

Florida Medicaid: Managed Care Rate Setting

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Statewide Medicaid Managed Care Program

- The 2011 Florida Legislature directed implementation of this program.
- Most Medicaid recipients are in one or both components:

(December 2016 Enrollment)

- Long-term Care: 94,320
 - Managed Medical Assistance: 3,225,180
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- Small percentage of recipients receive services through the fee-for-service delivery system.
 - Most of these are eligible for a limited benefit package (ex: dual eligibles, medically needy)



Florida Medicaid Reimbursement

- The Florida Medicaid program makes payments to providers in two ways:
 - Fee-For-Service payments made by the Florida Medicaid program directly to individual providers.
 - Capitated Payments to managed care health plans (health plans) which, in turn, make payments to providers in the plan network for services rendered.



What is Managed Care?

- Managed care is when health plans manage how their enrollees receive health care services.
 - Health plans work with different providers to offer quality health care services.
 - Plans also work to make sure enrollees have access to all needed doctors and other health care providers for covered services.
 - People enrolled in managed care receive their services from providers that have a contract with the plan.



Managed Care “At Risk” Contracts

- Health plans are “at risk” because their costs may exceed the total capitated payments.
- Plans must pay for all covered services for their enrollees, regardless of whether the cost of those services exceeds the capitation rate received from the Agency.



