Launch of Medicaid Managed Long-Term Care In Florida Yields Many Lessons for Consideration

INTRODUCTION
In August 2013, Florida began the first phase of mandatory enrollment in Medicaid’s new Managed Care Long-Term Care program.

While some Medicaid beneficiaries already had been receiving long-term care services through managed care plans, the mandatory transition of large numbers of consumers who use long-term care services – the elderly and young adults with disabilities – from fee-for-service to managed care is unprecedented.

This brief describes the first phases of implementation and provides recommendations that could help community organizations, health advocacy groups and the State of Florida, ensure optimal outcomes. These recommendations can guide the continued phase-in of the new Long-Term Care program, as well as be useful as Florida prepares to implement the Medicaid Managed Medical Assistance Program for acute care services in 2014.

The brief draws on interviews with a variety of stakeholders across the state. In addition to lifting up common concerns, the brief highlights issues to consider and offers suggestions for continuing operations in three program areas: plan choice and enrollment, the availability of services and quality assurance.

A GUIDE FOR STAKEHOLDERS
In addition to this brief, experts at Georgetown University have provided a guide and checklist for those wishing to monitor Medicaid Managed Long-Term Care program activities. See “Activities to Promote Quality In Florida’s Medicaid Managed Long-Term Care Program — Guidance for Stakeholders,” available at hpi.georgetown.edu/floridamedicaid

This educational brief, authored by Laura Summer of the Health Policy Institute at Georgetown University, builds on nearly a decade of research by Georgetown into Florida’s effort to reform its Medicaid program.

The new managed Long-Term Care program divides the state into 11 regions. As of December 2013, the transition was complete in six regions (2 and 7-11). Beneficiaries in the five other regions had received their first notification of program change.

A phased launch and other transition policies were helpful, but many details were unclear as operations began. More lead time was needed to get contracts and provider networks in place, train staff and resolve billing and payment questions.

More than one-third of enrollees failed to choose a managed care organization, suggesting that more expansive information and counseling efforts are needed. The capacity of community-based organizations to assist consumers is tested as they lose staff to managed care organizations, contend with new administrative requirements and face uncertainty about future roles.

Stakeholders are concerned about whether case managers employed by managed care organizations will be advocates for enrollees or gatekeepers for plans.

The rollout of the Managed Medical Assistance program later in 2014 will affect all Long-Term Care enrollees, adding complexity to their coverage and posing challenges for service coordination.

Outstanding questions about program quality underscore the need for ongoing monitoring by all stakeholders.

Stakeholders question whether two key program goals can be achieved: promoting a shift to community-based services and improving quality while reducing costs.
BACKGROUND
The State of Florida passed legislation in 2011 to create the Statewide Medicaid Managed Care Program, which has two parts: the Managed Care Long-Term Care Program (LTC) and the Managed Medical Assistance Program (MMA).

The Centers for Medicare and Medicaid Services (CMS) approved the programs in 2013 (see Exhibit 1). An earlier brief describes the MMA program.1

Federal approval was required for both parts of the Medicaid Managed Care Program. Since Medicaid is jointly financed and administered by the federal and state governments, waiver authority is required when a state proposes to make program changes that eliminate or change certain federal requirements or seek to spend Medicaid funds in a different way. The MMA program was approved under an 1115 demonstration waiver. The Long-Term Care program required approval of both a 1915(b) waiver, which permits states to mandatorily enroll consumers in Medicaid managed care plans and to selectively contract with certain service providers, and a 1915(c) waiver, which allows states to provide services in a community-based setting to certain groups of individuals who otherwise would require institutional services reimbursable by Medicaid. Each waiver has specific terms

EXHIBIT 1: FLORIDA’S NEW MEDICAID MANAGED CARE PROGRAM

<table>
<thead>
<tr>
<th>Program</th>
<th>Services</th>
<th>Federal Approval</th>
<th>Enrollment Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Long-Term Care Program (LTC)</td>
<td>Services that assist consumers with activities of daily living such as bathing, dressing, eating, or medication management and are delivered in nursing facilities, assisted living facilities, or at home.</td>
<td>Medicaid 1915(b) and 1915(c) waivers approved February 2013</td>
<td>August 1, 2013 – March 1, 2014</td>
</tr>
<tr>
<td>Managed Medical Assistance Program (MMA)</td>
<td>Medical services for acute and chronic conditions, including prevention, diagnosis, and treatment delivered in a hospital, clinic or doctor’s office, or other medical setting.</td>
<td>Medicaid 1115 waiver approved June 2013</td>
<td>Phase-in expected to begin in May 2014</td>
</tr>
</tbody>
</table>

