Florida Medicaid
1915(b) Managed Care Waiver
Long-Term Care Program
(Waiver #FL-17)

Effective Dates: 4/1/22 – 3/31/27

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

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Acronyms / Abbreviations used throughout the 1915(b) Waiver Document

AHRQ	Agency for Healthcare Research and Quality
ALF	Assisted Living Facility
BY	Budget Year
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan/Cost Allocation Plan
CARES	Comprehensive Assessment and Review for Long-Term Care Services Bureau
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DOEA	Department of Elder Affairs
DOP	Date of Payment
DOS	Date of Service
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
ECGA	Enrollee Complaints, Grievances, and Appeals
EPSDT	Early Periodic Screening Diagnostic Testing
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FS	Florida Statutes
GME	Graduate Medical Education
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HSAG	Health Services Advisory Group
ICF	Intermediate Care Facility
ICSP	Independent Consumer Support Program
IID	Individuals with Intellectual Disabilities
LTC	Long-term Care
LTCOP	Long-term Care Ombudsman Program
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization

MCOC	Medicaid Complaint Operations Center
MMA	Managed Medical Assistance
NCQA	National Committee Qualified Assessment
PACE	Program of All-Inclusive Care
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Projects
PMO	Agency for Health Care Administration's Bureau of Plan Management Operations
PMPM	Per Member Per Month
PNV	Provider Network Verification System
PPE	Potentially Preventable Event
RO	Regional Office
SMMC	Statewide Medicaid Managed Care
SPA	State Plan Amendment
SSI	Supplemental Security Income
STC	Special Terms and Condition
SURS	Surveillance and Utilization Review System
The Act	Social Security Act
The Agency/AHCA	Agency for Health Care Administration
TPL	Third Party Liability
UPL	Upper Payment Limit

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendmentrequest.

The **State of Florida** requests a waiver renewal under the authority of section 1915(b) of the Social Security Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is the "Florida Long-Term Care (LTC) Managed Care Program" (Please list each program name if the waiver authorizes more than one program)

Type of request.

____ Initial request for new waiver

____ Amendment request for existing waiver, which modifies Section/Part

___Replacement pages are attached for specific Section/Part being amended

___Document is replaced in full, with changes highlighted and as noted in Summary of Changes document submitted with this amendment to phase out the waiver.

_X__ Renewal request

___This is the first time the State is using this waiver format to renew an existing waiver.The full preprint (i.e. Sections A through D) is filled out.

Section A is ___Replaced in full
_X_ The state assures the same Program Description from the previous waiver period was used, except for technical changes.

Section B is _X_ Replaced in full
__ The state assures the same Monitoring Plan from the previous waiver period was used, except for technical changes.

Section C is _X_ Replaced in full
___ The state assures the same Monitoring Activity from the previouswaiver period was used, except for technical changes.

Section D is _X_ Replaced in full
___The state assures the same cost-effectiveness methodology was used from the previous waiver period for this amendment.

Effective Dates:

This waiver renewal is requested for a period of 5 years; effective April 1, 2022 and ending March 31, 2027. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date,and end of the waiver period as the end date)

This section 1915(b) waiver will provide managed long-term care services to populations that include dual eligibles and will operate concurrently with a renewal section 1915(c) waiver also being submitted to CMS for approval.

State Contact:

The State contact person for this waiver is **Kimberly Quinn.**

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Section A: Program Description

Part 1: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The State notified the two Tribal Organizations in the State of Florida prior to the start of the public comment period and the submission of this waiver renewal request. See **Attachment I** for tribal correspondence, e-mailed on August 18, 2021. This notification provides the Tribal Organizations with an opportunity to obtain additional information on Florida's Long-Term Care (LTC) program or to provide comments regarding the renewal of the LTC Waiver. This is consistent with the State of Florida's approved tribal consultation SPA #2010-011.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

In 2011, the Florida Legislature created Part IV, Medicaid Managed Care, in Chapter 409, Florida Statutes (F.S.), to implement a Statewide Medicaid Managed Care (SMMC) program. The SMMC program is separated into two components, the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) managed care program. Section 409.978, F.S, directed the Agency for Health Care Administration (AHCA) to develop a Long-term Care program for Florida Medicaid recipients who meet financial eligibility requirements and are (a) age 65 years or older, or (b) age 18 years or older and eligible for Florida Medicaid by reason of a disability, and (c) determined to require nursing facility level of care. The State requested 1915(b)/(c) Waiver authority to implement the LTC program. The 1915(b)/(c) Waiver authority allows the State to require eligible Florida Medicaid recipients to receive nursing facility, hospice, and home and community-based services (HCBS) through managed care plans. The State received federal approval from the Centers for Medicare & Medicaid Services (CMS) on February 1, 2013 for Florida's 1915(b)/(c) Long-term Care Waiver to begin on July 1, 2013.

The State selects LTC plans through a competitive procurement process. Nursing facility level of care is determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Bureau. Medicaid recipients eligible for the Florida LTC managed care program have a choice of plans and may select any plan available in their region. The State is divided into eleven regions, each of which is required to have a specified number of LTC plans.

The State transitioned recipients into the LTC program beginning August 2013 through March 2014. The Agency, together with DOEA, monitored plan performance, measure quality of service delivery,identifies and remediates any issues, and facilitates working relationships between LTC plans and providers. Through these efforts, the State provides incentives to serve recipients in the least restrictive setting and eligible recipients receive improved access to care and quality of care.

Florida finalized program contracts in June 2013 and submitted the documents to the Centers for

Medicare and Medicaid Services (CMS) for review and approval.

The 1915(b)(c) Long-Term Care (LTC) Waiver was last approved for a 5-year period on December 19, 2016, and was made effective from December 28, 2016 until December 27, 2021. During this waiver period, the Agency submitted, and received approval for, one 1915(b) and four 1915(c) amendments.

The first 1915(c) amendment was approved with an effective date of June 14, 2017 and sought to simplify waiver language in regards to the definitions of "respite," "attendant care," and "intermittent and skilled nursing." It also adjusted the description of Fair Hearings and the associated rights for improved clarity.

During the 2017 Florida Legislative Session, the legislature directed the Agency to consolidate the 1915(c) Adults with Cystic Fibrosis (ACF); Traumatic Brain and Spinal Cord Injury (TBI/SCI); and the Project AIDS Care (PAC) Waivers into the LTC Waiver. The Agency submitted a 1915(b)(c) amendment to implement this legislative action and on November 9, 2017, CMS approved this amendment with an effective date of December 1, 2017. This consolidation led to the following changes in the LTC Waiver:

- The ACF Waiver had a capacity of 150 participants. All ACF participants were transferred to the LTC Waiver under the same eligibility criteria as the ACF waiver, and the LTC waiver was amended to include the following eligibility requirements to ensure continuity of care and continued access:
    - Over the age of 18 years
    - Diagnosed with Cystic Fibrosis
    - Hospital level of care

- Approximately 1,100 of the 8,200 participants enrolled in PAC Waiver had a hospital level of care and were transitioned to the LTC Waiver in order to continue receiving Home and Community Based Services (HCBS). Those who used HCBS services like case management, therapeutic massage, and/or specialized medical equipment or supplies remained eligible for those services through the 1115 Managed Medical Assistance (MMA) Waiver. Approximately 5,300 of the 8,200 enrollees did not use or need HCBS through the PAC Waiver.

- Recipients under the TBI/SCI Waiver (468) were already eligible for the LTC Waiver, so there were no necessary changes to the LTC waiver to accommodate this group.

The final 1915(c) amendments were approved by CMS and went into effect on December 13, 2019 and December 17, 2020. The December 13, 2019 amendment increased the point in time count for the waiver and the December 17, 2020 amendment increased both the unduplicated count as well as the point in time count for the waiver.

In 2017, the Agency began the reprocurement process for the SMMC program, which the LTC program is a component of. This was Florida's first SMMC reprocurement effort. The invitation to negotiate was disseminated in July 2017 and the health plan contract award announcement occurred in April 2018. There were five different SMMC program plan types for the 2018-2024 contract term, all of which fall into one of the following classifications:

- Comprehensive Plans: Provides LTC and Managed Medical Assistance (MMA) services to eligible recipients.

- Long-Term Care Plus Plans: Provides both MMA and LTC services to recipients enrolled in the LTC program. This plan type cannot provide services to recipients who are only eligible for MMA services.

- Managed Medical Assistance Plans: Provides MMA services to eligible recipients. This plan type cannot provide services to recipients who are eligible for LTC services.

- Specialty Plans: Provides MMA services to eligible recipients who qualify as a member to a specialty population.

- Dental Plans: Provides preventive and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

Eight health plans were awarded contracts in the LTC program. Implementation of the new health plans and contract terms began in December 2018 and concluded in February 2019.

A. Statutory Authority

1. Waiver Authority.

The State's waiver program is authorized under section 1915(b) of theAct, which permits the Secretary to waive provisions of section 1902 for certain purposes.Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. _X_ 1915(b)(l) - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. ___1915(b)(2)- A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ____1915(b)(3) -The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(l) or (b)(4) authority.

d. _X_1915(b)(4) -The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs:
X MCO
__PIHP
__PAHP
__PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.) FFS Selective Contracting program (please describe)

2. Sections Waived.

Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ___Section 1902(a)(I)- Statewideness--This section of the Act requires a MedicaidState plan to be in effect in all political subdivisions of the State.
_X_ Section 1902(a)(10)(B)- Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

b. _X_ Section 1902(a)(23)- Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

c. ____Section 1902(a)(4)- To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

d. ____Other Statutes and Relevant Regulations Waived - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1 . Delivery Systems.

The State will be using the following systems to deliver services:

a. _X_ MCO: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. __ PIHP: Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

__ The PIHP is paid on a risk basis. (Capitated PIHPs and Fee for Service Provider Service Networks with a shared-savings arrangement)

____The PIHP is paid on a non-risk basis.

c. ___PAHP: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes

capitated PCCMs.

___The PAHP is paid on a risk basis.

___The PAHP is paid on a non-risk basis.

d. PCCM: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. Fee-for-service (FFS) selective contracting: A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___The same as stipulated in the state plan

___is different than stipulated in the state plan (please describe)

f. Other:(Please provide a brief narrative description of the model.)

2. *Procurement.*

The State selected the contractor in the following manner. Please complete foreach type of managed care entity utilized (e.g. procurement for MCP; procurement for PIHP, etc):

_X_ Competitive bid process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
___Open cooperative procurement process (in which any qualifying contractor may participate)
___Sole Source procurement
_X_ Other (Please Describe)

Qualified Medicare Advantage plans that exclusively serve dual eligibles may opt to participate as a Medicaid Long-Term Managed Care plan without participating in a competitive procurement process.

Florida law states: Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of recipients who are deemed dually eligible for Medicaid and Medicare services. Otherwise, Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-Sponsored Organizations, and Medicare Advantage Special Needs Plans are subject to all procurement requirements.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

A. Assurances

_X_ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability toaccess services.

B. Details

The State will provide enrollees with the following choices (please replicate for each program in waiver):

_X_Two or more MCOs

___Two or more primary care providers within one PCCM system. A PCCM or one or more MCOs

_ _Two or more PIHPs.

____Two or more PAHPs.

____Other: (please describe)

In each of the 11 geographic regions of the State, enrollees have a choice of at least two MCOs. The State contracts with two to ten MCOs in each region, depending on the size of the region and qualifications of the interested plans.

C. Rural Exception

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas (“rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(l)(ii)).

D. 1915(b)(4) Selective Contracting

____Beneficiaries will be limited to a single provider in their service area (please define service area).

_X_ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. General.

Please indicate the area of the State where the waiver program will be implemented.(If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

_X_ Statewide -- all counties, zip codes, or regions of the State

_____Less than Statewide

2. Details.

Regardless of whether item 1 or 2 is checked above, please list in the chart below theareas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

Region	County	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)*
Region 1	Escambia, Santa Rosa, Walton, and Okaloosa	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan*
Region 2	Holmes, Washington, Jackson, Leon, Gadsden, Liberty, Calhoun, Franklin Wakulla, Jefferson, Madison, Gulf, Bay, and Taylor	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan*
Region 3	Hamilton, Suwannee, Columbia, Union, Gilchrist,Alachua, Marion, Lake, Sumter, Levy, Dixie, Lafayette, Bradford, Citrus, Hernando, and Putnam	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • United Healthcare of Florida, Inc.
Region 4	Baker, Nassau, Duval, Flagler, Clay, St. Johns, andVolusia.	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • United Healthcare of Florida, Inc.
Region 5	Pinellas and Pasco	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • Simply Healthcare Plan
Region 6	Hillsborough, Manatee, Polk,Hardee, and Highlands	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • Aetna Better Health Plan • Simply Healthcare Plan • United Healthcare Plan
Region 7	Orange, Osceola, Brevard,and Seminole	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • Aetna Better Health Plan • Simply Healthcare Plan
Region 8	Charlotte, Collier, DeSoto,Glades, Hendry, Lee, andSarasota	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • Molina Healthcare Plan
Region 9	Okeechobee, Indian River,St. Lucie, Martin and PalmBeach	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan*
Region 10	Broward	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Simply Healthcare Plan
Region 11	Miami-Dade and Monroe	MCO	• Humana Medical Plan • Sunshine State Health Plan Inc. • Florida Community Care • Staywell Healthcare Plan* • Aetna Better Health Plan • Molina Healthcare Plan • Simply Healthcare Plan • United Healthcare of Florida, Inc.

*Staywell Healthcare Plan is merging with Sunshine State Health Plan Inc. effective 10/1/2021.

E. Populations Included in Waiver

Please note that the eligibility categories of included populations and excluded populations below may be modified as needed to fit the State's specific circumstances.

1. *Included Populations:*

The following populations are included in the Waiver Program:

___**Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_____Mandatory enrollment
_____Voluntary enrollment

___**Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_____Mandatory enrollment
_____Voluntary enrollment

_X_ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X_Mandatory enrollment *(for individuals determined to require a nursing facility level of care; and individuals ages 18 years or older with a diagnosis of cystic fibrosis; and those who transitioned from the Project AIDS Care Waiver who require hospital level of care)*
_____Voluntary enrollment

___**Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_____Mandatory enrollment
_____Voluntary enrollment

_X_ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

_X___ Mandatory enrollment *(for individuals determined to require a nursing facility level of care)*
_____Voluntary enrollment

___**Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

_____Mandatory enrollment
_____Voluntary enrollment

___**TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

_____Mandatory enrollment
_____Voluntary enrollment

2. *Excluded Populations:*

Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

___Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section1902(a)(lO)(E))

___Poverty Level Pregnant Women - Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

___Other Insurance--Medicaid beneficiaries who have other health insurance.

_X_Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

- *This waiver population excludes Medicaid participants who reside in any Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFI/IID) licensed by the State of Florida (Medicaid participants who reside in nursing facilities are included in the waiver population).*

_X_ Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

- *This waiver excludes Medicaid participants who enroll in PACE.*
- *This waiver serves Medicaid participants enrolled in the Medicaid Managed MedicalAssistance Program.*

_X_ Eligibility Less Than 3 Months-Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

_X_ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS), also referred to as a 1915(c) waiver

- *Participants in the Long-term Care Waiver can be enrolled only in this program for their HCBS services.*
- *Age-appropriate enrollees in any other Florida Medicaid home and community-based waiver are excluded from the Long-term Care Waiver unless they disenroll from their current waiver and request enrollment in the Long-term Care Waiver.*

___American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

- *The State of Florida assures that it will comply with the provisions of section 1932(h) of the Social Security Act that govern contracts with managed care plans and the treatment of Indians and Indian health care providers.*

___Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

_X_SCIDP Title XXI Children - Medicaid beneficiaries who receive services through the SCHIP program.

_X_Retroactive Eligibility - Medicaid beneficiaries for the period of retroactive eligibility.

_X_Other (Please define):

Medicaid participants in the following programs or eligibility groups are excluded from this waiver:

- *PACE (noted earlier under "Enrolled in Another Managed Care Program")'*
- *Women who are eligible only for family planning services (Family planning 1115 demonstration waiver enrollees);*
- *Women who are eligible through the breast and cervical cancer services program;*
- *Persons who are only eligible for emergency services;*
- *Refugee-eligibles;*
- *Medically Needy;*
- *Individuals under age 18.*

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

Covered Services	
Nursing Facility Services	Intermittent and Skilled Nursing
Assisted Living Services	Medication Administration
Caregiver Training	Medication Management
Adult Day Health Care	Nutritional Assessment and Risk Reduction
Personal Care Services	Respite Care
Home Accessibility Adaptation	Transportation
Behavior Management	Personal Emergency Response System
Home Delivered Meals	Adult Companion
Case Management	Attendant Care
Assistive Care Services	Homemaker
Speech Therapy	Respiratory Therapy
Physical Therapy	Hospice
Medical Equipment and Supplies, including incontinence supplies	Occupational Therapy

1. Assurances.

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51 (b) *Note: Family planning services are not a covered service under this waiver.*
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which apply, and what the State proposes as an alternative requirement, *if* any.

  (See note below for limitations on requirements that may be waived).

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

___The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1) - (4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) --adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb)-prospective payment system for FQHC
- Section 1902(a)(lO)(A) as it applies to 1905(a)(2)(C) - comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) --freedom of choice of family planning providers
- Sections 1915(b)(l) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers

2. *Emergency Services:*

In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X_The PIHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

- *Emergency services are not included in this waiver program.*

3. *Family Planning Services:*

In accordance with sections 1905(a)(4) and 1915(b) of the Act, and42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out of Network family planning services are reimbursed in the following manner:

___The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___The State will pay for all family planning services, whether provided by network or out-of-network providers.

_X_Family planning services are not included under the waiver.

___Other (please explain):

4. *FQHC Services:*

In accordance with section 2088.6 of the State Medicaid Manual access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___The program is **voluntary,** and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

___The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected: Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

_X_The program is **mandatory** and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

5. *EPSDT Requirements.*

_X_The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. *1915(b)(3) Services.*

__This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. *Self-referrals.*

___The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Part 2: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibitsrestrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. *Assurances for MCO, PIHP, or PAHP programs.*

_X_ The State assures CMS that it complies with section 1932(c)(l)(A)(i) of the Act and 42CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of moreof the regulatory requirements listed above for MCO, PIHP, or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternativerequirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Officefor approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continuewith Part B. Capacity Standards. NOTE-There is no PCCM component included underthis waiver program.

2. *Details for PCCM program.*

The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services. *N/A*

a. Availability Standards.

The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiaries normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

- PCPs (please describe):
- Ancillary providers (please describe):
- Dental (please describe):
- Hospitals (please describe):
- Mental Health (please describe):
- Pharmacies (please describe):
- Substance Abuse Treatment Providers (please describe):
- Other providers (please describe):

b. Appointment Scheduling:

Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State'sPCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

- PCPs (please describe):
- Specialists (please describe):
- Ancillary providers (please describe):
- Dental (please describe):
- Mental Health (please describe):
- Substance Abuse Treatment Providers (please describe):
- Urgent care (please describe):
- Other providers (please describe):

c. In-Office Waiting Times:

The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

- PCPs (please describe):
- Specialists (please describe):
- Ancillary providers (please describe):
- Dental
- Mental Health (please describe):
- Substance Abuse Treatment Providers (please describe):
- Other providers (please describe):
- Other Access Standards (please describe)

d. Details for 1915(b)(4) FFS selective contracting programs:

Please describe how the State assures timely access to the services covered under the selective contracting program. *N/A.*

B. Capacity Standards

1. *Assurances for MCO, PIHP, or PAHP programs.*

_X_The State assures CMS that it complies with section 1932(b)(5) of the Act and 42CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for MCO, PIHP, or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP,or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part C. *Coordination and Continuity of Care Standards.* NOTE-There is no PCCM component included under this waiver program.

2. *Details for PCCM program.*

The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program. *N/A.*

a. The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b. The State ensures that there are an adequate number of PCCM PCPs with open panels. Please describe the State's standard.

c. The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d. The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Number of Providers			
Provider Type	#Before Waiver	#In Current Waiver	#Expected in Renewal
Pediatricians			
Internist			
RHCs			
Nurse Midwives			
Additional Types of Providers to be in PCCM			

*Please note any limitations to the data in the chart above here:

e. ___The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f. PCP Enrollee Ratio. The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

PCP to Enrollee Ratio	
Area (City/County/Region)	PCCM-to-Enrollee Ratio

g. ___Other capacity standards (please describe):

3. *Details for 1915(b)(4) FFS selective contracting programs:*

Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility)-for facility programs, or vehicles (by type, per contractor)- for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver. *N/A.*

C. Coordination and Continuity of Care Standards

1. *Assurances for MCO, PIHP, or PAHP programs.*

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for MCO, PIHP, or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP,or PCCM.

2. *Details on MCO/PIHP/PAHP enrollees with special health care needs.*

The following items are required.

a. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

Based on the eligible population and scope of services, the State has determined that all enrollees of the waiver have special health care needs and, therefore, separate identification of enrollees with special health care needs within this waiver is unnecessary. The scope of services covered in this waiver is limited to institutional and HCB waiver services provided by Long-Term Care (LTC) plans that qualify as MCOs. Primary, acute, and behavioral health care services are not covered and are the responsibility of Medicare for dual eligibles and the Managed Medical Assistance Program managed care plans for other Medicaid recipients. The LTC plans are required to coordinate with the Managed Medical Assistance managed care plans.

b. ___ Identification. The State has a mechanism to identify persons with

special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___Assessment. Each MCOIPIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d. ___Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. In accord with any applicable State quality assurance and utilization review standards.

e. ___Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. Details for PCCM program.

The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees. *N/A*

a. Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.

b. Each enrollee selects or is assigned to· a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. Each enrollee is receives health education/promotion information. Please explain.

d. Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.

e. There is appropriate and confidential exchange of information among providers.'

f. Enrollees receive information about specific health conditions that require follow-upand, if appropriate, are given training in self-care.

g. Primary care case managers address barriers that hinder enrollee

compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. Referrals: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. *Details for I915(b)(4) only programs:*
If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program. *N/A.*

Part 3: Quality

1. Assurances for MCO or PIHP programs.
The State assures CMS that it complies with section 1932(c)(I)(A)(iii)-(iv) of the Act and 42CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230,438.236, 438.240, and 438.242 in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP and MCO programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42CFR 438.202,438.204, 438.210, 438.214,438.218, 438.224, 438.226, 438.228, 438.230,438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_X_ Section 1932(c)(I)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State submitted its quality strategy to the CMS Regional Office with the managed care plans' contracts for CMS approval on October 24, 2014. The State's quality strategy is found in Section B.

_X_The State assures CMS that it will comply with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract.
Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The results from the most recent independent assessment have been included as Attachment II. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

2. Assurances for PAHP program.

N/A

The State assures CMS that it complies with section 1932(c)(l)(A)(iii) (iv) of the Act and 42CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, insofar as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s)to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (l)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. Details for PCCM program.

The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program. *N/A.*

a. ___The State has developed a set of overall quality improvement guidelines for its PCCM program. Please attach.

b. State Intervention: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___Provide education and informal mailings to beneficiaries and PCCMs;
2. ___Written telephone and/or mail inquiries and follow-up;
3. ___Request PCCM's response to identified problems;
4. ___Refer to program staff for further investigation;
5. ___Send warning letters to PCCMs;
6. ___Refer to State's medical staff for investigation;
7. ___Institute corrective action plans and follow-up;
8. ___Change an enrollee's PCCM;
9. ___Institute a restriction on the types of enrollees;
10. ___Further limit the number of assignments;
11. ___Ban new assignments;
12. ___Transfer some or all assignments to different PCCMs;

13. ___Suspend or terminate PCCM agreement;
14. ___Suspend or terminate as Medicaid providers; and
15. ___Other (explain):

c. ___Selection and Retention of Providers: This section provides the State the opportunityto describe any requirements, policies, or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ___Has a recredentialing process for PCCMs that is accomplished within the timeframe set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ initial credentialing

   B. ___Performance measures, including those obtained through the following (check all that apply):

      ___The utilization management system.
      ___The complaint and appeals system.
      ___Enrollee surveys.
      ___Other (Please describe).

4. ___Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___Other (please describe).

d. __ Other quality standards (please describe):

4. Details for 1915(b)(4) only programs:

Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted: *N/A.*

Part 4: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; insofar as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR
438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1. ___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCMor selective contracting FFS providers.

2. ____ The State permits indirect marketing by MCO/PIHPIPAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3. __X_ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid

beneficiaries). Please list types of direct marketing permitted.

Marketing is permitted at health fairs and public events for the primary purpose of providing community outreach. All marketing activities must be approved by the State in advance of managed care plan participation and all marketing materials must be approved by the State prior to distribution.

3. Description.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. _X_The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs selective contractingFFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

   Section 409.9122(2)(d), F. S. provides that managed care plans are prohibited from providing inducement to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans. The State monitors this prohibition through on-site secret shopping events and a consumer complaint hotline.

2. ___The State permits MCOs/PIHPs/PAHPs/PCCMs selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. _X_The State requires MCO/PIHP/PAHP/PCCM selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

   Spanish and Haitian-Creole

   The State has chosen these languages because (check any that apply):

   a. ___The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

   b. _X_The languages comprise all languages in the service area spokenby approximately _5_ percent or more of the population.

   c. ___Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; insofar as these regulations are applicable.

___The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHPor PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages

_X_ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages listed below (If the State does not require written materials to be translated, please explain):

- *Spanish*
- *Haitian-Creole*

The State has chosen these languages because (check any that apply):

a. The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

b. _X_The languages comprise all languages in the service area spoken by approximately _5_ percent or more of the population.

c. Other (please explain):

_X_Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The approved LTC contract specifies:

Attachment II, Section V. Enrollee Services, Sub-Heading B. Enrollee Material

2. Requirements for Written Material

c. The Managed Care Plan shall make all written material available in multiple languages, as prescribed by the Agency. The Managed Care Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(3))

d. If the Managed Care Plan meets the five percent (5%) threshold for language translation, the Managed Care Plan shall place the following alternate

language disclaimer on all enrollee materials, unless otherwise indicated in this section:

"This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation]."

The Managed Care Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Managed Care Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version. Information on language use may be found at https://www.census.gov/topics/population/language-use.html#tab2.

e. *The Managed Care Plan shall include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. Information on the top fifteen (15) non-English languages is located at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf.*

Attachment II, Section V. Enrollee Services, Sub-heading C. Enrollee Services

2. Translation and Interpretation Services

a. *The Managed Care Plan is required to provide interpretation services at all points of contact to any potential enrollee or enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. This includes written translation, oral interpretation, and the use of auxiliary aids such as TTY/TDY and American Sign Language. (42 CFR 438.10(d)(4); and 42 CFR 438.406(a))*

b. *The Managed Care Plan is required to notify its enrollees of the availability of interpretation services and to inform them of how to access such services. Interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services. (42 CFR 438.10(d)(5)(i)-(iii), 42 CFR 438.10(d)(4))*

c. *Upon request, the Managed Care Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English. (42 CFR 438.10(d)(4)).*

_X_ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The State contracts with an independent enrollment broker to handle outreach, informing and enrollment-related activities.

a. Potential Enrollee Information. Information is distributed to potential enrollees by:

_X_ State contractor (Automated Health Systems) An independent enrollment broker is responsible for providing required information to potential enrollees.

_____ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

b. X Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

____the State

_X_State contractor (please specify): *Automated Health Systems*

____the MCO/PIHP/PAHP/PCCM/FFS selective contracting providers.

C. Enrollment and Disenrollment

1. Assurances.

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CPR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identifyeach regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirementsin section A.I.C)

_X_The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CPR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ Outreach. The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The State of Florida conducted public information sessions, including outreach to tribal organizations, about this program in each of the State's 11 geographic regions. The State contracted with an independent enrollment broker to handle outreach, informing and enrollment-related activities.

The State developed strategies to inform potential enrollees, providers, and others of the LTC Program. The outreach and education efforts helped to facilitate the transition of all affected individuals by ensuring they were informed of changes and potential impacts. The State assessed all outreach strategies to identify additional information that was needed to conduct an effective outreach

for this program.

Outreach activities were targeted at providers, advocates, other agencies, current and potential Medicaid participants, and other stakeholders. To accomplish this, the State developed strategic partnerships with community providers, including the local Aging and Disability Resource Centers and other entities, to provide increased awareness of the LTC program in each geographic region. Education activities focused on informing current and potential Medicaid enrollees of the LTC program and the benefits of coordinating institutional and HCBS under one contracted managed care organization.

b. Administration of Enrollment Process.

____State staff conducts the enrollment process.

__X_The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

__X_The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section1903(b) of the Act and 42 CFR 438.810.

Broker name: *Automated Health Systems*

Please list the functions that the contractor will perform:
_X_Choice counseling
_X_Enrollment
___Other (please describe):

_____State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

__This is a new program. Please describe the implementation schedule (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

Describe the state's strategy to assist beneficiaries entering the long-term managed care LTC program with enrollment, choice counseling, and complaints.

The Agency provides choice counseling assistance to recipients who are in the enrollment process. The enrollment broker provides recipients information about the selected LTC plans in the recipient's region. The enrollment broker can be reached via toll-free number or through a secure web-based application; however, recipients may contact the Agency for clarification or assistance. Recipients retain the right to petition the State, for a Fair Hearing and may also engage the Agency's online and telephone complaint system for any complaints with the LTC plan. The Agency also supports recipients' choice to change managed care plans within the 60-day open enrollment period each year.

Mandatory and voluntary recipients receive welcome letters and plan information

within two business days of the enrollment broker being notified of their eligibility for the LTC program. The letter informs them of their auto-assignment or options to enroll. Voluntary recipients can select a plan at any time and are not subject to annual open enrollment periods. Mandatory recipients are auto-assigned. Mandatory recipients can select a plan before their auto-assignment effective date. From the effective date of their plan choice or auto-assignment, the recipient contacts the enrollment broker within 120 days of enrollment, the choice of another plan is effective on the first day of the following month. After 120 days, Mandatory recipients are subject to annual open enrollment periods or may change plans for cause. Mandatory or voluntary recipients who make their plan selections will receive a letter for the new plan enrollment.

LTC plans are required to develop an enrollee information program that includes detailed information about the various important aspects of the enrollee's care. Written information is provided in various forms of required communication (i.e., enrollee welcome package). LTC plans are required to maintain a website where recipients can obtain general information without logging in, and personal information through a secure mechanism. Additionally, plans are required to maintain a strict level of personal contact with the recipients as part of case management requirements. This provides recipients the opportunity to discuss questions or concerns with someone familiar with their needs. Lastly, plans must operate a customer service line to answer recipient questions and address their concerns. These requirements are monitored by the State via the document approval process, LTC plan reporting requirements, centralized Complaint system, and annual monitoring.

Please provide a protocol for notifying, offering choice, and transitioning beneficiaries who may reside in a non-compliant assisted living facility (ALF) or ALF under CAP when the beneficiary is enrolled into the waiver.

LTC plans are required to have policies and procedures to manage this scenario. The State reviewed all policies and procedures during the plan readiness review period.

Satisfactory policies and procedures were a condition of approval to begin enrolling recipients. Furthermore, the State required plans to include language in residential provider contracts detailing the provider's responsibility to conform to the expected settings requirements as detailed in the waiver application. Plans are required to monitor ALFs and ALFs under CAP for compliance with all requirements prior to recipients accessing waiver services.

LTC plans are required to notify their recipients if they reside in a non-compliant ALF. The plan follows its standard notification procedure of sending written notification to the recipient and their legal representatives coupled with personal contact via the case manager. The case manager meets with the resident, and others chosen by the resident, to inform them of their choices to transition to any other network ALF. The case manager may facilitate visits to the prospective residences, if desired by the recipient. Once the recipient has chosen a new residence, the case manager will facilitate the move.

If a recipient chooses to remain in a non-compliant ALF the recipient may be disenrolled from the waiver. Disenrolling a recipient as a result of their choice to remain in a non-compliant ALF is an extreme, last resort, measure and would only be considered after the LTC plan and the State are unable to resolve the issue to

the resident's satisfaction.

For involuntary disenrollment from the LTC plan, the State requires the LTC plan to submit the case notes, care plan, disenrollment recommendation, and other pertinent documentation to the Agency. The Agency must approve the involuntary disenrollment. The Aging and Disabled Adult Resource Centers works with the affected recipient to assist in finding suitable services that are not funded by the LTC program.

Provider Credentialing: What is the LTC plans' responsibility for provider credentialing?

Long-term Care plans are responsible for credentialing and re-credentialing network providers to ensure they meet the minimum Medicaid provider participation criteria. Plans must ensure providers:

- *Meet minimum licensing standards as defined in the LTC managed care contract agreement.*
- *Have not had their license revoked or suspended, and are not under a moratorium at the behest of the Agency or Department of Health.*
- *Have valid Level 2 background checks for all appropriate staff.*
- *Have made the appropriate ownership, management, business transaction and conviction disclosures.*
- *Have disclosed their professional liability claims history.*
- *Have disclosed any Medicaid or Medicare sanctions.*
- *Have demonstrated a current Medicaid ID identification number, Medicaid provider registration number, or submission of the Medicaid provider registration form.*

Long-term Care plans are required to develop written credentialing policies and procedures designating the process for conducting and verifying provider credentialing and re-credentialing and maintain credentialing files. Plans submit network files weekly and the files are monitored against contract network requirements for compliance.

The State reviewed basic licensing information for the providers that LTC plans submitted to demonstrate prima-facie network adequacy as part of the solicitation process. Plans awarded contracts were required to submit complete network information.

___This is an existing program that will be expanded during the renewal period. Please describe the implementation schedule (e.g. new population, implemented statewide all at once, phased in by area, phased in by population, etc.):

_X_ If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

_X_ Potential mandatory enrollees will have_120_ days to change their plan after initial enrollment. Voluntary recipients can select a plan at any time.

_X_ Please describe the auto assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

All LTC waiver recipients are considered to have special health needs; therefore, all LTC plans, and their network providers, must be able to serve populations with special health needs. The auto assignment process is based on prioritizing an existing relationship with SNP or Medicare advantage plan, existing relationship with a Managed Medical Assistance (MMA) plan, family members with the same case, or round robin assignment process where all LTC plans in a given region have an equal chance to receive mandatory recipient assignments as mandatory recipients become eligible..

____ The State automatically enrolls beneficiaries
____ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (pleasealso checkIterm A.I.C.3)
____ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.l)
____ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _

____ The State provides **guaranteed eligibility** of____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

_X_ The State automatically re-enrolls a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment

_X_ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month. following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

I. __X__ Enrollee submits request to State.

Disenrollment for cause reasons for mandatory enrollees to change their LTC plan choice outside the open enrollment period are specified in Rule 59G-8.600,F.A.C.

II. _____Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

III. _X_Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request. The State may require enrollees to seek redress through the long-term care plan grievance process except in cases in which immediate risk of permanent damage to the member's health is alleged.

The State does not permit disenrollment from a single PIHP/PAHP (authority under 1902(a)(4) authority must be- requested), or from an MCO, PIHP, or PAHP in a rural area.

_X_The State has a lock-in period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of **12** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

Managed Care Plan Rule 59G-8.600, Florida Administrative Code (FAC) states:

(3) For Cause Reasons.

(a) Reasons outlined in 42 CFR 438.56(d)(2) and Section 409.969(2), F.S., constitute cause for disenrollment at any time from a managed care plan:

1. The managed care plan does not cover the service the enrollee seeks because of moral or religious objections.

2. The enrollee would have to change his or her residential or institutional provider based on the provider's change in status from an in-network to an out-of-network provider with the managed care plan.

3. Fraudulent enrollment.

(b) Reasons outlined in 42 CFR 438.56(d)(2) and Section 409.969(2), F.S., constitute cause for disenrollment from a managed care plan when the enrollee first seeks resolution through the managed care plan's grievance process, as confirmed by AHCA, in accordance with 42 CFR 438.56(d)(5), except when there is an allegation of immediate risk of permanent damage to the enrollee's health:

1. The enrollee needs related services to be performed concurrently, but not all related services are available within the managed care plan's network, and the enrollee's primary care provider or another provider has determined that receiving the services separately would subject the enrollee to unneccessary risk.

2. Poor quality of care.

3. Lack of access to services covered under the managed care plan's contract with AHCA, including lack of access to medically-necessary specialty services.

4. There is a lack of access to managed care plan providers experienced in dealing with the enrollee's health care needs.

5. The enrollee experienced an unreasonable delay or denial of service pursuant to Section 409.969(2), F.S.

____*The State does not have a lock-in, and* enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

_X_The State permits *MCOs/PIHPs/PAHPs and PCCMs to request disenrollment of enrollees*. Please check items below that apply:

i. _X_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons: Examples of reasons: member death, fraudulent use of beneficiary ID card; beneficiaries moving outside the program's authorized service area; or ineligible for enrollment in managed care. State staff approves these disenrollment requests and monitors plan disenrollments for discriminatory practices.

ii. _X_The State reviews and approves all MCO/PIHP/PAHP/PCCM initiated requests for enrollee transfers or disenrollments.

iii. _X_If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. _X_The enrollee remains an enrollee of the MCO/PIHPIPAHPIPCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

__X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

___The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(S)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

____This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. Assurances for All Programs.

States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. Assurances for MCO or PIHP Programs.

MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section1932(b)(4) of the Act and 42 CFR 438 Subpart H.

_X_The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, insofar as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. *Details for MCO or PIHP programs.*

a. Direct access to fair hearing. The State requires enrollees to exhaust the MCO or PIHPgrievance and appeal process before enrollees may request a state fair hearing.

___The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes: The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an appeal is 30 days (between 20 and 90).

_X_The State's timeframe within which an enrollee must file a grievance is 365 days.

c. Special Needs: The State has special processes in place for persons with special needs. Please describe.

ALL LTC enrollees are considered to be persons with special needs. LTC plans are required to serve enrollees with special needs.

4. *Optional grievance systems for PCCM and PAHP programs.*

States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions,and suspensions of already authorized Medicaid covered services. *N/A.*

___The State has a grievance procedure for its _ PCCM and/or _ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

____The grievance procedure is operated by:
____The State

___The State's contractor. Please identify:
___The PCCM
___The PAHP.

___Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___Specifies a time frame from the date of action for the enrollee to file a request for review, which is:____(please specify for each type of request for review)

___Has time frames for resolving requests for review. Specify the time period set: _____(please specify for each type of request for review)

___Establishes and maintains an expedited review process for the following reasons:_____Specify the time frame set by the State for this process_____

___Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___Other (please explain):

F. Program Integrity

1. Assurances.

The State assures CMS that it complies with section 1932(d)(l) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above. The prohibited relationships are:

a. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
b. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's,or PAHP's equity;
c. A person with an employment, consulting, or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant

and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X_The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is:
   a. precluded from furnishing health care, utilization review, medical, social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR438.608 Program Integrity Requirements, insofar as these regulations are applicable.

_X_State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for MCO, PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(l) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the State will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and~~,~~ PIHP Programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the State and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66,438.202, and 438.726). The State must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs --There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs - there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."
- If **this waiver authorizes multiple programs,** the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/A Authorization	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation					X							
Consumer Self-Report data	X		X	X	X	X	X		X	X	X	X
Data Analysis (non-claims)	X		X	X	X	X						
Enrollee Hotlines	X	X	X	X	X	X	X		X	X	X	X
Focused Studies												
Geographic Mapping												
Independent Assessment				X	X							X
Measure any Disparities by Racial or ethnic Group	X				X	X					X	X
Network				X			X	X			X	X
Adequacy Assurances by Plan												
Ombudsman	X					X						
On-Site Review	X		X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects				X			X	X	X		X	X
Performance Measures				X			X	X	X		X	X
Periodic Comparison of # of Providers				X	X		X	X			X	X
Profile Utilization by Provider Caseload				X	X		X	X			X	X
Provider Self-Report Data					X							X
Test 24/7 PCP Availability												X
Utilization Review				X	X	X	X	X	X	X	X	X
Other: Desk Reviews	X	X	X	X	X	X	X	X	X	X	X	X

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the State must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

A. Accreditation for Non-duplication

(i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___NCQA
___JCAHO (Joint Commission)
___AAAHC
___Other (please describe)

The State does not currently allow deeming.

B. _X_ Accreditation for Participation

(i.e. as prerequisite to be Medicaid plan)

_X_NCQA
__JCAHO
_X_AAAHC
__Other (Please Describe)

Applicable Program: LTC plan

Personnel Responsible: Long-term Care plans

Detailed Description of Strategy/Yielded Information:

Each LTC plan is to be accredited (by one of the state approved accrediting organizations checked above) within 18 months from the initial contract award date.

Frequency of Use: The LTC plan must submit documentation of accreditation to the State upon receipt of accreditation and at the end of each accreditation review.

C. _X_ Consumer Self-Report data

_X_CAHPS (please identify which one(s)
___State-developed survey
___Disenrollment survey

___Consumer/beneficiary focus groups

_X_Other-Consumer Complaint Resolution

The state requires the managed care plans to use the Home and Community-Based Services (HCBS) CAHPS Survey and have it conducted for their members on an annual basis using a National Committee for Quality Assurance (NCQA) -certified CAHPS vendor.

c.1 Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: LTC Plan Enrollee Survey – In 2018, the State discontinued the use of the State developed LTC Plan Enrollee Survey and adopted the Home and Community-Based Services CAHPS survey that was developed by the Centers for Medicare and Medicaid Services-LTC Plans are required to contract with a NCQA-certified vendor to conduct the survey on an annual basis. The LTC plans use the results of the survey to develop and implement plan-wide activities designed to improve member satisfaction: Activities include, but are not limited to, analyses of the following: formal and informal member complaints, disenrollment reason, policies and procedures, and any pertinent internal improvement plan implemented to improve member satisfaction.

Frequency of Use: The survey is conducted annually. The State reviews the results and if any deficiencies are identified, a corrective action plan is required. Activities pertaining to improving member satisfaction, resulting from the survey, must be reported to the State on a quarterly basis within 30 days after the end of a reporting quarter. The State reviews the quarterly Member Satisfaction Improvement report. If there is a deficiency, then a corrective action plan is required.

d. _X_Data Analysis (non-claims)

_X_ Denials of referral requests
_X_ Disenrollment requests by enrollee
_X_ From plan
___From PCP within plan
_X_ Grievances and appeals data
___PCP termination rates and reasons
___Other (please describe)

Applicable Program: LTC

Personnel Responsible: State staff /-LTC plans

Detailed Description of Strategy/Yielded Information: LTC Grievance System Review - The LTC plans are required to have a grievance system in place for enrollees that include a grievance process, an appeal process, and access to the Medicaid Fair Hearing system. The LTC plans must develop, implement, and maintain a grievance system as set forth under contract and that complies with federal laws and regulations, including 42 CFR 431.200 and 438, Subpart F. The grievance system must include procedures for ensuring persons with special needs are able to access the system. The LTC grievance system is monitored by the State through desk reviews and reports to the State. The desk review monitors the policies, procedures, and member materials and is performed during each contract period. Additional desk reviews are conducted as needed due to contract changes, as areas of concern are identified, and to evaluate ongoing compliance with contractual requirements. The LTC managed care contract requires monthly reporting of

new and outstanding grievances and appeals.

Frequency of Use: The LTC plans report new complaints and outstanding grievances and appeals monthly to the State. The Enrollee Complaints, Grievance, and Appeal Reports are reviewed monthly to ensure contract compliance.

e. **_X_ Enrollee Hotlines operated by State**

Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: The State provides a toll-free telephone system for consumers to call in order to file complaints, receive publications, information and referral numbers.

Frequency of Use: This system can be accessed between the hours of 8:00 a.m. and 6:00 p.m. Eastern time Monday through Friday.

f. **____Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. **__Geographic mapping of provider network**

h. **__Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)** In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The results from the most recent independent assessment have been included as Attachment II. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

i. **__Measurement of any disparities by racial or ethnic groups**

j. **_X_Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]**

Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Availability/Accessibility of Services. Long-term Care plans provide assurances that the plan has sufficient capacity to serve the expected enrollment in each service area. The plans are required to offer an appropriate range of services and access for the populations expected to be enrolled and to maintain sufficient number, mix, and geographic distribution of providers.

Frequency of Use: Printed provider directories are reviewed monthly to ensure that the plans are updating their directories monthly per the contract. The plans submit their entire LTC network weekly through the Provider Network Verification (PNV) system. Network adequacy reports resulting from the PNV submissions are maintained weekly and any issues determined from the reports are addressed with the plans monthly.

k. **_X_Ombudsman:**

Brief description of the Independent Consumer Support Program (ICSP):

The Independent Consumer Safety Program (ICSP) is a coordinated effort by the Florida Department of Elder Affairs' (DOEA)'s Bureau of Long-Term Care and Support working with

the statewide Long-term Care Ombudsman Program (LTCOP) and local Aging and Disability Resources Centers (ADRCs). DOEA has administered entrance into the Medicaid managed Long-term Care programs for more than 15 years and its role has included assisting enrollees in understanding coverage models and resolving problems and complaints regarding services, coverage, access and consumer rights within the managed care environment.

DOEA builds on its existing complaint resolution infrastructure to develop an even stronger independent consumer support process to serve Medicaid enrollees utilizing managed long-term care
services in both nursing facility and community-based settings.

I. _X_On-site review

I.1 Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: On-site reviews -The comprehensive survey encompasses the various areas of compliance authorized by 42 CFR 438, Title XIX of the Social Security Act (including sections 1915b and 1915c), and Florida Statutes. The scope of services and work to obtain compliance by all LTC plans are reviewed and monitored using comprehensive survey tools to identify any non-compliant areas. If non-compliant areas are identified, corrective action may be required within a given time frame. If the corrective action is not completed within the agreed upon time frames, the plan may be subject to sanctions or liquidated damages. The response to any corrective action and/or contract actions could be taken such as the imposition of sanctions or liquidated damages. If the non-compliance is not corrected in the given time frame, or fines may result from the findings of this survey process. The compliance measures in the LTC program are detailed in the comprehensive survey to cover all contract requirements. This survey is also used when a new plan signs a Medicaid contract. All comprehensive surveys are completed on site. Various components of the comprehensive surveys can also be completed by desk review prior to the on-site survey.

The State conducts on-site reviews of the LTC plans for assessment of compliancewith contract requirements. The State monitors the contractor on the quality, appropriateness, and timeliness of services provided under the contract. The State inspects any records, papers, documents, facilities, and services, which are relevant to thecontract. The contractor provides reports, which are used to monitor the performance of the contractual services. The comprehensive review is a focus on the main provisions of the contract including: Grievance System, Member Services, Quality Improvement, Utilization Management, Selected Example of Medical Records, Case Management, Credentialing of Providers, and Staffing Requirements. Minimally, the following components of the above stated provisions are reviewed:

- Administration and Management Policy and Procedures
- Staffing
- Disaster Plan
- Minority Provider Retention and Recruitment Plan
- Insurance documents
- Member Identification Card
- Credentialing and Re-credentialing Policy and Procedures
- Credentialing files
- Medical Record Requirements Policy and Procedures
- Member Handbook Provider Directories Key Personnel files
- Quality Improvement Policy and Procedures

- Member Services and Enrollment Policy and Procedures
- Utilization Management Policy and Procedures
- Case Management/Continuity of Care Policy and Procedures
- Request for Enrollment Form Sample Agent Application Provider Networks
- Provider Site Visit Form
- Grievance and Appeals Policy and Procedures
- Grievance and Appeals Letters Quality Benefit Enhancements Organization Chart Information Systems
- Model Subcontracts
- Prompt Payment Documentation
- Fraud and Abuse Prevention and Reports

Frequency of Use: On an ad hoc basis as needed

I.2 Applicable Program: LTC
Personnel Responsible: State staff
Detailed Description of Strategy/Yielded Information: LTC plan Disenrollment Summary- State staff performs reviews of recipient disenrollment files to assess the accuracy of these reports and to review the documentation of reasons for disenrollment. These reviews include a review of disenrollment due to patient deaths and disenrollment's for reasons reported as other.
Frequency of Use: Annually

m. _X_Performance Improvement projects [Required for MCO/PIHP]

_X_Clinical

_X_Non-clinical

Applicable Program: LTC

Personnel Responsible: State staff /LTC plans

Detailed Description of Strategy/Yielded Information: Quality of care studies -

Long-term Care plans must perform at least two (one clinical and one non-clinical), Agency-approved, quality of care studies that comply with 42 CFR 438.240. In addition, the quality of care studies: target specific conditions and health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation; use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions; use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered; implement system interventions to achieve improvement in quality; evaluate the effectiveness of the interventions; plan and initiate activities for increasing or sustaining improvement and monitor the quality and appropriateness of care furnished to enrollees with special health care needs. State staff reviews the studies according to 42 CFR 438.240 and the LTC contract. If plans are out of compliance, then corrective action may be required and/or other contract actions will be taken such as imposition of sanctions or liquidated damages.

Frequency of Use: Quarterly over each contract period

n. _X_Performance measures [Required for MCO/PIHP]

Process

Health status/outcomes

Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan provider characteristics
Enrollee safety and welfare

n.l Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Long-term Care plan quality and performance measure reviews are performed at least annually, at dates determined by the State. Monitoring activities include, but are not limited to, inspection of contractor's facilities; review of staffing patterns and ratios; audit and/or review of all records developed under this contract, including clinical and financial records; review of management information systems and outreach provided by the contractor; review of any other areas or materials relevant to or pertaining to the contract.

Frequency of Use: Annually and quarterly

n.2 Applicable Program: LTC

Personnel Responsible: State staff / LTC plans

Detailed Description of Strategy/Yielded Information: LTC plan staff licensure. The LTC plans are responsible for assuring that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the plan, are properly licensed under applicable State law and/or regulations and are eligible to participate in the Medicaid program. The State monitors each plan at least annually and reviews a representative sample of participating providers to ensure that all persons are properly licensed and eligible to participate in Medicaid.

Frequency of Use: Annually

n.3 Applicable Program: LTC

Personnel Responsible: State staff / LTC plans

Description of Strategy/Yielded Information: Quality Improvement - The LTC plans have a quality improvement program with written policies and procedures that ensure enhancement of quality of care and emphasize quality patient outcomes. Please see response to “m" above.

Frequency of Use: Quarterly during contract period

n.4 Applicable Program: LTC

Personnel Responsible: State staff / LTC plans

Detailed Description of Strategy/Yielded Information: HCBS CAHPS Survey - Long-term Care plans participate in enhanced managed care quality improvement through the HCBS CAHPS survey that assesses the experiences of adult Medicaid enrollees who receive long-term services and supports under Florida Medicaid. The survey covers topics such as getting needed services, communication with providers, case managers, choice of services, medical transportation, personal safety and community inclusion and empowerment.

Frequency of Use: Annually

n.5 Applicable Program: LTC

Personnel Responsible: State staff / LTC plans

Detailed Description of Strategy/Yielded Information: Availability/Accessibility of Services- See response to "j" above.

Frequency of Use: Provider directories are reviewed by the State semi-annually or more frequently when necessary.

o. Periodic comparison of number and types of Medicaid providers before and after waiver:

Each contracted LTC plan's network of providers are assessed for adequacy and readiness. All LTC plans are required to submit a report of their provider network, to ensure that numbers and types of providers are adequate. If the State determines that provider networks are not adequate, the State looks for specific trends that might impact access to services.

p. Profile utilization by provider caseload (looking for outliers)

The State performs periodic desk reviews and annual on-site reviews to determine if outliers exist for any of the providers. Monitoring for outliers will include periodic reviews of client assessments, plans of care, and service utilization reports. The State will look for trends in complaints, grievances, or fair bearing requests. Service utilization patterns before and after program implementation will be closely monitored to ensure that medically necessary services continue to be provided.

q. Provider Self-report data

__Survey of providers

___Focus groups

r. ___Test 24 hours/7 days a week PCP availability

s. _X_Utilization review (e.g. ER non-authorized specialist requests) LTC plans are required to submit periodic service utilization reports to be monitored by desk review. The State monitors whether LTC plans maintain and adhere to proper utilization review criteria, whether they apply them consistently, and if services are denied, whether enrollees are provided with appropriate and timely notice, including grievance and appeal rights.

t. _X_Other: (please describe)

Applicable Program: LTC

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Desk review:
Desk reviews are conducted monthly, quarterly, or on an *as needed* basis. An example is the review of marketing materials, events, and marketing agent qualifications. Desk reviews also take place when the State determines that there is a significant non-compliance issue with an MCO that can be resolved by review of specific information and documentation submitted by the MCO.

t.l Marketing Materials:
Applicable Program: LTC

Personnel Responsible: State staff/ LTC plans

Detailed Description of Strategy/Yielded Information: LTC plans are required to submit new or amended marketing materials to the State for review and approval utilizing a monthly submission schedule. Utilizing a monthly review cycle, the State conducts a review of the marketing materials. The LTC plans are notified of the outcome of the review. Denied materials must be revised and resubmitted to the State for review.

Frequency of Use: Monthly

t.2. Marketing, Public, Education Event Reports:
Applicable Program: LTC

Personnel Responsible: State staff/ LTC plans

Detailed Description of Strategy/Yielded Information

Each LTC Plan must submit a Marketing, Public, Educational Events Report to the State on a monthly basis indicating events scheduled to take place the following month. The event report is reviewed by the State in order to verify the location of the event, confirm submission requirements are met, and marketing agent scheduled to attend the event are licensed and appointed to the LTC plan in accordance with the Department of Financial Services licensure database. The LTC plans are notified of the outcome of the review.

Frequency of Use: Monthly

t.3. Marketing Agent Status Report
Applicable Program: LTC

Personnel Responsible: State staff / LTC Plans
Detailed Description of Strategy/Yielded Information

Each LTC Plan must submit a quarterly Marketing Agent Status Report. The report must include all plan appointed marketing agents, addition or termination of agents, and updates to reflect changes in agent information previously reported. Marketing Agent Status Reports are reviewed quarterly to ensure marketing agents maintain an active license/plan appointment and that only reported/active marketing agents are scheduled to attend approved events.

t.4. Marketing Related Complaints
Applicable Program: LTC

Personnel Responsible: State staff/ LTC plans

Detailed Description of Strategy/Yielded Information: When a marketing related complaint is received by the Agency through the toll-free telephone system, a referral is made to the Marketing Oversight Unit who reviews the allegation and determines plan compliance.

Frequency of Use: As needed - Marketing complaints are reviewed as reported to the State.

Section C: Monitoring Results

Section 19l5(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

____This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

_X_This is a renewal request.

> ___This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
>
> _X_The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action,** if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes,** if any, made as a result of monitoring findings.

Please replicate the template below for each of the activities identified in Section B:

Strategy:

Conducted as described:

___Yes
___No (Please Describe)

Summary of Results:

Problems Identified:

Corrective action (Plan/provider level):
Program change (system-wide level):

b. Strategy: Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

Conducted as described:
_X_Yes

___No (Please Describe)

Summary of Results: All eight plans participating in the LTC program submitted their accreditation within eighteen months of being awarded the contract and accreditation remains up to date.

Problems Identified: No problems identified

Corrective action (Plan/provider level): None

Program change (system-wide level): None

c. Strategy: Consumer Self-Report data

c.1 Strategy: LTC plans are required to use State developed LTC Plan Enrollee Survey to annually survey their plan members. In 2018, the State adopted the HCBS CAHPS survey, and the results of key composites are listed below.

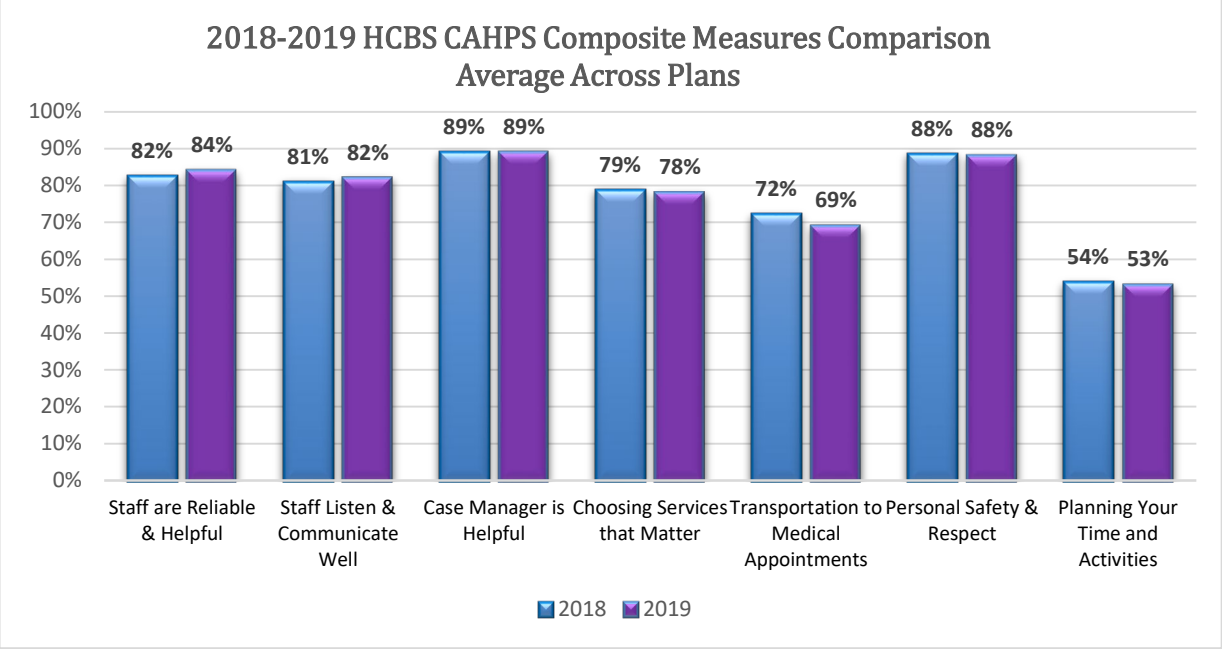
Conducted as described:

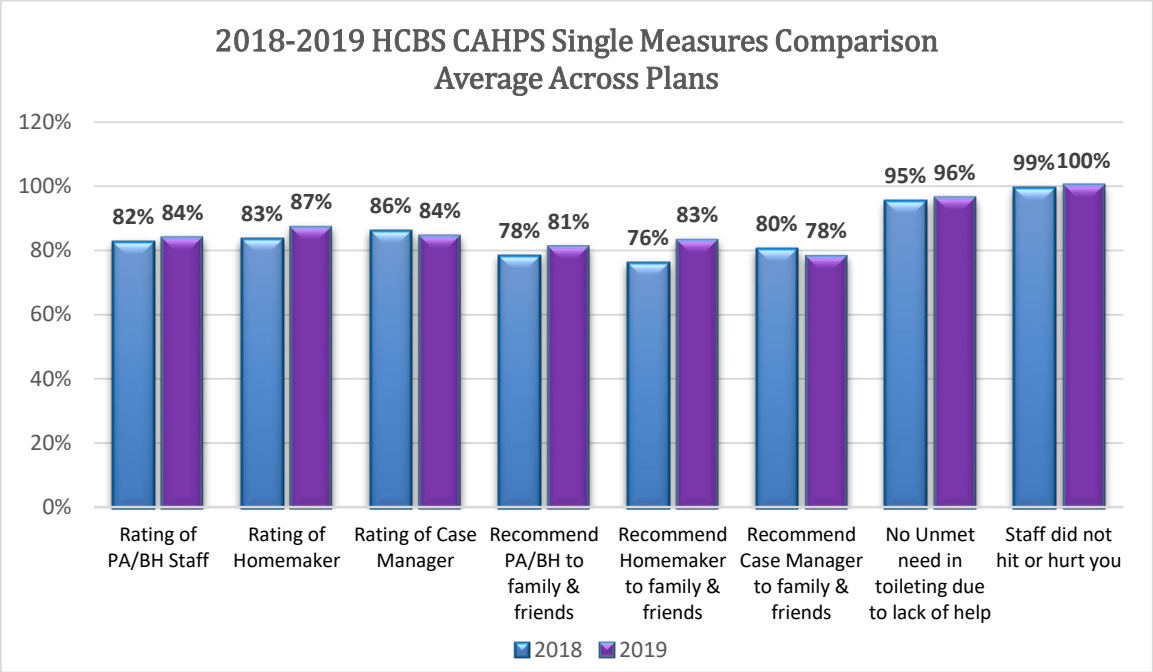
_X _Yes

___No (Please Describe)

Summary of Results:

Long-term Care Plan Enrollee Survey Results Summary2018 and 2019





Problems Identified: There was a slight decline in 5 of the 15 key metrics in 2019 from the previous year.

Corrective action: (Plan/provider level): The State is in the process of determining a corrective action plan for the reported items to increase the rates in those categories.

Program change: (system-wide level): None

c.2 Strategy: Marketing and pre-enrollment complaints

Conducted as described:

___Yes

_X_No (Please Describe)

Marketing related complaints are received via the Agency's toll-free telephone system and are referred to the Marketing Oversight Unit for review upon receipt.

Summary of Results: There were no marketing related complaints received by the Agency during the timeframe under review.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

d. Strategy: Data Analysis (non-claims)

Conducted as described:

___Yes

_**X**_No (Please Describe)

Summary of Results: The Agency has a complaint process to address LTC complaints.

Recipients can call the Medicaid Helpline toll-free at 1-877-254-1055, Monday through Friday, 8:00 am to 5:00 pm EST to submit a complaint by phone. Recipients can also submit complaints electronically, 24/7, at http://ahca.myflorida.com/Medicaid/complaints/index.shtml.

All complaint submissions are routed electronically to the Medicaid Complaint Operations Center (MCOC) for triage and assignment. For any urgent access to care issues, MCOC staff attempt to contact the recipient the same day the submission was received, and intervenes with the LTC Plan to initiate a resolution.

All complaint submissions are assigned a tracking number. Recipients can use this tracking number to check the status of a complaint by calling the Medicaid Helpline or electronically at http://ahca.myflorida.com/Medicaid/complaints/index.shtml.

The MCOC submits a detailed weekly report of closed complaints to the Agency's Bureau of Plan Management Operations (PMO) to assist with identifying potential compliance issues.

Problems Identified: The review of the Enrollee Complaints, Grievances, and Appeals (ECGA) reports revealed that some plans inaccurately reported data or were non-compliant with contractual requirements.

Corrective action (Plan/provider level): Changes made as necessary to address complaints. Plans were either provided technical assistance so that issues identified could be corrected and/or were issued a compliance action.

