Quarterly Statewide Medicaid Managed Care Report

Business Intelligence Unit
Medicaid Program Analysis

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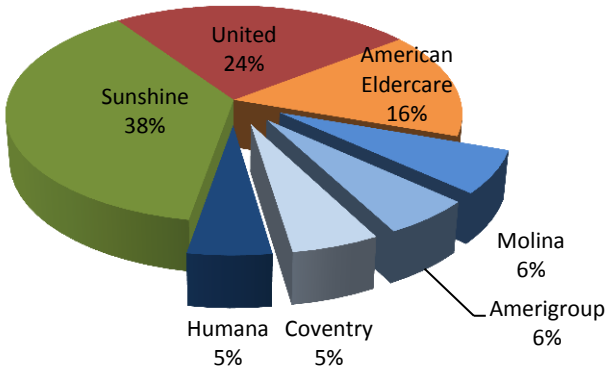
Executive Summary

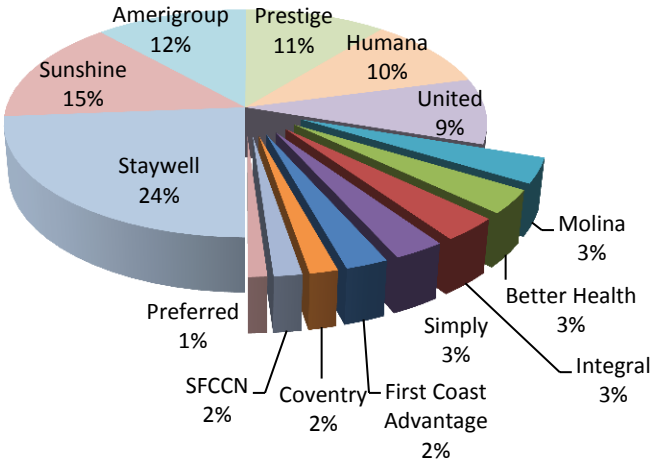
The 2011 Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency for Health Care Administration to create the Statewide Medicaid Managed Care (SMMC) program. The legislation requires that most Medicaid recipients in Florida receive services through managed care. SMMC consists of two distinct programs – the Long-term Care (LTC) program and the Managed Medical Assistance (MMA) program. The LTC program is the component of SMMC through which enrollees aged 18 and older receive long-term care supports and services. The MMA program coordinates and provides access to enrollees' medical, dental, and behavioral health care services. This report is the first of an ongoing series that produces summary level information about the program. This issue provides a preliminary look at the SMMC program during the roll-out and early months of operation, including data on enrollee demographics, capitation payments, plan-reported benefit expenditures, and additional LTC metrics. More emphasis is placed on the LTC program in this report because it was the first to implement, and more months of data are available for review.

This review covers the roll-out period August 2013 through September 2014. Due to differing implementation timelines for the LTC and MMA programs, and differing reporting schedules for data sources during this period, the time span of data used for analyses varies from section to section of the report.

September 2014 LTC Plan Enrollment



September 2014 MMA Standard Plan Enrollment



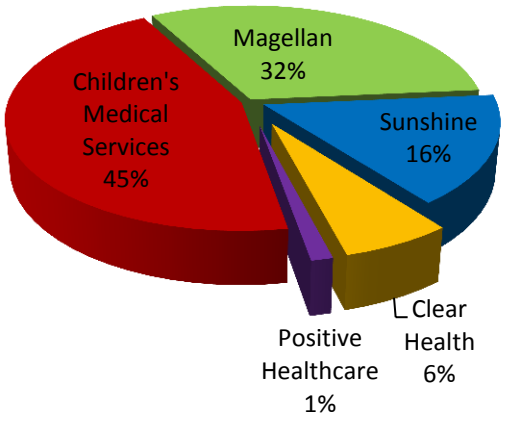
Future reports will utilize additional sources of data, and provide an in-depth analysis of the different facets of Florida's SMMC program.

SMMC Plans and Enrollment

- Currently there are seven LTC plans, fourteen MMA Standard plans, and six MMA Specialty plans which have contracted with the Agency to provide services in the SMMC program.
- SMMC LTC implemented on a regional basis from August 2013 to March 2014.
- By September 2014, the LTC program had over 84,500 enrollees.

- Enrollment in the MMA program occurred on a regional basis from May 2014 to August 2014.
- By September 2014, over 2.5 million enrollees were enrolled in an MMA Standard plan.

September 2014 MMA Specialty Plan Enrollment

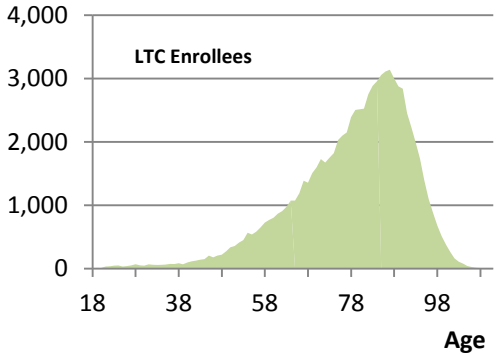


- Some MMA Specialty plans implemented on a different schedule from the Standard plans in the MMA program.
- By September 2014, 138,000 enrollees were in an MMA Specialty plan. The last MMA Specialty plan will be fully implemented in January 2015.

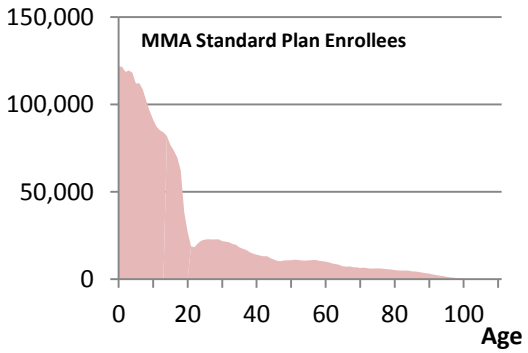
SMMC enrollment is discussed in-depth in the Statewide Medicaid Managed Care Enrollment sections of this report.

SMMC Demographics

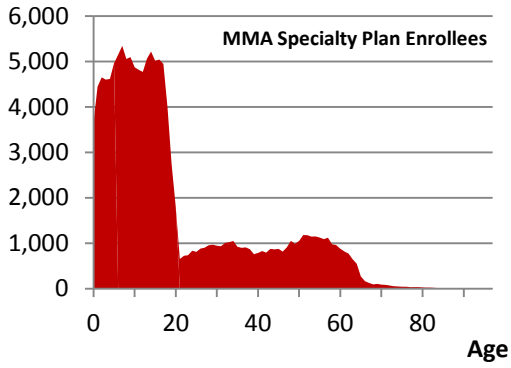
- LTC enrollees are individuals aged 18 and older who require nursing home level of care. Only 20 of the almost 85,000 LTC enrollees were under 21 years of age.
- Most LTC enrollees are white women over age 65 who receive Medicare, and are eligible for Medicaid due to receipt of Social Security Income (SSI).
- Plan-reported data shows that 43 percent of LTC enrollees resided in a nursing facility, 47 percent resided in a community setting, and 10 percent spent time in both types of settings during the first eight months of 2014.



- Over half of MMA Standard plan enrollees are children. Most are not Medicare recipients, are eligible for Medicaid through Temporary Assistance to Needy Families (TANF), and are fairly evenly split in designating themselves as White, Hispanic, or Black (about 29 percent each).



- MMA Specialty plans provide services to child welfare clients (children in the care and custody of the state), children and adults with chronic conditions, individuals with HIV/AIDS, and individuals with serious mental illness.
- The majority of Specialty plan enrollees are under age 21, half are male, 42 percent are eligible for Medicaid through TANF and 41 percent through SSI (without Medicare), and 31 percent identify as White, 27 percent as Black, and 17 percent as Hispanic.



SMMC Payments

Most SMMC plans are paid on a full-risk, capitated basis, which means they receive an average monthly capitation payment for each enrollee and must provide all medically necessary contracted services. American ElderCare and Children's Medical Services Network were paid based on a non-capitated reimbursement arrangement during this preliminary report period.

Generally, a plan's monthly capitation payments are dependent on the number of enrollees each month, and the characteristics of those enrollees. Capitation payments shown in this report do not reflect the cost of a fully implemented SMMC program since plans had not fully implemented in all regions for the eleven months of review. LTC capitation payments have been risk adjusted on a case mix basis. MMA capitation payments have been adjusted for the relative risk of a plan's population through either custom rate cells for special populations or diagnosis-based risk adjustment.

Florida paid a total of approximately $2.08 billion in capitation payments to SMMC plans from August 2013 through June 2014. Although the LTC program serves a smaller number of enrollees than the MMA program, the average cost of providing LTC services is higher per enrollee than the cost of providing standard MMA services.

SMMC Capitation Payments			
	LTC Plans	**MMA Standard Plans**	**MMA Specialty Plans**
Payment Date Range	8/2013 – 6/2014	5/2014 – 6/2014	5/2014 – 6/2014
Total Capitation Payments	$1,578,380,771	$482,392,603	$15,070,533
Average Payment Per Member Per Month	$3,284.92*	$267.90	$796.33*

*American ElderCare and Children's Medical Services Network were omitted from the calculations for average payments per member per month since they were paid on a non-capitated reimbursement arrangement.

LTC Plan-Reported Expenditures

In the first eleven months of operation of the LTC program (Aug 2013 – June 2014), LTC plans reported spending a total of $1.9 billion in benefit expenditures, $4.7 million in extra benefit expenditures, and $107 million in administrative expenditures. Extra benefits are additional services beyond core benefits provided by LTC plans. Since American ElderCare did not operate as a capitated plan during this period, American ElderCare's benefit expenditures were calculated using FLMMIS fee-for-service claims for their enrollees.

SMMC LTC Plan Expenditures		
Benefit Expenditures	**Extra Benefit Expenditures**	**Administrative Expenditures**
$1,919,929,936	$4,709,199	$107,218,396

While only half of all enrollee months on average were spent in a nursing facility, over $1 billion in service expenditures reported by plans covered skilled nursing facility services. On average, the costs of nursing home care are higher than the costs of providing supports and services in the community.

LTC Residence

Plan-reported information about enrollee residence indicates that from January 2014 through August 2014:

- About 43 percent of LTC enrollees resided in nursing facilities every month.
- About 47 percent of LTC enrollees resided in home and community based service (HCBS) settings every month.
- About 10 percent of LTC enrollees lived in both nursing facilities and HCBS settings at different points during the period.
- About half of all enrollee months for the period were spent in a nursing facility and the other half were spent in a community setting.
- Among enrollees who lived in HCBS settings, most lived in their own homes.

LTC Nursing Facility Transfers

Among enrollees who transferred between nursing facilities and HCBS settings from January 2014 through August 2014:

- More enrollees transferred out of nursing facilities to community settings than from community settings to nursing facilities.
- The net number of transfers out of nursing facilities generally increased over time for the review period.

LTC Issues and Complaints

The Agency collects and records issues and complaints from enrollees and providers with the Complaint Issues Reporting and Tracking System also known as CIRTS. Issues range from questions about the program or enrollment in the program to reported dissatisfaction with some aspect of the program. All reported questions, issues, and complaints are recorded in CIRTS and are referred to in this report as complaints. During the LTC program implementation period, the Agency and the Department of Elder Affairs made outbound calls to LTC program enrollees to solicit feedback and identify issues, and the issues identified during this process are included in CIRTS and in the numbers analyzed in this report. LTC program related issues and complaints from August 2013 to August 2014 are analyzed in this report. Through much of this period, there were almost 85,000 recipients enrolled in an LTC plan. A review of the issues and complaints shows:

- The number of complaints per 1,000 enrollees steadily declined over the 13 month period.
- Complaints were most often about difficulties in processing claims to pay providers (30%), errors in system information that prevent plan enrollment (29%), or issues with missed, reduced, and denied services (27%).

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Quarterly Statewide Medicaid Managed Care Plan Report

This report is the first of a series that will provide information about the Statewide Medicaid Managed Care (SMMC) plans and the enrollees in SMMC. The purpose of these quarterly reports is to synthesize data from a variety of sources to describe and evaluate the progress of the SMMC program and contracted plan performance. This report uses data to present information about the implementation and initial operation of the SMMC Long-term Care (LTC) program and the SMMC Managed Medical Assistance (MMA) program.

Features of this report include: enrollment criteria for the SMMC program; enrollment trends throughout implementation of the SMMC program; demographic characteristics of enrollees; capitation payments for SMMC plans; types of LTC-related complaints registered; residential setting of LTC enrollees; numbers of LTC enrollees who transferred between nursing facilities and the community; and financial information for each SMMC Long-term Care plan.

This first report focuses mainly on the SMMC Long-term Care component due to the amount of data available at the time of publication. Implementation of the SMMC LTC program began in August 2013 while implementation of the MMA program did not begin until May 2014. This report provides a first look at enrollment and capitation payments for the MMA program. Subsequent reports will provide more information about the MMA program.

Medicaid Overview

Medicaid is a joint federal/state program administered by states that provides health care services to low income individuals, seniors, and individuals with disabilities who have limited or no health insurance. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the Medicaid program. In Florida, the Agency for Health Care Administration is the single state agency designated by CMS to administer the Medicaid program. In fiscal year 2014-15, the Florida Medicaid program is estimated to provide health care services to 3.7 million recipients and spend $23.6 billion. Over half of the recipients are children and adolescents 20 years of age or younger.

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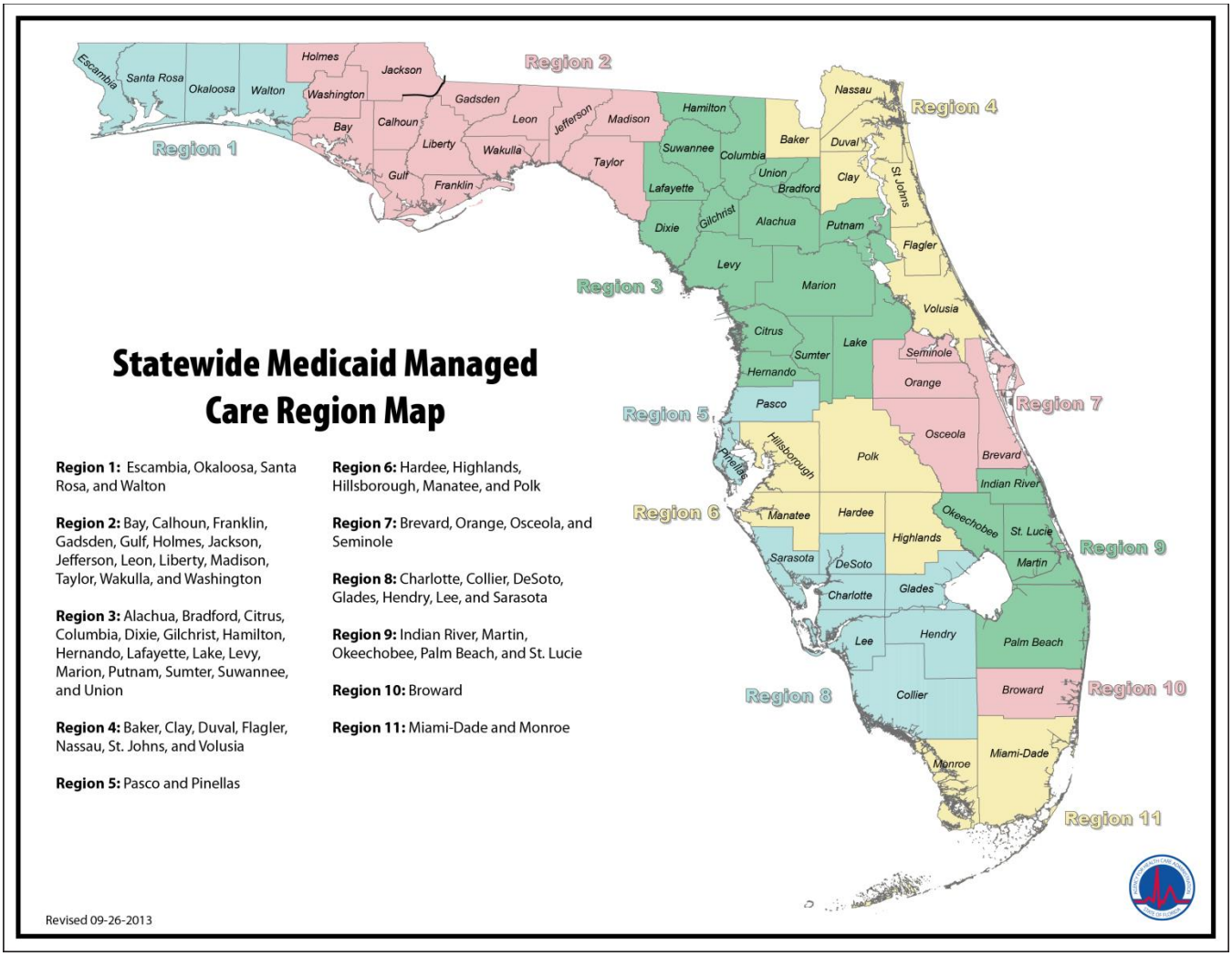
In June of 2011, Governor Scott signed into law landmark legislation to expand the Florida Medicaid managed care program statewide. The Agency then sought and received approval from CMS to implement a statewide managed Long-term Care program and a Managed Medical Assistance program. The Agency gradually phased in the program starting August 1, 2013 with the enrollment of recipients in the Long-term Care program and then with the enrollment of the larger Medicaid population in the Managed Medical Assistance program starting May 2014. The LTC program is the component of SMMC through which enrollees receive long-term care supports and services. The MMA program coordinates and provides access to enrollees' medical, dental, and behavioral health care services.

Figure 1: Map of Regions



AHCA has contracts with 7 LTC Plans, 14 Standard MMA Plans, and 6 Specialty MMA Plans.

Implementation (Roll-Out) Schedule

SMMC was implemented on a regional basis (Figure 1 shows a map of SMMC regions; Table 1 shows the plans that currently have contracts with AHCA.) The roll-out schedules for the SMMC programs are shown in Tables 3 (LTC), 8 (MMA Standard), and 11 (MMA Specialty). Because recipients were enrolled in SMMC in different months based on the roll-out schedule, a full year of LTC data for enrollees in all regions will be available in March 2015, one year after the final month of implementation. Similarly, a full year of MMA data will be available in September 2015, a year after the final month of MMA implementation. All results in this report must be considered introductory given the short time-span covered by the data. However, the data provide an initial look at the SMMC program during implementation and the early months of operation.

Table 1: SMMC Plans by Type

SMMC Plans		
LTC Plans	**MMA Standard Plans**	**MMA Specialty Plans**
American ElderCare	Amerigroup	Clear Health Alliance
Amerigroup	Better Health	Positive Healthcare
Coventry	Coventry	Children's Medical Services Network
Humana	First Coast Advantage	Magellan Complete Care
Molina	Humana	Sunshine
Sunshine	Integral	Freedom Health
United	Molina	
	Preferred	
	Prestige	
	SFCCN	
	Simply	
	Staywell	
	Sunshine	
	United	

Data Sources

Results in this report are based on analyses of data from several different sources. Data sources are detailed in the table below and cited with relevant tables and figures.

