

***Medicaid Reform  
Roundtable Discussion  
Hosted by Representative Soto***

***Presentation by  
Elizabeth Dudek, Secretary  
Agency for Health Care Administration***

***August 25, 2011***

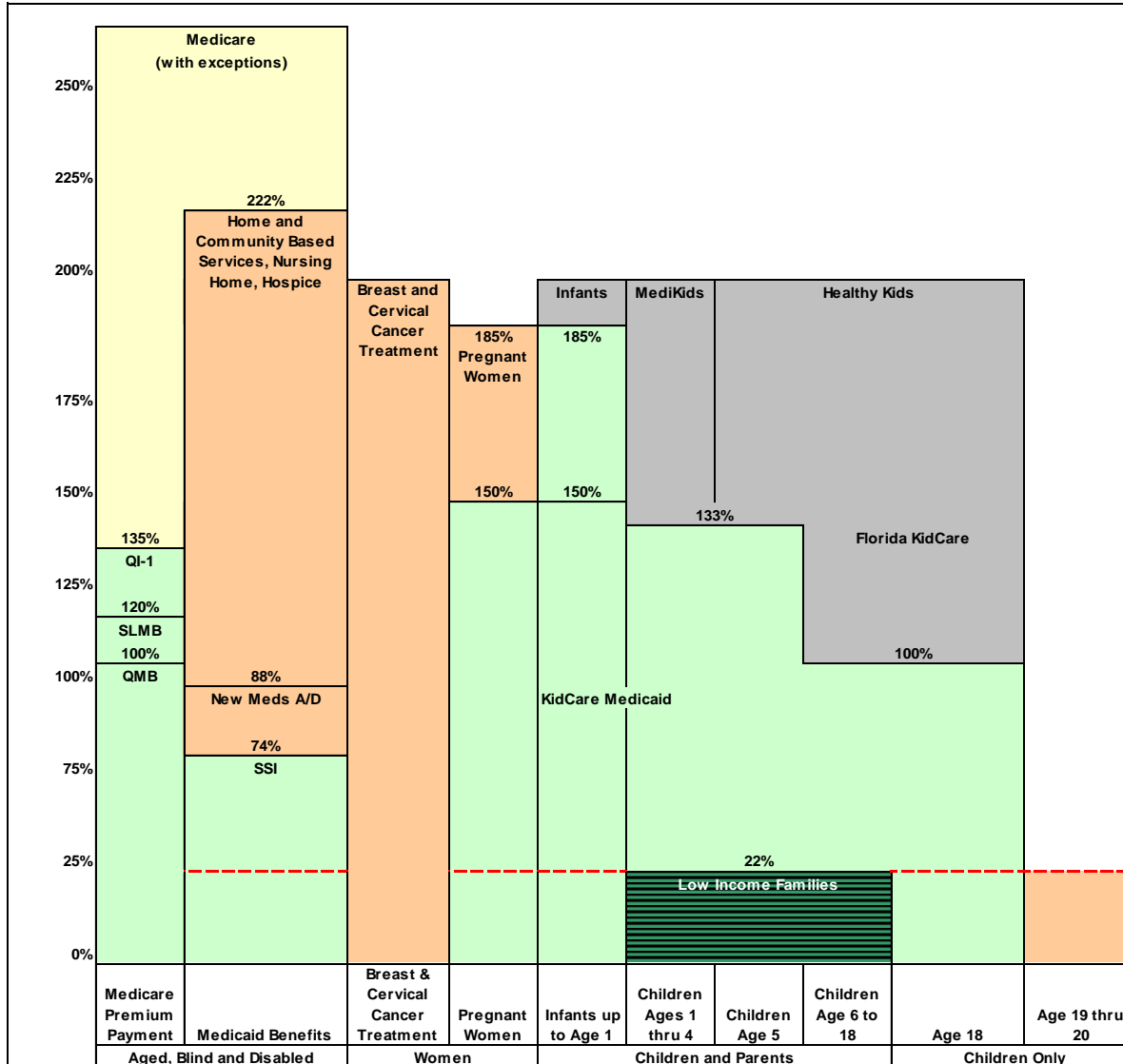
# Florida Medicaid – A Snapshot

<p><b><i>Expenditures</i></b></p>	<ul style="list-style-type: none"> <li>• \$20.3 billion estimated spending in Fiscal Year (FY) 2011-12</li> <li>• Federal-state matching program—55.94% federal, 44.06% state</li> <li>• Florida will spend approximately \$6,372 per eligible in FY 2011-12</li> <li>• 45% of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), Low Income Pool and Disproportionate Share Payments</li> <li>• 10% of all Medicaid expenditures cover drugs</li> <li>• Fifth largest nationwide in Medicaid expenditures</li> </ul>
<p><b><i>Eligibles</i></b></p>	<ul style="list-style-type: none"> <li>• 3.19 million eligibles</li> <li>• Elders, disabled, families, pregnant women, children in families below poverty</li> <li>• Fourth largest Medicaid population in the nation</li> </ul>
<p><b><i>Providers/Plans</i></b></p>	<ul style="list-style-type: none"> <li>• Approximately 80,000 active Fee-for-Service providers</li> <li>• 25 Medicaid Managed Care plans (19 HMOs and 6 PSNs)</li> </ul>