Program change (system-wide level): None

e. Strategy: Enrollee Hotline Operated by the State

Conducted as described:

_X_ Yes

__ No (Please Describe)
The Agency operates the Medicaid Helpline. Medicaid Helpline staff are available at 1-877-254-1055, Monday through Friday, 8:00 am to 5:00 pm EST; Telecommunications device for the deaf (TDD) is available at 1-866-467-4970. Assistance is available in all languages.

Summary of Results: MCOC staff work with the recipient or their designated authorized representative and the LTC plan to address identified problems individually as necessary using the recipient's preferred method of communication. The MCO also submits a detailed weekly report of closed complaints to the Agency's Bureau of PMO to assist with identifying potential plan compliance issues.

Problems Identified: Identified problems addressed individually as necessary.

Corrective action (Plan/provider level): None

Program change (system-wide level): None

f. Strategy: Focused Studies
Not applicable

g. Strategy: Geographic mapping of provider network

Conducted as described:

___ Yes

_X_ No (Please Describe)
The LTC contract requires provider networks to have at least two service providers foreach

covered service in each county in the plan's service area. The contract does notrequire provider networks to have distance and time metrics for provider network adequacy. LTC plans submit their provider network files weekly for verification of compliance with the contract requirements through the Provider Network Verification System (PNV) but are monitored on a monthly basis.**Summary of Results:** The weekly submissions have been verified. No issues were found in the number of servicing providers.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

h. Strategy: Independent assessment of program impact, access, quality, and cost-effectiveness

Conducted as described:

_X_Yes – See Attachment II

___No (Please Describe)

Summary of Results: Florida State University submitted the independent assessment for state fiscal years 2014-2015 through 2018-2019 to the Agency on May 25, 2021. The independent assessment results show that the total proportion of enrollees in nursing facilities declined by 12.7 percent over the five-year period (from 55.9% in the first month of the evaluation to 43.2% in the last month of the evaluation). Home and community-based service enrollment increased from 45.3 percent to 57.0 percent, or by 11.7 percentage points during the five consecutive state fiscal years between July 2014 and June 2019. Shifting LTC program services from more costly NF services to HCBS means that for the same funds allocated, more enrollees were provided with LTC program services.

Problems Identified: The independent assessment made the following recommendations: 1) The Agency should implement strict submission requirements for all assessments of enrollee functional status conducted by the plan case managers and enforce with financial penalties for non-compliance; 2) The health plans should regularly submit to the Agency electronic Excel spreadsheets representing the assessment scores for all categories of assessments for each enrollee to facilitate use and summarization of the data; and 3) Care plans and service authorizations should be placed in a machine-readable format so that the comprehensive assessment, care plans, and services authorizations may be linked to the encounter records.

Corrective action (Plan/provider level): None

Program change (system-wide level): None

i. Strategy: Measurement of any disparities by racial or ethnic groups

Conducted as described:

_X_Yes

__No (Please Describe)

Summary of Results: Florida State University submitted the independent assessment for state fiscal years 2014-2015 through 2018-2019 to the Agency on May 25, 2021. The independent assessment results show that most enrollees reported feeling "satisfied" with their overall quality of life regardless of race/ethnicity or location of care.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

j. Strategy: Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]

Conducted as described:

___Yes

_X_No (Please Describe)

The LTC plans are required to submit their provider directory policies and procedures, and make available a printed copy of their provider directory and information regarding web-accessible directories for review. The State reviewed the provider directories utilizing established review protocols to ensure compliance with contract provisions. Since the new contract period that began 12/1/2018, LTC plans update the printed provider directory at least every month and ensure the provider directory (either printed or online) matches the most recent provider network file submitted to the Agency.

Summary of Results: All LTC plan provider networks were determined to meet contract standards for adequacy. The State found the plan's provider directories and policies as well as their on-line provider directories to be compliant with the contract requirements.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

k. Strategy: Ombudsman

Conducted as described:

_X__Yes

___No (Please Describe)

Summary of Results:

Quarterly Independent Consumer Support Program Report Results January – March 2021	
Complaint Type:	**Number of Complaints:**
Coverage/Limitation Issue	0
Customer Service	17
Discharge/Eviction	0
Disenrollment	0
Eligibility	59
Enrollment/Plan Change	1
Grievance/Appeal	0
Missed Services	0
Other	4
Provider Payment	0
Reduction/Denial of Service	2
Waitlist	6
Total	**89**

Problems Identified: The reported issues were referred to Agency complaint hub for resolution.

Corrective action (Plan/provider level): The issues were resolved on an individual basis and did not represent a general trend requiring program changes.

Program change (system-wide level): None

I. **Strategy:** On-site review

I.1 Strategy: On-Site Reviews

Conducted as described:

_X_Yes

___No (Please Describe)

Summary of Results:

The annual on-site and desk reviews were completed by DOEA and results were forwarded to the Agency.

Starting in 2018, the desk reviews were completed on a quarterly basis by the Agency. The Agency requested revised and updated forms and care plans as necessary. Plans corrected their deficiencies revealed in the on-site and desk reviews.

Problems Identified: Although some plan's forms and care plans were incomplete, the Agency received the corrected information in follow-up submissions. The follow-up form submissions resolved the forms compliance issues.

Corrective action (Plan/provider level): None

Program change (system-wide level): None

I.2 Strategy: Disenrollment Summary

Conducted as described:

___Yes

_X_No (Please Describe)

The State's desk reviews examined each LTC plan's disenrollment files to verify accuracy. LTC plans may not voluntarily disenroll plan members. The Agency reviews and approves plan member disenrollment requests for voluntary disenrollment. Plans may request involuntary disenrollment of plan members for the following reasons: plan member moving out of the region; loss of Medicaid eligibility; enrollee death; and determination that an enrollee is an excluded population under the contract.

Summary of Results: Plans' disenrollment files were found to comply with contract requirements.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

m. Strategy: Performance Improvement Projects

Conducted as described:

___Yes

_X_No (Please Describe)

The State contracted with an EQRO to review the LTC plans' performance improvement projects. The plans' performance improvement submissions are due each year on October 1st for review and validation.

Summary of Results: Under the previous contracts, the Agency had separate Performance Improvement Projects (PIPs) for the LTC population. In the current contract, the LTC population is included in the plans' PIPs related to Potentially Preventable Events (PPEs), mental/behavioral health, and transportation. For SFY 2020–2021, seven of 14 SMMC health plans received an overall Met validation status for the Administration of the Transportation Benefit PIP. Six health plans demonstrated a decline in overall performance from last year's validation results. Considering the effects of the COVID-19 pandemic and the 2019 HEDIS data for the 7-day Follow-up after ED and hospitalization measures, the Agency determined that the behavioral health PIP topics needed to be amended to allow for a more collaborative and streamlined approach for addressing behavioral health. The Agency mandated all health plans implement interventions to address Improving 7-day Follow-up After Hospitalizations for People with Mental Health Conditions and Emergency Department Visits for People with Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence. The Health Services Advisory Group (HSAG) evaluated all 14 health plans for the Design and Implementation stages (steps 1 through 8) of the PIP. For the Reducing PPEs, PIP, 5 plans met the goals for all three performance indicators in all regions served.

Problems Identified: For the Potentially Preventable Events (PPEs) PIP, a number of plans did not meet all the targets for the metrics. The plans are continuing to work on interventions to aid their members in seeking care in the most appropriate setting and preventing unnecessary hospital admissions, readmissions, and emergency department visits.

Corrective action (Plan/provider level): The Agency and HSAG have provided feedback to plans who needed to resubmit their annual reports.

Program change (system-wide level): None

n. Strategy: Performance Measures

n.1Strategy: Quality and Performance Measure reviews

Conducted as described:

___Yes

_X_No (Please Describe)

The State conducts annual reviews of the Agency defined performance measures. The performance measures are calendar year based and have been reviewed annually for compliance with the LTC program contract.

Summary of Results: The initial performance measures exceeded the contract standards for care plan development and initial LTC plan member contacts. The performance measures were amended to reflect the actual contract standards for these requirements. In CY 2018, the State adopted four Long Term Services and Supports (LTSS) measures and by CY 2019 plans were reporting on an additional four measures, for a total of eight LTSS measures. The new LTSS measures are still not yet being publicly reported after two years of data collection. The State has developed benchmarks for plans until national standards are set and released.

Problems Identified: Overall, managed care plan performance improved on the four measures for which the plans reported two years of data. Some of the main problems were related to these measures being new to the plans, performance measure software vendors, and performance measure auditors, as there has been a learning curve with calculating and reporting on these measures. NCQA has included four of the LTSS measures in HEDIS and has collected data for two years but is not yet reporting anything publicly on these measures, which limits the state's ability to set standards for the plans compared to national benchmarks.

Corrective action (Plan/provider level): The Agency has provided technical assistance to the plans as they have posed questions related to the new LTSS measures. As needed, the Agency has contacted the federal CMS-contracted LTSS performance measures technical assistance team in order to get clarification on measure specifications.

Program change (system-wide level): Not applicable.

n.2 Strategy: Staff licensure reviews

Conducted as described:

___Yes

_X_No (Please Describe)

The LTC plans submit a quarterly report of all qualified providers. The Agency conducts a desk review to verify the plan's licensed staff.

For plan licensed staff, the Agency conducts a desk review to verify the plan's licensed staff on a quarterly basis.

Summary of Results: Plan provider networks were found to be in compliance with the program contract. Plan licensed staff were determined to be licensed as required by the contract.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

n.3 Strategy: Quality Improvement

Conducted as described:

___Yes

_X_No (Please Describe)

See item 'm' of this section for description.

Summary of Results: Plans with non-met items on their templates were given an opportunity to correct the template or design issues.

Problems Identified: The first two submissions reviewed the plans' basic design of their performance improvement plan using the CMS approved template.

Corrective action (Plan/provider level): None

Program change (system-wide level): None

n.4 Strategy: Independent Member Satisfaction Survey

Conducted as described:

___Yes

_X_No (Please Describe)

Since no long-term care version of the CAHPS was available the State developed the LTC Plan Enrollee Survey and required the LTC plans to contract with an independent survey vendor to conduct the survey on an annual basis. When a standard LTC survey was available, the State adopted the HCBS CAHPS survey and requires plans to report data annually using this version.

Summary of Results: See item c1 for chart displaying survey results from the standardized survey from CY 2018 and CY 2019.

Problems Identified: Rates fell in 5 key metrics for year-to-year comparison. We are looking to have plans submit to the Agency for Healthcare Research and Quality (AHRQ) database so that we can compare Florida Medicaid rates to other states.

Corrective action (Plan/provider level): The State is in the process of determining corrective action requirements for these items.

Program change (system-wide level): None

o. Strategy: Periodic comparison of number and types of Medicaid providers before and after waiver implementation.

Conducted as described:

___Yes

_X__No (Please Describe)

Quarterly desk reviews of PNV system reviews provide a basis for comparison of

service providers before and after implementation of the LTC Waiver.

Summary of Results: LTC plans have been able to attract more service providers for waiver services to their provider networks than contract network adequacy requirements.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

p. Strategy: Profile utilization by provider caseload (looking for outliers)

Conducted as described:

_X_Yes

___No (Please Describe)

Summary of Results: Desk reviews examined profile utilization difference by plan caseload. Differences in service utilization were based upon plan member preference for services in their home versus other service locations such as an adult day care center.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

q. Strategy: Provider Self-report Data

q.1 Strategy: Marketing Materials

Conducted as described:

_X_Yes

_ _No (Please Describe)

Summary of Results: Marketing materials submitted by the plans were reviewed monthly. Unapproved marketing materials were returned to the plans during the review process and required resubmission.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

q.2 Strategy: Health Fairs and Public Events

Conducted as described:

_X_Yes

__No (Please Describe)

On a monthly basis, each plan submits a Marketing, Public, and Educational Event Report to reflect event attendance for the following month. Each report was reviewed by the State to ensure contract provisions were met.

Summary of Results:

The State reviews found no compliance issues with plan event reports.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

q.3 Strategy: Marketing Representatives

Conducted as described:

_X_ Yes

__ No (Please Describe)

The State used two methods to verify the plan use of approved Marketing Representatives at events: 1) each LTC plan's Marketing, Public, and Educational Event Report was reviewed monthly to verify the licensure and appointment of the marketing agent to the plan. 2) the Marketing Status Agent Report was reviewed quarterly to identify any changes in marketing agent information that may impact the agent's eligibility to attend a previously approved event.

Summary of Results:
The State reviews did not identify the use of unlicensed or unappointed marketing representatives at events.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

r. Strategy: Test 24 hours/7 days a week PCP availability

Not applicable.

s. Strategy: Utilization Review

Conducted as described:

___ Yes

_X_ No (Please Describe)

Quarterly desk reviews are used by the State to review service utilization of LTC Plans. Plans submit sampled care plans to the Agency for review. Service utilization outliers are reviewed and followed up with the plans.

LTC plans submit monthly Service Authorization Performance Outcome Reports and Denial, Reduction, Termination or Suspension of Services reports, which allow the state to monitor timeliness of UM decisions, approval and denial rates, and conduct trending analysis for possible under or over-utilization of services.

Summary of Results: Plans have provided explanations for service utilizations that appeared to be excessivein some cases.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

t. Strategy: Desk Review

Conducted as described:

_X__Yes

___No (Please Describe)

Summary of Results: See item q. and item s. for examples of the State's use of desk reviews to examine a program issue.

Problems Identified: None

Corrective action (Plan/provider level): None

Program change (system-wide level): None

Section D: Cost Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming three-year waiver period, called Prospective Year 1 (P1), Prospective Year 2 (P2) and Prospective Year 3 (P3). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective three-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1.	Member Months
Appendix D2.S	Services in the Actual Waiver Cost
Appendix D2.A	Administration in the Actual Waiver Cost
Appendix D3.	Actual Waiver Cost
Appendix D4.	Adjustments in Projection
Appendix D5.	Waiver Cost Projection
Appendix D6.	RO Targets
Appendix D7.	Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS RO for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound mannerbased only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:

Tom Wallace
Telephone Number: 850-412-4117
E-mail: ThomasWallace@ahca.myflorida.com

c. The State is choosing to report waiver expenditures based on

_X_date of payment.

___date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a. ___ The State provides additional services under 1915(b)(3) authority.
b. ___ The State makes enhanced payments to contractors or providers.
c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.
d. ___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a. _X_ MCO
b. ___PIHP

c. ____ PAHP
d. ____ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ____ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1.____ First Year: $____per member per month fee
   2.____ Second Year: $____per member per month fee
   3.____ Third Year: $____per member per month fee
   4.____ Fourth Year: $____per member per month fee

b. ____ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ____ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.____ Other reimbursement method/amount. $_____Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

For Initial Waivers only:

Please mark all that apply.

a. ___ Population in the base year data
   1.__ Base year data is from the same population as to be included in the waiver.
   2. _ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ____ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c. ____ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _____

d. ___[Required] Explain any other variance in eligible member months from BY to P3:___ _____

e. ____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f. _____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _SFY_____.

g. _____[Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

a. _X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. _____For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. _X__[Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Member month increases were based on actual growth trends.

d. ____ [Required] Explain any other variance in eligible member months from BY/R1 to P2: _____

e. _X_ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
R1: 12/28/2018-12/27/2019

R2: 12/28/2019-12/27/2020

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. ____[Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a. ____ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: *Same services*

b. ____ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: *no exclusions*

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. Appendix D5 should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period

The allocation method for either initial or renewal waivers is explained below:

a. X The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. Note: this is appropriate for MCO/PCCM programs.

b. __ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Note: this is appropriate for statewide PIHP/PAHP programs.

c. ____ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a. ____ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Total			

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This

amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

b. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. _X__Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stop loss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2._X__The State provides stop/loss protection (please describe):

The LTC program includes a budget-neutral Community High Risk Pool (CHRP) risk mitigation mechanism for the HCBS rate cell. A percentage of HCBS rates is withheld to fund the CHRP. Seventy-five percent of member expenditures greater than $7,500 per month ("pooled claims") are eligible to be reimbursed by the CHRP. At the end of the contract period, if CHRP funds are inadequate to reimburse all pooled claims, the pooled claims will be

funded on a proportional basis for each MCO. If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to MCOs on a PMPM basis.

d. _____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. _____[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2. _____For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 through P3. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. ____**State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P3). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases

separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.____ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present).* Please document how that trend was calculated:

2.____[Required, to trend BY to P1 through P3 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) *(i.e., trending from present into the future)*.

i. ____State historical cost increases. Please indicate the years on which the rates are based: base years_____In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii._____National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 through P3.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b._a.___**State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for

changes that occur after the BY (or after the collection of the BY data) and/or during P1, P2 and P3 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.____ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.____ An adjustment was necessary. The adjustment(s) is (are) listed and described below:

i.___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.___ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv. ___Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ____ Other (please describe):

v. ___ Other (please describe):

A. ____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ____ Other (please describe):

c.____ Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in thewaiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost- effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ____ No adjustment was necessary and no change is anticipated.

2. ___ An administrative adjustment was made.

i. FFS administrative functions will change in the period between the beginning of P1 and the end of P3. Please describe:

A. ____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. _ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ____ Other (please describe):

ii. ____ FFS cost increases were accounted for.

A. ____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ____ Other (please describe):

iii. ____ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential

smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above_____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d.____1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is:_____. Please provide documentation.

2.____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above_____.

e.____Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**. _____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

f.____Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.____ We assure CMS that GME payments are included from base year data.

2.____ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.____ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.____ GME adjustment was made.

i.____ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.____ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.____ No adjustment was necessary and no change is anticipated.

Method:

1.____ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.____ Determine GME adjustment based on a pending SPA.
3.____ Determine GME adjustment based on currently approved GME SPA.
4.____ Other (please describe):

g.Payments / Recoupments not Processed through MMIS Adjustment: Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.____ Payments outside of the MMIS were made. Those payments include (please describe):
2.____ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.____ The State had no recoupments/payments outside of the MMIS.

h.Copayments Adjustment: This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.____ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.____ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not made an adjustment because the same copayments are collected in managed care and FFS.
4.____ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.____ No adjustment was necessary and no change is anticipated.
2____ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.____ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.____ Determine copayment adjustment based on pending SPA.
3.____ Determine copayment adjustment based on currently approved copayment SPA.
4.____ Other (please describe):

i.Third Party Liability (TPL) Adjustment: This adjustment should be used only if the Stateis converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ___ No adjustment was necessary
2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ____ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ____ The State made this adjustment:*
    i. ____ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
    ii. ____ Other (please describe):

j.Pharmacy Rebate Factor Adjustment : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3. ___ Other (please describe):

k.Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has an FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost- effectiveness calculations.

1. __ We assure CMS that DSH payments are excluded from base year data.
2. ____ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ____ Other (please describe):

l.Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year cost must be adjusted to reflect this.

1. ___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. __This adjustment was made:
    a. ___Potential Selection bias was measured in the following manner:
    b.____The base year costs were adjusted in the following manner:

m.FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.____ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.____ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.____ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. ___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.____ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
b.____ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

c._ Not applicable for an initial application utilizing FFS data for projections.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness

Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. Incomplete Data Adjustment (DOS within DOP only)– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported. Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3. ___Other (please describe):

o.PCCM Case Management Fees (Initial PCCM waivers only) – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1. __This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. __This adjustment was made in the following manner:

p.Other adjustments: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

    1. __No adjustment was made.
    2____This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method, and mathematically account for the adjustment in Appendix D5.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments

may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.____ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2._X__[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) *(i.e., trending from present into the future)*.

i. __X__State historical cost increases. Please indicate the years on which the rates are based: base years __*waiver authority 2019 and 2020*__In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.).
Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The State's actual expenditure data were the primary source for determining trend for the prospective period. For the prospective time periods, the state assumed a 7% trend. Column J of Appendix D.5 reflects the annualized trend. The trend from P1 to P2, P2 to P3,P3 to P4, and P4 to P5 was assumed at the projected average of 7% based upon the historical averages.

ii. ____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.__X_The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

Utilization trends are not developed separately from unit cost trends.

ii. Please document how the utilization did not duplicate separate cost increase trends.

Utilization trend is considered in the State's overall analysis of trend. Separate trends are not developed for utilization.

b. _____**State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon*

approval of the SPA. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program. Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

ii.___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.___ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.___ Changes in legislation (please describe):
For each change, please report the following:

A. ____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ____ Other (please describe):

vi. _____ Other (please describe):
A. ____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ____ Other (please describe):

c. ____ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. _X__ No adjustment was necessary and no change is anticipated.
2. ____ An administrative adjustment was made.
   i. ____ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
   ii. ____ Cost increases were accounted for.
      A. ____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
      B. ____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
      C. ___ State Historical State Administrative Inflation. The actual trend rate used is:_____. Please document how that trend was calculated:

      D. ___ Other (please describe):
   iii. ____ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
      A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on

which the rates are based: base years_____In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above_____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.____ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is:_____. Please provide documentation.

2.____ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above_____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***:

Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3. Other (please describe):

___

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**: D.I.E.c.

Explain the reason for any increase or decrease in member months projections from the base year or over time:

The membership projections assume enrollment growth at approximately 1.1% per quarter.

D.I.E.d Explain any other variance in eligible member months from BY toP5:

There is no other variance in eligible member months.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   The State did not estimate cost changes separate from the utilization changes. Utilization did not duplicate separate cost increase trends. Utilization trend is considered in the State's overall analysis of trend. Separate trends are not developed for utilization.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   For the prospective time periods, the state assumed a 7% trend. Column J of Appendix D.5 reflects the annualized trend. The trend from P1 to P2, P2 to P3, P3 to P4 and P4 to P5 was assumed at the projected average of 7% based upon the historical averages and fluctuations experienced by this population.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Attachment I:
Tribal Letters

Miccosukee Tribe of Florida

Dear Ms. Osceola:

This correspondence is being sent to solicit comments from the Miccosukee Tribe of Indians of Florida on the upcoming renewal requests for Florida Medicaid's concurrent 1915(b)/(c) Managed Care Waiver for the Long-Term Care (LTC) Waiver (FL-17 and FL.0932). In addition to the waiver renewal requests, Florida is requesting a temporary extension for these waivers. The proposed temporary extension would cover December 28, 2021 through December 31, 2021. The temporary extension would align the start date of the renewal requests with the standard federal reporting quarters.

The 1915(b) Managed Care Waiver for the Long-Term Care Program is the Federal Authority that allows the LTC program to operate under a managed care system. As such, this waiver runs concurrently with the 1915(c) Long-Term Care Waiver, both of which are up for renewal. The Long-Term Care program provides long-term care services and supports to eligible disabled individuals age 18-64 and elderly individuals age 65 or older, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. Program recipients receive their services through competitively selected managed care organizations.

Significant changes that have been made within the 1915(b) renewal application include:

- Updates to the Monitoring Plan and Results in Sections B and C of the waiver document.
- In accordance with the 1915(b) waiver requirements, an independent assessment was conducted for the first two waiver periods. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

Significant changes that have been made within the 1915(c) renewal application include:

- Updated performance measure language and language throughout the waiver that stated the Department of Elder Affairs was the monitoring agency over the LTC plans to include the Agency for Health Care Administration as the LTC plan monitoring agency.
- Removed language from transition plan in the Main Section, Attachment 1 that referenced the 2018 consolidation of the 1915(c) Traumatic Brain and Spinal Cord Injury, Adults with Cystic Fibrosis, and Project AIDS Care Waivers into the Statewide Medicaid Managed Care Long-term Care program.
- Updated language to comply with CMS guidance in the Main Section, Attachment 2.
- Updated reporting requirement list and language in Appendix A-6, Assessments.
- Updated unduplicated numbers of participants in Appendix B-3.
- Updated the maximum number of participants served at any point during the year in Appendix B-3.
- Updated Appendix J data.

A full description of the proposed renewal requests, as well as the current waivers, is located on the Agency for Health Care Administration's (Agency's) website at the following link:

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/ltc_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the temporary extension requests and the waiver renewal applications to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from August 18, 2021 to September 16, 2021.

If you have any questions about this amendment or would like to hold a call, please contact me by replying to this email by September 16, 2021.

Sincerely,

Seminole Tribe of Florida

Dear Dr. Kiswani-Barley:

This correspondence is being sent to solicit comments from the Seminole Tribe of Florida on the upcoming renewal requests for Florida Medicaid's concurrent 1915(b)/(c) Managed Care Waiver for the Long-Term Care (LTC) Waiver (FL-17 and FL.0932). In addition to the waiver renewal requests, Florida is requesting a temporary extension for these waivers. The proposed temporary extension would cover December 28, 2021 through December 31, 2021. The temporary extension would align the start date of the renewal requests with the standard federal reporting quarters.

The 1915(b) Managed Care Waiver for the Long-Term Care Program is the Federal Authority that allows the LTC program to operate under a managed care system. As such, this waiver runs concurrently with the 1915(c) Long-Term Care Waiver, both of which are up for renewal. The Long-Term Care program provides long-term care services and supports to eligible disabled individuals age 18-64 and elderly individuals age 65 or older, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. Program recipients receive their services through competitively selected managed care organizations.

Significant changes that have been made within the 1915(b) renewal application include:

- Updates to the Monitoring Plan and Results in Sections B and C of the waiver document.
- In accordance with the 1915(b) waiver requirements, an independent assessment was conducted for the first two waiver periods. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

Significant changes that have been made within the 1915(c) renewal application include:

- Updated performance measure language and language throughout the waiver that stated the Department of Elder Affairs was the monitoring agency over the LTC plans to include the Agency for Health Care Administration as the LTC plan monitoring agency.
- Removed language from transition plan in the Main Section, Attachment 1 that referenced the 2018 consolidation of the 1915(c) Traumatic Brain and Spinal Cord Injury, Adults with Cystic Fibrosis, and Project AIDS Care Waivers into the Statewide Medicaid Managed Care Long-term Care program.
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The Agency will conduct a 30-day public notice and comment period prior to the submission of the temporary extension requests and the waiver renewal applications to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from August 18, 2021 to September 16, 2021.

If you have any questions about this amendment or would like to hold a call, please contact me by replying to this email by September 16, 2021.

Sincerely,

Attachment II
Independent Assessment

Independent Assessment of the Florida Statewide Medicaid Managed Care Long-term Care Program

Final Report (SFYs 2014-2015 through 2018-2019)

Deliverable 41

Prepared for Florida Medicaid
MED 186 May 25, 2021

Florida Medicaid Long-term Care Program
Final Report
(SFYs 2014-2015 through 2018-2019)

Executive Summary

The Florida Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program rollout began in August 2013. During the remainder of the state fiscal year, the program successfully moved 83,000 recipients enrolled in pre-SMMC LTC waivers/programs such as Nursing Home Diversion, Channeling Waiver, and Assisted Living Waiver to the new SMMC LTC program model.

The federally approved SMMC LTC waiver includes a requirement for an independent assessment of the SMMC LTC program. The Florida Agency for Health Care Administration (AHCA), hereinafter referred to as "the Agency," contracted with Florida State University (FSU) College of Medicine to conduct the required assessments of the first two waiver periods, as well as annual assessments of the program. The evaluation period for this report is State Fiscal Year (SFY) 2014 - 2015 through SFY 2018 - 2019.

The FSU evaluation team, in concert with the Agency, identified key issues of importance to policy makers and LTC stakeholders and developed research questions (RQs) to address those issues. These issues relate to access to care, quality of care, and cost-effectiveness of care, of Florida's SMMC LTC program.

Access to Care

The evaluation team used the following five RQs to guide their assessment of access to care:

1. Have there been changes in the accessibility of services for enrollees over time?
2. How has the population served in the LTC program shifted (characteristics of the population and service utilization) between nursing facilities (NF) and home and community-based services (HCBS) over time? What LTC plan strategies are impacting these shifts?
3. What are the levels of service utilization for enrollees prior to transitioning into the nursing facility?
4. Do plans offer additional (expanded) benefits and ways to access services, including a Participant Directed Option (PDO), and to what extent do enrollees use these services?
5. Are there disparities by racial and ethnic groups in enrollees' placements in certain settings and utilization of services?

The principal findings resulting from analysis of the RQs are:

- The total proportion of enrollees in NF declined by 12.7 percent over the five-year period (from 55.9% in the first month of the evaluation to 43.2% in the last month of the evaluation). Additionally, shifts in cost indicate that significant progress was made toward the statutory goal to transition 65 percent of LTC program enrollees from NFs to HCBS settings.[1] HCBS enrollment changed from 45.3 percent to 57.0 percent, or by 11.7 percentage points during the five consecutive state fiscal years between July 2014 and June 2019.
- Among 48,640 enrollees meeting research question inclusion criteria, 21,754 or 44.7 percent transitioned into the community at some point during the evaluation period. (See Table 10.)
- Among the 21,754 enrollees who attempted transition (i.e., lasting 90 days or more), 13,683 (63%) were successful, 5,258 (24%) were unsuccessful, and 2,813 (13%) were indeterminate.
- Regions with more rural counties had lower rates of transition. Regions with lower rates of transition into HCBS were those with lower rates of access to assisted living facilities (ALFs).
- Enrollees of all other races/ethnicities (Hispanic, Asian, Native American, and Pacific Islander) were much more likely to reside in HCBS settings than Black and White LTC program enrollees.
- White enrollees were over twice as likely as Black enrollees to reside in ALFs throughout the entire evaluation period.

Additional Improvements in Access to Care

- The Expanded Benefit (EB) program in SFY 2018 - 2019 was compared to the program in SFY 2013 - 2014. Plans largely offered the same mix of EBs in those two time periods.
- From SFY 2014 - 2015 to SFY 2018 - 2019, participation in Participant Direction Option (PDO) programs grew from 4.7 percent to 11.4 percent of enrolled months for home-based enrollees (excluding ALFs and nursing facilities).
- Utilization of common services, e.g., adult companion care, adult day health care, homemaker services and personal care services increased from SFY 2014 - 2015 to SFY 2018 - 2019. (See Tables 3-5 for specific data points.)

In summary, during the five-year evaluation period, the proportion of LTC program enrollees residing in NFs declined substantively. Enrollee transitions from a NF to a community-based setting were more often successful (63%) than unsuccessful based on study definitions. The increased placement in community-based settings was associated with an increase in the utilization of Long-Term Care

[1] Incentive adjustments must continue until no more than 35 percent of each plan's enrollees reside in institutional settings. See: http://www.flsenate.gov/Laws/Statutes/2018/409.983

Support Services. Finally, enrollee choice was enhanced not only by increased placement in community settings but by increased use of the Expanded Benefit program and the Participant Direction Option over the evaluation period.

Quality of Care

The evaluation team used the following five RQs to guide their assessment of quality of care under Florida's SMMC LTC program:

1. Are long-term care (LTC) services effective at achieving positive health outcomes?
2. Are LTC services effective at achieving equitable, positive health outcomes by gender, race/ethnicity, and geographic location?
3. Are patient-centered enrollee transitions reducing the number of potentially preventable transitions?
4. Are patient-centered needs of enrollees being met?
5. Has enrollee safety improved over time?

The principal findings and findings and recommendations resulting from analysis of the RQs are:

- Health related quality of life (HRQOL) indicators by setting of care were analyzed for trends across the study period. Most indicators remained the same or improved over the five-year CMS waiver implementation period.
- Focus future Performance Improvement Projects (PIPs) and other ongoing quality evaluations on reducing preventable hospitalizations, specifically those related to diabetes management based on utilizing best practices across all three sites of care. This recommendation is based on the disproportionate number and percentage of preventable hospitalizations that were associated with diabetic issues. (See Table 59.)
- Focus future PIPs and other ongoing quality evaluations on reducing preventable hospitalizations associated with bacterial infection and onsite infections by increasing rates of vaccinations and implementing best practices regarding infection control, specifically in NFs. This recommendation is based on the declining rates of immunizations and incidence of bacterial infections among enrollees who are hospitalized. (See Tables 34 and 42.)
- Improve and/or increase the monitoring of home-based enrollees, especially those recently transferred into the community, for social isolation and increased pain. This recommendation is based upon declining reports of excellent or very good quality of life among home-based enrollees, reports of losses of available help, greater incidence of pain, and limiting daily activities due to fear of falling. (See Table 27.)
- Improve and/or increase the monitoring of quality of care and quality of life for ALF enrollees.

These recommendations are made to recognize, enhance, and promote the value of the Agency's ongoing quality improvement initiatives.

Cost-effectiveness of Care

The evaluation team used the following two RQs, to guide their assessment of cost-effectiveness of care under Florida's SMMC LTC program:

1. How is the magnitude of capitation changing and why? How is the distribution by service category changing, and how is that affecting the magnitude of the capitation?
2. Has a shift between home and community-based services (HCBS) and nursing facility services (NF) affected overall Medicaid costs under the LTC program, and if so, how? How do the average or per member per month (PMPM) costs before and after transition compare for the recipients who transferred into and out of the nursing facility?

The principal findings and recommendations resulting from analysis of the RQs, using quantitative methods, are:

- The Agency's LTC fee-for-service (FFS) claims cost increased at an annual average rate of 1.7 percent. During the same timeframe, LTC enrollment increased by approximately 3.4 percent. Given that the enrollment grew at a faster pace than cost, per member per month (PMPM) cost declined by 1.6 percent per year on average.
- Corrected for higher utilization of services and inflation, direct Medicaid FFS claims costs dropped in real PMPM cost at an average of $1.01 per enrollee, meeting the Agency's goal of cost-neutrality.
- The five-year HCBS and NF services averages (PMPM) were $1,425.84 and $5,525.20 per month, respectively. Shifting LTC program services from more costly NF services to HCBS, meant that for the same funds allocated, more enrollees were provided with LTC program services.
- Nursing facility enrollees showed an overall annualized enrollee decrease of 0.4 percent. Average direct monthly cost for NF services showed an annualized increase of 1.7 percent. This resulted in an annualized NF PMPM cost increase of 2.1 percent (i.e., from PMPM $5,435.84 in SFY2014 - 2015 to $5,903.72 in SFY 2018 - 2019).
- HCBS enrollment showed annualized increases of 11.9 percent. Direct cost also grew at an annualized rate of 17.8 percent. Since HCBS cost had a higher annualized growth rate

over enrollment, HCBS PMPM cost increased at an annualized rate of 5.3 percent (i.e., from $1,276.54 PMPM in SFY2014 - 2015 to $1,568.18 in SFY 2018 - 2019).

Report Prepared By

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Table 1. List of Acronyms.

Acronym	Meaning
A/DA	Aged/Disabled Adult
ADL	Activities of Daily Living
AEC	American Eldercare, Inc.
AFCH	Adult Family Care Homes
AHCA	Agency for Health Care Administration (Florida)
AHRQ	Agency for Healthcare Research and Quality (United States)
ALF	Assisted Living Facility
AMG	Amerigroup Florida, Inc., d/b/a Amerigroup Community Care
CARES	Comprehensive Assessment and Review for Long-term Care Services
CIRTS (DOEA)	Client Information and Registration Tracking System
CIRTS (AHCA)	Complaint Issues Reporting and Tracking System
CMS	Centers for Medicare and Medicaid Services (United States)
COV	Coventry Health Care of Florida
DOEA	Department of Elder Affairs (Florida)
EQRO	External Quality Review Organization
FSU	Florida State University
GAO	United States Government Accountability Office
HCBS	Home and Community-Based Services
HUM	Humana Medical Plan, Inc.
LTC	Long-term Care/The period following the implementation of SMMC LTC
MDS	Minimum Data Set
MOL	Molina Health Care of Florida, Inc.
NF	Nursing Facility
ORS	Other Residential Settings
OTC	Over the Counter
PERS	Personal Emergency Response System
PHQ-9	Patient Health Questionnaire (9 items)
PIPs	Performance Improvement Projects
POC	Plan of Care
Pre-LTC	The period prior to the implementation of SMMC LTC
QM	Quality Measure
RAP	Resident Assessment Protocol
RQ	Research Question
SMMC	Statewide Medicaid Managed Care
SUN	Sunshine State Health Plan, Inc.
URA	UnitedHealthcare of Florida, Inc.

Table 2. Glossary.

Term	Meaning
Case Managers or Case Management	LTC plan employees who deliver case management services to LTC enrollees.
Dually Eligible	LTC recipients or enrollees eligible for Medicare and Medicaid.
Enrollee(s)	Recipients in managed care plans
Frail Elder Option	A Pre-LTC program for qualifying members of the LTC population.
Individual(s)	Persons not yet eligible for Medicaid
Legacy	Programs and waivers in place during the Pre-LTC period.
Legacy Waivers or HCBS Legacy Waivers	HCBS waivers operated by Department of Elder Affairs (DOEA) during the Pre-LTC period: (Aged/Disabled Adult, Assisted Living Waiver, Channeling Waiver, and Nursing Home Diversion).
Participant(s)	Managed Care enrollees who elect the Participant Direction Option
Plans or LTC plans	Managed care plans contracted under the Statewide Medicaid Managed Care (SMMC) plan
Recipient(s)	Individuals eligible for Medicaid regardless of whether or not they are receiving services

Background

In 2011, the Florida Legislature voted to move most Medicaid recipients, including those receiving long-term care (LTC) services, into a managed care system. Specifically, House Bill 7107 created Part IV of Chapter 409 of Florida Statutes to establish the Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program for Medicaid recipients who are (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; and (b) determined to require nursing facility (NF) level of care.[2] The Florida Agency for Health Care Administration (AHCA), hereinafter referred to as "the Agency," subsequently submitted a 1915(b) and 1915(c) waiver application to the Centers for Medicare and Medicaid Services (CMS) requesting to implement the Florida Long-term Care Managed Care Program. The Agency received approval for both waivers from CMS on February 1, 2013 and began administering the program in partnership with the Department of Elder Affairs (DOEA).

The Agency used a staggered rollout schedule to successively introduce the program in eleven regions of the state starting in August 2013 and concluding in March 2014. Approximately 83,000 Medicaid recipients were moved from the previous multi-waiver, mixed reimbursement system[3] directed by the state to a managed care model using capitated payments to private managed care plans. In addition, over 100,000 new[4] Medicaid recipients who did not receive LTC services prior to August 2013 have been enrolled in the LTC program since the state implemented it. The Legislature directed the Agency to adjust managed care plan capitated rates annually, to provide an incentive to shift services from nursing facilities (NF) to home and community-based settings (HCBS). Seven[5] managed care plans were contracted by the Agency to provide LTC services to nearly all Medicaid recipients who met the financial qualifications and level of care requirements. Each of the state's eleven regions has at least two managed care plans offering services to enrollees. A secondary rollout period necessitated by the re-procurement process saw the addition of three new plans and removal of one original plan between December 2018 and February 2019. As of February 2019, there were eight plans operating in the state that offer LTC services to program enrollees.

[2] Long-term Care recipients in certain legacy waiver programs were initially allowed to voluntarily transition to the Statewide Managed Medical Care Long-term Care (SMMC LTC) if they were also receiving long-term care services and met LTC program criteria: Developmental Disabilities, Model, Traumatic Brain and Spinal Injury, Project AIDS Care, Adult Cystic Fibrosis, and Familial Dysautonomia Waiver participants as well as those receiving services under the Program of All-Inclusive Care for the Elderly. All other eligible Medicaid recipients of LTC services in the pre-LTC era were required to transition into the SMMC LTC program. This population included those meeting eligibility requirements who were receiving services under any of the five waivers described in footnote 2 below as well as those receiving Medicaid funded long-term nursing facility care. As of January 1, 2018, all participants were mandatorily enrolled into SMMC LTC.

[3] Pre-LTC reimbursement systems for waivers required to transition by law were structured as follows: the Aged & Disabled Adult waiver used a fee-for-service reimbursement system; the Nursing Home Diversion waiver used a risk-adjusted, capitated monthly rate system; the Assisted Living for the Elderly waiver used a mixed system, with assisted living services reimbursed at a daily rate, case management services reimbursed at a monthly rate, and incontinence supplies reimbursed at a monthly use-based rate; the Channeling for the Frail Elder waiver used a contracted per-person daily rate.

[4] For the purposes of this report anyone who enrolled in the LTC program starting in August 2013 through June 2018 and did not receive LTC services through Florida Medicaid prior to August 2013 is designated a "new" enrollee.

[5] In September 2013 Humana received regulatory approval to acquire American Eldercare, Inc. The plans officially merged in July 2015, after which there were only six LTC plans in operation in the state.

The federally approved SMMC LTC waiver includes a requirement for independent assessment of the SMMC LTC program. The Agency contracted with Florida State University (FSU) College of Medicine to conduct the required assessments of the first two waiver periods as well as annual assessments of the program. The evaluation team at FSU analyzed Agency-provided administrative data. The FSU team previously examined access to care, quality of care, and cost of care in separate comprehensive reports for state fiscal years (SFYs[6]) 2013 - 2014 and 2014 - 2015. The evaluation period for this report is SFY 2014 - 2015 through SFY 2018 - 2019.

The Agency is responsible for making payments to the managed care plans, adjusting capitation rates to reflect budgetary changes in the Medicaid program, and reconciling payments for nursing facilities and hospices. The Agency's goals for the managed LTC program include the following:[7]

- Enhance fiscal predictability and financial management by converting the purchase of Florida Medicaid services to capitated, risk-adjusted, payment systems,
- Transition LTC individuals who wish to go home from nursing facility care to assisted living or their own homes,
- Improve patient centered care, personal responsibility, and active patient participation,
- Provide recipients with a choice of plans and benefit packages,
- Improve the health of recipients and not just pay claims when people are sick,
- Promote an integrated health care delivery model that incentivizes quality and efficiency, and
- Increase accountability and transparency.

Managed care plans must have centralized executive administration and adequate staffing, as well as information systems capable of ensuring they can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter, or other necessary data to the Agency and its affiliates. The managed care plans are required to report financial information to the Agency, including quarterly and annual financial statements. The Agency maintains a system for processing and storing this information. For encounter

[6] Each state fiscal year encompasses July 1 through June 30 of two consecutive calendar years.
[7] Kidder, B., Statewide Medicaid Managed Care Program, January 2017. Retrieved from: https://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf

records, this processing includes data validation. The Agency also established functions and activities governing program integrity to reduce the incidence of fraud and abuse.

Florida's LTC program employs a shared-savings model, known as the achieved savings rebate (ASR), under which the Agency calculates a managed care plan's pretax income as a percentage of revenues. Managed care plans are required to share their income with the Agency based on three revenue tiers[8] and ultimately may retain up to 7.5 percent of pretax revenue as income. Moreover, a managed care plan that exceeds the Agency's quality measures to achieve better health outcomes for enrollees may retain an additional 1 percent of that revenue.

Program Monitoring for Program Integrity, Compliance, and Data Quality

- The state's process for monitoring the program improved over the past five years. Report Guide spreadsheets were completed and submitted by the plans in a more standardized format with fewer data entry errors.
- The Agency has used compliance actions of various types to incentivize the plans to make changes and improvements when plans were deficient in some aspect of contract compliance.
- In general, the Agency has made gradual but continuous progress in its efforts to improve data used by the evaluation team.

To comply with CMS guidance, the evaluation team reviewed External Quality Review Organization (EQRO) reports as part of this report. The EQRO found that the LTC plans continued to have adequate validation processes in place to ensure data completeness and accuracy for reporting year (RY) 2019. Additionally, the LTC plans were compliant with all NCQA HEDIS Compliance Audit Information Systems (IS) standards. The EQRO had no concerns with the data systems and processes used by the LTC plans for measure calculations based on the information presented in the final audit reports (FARs).

[8] a. 100% of income up to and including 5% of revenue shall be retained by the plan;
b. 50% of income above 5% and up to 10% shall be retained by the plan, with the other 50% refunded to the state;
c. 100% of income above 10% of revenue shall be refunded to the state.

Access to Care

Purpose

The Independent Assessment of the Florida Statewide Medicaid Managed Care Long-Term Care Program examined the impact on enrollees' access to care during the five consecutive state fiscal years between July 2014 and June 2019. The evaluation team and the Agency identified key issues of importance to policy makers and LTC stakeholders. The evaluation team, in concert with the Agency, developed five research questions (RQs) to guide the evaluation, which uses quantitative analysis of administrative data to support findings. Appendix 1 to this report provides additional information on the methodology and data sources for assessing enrollees' access to care.

The five RQs guiding this evaluation are as follows:

1. Have there been changes in the accessibility of services for enrollees over time?
2. How has the population served in the LTC program shifted (characteristics of the population and service utilization) between nursing facilities (NFs) and home and community-based services (HCBS) over time? What LTC plan strategies are impacting these shifts?
3. What are the levels of service utilization for enrollees prior to transitioning into the NF?
4. Do plans offer additional (expanded) benefits and ways to access services, including a Participant Directed Option (PDO), and to what extent do enrollees use these services?
5. Are there disparities by racial and ethnic groups in enrollees' placements in certain settings and utilization of services?

Findings

RQ1: Have there been changes in the accessibility of services for enrollees over time?

As more and more enrollees shift out of nursing facilities (NFs) and into home and community-based services (HCBS), one major area of concern is potential changes in the accessibility of services over time. As more enrollees' transition into HCBS settings, the LTC plans should maintain levels of service for the existing HCBS population and provide similar levels of service to new enrollees. Levels of service utilization should track with objective measures of need for help with Activities of Daily Living (ADLs). In other words, enrollees should have equal access to services and higher levels of utilization are expected to be reflected in administrative encounter data for enrollees with greater needs. The analysis for RQ1 responds to these concerns by assessing changes in service utilization over time and exploring the relationship between service utilization and enrollees' functional status, as measured by their ability to carry out several activities of daily living.

I. Trends in service utilization over time

One of the goals of the LTC Program is to reduce the proportion of LTC enrollees who reside in NFs and increase the proportion in HCBS settings. Table 3 (columns 7-11) shows the mean monthly counts of enrollees who received HCBS and which count increased over time for many - including the most widely used - service categories. Table 3 also presents the mean monthly percentage of unique HCBS enrollees who received a given service in each state fiscal year (columns 2-6). Not only has mean monthly counts of enrollees who received the most prevalent services increased over time, as expected, but also the proportions of total HCBS enrollees who received these services increased over time, although lesser used services remain flat. Notable exceptions were assisted living and respite care services; both trend down over time.

Over the five-year research period, higher proportions of HCBS enrollees received adult companion care, adult day health care, Home-Delivered Meals, homemaker, medical equipment and supplies, personal care, personal emergency response systems (PERS), and transportation services. In contrast and as stated above, lower proportions of enrollees resided in assisted living facilities (ALFs) and received respite care over time. Considered together, these results were compatible. If the proportion of enrollees residing in ALFs is decreasing, then the proportion receiving HCBS should increase, which is exactly what the results indicate. Note that to be counted for the month, an enrollee needed to receive at least one unit of service for a procedure code that falls under the service category.

Table 3 provides an overview of service utilization over time. It is apparent that five services (Assisted Living, Home-Delivered Meals, Homemaker Services, Intermittent and Skilled Nursing, and Personal Care) account for 85 percent of the services utilized over the five-year period. Differences over time are observed for most service categories. However, it is unclear whether those differences represent statistically meaningful changes. As a result, the apparent trends were tested for statistical significance in Table 4. Table 5 quantifies the intensity of the services utilized by LTC enrollee.

Table 3. Mean Monthly Percentage and Count of Enrollees in HCBS Settings Receiving Each LTC Service.

LTC Service Category	Mean Monthly percentage of HCBS Enrollees Receiving Service					Mean Monthly Count of HCBS Enrollees Receiving Service				
	SFY 2015[A]	SFY 2016	SFY 2017	SFY 2018	SFY 2019[B]	SFY 2015[A]	SFY 2016	SFY 2017	SFY 2018	SFY 2019[B]
Adult Companion Care	10.1%	12.1%	14.4%	15.4%	16.3%	3,927	5,447	7,131	8,582	9,818
Adult Day Health Care	6.9%	7.8%	7.9%	8.1%	8.1%	2,680	3,506	3,907	4,490	4,850
Assisted Living	30.2%	28.7%	28.2%	26.0%	26.3%	11,661	12,875	13,952	14,437	15,818
Assistive Care Services	0.0%	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0
Attendant Care	0.6%	0.4%	0.4%	0.4%	0.2%	213	180	208	223	127
Behavioral Management	0.3%	0.2%	0.2%	0.2%	0.2%	116	107	111	123	132
Caregiver Training	0.0%	0.0%	0.0%	0.0%	0.0%	4	3	4	1	1
Case Management[C]	8.8%	7.1%	6.7%	2.8%	2.8%	3,389	3,174	3,305	1,564	1,704
Home Accessibility	0.2%	0.2%	0.2%	0.2%	0.2%	82	100	113	107	106
Home-Delivered Meals	23.6%	26.0%	27.9%	27.3%	26.6%	9,130	11,697	13,813	15,151	15,985
Homemaker Services	39.4%	44.0%	46.8%	48.3%	48.4%	15,260	19,784	23,211	26,840	29,113
Intermittent & Skilled Nursing	0.7%	0.6%	0.7%	0.7%	0.8%	271	274	334	396	453
Medical Equipment/Supplies	30.7%	36.5%	40.6%	42.9%	43.2%	11,869	16,419	20,163	23,839	25,988
Medication Administration	0.1%	0.1%	0.1%	0.1%	0.0%	30	43	38	34	30
Medication Management	0.4%	0.7%	0.1%	0.1%	0.1%	138	321	35	38	44
Nutritional Assessment	0.1%	0.1%	0.1%	0.0%	0.0%	30	30	26	5	0
Occupational Therapy	0.1%	0.1%	0.1%	0.1%	0.1%	23	28	40	73	70
Personal Care	40.3%	44.7%	47.2%	49.2%	48.6%	15,601	20,083	23,403	27,325	29,226
PERS	17.5%	18.7%	20.6%	20.6%	21.2%	6,781	8,409	10,211	11,468	12,772
Physical Therapy	0.2%	0.2%	0.3%	0.3%	0.3%	66	87	134	178	199
Respiratory Therapy	0.0%	0.0%	0.0%	0.0%	0.1%	5	7	9	16	31
Respite Care	8.8%	9.6%	9.8%	7.9%	6.7%	3,390	4,311	4,838	4,373	4,016
Speech Therapy	0.0%	0.0%	0.0%	0.0%	0.0%	5	9	15	23	25
Transportation	3.1%	3.8%	3.3%	5.1%	5.3%	1,205	1,713	1,657	2,820	3,214

Note: The mean monthly count of HCBS enrollees was 38,659 in SFY 2015, 44,902 in SFY 2016, 49,584 in SFY 2017, 55,569 in SFY 2018, and 60,162 in SFY 2019.
Note: The underlying population of the LTC program grew during this time period.
[A] Excludes July 2014 and August 2014 because AEC was a FFS-based plan.
[B] Excludes the second half of SFY 2019 (i.e., all of 2019) because encounter records appear to be underrepresented for the new plans added under the new contract.
[C] Not an accurate representation of case management services; most plans handle case management internally and, thus, do not have case management encounters.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records

Table 4 presents the results of tests for each trend in the proportion of HCBS enrollees who received a given LTC service.[9] The table is limited to categories in which at least 1 percent of HCBS enrollees received services (on average each month). The results indicate that all positive monthly trends were statistically significant, except for home-delivered meals. In addition, the downward trend in the proportion of enrollees residing in assisted living facilities (ALFs) is statistically significant. If access to care were diminishing over

[9] See the Appendix for plots showing the actual and fitted trends. Analysis for a few categories is potentially confounded where some plans' reporting was inconsistent. The Appendix highlights these inconsistencies, although they appear unlikely to have altered the direction nor the interpretation of any of the trends.

time due to increasingly higher numbers of enrollees residing in HCBS settings, the trends in Table 3 would all be statistically significant in the negative direction. Instead, the trends were all positive, except for ALF services. Hence, there is no evidence that increases in enrollees who received HCBS impacts the accessibility of HCBS. Nevertheless, this metric does not capture the intensity of service utilization, which is examined in Table 5.

Table 4. Mean Monthly Linear Trends in the Percentage of HCBS Enrollees Receiving Each LTC Service Over Time for Selected Service Categories, SFY 2014-2015 to SFY 2018-2019.

LTC Service Category	Monthly trend
Adult Companion Care	+0.14%*
Adult Day Health Care	+0.02%*
Assisted Living	-0.11%*
Home-Delivered Meals	+0.06%
Homemaker Services	+0.21%*
Medical Equipment and Supplies	+0.27%*
Personal Care	+0.19%*
PERS	+0.08%*
Respite Care	-0.03%
Transportation	+0.05%*

*Significant at the p < .005 level (Bonferroni adjusted alpha level)
Notes: Same exclusions apply as in Table 1. For full model results see the Appendix.
Note: The underlying population of the LTC program grew during this time period.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records

Examination of service intensity for the most widely received services is presented in Table 5. Note that 1) services using different units of time were rescaled to allow for a single measure of intensity (i.e. in hours) for each service category (see also Table 84), and that 2) use of respite care services are influenced by enrollee need and caregiver need. Table 5 indicates increases in the mean monthly intensity for the most commonly received services. Between SFY 2014 - 2015 and SFY 2018 - 2019, the following changes in mean units of service per month were observed:

1) adult companion care increased by 7 hours per month (standardized beta = 0.99, p=0.0021),
2) adult day health care increased by 11.5 hours per month (standardized beta = 0.99, p=0.0022),
3) homemaker services increased by 5.5 hours per month (standardized beta = 0.98, p=0.0035),
4) personal care services increased by 12.75 hours per month (standardized beta = 0.99, p=0.0003),
5) home delivered meals remained flat at 28-29 meals per month (no change, p=0.1818), suggesting delivery on practically every day of each month,
6) transportation trips increased from 35 to 58 trips and then declined to 33 trips per month (no change, p=0.8859), and
7) respite care services (no change, p=0.8342).

These estimates are not adjusted for differences in enrollee characteristics, plan, or state region.

Table 5. Mean Units of Service Received per Month Over Time for Selected Service Categories.

LTC Service Category	Mean Units (Hours) of Service Received per Month (STD)					Unit
	SFY 2015[A]	SFY 2016	SFY 2017	SFY 2018	SFY 2019[B]	
Adult Companion Care	24.75 (0.75)	25.50 (0.75)	28.50 (1.00)	30.50 (1.75)	31.75 (0.75)	Hours
Adult Day Health Care	123.50 (6.75)	128.00 (5.25)	130.75 (6.25)	133.00 (8.75)	135.00 (6.00)	Hours
Home-Delivered Meals	28 (1)	28 (1)	28 (1)	28 (1)	29 (1)	Meals
Homemaker Services	21.75 (0.75)	23.00 (0.75)	25.50 (1.00)	26.00 (1.00)	27.25 (0.75)	Hours
Personal Care	38.00 (1.25)	40.00 (1.25)	44.00 (1.50)	47.25 (2.25)	50.75 (1.00)	Hours
Respite Care	34.25 (1.25)	35.00 (1.00)	37.75 (1.25)	33.75 (1.75)	34.25 (1.00)	Hours
Transportation	35 (3)	40 (5)	58 (7)	50 (12)	33 (10)	Trips

[A & B] Same exclusions apply as in Table 1.
Note that PERS is excluded because enrollees only receive one unit per month once the service has been installed. Medical equipment and supplies were excluded due to the wide variability in supply types and the resulting uncertainties in interpretation of changes at the aggregate level. Changes at the enrollee level for this service category are, however, more meaningful.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records

II. Change in service utilization in relation to change in ADL needs.

Ideally, services track with enrollees' individual needs. Need for services are difficult to measure, but a reasonable proxy is enrollees' ADL needs. One would expect that changes in bathing, dressing, eating, toileting, transferring, or walking abilities result in parallel changes in service needs, especially for enrollees who experience sudden, severe ADL limitations. Therefore, the evaluation team developed statistical models designed to assess whether the intensity of services escalated/declined for enrollees who experience changes in their ADL needs. Note that this analysis excludes any enrollees who resided in ALFs because ALFs provide comprehensive LTC services that were not measurable via encounter data. For instance, if a person receives personal care services in an ALF, this service is not usually reported as a separate encounter. Any attempt to measure changes for those who resided in an ALF and then moved into a home-based setting, or vice versa, could overestimate changes in service utilization, regardless of any change in ADL needs.

Based on each enrollee's 701B comprehensive assessment[10] via the Client Information and Registration Tracking System (CIRTS) and LTC encounter records, the evaluation team calculated all changes in ADL needs, changes in the intensity of service use (within each service category), and changes in relevant

[10] DOEA staff first perform these assessments to determine if Medicaid recipients who apply for LTC services meet the eligibility requirements, viz., require nursing facility level of care. Case managers are then required to complete assessments for home and community-based enrollees on at least an annual basis to track enrollees' functional, health, and cognitive status as well as their existing support systems.

covariates between each instance of a new CIRTS assessment record for qualifying[11] enrollees. The analysis includes measures of four separate ADL needs: hygiene needs (bathing and dressing combined), eating needs, toileting needs, and mobility needs (transferring and walking combined). Each need is measured on a scale from 0-4, with 0 indicating "no assistance needed" and 4 indicating "total assistance needed."

For each of the nine service categories that met the 1% utilization threshold, the analysis team assessed the relationship between changes in the mean units of service received per 30 days and changes in enrollees' ADL needs. Table 5 presents the results. Changes in hygiene needs were positively related to changes in service intensity for adult companion care and personal care services. Specifically, when holding other conditions related to service use (e.g., caregiver availability) constant, for every 1-point increase in an enrollee's hygiene needs score, their expected units of service increased by about 4.3 minutes per month for adult companion care services, and about 27.2 minutes per month for personal care services (see highlights). Unexpectedly, changes in mobility needs were related to the use of personal emergency response systems in the opposite direction. However, it is unlikely that this relationship is meaningful.[12]

Because individual service needs, and preferences vary - even for enrollees with the same ADL scores - a combined measure of intensity may more fully capture the relationship between need and use. Adult companion care, adult day health care, homemaker, personal care, and respite care services were all measurable in minutes. The evaluation team created a blended measure of intensity for services that were measured in the same type of units. All but respite care was combined into one measure of intensity. Respite care was excluded because receipt is highly contingent on unmeasurable factors affecting primary caregivers. The results indicate that, when holding other conditions related to service use constant, a 1-point increase in an enrollee's hygiene needs score was associated with an additional half-hour (30.8 minutes) of services each month. The results for changes in toileting needs, which were marginally significant (p = 0.0187, see Appendix A) after correcting for multiple tests of significance, indicate that changes in toileting needs may also be similarly associated with a higher intensity of services. A 1-point increase in an enrollee's toileting needs score was associated with an additional 26.3 minutes of services each month.

[11] See Appendix A.

[12] Going from needing no help with mobility to total assistance with mobility would reduce the proportion of months with a PERS by 0.2%. For a full year, this represents a reduction in PERS services for about 1 day per year, which is a meaningless quantity when an enrollee can either receive (1 UOS) or not receive (0 UOS) PERS services in a given month.

Table 6. Expected Change in Mean Units of Service per Month as a Function of Change in ADL Needs for Selected Service Categories.

LTC Service Category	ADL	Change	Unit Type
Adult Companion Care	Hygiene	4.3*	minutes
	Eating	1.4	minutes
	Toileting	0.3	minutes
	Mobility	0.4	minutes
Adult Day Health Care	Hygiene	-5.1	minutes
	Eating	-9.1	minutes
	Toileting	10.6	minutes
	Mobility	-5.3	minutes
Home-Delivered Meals	Hygiene	0.0	meals
	Eating	-0.1	meals
	Toileting	0.0	meals
	Mobility	0.0	meals
Homemaker Services	Hygiene	4.4	minutes
	Eating	-0.1	minutes
	Toileting	5.1	minutes
	Mobility	-0.1	minutes
Medical Equipment and Supplies	Hygiene	0.3	items
	Eating	0.1	items
	Toileting	0.1	items
	Mobility	0.0	items
Personal Care	Hygiene	27.2*	minutes
	Eating	6.0	minutes
	Toileting	10.4	minutes
	Mobility	6.1	minutes
PERS[13]	Hygiene	0.1	% of months
	Eating	-0.1	% of months
	Toileting	-0.2	% of months
	Mobility	-0.2*	% of months
Respite Care	Hygiene	1.2	minutes
	Eating	0.7	minutes
	Toileting	1.5	minutes
	Mobility	1.9	minutes
Transportation	Hygiene	0.0	trips
	Eating	0.0	trips
	Toileting	-0.1	trips
	Mobility	0.0	trips
Adult Companion Care, Adult Day Health Care, Homemaker Services, Personal Care, combined	Hygiene	30.8*	minutes
	Eating	-1.7	minutes
	Toileting	26.3	minutes
	Mobility	1.0	minutes

*Significant at Bonferroni adjusted alpha level of 0.00125.

Note: For full model results see the Appendix. Each model controls for changes in caregiver status (loss or gain), significant weight loss (5% bodyweight or more), health shocks (new amputation, cancer diagnosis, diabetes diagnosis, cardiac problems, kidney disease, liver disease, lung problems, Parkinson's diagnosis, paralysis event(s), seizure event(s), stroke event(s), and/or tumor occurrences), aggregate changes in IADL needs, changes in the number of inpatient days between periods, percent change in the length of each period, changes in plan membership, changes in region of residence, and quarter of measurement.

Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility data (for demographic information), FL Center inpatient data, 701B Assessments

[13] Since an enrollee can only receive one PERS UOS per month, PERS service use was measured differently than the other services. The analyst measured this service use as the proportion of months an enrollee had a PERS during each period.

III. Time to First Service Delivery (home-based enrollees only)

The time to first service delivery provides a crude measure of the timeliness of LTC services. This measure is limited to new enrollees who entered into the LTC program at some point during the evaluation period and who also resided in a home-based setting upon program entry.[14] Time to first service delivery is calculated as the number of days from program entry to first service receipt. If an enrollee received a service on their entry date, then the time to first service delivery is zero days. Table 7 presents the mean number of days until first LTC service delivery stratified by year of entry for enrollees who already resided in a home-based setting when they entered the program; 48,529 total enrollees were included in the table. The time to first service delivery hovered at around 20 days on average, except for SFY 2016 - 2017 when it dropped to a low of 15 days. Not surprisingly, the most common first services track closely with the most commonly received HCBS services reported in Table 5. In order of commonality, the top five most common first services received are personal care, homemaker, medical equipment and supplies, home-delivered meals, and adult day health care services. Overall, LTC home-based enrollees received their first service less than a month from their first enrollment date.

Table 7. Mean Number of Days until First Service Delivery.