Table 2: Data Sources Used in This Report

Data	Period	Source
Enrollment and Demographic Information	August 2013 – September 2014; Data as of October 10, 2014	Florida Medicaid Management Information System (FLMMIS) Eligibility Information
Capitation Payments	August 2013 – June 2014; Data as of December 4, 2014	Florida Medicaid Management Information System (FLMMIS)
Complaints	August 2013 – August 2014; Data as of August 29, 2014	Complaints Issues Reporting and Tracking System (CIRTS)
LTC Plan Financial Information (excluding American ElderCare)	August 2013 – June 2014; Data as of October 13, 2014	Unaudited financial information submitted by the plans
LTC Financial Information for American ElderCare	August 2013 – June 2014; Data as of November 18, 2014	Florida Medicaid Management Information System (FLMMIS) fee-for-service claims
LTC Plan-Reported Residence Data	January 2014 – August 2014; Data as of December 2, 2014	Enrollee Roster and Facility Residence Report
LTC Plan-Reported Nursing Facility Transfer Data	January 2014 – August 2014; Data as of December 2, 2014	Nursing Facility Transfer Report

LTC Managed Care Program

The LTC program is designed to meet the needs of persons eligible for Medicaid who are aged or disabled, who are 18 years of age or older, and who are assessed to require skilled nursing level of care services. Nursing facility level of care services can be provided in a facility or in the community. Recipients enrolled in LTC plans receive home and community based services (HCBS) or nursing facility services through their Long-term Care plan. Plans provide a complete range of LTC supports and services and have nursing facilities, assisted living facilities, hospice, and home and community based service providers in their networks.

The Agency has contracted with seven LTC plans for the provision of LTC services. These organizations are: 1) American ElderCare, Inc., 2) Amerigroup, 3) Coventry, 4) Humana, 5) Molina, 6) Sunshine Health Plan, and 7) United Healthcare.

LTC Plans

Enrollment Requirements

To enroll in an LTC plan, recipients must meet the nursing facility level of care as evaluated by the Department of Elder Affairs through its Comprehensive Assessment and Review for Long-Term Care Services (CARES) program. Additional requirements for enrollment are based on age and physical disabilities. While most recipients who meet these requirements are required to enroll in an LTC plan, a small number of qualified recipients may choose whether or not to enroll. Medicaid recipients who are required to enroll have at least 30 days to choose an LTC plan in their region or the Agency will choose one for them. Subsequently, there is a period during which these recipients may change plans.

Mandatory Enrollment – Enrollment is mandatory for Medicaid eligible recipients who are aged 65 and older or individuals with disabilities aged 18 through 64, who meet nursing facility level of care. Enrollment was also mandatory for individuals who were enrolled in one of the following predecessor waiver programs at the time of LTC implementation:

- Aged and Disabled Adult (A/DA) Waiver
- Consumer Directed Care Plus for individuals in the A/DA Waiver
- Assisted Living Waiver
- Nursing Home Diversion Waiver
- Frail Elder Option
- Channeling Services Waiver

Voluntary Enrollment - Individuals who are enrolled in the following programs are not required to enroll, but may opt to enroll in an LTC plan if they meet the enrollment criteria listed below. However, individuals cannot be enrolled in an LTC plan and a waiver program at the same time.

- Developmental Disabilities Waiver Program
- Traumatic Brain & Spinal Cord Injury (TBI) Waiver
- Project AIDS Care (PAC) Waiver

- Adult Cystic Fibrosis Waiver
- Program of All Inclusive Care for the Elderly (PACE)
- Familial Dysautonomia Waiver
- Model Waiver

LTC Implementation Schedule

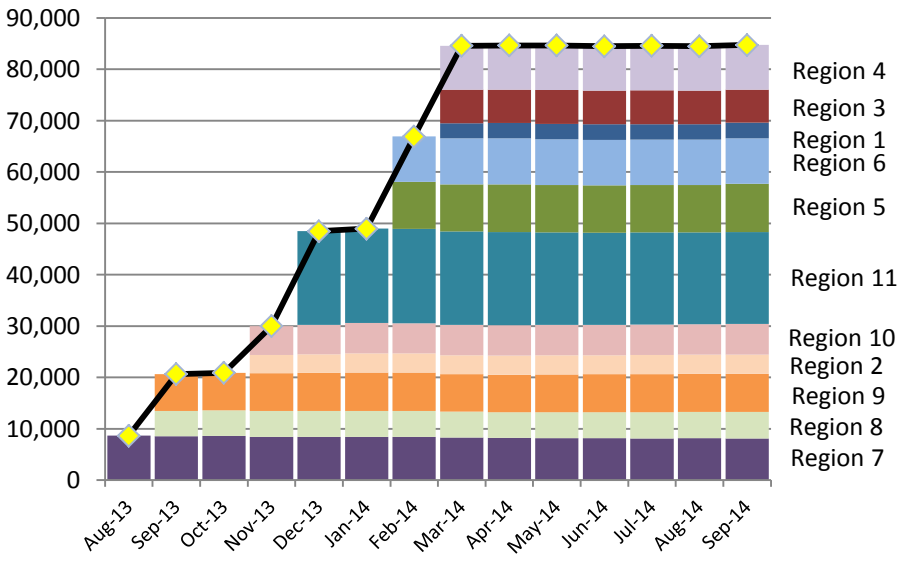
In August 2013, enrollment for the SMMC LTC program began in Region 7 and continued through March 2014 throughout the remaining regions. Table 3 displays the LTC implementation schedule by date and by region.

Table 3: Implementation Schedule for LTC Program

LTC Rollout Schedule											
Plans	2013						2014				
	Aug	Sep		Nov		Dec	Feb		Mar		
	Regions										
	7	8	9	2	10	11	5	6	1	3	4
American ElderCare	x	x	x	x	x	x	x	x	x	x	x
Amerigroup					x	x					
Coventry	x		x			x		x			
Humana					x	x					x
Molina						x	x	x			
Sunshine	x	x	x		x	x	x	x	x	x	x
United	x	x	x	x		x	x	x		x	x

Figure 2 shows the progression of enrollment in the LTC program for the first year of SMMC. Just over 8,600 individuals were enrolled in the LTC program in the first month of the program. By March 2014, the last month of implementation, almost 85,000 individuals had enrolled in the program. Enrollment has remained consistent at just under 85,000 through September 2014.

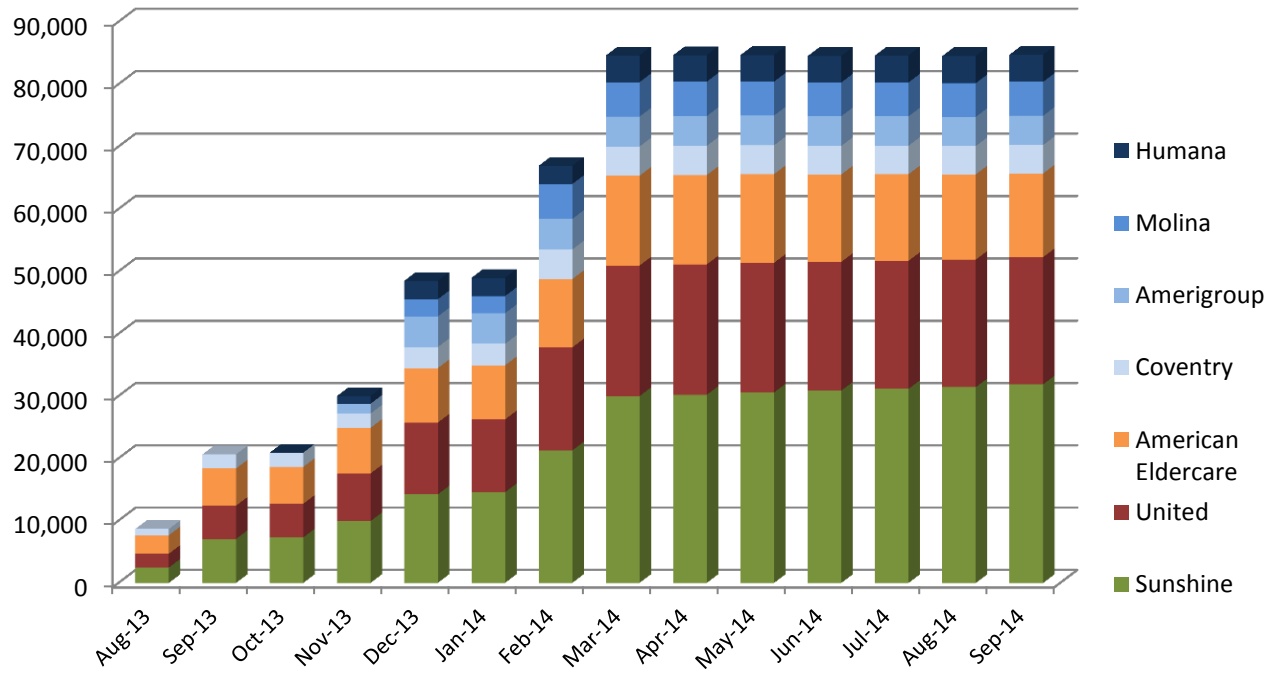
Figure 2: Number of Individuals Enrolled in SMMC LTC, August 2013 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, August 2013 - September 2014.

Figure 3 shows enrollment by LTC plan. During the first three months, only four plans operated in regions with active enrollment – American ElderCare, Coventry, Sunshine, and United. Enrollment numbers remained steady for each LTC plan from March through September 2014.

Figure 3: Monthly Enrollment by LTC Plan, August 2013 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, August 2013 - September 2014.

The distribution of recipients' enrollment by LTC plan and by region is displayed in Table 4. Each table cell shows the number of member months for each plan and region. American ElderCare is the only LTC plan that operates in all eleven regions and has eighteen percent of total member months for the period. Sunshine has the most member months with about thirty-five percent of total member months, and operates in ten regions. United operates in nine regions and has almost twenty-five percent of the member months. Amerigroup operates in the fewest regions and has slightly less than six percent of member months. Coventry, Amerigroup, Humana and Molina collectively have almost twenty-three percent of member months.

Table 4: LTC Member Months by Plan and Region, August 2013 - September 2014

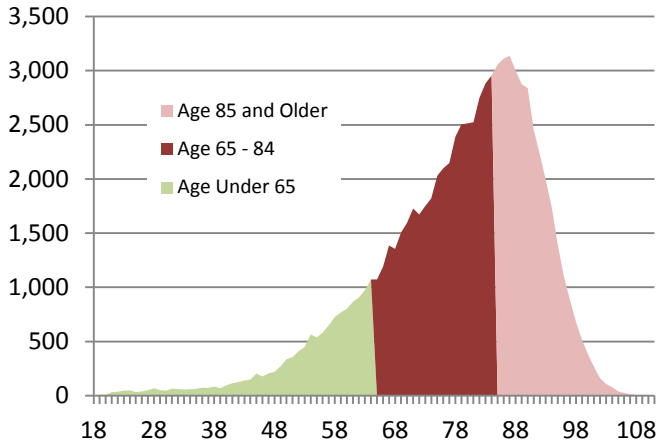
	Regions											
Plan	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
American ElderCare	10,796	14,113	4,719	9,087	11,370	7,639	37,110	15,149	20,120	4,608	13,737	**148,448**
Amerigroup										18,203	31,282	**49,485**
Coventry						9,596	13,053		17,466		11,558	**51,673**
Humana				9,322						13,799	16,881	**40,002**
Molina					12,627	9,986					26,576	**49,189**
Sunshine	10,185		26,259	25,260	28,635	26,702	36,707	31,775	37,221	27,977	42,244	**292,965**
United		26,731	14,892	16,785	21,163	17,189	29,986	18,506	21,068		38,766	**205,086**
Total	**20,981**	**40,844**	**45,870**	**60,454**	**73,795**	**71,112**	**116,856**	**65,430**	**95,875**	**64,587**	**181,044**	**836,848**

Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, August 2013 - September 2014.

LTC Enrollment Demographics

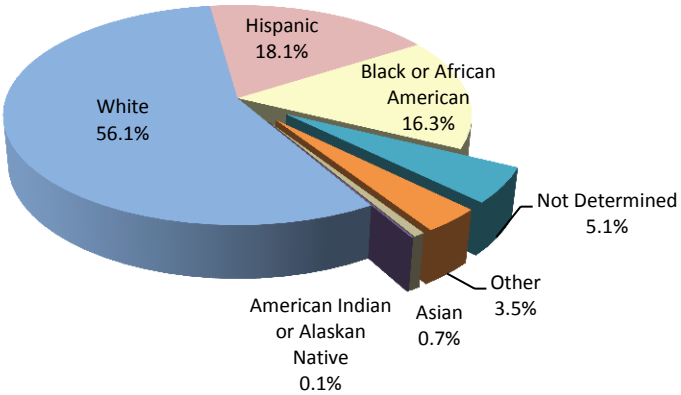
The typical LTC enrollee is a woman over age 65 receiving SSI (Supplemental Security Income) and Medicare who defines her race or ethnicity as White. Eighty-five percent of LTC enrollees are age 65 or older, and thirty-eight percent are 85 or older (Figure 4). Fifty-six percent of enrollees define their race or ethnicity as White. The second largest ethnic group defines themselves as Hispanic (Figure 5).

Figure 4: LTC Enrollees by Age, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

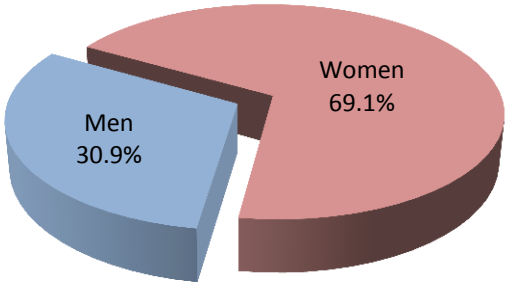
Figure 5: Percentage LTC Enrollees by Race and Ethnicity, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

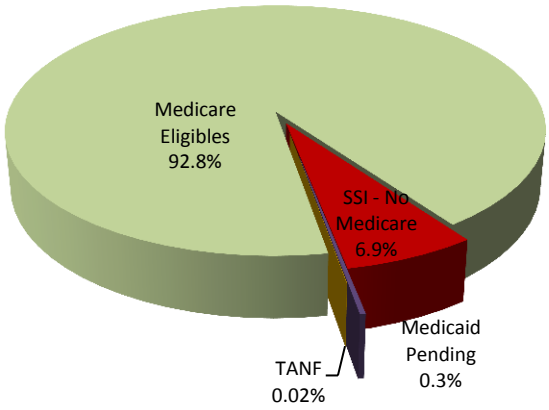
Sixty-nine percent of LTC enrollees are female (Figure 6). Ninety-three percent of LTC enrollees are eligible for Medicare and Medicaid through SSI (Figure 7). Just over seven percent of LTC enrollees are eligible for Medicaid through SSI but are not eligible for Medicare. A very small portion of LTC enrollees are eligible for Medicaid based on Temporary Assistance to Needy Family (TANF) standards.

Figure 6: Percentage of LTC Enrollees by Gender, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 7: Percentage of LTC Enrollees by Program Category, September 2014

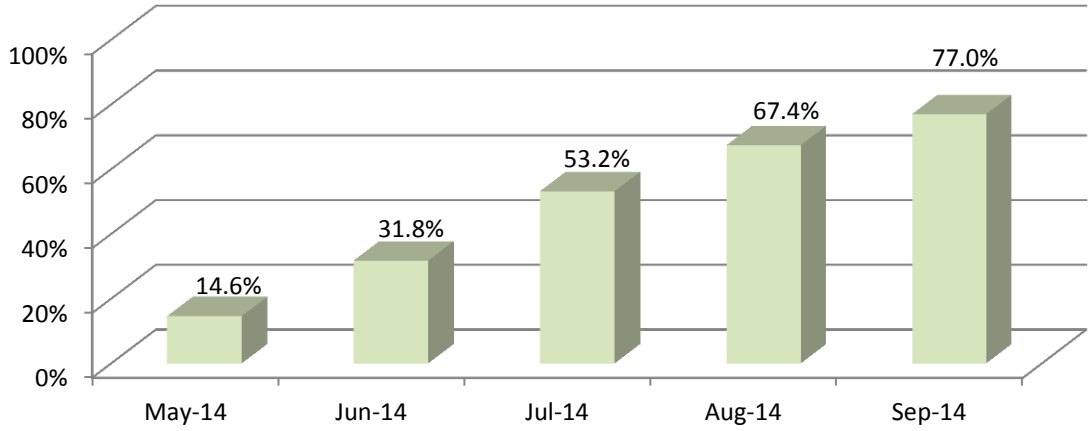


Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

LTC Enrollees in the MMA Program

Most SMMC LTC enrollees may also enroll in and receive medical services from an MMA Standard or Specialty plan. Figure 8 shows the percentage of LTC enrollees who were enrolled in an MMA plan as the MMA program was implemented. As of September 2014, seventy-seven percent of the LTC enrollees were enrolled in an MMA plan. With the exception of a small number of enrollees with a Medicaid Pending status, the remaining LTC enrollees are Medicare Advantage Plan enrollees. In February 2015, the Medicare Advantage enrollees will be enrolled in MMA plans.

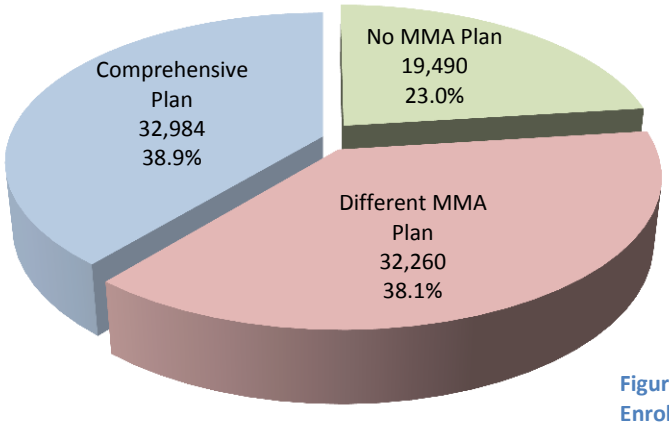
Figure 8: Percentage of LTC Enrollees in an MMA Plan, May 2014 – September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2013 - September 2014.

