Statewide Medicaid Managed Care

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- As requested by the Committee, this presentation will address:
  1. Update on the Statewide Medicaid Managed Care (SMMC) Program
  2. Medicaid Expansion utilizing SMMC Managed Medical Assistance Plans
  3. Medicaid Expansion Utilizing phased transition, Phase One, initially enroll new adult group in MMA plans then move them in Phase Two to a new delivery mechanism, including Florida Healthy Kids and Florida Health Choices

Statewide Medicaid Managed Care Program

The Statewide Medicaid Managed Care Program

- In 2011, the Florida Legislature required the Agency to expand managed care statewide for most Medicaid recipients.
- The Agency successfully implemented the Statewide Medicaid Managed Care (SMMC) program August 1, 2013, through August 1, 2014.
- The program has two components: the Long-Term Care (LTC) program and the Managed Medical Assistance (MMA) program.
  - MMA covers most recipients of any age who are eligible to receive full Medicaid benefits.
  - LTC covers most recipients 18 years of age or older who need nursing facility level of care.

SMMC Program Goals

The goals of the Statewide Medicaid Managed Care Program are:

- To improve coordination of care
- Improve the health of recipients, not just paying claims when people are sick
- Enhance accountability
- Allow recipients a choice of plans and benefit packages
- Allow plans the flexibility to offer services not otherwise covered
- Enhance prevention of fraud and abuse through contract requirements.

MMA Program Elements

- Plan Choice
- HMOs and PSNs (provider service networks)
- Specialty Plans in MMA
- Choice of Benefit Package
- Choice Counseling
- Risk Adjusted Rates
- Low Income Pool

MMA Program Enhancements: Expanded Benefits

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

MMA Program Enhancements: Plan Accreditation

- Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed.
- For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment.

MMA 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.

MMA Program Enhancements: Competitive Rates

- Competitive procurement required .
- "Best value" to the state included negotiated capitation rates for the period of May 1, 2014 – Aug 31, 2015 for MMA.
- Rate-related negotiation goals:
  - Actuarially sound.
  - Take advantage of competitive process; listen to industry.
  - Achieve savings target established in statute.
  - Establish common base rates for all selected standard plans in each region.

MMA Program Enhancements: Risk Adjusted Rates

- Under the MMA program rate cells are developed for various eligibility groups.
- For TANF and SSI groups, rates are risk adjusted based on historical claims/ encounter data.
- Separate rates developed for special populations:
  - HIV/AIDS
  - Child Welfare
  - MMA enrollees also enrolled in the LTC program

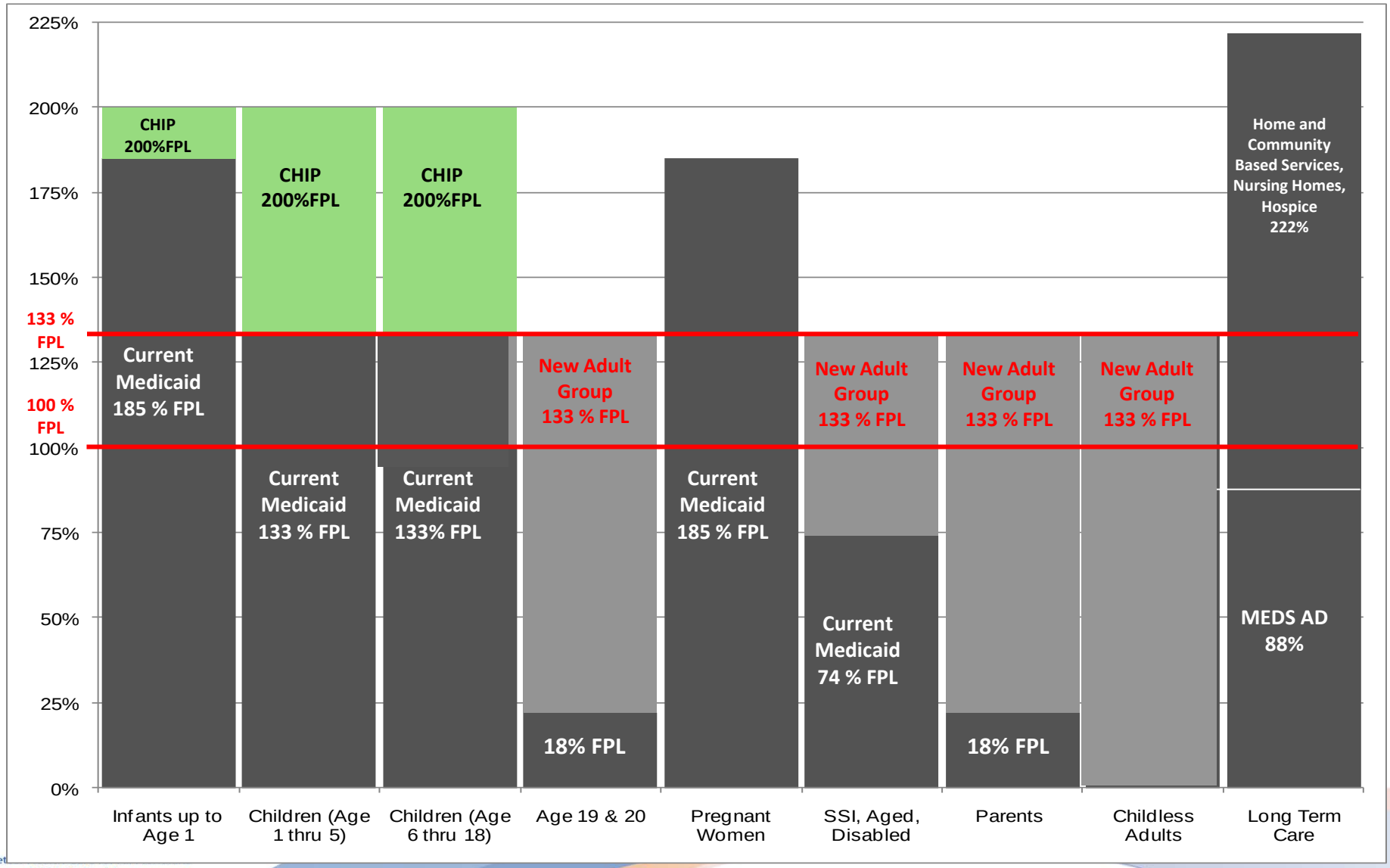
MMA Program Enhancements: Enhanced Accountability

