



Florida Medicaid: Program Overview

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Medicaid

A State and Federal Partnership

- In 1965, the federal Social Security Act was amended to establish two major national health care programs:
 - Title XVIII (Medicare).
 - Title XIX (Medicaid).
- Medicaid is jointly financed by state and federal funds.
- States administer their programs under federally approved state plans.

Florida Medicaid – A Snapshot

<p><i>Expenditures</i></p>	<ul style="list-style-type: none"> • \$17.9 billion estimated spending in Fiscal Year 2009-10 • Federal-state matching program –67.64% federal, 32.36% state. • Florida will spend approximately \$6,625 per eligible in Fiscal Year 2009-2010. • 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. • 10% of all Medicaid expenditures cover drugs. • Fifth largest nationwide in Medicaid expenditures.
<p><i>Eligibles</i></p>	<ul style="list-style-type: none"> • 2.7 million eligibles. • Elders, disabled, families, pregnant women, children in families below poverty. • Fourth largest Medicaid population in the nation.
<p><i>Providers/Plans</i></p>	<ul style="list-style-type: none"> • Approximately 80,000 Fee-For-Service providers; 23 Medicaid Managed Care plans (16 HMOs and 7 PSNs).

Medicaid Structure

- Medicaid does not cover all low income individuals.
- Medicaid serves the most vulnerable; in Florida:
 - 27% of children.
 - 51.2% of deliveries.
 - 63% of nursing home days.
 - 1,094,709 adults - parents, aged and disabled.

Medicaid Structure

- Federal Medicaid laws mandate certain benefits for certain populations.
- Medicaid programs vary considerably from state to state, and within states over time.
- State Medicaid programs vary because of differences in:
 - optional service coverages.
 - limits on mandatory and optional services.
 - optional eligibility groups.
 - income and asset limits on eligibility.
 - provider reimbursement levels.

Who's Eligible?

- Medicaid eligibility is determined by:
 - Categorical groups, i.e., pregnant women; families and children; and aged, blind, and disabled individuals.
 - Income.
 - Assets.
 - Citizenship.
 - Residency.
 - Cooperation with Child Support Enforcement (when one or both parents are absent from the home).
 - Medical need for home and community-based services, and persons in nursing facilities.
 - Level of medical bills (for Medically Needy).

Who Can Provide Medicaid Services?

- Any willing health care practitioner or entity who:
 - provides one of the Medicaid covered services;
 - submits an application to Medicaid;
 - is licensed or certified to practice in the State of Florida;
 - is not terminated from any government health care program; and
 - signs an agreement with Medicaid.
- Managed Care plans with appropriate provider networks.

Florida Medicaid State Plan

Major Federal Requirements

- ▶ States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS).
- ▶ Mandatory eligibility groups and services must be covered.
- ▶ Services must be available statewide in the same amount, duration and scope.

Florida Medicaid State Plan

- Florida's Medicaid State Plan (Plan) is a large, comprehensive written statement describing the scope and nature of the Medicaid program.
- As a condition for receipt of Federal funds under title XIX of the Social Security Act, the state Medicaid agency submits their state plan and through the plan agrees to administer the program in accordance with the provisions of the plan and the requirements of Titles XI and XIX of the Social Security Act.
- The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the State program receives matching federal funds under title XIX of the Social Security Act.
- In general, medical services and fee structures defined within the state plan can not be limited by geographic areas, amount, duration or scope (i.e., must apply to all beneficiaries and providers equally).

Medicaid Waivers

What is a Medicaid Waiver?

- In order for states to implement programs which deviate from their state plan (to vary by geographic areas, amount, duration and scope), the state must request a waiver.
- A waiver is a program requested by a state and approved by the Centers for Medicare and Medicaid Services (CMS) that waives certain provisions of the Social Security Act.
- The type of waiver requested indicates which provisions of the Social Security Act are waived.
- Waiver types:
 - 1915(b)
 - 1915(c)
 - 1115
- Another option is the 1915(i) state plan option as outlined in the 2005 Deficit Reduction Act, or DRA.

