Post Award Forum for Florida's 1115 Managed Medical Assistance Waiver

Presented at the October 13, 2015

Medical Care Advisory Committee Meeting

Medicaid

- Medicaid is a federal/state partnership jointly financed by state and federal funds.
- If a state chooses to participate in the Medicaid program, they must abide by certain federal rules.
- Medicaid is an "entitlement" program, which means that anyone who meets eligibility rules has a right to enroll and receive medically necessary services for which they qualify.

Medicaid

- Federal law requires the coverage of certain eligibility groups and services (mandatory groups and services), and states have the option of covering additional eligibility groups and services (optional groups and services).
- State legislatures may change Medicaid eligibility, services, and/or reimbursement at any time, within the federal parameters.
  - Must maintain minimum mandatory eligibility groups and services
  - Must provide all medically necessary services to children and pregnant women
- States cannot stop providing services or freeze eligibility based on an expenditure cap.

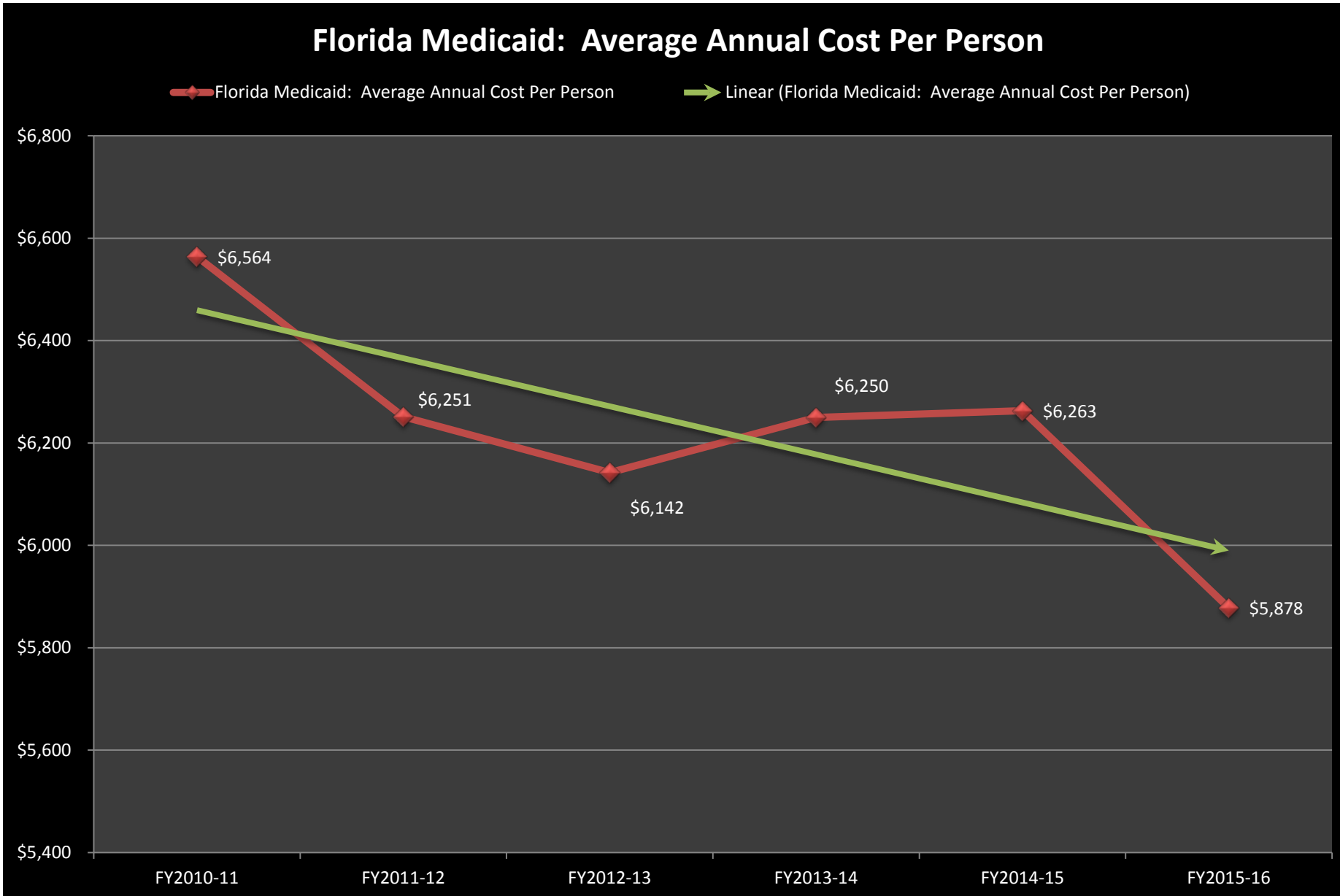
Medicaid

- States have several main ways to control program costs:
  - Reduce reimbursements to providers
  - Eliminate optional services for adults
  - Eliminate optional eligibility groups
  - Implement delivery system reform
- Florida most recently has implemented delivery system reform through the Statewide Medicaid Managed Care program.

Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both of the components of the Statewide Medicaid Managed Care (SMMC) program:
  - Long-term Care program
  - Managed Medical Assistance program.
- Implemented during 2013 and 2014.
- Designed to incentivize higher quality without causing inflation.

Florida Medicaid: Average Annual Cost Per Person



FY 2013-14 and prior data is from the final year end budgets.
FY 2014-15 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC
FY 15-16 Medicaid Expenditures data from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

SMMC Program Goals

- The goals of the Statewide Medicaid Managed Care Program are:
  - Improve coordination of care
  - Improve the health of recipients, not just paying claims when people are sick
  - Enhance accountability
  - Allow recipients a choice of plans and benefit packages
  - Allow plans the flexibility to offer services not otherwise covered
  - Enhance prevention of fraud and abuse through contract requirements.

SMMC Program Design

- Plan Choice
  - Choice Counseling
  - HMOs and Provider Service Networks
