

## Medicaid Managed Long Term Care in Florida Issue Brief December 2017

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*Henry is a 76 year old, previously self-employed, very frail man with advanced COPD and in need of 24 hour oxygen, who lives alone in a vacant, dilapidated house without a close family member. Henry has minimal resources with \$1202 monthly social security income and less than \$2000 in assets. He exceeds the Supplemental Security Income (SSI) amount. Henry does not want to go into a nursing home even though he does qualify for Medicaid funded institutional care according to his doctor. He is alert and competent, so protective services will not assist with Henry being moved to the top of the state's wait list for community-based services. Some families have found that is the only way to get access to necessary services for their loved ones which means others continue to move down the wait list. Henry has to decide whether to purchase food or medications with his limited income and he depends on uncertain sources for transportation to medical appointments. The state's waiting list for Medicaid funded home and community based services is filled with people like Henry.*

Medicaid is a very important health insurance program for elders and persons with disabilities in need of long term care. It is the only long term care assistance program that has traditionally ensured frail, vulnerable people the right to nursing home care. Because most people desire to remain in the community as long as possible, and federal and state policy makers' drive to reduce the rate of growth in long term care budgets, there has been support for more funding of community based care. States are increasingly turning to home and community based services as a cost effective alternative to nursing home care through a policy called "rebalancing" of the funding.

For many years the states were able to access federal Medicaid waivers to use the long term care Medicaid funds for both nursing home and community based care. The nursing home admissions continued as an entitlement and home and community based services based on the number of slots approved in the waivers. The limit on slots resulted in persons being placed on a wait list for services. Those most in need, e.g. discharged from a nursing home or at immediate risk of nursing home placement, were more likely to be placed at the top of wait lists and to receive community based services through the aging nonprofit service provider network.

Now state Medicaid programs are turning increasingly to managed care organizations (MCOs) to rebalance their long term care programs through Medicaid Managed Long Term Services and Supports (MMLTSS). Florida is one of 28 states with Medicaid managed long term care through HMOs and other managed care entities which provide services funded by a blended capitated rate for a person at risk of nursing home placement. The HMOs are responsible for serving members in the community or in an ALF or nursing home. Increasingly, however, individual eligible for care are being placed on a wait list in the community. Florida now has over 65,000 seniors on a wait list for services according to the state Department of Elder Affairs, 47,000 of whom are Medicaid eligible.

## Florida's Brief History

The 2011 Florida Legislature passed House Bill 7107, creating Part IV of Chapter 409, Florida Statutes, to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC). Earlier studies conducted by the University of South Florida's Aging Policy Center found the aging network of nonprofit service providers to be cost effective. The nonprofit aging providers charged much less for administrative overhead than the for-profit managed care organizations in the Nursing Home Diversion Medicaid Waiver Program. In fact, the April 19, 2010 St. Pete Times article by Steve Nohlgren was entitled "Florida House Ignores Own Analysts who Warn of Pushing elderly to Managed Care."

The HMO's convinced the Florida Legislature and the Governor that they could reduce nursing home admissions and produce a 5% savings by redirecting persons to community based care. The Agency for Health Care Administration moved quickly in 2012 to build the framework for the managed care takeover.

**September 2012 baseline for the Florida Medicaid LTC waiver: 58% of Florida Medicaid's 86,000 LTC beneficiaries were in nursing homes with 42% or 36,000 in community based care. There were 34,600 persons on the waiting lists for community based services.** The goal was to get the state to a 65% home and community based care and 35% nursing home rate for the Medicaid LTC services.

CMS approved Florida's waiver applications for both the LTC (1915 b and c) and the Medicaid Managed Care (MMA) (1115 demonstration waiver) in early 2013 for statewide implementation by 2014. The Florida Medicaid waiver cap was set at 36,795 slots for community based care. The approved waiver only increased the community based by 795 slots from the 2012 number served in the community. Implementation began in August 2013 with a roll out across the state over the next year. There were many negotiations between the managed care providers and the aging network nonprofit service providers over appropriate, fair payment for contract services.

