

Florida Medicaid: Policy and Fiscal Solutions for 2011



Converting to a full risk managed care system for Medicaid would save up to \$3 billion over the next 10 years.

The Problem:

Florida's Medicaid program is expanding rapidly, consuming ever larger portions of the state's budget. This is despite Florida's efforts to slow the growth of its Medicaid program through limiting optional eligibility, limiting optional services, and reducing provider reimbursements. In addition, federal health care reform contains the largest expansion of Medicaid since the program's inception, which will make the situation more dire.

Although rebounding, Florida's recent economic downturn has resulted in a rapid expansion of Medicaid enrollment and the highest level of spending in the program's history. In FY 2010-11, Florida Medicaid is projected to serve over 2.9 million people at a cost of \$20.2 billion – \$214.1 million higher than the FY 2009-10 appropriations. Based on current estimates, Medicaid will consume 26% of the entire state budget in this fiscal year (up from 6% of the state budget in FY 1984-85), and left unchecked, Medicaid expenditures are expected to exceed \$22.5 billion by FY 2012-13. This imbalance is despite the more than \$3.8 billion in cost containment/reduction initiatives implemented since FY 1996-97.

The question becomes, how can the state ensure individuals receive their Medicaid services in a way that creates a predictable fiscal environment?

THE ANSWER: Bend the Medicaid cost curve.

Build on Florida's successful strategies, and proven models from other states, to "bend the cost curve" of Medicaid spending, especially long-term care expenses. Specifically, policymakers should increase the transition of all Medicaid recipients away from outdated fee-for-service to full risk-bearing managed care plans. This process should include:

- eliminating MediPass and traditional fee-for-service requiring all Medicaid recipients to enroll in managed care plans, including persons using long-term care services;
- creating incentives for geographic expansion of managed care, including modifying provider payment arrangements to ensure a level playing field; and,
- using health plans that adhere to medical home principles that go beyond just primary care to ensure comprehensive services which are coordinated from birth to end-of-life, preventive to acute care, and even skilled nursing home care.



Transitioning Beneficiaries Into Medicaid HMOs – Guiding Principles.

Florida has made substantial progress toward moving people out of fee-for-service. Over 1 million people are currently enrolled in Medicaid HMOs, or approximately 40% of all Medicaid beneficiaries, saving the state 10% per year. But more can be accomplished at substantial cost savings to the state.

Additional transitioning efforts should focus on certain principles, including:

1. Ensure that the patient's needs are being met and continuity of care is ensured.
2. Increase access to and coordination of care, especially in rural areas and for certain specialties.
3. Allow health plan flexibility and innovation so they can better meet the needs of their enrollees.
4. Increase accountability for patients and providers, and in particular, fight fraud and abuse, while preserving meaningful choices for plan enrollees.
5. Enhance fiscal predictability and financial management by requiring all plans to assume full risk.

By consolidating acute and long-term care services under a managed care model, cost estimates project that the state can achieve up to \$3 billion in cost savings over the next 10 years.

Research Proves Managed Care Success

A University of Florida study of Medicaid managed care in Florida showed that moving an unmanaged population into a managed environment can reduce per member per month expenditures by **approximately ten percent**. (Harman, J.S. and R.P. Duncan. "An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration." Department of Health Services Research, Management and Policy, University of Florida. June 2009.)

In one of the more comprehensive studies of Medicaid managed care, the Lewin Group has shown that cost savings associated with managed care **can be as high as 20%**, especially if SSI and other long-term care costs are incorporated. (The Lewin Group. [Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies](#). March 2009.)

Tools For Empowering Managed Care Plans To Meet Quality And Performance Standards So They Can Ensure Access For Patients While Combating Fraud and Abuse

There is a risk that the efficiencies managed care brings to the Medicaid program will be "watered down." As providers attempt to maintain a fee-for-service system within the new Medicaid program, they will advocate policies that will reduce the cost-saving benefits of the full risk managed care model. **The following are the most critical components of the new Medicaid model:**

1. **Eliminate "any willing provider" language.** "Any willing provider" language requires a health plan to include certain providers (i.e., physician, hospital, pharmacy, etc.) in their networks as long as the provider accepts the reimbursement the plan would normally pay.