  - Comprehensive Plans
  - Specialty Plans in MMA
  - Accredited Plans
- Added Benefits
  - Choice of Benefit Package
  - Expanded Benefits
- Enhanced Access
- Enhanced Quality Measures
- Increased Transparency
- Risk Adjusted Rates

Plan Choice

- In addition to the availability of standard plans and comprehensive plans, the following specialty plans types are available under the MMA component of the SMMC program:
  - Child Welfare
  - Children's Medical Services Network
  - HIV/AIDS
  - Serious Mental Illness

Plan Choice

- MMA Plan Accreditation
  - Each health plan is accredited by a nationally recognized accrediting body.

Added Benefits

- Expanded Benefits:
  - The Agency negotiated with health plans to provide extra benefits at no cost to the state. These benefits include:
    - Adult dental
    - Hearing and vision coverage
    - Outpatient hospital coverage
    - Physician coverage, among many others.

Enhanced Access

- Network Adequacy Standards
  - Time and distance standards
  - Ratios of patients to providers
  - Increasing the number of primary care and specialist providers accepting new Medicaid enrollees
  - Increasing the number of primary care providers that offer appointments after normal business hours
  - Extremely low level of complaints/issues.

Enhanced Access:
Increased Physician and Dental Provider Participation

Dental Providers	November 2013	June 2015	Total % Change from Nov-2013 to Jun-2015
Total Participating FFS Fully Enrolled MDs and DOs	35,317	37,076	4.98%
Total Participating Registered MDs and DOs	4,382	5,573	27.18%
Total Participating MDs and DOs	39,699	42,649	7.43%
Total Participating FFS Fully Enrolled Dentists	1,414	1,544	9.19%
Total Participating Registered Dentists	470	775	64.89%
Total Participating Dentists	1,884	2,319	23.09%

Source: These data were pulled from the monthly DSS provider enrollment reports.

Enhanced Transparency

- Centralized Complaint Hub:
  - Allows the Agency to streamline and better track and respond to all complaints and issues received.
  - Provides a mechanism to review trends related to specific issues, or complaints against specific plans.

Enhanced Transparency

- SMMC Quarterly Reports:
  - The Agency is releasing a series of quarterly reports that will provide up-to-date information on the progress of the SMMC program.
  - The first two reports are available on the Agency's website.
  - The Agency will continue to provide analyses of the program through these reports that will provide insight into:
    - the program's cost effectiveness
    - quality of care, and
    - other significant aspects of the program.