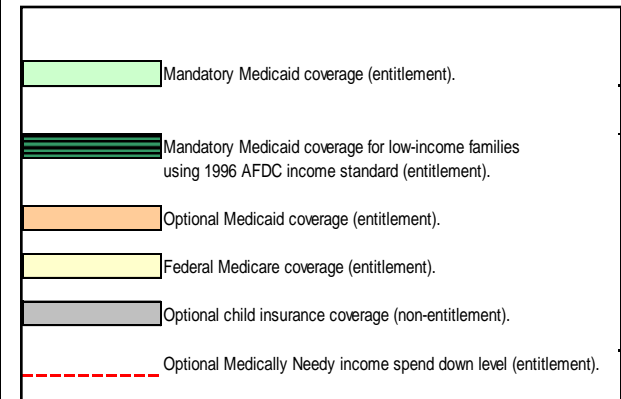
## *Medicaid by the Numbers*

- Number of Medicaid recipients as of June 30, 2011: 3,029,133
- Number of enrolled providers as of July 2011: 115,821
- Number of active providers who submitted a claim between July 2010-July 2011: 74,034
- Number of claims processed per month, on average: 13,278,295
- Medicaid does not cover all low income individuals.
  - 27% of children
  - 51.2% of deliveries
  - 63% of nursing home days
  - 1,162,020 adults—parents, aged and disabled

# Medicaid Eligibility - A Complex System of Coverages



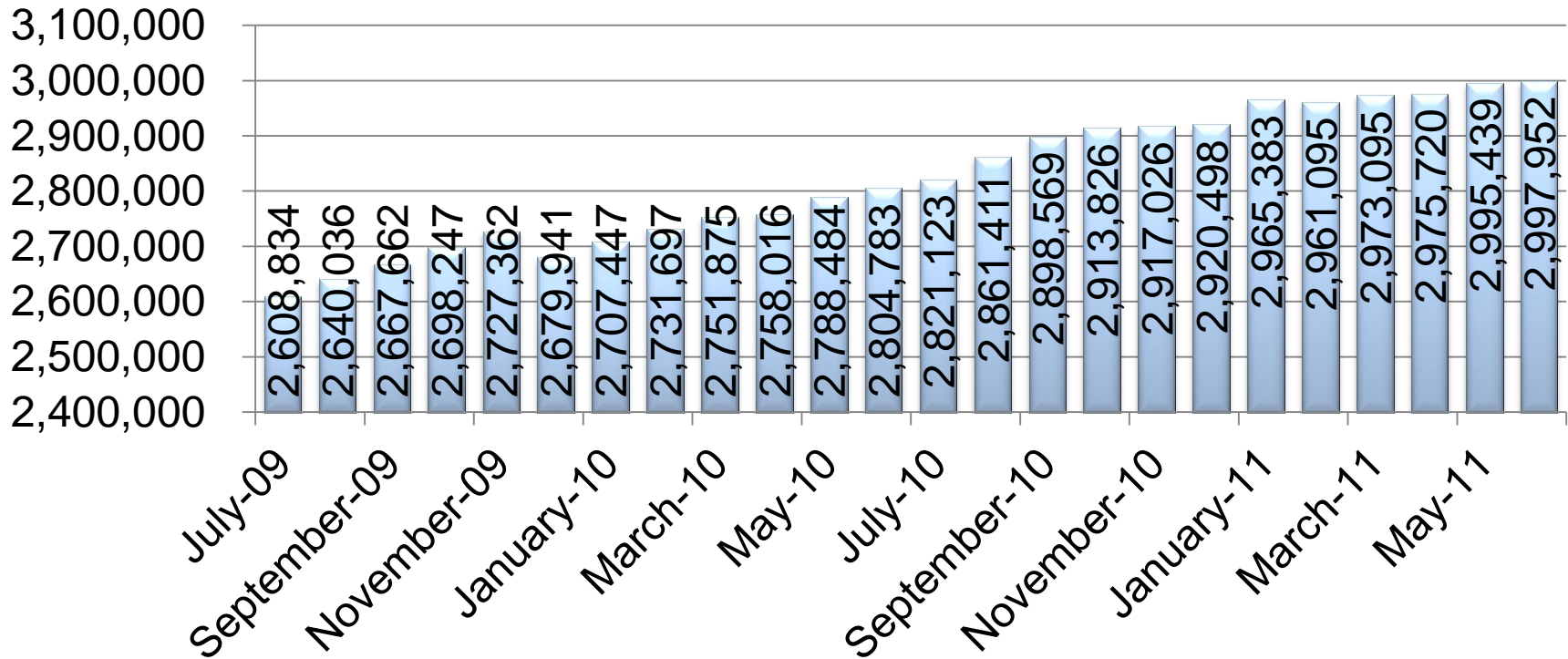
Family Size	**Monthly Income
1	\$908
2	\$1,226
3	\$1,545
4	\$1,863
5	\$2,181
6	\$2,500
7	\$2,818
8	\$3,136
Each Additional	\$319