"Any willing provider" language takes away one of managed care's greatest benefits: the opportunity to remove providers who do not meet the heightened quality measures of the plan or who may be committing fraud and/or abuse.

Ensuring that health plans have the ability to control their networks empowers the health plan to control quality and reduce fraud and abuse. The current Medicaid fee-for-service program has 80,000 providers and is rampant with fraud and abuse. Any willing provider language is simply a tool to maintain this access for those providers.

Some providers will argue that federal law requires "any willing" language, however, this is inaccurate. Federal law only requires reasonable access, similar to what a person in the commercial market experiences

2. **Payment reforms.** One of the main barriers to Medicaid managed care expansion is the inability of HMOs to contract with certain health care providers who may be the sole provider in a particular area. For example, a rural hospital or a large physician group may be the only health care provider in a county. If this provider refuses to contract with a Medicaid managed care plan, the state has little ability to achieve the cost savings associated with managed care enrollment in that geographic area.

Another serious problem occurs when an enrollee goes out of network and a provider agrees to treat the patient without a contract with their health plan. In this case, the provider often demands usual and customary charges, rates that far exceed regular contracting rates.

We support solutions that eliminate undue market influence by either the plan or the provider, including ensuring protections for plans and providers when out-of-network or emergency department service are provided. These solutions should ensure that patients receive the care they need in a way that state can realize maximum savings and budget predictability.

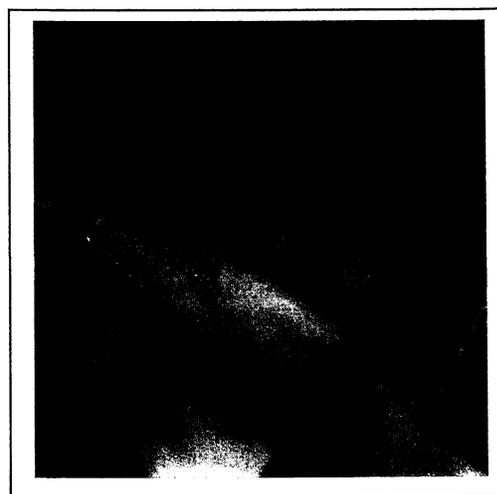
Solutions should provide incentives for all providers to contract with managed care plans. Plans should make three good-faith attempts at negotiations with providers, but if an agreement cannot be reached, out-of-network charges should be limited and the provider should be required to accept a discount off of the Medicaid fee-for-service reimbursement, as defined by the state. For example, when an enrollee is treated out of network, the maximum payment allowed should be no more than the average rate paid under existing Medicaid contracts in that county, or 100% of the Medicaid rate, whichever is less. This maximum out-of-network charge should apply during the entire course of treatment for a patient who initiated care through an emergency department.

3. **Level playing field.** The new Medicaid model should allow different types of health plans to participate, **as long as they operate under the same rules (a level playing field).** Under these rules, financial incentives are aligned in ways which maximize savings and preserve budget predictability. At the same time, these rules should help preserve the safety net system and help providers and patients transition and adapt to managed care. Further, all efforts should be made to make sure the transition preserves the patient/provider relationship.

The rules should include accepting full financial risk, accepting the same solvency standards, and complying with the same quality and performance measures as determined by law. The rules should also require all plans to contract with safety net providers through the transition period away from fee-for-service, as long as the rates are on par with the Medicaid rate.

Some provider sponsored networks (PSNs) will argue that they need time to transition from a fee-for-service system to full risk.