Year of Entry	Number of New Home-based Enrollees (after July 1, 2014)	Mean Number of Days (STD)
SFY 2015	8,312	19.3 (40.6)
SFY 2016	9,682	20.3 (39.0)
SFY 2017	11,199	15.0 (34.2)
SFY 2018	12,950	21.1 (41.1)
SFY 2019[A]	6,386	22.2 (39.5)

[A] Excludes the second half of SFY 2018-2019 (i.e., all of 2019), for mentioned reason.

Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records

IV. Summary of RQ1 Findings

The absolute number of enrollees who received the most common services are increasing over time and the proportions of total HCBS enrollees who received these services are also increasing over time. However, changes in service use as related to changes in need for assistance with ADLs is a stronger indicator of the program responding to the needs of the HCBS population. The evaluation team found that changes in hygiene needs were positively related to changes in service intensity for LTC service categories of adult companion care and personal care services. These correlations provide face validity to the interpretation that service delivery to enrollees increased as the need in enrollees became greater.

Timeliness of receiving services is also an important aspect of access to care. Overall, LTC home-based enrollees received their first service less than a month from their first enrollment date. This is a positive finding for the LTC program. However, other factors, not included in this analysis, may have influenced timeliness. For example, frailty may hinder the enrollees' effective connection and scheduling tasks with

[14] Enrollees who reside in ALFs are excluded, as facilities often provide comprehensive services that are not captured by the encounter data.

the provider network. Likewise, the availability of support from family and friends may facilitate timely connection and follow-up with the provider network and thereby enhance timeliness of service delivery.

The findings for RQ1 are encouraging but the interpretation cannot conclude a causal relationship because the study design does not rule out other possible explanations. Addition of a concurrent comparison population or the Florida population prior to statewide managed LTC as a comparison group would strengthen the ability to infer causal relationships.

RQ2: How has the population being served in the LTC program shifted (characteristics of the population and service utilization) between NFs and HCBS over time? What LTC plan strategies are impacting these shifts?

Reducing the proportion of LTC program enrollees who receive care in a NF and increasing the proportion who receive care in HCBS settings is an important policy goal of the State. When the Legislature designed the Statewide Medicaid Managed Care program, it included in Florida Statutes an incentive to encourage the transitions from nursing facility to community-based care. The incentive is in the form of a mandatory adjustment to the monthly, all-inclusive capitation rates that the Agency pays the LTC plans for each LTC enrollee. These rate adjustments target a rate of transition from nursing facility to community of two to three percent per year. The statute[15] requires this rate incentive to continue until no more than 35 percent of a plan's enrollees are residing in nursing facilities. Hence, RQ2 examines global location of care rates as well as shifts in these rates over time. Given the frailty and vulnerability of the LTC program population, central to this RQ is an assessment of the success of transitions into HCBS settings for enrollees who once resided in nursing facility settings. Accordingly, an accurate monthly location of care record for each enrollee is essential. The evaluation team relied on LTC encounter data and minimum data set (MDS) records to determine enrollees' location of care in a given month. Readers should refer to Appendix A for a detailed description of the methodology.

I. Trends in Enrollee Locations of Care Over Time

Table 8 summarizes enrollee month counts by NF and HCBS locations of care for each fiscal year. This table provides a gross overview of how the population of LTC enrollees shifted over time. There was a reduction in the number of enrollee months in which enrollees resided in NFs from the first fiscal year of the evaluation (54.9% of total enrollee months in SFY 2014 - 2015) to the final fiscal year of the evaluation (43.2% of total enrollee months in SFY 2018 - 2019) and a corresponding increase in the number of enrollee months in which enrollees resided in HCBS settings (45.1% of total enrollee months in SFY 2014 - 2015 versus 56.8% in SFY 2018 - 2019). This simple metric reveals that the plans were fulfilling the Florida Legislature's stated policy goal of shifting enrollees into HCBS settings. Additional analysis presented below provides deeper insight into the population shifts over time.

[15] Florida statute 409.983(5)

Table 8. Total Enrollee Months by Location of Care.

State Fiscal Year	Total Enrollee-Months	Count of NF Months	Proportion NF Months	Count of HCBS Months	Proportion HCBS Months
SFY 2015	1,020,188	560,088	54.9%	460,100	45.1%
SFY 2016	1,085,418	546,599	50.4%	538,819	49.6%
SFY 2017	1,138,626	543,617	47.7%	595,009	52.3%
SFY 2018	1,201,312	534,489	44.5%	666,823	55.5%
SFY 2019	1,285,991	555,391	43.2%	730,600	56.8%
All Combined	5,731,535	2,740,184	47.8%	2,991,351	52.2%

Source: FSU created enrollee LOC file

Table 9 and Figure 1 present enrollee location of care rates over time. Nursing facility residency rates decreased at a fairly constant rate, approximately 3 percentage points each year, throughout the first four fiscal years. They appear to have plateaued in the final fiscal year of the evaluation period. This may be a temporary condition, such that the downward trend will resume in future years. Alternatively, it could represent characteristics of the LTC population related to need for assistance that made nursing facilities a more appropriate care setting.

These results indicate that the LTC plans steadily transitioned enrollees into HCBS settings during the first four full program years, yet it remains unclear whether changes in these residency rates are driven by plans enrolling persons newly eligible for the LTC program who already reside in HCBS settings or by shifting earlier program entrants who resided in NFs out of these facilities and into HCBS settings. Table 9 addressed that distinction.

Table 9. Enrollee Location of Care Rates Over Time.

State Fiscal Year	Month	Count Unique Enrollees	Number in NFs	Proportion in NFs	Number in HCBS settings	Proportion in HCBS settings
SFY 2015	Jul.	83,275	46,566	55.9%	36,709	44.1%
	Aug.	83,282	46,478	55.8%	36,804	44.2%
	Sep.	83,471	46,617	55.8%	36,854	44.2%
	Oct.	84,139	46,863	55.7%	37,276	44.3%
	Nov.	84,762	46,968	55.4%	37,794	44.6%
	Dec.	85,077	46,929	55.2%	38,148	44.8%
	Jan.	85,264	46,669	54.7%	38,595	45.3%
	Feb.	85,156	46,397	54.5%	38,759	45.5%
	Mar.	85,797	46,550	54.3%	39,247	45.7%
	Apr.	86,167	46,654	54.1%	39,513	45.9%
	May	86,711	46,642	53.8%	40,069	46.2%
	Jun.	87,087	46,755	53.7%	40,332	46.3%
SFY 2016	Jul.	87,498	44,890	51.3%	42,608	48.7%
	Aug.	88,371	45,319	51.3%	43,052	48.7%
	Sep.	89,244	45,594	51.1%	43,650	48.9%
	Oct.	89,838	45,700	50.9%	44,138	49.1%
	Nov.	90,575	45,893	50.7%	44,682	49.3%
	Dec.	90,940	45,911	50.5%	45,029	49.5%

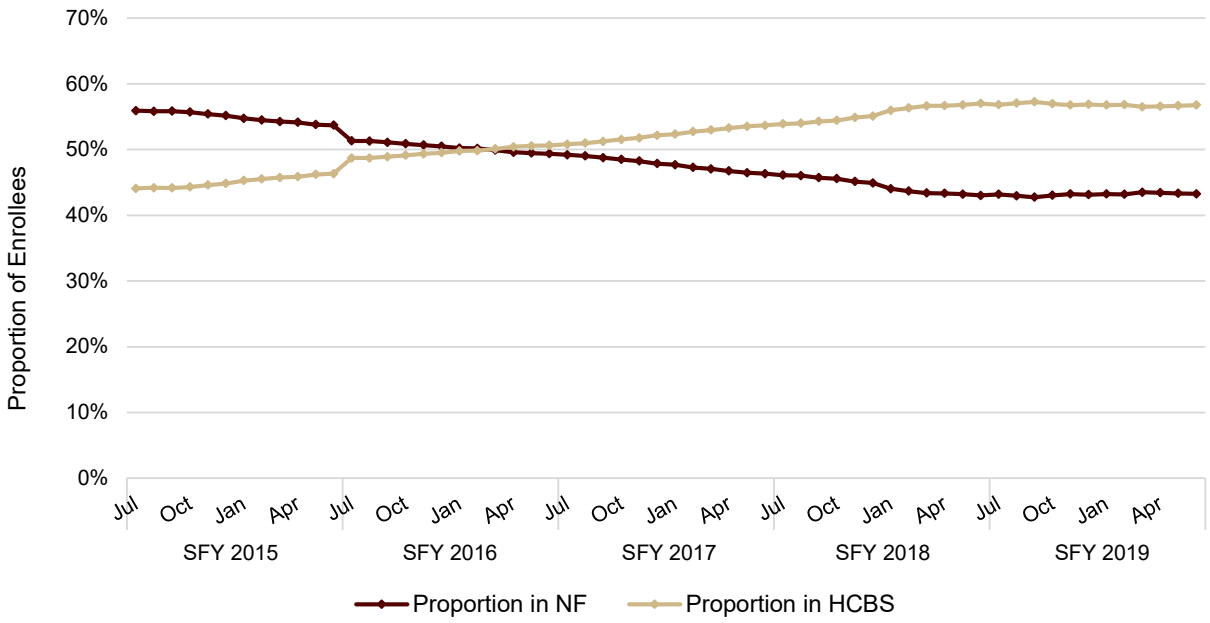
Table 9. Enrollee Location of Care Rates Over Time (cont.)

State Fiscal Year	Month	Count Unique Enrollees	Number in NFs	Proportion in NFs	Number in HCBS settings	Proportion in HCBS settings
SFY 2016	Jan.	91,055	45,728	50.2%	45,327	49.8%
	Feb.	91,010	45,659	50.2%	45,351	49.8%
	Mar.	91,224	45,530	49.9%	45,694	50.1%
	Apr.	91,455	45,353	49.6%	46,102	50.4%
	May	91,817	45,407	49.5%	46,410	50.5%
	Jun.	92,391	45,615	49.4%	46,776	50.6%
SFY 2017	Jul.	92,789	45,646	49.2%	47,143	50.8%
	Aug.	93,202	45,689	49.0%	47,513	51.0%
	Sep.	93,721	45,703	48.8%	48,018	51.2%
	Oct.	94,445	45,783	48.5%	48,662	51.5%
	Nov.	94,671	45,663	48.2%	49,008	51.8%
	Dec.	94,871	45,394	47.8%	49,477	52.2%
	Jan.	95,250	45,412	47.7%	49,838	52.3%
	Feb.	95,098	44,953	47.3%	50,145	52.7%
	Mar.	95,210	44,787	47.0%	50,423	53.0%
	Apr.	95,845	44,795	46.7%	51,050	53.3%
	May	96,326	44,768	46.5%	51,558	53.5%
	Jun.	97,198	45,024	46.3%	52,174	53.7%
SFY 2018	Jul.	97,855	45,117	46.1%	52,738	53.9%
	Aug.	98,681	45,413	46.0%	53,268	54.0%
	Sep.	99,348	45,420	45.7%	53,928	54.3%
	Oct.	98,971	45,108	45.6%	53,863	54.4%
	Nov.	98,950	44,650	45.1%	54,300	54.9%
	Dec.	99,499	44,688	44.9%	54,811	55.1%
	Jan.	100,831	44,410	44.0%	56,421	56.0%
	Feb.	100,672	43,959	43.7%	56,713	56.3%
	Mar.	100,743	43,693	43.4%	57,050	56.6%
	Apr.	101,295	43,899	43.3%	57,396	56.7%
	May	101,905	44,030	43.2%	57,875	56.8%
	Jun.	102,562	44,102	43.0%	58,460	57.0%
SFY 2019	Jul.	103,041	44,506	43.2%	58,535	56.8%
	Aug.	103,966	44,656	43.0%	59,310	57.0%
	Sep.	105,057	44,906	42.7%	60,151	57.3%
	Oct.	105,825	45,538	43.0%	60,287	57.0%
	Nov.	108,267	46,812	43.2%	61,455	56.8%
	Dec.	107,688	46,454	43.1%	61,234	56.9%
	Jan.	107,002	46,257	43.2%	60,745	56.8%
	Feb.	107,213	46,309	43.2%	60,904	56.8%
	Mar.	108,430	47,177	43.5%	61,253	56.5%
	Apr.	108,857	47,270	43.4%	61,587	56.6%
	May	109,981	47,648	43.3%	62,333	56.7%
	Jun.	110,664	47,858	43.2%	62,806	56.8%

Source: FSU created enrollee LOC file

Figure 1 plots the information from Table 9 to visually display the decline in nursing facility residency rates over the first 4 full program years and subsequent plateau in SFY 2018 - 2019.

Figure 1. Proportion of Enrollees Residing in a Nursing Facility or HCBS Setting Over Time



Source: FSU created enrollee LOC file

II. Shifts between Locations of Care and Transition Success Rates

Table 10 summarizes shifts between locations of care for LTC enrollees, including rates of successful versus unsuccessful transitions into the community, in the first five full program years. The summary statistics provide a glimpse into how successful LTC plans were at transitioning the LTC population into less restrictive settings, with the assumption that they should aim to minimize the number of times frail enrollees relocate. A transition into the community was considered successful when an enrollee shifted out of a NF and into a HCBS setting where s/he subsequently resided for at least six months. Conversely, an unsuccessful transition is any transition into the community from a NF after which an enrollee returned to a NF within fewer than six months. A NF stay is considered an interruption in HCBS services when an enrollee transitioned into a NF where s/he subsequently resided for fewer than three months. These incidents frequently followed inpatient hospital stays, so they likely represent spells of acute care. Shifts and transitions are labeled indeterminate when there was insufficient observation time to determine whether an enrollee reached the three or six-month threshold (due to loss of eligibility, death, or relocating toward the end of the evaluation period[16]).

Overall, transition attempts were more likely to be successful than unsuccessful. Specifically, 21,754 enrollees were in a nursing facility at the start of the evaluation period or, if enrolled later, were in a nursing

[16] The evaluation team did not have eligibility data beyond June of 2019.

facility during their first month of enrollment who then transitioned into the community at some point during the observation period. The transition was successful for 13,683 enrollees, unsuccessful for 5,258 enrollees, and indeterminate for 2,813 enrollees.[17] Limiting the scope to enrollees for which the outcome is known, 72.2 percent of transitions were successful, while 27.8 percent were unsuccessful. Transitions were more than twice as likely to be successful than unsuccessful.

Subsequent analysis examines potential strategies impacting enrollee shifts.

[17] Starting in a nursing facility and shifting four or more times is considered an unsuccessful transition attempt(s).

Table 10. Shifts between Locations of Care.

Shifts	Start	Summary	Persons	%
0	Started in HCBS	Resided in the community for the entire observation period	63,756	33.6%
	Started in NF	Resided in a NF for the entire observation period	77,256	40.7%
1	Started in HCBS	Shifted into a NF[A]	8,403	4.4%
		Indeterminate shift into a NF	2,503	1.3%
	Started in NF	Successful transition[B]	10,601	5.6%
		Indeterminate transition	2,813	1.5%
2	Started in HCBS	NF interruption[C], then returned to the community	7,126	3.8%
		Shifted into a NF[A], then successfully transitioned back into the community[B]	1,450	0.8%
		Shifted into a NF[A], then an indeterminate transition back into the community	538	0.3%
	Started in NF	Successful transition[B], then shifted back into a NF[A]	1,349	0.7%
		Successful transition[B], then an indeterminate shift back into a NF	474	0.2%
		Unsuccessful transition[D], then returned to a NF	2,475	1.3%
3	Started in HCBS	NF interruption[C], returned to the community, then shifted into a NF[A]	1,368	0.7%
		NF interruption[C], returned to the community, then an indeterminate shift into a NF	577	0.3%
		Shifted into a NF[A], successfully transitioned back into the community[B], then shifted back into a NF[A]	253	0.1%
		Shifted into a NF[A], successfully transitioned back into the community[B], then an indeterminate shift into a NF	75	0.0%
		Shifted into a NF[A], unsuccessfully transitioned back into the community [D], then returned to a NF	429	0.2%
	Started in NF	Successful transition[B], NF interruption[C], then returned to the community	979	0.5%
		Successful transition[B], shifted back into a NF[C], then another successful transition[B]	224	0.1%
		Successful transition[B], shifted back into a NF[A], then an indeterminate transition into the community	56	0.0%
		Unsuccessful transition[D], returned to a NF, then successfully transitioned into the community[B]	581	0.3%
		Unsuccessful transition[D], returned to a NF, then an indeterminate transition into the community	214	0.1%
4+	Started in HCBS	Started in the community and moved 4+ times	4,164	2.2%
	Started in NF	Started in a NF and moved 4+ times	1,988	1.0%

[A] Stayed 3 months or more
[B] Remained for 6 months or more.
[C] Stayed less than 3 months.
[D] Remained less than 6 months.
Source: FSU created enrollee LOC file

III. Factors Associated with Attempted Transition into the Community

The evaluation team developed a statistical model to uncover the factors associated with attempted transition into the community for all enrollees who resided in a NF during their first month of enrollment and who have at least six months of observed enrollment. Over 70,000 enrollees were included in the model. Full model results are presented in the Appendix A. Although the evaluation team does not have direct access to plan strategies for transition, the results presented in Table 11 provide a glimpse into potential strategies for transitioning enrollees into the community. All data on frailty, functional status, health status, and cognitive impairment were collected from MDS assessments records.

The first finding is that enrollees were more likely to transition in SFY 2015 - 2016 and SFY 2016 - 2017 than in any other fiscal year and were less likely to transition in the most recent fiscal year (SFY 2018 - 2019). The finding of a plateau in location of care rates in SFY 2018 - 2019 may be temporary or long-lasting. The second finding is that relative to enrollees in region 11, which is the largest region that also has the proportionally lowest NF population, enrollees in regions 1, 2, 3, 4, 7, and 8 were less likely to transition; enrollees in regions 5, 6, and 9 were equally likely to transition; and enrollees in region 10 were more likely to transition. This finding is consistent with differential levels of access to ALFs, as shown in Table 5. The regions with the most ALFs per enrollee at the county-level were, in descending order of access, region 11, 10, 6, 7, 9, 5, 8, 4, 3, 2, 1. It is clear that, except for region 7, enrollees were more likely to transition in regions where they have greater access to ALFs.

Enrollee transition likelihoods are correlated with levels of frailty, functional status, health status, cognitive impairment, and age. Enrollees who have fallen, were less likely to transition than enrollees who have not fallen. Enrollees with lower levels of functional ability (higher ADL scores) and, therefore, greater care needs, were less likely to transition than enrollees with higher levels of functional ability. Enrollees who died during the evaluation period, a proxy for lower levels of health, were less likely to have transitioned than enrollees who did not die during the evaluation period. Enrollees with mild to severe cognitive impairments were less likely to transition than enrollees who do not demonstrate cognitive impairments. Lastly, younger enrollees were more likely to transition than older enrollees. Table 11 summarizes factors associated with attempted transition from NFs into the community found to be statistically significant as indicated by an asterisk. The direction of the effect is negative if the odds ratio is greater than zero but less than one and positive if the odds ratio is greater than one.

Table 11. Factors Associated with Attempted Transition from Nursing Facilities into the Community.

Factor		Odds
Sex	Female	0.88*
	Male	
Race/Ethnicity	Black	1.01
	Hispanic	1.42*
	Other	1.29*
	White	
Age	Natural log of the age at program	0.14*
Plan	American Eldercare-Humana	1.38*
	Amerigroup	1.07
	Coventry (now Aetna Coventry)	0.93
	Molina Healthcare	0.84*
	Other (new plans as of SFY 2019)	1.09
	UnitedHealthcare	0.92
	Sunshine Health	
Region	1	0.52*
	2	0.45*
	3	0.74*
	4	0.57*
	5	1.00
	6	1.03
	7	0.72*
	8	0.80*
	9	0.91
	10	1.18*
	Unknown[A]	25.92*
	11	
First SFY Enrolled	SFY 2015	
	SFY 2016	1.62*
	SFY 2017	1.36*
	SFY 2018	0.94
	SFY 2019	0.67*
Fell	Yes	0.88*
	No	
Enrollee Death During Evaluation	Death	0.49*
	No death	
Cognitive Status	Impaired	0.73*
	Severely Impaired	0.54*
	No Impairment	
Active Diagnoses[B]	Cancer	1.14
	Heart/Circulatory	0.50*
	Gastrointestinal	1.31*
	Urinary	0.97
	Infection	1.46*
	Metabolic	1.03
	Musculoskeletal	1.17*
	Neurological	0.56*

Table 11. Factors Associated with Attempted Transition from Nursing Facilities into the Community (cont.)

Factor		Odds
Active Diagnoses [B]	Nutritional	1.00
	Psychiatric/Mood Disorder	0.84*
	Pulmonary	1.03
	Vision	0.76*
Functional Status (Enrollee needs either extensive assistance or total help with…)	Bathing and/or Dressing	0.74*
	Bathing and toileting	0.69*
	Bathing, dressing, and toileting	0.58*
	Bathing, dressing, and transferring	0.61*
	Bathing, toileting, and transferring	0.69*
	Bathing, dressing, toileting, and	0.47*
	Bathing, dressing, toileting,	0.37*
	Other combination	0.75*
	None	

*Significant at $p < .001$ level.

[A] Less than 0.01% of enrollees, so the result should be interpreted as statistical noise.

[B] Reference group is absence of any diagnosis under the condition category.

Full model results are presented in the Appendix.

Note: Factors without odds ratios are the reference group for each category. Odds ratios greater than 1 indicate a population characteristic associated with increased odds of a transition and an odds ratio less than 1 indicate a population characteristic associated with decreased odds of a transition (relative to the reference group for the category).

Sources: FSU created enrollee LOC file, MDS assessments, enrollee demographic file.

IV. Summary of RQ2 Findings

A goal of the LTC program is to reduce the amount of time that enrollees spend in nursing facilities. Compared to the first fiscal year of the evaluation, the evaluation team identified a reduction in the number of enrollee months in which enrollees resided in nursing facilities. The Agency appears to be successful, moving in the right direction in its efforts to reduce utilization of nursing facility services. This is a positive finding for the program.

The evaluation team developed a comprehensive statistical model that controlled for many factors associated with attempted transition. That model may be useful for prioritizing or targeting enrollees for transition into the community. Frailty, functional ability, health, and cognitive impairment are correlated with lower transition likeliness.

RQ3: What are the levels of service utilization for enrollees prior to transitioning into a nursing facility?

The evaluation team investigated the relationship between service utilization and enrollee transitions from HCBS settings into NFs. This analysis includes enrollees who resided in HCBS settings but excludes those who resided in ALFs (i.e., the included locations of care are personal, group, and adult family care homes).[18]

[18] Enrollees who reside in ALFs are excluded, as facilities often provide comprehensive services that are not captured by the encounter data.

Understanding if enrollees in NFs had markedly different levels of utilization for any category of services prior to transitioning requires comparing their levels of service use to levels for enrollees who remained in-home. This analysis is particularly complex, as those who transition differ from those who remain in-home in many ways that are related to both service utilization and the probability of transitioning. The evaluation team tried to mitigate these differences by matching enrollees based on observed characteristics as described in Appendix A. One might expect that the level of service use within each category could be higher or lower for those who transition. Service use levels may be higher and merely associative if those who transitioned happen to have greater service needs, while levels may be lower and causal if transitioning into a NF was more likely to occur when enrollees were not receiving the services they need. If both scenarios held, the heterogeneous effects of service use may wash out in the aggregate. With these complications in mind, the evaluation team examined the relationship between service use intensity and transition. Additional criteria for inclusion, and other methodological considerations, are detailed in Appendix A.

I. Comparison of the levels of service utilization for enrollees who transitioned into nursing facilities versus levels for enrollees who remained in their homes.

After matching[19] enrollees who moved into NFs to those who remained in-home, the evaluation team ran a conditional logistic regression model that predicts transition into a nursing facility for each of the nine service categories that met the 1 percent utilization threshold. The models include an indicator (Service Received) for whether the enrollee received any services that fell under a given service category and a measure of service use intensity (Intensity). Intensity was measured via the mean number of units of service (UOS) received per thirty-days.[20] All enrollees included in the model were observed for six consecutive months, either directly prior to the transition date for enrollees who moved into a nursing facility or for a matched six-month period for enrollees who remained in-home. There were 4,603 pairs of enrollees included in the model.

A basic measure of utilization is to identify whether an enrollee used a given service. That is, observed use of one or more units of service in a category means the enrollee is classified as having received that service. The results in Table 12 suggest that receiving at least one unit of service for adult companion care, homemaker, medical equipment and supplies, or personal care services was enough to establish a statistical association with the odds of transitioning into a NF for each of those categories. Use of a personal emergency response system also is significantly related to transitions. The odds of transitioning into a NF for enrollees who receive adult companion care services are 34 percent higher than the odds for enrollees who do not receive this service at least once. The odds are 25 percent higher for homemaker services, 32

[19] The matching method is detailed in Appendix A, but to summarize, enrollees were matched on a score that predicts—independent of service utilization levels—the risk of transitioning into a nursing facility. Matched participants are more similar in observed characteristics and may also be more similar in unobserved and, therefore, statistically non-controllable characteristics.

[20] PERS intensity not measured because only one unit of service allowed per month, and most enrollees with a personal emergency response system have it for all six observation months.

percent higher for medical equipment and supplies services, 40 percent higher for personal care services, and 41 percent higher for those who have a personal emergency response system.

Intensity of service utilization among service categories is a more useful measure than this simple one or more (yes/no) approach. Units of service used in each of the categories, when observed over time, are expected to be associated with patient need and therefore, risk of a transition. However, this evaluation found no relationship between service use intensity and the odds of transitioning for any of these services. It is surprising that receiving one or more services in a category, but not the intensity of their use, is predictive of transition. It could mean that needing these services and/or personal preference for these services are related to some unmeasured factor(s) that is associated with transition into nursing facilities.

The results for Home-Delivered Meals were more complicated. In this case, the intensity of services is associated with the probability of transitioning. Of the enrollees who received at least one home delivered meal per thirty days[21], about three out of four (73%) received at least fifteen home-delivered meals. The odds of transitioning for those who received fifteen Home-Delivered Meals are 12 percent higher than the odds for those who received no meals, while the odds of transitioning for those who received thirty home-delivered meals are 50 percent higher than the odds for those who received no meals.[22] Lastly, the results for intensity of respite care likely indicate a relationship between caregiver supports and the odds of transitioning.

[21] 1,748 out of 4,603, so 38%, averaged at least one meal per 30 days (rounded to the nearest whole number).
[22] Approximately 5% of enrollees in the sample averaged at least 30 meals every 30 days.

Table 12. Odds of Transitioning into a Nursing Facility as a Function of Service Utilization Intensity for Selected Service Categories.[23]

LTC Service Category	Measure	Transition Odds Ratio
Adult Companion Care	Service Received	1.34*
	Intensity	1.00
Adult Day Health Care	Service Received	1.26
	Intensity	1.00
Home-Delivered Meals	Service Received	0.83
	Intensity	1.02*
Homemaker Services	Service Received	1.25*
	Intensity	1.00
Medical Equipment and Supplies	Service Received	1.32*
	Intensity	1.00
Personal Care	Service Received	1.40*
	Intensity	1.00
PERS	Service Received	1.41*
Respite Care	Service Received	0.97
	Intensity	1.00*
Transportation	Service Received	1.28
	Intensity	1.00

*Significant at Bonferroni adjusted alpha level of 0.0028.
Note: For full model results see the Appendix.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility data (for demographic information), FL Center inpatient data, 701B Assessments.

1. Summary of RQ3 Findings

Patterns of LTC service use and/or intensity of utilization among HCBS enrollees might help to identify persons at risk of transitioning to a NF. Closely tracking trends in objective measures of individual enrollees' need for assistance with ADLs may be useful in identifying when the enrollee's Plan of Care should be reassessed. The evaluation team compared levels of service utilization for enrollees who transitioned from home into nursing facilities versus levels for enrollees who remained in their homes. The evaluation team examined the odds of transitioning into a NF as a function of any HCBS utilization. Additionally, the intensity of HCBS utilization was modeled to identify how utilization levels prior to a transition from the community to a NF might be predictive of which enrollees were at risk of the transition to a NF. The evaluation team found that use of any amount of adult companion care, homemaker services, medical equipment and supplies, personal care services and having a personal emergency response system were associated with transitioning into a nursing facility. This analysis found no relationship between service use intensity and the odds of transitioning into a nursing facility for any of these community-based services. The absence of a relationship between objective measures of need (ADLs) and observed intensity of utilization is unexpected and hinders interpretation. The fact that an imprecise measure, use of one or more services, is related to transition but not the intensity of service utilization is perplexing. This suggests that the need

[23] The reader should note that standard measures of health status/risk, which is undoubtedly related to the odds of transitioning into a nursing facility, could not be included in the models. The reason being most enrollees in the LTC program (upwards of 90%) are dually eligible for Medicare and obtaining Medicare claims data was cost prohibitive. The number of inpatient days in the 6-month period was included in the matching process to serve as a rough proxy for health status.

for these services and/or personal preferences for these services are related to some unmeasured factor(s) associated with transition into nursing facilities.

RQ4: Do plans offer additional (expanded) benefits and ways to access services, including a Participant Direction Option (PDO), and to what extent do enrollees use these services?

RQ4 investigates expanded benefit service offerings and Participant Direction Option (PDO) participation and service utilization in the LTC period.

I. Expanded Benefits

Table 13 presents the expanded benefits offered by each LTC plan. Expanded benefits are services covered by the plan that are not otherwise covered by Medicaid. Blank cells indicate an LTC plan did not offer the specific service. The range of expanded benefits offered across all plans was five to thirteen services. All plans offered every expanded benefit indicated in each region for which they were contracted. Dental services, over the counter (OTC) medication/supplies, and support to transition out of a NF were commonly offered expanded benefits. In fact, every plan offered those services.

Table 13. List of Expanded Benefits Offered by the Plans.

Expanded Benefits that appear in Choice Counseling materials	AMG	COV	HUM/ AEC	MOL	SUN	URA	Total
ALF/AFCH Bed Hold	X	X	X	X	X		5
Caregiver Therapy Sessions (Individual)			X		X	X	3
Cellular Phone Service	X	X	X		X		4
Dental Services	X	X	X	X	X	X	6
Emergency Financial Assistance		X					1
Hearing Evaluation		X	X		X		3
Mobile PERS					X		1
Non-Medical Transportation			X		X	X	3
OTC Medications/Supplies	X	X	X	X	X	X	6
Support to Transition Out of a Nursing Facility	X	X	X	X	X	X	6
Vision Services	X	X	X	X	X		5
Expanded Benefits that do not appear in Choice Counseling materials	**AMG**	**COV**	**HUM/ AEC**	**MOL**	**SUN**	**URA**	**Total**
Box Fan					X		1
Caregiver Information/Support			X		X		2
Document Keeper			X		X		2
Emergency Meal Supply		X	X				2
Household Set-Up Kit						X	1
Welcome Home Basket						X	1
Nurse Helpline Services	X					X	2
Pill Organizer		X	X				2
Total	7	10	13	5	13	8	56

Sources: LTC Plan contracts, Florida Medicaid Long-term Care Program Documentation[24]

The results of mining the LTC encounter records for evidence of expanded benefit utilization (see Table 14) reveal that, while plans offer expanded benefits, enrollees only access half of the measurable[25] services highlighted in the choice counseling materials: bed holds, dental services, mobile PERS, non-medical transportation, and vision services.[26] The most widely received expanded benefit service is ALF and AFCH bed holds. Approximately 15 percent of LTC enrollees have an encounter record for a bed hold each year of the evaluation, except for the first year (SFY 2014 - 2015), when the percentage was 12.2.

[24] https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf, accessed March 29, 2020. https://ahca.myflorida.com/medicaid/mcac/docs/2018-07-10_Meeting/SMMC_Update_7-2018.pdf, accessed March 29, 2020.

[25] The evaluation team was not aware of a procedure code for emergency financial assistance.

[26] Services not listed in Choice Counseling materials are not searchable via the encounter data.

Table 14. Expanded Benefits Service Utilization Over Time.

Expanded Benefit Service	Counts and Percentages of Enrollees who Received the Service each Year									
	SFY 2015[A]		SFY 2016		SFY 2017		SFY 2018		SFY 2019[B]	
	N	%	N	%	N	%	N	%	N	%
ALF/AFCH Bed Hold	12,944	12.2%	17,305	15.1%	18,908	15.7%	20,049	15.7%	17,956	15.1%
Caregiver Therapy	110	0.1%	83	0.1%	73	0.1%	65	0.1%	56	0.0%
Cellular Phone	181	0.2%	193	0.2%	195	0.2%	195	0.2%	112	0.1%
Dental	1,111	1.1%	1,112	1.0%	1,036	0.9%	969	0.8%	516	0.4%
Hearing Evaluation	7	0.0%	10	0.0%	8	0.0%	17	0.0%	4	0.0%
Mobile PERS	3,435	3.2%	4,896	4.3%	6,082	5.0%	6,879	5.4%	6,872	5.8%
Non-Medical Transportation	3,430	3.2%	5,229	4.6%	5,078	4.2%	8,882	7.0%	8,501	7.1%
OTC Medications/ Supplies	0	0.0%	0	0.0%	0	0.0%	2	0.0%	0	0.0%
Support to Transition	15	0.0%	8	0.0%	14	0.0%	12	0.0%	3	0.0%
Vision	5,494	5.2%	3,272	2.9%	4,206	3.5%	464	0.4%	222	0.2%

The number of unique enrollees was 105,785 in SFY 2015 (excluding July and August), 114,477 in SFY 2016, 120,561 in SFY 2017, 127,387 in SFY 2018, and 119,039 in the first half of SFY 2019.

[A] Excludes July 2014 and August 2014 because AEC was a FFS-based plan.

[B] Excludes the second half of SFY 2019 (i.e., all of 2019) because encounter records appear to be underrepresented for the new plans, added under the new contract.

Sources: Expanded benefit services crosswalk, FSU created enrollee LOC file, LTC encounter records

II. Participant Direction Option

Participant Direction Option (PDO) is a service delivery model that empowers LTC enrollees by allowing them to hire, train, supervise, and dismiss direct service worker(s) providing certain LTC services. A PDO is available to all LTC enrollees who (a) have any PDO service listed on their authorized care plan and (b) live in their own home or family home. In accordance with state and federal regulations, PDO services must be medically necessary and cost-effective. The five allowable PDO services are adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care.

Participant independence and personal choice is the primary focus of a PDO. Enrollees who select this option must be interested in actively managing their own health care and be willing to take responsibility for hiring and managing their direct service worker(s). A PDO participant may choose a representative to assist with the employer responsibilities of PDO. The representative cannot be compensated for their services nor be a direct service worker. Participants may hire any individual of their choosing to provide their PDO services, including family members, neighbors, or friends. The enrollee's LTC plan is responsible for ensuring each direct service worker only receives payment for the hours and approved PDO services that

are listed in the participant's authorized care plan and on the Participant/Direct Service Worker Agreement. A participant's direct service worker(s) does not have to be in the LTC plan's provider network.

Key components of PDO include:

1. PDO Services – These are the services enrollees may self-direct. An enrollee must have at least one of the five PDO services on their care plan to participate in PDO.
2. Participant – This is the Medicaid LTC program enrollee who has chosen to participate in PDO for one or more services and who acts as the employer.
3. Case Manager – In addition to the duties outlined in the LTC plan contract, the case manager is responsible for providing ongoing PDO-related technical assistance to the participant as needed and requested. This responsibility includes providing initial PDO training to the participant upon opting to participate in PDO.
4. Direct Service Worker – This is the employee, directly hired by a participant, who provides PDO services as authorized under the care plan. The direct service worker(s) may be any qualified individual chosen by the participant. The direct service worker(s) is paid by the LTC plan based on a set rate.
5. Fiscal/Employer Agent (F/EA) Services – Each managed care plan is responsible for providing F/EA services, as described in the LTC plan contract, to the participants who choose PDO. The F/EA functions include payroll services and processing, filing, and paying all state and federal taxes on behalf of participants and their direct service workers.

Table 15 summarizes PDO enrollment, limited to home-based enrollee months (i.e., months with ALF residency are excluded), for each year of the evaluation. Of the total number of months enrollees resided in home-based settings, enrollees opted into the Participant Direction Option for 9.3 percent of the time.

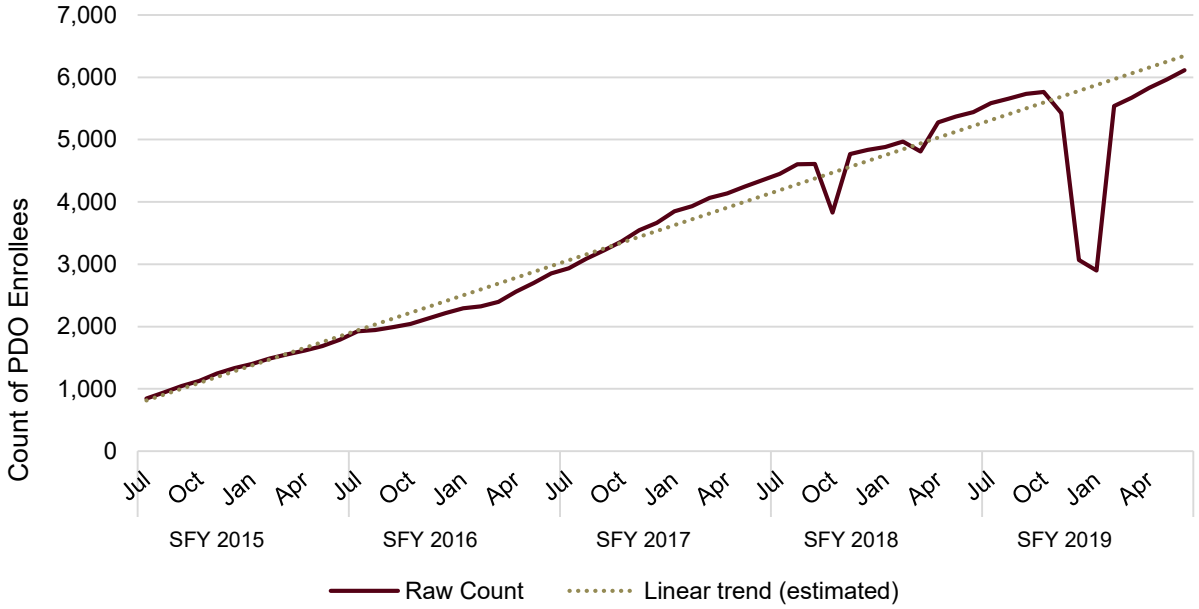
Table 15. Home-Based Enrollee Months with PDO Utilization.

SFY	Count Unique Enrollees Opted into PDO	Total Enrollee Months Opted into PDO	Total Home-Based Enrollee Months	Percentage of Home-Based Enrollee Months Opted into PDO
SFY 2015	2,109	16,068	339,733	4.7%
SFY 2016	3,562	27,367	398,105	6.9%
SFY 2017	5,284	44,399	443,143	10.0%
SFY 2018	6,735	57,842	506,955	11.4%
SFY 2019	7,780	63,257	567,658	11.4%

Note: Missing data for AEC in July 2014, URA in October 2017, and AMG in March 2018. PDO enrollment is underreported during the secondary rollout period that resulted from the re-procurement process.
Sources: LTC Plan PDO Roster reports, FSU created enrollee LOC file

Figure 2 presents PDO enrollment by month. PDO enrollment for home-based enrollees steadily increased throughout the entire evaluation period.

Figure 2. PDO Enrollment Over Time.



Note: Missing data for AEC in July 2014, URA in October 2017, and AMG in March 2018. PDO enrollment is underreported during the secondary rollout period that resulted from the re-procurement process.
Sources: LTC Plan PDO Roster reports

Table 16 summarizes PDO enrollment by plan for the entire evaluation period, limited to home-based enrollee months. Sunshine State Health Plan enrollees experienced the highest rate of PDO enrollment (14.9% of all home-based enrollee months), while Molina Healthcare enrollees experienced the lowest rate of PDO enrollment (2.5% of all home-based enrollee months).

Table 16. Home-Based Months with PDO Enrollment by Plan.

Plan	Total Enrollee Months Opted into PDO	Total Home-Based Enrollee Months	Proportion of Home-Based Enrollee Months Opted into PDO
AEC-HUM	46,827	658,529	7.1%
AMG	7,110	127,207	5.6%
COV	10,297	103,067	10.0%
MOL	5,549	221,191	2.5%
SUN	95,244	640,555	14.9%
URA	38,550	505,045	7.6%

Note: Missing data for AEC in July 2014, URA in October 2017, and AMG in March 2018.
Sources: LTC Plan PDO Roster reports, FSU created enrollee LOC file

Table 17 summarizes PDO enrollees' selected service types for each month on average. The most frequent service is Personal Care services, with an average of 91.1 percent of PDO enrollees receiving this service

through the PDO each month, followed by Homemaker services (at 80.7%). Few PDO enrollees receive Attendant Care services (at 1.1% on average each month) or Intermittent and Skilled Nursing services (at 0.5%) via the PDO.

Table 17. Selected PDO Service Types.

Mean monthly proportion of PDO enrollees selecting:				
Adult Companion services	Attendant Care services	Homemaker services	Intermittent and Skilled Nursing services	Personal Care services
34.3%	1.1%	80.7%	0.5%	91.1%

Note: Missing data for AEC in July 2014, URA in October 2017, and AMG in March 2018. PDO enrollment is underreported during the secondary rollout period that resulted from the re-procurement process.
Sources: LTC Plan PDO Roster reports

Table 18 summarizes how often enrollees receive a PDO service each month, when that service is one of those services they chose to receive via the PDO. Overall, the correspondence between the services indicated and the services received is quite high for the most common indicated services (adult companion care, homemaker service, and personal care services). For the two services that were rarely used in the HCBS population as a whole (attendant care services and intermittent and skilled nursing services), the correspondence is lower. Nevertheless, enrollees in the PDO were receiving both services at much higher levels than the general population of LTC enrollees (relative to services received as reported in Table 1). These results suggest that PDO is serving enrollees as intended.

Table 18. Received PDO Service Types.

Proportion of months with the PDO service indicated that have a corresponding encounter record for the service:				
Adult Companion services	Attendant Care services	Homemaker services	Intermittent and Skilled Nursing services	Personal Care services
89.9%	58.7%	92.8%	82.6%	94.8%

II. Summary of RQ4 Findings

LTC plans offer several services that are generally outside the scope of the core LTC program plan. These services are categorized as expanded benefits and the Participant Direction Option (PDO). The evaluation team conducted a descriptive analysis of these two service types to understand the scope of services offered.

The range of expanded benefits offered by each plan is specific to each plan. Plans are contracted to offer the selected services by region and must maintain those offerings over the course of their state contract. The number of services across all plans ranged from five to thirteen services. Dental services, over the counter (OTC) medication/supplies, and support to transition out of a NF were offered by every plan. Other expanded benefits varied by plan. While plans offered expanded benefits, enrollees only received half of

the measurable services listed in the choice counseling materials: bed holds, dental services, mobile PERS, non-medical transportation, and vision services.

All plans are required to offer PDO services. Enrollment for home-based enrollees steadily increased throughout the entire evaluation period (see Figure 2). The proportion of home-based enrollee months with PDO enrollment varied considerably by plan from 2.5 to 14.9 percent (see Table 16). Popular PDO services were personal care and homemaker services selected by 91.1 percent and 80.7 percent of enrollees on average each month, respectively (see Table 17). The relationship between the services selected and the corresponding services received was quite high at 90 percent or greater for commonly selected services (adult companion care, homemaker service, and personal care services). Attendant care services and intermittent and skilled nursing services were rarely selected, with respectively 1.1 percent and 0.5 percent of enrollees selecting the service each month (see Table 17). Nevertheless, enrollees in PDO were receiving both services at much higher levels than the general population of LTC enrollees. These descriptive results suggest that PDO is serving enrollees as intended.

RQ5: Are there disparities by racial and ethnic groups in enrollees' placements in certain settings and utilization of services?

There is a long-standing agreement among health policy experts that socio-demographic factors, especially ethno-racial minority status, underlie systematic differences in location of care and LTC service utilization. Variations in enrollees' location of care settings may be motivated by more benign differences in socio-cultural preferences for care or more circumstantial differences in the availability of a caregiver. However, some ethno-racial minority groups may experience institutional disparities in access to high-quality LTC services and facilities in the United States.[27] As a result, both the types of services received, and the intensity of utilization can vary considerably across subpopulations within a given state. Accordingly, RQ5 of this evaluation aims to assess differences and potential disparities in access to care among ethno-racial groups in Florida Medicaid's LTC program.

I. Enrollee Locations of Care

Table 19 and Figure 3 provide an overview of the systematic differences in enrolled months by location of care by race/ethnicity. Hispanic enrollees had a much higher proportion of total enrollee months in HCBS settings than Black and White enrollees across all years. Black enrollees and White enrollees experienced fairly equivalent proportions of their enrolled months by setting across all years, although the nursing facility rates for Black enrollees versus White enrollees are slightly lower after SFY 2014 - 2015.

[27] Smith DB, Feng Z, Fennell ML, Zinn J, Mor V. Racial disparities in access to long-term care: The illusive pursuit of equity. J Health Polit Policy Law. 2008; 33(5):861-881.

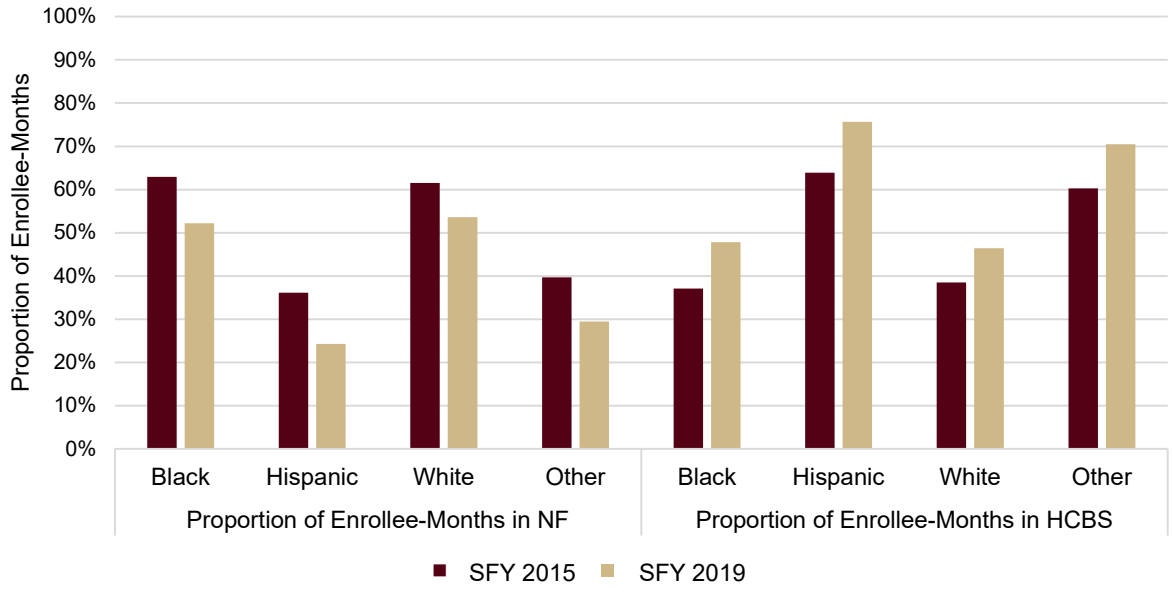
Table 19. Total Enrollee Months in each Location of Care by Race/Ethnicity.

Evaluation Period	Race/ Ethnicity	Count of Unique Persons	Total Enrollee-Months	Count of NF Months	Proportion of NF Months	Count of HCBS Months	Proportion of HCBS Months
SFY 2015	Black	17,673	168,488	106,053	62.9%	62,435	37.1%
	Hispanic	20,391	193,097	69,626	36.1%	123,471	63.9%
	White	61,355	564,798	347,198	61.5%	217,600	38.5%
	Other	10,479	93,805	37,211	39.7%	56,594	60.3%
SFY 2016	Black	18,183	176,449	102,118	57.9%	74,331	42.1%
	Hispanic	22,260	217,631	64,125	29.5%	153,506	70.5%
	White	61,503	574,843	338,790	58.9%	236,053	41.1%
	Other	12,531	116,495	41,566	35.7%	74,929	64.3%
SFY 2017	Black	18,808	183,324	101,465	55.3%	81,859	44.7%
	Hispanic	24,247	234,570	65,684	28.0%	168,886	72.0%
	White	62,416	582,405	330,231	56.7%	252,174	43.3%
	Other	15,090	138,327	46,237	33.4%	92,090	66.6%
SFY 2018	Black	19,573	189,042	99,474	52.6%	89,568	47.4%
	Hispanic	27,019	261,265	66,377	25.4%	194,888	74.6%
	White	63,189	586,018	319,397	54.5%	266,621	45.5%
	Other	17,606	164,987	49,241	29.8%	115,746	70.2%
SFY 2019	Black	20,876	200,681	104,745	52.2%	95,936	47.8%
	Hispanic	29,247	284,774	69,096	24.3%	215,678	75.7%
	White	65,968	604,820	323,883	53.6%	280,937	46.4%
	Other	20,973	195,716	57,667	29.5%	138,049	70.5%

Sources: FSU created enrollee LOC file, enrollee eligibility file (demographic data)

Figure 3 presents the information from Table 12 for the first (SFY 2014 - 2015) and last (SFY 2018 - 2019) evaluation years.

Figure 3. Proportion of Enrollee Months in a NF or HCBS Setting by Race/Ethnicity, SFY 2014-2015 and SFY 2018-2019.



Sources: FSU created enrollee LOC file, enrollee eligibility file (demographic data)

Figures 4 and 5 display changes in HCBS versus NF location of care by race/ethnicity over time. While Black, Hispanic, and White enrollees all experienced reductions in NF enrollee months throughout the course of the evaluation period, there were differences in the degree of reduction among these subpopulations. Hispanic enrollees experienced the greatest decline in nursing facility residency rates between the first and last month of the evaluation period, with a 12.9 percent decrease (and a corresponding increase in their rate of HCBS residency). Black enrollees experienced a 11.4 percent decrease in their rates of NF residency, while White enrollees experienced a 9.8 percent decrease; enrollees of other racial/ethnic backgrounds experienced an 8.3 percent decrease. Observed differences in the level of change in enrollee location rates over time may be driven by differences that are not inherent to the subpopulations themselves. Nevertheless, the model of Factors Associated with Attempted Transition from NFs into the Community (see Table 10) revealed that even after controlling for age, region, plan, health status, functional status, and other relevant factors, Hispanic enrollees were still more likely to transition into the community than both Black and White enrollees. Key differences may remain in support structures, such as the availability of extended family members or community ties; in cultural motivations to be at home versus in a facility; in unmeasured levels of need; and/or in plan choices.

Figure 4. Trends in the Proportion of Enrollees Residing in a Nursing Facility Over Time by Race/Ethnicity.

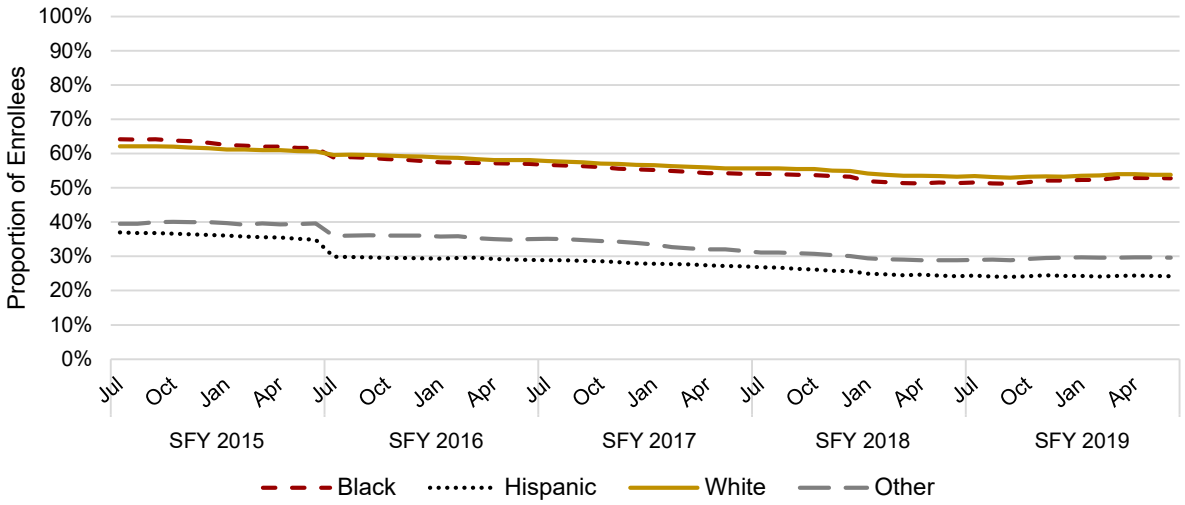
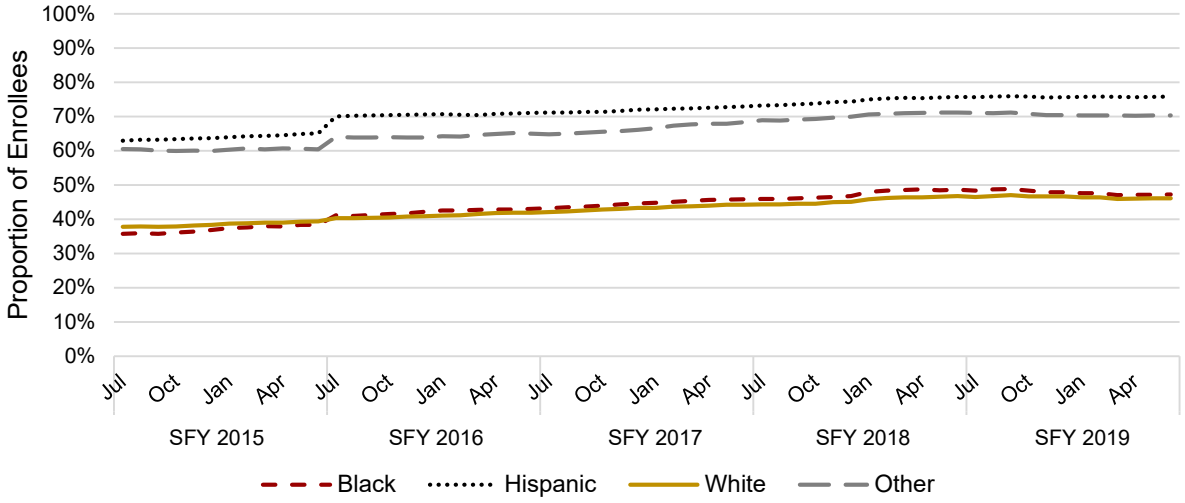


Figure 5. Trends in the Proportion of Enrollees Residing in an HCBS Setting Over Time by Race/Ethnicity.

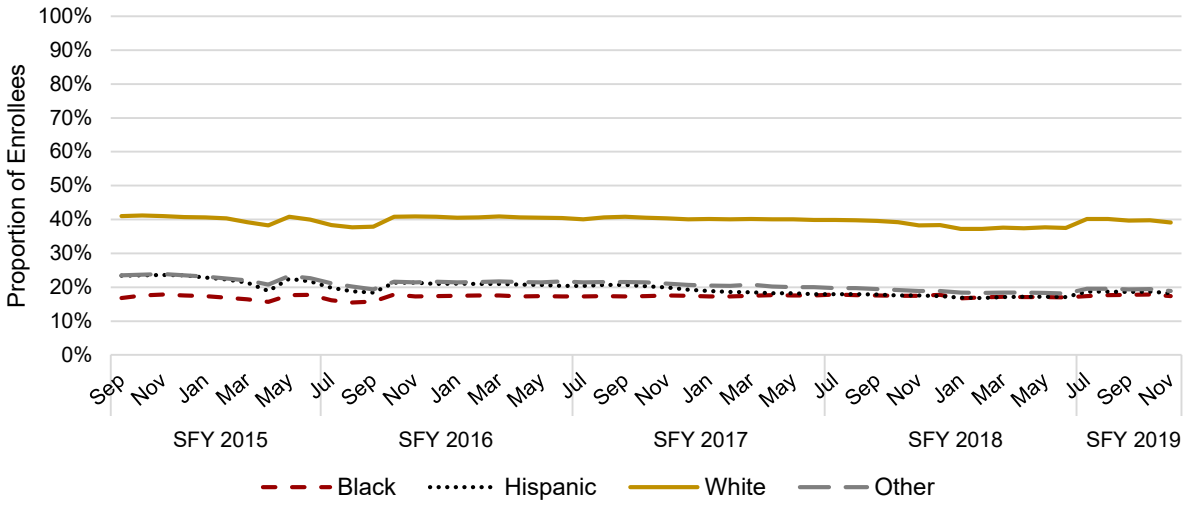


Sources: FSU created enrollee LOC file, enrollee eligibility file (demographic data)

Regarding ALF services, Figure 6 reveals that White enrollees were over twice as likely as Black enrollees to reside in ALFs throughout the entire evaluation period, and the gap between White and Hispanic enrollees widened throughout the evaluation period from 17.6 percent in the first observed month of SFY 2014 - 2015 to 20.9 percent in the last observed month of SFY 2018 - 2019. As a result of this widening gap, White enrollees were more than twice as likely to reside in ALFs as Hispanic enrollees by November of 2016. Throughout the evaluation period, ALF residency rates held roughly constant for Black enrollees, increasing by only 0.6 percent; fell for Hispanic enrollees and enrollees of other racial/ethnic groups by 5.2 and 4.6 percent respectively; and fell for White enrollees, but only by 1.9 percent. The difference in ALF

residency rates between White enrollees and Black enrollees is especially surprising since both groups experienced similar nursing facility residency rates throughout the entire evaluation period. This finding may represent a true disparity in access among racial/ethnic subgroups of the LTC population or a cultural preference for home-based care.

Figure 6. Trend in Proportion of Enrollees Residing in an Assisted Living Facility Over Time by Race/Ethnicity.



Note: July and August of SFY 2015 is excluded because AEC was a FFS plan until September 2014. The second half of SFY 2019 is excluded because encounter records appear to be underrepresented for the new plans added under the new 5-year contract.
Sources: FSU created enrollee LOC file, enrollee eligibility file (demographic data)

II. Service Utilization (home-based enrollees only)

Table 20 presents the mean monthly percentage of enrollees in home-based settings who received a given LTC service by race/ethnicity for the ten most common received LTC services, excluding ALF services. Because of the sizeable difference in the proportion of White enrollees residing in ALFs, this table is limited to home-based enrollees and is not directly comparable to Table 3.

The most notable pattern is that lower proportions of White home-based enrollees received seven of the nine service types, except for personal emergency response systems (PERS) and adult companion care. Greater proportions of White enrollees had PERS than any other group in SFY 2014 - 2015, while the proportion of Black enrollees who had PERS was similar by SFY 2018 - 2019. Likewise, similar proportions of White and Black enrollees receive adult companion care services. Other notable differences include the following: the proportion of enrollees receiving adult day health care, homemaker, personal care, respite care, and transportation services was higher among Hispanic enrollees than among Black and White enrollees, and the proportion of enrollees receiving home-delivered meal services was higher among Black enrollees than among all other enrollees. Differences in the magnitude of need between racial and ethnic groups as well as differences in enrollee preferences may explain some of these observed results.

Table 20. Mean Monthly Percentage of Enrollees in Home-Based Settings Receiving Selected LTC Services by Race/Ethnicity, SFY 2014-2015 versus SFY 2018-2019.

	Black		Hispanic		White		Other	
Service Category	**SFY 2015[A]**	**SFY 2019[B]**	**SFY 2015[A]**	**SFY 2019[B]**	**SFY 2015[A]**	**SFY 2019[B]**	**SFY 2015[A]**	**SFY 2019[B]**
Adult Companion Care	14.3% (0.8%)	20.3% (0.6%)	14.8% (1.1%)	24.2% (0.5%)	14.5% (0.9%)	20.8% (0.7%)	13.7% (1.3%)	22.2% (0.4%)
Adult Day Health Care	7.5% (0.2%)	6.8% (0.1%)	16.7% (0.7%)	16.3% (0.9%)	4.5% (0.1%)	3.9% (0.2%)	13.6% (0.4%)	16.3% (0.6%)
Home-Delivered Meals	40.1% (0.6%)	39.5% (1.4%)	33.7% (1.6%)	37.9% (1.9%)	32.9% (1.0%)	35.6% (1.5%)	28.7% (1.0%)	30.9% (1.2%)
Homemaker Services	53.4% (1.7%)	64.0% (1.3%)	62.3% (2.8%)	72.0% (1.8%)	53.6% (1.6%)	60.0% (2.0%)	55.0% (1.8%)	65.2% (1.5%)
Medical Equipment/ Supplies	48.3% (1.6%)	58.6% (1.9%)	46.4% (2.5%)	59.7% (4.2%)	38.1% (1.6%)	47.8% (2.5%)	41.8% (2.2%)	56.9% (2.8%)
Personal Care	55.9% (1.3%)	65.3% (2.1%)	68.8% (2.4%)	74.4% (3.8%)	49.3% (1.4%)	55.1% (2.1%)	59.7% (1.6%)	69.4% (2.5%)
PERS	27.7% (1.0%)	33.3% (1.1%)	19.2% (0.7%)	24.6% (0.8%)	30.0% (0.9%)	33.6% (1.2%)	20.1% (0.7%)	24.2% (0.5%)
Respite Care	13.0% (0.4%)	8.4% (0.2%)	15.0% (0.5%)	11.3% (0.4%)	10.0% (0.3%)	6.5% (0.2%)	14.0% (0.5%)	9.7% (0.4%)
Transportation	3.8% (0.2%)	5.4% (0.3%)	6.4% (0.2%)	9.0% (0.4%)	2.3% (0.1%)	3.3% (0.3%)	5.8% (0.2%)	9.3% (0.5%)

[A] Excludes July 2014 and August 2014 because AEC was a FFS-based plan.
[B] Excludes the second half of SFY 2019 (i.e., all of 2019) because encounter records appear to be underrepresented for the new plans, added under the new contract.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility file

III. Time to First Service Delivery (home-based enrollees only)

Table 21 presents time to first service delivery results for SFY 2014 - 2015 and SFY 2018 - 2019 stratified by race/ethnicity. Again, this metric is limited to new enrollees who entered the LTC program and were initially placed in a home-based setting upon entry. On average, Hispanic enrollees received their first HCBS LTC services earlier than all other racial/ethnic groups. In Florida, the Hispanic population is concentrated in south Florida, so regional differences in access could explain these disparities. Nevertheless, follow-up analysis (not shown) limited to region 11, which contains Miami-Dade and Monroe counties, revealed that the difference persists for Black enrollees but somewhat attenuates for White enrollees within that region. Moreover, the mean number of days until first service delivery for Hispanic enrollees relative to Black and White enrollees in other regions was either lower or equivalent. It is well established in the literature that racial differences in utilization is partly due to racial and cultural differences and communication barriers for Black and Hispanic patients when their physician is White[28]. Therefore, it

[28] Saha, S., et al., *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care.* Archives of Internal Medicine, 1999. **159**(9): p. 997-1004.

may be the case in Florida that Hispanic enrollees have greater access to culturally concordant providers in some regions and/or experience more advocacies on behalf of caregivers or other community support figures.