EXHIBIT 2: FLORIDA’S NEW LTC PROGRAM, BY REGION

<table>
<thead>
<tr>
<th>First Notification</th>
<th>Enrollment Date</th>
<th>Regions</th>
<th>Counties</th>
<th>Participating Plans</th>
<th>Projected Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2013</td>
<td>August 1, 2013</td>
<td>7</td>
<td>Brevard, Orange, Osceola, Seminole</td>
<td>American Elder Care, Coventry, Sunshine, UnitedHealthcare</td>
<td>9,338</td>
</tr>
<tr>
<td>May 1, 2013</td>
<td>September 1, 2013</td>
<td>8</td>
<td>Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota</td>
<td>American Elder Care, Sunshine, UnitedHealthcare</td>
<td>5,596</td>
</tr>
<tr>
<td>July 1, 2013</td>
<td>November 1, 2013</td>
<td>2</td>
<td>Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington</td>
<td>American Elder Care, UnitedHealthcare</td>
<td>4,058</td>
</tr>
<tr>
<td>August 1, 2013</td>
<td>December 1, 2013</td>
<td>11</td>
<td>Miami-Dade, Monroe</td>
<td>American Elder Care, Amerigroup, Humana, Sunshine</td>
<td>17,257</td>
</tr>
<tr>
<td>October 1, 2013</td>
<td>February 1, 2014</td>
<td>5</td>
<td>Pasco and Pinellas</td>
<td>American Elder Care, Molina, Sunshine, UnitedHealthcare</td>
<td>9,963</td>
</tr>
<tr>
<td>November 1, 2013</td>
<td>March 1, 2014</td>
<td>4</td>
<td>Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia</td>
<td>American Elder Care, Sunshine, UnitedHealthcare</td>
<td>9,087</td>
</tr>
</tbody>
</table>
and conditions, which apply to the program operations associated with that waiver. Therefore, some of the requirements and consumer protections included in the MMA waiver do not extend officially to the Long-Term Care program and vice versa.

The use of a Medicaid managed care approach for long-term care services is not entirely new in Florida. The state’s Long-term Care Community Diversion Program has been operating since 1998, however, it was not available in all counties, it was not available to younger beneficiaries with disabilities and program enrollment was voluntary. The mandatory transition of large numbers of beneficiaries who use long-term care services – the elderly and young adults with disabilities – is unprecedented.

The Medicaid Long-Term Care population will be affected not only by the current shift from fee-for-service to managed care for long-term care services, but also by a similar shift for acute care services under the MMA program later in 2014.

In addition, almost all of the beneficiaries who use long-term care services – 95 percent – are dually eligible for the Medicaid and Medicare programs and therefore have coverage for most acute medical services as well as pharmacy benefits through the Medicare program. Thus, this vulnerable population with complex needs will have multiple coverage decisions to make, which will likely be confusing and pose challenges to achieving effective service continuity and coordination.

The trend toward Medicaid managed long-term care is not unique to Florida. CMS reports that more than half of states are expected to be operating Medicaid capitated risk-based managed long-term care programs by 2014. In May 2013, CMS released principles for long-term services and supports delivered through Medicaid managed care programs and noted that states are expected to incorporate the principles into any managed long-term care program. CMS is also sponsoring a set of financial alignment demonstrations, many of which use capitated managed care arrangements to integrate the delivery of Medicaid and Medicare services, including long-term care services.

Florida’s Long-Term Care program is administered by the state’s Agency for Health Care Administration (AHCA) with the Department of Elder Affairs (DOEA) playing a prominent role. Program implementation is occurring in phases across 11 regions of the state. Enrollment began in the first region on August 1, 2013 and will be completed in the last region by March 1, 2014.

AHCA negotiated contracts with seven managed care organizations (MCO), or plans, comprising six Health Maintenance Organizations and one Provider Service Network. Consumers in each region can choose between at least two plans. American Elder Care, the Provider Service Network, is the only plan operating in every region of the state (see Exhibit 2).

Most beneficiaries receiving long-term care services in nursing facilities or in the community through existing Home and Community-Based waiver programs are required to enroll in the new program. In September 2012, prior to the implementation of the new program, about 58 percent of the almost 86,000 Medicaid Long-Term Care beneficiaries were in nursing facilities and 42 percent — just more than 36,000 beneficiaries — were in community-based waiver programs.

An additional 34,600 individuals were on waiting lists for Medicaid community-based services. The waiting list increased to 40,490 by September 2013, meaning that more than 76,000 people were receiving or waiting to receive community based services.

The new Long-Term Care program maintains the Medicaid entitlement to nursing facility care but sets a cap of 36,795 slots for community-based services. Thus, unless the waiver is amended to increase the numbers served in the community, long waiting lists will persist.

Enrollment figures for the new Long-Term Care program show that among the Long-Term Care program enrollees in regions 7, 8, and 9, approximately 84 percent are age 65 and older. The remaining 16 percent are age 18 to 64 (see Exhibit 3).

| EXHIBIT 3: LONG-TERM CARE PROGRAM ENROLLMENT IN REGIONS 7, 8 AND 9 |
|-----------------|-----------|-----------|-----------|
|                 | REGION 7  | REGION 8  | REGION 9  |
| #    | %        | #    | %        | #    | %        |
| 18-64 | 1,220 14% | 714 14% | 845 12% |
| 65+  | 7,192 86% | 4,235 86% | 6,334 88% |
| Total | 8,412 100% | 4,949 100% | 7,179 100% |

Source: Florida Agency for Health Care Administration Enrollment reports, October 1, 2013
PLAN CHOICE AND ENROLLMENT

Four months prior to enrollment, beneficiaries in each region receive a notification letter by mail informing them of upcoming program changes.

Two months later, a welcome letter and brochure provide instructions about how to choose a managed care plan. The letter specifies the plan to which the consumer will be assigned if he or she does not make a choice by a certain date.

Beneficiaries who received welcome letters but have not made a voluntary choice receive a final reminder letter one month before enrollment, which reminds them of their pending plan assignment.

Beneficiaries who do not choose are auto-assigned to a plan, taking their current providers, and plan capacity into account. Florida has a contract with Automated Health Systems, an enrollment broker tasked with helping beneficiaries who request assistance compare MCOs either by telephone or in person.

