Florida Medicaid Update

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Florida Medicaid Update

- Update on Medicaid Fiscal Agent
- Update on Medicaid Reform
- Update on Affordable Care Act

Update on Medicaid Fiscal Agent

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Medicaid Fiscal Agent Operations – Claims Processing Statistics

- HP is processing an average count of 12.8 million claim lines per month for provider submitted claims, and approximately 3.2 million capitated (HMO and Other) transactions per month. The previous fiscal agent was processing approximately 11.25 million provider claim lines and 2.5 million capitated claims per month. Current increase is due to the beneficiary caseload growth the past year and a half.
- HP has an electronic - to - paper claims processing ratio average of 97%, a comparable ratio to the previous fiscal agent and "Legacy" MMIS.
- HP processes electronically submitted claims on average within 8.1 days, and paper claims on average within 30 days. These ratios are also comparable to that of the previous fiscal agent.

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Medicaid Fiscal Agent Operations – Claims Processing Statistics

- Statistics on HP Suspense Locations
  - Between 1% and 3% of new-day submitted claims suspend each week for various suspend reasons such as:
    - Requirements for manual intervention according to Medicaid Handbook rules, prior to final claim adjudication.
    - Servicing or Pay-to Providers are on ‘Review’.
    - Procedure requires review of the procedure’s modifier.
  - Retroactive “Reprocessings” also fall into suspense locations awaiting fiscal agent and state review prior to releasing for final adjudication.
  - Total suspense inventories have decreased in the past 9 months from an average, compared to the prior 9 months, of 1 million claims down to approximately 500,000 currently.

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Medicaid Fiscal Agent Operations – Claims Processing Statistics

- Claims Paid/Denied Ratios
  - Fiscal Year end historical ratios for 2005 thru 2008:
    - Between 68% - 73% Paid
    - Between 32% - 27% Denied.
  - Current over past several months at approximately 70% Paid and 30% Denied, an expected ratio.
  - There are approximately 650 Denial Edits, in both the old “Legacy” MMIS and the new *interChange.*
  - There are approximately 20 to 25 recurring edits in any given month that comprise approximately 70+% of all denial edits (the count), with those same edits occurring in the current *interChange* and in the previous “Legacy” MMIS.

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Medicaid Fiscal Agent Operations – Claims Processing Statistics

Sample of Top 20 Occurring Denial Edits

- Exact Duplicate
- Procedure Not Covered
- Recipient Ineligible for DOS
- Not Authorized by MediPass
- TPL on Recipient Not on Claim
- Medicare Coverage is Present
- Invalid Recipient ID
- Unit Limit Exceeded
- Procedure/Place of Service Conflict
- Servicing Provider Ineligible for DOS
- Medical IP Prior Authorization Not on File or DOS is Incorrect
- Recipient Enrolled in HMO
- Rendering Provider Not on Provider Database
- Claim Exceeds 12 Month Filing Limit
- Treating Provider # is Missing
- Servicing Provider is a Group Provider
- Invalid Combination of Procedure Codes
- Alien Claim Requires Medical Review
- Procedure Incompatible with Diagnosis
- Refill Too Early

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Medicaid Options

- Provides enrollment broker services for the 62 non-Reform counties.
- Provides toll-free number for recipients to select a health plan.
- Web portal plan enrollment tool will be available soon.

