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Medicaid Managed Long-Term Care: Is Florida Ready

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MEDICAID MANAGED LONG-TERM CARE: IS FLORIDA READY?

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PART I. INTRODUCTION

Medicaid is a nationwide health insurance program, created in 1965 as Title XIX of the Social Security Act[1] for the poorest and sickest individuals. The Medicaid program operates through a federal and state partnership with the Centers for Medicare and Medicaid Services ("CMS") providing federal oversight. States must provide coverage of certain groups and services in order to receive federal funds for their Medicaid programs. However, states may include additional "optional" groups and services in each state plan.[2]

States use different methods of service delivery to Medicaid beneficiaries. In July 2011, a national average of 74.22% of Medicaid beneficiaries were enrolled in managed care organizations.[3] Although Medicaid managed care organizations grew rapidly in the mid-1990s, few states implemented a managed care program for Medicaid long-term care and instead used various models of delivering services within the fee-for-service system.[4] State and Federal governments have been looking at Medicaid managed long-term care again because of increased budget

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1. Social Security Act, 42 U.S.C. §§ 1396–1396w-5 (1965).

2. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Eligibility*, MEDICAID (last visited Sept. 15, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html. Mandatory coverage groups include people that receive federally-assisted income-maintenance payments and related groups not receiving cash payments. *Id.*

3. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT REPORT 4 (2011) [hereinafter CMS SUMMARY STATISTICS], http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

4. PAUL SAUCIER & WENDY FOX-GRAGE, AARP PUB. POL'Y INST., MEDICAID MANAGED LONG-TERM CARE 1 (2005), http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf.

pressures.[5]

Part II of this article will describe how Medicaid managed care functions.[6] Florida's historical use of Medicaid managed care and the current, unprecedented implementation of a new statewide, mandatory Medicaid managed care program is examined in Parts III and IV.[7] Part V will explain developments on the federal level in the area of Medicaid managed care and specifically with the dual-eligible population, including the recently issued CMS Guidelines for providing long-term services and supports ("LTSS") through Medicaid waivers.[8] Part VI will evaluate Florida's implementation of Medicaid Managed Long-Term Care ("MMLTC") in comparison to the CMS Guidelines.[9] Part VII will look at Arizona as a model for Medicaid managed long-term Care.[10] The article concludes that although Medicaid managed care has potential to improve coordination of health care services and decrease Medicaid spending, Florida's Medicaid Long Term Care Program must be implemented with substantial, continual monitoring and oversight with emphasis on increased improvement in quality assurance measures and procedures.[11]

PART II. HOW MEDICAID MANAGED CARE FUNCTIONS

State lawmakers view Medicaid managed long-term care as a way to address the concerns over the increased enrollment and achieve budget stability over time through a capitated rate system.[12] The state Medicaid agency gives all responsibility to private managed care organizations ("MCOs"), (sometimes called health maintenance organizations ("HMOs") or provider service networks) for providing all long-term care services to enrollees for a fixed rate, called a capitated rate.[13] The fixed rate aspect of this model limits the states' financial risk by passing it on to the MCOs and allows the states to hold the MCOs accountable for service use and quality of care, which is impossible with a fee-for-service system.[14] The MCO

5. *See id.*; *see also infra* notes 54–60 and accompanying text on recent developments at the federal and state levels.

6. *See infra* Part II.

7. *See infra* Part III–IV.

8. *See infra* Part V.

9. *See infra* Part VI.

10. *See infra* Part VII.

11. *See infra* Part VIII.

12. *See* SAUCIER & FOX-GRAGE, *supra* note 4, at 3.

13. *See id.* at 1–2. In contrast, in a fee-for-service model, providers are reimbursed for services provided. *Id.* Additionally, fee-for-service providers usually provide a single type of service, whereas a managed long-term care provider provides a wide arrange of services. *Id.* at 2.

14. *See id.* at 3.

assumes financial risk because if the cost of delivery of services is more than the capitated rate, the MCO loses money; if the cost of delivery of services is less than the capitated rate, the MCO profits.[15] The financial risk varies by program.

A state must usually apply to CMS for either a Section 1915(b) freedom-of-choice waiver or a Section 1115 research and demonstration waiver to establish and require enrollment in a Medicaid managed care program.[16] Before the Balanced Budget Act of 1997,[17] federal law required states to obtain waivers when a Medicaid program required beneficiaries to choose a primary care provider without being able to change the provider for more than one month at a time or the program only would be operating in part of the state or limited to certain categories of beneficiaries.[18] The passage of the Balanced Budget Act of 1997 provided a third statutory method of requiring enrollment in Medicaid managed care by creating section 1932 of the Social Security Act.[19] Instead of requiring a waiver, section 1932 allows a state to file an amendment to its Medicaid plan.[20] Unlike Section 1915 or Section 1115 waivers, neither budget neutrality nor cost effectiveness is a requirement under a Section 1932 Medicaid managed care program.[21]

PART III. MEDICAID MANAGED CARE IN FLORIDA

Florida first implemented Medicaid managed care in 1981 in Palm Beach County.[22] Between 1984 and 1990, Florida was one of five states operating a voluntary enrollment into Medicaid HMOs in certain parts of the state.[23] The Health Care Financing Administration ("HCFA," now

15. *See id.* at 1.

16. *See* HENRY J. KAISER FAMILY FOUND., *Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997*, http://www.kff.org/medicaid/2102-budget_repl.cfm; *see also* Centers for Medicare & Medicaid Services, *Waivers*, MEDICAID, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited Dec. 5, 2013) [hereinafter *Waivers*].

17. Pub. L. No. 105-33, 111 Stat. 251 (1997).

18. *See* HENRY J. KAISER FAMILY FOUND., *supra* note 16.

19. 42 U.S.C. § 1396u-2 (2012).

20. CHRISTIE HERRERA, FOUND. FOR GOV'T ACCOUNTABILITY, MEDICAID WAIVERS AND STATE PLAN AMENDMENTS: WHICH IS RIGHT FOR YOUR STATE? 3 (2013), http://www.medicaidcure.org/wp-content/uploads/2013/05/Medicaid-Waivers-and-State-Plan-Amendments.pdf.

21. *See id.* at 3. The exemption of children with special needs and Medicare beneficiaries, including dual eligibles, from mandatory enrollment under Section 1932 is an additional difference from Section 1915 and Section 1115 waivers. *Id.*

22. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., MANAGED CARE QUALITY ASSESSMENT AND IMPROVEMENT STRATEGIES: 2011/2012 UPDATE 1 (2012) [hereinafter AHCA QAIS], http://ahca.myflorida.com/medicaid/quality_mc/pdfs/QAIS_2011-2012_8-24-2012_final.pdf.

23. *See id.*

known as "CMS") approved Florida's first 1915(b) waiver in 1990, which allowed implementation of the Medicaid Physician Access System ("MediPass").[24] A variety of managed care plans developed after MediPass until 2002, when the final rules under the Balanced Budget Act of 1997 were implemented, requiring revisions to managed care contracts and quality assessment and improvement strategies by states.[25]

On October 19, 2005, CMS approved a Medicaid reform pilot that required mandatory enrollment in managed care plans under a Section 1115 research and demonstration waiver.[26] A waiver was required for this pilot program because of the unprecedented flexibility the program gave to insurers to (1) determine the benefits available for enrollees and (2) vary from the standard set of benefits upon which Medicaid beneficiaries rely.[27] The managed care plans were permitted to create customized benefit packages, which had to cover all mandatory services under the State Plan but could vary the amount, duration, and scope of the services.[28] The mandatory participation for certain populations in managed care existed as an additional unique aspect of the Medicaid Reform waiver.[29] The Temporary Assistance for Needy Families ("TANF") and the Aged and Disabled group comprising of Supplemental Security Income ("SSI") beneficiaries were the specific categories of Medicaid beneficiaries who were enrolled.[30] The Florida Agency for Health Care Administration

24. *See id.*

25. *See id.*

26. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., FLORIDA MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION FACT SHEET 1 (2013) [hereinafter FLORIDA MANAGED MEDICAL ASSISTANCE FACT SHEET], http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf.

27. *See* JOAN ALKER & JACK HOADLEY, JESSIE BALL DUPONT FUND., AS LEGISLATORS WRESTLE TO DEFINE NEXT GENERATION OF FLORIDA MEDICAID, BENEFITS OF REFORM ARE FAR FROM CLEAR at 1 (2011), http://ihcrp.georgetown.edu/floridamedicaid/pdfs/Medicaid_Reform_FL_2011.pdf; JOHN HALL & MIKE WALSH, FLA. CTR. FOR FISCAL & ECON. POL'Y, MEDICAID: A PROGRAM THAT SERVES ONE IN SEVEN FLORIDIANS SHOULD NOT CHANGE NOW 1 (2010), http://www.fcfep.org/attachments/20100423--Medicaid%20Program%20Shouldn%27t%20Change%20Now.pdf [hereinafter HALL & WALSH APR. 2010]. Seventy percent of Medicaid recipients receive services through managed care plans. HALL & WALSH APR. 2010, *supra*. However, the reform pilot project differs in that "plans can offer additional and varying benefits; provider-based models of managed care are authorized;" enhanced benefits and incentives are offered for healthy behavior; "recipients can opt out and use Medicaid funds to purchase employer-based health insurance;" and risk-adjusted capitated rates are used. *Id.*

28. *See* FLORIDA MANAGED MEDICAL ASSISTANCE FACT SHEET, *supra* note 26, at 4.