The choice process may be more complicated or disruptive for some than for others depending on beneficiaries’ circumstances prior to the program change.

Essentially, there are four sets of circumstances, which are described in Exhibit 4.

AHCA reports that 65 percent of enrollees made a voluntary plan selection and 35 percent were auto-assigned to a plan in region 7 as of August 1, 2013. Similar proportions were auto-assigned in other regions.

ISSUES TO CONSIDER

The notification system assumes that all beneficiaries receive and respond to appropriate notices.

Although AHCA relied on contact information on file and supplemented it with information that DOEA collected from local case management agencies, there were early reports of glitches. In some instances, the state did not have up-to-date information about current residence. Some beneficiaries received notices for the wrong region with the wrong enrollment time frame.

In some cases, this was an unintended consequence of the decision to implement the program in phases. It caused confusion for representatives who receive beneficiaries’ mail but do not live in the same region as the beneficiary.

For the population receiving Medicaid long-term services and supports, living situations change as needs or economic circumstances change or as better alternatives become available. Thus, addresses on file do not always match beneficiaries’ current place of residence.

Respondents credited state officials with working on a case-by-case basis to remedy the address problems that they were aware of, but also noted that the volume of cases that need individual attention is likely to increase as the program is rolled out in more regions with larger populations.

There was no help for beneficiaries who did not receive notices or did not report problems.

The program is designed on the assumption that nonresponsive beneficiaries have decided not to choose plans. If they do not receive information about the change, however, they do not have the opportunity to choose.

Also, stakeholders report that among the population using long-term services and supports, some beneficiaries don’t open, read, or understand their mail.

To make informed decisions, beneficiaries and those who assist them need complete information about MCO characteristics.

EXHIBIT 4: CHOICE OPTIONS FOR GROUPS OF LTC BENEFICIARIES

<table>
<thead>
<tr>
<th>GROUPS OF BENEFICIARIES</th>
<th>OPTIONS</th>
<th>NUMBER OF ENROLLEES IN EACH CATEGORY PRIOR TO TRANSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled in a Diversion program MCO that is also a new LTC program MCO (older beneficiaries)</td>
<td>Beneficiaries will see little change. They have the option to choose a new plan, but they also have the option to continue receiving services just as they have in the past.</td>
<td>Region 7: 1,094 Region 8: 279 Region 9: 466</td>
</tr>
<tr>
<td>Enrolled in a Diversion program MCO that will not be offered through the new LTC program (older beneficiaries)</td>
<td>Beneficiaries already are familiar with the managed care concept, but they must change plans and perhaps providers.</td>
<td>Region 7: 504 Region 8: 374 Region 9: 889</td>
</tr>
<tr>
<td>Enrolled in one of the other community-based LTC waivers (older and younger beneficiaries)</td>
<td>Beneficiaries must become familiar with the managed care concept. They must choose plans, and perhaps providers.</td>
<td>Region 7: 1,863 Region 8: 977 Region 9: 1,524</td>
</tr>
<tr>
<td>Receiving services in a nursing facility on a fee-for-service basis (older and younger beneficiaries)</td>
<td>Beneficiaries must become familiar with the managed care concept. They must choose plans. Generally, they can stay with their current providers.</td>
<td>Region 7: 5,011 Region 8: 3,362 Region 9: 4,196</td>
</tr>
<tr>
<td>Total enrollees as of September 10, 2013</td>
<td></td>
<td>Region 7: 8,472 Region 8: 4,992 Region 9: 7,075</td>
</tr>
</tbody>
</table>

Source: Florida Agency for Health Care Administration
Stakeholders report that enrollment letters are well written and present information in a simple, useful manner. Program guidance materials for beneficiaries advise them to consider the services offered by each plan.

AHCA developed region-specific charts that list the services each plan offers. Although these provide useful information, the format highlights differences among plans with regard to extra services such as personal emergency response systems, non-medical transportation, or dental services.

Respondents say that many beneficiaries were apt to choose the plan that appeared to have the most extra services. As a practical matter, however, all plans are required to provide the same standard long-term care plan benefits. Also, neither the standard or extra benefits are provided unless they are part of an approved plan of care.

Guidance materials also advise beneficiaries to consider whether the service providers they use or think they will need are in the plans’ networks.

In the early regions, complete information about provider networks was not available on the website in a timely manner. Those who assist beneficiaries report that it is not uncommon to have to make three or four phone calls to determine if multiple community-based service providers – for example meals, personal care, or homemaking services – are part of each plan’s network. In instances where plans contract with some but not all providers the consumer has to decide which providers are most important in terms of maintaining continuity.

**The lengthy contracting process caused uncertainty in some cases.**

The combination of a complex contracting process and a short time frame for contract negotiations meant that some contracts between MCOs and providers were not in place even as beneficiaries had to choose plans.

Plans must submit executed contracts to AHCA, which then checks its provider network verification system. Information about which providers are participating in plan networks must be communicated to enrollment brokers and plans must update their network lists. These procedures have been more time consuming than anticipated, according to respondents. As a result, information on participating providers was not current when beneficiaries were being asked to choose plans. For example, even though all nursing facilities are required to participate in plans, enrollment counselors told residents of one nursing facility that they only had one plan option because it was the only one listed with a confirmed contract.