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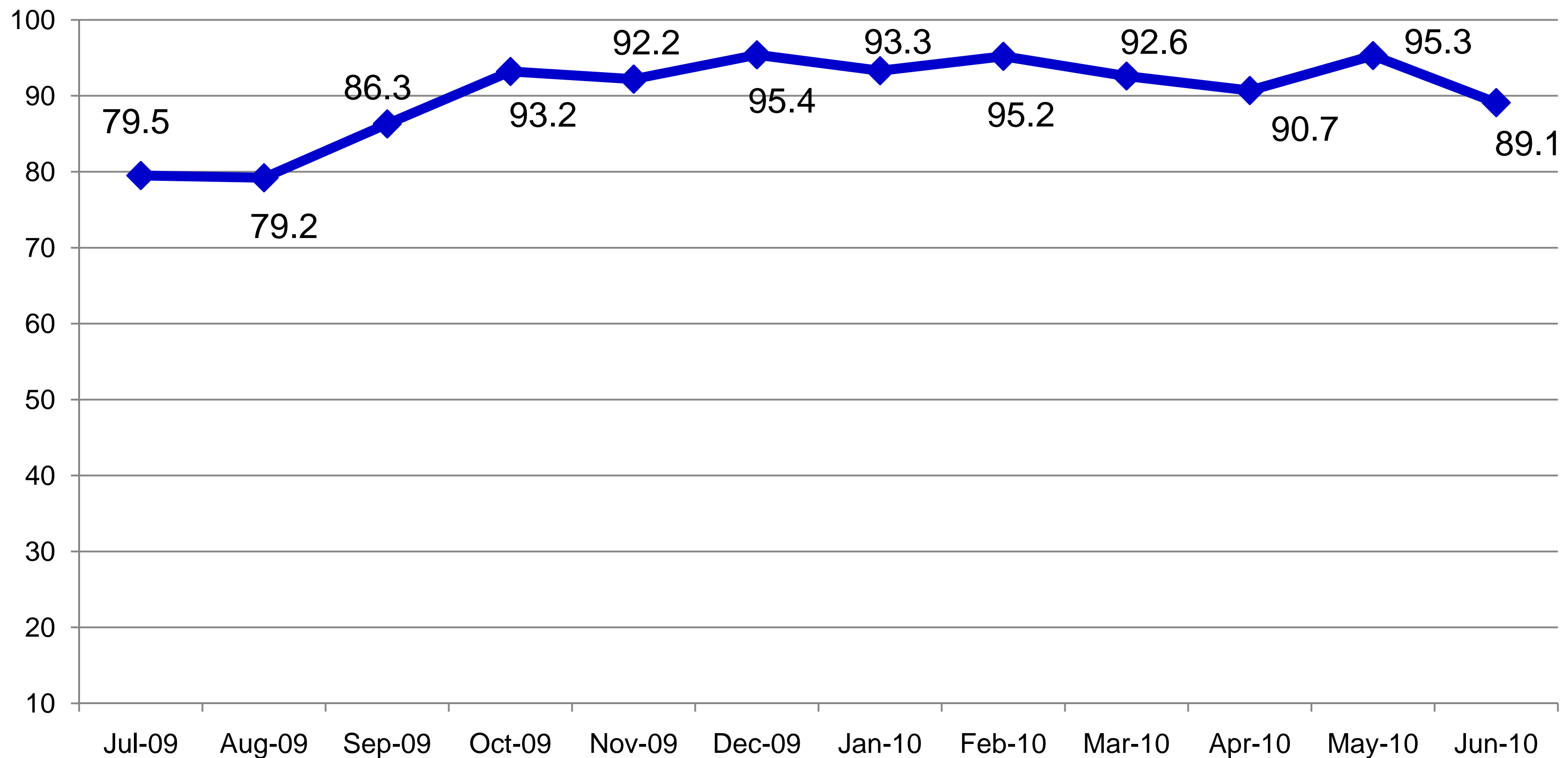