29. *See id.* at 2; *see also* FLA. COMMUNITY HEALTH ACTION INFORMATION NETWORK (CHAIN), MEDICAID REFORM FACT SHEET (2011) [hereinafter FLA. CHAIN FACT SHEET], http://floridachain.org/wp-content/uploads/2012/09/Medicaid-Reform-Fact-Sheet.pdf (explaining that plans can also have confusing and varied benefits).

30. *See* FLORIDA MANAGED MEDICAL ASSISTANCE FACT SHEET, *supra* note 26, at 3

("AHCA") implemented the program for Medicaid beneficiaries in Broward and Duval counties on July 1, 2006, and expanded the program to Baker, Clay and Nassau counties on July 1, 2007.[31] Section 1115 waivers are initially approved for five years. Accordingly, the original Section 1115 waiver expired on June 30, 2011. In December 2011, CMS approved Florida's request to extend the Section 1115 waiver through June 30, 2014.[32]

PART IV. 2011 FLORIDA LEGISLATION AND WAIVER APPLICATIONS TO CMS

Although the initial phase of the Medicaid Reform program that began in 2005 was limited both geographically and also in its categories of Medicaid enrollees,[33] the program intended to expand mandatory participation to all Medicaid beneficiaries in future phases and geographically expand the program statewide.[34] The Florida legislature, during a 2010 special session, created a resolution urging the United States Congress to amend the Social Security Act and declaring its intent to amend the Florida Statutes relating to Medicaid.[35] Florida House Bill 7107 was signed by Governor Rick Scott on June 2, 2011, creating Chapter 409, Part IV, Florida Statutes, which: authorized the continuation of the 5-county pilot project; expanded mandatory enrollment into Medicaid managed care statewide; expanded mandatory enrolled populations to include virtually all Medicaid beneficiaries, except for the developmentally

(providing the age and poverty level required to meet these eligibility groups); *see also* AARP ET AL., RECOMMENDATIONS FOR A BENEFICIARY-CENTERED FEDERAL COORDINATED HEALTH CARE OFFICE 1 (2010), http://www.medicareadvocacy.org/InfoByTopic/Reform/10_07.22.CHCORecommendations.pdf [hereinafter RECOMMENDATIONS] (commenting on the application pathways for elders and younger adults living with disabilities); FLA. CHAIN FACT SHEET, *supra* note 29. Under the Medicaid Reform pilot program, the most vulnerable populations, such as the elderly, were excluded because of the increased risk due to their special needs. FLA. CHAIN FACT SHEET, *supra*.

31. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MEDICAID REFORM YEAR 4 ANNUAL REPORT 1 (2010), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/reform_final_annual_report_yr4_070109-063010.pdf.

32. *See* AHCA QAIS, *supra* note 22, at 2.

33. *See supra* text accompanying notes 26–31; *see also* FLORIDA MANAGED MEDICAL ASSISTANCE FACT SHEET, *supra* note 26, at 4 (providing full list of excluded groups from mandatory participation).

34. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID REFORM SECTION 1115 DEMONSTRATION 8 (n.d.), http://ahca.myflorida.com/medicaid/medicaid_reform/lip/docs/cms_stc.pdf [hereinafter CMS SPECIAL TERMS AND CONDITIONS].

35. S. Res. SM 4-A, 2010 Leg., (Fla. 2010), http://www.flsenate.gov/public/GetFile.cfm?File=sAGkmbbz3P9uxteE4scU6Az7BzU%3D|10%2FPublic%2FBills%2F0001A-0099A%2F0004A%2F_s0004Aer.PDF.

disabled; and directed the AHCA to apply for and implement state plan amendments and waivers of applicable federal laws and regulations necessary to implement the Statewide Medicaid Managed Care (SMMC) program.[36] The passage of the legislation occurred during a difficult economic environment, in which the state of Florida faced a significant budget shortfall with very little non-essential spending remained to cut.[37] These circumstances contributed to the urgency of passing a Medicaid Reform bill that accomplished these expansions.

On August 1, 2011, AHCA submitted both an Amendment to the original Section 1115 Medicaid Waiver and Demonstration project to CMS in order to implement the Statewide Managed Medical Assistance Program (providing acute medical care services) and also applications for Section 1915(b) and Section 1915(c) Medicaid Waivers in order to implement the Long Term Care Managed Care Program ("LTCMC") (providing long-term care services).[38] A Section 1915(b) Managed Care waiver allows states "to provide services through managed care delivery systems or otherwise limit people's choice of providers."[39] A Section 1915(c) Home and Community-Based Services ("HCBS") waiver allows states "to provide long-term care services in home and community settings rather than institutional settings."[40] A concurrent Section 1915(b) and 1915(c)

36. H.B. 7107, 2011 Leg. (Fla. 2011), *available at* http://laws.flrules.org/2011/134; *see also* JOAN ALKER ET AL., JESSIE BALL DUPONT FUND, LOOKING AHEAD TO 2012, WHAT CHANGES ARE IN STORE FOR FLORIDA'S MEDICAID PROGRAM? 1 (2011), http://ihcrp.georgetown.edu/floridamedicaid/pdfs/2011%20December%20Medicaid%20Brief%201%20FINAL.pdf (explaining that H.B. 7107 expands the five-year program operating in Broward, Duval and three rural counties since 2006 to a statewide program).

37. *See* GREG MELLOWE, FLA. CTR. FOR FISCAL & ECON. POL'Y, ADDRESSING MISCONCEPTIONS IN FLORIDA MEDICAID, PART 1 OF 3–THE BASICS: HOW MUCH AND FOR WHOM? 1 (2010) [hereinafter MELLOWE, ADDRESSING MISCONCEPTIONS], http://www.fcfep.org/attachments/20101130--Medicaid%20an%20Inappropriate%20Scapegoat2.

38. Letter from Roberta K. Bradford, Deputy Sec'y, Fla. Medicaid, to Richard Jensen, Dir., Div. of State Demonstrations and Waivers, Centers for Medicare and Medicaid Services (Aug. 1, 2011) (on file with AHCA), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf.

39. *Waivers*, *supra* note 16.

40. *Id*; *see* OFFICE OF PROGRAM POL'Y ANALYSIS & GOV'T ACCOUNTABILITY, PROFILE OF FLORIDA'S MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS, REPORT 13-07 6–7 (2013), http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1103rpt.pdf [hereinafter OPPAGA REPORT 13-07] (explaining that the Nursing Home Diversion ("NHD") program is a current Medicaid managed care long-term care program operating in Florida under a section 1915(c) waiver using a capitated rate to reimburse its providers); *see also* Government Program Summaries, *Department of Elder Affairs: Medicaid Home and Community-Based Services*, OFFICE OF PROGRAM POL'Y ANALYSIS & GOV'T ACCOUNTABILITY, http://www.oppaga.state.fl.us/profiles/5023/ (last updated Jun. 4, 2013) [hereinafter *OPPAGA Summary 5023*] (explaining that the NHD provides Medicaid-covered physician services and prescribed drugs).

Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget

waiver allows a state to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, whether recipients reside in a skilled nursing facility, assisted living facility, or at home, with a managed care organization responsible for delivery of services. Existing federal regulations mandate that a state Medicaid plan may not require recipients who are also eligible for Medicare to enroll in a managed care organization ("MCO").[41] States are able to circumvent this regulation through enrolling dual eligibles under a section 1115 waiver or under a section 1915(b) waiver.[42] CMS issued its approval for concurrent 1915(b) and 1915(c) waivers on February 1, 2013, for a three-year period beginning July 1, 2013, through June 30, 2016.[43] CMS requires the state to report performance-measure information to CMS on a quarterly basis for the first two years and requires the state to continue to meets its obligation under the American with Disabilities Act and the Olmstead decision.[44]

On June 14, 2013, CMS issued its approval of an amendment to the original Section 1115 Demonstration, officially changing the name of the Demonstration project from Medicaid Reform to the Managed Medical Assistance Program and expanding the Demonstration project statewide.[45] The amendment is subject to approval of an implementation plan and plan readiness review, which will include the state evaluating capacity, out-of-network access to care, access to care for special needs enrollees, and cultural considerations. [46]

As of July 1, 2011, 63.81% of Florida Medicaid enrollees were

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Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement.

OPPAGA REPORT 13-07, at i.

41. *See* 42 C.F.R. § 438.50(d)(1) (2012); SAUCIER & FOX-GRAGE, *supra* note 4, at 14–15 (providing the evolution of legal authority for Medicaid managed long-term care in exhibit 6). Implementation of the Medicare and Modernization Act of 2003 changed Medicare managed care rates and allowed for new methods of serving dual eligibles in special needs plans and increasing potential contractors for states. SAUCIER & FOX-GRAGE, *supra*.

