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Medicaid Managed Care – an eye on Florida
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The managed care takeover of states' Medicaid funded long term care (LTC) systems has generated several recurring concerns. One of the ongoing major concerns is the lack of reported data on how many people are provided specific services, nor is there good service intensity data provided. For many years Florida key informants reported on the cost effectiveness of the Aging nonprofit network's home and community based services programs. 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.

State and national advocates. as far back as 2010, stressed that 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 70,000 frail seniors in need of home and community based services. Many advocates originally 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 have now seen this happen. 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 multiple evaluations conducted by states such as Florida and those funded by the Centers for Medicaid and Medicare Services (CMS), as well as the recent critique of the Research Triangle Institute's multi-state evaluations of the dual eligible managed care programs by Community Catalyst, the Commonwealth Foundation and CMS are hindered in their assessments of cost effectiveness by the continued lack of Medicaid encounter data not reported by the managed care companies.

The four 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 General Accounting Office (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 which is surprising. 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.

Year Four Assessment: 2019 Final Florida Research Reports – "Independent Assessment of the Florida Statewide Medicaid LTC Program"

The final evaluation (SFYs 2015-16, 2016-17 and 2017-18 data review) prepared in 2019 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 23 – Final Research Report: Accessibility and Utilization of LTC Services (SFY 2016-2018)
- Deliverable 24 - Research Report: Long-Term Care Program Nursing Facility Plans of Care and Case Management (SFY 2018-19)
- Deliverable 25 – Research Report: Cost-effectiveness of the LTC Program (SFYs 2015-16, 2016-17 and 2017-18)
- Deliverable 26 – Special Research Report: Current Practices and Factors Associated with Transition into Home & Community-based Settings SFYs 2015-16, 2016-17, 2017-18)

The fourth year evaluation of the accessibility and utilization of long term care services in **Deliverable 23** continues to address the same two questions: 1. Have there been changes in the accessibility of services for enrollees over time? ("no changes in accessibility using utilization levels as a proxy measure for accessibility")

2.What are the levels of service utilization for enrollees prior to transitioning into the nursing home? ("intensity of service utilization was not predictive of transition to a nursing facility.").

There is an important explanation in Deliverable 23 on page 11: ***"The evaluation team was only able to assign approximately 57% of the 74.5 million encounter records provided to one of the 26 services mandated by the SMMC-LTC contract. The evaluation team's concern is that the useable encounter records may not provide a representative sample of the Florida LTC program during SFY 2015-18."*** The evaluators leave it to the Agency to determine if the sample is representative enough to be used for decision-making.

Deliverable 24, LTC program Nursing Facility Plans of Care and Case Management, is a continuation of the review in Deliverable 16 which reported minimal differences between LTC enrollees and non-LTC NF residents' quality indicators. The year four deliverable states that the earlier findings were validated for this reporting period by "assessing the potential influence of case management on quality of care through interviews" with a sample of 74 LTC plan case managers, 43 enrollees and 69 caregivers.

A very interesting outcome of the interviews is the "enrollees and their caregivers are not aware of these necessary case management tasks" of the LTC plan case managers. The evaluators surmise that the plan case managers' work is not visible to the enrollees. For example, the enrollees who left the nursing home for the community reported that NF staff were most important for the transition. The evaluation report encourages the Plans to better "demonstrate case managers' utility to enrollees and caregivers." The evaluators reviewed 300 plans of care and case notes and found them "seldom timely" with wide variety in stated goals for individuals. The evaluators also identified a "need for a repository of community services available to Plan case managers, caregivers and enrollees."

Deliverable 25, Cost-effectiveness of the LTC Program, also builds on deliverable 15 that reported cost neutrality and a shift from nursing home to community based care overall. The Deliverable 25 found that from 2015 – 2018, there was a 7% increase in capitated payments. The evaluation reports a 10.7% increase in LTC enrollment which resulted in an average 3.3% cost decline because of the increased enrollment. The percentage of enrollees receiving HCBS services increased from 49% in SFY 2015 to 54.7% in SFY 2017-18. "In conclusion, direct Medicaid LTC program costs show no significant changes, while the number of enrollees receiving services has increased 10.7%....These shifts indicate that significant progress is being made toward the Agency's goal to transition to 65% of LTC program enrollees" in the community settings. There is no consideration of the intensity of services provided only that an enrollee had to have one service in a month to be considered in the equation.

