Statewide Medicaid Managed Care

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Agency for Health Care Administration

Medical Care Advisory Committee Meeting
January 19, 2016

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1. Amendment Request for Florida's 1115 Managed Care Waiver
2. Statewide Medicaid Managed Care Program Update

Amendment Request for Florida's 1115 Managed Medical Assistance Waiver

Introduction (not on screen)

- Welcome. There is a sign in sheet as you come in the door, if you sign in and include an email address, we will add you to our interested parties list.
- The purpose of this meeting it to obtain public comment regarding the proposed amendment to the 1115 Waiver which authorizes the Managed Medical Assistance Program

Introduction (not on screen)

- We intend for this meeting to be a listening session – We will have a brief presentation regarding the Program and the proposed amendment, and then will open the floor to public comment.
- Please indicate when you sign in whether you would like to speak during the public comment period at the end of the Agenda.
- Once this presentation is completed, we will take public comments from those who have signed in and indicated that they would like to speak.

Introduction (not on screen)

- For those who are joining us by phone, we have an operator assisted call today.
- At the end of the presentation, the operator will ask whether any phone participants wish to make public comments.

Introduction (not on screen)

- You can also pick up a "Comment Form" near the entrance which will allow you to submit comments in writing, either here today, or through email or mail.
- The comment form contains information on the email address, website address and physical mailing address.
- We encourage everyone to complete a comment form if they are able, even if you make comments here today.

Amendment of the 1115 Waiver

- Changes related to features of the research and demonstration waiver must be submitted to CMS as amendments to the waiver.
- Types of changes requiring CMS approval are eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, Low Income Pool, sources of non-federal share of funding, budget neutrality, and other comparable program and budget elements.

Amendment of the 1115 Waiver

- **Federal Waiver Amendment 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 amendment 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 January 12, 2016 – February 11, 2016
- INSERT LIVE LINK
- Written comments may be e-mailed to FLMedicaidWaivers@ahca.myflorida.com or mailed to:

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

MMA Waiver Amendment - Overview

- The State is seeking federal authority to amend Florida's 1115 MMA Managed Medical Assistance (MMA) Waiver to make the following changes:
  - Amend the language related to the Hemophilia program to allow for up to three vendors in order to provide the State the flexibility to contract with 1-3 vendors.
  - Amend the waiver to include payment in MMA capitation rates for nursing facility services for recipients under the age of 18 years.
  - Amend the waiver to all allow flexibility for Specialty plans that do not have sufficient numbers of eligible members for the mandatory Performance Improvement Projects (PIP) to conduct PIPs on other topics that have more impact on their members, with Agency approval.

MMA Waiver Amendment – Hemophilia program

- Currently, the approved language specifies that the Agency for Health Care Administration (Agency) contracts with two vendors. By allowing more flexibility on the amount of contracted vendors, the State has the ability to procure the highest-quality, most efficient and lowest cost vendor.

MMA Waiver Amendment – Nursing Facility Services

- Currently, MMA plans are not capitated for providing nursing facility services to children under 18, and this service is reimbursed outside of managed care on a fee-for-service basis.
- Requiring MMA plans to provide this service for children under 18 years of age eliminates a payment carve out and ensures that MMA plans are accountable for and incentivized to provide:
  - Comprehensive discharge planning and follow-up following hospitalizations;
  - High quality enhanced care coordination for children under 18 in nursing facilities; and
  - Community-based options and supports for children under 18 to transition safely from the nursing facility to non-institutional placements.

MMA Waiver Amendment – Specialty Plan; PIP

- The two mandatory PIPs included in Special Terms and Conditions (STC) #108 are:
  - Improving Prenatal Care and Well-child Visits in the First 15 Months
  - Preventive Dental Care for Children.

- There are four MMA Specialty plans that are for specific health conditions and populations that include primarily adults and non-pregnant women.
  - HIV/AIDS Specialty plans
  - Serious Mental Illness plan
  - Specialty plan for Dual Eligible with Chronic Conditions
- Due to the populations served by these plans, one or both of the mandatory PIP topics are not feasible for the plans due to their having few (if any) members meeting the eligibility criteria for the measures/areas targeted for improvement.

Public Meetings

Schedule of Public Meetings		
Location	Date	Time
Tallahassee **Agency for Health Care Administration** **2727 Mahan Drive** **Building 3** **Conference Room A** **Tallahassee, FL 32308** **Conference Line: 1-888-670-3525** **Participant Code: 371 527 4100#**	January 19, 2016	2:00 – 4:00 pm
Tampa **Agency for Health Care Administration** **6800 North Dale Mabry Highway** **Main Training Room** **Tampa, FL 33614** **Conference Line: 1-877-299-4502** **Participant Code: 639-773-84#**	January 21. 2016	1:00 p.m. -2:30 p.m.