42. *See* 42 C.F.R. § 438.50(a).

43. *See* Letter from Ralph F. Lollar, Dir., Div. of Long Term Servs. and Supports, CMS, & Nancy Klimon, Dir. of Div. of Integrated Health Sys., CMS, to Justin Senior, Deputy Sec'y for Medicaid, AHCA (Feb 1, 2013) http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf.

44. *See id.*

45. *See* Letter from Cindy Mann, Dir., CMS, to Justin Senior, Deputy Sec'y for Medicaid, AHCA (June 14, 2013) [hereinafter CMS Approval Letter to AHCA], http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf.

46. *Id.*

Medicaid managed care enrollees.[47] As Florida completes the enrollment of Medicaid beneficiaries into the Long Term Care Managed Care program in 2014, this percentage will grow closer to 100%.[48]

PART V. DEVELOPMENTS AT THE FEDERAL LEVEL

The development of Florida's statewide, mandatory Medicaid managed care program is being implemented at a time of both dramatic changes in the nation's health care system and a dramatic increase in the aging population. The age eighty-five and older population, whom have a much higher degree of disability, is expected to triple between 2012 and 2050.[49] Dual eligibles compose approximately 9 million (or fifteen percent) of the Medicaid beneficiaries and have unique and complex issues surrounding eligibility for and access to care.[50] Dual eligibles are low-income seniors and younger persons with disabilities who are enrolled in Medicare and Medicaid.[51] In 2008, thirty-nine percent of Medicaid spending was on dual eligibles, which is attributed to their greater health care needs and service utilization when compared to other Medicare beneficiaries.[52] Historically, poverty-related populations, such as low-income adults and children, compose the majority of enrollees in Medicaid managed care because these populations generally require fewer and less expensive services than the elderly and disabled populations.[53] However,

47. *See* CMS SUMMARY STATISTICS, *supra* note 3, at 4. *See generally* Comprehensive Medicaid Managed Care Enrollment Report, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml (last visited Sept. 15, 2013) (providing the eleven individual sections making up the comprehensive report).

48. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., 2013–2018 LONG-TERM CARE HEALTH PLAN MODEL CONTRACT, ATTACHMENT II ex. 3 5–7 (2013), http://www.ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/LTC_Model_Contract_2013_05_06.pdf [hereinafter MODEL CONTRACT ATTACHMENT II 2013] (providing for a list of mandatory, voluntary and excluded populations).

49. *See* ARI HOUSER, ET AL., AARP PUB. POL'Y INST., ACROSS THE STATES 2012: PROFILES OF LONG-TERM SERVICES AND SUPPORTS 1 (2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-in-brief-AARP-ppi-ltc.pdf.

50. *See* KATHERINE YOUNG ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 1 (2012) http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf [hereinafter KAISER COMMISSION, DUAL ELIGIBLES]; *see also* RECOMMENDATIONS, *supra* note 30.

51. *See* KAISER COMMISSION, DUAL ELIGIBLES, *supra* note 50.

52. *Id.* at 7.

53. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *Medicaid and Managed Care – Policy Brief*, HENRY J. KAISER FAMILY FOUND. (May 30, 1995) [hereinafter KAISER COMM'N, NUMBER 2043], http://www.kff.org/medicaid/2043-managed.cfm; *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE TO STATES USING 1115 DEMONSTRATIONS OR 1915(B) WAIVERS FOR MANAGED LONG TERM SERVICES AND SUPPORTS PROGRAMS 2 (2013),

providing LTSS through Medicaid managed care is becoming an increasingly popular model.[54] "MMLTC has been slow to develop, in part because it involves complex policy choices and intense stakeholder engagement."[55]

The creation of a new federal office, the Federal Coordinated Health Care Office, strictly for the purpose of designing new models of integration and care coordination for the dual eligible population evidences the complexity of their healthcare.[56] In April 2011, the State Demonstrations to Integrate Care for Dual Eligible Individuals initiative was launched through the Center for Medicaid and Medicare Innovation.[57] Eight states have signed Memorandums of Understanding to implement demonstration projects, while thirteen other states have proposals pending with CMS.[58] The American Taxpayer Relief Act of 2012[59] created the Federal Commission on Long Term Care. The Commission was tasked with 'developing a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports . . . ."[60] The Commission issued its final

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http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf [hereinafter CMS GUIDELINES] (explaining that seniors and disabled adults were excluded from managed care arrangements).

54. *See* CMS GUIDELINES, *supra* note 53, at 1–2. "The number of states with MLTSS programs increased from 8 in 2004 to 16 in 2012, and CMS has experienced increasing interest from states in the form of concept papers, waiver applications and requests for technical assistance." *Id.*

55. SAUCIER & FOX-GRAGE, *supra* note 4, at 10. Different models for MMLTC exist with the choices involving mandatory versus voluntary enrollment; fee-for-service versus capitated rate benefits; eligibility of the larger long-term care Medicaid population versus only those eligible for nursing home care; service area of statewide versus regional; payment rates; quality assurances; and obtaining Section 1115 versus Section 1915 waivers or no waiver at all. *Id.*

56. *See* RECOMMENDATIONS, *supra* note 30, at 1. *see also* KAISER COMMISSION, DUAL ELIGIBLES, *supra* note 50, at 16. The Affordable Care Act established two new federal entities—the Federal Coordinated Health Care Office (FCHCO) and the Center for Medicare and Medicaid Innovation ("Innovation Center")—both of which have been studying improvement of care for dual eligible beneficiaries. *Id.*

57. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid, CHIP and Survey & Certification, and Melanie Bella, Dir., Medicare-Medicaid Coordination Office, to State Medicaid Dir. (July 8, 2011), http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

58. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, State Demonstration Proposals to Integrate Care and Align Financing and/or for Dual Eligible Beneficiaries, HENRY J. KAISER FAMILY FOUND. http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries (last visited Nov. 15, 2013) [hereinafter State Demonstration Proposals].

59. American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2313 (2013).

60. American Taxpayer Relief Act of 2012 § 643(b)(1); *see also Federal Commission on*

recommendations on September 12, 2013.[61] However, five of the original commissioners voted against the final report and instead issued alternate recommendations.[62]

A. CMS GUIDELINES

With the development of programs, such as the programs described above, that provide long-term services and supports in a managed care setting, CMS has issued guidelines for best practices in providing LTSS through a 1115 Demonstration or 1915(b) waiver.[63] CMS identified ten key elements that CMS expects to be incorporated in any new or existing Medicaid MLTSS program.[64] MLTSS programs include both home and community-based services and institutional care services.

One of the most important elements under the Guidelines is Key Element One, Adequate Planning, where CMS requires states to provide oversight of the implementation and transition into the new program.[65] Oversight should be maintained before, during, and after the transition from FFS to managed care.[66] CMS Guidelines also require continuing oversight in specific areas, which include the payment structure.[67] CMS Guidelines also reinforces the amount, duration, and scope requirement under Key Element Seven, Comprehensive, Integrated Service Package.[68] The necessity of maintaining the same amount, duration, and scope is crucial under revaluation assessment of needs and in transition plans of care to support the goal of increased home and community-based services.[69]

The fifth and last three key elements of the CMS guidelines (support

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Long-Term Care Holds First Meeting, CTR. FOR MEDICARE ADVOCACY, INC., http://www.medicareadvocacy.org/federal-commission-on-long-term-care-holds-first-meeting/#_edn2 (last modified July 3, 2013) (explaining that the Commission must complete its work by September 2013 under the statute's current timeline).

61. *See Commission on Long-Term Care Summary of Recommendations*, COMM'N ON LONG-TERM CARE (Sept. 12, 2013), http://www.ltccommission.senate.gov/recommendations.cfm.

62. *See Federal Commission on Long-Term Care Concludes Its Work*, CTR. FOR MEDICARE ADVOCACY, INC., http://www.medicareadvocacy.org/federal-commission-on-long-term-care-concludes-its-work/ (Sept. 19, 2013) (indicating that the five commissioners asserted that the Commission in the final report did not "fulfill its comprehensive charge").

63. *See* CMS GUIDELINES, *supra* note 53, at 1.

64. *Id.*

65. *See id.* at 4–5.

66. *Id.* at 6.

67. *Id.* at 8–9.

68. *Id.* at 11–12.

69. *See* CMS GUIDELINES, *supra* note 53, at 11–12.

for beneficiaries, qualified providers, participant protections and quality improvement strategies) all ensure quality of services to enrollees. Support for beneficiaries includes the requirement of offering "conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, meaningful, and consumer-friendly."[70] CMS suggests in a footnote that states consider conflict-free case management as is required for states participating in the Balancing Incentive Program.[71] CMS weakens their support for beneficiary element by not requiring conflict-free case management for all MLTSS programs.

PART VI. LIKELIHOOD OF A SUCCESSFUL MMLTC PROGRAM: DOES FLORIDA MEET THE CMS GUIDELINES?