Unfortunately, this argument has been more of a delay tactic with some providers "betting against" the state moving to full managed care. In the end, if some health plans are allowed to remain fee-for-service, even with annual cost reconciliation, they have an unfair advantage in the market. Further, the PSN is a competitor and directly benefits if HMOs are unable to contract with the providers in their networks by getting more enrollees



Fraud and Abuse Prevention

Florida's Medicaid fee-for-service system creates perverse incentives to commit fraud and abuse. As provider rates are cut, there is a pattern of increasing utilization, most likely a way that some providers are trying to offset cuts. In 2010, the Agency for Health Care Administration testified that 97% of fraud and abuse occurs in fee-for-service.

http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/index.shtml

HMOs are able to prevent, reduce, or eliminate fraud and abuse in the system in a number of ways including:

- Requiring greater credentialing requirements for their networks.
- Using innovative data monitoring systems to identify unusual billing and service patterns.
- Using special investigative units to track down and recover losses.
- Requiring prior authorization and other utilization management techniques which identify fraud before it is committed.

These, and other issues, would no longer be the concern of the state if the risk for these errors were transferred to the health plans by moving to managed care.

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To better the health of Florida's citizens by promoting the growth of health plans dedicated to providing the best service, highest quality of care, best value and affordability, and access to their members and business partners.

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Full Risk, Managed Care Through HMOs: The Value Proposition

Managed care has value for Medicaid recipients and the State that extends well beyond those provided through the fee-for-service and PSN systems.

State policymakers demand value from the healthcare system in terms of quality and accessibility. HMOs address the healthcare disparities of enrollees through emphasis on primary care medical home, member education, disease and case management, and provider collaboration.

Medicaid HMOs are uniquely positioned to address disparities in healthcare for vulnerable populations because of these core competencies, many contractually required by Medicaid agencies, such as:

- Facilitation of primary care provider medical homes;
- Outreach and education to populations most affected by health disparities;
- Disease management programs to members with chronic conditions;
- Case management for members with elevated healthcare needs; and
- Third party accountability for reducing fraud, waste and abuse.

The Value Proposition Supported By Research

- A study in *Health Affairs* evaluated the effectiveness of disease management for patients with diabetes; the intervention resulted in a 22-30% reduction in hospitalization.
- A study by Wheeler published in *Medical Care* evaluated the impact of a heart disease management program on hospital service utilization showed that participants experienced 46% fewer inpatient days and 49% lower inpatient costs than the control group.
- In *Managed Care*, Gold and Kongstvedt (2003) found that individuals enrolled in the disease management program had 14% fewer hospital admissions, 8% fewer ER visits, and significant improvement in diabetics' HbA1c levels than the control group.
- And in casual research conducted in Florida by Health Management Associates, persons in Medicaid HMOs were less likely to use emergency departments than those in traditional fee-for-service.

The Roadmap

The continued transition of Medicaid participants into managed care could start immediately. The Legislature could require MediPass enrollees to move into capitated plans in counties that have 2 or more plans starting in Year 1. Other steps could include:

- Contracting with managed care plans across the state to serve as the sole delivery system for most Medicaid services, operating on a level playing field with uniform rates and benefits.
- Requiring Medicaid recipients to enroll in a managed care plan upon eligibility determination.
- Requiring providers to negotiate in good faith with all qualified managed care plans, or reduce their fee-for-service reimbursement, and limit out-of-network charges to the average paid by existing contracts in the county.
- Work to maintain IGTs in the system, but if local taxing authorities no longer choose to provide IGT for any reason, the "Medicaid rate" shall be defined as the "county billing rate."
- Integrate long-term care as early as possible.