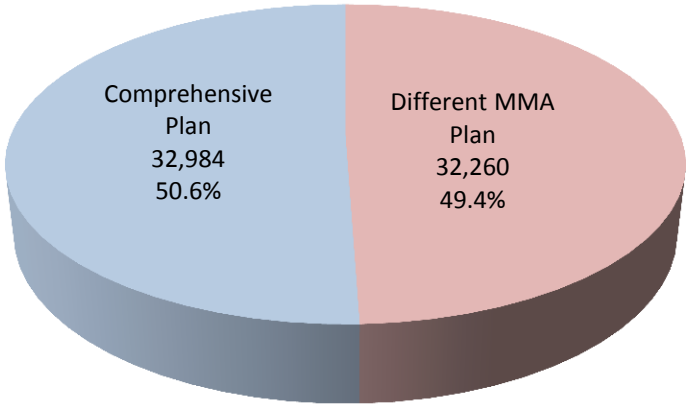
In most regions, Medicaid recipients may choose the same plan for their MMA and LTC benefits. If the enrollee is in the same LTC and MMA Standard plan in the same region, the plan is referred to as a Comprehensive plan. No Comprehensive plan is available in Regions 1 and 2. Figure 9 displays information about LTC enrollees who are either in a Comprehensive plan, in an MMA plan different from their LTC plan, or not enrolled in an MMA plan. Figure 10 shows the percentage of LTC enrollees enrolled in an MMA plan who are in a Comprehensive plan. Slightly more than half of the LTC enrollees who are enrolled in an MMA plan, are enrolled in a Comprehensive plan.

Figure 9 : Percentage of LTC Enrollees by MMA Plan Status, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

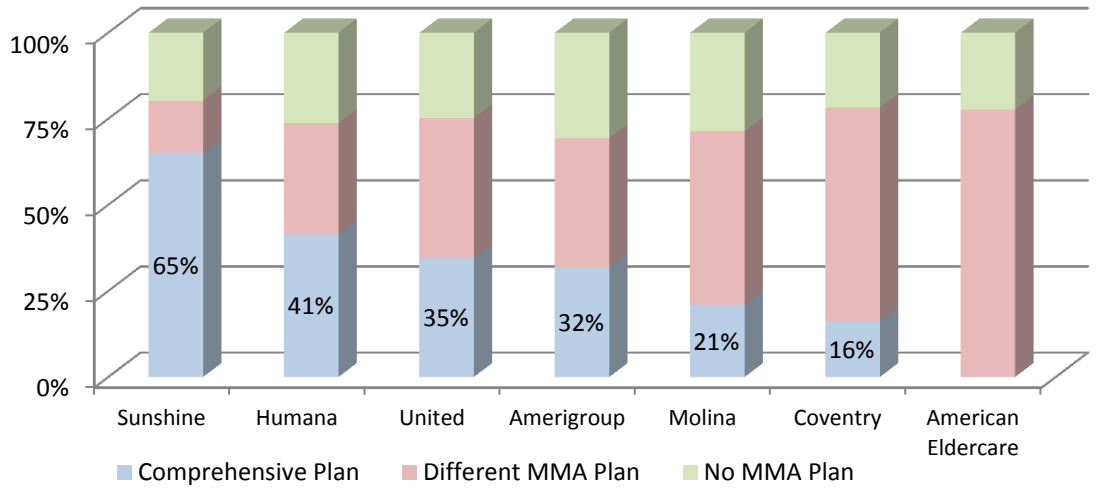
Figure 10: Percentage of LTC Enrollees Who Are Also Enrolled in MMA by Comprehensive Plan Status, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 11 shows the percentage of enrollees in each LTC plan who are in a Comprehensive plan. Sunshine has the largest percentage of LTC enrollees in a Comprehensive plan at 65%. Coventry has the smallest percentage of LTC enrollees in a Comprehensive plan. American ElderCare does not have an MMA plan so none of its members are enrolled in a Comprehensive plan.

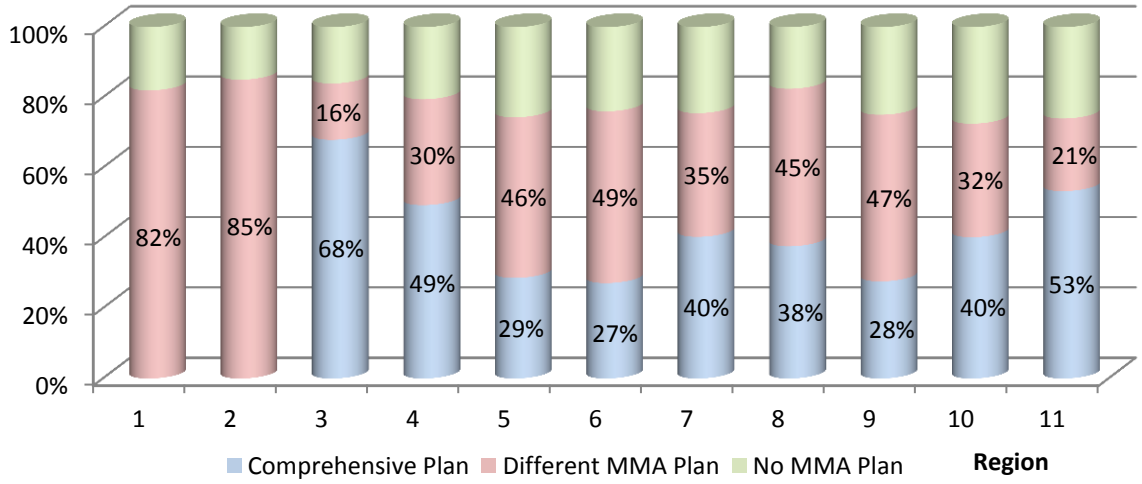
Figure 11 : Percentage of LTC Enrollees in a Comprehensive Plan by LTC Plan, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 12 shows Comprehensive plan enrollment by region. Region 3 has the largest percentage of LTC enrollees in a Comprehensive plan. Neither Region 1 nor 2 has a Comprehensive plan available.

Figure 12 : Percentage of LTC Enrollees by MMA Plan Status by Region, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Payments to LTC Plans

Most LTC plans are paid on a full-risk, capitated basis, which means they receive an average monthly capitation rate for each enrollee and must provide all medically necessary contracted services. American ElderCare was paid based on a non-capitated reimbursement arrangement during this preliminary report period. American Eldercare operated as a fee-for-service provider service network (PSN), which means it was paid an administrative allowance and a small capitation for transportation services for its enrollees, but providers were paid directly by AHCA. This arrangement existed from program inception through August 31, 2014, at which time American Eldercare converted to a full-risk capitation arrangement.

LTC capitation payments are adjusted on a case mix basis. Because it is more costly to provide LTC services in an institutional than a community setting, base capitation rates are greater for enrollees receiving services in a nursing facility than a community setting. Each plan's capitation payments are adjusted according to its mix of enrollees in each type of setting, and further adjusted to reflect statutory targets to encourage the increased utilization of home and community based services and reduce institutional placement.

The following table shows capitation payments from August 2013 through June 2014 for each plan by region. Sunshine received $703 million in capitation payments which is forty-five percent of the total reimbursement paid to LTC plans. United Healthcare received $487 million or thirty-one percent of the total reimbursement. Together, these plans received a little over 75% of the total capitation payments. (See Figure 13)

Table 5: Capitation Payments (in dollars) by Plan and Region, August 2013 – June 2014

	Plan							
Region	**Amerigroup**	**Coventry**	**Humana**	**Molina**	**Sunshine**	**United**	**American ElderCare+**	**Totals**
1					21,265,483		999,892	**22,265,375**
2						65,241,848	1,790,505	**67,032,353**
3					53,992,253	32,145,237	372,216	**86,509,706**
4			20,168,500		55,621,108	35,379,145	725,814	**111,894,567**
5				28,331,336	63,036,465	54,630,030	880,019	**146,877,850**
6		22,396,882		20,329,671	51,183,808	37,156,833	577,928	**131,645,122**
7		30,608,730			103,236,261	82,720,807	4,548,773	**221,114,571**
8					91,172,369	57,127,891	2,192,706	**150,492,966**
9		42,250,261			104,804,181	68,054,384	2,430,777	**217,539,603**
10	36,496,053		28,509,467		70,741,318		332,891	**136,079,729**
11	46,559,736	23,607,938	31,690,187	40,162,609	88,438,256	54,909,775	1,560,428	**286,928,929**
Totals	**83,055,789**	**118,863,811**	**80,368,154**	**88,823,616**	**703,491,502**	**487,365,950**	**16,411,949**	**1,578,380,771**

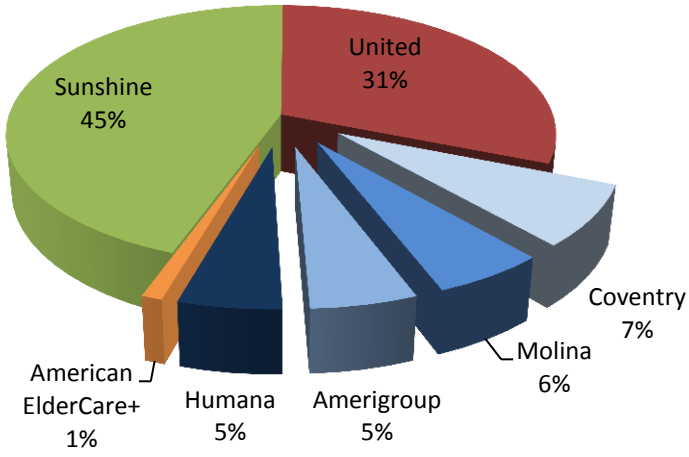
Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, August 2013 - June 2014, as extracted December 4, 2014.

Note: Capitation payments to LTC plans are adjusted on a case mix basis.

+American Eldercare operated as a fee-for-service provider service network from August 2013 through August 2014. As such, American Eldercare received administrative allocations, not full capitation payments. Therefore, the payments to American Eldercare are much lower than for other LTC plans.

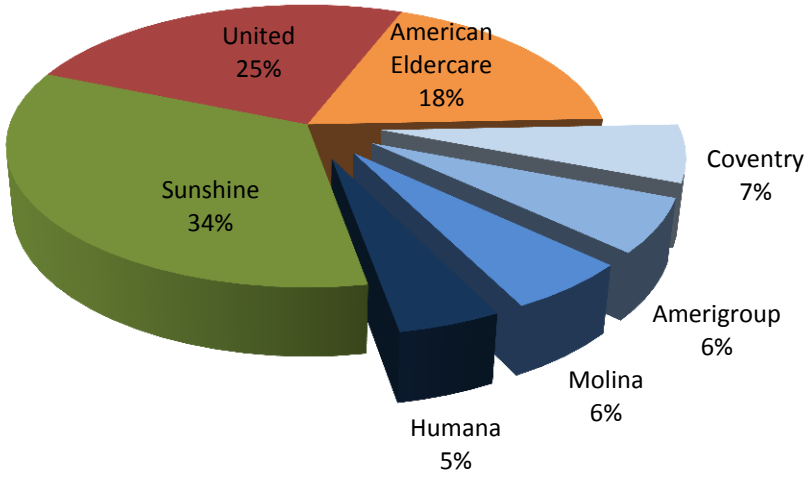
Figure 13 shows the percentage of capitation payments allocated to each LTC plan, and Figure 14 shows the percentage of member months covered by each plan for the review period. Sunshine received the largest allocation of capitation payments and covered the greatest portion of member months for the period.

Figure 13: Percent of LTC Capitation Payment Amounts by Plan, August 2013 - June 2014



Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, August 2013 - June 2014, as extracted December 4, 2014.

Figure 14: The Percentage of LTC Member Months by Plan, August 2013 - June 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, August 2013 – June 2014.

LTC Residence

Introduction

LTC enrollee residential patterns and residential transfers between nursing facilities and community settings are examined using plan-reported data from January 2014 through August 2014. Two plan reports - the Enrollee Roster and Facility Residence Report and the Nursing Facility Transfer Report – are used to analyze residence patterns and residential transfers.

Enrollee Residence

Each LTC plan submits an Enrollee Roster and Facility Residence Report to the Agency monthly. The report lists residence information about each member in the plan. In reports submitted from January 2014 to August 2014, the residence information is used to examine the type of setting where residents lived.

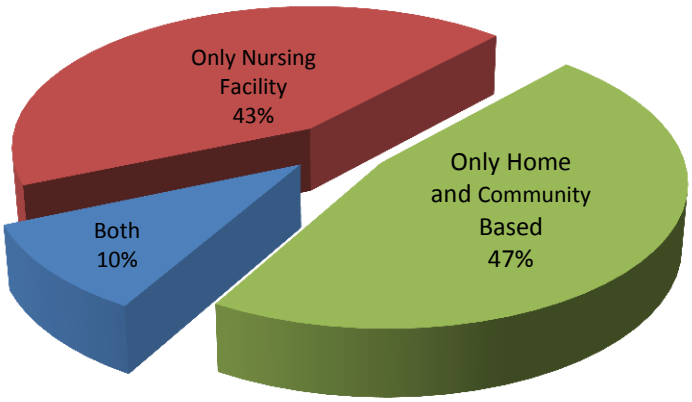
Table 6: Member months by Residential Setting for LTC Enrollees (aged 18 and older), January 2014 - August 2014

Residential Setting	Member Months	Percentage
Institutional	318,368	51.0%
Home and Community Based	306,215	49.0%

Source: Plan-reported data, Enrollee Roster and Facility Residence Report, January 2014 - August 2014.

Just over half of all member months were spent in an institutional setting (nursing facility) and just under half were spent in a home and community-based setting (Table 6). A different pattern emerges when examining the residential setting of enrollees across all months. Ten percent of enrollees resided in both an institutional and a home and community based setting at different points (Figure 15). Some LTC enrollees may at times need short-term institutional convalescent care that can lead to movement between institutional and home and community based residential settings. The number of enrollees who lived exclusively in an institutional setting was similar to the number of enrollees who lived exclusively in a home and community based setting with less than five percent difference between the two.

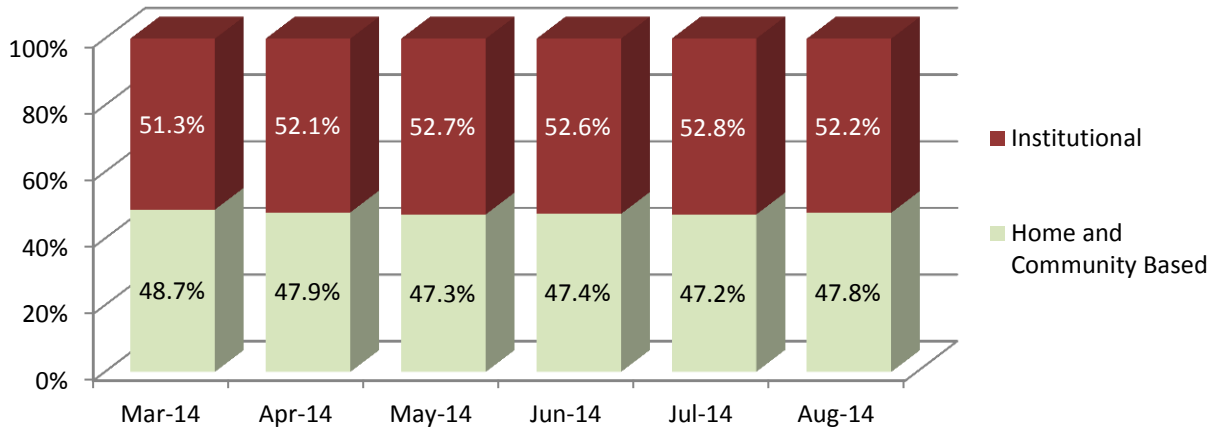
Figure 15: Enrollees by Residential Setting, January 2014 - August 2014



Source: Plan-reported data, Enrollee Residence Report, January 2014 - August 2014.

Once implementation was complete in March 2014, LTC enrollees' residence patterns were stable through August 2014 (Figure 16). The percentage of enrollees who resided in an institutional setting stayed between 51 and 53 percent each month.

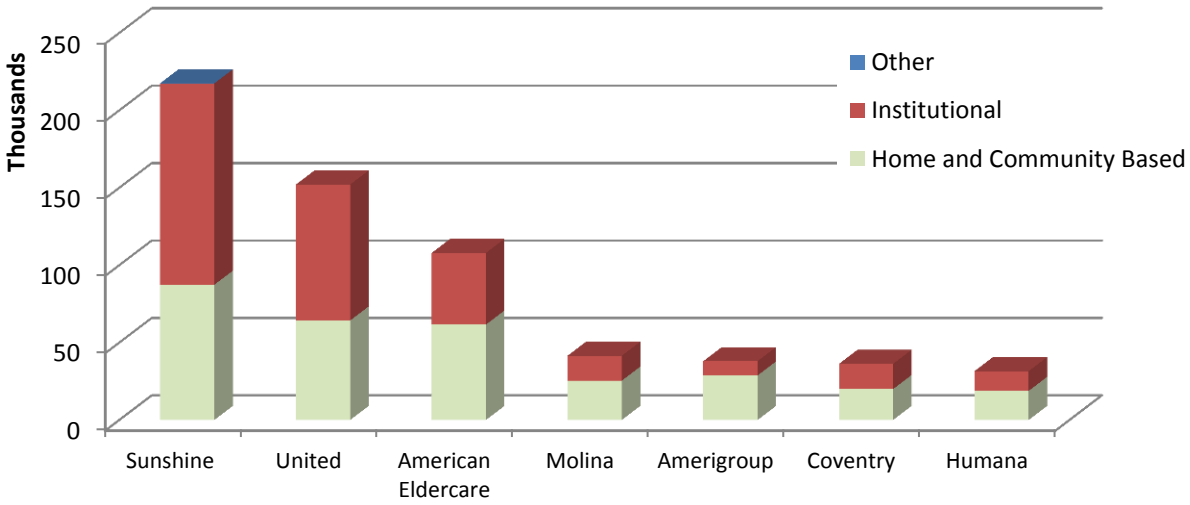
Figure 16: Enrollees' Residential Setting by Month, March 2014 - August 2014



Source: Plan-reported data, Enrollee Residence Report, March 2014 - August 2014.

While LTC enrollees were equally likely to live in an institutional or an HCBS setting within the LTC program as a whole, the percentage living in an institutional versus an HCBS setting varied across plans. Figure 17 indicates a majority of Sunshine and United's enrollee months were spent in an institutional setting. American ElderCare, Molina, Coventry, Amerigroup, and Humana all have a higher proportion of enrollee months spent in an HCBS setting than an institutional setting institutional. These differences are likely due to the plans initially chosen by enrollees given the early months of operation of the LTC program covered in this report.

