Medicaid Outlook
Managed Care and Developmental Disabilities

Florida Association of Rehabilitation Facilities

Seminar

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Facts about Florida Medicaid

- By the end of Fiscal Year 2011, more than 2.9 million Floridians will be enrolled.

- Medicaid is expected to spending $20.2 billion in Fiscal Year 2010-11, up 9.2% over the previous fiscal year despite $832.2 reductions authorized by the General Appropriations Act.

- By Fiscal Year 2013-14 the program is expected to grow to $23.1 billion. An additional $2.0 billion in state and federal dollars will be required to implement the Affordable Care Act.

Problems: Access and Quality

- Patients cannot access specialists or may travel long distances to receive specialty care.

- Some patients are forced to drive past Medicaid providers who will not see them in order to access the providers who will.

- In some cases, the van drivers are paid more than physicians.

Problems: Cost

- FY 1999/2000, total expenditures for Florida Medicaid:
  - $7.42 billion (17.8% of the total state budget).

- FY 2009/2010, total estimated expenditures for Florida Medicaid:
  - $18.81 billion (28.3% of the total state budget).

- If the growth rates continue at the same levels as they have averaged over the last twelve years, by FY 2014-15 Medicaid expenditures are estimated to be:
  - $28.0 billion (33.4% of the total state budget).

Problems: System Failures…

- Inefficient service delivery:
  - Needed services may not be available or accessible.

- Uneven quality of services:
  - Lack of systemic quality protection or incentives for continuing improvements.

- Overutilization:
  - Lack of coordinated care results in hospitalizations that should have been preventable (and often times inappropriate) use of emergency care.

…Problems: System Failures

- Rising cost of care:
  - Medicaid costs continue to rise despite many containment efforts.
- Fraud and abuse:
  - ”Pay and chase” fraud fighting is ineffective;
  - Prevention efforts produce a modest impact in fee-for-service.
- Low rates for fee-for-service providers:
  - Fees for many physician services have not increased in 20 years.

Why Systemic Change?...

- Current system too complex:
  - Multiple managed care models;
  - Unlimited providers;
  - County-by-county contracting.

- Difficult to manage:
  - 80,000-100,000 fee-for-service providers;
  - Complex rate-setting with multiple variations;
  - 23 managed care organizations including 16 HMOs and 7 PSNs (more than 150 separate contracts);
  - Dozens of individual programs and special projects.

…Why Systemic Change?

- Current program lacks consistent principles.
  - Numerous special interest carve outs, exceptions, preferences:
  - Exceptions for specific services or populations;
  - Special projects operate only in selected areas;
  - Vendor-specific preferences.

Proposed Principles of Transformation…

- Continuous quality improvement:
  - Accountability through appropriate reporting and measurement;
  - Transparency of performance metrics and data;
  - Consequences for performance.

- Efficient service delivery:
  - More coordinated care;
  - Better network development and oversight.

…Proposed Principles of Transformation

- Predictable spending levels:
  - Increased use of pre-paid financing systems;
  - Cost containment through care coordination and incentives for system improvement;
  - Smarter purchasing practices.

- Patient centered care systems:
  - Encourage responsiveness to unique patient needs;
  - Require plans to communicate better with consumers;
  - Incentives for healthy behaviors enabling patients to purchase additional services ;
  - Flexibility allowing patients to purchase private insurance and other health care services.

What is Managed Care?

- Need to clarify terms and definitions.
- Managed care includes, but is more than HMOs.
- Managed care organizations include HMOs, provider service networks, preferred provider organizations, exclusive provider organizations, accountable health plans, medical homes, and others.
- Management techniques include:
  - Provider contracting
  - Negotiated discounts
  - Utilization management
  - Care coordination
  - Incentivizing quality improvement

Overview of HB 7223/7225

- House Medicaid proposal consisted of 2 bills:
  - HB 7223 creates numerous new sections of law in Chapter 409 phased in over 5 years
  - HB 7225 makes date-specific, conforming changes to current law
- Medicaid is established as a statewide integrated managed care program for all covered services.
- All Medicaid recipients are enrolled in managed care unless specifically exempt; exempted recipients include:
  - Persons eligible for only limited services (family planning and breast and cervical cancer patients)
  - Persons eligible for only emergency coverage

Overview of HB 7223/7225

- Qualified managed care plans include:
  - Provider Service Networks (PSN)
  - Exclusive Provider Organizations
  - Health Maintenance Organizations
  - Health Insurers
- Plans may target special populations, but no carve-outs—all services must be covered.
- A limited number of plans will be selected for each region
- Medicaid payment rates are negotiated as part of the procurement process, but based on historic spending and adjusted for clinical risk

Overview of HB 7223/7225

Statutory Criteria

- Accreditation
- Experience
- Community partnerships
- Commitment to quality
- Additional benefits
- Consideration of Medicaid history (i.e.withdrawals)
- Network participation