The negotiation process was lengthier than anticipated in some instances because plans and providers were waiting for clarification from AHCA. Also, the contracting process was new to providers that have always operated on a fee-for-service basis or been grant-based. They were not only entering into contracts for the first time, but also were negotiating with multiple plans. Nursing facility and hospice rates are set by the state but significant negotiations regarding payment rates occurred between plans and some community-based providers.

At the same time that providers were negotiating contracts, they were concerned about payments for services provided during the 60-day transition period when they were obligated to continue providing services to current clients even if they were not going to be in the new plans’ networks.

Stakeholders observed that AHCA has done a good job of communicating policies regarding service continuity to plans and providers, but that frequently the agency could not answer questions about operational details such as how and when payments would occur. This was of particular concern for small providers who may have cash flow problems.

Unanticipated questions such as whether providers who had already signed contracts with plans would be paid at the new or old rates took time to resolve. Some providers noted that they could not assure current clients of continuity of care because they had not yet completed contract negotiations. Even those with contracts in place were uncertain about whether plans would continue to use their services for current clients.

**LOOKING AHEAD**

Proactive follow-up with non-respondents can help ensure that beneficiaries are enrolled in appropriate MCOs and can reduce confusion, requests for plan changes and administrative resources devoted to troubleshooting as the new program is implemented.

For example, in New York City, where a group of consumers transitioned from Medicaid fee-for-service to managed care, staff at the Human Resources Administration made outreach calls to beneficiaries who had not chosen a plan. They arranged three-way conference calls to include the enrollment broker. Consequently, the program reported an auto-assignment rate of less than two percent.

**Investment in activities to educate consumers and providers,** including the presentation of information in multiple formats to multiple audiences, has been cited as an enrollment strategy that can promote choice.

“High-touch” personalized communication including in-person, one-on-one counseling and phone support were found to be the most effective strategies for engaging beneficiaries when California conducted mandatory enrollment of seniors and people with disabilities into managed care. Mailings and written materials were judged least effective.
Past experience in Florida and other states indicates that confusion regarding enrollment is common when consumers are asked to choose managed care plans. Extensive education campaigns for local community-based service providers – particularly those that are trusted by beneficiaries who seek culturally competent, language appropriate advice – to ensure they have complete information about program and plan options and the enrollment process can also promote choice and reduce auto-assignment and subsequent plan-switching rates.

The development of Long-Term Care program materials that do not feature extra services so prominently but that give more prominence to the set of services all plans must provide and explain that the provision of services depends on assessments and care plans was also suggested by stakeholders.

The extension of implementation time frames is a strong recommendation from those involved in or affected by the contracting processes and by those who see the need for time to accommodate more extensive education and counseling efforts.

Respondents noted that the phase-in design of the program is helpful in that it provides opportunities to make adjustments based on early experience. Many suggested that a longer implementation time frame could provide opportunities for smoother transitions.

The decision to slow program implementation is not unprecedented. Several states participating in the CMS alignment demonstrations have made schedule changes to ensure that policies are in place, systems are working well, and beneficiaries and providers are well informed prior to the start of the program. In Florida, the Terms and Conditions for the MMA program include a “pause” provision requiring that any problems in one region be addressed before implementation can proceed in other regions.

### EXHIBIT 5: STANDARD LONG-TERM PLAN BENEFITS THAT ALL PLANS MUST OFFER

- Adult companion care
- Adult day health care
- Assisted living services
- Assistive care services
- Attendant care
- Behavioral management
- Care coordination/Case management
- Caregiver training
- Home-delivered meals
- Transportation, non-emergency
- Hospice
- Intermittent and skilled nursing
- Medical equipment and supplies
- Medication administration
- Medication management
- Nursing facility
- Nutritional assessment/Risk reduction
- Personal care
- Respite care
- Home accessibility adaptation
- Personal emergency response system (PERS)
- Homemaker Therapies, occupational, physical, respiratory, and speech

### AVAILABILITY OF SERVICES

At a minimum, Managed Care Organizations must provide a specified set of long-term services and supports (see Exhibit 5). To receive Medicaid Long-Term Care services, applicants must be financially eligible and must meet clinical or functional “nursing facility level of care” criteria.

In the new program, DOEA will continue to determine functional eligibility. However, the task of working with beneficiaries to develop plans of care, which specify the types and amounts of services each beneficiary receives, is now the responsibility of case managers employed by the MCOs.

Program design requires that case managers assigned to each enrollee have monthly telephone contact and face-to-face visits at least every three months. Case managers will also conduct new assessments for enrolled beneficiaries annually. Providers who are part of each MCO’s network must deliver authorized services.

The design of Florida’s new Long-Term Care program includes a number of important protections to help ensure service continuity for beneficiaries during the transition from fee-for-service to managed care. Every MCO must offer network contracts to all nursing facilities, hospices and current aging service providers in each region. Beneficiaries can be assigned to the nursing facility where they already reside and, unless they make a different choice, beneficiaries already enrolled in the Nursing Home Diversion program are assigned to their current plan if the plan is also participating in the new Long-Term Care program.

The process is more complicated for enrollees in the 14 Diversion program plans that are not participating in the new Long-Term Care program. It is also complicated for those receiving services in the community through other waiver programs because often they have multiple providers who may or may not have contracts with all plans. Anticipating this, prior to the transition, DOEA gathered information from enrollees’ current case managers about the services and providers they use so that information will be readily available when plan assignments are made.