The December 2013 Georgetown University Health Policy Institute educational brief entitled "Launch of Medicaid Managed LTC in Florida Yields Many Lessons for Consideration" noted that the importance of program data related to program cost and quality was essential to ensuring program integrity.

## **2012 – Advocates appeal to CMS**

The FSU Claude Pepper Center worked with Florida CHAIN in 2012 on the critique of the Florida Agency for Health Care Administration's applications for Medicaid waivers to implement the Managed Long Term Care Program created by the 2011 Florida Legislature. The culminating letter that was submitted to CMS on February 18, 2012, urged a rejection of the Florida waivers' application. Rejection was urged because there was no credible evidence that managed care providers would provide services as efficiently, cost effectively or free of fraud as those provided by the statewide network of Area agencies on Aging and other non-profit aging service providers

over the past three decades. Furthermore, Florida already had one of the strictest nursing home bed formulas in the US which served to limit nursing home access to those most in need (2.3% of residents over 65 compared to the national average of 3.7%). As noted in the advocates' letter to CMS, Medicaid's nursing home population dropped from 49,000 to 42,000 by 2012 which meant the sickest of the sick were in nursing homes and the proposed managed care system might "squeeze the nursing home lemon a lot tighter."

The February 2012 letter to CMS included evidence from several studies by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) between 2003 and 2010 and the University of South Florida's Florida Policy Center on Aging. The studies showed that the Aging Network Medicaid waiver programs were much less expensive on a per person per month basis than the Nursing Home Diversion managed care waiver program operated by for profit HMOs. CMS was asked why federal policy makers would adopt a more expensive LTC policy especially with the anticipated growth of Florida's aging population. The 2010 Pacific Health Policy Group report for the Florida Legislature concluded that in order to contain costs, the state must tighten the preadmission screening criteria and limit community based service slots.

Other informed organizations also raised concerns to CMS in 2012 about the lack of cost-effectiveness of the proposed managed LTC programs in comparison with the Aging Network system, including the Health Policy Institute at Georgetown University and the Winter Park Health Foundation. AARP's Joyce Roger's letter to Secretary Mann noted that the waiver proposal raises many "unanswered questions, e.g. about specific procedures, quality outcomes and measurements, transparency and adequacy of service networks."

The major concern of all the organizations urging CMS to reject Florida's 1915(b) (c) waivers was related to the lack of substantive information in the application to support improved service offerings and/or cost effectiveness. There was shared concern about the state's singled minded pursuit of containing LTC Medicaid spending with little attention paid to service access and quality.

The Florida CHAIN letter highlighted the following unanswered concerns:

1. The Florida waiver proposed to reduce the state's capacity to provide appropriate levels of care for a rapidly expanding population of eligible persons needing LTC services by restricting eligibility, manipulation of the wait list procedures, arbitrary reductions in nursing home appropriations, and indifference to insufficient home and community-based service capacity.
2. An irreversible displacement of the more efficient and cost-effective Aging Network.
3. The proposed waiver's only concrete measure to be reported was a reduction in nursing home use.
4. The proposed "achieved savings rebate" (ASR), as opposed to a medical loss ratio (MLR), was found to be inadequate and ineffective to ensuring the services would be maintained at an appropriate level.

Summary of 2012 Actions: CMS failed to respond to any of the concerns raised by the organizations aforementioned. The major question of why CMS would allow the state to adopt a more expensive LTC Medicaid program with little regard for service access and quality would go unanswered. CMS proceeded to quickly approve the Florida Medicaid waiver application prior to the CMS 2013 release of recommended standards for managed care Medicaid waiver programs. Since Florida's waivers were approved prior to the CMS standards' release, Florida was not held accountable for the federal 10 essential program quality standards that came after the state's waiver approval.