1915 (b) Waivers

➤ Freedom of Choice

Purpose: Allow state Medicaid programs to waive the requirement that “any willing qualified provider” can enroll and provide Medicaid reimbursable services. This is often done to improve continuity of care and ensure cost-savings.

Provisions waived: Any section of 1902 of the Social Security Act depending on the design of the waiver request. A waiver request can include any or all of these components:

1915(b)(1): Managed Care

1915(b)(2): Choice counseling for managed care plans

1915(b)(3): Additional services from cost savings

1915(b)(4): Require beneficiaries to use specified providers

1915 (c) Waivers

- Home and Community Based Services
 - Purpose: Allow state Medicaid programs to cover services traditionally viewed as “long-term care” and provide them in a community setting to individuals instead of nursing home or ICF/DD care
 - Provisions waived:
 - Comparability: 1915(c) waiver services may be limited to a targeted group of individuals (e.g., elderly or disabled adults)
 - State-wideness: 1915(c) waiver services may be limited to particular geographic areas (e.g., county, region)

1115 Waivers

- Research and Demonstration Waivers
 - Purpose: To test or pilot a unique program or method of service delivery. These waivers are often academic in nature and often require comprehensive evaluations of effectiveness.
 - Provisions waived: Any section of 1902 and 1905 of the Social Security Act depending on the design of the waiver request

1915(i) State Plan Option

- Section 1915(i) authority established by Deficit Reduction Act of 2005 (DRA)
- State option to amend the state plan to offer Home and Community Based Services as a state plan benefit
- Income of participants can not exceed 150% FPL.
- Recipients must reside in the community
- Can limit the number of participants, and can create waiting lists,
- Can waive statewideness
 - Services can be limited to a specific geographic area or provided statewide
- States must establish needs-based criteria, but needs-based criteria for participants must be less stringent than for institutional-level care
 - Eligibility for services cannot be limited based on age or diagnosis but must be determined using needs-based criteria

Florida's Medicaid Waivers

Florida's Waivers

- 1915(b)
 - Non-Emergency Transportation
 - Medicaid Managed Care
- 1915(c)
 - 15 specialized home and community based services waivers
- 1115
 - Family Planning
 - Meds-AD (1115)
 - Medicaid Reform

Florida's 1915(b) Managed Care Waiver

➤ Waiver Authorities:

- 1915(b)(1) medical care through PCCM or specialty physician arrangements;
- 1915(b)(3) share savings by providing additional services (not covered by State Plan);
- 1915(b)(4) Restrict providers.

➤ Sections Waived:

- 1902(a)(1) Statewideness (not all programs statewide);
- 1902(a)(19)(B) Comparability (includes services not covered by State Plan);
- 1902(a)(23) Restrict choice of providers;
- 1902(a)(4) Mandates recipients into program & restrict disenrollment; also waives 42 CFR 438.52 & 438.56.

Florida's 1915(b) Managed Care Waiver

- Since initial approved in 1990, the waiver has evolved into a variety of 16 plan types including:

Health Maintenance Organizations (MCO)

Frail / Elderly Program (MCO)

Exclusive Provider Organization (MCO)

MediPass (PCCM)

Children's Medical Services Network (PCCM)

Provider Service Network (PIHP)

Prepaid Mental Health Plan (PAHP)

Prepaid Dental Health Plan (PAHP)

Healthy Start Coordinated Care System (PAHP)

Minority Physicians Networks (PAHP)

Pediatric Emergency Room Diversion Program (PAHP)

Integrative Medical Therapies (PAHP)

Disease Management Initiative (PAHP)

Medicaid Comprehensive Hemophilia Management (PAHP)

Therapy Utilization Management Program (PAHP)

Hospitalist Program

Florida's 1115 Waiver Programs

➤ Family Planning (1115)