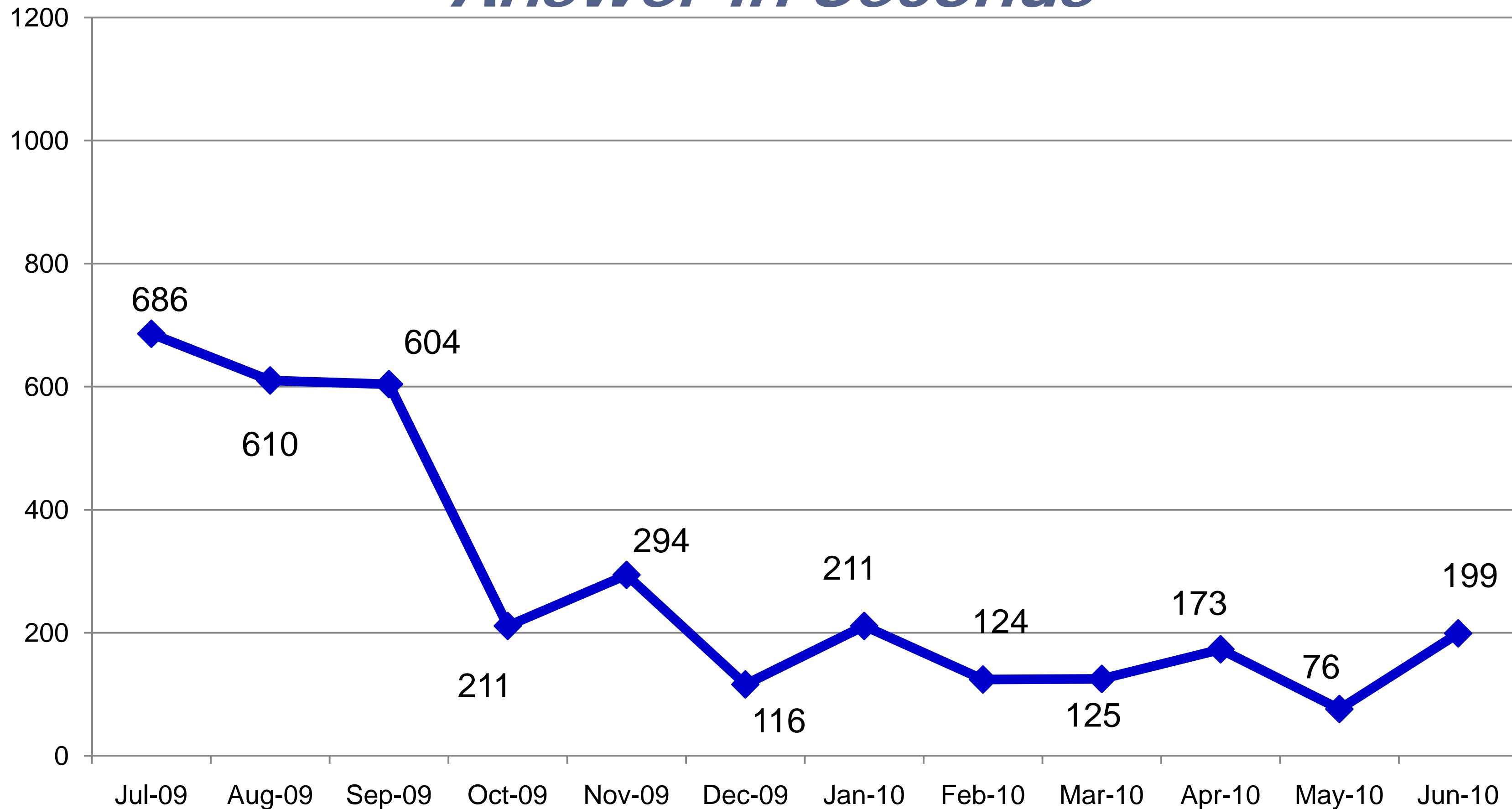
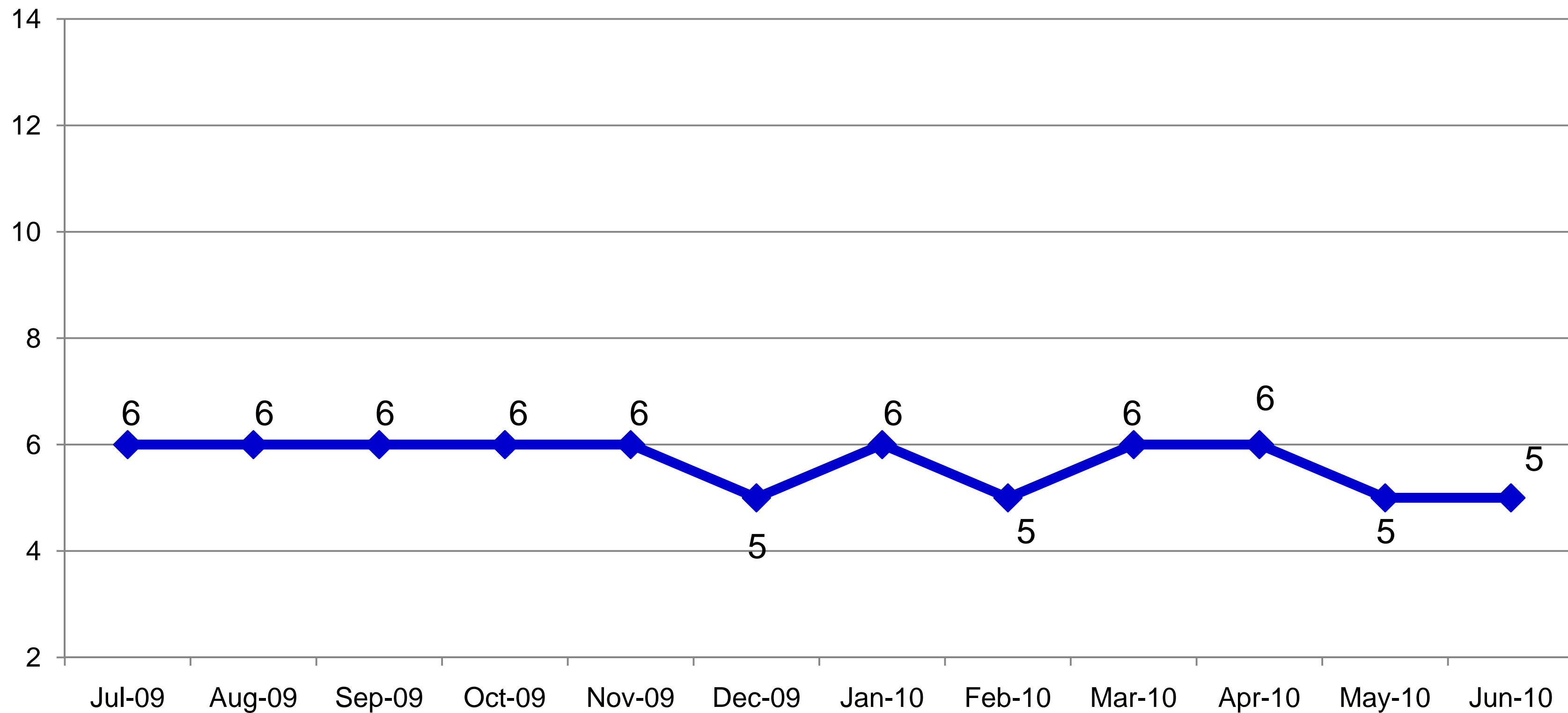
Medicaid Options – Percent of Calls Answered



