

# Florida Medicaid

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# Medicaid

- Medicaid is a federal/state partnership jointly financed by state and federal funds.
- If a state chooses to participate in the Medicaid program, they must abide by certain federal rules.
- Medicaid is an “entitlement” program, which means that anyone who meets eligibility rules has a right to enroll and receive medically necessary services for which they qualify.



# Medicaid

- Federal law requires the coverage of certain eligibility groups and services (mandatory groups and services), and states have the option of covering additional eligibility groups and services (optional groups and services).
- State legislatures may change Medicaid eligibility, services, and/or reimbursement at any time, within the federal parameters.
  - Must maintain minimum mandatory eligibility groups and services
  - Must provide all medically necessary services to children and pregnant women
- States cannot stop providing services or freeze eligibility based on an expenditure cap.



# Medicaid

- States have several main ways to control program costs:
  - Reduce reimbursements to providers
  - Eliminate optional services for adults
  - Eliminate optional eligibility groups
  - Implement delivery system reform
- Florida most recently has implemented delivery system reform through the Statewide Medicaid Managed Care program.



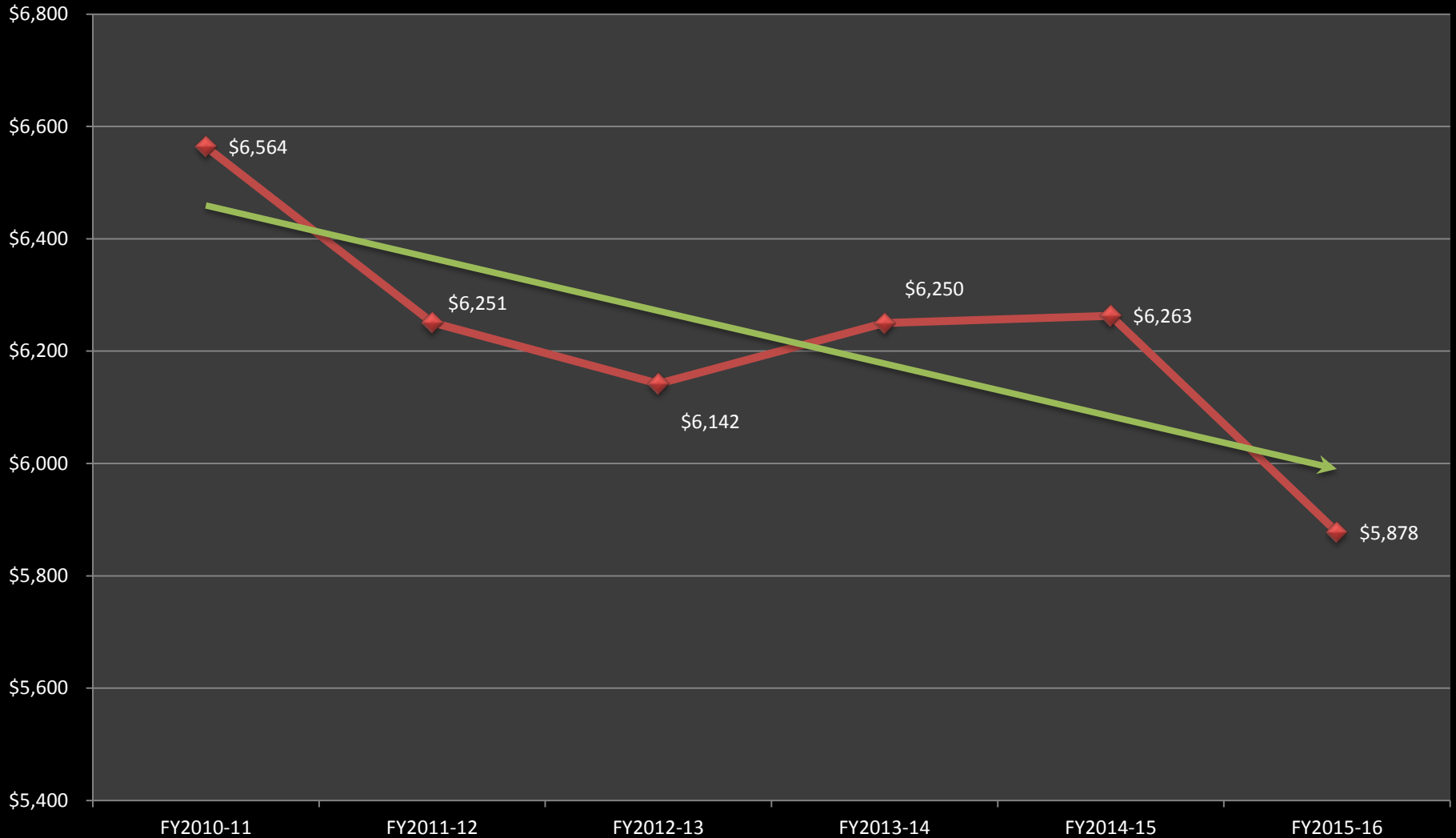
# Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both of the components of the Statewide Medicaid Managed Care (SMMC) program:
  - Long-term Care program
  - Managed Medical Assistance program.
- Implemented during 2013 and 2014.
- Designed to incentivize higher quality without causing inflation.