Table 21. Mean Number of Days until First Service Delivery by Race/Ethnicity, SFY 2014-2015 versus SFY 2018-2019.

	Number of New Already Home-based Enrollees	Mean Number of Days	Number of New Already Home-based Enrollees	Mean Number of Days
Race/Ethnicity	**SFY 2015**		**SFY 2019[A]**	
Black	1,264	20.7 (41.5)	790	25.2 (43.4)
Hispanic	2,483	13.3 (31.4)	2,054	14.9 (28.2)
White	3,208	24.3 (46.9)	2,035	31.1 (48.1)
Other	1,357	17.4 (37.0)	1,507	18.6 (34.9)

[A] Excludes the second half of SFY 2019 (i.e., all of 2019), for aforementioned reason.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility file

Summary of RQ5 Findings

- Overall, the analysis for RQ5 suggests that Black enrollees experienced lower levels of placement in ALFs relative to White enrollees as well as lower levels of services and slower times to first service delivery relative to Hispanic enrollees.

- Hispanic enrollees also experienced lower levels of placement in ALFs relative to White enrollees but experience faster times to first service delivery relative to all other groups.

- White enrollees were observed to use a collection of services that differ from minority enrollees. The differences may be due to differences in need for care. What remains unclear is whether these differences represent true institutional disparities in access to care, more benign differences in socio-cultural preferences for care, or more circumstantial differences in the availability of a caregiver.

Study Limitations

- Inadequate identification of the level of need for help with Activities of Daily Living is a study limitation. The expected correlation between increased levels of need and increased service utilization was not observed. This may be alleviated if comprehensive assessments and care plans created by case managers were made available to the Agency and the evaluation team. Further information on this limitation is presented below.
- A related but separate issue is the lack of a risk stratification metric based on medical encounters and/or retail pharmaceutical utilization. Obtaining medical claims, encounters and filled prescription records from Medicare managed care plans, as well as traditional

Medicare, might be useful for future analyses. Plans that operate both Medicare and Medicaid managed care plans in Florida (e.g., Humana or United Health) might be a useful starting point. Pharmacy data alone may be adequate, and it has been successfully used to calculate a valid chronic disease score useful for risk stratification.

- Threats to internal validity of the study findings due to lack of a comparison group.
- Lack of internal validity means the evaluation team may not be able to trust inferences made from the findings due to the design of the research.
- Alternatively, published findings from a valid study of a large LTC population with characteristics similar to the Florida LTC population might be useful as a valid comparison group. The ability to statistically adjust for differences between the two populations would be necessary for this approach to be valid.

The first unresolved issue relates to measures of enrollee need created by plan case managers and to some extent by DOEA. An accurate assessment of the enrollees needs for help with their Activities of Daily Living (ADLs) is not only vital for designing a Care Plan (CP) but also for use by the evaluation team to be able to group the LTC population into five or more groups (e.g., 1 to 5), where each higher numbered group indicates a greater level of need. The evaluation team has noted that the ADL measures available for this purpose demonstrate only a weak association between the level of need and the number of services provided. This is unexpected. One issue may be that most of the Comprehensive Assessments (CAs) done by the plans' case managers were not available to the evaluation team. The CAs completed by DOEA and supplied to the Agency appear much less frequent than expected. In short, CAs and Plan of Care (PC) as well as the Service Authorization (SA) prepared by plan case managers should be made available to the Agency as an electronic database. The electronic database of CAs, PCs and SAs will allow the Agency to more closely surveil this aspect of plan provision of care. This would make it easier to conduct systematic analysis that could include a large proportion of the enrollee CA and PCs.

In summary, case managers are at the heart of the process by which enrollees receive their CA, a CP which determines which services are needed, and finally a SA that documents approval for the services to be made available to the enrollee.

Conclusions and Recommendations

1. Nursing facility residency rates decreased at a fairly constant rate throughout the first four fiscal years but appear to have plateaued in the final fiscal year of the evaluation period (Table 6). The evaluation team believes this is either a temporary situation or the LTC plans have driven the nursing facility residency rates as low as possible given LTC population needs and characteristics. The evaluation team recommends observing the situation for another year.

2. The difference in assisted living residency rates between White enrollees and enrollees of all other race/ethnicities is striking, especially when the residency rate in nursing facilities for Black and White enrollees is roughly equivalent at all points in time. The evaluation team recommends additional analysis of ALF residency location to include stratification of geographic region; race, ethnicity, and county rural status (see Table 8). Understanding this phenomenon and whether it is driven largely by the geographic availability of ALFs, personal preferences of the enrollees, or enrollee level of need should be useful for future planning of service delivery.

3. The evaluation team recommends additional analysis of HCBS versus NF residency location to include stratification of geographic region; race, ethnicity, and county rural status (see Table 8). Some analysis has been done in this area for various annual reports. However, an in-depth analysis, as the sole question for a given evaluation year, may provide insights that improve care delivery and further explain observed differences in service levels utilized.

4. The evaluation team recommends additional monitoring, oversight, and investigation in cases where enrollee transitions fail (see Table 7).

5. The evaluation team recommends that strict submission requirements for all assessments of enrollee functional status conducted by the plan case managers be enforced with financial penalties for non-compliance. Plans should regularly submit to the Agency electronic spreadsheets (Excel format but not PDF format) representing the assessment scores for all categories of assessment forms for each enrollee in a format that facilitates use and summarization of the data. Care plans and service authorizations in a machine-readable format would also be useful so that the comprehensive assessment, care plans and services authorizations may be linked to the encounter records.

Quality of Care

Purpose

The Independent Assessment of the Florida Statewide Medicaid Managed Care Long-term Care Program examined the impact on enrollees' quality of care during five consecutive state fiscal years from July 1, 2014 through June 30, 2019. The evaluation team and the Agency identified key issues of importance to policy makers and LTC stakeholders. The evaluation team, in concert with the Agency, developed five research questions (RQs) to guide the evaluation.

The research questions were viewed within the context of other ongoing quality initiatives undertaken by the Agency. For example, the evaluation team consistently used enrollee outcomes as the gold standard for evaluating quality. This decision, while based on research, is consistent with the External Quality Review (EQR) Technical Report (SFY 2018 - 2019)[29] and the Florida Medicaid Comprehensive Quality Strategy.[30] This evaluation also examined the equity of healthcare quality, which is a stated goal in the Florida Medicaid Comprehensive Quality Strategy. Specifically, this report examined equity in healthcare quality outcomes as it relates to race, ethnicity, sex, and geographic location. Of importance, geographic location in the SMMC LTC program was linked to specific Plan providers.

This report may serve as a tool that can be used to guide ongoing process evaluations such as the EQR evaluation and the Florida Medicaid Comprehensive Quality Strategy. Finally, the Department of Health and Human Services directs that the findings of the independent evaluation be used "to improve and ensure quality of care." The Conclusions and Recommendations section of this report outline six ways to improve and/or ensure quality of care within the SMMC LTC program based on the findings within this section.

Appendix B to this report provides additional information on the methodology and data sources.

These five RQs guide the evaluation:

1. Are long-term care (LTC) services effective at achieving positive health outcomes?
2. Are LTC services effective at achieving equitable, positive health outcomes by gender, race/ ethnicity, and geographic location?
3. Are patient-centered enrollee transitions reducing the number of potentially preventable transitions?
4. Are patient-centered needs of enrollees being met?
5. Has enrollee safety improved over time?

Overview of the Methodology

[29] Health Services Advisory Group. (2020). *SFY 2018-2019 External quality review technical report.* Retrieved from Agency for Health Care Administration website: https://ahca.myflorida.com/Medicaid/quality_mc/mgd_care_eqr.shtml

[30] Agency for Health Care Administration. (2017). *Comprehensive quality strategy.* Retrieved from the Agency for Health Care Administration website: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf

To measure quality and quality improvement, the evaluation team adopted the definition of the Centers for Medicare and Medicaid Service (CMS): "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[31] Further, the evaluation team applied arguably the most influential framework of health care quality put forth by the Institute of Medicine[32] to increase knowledge and understanding of health care quality in the Florida SMMC LTC program. This framework of quality of care includes four domains that are applicable to the evaluation team's analyses:

1. **Effectiveness** relates to providing services and achieving positive health outcomes.
2. **Equity** relates to providing health care of equal quality to people with differing personal characteristics other than their clinical condition.
3. **Patient centeredness** relates to meeting patients' needs and preferences and providing education and support.
4. **Safety** relates to actual or potential bodily harm to enrollees.

Effectiveness was evaluated by observing to what extent specific LTC services improve health-related quality of life (HRQOL) indicators over time (RQ 1). Effectiveness was further evaluated to test that services are **equitable** to enrollees with differing personal characteristics other than their clinical condition (RQ 2). In addition, **patient-centeredness** was evaluated to ensure that enrollee needs, and preferences were being met, including when they transitioned to other locations of care (RQs 3 and 4). **Safety** was evaluated to ensure that enrollees' safety improved over time (RQ 5).

The LTC program serves enrollees in two broad settings: 1) home and community-based settings (HCBS) and 2) nursing facilities (NFs). As the name implies, homes and communities can be further broken down into enrollee homes and other residential settings (i.e., community settings), and other residential settings can be further broken down into different types of home-like environments that are shared with others and are considered social rather than medical settings. These community settings vary in their services and populations. For this evaluation, the largest community setting (assisted living facilities [ALFs]) was presented in addition to enrollee home settings. Further, enrollees within HCBS and enrollees within NFs receive different yearly assessments. These assessments are the crux of the evaluation. However, because the assessments are not consistent across HCBS and NF settings, this report used different quality metrics for HCBS enrollees and NF enrollees.

Enrollees living within the community and those residing in small group homes, ALFs, and/or other congregate homes licensed by the Agency, are assessed using the 701B form, which is unique to Florida and is housed at the Department of Elder Affairs. The 701B Comprehensive Assessment is administered in face-to-face meetings

[31] Lohr, K. N., & Schroeder, S. A. (1990). A strategy for quality assurance in Medicare. *New England Journal of Medicine*, *322*, 707-712.
[32] Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st century. Washington, D.C: National Academy Press.

with a (potential) LTC enrollee by a Comprehensive Assessment and Review for Long-Term Care Services (CARES) assessor or LTC plan case manager. The 701B assessment is completed upon initial assessment for the LTC program and annually while enrolled in the LTC program with information provided by the enrollee, observed directly, or verified by records.[33]

Enrollees residing in NFs are assessed using the federally mandated Minimum Data Set (MDS) 3.0, which is housed at the Centers for Medicare and Medicaid Services. NF enrollees receive this assessment at intake into a NF, when their condition changes, and/or annually. The items in the MDS are used to comprehensively assess NF resident's functioning.[34]

Under each research question, findings are presented for home and community-based enrollees, then for NF enrollees. Where comparisons between the HCBS and NF populations are possible using the different assessments, they are discussed within the HCBS section and are briefly referenced in the NF section of each research question.

Findings

RQ1: Are long-term care (LTC) services effective at achieving positive health outcomes?

Trends in health-related quality of life by setting

HCBS Settings

Quality of Life

Given that quality of life is an optimal goal of all persons, it is one indicator that is appropriate to all sites of care. Health plays an important role in how individuals experience their quality of life. Indeed, the Department of Health and Human Services notes that quality of life is an essential outcome in designing an independent assessment.[35] Furthermore, how an individual perceives his or her health, i.e., as poor, fair, good, very good or excellent, is a recognized predictor of functional decline and mortality.[36] This evaluation examined whether perceived health status changed over the evaluation period irrespective of site of care (e.g., Home-based versus ALF). Does perception of health increase (greater reports of good, very good, excellent) or decrease (greater reports of fair or poor) over the course of the evaluation period?

Table 22 summarizes the responses of Home-based enrollees to items included in the most recent enrollee 701B assessment instrument related to their quality of life and self-reported health and whether either of these

[33] For more information about the 701B assessment, refer to the 701D Instructions: Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment, which can be accessed through this link: http://elderaffairs.state.fl.us/doea/forms/701D_Assessment_Instructions.pdf

[34] For more information regarding the MDS 3.0, refer to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual that can be accessed at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

[35] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[36] Stewart, A.L., & Ware, J.E. (1992). Measuring functioning and well-being: The Medical Outcomes Study approach. Durham NC: Duke University Press.

has changed over the five-year evaluation period. Table 23 does the same, but for ALF enrollees. Both tables show the counts (n) and percentages (%) of the total number of respondents over the five-year evaluation period.

- When asked how satisfied they were with their overall quality of life, the proportion of Home-based enrollees indicating they were “very satisfied” decreased (from 8% in SFY 2014 - 2015 to five percent in SFY 2018 - 2019) and the proportions of Home-based enrollees indicating they are “neither satisfied nor dissatisfied” (from 21% in SFY 2014 - 2015 to 28% in SFY 2018 - 2019) and “dissatisfied” (from 9% in SFY 2014 - 2015 to 10% in SFY 2018 - 2019) increased.
- Indicating a positive trend, the proportion of ALF enrollees indicating they were “very dissatisfied” with their overall quality of life declined (from 2% in SFY 2014 - 2015 to 1% in SFY 2018 - 2019).
- The proportion of Home-based enrollees who indicated that they felt “much worse” about their quality of life (from 1% in SFY 2014 - 2015 to 2% in SFY 2018 - 2019) and health (from 2% in SFY 2014 - 2015 to 5% in SFY 2018 - 2019) compared to a year ago increased over the five-year period. On the other hand, the proportion of ALF enrollees who indicated that they felt “much worse” about their quality of life did not increase. Instead, more ALF enrollees indicated that they felt “better” about their health increased compared to a year ago (from 11% in SFY2014 - 2015 to 14% in SFY 2018 - 2019).

Table 22. Quality of life and self-reported health among in enrollees in their Homes.

	Home-based Enrollees Self-Reported Quality of Life									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
How satisfied are you with your overall quality of life?										
Very Satisfied	1,007	8	1,162	7	1,099	6	1,181	5	1,225	5
Satisfied	7,860	60	10,268	61	11,139	59	12,320	57	13,294	56
Neither	2,821	21	3,780	22	4,539	24	5,822	27	6,653	28
Dissatisfied	1,214	9	1,481	9	1,721	9	2,107	10	2,394	10
Very Dissatisfied	270	2	276	2	281	1	335	2	383	2
Thinking about how you were doing this time last year, how do you feel about the way things are now?										
Much Better	480	4	585	3	523	3	553	3	616	3
Better	1,879	14	2,438	14	2,620	14	3,121	14	3,465	14
About the Same	8,726	66	11,214	66	12,384	66	13,870	64	14,915	62
Worse	1,951	15	2,558	15	2,977	16	3,868	18	4,488	19
Much Worse	136	1	172	1	275	1	353	2	465	2
How would you rate your overall health at the present time?										
Excellent	180	1	195	1	218	1	217	1	214	1
Very Good	777	4	890	4	896	4	1,084	4	1,125	3
Good	5,174	29	6,616	29	7,178	28	8,123	28	8,766	27
Fair	8,951	50	11,406	50	12,681	50	14,610	50	16,192	50
Poor	2,782	16	3,605	16	4,225	17	5,249	18	6,354	19
Compared to a year ago, how would you rate your health?										
Much Better	555	3	721	3	640	3	632	2	663	2
Better	2,115	12	2,611	11	2,848	11	3,304	11	3,665	11
About the Same	9,975	56	12,784	56	14,061	56	15,603	53	16,676	51
Worse	4,806	27	6,111	27	6,828	27	8,544	29	10,009	31
Much Worse	413	2	485	2	821	3	1,200	4	1,638	5

Note: Frequencies between Questions 1 and 2 are different from Questions 3 and 4 because of the skip logic within the 701B, where Questions 1 and 2 were skipped if the enrollee was not answering the assessment questions.

Sources: FSU created enrollee LOC file, 701B assessments

Table 23. Quality of life and self-reported health among in enrollees in ALFs.

	ALF-based Enrollees Self-Reported Quality of Life									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
How satisfied are you with your overall quality of life?										
Very Satisfied	329	8	374	7	360	6	362	6	400	6
Satisfied	2,530	63	3,288	63	3,641	63	3,845	65	4,296	63
Neither satisfied	803	20	1,089	21	1,269	22	1,350	23	1,634	24
Dissatisfied	283	7	365	7	415	7	346	6	417	6
Very Dissatisfied	69	2	84	2	60	1	55	1	48	1
Thinking about how you were doing this time last year, how do you feel about the way things are now?										
Much Better	138	3	184	4	164	3	178	3	209	3
Better	586	15	831	16	979	17	1,087	18	1,270	19
About the Same	2,878	72	3,682	71	4,020	70	4,035	68	4,522	67
Worse	382	10	476	9	548	10	623	10	744	11
Much Worse	30	1	27	1	34	1	35	1	50	1
How would you rate your overall health at the present time?										
Excellent	97	1	119	1	118	1	101	1	123	1
Very Good	345	5	435	5	514	6	520	6	597	6
Good	2,652	39	3,380	40	3,757	41	4,074	44	4,606	45
Fair	2,975	44	3,728	44	3,922	43	3,830	41	4,151	41
Poor	652	10	759	9	757	8	740	8	767	7
Compared to a year ago, how would you rate your health?										
Much Better	133	2	187	2	166	2	126	1	179	2
Better	712	11	973	12	1,134	13	1,203	13	1,395	14
About the Same	4,495	67	5,537	66	6,022	66	5,983	65	6,405	63
Worse	1,272	19	1,612	19	1,634	18	1,786	19	2,095	20
Much Worse	109	2	112	1	112	1	167	2	170	2

Note: Frequencies between Questions 1 and 2 are different from Questions 3 and 4 because of the skip logic within the 701B, where Questions 1 and 2 were skipped if the enrollee was not answering the assessment questions.
Sources: FSU created enrollee LOC file, 701B assessments

Depression

Depression is a recognized problem for older adults in general and especially for frail older adults.[37] In the Medicaid population, many enrollees have a lack of resources that may exacerbate the risk for depression.

The evaluation team examined data from the nine-item Patient Health Questionnaire (PHQ-9) that is embedded in the 701B Comprehensive Assessment[38] for enrollees in HCBS and in the MDS for enrollees in NF settings to determine the presence of depressive symptoms. The nine items are summed to create a severity score, which are then classified into five categories. Scores of zero to four indicate none to minimal depressive symptoms, five to nine indicates mild depressive symptoms, ten to fourteen indicates moderate depressive symptoms, fifteen to nineteen indicates moderately severe depressive symptoms, and twenty to twenty-seven indicates severe depressive symptoms. While clinical judgment may be exercised to treat mild or moderate depression,

[37] Soysal, P., N. Veronese, T. Thompson, et.al. (2017). Relationship between depression and frailty in older adults: A systematic review and meta-analysis. *Ageing Research Reviews*, *36*, 78-87.
[38] The 701B Comprehensive Assessment was developed by the Florida Department of Elder Affairs to assess any client of a Department-funded case-managed program. The assessment occurs at intake into a program, as well as at least annually and covers items such as a client's health, functioning, needs, and resources.

moderately severe and severe depression scores warrant treatment with therapies, medications, or both.[39] The depression score results are displayed in Table 24, which shows the counts and percentages for HCBS and NF enrollees.

- Home-based enrollees' depression scores remained fairly consistent over the evaluation period.
- Proportions of ALF and NF enrollees with moderately severe and severe depression scores decreased over the evaluation period (from 1% in SFY 2014 - 2015 to 0% in SFY 2018 - 2019 for both groups), indicating a positive trend.

Table 24. Depression as Measured by PHQ-9 Scores among HCBS Enrollees.

	Depression (PHQ-9) Scores HCBS									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Enrollees at Home										
None	5,963	45	7,938	47	8,852	47	10,054	46	10,552	44
Minimal	4,787	36	6,076	36	6,693	36	7,817	36	8,874	37
Mild	1,703	13	2,106	12	2,235	12	2,711	12	3,203	13
Moderate	472	4	543	3	656	3	760	3	883	4
Moderately	180	1	248	1	269	1	326	1	321	1
Severe	67	1	56	0	74	0	97	0	116	0
Enrollees in ALFs										
None	2,095	52	2,853	55	3,145	55	3,272	55	3,633	53
Minimal	1,446	36	1,771	34	2,023	35	2,091	35	2,470	36
Mild	362	9	439	8	438	8	474	8	563	8
Moderate	83	2	93	2	94	2	77	1	90	1
Moderately	23	1	40	1	39	1	40	1	28	0
Severe	>10	0	>10	0	>10	0	>10	0	>10	0
Enrollees in NFs										
None	23,233	53	23,425	57	22,669	59	21,886	63	19,622	64
Minimal	13,137	30	11,875	29	10,563	28	9,261	27	7,845	26
Mild	5,695	13	4,778	12	4,069	11	3,159	9	2,607	9
Moderate	1,118	3	871	2	655	2	445	1	373	1
Moderately	343	1	263	1	158	0	99	0	73	0
Severe	54	0	32	0	14	0	>10	0	>10	0

Sources: FSU created enrollee LOC file, 701B assessments, MDS 3.0

[39] DeJesus, R. S., Vickers, K. S., Melin, G. J., & Williams, M. D. (2007, November). A system-based approach to depression management in primary care using the Patient Health Questionnaire-9. In *Mayo Clinic Proceedings* (Vol. 82, No. 11, pp. 1395-1402). Elsevier.

Social Participation

Social participation is the involvement of a person in activities that provide interaction with other people in their community. It provides a sense of value and identity and is associated with better health among older adults. The inverse of social participation (i.e., social isolation), has been found to be detrimental to older adults' health.[40] Table 25 shows the counts and percentages of the social participation reported by Home-based enrollees. Table 26 shows the same for enrollees living in ALFs.

- Enrollees living at home demonstrated declines in having someone available to help if needed (from 58% in SFY 2014 - 2015 to 48% in SFY 2018 - 2019).
- Additionally, the proportions of enrollees living at home who never talked to friends or family remained the same over the study period (about 5% of the population). The amount of time they spoke with friends or family "two to six times per week" increased over the study period. (from 25% in SFY 2014 - 2015 to 27% in SFY 2018 - 2019). These are positive trends.
- Home-based enrollees had a small proportional decrease in "once per day" interactions with others who do not live with them (from 27% in SFY 2014 - 2015 to 22% in SFY 2018 - 2019).
- The proportion of home-based enrollees who only saw others "a few times per year" slightly increased over the study period.
- Finally, Home-based enrollees experienced a decrease in enrollees who "never" participated in activities outside their homes that are of interest to them (from 23% in SFY 2014 - 2015 to 19% in SFY 2018 - 2019). This is a positive trend.
- Enrollees living in ALFs also demonstrated declines in having someone available to help if needed (from 58% in SFY 2014 - 2015 to 56% in SFY 2018 - 2019).
- For enrollees living in ALFs, the proportion of enrollees who never talked to friends or family decreased over the study period (from 14% in SFY 2014 - 2015 to 8% in SFY 2018 - 2019), which is a positive finding. ALF enrollees grew in the "once per day" (from 22% in SFY 2014 - 2015 to 26% in SFY 2018 - 2019) and "two to six times per week" (from 24% in SFY 2014 - 2015 to 29% in SFY 2018 - 2019) categories. These are positive findings.
- ALF enrollees experienced decreases in enrollees who "never" participated in activities outside their homes that are of interest to them (from 34% in SFY 2014 - 2015 to 29% in SFY 2018 - 2019), which is positive.

[40] Cudjoe, T. K., Roth, D. L., Szanton, S. L., Wolff, J. L., Boyd, C. M., & Thorpe Jr, R. J. (2020). The epidemiology of social isolation: National health and aging trends study. *The Journals of Gerontology: Series B*, *75*(1), 107-113.

Table 25. Social Help and Social Activities among Enrollees Living at Home.

	Home-based Enrollees Self-Reported Social Participation									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
If needed, is there someone who could help you?										
Yes	10,45	58	12,98	57	13,96	55	15,68	54	16,94	48
No	7,414	42	9,724	43	11,23	45	13,59	46	15,70	52
About how often do you talk to friends, relatives, or others?										
Once per day	8,577	48	11,26	50	12,58	50	14,30	49	15,75	48
2-6 times per week	4,403	25	5,835	26	6,566	26	7,932	27	8,734	27
Once per week	1,717	10	1,971	9	2,188	9	2,752	9	3,137	10
Several times per month	1,058	6	1,383	6	1,485	6	1,659	6	2,024	6
Every few months	431	2	504	2	624	2	670	2	762	2
A few times per year	288	2	366	2	376	1	457	2	548	2
Never	1,390	8	1,386	6	1,375	5	1,509	5	1,696	5
How often do you spend time with someone who does not live with you?										
Once per day	4,834	27	6,178	27	6,423	25	6,743	23	7,153	22
2-6 times per week	6,104	34	7,925	35	8,741	35	10,20	35	11,20	34
Once per week	2,658	15	3,235	14	3,817	15	4,727	16	5,454	17
Several times per month	1,826	10	2,393	11	2,852	11	3,417	12	3,933	12
Every few months	884	5	1,137	5	1,389	6	1,777	6	2,062	6
A few times per year	592	3	816	4	915	4	1,074	4	1,256	4
Never	966	5	1,028	5	1,061	4	1,345	5	1,584	5
How often do you participate in activities outside the home that interest you?										
Once per day	1,255	7	1,467	6	1,420	6	1,495	5	1,745	5
2-6 times per week	3,107	17	3,909	17	4,205	17	4,735	16	5,143	16
Once per week	2,387	13	2,987	13	3,436	14	4,066	14	4,505	14
Several times per month	2,878	16	4,122	18	4,731	19	5,500	19	5,929	18
Every few months	2,183	12	3,017	13	3,689	15	4,523	15	4,951	15
A few times per year	1,997	11	2,669	12	3,061	12	3,664	13	4,270	13
Never	4,057	23	4,541	20	4,656	18	5,300	18	6,108	19

Sources: FSU created enrollee LOC file, 701B assessments

Table 26. Social Help and Social Activities among Enrollees Living in ALFs.

	ALF-based Enrollees Self-Reported Social Activities									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
If needed, is there someone who could help you?										
Yes	3,915	58	5,041	60	5,294	58	5,267	57	5,727	56
No	2,806	42	3,380	40	3,774	42	3,998	43	4,517	44
About how often do you talk to friends, relatives, or others?										
Once per day	1,462	22	1,891	22	2,089	23	2,287	25	2,620	26
2-6 times per week	1,615	24	2,190	26	2,517	28	2,551	28	3,011	29
Once per week	1,070	16	1,322	16	1,480	16	1,525	16	1,566	15
Several times per month	893	13	1,152	14	1,226	14	1,203	13	1,291	13
Every few months	405	6	473	6	481	5	481	5	559	5
A few times per year	315	5	329	4	334	4	358	4	356	3
Never	961	14	1,064	13	941	10	860	9	841	8
How often do you spend time with someone who does not live with you?										
Once per day	807	12	961	11	989	11	973	11	1,039	10
2-6 times per week	1,477	22	1,876	22	2,026	22	2,087	23	2,466	24
Once per week	1,334	20	1,686	20	1,824	20	1,905	21	2,132	21
Several times per month	1,306	19	1,694	20	1,898	21	1,830	20	1,994	19
Every few months	654	10	812	10	945	10	1,009	11	1,114	11
A few times per year	505	8	589	7	636	7	685	7	701	7
Never	638	9	803	10	750	8	776	8	798	8
How often do you participate in activities outside the home that interest you?										
Once per day	229	3	276	3	270	3	286	3	302	3
2-6 times per week	588	9	701	8	755	8	789	9	939	9
Once per week	713	11	896	11	945	10	995	11	1,129	11
Several times per month	1,083	16	1,467	17	1,672	18	1,790	19	1,976	19
Every few months	878	13	1,167	14	1,493	16	1,641	18	1,906	19
A few times per year	978	15	1,281	15	1,494	16	1,558	17	1,687	16
Never	2,252	34	2,633	31	2,439	27	2,206	24	2,305	23

Sources: FSU created enrollee LOC file, 701B assessments

Nutrition

Good nutrition improves HRQOL by promoting health, preventing dietary deficiency disease, and malnutrition.[41] Further, sharing meals with family and friends has been shown to also improve nutrition among older adults, as well as lower their risk of experiencing social isolation.[42] Table 27 shows the counts and percentages of nutrition factors reported by HCBS enrollees.

- Of Home-based enrollees who lost weight, the number of them who intentionally lost weight declined over the five-year period (from 19% in SFY 2014 - 2015 to 15% in SFY 2018 - 2019).

[41] Amarantos, E., Martinez, A., & Dwyer, J. (2001). Nutrition and quality of life in older adults. *The Journals of Gerontology series A: Biological sciences and Medical sciences*, *56*(suppl_2), 54-64.
[42] Vesnaver, E., & Keller, H. H. (2011). Social influences and eating behavior in later life: a review. *Journal of Nutrition in Gerontology and Geriatrics*, *30*, 2-23.

- The percentage of ALF enrollees who ate at least two meals per day decreased over the study period (from 99% in SFY 2015 - 2015 to 98% in SFY 2018 - 2019) and those who ate alone most of the time increased (from 12% in SFY 2015 to 14% in SFY 2019).

Table 27. Nutrition among Enrollees Living at Home.

	Home-based Enrollees Self-Reported Nutrition									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Home Enrollees										
Do you usually eat at least two meals a day?										
Yes	17,437	98	22,154	98	24,587	98	28,462	97	31,682	97
No	427	2	558	2	611	2	821	3	969	3
Do you eat alone most of the time?										
Yes	6,235	35	7,696	34	8,666	34	10,388	35	11,811	36
No	11,629	65	15,016	66	16,532	66	18,895	65	20,840	64
Of people who lost weight in the past few months, was it purposely?										
Yes	856	19	1,000	18	1,071	18	1,273	16	1,388	15
No	3,757	81	4,590	82	5,023	82	6,548	84	7,809	85
ALF Enrollees										
Do you usually eat at least two meals a day?										
Yes	6,652	99	8,326	99	8,952	99	9,128	99	10,078	98
No	69	1	95	1	116	1	137	1	166	2
Do you eat alone most of the time?										
Yes	837	12	957	11	1,006	11	1,272	14	1,448	14
No	5,884	88	7,464	89	8,062	89	7,993	86	8,796	86
Of people who lost weight in the past few months, was it purposely?										
Yes	183	12	217	12	210	12	244	12	260	12
No	1,288	88	1,619	88	1,569	88	1,784	88	1,954	88

Sources: FSU created enrollee LOC file, 701B assessments

Number of Inpatient Hospitalization Days per Month

Table 28 provides the average number of days enrollees, normally residing in their Homes, ALFs, and NFs, spent in inpatient hospital settings.

- The mean of inpatient days for enrollees living at home steadily declined over the five-year evaluation period (from an average of 0.63 days in SFY 2014 - 2015 to 0.49 days in SFY 2018 - 2019).
- The mean of inpatient days for ALF enrollees stayed relatively the same throughout the evaluation period (ranging from 0.48 days to 0.54 days throughout the study period).
- The mean of inpatient days for NF enrollees stayed relatively the same throughout the first four years of the evaluation period (ranging from 0.56 days to 0.60 days) but dropped in the fifth year to 0.51 days.

Table 28. Average Number of Inpatient Hospitalizations per Month by Setting.

	Average Number of Inpatient Days by Setting (Min = 0; Max = 31)				
Setting	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**SFY 2019**
Home					
Mean	0.63	0.61	0.62	0.56	0.49
Std Dev	2.90	2.90	2.92	2.76	2.50
Minimum	0	0	0	0	0
Maximum	31	31	31	31	31
ALF					
Mean	0.50	0.50	0.54	0.52	0.48
Std Dev	2.25	2.27	2.40	2.38	2.22
Minimum	0	0	0	0	0
Maximum	31	31	31	31	31
NF					
Mean	0.58	0.58	0.60	0.56	0.51
Std Dev	2.59	2.64	2.67	2.55	2.39
Minimum	0	0	0	0	0
Maximum	31	31	31	31	31

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Number of Emergency Room Hospitalization Days per Month

Table 29 provides the average number of days enrollees, normally residing in their homes, ALFs, and NFs, spent in emergency room settings.

- Enrollees living at home showed no change in the average of emergency room days throughout the evaluation period.
- Those enrollees who resided in ALFs showed negligible change over this same period.
- The mean of emergency room hospitalizations declined over the study period (from 0.63 days in SFY 2014 - 2015 to 0.49 days in SFY 2018 - 2019), an indicator of positive HRQOL.

Table 29. Average Number of Emergency Room Hospitalizations per Month by Setting.

	Average Number of Emergency Room Days by Setting				
	SFY	SFY	SFY	SFY	SFY
Home					
Mean	0.07	0.07	0.08	0.07	0.07
Std Dev	0.32	0.32	0.34	0.34	0.33
Minimum	0	0	0	0	0
Maximum	12	16	13	18	16
ALF					
Mean	0.08	0.08	0.09	0.09	0.09
Std Dev	0.33	0.33	0.37	0.35	0.36
Minimum	0	0	0	0	0
Maximum	9	11	18	12	11
NF					
Mean	0.63	0.61	0.62	0.56	0.49
Std Dev	2.90	2.90	2.92	2.76	2.50
Minimum	0	0	0	0	0
Maximum	31	31	31	31	31

Sources: FSU created enrollee LOC file, Florida Center Data (ER)

Caregivers in Crisis

While the focus on enrollee outcomes is paramount in measuring quality, the LTC program also seeks to support caregivers. Non-paid, informal caregivers (i.e., family members, close friends) provide most of the care to support enrollees' instrumental activities of daily living (IADLs, e.g., shopping, money management) and are essential to allowing enrollees to age in place. For enrollees living at home, these informal caregivers may also provide ADL support such as assistance in bathing, dressing, and toileting. Indeed, caregiver support is one of the essential elements that allows enrollees to remain in their homes. Often a caregiver crisis will trigger an enrollee's transition to a NF or from home to another residential setting.[43]

When conducting 701B assessments, case managers assess whether caregivers are in crisis. If the answer is yes, caregivers are asked to provide greater specificity regarding the type of crisis. Results from these data for SFYs 2015 through 2019 are presented in Table 30. Type of crisis was excluded for ALF enrollees to ensure confidentiality, because the number of caregivers experiencing each type of crisis was very small (>10), which is a positive finding.

- Roughly half of enrollees living at home (ranging from 47 to 50% over the study period) and only 1 percent of enrollees in ALFs had a primary caregiver.
- Caregivers in crisis varied between 15 to 18 percent for caregivers of enrollees living at home and varied between 14 to 29 percent for caregivers of enrollees living in ALFs over the five-year evaluation period.

[43] National Alliance for Caregiving & AARP Public Policy Institute, *Caregiving in the US.* Retrieved from www.caregiving.org/caregiving2015

The volatility in the ALF caregivers' crisis status is likely due to the small sample size of ALF caregivers (ranging from 52 to 110 caregivers during the study period).

Table 30. Assessment of Caregivers among HCBS Enrollees.

	Home-based Enrollees Caregiver Status (Assessor Observation)									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Home Enrollees										
Is there a primary caregiver?										
Yes	8,458	47	11,370	50	12,325	49	14,415	49	16,472	50
No	9,406	53	11,342	50	12,873	51	14,869	51	16,179	50
Caregiver in crisis										
Yes	1,384	16	1,697	15	1,885	15	2,341	16	2,895	18
No	7,074	84	9,673	85	10,440	85	12,074	84	13,577	82
Type of crisis										
Emotional crisis	823	59	1,083	64	1,201	64	1,513	65	1,881	65
Financial crisis	548	40	658	39	784	42	1,044	45	1,180	41
Physical crisis	797	58	966	57	1,054	56	1,313	56	1,684	58
ALF Enrollees										
Is there a primary caregiver?										
Yes	42	1	56	1	66	1	93	1	109	1
No	6,679	99	8,365	99	9,002	99	9,173	99	10,135	99
Caregiver in crisis										
Yes	10	24	>10	14	15	23	27	29	18	16
No	32	76	48	86	51	77	66	71	92	84

Sources: FSU created enrollee LOC file, 701B assessments

Nursing Facilities

CMS has developed quality measures to assist families in choosing a NF or in evaluating a NF where a family member currently lives. These quality measures are also intended to facilitate quality improvement (QI) within NFs by providing discussion points with staff regarding current quality issues.

The following is a list of the current CMS long-stay NF quality measures:

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Residents Who Self-Report Moderate to Severe Pain
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents with a Urinary Tract Infection
- Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
- Percent of Residents Who Lose Too Much Weight
- Percent of Residents Who Have Depressive Symptoms
- Percent of Long-Stay Residents Who Received an Antipsychotic Medication

The evaluation team reviewed the CMS QMs to determine the appropriateness for inclusion in this report. The evaluation team chose to exclude ADL declines as a measure of quality because NF residents usually experience ADL declines as they approach the end of life, making it less meaningful in this setting. For an explanation of depressive symptoms among NF enrollees, refer to Table 24, as the same measure (i.e., PHQ-9) was used across settings making it possible for comparison.

Falls

Older adults living in institutional settings have a higher risk of falling than older adults residing in a community.[44] Falls are dangerous for older adults, as they can lead to bone fractures, loss of independence, and even death. Table 31 shows the counts and percentages of falls and severity of falls of NF enrollees.

- The proportion of NF enrollees experiencing falls (from 28% in SFY 2014 - 2015 to 27% in SFY 2018 - 2019) decreased over the five-year observation period, which is a positive finding.

Table 31. Falls among Enrollees living in Nursing Facilities.

	Falls among Enrollees living in Nursing Facilities									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Any Falls Since Admission/Entry or Reentry or Prior Assessment										
Yes	20,014	28	20,584	28	20,234	28	19,559	27	19,113	27
No	51,107	72	52,312	72	52,537	72	51,600	73	51,728	73
Fall with No Injury										
Yes	16,800	84	17,356	84	17,038	84	16,549	85	16,021	84
No	3,181	16	3,215	16	3,186	16	3,003	15	3,088	16
Fall with Minor Injury										
Yes	7,045	35	7,497	36	7,357	36	7,027	36	6,708	35
No	12,935	65	13,062	64	12,852	64	12,513	64	12,398	65
Fall with Major Injury										
Yes	670	3	721	4	694	3	608	3	571	3
No	19,291	97	19,835	96	19,509	97	18,927	97	18,537	97

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Pain

While pain is a common symptom experienced in older adulthood, and pain management does not seek to ameliorate all pain, pain should be treated when it is moderate or severe. Moderate and severe pain indicates that the pain experienced by enrollees interferes with their daily activities. Table 32 shows the counts and percentages of moderate and severe pain of NF enrollees.

[44] Datta, A., Datta, R., & Elkins, J. (2019). What factors predict falls in older adults living in nursing homes: a pilot study. *Journal of Functional Morphology and Kinesiology*, *4*(1), 3.

- The proportion of enrollees experiencing moderate or severe pain decreased over the five-year observation period (from 41% in SFY 2014 - 2015 to 38% in SFY 2018 - 2019) over the five-year observation period, which is a positive finding.

Table 32. Moderate or Severe Pain among Enrollees living in Nursing Facilities.

	Moderate or Severe Pain Presence									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Moderate or Severe Pain Presence in the last 5 days										
Yes	23,945	41	24,914	41	23,875	40	23,469	40	22,410	38
No	34,982	59	35,985	59	36,023	60	35,042	60	36,256	62

Sources: FSU created enrollee LOC file, MDS 3.0

Pressure ulcers

A pressure ulcer is a localized sore that results from unrelieved pressure to the skin and underlying tissue. Pressure ulcers may be caused by pressure to the skin from immobility, chafing of the skin, or moisture on the skin. Decreased ability to feel pain and malnutrition can also contribute to pressure ulcers. Table 33 shows the counts and percentages of unhealed pressure ulcers and their severity among NF enrollees.

- Overall, the proportion of NF enrollees with any type of pressure ulcer decreased (from 14% in SFY 2014 - 2015 to 12% in SFY 2018 - 2019).
- Of the NF enrollees who did have pressure ulcers, the proportions of those with Stage 1 or 2 pressure ulcers decreased (Stage 1: from 21% in SFY 2014 - 2015 to 13% for SFY 2018 - 2019; Stage 2: from 38% in SFY 2014 - 2015 to 29% in SFY 2018 - 2019). The proportions of those with Stage 3 or 4 pressure ulcers increased over the evaluation period (Stage 3: from 23% in SFY 2014 - 2015 to 26% in SFY 2018 - 2019; Stage 4: from 16% in SFY 2014 - 2015 to 21% in SFY 2018 - 2019). Stage 1 and 2 pressure ulcers are less severe than Stage 3 and 4 pressure ulcers.

Table 33. Pressure Ulcers among Enrollees living in Nursing Facilities.

	Pressure Ulcers among Enrollees living in Nursing Facilities									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Unhealed Pressure Ulcer at Stage 1 or Higher										
Yes	10,175	14	10,264	14	10,011	14	9,623	14	8,837	12
No	61,248	86	62,917	86	62,864	86	61,615	86	62,117	88
At Least One Unhealed Pressure Ulcer at Stage 1										
Yes	1,740	21	1,600	19	1,294	17	1,199	16	891	13
No	6,666	79	6,815	81	6,501	83	6,190	84	5,813	87
At Least One Unhealed Pressure Ulcer at Stage 2										
Yes	3,832	38	3,731	36	3,334	33	2,966	31	2,571	29
No	6,329	62	6,518	64	6,667	67	6,643	69	6,249	71
At Least One Unhealed Pressure Ulcer at Stage 3										
Yes	2,338	23	2,484	24	2,446	24	2,392	25	2,315	26
No	7,823	77	7,765	76	7,556	76	7,218	75	6,506	74
At Least One Unhealed Pressure Ulcer at Stage 4										
Yes	1,665	16	1,823	18	1,980	20	1,856	19	1,817	21
No	8,495	84	8,426	82	8,022	80	7,753	81	7,007	79

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Vaccinations

Older adults, especially frail older adults, are at risk of dying from complications of influenza and pneumonia.[45] To combat mortality associated with influenza and pneumonia, vaccinations have been developed and administered for these diseases. Table 34 shows the counts and percentages of vaccinations records among NF enrollees.

- The proportions on NF enrollees with up-to-date influenza and pneumococcal vaccines decreased over the five-year evaluation period. Influenza vaccinations decreased from 75 percent in SFY 2014 - 2015 to 70 percent in SFY 2018 - 2019. Pneumococcal vaccinations decreased from 56 percent in SFY 2014 - 2015 to 52 percent in SFY 2018 - 2019.

[45] Centers for Disease Control and Prevention. (2019). Study show hospitalization rates and risk of death from seasonal flu increase with age among people 65 years and older. Retrieved from https://www.cdc.gov/flu/spotlights/2018-2019/hopitalization-rates-older.html

Table 34. Vaccinations among Enrollees living in Nursing Facilities.

	Vaccinations among Enrollees living in NFs									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Influenza Vaccine is Up to Date										
Yes	52,976	75	52,996	73	50,890	71	49,474	71	49,325	70
No	17,572	25	19,368	27	20,544	29	20,370	29	20,648	30
Pneumococcal Vaccine Up to Date										
Yes	39,311	56	39,314	54	37,579	53	36,468	52	36,064	52
No	31,216	44	33,056	46	33,771	47	33,266	48	33,794	48

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Bladder and Bowel Control

While risk of bladder and bowel incontinence increases with age, incontinence has an impact on the quality of life of older adults.[46, 47] Furthermore, when catheterization is required, risk of urinary tract infections and asymptomatic bacteriuria increases for older adults.[48] Table 35 shows the counts and percentages of bladder and bowel incontinence records among NF enrollees. Bladder incontinence decreased proportionally over the five-year period.

- Bladder and bowel incontinence decreased over the five-year period, which is a positive finding. Bladder incontinence has decreased from 16 percent in SFY 2014 - 2015 to 12 percent in SFY 2018 - 2019. Bowel incontinence decreased from 24 percent in SFY 2014 - 2015 to 21 percent in SFY 2018 - 2019.

[46] Emmons, K. R., & Robinson, J. P. (2014). The impact of urinary incontinence on older adults and their caregivers*. *Aging Life Care Association*.
[47] Bartlett, L., Nowak, M., & Ho, Y. H. (2009). Impact of fecal incontinence on quality of life. *World Journal of Gastroenterology: WJG*, *15*(26), 3276.
[48] Rowe, T. A., & Juthani-Mehta, M. (2013). Urinary tract infection in older adults. *Aging Health*, *9*, 519-528.

Table 35. Bladder and Bowel Control among Enrollees living in Nursing Facilities.

	Bladder and Bowel Control among Enrollees living in NFs									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Bladder Continence										
Continence	56,772	84	58,869	85	59,055	86	58,505	88	58,627	88
Incontinence	10,863	16	10,448	15	9,252	14	8,196	12	8,071	12
Indwelling catheter										
Yes	5,749	8	5,816	8	5,535	8	5,164	7	5,219	7
No	65,388	92	67,093	92	66,207	92	64,852	93	64,880	93
Intermittent catheterization										
Yes	236	0	241	0	249	0	239	0	211	0
No	70,893	100	72,668	100	71,493	100	69,777	100	69,888	100
External catheter										
Yes	364	1	369	1	343	0	325	0	375	1
No	70,773	99	72,541	99	71,399	100	69,691	100	69,724	99
Bowel Continence										
Continence	53,059	76	55,023	77	54,970	78	54,479	79	54,404	79
Incontinence	16,883	24	16,630	23	15,494	22	14315	21	14,485	21
Ostomy										
Yes	1,728	2	1,701	2	1,707	2	1,627	2	1,680	2
No	69,409	98	71,209	98	70,034	98	68,389	98	68,419	98

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Physical Restraints

Table 36 shows the counts and percentages of use of restraints among NF enrollees.

- The proportional use of physical restraints decreased from 3 percent in SFY 2014 - 2015 to 1 percent in SFY 2018 - 2019 over the study period, which is a positive outcome.

Table 36. Enrollees living in Nursing Facilities who were Physically Restrained.

	Physical Restraints used on NF Enrollees									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Restrained	2,358	3	1,704	2	1,045	1	825	1	825	1
Total	68,585		71,205		70,694		69,193		69,269	

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Weight Loss

Unintentional weight loss is a common problem among NF residents and is associated with adverse outcomes such as hospitalizations, morbidity, and mortality.[49] The MDS 3.0 defines a clinically significant weight loss episode as a loss equal to or greater than 5 percent within a one-month period or 10 percent within a six-month period. Table 37 shows the counts and percentages of unintentional weight loss among NF enrollees.

[49] Gaddey, H.L., &Holder K. (2014). Unintentional weight loss in older adults. *American Family Physician*, *89*: 718-722.

- The proportion of NF enrollees experiencing unintentional weight loss decreased in the five-year evaluation period from 17 percent in SFY 2014 - 2015 to 14 percent in SFY 2018 - 2019 in the five-year evaluation period, which is a positive finding.

Table 37. Unintentional Clinically Significant Weight Loss among Enrollees living in Nursing Facilities.

	Unintentional Clinically Significant Weight Loss									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Yes	11,915	17	12,092	17	11,075	15	10,395	15	9,740	14
No	59,323	83	60,922	83	60,596	85	59,568	85	60,345	86

Note: Unintentional weight loss is clinically significant when it is equal to or greater than 5% of a person's weight in the last month or 10% in last 6 months

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

Antipsychotic Medication

Antipsychotic medications are used to reduce and relieve symptoms of psychosis, as well as stabilize moods.[50] When NF residents have acute psychosis events, antipsychotic medications may also be used as a chemical restraint to induce calmness and eliminate confusion. However, the use of antipsychotics for this purpose is associated with severe adverse reactions, including early mortality. For this reason, CMS has indicated that antipsychotic medication prescriptions and use are an indicator of poor quality of care.[51] Table 38 shows the counts and percentages of enrollees living in NFs who are prescribed antipsychotic medication.

- The proportion of NF enrollees taking antipsychotic medicine decreased from 24 percent in SFY 2014 - 2015 to 21 percent in SFY 2018 - 2019 in the five-year evaluation period.

[50] Gareri, P., C. Segura-García, V.G. Manfredi, et al. (2014). Use of atypical antipsychotics in the elderly: a clinical review. *Clinical interventions in aging*, *9*, 1363.

[51] Quality Improvement Organizations. (2019). Retrieved from https://healthcentricadvisors.org/wp-content/uploads/2019/11/HCA-IPRO_QM_Manual_FINAL_Nov1919.pdf

Table 38. Antipsychotic Medication Prescriptions among Enrollees living in Nursing Facilities.

	NF Enrollees Prescribed Antipsychotic Medication									
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Yes	14,893	24	14,267	22	13,460	22	13,070	21	12,940	21
No	47,418	76	49,957	78	48,306	78	48,055	79	48,099	79

Sources: FSU created enrollee LOC file, MDS 3.0 assessments

II. Trends in preventable hospitalizations by setting

Disease prevention is a primary goal of quality healthcare.[52] When an enrollee has a disease, complications of that disease may be prevented by helping enrollees properly care for their illnesses. When appropriate care is not sought or provided to enrollees, preventable hospitalizations can occur.

This section shows the impact of LTC services on preventing hospitalizations, which can be used to evaluate how well these interventions meet the goals of preventing illness and disability. Preventable hospitalizations are recognized as important quality indicators within the most current EQR Technical Report.[53] Therefore, the evaluation team has provided comparisons of preventable hospitalizations over time (across the evaluation period) and across settings (Home-based, ALFs, and NFs).

The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) are a set of algorithms that use hospitalization records to identify ambulatory care sensitive conditions (ACSCs).[54] ACSCs are conditions that could be prevented with good quality outpatient care. If ACSCs are prevented or treated early, the subsequent need for hospitalization due to those ACSCs may be prevented.

While PQIs are based on hospitalization records, they illuminate quality of care outside of the hospital setting and prior to an enrollee's hospitalization. For example, enrollees who are adequately monitored and educated on their diabetes may never experience complications due to their disease. However, without proper treatment and treatment compliance, enrollees with diabetes can easily be hospitalized for diabetic complications.

Counts and percentages of preventable hospitalizations over the five-year evaluation period are presented for Home-based enrollees in Table 39, ALF enrollees in Table 40, and NF enrollees in Table 41.

- Home-based enrollees experienced decreases in proportions of preventable hospitalizations for chronic obstructive pulmonary disease (COPD) or asthma (8% in SFY 2014 - 2015 to 4% in SFY 2018 - 2019), heart failure (8% in SFY 2014 - 2015 to 7% in SFY 2019), bacterial pneumonia (5% in SFY 2014 - 2015 to 3% in SFY 2018 - 2019), and urinary tract infections ([UTIs]; 7% in SFY 2014 - 2015 to 4% in SFY 2018 - 2019). These are positive findings.

[52] Woolf, S. H. (2009). A closer look at the economic argument for disease prevention. *JAMA*, *301*, 536-538.
[53] Health Services Advisory Group. (2020). *SFY 2018-2019 External quality review technical report*. Retrieved from Agency for Health Care Administration website: https://ahca.myflorida.com/Medicaid/quality_mc/mgd_care_eqr.shtml
[54] https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2019.aspx for ICD-10 codes and https://www.qualityindicators.ahrq.gov/Archive/PQI_TechSpec_ICD09_v60.aspx for ICD-9 codes.

- Preventable hospitalizations caused by uncontrolled diabetes increased from 0 percent in SFY 2014 - 2015 to 1 percent in SFY 2018 - 2019 for Home-based enrollees.
- ALF enrollees experienced decreases in proportions of diabetes long-term complications (2% in SFY 2014 - 2015 to 1% in SFY 2018 - 2019), COPD or asthma (7% in SFY 2014 - 2015 to 5% in SFY 2018 - 2019), heart failure (6% in SFY 2014 - 2015 to 5% in SFY 2018 - 2019), bacteria pneumonia (4% in SFY 2014 - 2015 to 3% in SFY 2018 - 2019), and UTIs (10% in SFY 2014 - 2015 to 6% in SFY 2018 - 2019).
- Preventable hospitalizations caused by uncontrolled diabetes increased from 0 percent in SFY 2014 - 2015 to 1 percent in SFY 2018 - 2019 for ALF enrollees.
- NF enrollees experienced decreases in proportions of COPD or asthma (2% in SFY 2014 - 2015 to 1% in SFY 2018 - 2019) and UTIs (3% in SFY 2014 - 2015 to 2% in SFY 2018 - 2019).
- Preventable hospitalizations caused by heart failure increased from 2 percent in SFY 2014 - 2015 to 3 percent in SFY 2018 - 2019 for NF enrollees.

Table 39. Preventable Hospitalizations among Enrollees living in their Homes.

Home-based Enrollees Preventable Hospitalizations										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
PQI01 - Diabetes Short-Term	60	0	47	0	52	0	87	0	137	0
PQI03 - Diabetes Long-Term	429	2	277	1	376	2	487	2	533	2
PQI05 - COPD or Asthma	1,354	8	1,383	6	1,697	7	1,617	6	1,342	4
PQI07 - Hypertension	146	1	178	1	241	1	240	1	272	1
PQI08 - Heart Failure	1,396	8	1,608	7	1,852	7	2,125	7	2,130	7
PQI11 - Bacterial Pneumonia	850	5	869	4	757	3	872	3	891	3
PQI12 - Urinary Tract Infection	1,293	7	1,454	6	1,575	6	1,475	5	1,437	4
PQI14 - Uncontrolled Diabetes	56	0	208	1	270	1	298	1	279	1
PQI16 - Lower-Extremity	27	0	67	0	81	0	127	0	128	0

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Table 40. Preventable Hospitalizations among Enrollees living in ALFs.

ALF-based Enrollees Preventable Hospitalization										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
PQI01 - Diabetes Short-Term	14	0	27	0	14	0	27	0	27	0
PQI03 - Diabetes Long-Term	123	2	62	1	89	1	100	1	114	1
PQI05 - COPD or Asthma	481	7	496	6	695	8	551	6	508	5
PQI07 - Hypertension	49	1	41	1	59	1	63	1	70	1
PQI08 - Heart Failure	370	6	413	5	496	6	492	5	492	5
PQI11 - Bacterial Pneumonia	296	4	351	4	301	3	324	4	352	3
PQI12 - Urinary Tract Infection	656	10	709	8	836	9	755	8	642	6
PQI14 - Uncontrolled Diabetes	23	0	80	1	132	2	105	1	128	1
PQI16 - Lower-Extremity	4	0	8	0	9	0	17	0	13	0

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Table 41. Preventable Hospitalizations among Enrollees living in NFs.

NF-based Enrollees Preventable Hospitalization										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
PQI01 - Diabetes Short-Term	97	0	58	0	64	0	94	0	103	0
PQI03 - Diabetes Long-Term	572	1	327	0	552	1	614	1	641	1
PQI05 - COPD or Asthma	1,281	2	1,085	2	1,302	2	1,046	2	777	1
PQI07 - Hypertension	128	0	110	0	138	0	147	0	136	0
PQI08 - Heart Failure	1,656	2	1,682	2	1,851	3	1,900	3	1,786	3
PQI11 - Bacterial Pneumonia	1,659	2	1,315	2	1,096	2	1,062	2	1,053	2
PQI12 - Urinary Tract Infection	2,327	3	2,187	3	2,092	3	1,830	3	1,669	2
PQI14 - Uncontrolled Diabetes	50	0	217	0	307	0	255	0	264	0
PQI16 - Lower-Extremity	76	0	179	0	289	0	290	0	284	0

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Vaccinations and Preventable Hospitalizations

Because people who get the flu are more likely to get pneumonia, there are vaccinations for both the flu and bacterial pneumonia.[55] The evaluation team provided the frequencies and percentages of presence of vaccinations, as related to preventable hospitalizations due to bacterial pneumonia, in Table 42.

- Enrollees with up-to-date flu vaccinations experienced half as many preventable hospitalizations due to bacterial pneumonia compared to enrollees who were not up to date on their flu vaccinations (SFY 2014 - 2015: 2% vs. 4% and SFY 2018 - 2019: 1% vs. 2%).
- Enrollees with up-to-date PPV vaccines generally experienced the same rates of preventable hospitalizations, due to bacterial pneumonia, as enrollees who did not receive the vaccination.

[55] Labos, C. (2019). What you need to know about pneumonia and flu shots. Retrieved from https://www.mcgill.ca/oss/article/health/what-you-need-know-about-pneumonia-and-flu-shots

Table 42. Flu and Pneumococcal Vaccinations among Nursing Facility Enrollees who were Hospitalized for Bacterial Pneumonia.

Hospitalized for Bacterial Pneumonia (PQI 11)										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Up-to-Date Flu Vaccine	855	2	723	1	565	1	550	1	510	1
No Flu Vaccine	701	4	546	3	466	2	465	2	472	2
Up to Date PPV Vaccine	919	2	735	2	551	1	559	2	525	1
No PPV	636	2	531	2	475	1	460	1	455	1

Note: The proportion columns were calculated by using the number of enrollees in this table over the number of total enrollees who did or did not receive pneumococcal vaccines each year, which are reported in Table 12.
Sources: FSU created enrollee LOC file, Florida Center Data (IP)

III. Discussion of Findings for Research Question 1

These findings present a mixture of positive and negative indicators for enrollees across the three sites of care; however, on a population level, the outcome trends were generally positive. None the less it is important to look at both sides; positive trends and challenges.

Quality of life indicators were quite different based on site of care. Over the period of the study, enrollees living at home reported increasingly fewer positive responses to this indicator. There were decreases in positive responses (very satisfied) as well as concurrent increases in negative responses (very dissatisfied). Home-based enrollees also felt much worse about quality of life and health when compared to a year ago. This trend contrasts with responses from ALF respondents whose very dissatisfied responses regarding quality of life declined and reports of comparative health produced a positive trend.

Depression scores indicate neutral or positive trends with home-based enrollees having remained much the same and with levels of severe and moderate depression decreasing for ALF and NF enrollees. These findings are slightly positive.

Social isolation is an ongoing concern for enrollees living at home with a decline in the category of *having help available if needed*. Some other indicators showed slight positive trends regarding interaction with others. Similar trends were evident for ALF enrollees with decreases in *never participate outside the home* and *increases in frequencies of interactions*. However, ALF enrollees showed a trend, while modest, in *having someone to help when needed*.

Nutrition indicators were slightly elevated for eating alone for both home-based and ALF enrollees. Sharing a meal is a significant protective factor against social isolation and this trend raises a concern. ALF enrollees declined in reports of eating two meals a day, and both home-based and ALF enrollees declined in reports of planned weight loss.

Inpatient hospitalization days declined for enrollees living at home; stayed relatively the same across all five years for ALF enrollees; and stayed the same for four years with a decline in the fifth year for NF enrollees. Emergency room days showed little or no change for home and ALF enrollees. However, a notable positive finding was that NF enrollees had reduced emergency room days.

Primary caregivers were present for about half of home-based enrollees but only for 1 percent of ALF enrollees. Caregiver status (caregivers in crises) remained the same across the study period at both sites of care.

The following quality indicators relate specifically to NF enrollees.

The proportions of falls remained the same except for those with major injury, which declined. Pain slightly declined, and the presence of pressure ulcers declined. However, more serious (Stage 3 or 4) pressure ulcers increased, suggesting that this may be an area for increased focus. Up-to-date vaccines for influenza decreased in both number and percentage over the study period as have pneumococcal vaccines that are up to date. These decreases put NF enrollees at risk for serious negative outcomes.

Bladder and bowel incontinence, use of physical restraints, and use of antipsychotic medications, all declined indicating improved HRQOL.

Finally, preventable hospitalizations provide a mixed picture dependent upon the PQI under consideration. For example, preventable hospitalizations for bacterial pneumonia and urinary tract infections decreased for enrollees in all three sites of care. This is an important improvement as infections in older adults have potentially catastrophic consequences. Yet, when considered with the decline in vaccination rates, more can be done to prevent hospitalizations for these diseases.

Summary

Overall, based on the quantitative findings, the picture for enrollees' HRQOL is a positive one. Most indicators noted improvement or maintenance over the five-year study period. Quality of life was maintained by those living in ALFs; depression scores remained the same or shown positive improvement; in-patient hospitalization stays and emergency room days were down.

However, there are specific areas of concern. These data indicate that enrollees living at home are especially at risk for social isolation and report diminished quality of life and self-reported health. Data also indicated a decline in vaccination rates.

RQ2: Are LTC services effective at achieving equitable, positive health outcomes by sex, race/ethnicity, and geographic location?

In addition to presenting aggregate trends in HRQOL indicators and preventable hospitalizations, it was imperative to evaluate whether all enrollees are receiving the same quality of care regardless of their sex, race/ethnicity, or geographic location. Therefore, RQ2 sought to evaluate how equitable LTC services are for LTC enrollees by sex, race/ethnicity, and geographic location.

I. Trends in HRQOL indicators by setting and sex, race/ethnicity, and geographic location.

Trends by Sex

Counts and percentages of quality-of-life indicators by sex over the five-year evaluation period are presented for Home-based enrollees in Table 43 and ALF enrollees in Table 44.

- The direction of the quality-of-life indicator changes that occurred over the evaluation period was the same for males and females; however, the magnitude of the differences over time varies by sex.