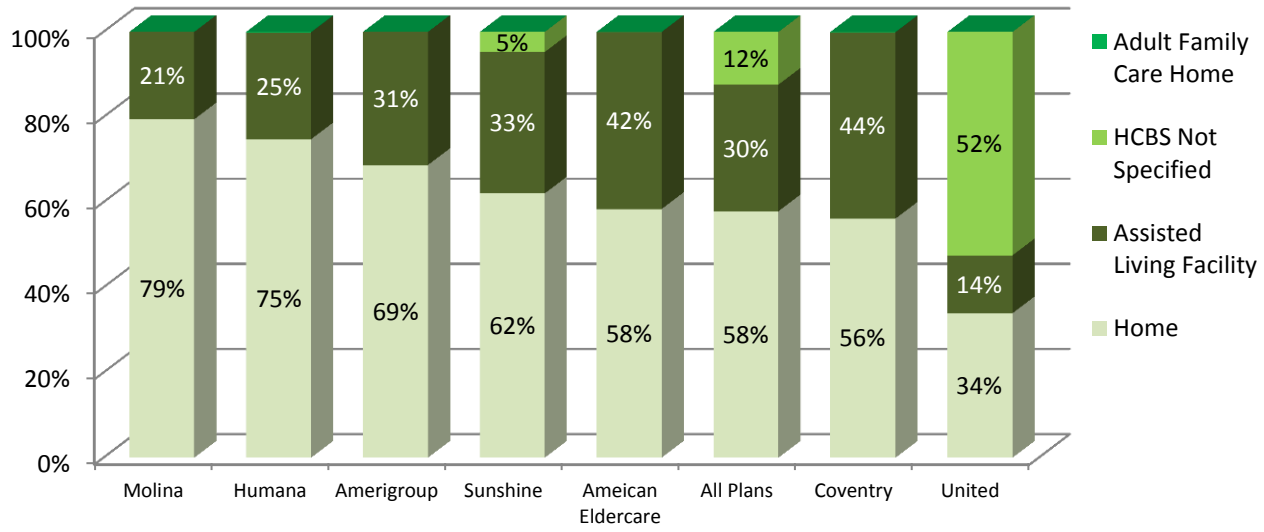
Figure 17: LTC Enrollees' Residential Setting by Plan, January 2014 - August 2014



Source: Plan-reported data, Enrollee Residence Report, January 2014 - August 2014.

Not all home and community based services are provided in the same setting. Home and community based services can be provided in the individual's own home, an assisted living facility (ALF), an adult family care home (AFCH), or another less common HCBS arrangement. Figure 18 shows the percentage of HCBS enrollees in each plan who lived in their own home as opposed to one of the other types of HCBS setting between January 2014 and August 2014.

Figure 18: Percentage of HCBS Enrollees Living at Home by Plan, January 2014 – August 2014



Source: Plan-reported data, Enrollee Residence Report, January 2014 - August 2014.

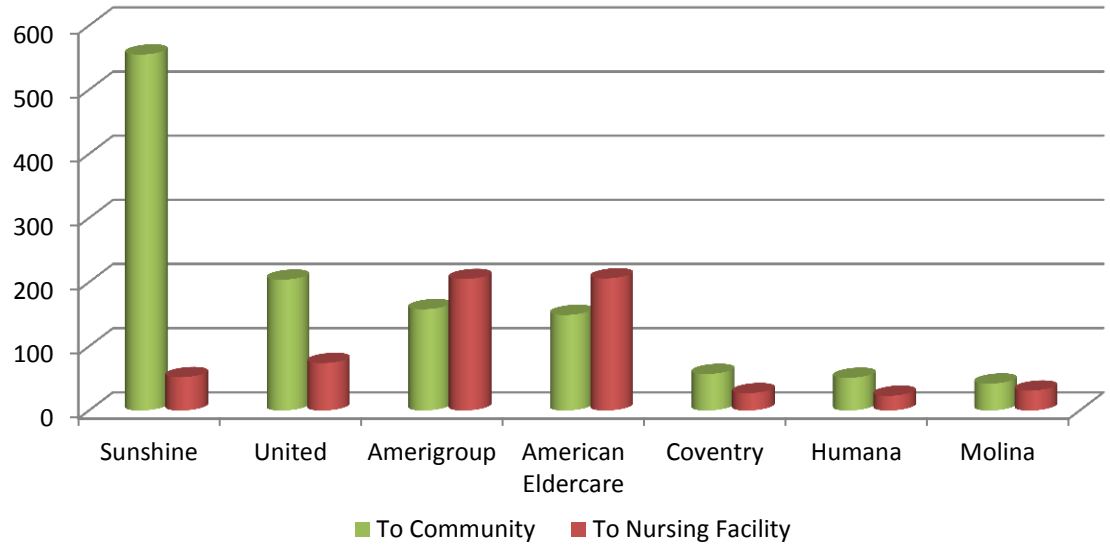
Figure 18 demonstrates that a majority of home and community based service clients in most plans resided in their own homes. Molina served a larger percentage of its HCBS member months in their own home than any other plan at 79 percent, while Sunshine served the greatest overall number of member months at home. Coventry, American ElderCare, and Sunshine served the highest percent of enrollee months in an assisted living facility of any plan at 44, 42, and 33 percent respectively.

Nursing Facility Transfers

The Nursing Facility Transfer Report identifies enrollees in each plan who transfer from a nursing facility into a home and community based setting, and vice versa. Each plan submits a Nursing Facility Transfer Report to the Agency monthly. Information from these reports was used to examine relative numbers of enrollees transferring into versus out of nursing facilities.

Figure 19 shows the number of enrollees in each plan who were transferred from a nursing facility into a home and community based setting, and the number of clients who went to a nursing facility from a home and community based setting from January 2014 to August 2014.

Figure 19: Transfers To and From Nursing Facilities by Plan, January 2014 – August 2014



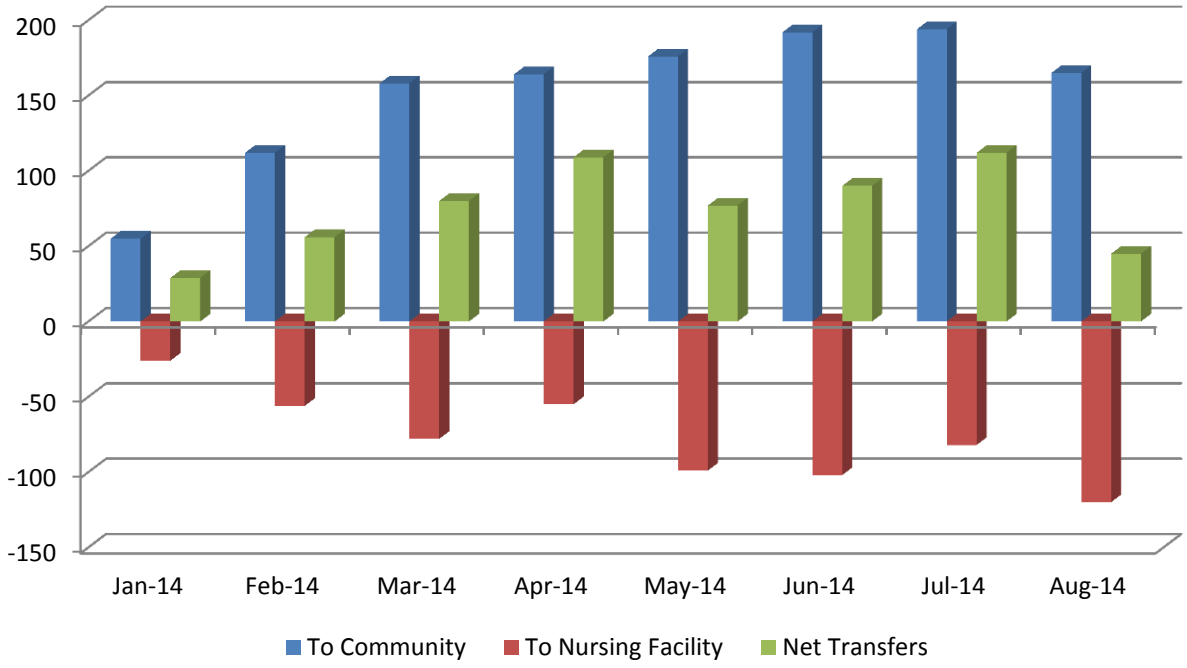
Source: Plan-reported data, Nursing Facility Transfer Report, January 2014 - August 2014.

All plans except American ElderCare and Amerigroup brought more enrollees out of a nursing facility than into a nursing facility. Besides American ElderCare with 206 transfers and Amerigroup with 205 transfers, no other plan had more than 75 transfers into a nursing facility. The rate of enrollees transferring out of as opposed to into a nursing facility varied between plans. Sunshine had the highest rate of transfers out of a nursing facility with 10.7 enrollees transferring from a nursing facility for every enrollee who transferred into a nursing facility. United had 2.8 enrollees transferring out of a nursing facility for every enrollee who transferred into a nursing facility.

Transfers to and from nursing facilities and the net number of transfers out of nursing facilities each month from January 2014 to August 2014 are shown in Figure 20. Both transfers out of nursing facilities (blue bar) and transfers into nursing facilities (red bar) generally increased over time. A positive net to community (green bar) – calculated by subtracting the number of transfers into nursing facilities from the number of transfers out of nursing facilities – indicates more transfers out of nursing facilities than into nursing facilities occurred during

the month. Net transfers to the community were positive in all months since January 2014, and tended to increase in size over time.

Figure 20: Transfers To and From Nursing Facilities by Month, January 2014 – August 2014

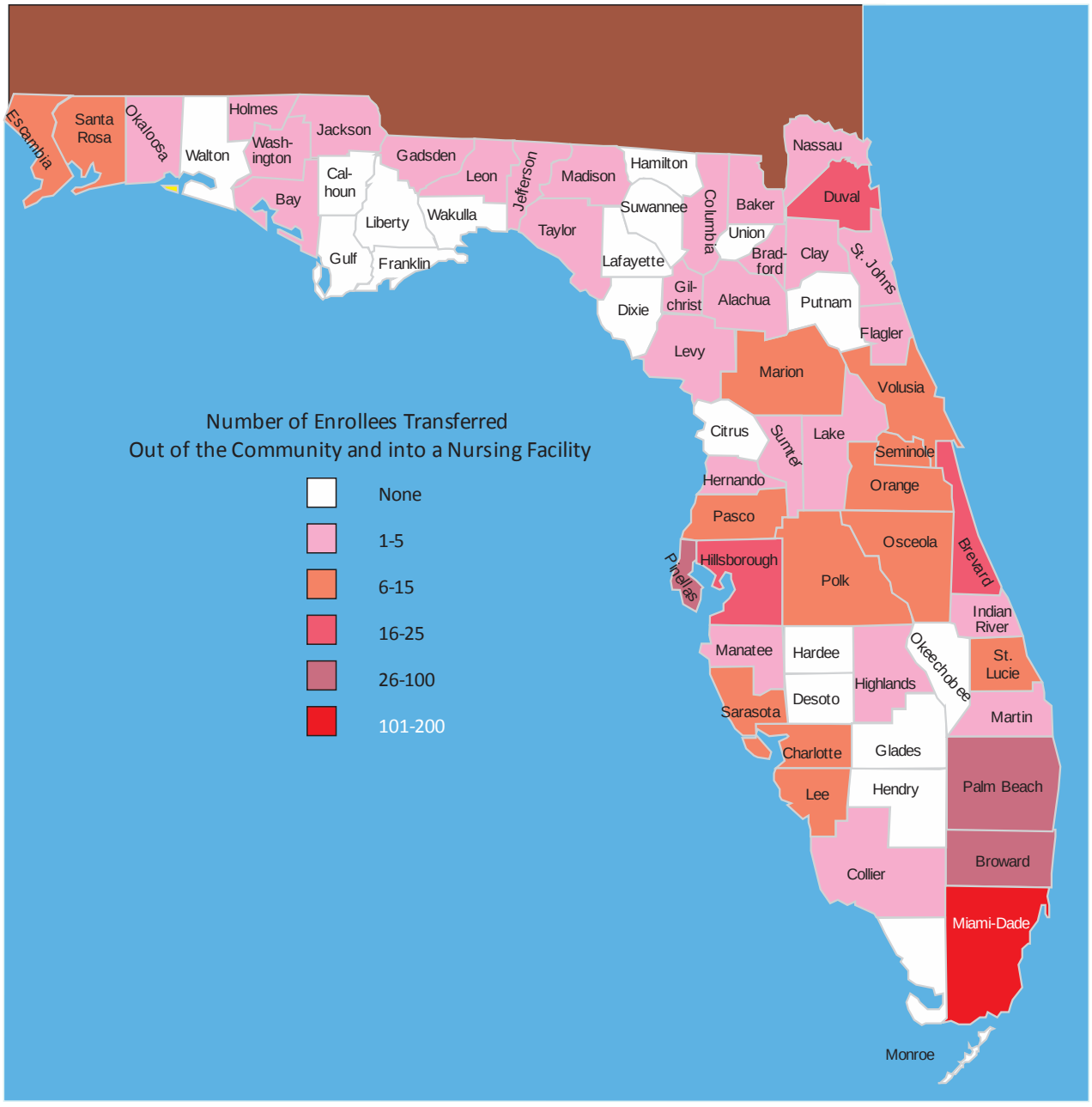


Source: Plan-reported data, Nursing Facility Transfer Report, January 2014 - August 2014.

With information about the resident's county, the number of transfers to and from nursing facilities can be mapped. Three maps are used to show how transfers between the community and nursing facilities vary by county. The first shows the number of enrollees by county who transferred from a community setting to a nursing facility. The second shows the number of enrollees by county who transferred to a community setting from a nursing facility. The third shows the net number of enrollees who transferred to a community setting from a nursing facility (the number in each county who transferred to a community setting minus the number who transferred to a nursing facility). In each map, transfers are included in the county of the community setting. The nursing facility is often, but not always, in the same county as the community during a transfer. Each map shows raw numbers; that is, they have not been normalized by county population or number of enrollees.

Figure 21 shows counties with greater numbers of transfers from HCBS to nursing facilities as darker red. Smaller numbers of transfers are shown in pink. More populated counties like Miami-Dade and Broward tend to have more enrollees transferring to a nursing facility. A few of the less populated counties like Walton, Lafayette, and Desoto did not have any enrollees transferring into a nursing facility.

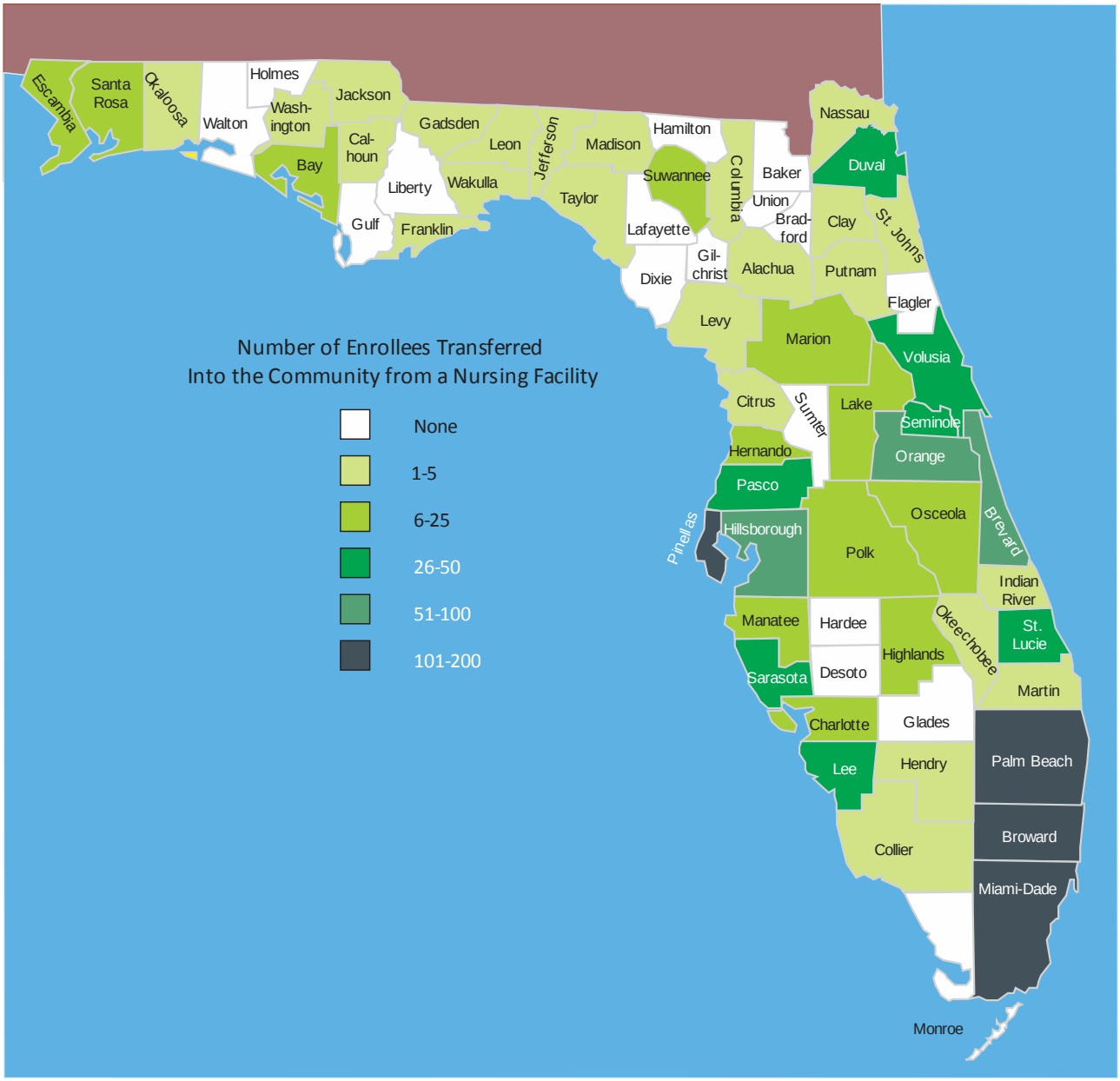
Figure 21: Number of Enrollees Who Transferred from HCBS into Nursing Facilities by County of HCBS, January 2014 – August 2014



Source: Plan-reported data, Nursing Facility Transfer Report, January 2014 - August 2014.

Figure 22 shows counties with a greater number of transfers from a nursing facility to a community setting as darker green. Smaller numbers are shown in lighter green. More populated counties like Broward, Palm Beach, Pinellas and Miami-Dade also tend to have more enrollees transferring from a nursing facility to the community. Some of the less populated counties like Holmes, Baker, and Glades counties did not have any enrollees transferring out of a nursing facility.