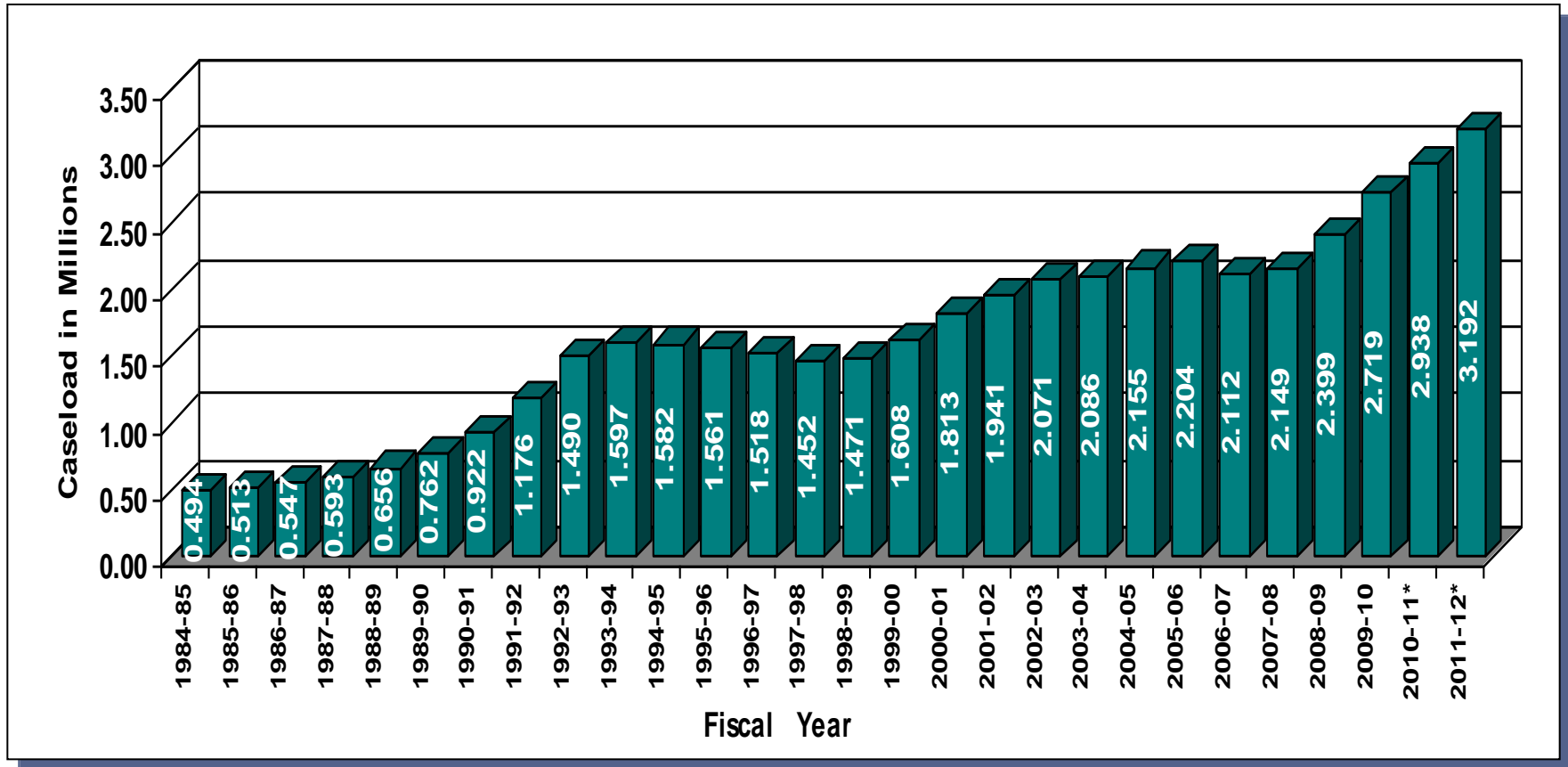
\*Coverage for infants up to 185% Federal Poverty Level is required in order for states to receive Title XXI funding.