- Provides women who have lost Medicaid coverage for any reason access to limited family planning services for up to 24 months
- Must be at or below 185% of the federal poverty level
- 57,000 eligibles
- \$7 million projected expenditures (2008-2009)

➤ Meds-AD (1115)

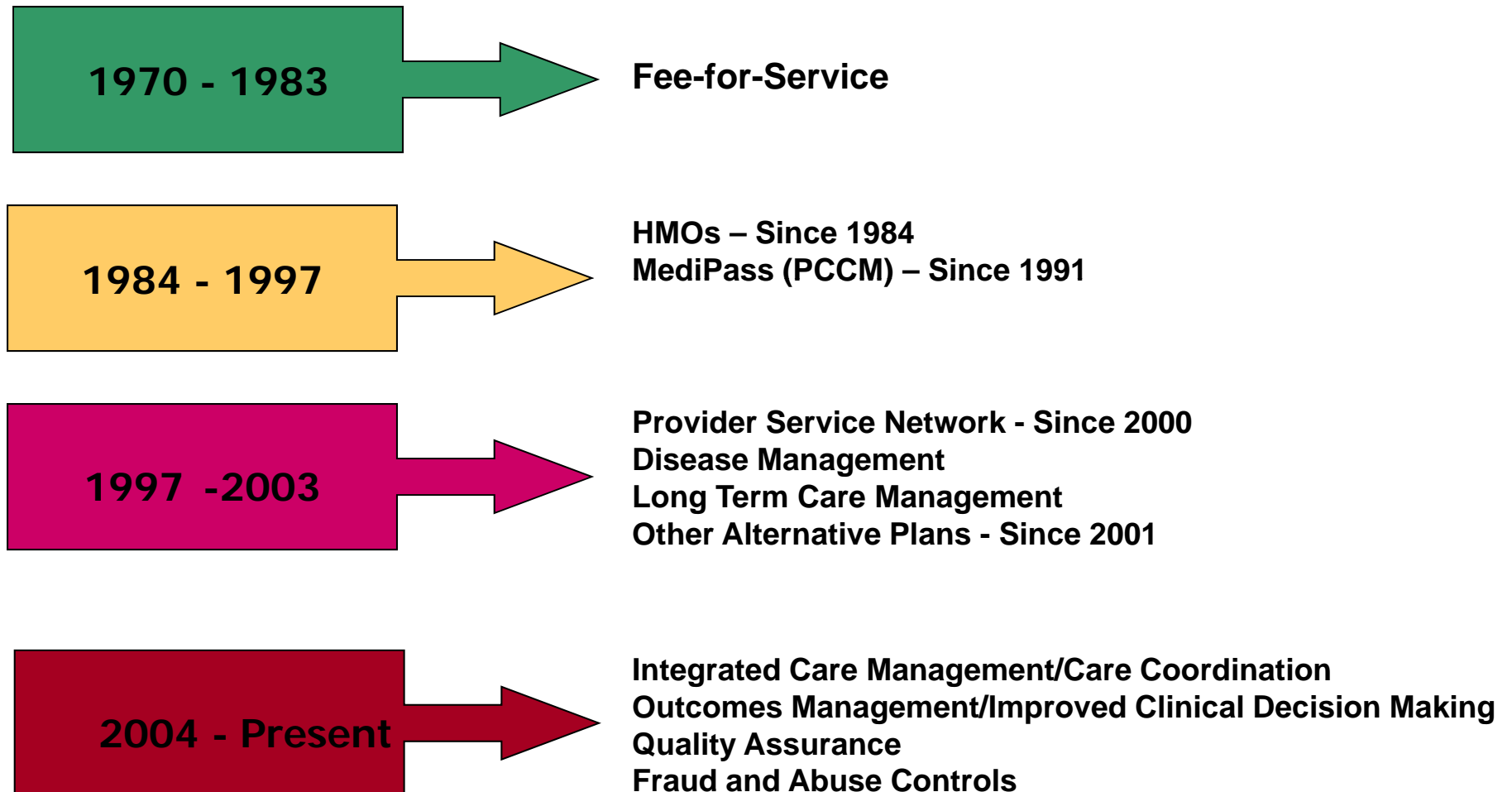
- Extends eligibility and full Medicaid coverage to individuals who are disabled or age 65 older and non-dual (with some exceptions)
- Incomes are at or below 88% of the Federal poverty level
- Provides high intensity pharmacy case management
- 27,000 eligibles
- \$391 million projected expenditures (2008-2009)