Managed Medical Assistance Program Capitation Rate Setting

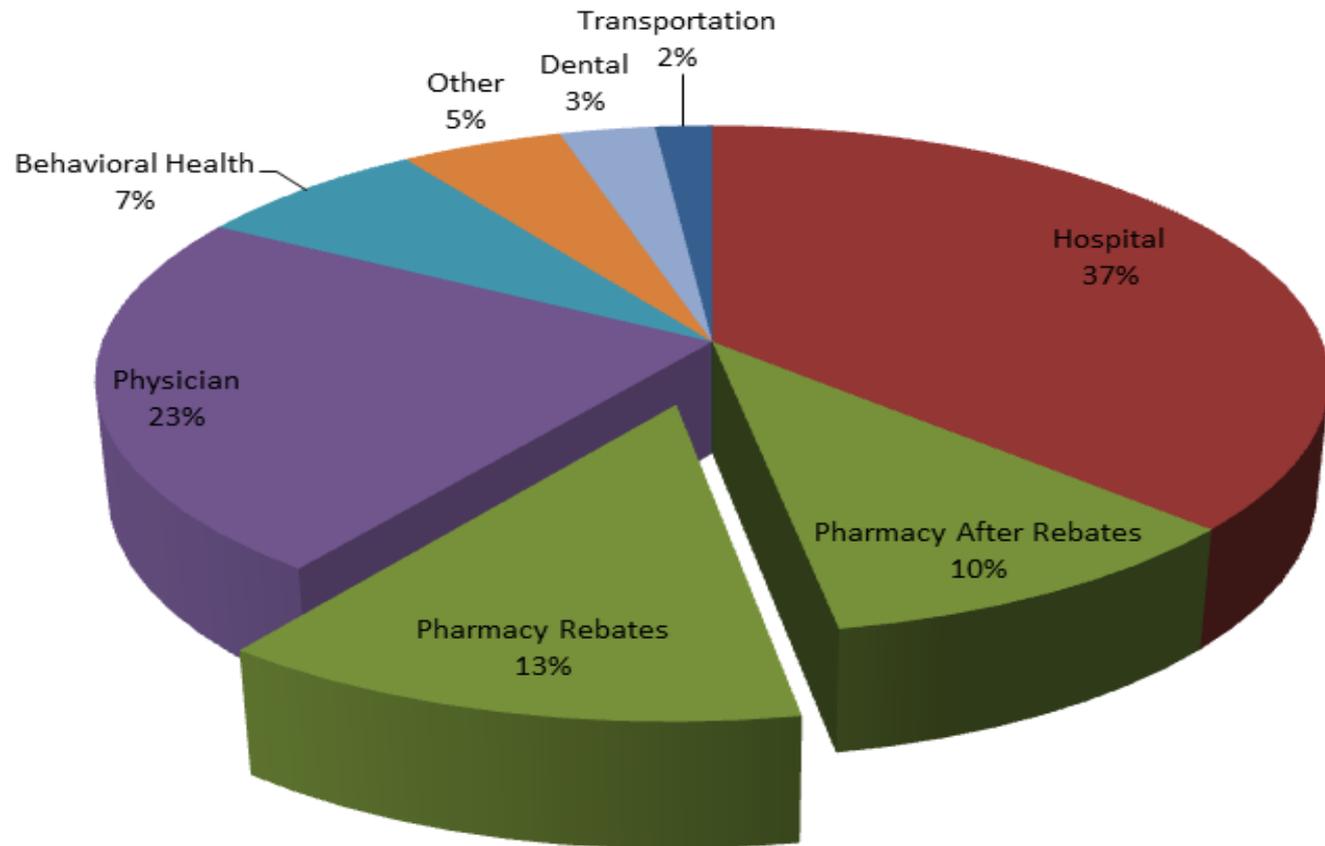


Managed Medical Assistance (MMA) Program

- Covers recipients of any age who are eligible to receive full Medicaid benefits.
- Covers acute care, preventive, and other health care services such as:
 - Hospital
 - Physician
 - Pharmacy
 - Behavioral Health
 - Dental
 - Transportation to medical services
 - Other (e.g., Medical Equipment and Supplies, Therapies, Home Health)



Largest Portion of MMA Plan Spending on Services is for Hospital, Physician, and Pharmacy*



*Before Pharmacy Manufacturer Rebates

Source: Audited Achieved Savings Rebate Reports 10/2015 – 9/2016



Capitation Rate Setting

- Rates paid to the MMA plans must be “Actuarially Sound”
 - Required by 42 CFR 438.4(b).
- Rates must be certified by an actuary.
 - Florida Medicaid contracts with an actuarial firm for rate setting.
- Rates must be approved by the federal Centers for Medicare and Medicaid Services (CMS).
 - A detailed CMS checklist is completed by the actuary and submitted to CMS along with the full rate report.
 - Any changes to rates must be accompanied by documentation from the actuary.