Deliverable 26, "Current Practices and Factors Associated with Transition in Home and Community-based Settings" is primarily a descriptive reporting of 43 completed enrollee interviews out of a potential sample of 364 enrollees. The main findings support the overall program goal of an increasing use of Home and Community based services with the following indications:

Four out of five enrollees who had a change of location successful transitioned to Home and community based services for at least 6 month with one in five returning to the NF being an unsuccessful transition. The transition in an ALF was found to be a positive transition. It was noted that "half of the transitioned enrollees experienced multiple moves and the evaluation team recommends that protocols be examined to reduce the frequency of those moves and support continued successful transitions. "

Summary Perspectives on the first Florida 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 five 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.

A major question that is not addressed in this evaluation relates to the State of Florida cap on slots in the Medicaid LTC Waiver program. Where does the 62,500 cap on slots come into play with the operationalization of the Medicaid LTC waiver? The major findings include the 10.7% increase in enrollee months and a 3.3% cost decline in per member per month. Does that infer that while more enrollees are being served over the three years, there are less services and less time served so the capped slots are never exceeded? The approved waiver submitted by AHCA to CMS shows on page 24 (of 233 pages) that the slots are capped at 62,500 for each of the five years including the period of the FSU evaluation, and that no more than 60,000 may be served within a month. Is there any link of those waiver limits to the evaluation of enrollee months? Also there is no assessment of services per person per plan at the statewide level nor at the regional level which was identified in the second evaluation as desirable.

Research Triangle International (RTI) evaluations of the CMS funded Financial Alignment Initiative

The Commonwealth Fund's November 4, 2019 ("Improving Care for Individuals Dually Eligible for Medicare and Medicaid" by Ann Hwang, Laura Keohane and Leena Sharma) publication of a critique of five state evaluations by RTI: California, Illinois, Massachusetts, Ohio and Texas, reports the same lack of Medicaid data as reported in the Florida evaluations with an inability to assess service use or clear cost-savings. The Affordable Care Act promoted new approaches to integrating Medicare and Medicaid for the dual eligible populations. Thirteen states participated in the FAI. Ten of the states have a single managed care plan with a capitated Medicare/Medicaid rate; while three states have a fee for service model. All of the evaluations to date have been hindered by the lack of Medicaid service utilization and expenditure data.

January 2017 (GAO-1-145) and the August 2017 GAO report to Congress "Medicaid Managed Care: CNS Should Improve Oversight of Access and Quality in States' Long Term Services and Supports Programs" The GAO 2017 studies support the need for much stronger oversight of the states' Medicaid managed LTC programs with a call for CMS to provide minimum standards for encounter data to be reported by states.

National Bureau of Economic Research (NBER) Working Paper Series: "Private vs Public Provision of Social Insurance Evidence from Medicaid" by Timothy Layton, et. all. July 2019

This study of Texas Medicaid's shift of adults with disabilities from the public Medicaid plan to private managed care Medicaid plans from 2004-10 tries mightily to show improvements in the Texas Medicaid system's shift to privatization but even the authors note that "it is impossible to conclude which ultimately led to the effects we observe (p. 42)". The study attempts to show a decrease in inpatients' hospitalizations concurrent with the private plans' increased coverage of drugs, but the relaxes drug rationing could have occurred under the public sector as well. Furthermore the concurrency does not equal cause and effect. The NLBR study is very complex with many fine charts for a most uncertain outcome. Furthermore, the Dallas Morning News 2018 "Pain and Profit" investigative series into Texas' Medicaid Managed Long Term Care and Chronic care Programs show how corporate managed care companies have made huge profits by denying care to very sick Texans.