Preferences

- Medical homes
- Participation by minority providers
- Comprehensive plans

Overview of HB 7223/7225

<u>Additional Provisions</u>

- 5-year contracts with no renewals
- Requirement to pay for non-contracted emergency services
- Requirement to meet network adequacy standards and transparency on network participation
- Continuous improvement process
- Required activities to prevent fraud and abuse
- Grievance resolution process by plans and by AHCA
- Penalties for early withdrawal
- Requirements for enrollment, choice counseling, etc.
- Encounter data analysis by AHCA

Overview of HB 7223/7225

Additional Provisions

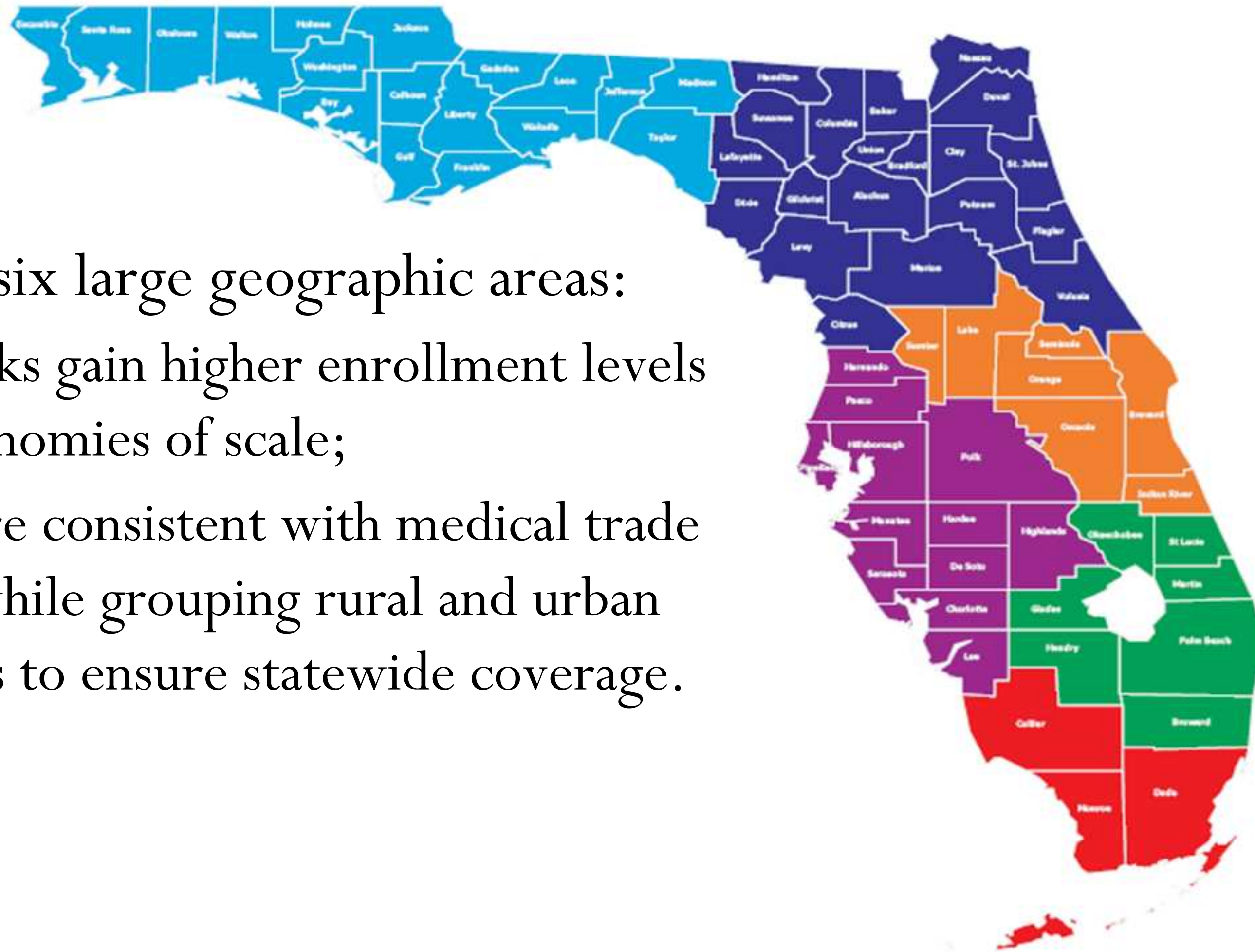
- Children's Medical Services is qualified plan and exempt from competitive procurement
- Medical loss ratios
  - Pay backs for less than 85% spending
  - Loss of assignments and payback for less than 75% spending
  - DD plans must spend 92% of Medicaid premium
- Must cover all current mandatory and optional services, but may customize
- Plans must include some providers and may eliminate providers for failure to meet transparent quality standards

Overview of HB 7223/7225

Covered Services

- ICF/DD services
- Services in alternative residential settings
- Adult day training
- Behavior analysis
- Companion services
- Consumable medical supplies
- Durable medical equipment and supplies
- Environmental accessibility applications
- In-home support services
- Therapies (occupational, speech, respiratory, and physical)
- Personal care assistance
- Residential habilitation
- Intensive behavioral residential habilitation
- Behavior focus residential habilitation
- Residential nursing services
- Respite care
- Case management
- Supported employment
- Supported living coaching
- Transportation

Administrative Reforms…



- Regions: six large geographic areas:
  - Networks gain higher enrollment levels and economies of scale;
  - Areas are consistent with medical trade areas, while grouping rural and urban counties to ensure statewide coverage.

