Extension Request for Florida's 1115 Managed Medical Assistance Waiver

Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration

Presented at the October 2013
Public Input Meeting

Federal Waiver Authorization

- **Initial 5-Year Period** (2006-2011): On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named “Medicaid Reform” was approved by the Centers for Medicare and Medicaid Services (Federal CMS). The program was implemented in Broward and Duval Counties July 1, 2006 and expanded to Baker, Clay and Nassau Counties July 1, 2007.

- **Three-Year Extension Period** (2011-2014): An extension of the waiver was granted by Federal CMS to maintain and continue operations for the current program for the period December 16, 2011 to June 30, 2014.

- **Managed Medical Assistance Amendment** (2013): The amendment to implement the Managed Medical Assistance program as authorized Florida Statutes, was granted by Federal CMS on June 14, 2013.

1115 Research and Demonstration Waivers

- Experimental, Pilot or Demonstration Projects.
  - Benefit Packages, Reimbursement Methodologies, Covering Expanded Groups.
  - States Commit to a Policy Experiment that must be Formally Evaluated.
- 1115(a)(1) allows the Secretary to waive compliance with most of the requirements in the Medicaid and SCHIP State Plans.
- 1115(a)(2) allows the Secretary to regard as expenditures costs that would not otherwise be matchable under Medicaid or SCHIP.
- If granted, the initial approval period is 5 years and the State may request two 3 year extensions of the program.

Extension of the 1115 Waiver

- The current waiver authority expires June 30, 2014.
- The Florida Legislature has directed the Agency in Part IV of Chapter 409, Florida Statutes, to obtain approval of any state plan or waivers necessary to implement the MMA program.
- The extension of the waiver will allow continued operation of the MMA program to be implemented in 2014.
- Experience to date shows that operational changes can be made within the framework of the approved waiver in response to public input.

Extension of the 1115 Waiver

- **Federal Waiver Extension Requirements**: Florida is required to publish on the Agency's website a "Public Notice" document for public input 30 days prior to submitting the waiver extension request. The document must include a comprehensive description of the program and the information outlined on the next slide.
- The public notice document is available at the following link for review and comment from October 1 to October 30, 2013.

  http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA
- Written comments may be e-mailed to FLMedicaidWaivers@ahca.myflorida.com or mailed to:

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Elements of the Public Notice Document

- Program description, goals and objectives.
- Proposed health care delivery system and eligibility requirements, benefit coverage and cost sharing required of individuals impacted by the waiver.
- Estimate of expected increase or decrease in annual enrollment and annual aggregate expenditures.
- Hypothesis and evaluation parameters of the waiver.
- Specific waiver and expenditure authorities.
- Locations and Internet address where the public notice document is available for public review.
- Postal and Internet e-mail addresses where comments may be submitted and reviewed by the public for a minimum of 30-days.
- The location, date and time of at least two public hearings held to solicit public input on the waiver extension request.

Elements of the Waiver Extension Request

- Historical narrative summary of the demonstration project.
- Documentation of compliance with special terms and conditions of the waiver.
- List of waiver and expenditure authorities requested .
- Summary of quality activities under the waiver.
- Documentation of compliance with budget neutrality cap and financial data.
- Evaluation report including evaluation activities and findings to date.
- Documentation of public process in accordance with federal and state regulations.

Current Programs – Primary and Acute Care

- **1115 Managed Medical Assistance Waiver:**

  The current program, Medicaid Reform, operates in Broward, Duval, Baker, Clay and Nassau Counties until implementation of the MMA program by region in 2014. Most Medicaid eligibles are required to enroll in a health plan (either a capitated plan or a fee-for-service provider service network) for their primary and acute care services as a condition for receiving Medicaid.

- **1915(b) Managed Care Waiver**:

  The original waiver was approved in January 1990 which allowed for the implementation of the MediPass program to coordinate primary and acute care services for eligible recipients. Since implementation, the waiver evolved into a variety of managed care options including managed care organizations, primary care case management programs, prepaid inpatient health plans and prepaid ambulatory health plans.

MMA Program - Goals

The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers, as well as higher standards and more significant accountability measures for plans. The program goals include:

- Improving coordination of health care in the most appropriate and cost-effective setting;
- Fostering personal responsibility and rewarding healthy behaviors; and
- Reducing fraud, abuse and waste.

MMA Program – Objectives

- Improved program performance by expanding key components of managed care statewide, while strengthening accountability for improved patient outcomes and preserving meaningful choices.
- Improved access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Enhanced fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems and shared savings model.
- Use of the expertise of MCOs to provide all coverage and services for medical assistance.
- Provide a choice of competitively selected managed care plans providing enhanced individual choice.
- Stabilize plan participation by competitively procuring high quality plans on a regional basis, extending plan contract period to five years and imposing penalties for plan withdrawals.