\*\*Federal Poverty Level as of January 2011

# Medicaid Enrollment July 2009-June 2011



# Growth in Medicaid Average Monthly Caseload

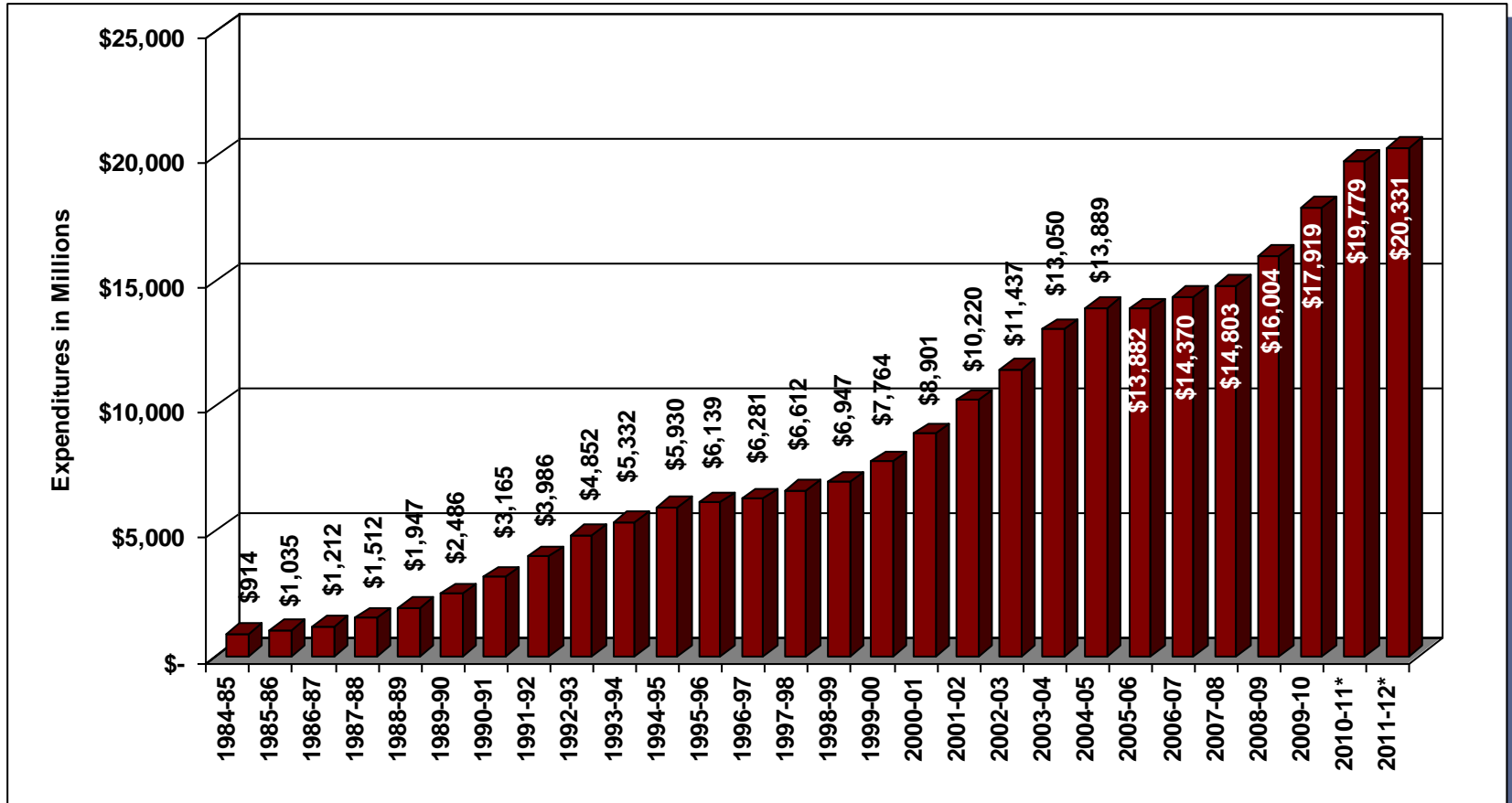


Source: Medicaid Services Eligibility Subsystem Reports.

\*FY 2010-11 January 2011 Caseload Social Services Estimating Conference.

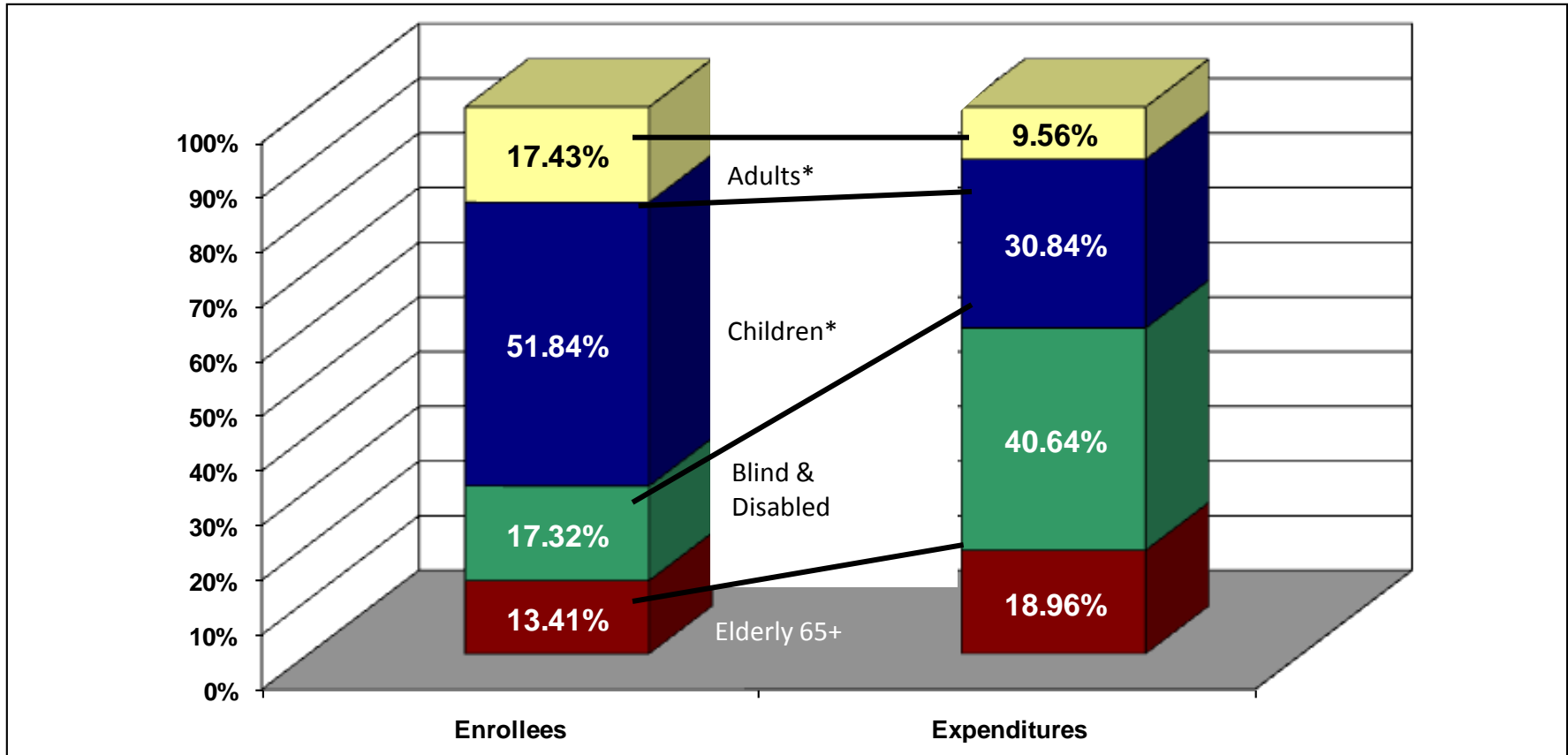
\*FY 2011-12 General Appropriations Act.

