Update on Statewide Medicaid Managed Care and Low Income Pool Program

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Statewide Medicaid Managed Care (SMMC) Program

- The Agency successfully implemented the SMMC program between August 1, 2013, through August 1, 2014.
- The program uses a competitive market for health plans.
- The program enrolls most Medicaid recipients in health plans.
- The program has two components: the Long-term Care program and the Managed Medical Assistance program.

Statewide Medicaid Managed Care

- The Agency contracts with 19 health plans to provide fully integrated care, including dental services and behavioral health.
- Health plans provide extra benefits at no cost to the state. These expanded benefits include: adult dental, hearing, vision coverage, outpatient hospital coverage, and physician coverage, among many others.
- The SMMC contract incentivizes quality and enhanced accountability through quality measures and nationally recognized measures.

Statewide Medicaid Managed Care

- Most Medicaid recipients are enrolled in a managed care plan under the Statewide Medicaid Managed Care (SMMC) program. Two key SMMC components:
  - Long-term Care (LTC) Program:
    - Most recipients 18 years of age or older who need nursing facility level of care.
    - 85,169 recipients enrolled in LTC plans as of December 1, 2014.
  - Managed Medical Assistance (MMA) Program:
    - Most recipients of any age who are eligible to receive full Medicaid benefits.
    - 3,053,463 recipients enrolled in MMA plans, or pending enrollment as of December 31, 2014

Statewide Medicaid Managed Care Rollout

- The Agency put into place several provisions to ensure a smooth transition to the SMMC program:
  - Regional rollout
  - Choice counseling
  - Continuity of care
  - Centralized issues hub
  - Comprehensive outreach approach

SMMC Rollout: Continuity of Care Provisions

- Ensured that recipients did not experience a break in services or care coordination while transitioning from:
  - one service delivery system to another,
  - one managed care plan to another,
  - or from one service provider to another.
- Plans were required to continue payments to existing providers – including non-participating providers- at the prior rate during this period or until such time as the provider entered into contract with the health plan.

SMMC Program Enhancements

- Expanded benefits (LTC and MMA)
- Enhanced network adequacy standards (LTC and MMA)
- Physician pay increase (MMA Program)
- Enhanced standards related to claims processing, prior authorization, and enrollee/provider help line (call center operations) (LTC and MMA)

SMMC Program Enhancements: Expanded Benefits

- Negotiated with health plans to provide extra benefits at no cost to the state.
  - Expanded adult dental, hearing, vision coverage, outpatient hospital coverage, and physician coverage, among many others.

SMMC Program Enhancements: Network Adequacy Standards

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

SMMC Program Enhancements: Physician Pay Increase

- Plans must increase physician payment until rates equal or exceed Medicare rates for similar services.
  - The Agency may impose fines or other sanctions including liquidated damages on a plan that fails to meet this performance standard after 2 years of continuous operation.

Next Steps: Report Cards

- Enrollees will soon be able to choose plans based upon quality.
- In the early part of 2015, Medicaid will begin publishing a consumer-focused Medicaid health plan report card.
- The report card will include ratings on how Florida's managed care plans are doing on getting children into well-child visits and to dental care.

Next Steps:
Achieved Savings Rebate

- A percentage of savings achieved by health plans is retained by the plan and a percentage of savings achieved is returned to the state.
- The Agency is responsible for verifying achieved savings through compliance audits on plan financial reports conducted by an independent certified public accountant. Plans are responsible for the costs of the audits.

Questions?

Low Income Pool Program

History of the Low Income Pool Program: Change for SFY 2014-2015

- Current state and federal authority for the annual Low Income pool (LIP) program is $2.17 Billion.
- The Florida Managed Medical Assistance Program Waiver (Waiver) received approval from federal CMS on June 30, 2014 to continue the LIP for the current fiscal year.
- Current LIP Federal authority (through the Florida Managed Medical Assistance Program Waiver) will expire June 30, 2015.
- Federal approval required an independent study and report on the State's funding mechanisms for LIP.

What Is LIP?