Begin Public Comment Period

Statewide Medicaid Managed Care Program Update

Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both components of the Statewide Medicaid Managed Care (SMMC) program, Long-term Care program and Managed Medical Assistance program
- Now that the SMMC program is operational, program performance data is coming in:
  - Initial evidence shows
    - Florida's Medicaid program is currently operating at the highest level of quality in its history, and that it is doing so at a substantial per person savings to Florida's taxpayers.
    - Consumer satisfaction is high.

SFY 2016-17 Low Income Pool

- The total amount of LIP funding for SFY 2016-2017 is approximately $608 million ($607,825,452).
- Funds may be used for health care costs that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act.
- For SFY 2016-2017 these health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the Healthcare Financial Management Association.

SFY 2016-17 Low Income Pool

- Distribution **can** include both hospital providers and medical school faculty plan providers.
- For each provider type included, the LIP distribution model:
  - Must rank providers by their amount of uncompensated charity care costs or charges as a percentage of their privately insured patient care costs or charges (commercial pay).
  - Can include up to four tiers for distribution.
  - Must pay providers for the same percentage of their charity care cost within each tier.

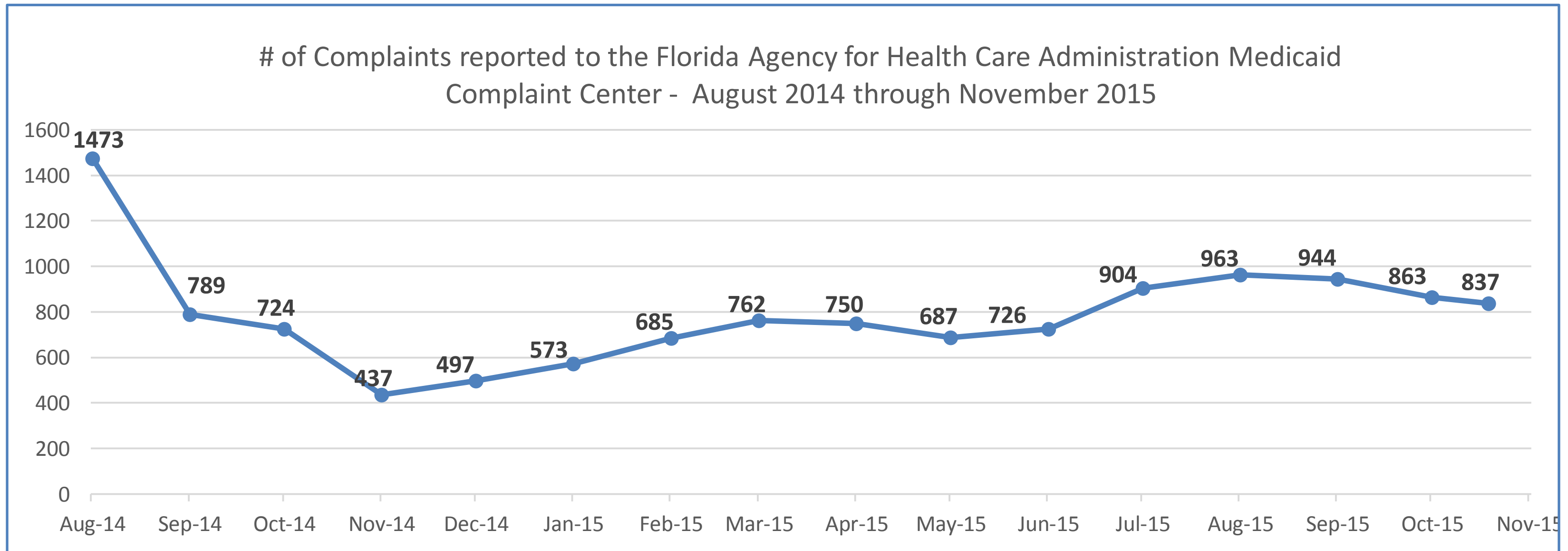
SFY 2016-17 Low Income Pool

- There are a number of areas where the state has the flexibility in creating the distribution model for SFY 2016-2017. Questions that will need to be answered are:
  - Which providers to include?
  - What portion of the $608 million should be allocated to each provider type included?
  - How many tiers should the model include?
  - What should the thresholds be for each tier?
  - How much funding should be allocated to each individual tier?
  - Which dataset should be used for the charity care/ commercial care ratio?