A. LESSONS LEARNED FROM MEDICAID REFORM PILOT

An evaluation of the Medicaid Reform program by researchers revealed costly administrative burdens from the program's implementation due to additional training processes and system modifications, among other things.[72] The plans did not have sufficient resources to adequately implement the Reform.[73] HMOs have the capacity to bear the risk of long-term care beneficiaries but lack experience with dual eligibles.[74] The Medicaid Reform pilot was plagued with problems and did not even enroll

70. *Id.* at 9.

71. *See id.* at 9 n.11.

72. Amy Yarbrough Landry et al., *Successful Implementation in the Public Sector: Lessons Learned from Florida's Medicaid Reform Program*, 7 J PUB. HEALTH MGMT. PRAC. 154, 161 (2011), http://mre.phhp.ufl.edu/publications/Successful%20Implementation%20in%20the%20Public%20Sector%20Lessons%20Learned%20from%20Florida%27s%20Medicaid%20Reform%20Program_Journal%20of%20Public%20Health%20Management%20Practice_January%202011.pdf.

73. *Id.* at 162; *see* Letter from Greg Mellowe, Policy Dir., Florida CHAIN, to The Hon. Cynthia R. Mann, Dir., Ctr. For Medicaid & State Operations, Ctrs. For Medicare & Medicaid Servs. 12 (July 18, 2010) (on file with author) (identifying numerous plan withdrawals and the resulting upheaval for participants in the Reform program).

74. RECOMMENDATIONS, *supra* note 30, at 1; *see also* FLA. AGENCY FOR HEALTH CARE ADMIN., REPLACEMENT WAIVER: STATEWIDE MANAGED MEDICAL ASSISTANCE PROGRAM, 1115 RESEARCH AND DEMONSTRATION WAIVER 53 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-pa.pdf (last visited Sept. 15, 2013) [hereinafter 1115 RESEARCH AND DEMONSTRATION WAIVER]. The Senate Resolution, passed in November, 2010, stated its intent was to improve "access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement . . . ." 1115 RESEARCH AND DEMONSTRATION WAIVER, *supra*, at 4. Despite the Senate's intent to exclude Medicaid beneficiaries in institutional placement, the MMA amendment will mandatorily enroll dual eligibles in managed care plans. *Id.* at 37–38.

those individuals with the most complex healthcare needs.[75] Under the Medicaid Reform program, only one specialty plan was created, which occurred in May of 2010, and it served only one county.[76] CMS communicated to AHCA that accountability measures and adequate protections for Medicaid beneficiaries are required before further expansion of Florida Medicaid Reform.[77]

B. CMS GUIDELINES

Adequate Planning

Adequate planning is "Essential Element #1" of the CMS Guidelines.[78] Developing a successful program requires a "deliberative, transparent [process] for implementing and evaluating models."[79] Studies have suggested that enrolling dual eligibles in Medicaid managed care should take place in phases in order to address the issues of having sufficient specialists in provider networks, and in order to adequately compensate providers for the costly health care required for this special needs population.[80] Florida has appropriately implemented the MMLTC program in phases, staging the eleven regions of the state to be implemented one at a time.[81] If a sufficient amount of time to correct

75. *See* KAISER COMM'N, NUMBER 2043, *supra* note 53 ("It may be prudent to use managed care demonstration programs to gain experience in developing payment rates and in recruiting an appropriate mix of specialty and primary care providers before enrolling large numbers of elderly and disabled beneficiaries into managed care programs.").

76. *See* Letter from Greg Mellowe to The Hon. Cynthia R. Mann, *supra* note 73, at 40 (finding "the length of time needed to reach that point (45 months into the Pilot), the fact that there is one plan, it serves only one county, has enrolled a handful of recipients and may not be sustainable demonstrates the extent to which the goal [of providing benefit packages that best meets beneficiaries needs] has yet to be met.").

77. Letter from Richard Jensen, Dir., Division of State Demonstrations and Waivers, Ctrs. for Medicaid and Medicare Servs., to Elizabeth Dudek, Sec'y, Fla. Agency for Health Care Admin. (Apr. 28, 2011), http://www.fdhc.state.fl.us/medicaid/medicaid_reform/pdf/FL_letter_from_CMS_to_AHCA_dated_4-28-11_.pdf.

78. CMS GUIDELINES, *supra* note 53, at 4–6.

79. *See* RECOMMENDATIONS, *supra* note 30, at 2 (referencing the successful PACE program that took years to develop).

80. *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MEDICAID MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 3–4 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf [hereinafter KAISER COMM'N, MEDICAID MANAGED CARE]; *see also* FLORIDA MANAGED MEDICAL ASSISTANCE FACT SHEET, *supra* note 26, at 7–8 (requiring that the Florida Medicaid Reform be implemented in phases and mandating that the population expansion only occur after first gradually accomplishing the geographic expansion).

81. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., A SNAPSHOT OF THE FLORIDA MEDICAID

problems in the system is not permitted between implementation in the different phases, particularly after the first phase, the adequate planning element is not met. Thirty days is insufficient to make corrections if misleading and incorrect plan information and enrollment deadlines are provided to the first enrollees in the MMLTC program. Plan readiness should include tests of the information systems to ensure enrollees receive accurate information.[82] An additional aspect of plan readiness is ensuring provider contracts are in place. AHCA has informed enrollees that in choosing a MCO plan, the enrollee must determine whether her current providers have contracts with the MCO.[83] Accordingly, adequate planning requires Choice Counselors to possess an accurate list of providers and requires MCO websites to contain an accurate list. If, despite a readiness evaluation requirement, misinformation is provided to mandatory enrollees, disrupting the intended smooth transition that is expected of a state implementing a new MLTSS program, there should be a system in place to quickly and efficiently address "operational bugs."[84]

Enhanced Provision of HCBS

Many MLTSS programs have been developed and grown due to programs such as Money Follows the Person,[85] participant-directed services, and the Balancing Incentive Program.[86] CMS directs states to take advantage of these initiatives in order to reinvest savings into innovation, developing community infrastructure, and expanding service

LONG-TERM CARE PROGRAM (2013), http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC (displaying the regional implementation diagrams).

82. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., MEDICAID LONG-TERM SERVICES AND SUPPORTS: KEY CONSIDERATIONS FOR SUCCESSFUL TRANSITIONS FROM FEE-FOR-SERVICE TO CAPITATED MANAGED CARE PROGRAMS 13 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf [hereinafter KAISER COMM'N KEY CONSIDERATIONS].

83. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., STATEWIDE MEDICAID MANAGED CARE LONG-TERM CARE SERVICES (NURSING HOME AND IN-HOME CARE SERVICES) 3 (2013) http://ahca.myflorida.com/medicaid/statewide_mc/pdf/LTC/AHCA_LTC_4-page_brochure_COLOR_PRINT.PDF.

84. *See* TRUVEN HEALTH ANALYTICS, TIMELINE FOR DEVELOPING A MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM 8 (2013) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Timeline.pdf.

85. *See* CMS GUIDELINES, *supra* note 53, at 1. "The Money Follows the Person program, under section 1915(i) of the Social Security Act, was initially authorized by section 6071(h) of the Deficit Reduction Act of 2005. It was due to expire but was extended by section 2403 of the Affordable Care Act of 2010 (Pub. L. 111-148)." *Id.*, at 1 n.1.

86. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10202, 124 Stat. 119, 923 (2010) (authorizing the Balancing Incentive Program).

capacity.[87] Expanding service capacity is especially crucial in the area of Home and Community-based Services. Both the CMS Guidelines and Florida's approval letter from CMS for the 1915(b) and 1915(c) waivers requires Florida to implement its MLTSS consistent with the American with Disabilities Act ("ADA")[88] and the U.S. Supreme Court case, *Olmstead v. L.C. ex rel. Zimring*.[89] The ADA requires public entities to administer their services, programs, and activities in the "most integrated setting appropriate" for disabled individuals.[90] *Olmstead* provides that unnecessarily forcing persons with disabilities into nursing homes violates the integration mandate when: (1) the state's reasonable assessment determines that community placement is appropriate; (2) the individual does not oppose community placement; and (3) community placement can be reasonably accommodated given the resources of the state's services or programs.[91]

The existence of a long wait list for home and community-based services in Florida violates the integration mandate when individuals requiring assistance are forced into nursing homes. Unlike Medicaid institutional services, home and community-based services are not an entitlement and are subject to funding by the state legislature.[92] A spouse who is desperately attempting to care for their spouse with dementia at home, but cannot afford home health care, is often times forced to move their spouse to institutional care because HCBS services are not available in the home. The limited funding states, including Florida, are willing to direct towards HCBS, supports the institutional bias and violates the integration mandate.[93]

The integration mandate is also violated when individuals who could have their needs met at an assisted living facility are forced into a nursing home because of an inability to afford the assisted living facility costs. Federal law regulates many aspects of Medicaid managed care, including

87. *See* CMS GUIDELINES, *supra* note 53, at 2.

88. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (2012).

89. Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999); CMS GUIDELINES, *supra* note 53, at 3.

90. 28 C.F.R. § 35.130(d) (2013).