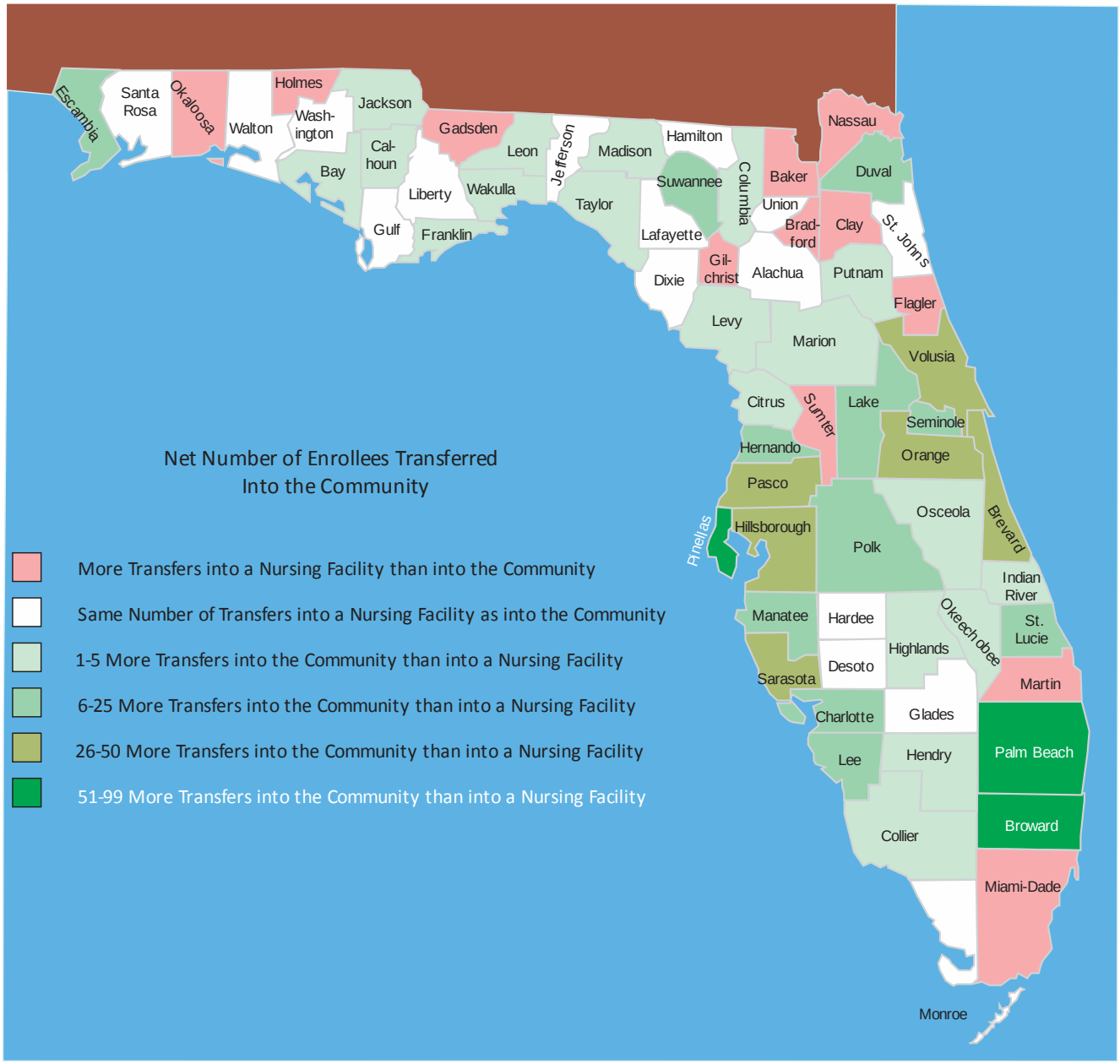
Figure 22: Numbers of Enrollees Who Transferred out of Nursing Facilities to HCBS by County of HCBS, January 2014 – August 2014



Source: Plan-reported data, Nursing Facility Transfer Report, January 2014 - August 2014.

Figure 23 shows the net number of enrollees who transferred from a nursing facility to a community setting. The net number is the difference between the number of enrollees who transferred out of a nursing facility to the community and the number of enrollees who transferred into a nursing facility from the community. Transfers are counted in the county of the community setting. If more enrollees transfer into a nursing facility than into a community setting in a county, the county is shown in pink (Nassau, Sumter, and Miami-Dade). Counties with the same number of transfers into and out of nursing facilities are shown in white (Santa Rosa, Alachua, and Monroe). If more enrollees transfer to a community setting than to a nursing facility, the county is shown in green. Darker green counties have a larger net difference in transfers.

Figure 23: Net Number of Enrollees Transferred between Nursing Facility and HCBS by County of HCBS, January 2014 – August 2014



Source: Plan-reported data, Nursing Facility Transfer Report, January 2014 - August 2014.

This map is less affected by population differences between the counties as it is based on the net difference in transfers rather than the total number of transfers in each county. Counties in the lightest green (for example, Leon, Marion, and Collier) have the fewest net transfers to the community. Counties in the darker green (Broward, Palm Beach and Pinellas) have the greatest number of net transfers to the community with over fifty in each county. In general, the darker green counties are the more populated ones in Central and South Florida, but there are clear exceptions. Miami-Dade had 13 more transfers into a nursing facility than into a community setting, but with 373 total transfers in Miami-Dade, that represents three percent of all transfers.

Plan Expenditures

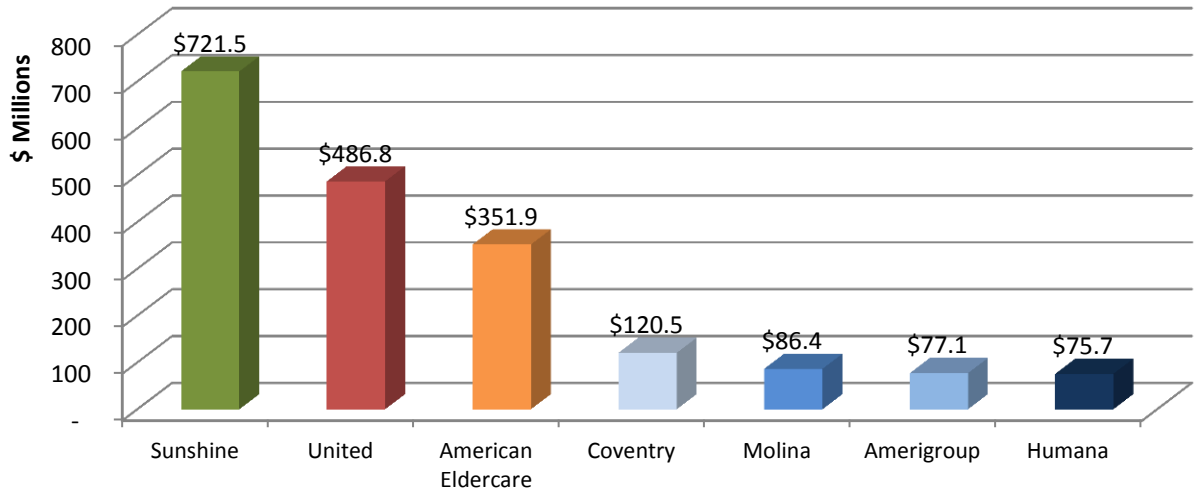
Introduction

Plan expenditures for LTC supports and services are examined using unaudited financial reports submitted by six of the seven LTC plans. The reports cover LTC plan activity from August 2013 through June 2014. The financial reports show the expenditures related to providing LTC supports and services and the type of LTC services plans purchased for enrollees. Fee-for-service claims from the Florida Medicaid Management Information System were used to calculate American ElderCare's service expenditures.

LTC Benefit Expenditures

Benefit expenditures are the money spent by plans to provide long-term care services to enrollees. It includes payments to individual providers of LTC services but does not include administrative expenditures associated with operating the plan. LTC benefit expenditures for each LTC plan are shown in Figure 24. Benefit expenditures for American ElderCare were calculated using fee-for-service claims from the Florida Medicaid Management Information System. Benefit expenditures for all other plans were reported by each plan.

Figure 24: LTC Benefit Expenditures by Plan, August 2013 – June 2014

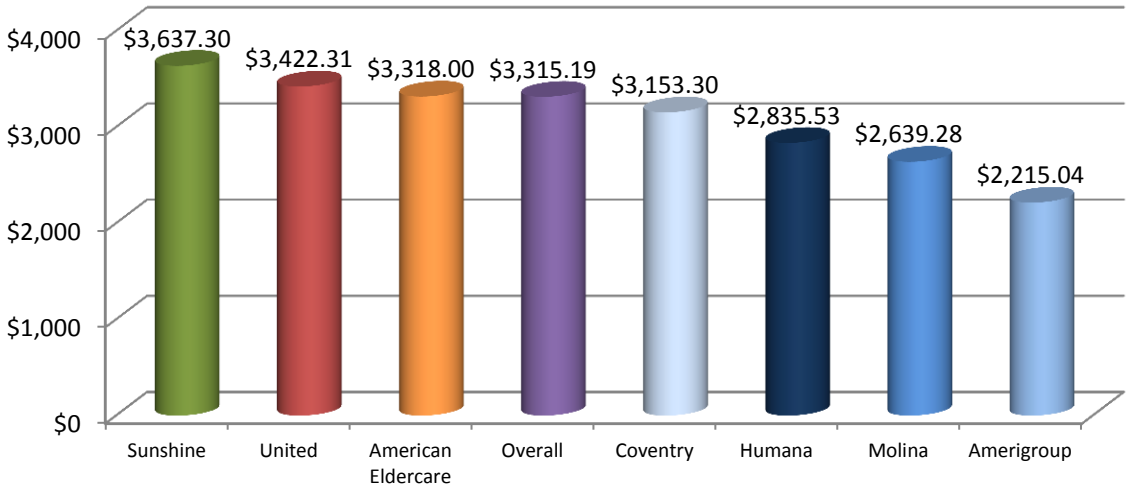


Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014. American ElderCare expenses from Florida Medicaid Management Information System (FLMMIS) fee-for-service claims, August 2013 - June 2014.
Note: Expenditures include amounts reported by each plan for services rendered but not paid as of June 30, 2014.

Sunshine and United reported the largest amount of LTC expenditures. The larger LTC expenditures for Sunshine and United are consistent with the larger number of member months for these plans. American ElderCare operated as a fee-for-service plan for the period under review. As a fee-for-service plan, most LTC expenditures were billed directly to Medicaid. Service providers were reimbursed by the Agency rather than by American ElderCare.

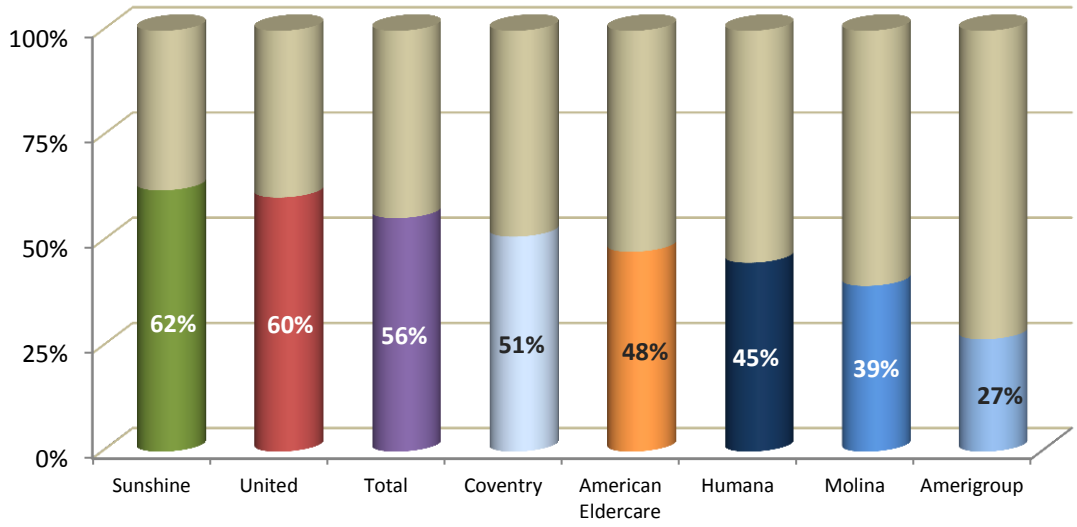
Figure 25 shows LTC benefit expenditures per member month by plan. Benefit expenditures vary from a high of 3,600 dollars per member month for Sunshine to a low of 2,200 dollars per member month for Amerigroup, typically reflective of each plan's own proportion of enrollees in nursing facilities or community settings (Figure 26).

Figure 25: LTC Benefit Expenditure per Member Month by Plan, August 2013 – June 2014



Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014. American ElderCare expenses from Florida Medicaid Management Information System (FLMMIS) fee-for-service claims, August 2013 - June 2014.

Figure 26: LTC Case Mix - Percentage in Nursing Facility by Plan, August 2013 - June 2014



Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014.

LTC Services Provided

Plans provide a variety of LTC supports and services. Table 7 shows the LTC services purchased by plans, and the expenditures spent on each type of service. From August 2013 through June 2014, most LTC expenditures were used to purchase skilled nursing facility services. Over $1 billion in expenditures in the LTC program were spent on skilled nursing facility services. Almost $295 million were spent on home and community based services, and over $270 million were spent on services provided but not yet paid (IBNP). Most of these services were likely for nursing facility services although the exact percentage is not specified in the plan reports. Later reports in this series will provide analyses based on plan-submitted encounter data which will allow for greater detail regarding service provision.

Table 7: Breakdown of LTC Plan Benefit Expenditure, August 2013 - June 2014

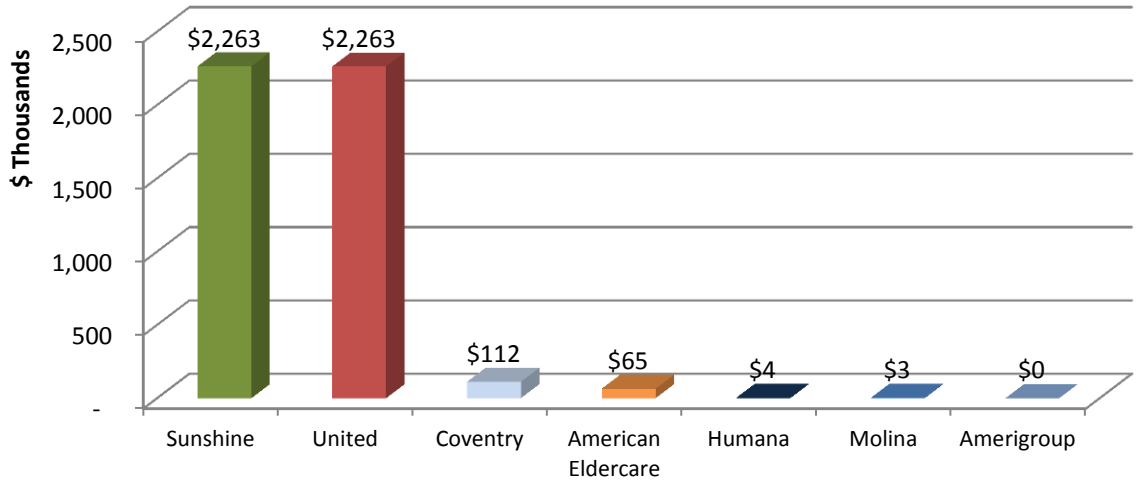
Service Category	Expense
Nursing Facility	$1,270,647,107
Home and Community Based	$294,875,584
Incurred but Not Paid	$270,901,173
Hospice - Institutional	$83,506,072
Total	$1,919,929,937

Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014. American ElderCare expenses from Florida Medicaid Management Information System (FLMMIS) fee-for-service claims, August 2013 - June 2014.
Note: Expenditures include amounts reported by each plan for services rendered but not paid.

Extra Benefit Expenditures

Extra benefits are benefits that LTC plans offer in addition to the core services they provide. Costs of these services are not included in the capitation rate the plans receive. Some of these extra benefits include an Assisted Living Facility/ Adult Family Care Home Bed Hold benefit, Cellular Phone Services, Dental Services, Emergency Financial Assistance, Hearing Evaluations, Mobile Personal Emergency Response System, Non-Medical Transportation, Over-The-Counter Drugs/ Supplies, Support to Move Out of a Nursing Facility, Vision Care, and a Wellness Grocery Discount. The benefits within each category vary by LTC plan and by region.

Figure 27: Extra Benefit Expenditures by LTC Plan, August 2013 - June 2014

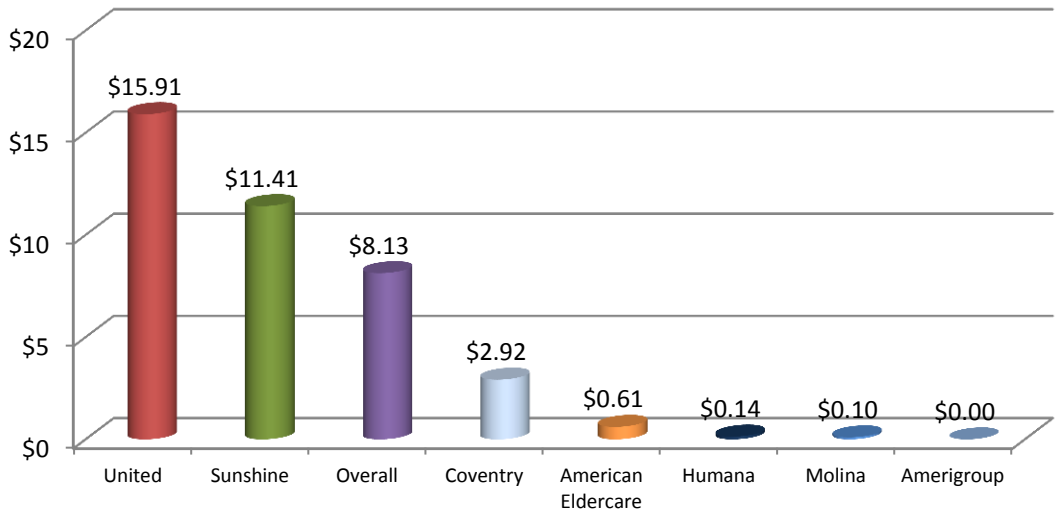


Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014.
Note: Expenditures include amounts reported by each plan for services rendered but not paid.

The extra benefit expenditures reported by each LTC plan are shown in Figure 27. The two LTC plans that are closest to serving statewide, Sunshine and United, each spent more than 22 times as much on extra benefits as the next largest provider of extra benefits, Coventry, which in turn, is over 28 times as much as other providers. Even though these values may seem large, they are no more than half of a percent of total LTC expenditures for each plan.

The amount of extra benefit expenditures per member month by each plan is shown in Figure 28. Amongst plans that provided extra benefits, the amount spent per member month ranged from a high of over 15 dollars per member month for United to a low of 10 cents per member month for Molina.