Consumer Protections

- Increasing recipient participation on Florida's Medical Care Advisory Committee (MCAC) and convening smaller advisory committees to focus on key special needs populations;
- Ensuring the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan (no more than 60 calendar days after the effective date of enrollment);
- Ensuring immediate review of recipient complaints, grievances and appeals for resolution as part of the rapid cycle response system;
- Establishing Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requiring plans offer a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan;

Consumer Protections

- Requiring Florida's External Quality Review Organization (EQRO) to validate each plan's encounter data every three years;
- Enhancing the plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health and reducing per capita Medicaid expenditures;
- Enhancing metrics on plan quality and access to care to improve plan accountability; and
- Creating a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

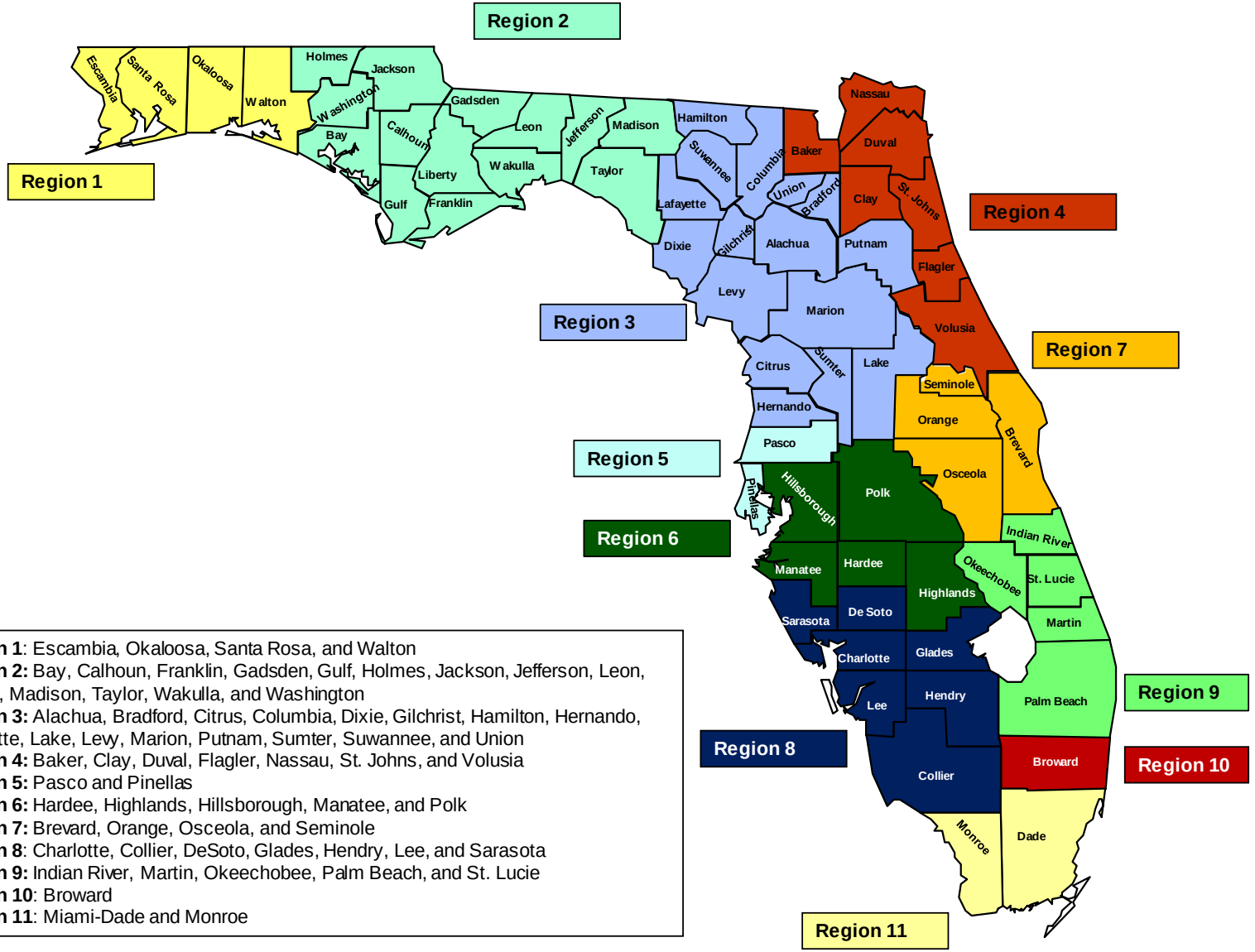
The MMA Program does not/is not:

- The program ***does not*** limit medically necessary services.
- The program ***is not*** linked to changes in the Medicare program and does not change Medicare benefits or choices.
- The program ***is not*** linked to National Health Care Reform, or the Affordable Care Act passed by the U.S. Congress.
  - It does not contain mandates for individuals to purchase insurance.
  - It does not contain mandates for employers to purchase insurance.
  - It does not expand Medicaid coverage or cost the state or federal government any additional money.