MMA Program Quality

- Medicaid recipients enrolled in Managed Medical Assistance plans now have access to the highest quality of care in the history of the Florida Medicaid program
  - HEDIS Scores
  - Health Plan Report Cards
  - Consumer Satisfaction Survey

Complaints reported since August 1, 2014
Statewide Medicaid Managed Care (Includes both MMA & LTC)



SMMC Enrollment:	2,843,379	2,808,135	2,832,433	2,858,539	2,937,619	2,953,484	2,999,096	3,038,586	3,056,535	3,089,246	3,094,423	3,137,972	3,165,257	3,172,113	3,180,800	3,197,781
# Issues per 1,000 Enrollees:	0.518	0.281	0.256	0.153	0.169	0.194	0.228	0.251	0.245	0.222	0.235	0.288	0.304	0.298	0.271	0.262

Note - The Agency has actively encouraged all stakeholders to surface any potential issue, concern, or complaint regarding the SMMC Program to the SMMC Complaint Operations Center. All allegations and issues have been recorded, regardless of whether they were found to be accurate or substantiated.

Complaints can be reported by phone at 1-877-254-1055, or online at https://apps.ahca.myflorida.com/smmc_cirts/

Focused Complaints reported since August 1, 2014
Statewide Medicaid Managed Care (Includes both MMA & LTC)

of Transportation, Durable Medical Equipment, Dental, Therapy and Home Health Complaints reported to the Florida Agency for Health Care Administration Medicaid Complaint Center - Aug. 2014 through Nov. 2015

120
100
80
60
40
20
0

Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15

# of Transportation Complaints
# of Therapy Complaints
# of DME Complaints
# of Home Health Complaints
# of Dental Complaints

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MMA Program Quality: Overall HEDIS Scores Trend Upward

	Managed Care Calendar Year 2010	Managed Care Calendar Year 2011	Managed Care Calendar Year 2012	Managed Care Calendar Year 2013	MMA Calendar Year 2014
Scores at the National Average	9%	2%	21%	12%	10%
Scores better than the National Average	25%	32%	24%	29%	55%

0% 10% 20% 30% 40% 50% 60% 70%

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%.

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MMA Program Quality: Dental Visit Scores Trend Upward

Time Period	MMA	Reform Pilot Plans	Prepaid Dental Carve Out
CY 2007 (Reported in 2008)	N/A	*15.2%*	N/A
CY 2008 (Reported in 2009)	N/A	*28.5%*	N/A
CY 2009 (Reported in 2010)	N/A	*33.4%*	N/A
CY 2010 (Reported in 2011)	N/A	*34.0%*	N/A
CY 2011 (Reported in 2012)	N/A	*35.3%*	N/A
CY 2012 (Reported in 2013)	N/A	40.40%	40.92%
CY 2013 (Reported in 2014)	N/A	42.3%	37.04%
MMA Year 1	**43.1%**	N/A	N/A

Reform Pilot Plan Notes: Data above is the weighted mean across all plans.
Prepaid Dental Carve Out Notes: 2012 is the first year the PDHPs submitted performance measures that were audited by an NCQA-certified HEDIS auditor. Data is weighted across all plans.
MMA Year 1 Notes: The Agency used the same parameters required to calculate the HEDIS children's dental care annual dental visit measure with two variations: 1) HEDIS requires that a calendar year be used; the Agency used an August through July time period, 2) HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; the Agency's analysis required that they be enrolled on July 31 of the measurement year.

