Introductions

Gail Wilk
What Medicaid Reform Is

- Increased access to appropriate care.
- Benefits that better meet recipients’ needs.
- Access to services not traditionally covered by Medicaid.
- An opportunity to provide choice and control to recipients in regard to health care decisions.
- Ability to earn credit to pay for non-covered services.
- Bridge to private insurance.
What Medicaid Reform is Not

- Reform will NOT change who receives Medicaid.
- Eligibility does not change.
- Reform will NOT “cut” the Medicaid budget. The budget will continue to grow each year.
- Reform is NOT correlated with Medicare Part D.
- The state will NOT limit medically necessary services for pregnant women.
- The state has NOT asked to waive Early and Periodic Screening Diagnosis and Treatment (EPSDT) for children. This means children will be able to access all medically necessary services.
- The state will NOT increase cost sharing requirements.
Key Elements of Reform

- New Options/Choice:
  - Customized Plans.
  - Opt-Out.
  - Enhanced Benefits.

- Financing:
  - Premium Based.
  - Risk-Adjusted Premium.
  - Comprehensive and Catastrophic Component.

- Delivery System:
  - Coordinated Systems of Care (PSN and HMOs):
    - HMOs are capitated.
    - PSNs are Fee-for-Service up to three years, then capitated.
What Will Change With Reform?

- Comprehensive choice counseling.
- Education needs will dramatically change:
  - Recipients will need to understand differences between benefit packages, plans may offer.
  - New requirements on information provided.
  - Information on opting out of a Medicaid plan.
- New recipients will receive only emergency services until they enroll or are assigned to a plan.
- With certain services, plans may vary in amount, duration and scope.
Types of Reform Plans: FFS vs. Capitated

- What are going to be the different types of managed care organizations that are going to be participating?
  - Provider Service Network (PSN)
    - Fee For Service (FFS) PSN
    - Capitated PSN
  - Health Maintenance Organizations (HMO)
  - Letter of Intent
Customized Benefit Packages
Plan Design Guidelines

- Levels of amount, scope and duration flexibility:
  - Certain services must be provided at least to current coverage levels.
  - Other services must be provided at least to meet benefit sufficiency standards.
  - Remaining services must be offered, but amount, scope and duration are flexible.

- Reform plans can enhance any service above current levels.
- Reform plans can add services not currently covered.
Customized Benefit Packages
Plan Design Guidelines (continued)

- Physician and physician extender services.
- Hospital inpatient care.
- Emergency care.
- EPSDT and other services to children.
- Maternity care and other services to pregnant women.
- Transplant services.
- Medical/drug therapies (chemo, dialysis).
- Family planning.
- Outpatient surgery.
- Laboratory and radiology.
- Transportation (emergent and non-emergent).
- Outpatient mental health services.
Customized Benefit Packages
Plan Design Guidelines (continued)

- Required and tested for benefit sufficiency:
  - Hospital outpatient services.
  - Durable medical equipment.
  - Home health care.
  - Prescription drugs.
Customized Benefit Packages
Plan Design Guidelines (continued)

- Required to be offered, but amount, scope and duration are flexible:
  - Chiropractic care.
  - Podiatry.
  - Outpatient therapy.
  - Adult dental services.
  - Adult vision services.
  - Adult hearing services.
Customized Benefit Packages

Goals

- Goals for Medicaid Eligible Individuals
  - Variety of plan choices
  - Ability to select a plan that best meets their needs
  - Greater engagement in health care decisions
Customized Benefit Packages
Target Populations

- July 1, 2006 target populations will be
  - Children and Families
  - Aged and Disabled
  - Specialty Populations
    - Children with Chronic Conditions
    - HIV / AIDS Patients (Capitated Plans)
Provider Enrollment

Tracy Hurd
Enrollment Options

- Plan choice.
- Participation in multiple networks.
- Not locked into a plan.
Things to Think About When Considering Joining a Plan Network

- Benefit Packages Offered
  - Case management services.
  - Disease specific education programs.

- Matching Clientele
  - Plan’s benefits match the needs of your patients.