# Growth In Medicaid Service Expenditures



Source: Medicaid Services' Budget Forecasting System Reports.  
 \*FY 2010-11 February 2011 Social Services Estimating Conference.  
 \*FY 2011-12 July 2011 Social Services Estimating Conference.

# Medicaid Budget How it is Spent FY 2009-10

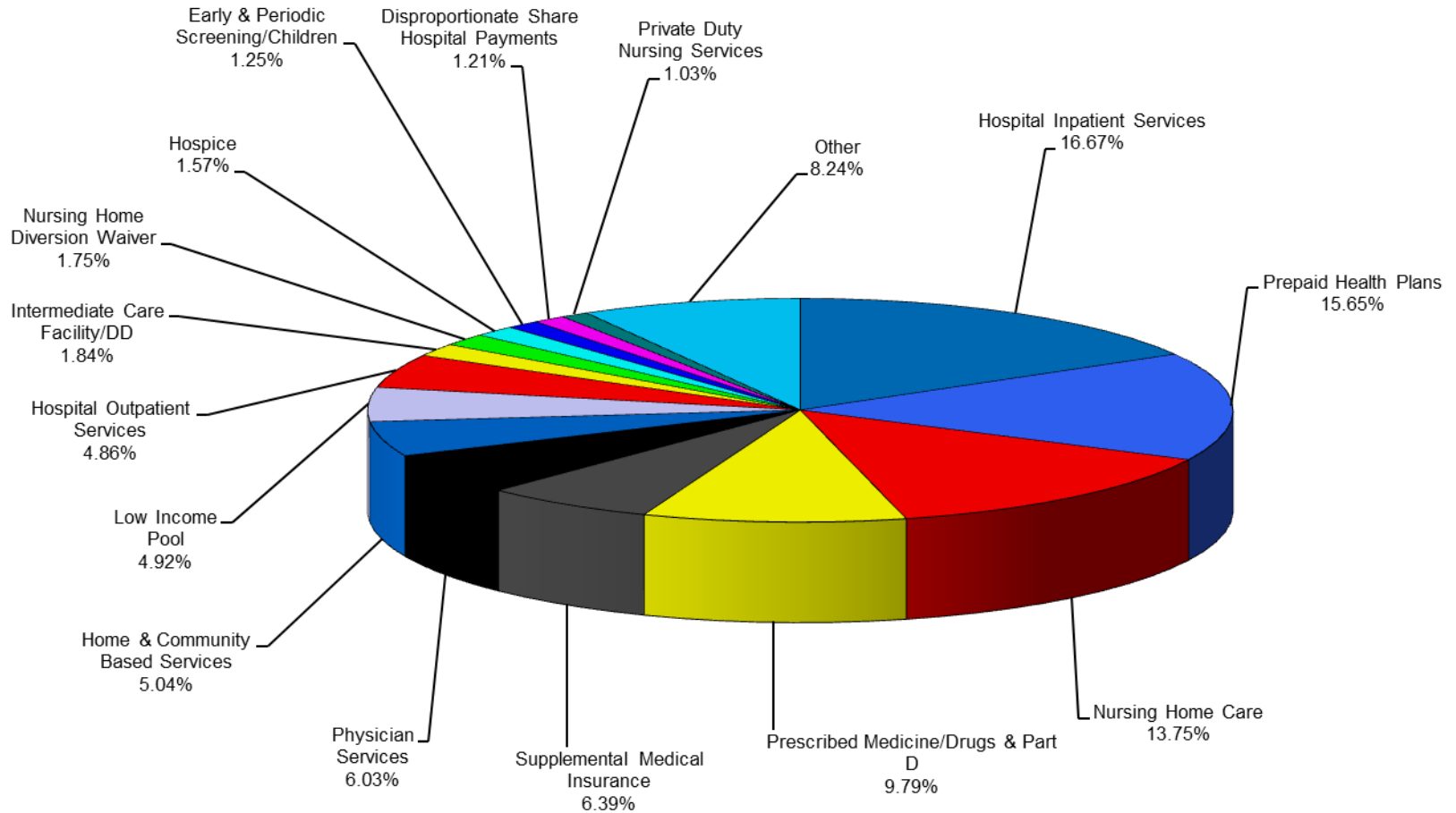


\*Adults and children refers to non-disabled adults and children.