Medicaid Options – Average Speed of Answer in Seconds



Medicaid Options – Average Talk Time



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FMMIS Certification

- Florida Medicaid Management Information System (MMIS) received full federal certification from the Centers for Medicare and Medicaid Services (CMS).
- Certification is provided when CMS determines the state's system is likely to provide more efficient, economical and effective administration of the state's Medicaid program.
- Funding for the operation of the system since July 1, 2008 was 50% federal match. The certification allows Florida to receive the maximum federal funding of 75% for the operation of the system, and the 75% match is retroactive to the system's first day of operation, June 23, 2008.

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FMMIS Certification

- The Agency provided the CMS onsite review team information on privacy and security, the pharmacy benefit management system and the decision support system. The Agency also gave detailed documentation on the following subsystems:
  - Provider
  - Recipient
  - Reference File
  - Claims Processing
  - Managed Care
  - Third Party Recovery
  - Management Administrative Reporting
  - Surveillance Utilization Review

Update on Medicaid Reform

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Authorization for Reform

- In 2005, the Florida Legislature authorized the Agency, through Section 409.91211, Florida Statutes, to:
  - Seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program.
  - Implement the Medicaid Managed Care Pilot program in Broward County and Duval County.
  - Expand into Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational.

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1115 Research and Demonstration Waivers

- Experimental, Pilot or Demonstration Projects.
  - Benefit Packages, Reimbursement Methodologies, Covering Expanded Groups.
  - States Commit to a Policy Experiment that must be formally evaluated.
- 1115(a)(1) allows the Secretary to waive compliance with most of the requirements in the Medicaid and SCHIP State Plans.
- 1115(a)(2) allows the Secretary to regard as expenditures costs that would not otherwise be matchable under Medicaid or SCHIP.
- If granted, the initial approval period is 5 years and the State may request two 3 year extensions of the program.

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Florida's 1115 Medicaid Reform Waiver

- Allows Florida Medicaid to conduct a demonstration Pilot requiring managed care plan enrollment for most Medicaid eligibles in certain areas of the state.
- Provides the State with the authority to mandatorily assign eligible beneficiaries.
- Provides authority to enroll additional populations not included under the 1915(b) Managed Care Waiver:
  - Individuals with Medicare Coverage
  - SOBRA Pregnant Women
  - Children in Foster Care
  - Children with Chronic Conditions

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Extension of the 1115 Waiver

- The current Medicaid Reform Waiver expires June 30, 2011.
- The Florida Legislature has directed the Agency, through SB 1484, to request an extension of the waiver and to ensure that the waiver remains active and current.
- The Agency is required to report monthly to the Legislature on progress in negotiating the terms of the waiver extension.
- Governor Crist signed the bill into law (Chapter 2010-144, Laws of Florida) on May 28, 2010.

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Extension of the 1115 Waiver

- The Agency was not authorized to amend the waiver.
- An extension would maintain the program in the current geographic areas of operation.
- Any expansion into new geographic areas or substantial changes would require Legislative authorization.
- Experience to date shows that operational changes can be made within the framework of the approved waiver in response to public input.
- The Agency held 6 public forums solely dedicated to the 1115 waiver extension to continue dialogue and provide the Agency with new opportunities to continually improve the program.
- Forums were videotaped and can be viewed on the Agency's website: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

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Extension of the 1115 Waiver

- Federal Requirements for extension.
- (STC #8) - Florida is responsible for reviewing, complying and adhering to the timeframes and reporting requirements in Section 1115(e) of Social Security Act. In addition, Florida must submit documentation of:
  - How the state has met the demonstration objectives,
  - Complied with STCs of the waiver,
  - Summary of beneficiary satisfaction and quality of care,
  - Compliance with budget neutrality cap, and
  - Public process used to obtain stakeholder input.
- Extension request submitted June 30, 2010 and can be viewed on the Agency's website: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

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Key Elements of Reform

- Low Income Pool (LIP)
- Outreach Efforts
- Delivery System:
  - Coordinated Systems of Care (Health Maintenance Organizations and Provider Service Networks)
- New Options / Choice:
  - Customized Plans
  - Enhanced Benefits
  - Opt-Out
- Financing:
  - Premium Based
  - Risk-Adjusted Premium
  - Comprehensive and Catastrophic Component
- Choice Counseling.

Update on Affordable Care Act

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Analysis

- This analysis addresses only the direct impact of changes to enrollment in the Title XIX (Medicaid) and Title (XXI) CHIP programs and the required increase in reimbursement rates to Medicaid primary care providers.
- At this time, impacts are not included for administration of new program elements, changes to the federal pharmacy rebate or changes to state disproportionate share allowances.