Figure 28: Extra Benefit Expenditures per Member Month by LTC Plan, August 2013 - June 2014



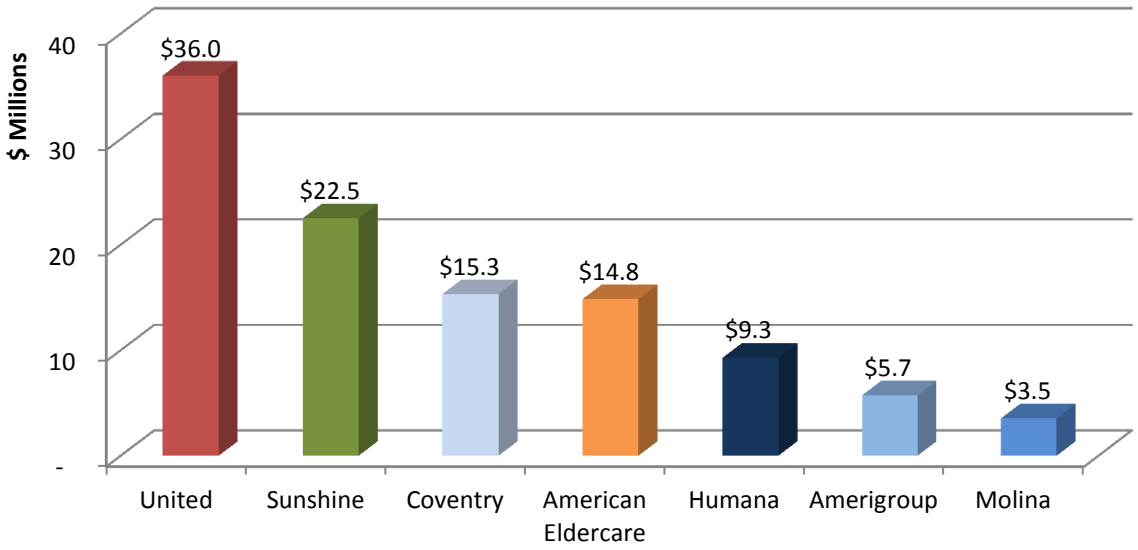
Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014.
Note: Expenditures include amounts reported by each plan for services rendered but not paid.

Administrative Expenditures

Administrative expenditures are the expenditures associated with operating the plan. Examples of administrative expenditures include staff salaries, computers and other equipment, and building expenditures.

The total amount of administrative expenditures for each plan is shown in Figure 29. United reported the largest administrative expenditure at $36 million. Molina reported the smallest administrative expenditure at $4 million. Administrative expenditures are expected to vary according to the number of regions in which a plan is contracted, the number of lives it covers, and its service delivery/care coordination model. In addition, administrative expenditures for the reported time period may be influenced by "start-up costs," or one-time expenditures associated with starting a new program in a new geographic area.

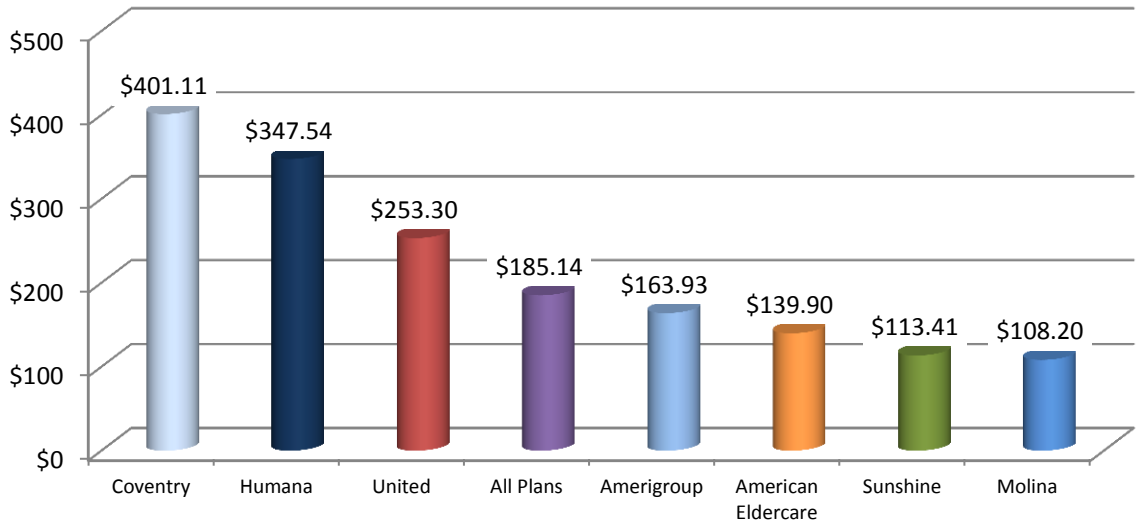
Figure 29: Administrative Expenditures by LTC Plan, August 2013 to June 2014



Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014.

In order to account for some of the variation in amounts of overall LTC expenditures across the LTC plans, the amount of Administrative Expenditures spent per member month is also presented (Figure 30). Coventry reports a larger amount of administrative cost per member month than any other LTC plan. Coventry and Humana report spending over $300 per member month on administrative expenditures. American ElderCare, Sunshine and Molina are the only LTC plans that report spending less than $150 per member month on administrative costs.

Figure 30: Administrative Expenditure per Member Month by LTC Plan, August 2013 - June 2014



Source: Plan-reported Financial Reports, Unaudited financial information submitted by the plans, August 2013 - June 2014.

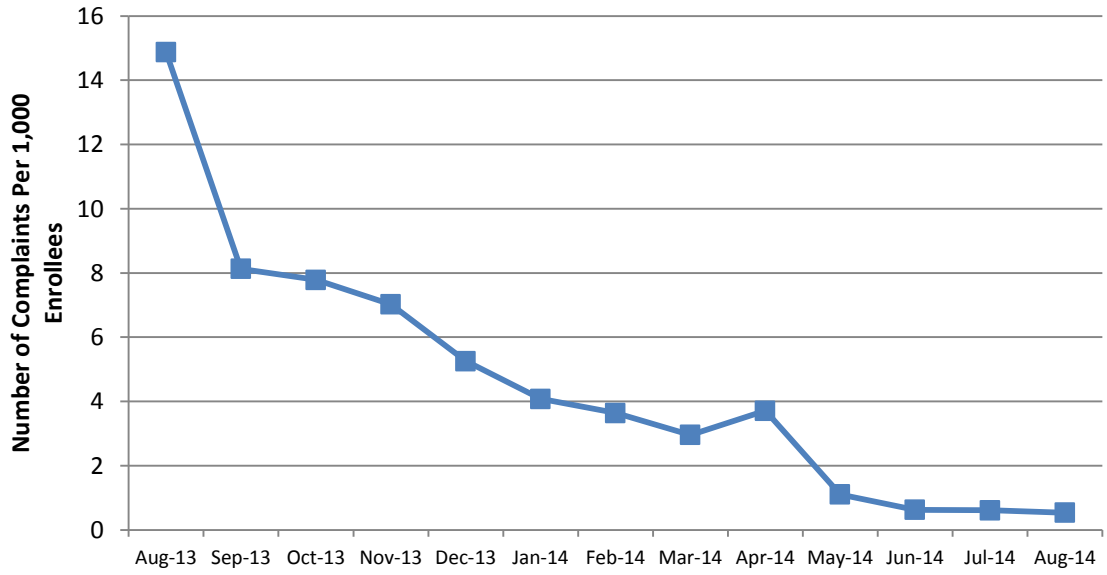
LTC Issues and Complaints

The Agency records issues and complaints about the LTC program. Issues range from questions about the program or enrollment in the program to reported dissatisfaction with some aspect of the program. All reported questions, issues, and complaints are recorded in CIRTS and analyzed as complaints in this report. Complaints received at the Agency, at the Governor's Office, by other agencies, or in the Agency's Division of Health Quality Assurance Call Center are transferred to the appropriate offices and recorded in the Medicaid Complaint Issues Reporting and Tracking System also known as CIRTS. Complainants, Medicaid recipients, health care providers and other sources may call, email, write, or complete the Online SMMC Complaint Form. Data compiled in CIRTS are used by management for tracking trends and targeting necessary improvements to the LTC program.

During the first ten days following the transition to the LTC program in each region, Department of Elder Affairs and Agency for Health Care Administration staff made outreach calls to LTC enrollees with a new managed care provider who live in their own homes. The goal was to ensure that service levels were maintained during the transition to the LTC program. Any dissatisfaction discovered during this outreach effort was recorded as a complaint in CIRTS. In addition, during implementation, Agency staff members who received reports of file errors, incorrect county code, incorrect address, or other incorrect information in the system were directed to record the event as a complaint in CIRTS. Tracking these issues in CIRTS aided in assuring continuity of service and correcting recipient information, but it gives the appearance of an increased number of complaints.

Figure 31 shows the number of complaints per 1,000 enrollees in SMMC from August 2013 through August 2014. During the first month of enrollment, there were approximately fifteen complaints per 1,000 enrollees. However, as the rollout continued over the following months, the number of complaints per 1,000 enrollees declined steadily to less than one (0.5) per 1,000 enrollees.

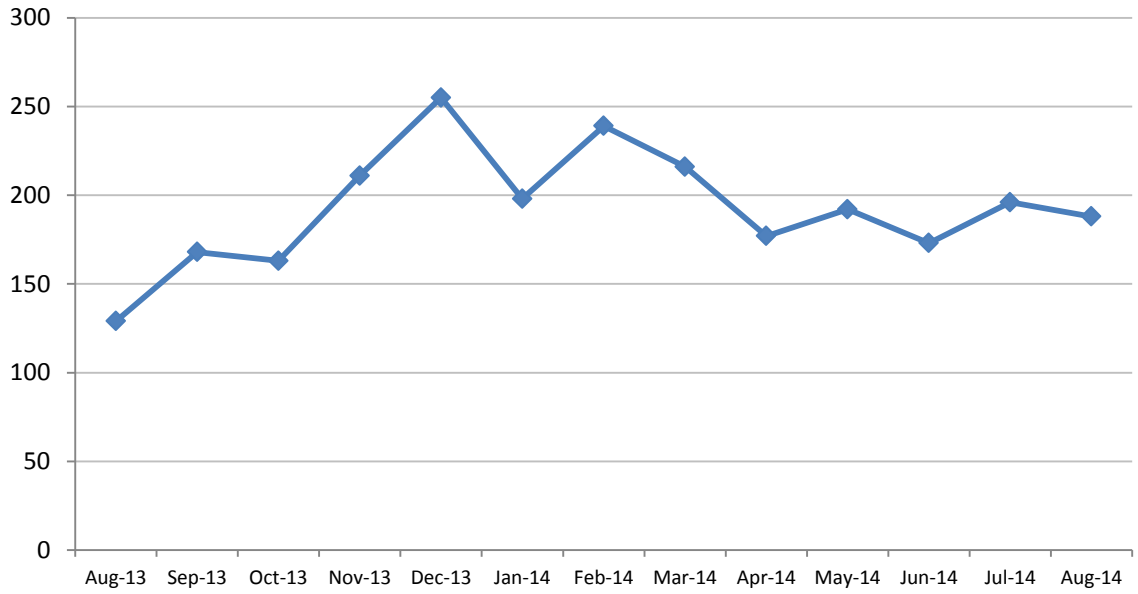
Figure 31: Number of Complaints Per 1,000 Enrollees by Month, August 2013 – August 2014



Source: Complaint Issues Reporting and Tracking System (CIRTS), Information about complaints registered with the Agency, August 2013 - August 2014.

If we look at the raw number of complaints in Figure 32, complaints increased slightly during the implementation of the LTC program between August 2013 and August 2014. The majority of calls recorded as complaints during LTC program implementation were resolved by Agency staff who provided guidance to recipients who had questions or concerns about the program or who needed assistance with changes of address to ensure enrollment in the correct region.

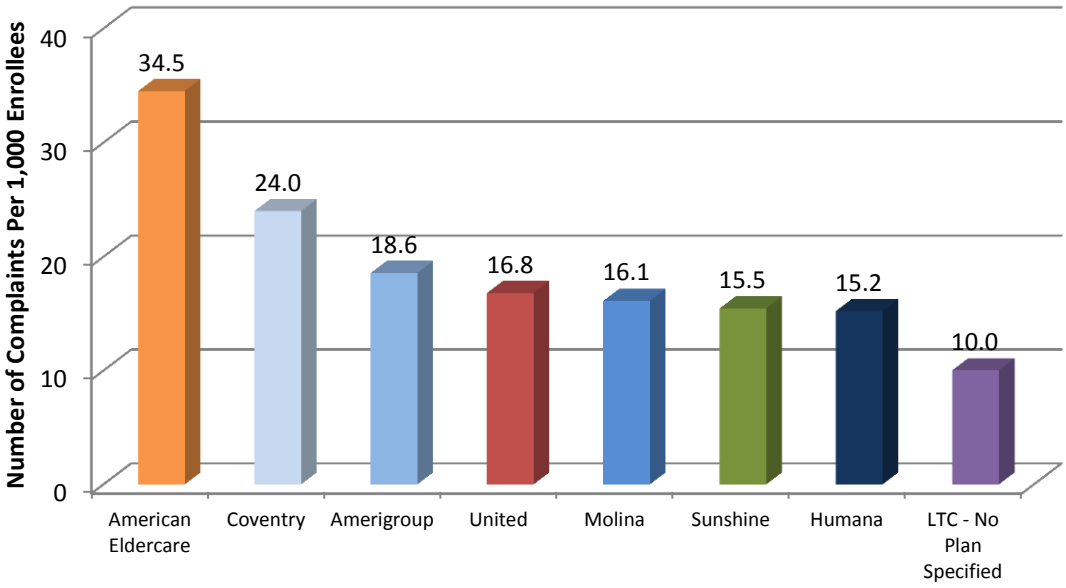
Figure 32: Number of Complaints by Month, August 2013 – August 2014



Source: Complaint Issues Reporting and Tracking System (CIRTS), Information about complaints registered with the Agency, August 2013 - August 2014.

The number of complaints per 1,000 enrollees between August 2013 and August 2014 for each LTC plan is shown in Figure 33. American ElderCare and Coventry had the most complaints per 1,000 enrollees. American ElderCare serves every region in Florida, and Coventry serves four regions. Humana, which serves three Florida regions, had the least number of complaints.

Figure 33: Number of Complaints per 1,000 Enrollees by LTC Plan, August 2013 – August 2014

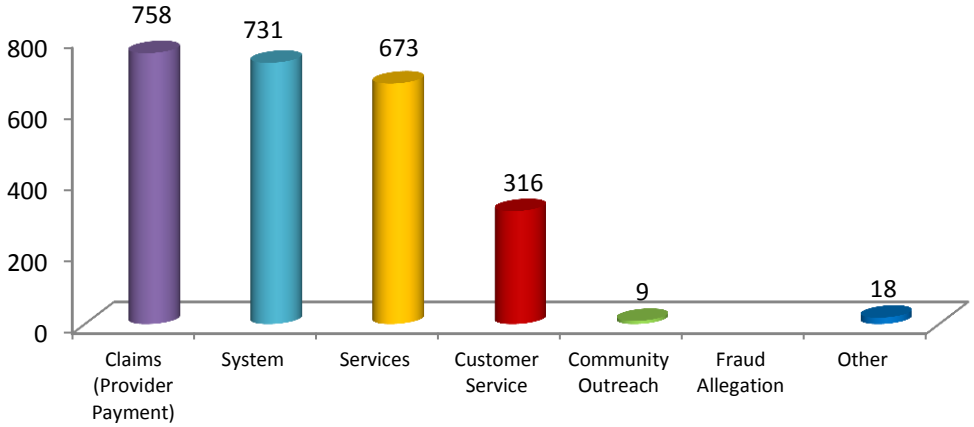


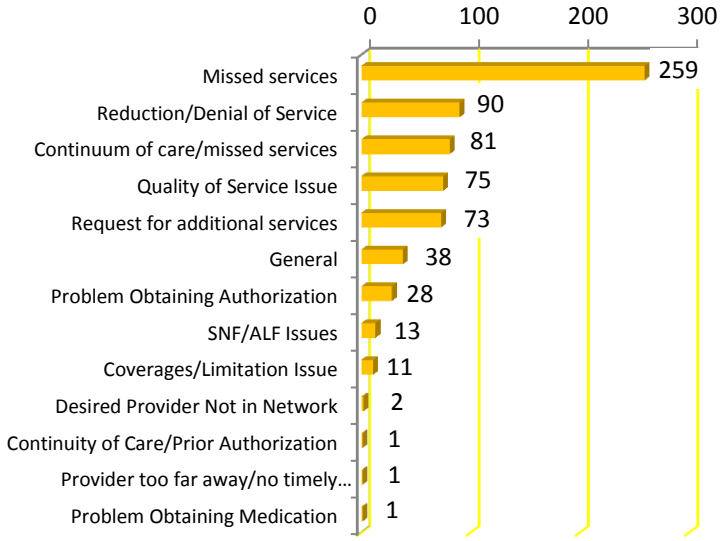
Source: Complaint Issues Reporting and Tracking System (CIRTS), Information about complaints registered with the Agency, August 2013 - August 2014.

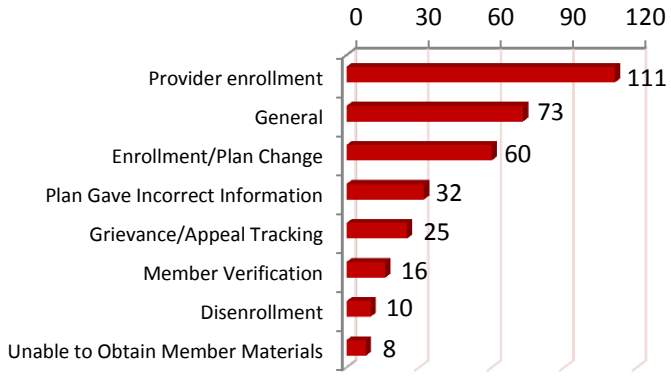
Figure 34 shows the number of LTC plan complaints between August 2013 and August 2014 by the type of issue involved in the complaint. There are six general categories of issue types by which complaints are categorized: Claims, Community Outreach, Customer Service, Other, Services, and System.

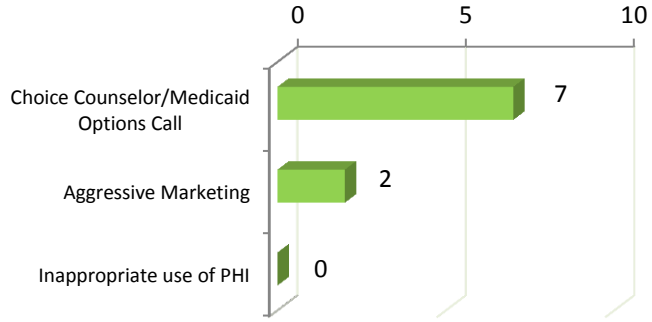
Complaints were more often about claims or system related issues than any other type of issue. Claims complaints refer to delays or difficulties providers experience obtaining payment for services provided. The majority of system complaints are related to file errors. System file errors refer to errors such as missing recipient level of care information which prevent plan enrollment. Complaints about errors in county code information and recipient eligibility information were also a common system related issues. The highest number of issues recorded about services associated with LTC plans were categorized as Missed Services. Many of these were from recipients who had questions or who were worried about the process of obtaining services in the new program. Reduction or denial of service, quality of service, and continuum of care were also issues. The most common complaints about customer service involved issues with providers enrolling as a service provider, issues identifying a case manager or obtaining general plan information, and issues enrolling members in or changing plans.