- LIP and similar programs in other states have been used to ease transitions to managed care. They provide a way to continue to pay providers who have received certain types of supplemental payments in fee-for-service Medicaid.
- These arrangements in 1115 Research and Demonstration waivers have allowed states to continue to make supplemental payments to critical providers despite a general federal regulation that states can't make payments directly to providers for services covered under the managed care contract.
- LIP is a program that started in State Fiscal Year (SFY) 2006-07 as part of the Medicaid Reform 1115 waiver.

What Is LIP?

- Established for 5 years at $1 billion annual total computable.
- LIP continued with an waiver extension granted in December 2011 – three more years at $1 billion each year.
- The current one-year LIP authority ends June 30, 2015.

What Is LIP?

- Current Participants:
  - Funding in the LIP Program allows many Provider Access Systems (PAS) in Florida to receive additional payments to cover the cost of providing services to Medicaid, uninsured, and underinsured individuals. PAS entities are defined in the waiver as providers with access to LIP funding and services funded from LIP.
  - PAS entities include entities such as hospitals, clinics, or other provider types and entities designated by Florida Statutes to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured.

What Is LIP?

- Low Income Pool funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act.
- These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for:
  - Uncompensated medical care costs of medical services for the uninsured.
- Medicaid shortfall (after all other Title XIX payments are made)
- Funding Source:
  - Local governments, such as counties, hospital taxing districts and other state agencies (e.g. Florida Department of Health) provide funding for the non-federal share of the LIP distributions.
  - Federal funds are drawn down to match the non-federal funds.

Why Is LIP Changing?

- While not technically "supplemental payments" in the traditional sense, self-funded (IGT) hospital rate enhancements have been used by Florida for several years to allow hospitals with local funding sources to "buy back" rate cuts. These types of facility specific add-ons were not expected to continue to work well in managed care.
  - SFY 2013-14 value: $963.2 million total computable.
- Supplemental payments to medical school physician practices – a traditional supplemental payment structure that would greatly diminish under SMMC.
  - SFY 2013-14 value: $204.5 million total computable.

Why Is LIP Changing?

- CMS approved one year extension for LIP through June 30, 2015, to continue the current LIP program at a higher funding level of $2.167 billion.
- The increase from $1 billion to $2.167 billion includes the medical school physician supplemental payment program and the dollars previously used for self-funded hospital rate enhancements. Those dollars were shifted into the LIP for the one-year extension.
- The extension allows for transition to Medicaid managed care and further study about how best to fund and pay critical types of providers like these participating in the LIP.

Low Income Pool
SFY 2014-15

Following are the new LIP Program funding levels (in millions) and its component parts:

Low Income Pool, Hospital	$766.9
Special Low Income Pool	$116.5
Low Income Pool, Non-Hospital	$117.3
Self-funded Hospital	$963.2
Medical School Physicians Supplemental	$204.5
Total	**$2.16 billion**

Low Income Pool Participation Requirements

New LIP Participation Requirements:

- Hospitals –
  - i. Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;
  - ii. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,
  - iii. Participate in the Florida Event Notification program.
- Medical School Physician Practices –
  - i. Must participate in the Florida Medical School Quality Network.
- County Health Departments –
  - i. Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.
- Federally Qualified Health Centers-
  - i. Non-hospital institutional providers must continue their participation in LIP programs that support specific projects to increase access to healthcare services for low income/indigent uninsured population in addition to providing access to the Medicaid population.

Low Income Pool
SFY 2014-15

- Distribution methodology similar to prior years, with new categories for the prior self-funded dollars and prior physician supplemental payments.
- Tier 2 milestones reporting requirements are no longer in place. This covered the Top 15 Hospital Initiatives started in SFY 2012-13.
- CMS will work with the Agency to review prior year LIP payments to determine any possible overpayments and some reductions via a disallowance may occur.

The LIP Report

- A mandatory report from an independent entity on Medicaid provider payment that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms.
- Total funding up to $500,000 for the report.
- The report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in SFY 2015-16, to move toward Medicaid fee-for-service and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through LIP.
- The Agency secured Navigant to complete the report.
- Per the SFY 2014-15 GAA the report must be submitted to the Governor, President of the Senate, and Speaker of the House by January 15, 2015.
- The Special Terms and Conditions of the 1115 waiver state that a draft report is due to CMS by January 15, 2015, with final report due March 1, 2015.