Changes to Medicaid and CHIP

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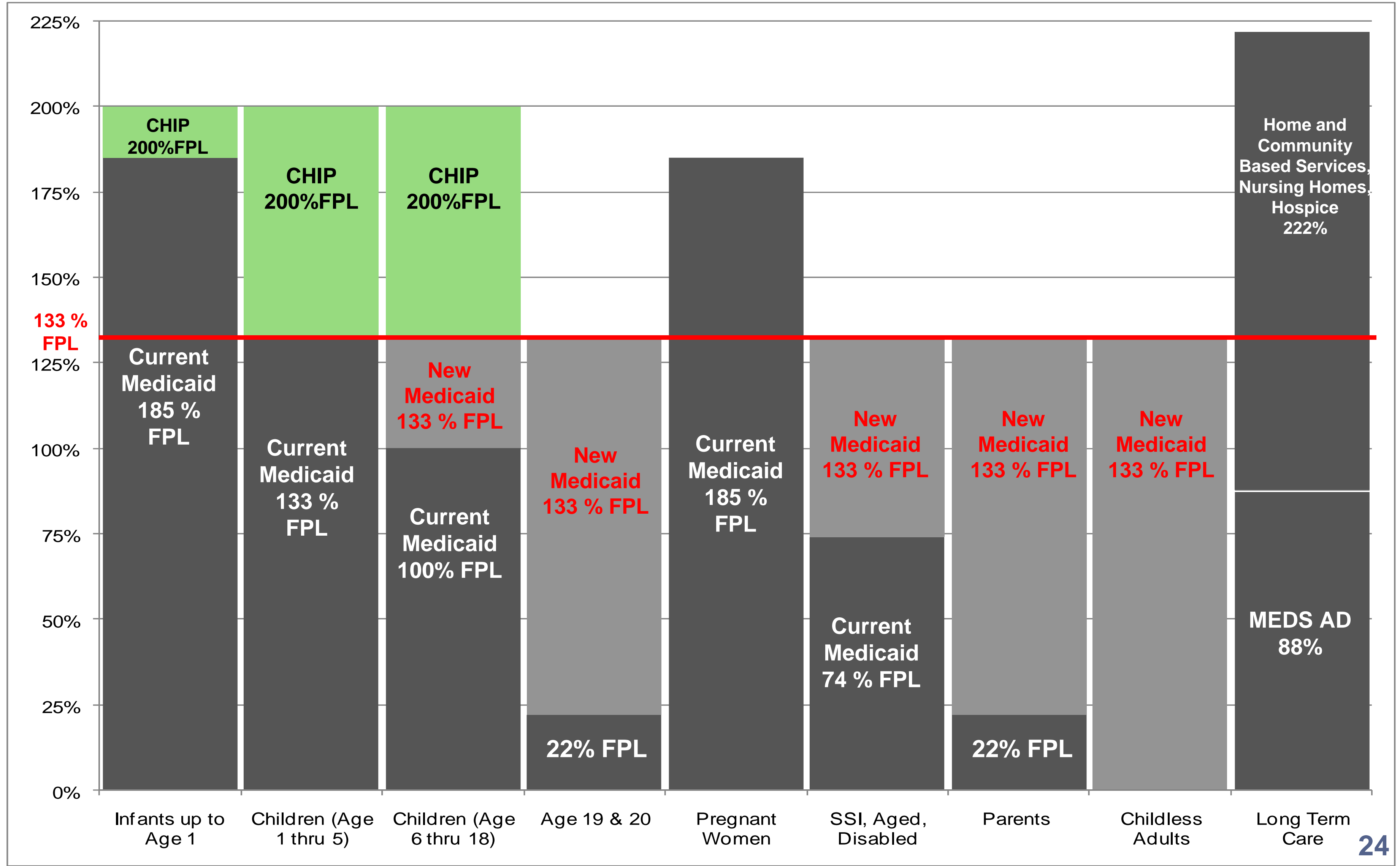
KEY ELEMENT	Affordable Care Act
Medicaid Expansion	Expand eligibility to 133% Federal Poverty Level – beginning 1/1/2014 •133% FPL for a family of 4: $29,326
FMAP/ Medicaid Expansion	Provides for enhanced FMAP for expansion population: •100% CY 2014 •100% CY 2015 •100% CY 2016 •95% CY 2017 •94% CY 2018 •93% CY 2019 •90% CY 2020 and beyond
FMAP/ Current Eligibility Level	Regular FMAP (57.44%)
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program Since our analysis begins on July 1,2013 (2013-2014 Fiscal Year), the following FMAP are used for CHIP children under 133% FPL transitioning to Medicaid: •70.21% SFY 2013-2014: •70.21% SFY 2014-2015 •87.46% SFY 2015-2016 •93.21% SFY 2016-2017 and beyond
FMAP/ CHIP	Anticipated enhanced FMAP for CHIP Population begins 10/1/2015 (134% Federal Poverty Level and above) •10/1/2015: 70.21+23.0=93.21%
Increased Rate for Practitioners	100% federal funded increase to select codes for primary care providers for 2013 and 2014. This impacts approximately 35% of primary care codes under the Florida Medicaid Program (Impact of this change not include in this current analysis (7/20/2010)

Current and Future Medicaid / CHIP Eligibility Levels



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Assumptions

- Expenditures:
  - Expenditures are based on February 12, 2010, SSEC estimate for SFY 2012-13 and then held flat for remainder of analysis.
  - FMAP used is based on estimates from November 2, 2009, FMAP Estimating Conference for SFY 2012-13 and then held flat for remainder of analysis.
- Caseload:
  - Title XIX Caseloads are based on January 26, 2010, Caseload Conference estimate for SFY 2012-13 and then held flat for remainder of analysis. *Have not yet been updated based on July 2010 Caseload Conference*
  - The expansion caseload is based on 2009 U.S. Census data regarding the uninsured. Increased by 1.6% through 2014 and then held flat for remainder of analysis.

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Assumptions

- Other Assumptions:
  - Based on analysis of those under 65 years of age.
  - *NOTE:* Prior analyses of impact were reported based on calendar year. This analysis, and analyses going forward will be reported based on state fiscal year.