For enrollees living at home:

- Over the evaluation period, the Home-based population who reported their sex grew from 17,864 enrollees to 32,655 enrollees. The number of females grew from 13,213 females to 22,755 females (i.e., from 74% to 70% of the LTC Home-based population). The number of males grew from 4,651 males to 9,900 males (i.e., from 26% to 30% of the LTC Home-based population).
- Percentages of males and females rating their overall health as “very good” both dropped by one percentage point – for women, it dropped from 4 percent in SFY 2014 - 2015 to 3 percent in SFY 2018 - 2019; for men, it dropped from 5 percent in SFY 2014 - 2015 to 4 percent in SFY 2018 - 2019, respectively.
- In SFY 2015, 16 percent (2,051) of females rated their overall health as “poor” while 20 percent (4,593) did in SFY 2018 - 2019. The rates of males reporting “poor” overall health was 16 percent (731) in SFY 2014 - 2015 versus 18 percent (1,761) in SFY 2018 - 2019. In SFY 2015, 3 percent of females rated their health as “much better” than a year ago. This dropped to 2 percent in SFY 2018 - 2019. The percentage of males rating their health as “much better” than a year prior stayed about the same (around 3%) throughout the study period. Both males (3% in SFY 2014 - 2015 to 5% in SFY 2018 - 2019) and females (2% in SFY 2014 - 2015 to 5% in SFY 2018 - 2019) presented increases in reporting their overall health as “much worse” over the study period.
- When asked about overall quality of life, both female and male respondents reported declines (from 6% in SFY 2014 - 2015 to 4% in SFY 2018 - 2019) in being “very satisfied.” Males also showed a 1 percent decrease in both “dissatisfied” and” very dissatisfied,” which is a positive finding.

- Females reported a decline in feeling “much better” (from 3% in SFY 2015 to 2% in SFY 2019) and had a corresponding increase in feeling “worse” (11% in SFY 2015 to 14% in SFY 2019) over the study period. Males reported a similar decline in feeling” much better” and a corresponding increase in feeling “worse” over the study period (11% in SFY 2015 to 12% in SFY 2019).

Table** 43. **Quality of Life Indicators among Enrollees living in their Homes by Sex.

Quality of Life by Sex for Home Enrollees											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Sex	n	%	n	%	n	%	n	%	n	%
How would you rate your overall health at the present time?											
Excellent	F	101	1	124	1	131	1	127	1	129	1
	M	79	2	71	1	87	1	90	1	85	1
Very Good	F	541	4	611	4	561	3	663	3	682	3
	M	236	5	279	4	335	5	421	5	443	4
Good	F	3,72	28	4,63	28	4,98	28	5,47	27	5,79	25
	M	1,45	31	1,97	32	2,19	31	2,64	30	2,97	30
Fair	F	6,79	51	8,48	51	9,26	51	10,5	51	11,5	51
	M	2,15	46	2,92	47	3,41	48	4,07	47	4,63	47
Poor	F	2,05	16	2,64	16	3,07	17	3,77	18	4,59	20
	M	731	16	963	15	1,14	16	1,47	17	1,76	18
Compared to a year ago, how would you rate your health?											
Much Better	F	399	3	496	3	421	2	415	2	413	2
	M	156	3	225	4	219	3	217	2	250	3
Better	F	1,46	11	1,77	11	1,88	10	2,14	10	2,31	10
	M	647	14	832	13	967	13	1,15	13	1,34	14
About the Same	F	7,39	56	9,25	56	10,0	56	10,8	53	11,4	51
	M	2,58	56	3,52	57	4,00	56	4,71	54	5,17	52
Worse	F	3,66	28	4,61	28	5,08	28	6,26	30	7,34	32
	M	1,14	25	1,49	24	1,74	24	2,28	26	2,66	27
Much Worse	F	294	2	353	2	578	3	864	4	1,17	5
	M	119	3	132	2	243	3	336	4	459	5
How satisfied are you with your overall quality of life?											
Very Satisfied	F	734	6	832	5	758	4	812	4	835	4
	M	273	6	330	5	341	5	369	4	390	4
Satisfied	F	5,86	44	7,48	45	8,00	44	8,67	42	9,19	40
	M	1,99	43	2,78	45	3,13	44	3,64	42	4,09	41
Neither Satisfied nor Dissatisfied	F	2,09	16	2,77	17	3,28	18	4,08	20	4,61	20
	M	728	16	1,00	16	1,25	17	1,74	20	2,04	21
Dissatisfied	F	841	6	1,08	7	1,22	7	1,48	7	1,68	7
	M	373	8	400	6	494	7	621	7	708	7
Very Dissatisfied	F	163	1	193	1	195	1	223	1	262	1
	M	107	2	83	1	86	1	112	1	121	1
Thinking about how you were doing this time last year, how do you feel about the way things are now?											
Much Better	F	342	3	405	2	329	2	378	2	386	2
	M	138	3	180	3	194	3	175	2	230	2
Better	F	1,34	10	1,67	10	1,79	10	2,05	10	2,25	10
	M	533	11	765	12	824	11	1,07	12	1,20	12
About the Same	F	6,46	49	8,21	50	8,96	50	9,81	48	10,3	45
	M	2,26	49	2,99	48	3,41	48	4,05	47	4,57	46
Worse	F	1,45	11	1,95	12	2,19	12	2,79	14	3,27	14
	M	495	11	603	10	784	11	1,07	12	1,21	12
Much Worse	F	90	1	118	1	193	1	237	1	330	1
	M	46	1	54	1	82	1	116	1	135	1

Sources: FSU created enrollee LOC file, 701B Assessments

For the same items, enrollees living in ALFs indicated much smaller proportional changes with small differences (< 10%) when examined by sex.

- Over the evaluation period, the ALF population who reported their sex grew from 6,721 enrollees to 10,244 enrollees. The number of females grew from 4,874 females (73% of the LTC ALF population) to 6,828 females (67% of the LTC ALF population). The number of males grew from 1,847 males (27% of the LTC ALF population) to 3,416 males (33% of the LTC ALF population).
- Males and females living in ALFs increased in reporting “good” overall health over the study period, with males feeling more positive (males: 40% in SFY 2014 - 2015 to 47% in SFY 2018 - 2019; females: 39% in SFY 2015 to 44% in SFY 2019).
- When comparing health to a year prior, both males and females reported increases in “better” health (males: 12% in SFY 2014 - 2015 to 16% in SFY 2018 - 2019; females: 10% in SFY 2014 - 2015 to 13% in SFY 2018 - 2019) as well as in “worse” health (males: 16% in SFY 2014 - 2015 to 18% in SFY 2018 - 2019; females: 20% in SFY 2014 - 2015 to 22% in SFY 2018 - 2019). There was a corresponding decrease for both males and females in reporting “about the same” health compared to a year ago over the study period. (males: 68% in SFY 2014 - 2015 to 63% in SFY 2018 - 2019; females: 66% in SFY 2014 - 2015 to 63% in SFY 2018 - 2019).
- When asked about overall quality of life, both females and males reported increases in being “satisfied” (males: 41% in SFY 2014 - 2015 to 45% in SFY 2018 - 2019; females: 37% in SFY 2014 - 2015 to 41% in SFY 2018 - 2019) and “neither satisfied nor dissatisfied” (males: 14% in SFY 2014 - 2015 to 19% in SFY 2018 - 2019; females: 11% in SFY 2014 - 2015 to 15% in SFY 2018 - 2019).
- When asked to compare their quality of life to the year prior, both female and male respondents showed increases in feeling “better” (males: 11% in SFY 2014 - 2015 to 14% in SFY 2018 - 2019; females: 8% in SFY 2014 - 2015 to 12% in SFY 2018 - 2019) and “about the same” (males: 47% in SFY 2014 - 2015 to 49% in SFY 2018 - 2019; females: 41% in SFY 2014 - 2015 to 42% in SFY 2018 - 2019) over the study period.

Table 44. Quality of Life Indicators among Enrollees living in ALFs by Sex.

Quality of Life by Sex for ALF Enrollees											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Sex	n	%	n	%	n	%	n	%	n	%
How would you rate your overall health at the present time?											
Excellent	F	57	1	69	1	79	1	72	1	80	1
	M	40	2	50	2	39	1	29	1	43	1
Very Good	F	245	5	292	5	339	6	321	5	379	6
	M	100	5	143	6	175	6	199	7	218	6
Good	F	1,917	39	2,304	39	2,513	41	2,660	43	3,001	44
	M	735	40	1,076	42	1,244	43	1,414	46	1,605	47
Fair	F	2,162	44	2,643	45	2,707	44	2,643	43	2,823	41
	M	813	44	1,085	42	1,215	42	1,187	39	1,328	39
Poor	F	493	10	549	9	540	9	518	8	545	8
	M	159	9	210	8	217	8	222	7	222	7
Compared to a year ago, how would you rate your health?											
Much Better	F	90	1	130	2	115	2	89	1	111	2
	M	43	2	57	2	51	2	37	1	68	2
Better	F	495	10	635	11	719	12	724	12	857	13
	M	217	12	338	13	415	14	479	16	538	16
About the Same	F	3,235	66	3,827	65	4,093	66	4,026	65	4,266	63
	M	1,260	68	1,710	67	1,929	67	1,957	64	2,139	63
Worse	F	978	20	1,182	20	1,173	19	1,251	20	1,467	22
	M	294	16	430	17	461	16	535	18	628	18
Much Worse	F	76	2	83	1	78	1	124	2	127	2
	M	33	2	29	1	34	1	43	1	43	1
How satisfied are you with your overall quality of life?											
Very Satisfied	F	228	5	249	4	228	4	231	4	248	4
	M	101	6	125	5	132	5	131	4	152	4
Satisfied	F	1,782	37	2,198	38	2,387	39	2,461	40	2,777	41
	M	748	41	1,090	43	1,254	43	1,384	45	1,519	45
Neither Satisfied nor Dissatisfied	F	549	11	678	12	782	13	806	13	998	15
	M	254	14	411	16	487	17	544	18	636	19
Dissatisfied	F	178	4	213	4	243	4	189	3	244	4
	M	105	6	152	6	172	6	157	5	173	5
Very Dissatisfied	F	38	1	46	1	37	1	28	1	36	1
	M	31	2	38	2	23	1	27	1	12	0
Thinking about how you were doing this time last year, how do you feel about the way things are now?											
Much Better	F	97	2	111	2	100	2	120	2	130	2
	M	41	2	73	3	64	2	58	2	79	2
Better	F	385	8	546	9	619	10	627	10	789	12
	M	201	11	285	11	360	13	460	15	481	14
About the Same	F	2,003	41	2,406	41	2,574	42	2,549	41	2,852	42
	M	875	47	1,276	50	1,446	50	1,486	49	1,670	49
Worse	F	272	6	304	5	363	6	396	6	501	7
	M	110	6	172	7	185	6	227	7	243	7
Much Worse	F	18	0	17	0	21	0	23	0	31	1
	M	12	1	10	0	13	0	12	0	19	1

Sources: FSU created enrollee LOC file, 701B Assessments

Trends by Race/Ethnicity

Counts and percentages of quality-of-life indicators by race/ethnicity over the five-year evaluation period are presented for Home-based enrollees in Table 45 and ALF enrollees in Table 46.

For enrollees living at home:

- Over the evaluation period, there has been a noticeable demographic shift. For example, the Home-based population who reported their race/ethnicity grew from 17,041 enrollees to 29,967 enrollees. The number of Black enrollees grew from 2,737 (16% of the LTC Home-based population) to 4,951 (17% of the LTC Home-based population). The number of Hispanic enrollees grew from 6,590 (39% of the LTC Home-based population) to 14,091 (47% of the LTC Home-based population). The number of White enrollees grew from 7,714 (45% of the LTC Home-based population) to 10,925 (36% of the LTC Home-based population).
- Regarding current overall health, Black and White enrollees living at home had similar proportions across ratings and most reported that they were "fair." In SFY 2018 - 2019, 47 percent of Black enrollees, 55 percent of Hispanic enrollees, and 43 percent of White enrollees reported "fair" health. In addition to more Hispanic enrollees reporting that they were "fair", more Hispanic enrollees reported having "poor" health. For example, in SFY 2018 - 2019, 23 percent of Hispanic enrollees, 16 percent of Black enrollees, and 17 percent of White enrollees reported "poor" health.

For enrollees living in ALFs:

- Over the evaluation period, the ALF population who reported their race/ethnicity grew from 6,415 enrollees to 9,464 enrollees. The number of Black enrollees grew from 503 (8% of the LTC ALF population) to 902 (10% of the LTC ALF population). The number of Hispanic enrollees grew from 1,661 (26% of the LTC ALF population) to 2,481 (26% of the LTC ALF population). The number of White enrollees grew from 4,251 (66% of the LTC ALF population) to 6,081 (64% of the LTC ALF population).
- In ALF settings, Black and White enrollees also had similar proportions across ratings and most reported that they had "good" health. In SFY 2018 - 2019, 49 percent of Black and White enrollees reported "good" health, while only 33 percent of Hispanic enrollees reported "good" health. Most Hispanic enrollees reported "fair" health. In SFY 2018 - 2019, 51 percent of Hispanic enrollees reported "fair" health compared to 38 percent of Black enrollees and 37 percent of White enrollees. Similarly, more Hispanic enrollees reported "poor" health (12%) compared to Black (5%) and White (6%) enrollees.

Overall Findings

For enrollees living in the community:

- Most enrollees reported feeling “about the same” as compared to a year ago, regardless of race/ethnicity or location of care. Between 50 to 61 percent of enrollees living at home reported feeling “about the same” and between 62 to 68 percent of enrollees living in ALFs. However, Black, and Hispanic enrollees living at home increased the reporting of being “worse” or “much worse” than they were the year prior. Black enrollees increased by 4 percent and Hispanic enrollees by 11 percent over the study period. White enrollees also increased, but at a lower magnitude (2%) over the study period. In ALFs, Hispanic enrollees gained most in “worse” or “much worse” health (7%) when compared to Black (-2%) and White enrollees (0%).
- Most enrollees reported feeling “satisfied” with their overall quality of life regardless of race/ethnicity or location of care. Between 38 to 47 percent of Home-based enrollees and between 55 percent and 68 percent of ALF enrollees reported feeling “satisfied. Hispanic enrollees living at home and in ALFs were less likely to report being “very satisfied” compared to Black and White enrollees. For example, in SFY 2019, 2 percent of Hispanic enrollees living at home compared to 5 percent of Black and White enrollees reported being “very satisfied.” In the same year, 3 percent of Hispanic enrollees in ALFs reported being “very satisfied” compared to 7 percent of Black and White enrollees.
- Compared to a year ago, Black, Hispanic, and White enrollees living at home reported similar feelings about their quality of life and are trending in the same direction. Most enrollees, regardless of race/ethnicity or location of care reported feeling “about the same” compared to last year (ranging from 44% to 54% among home-based enrollees and 65% to 79% among ALF enrollees).

Table 45. Quality of Life Indicators among Enrollees living in their Homes by Race/Ethnicity.

Home-based Enrollees Quality of Life by Race/Ethnicity											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Race	n	%	n	%	n	%	n	%	n	%
How would you rate your overall health at the present time?											
Excellent	B	32	1	39	1	48	1	41	1	43	1
	H	32	0	33	0	28	0	33	0	32	0
	W	112	1	111	1	123	1	122	1	109	1
Very Good	B	146	5	189	5	187	5	227	5	218	4
	H	120	2	148	2	143	1	174	1	222	2
	W	464	6	506	6	504	5	592	6	590	5
Good	B	880	32	1,149	32	1,339	34	1,494	33	1,561	32
	H	1,526	23	2,142	24	2,195	22	2,531	21	2,825	20
	W	2,500	32	2,935	33	3,132	33	3,486	33	3,618	33
Fair	B	1,269	46	1,675	47	1,837	47	2,094	46	2,337	47
	H	3,894	59	5,276	58	5,875	58	6,905	57	7,774	55
	W	3,412	44	3,886	44	4,269	44	4,676	44	4,743	43
Poor	B	410	15	511	14	537	14	680	15	792	16
	H	1,018	15	1,484	16	1,864	18	2,467	20	3,238	23
	W	1,226	16	1,436	16	1,604	17	1,757	17	1,865	17
Compared to a year ago, how would you rate your health?											
Much Better	B	108	4	172	5	151	4	133	3	152	3
	H	126	2	143	2	137	1	129	1	168	1
	W	298	4	366	4	314	3	315	3	283	3
Better	B	413	15	563	16	647	16	711	16	769	16
	H	472	7	651	7	714	7	827	7	984	7
	W	1,135	15	1,255	14	1,331	14	1,571	15	1,616	15
About the Same	B	1,551	57	1,965	55	2,176	55	2,499	55	2,619	53
	H	4,029	61	5,485	60	5,950	59	6,646	55	7,255	51
	W	3,924	51	4,650	52	5,055	52	5,385	51	5,431	50
Worse	B	611	22	804	23	882	22	1,067	24	1,241	25
	H	1,831	28	2,603	29	2,945	29	3,937	33	4,869	35
	W	2,146	28	2,403	27	2,618	27	2,954	28	3,070	28
Much Worse	B	54	2	59	2	92	2	126	3	170	3
	H	132	2	201	2	359	4	571	5	815	6
	W	211	3	200	2	314	3	408	4	525	5
How satisfied are you with your overall quality of life?											
Very Satisfied	B	216	8	260	7	225	6	248	5	245	5
	H	217	3	236	3	231	2	243	2	313	2
	W	526	7	620	7	583	6	625	6	562	5
Satisfied	B	1,203	44	1,630	46	1,846	47	2,049	45	2,180	44
	H	2,970	45	4,173	46	4,466	44	4,850	40	5,311	38
	W	3,354	43	3,981	45	4,275	44	4,703	44	4,784	44
Neither satisfied nor dissatisfied	B	304	11	446	13	537	14	676	15	818	17
	H	1,148	17	1,662	18	1,980	20	2,760	23	3,170	22
	W	1,263	16	1,524	17	1,792	19	2,051	19	2,197	20
Dissatisfied	B	149	5	207	6	237	6	283	6	299	6
	H	310	5	377	4	497	5	681	6	896	6
	W	715	9	812	9	895	9	995	9	1,011	9

Table 45. Quality of Life Indicators among Enrollees living in their Homes by Race/Ethnicity (cont.)

Home-based Enrollees Quality of Life by Race/Ethnicity											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Race	n	%	n	%	n	%	n	%	n	%
Very Dissatisfied	B	45	2	42	1	41	1	52	1	49	1
	H	45	1	65	1	57	1	72	1	96	1
	W	163	2	156	2	167	2	196	2	210	2
Thinking about how you were doing this time last year, how do you feel about the way things are now?											
Much Better	B	94	3	126	4	123	3	125	3	129	3
	H	60	1	89	1	80	1	80	1	126	1
	W	301	4	336	4	293	3	309	3	310	3
Better	B	368	13	514	14	544	14	660	15	717	14
	H	385	6	596	7	601	6	749	6	908	6
	W	1,051	14	1,210	14	1,330	14	1,522	14	1,546	14
About the Same	B	1,215	44	1,606	45	1,815	46	2,051	45	2,164	44
	H	3,546	54	4,818	53	5,328	53	6,014	50	6,565	47
	W	3,620	47	4,302	48	4,617	48	5,019	47	5,095	47
Worse	B	227	8	312	9	370	9	440	10	523	11
	H	669	10	968	11	1,133	11	1,635	14	2,014	14
	W	965	13	1,148	13	1,334	14	1,543	15	1,611	15
Much Worse	B	13	0	27	1	34	1	32	1	58	1
	H	30	0	42	0	89	1	128	1	173	1
	W	84	1	97	1	138	1	177	2	202	2

Sources: FSU created enrollee LOC file, 701B Assessments

Table 46. Quality of Life Indicators among Enrollees living in ALFs by Race/Ethnicity.

ALF-based Enrollees Quality of Life by Race/Ethnicity											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Race	n	%	n	%	n	%	n	%	n	%
How would you rate your overall health at the present time?											
Excellent	B	>10	2	10	1	13	2	10	1	13	1
	H	>10	0	15	1	13	1	>10	0	16	1
	W	78	2	87	2	85	2	77	1	85	1
Very Good	B	29	6	33	5	44	6	49	6	56	6
	H	32	2	40	2	55	2	63	3	69	3
	W	271	6	338	7	380	7	377	7	434	7
Good	B	218	43	293	42	342	45	403	48	444	49
	H	475	29	580	28	645	29	684	30	823	33
	W	1,839	43	2,302	45	2,521	46	2,696	49	2,964	49
Fair	B	217	42	309	44	317	41	323	39	345	38
	H	945	57	1,172	56	1,224	55	1,199	53	1,264	51
	W	1,685	40	2,040	40	2,128	39	2,047	37	2,227	37
Poor	B	39	8	57	8	51	7	47	6	44	5
	H	209	13	274	13	293	13	303	13	309	12
	W	378	9	397	8	377	7	355	6	371	6
Compared to a year ago, how would you rate your health?											
Much Better	B	13	3	18	3	21	3	19	2	24	3
	H	26	2	33	2	28	1	10	0	17	1
	W	89	2	126	2	113	2	93	2	124	2

Table 46. Quality of Life Indicators among Enrollees living in ALFs by Race/Ethnicity (cont.)

ALF-based Enrollees Quality of Life by Race/Ethnicity											
		SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	Race	n	%	n	%	n	%	n	%	n	%
Better	B	66	13	112	16	113	15	125	15	155	17
	H	122	7	138	7	178	8	183	8	200	8
	W	492	12	665	13	771	14	814	15	939	15
About the Same	B	338	66	461	66	524	68	565	68	576	64
	H	1,130	68	1,423	68	1,506	68	1,453	64	1,538	62
	W	2,835	67	3,350	65	3,608	66	3,562	64	3,780	62
Worse	B	89	17	107	15	99	13	113	14	139	15
	H	358	21	457	22	473	21	549	24	658	27
	W	770	18	954	18	947	17	996	18	1,155	19
Much Worse	B	6	1	4	1	10	1	10	1	8	1
	H	30	2	30	1	45	2	61	3	68	3
	W	65	2	69	1	52	1	87	2	83	1
How satisfied are you with your overall quality of life?											
Very satisfied	B	26	8	24	5	28	6	35	6	41	7
	H	39	5	48	5	48	4	46	4	45	3
	W	255	9	285	8	263	7	260	7	291	7
Satisfied	B	204	66	300	68	326	67	369	67	397	63
	H	504	64	660	66	687	61	703	60	718	55
	W	1,712	62	2,145	61	2,420	64	2,545	65	2,854	65
Neither Satisfied nor Dissatisfied	B	53	17	81	18	104	21	118	21	159	25
	H	200	25	233	23	318	28	339	29	450	35
	W	523	19	732	21	771	20	806	21	916	21
Dissatisfied	B	22	7	25	6	28	6	22	4	29	5
	H	46	6	51	5	71	6	71	6	75	6
	W	205	7	270	8	301	8	233	6	281	6
Very Dissatisfied	B	5	2	10	2	4	1	5	1	2	0
	H	4	1	8	1	8	1	5	0	10	1
	W	55	2	61	2	45	1	43	1	32	1
Thinking about how you were doing this time last year, how do you feel about the way things are now?											
Much Better	B	18	6	15	3	17	3	21	4	29	5
	H	14	2	20	2	18	2	12	1	12	1
	W	100	4	142	4	125	3	138	4	156	4
Better	B	44	14	85	19	87	18	105	19	127	20
	H	91	11	93	9	133	12	136	12	155	12
	W	428	16	595	17	706	19	782	20	898	21
About the same	B	220	71	302	69	353	72	382	70	426	68
	H	605	76	789	79	838	74	880	76	918	71
	W	1,939	71	2,415	69	2,603	69	2,544	65	2,851	65
Worse	B	27	9	35	8	31	6	41	7	42	7
	H	77	10	92	9	133	12	131	11	203	16
	W	262	10	324	9	345	9	395	10	438	10
Much Worse	B	1	0	3	1	2	0	0	0	4	1
	H	6	1	6	1	10	1	5	0	10	1
	W	21	1	17	0	21	1	28	1	31	1

Sources: FSU created enrollee LOC file, 701B Assessments

Trends by Region

Counts and percentages by region have not been included in this report because of the size of the tables and the need for redaction within many of the quality-of-life indicators due to small sample sizes. However, noteworthy findings are the following:

- Most responses for all regions in both HCBS settings were in the “good” and “fair” categories for current overall health. Region 11 had the lowest proportion of “good” responses (19% in Homes in SFY 2018 - 2019; 29% in ALFs in SFY 2018 - 2019) and the highest proportion of “fair” responses (58% in Home in SFY 2018 - 2019; 56% in ALFs in SFY 2018 - 2019).
- Most responses for all regions in both HCBS settings were in the “about the same” category for overall health compared to a year ago (43% to 55% in Homes, and 58% to 68% in ALFs in SFY 2018 - 2019).
- Most responses for all regions in HCBS settings were in the “satisfied” category for their quality of life (ranging from 51% to 60% in Homes, and 61% to 71% in ALFs (except for Region 11)). Only 50 percent of ALF enrollees in Region 11 reported being “satisfied” with their quality of life, and 40 percent were “neither satisfied nor dissatisfied”. Regions 1 through 10 reported “neither satisfied nor dissatisfied” between 17 and 28 percent in SFY 2018 - 2019.
- Most responses for all regions in HCBS settings were in the “about the same” category of quality life compared to last year (ranging from 51% to 70% in Homes and 60 to 75% in ALFs (except for Region 2)). Region 2 had about double the proportion of “much better” responses compared to the other regions (9% in Region 2 versus an average of 4% for the other regions in SFY 2018 - 2019).

II. Trends in preventable hospitalizations by setting and gender, race/ethnicity, and geographic location

Trends by Sex

Due to small sample sizes, all the types of preventable hospitalizations were aggregated by sex, race/ethnicity, and geographic location.

Results for preventable hospitalizations by sex are presented for enrollees living in HCBS and NF settings in Table 47.

- Over the evaluation period, approximately 70 to 73 percent of home-based residents were female, approximately 65 to 70 percent of ALF enrollees were female and approximately 65 percent of NF residents were female.
- There does not appear to be disproportionate preventable hospitalizations by sex in Home-based, ALF, or NF settings, which indicates equity in care between males and females.
- However, the proportion of males experiencing preventable hospitalizations has grown over the evaluation period, which is an undesirable outcome. Males living at home experienced an increase from

28 percent in SFY 2014 - 2015 to 30 percent in SFY 2018 - 2019. Males living in ALFs experienced an increase from 30 percent in SFY 2014 - 2015 to 33 percent in SFY 2018 - 2019.

- Females, however, experienced decreases in preventable hospitalizations over the same period. Women living in homes decreased from 72 percent in SFY 2014 - 2015 to 70 percent in SFY 2018 - 2019. Women living in ALFs decreased from 70 percent in SFY 2014 - 2015 to 67 percent in SFY 2018 - 2019.

Table 47. Preventable Hospitalizations among Enrollees by Setting and Sex.

Preventable Hospitalization for Home-based Enrollees by Setting and Sex												
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
Sex	n	%	n	%	n	%	n	%	n	%	n	%
Home												
F	4,030	72	4,373	72	4,724	69	5,108	70	4,883	68	**23,11**	**70**
M	1,581	28	1,718	28	2,177	31	2,220	30	2,266	32	**9,962**	**30**
Total	**5,611**		**6,091**		**6,901**		**7,328**		**7,149**		**33,08**	
Assisted Living Facilities												
F	1,416	70	1,498	69	1,752	67	1,576	65	1,515	65	**7,757**	**67**
M	600	30	689	31	879	33	858	35	831	35	**3,857**	**33**
Total	**2,016**		**2,187**		**2,631**		**2,434**		**2,346**		**11,61**	
Nursing Facilities												
F	5,207	66	4,798	67	5,105	66	4,727	65	4,251	63	**24,08**	**66**
M	2,639	34	2,362	33	2,586	34	2,511	35	2,462	37	**1,256**	**34**
Total	**7,846**		**7,160**		**7,691**		**7,238**		**,6713**		**36,64**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Trends by Race/Ethnicity

Results for preventable hospitalizations by race/ethnicity are presented for enrollees living at home in Table 48, enrollees living in ALFs in Table 49, and enrollees living in NFs in Table 50. When interpreting the results of Tables 47, 48, and 49, it is important to interpret the findings within the context of the racial/ethnic distribution of the overall LTC population during the evaluation period.

- Over the evaluation period, Home-based enrollees were approximately 16 to 17 percent Black, 39 to 47 percent Hispanic, and 35 to 37 percent White. White enrollees were disproportionately overrepresented in preventable hospitalizations by about 40 percent. For example, based on the population distribution, White enrollees were expected to experience 36 percent of preventable hospitalizations; instead, they experienced 62 percent.

- ALF-based enrollees were approximately 8 to 10 percent Black, 26 percent Hispanic, and 64 to 66 percent White. Hispanic ALF enrollees were over-represented in preventable hospitalizations by about 35 percent, and Black ALF enrollees were over-represented by about 100 percent. Based on the population distribution, Black enrollees were expected to experience 9 percent and Hispanic enrollees were expected to experience 26 percent of preventable hospitalizations. Instead, Black enrollees experienced 20 percent and Hispanic enrollees experienced 35 percent of preventable hospitalization.

- The proportion of preventable hospitalizations experienced by Hispanic enrollees in ALFs increased from 30 percent in SFY 2014 - 2015 to 38 percent in SFY 2018 - 2019, while the proportion decreased for White enrollees (from 50% in SFY 2014 - 2015 to 41% in SFY 2018 - 2019).

- NF-based enrollees were approximately 19 to 20 percent of Black, 13 to 16 percent Hispanic, and 65 to 68 percent White. White and Hispanic enrollees are under-represented in preventable hospitalizations by about 10 percent, and Black enrollees are over-represented by about 10 percent. Based on the population distribution, Black enrollees were expected to experience 20 percent of preventable hospitalizations. Instead, Black enrollees experienced 22 percent of preventable hospitalization.
- The proportion of preventable hospitalizations experienced by Black enrollees in NFs increased from 20 percent in SFY 2014 - 2015 to 23 percent in SFY 2018 - 2019, while the proportion decreased for White enrollees (from 60% in SFY 2014 - 2015 to 58% in SFY 2018 - 2019).

Table 48. Preventable Hospitalizations among Enrollees living in their Homes by Race/Ethnicity.

Preventable Hospitalizations for Home-based Enrollees by Race/Ethnicity												
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
Race	n	%	n	%	n	%	n	%	n	%	n	%
B	148	8	171	8	213	9	202	9	206	9	**940**	**8**
H	562	29	656	31	718	29	732	31	576	26	**3,244**	**29**
W	1,220	63	1,272	61	1,569	63	1,392	60	1,448	65	**6,901**	**62**
Total	**1,930**		**2,099**		**2,500**		**2,326**		**2,230**		**11,08**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Table 49. Preventable Hospitalizations among Enrollees living in ALFs by Race/Ethnicity.

Preventable Hospitalization for ALF-based Enrollees by Race/Ethnicity												
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
Race	n	%	n	%	n	%	n	%	n	%	n	%
B	1,073	20	1,187	20	1,289	20	1,443	21	1,437	21	**6,429**	**20**
H	1,595	30	1,913	33	2,340	35	2,622	37	2,594	38	**11,06**	**35**
W	2,702	50	2,725	47	2,969	45	2,970	42	2,774	41	**14,14**	**45**
Total	**5,370**		**5,825**		**6,598**		**7,035**		**6,805**		**31,63**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Table 50. Preventable Hospitalizations among Enrollees living in NFs by Race/Ethnicity.

Preventable Hospitalization for NF-based Enrollees by Race/Ethnicity												
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
Race	n	%	n	%	n	%	n	%	n	%	n	%
B	1,524	20	1,419	21	1,589	22	1,492	22	1,438	23	**7,462**	**22**
H	1,423	19	1,154	17	1,366	19	1,364	20	1,201	19	**6,508**	**19**
W	4,491	60	4,184	62	4,307	59	3,947	58	3,691	58	**20,62**	**60**
Total	**7,438**		**6,757**		**7,262**		**6,803**		**6,330**		**34,59**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

Trends by Region

Results for preventable hospitalizations by region are presented for enrollees living at home in Table 51, for enrollees living in ALFs in Table 52, and for enrollees living in NFs in Table 53.

- Over the evaluation period, Region 1 accounted for 2 to 3 percent of the Home-based population, Region 2 accounted for 2 to 4 percent, Region 3 accounted for 5 to 7 percent, Region 4 accounted for 7 to 8 percent, Region 5 accounted for 6 to 8 percent, Region 6 accounted for 8 to 10 percent, Region 7 accounted for 7 to 8 percent, Region 8 accounted for 3 to 4 percent, Region 9 accounted for 6 to 8 percent, Region 10 accounted for 5 to 9 percent, and Region 11 accounted for 39 to 40 percent.
    - Region 11 is disproportionately underrepresented in Home population by 20 percent, which was positive for Region 11. Based on the population distribution, approximately 40 percent of preventable hospitalizations should have been experienced in Region 11; instead, only 31 percent were experienced.
- Region 1 accounted for 2 to 3 percent of the ALF population, Region 2 accounted for 0 to 1 percent, Region 3 accounted for 5 to 6 percent, Region 4 accounted for 4 to 6 percent, Region 5 accounted for 15 to 16 percent, Region 6 accounted for 11 to 17 percent, Region 7 accounted for 7 to 8 percent,

Region 8 accounted for 4 to 5 percent, Region 9 accounted for 7 to 8 percent, Region 10 accounted for 10 to 13 percent, and Region 11 accounted for 23 to 27 percent.

  - Region 11 is roughly 40 percent over-represented in preventable hospitalizations in the ALF population, which is a negative finding for Region 11. Only 25 percent of preventable hospitalizations were expected to be in Region 11, but 29 percent were experienced.

- Region 1 accounted for 4 percent, Region 2 accounted for 4 to 5 percent, Region 3 accounted for 9 percent, Region 4 accounted for 11 to 12 percent, Region 5 accounted for 3 percent, Region 6 accounted for 11 percent, Region 7 accounted for 11 percent, Region 8 accounted for 7 to 8 percent, Region 9 accounted for 10 percent, Region 10 accounted for 6 percent, and Region 11 accounts for 12 to 13 percent.
  - Region 5 is over-represented in preventable hospitalizations for NF enrollees by 30 percent, and Region 11 is over-represented by about 50 percent. Region 5 was expected to account for 9 percent of preventable hospitalizations but accounted for 12 percent. Region 11 was expected to account for 13 percent but accounted for 19 percent.

When examined by region, Tables 51, 52, and 53 provide data regarding preventable hospitalizations. For enrollees living at home:

- Region 1 (-2%), Region 2 (-1%), Region 3 (-2%), Region 5 (-1%), and Region 7 (-2%) showed proportional reductions in preventable hospitalizations over the study period. These reductions demonstrate a positive outcome.
- Region 6 (+2%), Region 9 (+1%), Region 10 (+3%), and Region 11 (+2%) had proportional increases in preventable hospitalizations over the study period.

Table 51. Preventable Hospitalizations among Enrollees living in their Homes by Region.

Preventable Hospitalizations for Home-based Enrollees Region												
Region	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
1	213	4	171	3	195	3	183	3	133	2	**895**	**3**
2	247	4	236	4	266	4	293	4	242	3	**1,284**	**4**
3	438	8	411	7	470	7	459	6	425	6	**2,203**	**7**
4	444	8	491	8	593	9	547	8	555	8	**2,630**	**8**
5	466	8	499	8	513	8	502	7	522	7	**2,502**	**8**
6	574	10	632	10	685	10	868	12	837	12	**3,596**	**11**
7	517	9	539	9	572	8	580	8	500	7	**2,708**	**8**
8	254	5	242	4	319	5	340	5	335	5	**1,490**	**5**
9	490	9	562	9	581	8	625	9	689	10	**2,947**	**9**
10	344	6	466	8	572	8	556	8	672	9	**2,610**	**8**
11	1,611	29	1,830	30	2,114	31	2,359	32	2,225	31	**10,139**	**31**
Total	**5,598**		**6,079**		**6,880**		**7,312**		**7,135**		**33,004**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

For enrollees living in ALFs:

- Region 3 (+2%), Region 5 (+1%), Region 7 (+1%), and Region 10 (+3%) had increases in proportions of preventable hospitalizations over the study period.
- Region 4 (-1%) and Region 11 (-6%) had small decreases.

Table 52. Preventable Hospitalizations among Enrollees living in ALFs by Region.

Preventable Hospitalizations for ALF-based Enrollees Region												
Region	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
1	43	2	44	2	50	2	57	2	46	2	**240**	**2**
2	10	1	9	0	10	0	4	0	14	1	**47**	**0**
3	68	3	118	5	126	5	101	4	109	5	**522**	**5**
4	71	4	74	3	83	3	65	3	74	3	**367**	**3**
5	284	14	299	14	412	16	308	13	356	15	**1,659**	**14**
6	317	16	318	15	413	16	382	16	369	16	**1,799**	**16**
7	133	7	150	7	170	7	165	7	180	8	**798**	**7**
8	92	5	72	3	106	4	122	5	112	5	**504**	**4**
9	152	8	165	8	208	8	193	8	187	8	**905**	**8**
10	230	11	274	13	283	11	262	11	324	14	**1,373**	**12**
11	611	30	662	30	769	29	770	32	568	24	**3,380**	**29**
Total	**2,011**		**2,185**		**2,630**		**2,429**		**2,339**		**11,594**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

For enrollees living in NFs:

- Region 3 (+2%), Region 5 (+2%), Region 6 (+2%), Region 7 (+1%), and Region 8 (+2%) had increases in preventable hospitalizations over the study period. Region 1 (-1%), Region 2 (-1%), Region 4, (-1%), Region 10 (-1%), and Region 11 (15%) demonstrated decreases in preventable hospitalizations.

Table 53. Preventable Hospitalizations among Enrollees living in NFs by Region.

Preventable Hospitalizations for NF-based Enrollees Region												
Region	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
1	324	4	238	3	239	3	236	3	206	3	**1,243**	**3**
2	395	5	377	5	373	5	333	5	271	4	**1,749**	**5**
3	661	8	672	9	673	9	657	9	648	10	**3,311**	**9**
4	768	10	635	9	716	9	697	10	632	9	**3,448**	**9**
5	874	11	874	12	914	12	860	12	866	13	**4,388**	**12**
6	779	10	846	12	924	12	830	12	772	12	**4,151**	**11**
7	718	9	712	10	775	10	683	9	678	10	**3,566**	**10**
8	405	5	391	6	442	6	416	6	473	7	**2,127**	**6**
9	744	10	706	10	754	10	746	10	673	10	**3,623**	**10**
10	478	6	382	5	480	6	411	6	349	5	**2,100**	**6**
11	1,686	22	1,324	19	1,399	18	1,362	19	1,136	17	**6,907**	**19**
Total	**7,832**		**7,157**		**7,689**		**7,231**		**6,704**		**36,613**	

Sources: FSU created enrollee LOC file, Florida Center Data (IP)

III. Discussion of Findings for Research Question 2

When examining healthcare quality, especially HRQOL, it is important to use enrollee outcomes as the gold standard. It is likewise important to determine that all enrollees are equally served. In this section, the evaluation team addressed two quality of life indicators: 1) quality of life; and 2) self-reported health for home-based and ALF settings. (Data for NF enrollees are not available for these two quality indicators as they are contained in the 701B assessment measure used in HCBS and not the MDS 3.0 used for NFs). These indicators were parsed by sex and race/ethnicity.

Indicators of quality of life showed similar trajectories for both females and males. However, the degree of change did differ slightly. Both females and males reported declines in their reports of much better quality of life and excellent self-reported health over the five-year study period. There were also increases in reports of poor health and much less satisfaction with life. While there was little indication of a “sex effect,” these trajectories did not move in the desirable direction.

When quality-of-life indicators were examined by race/ethnicity, White enrollees reported more positive evaluations of their overall health than Black or Hispanic respondents. Hispanic enrollees, both those living at home and in ALF settings, showed decreases in positive reports (good, much better, better) and increases in negative reports (poor, worse, much worse) when describing and comparing their overall health and quality of life to the previous year.

In addition, the evaluation team examined an established healthcare quality outcome, preventable hospitalizations, for three settings of care: 1) home; 2) ALFs; and 3) NFs. This outcome measure was analyzed by sex, race/ethnicity, and region.

When examined by sex, there were slight decreases in preventable hospitalizations for females and slight increases for males. When examined by race/ethnicity, White enrollees living at Home were over-represented in preventable hospitalizations but under-represented in preventable hospitalizations within ALFs and NFs. Conversely, Black enrollees residing at Home were under-represented in preventable hospitalizations but were over-represented in preventable hospitalizations if they lived within ALFs and NFs. Only Hispanic enrollees residing in ALFs were over-represented in preventable hospitalizations.

When preventable hospitalizations were examined by region in all three sites of care, Regions 1 and 4 produced positive results with some decrease. Regions 6, 8, and 9 had increases in preventable hospitalizations. Other regions had mixed results.

Summary

There were no discernable differences between male and female enrollees for these quality indicators with small exceptions for preventable hospitalizations. However, there was a noticeable pattern of fewer positive indicators for self-reported health and quality of life for Hispanic enrollees living at home or in ALFs. Black enrollees also reported less favorable indications overall when compared to White enrollees. Further, there were disparities in preventable hospitalizations by race/ethnicity. White enrollees living at Home, Black enrollees living in ALFs and NFs, and Hispanic enrollees living in ALFs were all over-represented in preventable hospitalizations.

RQ3: Are patient-centered enrollee transitions reducing the number of potentially preventable transitions?

I. Successful transitions and presence of HRQOL indicators

The Florida Medicaid Comprehensive Quality Strategy[56] promotes successful transitions into the community. It is essential, therefore, that the independent evaluation examine the enrollee outcomes and characteristics associated with successful (i.e., lasting 90 days or more) and safe transitions into the community.

[56] Agency for Health Care Administration. (2017). *Comprehensive quality strategy.* Retrieved from the Agency for Health Care Administration website: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf

Cognitive Impairment

Prior to transitioning, there were significant differences in the distributions of enrollees with cognitive impairments, which are shown in Table 54:

- Enrollees who transitioned were less than half as likely to have severe cognitive impairments (average of transitioned: 19%) as compared to enrollees who remained in a NF (43%).
- The rates of severe cognitive impairments were 16 percent for enrollees who successfully transitioned and 19 percent for enrollees who unsuccessfully transitioned as compared to enrollees who remained in a NF (43%).
- Rates of moderate cognitive impairment were lower for enrollees who successfully transitioned (17%) and unsuccessfully transitioned (20%), as compared to enrollees who remained in a NF (24%).
- For enrollees who unsuccessfully transitioned, the differences in the cognitive impairment distributions pre- and post-transition were statistically significant. More enrollees had a moderate or severe cognitive impairment upon returning to a NF than before they unsuccessfully transitioned (766 enrollees' post-transition versus 672 enrollees' pre-transition, a statistically significant increase).

Table 54. Frequency of Cognitive Impairment among Enrollees who Transitioned versus among Enrollees who Remained in a Nursing Facility.

Group	N with MDS assessment (quarterly or discharge only)	N with BIMS data	No cognitive impairment	Moderate cognitive impairment	Severe cognitive impairment
Remained in NF	77,276	61,908	20,320	14,782	26,806
		(80%)	(33%)	(24%)	(43%)
Successfully transitioned (pre)	8,140	6,609	4,404	1,139	1,066
		(81%)	(67%)	(17%)	(16%)
Unsuccessfully transitioned (pre)	2,758	2,103	1,308	389	406
		(76%)	(62%)	(19%)	(19%)
Unsuccessfully transitioned (post)	2,723	2,351	1,326	482	543
		(86%)	(56%)	(21%)	(23%)

Chi-square test of independence: χ^2 (6, N = 72,971) = 4082.49, p < .0001

Sources: FSU created enrollee LOC file, MDS assessments

Bladder and Bowel Incontinence

There were significant differences in the distributions of enrollees with bladder and bowel incontinence, which are shown in Table 55:

- Enrollees who transitioned were less likely to have some level of bladder incontinence before their transition compared to enrollees who remained in a NF. Prior to transitioning, the rates of bladder incontinence were 56 percent for enrollees who successfully transitioned, 65 percent for enrollees who unsuccessfully transitioned, and 81 percent for enrollees who remained in a NF.
- Follow-up analysis (not shown) of catheterization assessment items for enrollees who unsuccessfully transitioned revealed that use of indwelling catheters was at 6 percent pre-transition (155 enrollees) and 11 percent post-transition (301 enrollees). The rate of catheterization significantly increased, nearly doubling for enrollees after unsuccessful transitions.
    - When limited to enrollees who did not use catheters pre- or post- transition (2,249 enrollees), the rate of any level of incontinence significantly increased after unsuccessful transitions (68% pre-transition (1,519 enrollees) to 78% post-transition (1,764 enrollees)).
- Enrollees who transitioned were less likely to have some level of bowel incontinence before their transition compared to enrollees who remained in a NF. Prior to transitioning, the rates of bowel incontinence were 43 percent for enrollees who successfully transitioned, 51 percent for enrollees who unsuccessfully transitioned, and 73 percent for enrollees who remained in a NF.
- Follow-up analysis (not shown) showed that when limited to enrollees who did not have bowel incontinence pre or post transition (2,439 enrollees), the rate of any level of incontinence significantly increased after unsuccessful transitions (53% pre-transition (1,294 enrollees) to 67% post-transition (1,640 enrollees)).

Table 55. Frequency of Incontinence among Enrollees who Transitioned versus among Enrollees who Remained in a Nursing Facility.

Type	Group	N with MDS assessment (quarterly or discharge only)	N with data on continence	Continent	Incontinent	Not rated*
Bladder	Remained in NF	77,276	76,671	10,900	61,865	3,906
			(99%)	(14%)	(81%)	(5%)
	Successfully transitioned (pre)	8,140	8,032	3,168	4,496	368
			(99%)	(39%)	(56%)	(5%)
	Unsuccessfully transitioned (pre)	2,758	2,708	809	1,749	150
			(98%)	(30%)	(65%)	(6%)
	Unsuccessfully transitioned (post)	2,723	2,691	519	1,892	280
			(99%)	(19%)	(70%)	(10%)
Bowel	Remained in NF	77,276	76,663	19,198	56,050	1,415
			(99%)	(25%)	(73%)	(2%)
	Successfully transitioned (pre)	8,140	8,030	4,378	3,460	192
			(99%)	(55%)	(43%)	(2%)
	Unsuccessfully transitioned (pre)	2,758	2,708	1,235	1,394	79
			(98%)	(46%)	(51%)	(3%)
	Unsuccessfully transitioned (post)	2,723	2,689	842	1,749	98
			(99%)	(31%)	(65%)	(4%)

*Resident had a catheter, ostomy, or no output during the 7-day observation period.
Bladder chi-square test of independence: χ^2 (6, N = 90,102) = 3,788.20, p < .0001
Bowel chi-square test of independence: χ^2 (6, N = 90,090) = 3,663.89, p < .0001
Sources: FSU created enrollee LOC file, MDS assessments

Pain

Prior to transitioning, there were significant differences in the distributions of enrollees reporting pain, which are shown in Table 56.

- Relative to enrollees who remained in a NF, enrollees who transitioned were more likely to report experiencing pain before their transition. Prior to transitioning, the rates of reported pain were 34 percent for enrollees who successfully transitioned, 38 percent for enrollees who unsuccessfully transitioned, and 25 percent for enrollees who remained in a NF.
- Follow-up analysis (not shown) showed that when limited to the population with data on pain both before and after transition (1,555 enrollees), the rate of reported pain significantly increased by 10 percent after unsuccessful transitions (38% pre-transition (593 enrollees) to 48% post-transition (748 enrollees)).

Table 56. Frequency of Reported Pain among Enrollees who Transitioned versus among Enrollees who Remained in a Nursing Facility.

Group	N with MDS assessment (quarterly or discharge only)	N with data on pain	Reported pain	No pain reported
Remained in NF	77,276	57,851	14,544	43,307
		(75%)	(25%)	(75%)
Successfully transitioned (pre)	8,140	5,906	2,027	3,879
		(73%)	(34%)	(66%)
Unsuccessfully transitioned (pre)	2,758	1,906	717	1,189
		(69%)	(38%)	(62%)
Unsuccessfully transitioned (post)	2,723	2,219	1,047	1,172
		(81%)	(47%)	(53%)

Chi-square test of independence: χ^2 (3, N = 67,882) = 829.55, p < .0001

Sources: FSU created enrollee LOC file, MDS assessments

Pressure Ulcers

Prior to transitioning, there were significant differences in the distributions of enrollees with at least one pressure ulcer of any level, which are shown in Table 57:

- Six percent of enrollees who remained in a NF had at least one pressure ulcer of any level. Prior to transitioning, an equal proportion of enrollees who successfully transitioned had at least one ulcer (also 6%), whereas 9 percent of enrollees who unsuccessfully transitioned had at least one.
- Follow-up analysis (not shown) showed that when limited to the population with data on pressure ulcers both before and after transition (2,623 enrollees), the proportion of enrollees who unsuccessfully transitioned that had at least one pressure ulcer of any level doubled after unsuccessful transitions (9% pre-transition (226 enrollees) to 18% post-transition (470 enrollees)). The increase was statistically significant.

Table 57. Frequency of Pressure Ulcers among Enrollees who Transitioned versus among Enrollees who Remained in a Nursing Facility.

Group	N with MDS assessment (quarterly or discharge only)	N with data on pain	Has at least one pressure ulcer	No pressure ulcers reported
Remained in NF	77,276	77,243	4,435	72,808
		(≈100%)	(6%)	(94%)
Successfully transitioned (pre)	8,140	8,138	506	7,632
		(≈100%)	(6%)	(94%)
Unsuccessfully transitioned (pre)	2,758	2,756	238	2,518
		(≈100%)	(9%)	(91%)
Unsuccessfully transitioned (post)	2,723	2,723	496	2,227
		(100%)	(18%)	(82%)

Chi-square test of independence: χ^2 (3, N = 90,860) = 726.63, p < .0001

Sources: FSU created enrollee LOC file, MDS assessments

II. Successful transitions and presence of preventable hospitalizations

The evaluation team investigated the relationship between the occurrence of at least one preventable hospitalization within six months of transition and enrollee transitions from NFs to HCBS. Enrollees who remained in the NF for the duration of their observed enrollment serve as the reference group for comparison

purposes. All enrollees included in the model were observed for six consecutive months, either directly after their transition month for enrollees who moved into HCBS or for a randomly selected six-month period for enrollees who remained in a NF. Enrollees who moved into HCBS were only included in the analysis if they first resided in a NF for at least three consecutive months prior to the transition event. A transition into HCBS was considered successful when an enrollee shifted out of a NF and into the HCBS where they subsequently resided for at least six months. Conversely, an unsuccessful transition was any transition into HCBS from a NF after which an enrollee returned to a NF within fewer than six months. Note that for enrollees with multiple transitions, only the first event was included in this analysis. Preventable hospitalizations were identified via standard publicly available algorithms developed by the Agency for Healthcare Research and Quality (AHRQ).[57] Table 58 presents the results of the analysis.

- The overall rates of preventable hospitalizations in a six-month period were 5 percent for enrollees who remained in a NF (4,276 of 77,795 total enrollees), 9 percent for enrollees who successfully transitioned to HCBS (924 of 9,876 total enrollees), and 26 percent for enrollees who unsuccessfully transitioned back to a NF (733 of 2,797 total enrollees).
- Relative to the six-month period after enrollees successfully transition, enrollees who remained in a NF have approximately 30 percent (Odds Ratio [OR] = 1.32, not shown) higher odds of experiencing a preventable hospitalization in a randomly selected six-month period.
- Conversely, the odds of preventable hospitalizations for enrollees who unsuccessfully transitioned are 1.75 times higher (OR = 2.75) than the odds for enrollees who remain in a NF

[57] See https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2019.aspx for ICD-10 codes, and https://www.qualityindicators.ahrq.gov/Archive/PQI_TechSpec_ICD09_v60.aspx for ICD-9 codes.

Table 58. Odds of at least one Preventable Hospitalization for Enrollees who Transitioned into the Community versus for Enrollees who remained in a Nursing Facility.

Group	Total N	N Preventable Hospitalization from Total N	N Included in the Model	Preventable Hospitalization Odds Ratio	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Successfully Transitioned	9,876	924	8,051	0.76*	0.69	0.83
Unsuccessfully Transitioned	2,797	733	2,385	2.75*	2.48	3.06
Remained in a NF (reference	77,795	4,276	72,073			

*Significant at *p* <. 0001

Note: The model includes controls for enrollee age, sex, race/ethnicity, plan membership, region, functional status, and numerous active diagnosis codes. For full model results see the Appendix.

Sources: FSU created enrollee LOC file, enrollee eligibility data (for demographic information), FL Center inpatient data, MDS assessments

Table 59 shows the types of preventable hospitalizations for enrollees who transitioned and experienced a subsequent preventable hospitalization within the next six months.

- Urinary tract infections (UTIs) account for approximately one-third of preventable hospitalizations in both successfully (31%) and unsuccessfully (36%) transitioned enrollees.
- Heart failure and COPD or Asthma make up approximately one-fifth of preventable hospitalizations in both successfully (28%) and unsuccessfully (20%) transitioned enrollees.
- Diabetes and pneumonia made up an average of 15 percent of preventable hospitalizations in both successfully and unsuccessfully transitioned enrollees.

Table 59. Summary of Preventable Hospitalization Events for Enrollees who Transitioned.

Transition Group	N with Preventable Hospitalization	UTI	Heart Failure	COPD/ Asthma	Diabetes Compli-cations	Community-acquired Pneumonia	Amputation, cause diabetes	Hyper-tension
Successfully Transitioned	924	282	207	257	133	107	9	31
		(31%	(22%)	(28%)	(14%)	(12%)	(1%)	(3%)
Unsuccessfully Transitioned	733	263	165	148	117	92	26	24
		(36%	(23%)	(20%)	(16%)	(13%)	(4%)	(3%)

Note: Sums of the percentages and counts are greater than their respective total because some enrollees experience more than one type of preventable hospitalization.

Sources: FSU created enrollee LOC file, FL Center inpatient data, MDS assessments

Furthermore, of the enrollees who unsuccessfully transitioned, more than half of their returns to a NF were directly linked to a preventable hospitalization event (not shown in a table). Specifically, 481 (52%) enrollees entered a NF on the same day they were discharged from an inpatient hospitalization. The Prevention Quality Indicators distributions mirror Table 58 for this population.

Taken together, these data suggest that there were enrollee characteristics, specifically some identified quality indicators, which were markers for successful transitions. Enrollees with less cognitive impairment (no greater than slight), are continent of bladder and bowel, and do not have pressure ulcers were more likely to transition successfully. Those who were cognitively intact were able to participate in the decision to transition, a characteristic found to enhance the likelihood of successful transitions.[58] Therefore, considering enrollee characteristics and involving enrollees in the decision to transition are important factors in ensuring successful transitions.

Transition data also indicate that unsuccessful transitions are associated with losses in cognition and increases in incontinence. Furthermore, odds for preventable hospitalizations are almost three-fold higher for enrollees who experienced unsuccessful transitions when compared to NF enrollees. and the incidence of pain was higher for all enrollees who transition compared to enrollees who remain in the NF.

Summary

Enrollee characteristics, especially cognitive status, were important for enhancing successful transition. Unsuccessful transitions are associated with declines in cognitive ability, increases in incontinence, and the development of pressure ulcers. Unsuccessful transitions also were associated with a greater risk of preventable hospitalizations. All enrollees who transition reported higher levels of pain.

RQ4: Are patient-centered needs of enrollees being met?

Client Involvement in Assessment Process

One of the most basic principles in medical ethics is autonomy, the right to choose your own treatment. In addition, the essential element of person-centered care is involvement of the client in the assessment process (i.e., enrollees, when possible, should answer assessment questions related to their healthcare goals, quality of life, and preferences for medical treatment). This focus on person-centered care is consistent with the Florida Medicaid Comprehensive Quality Strategy.[59] Standardized assessment instruments are administered to assess enrollee healthcare goals, quality of life, and preferences. For enrollees in NFs, the MDS 3.0 is administered upon admission, quarterly, annually, and if there is a significant change in condition. For enrollees residing in HCBS settings, the Florida Department of Elder Affairs has developed the 701B assessment to be administered at a minimum of annually. Although there is some concern that data will be affected by the cognitive status of the enrollee, it is important to provide opportunities for all enrollees to participate as fully as possible in the assessment process. When enrollees were unable to participate, caregivers such as family, powers of attorney, and friends

[58] Dyrstad, D. N., Testad, I., Aase, K., & Storm, M. (2015). A review of the literature on patient participation in transitions of the elderly. *Cognition, Technology & Work*, *17*(1), 15-34.

[59] Agency for Health Care Administration. (2017). *Comprehensive quality strategy.* Retrieved from the Agency for Health Care Administration website: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf

served as surrogate respondents. Table 60 shows counts and percentages in HCBS enrollee participation in the assessment process.

- Over the five-year evaluation period, the proportion of enrollees participating in their assessments increased for Home-based enrollees from 45 percent in SFY 2014 - 2015 to 48 percent SFY 2018 - 2019. This is a positive finding.
- The proportion of enrollees participating in their assessments decreased for enrollees living in ALFs from 57 percent in SFY 2014 - 2015 to 48 percent in SFY 2018 - 2019.

Table 60. HCBS Enrollee Participation in the Assessment Process.

Enrollee Participation in the Assessment										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Home Enrollees										
Yes	8,051	45	10,479	46	11,565	46	13,587	46	15,646	48
No	9,813	55	12,233	54	13,633	54	15,696	54	17,005	52
ALF Enrollees										
Yes	3,831	57	4,561	54	4,614	51	4,574	49	4,896	48
No	2,890	43	3,860	46	4,454	49	4,691	51	5,348	52

Sources: FSU created enrollee LOC file, 701B assessments

One reason that enrollees may not participate in the assessment process is due to severe cognitive impairment. Table 61 shows the cognitive impairment of HCBS enrollees (assessed using the Brief Interview for Mental Status [BIMS] within the 701B assessments) during the five-year evaluation period. Enrollee-answered assessments are presented in one column and caregiver-answered assessments are presented in another column.

- Not many (close to 0%) Home-based and ALF enrollees were fully cognitively intact. However, approximately 269 Home-based enrollees and 105 ALF enrollees who were cognitively intact (thus, were able to complete the assessment) had a caregiver answer their assessment rather than themselves.
- Home-based and ALF enrollees who answered their own assessments had more moderate cognitive impairments (Home: 67%; ALF: 53%) than enrollees with caregivers who answered their assessments (Home-based: 19%; ALF: 14%).
- Home-based and ALF enrollees who answered their own assessments had more severe cognitive impairments (Home-based: 26%; ALF: 29%) than enrollees with caregivers who answered their assessments (Home-based: 21%; ALF: 18%).
- Caregiver-answered assessments “skipped” the BIMS assessment more often than enrollee-answered assessments (Home-based: 59% vs. 7%, and ALF: 67% vs. 17%). This may indicate that the enrollee is not participating in the assessment process; and, therefore, cannot

complete the BIMS assessment. However, 7 percent of Home-based enrollee-answered assessments and 17 percent of ALF enrollees-answered assessments also skipped these questions.

Table 61. Comparing Cognitive Functioning Between Home and ALF Enrollees.

BIMS category	Enrollee		Caregiver		Total
	n	%	n	%	n
Home Enrollees					
Cognitively intact	150	0%	269	0%	**419**
Moderate impairment	45,566	67%	11,567	19%	**57,133**
Severe impairment	17,787	26%	12,672	21%	**30,459**
Skipped	4,877	7%	34,820	59%	**39,697**
ALF Enrollees					
Cognitively intact	149	1%	105	0%	**254**
Moderate impairment	11,271	53%	3,152	14%	**14,423**
Severe impairment	6,189	29%	4,065	18%	**10,254**
Skipped	3,634	17%	15,154	67%	**18,788**

Sources: FSU created enrollee LOC file, 701B assessments

The evaluation team looked at unmet needs from the perspective of enrollees when possible or from caregivers when individual enrollees were unable to respond. Unmet need is defined as an identified need for which appropriate services are not provided. For HCBS enrollees, unmet needs were determined from the need for assistance in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and the availability of assistance to meet those needs. These include basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

An enrollee was identified as having a need for assistance if they answered that s/he “needs supervision or prompt”, “needs assistance (but not total help)”, or “needs total assistance (cannot do at all)” in the 701B assessment. When an enrollee was identified as having a need, they were then identified as having an unmet need if the enrollee also responded that they did not receive assistance for that same need. The evaluation team looked at unmet needs in three categories: 1) Assistive devices; 2) Activities of Daily Living (ADLs); and 3) Instrumental Activities of Daily Living (IADLs). Assistive devices include canes, wheelchairs, and transfer bars. ADLs include basic needs such as bathing, dressing, eating, and toileting. IADLs include more complex and cognitively influenced needs such as housekeeping, using the telephone, and managing money.

Unmet Need as Reported by Enrollees

Counts of enrollee-assessed unmet device need are presented for all HCBS enrollees in Table 62.

- For any given evaluation year, more than 95 percent of enrollees in HCBS settings had their identified sensory aid or assistive device needs met.
- ALF enrollees experienced a decrease in unmet sensory aid or assistive device needs (from 5% in SFY 2014 - 2015 to 3% in SFY 2018 - 2019) over the five-year evaluation period, which is a positive finding.

Table 62. Assistive Device Needs among Home and ALF Enrollees.

Home Enrollees Needing a Sensory Aid or Assistive Device										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Home Enrollees										
Unmet Need	437	4%	458	4%	525	4%	605	4%	597	4%
Need Met	9,376	96%	11,775	96%	13,108	96%	15,091	96%	16,408	96%
ALF Enrollees										
Unmet Need	149	5%	148	4%	139	3%	148	3%	187	3%
Need Met	2,741	95%	3,712	96%	4,315	97%	4,543	97%	5,161	97%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of enrollee-assessed unmet ADL need are presented for Home-based enrollees in Table 63. Only Home-based enrollees who identified that they had a specific need (i.e., bathing, dressing, eating, toileting, transferring, or walking) are included in this table and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 63 as the specific assistance (e.g., bathing) received for the specific need (e.g., bathing).