Administrative Reforms...

- Limited number of plans: minimum of 3 (except for persons with developmental disabilities) and maximum of 10 in a region:

Medical and Long Term Care	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Total Statewide
Total Enrollees	203,337	433,428	692,564	370,747	426,008	552,024	2,678,108
Minimum plans	3	4	5	4	4	5	25
PSN plans if responsive	1	1	2	1	1	2	8
Maximum plans	3	7	10	8	7	9	44
DD plans Min – Max (1 PSN each)	2	2 - 5	3 - 6	3 - 6	3 - 6	3 - 6	16 - 31

  - Sm
  - Large enough to promote competition and prevent dependency on a small number of vendors.

…Administrative Reforms…

- Better control by AHCA:
  - Periodic procurements/ongoing monitoring;
  - Upfront evaluation of plan qualifications and capabilities;
  - Focus on Accountability: Medical loss ratios with consequences;
  - Focus on Accountability: Authority to set specific performance expectations and impose consequences;
  - Sanctions for early withdrawal.

...Administrative Reforms

- More information / encounter data:
  - All plans required to submit;
  - Data to be used in rate-setting and performance evaluation.

- Greater transparency
  - Reporting of medical loss ratios
  - Better information about plans' providers
    - Online database
    - Customer feedback capability

Proposed Timeline

- Year 1: Waiver modifications
- Year 2: Begin LTC plan procurement
- Year 3: Complete LTC procurement and begin enrollment; begin medical care procurement
- Year 4: Complete medical care procurement and begin enrollment; begin procurement of DD plans
- Year 5: Complete procurement of DD plans and begin enrollment

Medicaid and Persons with Developmental Disabilities

- Medicaid for medical coverage (State Plan services) and home and community based care (waiver services)
- Medicaid coverage as supplement to Medicare; may include nursing home or other long term care services (dually eligible)
- Medicaid only for medical coverage
- Medicaid only for home and community based services.
- No Medicaid for medical services and on waitlist

Impacts: Developmentally Disabled Consumers

- Medical Coverage:
  - DD consumers who are covered by Medicaid state plan will be enrolled in a managed care organization for medical care;
  - CMS network may be an option for many DD consumers;
- Home and Community Based Services:
  - Managed care plans can be specialty plans—just covering HCBS services or comprehensive—covering both medical care and HCBS services.
  - Consumers will have a choice of plans.
- All services currently available will be covered. Additional services may also be offered by the plans to gain an advantage in the competitive procurement.
- At least 92% of premium revenue must be spent by the plans on covered services.
- For comprehensive plans, savings from coordinated medical care will need to be reinvested in HCBS due to the 92% requirement.

Impacts: Providers

- Plans need providers: leading up to the submission of the bid, providers should be able to negotiate favorable terms with the plans.
- Plans will be held to strict network adequacy standards.
- Possibility for higher payment rates:
  - Selection criteria favor plans that improve compensation for primary and specialty physicians;
  - MLR requirements may incentivize higher payments when utilization management reduces spending;
  - Requirements for performance incentives will lead to better compensation for quality care.
- Plans must include executives with experience in serving persons with developmental disabilities.
- Providers can form their own managing entity—PSNs.

…Provider Impacts: ICF/DD Facilities

- Medicaid patients in ICF/DDs will be enrolled in managed care plans.
- AHCA will continue to set ICF/DD rates.
- Selected plans will be required to pay AHCA rates.
- All ICF/DDs must be included in all selected plans.
- ICF/DDs, like other providers, may form Provider Service Networks and compete to be a selected plan; if a responsive bid is submitted, at least one PSN will be selected in each region.

…Provider Impacts: Intensive Residential Habilitation

- AHCA will continue to set rates for intensive behavior residential habilitation.
- Selected plans will be required to pay AHCA rates.
- Payment rates will be adjusted to reflect level of care.
- Intensive behavioral res hab, like other providers, may form Provider Service Networks and compete to be a selected plan; if a responsive bid is submitted, at least one PSN will be selected in each region.

Summary

- Without significant changes, Florida Medicaid is unsustainable.
- Changes must improve access and quality while containing costs.
- Developmentally disabled consumers have unique needs that must be addressed in any Medicaid system.
- Medicaid services for developmentally disabled consumers are already "managed" but the management is the government.
- Any future managed care system needs to have these characteristics:
  - Patient-centered;
  - Prevention focused;
  - Outcome-oriented; and,
  - Cost-effective.