91. *Olmstead*, 527 U.S. at 602–604. .

92. *See* NSCLC, SUMMARY OF FLORIDA'S LONG TERM CARE MANAGED CARE PROGRAM 1–2 (2013), http://www.nsclc.org/wp-content/uploads/2013/08/MLTSS-FL-Final-0319131.pdf [hereinafter FLORIDA'S LONG-TERM CARE SUMMARY]

93. *See* AARP, ACROSS THE STATES: PROFILES OF LONG TERM SERVICES AND SUPPORTS 12 (9th ed. 2012). The typical cost for HCBS is about one-third the cost of institutional care; however, 64 percent "of Medicaid LTSS dollars for older people and adults with physical disabilities went to nursing facility care, even though most people prefer to live at home." *Id.*

cost-sharing requirements and establishment of capitated rates.[94] Federal regulations govern cost sharing in Medicaid managed care programs.[95] Any cost-sharing charges imposed on Medicaid enrollees pursuant to a contract between the State agency and a managed care organization must be in accordance with requirements under federal law.[96] Although certain Medicaid beneficiaries may be expected to pay nominal cost-sharing charges, no cost sharing may be imposed on institutionalized individuals who are

> inpatient[s] in a hospital, long-term care facility, or other medical institution if the individual is required . . . as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.[97]

Medicaid beneficiaries receiving institutional care have some of the lowest income levels but the highest health care costs.[98] The prohibition of cost sharing should be extended to ALF residents.

Alignment of Payment Structures and Goals

The benefits of enrolling dual eligibles in managed care may include decreasing redundancy and high health care costs that result from managed care's emphasis on case management and preventive care; however, these benefits can be greatly diminished by the complexity of coordinating benefits and special health care needs, such as chronic conditions requiring long-term care and access to specialists.[99] This is particularly the case in a

94. *See* VERNON K. SMITH ET. AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE AND POLICY IN THE MIDST OF A RECESSION 41 (2009). *But see Consumer Voice Statement for House Hearing on Medicaid: Preserve Protections for People Receiving Long-Term Care*, THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE (Mar. 1, 2011), http://www.thec onsumervoice.org/node/694 ("We are deeply concerned about calls for flexibility in federal regulations as a solution to the budget problems now affecting many states, because historically, this budget 'solution' has threatened access to home and community-based services and public oversight of nursing homes.").

95. *See* 42 C.F.R. §§ 438.108, 447.15, 447.53, 447.60 (2013).

96. *See* 42 C.F.R. § 447.60.

97. 42 C.F.R. § 447.53(b)(3).

98. *See* MELLOWE, ADDRESSING MISCONCEPTIONS, *supra* note 37, at 5–6.

99. *See* KAISER COMM'N, NUMBER 2043, *supra* note 53. *But see* THE NAT'L COMM'N. ON FISCAL RESPONSIBILITY AND REFORM, THE WHITE HOUSE, THE MOMENT OF TRUTH 39 (2010), http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTrut h12_1_2010.pdf (recommending that dual eligibles be enrolled in Medicaid managed care for purposes of improving care coordination and administrative simplicity). Historically, study results on cost savings were almost equally divided between studies showing savings and those showing program costs similar to or above traditional fee-for-service and when savings occurred,

capitated-rate system.[100] A capitated-rate system providing a comprehensive set of benefits is advantageous from the perspective of reducing or even eliminating cost-shifting opportunities, improving coordination of care among multiple services to beneficiaries, and creating budget stability.[101] The disadvantage, however, is that the more services that are included in the set of benefits under the capitated rate, the more tightly these services will be managed, which can lead to a loss of choice of providers and access to care for consumers, such as access to specialists.[102] CMS has recognized this concern and the CMS Guidelines requires that:

> Rates must be sufficient to encourage adequate MCO and provider participation, as well as to appropriately meet the needs of participants. State payment structures, systems and review mechanisms must ensure that participants at all levels of need and all types of disabilities have the opportunity to choose their MLTSS providers and have appropriate access to community-based services.[103]

The payment structures include both the fixed, capitated rate paid to the MCOs and the rate each of the MCOs pay to their providers.[104] Use of insufficient data to establish the capitated rate may result in a capitated rate that is too low and may enhance the lack of choice of providers and enhance the lack of access to care.[105] This is particularly a problem with the skilled-nursing facilities since nursing homes receive the majority of their payment for residents from Medicaid, and thus they are "heavily dependent upon state and federal funds for operation."[106] The majority of nursing homes are also for-profit organizations.[107] AHCA has protected the nursing home industry from plan-controlled payments by maintaining the responsibility of establishing payments for the nursing homes.[108] The

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the savings were minimal. KAISER COMM'N, NUMBER 2043, *supra*.

100. *See* KAISER COMM'N, NUMBER 2043, *supra* note 53 ("In prepaid systems where providers are reimbursed a capitated payment per individual for a range of services, there is an incentive to limit service use, particularly inpatient and specialty care.").

101. *See* SAUCIER & FOX-GRAGE, *supra* note 4, at 11; *see also* KAISER COMM'N KEY CONSIDERATIONS, *supra* note 82, at 8 (describing the benefits of a risk-based capitated system).

102. *See* SAUCIER & FOX-GRAGE, *supra* note 4, at 2, 11; *see also* KAISER COMM'N, NUMBER 2043, *supra* note 53 (proposing the detrimental effect of reduced quality of care is more likely with a capitated rate system).

103. CMS GUIDELINES, *supra* note 53, at 9.

104. *See id.*

105. *See* KAISER COMM'N, NUMBER 2043, *supra* note 53 ("It also is important that payment levels to participating providers are adequate to maintain quality.").

106. JOHN HALL & MIKE WALSH, FLA. CTR. FOR FISCAL & ECON. POL'Y, FLORIDA NURSING HOMES: A REGULATORY, FINANCIAL AND QUALITY REVIEW 3 (2010), http://www.fcfep.org/attachments/20100318--Medicaid%20Nursing%20Homes.pdf.

107. *See id.* at 2.

108. *See, e.g.*, FLA. STAT. § 409.983(6) (2013).

MCOs, however, are responsible for setting the rates for a HCBS provider.

CMS requires that states design payment structures that support the goals of the MLTSS program.[109] Increasing home and community-based services is not only a goal of MLTSS programs but is also a directive from CMS pursuant to the ADA and *Olmstead*.[110] An increase in home and community-based services, however, will not occur unless reasonable rates are paid to the home health agencies that provide the home and community-based services. Many providers of long-term care services in Florida are non-profit companies in which volunteers and donations are used to ensure sufficient delivery of services.[111] Therefore, without adequate rates, providers will not be able to contract with the MCOs.

Both home health agencies and nurse registries can be providers of home and community-based services. Home health agencies, however, incur the costs of liability and malpractice insurance requirements[112] and can provide a higher quality of care, particularly to the elderly population, due to the requirements of a supervising nurse, Alzheimer's and dementia-related training for staff, and general quality assurance requirements that nurse registries do not have.[113] Payment structures will not support the goal of increasing home and community-based services if plans are permitted to offer low rates to providers, which results in either an insufficient number of providers or providers, such as nurse registries, which offer a lesser quality of services. CMS has directed states to "evaluate whether payment rates and structures are adequate to achieve participant access to quality providers for covered services."[114]

Support for Beneficiaries and Participant Protections

Support for beneficiaries includes conflict-free independent enrollment and disenrollment.[115] AHCA has followed CMS Guidelines with its enrollment procedures. The LTCMC Model Contract provides for

109. CMS GUIDELINES, *supra* note 53, at 8.

110. *See id.* at 9; *see also* Letter from Ralph F. Lollar & Nancy Klimon to Justin Senior *supra*, note 43; *supra* text accompanying notes 89–90.

111. *See* SAUCIER & FOX-GRAGE, *supra* note 4, at 12 ("[T]he majority of contractors have been nonprofit community-based organizations limited to local markets such as community hospitals, home health agencies, and disability service organizations.").

112. *See* FLA. AGENCY FOR HEALTH CARE ADMIN., HOW ARE FLORIDA'S DIFFERENT HOME CARE PROVIDERS REGULATED? 3 (2012), http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/docs/HHA-NR-NCO_COMPARISON_April2012.pdf.

113. *See id.* at 4, 6.

114. CMS GUIDELINES, *supra* note 53, at 9.

115. *See id.*

choice counseling; auto assignment, only after an enrollee has an opportunity to make a plan choice themselves; and an auto-assignment procedure that considers any current providers of the enrollee.[116] AHCA has further ensured conflict-free enrollment by having the Florida Department of Children continue to determine financial eligibility[117] and by having the Florida Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services ("CARES") conduct a functional assessment.[118]

Although AHCA has ensured conflict-free enrollment procedures, procedures for disenrollment, grievances, and appeals are less clear. In addition to conflict-free disenrollment procedures, states must assist participants in understanding their fair hearing rights.[119] The "good cause" determinations serve as one area of concern, since these procedures provide the only option for disenrollment after the initial ninety days of enrollment.[120] AHCA's contracts with the MCOs provide for AHCA to handle all disenrollments, including disenrollments giving the opportunity for a fair hearing;[121] but ultimately, the MCO is in the position to notify the enrollee of their rights.[122] Enrollee plan handbooks are required to have the information for requesting a fair hearing;[123] any plan-written notice is required to contain an enrollee's right to request a fair hearing;[124] and the plans are required to assist an enrollee in completing any forms or in following procedures to request a fair hearing.[125]

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116. *See id.* at 10; *see also* FLA. STAT. § 409.984(1), (2)(b) (2013) (mandating when and how automatic enrollment should take place); AHCA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at ex. 3, at 9.