Another important design feature is that plans are financially responsible for current services for up to 60 days or until an enrollee receives a comprehensive assessment, a plan of care is developed and services are arranged and authorized. Transition service plans are receiving most of the attention now, but several respondents mentioned that it will be important to monitor the types and amounts of services authorized for new enrollees or current enrollees at their annual reassessments to ensure that appropriate services are authorized.
In describing the care planning process, Florida has stressed that it will be “person-centered” and that consumers may choose a “participant direction” option, which allows enrollees living at home to hire, train, and supervise direct service workers who provide adult companion care, attendant care, homemaker services, personal care, or intermittent and skilled nursing services.

The program also emphasizes the desirability of providing services to beneficiaries in the least restrictive setting (for example in the community rather than in an institution) and includes incentives for MCOs to promote community-based services.

**ISSUES TO CONSIDER**

**Program design raises concerns about the critical case management role.**

Noting that case managers are now employed by organizations that have financial incentives to cut costs as well as provide services, several respondents questioned whether the primary role of case managers employed by MCOs will be that of advocate for the enrollee or gatekeeper for the plan. Anecdotes related by stakeholders are mixed. One positive report concerned an MCO case manager who recommended an increase in the types and amounts of services a consumer would receive in his or her home. There were also reports of MCO case managers discovering during the assessment process that beneficiaries were not receiving services that had been specified in their previous care plans and arranging to restore the services. However, other stakeholders mentioned hearing about MCO policies regarding caps on the amount of services to be authorized or increased emphasis on asking beneficiaries whether a neighbor, church member, or friend could perform some of the services that had been provided through the Medicaid program in the past.

MCO case managers had large numbers of clients to see in a short amount of time. As a result, there were reports of case managers being asked to work very long hours and of case managers being sent from one region to another to help with the transition. This practice may be expedient, but as a practical matter it means that case managers who conduct initial assessments may not be the ones to follow through with consumers.

Service providers are faced with a new dynamic and must learn how to interact with multiple MCO case managers who may not know consumers. Providers report that case managers asked for medical or financial information about enrollees, information that providers do not have the authority or staff to supply.

A significant number of case managers left community-based organizations to join MCOs because they were offered higher salaries and the promise of work going forward. They have the advantage of being familiar with Long-Term Care clients’ needs and with local providers and resources. Respondents noted that other new hires at plans had social work backgrounds, but little experience working with the population that uses long-term services and supports or familiarity with therapeutic, supportive, and ongoing services for adults with disabilities.

**Unanticipated circumstances have complicated transitions for some enrollees.**

The new Long-Term Care program was designed on the assumption that case managers in the community-based waiver programs would collaborate with the new MCO, but since a substantial number of case managers left the community-based agencies to work for MCOs, these agencies’ capacity to assist beneficiaries prior to and during transitions is diminished even as they are receiving requests for assistance. Respondents noted that with staff reductions the agencies’ capacity to perform other functions is also reduced. More frequently, remaining case managers are making telephone calls rather than face-to-face visits. Administrative tasks related to waiting lists for Medicaid services and the state-funded Community Care for the Elderly program may not be accomplished as quickly now.

Similarly, the new program requires that Diversion plans help beneficiaries with the transition to the new program. But Diversion plans that did not receive contracts are not obligated to operate until the transition date in their regions. Providers report that when Diversion plans leave the market some beneficiaries are “in limbo” and providers are confused about what to tell beneficiaries. Providers are also uncertain about how they will be paid for the period when Diversion plans leave the market but the new program has not started. Changes in service settings – for example transfers from waiting lists to community placements or moves between nursing facilities and the community, particularly when the settings are in different regions – have also caused confusion when information was not communicated to the MCO in a timely manner.

**The availability of high quality services depends on the composition of provider networks.**

Provider shortages were of concern before the new program and many respondents reiterated this concern. They questioned not only whether networks will include enough providers at locations throughout the state, but also whether providers are accessible and available and whether they have the expertise, skills and experience to assist older beneficiaries and people with disabilities who need a broad range of services and supports.

For example, CMS principles for long-term services and supports include the expectation that managed care networks will have adequate capacity and expertise to provide access to services that support community integration, such as employment supports, and the provision of training and technical assistance to providers. 12
Many provider organizations signed contracts with MCOs. But others found the process daunting or were hesitant when plans offered rates lower than what they had been receiving. Stakeholders report that uncertainty related to contracting and payment processes left some organizations concerned about their viability and raised concerns about whether beneficiaries will continue to have access to trusted community-based providers.

The goals of providing person-centered care plans with options for self-direction and greater use of community-based settings are endorsed by stakeholders, but some note that the option for participant direction is not well publicized or understood by case managers or MCOs. There is uncertainty about the payment rates and procedures, which may differ by plan. A number of respondents also expressed wariness about how the emphasis on community-based services would play out, given the current high level of need among the nursing facility population, the paucity of community-based alternatives in some areas of the state, and program caps on the number of people who can receive community-based services.

LOOKING AHEAD

Service plan monitoring will continue to be an important activity. State officials report that in an effort to ensure that adequate care plans were in place, staff from DOEA and AHCA called certain groups of enrollees – including those who transitioned from fee-for-service waiver programs to managed care and those who had been in the Diversion program, but had to make the transition to a new plan – to ask whether the types and amounts of services they were receiving had changed and whether their needs were being met. This is a helpful activity, but one that may be difficult to sustain as the phase-in continues.