The Florida Medicaid Managed LTC program was fully implemented by 2014 and there have been two evaluations completed under contract with the Florida Agency for Health Care Administration, the state's Medicaid agency. The following is a summary of the evaluation findings reported in 2016 and 2017.

**2016 first Florida state evaluation:** First Evaluation "Independent Assessment of the Florida Statewide Medicaid Managed Care LTC Program from 2013-14" by the Florida State University College of Medicine.

Major limitations were the short time period and the limited programs' evaluated. The evaluation was only the three month period right before the MMLTC program implementation. Furthermore, it was only a comparison with the state's most costly Medicaid program alternatives to nursing homes – the Nursing Home Diversion program and the high cost Brain and Spinal Cord injury program. There is no evaluation of the home and community based services provided through the aging nonprofit service providers. Furthermore, the evaluation does not reflect any encounter data, so there is no real understanding of quality of services or of the number and/or types of services per capita received.

**2017 second state evaluation:** The continuing problem with lack of encounter data limited the evaluation findings of the second report. The report's own recommendations summarize the need for more accuracy in reporting:

**Page 63: Recommendations:**

1. **Improve encounter record reporting.** The inability to evaluate the changes in services per person before and after the LTC managed care program implementation is a major omission. The cost effectiveness and the quality of services are not really evaluated without the encounter data.
2. **Improve reporting of where a plan enrollee is located in a given month.** The inability to identify location of each client being served impedes understanding of whether a client is enrolled while in a nursing home or in the community.
3. **Work with the Agency for Health Care Administration to understand the underreporting of case management.** The evaluators' assumption is that case management is "underreported" but there is limited data reported to really know the extent of the service.

4. **The Agency should develop a standardized service category classification scheme for data files.** Important data is missing due to the inconsistency in data files across managed care provider. This precludes a clear understanding of per capita costs and service plan utilization by geographic area as well as provider.
5. **Conduct more analyses at the plan and region level.** This is a critical area of missing information since the per person services by plan is not available. Such important encounter data is needed understand differences by regions.
6. **Examine differences in network robustness by county.** The evaluation could not determine if the plans provide the necessary services at the regional or county levels.
7. **Compare pathways through and services received under the program for the less elderly, disabled versus the elderly, frail population of enrollees. Evaluate outcomes for LTC enrollees across settings.** These pathways need to be understood for all potential and actual enrollees.

#### **Federal General Accounting Office Reports 2017:**

##### **Warnings from the GAO to CMS on lack of oversight of states' Medicaid Managed LTC programs**

The U. S. General Accounting Office (GAO) produced two critical reports in 2017 assessing the Centers for Medicare and Medicaid Services (CMS) oversight of states' Medicaid Managed Long Term Services and Supports (MLTSS) programs. The increasing use of managed care for Medicaid frail and vulnerable, aging or disabled beneficiaries in need of long term care is a significant change for what has traditionally been a nursing home program. By May 2017 27 states had implemented managed long term care programs through Medicaid to encourage the use of community alternatives to nursing home placement. "Using managed care to deliver long term services and supports can be a strategy for states to expand home and community based care, which many beneficiaries prefer and to lower costs," the GAO reported. "However given the potential vulnerability and needs of beneficiaries in these programs, oversight is crucial to ensure their access to quality care." Both GAO reports criticize the CMS lack of minimum standards for state operational procedures from rate setting and basic encounter data requirements to network adequacy and access to quality care.

The **January 2017 report (GAO-17-145)** (link here) reported that CMS had limited oversight of payment rates by the states with concerns on the appropriateness and reliability of data reported. According to the GAO: "To the extent that states use data that are not appropriate and reliable to set rates, the resulting rates could be too low, which could provide an incentive for managed care organizations (MCOs) to reduce care, or too high, which results in more federal spending than necessary." The report recommended that CMS specifically set minimum standards for reporting and validating encounter data in finding that the states were allowed to set their own policies and procedures. Florida was one of the six states selected for study with the finding that payments were not linked to program goals "such as enhancing the provision of community-based care." The only performance measure reported for Florida was based on beneficiary survey results reported through 2015.