Enhanced Transparency

- Health Plan Report Cards:
  - Enrollees can now choose plans based on quality.
  - In early 2015, Medicaid began publishing a consumer-focused Medicaid health plan report card.
  - The report card includes annual ratings on how Florida's health plans are doing on getting children into well-child visits and getting pregnant women into prenatal care.

Enhanced Quality

- Encounter Data:
  - Encounter data are electronic records of services provided to Medicaid enrollees by a capitated health plan.
  - Encounter data are submitted in a federally-mandated HIPAA-compliant format from health plans to the Florida Medicaid Management Information System.
  - The Agency has collected encounter data since 2008, but the data will be used more prominently in the SMMC program.
  - The Agency will use encounter data to monitor plans on a variety of metrics to ensure performance and quality measures are being met.

Enhanced Quality

- HEDIS Data and Information Set:
  - HEDIS = Healthcare Effectiveness Data and Information Set
  - HEDIS is the National Committee for Quality Assurance's (NCQA) standardized set of performance measures.
  - Used by over 90% of health plans in the U.S.
  - Detailed technical specifications ensure that measures are calculated consistently.
  - Allows "apples-to-apples" comparison of health plans.

Enhanced Quality

- HEDIS Audit:
  - NCQA certifies HEDIS auditors who must review the health plan's capability for collecting, storing, analyzing, and reporting health information.
  - HEDIS auditors determine if health plans have followed the HEDIS technical specifications and Agency requirements for performance measures.
  - The Agency requires that health plans undergo a HEDIS audit by a certified auditor and submit a final audit statement along with their performance measure report.