Expanded capacity for troubleshooting among state staff will likely be needed as the transition occurs in more regions and more beneficiaries and providers are affected, most by changes associated with the new Long-Term Care program and then the MMA program; others by operational questions associated with transitioning from one setting to another; and others by new procedures associated with the Medicaid application and waiting list processes. The focus of this discussion is on the Long-Term Care program, but it is important to note that as the Long-Term Care program is implemented, plans to implement the MMA program – which will affect Long-Term Care beneficiaries as well – are under way. Experience in other states confirms that this type of transition increases the need for care coordination.14

Providing sufficient support for community-based organizations that help beneficiaries can be a wise investment. Stakeholders report that consumers are more likely to seek advice from trusted organizations or individuals with whom they have ongoing relationships and that in some cases MCOs are referring enrollees to these organizations for assistance. Many lack resources and information to be responsive to all requests, however. The Florida Legislature provided additional funding for Aging and Disability Resource Centers as the Long-Term Care program rolled out. However, Florida is one of only three states that declined to apply for 2013 federal funds available to all states to support activities at Area Agencies on Aging, Aging and Disability Resource Centers and similar entities to help increase low-income Medicare beneficiaries’ access to benefits.15

Additional funds will likely be needed to assist Long-Term Care consumers as more changes in the delivery of Medicaid acute and long-term care services occur.

Timely training to help ensure that networks are robust was cited as a means to improve program quality. To develop more effective networks, respondents suggested that there is a need to help organizations that have been grant-based learn how to review and negotiate contracts, develop the capacity to bill multiple payers, and build other business skills.

Respondents also saw a need to train health plan staff and providers, including newly hired case managers, in working with people with disabilities. Stakeholders report that one MCO contracted and others were in discussions with an outside agency to provide disability sensitivity training for administrative staff. Many of these discussions occurred, however, as transitions and enrollment occurred. California’s experience in transitioning seniors and people with disabilities from Medicaid fee-for-service to managed care indicated that although health plans invested in ensuring network adequacy for the population with disabilities, investment in training was insufficient; stakeholders reported a negative impact on the health of some enrollees as a result.16 Recognizing the need for this type of training, CMS has worked with partners to develop and promote a Disability-Competent Care model and accompanying tools for plans and providers.17

An extended time frame for transition is another frequent suggestion that came up in discussions about the availability of services, just as it did in discussions related to plan choice and enrollment.

Stakeholders spoke about the need for sufficient time prior to program launch to ensure that contracts relevant to long-term care services can be developed; that contracts and provider networks are in place; that information is transmitted to all parties on time; and that there is adequate time for training. Research related to the transition of Medicaid beneficiaries with complex care needs to managed care in California showed that difficulties arose when data and information sharing took longer than anticipated. When health histories were not provided on time, provider or service continuity could not be assured in auto-assigning beneficiaries to plans. Also, plans did not have the information they needed to identify and recruit providers currently serving beneficiaries. In response to this finding, the
state revised implementation plans for the transition of dually eligible beneficiaries so that they could be enrolled in plans 60 days before they become active members of the plans.18

ASSURING QUALITY

The quality strategy for the new Medicaid Long-Term Care program relies primarily on monitoring activities conducted by AHCA and DOEA and on quality improvement plans developed and implemented by the managed care organizations.

The standard contract developed for the program indicates that MCOs must specify how they will monitor the quality and appropriateness of care and the quality of plan networks and how they will conduct performance measurement, performance improvement projects, and annual evaluations. MCOs are required to collect data and report annually on 12 performance measures specified in the contract and to meet performance targets for each measure.

Each plan must conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as well as a provider satisfaction survey and must evaluate its own cultural competency plan annually. Plans are also required to conduct two Performance Improvement Projects each year, one pertaining to nursing facility and the other to home and community-based services.

The Long-Term Care waivers approved by CMS list more than 40 performance measures, most of them process measures, which provide information about program operations but not outcomes.

AHCA must report to CMS quarterly for some measures and annually for others. State staff will obtain and analyze data on program operations from MCOs and will conduct annual onsite monitoring visits to each MCO, including audits of case records. The state will also track grievances filed by enrollees for denials of coverage and appeals related to the reduction, denial, suspension, or termination of services. Requests for Medicaid Fair Hearings, which enrollees may request at any time, are also tracked.

Another aspect of the quality assurance strategy is a requirement, this one included in the 1115 waiver, which indicates that the broader evaluation of Medicaid managed care will include a long-term care component.

Many of the details regarding quality assurance have been left to the MCOs. With each MCO developing its own monitoring plan, providers are concerned about the potential administrative burden of being asked to report similar information in different formats. Others note that making comparisons among plans will be more difficult if data are not collected and reported in a standard manner.

Most proposed measures are not specific to the long-term care population. The lack of established vetted measures for long-term care services is an issue that poses challenges for all states. MCOs routinely use established surveys to measure quality, but most of the measures are geared to primary care and preventive services and do not provide much relevant information about the quality of long-term services and supports, particularly those associated with community-based settings. Some states have developed and are using their own measures, which focus on quality of life as well as quality of care.

LOOKING AHEAD

Strong ombuds programs are elements of quality assurance strategies in many states. CMS endorses this approach and in some instances has helped to fund it.19 Florida’s ombuds program, which has been controversial, likely will not play an important role in the Long-Term Care program, at least initially. With a strong independent leader, a cadre of well trained volunteers across the state, and authority to respond to issues consumers raise about home and community-based services as well as institutional long-term care services it could be an important part of efforts to assure quality going forward.