- Home-based enrollees with bathing needs experienced increases in never having bathing assistance (SFY 2014 - 2015: 1%, SFY 2018 - 2019: 3%), rarely (SFY 2014 - 2015: 2%, SFY 2018 - 2019: 5%), and most of the time (SFY 2014 - 2015: 13%, SFY 2018 - 2019: 19%). They experienced a decrease in always having bathing assistance (SFY 2014 - 2015: 83%, SFY 2018 -2019: 73%).
- Home-based enrollees with dressing needs have experienced increases in never having dressing assistance (SFY 2014 - 2015: 2%, SFY 2018 - 2019: 3%), rarely (SFY 2014 - 2015: 2%, SFY 2018 - 2019: 5%), and most of the time (SFY 2014 - 2015: 14%, SFY 2018 - 2019: 19%). They experienced a decrease in always having dressing assistance (SFY 2014 - 2015: 82%, SFY 2018 - 2019: 73%).
- Home-based enrollees with eating needs experienced increases in never having eating assistance (SFY 2014 - 2015: 4%, SFY 2018 - 2019: 8%), and most of the time (SFY 2014 - 2015: 14%, SFY 2018 - 2019: 20%). They have experienced a decrease in always having eating assistance (SFY 2014 - 2015: 78%, SFY 2018 - 2019: 69%).
- Home-based enrollees with toileting needs experienced increases in rarely having toileting assistance (SFY 2014 - 2015: 4%, SFY 2018 - 2019: 5%), and most of the time (SFY 2014 - 2015: 17%, SFY 2018

- 2019: 22%). They experienced a decrease in always having toileting assistance (SFY 2014 - 2015: 77%, SFY 2018 - 2019: 70%).

- Home-based enrollees with transferring needs have experienced increases in rarely having transferring assistance (SFY 2014 - 2015: 4%, SFY 2018 - 2019: 5%), and most of the time (SFY 2014 - 2015: 18%, SFY 2018 - 2019: 20%). They experienced a decrease in always having transferring assistance (SFY 2014 - 2015: 75%, SFY 2018 - 2019: 72%).
- Home-based enrollees with walking needs experienced an increase in never having walking assistance (SFY 2014 - 2015: 3%, SFY 2018 - 2019: 4%), most of the time (SFY 2014 - 2015: 16%, SFY 2018 - 2019: 18%), and a decrease in always having walking assistance (SFY 2014 - 2015: 76%, SFY 2018 - 2019: 74%).

Table 63. Unmet ADL Needs among Home Enrollees.

Unmet ADL Needs among Enrollees at Home										
ADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Bathing										
Never	119	1%	222	2%	423	4%	350	3%	398	3%
Rarely	190	2%	288	3%	614	5%	575	4%	678	5%
Most of the time	1,055	13%	1,374	13%	1,833	16%	2,236	17%	2,606	19%
Always	6,854	83%	8,378	82%	8,553	75%	9,718	75%	10,126	73%
Dressing										
Never	111	2%	192	2%	350	3%	296	3%	371	3%
Rarely	168	2%	251	3%	561	5%	504	4%	589	5%
Most of the time	1,034	14%	1,327	15%	1,696	17%	2,071	18%	2,420	19%
Always	5,998	82%	7,354	81%	7,617	75%	8,638	75%	9,035	73%
Eating										
Never	78	4%	98	5%	171	7%	184	7%	228	8%
Rarely	63	3%	51	2%	119	5%	94	3%	100	3%
Most of the time	280	14%	343	16%	464	19%	507	19%	589	20%
Always	1,512	78%	1,605	77%	1,695	69%	1,930	71%	2,047	69%
Toileting										
Never	103	3%	145	3%	236	4%	183	3%	224	3%
Rarely	137	4%	138	3%	318	6%	242	4%	305	5%
Most of the time	660	17%	843	18%	984	19%	1,165	20%	1,393	22%
Always	2,995	77%	3,638	76%	3,732	71%	4,303	73%	4,516	70%
Transferring										
Never	94	3%	131	3%	205	4%	166	3%	190	3%
Rarely	150	4%	156	3%	318	7%	267	5%	271	5%
Most of the time	685	18%	751	16%	859	18%	1,020	19%	1,160	20%
Always	2,799	75%	3,526	77%	3,501	72%	3,902	73%	4,087	72%
Walking										
Never	118	3%	140	3%	189	4%	153	3%	172	4%
Rarely	146	4%	136	3%	241	6%	199	4%	204	4%
Most of the time	551	16%	610	15%	679	16%	755	16%	852	18%
Always	2,563	76%	3,305	79%	3,252	75%	3,515	76%	3,549	74%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of enrollee-assessed unmet ADL need are presented for ALF enrollees in Table 64. Only ALF enrollees who identified that they had a specific (i.e., bathing, dressing, eating, toileting, transferring, or walking) need are included in this table, and they were only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 64 as the specific assistance (e.g., bathing) received for the specific need (e.g., bathing).

- ALF enrollees with bathing needs have experienced increases in rarely (SFY 2014 - 2015: 0%, SFY 2018 - 2019: 1%), and most of the time (SFY 2014 - 2015: 3%, SFY 2018 - 2019: 5%) having bathing assistance. They also experienced a decrease in always having bathing assistance (SFY 2015: 95%, SFY 2019: 93%).
- ALF enrollees with dressing needs experienced increases in rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 3%, SFY 2019: 5%) having dressing assistance. They also experienced a decrease in always having dressing assistance (SFY 2015: 95%, SFY 2019: 93%).

- ALF enrollees with eating needs experienced increases in never (SFY 2015: 4%, SFY 2019: 5%), and most of the time (SFY 2015: 3%, SFY 2019: 4%) having eating assistance. They also experienced a decrease in always having eating assistance (SFY 2015: 92%, SFY 2019: 90%).
- ALF enrollees with toileting needs experienced increases in rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 3%, SFY 2019: 5%) having toileting assistance. They also experienced a decrease in always having toileting assistance (SFY 2015: 95%, SFY 2019: 93%).
- ALF enrollees with transferring needs experienced increases in rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 2%, SFY 2019: 4%) having transferring assistance. They also experienced a decrease in always having transferring assistance (SFY 2015: 96%, SFY 2019: 93%).
- ALF enrollees with walking needs experienced an increase in most of the time (SFY 2015: 3%, SFY 2019: 4%) having walking assistance, and a decrease in always having walking assistance (SFY 2015: 95%, SFY 2019: 93%).

Table 64. Unmet ADL Needs among ALF Enrollees.

Unmet ADL Needs among Enrollees at Home										
ADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Bathing										
Never	26	1%	23	1%	36	1%	35	1%	37	1%
Rarely	12	0%	17	1%	24	1%	24	1%	28	1%
Most of the	81	3%	113	3%	127	3%	179	5%	212	5%
Always	2,424	95%	3,134	95%	4,295	96%	3,427	94%	3,769	93%
Dressing										
Never	37	2%	38	1%	45	2%	36	1%	50	2%
Rarely	11	0%	17	1%	26	1%	13	0%	20	1%
Most of the	74	3%	100	4%	159	5%	160	5%	153	5%
Always	2,108	95%	2,597	94%	2,709	92%	2,709	93%	2,935	93%
Eating										
Never	32	4%	25	3%	50	5%	38	5%	41	5%
Rarely	8	1%	8	1%	5	1%	8	1%	7	1%
Most of the	27	3%	30	3%	42	4%	31	4%	38	4%
Always	806	92%	874	93%	843	90%	764	91%	787	90%
Toileting										
Never	30	2%	28	1%	40	2%	31	2%	36	2%
Rarely	7	0%	6	0%	19	1%	17	1%	16	1%
Most of the	49	3%	70	4%	92	5%	80	5%	84	5%
Always	1,509	95%	1,766	94%	1,721	92%	1,583	93%	1,712	93%
Transferring										
Never	22	2%	21	1%	31	2%	26	2%	25	2%
Rarely	7	0%	6	0%	10	1%	13	1%	13	1%
Most of the	34	2%	58	4%	93	6%	59	4%	63	4%
Always	1,365	96%	1,557	95%	1,414	91%	1,238	93%	1,329	93%
Walking										
Never	22	2%	18	1%	37	3%	27	3%	21	2%
Rarely	6	1%	6	0%	15	1%	7	1%	13	1%
Most of the	31	3%	37	3%	65	5%	43	4%	44	4%
Always	1,119	95%	1,260	95%	1,102	90%	960	93%	1,020	93%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of enrollee assessed unmet IADL need are presented for Home-based enrollees in Table 65. Only Home-based enrollees who identified that they had a specific need (i.e., housekeeping, chores, telephone, money, meals, shopping, medication, transportation) are included in this table, and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 65 as the specific assistance (e.g., housekeeping) received for the specific need (e.g., housekeeping).

- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 1%, SFY 2019: 3%), rarely (SFY 2015: 2%, SFY 2019: 6%), and most of the time (SFY 2015: 13%, SFY 2019: 19%) receiving assistance in housekeeping needs. They also experienced a decrease in always receiving assistance in housekeeping needs (SFY 2015: 83%, SFY 2019: 72%), presenting an area of concern.
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 1%, SFY 2019: 5%), rarely (SFY 2015: 4%, SFY 2019: 8%), and most of the time (SFY 2015: 11%, SFY 2019: 17%)

receiving assistance in chores needs. They also experienced a decrease in always receiving assistance in chores needs (SFY 2015: 84%, SFY 2019: 70%).

- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 6%, SFY 2019: 8%), rarely (SFY 2015: 2%, SFY 2019: 4%), and most of the time (SFY 2015: 12%, SFY 2019: 18%) receiving assistance in telephone needs. They also experienced a decrease in always receiving assistance in telephone needs (SFY 2015: 81%, SFY 2019: 71%).
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 2%, SFY 2019: 3%), rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 9%, SFY 2019: 13%) receiving assistance in money needs. They also experienced a decrease in always receiving assistance in money needs (SFY 2015: 88%, SFY 2019: 82%).
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 2%, SFY 2019: 3%), rarely (SFY 2015: 3%, SFY 2019: 6%), and most of the time (SFY 2015: 14%, SFY 2019: 20%) receiving assistance in meals needs. They also experienced a decrease in always receiving assistance in meals needs (SFY 2015: 82%, SFY 2019: 71%).
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 1%, SFY 2019: 2%), rarely (SFY 2015: 2%, SFY 2019: 5%), and most of the time (SFY 2015: 13%, SFY 2019: 19%) receiving assistance in shopping needs. They also experienced a decrease in always receiving assistance in shopping needs (SFY 2015: 84%, SFY 2019: 73%).
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 3%, SFY 2019: 4%), rarely (SFY 2015: 2%, SFY 2019: 3%), and most of the time (SFY 2015: 9%, SFY 2019: 13%) receiving assistance in medication needs. They also experienced a decrease in always receiving assistance in medication needs (SFY 2015: 87%, SFY 2019: 81%).
- Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 2%, SFY 2019: 3%), rarely (SFY 2015: 2%, SFY 2019: 4%), and most of the time (SFY 2015: 12%, SFY 2019: 17%) receiving assistance in transportation needs. They also experienced a decrease in always receiving assistance in transportation needs (SFY 2015: 84%, SFY 2019: 76%).

Table 65. Unmet IADL Needs among Home Enrollees.

Unmet IADL Needs among Enrollees at Home										
IADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Housekeeping										
Never	107	1%	212	2%	482	4%	413	3%	490	3%
Rarely	210	2%	386	3%	791	6%	827	5%	981	6%
Most of the time	1,266	13%	1,611	14%	2,161	16%	2,674	18%	3,101	19%
Always	7,964	83%	9,653	81%	9,848	74%	11,263	74%	11,848	72%
Chores										
Never	145	1%	256	2%	676	5%	661	4%	852	5%
Rarely	373	4%	546	4%	996	7%	1,136	7%	1,350	8%
Most of the time	1,083	11%	1,482	12%	1,857	14%	2,362	15%	2,796	17%
Always	8,160	84%	9,861	81%	10,004	74%	11,363	73%	11,812	70%
Telephone										
Never	85	6%	122	8%	131	7%	154	7%	185	8%
Rarely	28	2%	33	2%	77	4%	70	3%	88	4%
Most of the time	174	12%	205	13%	279	16%	338	16%	430	18%
Always	1,196	81%	1,222	77%	1,312	73%	1,549	73%	1,686	71%
Money										
Never	101	2%	141	2%	209	3%	236	3%	259	3%
Rarely	61	1%	86	1%	175	3%	133	2%	154	2%
Most of the time	433	9%	566	10%	782	12%	934	13%	1,016	13%
Always	4,436	88%	5,092	87%	5,229	82%	6,058	82%	6,396	82%
Meals										
Never	139	2%	209	2%	431	3%	384	3%	474	3%
Rarely	233	3%	406	4%	750	6%	753	5%	932	6%
Most of the time	1,251	14%	1,735	16%	2,232	18%	2,717	19%	3,062	20%
Always	7,259	82%	8,776	79%	9,123	73%	10,557	73%	11,113	71%
Shopping										
Never	103	1%	162	1%	352	3%	300	2%	364	2%
Rarely	181	2%	331	3%	689	5%	668	5%	811	5%
Most of the time	1,230	13%	1,618	14%	2,169	17%	2,644	18%	2,988	19%
Always	7,666	84%	9,229	81%	9,422	75%	10,750	75%	11,273	73%
Medication										
Never	147	3%	209	4%	284	4%	306	4%	334	4%
Rarely	79	2%	95	2%	212	3%	174	2%	219	3%
Most of the time	453	9%	571	10%	818	12%	973	13%	1,013	13%
Always	4,377	87%	5,014	85%	5,314	80%	6,213	81%	6,483	81%
Transportation										
Never	139	2%	179	2%	316	3%	327	3%	383	3%
Rarely	162	2%	242	2%	520	5%	467	4%	554	4%
Most of the time	1,014	12%	1,266	12%	1,705	15%	2,111	16%	2,349	17%
Always	7,141	84%	8,561	84%	8,878	78%	10,055	78%	10,626	76%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of enrollee assessed unmet IADL need are presented for ALF enrollees in Table 66. Only ALF enrollees who identified that they had a specific need (i.e., housekeeping, chores, telephone, money, meals, shopping, medication, transportation) are included in this table, and they are only included for the specific needs they

identified. Magnitude of unmet need is then reported in Table 66 as the specific assistance (e.g., housekeeping) received for the specific need (e.g., housekeeping).

- ALF enrollees with IADL needs experienced increases in rarely (SFY 2015: 0%, SFY 2019: 1%) and most of the time (SFY 2015: 2%, SFY 2019: 3%) receiving assistance in housekeeping needs. They also experienced a decrease in always receiving assistance in housekeeping needs (SFY 2015: 97%, SFY 2019: 96%), presenting an area of concern.
- ALF enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%) and most of the time (SFY 2015: 4%, SFY 2019: 5%) receiving assistance in chores needs. They also experienced a decrease in always receiving assistance in chores needs (SFY 2015: 98%, SFY 2019: 96%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 4%, SFY 2019: 5%) receiving assistance in telephone needs. They also experienced a decrease in always receiving assistance in telephone needs (SFY 2015: 92%, SFY 2019: 91%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) receiving assistance in money needs. They also experienced a decrease in always receiving assistance in money needs (SFY 2015: 97%, SFY 2019: 95%).
- ALF enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%) and most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in meals needs. They also experienced a decrease in always receiving assistance in meals needs (SFY 2015: 98%, SFY 2019: 97%).
- ALF enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 2%, SFY 2019: 4%) receiving assistance in shopping needs. They also experienced a decrease in always receiving assistance in shopping needs (SFY 2015: 97%, SFY 2019: 95%).
- ALF enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%) and most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in medication needs. They also experienced a decrease in always receiving assistance in medication needs (SFY 2015: 98%, SFY 2019: 97%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) receiving assistance in transportation needs. They also experienced a decrease in always receiving assistance in transportation needs (SFY 2015: 97%, SFY 2019: 96%).

Table 66. Unmet IADL Needs among ALF Enrollees.

Unmet IADL Needs among ALF Enrollees										
IADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Housekeeping										
Never	17	1%	20	1%	45	1%	39	1%	38	1%
Rarely	>10	0%	>10	0%	26	1%	19	0%	31	1%
Most of the time	67	2%	64	2%	151	4%	165	4%	154	3%
Always	2,753	97%	3,671	98%	4,089	95%	4,331	95%	4,969	96%
Chores										
Never	10	0%	14	0%	40	1%	27	1%	41	1%
Rarely	>10	0%	>10	0%	31	1%	28	1%	25	0%
Most of the time	49	2%	42	1%	120	3%	136	3%	133	2%
Always	2,823	98%	3,778	98%	4,246	96%	4,485	96%	5,129	96%
Telephone										
Never	34	3%	49	4%	68	5%	54	4%	52	3%
Rarely	>10	1%	>10	1%	13	1%	>10	1%	>10	1%
Most of the time	47	4%	62	5%	91	6%	76	5%	80	5%
Always	1,097	92%	1,244	91%	1,291	88%	1,286	90%	1,435	91%
Money										
Never	20	1%	26	1%	45	1%	35	1%	51	1%
Rarely	>10	0%	>10	0%	22	1%	11	0%	12	0%
Most of the time	58	2%	74	2%	127	3%	138	4%	138	3%
Always	2,425	97%	3,144	97%	3,448	95%	3,536	95%	3,973	95%
Meals										
Never	>10	0%	12	0%	40	1%	33	1%	41	1%
Rarely	>10	0%	>10	0%	22	0%	18	0%	14	0%
Most of the time	37	1%	46	1%	115	3%	135	3%	119	2%
Always	2,814	98%	3,756	98%	4,227	96%	4,443	96%	5,095	97%
Shopping										
Never	11	0%	19	1%	45	1%	26	1%	42	1%
Rarely	>10	0%	>10	0%	29	1%	20	0%	27	1%
Most of the time	67	2%	92	3%	195	5%	203	5%	187	4%
Always	2,671	97%	3,540	97%	3,935	94%	4,140	94%	4,732	95%
Medication										
Never	14	0%	20	1%	39	1%	32	1%	48	1%
Rarely	>10	0%	>10	0%	20	0%	>10	0%	13	0%
Most of the time	36	1%	35	1%	97	2%	112	3%	88	2%
Always	2,772	98%	3,668	98%	4,125	96%	4,312	97%	4,926	97%
Transportation										
Never	21	1%	18	0%	37	1%	26	1%	46	1%
Rarely	>10	0%	>10	0%	22	1%	20	0%	16	0%
Most of the time	55	2%	58	2%	139	3%	171	4%	148	3%
Always	2,722	97%	3,621	98%	4,009	95%	4,184	95%	4,785	96%

Sources: FSU created enrollee LOC file, 701B assessments

Unmet Need as Reported by Caregivers

Counts of caregiver-assessed unmet device need are presented for all HCBS enrollees in Table 67.

- For any given evaluation year, more than 95 percent of enrollees in HCBS settings had their identified sensory aid or assistive device needs met.
- Home-based enrollees experienced a decrease in unmet sensory aid or assistive device needs from 5percent in SFY 2015 to 4 percent in SFY 2019, which is a positive finding. ALF enrollees experienced an increase from 2 percent in SFY 2015 to 3 percent in SFY 2019 over the five-year evaluation period.

Table 67. Assistive Device Needs among HCBS and ALF Enrollees Reported by Caregivers.

Home Enrollees Needing a Sensory Aid or Assistive Device										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Home Enrollees										
Yes	406	5	432	4	472	4	585	4	668	4
No	7,645	95%	10,047	96%	11,093	96%	13,002	96%	14,978	96%
ALF Enrollees										
Yes	95	2	115	3	103	2	115	3	143	3
No	3,736	98%	4,446	97%	4,511	98%	4,459	97%	4,753	97%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of caregiver-assessed unmet ADL need are presented for Home-based enrollees in Table 68. Only caregivers of Home-based enrollees who identified that they had a specific need (i.e., bathing, dressing, eating, toileting, transferring, or walking) are included in this table and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 68 as the specific assistance (e.g., bathing) received for the specific need (e.g., bathing).

- Caregivers of Home-based enrollees with bathing needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 6%, SFY 2019: 13%) having bathing assistance. They also experienced a decrease in always having bathing assistance (SFY 2015: 93%, SFY 2019: 84%).
- Caregivers of Home-based enrollees with dressing needs experienced increases in rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 6%, SFY 2019: 14%) having dressing assistance. They also experienced a decrease in always having dressing assistance (SFY 2015: 93%, SFY 2019: 84%).
- Caregivers of Home-based enrollees with eating needs experienced increases in never (SFY 2015: 2%, SFY 2019: 3%), and most of the time (SFY 2015: 7%, SFY 2019: 12%) having eating assistance. They also experienced a decrease in always having eating assistance (SFY 2015: 91%, SFY 2019: 84%).
- Caregivers of Home-based enrollees with toileting needs experienced increases in rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 7%, SFY 2019: 12%) having toileting assistance. They also experienced a decrease in always having toileting assistance (SFY 2015: 91%, SFY 2019: 84%).

- Caregivers of Home-based enrollees with transferring needs experienced increases in rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 8%, SFY 2019: 13%) having transferring assistance. They also experienced a decrease in always having transferring assistance (SFY 2015: 90%, SFY 2019: 84%).
- Caregivers of Home-based enrollees with walking needs experienced an increase in rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 7%, SFY 2019: 12%) having walking assistance and a decrease in always having walking assistance (SFY 2015: 91%, SFY 2019: 85%).

Table 68. Unmet ADL Needs among HCBS Enrollees Reported by Caregivers.

Unmet ADL Needs among Enrollees at Home reported by Caregivers										
ADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Bathing										
Never	32	0%	55	1%	175	2%	72	1%	96	1%
Rarely	49	1%	131	1%	395	4%	303	2%	358	2%
Most of the time	471	6%	729	7%	1,325	12%	1,795	14%	2,023	13%
Always	7,253	93%	9,218	91%	9,351	83%	10,970	83%	12,617	84%
Dressing										
Never	42	1%	74	1%	167	2%	84	1%	94	1%
Rarely	40	1%	107	1%	382	3%	257	2%	315	2%
Most of the time	473	6%	754	8%	1,297	12%	1,738	14%	1,993	14%
Always	7,032	93%	8,941	91%	9,104	83%	10,724	84%	12,311	84%
Eating										
Never	90	2%	160	2%	184	3%	213	3%	273	3%
Rarely	27	1%	62	1%	188	3%	111	1%	120	1%
Most of the time	356	7%	485	7%	864	12%	1,053	13%	1,162	12%
Always	4,661	91%	5,788	89%	6,044	83%	7,044	84%	7,906	84%
Toileting										
Never	68	1%	97	1%	158	2%	102	1%	129	1%
Rarely	42	1%	102	1%	317	3%	202	2%	227	2%
Most of the time	500	8%	699	9%	1,143	13%	1,438	14%	1,659	14%
Always	5,788	90%	7,283	89%	7,517	82%	8,686	83%	9,995	83%
Transferring										
Never	63	1%	103	1%	142	2%	110	1%	116	1%
Rarely	52	1%	87	1%	282	3%	176	2%	185	2%
Most of the time	444	8%	603	8%	1,020	12%	1,233	13%	1,382	13%
Always	5,253	90%	6,643	89%	6,729	82%	7,663	83%	8,831	84%
Walking										
Never	72	1%	101	1%	133	2%	109	1%	100	1%
Rarely	43	1%	78	1%	242	3%	158	2%	164	2%
Most of the time	381	7%	516	7%	843	11%	1,014	12%	1,106	12%
Always	4,859	91%	6,197	90%	6,293	84%	7,086	85%	7,927	85%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of caregiver-assessed unmet ADL need are presented for ALF enrollees in Table 69. Only caregivers of ALF enrollees who identified that they had a specific need (i.e., bathing, dressing, eating, toileting, transferring, or walking) are included in this table and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 69 as the specific assistance (e.g., bathing) received for the specific need (e.g., bathing).

- Caregivers of ALF enrollees with bathing needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 4%) having bathing assistance. They also experienced a decrease in always having bathing assistance (SFY 2015: 98%, SFY 2019: 95%).
- Caregivers of ALF enrollees with dressing needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 4%) having dressing assistance. They also experienced a decrease in always having dressing assistance (SFY 2015: 97%, SFY 2019: 96%).

- Caregivers of ALF enrollees with eating needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) having eating assistance. They also experienced a decrease in always having eating assistance (SFY 2015: 95%, SFY 2019: 94%).
- Caregivers of ALF enrollees with toileting needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) having toileting assistance. They also experienced a decrease in always having toileting assistance (SFY 2015: 95%, SFY 2019: 94%).
- Caregivers of ALF enrollees with transferring needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) having transferring assistance.
- Caregivers of ALF enrollees with walking needs experienced an increase in most of the time (SFY 2015: 2%, SFY 2019: 3%) having walking assistance and a decrease in always having walking assistance (SFY 2015: 96%, SFY 2019: 95%).

Table 69. Unmet ADL Needs among ALF Enrollees Reported by Caregivers.

Unmet ADL Needs among Enrollees at ALF reported by Caregivers										
ADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Bathing										
Never	12	0%	>10	0%	21	0%	12	0%	21	0%
Rarely	>10	0%	16	0%	24	1%	17	0%	13	0%
Most of the time	57	2%	83	2%	127	3%	154	4%	174	4%
Always	3,650	98%	4,293	98%	4,295	96%	4,188	96%	4,406	95%
Dressing										
Never	16	0%	11	0%	27	1%	17	0%	17	0%
Rarely	>10	0%	13	0%	27	1%	20	0%	12	0%
Most of the time	68	2%	94	2%	129	3%	141	3%	156	4%
Always	3,496	97%	4,116	97%	4,071	96%	3,966	96%	4,130	96%
Eating										
Never	48	2%	55	2%	60	2%	60	2%	59	2%
Rarely	>10	0%	>10	0%	10	0%	>10	0%	>10	0%
Most of the time	56	2%	56	2%	60	2%	72	3%	72	3%
Always	2,284	95%	2,617	96%	2,547	95%	2,409	94%	2,365	94%
Toileting										
Never	21	1%	23	1%	27	1%	29	1%	32	1%
Rarely	>10	0%	11	0%	15	0%	11	0%	>10	0%
Most of the time	64	2%	76	2%	112	3%	112	3%	106	3%
Always	3,105	97%	3,584	97%	3,512	96%	3,288	96%	3,393	96%
Transferring										
Never	25	1%	31	1%	37	1%	30	1%	29	1%
Rarely	11	0%	13	0%	>10	0%	>10	0%	>10	0%
Most of the time	69	2%	70	2%	91	3%	77	3%	87	3%
Always	2,732	96%	3,113	96%	2,949	96%	2,773	96%	2,757	96%
Walking										
Never	31	1%	42	1%	37	1%	37	2%	29	1%
Rarely	11	0%	11	0%	>10	0%	>10	0%	>10	0%
Most of the time	54	2%	45	2%	73	3%	61	3%	71	3%
Always	2,344	96%	2,708	97%	2,521	95%	2,322	96%	2,311	95%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of caregiver assessed unmet IADL need are presented for Home-based enrollees in Table 70. Only caregivers of Home-based enrollees who identified that they had a specific need (i.e., housekeeping, chores, telephone, money, meals, shopping, medication, transportation) are included in this table and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 70 as the specific assistance (e.g., housekeeping) received for the specific need (e.g., housekeeping).

- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 1%, SFY 2019: 2%), and most of the time (SFY 2015: 5%, SFY 2019: 12%) receiving assistance in housekeeping needs. They also experienced a decrease in always receiving assistance in housekeeping needs (SFY 2015: 94%, SFY 2019: 85%), presenting an area of concern.

- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 1%, SFY 2019: 3%), and most of the time (SFY 2015: 5%, SFY 2019: 12%) receiving assistance in chores needs. They also experienced a decrease in always receiving assistance in chores needs (SFY 2015: 94%, SFY 2019: 84%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) receiving assistance in telephone needs. They also experienced a decrease in always receiving assistance in telephone needs (SFY 2015: 97%, SFY 2019: 95%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 3%, SFY 2019: 8%) receiving assistance in money needs. They also experienced a decrease in always receiving assistance in money needs (SFY 2015: 96%, SFY 2019: 91%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 0%, SFY 2019: 2%), and most of the time (SFY 2015: 4%, SFY 2019: 11%) receiving assistance in meals needs. They also experienced a decrease in always receiving assistance in meals needs (SFY 2015: 95%, SFY 2019: 87%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 4%, SFY 2019: 10%) receiving assistance in shopping needs. They also experienced a decrease in always receiving assistance in shopping needs (SFY 2015: 95%, SFY 2019: 89%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 3%, SFY 2019: 8%) receiving assistance in medication needs. They also experienced a decrease in always receiving assistance in medication needs (SFY 2015: 96%, SFY 2019: 91%).
- Caregivers of Home-based enrollees with IADL needs experienced increases in never (SFY 2015: 0%, SFY 2019: 1%), rarely (SFY 2015: 0%, SFY 2019: 1%), and most of the time (SFY 2015: 4%, SFY 2019: 9%) receiving assistance in transportation needs. They also experienced a decrease in always receiving assistance in transportation needs (SFY 2015: 95%, SFY 2019: 89%).

Table 70. Unmet IADL Needs among Home Enrollees Reported by Caregivers.

Unmet IADL Needs among Enrollees at Home Reported by Caregivers										
IADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Housekeeping										
Never	23	0%	51	0%	146	1%	81	1%	83	1%
Rarely	43	1%	117	1%	370	3%	286	2%	326	2%
Most of the time	431	5%	676	6%	1318	11%	1610	12%	1897	12%
Always	7,514	94%	9,567	92%	9,666	84%	11,543	85%	13,266	85%
Chores										
Never	30	0%	65	1%	216	2%	143	1%	141	1%
Rarely	79	1%	177	2%	454	4%	409	3%	489	3%
Most of the time	386	5%	617	6%	1,201	10%	1,546	11%	1,852	12%
Always	7,547	94%	9,606	92%	9,674	84%	11,458	85%	13,134	84%
Telephone										
Never	25	1%	23	1%	34	1%	53	1%	55	1%
Rarely	>10	0%	>10	0%	17	0%	19	1%	16	0%
Most of the time	63	2%	73	2%	108	3%	118	3%	120	3%
Always	3,111	97%	3,678	97%	3,650	96%	3,487	95%	3,661	95%
Money										
Never	38	0%	53	1%	114	1%	94	1%	110	1%
Rarely	15	0%	36	0%	146	1%	78	1%	84	1%
Most of the time	253	3%	394	4%	873	8%	1,039	8%	1,129	8%
Always	7,466	96%	9,604	95%	10,016	90%	11,846	91%	13,675	91%
Meals										
Never	24	0%	46	0%	114	1%	70	1%	78	1%
Rarely	31	0%	83	1%	296	3%	228	2%	244	2%
Most of the time	349	4%	609	6%	1,248	11%	1,459	11%	1,735	11%
Always	7,585	95%	9,643	93%	9,822	86%	11,743	87%	13,490	87%
Shopping										
Never	25	0%	40	0%	114	1%	75	1%	75	0%
Rarely	23	0%	60	1%	254	2%	165	1%	162	1%
Most of the time	328	4%	547	5%	1,144	10%	1,370	10%	1,545	10%
Always	7,638	95%	9,768	94%	9,971	87%	11,901	88%	13,761	89%
Medication										
Never	35	0%	52	1%	111	1%	97	1%	111	1%
Rarely	17	0%	40	0%	181	2%	104	1%	125	1%
Most of the time	248	3%	426	4%	897	8%	1,070	8%	1,155	8%
Always	7,449	96%	9,531	95%	9,943	89%	11,763	90%	13,537	91%
Transportation										
Never	29	0%	50	0%	129	1%	94	1%	98	1%
Rarely	25	0%	63	1%	252	2%	152	1%	156	1%
Most of the time	328	4%	513	5%	1,052	9%	1,236	9%	1,363	9%
Always	7,564	95%	9,701	94%	9,941	87%	11,873	89%	13,742	89%

Sources: FSU created enrollee LOC file, 701B assessments

Counts of caregiver assessed unmet IADL need are presented for ALF enrollees in Table 71. Only caregivers of ALF enrollees who identified that they had a specific need (i.e., housekeeping, chores, telephone, money, meals, shopping, medication, transportation) are included in this table and they are only included for the specific needs they identified. Magnitude of unmet need is then reported in Table 71 as the specific assistance (e.g., housekeeping) received for the specific need (e.g., housekeeping).

- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 3%) receiving assistance in housekeeping needs. They also experienced a decrease in always receiving assistance in housekeeping needs (SFY 2015: 99%, SFY 2019: 97%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in chores needs. They also experienced a decrease in always receiving assistance in chores needs (SFY 2015: 99%, SFY 2019: 97%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 2%, SFY 2019: 3%) receiving assistance in telephone needs. They also experienced a decrease in always receiving assistance in telephone needs (SFY 2015: 97%, SFY 2019: 95%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in money needs. They also experienced a decrease in always receiving assistance in money needs (SFY 2015: 99%, SFY 2019: 98%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 0%, SFY 2019: 2%) receiving assistance in meals needs. They also experienced a decrease in always receiving assistance in meals needs (SFY 2015: 99%, SFY 2019: 98%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 3%) receiving assistance in shopping needs. They also experienced a decrease in always receiving assistance in shopping needs (SFY 2015: 99%, SFY 2019: 97%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in medication needs. They also experienced a decrease in always receiving assistance in medication needs (SFY 2015: 99%, SFY 2019: 98%).
- ALF enrollees with IADL needs experienced increases in most of the time (SFY 2015: 1%, SFY 2019: 2%) receiving assistance in transportation needs. They also experienced a decrease in always receiving assistance in transportation needs (SFY 2015: 99%, SFY 2019: 97%).

Table 71. Unmet IADL Needs among ALF Enrollees Reported by Caregivers.

Unmet IADL Needs among ALF Enrollees Reported by Caregivers										
IADL	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
Categories	n	%	n	%	n	%	n	%	n	%
Housekeeping										
Never	>10	0%	11	0%	15	0%	18	0%	>10	0%
Rarely	>10	0%	>10	0%	16	0%	15	0%	>10	0%
Most of the time	33	1%	42	1%	94	2%	114	3%	134	3%
Always	3,769	99%	4,479	99%	4,461	97%	4,398	97%	4,701	97%
Chores										
Never	>10	0%	10	0%	15	0%	21	0%	15	0%
Rarely	>10	0%	>10	0%	14	0%	17	0%	17	0%
Most of the time	24	1%	41	1%	93	2%	98	2%	114	2%
Always	3,794	99%	4,503	99%	4,485	97%	4,431	97%	4,736	97%
Telephone										
Never	25	1%	23	1%	34	1%	53	1%	55	1%
Rarely	>10	0%	>10	0%	17	0%	19	1%	16	0%
Most of the time	63	2%	73	2%	108	3%	118	3%	120	3%
Always	3,111	97%	3,678	97%	3,650	96%	3,487	95%	3,661	95%
Money										
Never	>10	0%	10	0%	17	0%	17	0%	18	0%
Rarely	>10	0%	>10	0%	11	0%	10	0%	>10	0%
Most of the time	29	1%	44	1%	87	2%	76	2%	84	2%
Always	3,731	99%	4,426	99%	4,413	97%	4,359	98%	4,664	98%
Meals										
Never	>10	0%	>10	0%	15	0%	13	0%	13	0%
Rarely	>10	0%	>10	0%	15	0%	15	0%	3	0%
Most of the time	16	0%	32	1%	72	2%	77	2%	80	2%
Always	3,806	99%	4,504	99%	4,509	98%	4,461	98%	4,784	98%
Shopping										
Never	>10	0%	>10	0%	16	0%	18	0%	>10	0%
Rarely	>10	0%	>10	0%	13	0%	13	0%	>10	0%
Most of the time	36	1%	48	1%	98	2%	104	2%	126	3%
Always	3,758	99%	4,466	99%	4,458	97%	4,399	97%	4,708	97%
Medication										
Never	>10	0%	12	0%	18	0%	17	0%	11	0%
Rarely	>10	0%	>10	0%	10	0%	13	0%	>10	0%
Most of the time	20	1%	33	1%	68	1%	67	1%	75	2%
Always	3,786	99%	4,487	99%	4,500	98%	4,459	98%	4,764	98%
Transportation										
Never	>10	0%	>10	0%	17	0%	18	0%	11	0%
Rarely	>10	0%	>10	0%	13	0%	17	0%	11	0%
Most of the time	27	1%	44	1%	89	2%	82	2%	105	2%
Always	3,762	99%	4,451	99%	4,456	97%	4,412	97%	4,705	97%

Sources: FSU created enrollee LOC file, 701B assessments

II. Discussion of Findings for Research Question 4

Patient-centered care, which includes enrollee involvement in their assessment of needs, is essential to quality care. Enrollees in HCBS settings answered their own 701B assessments about half of the time, while their caregivers answered the 701B assessments the other half of the time. The evaluation team noted that this was probably largely due to severe cognitive impairment. Most of the caregiver-answered assessments (Home-based: 59%; ALF: 67%) skipped the BIMS cognitive assessment, which indicates that enrollees were not answering assessment questions.

However, when comparing enrollee-answered and caregiver-answered assessments, the evaluation team found that a small number of caregiver-answered assessments were filled out for enrollees who were cognitively intact (Home-based: *n*=269; ALF: *n*=105) or moderately impaired (Home-based: 19%; ALF: 14%). These assessments could very likely have been answered by enrollees rather than caregivers, indicating that their care may not be patient centered. Even if enrollees requested that their caregiver complete the assessment on their behalf, there is a well-known issue of health care proxies—usually caregivers who are close family members and friends—not being good at identifying their loved one's needs and wants.[60] Because this is often the case, care directed by caregivers is often not considered patient-centered.

In addition, for enrollee-answered assessments, some enrollees (7% in Homes and 17% in ALFs) skipped the BIMS assessment, which indicates that the enrollee probably was not answering the questions. However, this is contradictory to their case manager's previous indication within 701B assessment in that the enrollee is the person answering the assessment questions. This is a data problem that could be indicative of a lack of patient-centered care.

Across HCBS settings, regardless of who primarily participated in the assessment process (i.e., enrollees or their caregivers), most enrollees (over 95%) who needed ADL or IADL assistance received it always or most of the time. Further, enrollees receiving care in ALFs have positive or neutral trends regarding the amount of assistance they receive for their ADL and IADL needs—that is, there is little change in the amount of assistance they receive for their needs. This points to good quality care within the LTC program.

However, there are concerning trends that need to be addressed for enrollees who received care in their Homes. Home-based enrollees experienced increases in never and rarely receiving assistance for their ADL and IADL needs, and experienced subsequent decreases in always receiving assistance for their needs. Future evaluations could focus on assessing why more enrollees were receiving less assistance for their needs, but this could indicate an issue of access to personal care providers. If this were the case, the Agency could incentivize creating and expanding personal care providers to fill this need for services.

These findings support the importance of having a caregiver when living at Home, because informal caregivers (e.g., family members and friends) may provide care when a LTC service provider is unavailable. However, sole

[60] Holland, M. M., & Prost, S. G. (2019). The end of life within social work literature: a conceptual review. *OMEGA-Journal of Death and Dying*, 0030222819835650.

reliance on health care proxies—usually caregivers who are close family members and friends—is not sufficient in identifying enrollee needs and wants.[61] Future evaluations could qualitatively (likely through interviews) explore the causes of the differences in enrollee and caregiver answers.

RQ5: Has enrollee safety improved over time?

I. Trends in the proportion of enrollees reporting HRQOL indicators.

Safety is an important component of quality care in long-term care settings that is secondary to quality of life because of patient preferences. When patients think about healthcare quality, they assume that safety is present in care and instead stress quality of life.[62] When providers think of healthcare quality, they seek the best health and safety outcomes for patients, which makes safety an important component of healthcare quality. Counts and percentages of quality-of-life indicators by sex over the five-year evaluation period are presented for Home-based enrollees in Table 72 and ALF enrollees in Table 73.

- The proportion of Home-based enrollees who did not have medications managed properly (from 4% in SFY 2015 to 3% in SFY 2019), and who needed a new medication review by a doctor or pharmacist decreased over the evaluation period (from 3% in SFY 2015 to 2% in SFY 2019).
- The proportion of enrollees who took three or more medications per day (SFY 2015: 98%; SFY 2019: 97%), and who needed a new medication review (SFY 2015: 2%; SFY 2019: 1%) decreased moderately among ALF enrollees, which is a positive finding.
- Home-based enrollees experienced more falls (0.6 falls over six months) than ALF (0.4 falls over six months) enrollees. There was a subsequent growth in the proportion of Home-based enrollees who changed their activities “all of the time” because they were afraid to fall (SFY 2015: 33% vs. SFY 2019: 41%).

[61] Holland, M. M., & Prost, S. G. (2019). The end of life within social work literature: a conceptual review. *OMEGA-Journal of Death and Dying*, 0030222819835650.
[62] Kane, R. L., & Kane, R. A. (2001). What older people want from long-term care, and how they can get it. *Health Affairs*, *20*, 114-127.

Table 72. Safety among Home Enrollees

Safety among Home Enrollees										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Are the enrollee's medications managed properly?										
Yes	17,217	96	21,985	97	24,442	97	28,461	97	31,671	97
No	396	4	496	3	477	3	527	3	625	3
Do you take three or more prescribed or over the counter medications a day?										
Yes	17,195	96	21,902	96	24,280	96	28,220	96	31,438	96
No	669	4	810	4	918	4	1,063	4	1,213	4
Should the enrollee have a new medication review by a doctor or pharmacist?										
Yes	478	3	553	2	579	2	643	2	713	2
No	16,929	95	21,681	95	23,977	95	27,886	95	31,059	95
How often do you change or limit your activities out of fear of falling?										
All the Time	5,926	33	8,212	36	9,649	38	11,754	40	13,361	41
Often	4,849	27	6,214	27	7,119	28	8,395	29	8,838	27
Occasionally	4,476	25	5,413	24	5,698	23	6,270	21	6,950	21
Never	2,613	15	2,873	13	2,732	11	2,864	10	3,502	11
How many times have you fallen in the last 6 months?										
Mean	0.6		0.5		0.6		0.7		0.7	
Std Dev	1.8		1.7		2.1		2.3		2.3	
Minimum	0		0		0		0		0	
Maximum	60		60		96		90		98	

Sources: FSU created enrollee LOC file, 701B assessments

Table 73. Safety among ALF Enrollees

Safety among ALF Enrollees										
	SFY 2015		SFY 2016		SFY 2017		SFY 2018		SFY 2019	
	n	%	n	%	n	%	n	%	n	%
Are the enrollee's medications managed properly?										
Yes	6,617	98	8,271	98	8,913	98	9,131	99	10,082	98
No	71	1	94	1	76	1	77	1	96	1
Do you take three or more prescribed or over the counter medications a day?										
Yes	6,598	98	8,265	98	8,904	98	9,065	98	9,977	97
No	123	2	156	2	164	2	200	2	267	3
Should the enrollee have a new medication review by a doctor or pharmacist?										
Yes	150	2	146	2	148	2	142	2	131	1
No	6,416	95	8,105	96	8,664	96	8,861	96	9,839	96
Skipped	155	2	170	2	256	2	262	2	274	3
How often do you change or limit your activities out of fear of falling?										
All the Time	1,885	28	2,414	29	2,533	28	2,548	28	2,564	25
Often	1,472	22	1,795	21	2,068	23	2,203	24	2,370	23
Occasionally	1,869	28	2,386	28	2,681	30	2,813	30	3,080	30
Never	1,495	22	1,826	22	1,786	20	1,701	18	2,230	22
How many times have you fallen in the last 6 months?										
Mean	0.4		0.4		0.4		0.5		0.5	
Std Dev	1.2		1.2		1.2		1.6		1.5	
Minimum	0		0		0		0		0	
Maximum	20		24		25		60		52	

Sources: FSU created enrollee LOC file, 701B assessments

II. Discussion of Findings for Research Question 5

Using measures of counts of medications and falls, enrollees living at home reported concerns regarding safety. Notably, they reported an increase in limiting activities to avoid falling. However, there was a decrease in the need for medication management reviews.

In contrast, ALF enrollees had fewer safety concerns, taking fewer medications, needing fewer medication reviews, and not limiting activities due to fear of falling. These data suggest that enrollees living in home environments were at greater risk. It is important, however, to weigh these risks as compared with quality of life. Unfortunately, RQ1's findings indicate declines in overall health and quality of life for enrollees living in their homes, as well.

Conclusions and Recommendations

1. Focus future Performance Improvement Projects (PIPs) and other ongoing quality evaluations on reducing preventable hospitalizations, specifically those related to diabetes management based on utilizing best practices across all three sites of care. This recommendation stems from the prevalence of long- and short-term complications and lower-extremity amputations associated with diabetes resulting in hospitalizations across all sites of care.

2. Focus future PIPs and other ongoing quality evaluations on reducing preventable hospitalizations associated with bacterial infection and onsite infections by increasing rates of vaccinations and implementing best practices regarding infection control, specifically in NFs. This recommendation is based on the declining rates of immunizations and incidence of bacterial infections among enrollees hospitalized.

3. Target those Regions demonstrating increasing levels of preventable hospitalizations with monetary penalties. This recommendation is based upon a recognizable Region effect when analyzing combined data across all three sites of care by Region. This Region effect serves as a surrogate for Plan distribution; therefore, plans need to be accountable for these deficiencies.

4. Improve and/or increase the monitoring of home-based enrollees, especially those recently transferred into the community, for social isolation and increased pain. This recommendation is based upon declining reports of excellent or very good quality of life among home-based enrollees, reports of losses of available help, greater incidence of pain, and limiting daily activities due to fear of falling.

5. Improve and/or increase the monitoring of quality of care and quality of life for ALF enrollees. This recommendation is based upon the lack of primary caregivers for enrollees living in ALFs, leaving them without family or friends to monitor and advocate for them.

6. Stress cultural competence and cultural humility and require additional training focused on anti-racism for case managers and Plan personnel. These concepts are fully defined in Appendix B. This recommendation is based upon declines in indications of excellent self-reported health in HCBS settings, increases in reports of quality of life and self-reported health as worse in HCBS settings, and over-representation of Black and Hispanic enrollees in preventable hospitalizations in ALF and NF settings. Issues in self-reported quality indicators appear more prominently among Hispanic enrollees and issues in preventable hospitalizations appear more prominently

among Black enrollees. These recommendations are made to recognize, enhance, and promote the value of the Agency's ongoing quality improvement initiatives.

Cost-effectiveness of Care

Purpose

The cost-effectiveness assessment of the Medicaid LTC program used quantitative methods. A detailed description of the specific methodologies is provided in Appendix C to this report. The following research questions, as discussed with the Agency, were used to guide this evaluation report on cost-effectiveness:

1. How is the magnitude of capitation changing and why? How is the distribution by service category changing, and how is it affecting the magnitude of the capitation?
2. Has a shift between home and community-based services (HCBS) and nursing facility (NF) services affected overall Medicaid costs under the LTC program, and if so, how? How do the average or per member per month (PMPM) costs before and after transition compare for the recipients who transferred into and out of nursing facilities?

Evaluation in this report addressed the cost[63] of the Medicaid LTC program to the state. The terms cost-effectiveness and cost, though quite similar in name, have distinct meanings. “Cost” is the amount the Agency paid out to the managed care plans or the amount the plans paid out to fee-for-service (FFS) Medicaid LTC service providers. “Cost-effectiveness” has a specific interpretation in health services research. Cost-effectiveness analysis examines the relationship between health outcomes and the expenditures that affect them. The outcomes of interest are not predetermined, as researchers and/or stakeholders define them. For this report, the objectives of each research question (RQ) are as follows:

- RQ1a: How is the magnitude of capitation changing, and why?
- RQ1b: How is the distribution by service category changing, and how does that shift in service location affect the magnitude of the capitation?
- RQ2: Has a shift between HCBS and NF affected overall Medicaid costs under the LTC program, and if so, how?

Table 74 provides a summary of the monthly data used in these analyses.

[63] Cost here is defined as direct Medicaid LTC program claims and encounter costs.

Table 74. Average Per Month Summary of Medicaid Long Term Care Claims, and Medicaid Encounter; Nursing Facility, and Home and Community Based Services, SFY 2014-2015 through SFY 2018-2019.

	Variable	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2016 vs SFY 2015 Δ $	SFY 2017 vs SFY 2016 Δ $	SFY 2018 vs SFY 2017 Δ $	SFY 2019 vs SFY 2018 Δ $	SFY 2016 vs SFY 2015 Δ %	SFY 2017 vs SFY 2016 Δ %	SFY 2018 vs SFY 2017 Δ %	SFY 2019 vs SFY 2018 Δ %
Claims	Enrollees	92,002	98,048	102,280	105,191	105,260	6,046	4,232	2,911	69	6.6%	4.3%	2.8%	0.1%
	TDC ($M)	$345.85	$361.47	$371.88	$366.75	$370.36	$15.62	$10.41	($5.13)	$3.62	4.5%	2.9%	-1.4%	1.0%
	PMPM	$3,759.10	$3,686.61	$3,635.90	$3,486.47	$3,518.54	($72.49)	($50.70)	($149.44)	$32.07	-1.9%	-1.4%	-4.1%	0.9%
Encounter	Enrollees	77,527	85,895	90,787	95,524	96,992	8,369	4,891	4,737	1,468	10.8%	5.7%	5.2%	1.5%
	TDC ($M)	$274.86	$294.95	$305.19	$311.35	$332.87	$20.09	$10.24	$6.16	$21.53	7.3%	3.5%	2.0%	6.9%
	PMPM	$3,545.35	$3,433.82	$3,361.60	$3,259.37	$3,431.97	($111.53)	($72.23)	($102.23)	$172.60	-3.1%	-2.1%	-3.0%	5.3%
NF	Enrollees	42,289	44,326	44,059	42,846	41,696	2,037	(267)	(1,213)	(1,150)	4.8%	-0.6%	-2.8%	-2.7%
	TDC ($M)	$229.88	$240.02	$238.50	$234.55	$246.16	$10.15	($1.53)	($3.95)	$11.61	4.4%	-0.6%	-1.7%	5.0%
	PMPM	$5,435.84	$5,415.00	$5,413.17	$5,474.27	$5,903.72	($20.85)	($1.82)	$61.09	$429.46	-0.4%	0.0%	1.1%	7.8%
HCBS	Enrollees	35,228	41,559	46,716	52,668	55,283	6,331	5,157	5,952	2,615	18.0%	12.4%	12.7%	5.0%
	TDC ($M)	$44.97	$54.91	$66.68	$76.76	$86.69	$9.94	$11.77	$10.08	$9.93	22.1%	21.4%	15.1%	12.9%
	PMPM	$1,276.54	$1,321.28	$1,427.37	$1,457.45	$1,568.18	$44.74	$106.10	$30.08	$110.72	3.5%	8.0%	2.1%	7.6%

Note: Numbers may not sum exactly due to rounding, and a small fraction of enrollees is not categorized (missing variable entry).
Negative numbers are savings, positive numbers are costs or cost increases.
Sources: Medicaid FFS Claims, Medicaid Capitated Payments, and Medicaid Encounter data, SFY 2015 through SFY 2019

For the Medicaid FFS claims data, there was a steady rise in average monthly enrollee counts as well as the average monthly total direct costs (TDC). Given that the relative annual rate of increase on enrollee counts, at 3.4 percent (over the five years under analyses),[64] is higher than the same rate for total direct costs at 1.7 percent, the per member per month (PMPM) costs show a clear decrease (see negative numbers under Claims PMPM or third row in the mid and right-hand side section of Table 74).

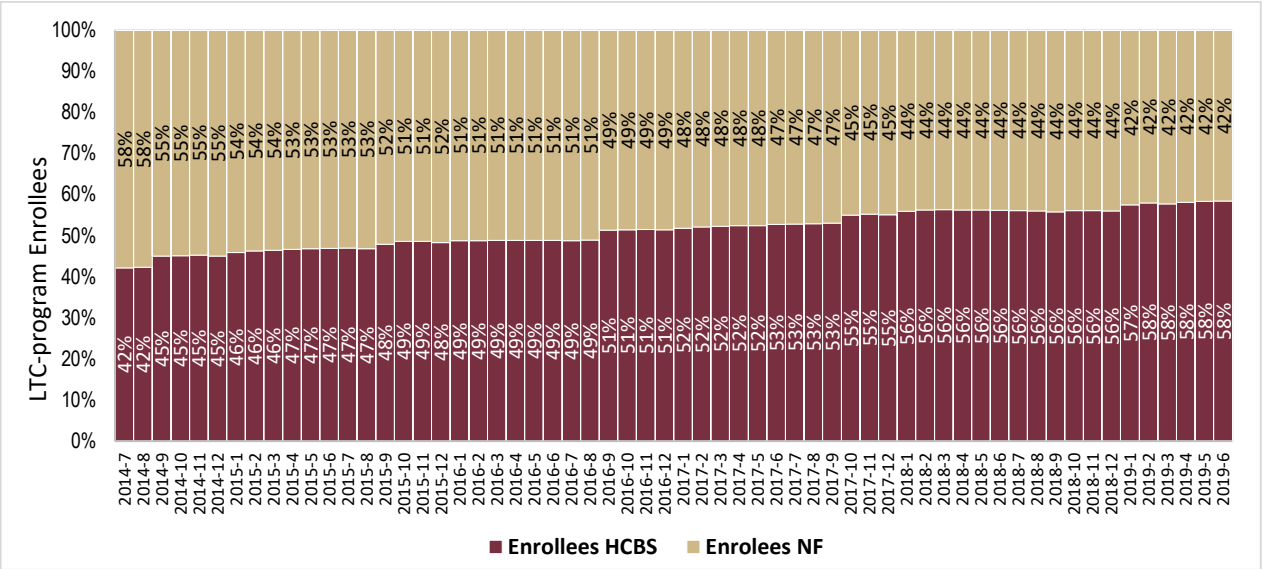
The encounter data shows a similar pattern: an average annual increase of 5.8 percent on enrollee count and 4.9 percent on cost. This led to decreasing costs per enrollee, at an average rate of 0.9 percent.

Entries on the two service categories, NF and HCBS, are breakouts from the encounter data. The NF enrollee count decreased at an annual rate of -0.4 percent, while the specific total direct costs increased by 1.7 percent, leading to a per member cost rate increase of approximately 2.1 percent annually. This fell in line with the overall objective of the agency, as the NF population in time was more aligned or needs-adjusted to the specific location of services. With HCBS, on the other hand, there was a clear rise in enrollee count, at an average of 11.9 percent annually, and similarly 17.8 percent on cost, which approximated a 5.3 percent increase in cost per enrollee. The mix of NF and HCBS services encountered, led to the mentioned decrease in cost per enrollee, at an average rate of 0.9 percent.

[64] e.g., first row Claims enrollees: $1.066*1.043*1.028*1.001^{1/4} - 1 = 3.4\%$

Figure 7 shows the change in distribution of enrollees between NF and HCBS. The number of enrollees who received home-based services increased from 45.3 percent on average in SFY 2015, to 57.0 percent on average in SFY 2019. Conversely, the percentage of Medicaid enrollees who received NF services decreased from 54.7 percent to 43.0 percent on average. These shifts indicate that significant progress was made toward the Agency's goal to transition up to 65 percent of LTC program enrollees receiving their LTC services in home-based settings.[65]

Figure 7. Medicaid LTC Program Relative Number of Enrollees per Location of Service; Home and Community Based Services, and Nursing Facility, SFY 2014-2015 through SFY 2018-2019.



Sources: Medicaid Encounter data, SFY 2015 through SFY 2019 (*i.e.*, July 1, 2014 through June 30, 2019)

[65] Incentive adjustments must continue until no more than 35 percent of each plan's enrollees reside in institutional settings. See: http://www.flsenate.gov/Laws/Statutes/2018/409.983

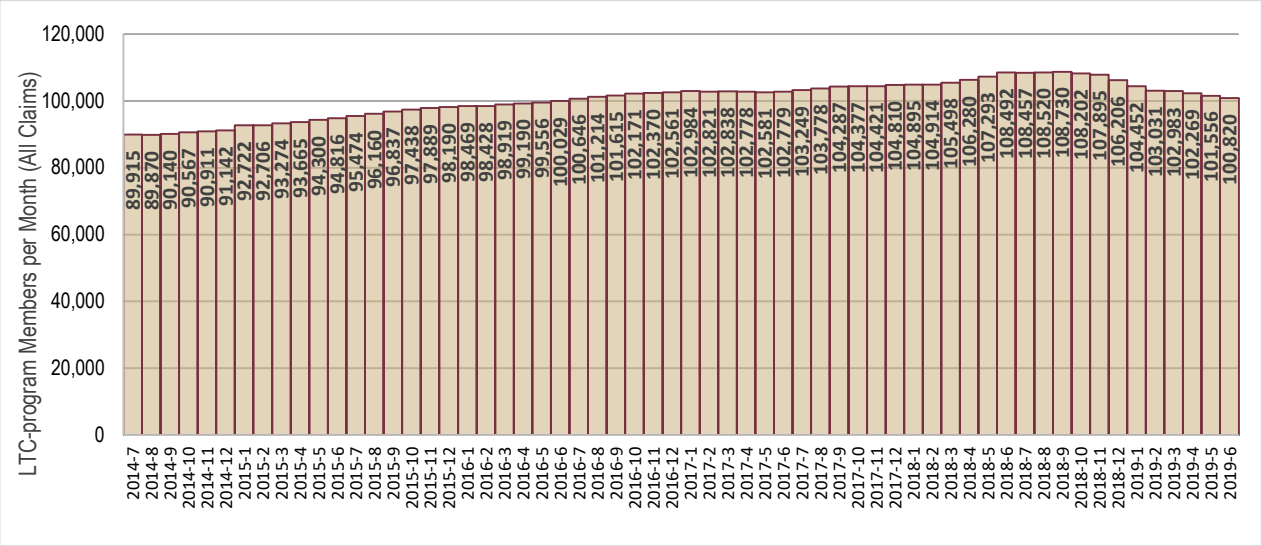
Findings

RQ1a: How is the magnitude of capitation changing and why?

Average monthly LTC program enrollee Claim counts increased 6.6 percent in SFY 2016, 4.3 percent in SFY 2017, 2.8 percent in SFY 2018, and finally 0.1 percent in SFY 2019 (see Table 75 below). This amounted to an average enrollee increase rate of 3.4 percent annually. At the same time, direct cost increased by 1.7 percent on average. By approximation, this left a difference or decrease in cost of almost 1.7 percent. Of the 1.7 percent, inflation usurps just over 1.6 percent, leaving a marginal 0.1 percent in average real savings.

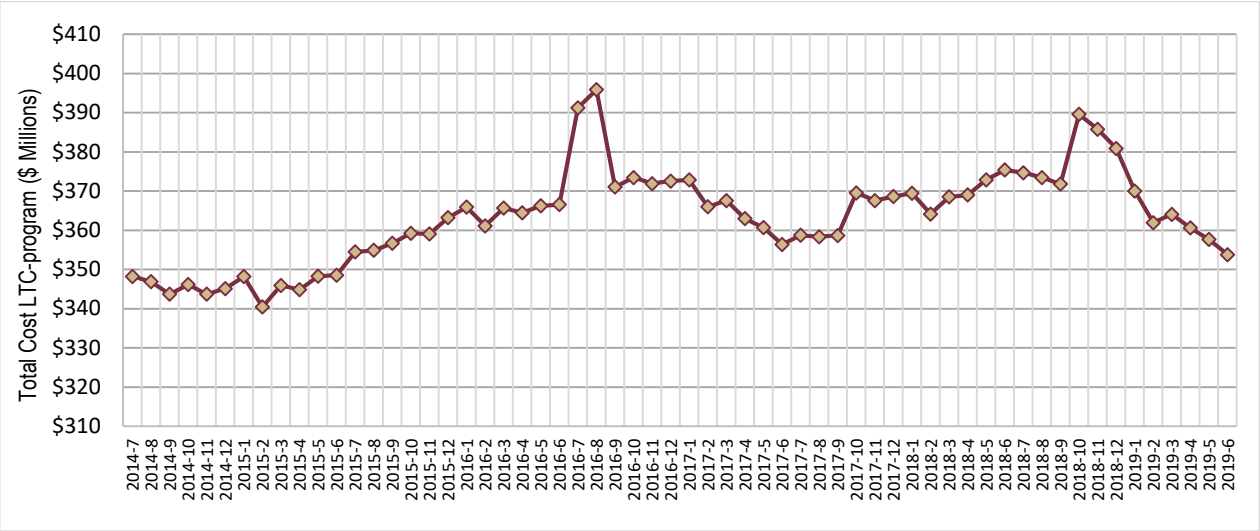
Figures 8, 9, and 10 show the magnitude of monthly change in LTC program enrollee Claim counts, direct costs, and PMPM costs, for the assessment period from SFY 2015 through SFY 2019.

Figure 8. LTC Program Enrollee Claim Counts by Month, SFY 2014-2015 through SFY 2018-2019.



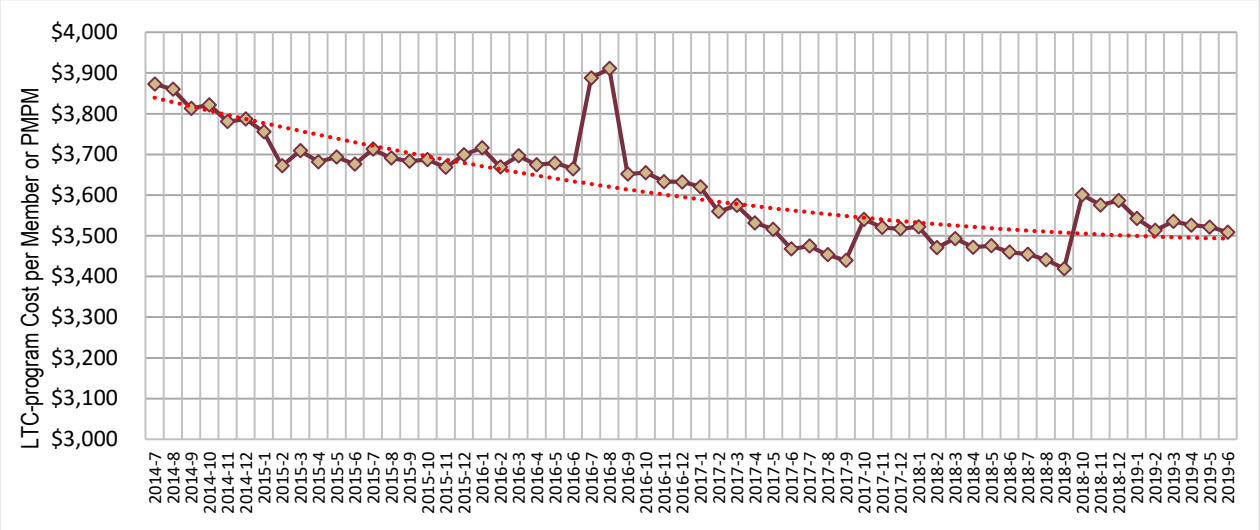
Sources: Medicaid FFS Claims and Medicaid Capitated Payments, SFY 2015 through SFY 2019

Figure 9. LTC Program Direct Enrollee Claim Costs by Month, SFY 2014-2015 through SFY 2018-2019.