MMA Program Quality: Dental Visit Scores

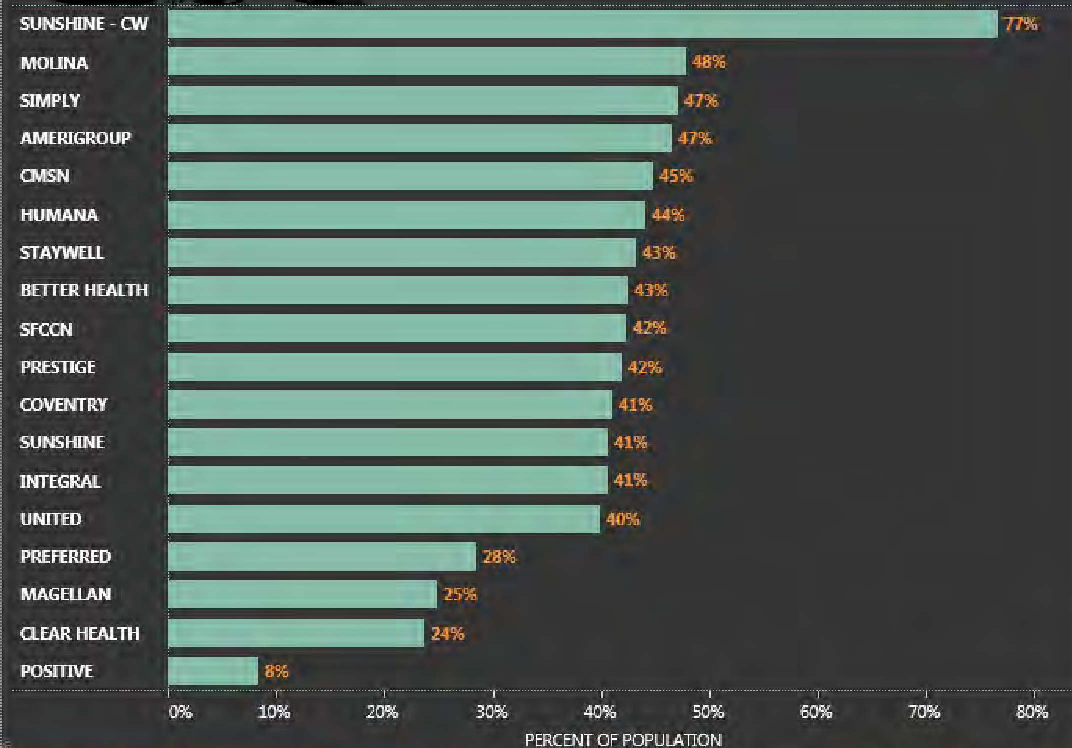
- The Agency conducted an analysis to determine the percent of MMA enrollees ages 2-21 years of age who received at least one dental service during the first year of MMA implementation (08/01/2014 through 07/31/2015).
- The Agency used the same parameters required to calculate the HEDIS children's dental care annual dental visit measure with two variations: 1) HEDIS requires that a calendar year be used; the Agency used an August through July time period, 2) HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; the Agency's analysis required that they be enrolled on July 31 of the measurement year.
- The HEDIS measure also requires that, for an enrollee to be included in the analysis, they must be age 2-21, enrolled for at least 11 out of the 12 months with a single MMA plan during the analysis period, and be enrolled on the last day of the measurement period (this is referred to as an "anchor date"). We used these parameters in our analysis.
- Using these parameters, the Agency determined that 43% of the children who qualified to be counted in this measure received dental services during this time period. This is slightly higher than the HEDIS scores, 42%, achieved in 2013 by Medicaid Reform plans.

MMA Program Quality: Dental Visit Scores

Florida Medicaid Data Visualization Series

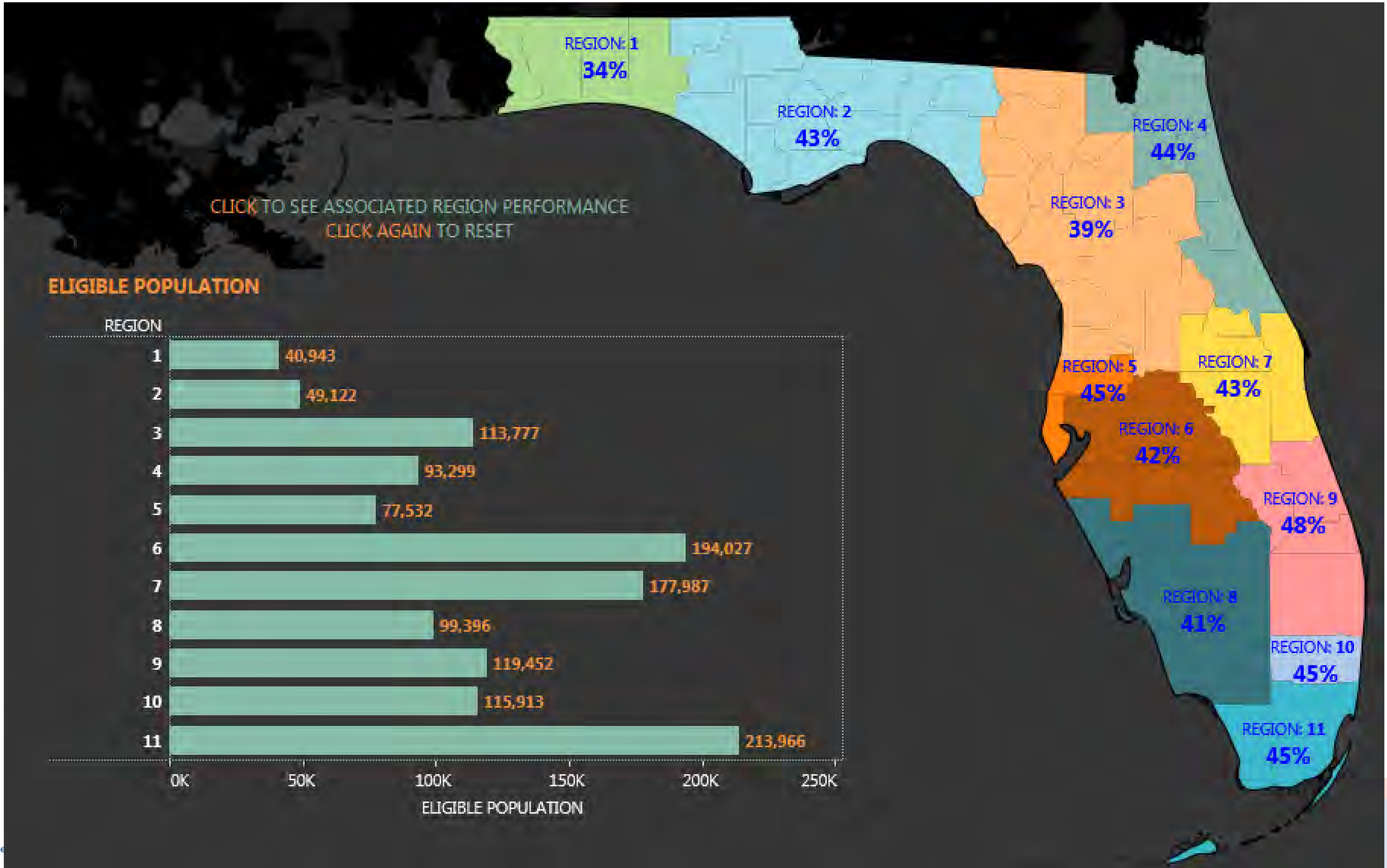
Program Profiles: *Managed Care - Dental Services (Children Ages 2 - 21) for MMA Year 1 Aug 2014 - July 2015*