Adequate resources are needed to ensure that measurement and monitoring activities specified for the program can be carried out effectively. The combination of state budgets that are already strained, staff reductions, and major new responsibilities related to Medicaid program changes pose challenges related to the state’s ambitious strategy for assuring quality. In recommendations regarding quality for managed long-term care programs, CMS stresses the need for states to ensure that the appropriate type and level of staff is available, noting that the skills and expertise for monitoring managed long-term care differ from those required for fee-for-service programs.20

All stakeholders should be involved in quality assurance activities. Efforts on the part of a variety of stakeholders can complement state and plan-based activities to promote quality. Additional resources, expertise, independent perspectives and experience with groups of beneficiaries who might otherwise be difficult to reach are assets that can help improve program-monitoring activities. A companion publication from Georgetown University provides guidance for stakeholders regarding activities to promote quality in Florida’s Long-Term Care program.21
Respondents frequently raised questions related to program operations and to whether the goals for the Long-Term Care program are achievable given certain of the program’s design features.

Will the program change significantly after the first year?

While stakeholders appreciate the program’s protections for beneficiaries during the transition period, they suggest that several issues bear watching as the program progresses. They questioned, for example, how provider networks will look after the first year and whether they will be more robust or more limited than current networks. Stakeholders also expressed concerns about whether current providers will remain viable program participants.

Given that providers can be excluded from a plan for failing to meet quality or performance standards after the first year, there is uncertainty about who will be offered new contracts and about the standards that plans will develop and use. Respondents say that it will be important to monitor increases or decreases in services approved as part of care plans after the first year.

Finally, they question how stable the managed care market will be. To help promote stability, MCOs in the Long-Term Care program have five-year contracts and face specific penalties if they reduce enrollment levels or leave a region before the end of the contract term, but based on prior experience with Medicaid and Medicare plans in the state, respondents think that plan activity bears watching.

How will beneficiaries be affected when the MMA program is implemented?

When the mandatory MMA program is introduced, enrollees in the Long-Term Care program will once again be faced with having to choose or be auto-assigned to managed care plans. There is potential for coordination across the full spectrum of services if they have the opportunity to choose the same plan sponsor for both long-term care and other Medicaid services, although at this point there is little clarity about how coordination will occur. Not all beneficiaries will be able to choose the same plan for both sets of Medicaid services, however.

As Exhibit 6 shows, only some Long-Term Care and MMA plans overlap in each region. Even where there is overlap, beneficiaries may already be enrolled in a long-term care plan that does not have an acute care counterpart. Stakeholders question whether consumers will have the option of changing long-term care plans when they have to choose MMA plans and note that plan alignment will be particularly difficult for consumers and administrative staff if enrollment periods for the two programs are not in sync.

AHCA plans to implement the MMA program in phases by region, but not in the same order that was used for the Long-Term Care program. For example, the expected MMA enrollment date for region 7 is August 1, 2014, one year after the enrollment date for the Long-Term Care program. This means that beneficiaries in that region will be able to make coordinated choices about whether to stay in their current long-term care plans and which MMA plans to enroll in. But in region 11, the most populous region with the most long-term care and MMA plans, the MMA enrollment date will come just six months after the Long-Term Care enrollment date. Another challenge to care coordination is that almost all Medicaid Long-Term Care beneficiaries are dually eligible. Therefore, Medicare covers most of their acute care.

For example, a dually eligible beneficiary could have a managed long-term care plan, another plan for Medicaid acute care, a third plan or fee-for-service arrangement for acute care covered by Medicare, and a fourth plan for the Medicare Part D prescription drug program.

MCO case managers are expected to coordinate and track services and to assist members in navigating the system of care, but more clarity about case manager responsibilities and authority would be helpful in anticipation of situations where consumers are enrolled in two or more different plans.

These circumstances suggest that there will continue to be a risk of confusion and service disruption for beneficiaries and providers and a substantial need for education, counseling and troubleshooting activities well into 2015.

Will a meaningful shift to community-based services occur?

The entitlement to nursing facility care remains under the Long-Term Care program, as does a cap on community-based enrollment that does not account for increased demand for services as the population ages. Waiting lists for community-based services persist.

Under the new program, plans have incentives to serve consumers in the least restrictive setting, but respondents note that the frailty level of Florida’s Medicaid nursing home population is high relative to other states and, therefore,

**EXHIBIT 6: OVERLAP BETWEEN LTC AND MMA PLANS, BY REGION**

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of LTC Plans</th>
<th>Number of MMA Plans*</th>
<th>Number of Overlapping Plans</th>
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<tr>
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<td>10</td>
<td>6</td>
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</tbody>
</table>

*Note: The agreement between American Eldercare and Humana may increase the potential for service coordination in these regions, but operational details are not yet clear.

Source: Florida Agency for Health Care Administration
the proportion of beneficiaries who can move back to the community is likely to be small. Stakeholders raise questions about who will decide and what criteria will be used as the basis for recommendations about the service setting. Several respondents also expressed uncertainty about whether the role of assisted living facilities will change in the new program. Some pointed out that beneficiaries who do not have the financial resources to pay for the room and board portion of their stay cannot use this community-based option.

**Can significant savings be achieved as the quality of services improves?**

Cost reductions and quality improvement are two important goals of the new Long-Term Care program, yet the program is designed to reward MCOs financially for reducing costs, but not specifically for improving quality.