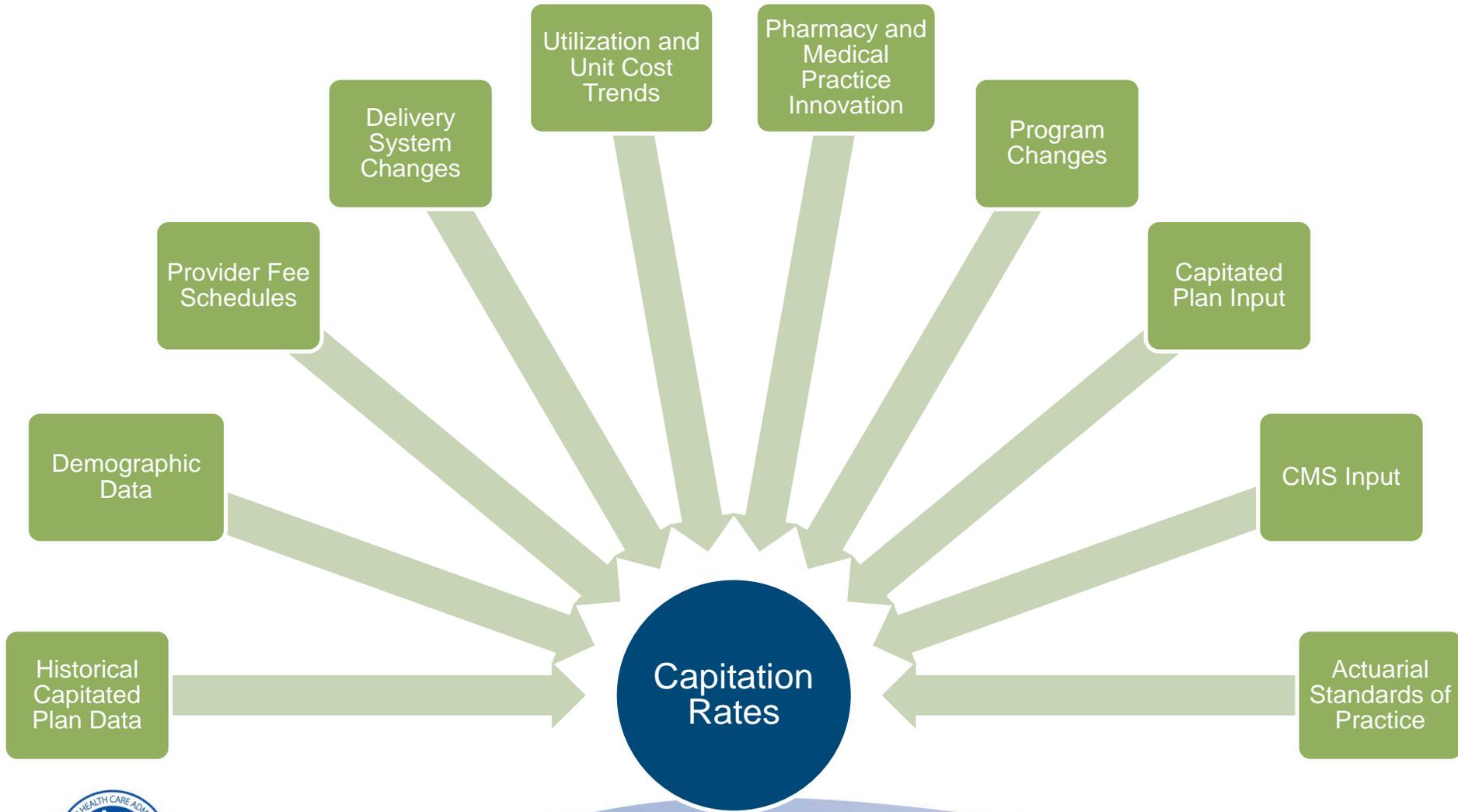


Capitation Rate Setting

- Actuarial Soundness:
 - Developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract, including:
 - Service costs
 - Administrative expenses
- Plans cannot arbitrarily raise provider contracts or other costs. Costs reflected in rate setting must be reasonable and will be judged against industry standards.
 - Actuarial and Florida Medicaid input



Information Used in Rate Setting



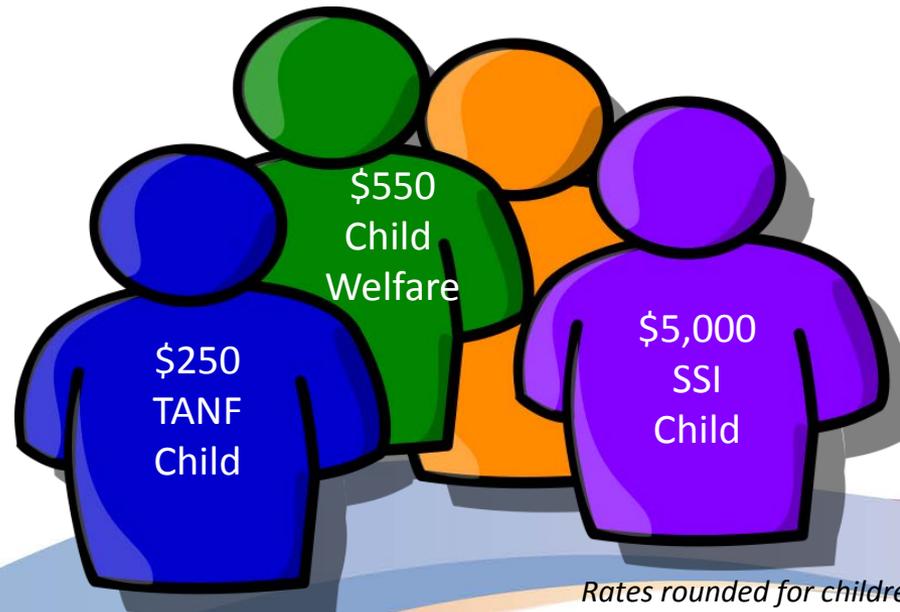
Steps in MMA Rate Setting

1. Start with validated historical utilization and cost data.
 - For 2016-2017 rates, used October 2014 – September 2015
2. Adjust for any changes to the program (e.g., benefit change, significant fee change for hospitals).
3. Revise rates to reflect the new rate period (“Trend”).
4. Allowance for health plan administrative costs and profit margin.