MMA Program – Key Elements

- Risk-Adjusted Premiums – is a process which predicts health care expenses from diagnoses, age, gender, and other factors. It allows distribution of payments to health plans based on the health risk of their enrollees resulting in more efficient use of Medicaid dollars by better matching payment to risk.
- Healthy Behaviors – the plans will each establish a program to encourage and reward healthy behaviors. Each plan will have, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan.
- Low Income Pool – will be maintained by the state to provide direct payment and distributions to safety net providers for the purpose of providing coverage to Medicaid, the uninsured and underinsured populations.

Statewide Medicaid Managed Care Regions Map



Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

MMA Program – Competitive Procurement

The Agency initiated separate but simultaneous procurements in all 11 regions of the state. The law establishes criteria for preference in reviewing Invitation to Negotiate (ITN) respondents, including:

- Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body;
- Experience serving similar populations, including achieving specific quality standards with similar populations;
- Availability and accessibility of primary care and specialty physicians in network;
- Establishment of community partnerships;
- Commitment to quality improvement;
- Provision of additional benefits, particularly dental care and disease management and other initiatives that improve health outcomes; and
- Documentation of policies for preventing fraud and abuse.

MMA Program – Notice of Intent of Award

- Released ITN on December 28, 2012, with final bids due from potential plans on March 29, 2013.
- Received 182 submissions from 27 health plans responding to the 11 Regional MMA ITNs.
- Posted Notice of Intent to Award on September 23, 2013 contracts with competitively selected managed care plans. To view the selected managed care plans visit the following link:

  http://www.myflorida.com/apps/vbs/vbs_www.search_r1.matching_ads_page

- 12 plans initially filed a Notice of Intent to Protest the intended awards and the Agency is prepared to respond to any formal protests, if filed.

MMA Program – Eligibility

Mandatory Participants – All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted.

Voluntary Participants – The following individuals may choose to enroll in program:

i. Individuals who have other creditable health care coverage, excluding Medicare;

ii. Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

iii. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); and

iv. Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients.

MMA Program – Eligibility

Excluded Participation – The following groups are excluded from program enrollment:

i. Individuals eligible for emergency services only due to immigration status;

ii. Family planning waiver eligibles;

iii. Individuals eligible as women with breast or cervical cancer; and

iv. Children receiving services in a prescribed pediatric extended care facility.

MMA Program – Covered Services

Minimum Required Covered Services: Managed Medical Assistance Plans	
Advanced registered nurse practitioner services.	Medical supply, equipment, prostheses and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exception)	Podiatric services
Healthy Start Services (some exception)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

MMA Program – Covered Services

- Plans are authorized to customize their benefits packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services.
  - The Agency is required to evaluate the proposed benefit package to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.
- Certain services are excluded from the plan benefit packages and are "carved out" to remain under the fee-for-service system.
  - Services provided in a prescribed pediatric extended care facility.
  - Provision of anti-hemophilic factor replacement products to recipients diagnosed with hemophilia through the Agency's hemophilia disease management program.

Added Value/ Benefits

- The Agency negotiated added value/benefits with selected managed care plans in the Managed Medical Assistance portion of the Statewide Medicaid Managed Care program.
- Areas where added value/benefits were achieved include:
  - Expanded benefits
  - Enhanced network adequacy standards
  - Establishing minimum thresholds for electronic health records (meaningful use) adoption
  - Enhanced standards related to claims processing, prior authorization, and enrollee/provider help line (call center operations).