CLICK PLAN NAME TO SEE ASSOCIATED COUNTY PERFORMANCE
CLICK AGAIN TO RESET



MEDICAID DATA ANALYTICS - DATA SCIENCE UNIT WORKBOOK: Dental Profile MMA Year 1 DATA SOURCE: D11_Tableau (WORKAPS) LAST UPDATE: 10/28/2015 3:54:21 PM

MMA Program Quality: Dental Visit Scores



MMA Program Quality: Health Plan Report Cards

- Health Plan Report Cards: Enrollees can now choose plans based on quality.
- Measures include important topics such as Pregnancy Related Care, Children's Dental Care, Keeping Kids Healthy, etc.
- 2014 Report Card: Contains information all plans participating during the entire 12 month period (SMMC plans)

MMA Program Quality: Health Plan Report Cards

1. Navigate to FloridaHealthFinder.gov

2. Select "Medicaid Health Plan Report Card"

3. Select a county, or view all counties

4. View Results

MMA Program Quality: Health Plan Report Cards

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2014

◉ **Medicaid Health Plan Report Card**
To view individual measures in a category, click one of the following:

- ○ Pregnancy-related Care
- ○ Living with Illness
- ○ Keeping Kids Healthy
- ○ Mental Health Care
- ○ Keeping Adults Healthy

Sorting Options:

Sort By Column ◉ Ascending (A-Z, 0-9) ○ Descending (Z-A, 9-0)

View Results

Statewide Information for Plans Currently Operating in Florida Counties

Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Keeping Adults Healthy	Living with Illness	Mental Health Care
Amerigroup Florida, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★★☆
Better Health, LLC	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆	★★★☆☆
Children's Medical Services	N/A	★★★★☆	N/A	★★★★★	★★★★☆
Clear Health Alliance	N/A	N/A	★★★★★	★★★☆☆	★☆☆☆☆
Coventry Health Care of Florida	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★☆☆☆☆
Florida MHS (Magellan)	★☆☆☆☆	N/A	N/A	N/A	★☆☆☆☆
Humana Medical Plan, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★☆☆☆
Molina Healthcare of Florida, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★☆☆☆	★★★☆☆
Positive Healthcare Florida	N/A	N/A	★★★★★	★★★☆☆	★★☆☆☆
Prestige Health Choice	★★★★☆	★★☆☆☆	★★★☆☆	★★★☆☆	★★☆☆☆
Simply Healthcare Plans, Inc.	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆	★★☆☆☆
South Florida Community Care Network	★★☆☆☆	★★★★☆	★★☆☆☆	★★★★☆	★★☆☆☆
Staywell	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★☆☆
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆
Sunshine State Health Plan, Inc. - Child Welfare	N/A	★★★☆☆	N/A	N/A	★★★★☆
United Healthcare of Florida, Inc.	★★★★☆	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆

Ratings Key:

★★★★★ **Best**	at or above 50% of all Medicaid health plans' scores
★★★★☆ **Good**	better than at least 40% of all Medicaid health plans' scores
★★★☆☆ **Fair**	better than at least 25% of all Medicaid health plans' scores
★★☆☆☆ **Poor**	better than at least 10% of all Medicaid health plans' scores
★☆☆☆☆ **Very Poor**	worse than 90% of all Medicaid health plans' scores
N/A	Not Measurable/Small Population

Change Health Plan Type | Change Location / County | Print | Save to Excel | Start Over

MMA Program Quality: CAHPS Survey

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.
  - Survey results were due to the Agency July 1, 2015.
  - Plans are required to use NCQA standards for conducting the survey and use NCQA CAHPs survey vendors.