- Centralized Complaint/Issues Hub
  - Monitor all complaints/issues from recipients, providers, and other stakeholders.
  - Identify trends and provides additional tool to take action to correct those issues.
- Performance Measures
  - Plans are required to report annually on 37 performance measures
- Report Cards
  - Publishing consumer-focused Medicaid health plan report card based on performance measures
  - Current information is for Reform and non-Reform plans, however, SMMC plans will be added once enough time has lapsed to collect this data.

Coverage of New Adult Group:

- Who would be covered:
  - Non-pregnant individuals age 19 through 64, not otherwise eligible for Medicaid, with income at or below 133% Federal Poverty level.
  - No resource (asset) test.
- Federal Authority Needed:
  - State plan amendment to add new group
  - 1115 Waiver amendment to enroll in SMMC plans
  - Need additional federal authority if we want to use an alternative benefit package.

Current Eligibility and New Adult Group



Utilizing MMA Plans

- MMA Plans have the infrastructure in place to provide comprehensive services to both adults and children
- Network standards based on Medicare ratios
  - Required to maintain networks for higher enrollment level than they will have
- Additional rate cells can be added to payment methodology for new adult group
- Choice Counseling and enrollment mechanisms already in place

Utilizing MMA Plans

- In order to add the new adult group under the MMA program:
- State Required Activities:
  - Amend federal authorities
  - Amend MMA Contracts to include new population
  - Develop transition plan
  - System changes to include new eligibility group
  - Choice Counseling ramp up
  - Build new capitation rates for the new eligibility group
  - Update provider network requirements for adults
  - Determine benefit package for new eligibility group

Utilizing MMA Plans

- In order to add the new adult group under the MMA program:
- MMA Plan Required Activities:
  - Expand provider networks if needed
  - Develop new member materials
  - Update systems

Utilizing MMA Plans

- No additional funding needed for state activities
  - Developing federal authority
  - Updating contracts and provider network requirements
  - Systems changes
- Minimize costs for state activities due to economies of scale with current vendor for
  - Choice counseling
  - Rate development

Utilizing Phased Transition

- Utilizing phased transition, Phase One, initially enroll new adult group in MMA plans then move them in Phase Two to a new delivery mechanism
  - Phase one close out activities would be required.
  - Phase two new delivery system start up activities would be required.

Utilizing Phased Transition

- Phase One Close Out: State Required Activities
  - Develop Transition Plan
  - Amend federal authorities
  - Amend MMA contracts
  - Amend Choice Counseling Contract
  - Revise Provider Network Requirements
  - Systems Changes
- Phase One Close Out: MMA Plan Required Activities
  - Amend Member Materials
  - Systems Changes

Utilizing Phased Transition

- Phase Two New Delivery System Required Activities
  - Program Infrastructure Development
    - Renegotiation of federal authorities
    - New health plan contracts or arrangements
    - Development/adoption of minimum plan standards
  - Systems development/changes
  - Rate development
  - Choice counseling/enrollment of recipients (contract with new vendor)
  - Outreach

Utilizing Phased Transition

- Other states have implemented premium assistance programs where states use Medicaid funds to purchase private coverage for the newly eligible adult group using 1115 waiver authority.
- Federal CMS has indicated that all alternative Medicaid expansion waivers (i.e., 1115 waivers) will end by December 31, 2016
- States looking to expand programs using a premium assistance model into 2017 and beyond must apply for State Innovation Waivers

Florida Healthy Kids Corporation

- Currently responsible for contracts with health plans to provide services to children (under the age of 19) through the Healthy Kids component of the Florida Children's Health Insurance Program (CHIP)
- Child focused:
  - Payment rates
  - Networks
- CHIP Program funding ends September 2015.

Florida Health Choices

- Operates two exchanges where people can purchase individual health plans, discount plans, limited benefit plans and identify theft protection
- 59 families and individuals have purchased discount plans
- During an abbreviated open enrollment period for comprehensive coverage, 56 lives enrolled.
- A third exchange will launch this month to serve membership of Florida's largest professional associations.