Figure 34: Number of Complaints, August 2013 – August 2014









Source: Complaint Issues Reporting and Tracking System (CIRTS), Information about complaints registered with the Agency, August 2013 - August 2014.

MMA Managed Care Program

The MMA program provides medical, dental, and behavioral health care services to most Medicaid recipients. There are some exceptions noted in the following section. The types of MMA plans are:

- MMA Standard Plans - Fourteen contracted entities provide MMA services: 1) Amerigroup, 2) Coventry, 3) Humana, 4) Molina, 5) Preferred, 6) Simply, 7) Sunshine Health, 8) Staywell, 9) United Healthcare, 10) Better Health, 11) First Coast Advantage, 12) Integral, 13) Prestige, and 14) South Florida Community Care Network.
- MMA Specialty Plans - Six contracted entities provide services to populations with a chronic medical condition, specific diagnosis, or specific age group: 1) Clear Health Alliance (HIV/AIDS), 2) Freedom Health (Disease Management), 3) Magellan Complete Care (Serious Mental Illness), 4) Positive Health Care Florida (HIV/AIDS), 5) Children's Medical Services Network (Child Chronic Conditions), and 6) Sunshine Health Care (Child Welfare).

MMA Standard Plans

Enrollment Requirements

Those eligible for Medicaid with full Medicaid service coverage must enroll in an MMA plan. However, there is a portion of this population for which coverage is voluntary as noted below (groups listed are based on the 2014 legislation). Additionally, Medicaid recipients with limited Medicaid coverage are excluded from enrollment.

Voluntary Enrollment

- Individuals who have other creditable health care coverage, excluding Medicare.
- Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility.
- Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF/DD).
- Individuals with developmental disabilities enrolled in the home and community based waiver and Medicaid recipients waiting for developmental disabilities waiver services.
- Children receiving services in a prescribed pediatric extended care (PPEC) facility[1].
- Individuals with developmental disabilities residing in a licensed group home facility.

Excluded Enrollment

- Individuals eligible for emergency services only due to immigration status.
- Those eligible for the Family Planning waiver.
- Individuals eligible as women with breast or cervical cancer.
- Individuals eligible and enrolled in the Medically Needy program with a share of cost.

[1] Voluntary enrollment for PPEC is pending Federal Centers for Medicare and Medicaid Services approval.

- Individuals with Medicare for whom Medicaid pays only the Medicare premium, coinsurance, or deductibles.

MMA Implementation Schedule

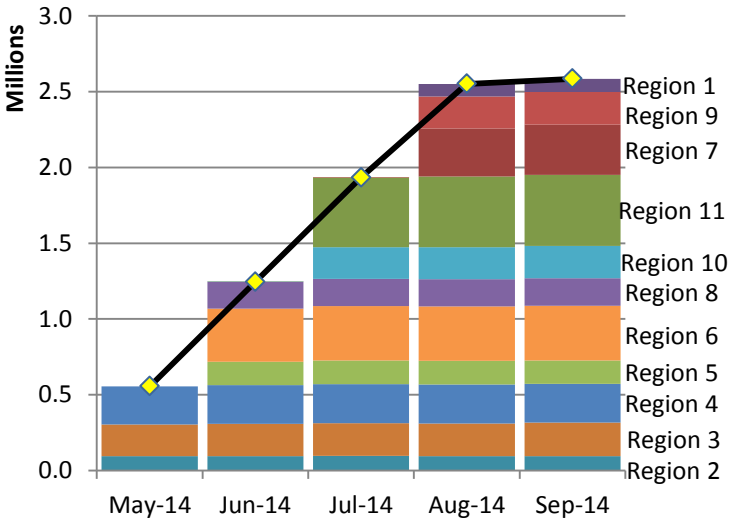
In May 2014, enrollment for the SMMC MMA program began in Regions 2, 3, and 7, and continued throughout the remaining regions over the next three months. Table 8 displays the MMA implementation schedule by date and by region for Standard MMA plans.

Table 8: Implementation Schedule for MMA Standard Plans

MMA Standard Plan Rollout Schedule											
Plans	2014										
	May			Jun			Jul		Aug		
	Regions										
	2	3	4	5	6	8	10	11	1	7	9
Amerigroup				x	x			x		x	
Better Health					x		x				
Coventry								x			
First Coast Advantage			x								
Humana					x		x	x	x		x
Integral					x	x			x		
Molina								x		x	x
Preferred								x			
Prestige	x	x		x	x	x		x		x	x
SFCCN							x				
Simply								x			
Staywell	x	x	x	x	x	x		x		x	
Sunshine Health		x	x	x	x	x	x	x			x
United Healthcare		x	x					x		x	

Figure 35 shows the progression of enrollment in the MMA program over the first five months of enrollment. The number of MMA enrollees increased from 555,000 during the first month of MMA enrollment to over two-and-a-half million by September 2014.

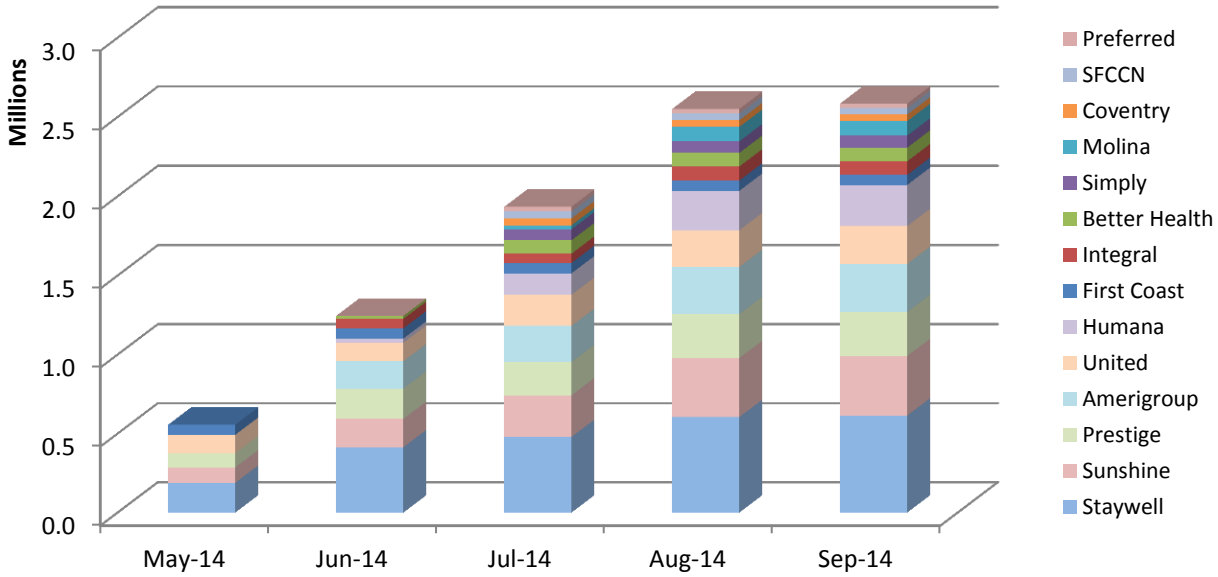
Figure 35: Number of Individuals Enrolled in MMA, May 2014 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

Figure 36 displays the distribution of enrollees across the MMA plans throughout the implementation period. Five MMA plans began serving enrollees in May 2014, the first month of implementation. All fourteen MMA plans were serving enrollees by July 2014, the third month of implementation. However, MMA plans were not serving enrollees in all Florida regions until August 2014, the final month of implementation. Enrollment numbers in each plan remained stable from August 2014 to September 2014.

Figure 36: Number of Enrollees by MMA Plan, May 2014 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

MMA plan enrollees were given the option to choose an MMA plan. Those who did not select an MMA plan were assigned to one by the Agency. The following table displays the distribution of enrollee months across plans and regions from May 2014 to September 2014. Each cell in the table shows the number of member months for each MMA plan and region. The number of regions served varies for each MMA plan. Coventry operates an MMA plan in only one region with just over one percent of all member months for the period. Sunshine has an MMA plan in nine regions and almost fifteen percent of all member months. Staywell operates in eight regions and covered the most member months of any plan with twenty-six percent of all member months. Amerigroup, Prestige, and United each covered over ten percent of member months for the period. The remaining plans each covered less than ten percent of member months, ranging from a low of one percent (Preferred) to a high of seven and a half percent (Humana) of total member months (Table 9).

Table 9: MMA Member Months by Plan and Region, May 2014 - September 2014

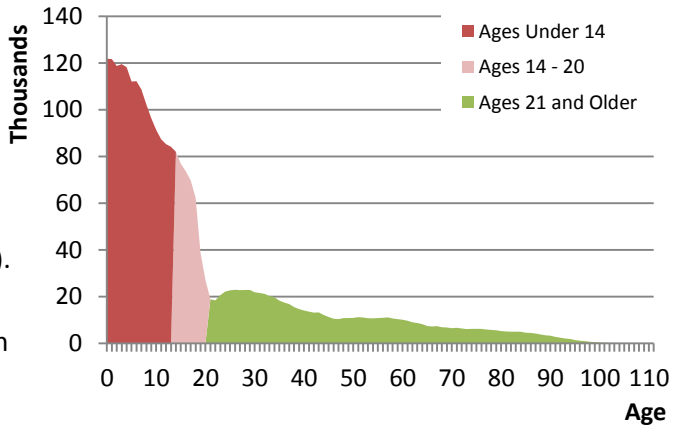
Plan	Region											Total	%
	1	2	3	4	5	6	7	8	9	10	11		
Amerigroup					262,477	449,132	139,529				151,128	**1,002,266**	11.3%
Better Health						75,407				200,691		**276,098**	3.1%
Coventry											127,929	**127,929**	1.4%
First Coast Advantage				321,732								**321,732**	3.6%
Humana	108,171					106,539			117,124	138,003	199,248	**669,085**	7.5%
Integral	61,477					72,567		157,658				**291,702**	3.3%
Molina							20,283		115,051		71,754	**207,088**	2.3%
Preferred											87,262	**87,262**	1.0%
Prestige		211,300	272,264		81,381	98,573	63,586	202,641	76,075		45,653	**1,051,473**	11.9%
SFCCN										126,706		**126,706**	1.4%
Simply											217,647	**217,647**	2.5%
Staywell		264,200	404,311	278,292	168,421	458,767	253,221	303,023			167,916	**2,298,151**	25.9%
Sunshine			133,081	359,027	107,980	168,268	104,164	52,469	118,310	170,644	76,503	**1,290,446**	14.5%
United			267,734	319,003			67,404				248,450	**902,591**	10.2%
Totals	**169,648**	**475,500**	**1,077,390**	**1,278,054**	**620,259**	**1,429,253**	**648,187**	**715,791**	**426,560**	**636,044**	**1,393,490**	**8,870,176**	100.0%

Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

MMA Enrollment Demographics

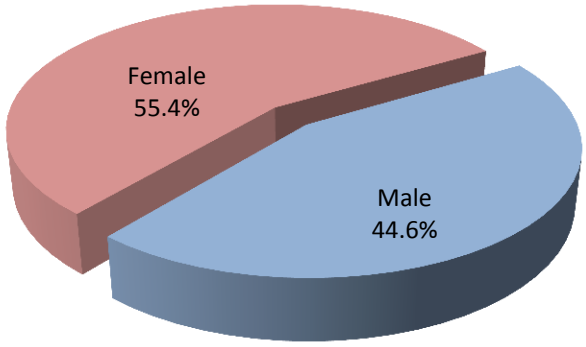
Over fifty-four percent of MMA enrollees are children under age 14. Fifty-five percent of all MMA enrollees are women, and seventy percent of all enrollees are under 21 years of age (Figure 37 & 38). Thirty percent of MMA enrollees classify themselves as Hispanic, twenty-nine percent as White, and twenty-nine percent as Black or African American (Figure 39). Fewer than seven percent of all MMA enrollees have Medicare coverage (Figure 40). Fifty-seven percent of MMA enrollees qualify for Medicaid under the Temporary Assistance for Needy Families (TANF) Children standards (Figure 41). Twenty percent qualify under TANF Family standards.

Figure 37: MMA Enrollees by Age, September 2014



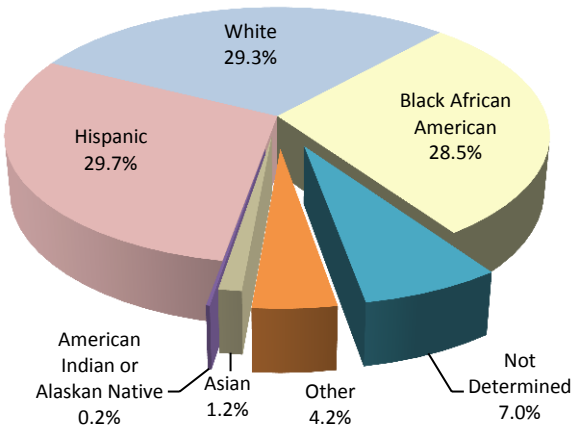
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 38: Percentage of MMA Enrollees by Gender, September 2014



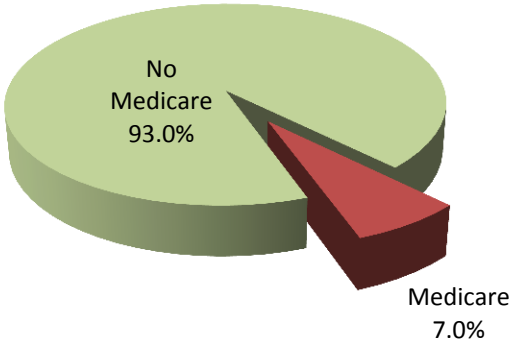
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 39: Percentage of MMA Enrollees by Race and Ethnicity, September 2014



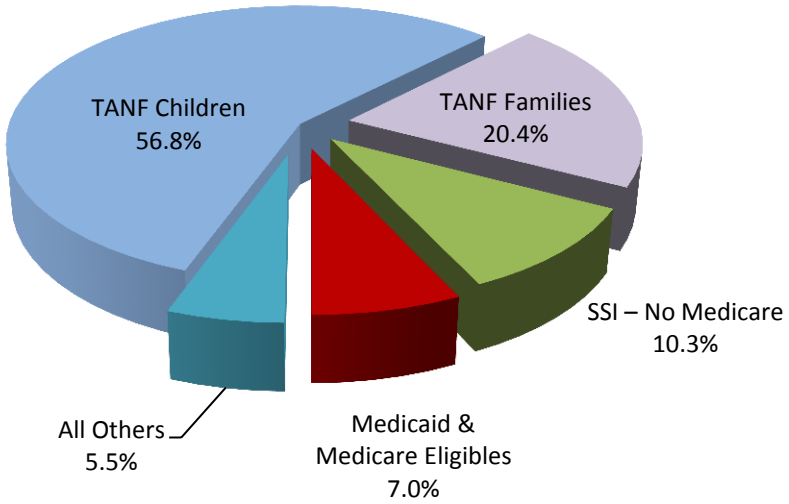
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 40: Percentage of MMA Enrollees by Medicare Status, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 41: Percentage of MMA Enrollees by Program Category, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Payments to MMA Standard Plans

MMA plans receive a monthly capitation or per member per month payment based on the number of enrollees they serve. MMA plans are paid on a full-risk, capitated basis, which means they receive an average monthly capitation rate for each enrollee and must provide all medically necessary contracted services. Capitation payments to plans are adjusted for the health risk of each plan's enrollees.

The following table displays the total monthly payments by region for each MMA plan for May and June 2014. Only plans that implemented in May or June 2014 appear in the table. The total amount paid to all MMA plans during the first two months of the program was $482,392,603. Staywell received the largest reimbursement over the period at $158,569,547 or thirty-three percent of the total reimbursement (Table 10).

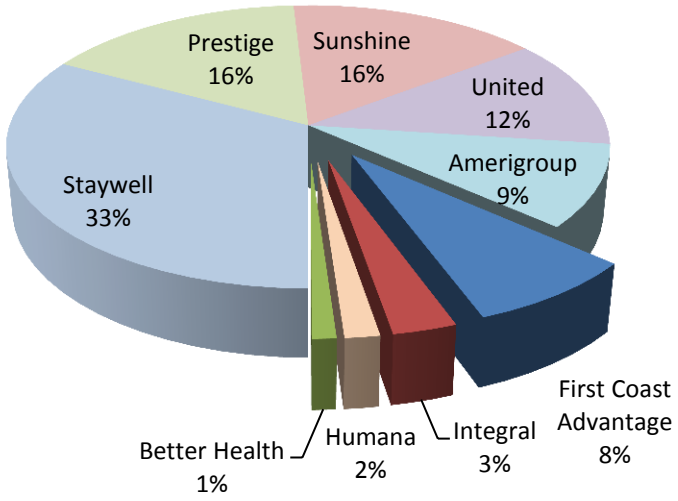
Table 10: Total Capitation Payments (in dollars) by MMA Standard Plan and Region, May 2014 - June 2014

Plan	Region											Total
	1	2	3	4	5	6	7	8	9	10	11	
Sunshine			14,652,072	37,403,496	8,268,956	11,000,593		3,530,510				**74,855,627**
United			28,872,884	31,367,774								**60,240,658**
First Coast Advantage				38,197,601								**38,197,601**
Prestige		21,426,944	30,492,228		6,543,869	6,580,010		13,221,814				**78,264,865**
Staywell		25,648,474	41,543,366	29,502,803	13,663,684	29,839,326		18,371,894				**158,569,547**
Better Health						5,285,738						**5,285,738**
Amerigroup					18,322,797	27,088,569						**45,411,366**
Integral						4,848,705		9,120,583				**13,969,288**
Humana						7,597,913						**7,597,913**
All Plans	**-0-**	**47,075,418**	**115,560,550**	**136,471,674**	**46,799,306**	**92,240,854**	**-0-**	**44,244,801**	**-0-**	**-0-**	**-0-**	**482,392,603**

Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, May 2014 - June 2014.

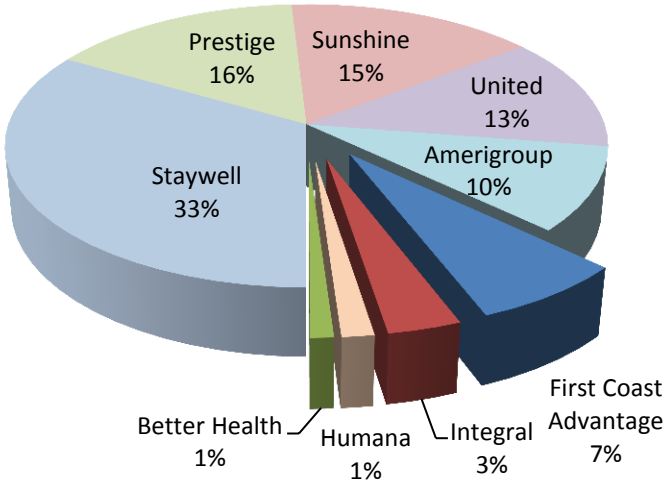
Figure 42 shows how monthly payments were distributed amongst the MMA plans, and Figure 43 shows the percentage of member months covered by each MMA plan. Staywell received a third of the total capitation amount for the period and covered the largest percentage of member months.

