Medicaid
Long-term Care Program

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Overview

• Program background
• Nursing facility transition
• Cost savings
• Billing data
Statewide Medicaid Managed Care: Fully Integrated Long-term Care Program

- Long-term Care program covers:
  - Nursing facility
    - Furnishes medical or allied inpatient care
    - Institution; more restrictive; generally more costly
  - Home and Community Based Services
    - Care in the home, family home, or assisted living facility
    - Designed to prevent or delay facility placement
    - Less restrictive, generally less costly
Member Characteristics

• All members must meet nursing facility level of care
• Enrolled in the program by:
  – Residing in a nursing facility or
  – Being scored as most frail and in need of services
• Average enrollee:
  – 67% age 75 and older
  – Needs assistance with more than one activity of daily living (e.g., bathing, dressing, eating, toileting), and 75% need help with three or more.
Nursing Facility “Transition”

• Transition: When a LTC enrollee leaves a nursing facility to move to a community setting
  – Community: Their own home, their family home, assisted living facility
• 12.1% decrease in the number of Medicaid recipients residing in a nursing facility since program implementation (2013-2016)
Who Makes Transition Happen?

- LTC plan care managers work with the individual to develop a plan for transition
- Modify their existing home (e.g., grab bars in bathroom) or locate a safe, affordable place to live
- Arrange for in-home supports (e.g., personal care aide, medical equipment and supplies, home-delivered meals)
- LTC plan can pay security and utility deposits, moving costs, basic home furnishings
Why is Transition Important?

- Enhances quality of life
- Complies with Americans with Disabilities Act and Florida Statutes
- Saves money
Transition Improves Quality of Life

- Living in the community means:
  - Being at home with loved ones
  - Living in a setting where they have cherished memories
  - Visiting with friends in a setting with which they are familiar and comfortable
  - Being a part of supportive communities

- 2016 LTC Enrollee Satisfaction Survey shows that:
  - 76% of respondents stated that their quality of life has improved since enrolling in their LTC plan.
Transition Complies with Federal & State Law

- **Americans with Disabilities Act**
  - Requires that individuals with disabilities be given opportunity to “receive services in the least restrictive setting appropriate to their needs”

- **Florida Statute**
  - Requires that the LTC program incorporate financial incentives to reduce the percentage of individuals on Medicaid in nursing facilities by 3% each year
  - Goal: No more than 35% of the state’s Medicaid long-term care recipients are in nursing facilities.
Transition Avoids Increased Costs

• Without the transitions that have taken place since the LTC program implementation, Medicaid LTC services would have cost an additional:
  – $284 million in FY 2014-2015
  – $432 million in FY 2015-2016
  – $200 million per year in subsequent years
Transition Continues Even After a Year-Long Nursing Facility Stay

- Out of all LTC program enrollees who have transitioned from a nursing facility to a home-like setting, 64% transitioned after more than 60 days of enrollment in the health plan.
  - Enrollment in the LTC plan generally occurs after a 60 day stay in a nursing facility, so you can assume the stay began at least 60 days earlier.
- 20% of transitions occur after 365 days enrollment in the health plan.
Long-term Care Program Payments

• The Agency pays LTC plans a monthly capitation payment to provide services to their enrollees.
• Plans must pay for all covered services for their enrollees, regardless of whether the cost of those services exceeds the capitation rate received from the Agency.
• Plans are required to pay nursing facilities and hospice providers the rate set by the Agency.
LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

• Plans have contractual requirements regarding the prompt payment of clean claims.
• The LTC plan must have a process for handling and addressing the resolution of provider complaints concerning claims issues.
• Providers can report any provider payment issues to the Agency.
LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

- The Agency is required to contract with an organization to provide assistance with the resolution of claim disputes that are not resolved by providers and health plans.
  - The Agency currently contracts with Maximus, an independent dispute resolution organization.
  - All providers who provide services to recipients in licensed HMOs (including Medicaid and commercial HMOs) can utilize the Agency’s Maximus Contract to file a dispute.
LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

• Clean claim:
  – A claim that can be processed without obtaining additional information from the provider or a third party.

• Electronically submitted clean claims:
  – Must pay within 10 business days of submission

• Paper clean claims:
  – Must pay within 20 business days of submission
Reasons Why a Nursing Facility Claim May Not Be Paid Timely

• Facility does not timely submit claims
  – LTC plans have no control over the time it takes for a facility to prepare and submit a claim
• Not a clean claim
  – E.g., Missing or inappropriate values in required claim fields.
• Claim requires additional documentation for payment
• Failure by plan to approve claim for payment.
Nursing Facility Claims Payment Analysis: Methodology and Assumptions

• The Agency analyzed paid claims data to determine how quickly LTC plans are paying nursing facility claims.
• The analysis uses calendar year 2016 data and includes:
  – Dates of Service January 2016 through December 2016
  – Dates of Payment January 2016 through December 2016
• January through September 2016 claims are reconciled to the LTC plans’ financial reports (Achieved Savings Rebate)
Nursing Facility Claims Payment Analysis: Methodology and Assumptions

• Assumes all claims were submitted to the LTC plan 1 week after the date of service.
• 14 calendar days equates to 10 business days.
• All claims are treated as if they were submitted electronically, even though there is a longer timeframe to pay paper claims.
• Assumes all claims were clean.
### Summary of Payment Timelines and Associated Dollars

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<th>SUNSHINE</th>
<th>AMERIGROUP</th>
<th>HUMANA</th>
<th>MOLINA</th>
<th>UNITED</th>
<th>COVENTRY</th>
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<td><strong>Average Days to Payment</strong></td>
<td>4.0</td>
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<td>7.7</td>
<td>7.8</td>
<td>9.5</td>
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#### Total Facility Payment Amount (in M)

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<td><strong>$1,144M</strong></td>
<td>$57M</td>
<td>$54M</td>
<td>$383M</td>
<td>$85M</td>
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*Over State Benchmark*

*Meets State Benchmark*
91% of Nursing Home Claims Paid Within State Benchmark
Summary of Payment Timelines and Associated Dollars

- **Statutory Benchmark**: $2.34B
- **15 to 30 Days**: $124M
- **31 to 45 Days**: $28M
- **46 to 60 Days**: $16M
- **61 to 90 Days**: $19M
- **91 to 120 Days**: $10M
- **180 Days and Greater than 180 Days**: $8M, $3M

- **% Facility Payment Amount**
  - **Statutory Benchmark**: 91.37%
  - **15 to 30 Days**: 5.12%
  - **31 to 45 Days**: 1.14%
  - **46 to 60 Days**: 0.67%
  - **61 to 90 Days**: 0.80%
  - **91 to 120 Days**: 0.43%
  - **180 Days**: 0.34%
  - **Greater than 180 Days**: 0.13%

Enforcing Compliance with the Contract

- The Agency monitors health plans to ensure they comply with their contract, e.g.:
  - Weekly reviews of recipient and provider complaints
  - Analysis of dozens of regular reports from plans
- If plans are out of compliance with their contract the Agency can impose:
  - Corrective action plans
  - Monetary liquidated damages, and/or
  - Sanctions (monetary or non-monetary)
- Have assessed and collected $80,000 in fines to two Long-Term care plans.
Questions?