MMA Rates Vary By Region, Age, and Eligibility

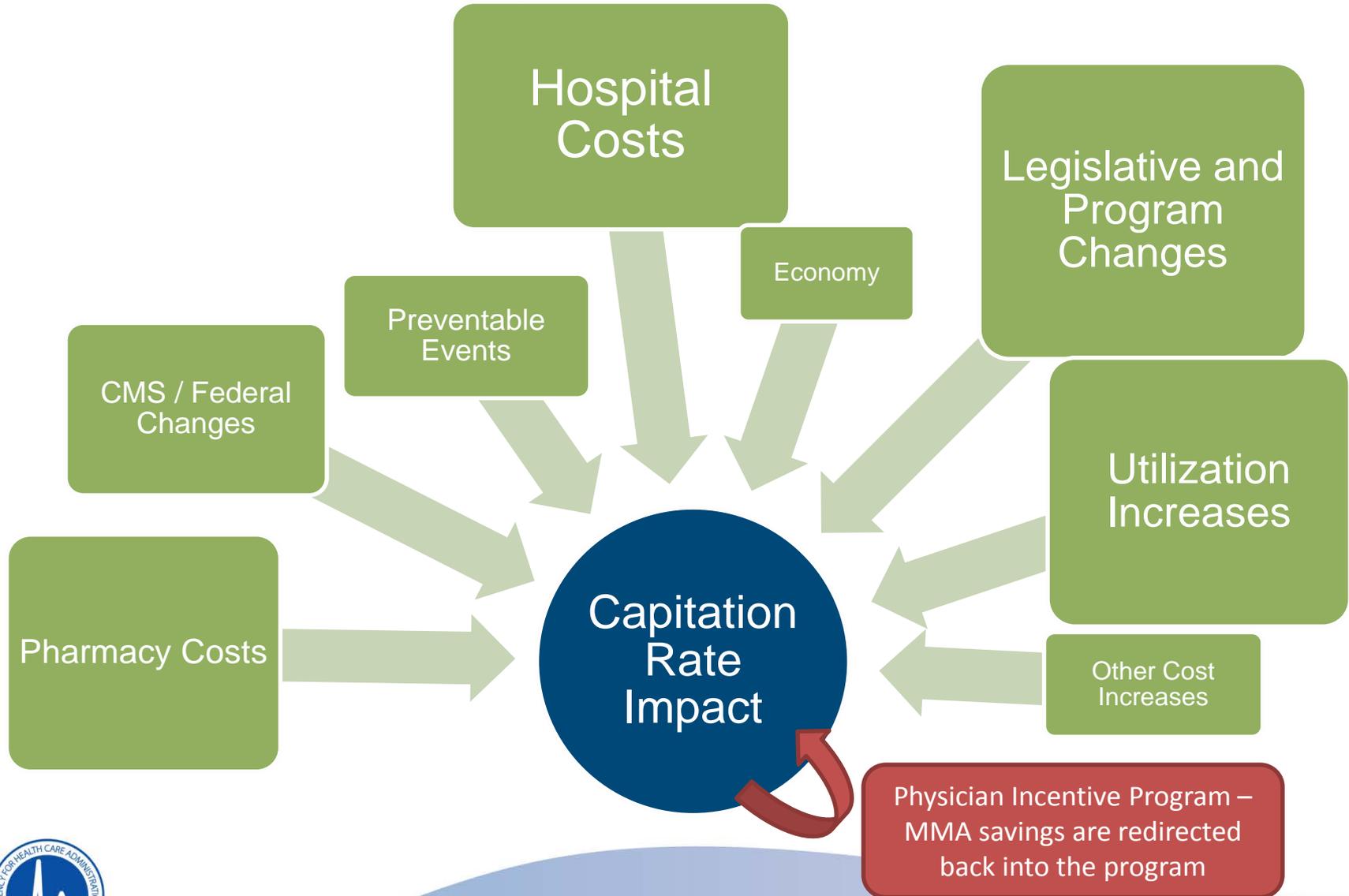
- Example:
 - For a healthy child in the TANF eligibility group, a plan receives a capitation payment of around **\$250** per month.
 - For a child with a disability in the SSI eligibility group, the plan receives a capitation payment of around **\$5,000** per month.