# Florida Medicaid: Average Annual Cost Per Person

Florida Medicaid: Average Annual Cost Per Person      Linear (Florida Medicaid: Average Annual Cost Per Person)



FY 2013-14 and prior data is from the final year end budgets.

FY 2014-15 Medicaid Expenditures data are from the March 4, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

FY 2015-16 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

# SMMC Program Goals

- The goals of the Statewide Medicaid Managed Care Program are:
  - 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.



# SMMC Program Design

- Plan Choice
  - Choice Counseling
  - HMOs and PSNs (provider service networks)
  - Comprehensive Plans
  - Specialty Plans in MMA
  - Accredited Plans
- Added Benefits
  - Choice of Benefit Package
  - Expanded Benefits
- Enhanced Access
- Enhanced Quality Measures
- Increased Transparency
- Risk Adjusted Rates





# Plan Choice

- In addition to the availability of standards plans and comprehensive plans, the following specialty plans types are available under the MMA component of the SMMC program:
  - Child Welfare
  - Children’s Medical Services Network
  - HIV/AIDS
  - Serious Mental Illness



# Plan Choice

- MMA Plan Accreditation
  - Each health plan is accredited by a nationally recognized accrediting body.



# Added Benefits

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



# Enhanced Access

- 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.



# Enhanced Access: Increased Physician and Dental Provider Participation

| Dental Providers  | November 2013 | June 2015 | Total % Change from<br>Nov-2013 to Jun-2015 |
|---|---------------|-----------|---|
| <b>Total Participating FFS Fully Enrolled MDs and Dos</b> | 35,317        | 37,076    | 4.98%                                       |
| <b>Total Participating Registered MDs and Dos</b>         | 4,382         | 5,573     | 27.18%                                      |
| <b>Total Participating MDs and Dos</b>                    | 39,699        | 42,649    | 7.43%                                       |
| <b>Total Participating FFS Fully Enrolled Dentists</b>    | 1,414         | 1,544     | 9.19%                                       |
| <b>Total Participating Registered Dentists</b>            | 470           | 775       | 64.89%                                      |
| <b>Total Participating Dentists</b>                       | 1,884         | 2,319     | 23.09%                                      |

Source: These data were pulled from the monthly DSS provider enrollment reports.



# Enhanced Transparency

- Centralized Complaint Hub:
  - Allows the Agency to streamline and better track and respond to all complaints and issues received.
  - Provides a mechanism to review trends in related to specific issues, or complaints against specific plans.



# Enhanced Transparency

- SMMC Quarterly Reports:
  - The Agency is releasing a series of quarterly reports that will provide up-to-date information on the progress of the SMMC program.
  - The first two quarterly reports are available on the Agency's website.
  - The Agency will continue to provide analyses of the program through these reports that will provide insight into:
    - the program's cost effectiveness
    - quality of care, and
    - other significant aspects of the program.



# Enhanced Transparency

- Health Plan Report Cards:
  - Enrollees can now choose plans based on quality.
  - In the early part of 2015, Medicaid began publishing a consumer-focused Medicaid health plan report card.
  - The report card includes ratings on how Florida's health plans are doing on getting children into well-child visits and to dental care.





# Enhanced Quality

- HEDIS Data and Information Set:
  - HEDIS = Healthcare Effectiveness Data and Information Set
  - HEDIS is the National Committee for Quality Assurance's (NCQA) standardized set of performance measures.
  - Used by over 90% of health plans in the U.S.
  - Detailed technical specifications ensure that measures are calculated consistently.
  - Allows “apples-to-apples” comparison of health plans.

