Medicaid Managed Care – an eye on Florida   February 6, 2019
The key point that has not been addressed is whether the state should allow profit making with health care not provided.

The managed care takeover of states' Medicaid funded long term care systems has generated several recurring concerns. As anticipated by Florida as well as national advocates as far back as 2010, the shift to a capitated system of care for a very frail, vulnerable population comes with many potential risks to persons in need of long term care services. The possibility that incentivized payments could reduce services was a critical underlying concern. For managed care organizations to operate within a capitated rate, there may be a disincentive to provide the full complement of needed serves. The rapid growth of frail, vulnerable elders and persons with disabilities in need of services, but who would end up on waiting lists rather than receiving services when they needed them, was a major concern.

Florida now has a growing wait list of over 65,000 frail seniors in need of home and community based services. Many advocates were also concerned about the diminishing role of the Aging Network providers if they were excluded from the Medicaid Managed LTC system in Florida and other states. The FSU Claude Pepper Center continues to research the literature and collect key informant information around these concerns for access and care quality in the Medicaid LTC program.

The three evaluations of the Florida Medicaid Managed Long Term Care program have been limited by the lack of encounter data that details the intensity of services received. The first 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.

The second state evaluation (2017) also suffered from a lack of accurate encounter data. The report's own recommendations summarize the need for improved reporting: *Page 63, Recommendations:* "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."

The third evaluation (2018) has limited encounter data reported by some of the health plans, but the data still does not permit the accurate measurement of the intensity of services provided. As reported in the "Independent Assessment of the Florida Statewide Medicaid Managed Care Long Term Care Program", Deliverable 12, MED 186, August 29, 2018: "increasingly higher proportions of LTC enrollees have received services…however, the trend in the level of service use intensity….remains unknown."   Since this type of data is not known, the evaluators used a definition of service utilization as "number/proportion of enrollees for a given service." A person just has to receive one unit of service in a month to be counted as a service recipient.

In sum, this means that managed long term care Medicaid funding has grown rapidly even as concerns continue about the reliability and limitations of the data reported. The GAO has called on CMS to provide more oversight of states and to set minimum standards for reporting and validating encounter data. To date, this has not occurred.

Year Three Assessment of Florida Medicaid LTC Program

The third evaluation (2016-17 data review) prepared in 2018 for Florida Medicaid by the Florida State University Medical School is divided into four individual reports under the rubric: "Independent Assessment of the Florida Statewide Medicaid Managed Care Long-term Care Program."

- Deliverable 12 – Research Report: Accessibility and Utilization of LTC Services (8/28/18)
- Deliverable 14 – Special Research Report: Current Practices and Factors Associated with Transition into Home and Community-based Settings ((9/10/18)
- Deliverable 15 – Research Report: Cost-effectiveness of the LTC Program (9/19/18)
- Deliverable 16 – Special Research Report: NF Plans of Care and Case Management Notes – Preliminary Report (6/29/18)

The **Deliverable 12** report covers two questions: Have there been changes in services' accessibility for enrollees over time; and service usage for enrollees prior to nursing facility admission. The findings included an increase in some services such as adult day health care, home delivered meals, homemaker services, medical equipment and supplies, personal care and respite care but the level of service use intensity remained unknown. The proportion of home and community based enrollees in assisted living declined while the number in the community increased. The reported use of personal emergency response systems, regular receipt of home delivered meals and the use of adult companion care were associated with a larger chance of nursing facility admission.

Deliverable 14 reports that while there are higher proportions of Medicaid enrollees in HCBS settings, there is uncertainty whether the increase is due to persons newly eligible and already in the community or if there is an increase in the number of people who transitioned out of nursing homes. There are geographical differences with Regions 10 and 11 (southeast Florida) enrollees' having a higher prevalence in ALFs and less residing in nursing facilities. The 2019 evaluation will study enrollees' support systems since this 2016-17 data review in 2018 found that the "presence of a primary caregiver is positively associated with a successful transition" to a community setting, and the transition into an ALF was found to be more successful than a transition in home-based settings. This report has two recommendations: 1. Conduct plan-level analysis of transition dynamics and 2. Look at provider networks at the regional level in assessing nursing facility risks across regions.

Deliverable 15, cost effectiveness of the LTC program, looks at three questions:

1. How has the LTC program affected the growth of Medicaid costs for LTC enrollees?
2. Has a shift to HCBS from NHs affected overall Medicaid costs for LTC?
3. Has there been an improved cost effectiveness of care measured by functional and cognitive status?

The evaluators concluded that the LTC program "remains cost-neutral" as the number receiving HCBS services has increased from 46.3% in 2013-14 to 52.9% in 2016-17 and the nursing facility percentage of Medicaid enrollees dropped from 53.7% to 47.1%. The results did not show any shifts in care locations based on frailty. This means that the level of frailty is similar for enrollees in nursing homes and in the community setting.

Deliverable 16, reports on two questions related to case management and plans of care:

1. How does quality of care for LTC plan enrollees in a nursing facility differ from nursing facility enrollees not enrolled in Medicaid?
2. How do case managers improve quality of care for NF enrollees, based on reviews of care plans and case notes?

The evaluators found only minor differences in the MDS 3.0 quality indicators between the LTC plan enrollees and the non-Medicaid nursing facility residents except for less pain reported by the LTC plan participants. The next report will include interviews with case managers on this topic.

Question 2 consists of a content analysis of the plans of care and case notes for the NF enrollees. The report notes that the managed LTC case managers do not have access to the MDS 3.0 assessments which are supposed to direct facility staff work. The 701B/701T form is administered by the Plan case manager. This form determines eligibility for the LTC program based on a person's medical, developmental, behavioral, social, financial and environmental status. The Plan case manager than develops a plan of care based on the 701B/701T assessment and is supposed to contact enrollees by phone on a monthly basis and face to face meetings quarterly or if there is a significant change.

The review found that "seldom were POCs and case notes completed timely" but were "somewhat timely" and "somewhat accurate." Accuracy rates reflect 24% of case managers referring to enrollees by inaccurate pronouns and names in POCs and notes. "Person-centered POCs and case notes were difficult for most plans, meaning the desires and values of the enrollee were sometimes missing or not mentioned." The researchers found much variance in the person-centered POCs and case notes as well as the setting of measurable goals across the Plans. More information will be collected via interviews with case managers for the next evaluation cycle.

Perspectives on the evaluations

Medicaid managed long term care was passed by the 2011 Florida Legislature to control the increasing Medicaid budget for nursing home care by contracting with managed care companies to redirect frail, vulnerable seniors and persons with disabilities from nursing homes to community based care. The state's commitment to controlling the numbers served is clearly expressed in the capped number to be served annually in Florida's Medicaid waiver approval from the Centers for Medicare and Medicaid Services (CMS). The state's waiting list is growing and is now greater than the number of approved slots in the Medicaid LTC waiver program. Is this the basis for the cost neutrality found by the evaluators over the past three years? The enrollees served in nursing homes and in the community (and therefore on the wait lists?) do not differ in terms of frailty. So is it only the cap on slots that is influencing the rate of increase in the cost of the Medicaid LTC program in Florida by not providing services to otherwise eligible frail, vulnerable seniors and persons with disabilities?

As noted by the evaluation team, the lack of accurate and complete encounter data limits the ability of evaluators to assess the intensity of services provided to determine how many services are being provided to persons in the community. The lack of information on regional variances in provider networks across the state is also a major concern.

The state's aging population continues to grow as do the needs but the Medicaid waiver is capped. The only place for people to go as long as there are no open slots is the waiting list.