Expanded Benefits

List of Expanded Benefits	# of Plans Offering
Expanded adult dental services	9
Expanded primary care visits for non-pregnant adults	10
Expanded home health care for non-pregnant adults	8
Expanded physician home visits	7
Expanded prenatal/perinatal visits	9
Expanded outpatient hospital services	8
Over the counter medication and supplies	9
Waived co-payments	9
Expanded vision services	10
Expanded hearing services	8
Newborn circumcisions	9
Pneumonia vaccine	9
Influenza vaccine	10
Shingles vaccine	8
Post-discharge meals	8
Nutritional counseling	8
Pet therapy	2
Art therapy	4
Equine therapy	1
Medically related lodging & food	5

Network Adequacy Standards

- The managed care plans agreed to enhanced network adequacy standards, which include:
  - Increasing the number of primary care and specialist providers in a region that are accepting new Medicaid enrollees;
  - Increasing the number of primary care providers that that offer after hour appointment availability; and
  - Establishing utilization rates for out-of-network specialty care and hospital admissions.

Electronic Health Records

- The Agency selected plans that were committed to assisting the Agency in our efforts to increase electronic health record adoption.
  - Managed Care Plans agreed to establish thresholds for the number of physicians and hospitals that would adopt meaningful use standards by the end of the second contract year.
  - Managed Care Plans agreed to establish thresholds for the number of enrollees who are assigned to primary care providers meeting meaningful use requirements.

Additional Enhanced Standards

- **Claims processing:** The Agency negotiated more timely claims processing timeframes than are required in state and federal regulations.
  - Examples:
    - Selected managed care plans will pay, deny, or contest electronic claims within 15 calendar days.
    - Selected managed care plans will pay, deny, or contest paper claims within 20 calendar days.
    - Selected managed care plans agree to pay 50% all clean claims within 7 calendar days of receipt.

Additional Enhanced Standards

- **Prior Authorization:** Selected managed care plans agreed to process standard and expedited prior authorization requests more timely. For many of the standards, the timeframes for processing the authorization request have been reduced by almost half.

- **Enrollee/Provider Help Line:** Selected managed care plans agreed to adhere to more stringent call center performance standards. Areas where we achieved added value include: reduced time for the average speed to answer, reduced call blockage rates, reduced call abandonment rates, and reduced wait times for calls placed in the queue.

New Contracting Requirement

- Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. (Section 409.967 (2)(a), F.S.)
  - The Agency may impose fines or other sanctions including liquidated damages on a plan that fails to meet this performance standard after 2 years of continuous operation.

Timeline of Recipient Plan Choice

- The outreach schedule is being developed and the Agency will inform individuals about their choices.
- Recipients will have 30 days to select a plan.
  - If no plan is selected, the Agency will assign the recipient to a plan.
- Recipients will have 90 days after plan enrollment to disenroll without cause and select another plan.
- Recipients can change plans at other times if good cause (as defined in state law and the waiver) exists.

MMA Program – Choice Counseling

- Access to make enrollments and plan changes will be available 24 hours per day, year round using the internet and Automated Voice Response System (AVRS).
- The Agency and our contracted enrollment broker, Automated Health Systems, will provide focused face-to-face choice counseling to special needs and high-risk recipients.
- The recipient enrollment portal will be enhanced to allow recipients to view copies of their communications via the internet as well has their eligibility and enrollment information.

MMA Program – Quality Initiatives

- MMA plans will be required to conduct performance improvement projects related to prenatal and postpartum care as well as well-child visits and pediatric dental care.
- Consumer report cards will be developed to provide information on plan performance to enrollees and other stakeholders on access to, quality, and timeliness of care.
- Plans that perform well on performance measures may receive an incentive tied to the achieved savings rebate.
- Plans performing below standards on performance measures may be subject to liquidated damages and/or sanctions.

Comprehensive Quality Strategy

Federal law requires all states to create and update a quality assessment and improvement strategy for their Medicaid managed care programs. With the approval of the MMA amendment, Florida is updating its strategy to a Comprehensive Quality Strategy (CQS). The CQS:

- Describes Florida Medicaid's strategy for measuring and improving quality
- Includes quality improvement initiatives for managed care and non-managed care.

Comprehensive Quality Strategy

- Describes steps being taken to improve quality of care under MMA, including enhanced accountability through:
  - Additional performance standards,
  - Provider network requirements,
  - Selective contracting with quality plans,
  - Implementation of an achieved savings rebate,
  - Consumer report cards for recipients on FloridaHealthFinder.gov, and
  - Greater emphasis on comprehensive, coordinated care for all recipients.
- Will be reviewed and updated annually, reflecting input received from the Medical Care Advisory Committee and other stakeholders.

MMA Program – Encounter Data

- Encounter data, an alternative claims data source, is required from all plans under the MMA program.
- Accurate and complete encounter data are critical to the success.
- Quality encounter data is used to set capitation rates, establish performance metrics, and generate accurate and reliable reports on utilization and cost information.
- Health plans are required:
  - To have data systems capable of submitting encounter data in accordance with industry standards;
  - To review and attest to the validity of encounter data prior to submission; and
  - To provide encounter data to the Agency no later than 7 calendar days following the plans' adjudication date.