MMA Program Quality:
CAHPS Survey

- Parents reported the following regarding their experience with their children in the Medicaid program:
  - 81 % of enrollees have high overall plan satisfaction (rating 8, 9, 10)
  - 90 % of enrollees rate their personal doctor highly (rating 8, 9, 10)
  - 83% of enrollees rate their specialists highly (rating 8, 9, 10)
  - 82% of enrollees say that they usually or always find it easy to get care
  - 89 % of enrollees say that they usually or always find it easy to get care quickly
  - 93 % of enrollees say that their doctor usually or always explains things to them well, listened carefully, showed respect and spent enough time in communications

Florida Kidcare Consumer Satisfaction Survey

- Kidcare is the umbrella name for children's coverage in Florida and includes the Children's Health Insurance Program (CHIP) and Medicaid for children.
- An annual satisfaction survey is performed as part of the annual KidCare Evaluation.
- The KidCare program consumer satisfaction survey shows that MMA enrollees have high levels of satisfaction with the care they are receiving.
- MMA plans scored above the National Medicaid benchmark and the National CHIP benchmark for:
  - Overall health care experience.
  - Experience with their primary care providers.
  - Experience with their specialty care providers.

LTC Program Quality

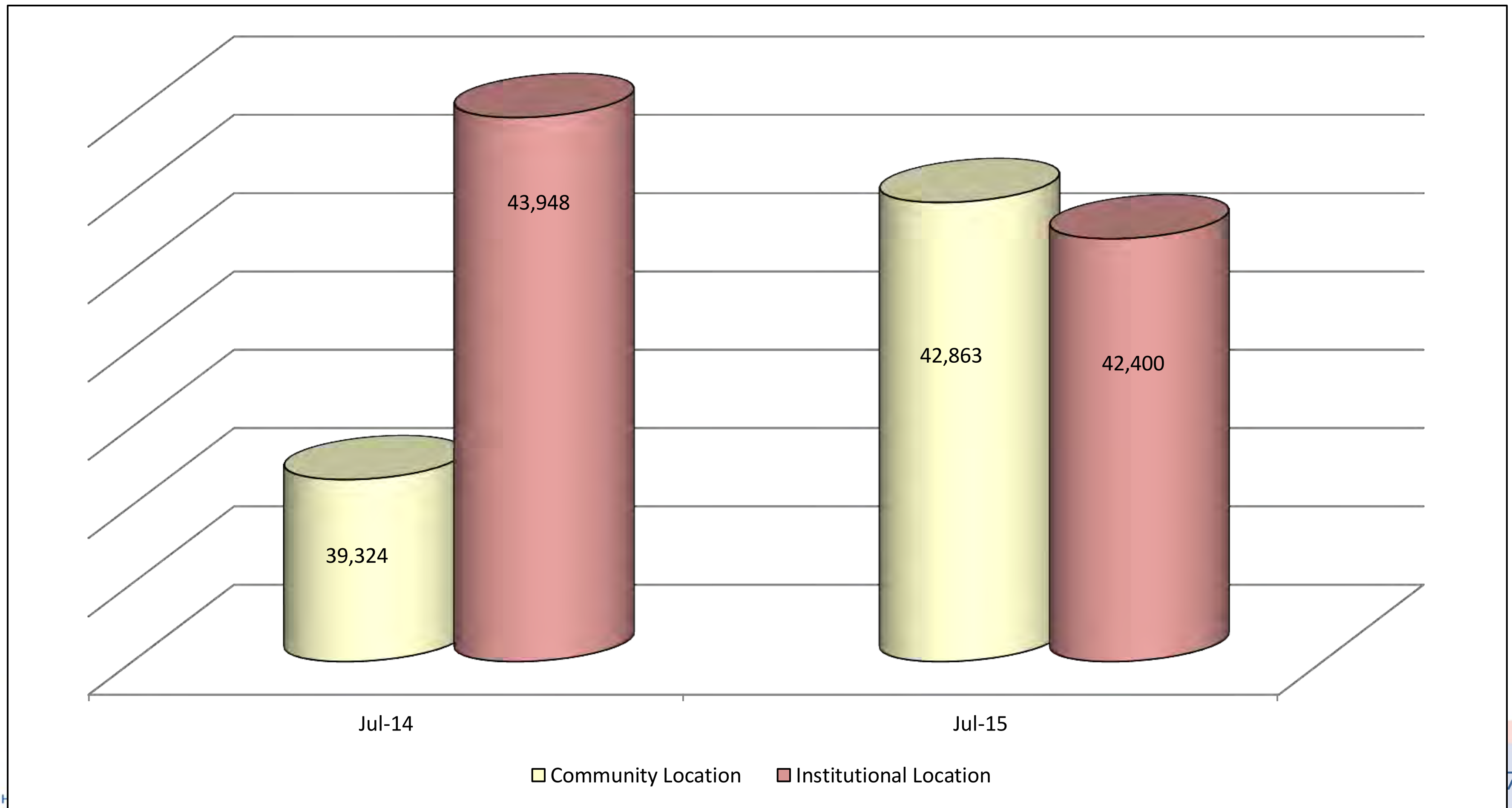
- The LTC program was designed with incentives to ensure patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs.
  - Transition of individuals who wish to go home from institutional care such as nursing facility care to the community.
  - Patient Satisfaction survey results.
  - LTC Evaluation Report.

