, consumers and family members about Medicaid managed care. FDDC has been provided with a simple curriculum used successfully in other states that can be easily adapted for Florida. AHCA should issue grants to advocacy organization to conduct this training.
8. Develop a plan for selecting choice counselors and training them. Choice counselors need to be trained both about the special needs of persons with developmental disabilities and the managed care organizations that have services meeting their needs. Choice counselors should receive extensive training about developmental disability and also be aware of the services provided in each managed care organization. If choice counseling is contracted out to community-based developmental disability service providers or state developmental disability agency staff, as long as they are not contracting with any managed care organization to provide services, this will avoid the need for extensive training about developmental disability. Standard choice counseling is not sufficient for persons with developmental disabilities. The choice counseling for this group population must mirror the Medicaid reform language and include outreach and face-to-counseling, rather than telephone-based procedures.

Mandatory Elements and Safeguards to be Included in the RFP that must be Documented by the MCO to Enroll Persons with Developmental Disabilities

9. Managed care organizations must ensure a process for identifying each individual's special needs and a building a care plan to meet those needs. The contractor must their plan for identifying members with developmental disabilities, assessing their needs and developing a care plan within 60 days of enrollment that is agreed upon by the consumer and/or his/her support network, and updated annually.
10. Managed care organizations must document that they have providers who can meet the needs of their enrollees with developmental disabilities. Plans need to ensure that their

provider networks include the full range of providers to meet the special needs of persons with developmental disabilities. Plans that do not have contracts with academic medical centers, Centers of Excellence, and other traditional providers serving persons with developmental disabilities must document that they have equivalent providers with this expertise and experience. Managed care organizations should identify a plan for surveying or otherwise assessing their provider networks on a regular basis to ensure that this experience exists. They also must ensure that information about specific providers with developmental disability expertise is easily available to members and choice counselors, that provider information is continually updated, and that it is available in multiple formats.

11. Managed care organizations must ensure that gatekeepers and individuals conducting prior authorization for persons with developmental disabilities enrolled in their plan have a developmental disability or rehabilitation background. Plans must ensure that their medical necessity criteria are at least as broad as, and no more restrictive than, the AHCA definition. In addition, because medical necessity does not always address the issues of frequency, scope and duration so critical for persons with developmental disabilities, plans must identify individuals within the plan responsible for prior authorization and referral who have experience with persons with developmental disabilities. Plans must identify their procedures an additional level of service authorization for persons with developmental disabilities that must include a process for ensuring reviews of all initial service denials for members with developmental disabilities by an individual with developmental disability expertise before the initial rejection decision is issued. This process must not be part of the grievance and appeals procedure, but must be an additional step that occurs as part of normal plan operations for persons with developmental disabilities.
12. Managed care organizations must ensure that their staff includes a sufficient number of care coordinators specifically hired to serve persons with developmental disabilities who have a developmental disability or rehabilitation background. Each plan must identify “developmental disability care coordinators” whose primary function should be to coordinate care for the population. The plan must document that these care coordinators also have knowledge of the APD system and waiver services, and will coordinate care with the APD service coordinator. The plan must document their plan for identifying the ratio of care coordinators to persons with developmental disabilities based on the care coordinators case mix and level of service needs; however, this ratio cannot exceed the ratio of APD services coordinators to clients.
13. Managed care organizations must describe how they will transition members with developmental disability to new providers. Plan must allow for a transition period if a member has to change providers. If an enrollee has a relationship with a care provider that is not in the managed care organization’s provider network, the managed care organization must allow a six-month period of transition, during which visits with the former provider are covered.
14. Managed care organizations must describe their plans for ensuring access to all needed services and their requirements for covering out of network care. Out-of-network services must be fully covered if there is no qualified provider in the managed care organization network. Managed care organizations are required to ensure that their network includes the range of specialty providers needed by persons with developmental disabilities. Plans should document how they will assess whether they have age-appropriate providers within 30 miles for primary care and 60 miles for specialty care who can meet all of the needs of persons with developmental disabilities. Plans should describe their plans for allowing out-

of-network care if there are no qualified providers in the network to meet the special needs of a member.