- Management Responsibilities
  - Be familiar with the requirements of the contract.
Things to Think About When Considering Joining a Plan Network (continued)

- Payment to providers:
  - Be familiar with payment structures in the contract.
  - Capitated:
    - Negotiated pricing with the contractor.
  - PSN Fee for Service (FFS):
    - Convert to capitated plan no later than fourth year of operation.
    - Regular Medicaid FFS rate.
Patient Enrollment

Tracy Hurd
**Patient Enrollment**

- Process of transitioning recipients to reform plans.
  - Based on recipient choice.
  - If the plan converts to a reform plan.
  - Required to enroll at redetermination date or open enrollment period.

- May be required to enroll sooner if:
  - Recipient is currently enrolled with a Medicaid managed care organization that converts to an approved reform plan.
  - If the recipient’s MediPass doctor joins a PSN.

- May also join a reform plan prior to the required redetermination date.
Mandatory Population
(Current Managed Care Eligibles)

❖ Beginning on July 1, 2006 in Duval and Broward Counties:
  – Temporary Assistance for Needy Families (TANF)
  – TANF-Related Group:
    • Low income single parent families.
    • Low income families with a disabled or unemployed parent.
  – Aged and Disabled (non dually eligible).
  – Specialty Populations
    • Children with Chronic Conditions
    • HIV / AIDS Patients (Capitated Plans)
Voluntary Populations

- The following individuals eligible under the below groups will be excluded from mandatory participation during the initial phase:
  - Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
  - Foster care children;
  - Individuals diagnosed with developmental disabilities;
  - Pregnant women with incomes above the TANF poverty level.
  - Individuals with Medicare coverage. (duals or QMB)
Who’s Enrolled?

- Who will remain on my MP (MediPass) panel?
  - Voluntary populations who don’t choose a plan.
  - New enrollees within the voluntary population category.
General Timeline for Patient Choice

- **Day 1**
  - Choice is triggered for patient
    - At time of provider’s enrollment or HMO conversion.
    - At re-determination date.
    - At open enrollment date.
    - At voluntary enrollment.
  - (30) days is given for the recipient to make a choice

- **Day 30**
  - If no choice has been made, recipient is mandatorily enrolled unless beneficiary falls in voluntary population group.
General Timeline for Patient Enrollment (continued)

- **Day 1 of Enrollment Period**
  - From their day of enrollment, recipients are given a (90) day window in which they may change their plan.

- **After 90 days**
  - Recipients are locked into their plan for the remaining 9 months.
How will the Enrollment Process Begin?

- MediPass Provider joins a PSN:
  - Beneficiaries’ choice is triggered.
- MediPass Provider contracts with HMO:
  - Beneficiaries continue to be MediPass
  - Beneficiaries’ choice is triggered at re-determination.
- MediPass provider does not join any plan:
  - Beneficiaries’ choice is triggered at re-determination.
Authorization Process
Requirements and
Quality of Care

Melanie Brown-Woofter
The Agency is going to strictly monitor the programs through our HQA program.

Contracts with private entities for quality assurance:
- External Quality Review Organization (EQRO), and
- Medicaid reform evaluation contract with UF.

Quality and Performance Standards reform team

Network requirements in rural/urban areas:
- 30 minutes / 30 miles to a PCP.
- 60 minutes to a hospital.
- Geographically spread access.
- 24 / 7 coverage required.
Resource Update

Gail Wilk
Resource Updates

- Website:
  - http://ahca.myflorida.com/Medicaid/medicaid_reform/

- Outreach:
  - 03/23/06 Duval County MediPass Provider Outreach
  - 03/23/06 Duval County Plan/Provider Outreach
  - 03/24/06 Broward County Plan/Provider Outreach

- List of Respondents to Request for Letter of Intent
Area Office Contacts

- Area 10 Medicaid Field Office (954) 202-3200: Gail M. Wilk, Field Office Manager
  - MediPass Unit:
    - Rafael Copa, Program Administrator
    - Halina Glassberg, Program Operations Administrator
  - Provider Services Unit:
    - Lisette Rodriguez, Program Administrator
    - Steve Comeau, Program Operations Administrator
    - Nicole Griffin, Program Operations Administrator

http://www.ahca.myflorida.com/Medicaid/medicaid改革/
Questions and Answers

Dyke Snipes