**August 2017 GAO report to Congress “Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States’ Long Term Services and Supports Programs”**

Summary statement by the GAO: “Medicaid beneficiaries who need long-term care can get it in their homes, community settings, or an institution such as a nursing home. Many states contract with managed care organizations to provide this care. The 6 states reviewed used various methods (e.g., beneficiary surveys) to monitor access and quality in managed long-term care programs. However, the Centers for Medicare & Medicaid Services did not always require the states to report information it needs for oversight, such as beneficiary concerns or whether there are enough providers.”

GAO conducted the study of Medicaid Managed Care because of the rapid MCO growth by the states in providing long term care to vulnerable populations. Six states were selected for close monitoring by the GAO: Arizona, Delaware, Kansas, Minnesota, Tennessee and Texas. The GAO found that CMS allowed “customized” reporting by each state rather than not required reporting which means that key indicators of network adequacy, access to care and the quality of care are not uniformly reported by the states. This permissive policy undermines effective accountability.

The Department of Health and Human Services (including CMS) responded that it will review its May 2016 Medicaid managed care regulations which are scheduled to take effect sometime in 2018 to ensure the requirements meet the concerns raised by the GAO. States will be required to annually report on network adequacy and validate network sufficiency, as well as access and availability of services, quality performance, appeals, grievances and state fair hearings. However, minimum standards of information to be reported to CMS have not been developed to date.

The managed care takeover of states’ Medicaid funded long term care systems has generated several recurring concerns. As anticipated by Florida and state as well as national advocates back in 2012, the shift to a capitated system of care for a very frail, vulnerable population comes with many risks to persons in need of long term care services. The possibility that incentivized payments could reduce services was a critical underlying concern. The rapid growth of frail, vulnerable elders and persons with disabilities in need of services but on waiting lists was sadly anticipated.

The GAO 2017 studies support the need for much stronger oversight of the states’ Medicaid managed LTC programs. The GAO studies confirm that the issues raised to CMS in 2012 continue to be an unaddressed public policy problem. Furthermore, the escalating wait list for home and community based services in Florida to over 65,000 elders is also a major public policy concern that is related to the reduction of people served through Florida’s Medicaid managed LTC program, a reported reduction of 5,019 persons per month by July 2015, according to the state of Florida’s second evaluation.

**Conclusions: Since the 2013 implementation of the Medicaid Managed Long Term Care program in Florida, the wait list number has doubled to more than 65,000 individuals.** There is a lack of information on the waiting lists that are growing across the nation with the growth of the aging population and persons with disabilities in need of long term care as well as uncertainty with the types and amounts of services provided in the community. Florida’s wait list for long term care, community-based services has doubled between 2012 and 2017. If this trend continues, there will be over 130,000 frail, vulnerable seniors on the wait list by 2022.

The number of people served monthly between July 2012 and July 2015 has decreased by 5,019 per month according to the second state evaluation. The lack of appropriate encounter data as reported by the two state evaluations and the GAO January 2017 study, limits the understanding of per capita services as well as service costs in the community. The cost effectiveness is reported as “cost neutral” on page 5 of the second state evaluation, but without a clear understanding of the types of services provided per capita, it is not possible to usefully interpret what cost neutrality means.

Florida was one of the six states selected by the GAO for review of their managed long term care payment structures and incentives for an expansion of community based care and CMS’ oversight. The GAO 2017 review of CMS’ terms and conditions for the approved waivers reported reliability concerns with the managed care encounter data. The GAO noted that CMS had not issued guidance with minimum standards for the reporting of encounter data. The GAO recommended that all states be required to report on progress toward goals to reduce nursing home use and for CMS to provide minimum standards for encounter data to be reported by state. The Department of Health and Human Services agreed with the GAO findings, but no date was set for strengthened regulatory oversight.