Sources: Medicaid FFS Claims and Medicaid Capitated Payments, SFY 2015 through SFY 2019

Figure 10. LTC Program Per Member per Month Claim Costs, SFY 2014-2015 through SFY 2018-2019.



Sources: Medicaid FFS Claims and Medicaid Capitated Payments, SFY 2015 through SFY 2019

The figures show growth in LTC program enrollment, which growth outpaced growth in direct total costs. The result is decline in the average or per member per month (PMPM) cost of the LTC program (see red dotted trend line). During the reporting period, there was a clear peak in direct costs in July and August of 2016. In those two months, the Agency applied a "negative transition rate," which artificially increased the final blended rates and payments to the plans during this period.[66] The changes in October 2017 and 2018 are also likely due to back payment adjustments, which can occur up to two or three years after the original month of service.[67]

[66] The reason provided by the Agency (e-mail 3/4/2019) for applying negative transition rates late in the contract year was; "to partially offset revenue lost by the LTC plans that resulted from the application of the full annual transition requirement (3%) at the beginning of the contract year instead of phasing it in monthly in 1/12 increments. Beginning in the next contract year, the transition requirement was phased in monthly, and no further revenue adjustments were applied."

[67] As per AHCA explanation (e-mail 2/21/2020).

Table 75 provides monthly averages in the direct LTC Medicaid program Claims costs using a difference analysis methodology. Difference analysis is an analytic tool which provides further breakouts on costs to both quantity (number of enrollees) and price (PMPM).[68] In addition, the difference analysis calculation includes an inflation adjustment. Difference analysis is the usual open-ended budgetary approach in the medical arena. It employs enrollee counts and inflation on price developments (considered to be beyond control of management). The remainder is a real cost change: the primary focus of budgetary accountability.

Table 75 provides the average monthly LTC program Claim cost differences (row 4), and successive breakouts in cost differences due to enrollment or utilization (row 5), cost differences due to services' price inflation (row 8), and a real price difference component (row 10).

Table 75. Average per Month Total Direct LTC Program Claims Cost, and Per Member Per Month (PMPM), SFY 2014-2015 through SFY 2018-2019.

Item	LTC Program SFY 2015 (1)	LTC Program SFY 2016 (2)	LTC Program SFY 2017 (3)	LTC Program SFY 2018 (4)	LTC Program SFY 2019 (5)	PMPM SFY 2016 (6)	PMPM SFY 2017 (7)	PMPM SFY 2018 (8)	PMPM SFY 2019 (9)
(1) Average Count of Enrollees per Month	92,002	98,048	102,280	105,191	105,260				
(2) Direct Cost	$345,845,871	$361,465,444	$371,879,630	$366,745,684	$370,361,406	$3,686.61	$3,635.90	$3,486.47	$3,518.54
(3) Comparative		$345,845,871	$361,465,444	$371,879,630	$366,745,684	$3,759.10	$3,686.61	$3,635.90	$3,486.47
(4) Cost Difference		$15,619,574	$10,414,186	$(5,133,946)	$3,615,722	$(72.49)	$(50.70)	$(149.44)	$32.07
(5) Difference due to Enrollment		$22,727,199	$15,600,188	$10,585,328	$240,276	$(55.22)	$(38.05)	$(60.13)	$2.13
(6) Difference due to PMPM and Case-Mix Changes		$(7,107,625)	$(5,186,002)	$(15,719,274)	$3,375,446	$(17.27)	$(12.65)	$(89.30)	$29.94
(7) Cost Difference		$15,619,574	$10,414,186	$(5,133,946)	$3,615,722	$(72.49)	$(50.70)	$(149.44)	$32.07
(8) Difference due to PMPM and Case-Mix Changes		$(7,107,625)	$(5,186,002)	$(15,719,274)	$3,375,446	$(17.27)	$(12.65)	$(89.30)	$29.94
(9) Difference due to Inflation		$6,669,350	$4,971,444	$15,284,218	$(3,373,236)	$16.20	$12.13	$86.83	$(29.92)
(10) Real Cost Difference		$(438,275)	$(214,558)	$(435,056)	$2,210	$(1.06)	$(0.52)	$(2.47)	$0.02

Note: Numbers may not sum exactly due to rounding. Negative numbers are savings, positive numbers are costs or cost increases.
Sources: Medicaid FFS Claims Data and Medicaid Capitated Payments, SFY 2015 through SFY 2019

Direct LTC program cost is defined here to include all Medicaid FFS LTC administrative claims, payments reported in the Medicaid fee-for-service claims database, and capitated payments reported in the separate capitated payments database for SFY 2015 through SFY 2019.

Direct cost for SFY 2015, the first full year of the LTC program, was $345.8 million per month on average (row 2 - column 1, ibid row 3 - column 2). This compares with an average of $361.5 million per month for SFY 2016 (row 2 column 2), or a monthly increase in costs of $15.6 million (row 4 column 2). Direct LTC program cost for SFY 2017 was $371.9 million per month, an increase of $10.4 million per month over SFY 2016. In SFY 2018 a

[68] See methodology in Appendix C2a.

decrease is seen of $5.1 million,[69] and for the last year SFY 2019 an increase of $3.6 million. The middle rows (rows 5 through 7) of Table 75 show the same cost differences (row 4 = row 7) but broken out into differences due to LTC program enrollment (row 5) and case-mix changes (row 6).[70] Differences due to enrollment trends from the Medicaid FFS Claims and Capitation databases seemed to drive direct LTC program costs in all years, while average monthly savings are noted due to case mix changes, except for SFY 2019 (row 6).

At the bottom part of the table (rows 8 through 10), a further distinction is made on the cost differences (row 6 = row 8), by adjusting costs for inflation. The result is real cost or cost based on same dollar values (row 10).[71] The first three years showed modest average monthly savings, where SFY 2019 showed a virtual break even. Columns 6 through 9 show the same costs per row, but on average per enrollee or PMPM. Of main interest are the PMPM cost differences; differences due to utilization (row 5), differences due to inflation (row 9), and real price differences (row 10).[72] The last row (row 10) shows cost increases corrected for inflation amount to average monthly PMPM savings of $1.06, $0.52, $2.47, and finally an increase of $0.02, for the respective state fiscal years (averaging to a savings of $1.01 PMPM).

RQ1b: How is the distribution by service category changing, and how does that shift in service location affect the magnitude of the capitation.

Nursing facility enrollees showed an overall annualized enrollee decrease of 0.4 percent. The average direct monthly cost for NF services showed an annualized increase of 1.7 percent. This leaves by approximation, an annualized NF cost increase of 2.1 percent. Home-based enrollment showed annualized increases of 11.9 percent. Direct cost also showed an annualized growth in cost of 17.8 percent. Since cost had a higher annualized growth rate over enrollment, HCBS cost increased at an approximate annualized rate of 5.9 percent.

Table 76, 77, and 78 describe annual average analyses for direct LTC program encounter costs (using the same difference analysis as above).[73] The results in Table 76 are based on all direct encounter costs reported in the Medicaid Encounter database. The results in Table 77 are based on direct NF costs, and the results in Table 78 are based on direct cost for HCBS.

[69] When reading Table 75 and similar subsequent tables on difference analyses, it is important to note, when a cost difference between years results in a savings, the amount is presented as a negative number (*i.e.,* between brackets). When a cost difference between years means an increase in cost, the amount is presented as a positive number.

[70] See methodology on difference analyses in Appendix C2a. The calculated inflation rate comes down to an average of 1.6% per year for the period under analyses.

[71] Example for SFY 2019 versus SFY 2018 (Table 75):
Cost difference due to PMPM and Case mix changes =
$\sum_{i=1}^{n}(Q_{i,t} \text{ x } P_{i,t}) - \sum_{i=1}^{n}(Q_{i,t} \text{ x } P_{i,t-1})$ = (105,260 x $3,518.54) – (105,260 x $3,486.47) = $370,361,406 – $366,985,960 = $3,375,446
Inflation =
$\sum_{i=1}^{n}(Q_{i,t-1} \text{ x } P_{i,t}) - \sum_{i=1}^{n}(Q_{i,t-1} \text{ x } P_{i,t-1})$ = (105,191 x $3,518.54) – (105,191 x $3,486.47) = $370,118,920 – $366,745,684 = $3,373,236
Real cost difference =
$3,375,446 – $3,373,236 = $2.210

[72] n.b. row 5 - row 9 + row 10 = row 4. For PMPM SFY 2016 column 6, this amounts to: -$55.22 - $16.20 + -$1.06 = -$72.49,

[73] See methodology in Appendix C2a.

Table 76. Average per Month Encounter Costs, LTC Program Per Member Per Month (PMPM), SFY 2014-2015 through SFY 2018-2019.

Item	LTC Program SFY 2015 (1)	LTC Program SFY 2016 (2)	LTC Program SFY 2017 (3)	LTC Program SFY 2018 (4)	LTC Program SFY 2019 (5)	PMPM SFY 2016 (6)	PMPM SFY 2017 (7)	PMPM SFY 2018 (8)	PMPM SFY 2019 (9)
(1) Average Count of Enrollees per Month	77,527	85,895	90,787	95,524	96,992				
(2) Direct Cost	$274,859,022	$294,948,798	$305,187,472	$311,346,913	$332,873,206	$3,433.82	$3,361.60	$3,259.37	$3,431.97
(3) Comparative		$274,859,022	$294,948,798	$305,187,472	$311,346,913	$3,545.35	$3,433.82	$3,361.60	$3,259.37
(4) Cost Difference		$20,089,776	$10,238,674	$6,159,441	$21,526,293	$(111.53)	$(72.23)	$(102.23)	$172.60
(5) Difference due to Enrollment		$29,669,246	$16,795,973	$15,924,717	$4,785,022	$(84.31)	$(51.95)	$(63.37)	$38.37
(6) Difference due to PMPM and Case-Mix Changes		$(9,579,469)	$(6,557,299)	$(9,765,276)	$16,741,271	$(27.22)	$(20.28)	$(38.86)	$134.24
(7) Cost Difference		$20,089,776	$10,238,674	$6,159,441	$21,526,293	$(111.53)	$(72.23)	$(102.23)	$172.60
(8) Difference due to PMPM and Case-Mix Changes		$(9,579,469)	$(6,557,299)	$(9,765,276)	$16,741,271	$(27.22)	$(20.28)	$(38.86)	$134.24
(9) Difference due to Inflation		$8,646,171	$6,204,009	$9,280,993	$(16,487,873)	$24.57	$19.19	$36.93	$(132.21)
(10) Real Cost Difference		$(933,298)	$(353,290)	$(484,283)	$253,398	$(2.65)	$(1.09)	$(1.93)	$2.03

Note: Numbers may not sum exactly due to rounding. Negative numbers are savings, positive numbers are costs or cost increases.
Source: Medicaid Encounter Data SFY 2015 through SFY 2019

In Table 76, the count of enrollees per month showed on average an increase of 8,369 enrollees in SFY 2016, 4,891 enrollees in SFY 2017, 4,737 enrollees in SFY 2018, and 1,468 in SFY 2019, or increased rates of 10.8 percent, 5.7 percent, 5.2 percent, and 1.5 percent, respectively. In short, enrollees increased at an overall annualized rate of 5.8 percent.

Similarly, direct cost increased at an annualized rate of 4.9 percent.

Given that the growth rate of enrollees was higher than the annualized growth rate of direct cost, by approximation this will decrease average enrollee cost or PMPM by 0.9 percent. As inflation is calculated at 0.7 percent, this leaves approximately 0.2 percent for real cost savings. Increases in LTC program enrollment (utilization, row 5) was the main driver of higher direct encounter costs in all years. Cost differences due to PMPM price and case-mix changes (row 6) showed negative values (*i.e.,* savings). Adjusted for inflation (row 9), the average direct cost difference per enrollee (PMPM) (row 10, last four columns) showed savings of $2.65, $1.09, and $1.93, for SFY 2016 through SFY 2018, and an increase of $2.03 for SFY 2019.

Tables 77 and 78 provide the results using the same difference analysis, but on reported encounter data broken out into direct costs associated with NF services and HCBS, respectively.

Table 77. Average per Month Nursing Facilities (NF) Encounter Cost, LTC Program Per Member Per Month (PMPM), SFY 2014-2015 through SFY 2018-2019.

Item	LTC Program SFY 2015 (1)	LTC Program SFY 2016 (2)	LTC Program SFY 2017 (3)	LTC Program SFY 2018 (4)	LTC Program SFY 2019 (5)	PMPM SFY 2016 (6)	PMPM SFY 2017 (7)	PMPM SFY 2018 (8)	PMPM SFY 2019 (9)
(1) Average Count of Enrollees per Month	42,289	44,326	44,059	42,846	41,696				
(2) Direct Cost	$229,877,625	$240,024,622	$238,496,660	$234,548,124	$246,159,739	$5,415.00	$5,413.17	$5,474.27	$5,903.72
(3) Comparative		$229,877,625	$240,024,622	$238,496,660	$234,548,124	$5,435.84	$5,415.00	$5,413.17	$5,474.27
(4) Cost Difference		$10,146,997	$(1,527,963)	$(3,948,536)	$11,611,615	$(20.85)	$(1.82)	$61.09	$429.46
(5) Difference due to Enrollment		$11,070,995	$(1,447,609)	$(6,566,177)	$(6,294,950)	$(19.24)	$(1.73)	$43.68	$111.70
(6) Difference due to PMPM and Case-Mix Changes		$(923,998)	$(80,354)	$2,617,641	$17,906,565	$(1.61)	$(0.10)	$17.41	$317.75
(7) Cost Difference		$10,146,997	$(1,527,963)	$(3,948,536)	$11,611,615	$(20.85)	$(1.82)	$61.09	$429.46
(8) Difference due to PMPM and Case-Mix Changes		$(923,998)	$(80,354)	$2,617,641	$17,906,565	$(1.61)	$(0.10)	$17.41	$317.75
(9) Difference due to Inflation		$881,543	$80,842	$(2,691,749)	$(18,400,406)	$1.53	$0.10	$(16.95)	$(309.45)
(10) Real Cost Difference		$(42,455)	$488	$(74,108)	$(493,842)	$(0.07)	$0.00	$0.47	$8.31

Note: Numbers may not sum exactly due to rounding. Negative numbers are savings, positive numbers are costs or cost increases.
Source: Medicaid LTC Encounter Data SFY 2015 through SFY 2019

NF enrollees showed an increase of 2,037 enrollees in SFY 2016, and decreases of 267, 1,213 and 1,150 enrollees per month in SFY 2017, SFY 2018 and SFY 2019. This makes for an overall annualized enrollee decrease rate of 0.4 percent. Likewise, the average direct monthly cost for NF services shows an annualized increase of 1.7 percent. That left, by approximation, an annualized cost increase at 2.1 percent. Clearly, low savings and especially the increase in SFY 2019 in cost differences due to PMPM and case mix changes drove the NF cost experience. Provided a calculated drop in inflation of 2.2 percent, savings were by approximation some 0.1 percent. Based on the data in the last row of the table (row 10) this translates to a virtually unchanged direct PMPM cost for NF services, on average per month over the years displayed.

Table 78. Average per Month Home and Community Based Services (HCBS) Encounter Cost, LTC Program Per Member Per Month (PMPM), SFY 2014-2015 through SFY 2018-2019.

Item	LTC Program SFY 2015 (1)	LTC Program SFY 2016 (2)	LTC Program SFY 2017 (3)	LTC Program SFY 2018 (4)	LTC Program SFY 2019 (5)	PMPM SFY 2016 (6)	PMPM SFY 2017 (7)	PMPM SFY 2018 (8)	PMPM SFY 2019 (9)
(1) Average Count of Enrollees per Month	35,228	41,559	46,716	52,668	55,283				
(2) Direct Cost	$44,969,592	$54,910,766	$66,681,274	$76,761,833	$86,693,584	$1,321.28	$1,427.37	$1,457.45	$1,568.18
(3) Comparative		$44,969,592	$54,910,766	$66,681,274	$76,761,833	$1,276.54	$1,321.28	$1,427.37	$1,457.45
(4) Cost Difference		$9,941,174	$11,770,508	$10,080,559	$9,931,751	$44.74	$106.10	$30.08	$110.72
(5) Difference due to Enrollment		$8,081,855	$6,814,147	$8,496,066	$3,810,758	$36.37	$61.42	$25.36	$42.48
(6) Difference due to PMPM and Case-Mix Changes		$1,859,320	$4,956,361	$1,584,493	$6,120,993	$8.37	$44.67	$4.73	$68.24
(7) Cost Difference		$9,941,174	$11,770,508	$10,080,559	$9,931,751	$44.74	$106.10	$30.08	$110.72
(8) Difference due to PMPM and Case-Mix Changes		$1,859,320	$4,956,361	$1,584,493	$6,120,993	$8.37	$44.67	$4.73	$68.24
(9) Difference due to Inflation		$(1,576,071)	$(4,409,202)	$(1,405,424)	$(5,831,494)	$(7.09)	$(39.74)	$(4.19)	$(65.01)
(10) Real Cost Difference		$283,249	$547,160	$179,069	$289,498	$1.27	$4.93	$0.53	$3.23

Note: Numbers may not sum exactly due to rounding. Negative numbers are savings, positive numbers are costs or cost increases.
Source: Medicaid LTC Encounter Data, SFY 2015 through SFY 2019

HCBS enrollment showed average increases of 6,331 enrollees per month in SFY 2016, 5,157 enrollees in SFY 2017, 5,952 in SFY 2018, and 2,615 in SFY 2019. This translated to relative increases of 18.0, 12.4, 12.7 and 5.0 percent for the years, respectively, or 11.9 percent annualized.

Direct cost also showed increase in all years, namely: 22.1, 21.4, 15.1 and 12.9 percent, respectively. This amounted to an annualized growth in cost of 17.8 percent.

Cost had a higher annualized growth rate over enrollment. Hence, cost increased at an approximate annualized rate of 5.3 percent PMPM (*e.g.,* costs in row 5). Adjusted for inflation (row 10), the direct costs for home and community-based services showed increases of $283,249, $547,160, $179,069, and $288,385, respectively. In PMPM cost, this came down to increases of $1.27, $4.93, $0.53, and $3.23 for the same respective years (row 10 last four columns).

RQ2: Has a shift between HCBS and NF affected overall Medicaid costs under the LTC program, and if so, how?

A large portion of the observed direct cost change is in fact a redistribution of costs between NF and HCBS; in total $428.6 million since introduction of the LTC program. Given the PMPM differences between NF and HCBS, this means that for the same funds more patients were provided with LTC program services.

In response to RQ2, the evaluation team used a shift-share analysis. Shift-share analyses are used in cost-analysis to determine what portion(s) of cost change can be attributed to different cost factors. Appendix C provides more detailed methodology.

A shift-share analysis takes the change over time of a cost variable and divides that change into various cost components. The analyses help identify cost drivers.

A traditional shift-share analysis splits cost changes into three components, namely: costs specific to a component ("within-effect"), costs common or shared by components ("shift-share"), and cost not further attributable ("mix-effect" or remainder). For the analyses, the evaluation team used the direct encounter costs and enrollees (per SFY), both total and per location of service (NF and HCBS).

This analysis provides an insight into shifts in cost due to changes in program services from NF to HCBS, hence the name "shift-share".[74]

In Table 79, total cost changes per SFY are shown in the first row, and cost changes per HCBS and NF services in the second and third row. In the middle of the table, costs are further broken out. Cost changes specific to NFs or HCBS services are identified as "within-effect". Cost with a "shared" characteristic by both NFs and HCBS services are identified as "shift-share" (*i.e.,* where a cost increase in one service, is reflected or mirrored in a similar cost savings in the other service). Costs not fit to be identified as specific to either NFs or HCBS, nor to its combination, are identified as "cross-term."[75] All breakouts provided add to the SFY cost change per service location (NF and HCBS), and ultimately to the changes in total encounter costs.

[74] For the share-shift methodology, see Appendix C2b.

[75] For a month -to -month depiction, based on annual changes (e.g., comparing costs in June 2019 to costs in June 2018 et cetera) of the share-shift analyses, see Appendix C3.

Table 79. Average Monthly Encounter Costs Shift-share Analyses, SFY 2014-2015 through SFY 2018-2019

SERVICE			SFY 2016 vs SFY 2015 ΔTot.D.Cost (in $ Mill.)	SFY 2017 vs SFY 2016 ΔTot.D.Cost (in $ Mill.)	SFY 2018 vs SFY 2017 ΔTot.D.Cost (in $ Mill.)	SFY 2019 vs SFY 2018 ΔTot.D.Cost (in $ Mill.)	SFY 2016 vs SFY 2015 ΔTot.D.Cost (in %)	SFY 2017 vs SFY 2016 ΔTot.D.Cost (in %)	SFY 2018 vs SFY 2017 ΔTot.D.Cost (in %)	SFY 2019 vs SFY 2018 ΔTot.D.Cost (in %)	Explanation
	Dir. Cost	$3,298.3	$3,539.4	$3,662.2	$3,736.2	$3,994.5					
	Δ Dir. Cost		**$241.1**	**$122.9**	**$73.9**	**$258.3**	7.3%	3.5%	2.0%	6.9%	total
total-effect	HCBS		$227.9	$179.6	$180.9	$226.4	6.4%	4.9%	4.8%	5.7%	total
	NF		$13.1	$(56.8)	$(106.9)	$31.8	0.4%	-1.5%	-2.9%	0.8%	total
within-effect	HCBS		$116.6	$63.2	$40.8	$147.2	3.3%	1.7%	1.1%	3.7%	growth
	NF		$124.4	$59.6	$33.2	$111.0	3.5%	1.6%	0.9%	2.8%	growth
shift-share	HCBS		**$104.2**	**$112.6**	**$137.5**	**$74.3**	**2.9%**	**3.1%**	**3.7%**	**1.9%**	**transfer in**
	NF		**$(104.2)**	**$(112.6)**	**$(137.4)**	**$(74.5)**	**-2.9%**	**-3.1%**	**-3.7%**	**-1.9%**	**transfer out**
cross-term	HCBS		$7.1	$3.8	$2.7	$4.8	0.2%	0.1%	0.1%	0.1%	mix
	NF		$(7.1)	$(3.8)	$(2.7)	$(4.8)	-0.2%	-0.1%	-0.1%	-0.1%	mix
	HCBS + NF		$241.1	$122.8	$74.0	$258.1	6.8%	3.4%	2.0%	6.5%	total

Note: Numbers may not sum exactly due to rounding, and a small fraction of enrollees is not categorized (missing location indicators).
Source: Medicaid LTC Encounter Data, SFY 2015 through SFY 2019

The top row of Table 79 shows the changes in direct encounter costs (in annual values): $241.1 million in SFY 2016, $122.9 million in SFY 2017, $73.9 million in SFY 2018, and $258.3 million in SFY 2019, or 7.3 percent, 3.5 percent, 2,0 percent, and 6.9 percent, respectively. The overall change suggests sort of a u-shape change for direct cost.[76]

Once total cost changes are broken out into HCBS and NF services (second and third row), the picture changes.[77] Direct HCBS cost increased by $227.9 million, $179,6 million, $180.9 million, and $226.4 million respectively, at relative rates of 6.4 percent, 4.9 percent, 4.8 percent, and 5.7 percent for the same years. Similarly, direct NF cost increased by $13.1 million in SFY 2016, decreased $56,8 million in SFY 2017 and $105.9 million in SFY 2018, to increase again in SFY 2019 by $31.8 million. Relative changes are 0.4 percent, minus 1.5 percent, minus 2.9 percent and 0.8 percent for the respective years.

In breaking direct costs out even further (using the shift-share analyses in the middle part of Table 79), a large portion of the observed direct cost change was actually a redistribution of costs between NF and HCBS:

In short, there was a clear encounter cost shift in the distribution of services from NF to HCBS of $104.2 million in SFY 2016, $112.6 million in SFY 2017, $137.5 million in SFY 2018, and $74.3 million in SFY 2019; a total of $428.6 million over the years since introduction of the LTC program.

[76] see also Appendix C3, Figure 5a
[77] see also Appendix C3, Figure 5b

Given the PMPM differences between NF and HCBS (see RQ1b Tables 77 and 78), this means that for the same (shifted or transferred) funds, more patients were provided with LTC program services. (See also Appendix C).

Conclusions and Recommendations

The results of the evaluation team's analysis indicate that the direct Medicaid LTC program Claims cost on average was $3,612.50 per member per month (PMPM), across the five years analyzed. The direct LTC Medicaid encounter costs averaged $3,400.79 per enrollee. This means that for the SFYs under consideration, the direct LTC program costs were close to cost-neutral (94.1%), and meets the LTC program policy objectives, while the number of enrollees receiving LTC services has increased.

The five-year monthly average LTC program Medicaid FFS Claim enrollee count went up by 3,314 or 3.4 percent annually. Similarly, direct cost increased by $6.1 million or 1.7 percent. In turn, the two leave a difference or decrease in cost of almost 1.7 percent. As inflation usurps just over 1.6 percent of the difference, this leaves a marginal 0.1 percent in average real savings. In addition, as long as added monthly (*i.e.,* marginal) PMPM cost remains lower with respect to the average LTC program cost since introduction of the LTC program, the (long term) average cost will continue to decline.

Regarding encounter costs, the five-year monthly average enrollee count sees a monthly increase of 4,866 or 5.8 percent annually. Likewise, direct cost increased by $14.5 million per month or 4.9 percent at an annualized rate. The result is a decrease of per enrollee cost by approximately 0.9 percent annually. As encounter inflation is calculated at 0.7 percent, this leaves approximately 0.2 percent for real cost savings. Nursing facilities showed a five-year average decrease in the number of enrollees of 148 per month or 0.4 percent annually. The five-year average direct monthly cost for NF services showed a monthly increase of $4.1 million or 1.7 percent per year. Hence, by approximation, average NF enrollee costs increased by 2.1 percent. Provided a calculated drop in inflation of 2.2 percent, savings were some 0.1 percent or a virtually unchanged PMPM cost. Home and community-based services enrollment showed annualized increases of 11.9 percent. Direct cost of HCBS showed a substantial five-year average monthly cost increase of $10.4 million or an annualized growth of 17.8 percent. This drove cost up at an approximate annualized rate of 5.9 percent. Adjusted for inflation at 5.3 percent, this meant a cost increase of 0.6 percent per year.

Additionally, the number of enrollees receiving HCBS services changed the relative balance between the two categories of HCBS and NF services. The percentage or share of enrollees receiving HCBS increased from 45.3% on average in SFY 2015, to 57.0% on average in SFY 2019. The percentage of Medicaid enrollees receiving NF services decreased from 54.7% to 43.0% on average, respectively. This redistribution in location of care led to a transfer of a total of $428.6 million in funds between the two locations of services since introduction of the LTC program.

Given the PMPM differences between HCBS and NF, this means that for the same funds allocated, more enrollees were receiving LTC program services.

These shifts indicate that significant progress is being made toward the Agency's goal to transition up to 65 percent of LTC program enrollees receiving their LTC in HCBS settings.[78] The continued transition from NF to HCBS is an actionable goal for the Agency. The Agency should continue its NF transition efforts.

[78] Incentive adjustments must continue until no more than 35 percent of each plan's enrollees reside in institutional settings. See: http://www.flsenate.gov/Laws/Statutes/2018/409.983

Appendix A - Access to Care

General Methodology

The evaluation team used quantitative methods to measure associations between the explanatory and outcome variables of interest. All data sources are retrospective data collected for administrative purposes by the Agency, DOEA, and the seven managed care plans during SFY 2015 through SFY 2019. The analyses in this report are either purely correlational or observational in nature. The evaluation team stresses that the results and subsequent interpretation do not imply any causal relationships. Significant findings of interest to the Agency may call for further investigation that, where possible, better leverages causal design strategies.

Each research question entailed multiple comparisons (hypothesis tests), so the evaluation team used a Bonferroni correction to adjust the significance threshold for each group of models. The correction requires dividing the standard alpha level of 0.05 by the number of tests conducted. It is a conservative approach to mitigating the probabilistic increase in false positives that occurs when multiple hypotheses are tested at once. Prominent statisticians[79] argue that conservatism is a benefit; chiefly, it reduces the number of spurious associations reported to stakeholders.

Analysis for each RQ relied on the measures and data sources outlined in Table 80. Additional detail about methods specific to individual RQs and measures follow this section.

[79] E.g., Johnson, VE. Revised standards for statistical evidence. *Proceedings of the National Academy of Sciences*. 2013;70(2):19313-19317.

Table 80. Research Questions, Associated Measures, and Data Sources.

RQ #	Research Question	Measures	Data Sources
1	Have there been changes in the accessibility of services for enrollees over time?	i. Trends in service utilization over time	i. AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records
		ii. Change in service utilization in relation to change in ADL needs	ii. AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, CIRTS assessment data, FL Center inpatient data
		iii. Time to First Service Delivery (home-based enrollees only)	iii. AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records
2	How has the population being served in the LTC program shifted (characteristics of the population and service utilization) between nursing facilities and HCBS over time? What LTC plan strategies are impacting these shifts?	i. Trends in enrollee locations of care over time	i. FSU created enrollee LOC file
		ii. Analysis of shifts between locations of care and transition success rates	ii. FSU created enrollee LOC file
		iii. Analysis of factors associated with attempted transition into the community	iii. FSU created enrollee LOC file, MDS assessments, enrollee eligibility file (demographic data)
3	What are the levels of service utilization for enrollees prior to transitioning into the nursing facility?	i. Comparison of the levels of service utilization for enrollees who transitioned into nursing facilities versus levels for enrollees who remained in their homes	i. AHCA LTC service category crosswalk, FSU created LOC file, enrollee eligibility file, LTC encounter records, CIRTS assessment data, FL Center inpatient data
4	Do plans offer additional (expanded) benefits and ways to access services, including a Participant Directed Option (PDO), and to what extent do enrollees use these services?	i. Expanded benefits service utilization over time	i. Expanded benefit services crosswalk, FSU created enrollee LOC file, LTC encounter records
		ii. PDO enrollment and service utilization over time	ii. FSU created enrollee LOC file, LTC encounter records, PDO Roster Reports
5	Are there disparities by racial and ethnic groups in enrollees' placements in certain	i. Trends in enrollee locations of care over time, stratified by race/ethnicity	i. FSU created enrollee LOC file, enrollee eligibility file

RQ #	Research Question	Measures	Data Sources
	settings and utilization of services?	ii. Service utilization over time, stratified by race/ ethnicity	ii. AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility file
		iii. Time to First Service Delivery (home-based enrollees only), stratified by race/ethnicity	iii. AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility file

Enrollee Location of Care File

The evaluation team used both LTC encounter and Minimum Data Set (MDS) assessment records for determining an enrollee's location of care in a given month. If an enrollee had a nursing facility encounter record or an MDS assessment record(s) that spanned the majority of a given month, the enrollee was assigned a NF location of care for the month; otherwise, the enrollee was assigned a HCBS location of care for the month. Only encounter records with positive dollar amounts reported in the special feed encounter data after summing by service category, procedure code, and month of service were used. Table 80 details the process of identifying where an enrollee was located during each month of enrollment in the LTC program. It is intended that any programmer could replicate the location of care determinations for each enrollee based on the table.

Table 81. Enrollee Location of Care Determination Process.

Data Source	Step/ Purpose	Process
Medicaid eligibility data	Step 1: Identify LTC eligibility months	1) Search for all records in the eligibility data where the LTC enrolled variable contains an "N" or "W" indicator, and the eligible month occurs in SFY 2014-2015 through SFY 2018-2019.
		2) Create a LTC program enrollment indicator for all days in each LTC eligible month.
LTC encounter data	Step 2: Identify monthly LOC from encounter data	1) Sum encounter amounts for each enrollee identified in Step 1 by service category, procedure code, and month of service.
		2) Drop any records where the amount corresponding to a record from (1) is not a positive dollar amount.
		3) Classify any months from (2) as months with a NF LOC if the service category is L2.3, L2.4, L2.6, L2.7, L2.8, or L2.9. Classify any months from (2) as months with a HCBS LOC if the service category is not one of the six NF service categories.
		4) For those months that were not classified (i.e., those that did not have any encounter records with positive dollar amounts), classify them as NF or HCBS LOC if the month immediately before *and* the month immediately after are both NF or both HCBS months, respectively.
		5) Leave the remaining unclassified enrollment months as unknown LOC.
MDS data	Step 3: Identify which enrollees resided in a nursing facility each month based on MDS assessment records	1) Select MDS records for enrollees identified in Step 1.
		2) Identify entry and discharge dates and reasons for each enrollee in (1).
		3) Create indicators identifying temporary discharges and subsequent readmissions for those discharged with the expectation to return who subsequently returned from the same facility type for reasons 03, 04, 05, 06, 07, and 09.
		4) For non-discharge records where there is not a subsequent assessment completed within 107 days, classify the record as a discharge. *
		5) Create day-level NF LOC indicators for each day between an entry assessment and subsequent quarterly or discharge assessment (inclusive) that occurred within 107 days, between each quarterly assessment and subsequent quarterly or discharge assessment (incl.) that occurred within 107 days, as well as between each temporary discharge and corresponding readmission record (incl.).
		6) Merge (by enrollee month) the indicators created in (5) with the LTC enrollment file created in Step 1.
		7) Set any LTC enrollment months where the enrollee spent at least half of the days in that month in a NF as a NF LOC month.
	Step 4:	1) Merge the resulting datasets from Step 2 and Step 3 by enrollee month.

Data Source	Step/ Purpose	Process
Files from Steps 2 & 3	Create final Location of Care file	2) Set any month that received a NF LOC determination in Step 2 or Step 3 as a NF LOC month.
		3) Set any months that did not receive a NF LOC in Step 2 or Step 3 as a HCBS LOC month
		4) Output final Location of Care file.

*CMS requires facilities to complete an MDS assessment for residents every 90 days, with a 3-day grace period. The evaluation team allowed for an additional 2-week grace period until making the assumption that an enrollee no longer resided in a NF.

Question-Specific Methods

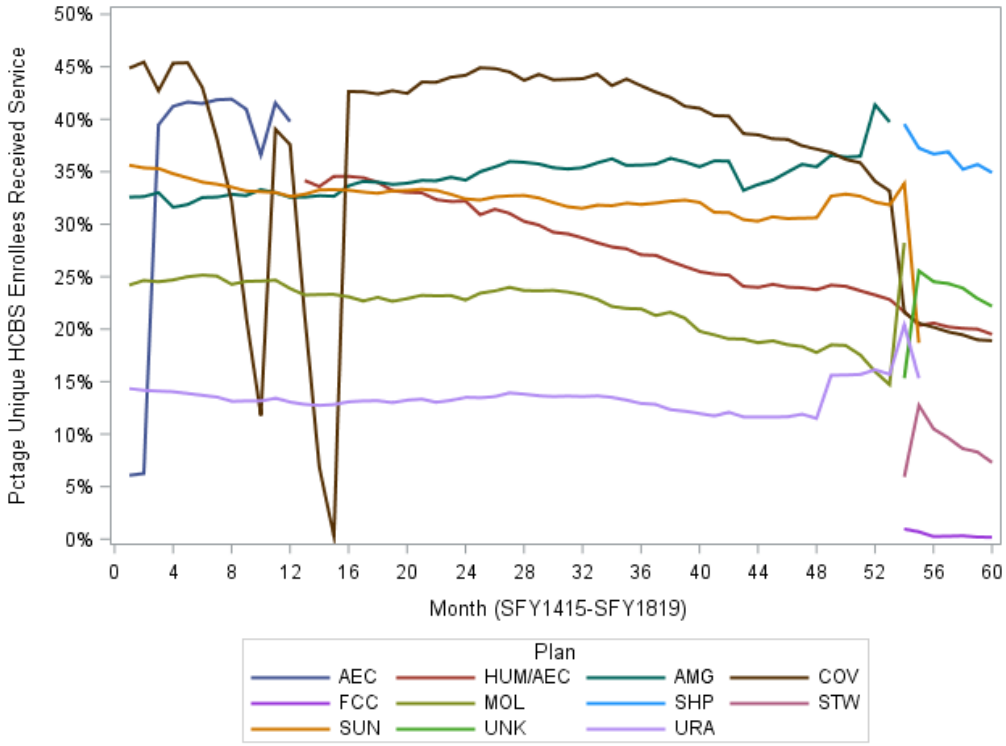
RQ1, Table 3

The plots showing the trend over time in the monthly proportion of unique HCBS enrollees who received services under each category indicate that a linear trend line suffices to model each relationship. However, this simple trend analysis was complicated by the detection of positive serial correlation in the errors, the presence of which can lead to overstating the statistical significance of the trend (by underestimating the standard errors). Hence, the evaluation team used the iterative Yule Walker method to correct for serial correlation in the error term, thereby producing valid test statistics for each trend estimate.

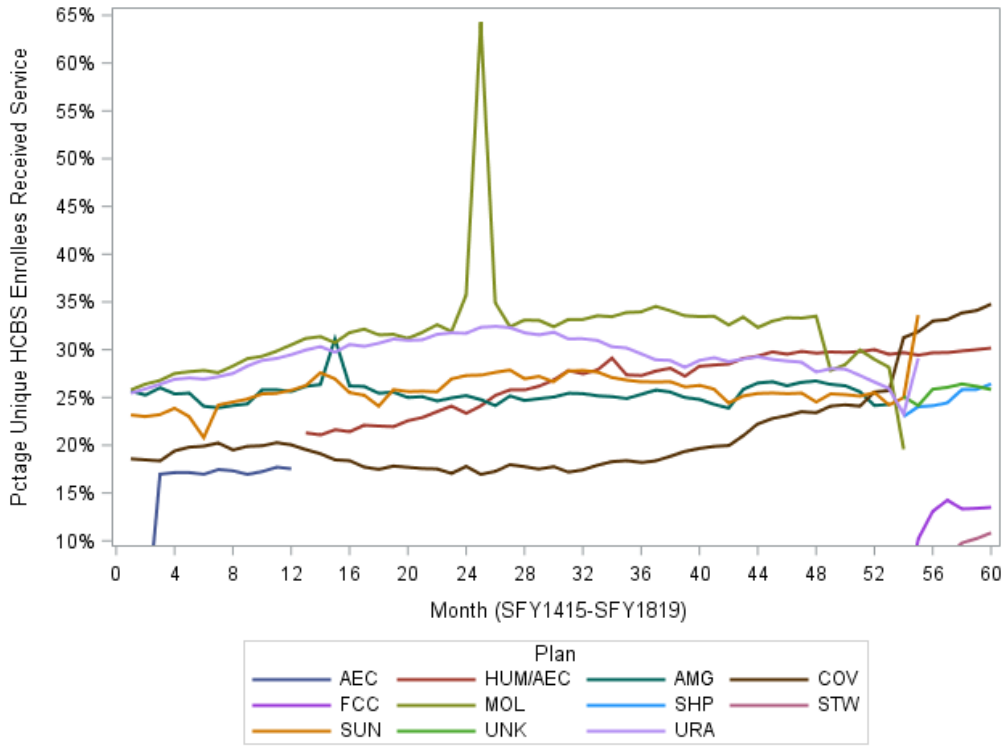
There were anomalies in the encounter records reported by some of the plans, which introduced slight inconsistencies in the trends for half of the selected service categories. Figure 11 shows these anomalies. Post hoc adjustment (not shown) for the inconsistencies indicates that they do not affect the direction of the trends nor the substantive interpretation of the results. Note that Humana acquired American Eldercare in July 2015.

Figure 11. Plots Showing Anomalies in the Encounter Data for Selected Service Categories.

Assisted Living



Home-Delivered Meals



RQ1, Table 5

Measuring service utilization intensity is difficult when units of service are measured differently (e.g., per hour, per diem, etc.) for procedure codes within the same service category. To address this issue, the evaluation team created a crosswalk that converts all procedure codes within a given category to the same unit scale (see Table A.3).

Table 82. Unit Scale for each LTC Service Category Used to Convert Procedure Codes with Different Units of Measurement.

LTC Service Category	Unit Scale
Adult Companion Care	quarter hour
Adult Day Health Care	quarter hour
Home-Delivered Meals	per meal
Homemaker Services	quarter hour
Medical Equipment and Supplies	per item
Personal Care	quarter hour
PERS	per month (max
Respite Care	quarter hour
Transportation	per trip

Note: 1 diem is considered 8 hours = 32 quarter hour increments

RQ1, Table 6

701B comprehensive assessments in DOEA's Client Information and Registry Tracking System (CIRTS) database measure ADL needs for each activity on a scale of 0 to 4, where 0 corresponds to no help needed, 1 corresponds to no help needed but relies on assistive device(s), 2 corresponds to supervision needed, 3 corresponds to some physical assistance needed, and 4 corresponds to total physical assistance needed. The evaluation team differenced these scores from the comparison and baseline periods for each enrollee to compute the change in ADL scores separately for all four needs. Likewise, the evaluation team differenced the mean units of service per thirty-days between the two periods for each service category to produce the outcome variables.[80] The evaluation team also created several relevant covariates to control for other changes that may be related to changes in service utilization.[81] For example, the mean number of inpatient days per thirty-days in the comparison period minus the mean number of inpatient days per thirty-days in the baseline period provided the measure of the change in inpatient days for that covariate.

Home-based[82] enrollees who had at least two 701B assessments between July 1, 2014 and April 1, 2019 with at least ninety consecutive days of enrollment between the first (baseline) and second (comparison) assessment and at least ninety days of consecutive days of enrollment following the second assessment were included in the analysis. The baseline period includes data from the first assessment and service utilization between the

[80] Once again, all units of service for procedure codes under the same category were converted to the same unit scale using Table 81.

[81] These include change in caregiver status indicators (loss or gain), a significant weight loss indicator (5% bodyweight or more), a health shock indicator (new amputation, cancer diagnosis, diabetes diagnosis, cardiac problems, kidney disease, liver disease, lung problems, Parkinson's diagnosis, paralysis event(s), seizure event(s), stroke event(s), and/or tumor occurrences), the aggregate change in IADL needs, the change in the number of inpatient days per 30-day period, the percent change in the length of the comparison and baseline periods, a change in plan membership indicator, a change in region of residence indicator, and time period dummies.

[82] Enrollees residing in assisted living facilities at any point during their potential observation periods were excluded from the analysis because ALFs provide fairly comprehensive LTC services that are not measurable via encounter data. For instance, if a person receives personal care services in an ALF, this service is not usually reported as a separate encounter.

first and second assessment; the comparison period includes data from the second assessment and service utilization between the second assessment and the next assessment or April 30, 2019, whichever is earlier. Enrollees may be included in the analysis more than once if they had three or more assessments with corresponding enrollment spans that meet these criteria. In the case of an enrollee with three assessments, there will be two analytic records—one for the changes in ADL needs between the first and second assessments and another for the changes in ADL needs between the second and third assessments. For this reason, the evaluation team applied clustered standard errors to adjust for correlation in the error term.

RQ2, Table 11

The analysis includes all enrollees who resided in a nursing facility during their first month of enrollment and who had at least six months of observed enrollment. The evaluation team searched for the MDS record closest to the first observed day of enrollment for these enrollees. Anyone who transitioned into a HCBS setting at some point during the evaluation period was coded as a "Transitioner." Anyone who stayed in a nursing facility for the entire evaluation period (or until date of death) was coded as a "Stayer." All variables included in the model were derived from the respective MDS record for each enrollee, excepting demographic information and dates of death. Finally, the evaluation team ran a logistic regression model to predict the probability of transitioning, regardless of success.

RQ3

Study groups

The transition group includes all enrollees with a pre-transition 701B assessment record who had resided in-home for at least 6 consecutive months and then transitioned into a nursing facility for at least three consecutive months. Enrollees in this group had not resided in a NF during the evaluation period prior to the date of the transition record that was included in this analysis. The control group includes all enrollees with a valid 701B assessment record who had resided in-home for at least six months and had not transitioned into a NF at any point during the evaluation period once they were observed in a home-based setting. Hence, some enrollees in the control group had previously resided in a NF and then successfully transitioned into a home-based setting. Once they transitioned from a NF into a home, they resided there for the remainder of their enrollment up through June 2018 (a minimum of 6 months). Including enrollees in the control group who had previously resided in nursing facilities but then successfully transitioned into a home-based setting is vital because these enrollees may have more similar profiles (in terms of ADL needs, frailty, etc.) to those in the transition group.

Matching

Using logistic regression, the evaluation team created a score analogous to a disease risk score (DRS) for each enrollee in the transition and control groups by modeling the probability of transitioning into a nursing facility as a function of the covariates listed in Table 82 and nine binary indicators for whether the enrollee received any services falling under a given service category during the six-month period. This model was then used to create a risk score predicting the probability of transition for each enrollee when no services were received (when all service indicators were set to 0). Hence, the risk score may be thought of as the risk (probability) of transitioning into a nursing facility independent of service utilization. Enrollees who transitioned were then 1:1 matched with enrollees who did not transition on the logit of the risk score using a greedy matching algorithm. The logic of this

process is that those with similar scores have a similar risk of transitioning into nursing facilities based on demographic, caregiver, required level of care, and health status[83] factors. If enrollees are similar on these covariates, then other differences, i.e., the intensity of service use or the frequency of missing services, could explain why one enrollee transitioned but the other did not.

Prognostic scores, like the DRS, in retrospective case-control studies mimic propensity scores in prospective observational studies.[84] While matching is not necessary in observational studies of association when the evaluation team can control for all posited observable confounders, matching may provide added value if it also succeeds in balancing unobservable confounders. This possibility, nevertheless, is untestable owing to the nature of unobservable information. Regardless, balancing is considered successful when the standardized difference in mean covariate values between the case (transition) and control groups is approximately equivalent to zero for all covariates. An absolute difference of less than 0.10 indicates the covariate is well-balanced between cases and controls.[85] Table 83 shows that several covariates are not well-balanced before matching, but that all covariates are well-balanced after matching. Figure 12 shows the overlap in the linearized risk scores; overlap is essential for producing valid matched sets.

[83] As measured via inpatient days

[84] Hansen BB. The prognostic analogue of the propensity score. Biometrika. 2008;95(2):481-488.

[85] Pfeiffer RM, Riedl R. On the use and misuse of scalar scores of confounders in design and analysis of observational studies. *Statistics in Medicine*. 2015;34(18):2618-2635.

Table 83. Covariate Balance – Standardized Differences Pre- and Post-matching.

Covariate	Pre-	After
Mean last month of 6-month encounter pull period	0.10	0.04
% female	0.03	0.02
% White	0.32	-0.06
% Black	0.14	0.03
% Hispanic	-0.24	0.04
Mean log(age)	0.29	0.03
Mean number of months between assessment and last month of 6-month encounter pull period	-0.36	0.05
Mean sum of inpatient days	0.50	0.05
% changed plan within 6-month encounter pull period	-0.05	-0.01
% with multiple assessments in the 6-month encounter pull period	0.58	0.04
% bath ADL = 1	0.05	0.00
% bath ADL = 2	-0.08	0.00
% bath ADL = 3	0.00	0.04
% bath ADL = 4	0.05	-0.02
% dress ADL = 1	0.09	0.02
% dress ADL = 2	-0.04	0.01
% dress ADL = 3	-0.04	0.04
% dress ADL = 4	0.01	-0.03
% eat ADL = 1	0.15	0.01
% eat ADL = 2	-0.12	0.01
% eat ADL = 3	-0.11	-0.01
% eat ADL = 4	-0.08	-0.04
% toileting ADL = 1	0.17	0.03
% toileting ADL = 2	-0.09	0.04
% toileting ADL = 3	-0.07	0.00
% toileting ADL = 4	-0.04	-0.04
% transferring ADL = 1	0.24	0.04
% transferring ADL = 2	-0.14	0.00
% transferring ADL = 3	-0.10	0.00
% transferring ADL = 4	-0.07	-0.03
% walking ADL = 1	0.29	0.03
% walking ADL = 2	-0.12	0.00
% walking ADL = 3	-0.13	0.01
% walking ADL = 4	-0.06	-0.04
% no months with primary caregiver	-0.04	0.00
% less than 6 months with primary caregiver	0.16	-0.03

Figure 12. Overlap in Linearized Risk Scores.

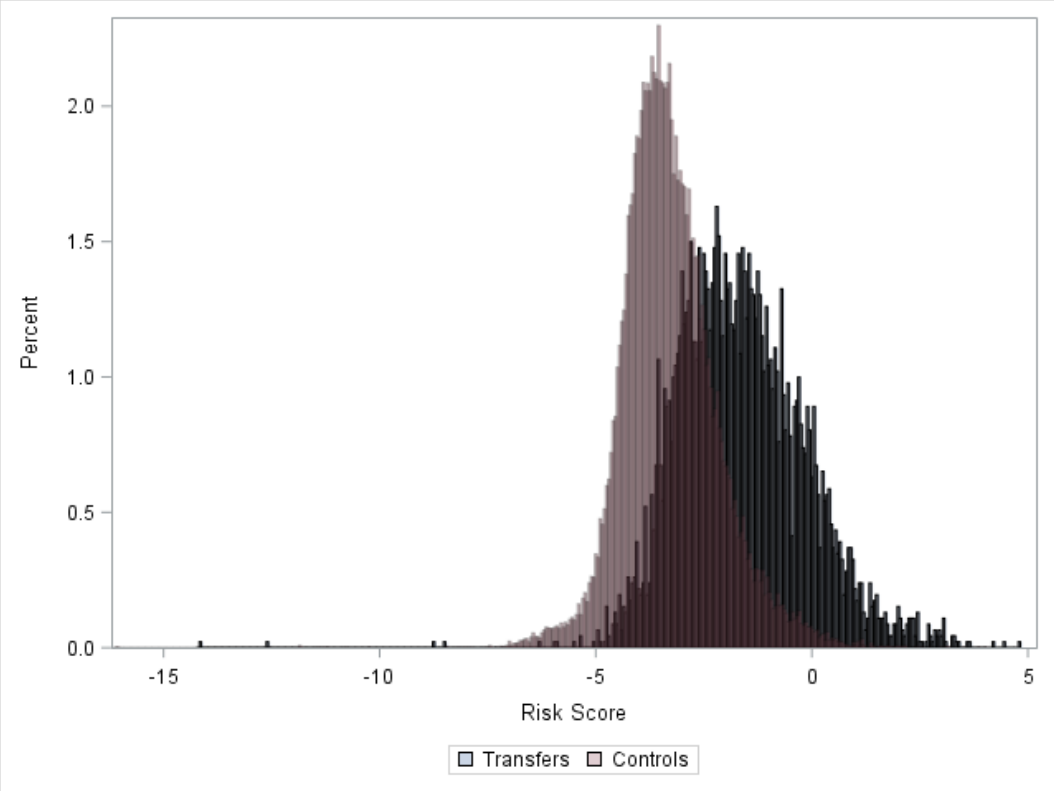
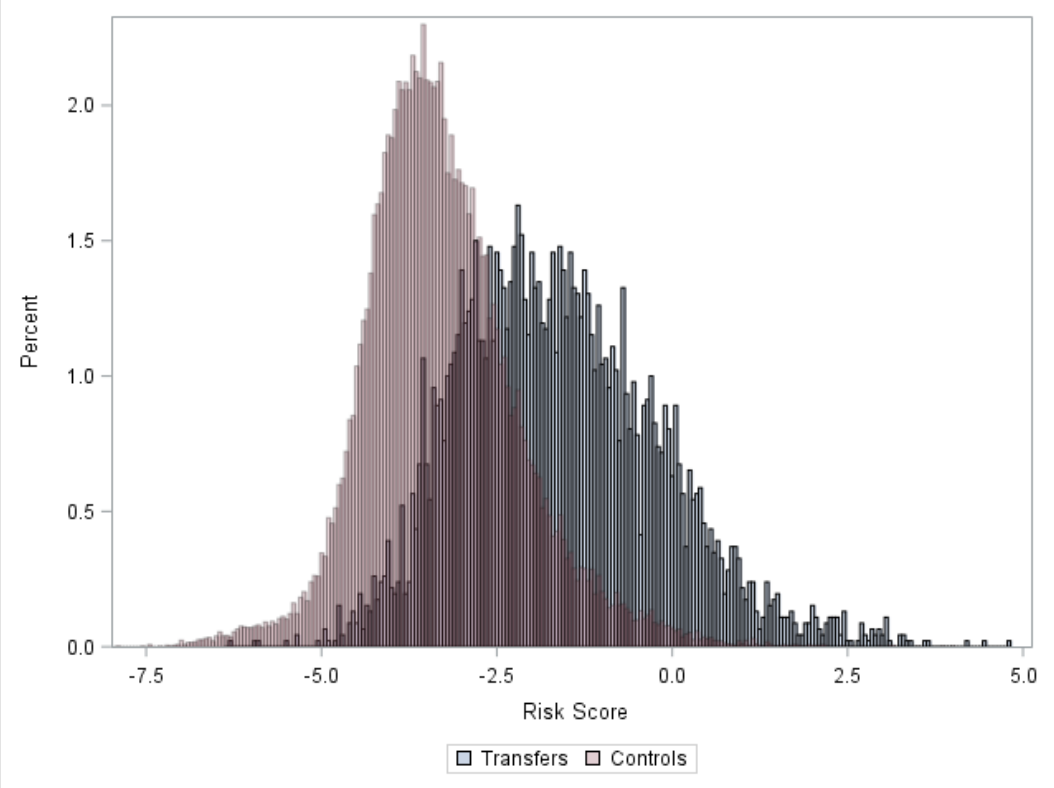


Figure 13. Overlap in Linearized Risk Scores – Zoomed In.



Additional Analysis

RQ2.III: Regional Variation in Access to Assisted Living Facilities

Table 84 summarizes the prevalence of ALFs in each region at the beginning of the evaluation period. Regional differences expressed in these data are probably fairly stable over time. Regions 10 and 11 had the lowest enrollee to ALF ratios and, therefore, enrollees in these areas had the greatest access to ALFs. In short, it is likely that greater access to ALFs is directly related to the likelihood of a transition attempt.

Table 84. Assisted Living Facilities by Region in SFY 2014-2015.

Region	Population weighted average county ranking	Population weighted mean number of enrollees per ALF in each county*	Number of counties	Number of counties with no ALF	Percentage of enrollees with no ALF in their county
11	3	18	2	1	0.4%
10	4	23	1		
6	16	49	5		
7	15	49	4		
9	17	58	5		
5	16	56	2		
8	27	81	7		
4	34	98	7		
3	33	120	16	3	3.4%
2	52	394	14	4	15.6%
1	53	305	4		

*Counties without ALFs are excluded because enrollee to ALF ratios are undefined for counties with zero ALFs.
Note: A ranking of 1 signifies the best enrollee to ALF ratio; a ranking of 63.5 signifies the worst.
Source: Provider Network Verification files from SFY 2015

Results Supplement

RQ1, Table 3

Full model results for RQ1, Table 4 are presented in Table 85 below.

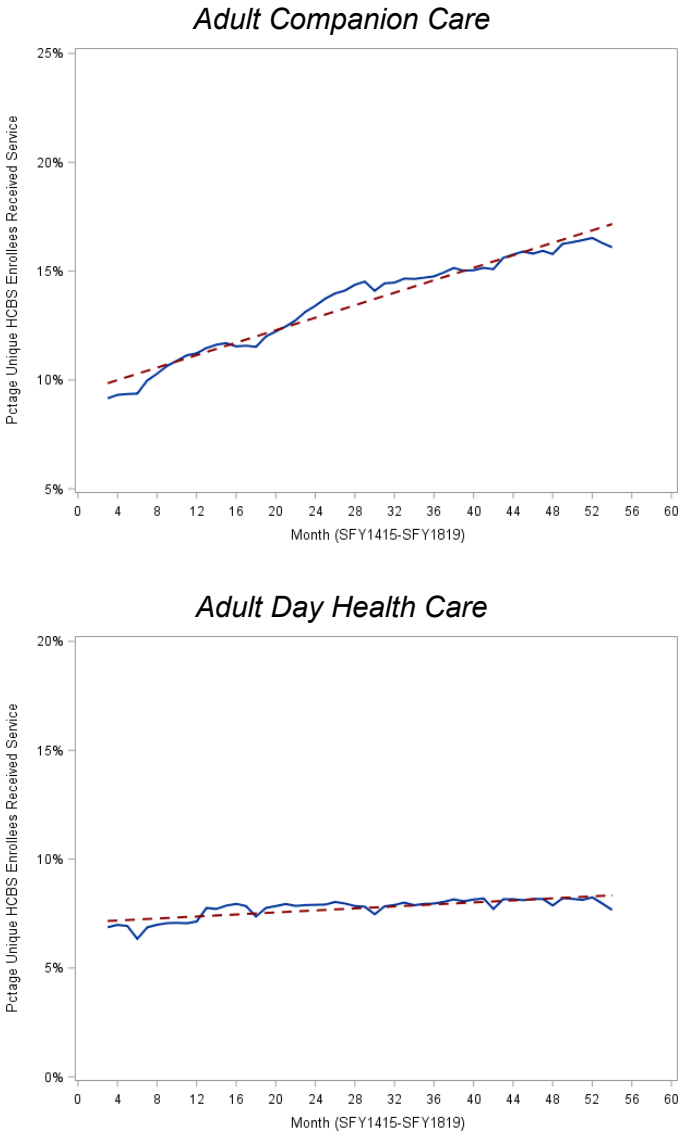
Table 85. Iteratively Adjusted Linear Regressions of the Monthly Percentage of Unique HCBS Enrollees Receiving Each LTC Service Over Time for Selected Service Categories.

LTC Service Category	Intercept	Intercept Std. Err.	Slope (trend over time)	Slope Std. Err.	Slope *p*-value	
Adult Companion Care	0.0974	0.0038	0.0014	0.0001	< .0001	*
Adult Day Health Care	0.0716	0.0015	0.0002	0.0000	< .0001	*
Assisted Living	0.3061	0.0046	-0.0011	0.0002	< .0001	*
Home-Delivered Meals	0.2435	0.0080	0.0006	0.0003	0.0163	
Homemaker Services	0.3947	0.0100	0.0021	0.0003	< .0001	*
Medical Equipment and Supplies	0.3130	0.0128	0.0027	0.0004	< .0001	*
Personal Care	0.4072	0.0083	0.0019	0.0003	< .0001	*
PERS	0.1743	0.0036	0.0008	0.0001	< .0001	*
Respite Care	0.0852	0.0138	-0.0003	0.0002	0.1237	
Transportation	0.0287	0.0038	0.0005	0.0001	< .0001	*

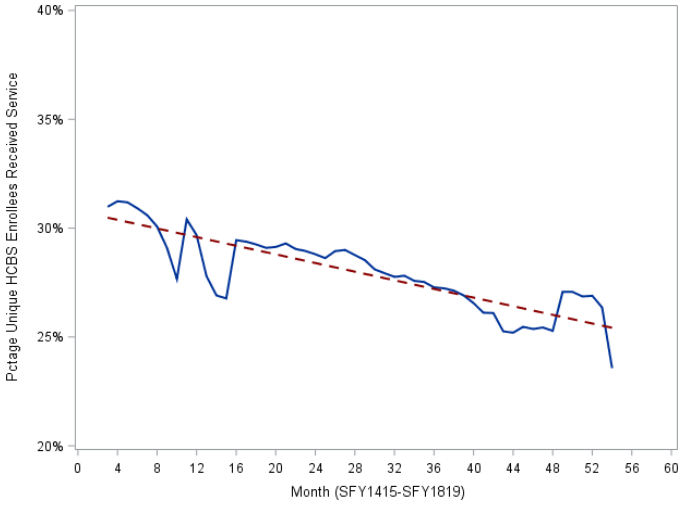
*Slope estimates significantly different from flat at a Bonferroni adjusted alpha level of 0.005.
Exclusions: Excludes July 2014 and August 2014 because AEC was a FFS-based plan. Excludes the second half of SFY 2019 (i.e., all of 2019) because encounter records appear to be underrepresented for the new plans added under the new contract.
Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records

The ten plots that follow show the trend over time in the monthly proportion of unique HCBS enrollees who received services under each category. The blue line is the unadjusted trend; the red dashed line is the fitted linear regression line.

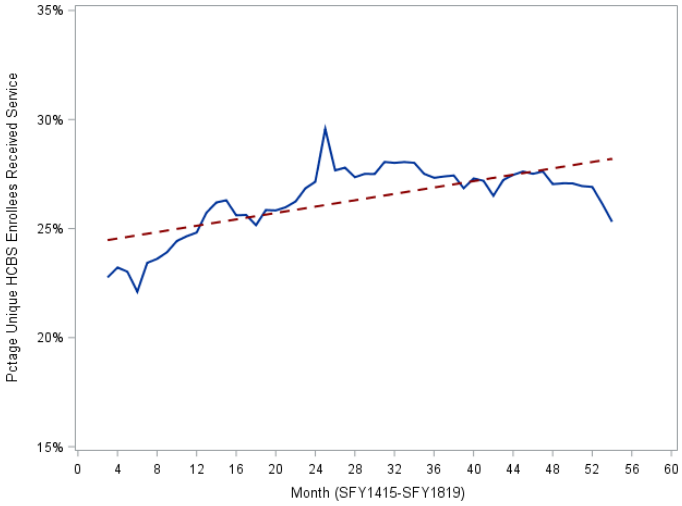
Figure 14. Plots of the Trends Over Time in the Monthly Proportion of Unique HCBS Enrollees Receiving Services Under each Category.