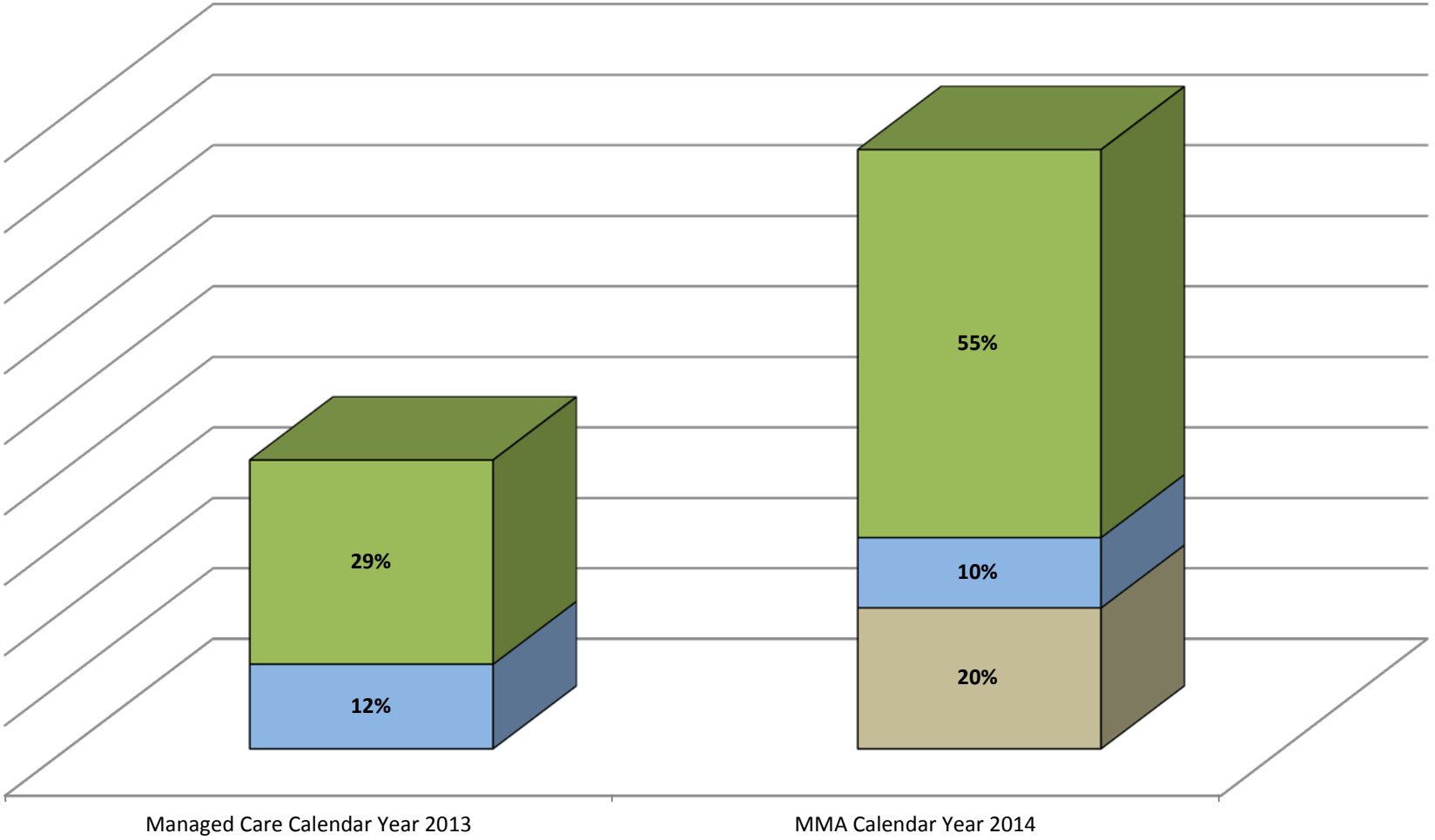
Enhanced Quality

- HEDIS National Means and Percentiles:
  - Published by NCQA annually.
  - Reports national benchmarks and thresholds for HEDIS measures.
    - Includes 10th, 25th, 50th, 75th, and 90th percentiles
    - The Agency also calculates the 40th and 60th percentiles for our use
  - Calculated based on data from all health plans who report data to NCQA for the previous calendar year (e.g., 2014 national means and percentiles are calculated using calendar year 2013 reported data).
  - The Agency compares each health plan's performance measure rates to the HEDIS national means and percentiles.
    - For each measure where the health plan's rate falls below the 50th percentile, the plan may receive liquidated damages.

Enhanced Quality

- Determining HEDIS Scores:
  - Florida Medicaid health plans submit their eligible member, denominator, numerator, and rate data for measures predetermined by the Agency for the previous calendar year by July 1 of each year.
  - Scores for each measure are aggregated to come up with a weighted mean for all Florida Medicaid health plans.
  - For HEDIS measures that health plans are required to report to the Agency each year, plans are to refer to the current year's technical specifications manual which includes information on how to calculate the eligible population, denominator, and numerator based on diagnosis codes and other factors.

Enhanced Quality:
HEDIS Compared to the National Mean



Note: If non-reform and Reform are separated when calculating the percentage of "the scores below the National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013", the overall percentage would be 14%.

Current Waiver – MMA Program

- The waiver implemented the Managed Medical Assistance (MMA) program, a component of the Statewide Medicaid Managed Care, as authorized in Florida law and in accordance with the Special Terms and Conditions of the waiver.
- The waiver authority expires June 30, 2017.
- The waiver authorized the continuation of the Low Income Pool program until June 30, 2015.
- The waiver authorizes the continuation of three additional programs:
  - Healthy Start program;
  - Program for All Inclusive Care for Children (a component of the Children's Medical Services Network);
  - Comprehensive Hemophilia program.

1115 MMA Amendments

Federal Waiver Amendment Requirements: Florida was required to conduct a 30-day public notice period and publish on the Agency's website a "Public Notice" document for public input.

The Agency submitted three amendments to the 1115 MMA waiver this year. The following slides provide a brief description of each amendment.

Amendment: Expand Populations That Can Choose MMA

- Medicaid-eligible recipients residing in group home facilities licensed under section 393.067, Florida Statutes and Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services can voluntarily enroll in MMA.

Amendment: Express Enrollment

- Individuals who are mandated to participate in Florida's MMA program will be enrolled in an MMA plan immediately after their Medicaid eligibility determination.
- Recipients will have 120 days following enrollment in an MMA plan to change plans.

Amendment: Low Income Pool (LIP)

- Redesign elements of the Low Income Pool (LIP) and extend the program until June 30, 2017.
- The redesigned LIP ensures access to care for low income populations that are not eligible to participate in Medicaid or other subsidized coverage programs and complements the MMA program by strengthening connections between critical safety net providers and the MMA program.

Waiver Evaluation

- The independent evaluation of the waiver is being restructured to end portions of the evaluation that are no longer relevant and to add evaluation elements related to the amendments.
- Discussions on the evaluation design are still underway.

We Value Your Input!

- What worked?
- What didn't work?
- Where can we improve?