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Medicaid Managed Care – an eye on Florida and the US
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The managed care takeover of states' Medicaid funded long term care systems has resulted in a general acceptance of the private, for profit, centralized model of care with a goal of moving care into the community and away from nursing homes. Forty states now have Medicaid Managed Care involved in their long term care systems. The stated intent was to have better budget control and increased services to the growing boomer population that will double to 84 million by 2050; the 85+ population will triple to 15 million by 2040. (National Governor's Association, March 2019)

Medicaid is the primary payer for long term care services with Medicare only covering brief stays in long term care hospitals and skilled nursing home facilities. An important consideration is that nursing home care is considered an "entitlement" while home and community based services are not. Florida has maintained a cap on home and community based slots at 62,500 annually with CMS approval. This is why Florida is allowed to maintain a wait list for community-based services. In fact, Florida has one of the longest wait lists in the country as the state has successfully ratcheted down the institutional rate in Florida from 54% in 2014 to 43% in 2019.

The managed care takeover of states' Medicaid funded long term care (LTC) systems has generated several recurring concerns. A major concern is the lack of consistently reported encounter data on how many people are provided specific services, nor is there good service intensity data provided. For many years Florida key informants reported on the cost effectiveness of the Aging nonprofit network's home and community based services programs. In fact, the April 19, 2010 St. Pete Times article by Steve Nohlgren was entitled "Florida House Ignores Own Analysts Who Warn of Pushing elderly to Managed Care." The HMO's convinced the Florida Legislature and the Governor that they could reduce nursing home admissions and produce a 5% savings by redirecting persons to community based care. The Agency for Health Care Administration moved quickly in 2012 to build the framework for the managed care takeover.

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

Florida now has a growing wait list of over 70,000 frail seniors in need of home and community based services. Many advocates originally concerned about the diminishing role of the Aging

Network providers if they were excluded from the Medicaid Managed LTC system in Florida and other states have now seen this happen. The FSU Claude Pepper Center continues to research the literature and collect key informant information around these concerns for access and care quality in the Medicaid LTC program.

The multiple evaluations conducted by states such as Florida and those funded by the Centers for Medicaid and Medicare Services (CMS), as well as the recent critique of the Research Triangle Institute's multi-state evaluations of the dual eligible managed care programs by Community Catalyst, the Commonwealth Foundation and CMS are hindered in their assessments of cost effectiveness by the continued lack of Medicaid encounter data not reported by the managed care companies.

The five year evaluations of the Florida Medicaid Managed Long Term Care program have been challenged by the limits of encounter data that fail to report the intensity of services received. The first evaluation does not reflect any encounter data, so there is no real understanding of quality of services or of the number and/or types of services per capita received.

The second state evaluation (2017) also suffered from a lack of accurate encounter data. The report's own recommendations in Deliverable 16 summarize the need for improved reporting: *Page 63, Recommendations:* "Improve encounter record reporting. The inability to evaluate the changes in services per person before and after the LTC managed care program implementation is a major omission. The cost effectiveness and the quality of services are not really evaluated without the encounter data."

The third evaluation (2018) has limited encounter data reported by some of the health plans, but the data still does not permit the accurate measurement of the intensity of services provided. As reported in the "Independent Assessment of the Florida Statewide Medicaid Managed Care Long Term Care Program", Deliverable 12, MED 186, August 29, 2018: "increasingly higher proportions of LTC enrollees have received services…however, the trend in the level of service use intensity…remains unknown." Since this type of data is not known, the evaluators used a definition of service utilization as "number/proportion of enrollees for a given service." A person just has to receive one unit of service in a month to be counted as a service recipient. This limitation of encounter data on service intensity continues through to 2020.

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

The Florida Agency for Health Care Administration should follow the guidance provided by the Florida State University evaluators in the earlier evaluations of the MMLTC program: 1) to improve encounter record reporting especially on units of services provided; 2) conduct more analyses at the plan and regional levels to understand the differences that impact service capacity; 3) assess what the different plans have done to improve quality of care; 4) improve the

health plans reporting on case management for the evaluators have been unable to determine if the problem is with the data reporting or if the case management has been done.