➤ Medicaid Reform (1115)

- Allows Florida Medicaid to conduct a Pilot requiring managed care enrollment for most Medicaid eligibles in certain areas of the state

Florida Medicaid Delivery Systems

The Evolution of Florida Medicaid Delivery Systems



Fee For Service

- The fee-for-service system serves those Medicaid recipients who are not eligible for or enrolled in MediPass, Managed Care or Disease Management.
- The fee-for-service system offers no generalized case management to its enrollees.
- Fee-for-service recipients may receive services from any enrolled Medicaid provider.
- Within the fee-for-service system the state can enroll Medicaid providers but has no authority to require enrolled providers to accept a certain number of Medicaid clients or to accept new Medicaid clients.

Managed Care - Coordinated Systems of Care

- Federal regulations define the types of managed delivery systems
 - Primary Care Case Managed Program (Florida's MediPass and Children's Medical Services Network)
 - Managed Care Organization (HMOs and Prepaid Provider Service Networks (PSN))
 - Prepaid Inpatient Health Plan (Fee-for-services PSN)
 - Prepaid Ambulatory Health Plan (Prepaid Mental Health/ Prepaid Dental Health)

Managed Care - Coordinated Systems of Care

- Federal regulations also outline those eligibles who can enroll in or be assigned to these managed delivery systems.
 - Included Groups
 - Aged and Disabled
 - TANF
 - MediKids
 - Groups that are exempted but can enroll voluntarily
 - Dual eligibles
 - Foster care
 - Native Americans
 - Excluded Groups
 - Family Planning and SOBRA pregnant women
 - Retroactive Eligibility
 - Medically Needy

Managed Care - Coordinated Systems of Care

- For September 2009, Florida Medicaid enrollment is as follows:
 - 2,581,406 total Medicaid recipients
 - 1,652,203 mandatory for managed care enrollment
 - 225,809 voluntary for managed care enrollment
 - 475,241 excluded from managed care enrollment

- MediPass is the Florida Medicaid primary care case management program;
- MediPass is operational in 62 counties outside of the demonstration counties (Medicaid Reform).
- MediPass is designed to build a relationship between families and their personal (primary care) physician by creating a medical home, assuring access to care, decreasing inappropriate utilization and reducing costs.

- Primary care physicians (PCPs) are responsible for providing primary care and authorizing the specialty care provided to their MediPass enrollees.
- Services such as vision, hearing, dental, mental health and family planning services are not managed by the MediPass PCP.
- MediPass providers (physicians, ARNPs, and physician assistants) are paid a \$2.00 monthly case management fee.
- Medicaid pays for services provided to MediPass members on a fee-for-service basis.

Medicaid Provider Service Networks

- Provider Service Network (PSN) is defined in s. 409.912 (4)(d), as an integrated health care delivery systems owned and operated by a health care provider, or group of affiliated health care providers which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers.
- PSNs are required by contract to ensure that their enrollees have access to all Medicaid state plan services, with a few exceptions, and a complete network of providers.
- PSNs are reimbursed on a FFS or prepaid basis.