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Assumptions: Newly Eligible Population

- Assumed 40% of new enrollees for the first year of expansion (beginning 1/1/2014).
- Assumed 90% of new enrollees for the second year of expansion (beginning 1/1/2015).
- Assumed 100% of new enrollees for the third year of expansion and beyond (beginning 1/1/2016).
- By fiscal year, that phase in translates as follows:
  - FY 2013-2014: 20%
  - FY 2014-2015: 65%
  - FY 2015-2016: 95%
  - FY 2016-2017 and beyond: 100%

Assumptions: Eligible but not Enrolled

- Assumed that 20% of the uninsured population under 133% FPL would be eligible for Medicaid under the current program and for those enrollees the state would receive the normal FMAP. A weighted average FMAP is then used to calculate the cost to the program of the total caseload, including that 20%. Assumed the Title XIX expansion population will receive the enhanced FMAP beginning 1/1/2014.

Assumptions: Eligible but not Enrolled

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- Phase in assumptions:
  - Assumed 40% of these enrollees for the first year of expansion (beginning 1/1/2014).
  - Assumed 90% of these enrollees for the second year of expansion (beginning 1/1/2015).
  - Assumed 100% of these enrollees for the third year of expansion and beyond (beginning 1/1/2016).
- By fiscal year, that phase in translates as follows:
  - FY 2013-2014: 20%
  - FY 2014-2015: 65%
  - FY 2015-2016: 95%
  - FY 2016-2017 and beyond: 100%

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Assumptions: Crowd Out Population

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- Assumed that 80% of those under 133% FPL who are currently privately purchasing insurance (excludes employer sponsored insurance) will enroll in Medicaid under this proposal.
- Assumed enhanced FMAP would be received for these enrollees.
- Phase in assumptions:
  - Assumed 40% of these enrollees for the first year of expansion (beginning 1/1/2014).
  - Assumed 90% of these enrollees for the second year of expansion (beginning 1/1/2015).
  - Assumed 100% of these enrollees for the third year of expansion and beyond (beginning 1/1/2016).
- By fiscal year, that phase in translates as follows:
  - FY 2013-2014: 20%
  - FY 2014-2015: 65%
  - FY 2015-2016: 95%
  - FY 2016-2017 and beyond: 100%

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Assumptions: Impact to CHIP Population

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- Children transitioning from CHIP to Medicaid:
  - Assumed that for children under 133% FPL who move from CHIP to Title XIX, Florida will receive regular Medicaid FMAP.
  - Based on June 2010 Enrollment for Florida Healthy Kids and Children's Medical Services enrollment.
- CHIP Eligible but not enrolled population based on 2009 Census data, with expenditures based on June 2010 caseload and PMPM for all KidCare categories.

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Assumptions: Impact to CHIP Population

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- Assume phase in for CHIP Population:
  - On January 1, 2014: 27% of Healthy Kids Title XXI children will move to Title XIX (based on current distribution of Healthy Kids Children by Income Level). For future years it is assumed that the number of children will grow in Medicaid at 5% per year (the same rate as approved by SSEC for the 7/13 - 6/14 FY for Healthy Kids).
  - On January 1, 2014: 24.5% of CMS Title XXI children will move to CMS Title XIX (Based on current distribution of CMS Children by Income Level). For future years it is assumed that the number of children will grow in Medicaid at 61 children per month (calculated as 24.5% of the monthly growth of 250 children approved by the SSEC).
  - Beginning January 2014, Full Pay Program Growth for both Healthy Kids and MediKids will stop and 5% of Full Pay Enrollment as of December 2013 will migrate to an Exchange each month (assumption).

Impact of Affordable Care Act

		Total: Impact of Enrollment and FMAP Changes to Title XIX and Title XXI	Total: Impact of Increased Rates for Primary Care Practitioners	Grand Total All Elements
SFY 2013-2014	State Cost	$140,377,356	$1,030,662	$141,408,018
	Total Cost	$1,531,234,398	$405,028,693	$1,936,263,091
	Enrollment	379,274	n/a	379,274
SFY 2014-2015	State Cost	$449,760,030	$161,212,123	$610,972,153
	Total Cost	$4,998,033,219	$870,960,654	$5,868,993,873
	Enrollment	1,232,637	n/a	1,232,637
SFY 2015-2016	State Cost	$538,038,142	$321,324,131	$859,362,273
	Total Cost	$7,320,487,445	$944,074,114	$8,264,561,559
	Enrollment	1,801,545	n/a	1,801,545
SFY 2016-2017	State Cost	$684,751,025	$327,336,326	$1,012,087,351
	Total Cost	$7,706,049,937	$956,460,788	$8,662,510,725
	Enrollment	1,896,363	n/a	1,896,363
SFY 2017-2018	State Cost	$866,289,113	$333,414,148	$1,199,703,261
	Total Cost	$7,704,163,075	$956,711,668	$8,660,874,743
	Enrollment	1,896,363	n/a	1,896,363
SFY 2018-2019	State Cost	$927,207,624	$335,516,529	$1,262,724,153
	Total Cost	$7,702,183,282	$956,974,904	$8,659,158,186
	Enrollment	1,896,363	n/a	1,896,363