Comparison of SFY 2013-14 LIP Funding to SFY 2014-15

Low Income Pool:	SFY 2013-14 GAA		SFY 2014-15 GAA
LIP Hospital	$766.9		$766.9
Special LIP	$116.0		$116.5
LIP Non-Hospital	$117.3		$117.3
Self-funded Hospital	$ 0.0		$963.2
Medical School Physician	$ 0.0	$204.5	Supplemental
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Total LIP (millions)	$ 1,000.2		$2,167.0

Where do the LIP dollars come from? (in millions)

State General Revenue	$9.1
Local Taxes & Other Agencies	$867.6
Federal Funds	$1,291.2
Total	**$2,167.9 billion**

LIP Allocated and Proportional Distribution

Funding of $1,729.6 million

- The same distribution methodology as approved in the 2013-14 GAA.
- Allocation factor is 8.5%
- Rural Hospitals are held harmless with same funding as current year.
- Increased $963.2 million due to the addition of the LIP 6 distribution.

LIP 6

Total Funding $963.2 million

- Existing funding but new to the LIP.
- Based on the SFY 2013-14 spending amount for self-funded Inpatient hospital DRG Add-on and Outpatient hospital rate exemptions and buybacks.
- Quarterly LIP payment contingent on the non-federal share of matching funds provided by local governmental entities.

Special Hospital LIP

Funding $116.5 million for the following initiatives:

– Rural	$ 5.6 m
– Primary Care	$ 12.0 m
– Specialty Pediatric	$ 1.4 m
– Trauma	$ 8.8 m
– Tier One Quality Measures	$ 15.0 m
– Safety Net	$ 73.1 m
– Independent Report	$ 0.5 m
Total Special LIP	**$ 116.5 m**

"Below the Line" Programs

Total Funding of $321.9 million

- Initiatives focused on primary care, emergency room diversion, disease management, poison control, and continued initiatives related to premium assistance programs for uninsured and underinsured individuals.
- Federally Qualified Health Centers, County Health Departments, Hospital based Primary Care Programs benefit from continued funding.
- Projects Include:
  - Poison Control Centers
  - Federally Qualified Health Centers
  - County Health Department Initiatives
  - Hospital Based Primary Care Initiatives
  - Premium Assistance Programs
  - Manatee, Sarasota, and Desoto County Emergency Room Diversion
  - Tier One Milestone Distribution

"Below the Line" Programs, Continued

Medical School Physician Supplemental Payments
Total Funding: $204.5 million

- Under Managed Care, supplemental payments can only be distributed within an 1115 Waiver. The only exception to this rule is Graduate Medical Education (GME) payments to hospitals.
- Medical School Physician Supplemental payments have been moved under the Managed Medical Assistance Program Waiver with the LIP Program and are no longer in a State Plan Amendment (SPA).
- Medical School Physician Supplemental payments are for services provided by teaching physicians providing the necessary education to medical students pursuant to existing statutes and written protocols, employed by or under contract with a medical school in Florida.

SMMC without LIP

- Capitation rates for managed care plans are developed based on reasonable expectations about plan/hospital contracted rates. Historically, plans have contracted based on the Medicaid hospital fee schedule.
- Currently, automatic IGTs for hospital inpatient and outpatient are still included in the Medicaid hospital fee schedule, and thus incorporated into capitation rates.
- The automatic IGTs included in hospital reimbursement, in general, are provided because of the 8.5% allocation factor paid back through LIP payments. Without waiver authority for this allocation factor, there is uncertainty around the receipt of these IGTs.
- If automatic IGTs and LIP funding are no longer available, pressure may be put on plan/hospital contracted rates, which could increase capitation rates without support from local funding.

Where can I find additional information on AHCA?

- Find more information at the following:
  - AHCA.myflorida.com
  - Youtube.com/AHCAFlorida
  - Facebook.com/AHCAFlorida
  - Twitter.com/AHCA_FL
  - Slideshare.net/AHCAFlorida

Questions?