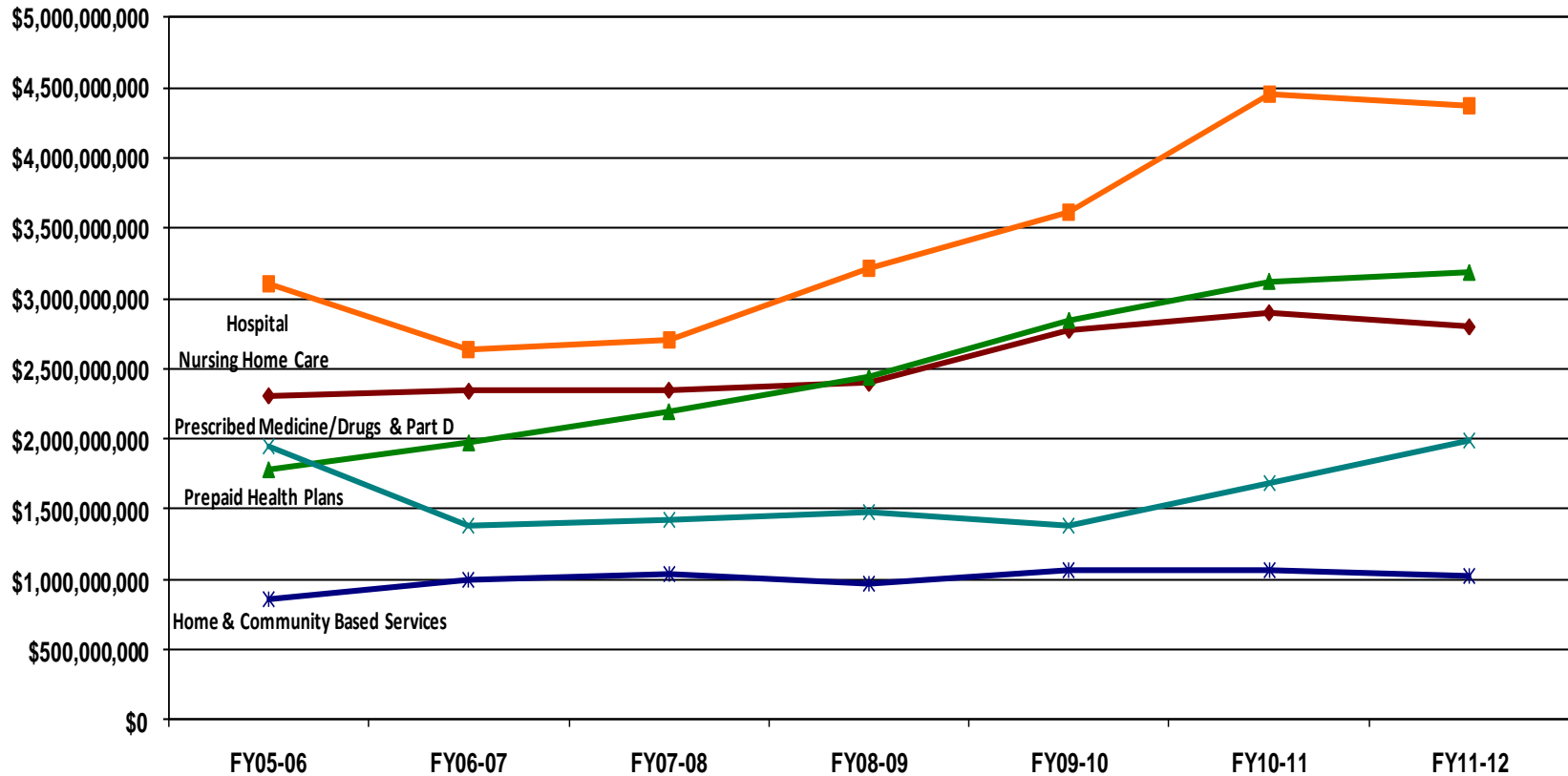
# *Medicaid Spending for FY 2011-12*

Service	FY 2011-12 Estimated Spending	Percent of Total
<b>Hospital Inpatient Services</b>	\$3,390,039,763	16.67%
<b>Prepaid Health Plans</b>	\$3,181,001,092	15.65%
<b>Nursing Home Care</b>	\$2,795,230,543	13.75%
<b>Prescribed Medicine/Drugs &amp; Part D</b>	\$1,991,389,946	9.79%
<b>Supplemental Medical Insurance</b>	\$1,299,861,984	6.39%
<b>Physician Services</b>	\$1,226,863,388	6.03%
<b>Home &amp; Community Based Services</b>	\$1,024,717,619	5.04%
<b>Low Income Pool</b>	\$1,000,250,001	4.92%
<b>Hospital Outpatient Services</b>	\$988,179,992	4.86%
<b>Intermediate Care Facility/DD</b>	\$373,081,505	1.84%
<b>Nursing Home Diversion Waiver</b>	\$355,766,695	1.75%
<b>Hospice Services</b>	\$318,982,493	1.57%
<b>Early and Periodic Screening/Children</b>	\$254,420,634	1.25%
<b>Disproportionate Share Hospital Payments</b>	\$246,570,577	1.21%
<b>Private Duty Nursing Services</b>	\$209,254,006	1.03%
<b>Other</b>	\$1,675,183,156	8.24%
<b>Total</b>	\$20,330,793,394	100.00%

# Estimated FY 2011-12 Medicaid Expenditures by Category



# Top 5 Medicaid Services Expenditures on Average



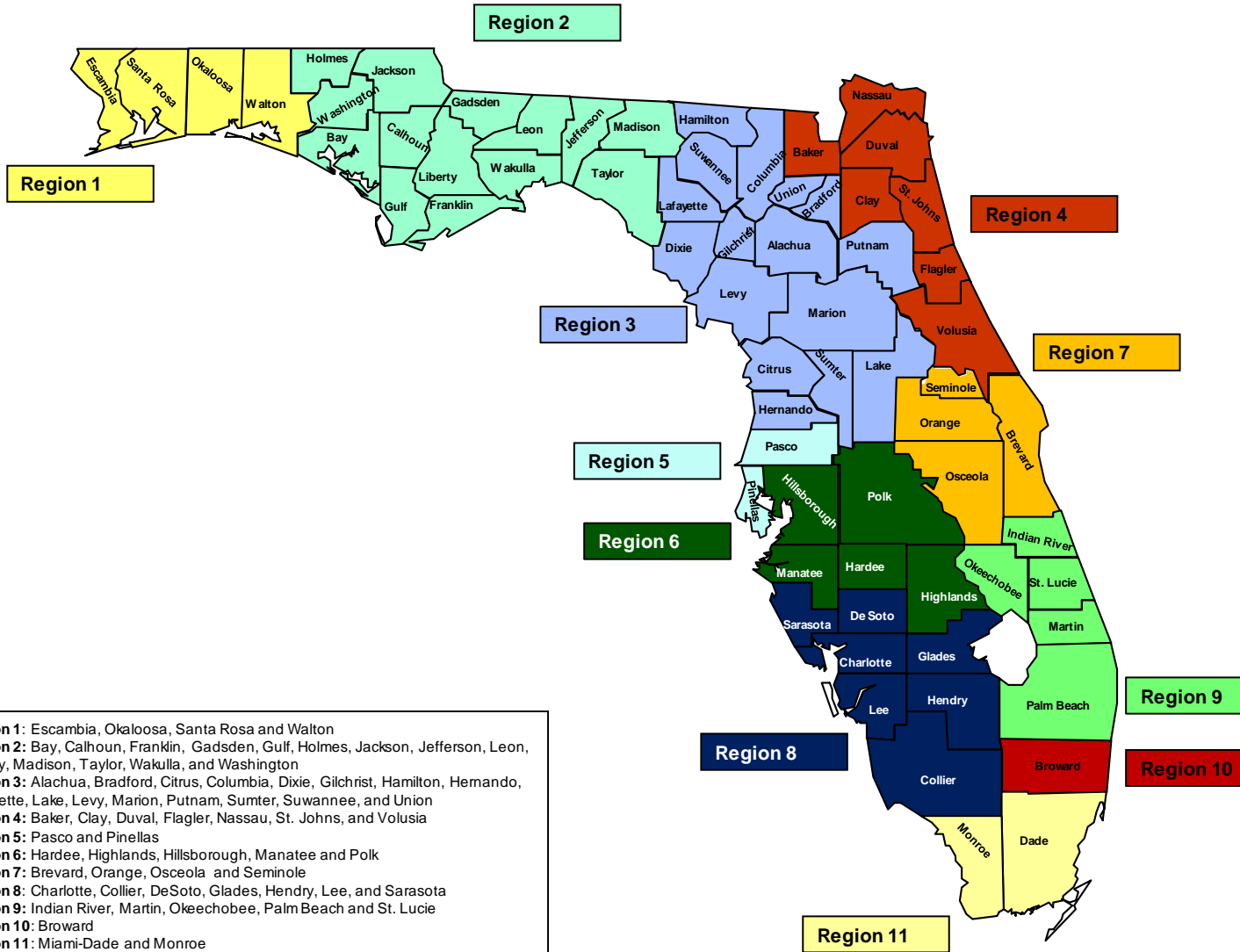
## *2011 Legislative Session*

- The House and Senate passed HB 7107 and HB 7109, which reform the Florida Medicaid Program.
- The legislation requires the state Medicaid program to implement a statewide long-term care managed care program and a statewide managed medical assistance program.
- All Medicaid recipients are required to enroll in a managed care plan unless specifically exempted in the legislation.
- Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

## *2011 Legislative Session*

- HB 7107 established 11 regions throughout the state.
- The Agency is required to separately procure for Long-term Care Managed Care plans and Managed Medical Assistance plans in each of the 11 regions.
- The Agency is required to select a limited number of eligible plans to participate in the Statewide Medicaid Managed Care program using invitations to negotiate.
- HB 7107 provides timelines for implementation of both the Long-term Care Managed Care program and the Managed Medical Assistance program with submission of the waiver request by August 1, 2011 and full program implementation by October 1, 2014.