LTC Program Quality: HCBS Incentives

- Incentives Shift to Home & Community Based Care Services:
  - The law requires that managed care plan rates be adjusted to provide an incentive to shift services from nursing facilities to community based care.
  - Transition percentages apply until no more than 35% of the plan's enrollees are in nursing facilities.
- An enrollee who starts the year in a nursing home is continued to be treated as nursing home for rate blended for the entire year, even after transition.
- Plans "win" financially if they beat the target, "lose" if they do not meet the target.

LTC Program Quality: HCBS Incentives

- Number of enrollees, for July 2014, and July 2015, by Residential Setting.



Percentage of LTC Enrollees by Residential Setting and Plan

Plan	Year	Home and Community	Institutional
Amerigroup	2014	73.9%	26.1%
Amerigroup	2015	76.0%	24.0%
Molina	2014	57.4%	42.6%
Molina	2015	60.9%	39.1%
American Eldercare	2014	57.3%	42.7%
American Eldercare	2015	58.8%	41.2%
Humana	2014	55.6%	44.4%
Humana	*2015	60.8%	39.2%
Coventry	2014	51.9%	48.1%
Coventry	2015	56.3%	43.7%
All Plans	2014	47.2%	52.8%
All Plans	2015	50.3%	49.7%
United	2014	41.7%	58.3%
United	2015	44.6%	55.4%
Sunshine	2014	38.8%	61.2%
Sunshine	2015	42.7%	57.3%

Note: Data is as of July 2014 and July 2015.
*Humana 2015 data is as of June 2015 due to Humana purchasing American Eldercare.

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LTC Program Quality:
LTC Enrollee Satisfaction Survey

- Developed by the Agency/Used by all plans.
- Satisfaction regarding:
  - LTC plan
  - Case manager
  - Services
  - Overall health
- Agency-approved independent survey vendor must be used.
- Results must be used by the plans to develop and implement activities to improve member satisfaction.
- The survey was completed in 2015.

LTC Program Quality: LTC Enrollee Satisfaction Survey

- 77.4% reported that their quality of life had improved since enrolling in their LTC plan

LTC Program Quality: LTC Enrollee Satisfaction Survey

- Survey respondents reported the following regarding their experience with the LTC Program:
  - 79.7% of respondents rated their Long-term Care plan an 8, 9, or 10.
  - 83.4% of respondents reported it usually or always being easy to get in contact with their case manager.
  - 84.4% of respondents rated their case manager an 8, 9, or 10.
  - 90% of respondents reported their long-term care services are usually or always on time.
  - 83.3% of respondents rated their LTC services an 8, 9, or 10.
  - 59.5% reported that their overall health had improved since enrolling in their LTC plan

Express Enrollment

- The State received approval of an amendment to Florida's 1115 MMA Managed Medical Assistance waiver to allow for Express Enrollment.
- Express Enrollment was implemented <u>for recipients mandatory for enrollment in the MMA program</u> on January 11, 2016.
- Express Enrollment does NOT impact the Long-term Care program.

Express Enrollment

- Under Express Enrollment, the state:
  - Gives recipients the opportunity to make a plan choice concurrent with eligibility application; and
  - Assigns Medicaid-eligible individuals who are mandated to participate in the MMA program to a health plan immediately after eligibility determination.
  - Allows new enrollees who are mandated to participate in the MMA program to immediately take advantage of robust provider networks access standards, and expanded benefits offered by the plan.