Figure 42: Percentage of Capitation Amounts by MMA Plan, May 2014 – June 2014



Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, May 2014 - June 2014.

Figure 43: Percentage of Member Months by MMA Plan, May 2014 - June 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May – June 2014.

MMA Specialty Plans

Specialty plans are designed to serve the needs of Medicaid populations with a specific diagnosis or chronic condition. Specialty plans cover the same services as Standard MMA plans but a recipient must meet the specified criteria in order to enroll in a Specialty plan. As Specialty plans are implemented, the Agency assigns recipients using available information about age, medical conditions, or diagnosis to the MMA Specialty plan that will accommodate the recipient. A recipient can choose to enroll in a Standard MMA plan, even if she or he is eligible for an MMA Specialty plan.

Enrollment Requirements

- Child Welfare: Medicaid recipients under the age of 21 who have an open case for child welfare services in the Department of Children and Families' Florida Safe Families Network database may be enrolled in Sunshine's Child Welfare plan.
- Serious Mental Illness: The Agency identifies the eligible population using specific diagnosis codes and/or medications used to treat the specified diagnoses. Medicaid recipients diagnosed with Schizophrenia, Bipolar Disorder, Major Depressive Disorder, or Obsessive Compulsive Disorder may be enrolled in Magellan's Complete Care plan.
- Children's Medical Services Network: Medicaid recipients under the age of 21 who meet the Department of Health's clinical screening criteria for chronic conditions may be enrolled in the Children's Medical Services Network plan.
- HIV/AIDS: Medicaid recipients diagnosed with HIV or AIDS may be enrolled in one of two Specialty plans – Clear Health Alliance or Positive Health Care. The Agency identifies the eligible population using specific diagnosis codes, laboratory procedure codes, and/or medications commonly used to treat HIV or AIDS.
- Chronic Conditions: Medicaid recipients aged 21 and older eligible for both Medicare and full Medicaid benefits with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) or Cardiovascular Disease (CVD), and may be enrolled in the Freedom Health Specialty plan.

Specialty Plan Implementation

The implementation of Specialty plans began in May 2014. By September 2014, most of the Specialty plans were in operation except for Freedom Health's Chronic Conditions plan which will begin operation in February 2015. Table 11 shows the MMA Specialty plan implementation schedule.

Table 11: Implementation Schedule for MMA Specialty Plans

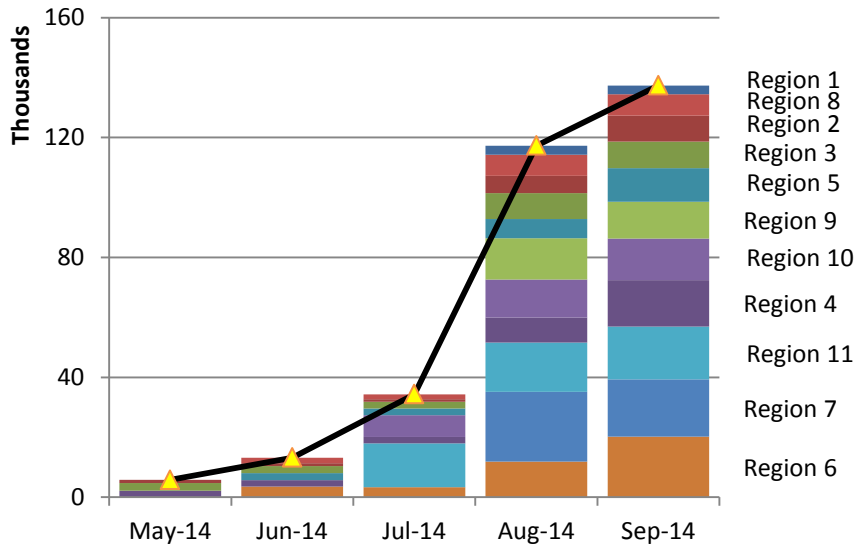
MMA Specialty Plan Rollout Schedule											
Plans	2014										
	May			Jun			Jul		Aug		
	Regions										
	2	3	4	5	6	8	10	11	1	7	9
Clear Health	x	x		x	x	x	x	x	x	x	x
Positive Healthcare							x	x			
Sunshine	x	x	x	x	x	x	x	x	x	x	x

MMA Specialty Plan with a Variant Rollout Schedule											
Plan	2014										
	Jul			Aug			Sep				
	Regions										
	8	10	11	1	7	9	2	3	4	5	6
Magellan		x	x		x	x	x		x	x	x

MMA Specialty Plan Schedule with a Single Rollout Date												
Plans	Rollout Date	Regions										
		1	2	3	4	5	6	7	8	9	10	11
Children's Medical Services	Aug 2014	x	x	x	x	x	x	x	x	x	x	x
Freedom Health	Feb 2015			x		x	x	x	x	x	x	x

Specialty plan enrollment is shown in Figure 44. Approximately 6,000 individuals were enrolled in a Specialty plan effective May 2014. By September of 2014, almost 138,000 individuals were enrolled in a Specialty plan. The Specialty plans are being implemented on a different schedule than the other MMA plans, and not all of the Specialty plans are available statewide.

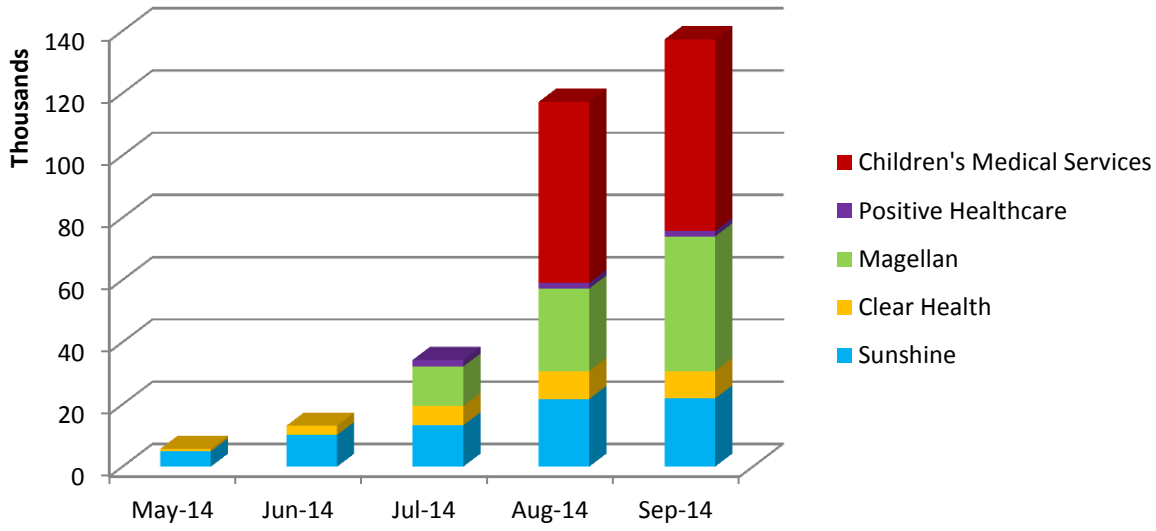
Figure 44: Number of individuals enrolled in a MMA Specialty Plan, May 2014 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

Figure 45 shows Specialty plan enrollment by plan for May 2014 through September 2014. Only two Specialty plans, Sunshine Health Care and Clear Health Alliance, had enrollees in May and June 2014. Four of the five had enrollees by July and all five had enrollees by August 2014. The sixth Specialty plan, Freedom Health, will begin enrollment in February 2015.

Figure 45: MMA Specialty Plan Enrollees by Plan, May 2014 - September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

Table 12 displays the distribution of Specialty plan enrollees across plans and regions from May to August 2014. Each cell shows the number of member months of enrollment for the Specialty plan and the region. The number of regions in which a Specialty plan operates varies. Children's Medical Services Network (CMS) and Sunshine Health Care each operate in all eleven regions. Clear Health Alliance operates in all but one region. Magellan Complete Care operates in eight regions but four of these regions did not begin enrollment until September 2014. Positive Health Care operates in two regions.

Table 12: Specialty MMA Member Months by Plan and Region, May 2014 - September 2014

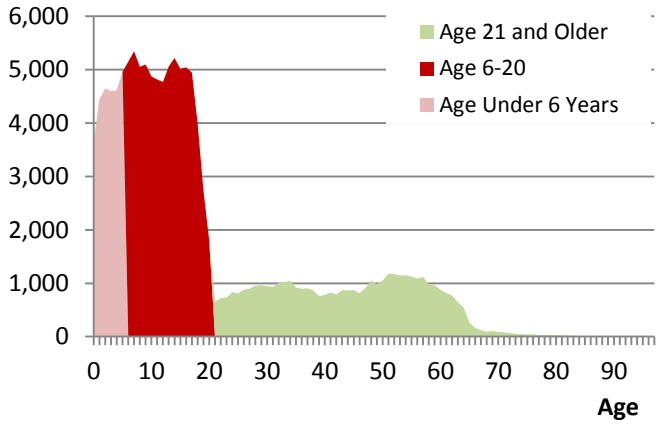
Region	Plan					Totals
	Children's Medical Services Network	Clear Health Alliance	Magellan Complete Care	Positive Health Care	Sunshine Health Care	
1	3,481	460			1,977	**5,918**
2	9,442	1,308	2,704		3,748	**17,202**
3	12,173	2,636			9,808	**24,617**
4	11,643		7,038		11,534	**30,215**
5	7,699	3,533	4,519		6,478	**22,229**
6	15,843	3,028	8,190		11,911	**38,972**
7	15,364	2,315	19,667		5,060	**42,406**
8	9,986	2,097			5,653	**17,736**
9	10,948	2,571	8,676		3,838	**26,033**
10	13,513	2,557	9,528	2,581	5,742	**33,921**
11	9,671	7,384	22,078	3,237	6,255	**48,625**
Total	**119,763**	**27,889**	**82,400**	**5,818**	**72,004**	**307,874**
Percent	38.9%	9.1%	26.8%	1.9%	23.4%	100.0%

Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 - September 2014.

Specialty Plan Enrollment Demographics

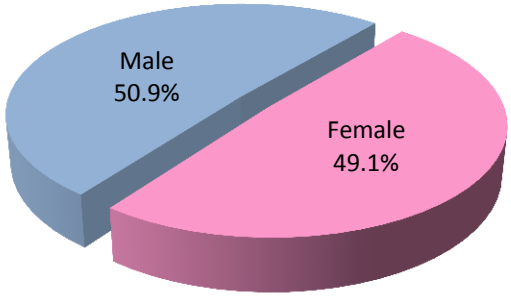
Typical Specialty plan enrollees are under 21-years-old without Medicare who classify their race or ethnicity as White and qualify for Medicaid because they receive SSI. Seventy percent of MMA Specialty plan enrollees are under the age of 21, fifty percent are between the ages of six and twenty (Figure 46). Children's Medical Services and Sunshine both serve only enrollees under age twenty-one. Slightly more than half of MMA Specialty plan enrollees are male which contrasts with the MMA Standard and LTC plans that have a higher percentage of females (Figure 47). Thirty-one percent of enrollees identify their race as White, almost twenty-seven percent identify as Black or African American, and seventeen percent identify as Hispanic (Figure 48). Three percent receive Medicare (Figure 49) and more than forty percent are eligible for Medicaid because they receive SSI (Figure 50). Thirty-one percent of Specialty plan enrollees are eligible for Medicaid through TANF Children standards. Eleven percent qualify through TANF Family standards.

Figure 46: Specialty Plan Enrollees by Age, September 2014



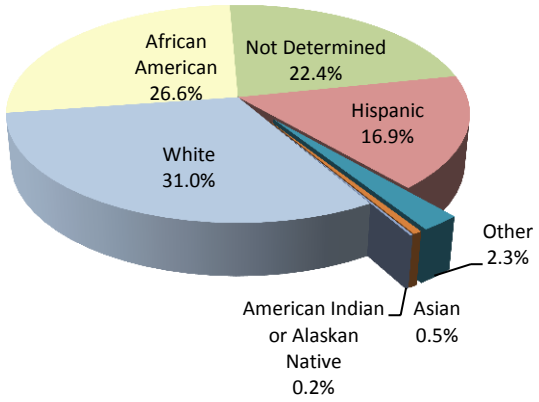
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 47: Percentage of Specialty Plan Enrollees by Gender, September 2014



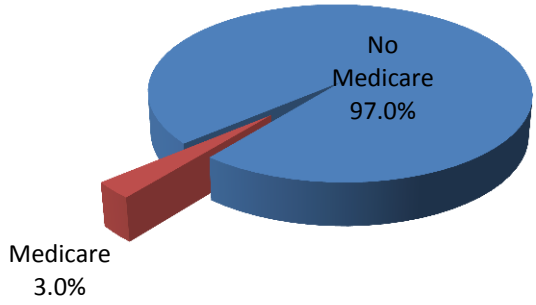
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 48: Percentage of Specialty Plan Enrollees by Race or Ethnicity, September 2014



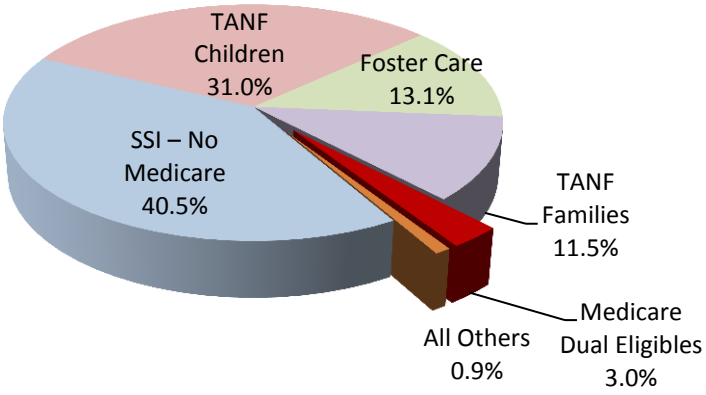
Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 49: Percentage of Specialty Plan Enrollees by Medicare Status, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Figure 50: Percentage of Specialty Plan Enrollees by Program Category, September 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, September 2014.

Payments to MMA Specialty Plans

MMA plans receive a monthly capitation payment based on the number of enrollees they serve. Most MMA plans are paid on a full-risk, capitated basis, which means they receive an average monthly capitation rate for each enrollee and must provide all medically necessary contracted services. However, the Children's Medical Services Network operates as a non-risk health plan, in which its expenses are reimbursed by AHCA. Capitation payments to plans are adjusted for the health risk of each plan's enrollees.

Table 13 displays the distribution of capitation payments by region for each Specialty plan for May and June 2014. Only two specialty plans had implemented by June – Sunshine and Clear Health. The total capitation amount paid to these two Specialty plans during the first two months of the MMA program was $15 million. Sunshine served six regions in its first two months of operation and received almost $8 million in capitation payments. Clear Health served five regions in the first two months of operation and received $7 million in capitation payments.

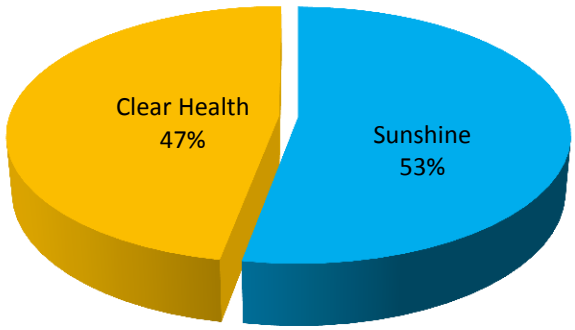
Table 13: Capitation Payments (in dollars) by MMA Specialty Plan and Region, May 2014 - June 2014

Region	Plan		Totals
	Sunshine	Clear Health	
1			
2	722,289	990,957	1,713,246
3	1,777,305	2,103,580	3,880,885
4	2,273,659		2,273,659
5	950,846	1,316,700	2,267,546
6	1,626,287	1,645,878	3,272,165
7			0
8	617,677	1,045,355	1,663,032
9			0
10			0
11			0
Totals	7,968,063	7,102,470	15,070,533

Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, May – June 2014.
Note: Capitation payments in this report are adjusted for the relative risk of the population for each plan.

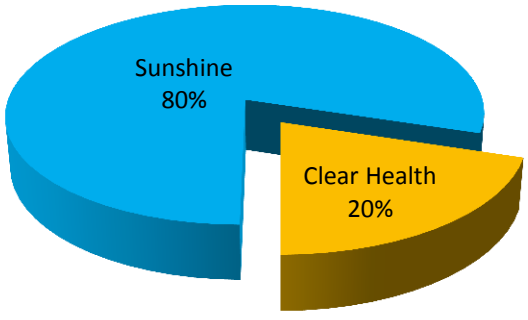
Figure 51 shows how capitation payments were distributed among the Specialty plans, and Figure 52 shows the number of member months covered by each plan for May and June 2014. Sunshine provides services for children receiving child welfare services. Clear Health covers services related to HIV-AIDS – services that can be costly to provide. Sunshine received 53 percent of capitation payments and covered 80 percent of all member months. Clear Health received 47 percent of the capitation amount and covered 20 percent of member months.

Figure 51: Percentage of Specialty Plan Capitation Amounts by Plan, May 2014 – June 2014



Source: Florida Medicaid Management Information System (FLMMIS), Information about capitation payments to plans, May 2014 – June 2014.

Figure 52: Percentage of Specialty Plan Member Months, May 2014 - June 2014



Source: Florida Medicaid Management Information System (FLMMIS) Eligibility Information, Enrollment and demographic information, May 2014 – June 2014.

Conclusion

From August 2013 to March 2014, the Agency successfully rolled out the SMMC LTC program. By September, almost 85,000 Medicaid recipients were enrolled in the program. In the first eleven months of operation, LTC plans received over 1.5 billion dollars in capitation payments. This is an average payment of $3,284.92 per member per month. Over $1 billion was spent on nursing facility care. While only half of all enrollee months were spent in a nursing facility, over half of LTC benefit expense covered nursing facility services. However, transfers between nursing facilities and community settings indicated more enrollees transferred out of nursing facilities to a community setting than the reverse.

By August 2014, the Agency had successfully implemented the SMMC MMA program. By September, over two-and-a-half million Medicaid recipients were enrolled in the MMA program - 2,584,810 were enrolled in an MMA Standard plan and 137,337 were enrolled in a Specialty plan. In the first two months of operation, MMA Standard plans received over 480 million dollars in capitation payments, an average payment of $267.90 per member per month. MMA Specialty plans received over 15 million dollars, an average payment of $796.33 per member per month.

As SMMC continues operation and data sources build and mature, the Agency will continue to provide analyses of the Statewide Medicaid Managed Care program and utilize information from additional data sources that will provide insight into the program's cost effectiveness, quality of care, and other significant aspects of the program.