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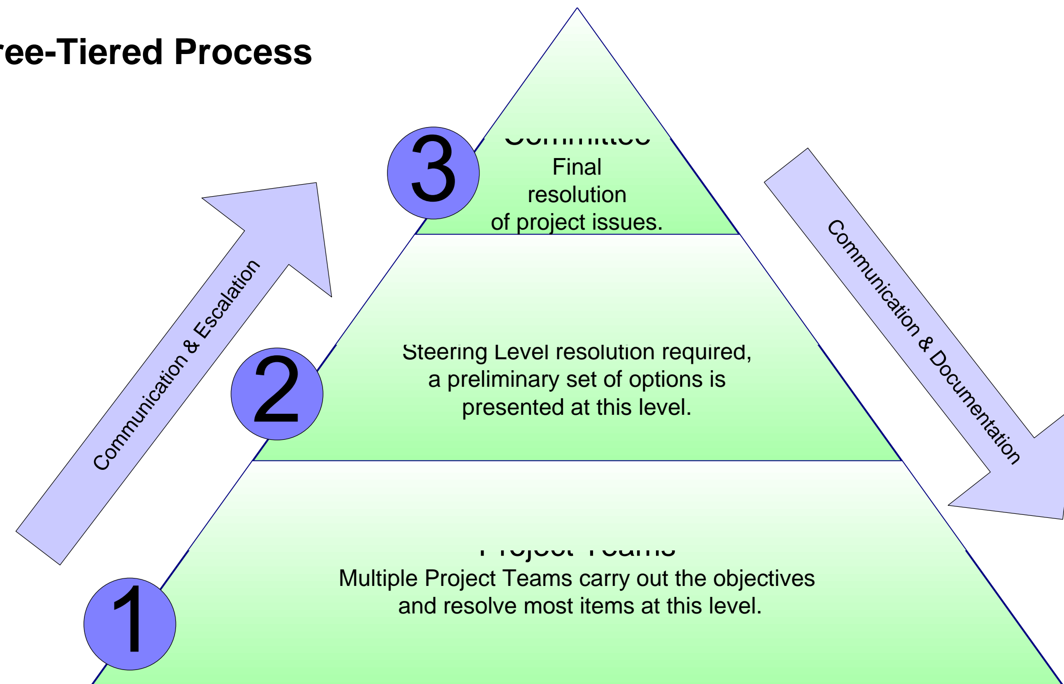
Structure for Contingency Planning

- These activities will be project managed.
- This is an Agency wide initiative.
- Coordination and Team members from other Agencies will be required to achieve requirements.

Three-Tiered Process



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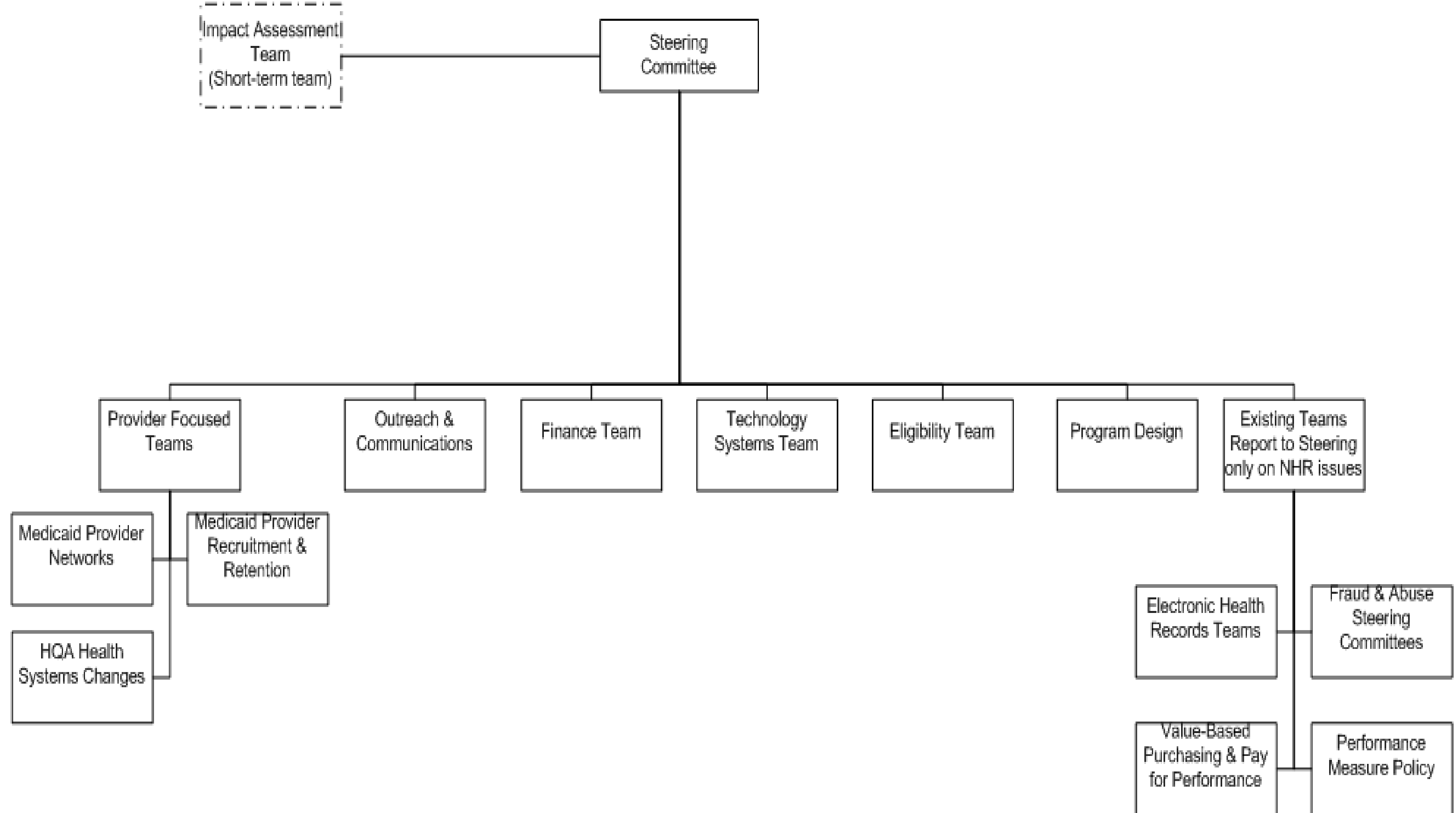
Contingency Planning Teams