Streamlined Credentialing Overview

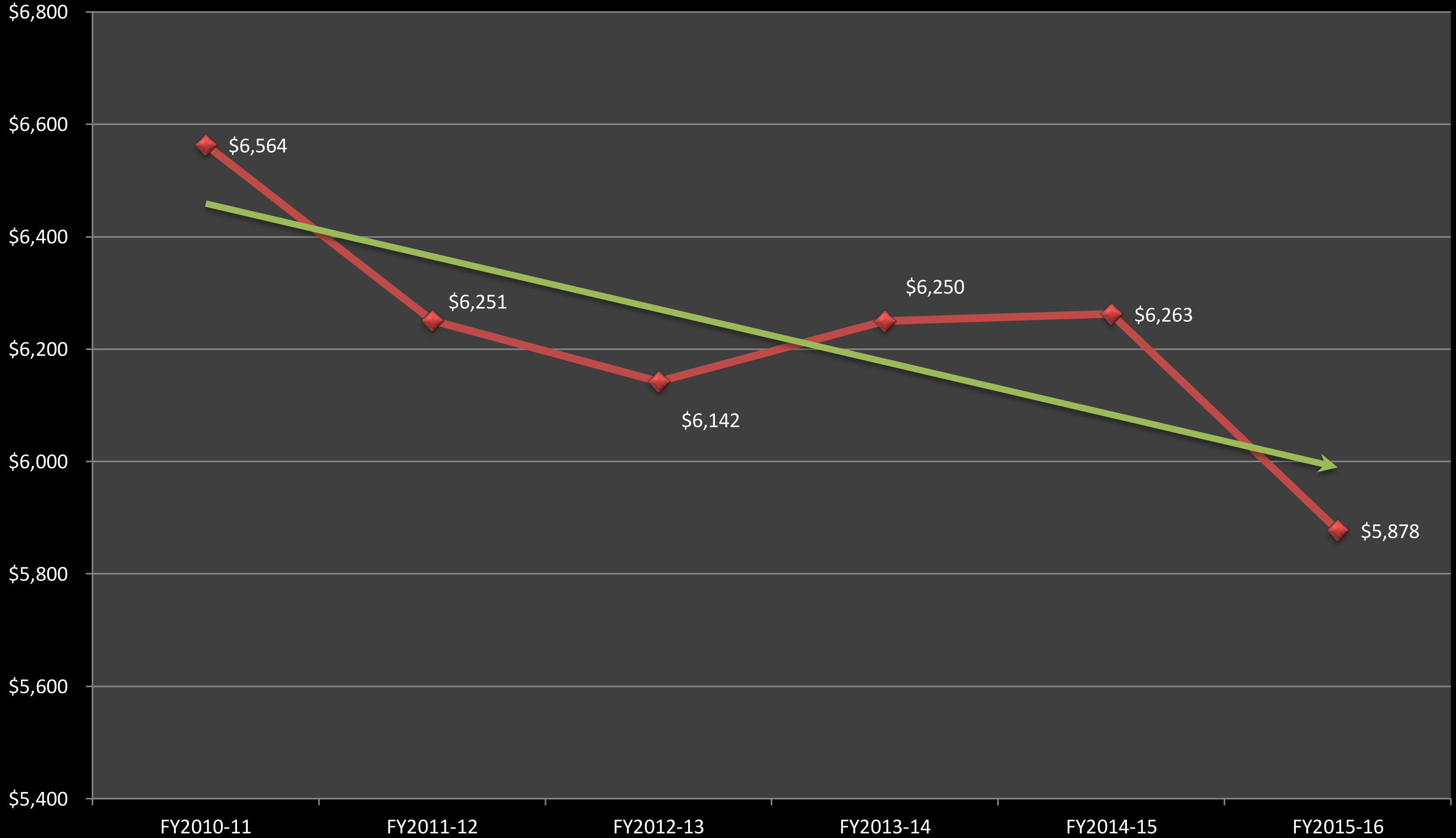
- Beginning in December 2015, providers seeking to participate in a Medicaid health plan had the option to complete a Limited Enrollment provider application.
- AHCA will issue Medicaid provider ID upon completion of Limited Enrollment without need to continue steps for Full Enrollment.
- Fee-for-service providers must seek traditional Full Enrollment in order to directly bill Medicaid for reimbursement.

Limited Enrollment Basics

- Basic credentialing activities are conducted as part of Limited Enrollment.
- AHCA will perform several basic credentialing activities:
  - Licensure verification
  - Federal exclusions list verification
  - Background screening, including criminal history through AHCA Background Screening Clearinghouse
- Limited Enrollment status should eliminate need for providers to undergo these basic credentialing activities for each health plan.

Limited Enrollment NOT Full Health Plan Credentialing

- The streamlined Limited Enrollment application and corresponding review process allows approved providers to receive their Medicaid provider IDs faster than with traditional Full Enrollment.
- Assignment of a Medicaid provider ID does not guarantee a place in the network of any plan.
- Each plan may apply their own standards for provider credentialing beyond what is required by Medicaid.


Florida Medicaid: Average Annual Cost Per Person
Florida Medicaid: Average Annual Cost Per Person
Linear (Florida Medicaid: Average Annual Cost Per Person)
$6,800
$6,600
$6,400
$6,200
$6,000
$5,800
$5,600
$5,400
$6,564
$6,251
$6,142
$6,250
$6,263
$5,878
FY2010-11
FY2011-12
FY2012-13
FY2013-14
FY2014-15
FY2015-16
FY 2013-14 and prior data is from the final year end budgets.
FY 2014-15 Medicaid Expenditures data are from the March 4, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC
FY 2015-16 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

Questions?