Rates rounded for children 3-11 months old, region 4.



MMA Capitation Cost Drivers



MMA Capitation Cost Drivers: Trend

- Factors applied to base data to revise rates to reflect the new rate period



- Determined by industry data, historical data, and national Medicaid trend projections
- Accounts for:
 - Changes in patterns of use of services
 - Changes in health care service costs
 - Innovations in medical practice and pharmacy



Long-term Care Program Rate Setting



Long-term Care (LTC) Program

- Recipients are mandatory for enrollment in the LTC program if they are:
 - 65 years of age or older AND need nursing facility level of care.
 - 18 years of age or older AND are eligible for Medicaid by reason of a disability, AND need nursing facility level of care.
- The LTC program provides home and community-based care and nursing facility care.
- \$4.0 Billion (SFY 2016/2017)



Long-term Care Program Rate Setting

- Follows the same basic steps as Managed Medical Assistance rate-setting
- Florida Statute requires Long-term Care plans to:
 - Pay nursing facilities an amount equal to or greater than the nursing facility-specific payment rates set by the Agency.
 - Pay hospice providers an amount equal to the prospective per diem rate set by the Agency.



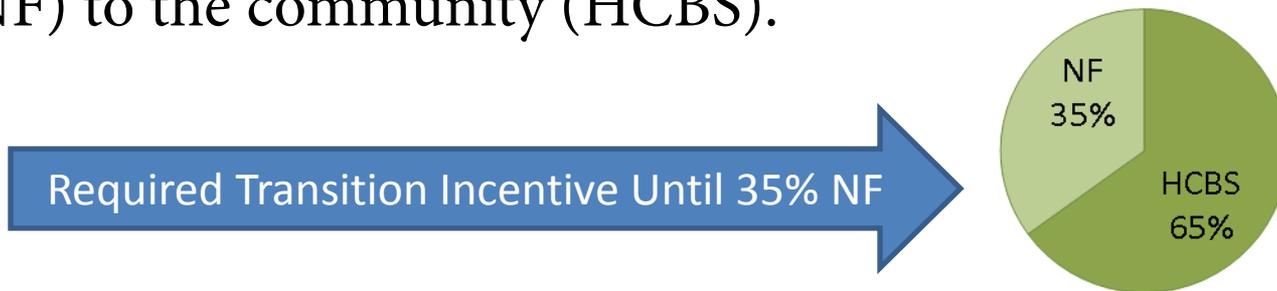
Long-Term Care Program Rate Setting

- Recipients enrolled in the LTC program can reside either in a Home and Community-Based setting (HCBS) or Nursing Facility (NF).
 - HCBS settings are: individual's own home or family home, assisted living facility, or adult family care home
- A rate is set for HCBS and NF and each region.
- The rate paid to the plans is a blend of the HCBS and NF rates based on the plan's enrolled population after applying a transition percentage.
 - Statutory transition targets at s. 409.983 (3) & (5).



Incentive to Transition to Community-Based Care

- The law requires that base rates be adjusted to provide an incentive to plans to transition enrollees from nursing facilities (NF) to the community (HCBS).