15. Managed care organizations must ensure that all network providers, including primary and specialty care providers, must be willing to take new patients with developmental disabilities. Plans must describe how they will monitor and assess this.
16. Managed care organizations must allow persons with developmental disabilities to choose the most appropriate primary care provider. Plans should document their policies for allowing members to select specialists to serve a primary care providers if that provider furnishes the patient with routine care.
17. The managed care plan must identify how they will integrate services for persons with developmental disabilities. Special areas for service integration to be identified include coordination with APD waiver services, coordination between physical and behavioral health services, and coordination with school-based services.
18. Managed care organizations must offer some benefit enhancements that are appropriate for persons with developmental disabilities. Plans should describe the specific benefit enhancements available for persons with developmental disabilities. These must include enhancements that are desirable to the population and equal to those provided to other Medicaid enrollees. The specific services can be identified by the plan, but might include benefits such as diapers, standers, DME, supplies and transportation not covered in the Medicaid state plan, behavioral intervention sessions, and genetic counseling services.

II. ISSUES STILL REQUIRING DISCUSSION TO BUILD CONSENSUS

There were three issues raised in which the group was unable to come to a final consensus and will require ongoing discussion. These include the following:

1. Whether specialty plans should be specific to persons with developmental disabilities or should be broader and encompass all persons with chronic conditions. The group agreed that specialty developmental disability models and language should include all persons with developmental disabilities instead of only APD clients or individuals with the five state-allowed diagnoses. However, there was no final consensus on how to define the developmental disability population for the purpose of managed care. But there was also the question of ensuring that services, elements, recommendations and language be targeted to persons with all chronic conditions.

Commentary: Once this is decided, then you can decide whether it should be included in the legislative platform. This will be needed if it appears that it is going to be controversial and/or is going to require a strong advocacy component. If the decision is to have specialized plans for persons with developmental disabilities only, the issue will probably not need to be addressed any further and it will not impact the RFP language.

Broadening the scope beyond all persons with developmental disabilities raises many concerns. While having broader managed care models for all persons with chronic conditions may avoid the problem of creating divisions among different populations of persons with disabilities and

chronic illnesses, these models are less likely to be able to meet the very specialized needs of any specific population. Even diversity within the developmental disability population itself, the diversity makes it challenging. Adding multiple, unspecified populations to your platform creates a new set of very complex concerns and work to be done.

There are some very serious and important things to consider when assessing this issue. Although on the surface, it may appear as though the HCTF should push for language and plans that are designed to meet the needs of all persons with chronic condition, the reality is quite different, and the impact on program implementation is significant and potentially dangerous. If the goal changes from developmental disability to all adults with chronic conditions, there is much discussion required. There are different needs of different populations and all of the language that can be used for persons with developmental disabilities will not necessarily be the same for other populations of persons with disabilities and chronic conditions. There will be the need to pull together a broader advocacy group, development of different elements and different specifications, etc. It becomes a much bigger project and requires and all of the RFP language modified to reflect that.

I think that this is far more than what FDDC is embarking on. I would not recommend raising this issue at this time. It is clear that, in the case of children, your plans (like CMS) are for children with special health care needs and it includes all children with chronic conditions. However, adults are different and I don't believe that you want to begin by establishing a platform for a program that is this broad; it is then not targeted, you cannot ensure that you can identify providers to meet the needs of all populations and you are far more likely to fail. In addition, you will have to engage with multiple other advocacy organizations and it is very likely that, in order to ensure that services meet the needs of all populations, the developmental disability language ends up being watered down. There is also likely to be conflict and differences of priorities among the advocacy groups and consumer groups representing different populations. There has been so much work done to build specialized language and a platform for the developmental disability populations; it will weaken your position at this time. So, I would not recommend that you go in this direction at this point. It is also a major change of direction in terms of your relationship and advocacy with AHCA and I don't think it will lead to a good outcome. Even though I have been involved in building managed care programs for broader populations, the very first step in building specialized plans is to identify your target population. FDDC has done that for adults with developmental disability. This does not preclude supporting the broader CMS model for children, which you are already doing.