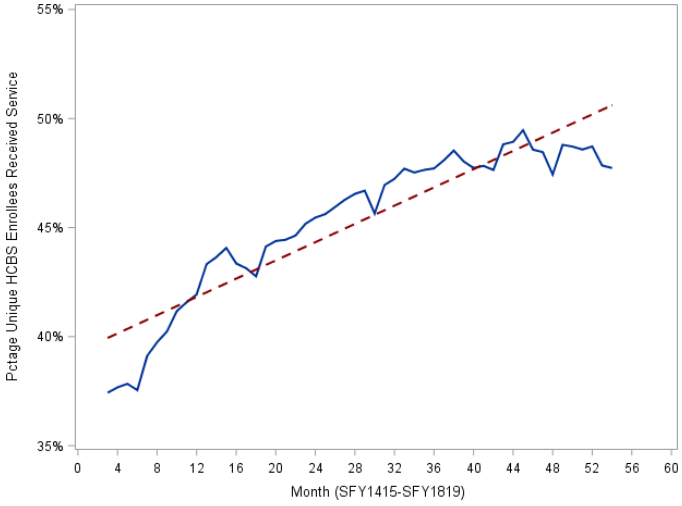
Assisted Living



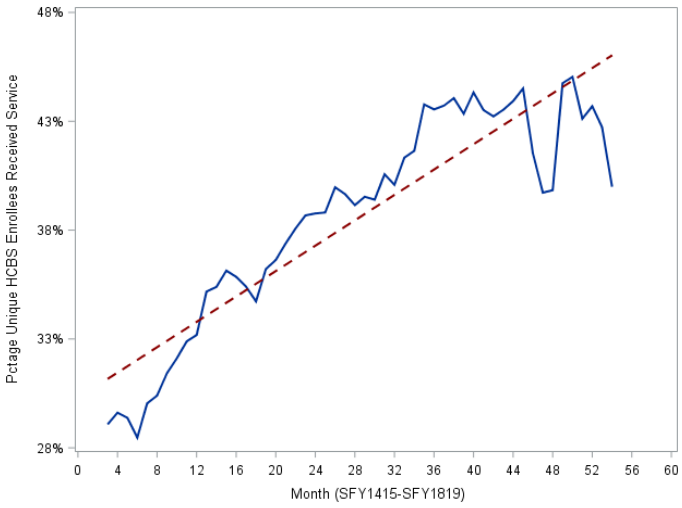
Home-Delivered Meals



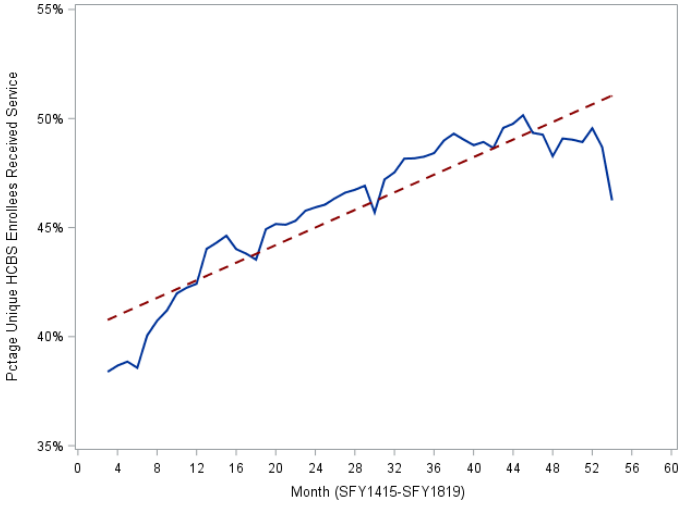
Homemaker Services



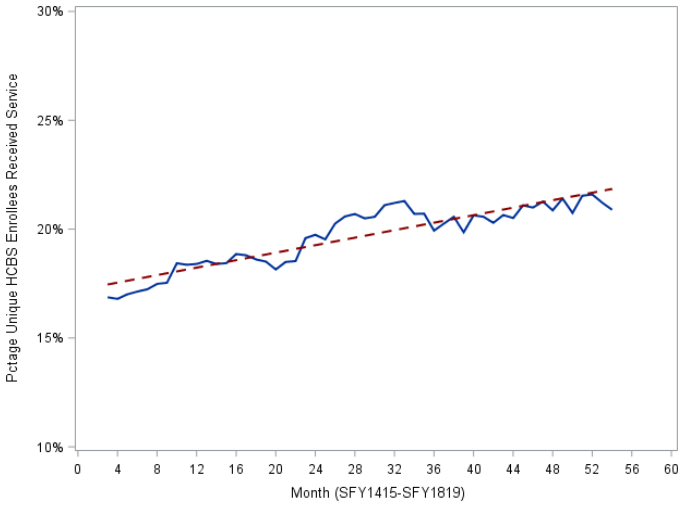
Medical Equipment and Supplies



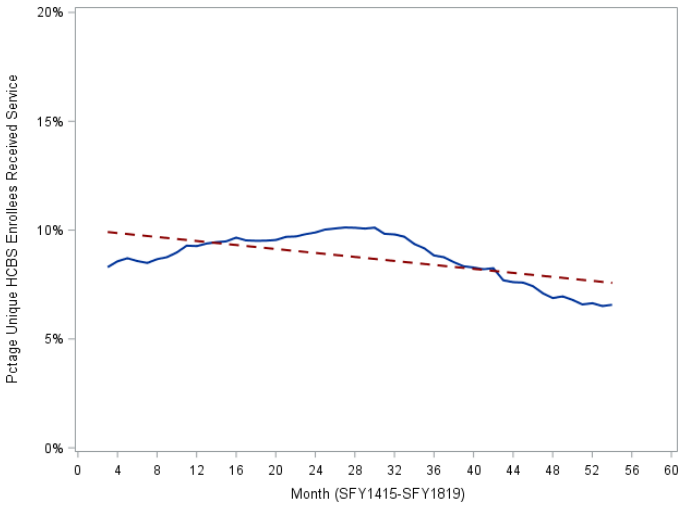
Personal Care



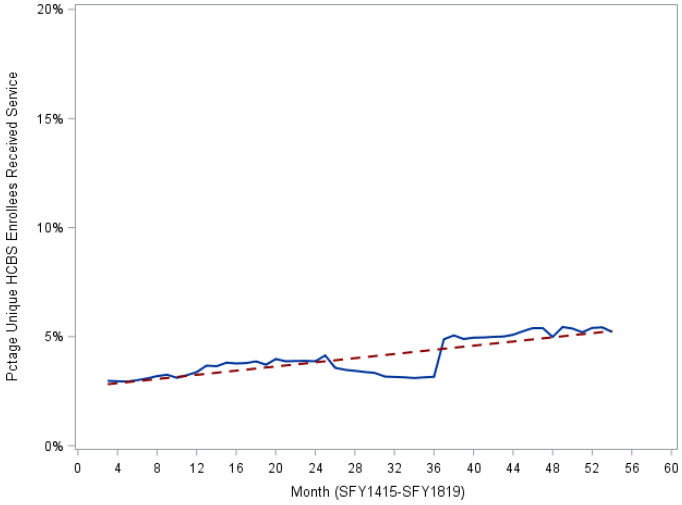
Personal Emergency Response System



Respite Care



Transportation



RQ1, Table 3

A summary of the point estimates of interest from Table 3 in the main body of the report are presented in Table 86.

Table 86. First-Difference Models of the Change in Mean Units of Service per Month as a Function of Change in ADL Needs for Selected Service Categories.

LTC Service Category	ADL	Estimate	Std. Err.	*p*-value
Adult Companion Care	Hygiene	0.2890	0.0650	<.0001*
	Eating	0.0959	0.1066	0.3681
	Toileting	0.0169	0.1195	0.8877
	Mobility	0.0254	0.0669	0.7039
Adult Day Health Care	Hygiene	-0.3413	0.2283	0.1349
	Eating	-0.6034	0.4494	0.1794
	Toileting	0.7073	0.6290	0.2608
	Mobility	-0.3553	0.2002	0.0760
Home-Delivered Meals	Hygiene	0.0086	0.0173	0.6204
	Eating	-0.0513	0.0326	0.1158
	Toileting	-0.0441	0.0257	0.0861
	Mobility	-0.0191	0.0139	0.1701
Homemaker Services	Hygiene	0.2917	0.1030	0.0046
	Eating	-0.0073	0.1383	0.9581
	Toileting	0.3396	0.2554	0.1837
	Mobility	-0.0060	0.0769	0.9377
Medical Equipment and Supplies	Hygiene	0.3146	0.1268	0.0131
	Eating	0.0670	0.1941	0.7300
	Toileting	0.1393	0.2415	0.5640
	Mobility	-0.0054	0.1391	0.9692
Personal Care	Hygiene	1.8144	0.1205	<.0001*
	Eating	0.3998	0.2057	0.0519
	Toileting	0.6924	0.2382	0.0037
	Mobility	0.4048	0.1621	0.0126
PERS[86]	Hygiene	0.0013	0.0005	0.0113
	Eating	-0.0007	0.0006	0.2804
	Toileting	-0.0015	0.0008	0.0614
	Mobility	-0.0018	0.0004	<.0001*
Respite Care	Hygiene	0.0774	0.0544	0.1548
	Eating	0.0473	0.1153	0.6817
	Toileting	0.1013	0.1013	0.3174
	Mobility	0.1265	0.0575	0.0278
Transportation	Hygiene	-0.0227	0.0280	0.4173
	Eating	-0.0018	0.0406	0.9650
	Toileting	-0.0702	0.0513	0.1706
	Mobility	0.0006	0.0309	0.9849
Adult Companion Care, Adult Day Health Care, Homemaker Services, Personal Care, combined	Hygiene	2.0539	0.3016	<.0001*
	Eating	-0.1149	0.5421	0.8321
	Toileting	1.7561	0.7467	0.0187
	Mobility	0.0689	0.2889	0.8114

*Significant at Bonferroni adjusted alpha level of 0.00125.

Note: Each model controls for changes in caregiver status (loss or gain), significant weight loss (5% bodyweight or more), health shocks (new amputation, cancer diagnosis, diabetes diagnosis, cardiac problems, kidney disease, liver disease, lung problems, Parkinson's diagnosis, paralysis event(s), seizure event(s), stroke event(s), and/or tumor occurrences), aggregate changes in IADL needs, changes in the number of inpatient days between periods, percent change in the length of each period, changes in plan membership, changes in region of residence, and quarter of measurement.

Sources: 701B Assessments, FSU created enrollee LOC file (see Appendix), AHCA's LTC service category crosswalk, LTC encounter records, FL Center inpatient data

Full results for the nine models presented in Table 3 in the main body of the report follow in Table 87. Each model controlled for changes in caregiver status (loss or gain), significant weight loss (5% bodyweight or more),

[86] Since an enrollee can only receive one PERS UOS per month, PERS service use was measured differently than the other services. The analyst measured this service use as the proportion of months an enrollee had a PERS during each period.

health shocks (new amputation, cancer diagnosis, diabetes diagnosis, cardiac problems, kidney disease, liver disease, lung problems, Parkinson's diagnosis, paralysis event(s), seizure event(s), stroke event(s), and/or tumor occurrences), aggregate changes in IADL needs, changes in the number of inpatient days between periods, percent change in the length of each period, changes in plan membership, changes in region of residence, and the quarter the comparison period midpoint fell in (where the first quarter is April through June of 2015).

Table 87. Full Model Results for the Change in Service Utilization in Relation to Change in ADL Needs

Adult Companion Care			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	4.1636	4.8841	0.3940
Loses caregiver	0.5923	0.5113	0.2467
Gains caregiver	2.9830	0.5417	<.0001
Change in Hygiene ADL score	0.2890	0.0650	<.0001
Change in Eating ADL score	0.0959	0.1066	0.3681
Change in Toileting ADL score	0.0169	0.1195	0.8877
Change in Mobility ADL score	0.0254	0.0669	0.7039
Significant weight loss	0.3286	0.2520	0.1922
Health shock	0.9619	0.2380	<.0001
Change in total IADL score	0.0393	0.0263	0.1349
Change in mean count inpatient days per 30-days	-0.5396	0.0638	<.0001
% change in length of comparison period versus length of the baseline period	3.7348	0.3313	<.0001
Changed plans in baseline period	0.1999	0.3911	0.6092
Changed plans in comparison period	-1.0680	0.3251	0.0010
Changed region in baseline period	-1.8892	0.6965	0.0067
Changed region in comparison period	0.0341	0.6289	0.9568
Comparison period midpoint in Quarter 2	0.4314	5.2189	0.9341
Comparison period midpoint in Quarter 3	-1.7333	4.9045	0.7238
Comparison period midpoint in Quarter 4	-0.8245	4.8941	0.8662
Comparison period midpoint in Quarter 5	-0.8542	4.9033	0.8617
Comparison period midpoint in Quarter 6	-0.2903	4.8980	0.9527
Comparison period midpoint in Quarter 7	-0.3686	4.8979	0.9400
Comparison period midpoint in Quarter 8	-0.7239	4.8982	0.8825
Comparison period midpoint in Quarter 9	-0.7501	4.9008	0.8783
Comparison period midpoint in Quarter 10	-1.4359	4.8974	0.7694
Comparison period midpoint in Quarter 11	-1.7628	4.8962	0.7188
Comparison period midpoint in Quarter 12	-1.4291	4.8969	0.7704
Comparison period midpoint in Quarter 13	-1.4697	4.9001	0.7642
Comparison period midpoint in Quarter 14	-0.6116	4.9011	0.9007
Comparison period midpoint in Quarter 15	-0.9370	4.9012	0.8484
Comparison period midpoint in Quarter 16	-0.3096	4.9038	0.9497
Comparison period midpoint in Quarter 17	-0.9852	4.9213	0.8413

Adult Day Health Care			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-31.5530	35.6896	0.3766
Loses caregiver	-11.7121	1.3029	<.0001
Gains caregiver	-0.0945	2.8983	0.9740
Change in Hygiene ADL score	-0.3413	0.2283	0.1349
Change in Eating ADL score	-0.6034	0.4494	0.1794
Change in Toileting ADL score	0.7073	0.6290	0.2608
Change in Mobility ADL score	-0.3553	0.2002	0.0760
Significant weight loss	-0.9156	0.8573	0.2855
Health shock	-0.1055	0.7624	0.8899
Change in total IADL score	-0.0784	0.0685	0.2529
Change in mean count inpatient days per 30-days	-1.2374	0.1391	<.0001
% change in length of comparison period versus length of the baseline period	5.1223	1.1164	<.0001
Changed plans in baseline period	2.4559	1.0671	0.0214
Changed plans in comparison period	0.6207	1.4488	0.6683
Changed region in baseline period	-2.3251	2.5334	0.3587
Changed region in comparison period	-1.5768	1.7957	0.3799
Comparison period midpoint in Quarter 2	31.1573	35.8578	0.3849
Comparison period midpoint in Quarter 3	28.2980	35.7025	0.4280
Comparison period midpoint in Quarter 4	30.9728	35.7052	0.3857
Comparison period midpoint in Quarter 5	31.0721	35.6901	0.3840
Comparison period midpoint in Quarter 6	30.9880	35.6924	0.3853
Comparison period midpoint in Quarter 7	31.2578	35.6886	0.3811
Comparison period midpoint in Quarter 8	31.1817	35.6925	0.3823
Comparison period midpoint in Quarter 9	28.2290	35.6936	0.4290
Comparison period midpoint in Quarter 10	29.0668	35.6959	0.4155
Comparison period midpoint in Quarter 11	29.2087	35.6919	0.4132
Comparison period midpoint in Quarter 12	31.7619	35.7097	0.3738
Comparison period midpoint in Quarter 13	31.4954	35.7250	0.3780
Comparison period midpoint in Quarter 14	30.3685	35.7191	0.3952
Comparison period midpoint in Quarter 15	29.3500	35.7405	0.4115
Comparison period midpoint in Quarter 16	29.6950	35.7952	0.4068
Comparison period midpoint in Quarter 17	33.1441	35.7600	0.3540

Home-Delivered Meals			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	0.6916	1.5165	0.6484
Loses caregiver	-0.5528	0.0964	<.0001
Gains caregiver	0.0901	0.1079	0.4040
Change in Hygiene ADL score	0.0086	0.0173	0.6204
Change in Eating ADL score	-0.0513	0.0326	0.1158
Change in Toileting ADL score	-0.0441	0.0257	0.0861
Change in Mobility ADL score	-0.0191	0.0139	0.1701
Significant weight loss	-0.0519	0.0740	0.4835
Health shock	0.0150	0.0520	0.7724
Change in total IADL score	-0.0196	0.0099	0.0485

Home-Delivered Meals			
Variable	**Estimate**	**Standard Error**	***p*-value**
Change in mean count inpatient days per 30-days	-0.2386	0.0168	<.0001
% change in length of comparison period versus length of the baseline period	0.9591	0.0765	<.0001
Changed plans in baseline period	0.3890	0.0960	<.0001
Changed plans in comparison period	-0.5475	0.0962	<.0001
Changed region in baseline period	-0.7457	0.1808	<.0001
Changed region in comparison period	-0.1725	0.1800	0.3379
Comparison period midpoint in Quarter 2	-1.1550	1.5681	0.4614
Comparison period midpoint in Quarter 3	-0.7456	1.5201	0.6238
Comparison period midpoint in Quarter 4	-0.6382	1.5180	0.6742
Comparison period midpoint in Quarter 5	-0.8626	1.5187	0.5701
Comparison period midpoint in Quarter 6	-0.6189	1.5181	0.6835
Comparison period midpoint in Quarter 7	-0.6106	1.5179	0.6875
Comparison period midpoint in Quarter 8	-0.7072	1.5181	0.6413
Comparison period midpoint in Quarter 9	-1.0291	1.5180	0.4978
Comparison period midpoint in Quarter 10	-1.0249	1.5195	0.5000
Comparison period midpoint in Quarter 11	-1.1514	1.5177	0.4481
Comparison period midpoint in Quarter 12	-1.0435	1.5176	0.4917
Comparison period midpoint in Quarter 13	-1.0712	1.5187	0.4806
Comparison period midpoint in Quarter 14	-0.7014	1.5209	0.6447
Comparison period midpoint in Quarter 15	-0.7413	1.5220	0.6262
Comparison period midpoint in Quarter 16	-0.6929	1.5195	0.6484
Comparison period midpoint in Quarter 17	-0.6513	1.5227	0.6688

Homemaker Services			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-8.0226	7.3568	0.2755
Loses caregiver	-1.9249	0.5045	0.0001
Gains caregiver	4.6679	0.6341	<.0001
Change in Hygiene ADL score	0.2917	0.1030	0.0046
Change in Eating ADL score	-0.0073	0.1383	0.9581
Change in Toileting ADL score	0.3396	0.2554	0.1837
Change in Mobility ADL score	-0.0060	0.0769	0.9377
Significant weight loss	0.7857	0.4662	0.0919
Health shock	1.8643	0.4552	<.0001
Change in total IADL score	-0.0529	0.0304	0.0816
Change in mean count inpatient days per 30-days	-2.0417	0.0933	<.0001
% change in length of comparison period versus length of the baseline period	7.9234	0.4204	<.0001
Changed plans in baseline period	-1.1696	0.5091	0.0216
Changed plans in comparison period	-5.8116	0.6818	<.0001
Changed region in baseline period	-5.7051	1.0536	<.0001
Changed region in comparison period	-0.1923	0.8885	0.8286
Comparison period midpoint in Quarter 2	5.9207	7.7032	0.4421
Comparison period midpoint in Quarter 3	10.8579	7.3812	0.1413
Comparison period midpoint in Quarter 4	11.9652	7.3632	0.1042

Homemaker Services			
Variable	**Estimate**	**Standard Error**	***p*-value**
Comparison period midpoint in Quarter 5	11.0357	7.3590	0.1337
Comparison period midpoint in Quarter 6	11.4604	7.3590	0.1194
Comparison period midpoint in Quarter 7	13.0129	7.3636	0.0772
Comparison period midpoint in Quarter 8	13.6765	7.3649	0.0633
Comparison period midpoint in Quarter 9	11.2564	7.3685	0.1266
Comparison period midpoint in Quarter 10	10.0961	7.3619	0.1703
Comparison period midpoint in Quarter 11	9.4348	7.3644	0.2002
Comparison period midpoint in Quarter 12	10.0526	7.3647	0.1723
Comparison period midpoint in Quarter 13	12.1453	7.3745	0.0996
Comparison period midpoint in Quarter 14	15.2902	7.3851	0.0384
Comparison period midpoint in Quarter 15	15.3886	7.3865	0.0372
Comparison period midpoint in Quarter 16	16.9289	7.4394	0.0229
Comparison period midpoint in Quarter 17	16.1824	7.4023	0.0288

Medical Equipment and Supplies			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-0.1644	6.2893	0.9791
Loses caregiver	-5.3548	0.9386	<.0001
Gains caregiver	5.2053	1.8757	0.0055
Change in Hygiene ADL score	0.3146	0.1268	0.0131
Change in Eating ADL score	0.0670	0.1941	0.7300
Change in Toileting ADL score	0.1393	0.2415	0.5640
Change in Mobility ADL score	-0.0054	0.1391	0.9692
Significant weight loss	0.0384	0.7296	0.9580
Health shock	-0.9531	0.5777	0.0990
Change in total IADL score	-0.0849	0.0552	0.1241
Change in mean count inpatient days per 30-days	-1.4704	0.2270	<.0001
% change in length of comparison period versus length of the baseline period	4.2015	0.8760	<.0001
Changed plans in baseline period	-1.7188	1.2595	0.1724
Changed plans in comparison period	0.8820	0.8846	0.3188
Changed region in baseline period	-5.8431	1.6500	0.0004
Changed region in comparison period	2.7627	1.5694	0.0784
Comparison period midpoint in Quarter 2	0.7824	7.1477	0.9128
Comparison period midpoint in Quarter 3	6.4063	6.4285	0.3190
Comparison period midpoint in Quarter 4	10.2312	6.3448	0.1069
Comparison period midpoint in Quarter 5	9.3109	6.4360	0.1480
Comparison period midpoint in Quarter 6	12.2545	6.3641	0.0542
Comparison period midpoint in Quarter 7	6.2390	6.3319	0.3245
Comparison period midpoint in Quarter 8	5.2863	6.3610	0.4059
Comparison period midpoint in Quarter 9	2.0900	6.3367	0.7415
Comparison period midpoint in Quarter 10	-1.8872	6.3509	0.7664
Comparison period midpoint in Quarter 11	-1.7599	6.3776	0.7826
Comparison period midpoint in Quarter 12	-2.6016	6.3462	0.6818
Comparison period midpoint in Quarter 13	0.8303	6.4331	0.8973
Comparison period midpoint in Quarter 14	4.1732	6.3627	0.5119

Medical Equipment and Supplies			
Variable	**Estimate**	**Standard Error**	***p*-value**
Comparison period midpoint in Quarter 15	10.1010	6.3617	0.1123
Comparison period midpoint in Quarter 16	12.9807	6.4327	0.0436
Comparison period midpoint in Quarter 17	12.0935	6.7013	0.0711

Personal Care			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	2.2551	13.6577	0.8689
Loses caregiver	-4.0835	0.9764	<.0001
Gains caregiver	11.5101	1.1111	<.0001
Change in Hygiene ADL score	1.8144	0.1205	<.0001
Change in Eating ADL score	0.3998	0.2057	0.0519
Change in Toileting ADL score	0.6924	0.2382	0.0037
Change in Mobility ADL score	0.4048	0.1621	0.0126
Significant weight loss	2.3707	0.5616	<.0001
Health shock	4.9472	0.8787	<.0001
Change in total IADL score	0.0191	0.0510	0.7079
Change in mean count inpatient days per 30-days	-3.7907	0.2020	<.0001
% change in length of comparison period versus length of the baseline period	15.3295	0.7836	<.0001
Changed plans in baseline period	-3.3735	1.9776	0.0880
Changed plans in comparison period	-10.1634	0.7356	<.0001
Changed region in baseline period	2.4897	8.6180	0.7727
Changed region in comparison period	0.2093	2.4726	0.9325
Comparison period midpoint in Quarter 2	0.7597	14.3382	0.9577
Comparison period midpoint in Quarter 3	6.0505	13.7031	0.6588
Comparison period midpoint in Quarter 4	5.8133	13.6660	0.6706
Comparison period midpoint in Quarter 5	4.6901	13.6743	0.7316
Comparison period midpoint in Quarter 6	6.7813	13.6644	0.6197
Comparison period midpoint in Quarter 7	8.5696	13.6717	0.5308
Comparison period midpoint in Quarter 8	8.5576	13.6734	0.5314
Comparison period midpoint in Quarter 9	8.0606	13.6777	0.5556
Comparison period midpoint in Quarter 10	7.9442	13.6727	0.5612
Comparison period midpoint in Quarter 11	7.6663	13.6753	0.5751
Comparison period midpoint in Quarter 12	9.5960	13.6732	0.4828
Comparison period midpoint in Quarter 13	10.2485	13.6772	0.4537
Comparison period midpoint in Quarter 14	15.9897	13.6945	0.2430
Comparison period midpoint in Quarter 15	14.9643	13.6911	0.2744
Comparison period midpoint in Quarter 16	17.4703	13.6941	0.2020
Comparison period midpoint in Quarter 17	20.1748	14.0148	0.1500

Personal Emergency Response System			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	0.0837	0.0654	0.2008
Loses caregiver	-0.0158	0.0033	<.0001
Gains caregiver	0.0083	0.0034	0.0146

Personal Emergency Response System			
Variable	**Estimate**	**Standard Error**	***p*-value**
Change in Hygiene ADL score	0.0013	0.0005	0.0113
Change in Eating ADL score	-0.0007	0.0006	0.2804
Change in Toileting ADL score	-0.0015	0.0008	0.0614
Change in Mobility ADL score	-0.0018	0.0004	<.0001
Significant weight loss	-0.0038	0.0016	0.0201
Health shock	0.0037	0.0016	0.0191
Change in total IADL score	-0.0020	0.0002	<.0001
Change in mean count inpatient days per 30-days	-0.0010	0.0005	0.0228
% change in length of comparison period versus length of the baseline period	0.0231	0.0025	<.0001
Changed plans in baseline period	0.0049	0.0025	0.0536
Changed plans in comparison period	-0.0161	0.0021	<.0001
Changed region in baseline period	-0.0194	0.0056	0.0005
Changed region in comparison period	-0.0072	0.0056	0.1998
Comparison period midpoint in Quarter 2	-0.0659	0.0667	0.3233
Comparison period midpoint in Quarter 3	-0.0803	0.0655	0.2206
Comparison period midpoint in Quarter 4	-0.0846	0.0655	0.1963
Comparison period midpoint in Quarter 5	-0.0859	0.0655	0.1894
Comparison period midpoint in Quarter 6	-0.0861	0.0655	0.1887
Comparison period midpoint in Quarter 7	-0.0796	0.0655	0.2239
Comparison period midpoint in Quarter 8	-0.0790	0.0655	0.2274
Comparison period midpoint in Quarter 9	-0.0878	0.0655	0.1800
Comparison period midpoint in Quarter 10	-0.0939	0.0655	0.1515
Comparison period midpoint in Quarter 11	-0.0847	0.0655	0.1958
Comparison period midpoint in Quarter 12	-0.0829	0.0655	0.2055
Comparison period midpoint in Quarter 13	-0.0755	0.0655	0.2485
Comparison period midpoint in Quarter 14	-0.0684	0.0655	0.2958
Comparison period midpoint in Quarter 15	-0.0697	0.0655	0.2871
Comparison period midpoint in Quarter 16	-0.0676	0.0655	0.3017
Comparison period midpoint in Quarter 17	-0.0642	0.0655	0.3270

Respite Care			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-4.3411	2.7906	0.1198
Loses caregiver	-2.6016	0.4706	<.0001
Gains caregiver	3.0096	0.5295	<.0001
Change in Hygiene ADL score	0.0774	0.0544	0.1548
Change in Eating ADL score	0.0473	0.1153	0.6817
Change in Toileting ADL score	0.1013	0.1013	0.3174
Change in Mobility ADL score	0.1265	0.0575	0.0278
Significant weight loss	0.6310	0.2684	0.0187
Health shock	0.6995	0.2454	0.0044
Change in total IADL score	0.0464	0.0246	0.0596
Change in mean count inpatient days per 30-days	-0.3309	0.0977	0.0007
% change in length of comparison period versus length of the baseline period	1.9024	0.3823	<.0001

Respite Care			
Variable	**Estimate**	**Standard Error**	***p*-value**
Changed plans in baseline period	1.0264	0.3279	0.0017
Changed plans in comparison period	2.7840	0.3276	<.0001
Changed region in baseline period	-2.7412	1.1859	0.0208
Changed region in comparison period	-0.7107	0.8071	0.3786
Comparison period midpoint in Quarter 2	5.2448	2.9237	0.0728
Comparison period midpoint in Quarter 3	6.4336	2.8601	0.0245
Comparison period midpoint in Quarter 4	6.4911	2.8100	0.0209
Comparison period midpoint in Quarter 5	5.9093	2.8082	0.0354
Comparison period midpoint in Quarter 6	6.3270	2.8189	0.0248
Comparison period midpoint in Quarter 7	6.3641	2.8253	0.0243
Comparison period midpoint in Quarter 8	6.4270	2.8117	0.0223
Comparison period midpoint in Quarter 9	5.1754	2.8128	0.0658
Comparison period midpoint in Quarter 10	3.8469	2.8118	0.1713
Comparison period midpoint in Quarter 11	3.6991	2.8236	0.1902
Comparison period midpoint in Quarter 12	3.3385	2.8099	0.2348
Comparison period midpoint in Quarter 13	2.9599	2.8148	0.2930
Comparison period midpoint in Quarter 14	1.4232	2.8146	0.6131
Comparison period midpoint in Quarter 15	1.8568	2.8315	0.5120
Comparison period midpoint in Quarter 16	2.2336	2.8123	0.4271
Comparison period midpoint in Quarter 17	4.3504	2.8416	0.1258

Transportation			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-0.2817	0.1925	0.1434
Loses caregiver	-0.2817	0.1881	0.1343
Gains caregiver	0.2528	0.2689	0.3471
Change in Hygiene ADL score	-0.0227	0.0280	0.4173
Change in Eating ADL score	-0.0018	0.0406	0.9650
Change in Toileting ADL score	-0.0702	0.0513	0.1706
Change in Mobility ADL score	0.0006	0.0309	0.9849
Significant weight loss	0.0134	0.1452	0.9265
Health shock	0.0582	0.1425	0.6828
Change in total IADL score	0.0083	0.0147	0.5711
Change in mean count inpatient days per 30-days	-0.0650	0.0213	0.0022
% change in length of comparison period versus length of the baseline period	0.2390	0.1440	0.0969
Changed plans in baseline period	-0.0500	0.2805	0.8585
Changed plans in comparison period	-2.1179	0.2695	<.0001
Changed region in baseline period	-0.6925	0.2764	0.0122
Changed region in comparison period	0.2627	0.3240	0.4176
Comparison period midpoint in Quarter 2	2.4627	1.3669	0.0716
Comparison period midpoint in Quarter 3	0.6341	0.2484	0.0107
Comparison period midpoint in Quarter 4	0.7024	0.2587	0.0066
Comparison period midpoint in Quarter 5	0.8005	0.2275	0.0004
Comparison period midpoint in Quarter 6	1.3789	0.3191	<.0001
Comparison period midpoint in Quarter 7	0.9034	0.2813	0.0013

Transportation			
Variable	**Estimate**	**Standard Error**	***p*-value**
Comparison period midpoint in Quarter 8	1.0158	0.2266	<.0001
Comparison period midpoint in Quarter 9	0.4890	0.2383	0.0401
Comparison period midpoint in Quarter 10	0.5168	0.2784	0.0635
Comparison period midpoint in Quarter 11	0.3401	0.2282	0.1362
Comparison period midpoint in Quarter 12	0.0847	0.2498	0.7346
Comparison period midpoint in Quarter 13	0.1110	0.2050	0.5884
Comparison period midpoint in Quarter 14	0.8125	0.2884	0.0048
Comparison period midpoint in Quarter 15	1.3171	0.3730	0.0004
Comparison period midpoint in Quarter 16	2.0909	0.4253	<.0001
Comparison period midpoint in Quarter 17	0.9111	0.3597	0.0113

Adult Companion Care, Adult Day Health Care, Homemaker Services, Personal Care,			
Variable	**Estimate**	**Standard Error**	***p*-value**
Intercept	-33.1570	28.2386	0.2403
Loses caregiver	-17.1282	1.9801	<.0001
Gains caregiver	19.0665	3.3031	<.0001
Change in Hygiene ADL score	2.0539	0.3016	<.0001
Change in Eating ADL score	-0.1149	0.5421	0.8321
Change in Toileting ADL score	1.7561	0.7467	0.0187
Change in Mobility ADL score	0.0689	0.2889	0.8114
Significant weight loss	2.5695	1.2033	0.0327
Health shock	7.6680	1.3159	<.0001
Change in total IADL score	-0.0729	0.1020	0.4752
Change in mean count inpatient days per 30-days	-7.6094	0.2943	<.0001
% change in length of comparison period versus length of the baseline period	32.1101	1.6073	<.0001
Changed plans in baseline period	-1.8872	2.4655	0.4440
Changed plans in comparison period	-16.4223	1.8516	<.0001
Changed region in baseline period	-7.4297	9.1509	0.4168
Changed region in comparison period	-1.5257	3.3323	0.6471
Comparison period midpoint in Quarter 2	38.2691	29.0620	0.1879
Comparison period midpoint in Quarter 3	43.4731	28.2994	0.1245
Comparison period midpoint in Quarter 4	47.9268	28.2724	0.0900
Comparison period midpoint in Quarter 5	45.9436	28.2560	0.1040
Comparison period midpoint in Quarter 6	48.9394	28.2494	0.0832
Comparison period midpoint in Quarter 7	52.4717	28.2459	0.0632
Comparison period midpoint in Quarter 8	52.6919	28.2585	0.0622
Comparison period midpoint in Quarter 9	46.7959	28.2621	0.0978
Comparison period midpoint in Quarter 10	45.6712	28.2559	0.1060
Comparison period midpoint in Quarter 11	44.5470	28.2587	0.1149
Comparison period midpoint in Quarter 12	49.9814	28.2738	0.0771
Comparison period midpoint in Quarter 13	52.4195	28.3010	0.0640
Comparison period midpoint in Quarter 14	61.0367	28.3058	0.0311
Comparison period midpoint in Quarter 15	58.7658	28.3378	0.0381
Comparison period midpoint in Quarter 16	63.7846	28.4082	0.0248
Comparison period midpoint in Quarter 17	68.5161	28.5144	0.0163

Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility data (for demographic information), FL Center inpatient data, 701B Assessments

RQ2, Table 11

Full model results for RQ2, Table 11 are presented in Table 88 below.

Table 88. Logistic Regression Model of the Factors Associated with Attempted Transition from Nursing Facilities into the Community.

Factor	Estimate	Standard Error	*p*-value
Intercept	9.1891	0.2536	<.0001
Sex – Female	-0.1245	0.0218	<.0001
Race – Black	0.0139	0.0292	0.6353
Race – Hispanic	0.3499	0.0365	<.0001
Race – Other	0.2528	0.0366	<.0001
Log (age at entry)	-1.9394	0.0593	<.0001
Plan – American Eldercare-Humana	0.3219	0.0274	<.0001
Plan – Amerigroup	0.0661	0.0665	0.3204
Plan – Coventry (now Aetna Coventry)	-0.0761	0.0513	0.1383
Plan – Molina Healthcare	-0.1803	0.0486	0.0002
Plan – Other (new plans as of SFY 2019)	0.0891	0.1845	0.6292
Plan – UnitedHealthcare	-0.0862	0.0284	0.0024
Region – 1	-0.6561	0.0641	<.0001
Region – 2	-0.803	0.0645	<.0001
Region – 3	-0.2981	0.0508	<.0001
Region – 4	-0.5583	0.0479	<.0001
Region – 5	-0.00219	0.0456	0.9618
Region – 6	0.0319	0.046	0.4885
Region – 7	-0.3244	0.0465	<.0001
Region – 8	-0.2241	0.0517	<.0001
Region – 9	-0.1002	0.0475	0.0347
Region – 10	0.1679	0.0509	0.0010
Region – Unknown	3.255	0.486	<.0001
First SFY enrolled - 1516	0.4814	0.0286	<.0001
First SFY enrolled - 1617	0.3067	0.0299	<.0001
First SFY enrolled - 1718	-0.0633	0.0338	0.0611
First SFY enrolled - 1819	-0.4008	0.046	<.0001
Fell	-0.1279	0.0285	<.0001
Enrollee Death During Evaluation Period	-0.7113	0.0233	<.0001
Cognitive Status – Impaired	-0.318	0.026	<.0001
Cognitive Status – Severely Impaired	-0.6261	0.0282	<.0001
Diagnosis – Cancer	0.1292	0.0962	0.1793
Diagnosis – Heart/Circulatory	-0.7023	0.0277	<.0001
Diagnosis – Gastrointestinal	0.2686	0.0399	<.0001
Diagnosis – Urinary	-0.0313	0.04	0.4341
Diagnosis – Infection	0.3778	0.033	<.0001
Diagnosis – Metabolic	0.0277	0.0219	0.2070
Diagnosis – Musculoskeletal	0.1534	0.0331	<.0001
Diagnosis – Neurological	-0.5727	0.022	<.0001
Diagnosis – Nutritional	-0.00165	0.0465	0.9718
Diagnosis – Psychiatric/Mood Disorder	-0.1776	0.0222	<.0001
Diagnosis – Pulmonary	0.0303	0.0242	0.2103
Diagnosis – Vision	-0.2729	0.0719	0.0001
Functional Status[A] – Bathing and/or Dressing	-0.2957	0.0332	<.0001
Functional Status[A] – Bathing and toileting	-0.3698	0.0691	<.0001
Functional Status[A] – Bathing, dressing, and toileting	-0.5382	0.0538	<.0001
Functional Status[A] – Bathing, dressing, and transferring	-0.4938	0.1195	<.0001
Functional Status[A] – Bathing, toileting, and transferring	-0.3782	0.0701	<.0001
Functional Status[A] – Bathing, dressing, toileting, and transferring	-0.7639	0.0309	<.0001
Functional Status[A] – Bathing, dressing, toileting, transferring, and	-0.9944	0.0445	<.0001
Functional Status[A] – Other combination	-0.2836	0.0638	<.0001

[A] Enrollee needs either extensive assistance or total help with…

Sources: FSU created enrollee LOC file, MDS assessments, enrollee demographic file

RQ3, Table 12

Full model results for RQ3, Table 11 are presented in Table 88 below.

Table 89. Results of Conditional Logistic Regression Models Predicting Transition into a Nursing Facility as a Function of Service Utilization Intensity for Selected Service Categories.

LTC Service Category	Measure	Estimate	Std. Err.	*p*-value
Adult Companion Care	Service	0.2937	0.0671	<.0001*
	Intensity	0.0005	0.0005	0.3803
Adult Day Health Care	Service	0.2298	0.1418	0.1051
	Intensity	0.0001	0.0003	0.6406
Home-Delivered Meals	Service	-0.1841	0.0783	0.0187
	Intensity	0.0196	0.0030	<.0001*
Homemaker Services	Service	0.2191	0.0551	<.0001*
	Intensity	0.0013	0.0004	0.0032
Medical Equipment and Supplies	Service	0.2753	0.0466	<.0001*
	Intensity	-0.0001	0.0002	0.5892
Personal Care	Service	0.3337	0.0501	<.0001*
	Intensity	0.0002	0.0002	0.3178
PERS	Service	0.3445	0.0454	<.0001*
Respite Care	Service	-0.0265	0.0705	0.7065
	Intensity	0.0015	0.0004	0.0009*
Transportation	Service	0.2448	0.0974	0.0119
	Intensity	0.0012	0.0013	0.3442

*Significant at Bonferroni adjusted alpha level of 0.0028.

Sources: AHCA LTC service category crosswalk, FSU created enrollee LOC file, LTC encounter records, enrollee eligibility data (for demographic information), FL Center inpatient data, 701B Assessments

Appendix B - Quality of Care

Definitions of Cultural Competence, Cultural Humility, and Anti-Racism

What is cultural competence?

"Cultural competence comprises behaviors, attitudes, and policies … that ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interactions and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among, and between groups" (U.S. Department of Health & Human Services, 2002, p. 249S).

What is cultural humility?

Cultural humility is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [client]" (Hook et al., 2013, p. 2).

What is anti-racism?

Anti-racism is the active process of identifying and eliminating racism by changing systems, organizations, policies, practices, and attitudes (ACLRC, n.d.).

The term "anti-racism" may elicit a negative reaction, because its prefix "anti" may have the connotation of focusing on negativity or producing conflict. That is not the intention. Instead, anti-racism is comprised of "learning, listening, educating, creating community collaboratively, role-modelling, and the refusal to participate/perpetuate racist ideas and behaviors" (ACLRC, n.d.).

Anti-racism adds to both cultural competence and cultural humility by recognizing that racial and ethnic disparities occur in our society, including in quality of care. These disparities often are the result of complex structural processes that "involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients" (Institute of Medicine [IOM], 2003, p. 1).

Does requiring cultural humility training mean that service providers need to feel humiliation? Does requiring anti-racist training mean that service providers are racist?

Absolutely not. The intention of teaching cultural humility is not to humiliate. Instead, it is to teach lifelong learning and critical self-reflection, recognize and challenge power imbalances, and engage in institutional accountability. Cultural humility is meant to empower service providers to regard their clients as experts of their own lives. Service providers trained in cultural humility learn to ask questions

and seek answers from their clients instead of making assumptions or relying on stereotypes.

Further, anti-racist training does not assume that people are racist. In fact, an anti-racist framework holds that no one is statically "racist" or "anti-racist." Instead, practicing anti-racism means being committed to evaluating and identifying racism within ourselves, organizational policies and programs, and society at large. Further, it is a commitment to eliminating racism when we have identified a racial disparity in our personal and professional lives.

What can trainings focused on cultural competence, cultural humility, and anti-racism do?

There is a longstanding consensus that the healthcare workforce's ability to deliver quality care to all individuals could be dramatically improved by monitoring client care with the expressed purpose of eliminating racial and ethnic disparities (IOM, 2003). Therefore, training in cultural competence, cultural humility, and anti-racism is one critical approach necessary to reduce racial disparities in quality of care. A systematic review that evaluated implicit racial/ethnic bias among healthcare professionals found that most health care providers have implicit bias, which, in this case, means the unconscious attribution of positive attitudes towards white patients and negative attitudes toward people of color (Hall et al., 2015). This same systematic review found that implicit bias was correlated with patient-provider interactions (such as satisfaction) and health outcomes. Education gives service providers the tools necessary to identify their own implicit biases within themselves and racial disparities within their organizations (Alang, 2019). Eliminating racial and ethnic inequality is only possible after service providers are made aware that racial disparities still exist. Education in cultural competence, cultural humility, and anti-racism provides the tools necessary for providers to identify and address racial disparities in quality of care, especially regarding client satisfaction and health outcomes.

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General Methodology

The evaluation team used quantitative methods to measure associations between the explanatory and outcome variables of interest. All data sources are retrospective data collected for administrative purposes by the Agency, DOEA, and the seven managed care plans during SFY 2015 through SFY 2019. As the analyses are either purely correlational or observational in nature, the evaluation team stresses that the results and subsequent interpretation do not imply any causal relationships. Significant findings of interest to the Agency may call for further investigation that, where possible, better leverages causal design strategies.

Each research question entailed multiple comparisons (hypothesis tests), so the evaluation team used a Bonferroni correction to adjust the significance threshold for each group of models. The correction requires dividing the standard alpha level of 0.05 by the number of tests conducted. It is a conservative approach to mitigating the probabilistic increase in false positives that occurs when multiple hypotheses are tested at once. Prominent statisticians[87] argue that conservatism is a benefit; chiefly, it reduces the number of spurious associations reported to stakeholders.

Analysis for each RQ relied on the measures and data sources outlined in Table 90. Additional detail about methods specific to individual RQs and measures follow this section.

[87] E.g., Johnson, VE. Revised standards for statistical evidence. *Proceedings of the National Academy of Sciences*. 2013;70(2):19313-19317.

Table 90. Research Questions, Associated Measures, and Data Sources.

Research Question	Analyses	Data Sources
RQ 1: Are long-term care (LTC) services effective at achieving positive health outcomes?	i. Trends in HRQOL indicators by setting ii. Trends in preventable hospitalizations	Client Information & Registration Tracking System (CIRTS), Minimum Data Set (MDS) 3.0, Florida Center data (inpatient (IP) and emergency room (ER)), LTC Encounter data, and Medicaid Managed Care Eligibility file
RQ 2: Are LTC services effective at achieving equitable, positive health outcomes by gender, race/ethnicity, and geographic location?	i. Trends in HRQOL indicators by setting ii. Trends in preventable hospitalizations	CIRTS, MDS 3.0, Florida Center data, LTC Encounter data, and Medicaid Managed Care Eligibility file
RQ 3: Are patient-centered enrollee transitions reducing the number of potentially preventable transitions?	i. Logit models for presence of HRQOL indicators ii. Logit models for preventable hospitalizations	Florida Center data (IP and ER), LTC Encounter data, and Medicaid Managed Care Eligibility file
RQ 4: Are patient-centered needs of enrollees being met?	i. Trends in the proportion of enrollees with unmet ADL and IADL needs in HCBS settings	CIRTS and Medicaid Managed Care Eligibility file
RQ 5: Has enrollee safety improved over time?	i. Trends in the proportion of enrollees reporting HRQOL indicators	MDS 3.0, CIRTS, Florida Center data (IP and ER), and Medicaid Managed Care Eligibility file

Enrollee Location of Care File

The evaluation team used both LTC encounter and Minimum Data Set (MDS) assessment records for determining an enrollee's location of care in a given month. If an enrollee had a nursing facility encounter record or an MDS assessment record(s) that spanned the majority of a given month, the enrollee was assigned a nursing facility LOC for the month; otherwise, the enrollee was assigned a home/community LOC for the month. Only encounter records with positive dollar amounts reported in the special feed encounter data after summing by service category, procedure code, and month of service were used. Table 91 details the process of identifying where an enrollee was located during each month of enrollment in the LTC program. It is intended that any programmer could replicate the location of care determinations for each enrollee based on the table.

Table 91. Enrollee Location of Care Determination Process.

Data Source	Step/ Purpose	Process
Medicaid eligibility data	Step 1: Identify LTC eligibility months	3) Search for all records in the eligibility data where the LTC enrolled variable contains an "N" or "W" indicator and the eligible month is in SFY 2015, SFY 2016, SFY 2017, SFY 2018, or SFY 2019.
		4) Create a LTC program enrollment indicator for all days in each LTC eligible month.
LTC encounter data	Step 2: Identify monthly LOC from encounter data	6) Sum encounter amounts for each enrollee identified in Step 1 by service category, procedure code, and month of service.
		7) Drop any records where the amount corresponding to a record from (1) is not a positive dollar amount.
		8) Classify any months from (2) as months with a NF LOC if the service category is L2.3, L2.4, L2.6, L2.7, L2.8, or L2.9. Classify any months from (2) as months with a HCBS LOC if the service category is not one of the six NF service categories.
		9) For those months that were not classified (i.e., those that did not have any encounter records with positive dollar amounts), classify them as NF or HCBS LOC if the month immediately before *and* the month immediately after are both NF or both HCBS months, respectively.
		10) Leave the remaining unclassified enrollment months as unknown LOC.
MDS data	Step 3: Identify which enrollees resided in a nursing facility each month based on MDS assessment records	8) Select MDS records for enrollees identified in Step 1.
		9) Identify entry and discharge dates and reasons for each enrollee in (1).
		10) Create indicators identifying temporary discharges and subsequent readmissions for those discharged with the expectation to return who subsequently returned from the same facility type for reasons 03, 04, 05, 06, 07, and 09.
		11) For non-discharge records where there is not a subsequent assessment completed within 107 days, classify the record as a discharge. *
		12) Create day-level NF LOC indicators for each day between an entry assessment and subsequent quarterly or discharge assessment (inclusive) that occurred within 107 days, between each quarterly assessment and subsequent quarterly or discharge assessment (incl.) that occurred within 107 days, as well as between each temporary discharge and corresponding readmission record (incl.).
		13) Merge (by enrollee-month) the indicators created in (5) with the LTC enrollment file created in Step 1.
		14) Set any LTC enrollment months where the enrollee spent at least half of the days in that month in a NF as a NF LOC month.
Files from Steps 2 & 3	Step 4: Create final Location of Care file	5) Merge the resulting datasets from Step 2 and Step 3 by enrollee-month.
		6) Set any month that received a NF LOC determination in Step 2 or Step 3 as a NF LOC month.
		7) Set any months that did not receive a NF LOC in Step 2 or Step 3 as a HCBS LOC month
		8) Output final Location of Care file.

*CMS requires facilities to complete an MDS assessment for residents every 90 days, with a 3-day grace period. The evaluation team allowed for an additional 2-week grace period until making the assumption that an enrollee no longer resided in a NF.

Question-Specific Methods

Research Question 3

Table 92. Full Model Results for Table 29.

Parameter	Estimate	Standard Error	*p*-value
Intercept	-1.6074	0.3942	<.0001
Unsuccessful Transition	1.0124	0.0540	<.0001
Successful Transition	-0.2742	0.0469	<.0001
Sex – Female	-0.0194	0.0315	0.539
Race – Black	0.1007	0.0406	0.0132
Race – Hispanic	0.2113	0.0498	<.0001
Race – Other	-0.0373	0.0563	0.5068
log(age)	-0.0219	0.0875	0.8022
Plan – American Eldercare-Humana	0.0266	0.0403	0.5085
Plan – Amerigroup	0.1195	0.0892	0.1805
Plan – Coventry (now Aetna Coventry)	-0.109	0.0729	0.135
Plan – Molina Healthcare	0.00219	0.0680	0.9743
Plan – Other (new plans as of SFY 2019)	-0.0549	0.1129	0.6269
Plan – UnitedHealthcare	-0.0552	0.0413	0.1813
Region – 1	-0.2949	0.0896	0.001
Region – 2	-0.2568	0.0852	0.0026
Region – 3	-0.2462	0.0693	0.0004
Region – 4	-0.5232	0.0682	<.0001
Region – 5	-0.2409	0.0634	0.0001
Region – 6	-0.3037	0.0635	<.0001
Region – 7	-0.3614	0.0636	<.0001
Region – 8	-0.5712	0.0767	<.0001
Region – 9	-0.2402	0.0655	0.0002
Region – 10	-0.3516	0.0751	<.0001
Region – Unknown	0.0454	0.5074	0.9288
Month of MDS Assessment	-0.0077	0.0009	<.0001
Fell	-0.0535	0.0416	0.1983
Bathing ADL score = 1	0.1018	0.1214	0.4018
Bathing ADL score = 2	0.0452	0.1275	0.7232
Bathing ADL score = 3	-0.0057	0.1173	0.961
Bathing ADL score = 4	-0.0688	0.1214	0.5707
Dressing ADL score = 1	-0.1293	0.1081	0.2315
Dressing ADL score = 2	-0.0835	0.1126	0.4587
Dressing ADL score = 3	-0.1138	0.1199	0.3426
Dressing ADL score = 4	-0.2289	0.1388	0.0991
Eating ADL score = 1	-0.0918	0.0383	0.0164
Eating ADL score = 2	-0.0517	0.0551	0.3476
Eating ADL score = 3	-0.1422	0.0560	0.0111
Eating ADL score = 4	-0.3348	0.0776	<.0001
Toileting ADL score = 1	0.0253	0.1117	0.8208
Toileting ADL score = 2	-0.0387	0.1211	0.7495
Toileting ADL score = 3	-0.0750	0.1269	0.5545
Toileting ADL score = 4	-0.1385	0.1395	0.3211

Table 92. Full Model Results for Table 29 (cont.)

Parameter	Estimate	Standard Error	*p*-value
Transfer ADL score = 1	0.2751	0.1013	0.0066
Transfer ADL score = 2	0.4338	0.1097	<.0001
Transfer ADL score = 3	0.6022	0.1147	<.0001
Transfer ADL score = 4	0.6658	0.1264	<.0001
Diagnosis – Cancer	-0.3237	0.2184	0.1384
Diagnosis – Heart/Circulatory	-0.7121	0.0375	<.0001
Diagnosis – Gastrointestinal	-0.1013	0.0853	0.2352
Diagnosis – Urinary	0.0329	0.0579	0.5694
Diagnosis – Infection	0.4542	0.0536	<.0001
Diagnosis – Metabolic	0.4129	0.0313	<.0001
Diagnosis – Musculoskeletal	-0.3540	0.0737	<.0001
Diagnosis – Neurological	-1.1737	0.0380	<.0001
Diagnosis – Nutritional	0.1786	0.0586	0.0023
Diagnosis – Psychiatric/Mood Disorder	-0.0791	0.0309	0.0106
Diagnosis – Pulmonary	0.1111	0.0444	0.0124
Diagnosis – Vision	-0.2256	0.1285	0.0792

Sources: FSU created enrollee LOC file, enrollee eligibility data (for demographic information), FL Center inpatient data, MDS assessments

Appendix C - Cost-Effectiveness of Care

Appendix C1: Study Design and Data

Data on LTC costs was used to create a set of measures for cost analyses. The data used for these measures include Medicaid encounter data and the CIRTS and MDS databases provided by the Agency. The time period included the months of LTC Program enrollees.

Methods

Cost-effectiveness, in principle, analyses the causal relation between inputs to final outcomes. Typically, this would be inputs as resources or cost thereof as cause (cost), and outcomes or revenues (effect). In principle, the cost of service (budget or blended rates) would be the input, and the number of service enrollees served by those dollar resources is the outcome. For the present analyses (first two research questions), inputs are enrollees where outcomes are payments made by AHCA or costs encountered by providers. In ratio format, cost-effectiveness is defined as:

$$Cost - effectiveness\ Ratio = \frac{Outcome}{Input}$$

In addition to the cost-effectiveness ratio, the cost analyses use comparative analyses calculated with the following equation, showing the year-to-year differences:

$$Cost.difference = Average\ Monthly\ Costs\ for\ LTC\ Services\ Provided_t - Average\ Monthly\ Costs\ for\ LTC\ Services\ Provided_{t-1}$$

The interpretation of cost-difference is equally straight-forward. Cost-neutral equals $0. A positive number would reflect an average monthly cost increase associated with the LTC program. A negative number would indicate cost savings.

Appendix C2a: Methodology Inflation Factors and Difference Analyses

Inflation is calculated as follows:

$$Inflation = \frac{\sum_{i=1}^{n}(\boldsymbol{Q}_{i,t-1}\ \mathbf{x}\ \boldsymbol{P}_{i,t}) - \sum_{i=1}^{n}(\boldsymbol{Q}_{i,t-1}\ \mathbf{x}\ \boldsymbol{P}_{i,t-1})}{\sum_{i=1}^{n}(\boldsymbol{Q}_{i,t-1}\ \mathbf{x}\ \boldsymbol{P}_{i,t-1})}$$

where:

n = number of observations of a specific service,

Q = the number, weight, or frequency (of a specific service) on each specific price level,

P = the various cost/price levels of the specific service,

t = period indicator (where the suffix -1 is a previous period, no matter what time period is taken),

$$Nonimal\ Price\ difference\ = \frac{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t}\ x\ P_{i,t}}) - \sum_{i=1}^{n}(\boldsymbol{Q_{i,t}\ x\ P_{i,t-1}})}{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t-1}\ x\ P_{i,t-1}})}$$

where inflation is part of the service nominal price difference:

$$Nominal\ Price\ difference - Inflation = Real\ Price\ difference$$

and

$$Quantity\ difference\ = \frac{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t}\ x\ P_{i,t-1}}) - \sum_{i=1}^{n}(\boldsymbol{Q_{i,t-1}\ x\ P_{i,t-1}})}{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t-1}\ x\ P_{i,t-1}})}$$

where:

$$Quantity\ difference + Nominal\ Price\ difference = Total\ Value\ difference$$

or

$$Quantity\ difference + Real\ Price\ difference + Inflation = Total\ Value\ difference$$

or

$$Total\ Value\ difference = \frac{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t}\ x\ P_{i,t}}) - \sum_{i=1}^{n}(\boldsymbol{Q_{i,t-1}\ x\ P_{i,t-1}})}{\sum_{i=1}^{n}(\boldsymbol{Q_{i,t-1}\ x\ P_{i,t-1}})}$$

Appendix C2b: Methodology Shift-share Analyses

Shift-share Analyses breaks out cost into three effects:

within effect $= (DC_t - DC_{t-1}) / \left(\frac{\sum Place\ of\ Service\ members_t}{\sum All\ LTC\ program\ members_t}\right)$

$\text{shift} - \text{share effect} = DC_t * \left(\frac{\sum Place\ of\ Service\ members_t}{\sum All\ LTC\ program\ members_t} - \frac{\sum Place\ of\ Service\ members_{t-1}}{\sum All\ LTC\ program\ members_{t-1}}\right)$

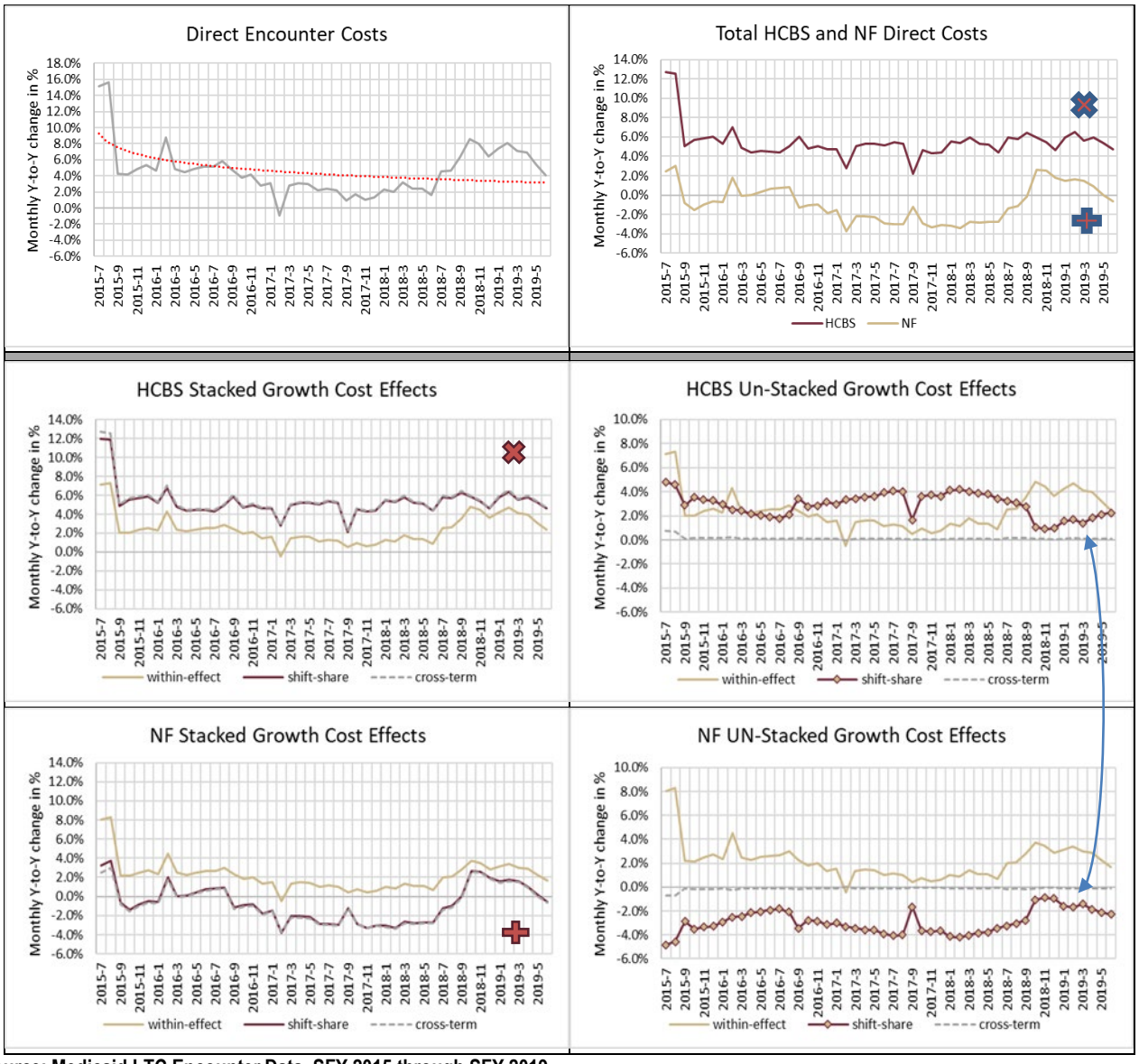
cross-term effect $= (DC_t - DC_{t-1}) / \left(\frac{\sum Place\ of\ Service\ members_t}{\sum All\ LTC\ program\ members_t} - \frac{\sum Place\ of\ Service\ members_{t-1}}{\sum All\ LTC\ program\ members_{t-1}}\right)$

where:
DC = Direct Cost
t = period indicator (where the suffix -1 is a previous period, no matter what time period is taken)

Appendix C3: Further Results on Direct Encounter Cost Shift-share Analyses; Nursing Facilities and in Home and Community Based Services.

Figure 15a, shows the overall direct encounter cost per month (year-to-year comparisons), this according to the Medicaid encounter data. Figure 15b shows the same direct cost growth broken out in the two service categories, HCBS (cross mark) and NF (add sign). Addition of the two direct cost will bring back the result as shown in Figure 15a. The two figures below to the left-hand side; Figure 15c and Figure 15e, show each direct services cost (as per Figure 15b) broken out according to the tool of shift-share analyses. In both figures, the respective broken out lines are stacked, and where the sum is identical with the direct service cost as per Figure 15b. Only in the unstacked depiction of the two figures on the right-hand side, Figures 15d and 15f, does one see the shared cost component as mirror images (see arrow), being the shift in costs between the two services NF and HCBS.

Figure 15. Direct Encounter Costs Shift-share Analyses, SFY 2016 through SFY 2019.



Source: Medicaid LTC Encounter Data, SFY 2015 through SFY 2019

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