Medicaid Health Maintenance Organizations

- A Health Maintenance Organization (HMO) is an entity licensed under Chapter 641, Florida Statutes.
- HMOs provide comprehensive Medicaid services to a defined population of Medicaid recipients.
- HMOs are required by contract to ensure that their enrollees have access to all Medicaid state plan services and a complete network of providers. HMO networks are not limited to Medicaid providers.
- Some plans have expanded their benefits beyond those required; example preventive adult dental.
- The Agency contracts with HMOs on a prepaid fixed monthly rate per member (e.g. capitation rate) for which the HMO assumes all risk for providing covered services to their enrollees.

Reimbursement of Medicaid Providers

Florida Medicaid Reimbursement Methods

- Medicaid providers in different delivery systems are reimbursed through different methods.
 - Fee-for-service
 - Includes reimbursement to MediPass providers for medical services
 - Cost based
 - Capitation

Fee for Service Reimbursement

- An established fee is paid for services provided by specific Medicaid provider types.
- The fees are established based on funding provided through the General Appropriations Act.
- Reimbursements are made for services as outlined in the Medicaid state plan.
- Reimbursements are made for services billed by using federally approved codes as outlined in the Medicaid state plan.

Fee for Service Reimbursement

- Specific services reimbursed by fee for service payments are:
 - Physicians/Nurses,
 - Dentists,
 - Pharmacies,
 - Laboratories,
 - DME Suppliers,
 - Home Health Agencies,
 - Dialysis Centers,
 - Emergency Transportation.

Cost Based Reimbursement

- Rates are established periodically for provider types based on provider's historic cost of providing services.
- Adjustments are typically indexed to predetermined health care inflation indices (price level increases) for institutional providers.
- Provider receives a rate per encounter or per day regardless of the number of services provided.

Cost Based Reimbursement

- Specific providers reimbursed by cost based means are:
 - Hospitals,
 - Nursing Homes,
 - Intermediate Care Facilities for the Developmentally Disabled
 - Rural Health Clinics,
 - County Health Departments,
 - Hospices, and
 - Federally Qualified Health Centers.

Capitation Rates

- Managed care organizations are reimbursed through capitation rates.
- Federal regulations require approval by the Centers for Medicare and Medicaid Services (CMS), and certification of actuarial soundness.
- Rates are set annually and are based upon two years of fee-for-service (FFS) claims for all recipients eligible for enrollment in an HMO. Current rates are based on SFY 2006-07 and 2007-08 data. This is the most current, complete data available for rate setting.
- Section 409.9124, Florida Statutes -- Managed care reimbursement
 - Based on fee-for-service expenditures or encounter data.
 - Requires actuarially sound rates.
 - Compliant with federal laws and regulations.

Capitation Rates

- Specific providers reimbursed by capitation rates include:
 - HMOs
 - Prepaid PSNs
 - Prepaid Dental plans
 - Prepaid Mental Health plans
 - Nursing Home Diversion providers

Quality Measures in Florida Medicaid Delivery Systems

Quality Measures and Contract Requirements: Fee-For-Service

- Fee for service:
 - Contractually, there are no quality measure reporting requirements for Medicaid providers in the fee-for-service system.
 - The program as a whole reports on federally required measures such as the Child Health Check-Up.

Quality Measures and Contract Requirements: MediPass

- The MediPass contract contains quality measures relating to
 - Comprehensive Diabetes Care
 - Mammography Screening
 - Cervical Cancer Screening
 - Child Health Check Up, and
 - Provider credentialing.

Quality Measures and Contract Requirements: Managed Care Organizations

- Operate a Quality Committee to oversee utilization management and performance improvement.
- Collect and report standardized performance measures, to include administrative and medical record review. Plans report on more than 20 performance measures, including:
 - Childhood and Adolescent Immunization Status
 - Well-Child visits and adolescent Well Care Visits
 - High blood pressure and diabetes care
 - Access to preventative and Ambulatory Health Services
 - Prenatal and Postpartum Care
 - Dental Care
 - Mental Health Utilization
 - Breast and Cervical Cancer Screening
- Conduct Performance Improvement Projects using a structured protocol developed by the Centers for Medicare and Medicaid Services

Questions?