MMA Program – Plan Accountability

- **Penalties for plan withdrawal**:
  - Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the Agency for the cost of enrollment changes and other transition activities.
    - If a plan leaves a region before the end of the contract term, the Agency will terminate all contracts with that plan in other regions.

MMA Program – Plan Accountability

- **Penalties for failure to submit encounter data**:
  - Managed care plans that fail to comply with encounter data reporting will be assessed a fine of $5,000 per day for each day of noncompliance beginning on the day 31.
    - Contract termination on day 90 if not in compliance.
    - Termination of all regional contracts held by the plan if the Agency terminates more than one regional contract due to noncompliance with encounter data requirements.

MMA Program
Evaluation and Performance

- MMA plans are required to submit audited performance measures annually.
- Required performance measures include both process and outcome measures in the areas of: behavioral health and substance abuse; well child care; prenatal and postpartum care; chronic and acute care; and preventive care.
- MMA plans are required to contract with a vendor to conduct surveys of enrollees' experiences and satisfaction with care annually, as well as provider satisfaction.
- Performance measure and enrollee survey results will be available on FloridaHealthFinder.gov.

MMA Program – Implementation

- Outreach activities are anticipated to begin January 1, 2014 with full program implementation occurring on or before October 1, 2014.
  - Mandatory recipients will transition into the plans on a staggered basis in 2014.
  - The implementation plan and schedule will be posted on the Agency's website.

Low Income Pool

- The LIP program was initially implemented effective July 1, 2006.
- The LIP program currently consists of an annual allotment of $1 billion, funded primarily by intergovernmental transfers from local governments matched by federal funds.
- Payments are made to qualifying Provider Access Systems, including hospitals, federally qualified health centers and county health departments working with community partners.
- The objective of LIP program is to ensure support for the provision of health care services to Medicaid, underinsured and uninsured population.

1115 Waiver – Additional Programs

On January 1, 2014, the following programs that are currently authorized under the 1915(b) Managed Care Waiver will transition to the 1115 MMA Waiver. The programs will continue to operate as they do today and will be available statewide.

- The Healthy Start program;
- The Program for All Inclusive Care for Children (a component of the Children's Medical Services Network); and
- The Comprehensive Hemophilia program.

Public Input and Program Improvements

- Florida Medicaid is open to feedback from any stakeholder, including recipients, providers, advocates and researchers.
- Based on feedback, Florida Medicaid will take advantage of opportunities to adapt and improve.
- Recommendations and suggestions regarding the program will be considered in response to public input, as appropriate.
- If the Agency receives comments that would require legislative action, we will review and make them available to the Legislature.

Begin Public Comment Period

Supplemental Information: Medicaid Overview

The Federal Medicaid Program

- Federal Medicaid laws and regulations mandate certain benefits for certain populations and states must administer their programs under federally approved state plans.

- To participate, states are required to cover certain mandatory populations and services, while federal matching funds are available if a state chooses to cover other optional populations and services.

The Federal Medicaid Program

- States must submit a Medicaid State Plan to the Centers for Medicare and Medicaid Services (CMS) and administer their programs under federally approved state plans.
- The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the State program receives matching federal funds under Title XIX of the Social Security Act.
- Services must be available statewide in the same amount, duration and scope.
  - Cannot choose to provide a service in only one geographic area.
  - Cannot have a higher service limit for a certain group of recipients (with the exception of children.)

The Florida Medicaid Program – Prior to SMMC

- There are approximately 113,000 Florida Medicaid enrolled individual providers and facilities offering health care services as well as 60 Medicaid managed care plans.
  - 21 Health Maintenance Organizations (HMOs)
  - 9 Provider Service Networks (PSNs)
  - 17 Nursing Home Diversion – Managed Care Plans
  - 11 Prepaid Mental Health Plans
  - 2 Prepaid Dental Health Plans
- Medicaid's contracted Fiscal Agent processes approximately 135 million claim lines every year.

The Florida Medicaid Program

- Florida is the fifth largest state in terms of Medicaid expenditures, with estimated spending of nearly $22.9 billion for fiscal year 2013-2014 (July 2013 through June 2014).

- Approximately 3.4 million Floridians are enrolled in the Florida Medicaid program. They are elders, disabled people, families, pregnant women and children in low-income families.

- Florida has the fourth largest Medicaid population in the country.

Florida Medicaid Mandatory Services

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation

Florida Medicaid Optional Services*

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management

*States are required to provide any medically necessary care required by child eligibles.