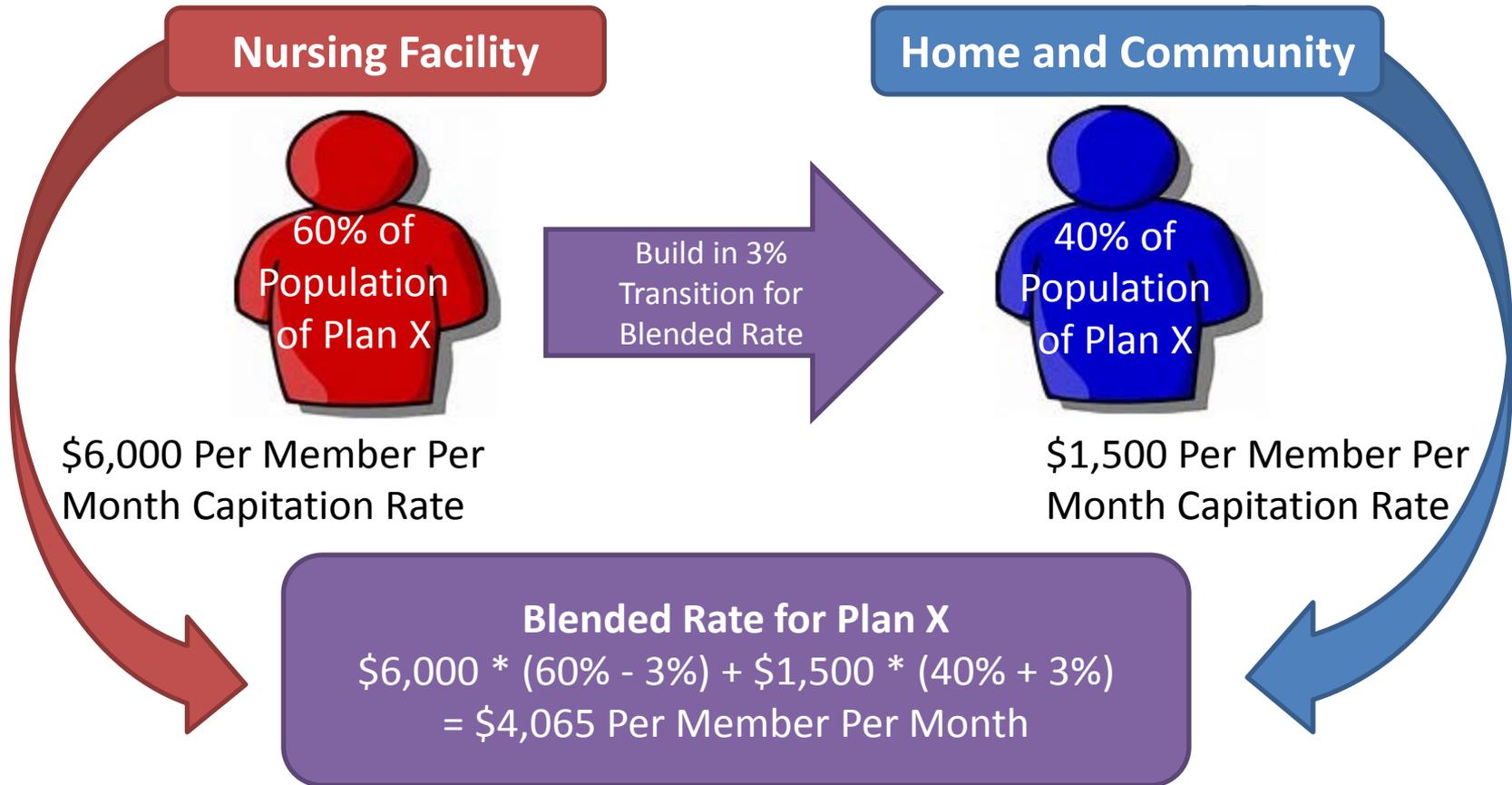


- An enrollee who starts the year in a nursing facility is treated as NF for rate blending for the entire year, even if they are transitioned to the community. A similar situation applies for enrollees starting the year in the community.
- Plans “win” financially if they beat the target transition percentage, “lose” if they do not meet the target.