117. *See* FLA. STAT. § 409.963 (2013); *see also* FLA. AGENCY FOR HEALTH CARE ADMIN., FREQUENTLY ASKED QUESTIONS 25 (2013), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_FAQs.pdf.

118. *See* FLA. STAT. § 409.912(14)(a) (2013).

119. *See* CMS GUIDELINES, *supra* note 53, at 14.

120. *See* FLA. STAT. 409.469(2) (2013) (listing examples of "good cause"); *see also* FLA. ADMIN. CODE ANN. 59G-8.600(2) (2013) (providing a full list of "good cause" situations).

121. AHCA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 37, ¶¶ 15–16.

122. FLA. AGENCY FOR HEALTH CARE ADMIN., 2013–2018 LONG-TERM CARE HEALTH PLAN MODEL CONTRACT, ATTACHMENT II 48 (2013) [hereinafter MODEL CONTRACT ATTACHMENT II 2013], http://www.ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/LTC_Model_Contract_2013_05_06.pdf.

123. *Id.* at 52.

124. *Id.* at 97–98.

125. *Id.* at 97–99; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-100, MEDICARE AND MEDICAID: CONSUMER PROTECTION REQUIREMENTS AFFECTING DUAL-ELIGIBLE BENEFICIARIES VARY ACROSS PROGRAMS, PAYMENT SYSTEMS, AND STATES 30 (2012), http://www.gao.gov/assets/660/650558.pdf [hereinafter GAO-13-100].

Despite CMS requirements in the Guidelines,[126] neither AHCA's waiver applications nor the approved Model Contract provide for any independent advocate or ombudsman services within the Medicaid managed care program. The independent advocate requirement is in addition to choice counseling.[127] Similarly, explanations of how to continue services during an appeal are not ensured under the contracts with the MCOs. The Plan is required to continue services if an appeal is filed with the Plan;[128] however, if an enrollee chooses to proceed directly with a fair hearing, and without knowing that an appeal with the plan is required to continue services, services may be terminated. CMS has advised states to adopt policies to ensure that services are provided in the same amount, duration, and scope during an appeal.[129]

A 2012 United States Government Accountability Office ("GAO") report evaluated Medicaid managed care plans in California, Minnesota and Arizona, and cited the most frequent need for corrective action plans ("CAP") in the area of grievance, appeals, and denials.[130] The CMS Guidelines reflect the necessity of increased consumer protections; and CMS has communicated this requirement to the states. Although the approved waiver applications and Model Contract Attachment II did not provide for an independent advocate or ombudsman services, AHCA has announced through a training presentation that an Independent Consumer Protection Program now exists as a new enrollee protection.[131] AHCA asserts that the Aging and Disabilities Resource Centers ("ADRCs") will now assist an enrollee with contacting the plan or filing a Medicaid Fair Hearing in order to resolve a complaint while the ombudsman will assist with facility complaints.[132]

Person Centered-Processes

CMS calls for "[c]onsistent, [u]niform, [p]erson-[c]entered and

126. *See* CMS GUIDELINES, *supra* note 53, at 11; *see also* FLORIDA'S LONG-TERM CARE SUMMARY, *supra* note 92, at 5; 5 n.13. (citing CMS's request for AHCA to ensure an independent consumer protection program both in the waiver application and in the letter from CMS to the State of Florida on February 20, 2013).

127. *See* CMS GUIDELINES, *supra* note 53, at 10.

128. *See* MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 101–157.

129. *See* CMS GUIDELINES, *supra* note 53, at 14–15; *see also* 42 C.F.R. 438.420 (2013).

130. *See* GAO-13-100, *supra* note 125, at 36–37.

131. *See* Fla. Agency for Health Care Admin., Training Presentation for Long-Term Care Enrollee and Provider Protections, Statewide Medicaid Managed Long-Term Care Program 38 (July 30, 2013), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/LTC_Enrollee_and_Provider_Protections_07-30-2013.pdf.

132. *See id.*

[s]tate-[a]pproved [n]eeds [a]ssessments."[133] AHCA has demonstrated attention to this important element with its revision of its 701 Assessment Instruments.[134] The Florida Department of Elder Affairs ("DOEA") conducted a collaborative effort with the aging network and several state university partners to review the assessment tools and instructions.[135] The drafts are pending official adoptions by the Department of State; however, DOEA is currently offering online training for the 701B instrument, which is an instrument used to determine eligibility for enrollment into a Medicaid managed care plan.[136]

Under the sub-element of "Opportunities and Supports for Self-Direction,"[137] Florida should be commended for integrating a participant direction option ("PDO");[138] however, MCOs need to be educated on this option in order for enrollees to take advantage of it. MCOs should be directed to discuss this option with enrollees.

Qualified Providers

Similar to the above alignment of payment structures and goals element requiring adequate payment rates for providers, the qualified providers' element requires additional support by the MCOs for the providers. Just as adequate rates allow qualified providers to participate in the MLTSS program, technical assistance to providers is required to ensure a sufficient network of providers to meet enrollees' service needs.[139] LTSS providers face great business challenges in transitioning from a fee-for-service system to a MLTSS system.

133. *See* CMS GUIDELINES, *supra* note 53, at 10.

134. *See The 701 Assessment Instruments*, DEP'T OF ELDER AFF., STATE OF FLA., http://elderaffairs.state.fl.us/doea/701b.php (last visited Sept. 29, 2013) (providing access to see the final drafts of 701A, 701B, 701C, and 701S forms).

135. *Id.*

136. *Id.*

137. *See* CMS GUIDELINES, *supra* note 53, at 11.

138. *See* Danielle Reatherford, Fla. Agency for Health Care Admin., presentation on Participant Direction Option (PDO) Training: Developed for the Statewide Medicaid Managed Care–Long Term Care Plans 6 (2013), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/LTC_PDO_Provider_Webinar_2013-03-14.pdf.

139. *See generally* TRUVEN HEALTH ANALYTICS, TRANSITIONING LONG TERM SERVICES AND SUPPORTS PROVIDERS INTO MANAGED CARE PROGRAMS (2013) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/TransitioningLTSS-.pdf (finding that the degree of technical assistance and the sufficiency of time given to LTSS providers to transition to the MLTSS program can greatly influence the quality of providers that participate in the program).

Quality

CMS advises that: "MLTSS programs should allow for ongoing innovation in the delivery of services such as the addition of new types of services that might better integrate care management; promote independence, employment, wellness and recovery; or detect and delay the progress of chronic disease."[140] Adequate quality and performance measures must be in place for ongoing innovation to occur.

Florida has been improving its quality assurance programs over the last six years, creating an infrastructure for measuring the quality of care delivered to Medicaid managed care enrollees.[141] Developments include engaging an External Quality Review Organization ("EQRO"), creating and reporting of Healthcare Effectiveness Data and Information Set ("HEDIS") measures and performance measures by MCOs, implementation of a performance improvement strategy, improving performance improvement projects ("PIPs") in coordination with the EQRO and within each MCO, creating a new fiscal agent system, and creating the Medicaid Encounter Data System.[142]

Having strict reporting requirements of encounter data is one aspect of ensuring quality through oversight and monitoring.[143] In order to be compliant with federal law and regulations, AHCA must collect encounter data on all Medicaid managed care services.[144] Federal regulations also require that all payments under managed care contracts must be actuarially sound.[145] Among the factors used to establish actuarially sound rates is base utilization and cost data obtained from the Medicaid population.[146]

140. *See* CMS GUIDELINES, *supra* note 53, at 2.

141. *See* AHCA QAIS, *supra* note 22, at 25.

142. *See id.* at 25.

143. *See* CMS GUIDELINES, *supra* note 53, at 16; *see also* FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, MEDICAID ENCOUNTER DATA SYSTEM PHARMACY CLAIMS COMPANION GUIDE 7 (2011), http://ahca.myflorida.com/Medicaid/meds/pdf/NCPDP_Companion_Guide_v2-6.pdf [hereinafter AHCA ENCOUNTER DATA SYSTEM] (describing encounter data more specifically as "components of a record that capture and describe the interaction(s) between a patient and a provider."); AHCA, *Medicaid Program Oversight (MPO)*, FLA. AGENCY FOR HEALTH CARE ADMIN., (2011), http://ahca.myflorida.com/Medicaid/meds/. Encounter data are the electronic records of the services provided by Medicaid to enrollees in a health plan. AHCA ENCOUNTER DATA SYSTEM *supra*.