It is also important to note that, although in theory the idea of plans for all adults with chronic conditions was discussed during the meeting, there was no support for diluting the ideas and language to move away from a developmental disability focus. What was suggested was to ensure that developmental disability is viewed broadly enough beyond the five diagnoses. This is a different battle and issue. That needs to be addressed in terms of AHCA ensuring that there is a screening process in place that identifies all persons with developmental disabilities and that all of these individuals become aware of any specialized options for them and have access. It is absolutely impossible to include language is targeted to all adults with chronic conditions and not lose the developmental disability focus and the idea of services to meet their special needs. By ensuring specificity and not trying to be too broad, you are more likely to get very clear language in the contract and structures built within the managed care program to meet the special needs of persons with developmental disabilities; a smaller pilot program like this has the best chance of being successful. This can then set the stage for other populations in the future. But I would not support the HCTF in taking the lead on too broad a platform outside your area of expertise at this time.

2. How to identify each individual's special needs within managed care and the level of care plan that is required. Although there was consensus that some type of assessment be conducted and care plan developed for each individual, there was not agreement as to who should conduct the assessment, when it should be conducted and what type and level of care plan should be required.

Commentary: This is addressed somewhat in #9, the first mandatory element. Typically, managed care plans are allowed to respond to an RFP regarding how they will meet the contract requirements. I believe that the language is specific enough in there and requires that the plans have and describe their process for identifying each individual's special needs and a building a care plan to meet those needs. It also specifies timelines and consumer involvement. If you want to add more to this, then I would add it there. However, you have to allow plans to indicate how they will meet the required specifications and standards.

3. All providers must indicate that they meet ADA access standards. We did not come to consensus about whether this needed to include all providers of all services, a specific proportion of providers, or all providers of certain types.

Commentary: This needs to be decided. Although desirable, it may not be realistic for all providers of all types to meet all ADA access standards, such as mental health or substance abuse treatment providers, but you do want to make sure at least some do. I would make a decision on this, and then include your specifications in the contract language specifications.

III. RECOMMENDATIONS FOR FURTHER RESEARCH AND/OR DISCUSSION

There were some areas that we did not have sufficient time to fully discuss, or that the group was unable to give full consideration to. These include the following:

1. Prior to implementing mandatory managed care, the state needs to consider what will happen to dual eligibles. Many managed care options, especially specialty plans and Medicaid-only plans, cannot enroll individuals who receive both Medicaid and Medicare. As a result, many persons with developmental disabilities will be required to disenroll from their managed care plans once they begin receiving Medicare benefits. As a large proportion of persons with developmental disabilities are in this category, this impact must be considered and planning done prior to mandatory enrollment.
2. Care coordination should be separated from utilization management. While many participants believed that allowing the care coordinator to also conduct utilization management leads to a conflict of interest and pressure to control costs that impacts service quality, studies have shown that this is not necessarily the case. In some of the managed care plans considered best practices for persons with disabilities, the shared role of care coordination and utilization management has been shown to be very successful.
3. Capitation rates must be sufficient to encourage health plans to meet members' needs. This can only be done if capitation rates are risk adjusted. This is particularly important

for managed care plans that serve persons with the most severe disabilities. Diagnosis- and severity-based risk adjustment models that include multiple categories of risk adjusters are most likely to pick up the many conditions that will allow for accurate capitation for persons with developmental disabilities. If rates are insufficient, plans providing care to the most difficult to serve individuals will not survive. There is a significant cost to AHCA to developing risk adjusted capitation rates. There is also no data indicating that pharmacy-based risk adjustment has been successful in setting rates for persons with developmental disabilities. It is critical that data be provided on how well a pharmacy-based risk adjustment model will work for persons with developmental disabilities; if AHCA does not have faith in this method and plans to move to a diagnosis-based and severity-based model after encounter data are collected, the costs of building one model and later having to invest in a different model need to be considered. It may make more sense to wait until encounter data are collected and a single plan for risk adjustment developed. Further discussion with AHCA about this is required.

4. Review of innovative models and best practices. The group did not have sufficient time to learn about and discuss the models or care being used for adults around the country. While there was some discussion of how the CMS program works, as well as knowledge by many individuals around the table, there was not sufficient time for review of other models. It would be beneficial if the group were to review several different models of managed care for persons with developmental disabilities, including specifics of how they are implemented and work on a daily basis. Many of the challenges these managed care models have experienced serving persons with developmental disabilities within managed care can provide input lesson and input. Given the differences between adults and children, it is recommended that this review and/or discussion of models be focused on adults.