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Contingency Planning Teams

- **Outreach and Communications:**

  This team will define scope of message for each of the stakeholders and timing of each message, with a focus on accuracy and consistency of information.

  - Provider/Recipient outreach.
  - Design web portal and handle interagency coordination of web presence.
  - Standardized format for presenting coverage options.
  - A Communications advisor will be placed on each team.

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Contingency Planning Teams

- **Finance**:

  This team will determine the impact and implement the financial pieces to the many components of this law.

  - Payment changes.
  - Drug Rebates.
  - DSH/LIP adjustments.
  - CHIP Match increase and developing eligibility for tax credits.
  - Establishing premium assistance (Opt Out Program).
  - Maintenance of Effort (MOE) impacts (applies to all waivers as well).
  - Provider Reimbursement/Rates.

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Contingency Planning Teams

- **Eligibility**:

  This team will coordinate the impact of eligibility changes to the Medicaid Program. While changes to the Florida System are outside the scope of this team, the coordination of efforts on these changes is within the scope. Enrollment simplification:

  - Changes to Dual.
  - HCBW modifications.
  - New eligibility options to include expanding Medicaid to non pregnant & non-elderly to 133% of FPL.
  - Auto assignment changes.
  - Transition CHIP to Medicaid.
  - Coordinate Exchange guidelines on eligibility.

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Contingency Planning Teams

- **Program Design:**

Scope: This team will be responsible for determining the impact and implementing the changes to Medicaid services.

- Handbook changes.
- Modify/amend waivers.
- New options to offer HCB Services to disabled.
- Expanded services, drugs and cessation programs.
- Evidence-based programs (to include EBR).
- Future of carve-outs.
- Legislative Language to implement.
- Medicaid/Medicare integration.
- Benefit tiers.
- Optional Services/ Programs.
- Integrated Long Term Care.

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Contingency Planning Teams

- **Medicaid Provider Networks:**
  - This team will focus on necessary changes to the provider networks.
  - Review existing Medicaid provider network for adequacy. (estimated 4.5 Million recipients - 2014)
  - Review Medicaid provider network appropriateness for new eligibles considering different health acuity than traditional Medicaid.

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Contingency Planning Teams

- **Medicaid Provider Recruitment and Retention**:

  This team will focus on Provider Enrollment and the surrounding processes.

  - Strategies for increasing provider participation.
  - Strategies for retaining providers in changing market place.
  - Provider Enrollment Process Improvements.
    - Streamline Process.
    - Electronic submission and maintenance.

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Planning Teams

- **HQA Health Systems Changes**:

  This team will identify impacts to AHCA's health care system regulation, and coordinate with other licensure and regulatory bodies (OIR, DOH, etc) on these impacts.

  - New Healthcare delivery systems- i.e. (PACO) Pediatric Accountable Care Orgs.
  - Cover Florida (State Plan from those over 133 to under 200% FPL).
  - Nursing facility disclosure.
  - Changes to State and Federal background screening requirements.

Planning Teams

- **Technology Systems:**

  This law will impact many of the systems AHCA utilizes for management of its programs. This is a service and support team whose main goals will be to inventory, assess, document and assist teams with their implementation of new functionality.

  - Changes to FMMIS for new eligibility, new payment structure, additional practitioners and plans.
  - Improved FRAUD tracking.
  - FRAES/Background Screening.
  - MEDS-Electronic Standard changes.
  - Claims processing changes.
  - Eligibility changes from Florida System (DCF).
  - Interaction with Exchange.
  - Central PSR/CSR writing/tracking related to this project.

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Contingency Planning Teams

- **Existing Teams**: Several currently existing teams will be impacted by the National Health Care Reform and will report on specific roles of the implementation.
  - Electronic Health Records Team
  - Fraud & Abuse Steering Committee
  - Performance Measure Policy Team
  - Value Based Purchasing & Pay for Performance Team

Questions?