144. *See* Social Security Act, 42 U.S.C. § 1396a (2012) (Title XIX of the Social Security Act); Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997); Elements of State Quality Strategies, 42 C.F.R. § 438.204 (2013); *see also* Fla. Stat. § 409.910(20) (2013); Fla. Stat. § 641.261 (2013).

145. *See* 42 C.F.R. § 438.6(c)(1)(i); CMS SPECIAL TERMS AND CONDITIONS, *supra* note 34, at 5.

146. *See* 42 C.F.R. § 438.6(c)(3); CMS SPECIAL TERMS AND CONDITIONS, *supra* note 34, at

Actuarially sound capitation rates are capitation rates that "are appropriate for the populations to be covered and the services to be furnished . . ."[147] Historically, information about health care utilization and costs for those with special needs has been scarce, in part because of the difficulty of obtaining claims and enrollment data; however, higher healthcare costs, due to a higher level of health services, are typical for those with special needs.[148] Because managed care plans receive a capitated rate, the plans have a poor track record for submitting claim information for their enrollees, which makes it difficult to identify enrollees with certain conditions.[149] Even when Medicaid managed care plans require submission of claims records, also known as encounter records, it may not be as complete as claims for enrollees in fee-for-service plans.[150]

AHCA was required by law to use risk-adjusted capitated rates with 100% of the plans by 2008.[151] Risk-adjusted rates are designed to serve beneficiaries who have the greatest health care needs by paying higher rates to plans that enroll less healthy beneficiaries.[152] The accuracy of the data collected to establish such rates, however, determines whether rates are appropriately established to ensure continuing quality of care. In developing the risk-adjusted rates, AHCA has only used the Medical Rx statistical model. The Medical Rx model "uses prescription drug information to identify medical conditions and . . . [in turn] predict[s] beneficiary health care costs."[153] AHCA selected the Medical Rx model because prescription drug information was readily available and current.[154]

5; *see also* S. 1972, 2011 Sess. (Fla. 2011) (addressing the federal requirement for actuarially sound rates in Section 41, 409.968).

147. *See* 42 C.F.R. § 438.6(c)(1)(i)(B).

148. *See* CAROL V. IRVIN & CHRISTOPHER JOHNSON, MATHEMATICA POL'Y RES., INC., MEDICAID POPULATIONS WITH CHRONIC AND DISABLING CONDITIONS: A COMPILATION OF DATA ON THEIR CHARACTERISTICS, HEALTH CONDITIONS, SERVICE USE, AND MEDICAID PAYMENTS 1 (2007), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Irvin.pdf. CMS focused on persons under the age of sixty-four with chronic and disabling conditions. *Id.* at 1–2. However, their difficulty with obtaining data from managed care plans applies to dual eligibles and Medicaid managed long-term care programs.

149. *See id.* at 14–15.

150. *See id.* at 15. Because of the difficulty in obtaining data from managed care plans, the CMS study only addressed fee-for-service plans. *Id.*

151. *See* OFF. OF PROGRAM POL'Y ANALYSIS & GOV'T ACCOUNTABILITY, MEDICAID REFORM: RISK-ADJUSTED RATES USED TO PAY MEDICAID REFORM HEALTH PLANS COULD BE USED TO PAY ALL MEDICAID CAPITATED PLANS, REPORT NO. 08-54 4–5 (2008), http://www.oppaga.state.fl.us/Reports/pdf/0854rpt.pdf [hereinafter OPPAGA REPORT NO. 08-54].

152. *See id.* at 3.

153. *Id.* at 2.

154. *Id.* at 4.

HMO officials, however, disfavor the Medicaid Rx model because the pharmacy data can reflect physician prescribing patterns, but not necessarily beneficiary health status, and thus favor a Chronic Illness and Disability Payment System ("CDPS") model or combined model.[155]

AHCA planned to begin using the CDPS, a diagnosis based model, to calculate risk-adjusted rates once encounter data became available.[156] The CDPS model better predicts beneficiary health care costs than the Medical Rx model.[157] AHCA was directed by law as part of the Medicaid Reform pilot program to establish an encounter database to collect data on health services provided to enrollees in the managed care plans.[158] AHCA was also required to establish reasonable deadlines for implementing an encounter data system and to ensure that data was accurate and complete.[159] Collecting encounter data has been difficult because plans that pay providers using capitated rate payments do not typically receive encounter data nor have providers been required to submit encounter data.[160] An AHCA meeting taking place in December 2010, provided observations of poor and insufficient reporting by managed care plan providers and that "[d]iagnosis reporting needs to be improved in order to support a diagnosis-based risk adjustment model."[161]

AHCA has developed mechanisms to address the weaknesses regarding the collection of encounter data in the Medicaid Reform pilot program.[162] AHCA's Medicaid Program Oversight Unit ("MPOU") "collects, processes, stores, reports and analyzes the encounter data from managed care service activities and prescription drug utilization for all

155. *See id.* at 5.

156. *Id.* at 4; Fla. Agency for Health Care Admin., Presentation for Medicaid Encounter Data System (MEDS), 1 (Dec. 3, 2010), http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/docs/2010/MEDS_TAP_12-03-2010.pdf [hereinafter AHCA Tech. Adv. Panel] (showing on Slide 1 the schedule of collection of encounter data beginning in 2007 into 2011 and the CDPS Model not being used to set rates until March, 2011).

157. *See* OPPAGA REPORT NO. 08-54, *supra* note 149, at 4. OPPAGA also found that using diagnostic and pharmacy information may prove to be an even better predictor of health care costs. *Id.*

158. *See* FLA. STAT. § 409.91211(1)(p)(4) (2011); CMS SPECIAL TERMS AND CONDITIONS, *supra* note 34, at 6.

159. *See* FLA. STAT. § 409.91211(1)(p)(7)–(8) (2011).

160. *See* OPPAGA REPORT NO. 08-54, *supra* note 151, at 6; Jenna Eddy, Fla. Agency for Health Care Admin., Presentation for Medicaid Encounter Data, 1 (June 2011), http://www.fdhc.state.fl.us/medicaid/mcac/Archive/docs/2011/06-07/Medicaid_Encouter_Data_MCAC_Meeting_06072011.pdf.

161. *See* AHCA Tech. Adv. Panel, *supra* note 156, at 5; OPPAGA REPORT NO. 08-54, *supra* note 151, at 6 n. 24 (stating that HMO plan officials believe sufficient data to set rates will not be available for "several years after the encounter system is operational").

162. *See* FLA. STAT. § 409.967(2)(d) (2012).

Florida Medicaid capitated Health Plans."[163] The MPOU also assists with rate setting and the risk model computations that establish the capitated amounts paid to managed health care entities.[164] AHCA has integrated thorough encounter data collection methods.[165] Under the MCO's contract with AHCA, the MCO is required to have adequate staffing and informational systems in order to collect and submit encounter data each year, including a trained and experienced claims manager.[166] Providers must also "submit timely, complete and accurate encounter data to the Health Plan . . . ."[167] Moreover, the Health Plan's provider handbook must include procedures for submitting encounter data to the Health Plan.[168]

Other aspects of quality improvement strategies include PIPs used to address the necessary changes to quality oversight.[169] The MCOs, working with AHCA, are required to perform PIPs that significantly improve quality of care and service delivery under strict documentation and report submission requirements.[170] The MCO's PIPs are subject to review and validation by the EQRO.[171]

States are required to use an External Quality Review ("EQR") process as a whole in the implementation of a LTSS program to assess and validate critical quality elements.[172] AHCA has dictated the MCO's responsibility regarding reporting to the EQRO in the contracts, but the State is ultimately responsible for oversight and monitoring.[173] A specific method used by the State to continue its oversight and monitoring of MCOs is the collection of data acquired from enrollee performance measures.[174] CMS recommends using performance measure data to create MCO report

163. *See* AHCA, *Medicaid Program Oversight (MPO)*, FLA. AGENCY FOR HEALTH CARE ADMIN. (2011), http://ahca.myflorida.com/Medicaid/meds/.

164. *Id.*

165. *See* AHCA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 109.

166. *See id.* at 40, 103, 105.

167. *Id.* at 75, ¶ ee.

168. *See id.* at 80, ¶ 13.

169. *See* CMS GUIDELINES,, *supra* note 53, at 16.

170. *See* FLA. STAT. §409.967(2)(e) (2012); ACHA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 88–89.

171. *See* ACHA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 89; *see also* SAUCIER & FOX-GRAGE, *supra* note 4, at 12–13 (recommending that submission of data by providers be part of quality components that include quality management strategies to address consumer problems and also independent reviews of program quality by external organizations). The EQR process analyzes and evaluates "aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a managed care plan." ACHA MODEL CONTRACT ATTACHMENT II, *supra* at 15.

172. *See* CMS GUIDELINES, *supra* note 53, at 16.