# SMMC Medicaid Regions



**Region 1:** Escambia, Okaloosa, Santa Rosa and Walton  
**Region 2:** Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington  
**Region 3:** Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union  
**Region 4:** Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia  
**Region 5:** Pasco and Pinellas  
**Region 6:** Hardee, Highlands, Hillsborough, Manatee and Polk  
**Region 7:** Brevard, Orange, Osceola and Seminole  
**Region 8:** Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota  
**Region 9:** Indian River, Martin, Okeechobee, Palm Beach and St. Lucie  
**Region 10:** Broward  
**Region 11:** Miami-Dade and Monroe

# *Key Elements of the Statewide Medicaid Managed Care Program*

- Mandatory, voluntary or excluded populations
- Patient centered care, personal responsibility and active patient participation
- Provide for fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program
- Implement innovations in reimbursement and quality and increased plan accountability

# *Mandatory, Voluntary and Excluded Populations*

## ➤ For the Managed Medical Assistance Program:

Required to Enroll	Voluntary (May Enroll)	Excluded (May NOT enroll)
Temporary Assistance for Needy Families (TANF) and TANF related	Medicaid recipients who have other creditable health care coverage, excluding Medicare	Women who are eligible only for family planning services
Children with chronic conditions, including foster care children	Medicaid recipients residing in residential commitment facilities operated through DJJ or mental health treatment facilities as defined by section 394.455(32), F.S.	Women who are eligible only for breast and cervical cancer services
Pregnant women	Persons eligible for refugee assistance	Persons who are eligible for emergency Medicaid for aliens
Medically Needy recipients	Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville	Children receiving services in a prescribed pediatric extended care center
Individuals with Medicare coverage (Medicaid acts as a secondary payer)	Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393; Medicaid recipients waiting for waiver services	

## *Mandatory and Excluded Populations*

- For the Long-term Care Managed Care Program:
- Required to enroll: Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs:
  - Assisted Living for the Elderly
  - Aged/Disabled Adult
  - Adult Day Health Care
  - Consumer-Directed Care Plus Program
  - PACE
  - Nursing Home Diversion
  - Channeling
- Excluded (may NOT enroll): HB 7107 does not expand enrollment to include those currently on home and community based services wait lists.

## ***Fully Integrated Care through Alternative Delivery Models***

- Patients will have a choice of plans that will offer a variety of alternative delivery models.
- Patients will have the opportunity for fully integrated care—all plans are required to cover both physical and behavioral health care. Services previously excluded from managed care, including certain behavioral health services, patient transportation and dental services, will be coordinated within the plan. This will provide for continuity of care across service types.
- A variety of plan types and delivery models will be eligible to provide services to patients under the SMMC program, including health maintenance organizations, provider services networks, accountable care organizations, exclusive provider organizations and specialty plans.

## *Network Adequacy Standards*

- The Agency will establish specific standards for the number, type, and regional distribution of providers in plan networks to ensure access for all patients to needed providers and services.
- Plans are required to establish and maintain online an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the Agency deems necessary.
- The provider database must allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

## *Essential Providers*

- Certain providers are classified as essential and must be included in plan networks for at least the first contact year. Plans may limit the providers in their networks, but must include providers classified as essential, which shall include at a minimum:
  - Federally qualified health centers
  - Statutory teaching hospitals as defined in s. 408.07(45)
  - Hospitals that are trauma centers as defined in s. 395.4001(14)
  - Hospitals located at least 25 miles from any other hospital with similar services.
- Other providers are considered statewide essential providers and must be included in all plan networks, including:
  - Faculty plans of Florida medical schools
  - Regional perinatal intensive care centers as defined in s. 383.16(2).
  - Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28)
  - Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

## *Quality and Accountability*

- The SMMC program establishes enhanced quality and performance measures for plans, including requirements that plans:
  - establish an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys,
  - establish a system of incentives and disincentives for network providers,
  - establish standards for the collection and reporting of Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan website,
  - achieve accreditation within 1 year of contract execution, and
  - establish programs and procedures to improve pregnancy outcomes and infant health.
- The SMMC program establishes enhanced program integrity requirements for plans, including requirements that:
  - plans must have an effective prepayment and post payment review process including data analysis, system editing and auditing of network providers;
  - plans must have in place procedures for reporting instances of fraud and abuse; and
  - plans must have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse.
- Plans are required to submit audits and meet reporting requirements.

***Thank you!***  
***Questions?***