Stakeholders stressed the importance of ensuring that the two goals receive equal emphasis. Florida’s MMA program includes a Medical Loss Ratio provision, which requires that MCOs spend at least 85 percent of premium revenues on medical services with the remainder available for administration, advertising, and profits. Having a Medical Loss Ratio in place does not guarantee the delivery of high quality services, but the policy is designed to help ensure a certain level of spending on services for consumers. This requirement does not apply to the Long-Term Care program, however.

**CONCLUSION**

Reports regarding early implementation of the new Medicaid Long-Term Care program in Florida indicate that aspects of program design – the phase-in, the transfer of information about beneficiaries, and assistance from state staff and the enrollment broker – were helpful.

The capacity of community-based organizations that historically have provided information and services for beneficiaries was hampered, however, by loss of staff, limited resources, and lack of clarity about program policies. Certain activities, such as contract negotiations and the transfer of information required more time than had been anticipated, causing uncertainty for providers and consumers. A common comment from stakeholders in the early stages was that the timeline for the rollout was too compressed; decisions were made even as implementation was occurring.

Other regions of the state should benefit from early experience, but the level of assistance and troubleshooting that occurred in the first region may be difficult to sustain as the number of people enrolled in the new program grows and administrative tasks increase and as the MMA program is introduced. All Long-Term Care enrollees will have to choose new MMA plans. Although they will account for just a small fraction of MMA enrollees, Long-Term Care beneficiaries are among the most vulnerable, high-cost enrollees. Given that most have Medicare coverage as well, they will have complicated coverage decisions to make.

Yet neither the Long-Term Care nor MMA programs has special provisions for assisting this group during the MMA roll out. Early investment in more expansive information and counseling could reduce subsequent program costs associated with troubleshooting, plan switching and poorly coordinated care.

Looking forward, questions related to program cost and quality will persist. Strong oversight on the part of all stakeholders, including the timely collection, analysis, and public presentation of program data going forward will be essential for achieving program integrity and improvement.

Finally, although most attention currently is focused on details related to Long-Term Care program implementation, core questions about how to achieve program goals must still be addressed. Modifications in program design, such as adopting a medical loss ratio for long-term care services, as is required in Florida for MMA services, could help ensure that all plans spend a certain amount on long-term care services, a feature that has been associated with better clinical quality measures. The goal of increasing the availability of community-based services could be achieved more readily, for example, if program savings were reinvested to fund more slots for community-based services, as other states have done.
ENDNOTES

(1) A new Issue Brief, Medicaid Managed Care in Florida: Federal Waiver Approval and Implementation, by Joan Alker and Jack Hoadley of the Health Policy Institute at Georgetown University as well as previous work in the series of briefs on Florida’s experience with Medicaid reform are available at hpt.georgetown.edu/fluoridaamedicaid.


(4) As of October 2013, CMS had finalized memoranda of understanding with eight states (California, Illinois, Massachusetts, New York, Ohio, South Carolina, Virginia, and Washington) to test new models to integrate care and align Medicare and Medicaid financing for dually eligible beneficiaries. Florida did not submit a proposal for the demonstration.

(5) The HMOs receive capitated payments to provide a set of services for Medicaid beneficiaries. They authorize services and contract with a network of health care providers and pay the providers for services. In the PSM model, Medicaid pays providers after claims are submitted to the plan for authorization.

(6) In late July, Humana announced that it had reached an agreement to acquire American Eldercare.

(7) Medicaid beneficiaries are required to be enrolled in the new Long-Term Care program if they are: 65 years of age or older and need nursing facility level of care; 18 years of age or older and are eligible for Medicaid by reason of disability and need nursing facility level of care; enrolled in the Aged and Disabled Adult (A/DA) Waiver; enrolled in the Consumer-Directed Care Plus for individuals in the A/DA waiver; enrolled in the Assisted Living Waiver; enrolled in the Nursing Home Disenrollment Waiver; enrolled in the Frail Elder Option; or enrolled in the Channeling Services Waivers. Beneficiaries who are enrolled in the following programs are not required to enroll, although they may enroll if they choose to: Developmental Disabilities Waiver program, Traumatic Brain & Spinal Cord Injury (TBI) Waiver, Project AIDS Care (PAC) Waiver, Adult Cystic Fibrosis Waiver, Program of All-Inclusive Care for the Elderly (PACE), Familial Dysautonomia Waiver, Model Waiver.


(9) Saucier et al, AARP, July 2013.

(10) Wunsch, Bobbie and Karen Linkins, A First Look: Mandatory Enrollment of Medi-Cal’s Seniors and People with Disabilities into Managed Care, California HealthCare Foundation, August 2012.


(14) Graham, Carrie, Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Lessons from California, for Medicaid Managed Care in the Era of Health Reform briefing, Kaiser Commission on Medicaid and the Uninsured, June 25, 2013.


(16) Wunsch and Linkins, August 2012.

(17) More information is available at www.resourcesforintegratedcare.com

(18) Comments of Carrie Graham, UC Berkeley School of Public Health and Jane Ogle, California Department of Health Care Services at Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Lessons from California, for Medicaid Managed Care in the Era of Health Reform briefing, Kaiser Commission on Medicaid and the Uninsured, June 25, 2013.


(21) Release of the publication Activities to Promote Quality in Florida’s Medicaid Managed Long-Term Care Program, Guidance for Stakeholders, is anticipated for December 2013.

(22) McCue, Michael and Michael Balit, Assessing the Financial Health of Medical Managed Care Plans and the Quality of Patient Care They Provide, The Commonwealth Fund, June 2011.