173. *See id.*

174. *See id.*

cards that are "public, transparent, easily-understandable and useful to participants in choosing a MCO."[175] The Model Contract calls for MCOs to collect data on enrollee performance measures as defined by HEDIS, or otherwise by AHCA, with sanctions imposed for the failure to make the required reports.[176]

Collection and validation of encounter data is also necessary for Medicaid managed care fraud and abuse detection.[177] Fraud and abuse reporting is part of critical reporting requirements to ensure quality oversight under the CMS Guidelines.[178] A report prepared in February of 2008 indicated that AHCA needed to improve managed care oversight, specifically in the area of corporate fraud detection.[179] Fraud can occur when funds are diverted to increase profits to the detriment of the enrolled beneficiaries. The 2008 report indicated that AHCA needs to ensure that capitated payments provide medically necessary services and that the medical loss ratios are reasonable.[180] Florida Office of Insurance Regulation considers reasonable medical loss ratios for commercial HMOs to be from 0.80 to 0.90.[181] Although the proposed Senate version of the current Part IV, Chapter 409 of the Florida Statutes established a minimum medical loss ratio of ninety percent under the statute providing for plan accountability,[182] the final legislation that passed did not include a medical loss ratio.[183] CMS did not require a medical loss ratio in the Section

175. *Id.* at 17.

176. *See* ACHA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 89–90; *see also* AHCA, *Florida Medicaid Quality Managed Care*, FLA. AGENCY FOR HEALTH CARE ADMIN., http://ahca.myflorida.com/Medicaid/Quality_mc/index.shtml (last visited Sept. 15, 2013) (providing access to the 2012 version of the Medicaid HMO and PSN Performance Measures, which include twenty-three HEDIS measures and ten Agency-Defined measures).

177. *See* Roberta K. Bradford, Deputy Sec'y for Medicaid, Fla. Agency for Health Care Admin., Fraud and Abuse Prevention in Medicaid Managed Care Organizations, presentation to House Select Council on Strategic and Economic Planning, 15 (Mar. 5, 2010), http://www.myfloridahouse.gov/sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2546&Session=2010&DocumentType=Meeting%20Packets&FileName=SPCSEP_Mtg_3-5-10_online.pdf.

178. *See* CMS GUIDELINES, *supra* note 53, at 16; ACHA MODEL CONTRACT ATTACHMENT II, *supra* note 48, at 33, 74. The Model Contract addresses the role of the Medicaid Fraud Control Unit. ACHA MODEL CONTRACT, ATTACHMENT II, *supra*, at 75.

179. OFF. OF PROGRAM POL'Y ANALYSIS & GOV'T ACCOUNTABILITY, AHCA MAKING PROGRESS BUT STRONGER DETECTION, SANCTIONS, AND MANAGED CARE OVERSIGHT NEEDED, REPORT NO. 08–08 1–2 (2008), http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0808rpt.pdf [hereinafter OPPAGA REPORT NO. 08-08].

180. *See* OPPAGA REPORT NO. 08-08, *supra* note 179, at 5–6.

181. *See id.* at 6 n.18.

182. *See* S. 1972, 2011 Sess. (Fla. 2011).

183. See FLA. STAT. § 409.967(3) (2012) (creating an "achieved savings rebate" instead of a medical loss ratio).

1915(b)/(c) waiver for the Long Term Care Managed Care Program ("LTCMC"). However, CMS required a medical loss ratio of eighty-five percent in the December 2011 renewal of the Section 1115 Waiver, for which an amendment was approved June 14, 2013, creating the Managed Medical Assistance Program and retaining the eighty-five percent medical loss ratio.[184] Even with a high minimum medical loss ratio, however, a high quality of care is not ensured unless the encounter data is examined to identify irregularities to ensure that beneficiaries are receiving quality care.[185]

PART VII. ARIZONA AS A MODEL FOR MEDICAID MANAGED LONG-TERM CARE

Arizona was the first state to implement state wide Medicaid managed care under their Arizona Health Care Cost Containment System ("AHCCCS"), which began in October 1982.[186] The Arizona Long-Term Care System ("ALTCS") was incorporated into AHCCCS in 1989, which provides a broad range of home and community-based services and nursing home services.[187] Because of how long Arizona has utilized a state-wide Medicaid managed care system, studies have evaluated AHCCCS to determine the success of Medicaid managed care, in particular Medicaid managed long-term care. Recommendations regarding implementation of a new Medicaid managed care program from studies of AHCCCS include maintaining state involvement in the beginning of the program, especially in management responsibilities, even to the extent of assuming some of the risk of delivering services by retroactively adjusting the capitated rate.[188] State management responsibility includes quality assurance measures and monitoring access and utilization activities, especially in a capitated program.[189] The initial problems of AHCCCS are attributed to the lack of state-managed responsibility.[190]

184. *See* CMS Approval Letter to AHCA, *supra* note 45.

185. *See* OPPAGA REPORT NO. 08-08, *supra* note 179, at 6 (finding that "AHCA required Medicaid HMOs to report medical loss ratios but does not use the information to enforce minimum standards to ensure the delivery of health care").

186. *See* Nelda McCall, *Lessons from Arizona's Medicaid Managed Care Program*, 16 HEALTH AFFAIRS 194, 194 (1997), http://content.healthaffairs.org/content/16/4/194.full.pdf.

187. *Id.*

188. *See id.* at 197.

189. *See id.* at 198 ("Important areas include activities to detect underuse of services, review of treatment patterns by diagnosis, monitoring of selected procedures, detection of fraud and abuse, and profiling of plans and physicians for quality and appropriateness.").

190. *See id.* at 198 ("Not having financial management structures in place resulted in Arizona's not being able to detect impending plan bankruptcies until they were imminent.").

Stewart Grabel, from the Pima (County, AZ) Council on Aging, also attributes the successful portions of AHCCCS to when government supervision was at its highest.[191] During the increased government supervision time period, the individual counties contracted with providers and case managers were assigned to each participant.[192] The case managers ensured that the participant received the services for which the county was paying.[193] Because of budget cuts, however, all counties except Pima County have now withdrawn from this role and the quality of care has been affected by services being cut.[194] Case managers continue to be utilized, but the private, for-profit managed care organization employs the case manager, a model that is much less effective.[195]

The director of AHCCCS reported in 2008 that "Arizona [had] the third lowest average annual payment per member, spending $3,035 per [Medicaid beneficiary], with only California and Tennessee spending less."[196] The director attributes the cost savings to establishing provider networks that can meet health care needs of special needs populations, employee retention, data collection and reporting, and timely reimbursement to the providers.[197] In July of 2012, the director of AHCCCS, in testimony to the U.S. Senate Special Committee on Aging, built his case that Medicaid managed care for dual-eligible members was not simply an experiment but a proven success in Arizona.[198] The Director describes an increase over the past decade from forty percent to seventy-two percent of their elderly and disabled population living in home and community-based settings instead of institutional care settings, at a savings of $300 million the past year.[199] As part of the deliberate, cautious implementation of Medicaid managed care, and particularly Medicaid managed long-term care, including its goal of increasing home and

191. Telephone Interview with Stewart Grabel, Ombudsman for the Elderly, Pima Council on Aging (Mar. 22, 2011).

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.*; *see State Demonstration Proposals, supra* note 58. AHCCCS applied for a Dual-Eligible Demonstration with CMS but has since withdrawn this application. *State Demonstration Proposals, supra.*

196. Matthew Gever, *Lessons in Medicaid Managed Care from Arizona,* STATE HEALTH NOTES (Jan 7, 2008), http://www.ncsl.org/print/health/shn/shn506.pdf.

197. *Id.*

198. *See* THOMAS J. BETLACH, DIR., ARIZ. HEALTH CARE COST CONTAINMENT SYS., BUILDING UPON THE SUCCESS OF MEDICAID MANAGED CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: OVERVIEW OF TESTIMONY BEFORE THE U.S. SENATE SPECIAL COMMITTEE ON AGING 1 (2012) http://www.azahcccs.gov/reporting/Downloads/Integration/Director%27sTestimony_US_SenateSpecialCommittee_Aging7_18_12.pdf.

199. *Id.* at 1–2.

community-based care, Florida would be wise to examine Arizona's model.

PART VII. CONCLUSION

Budget crises and the need for spending cuts created the impetus for Medicaid Reform. However, the geographic expansion from five to sixty-seven counties and population category expansion from TANF and SSI beneficiaries to virtually all Medicaid beneficiaries, including some of the most vulnerable populations, into Medicaid managed care could cause substantial detriment to the Medicaid beneficiaries enrolled. Sufficient time and resources, combined with continuous monitoring and oversight of program implementation are required to realize the benefits of Medicaid managed care.[200] Establishing appropriate capitated rates based on accurate encounter data and maintaining current federal regulations are a necessary part of the implementation process. As implementation begins, the success or failure of Florida's Medicaid Long Term Care Manage Care program will become evident as plan accountability reports become available and Medicaid beneficiary feedback is gathered.

200. *See* KAISER COMM'N, NUMBER 2043, *supra* note 53, at 5; HALL & WALSH APR 2010, *supra* note 27, at 4–5 ("Until there is better assurance that Medicaid recipients (especially those new populations slated to be put under the managed care umbrella) will have appropriate access to needed services . . . the proposed expansion [should] be studied further and not rushed.").