Long-term Care Rate Calculation

Example for One Plan

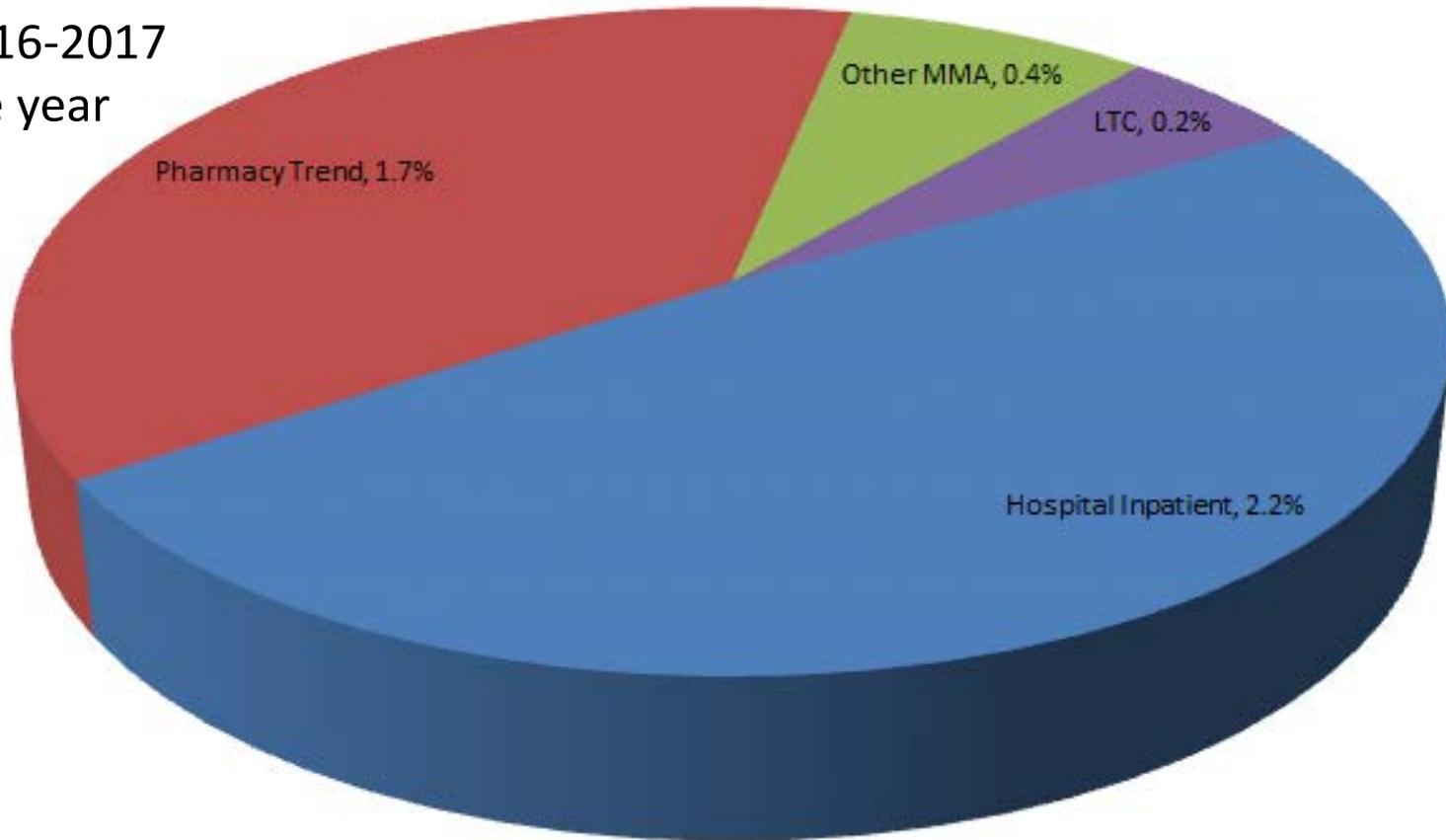


Enrollment distribution varies by plan and rates vary by region.



Largest Cost Drivers of SMMC Rate Increase

4.5% increase
for 2016-2017
rate year



Future Rate Change Environment



Future Rate Change Environment

- Future SMMC rate changes will be impacted by local conditions, national trends, and future federal and state policy changes
 - Recent CMS trend projections predict higher trends in Medicaid benefit expenditures per enrollee compared to recent years
- Florida-specific factors may include:
 - Hospital and other provider rate changes
 - Pharmacy changes (e.g., new “blockbuster” drug treatments)
 - Program efficiencies achieved through quality improvement initiatives to reduce undesirable events
 - E.g., Non-emergency use of the emergency department, preventable hospitalizations and readmissions
 - Requirement to redirect MMA program savings into enhanced physician compensation
 - Future LTC population transition goals
 - Program changes and reaction to any federal policy changes



SMMC Re-Procurement

- SMMC contracts are for a five-year period and must be re-procured after each five-year period.
- Competitive procurement required
- Agency anticipates release of an Invitation to Negotiate in Summer 2017.
- Rate-related negotiation goals:
 - Actuarially sound.
 - Use competitive process to get best value for the state.



Questions