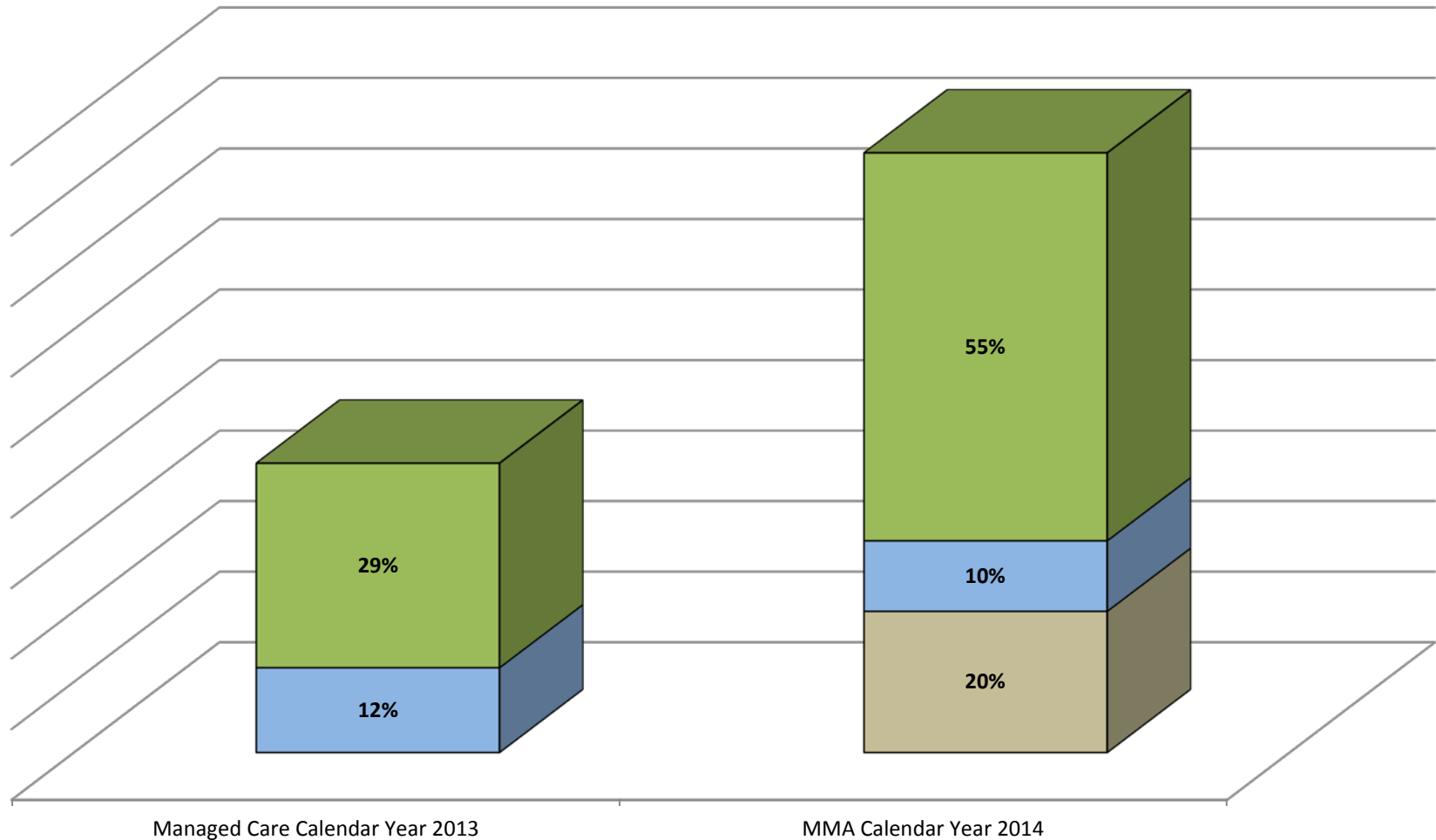


# Enhanced Quality

- Determining HEDIS Scores:
  - Florida Medicaid health plans submit their eligible member, denominator, numerator, and rate data for measures predetermined by the Agency for the previous calendar year by July 1 of each year.
  - Scores for each measure are aggregated to come up with a weighted mean for all Florida Medicaid health plans.
  - For HEDIS measures that health plans are required to report to the Agency each year, plans are to refer to the current year's technical specifications manual which includes information on how to calculate the eligible population, denominator, and numerator based on diagnosis codes and other factors.



# Enhanced Quality: HEDIS Compared to the National Mean



- Scores better than the National Mean
- Scores at the National Mean
- Scores below National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013

Note: If non-reform and Reform are separated when calculating the percentage of “the scores below the National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013”, the overall percentage would be 14%.

# Questions?