Comparison of Covered Services
 Medicaid - Small Group Standard HMO Plan
 Draft - 10/10/09

Covered Services	Medicaid	Small Group Standard Plan	Limitations/Comments
<u>Mandatory Medicaid Services</u>			
Hospital Inpatient	x	x	
Hospital Outpatient	x	x	
Physician services	x	x	
Nursing Facility	x	x	Lifetime benefit of 100 days.
Personal Care Services	x		Services not generally provided in a commercial plan.
Childhood Screening/Check-Up	x	x	Childhood exams, immunizations, etc., are provided as required by the American Academy of Pediatrics
Portable X-ray	x	x	
Private Duty Nursing	x		Limited part-time or intermittent care by RN or LPN.
Respiratory, Speech, Occupational Therapy	x	x	Limited to 20 visits per policy year.
Rural Health	x		Required provider for Medicaid-provides services generally provided in physician office for commercial plan.
Therapeutic Services for Children	x		
Transportation	x		Not covered except for transportation limited to \$1,000 for newborns needing specialized care
<u>Optional Medicaid Services</u>			
Adult Dental	x		Only in the event of an injury or accident or when medically complex surgery is required.
Adult Health Screening	x	x	Periodic health assessment including pap smear and breast exams subject to dollar limits in policy.
Ambulatory Surgical Centers	x	x	
Assistive Care Services	x		Services not generally provided in a commercial plan.
Birth Center Services	x	x	
Children's Dental Services	x		See adult dental plus services needed for developmentally disabled children
Hearing Services	x		Limited to newborn hearing screening and any required follow-up until 12 months of age unless child has permanent hearing impairment.
Vision Services	x		Limited to physician services needed to treat injury to or disease of the eyes plus initial glasses or contact lenses after cataract surgery
Chiropractic	x	x	Limited to 10 visits per policy year.
Community Mental Health	x		Mental health and substance abuse services are optional services that may be provided at additional cost and are have dollar and visit limitations.

Comparison of Covered Services
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County Health Department Clinic Services	x		Required provider for Medicaid-provides services generally provided in physician office for commercial plan.
Dialysis Facility Services	x	x	
Durable Medical Equipment	x		Limited to specified items and subject to dollar limitations
Early Intervention Services	x		
Healthy Start Services	x		
Home and Community-Based Services	x		
Hospice Services	x	x	For persons not expected to live longer than 1 year
Intermediate Care Facilities/Developmentally Disabled	x		
Intermediate Nursing Home Care	x		
Optometric Services	x		See vision services.
Orthodontic Services	x		See dental services.
Physician Assistant Services	x	x	
Podiatry Services	x	x	
Prescribed Drugs	x	x	Subject to applicable copayments and/or coinsurance as provided in policy
Registered Nurse First Assistant Services	x	x	
School-Based Services	x		School based providers are not generally contracted providers for commercial plans
State Mental Hospital Services	x		Provides long term inpatient services to person over 65. Such services are not typically covered by a commercial plan.
Subacute Inpatient Psychiatric Program for Children	x		Provides long term inpatient services to person 17 or younger. Such services are not typically covered under a commercial plan.

Managed Care Model

IGT TAP

10/27/10

Assumptions

- Overall value of MediPass to MC change to Hospitals is on average 44% total Exempt/IGT \$\$\$ (Mandatory days 64% of total, and transfer rate is 70% leaving 56% in FFS)
- Goal is to return to hospitals current level of funding +/- 10%
- MC membership is 70% of MediPass / FFS PSN membership from Sept 2010 annualized
- IP Utilization is 70% Mandatory Bed days from AHCA IGT Report
- OP Utilization is derived from IP % by hospital using same 70% Mandatory calculation
- All reimbursements to hospitals based on 100% FFS payment rate
- Model focus is on incremental Exempt and Buy Back payments absent LIP distributions

Assumptions

- Hospital rates are subject to unit cost adjustment up or down based on an 80% floor and 120% ceiling on their current FFS rate
- Downward adjustment are made to bring rate to 120% of FFS rate , upward adjustment made to bring rate to 80% of current FFS rate
- MC rates adjust semi annually to coincide with hospital rate changes
- MC rate based on utilization from annualized utilization, completed with 1 Q run out
- (ex. utilization July 2010-June 2011 paid through Sept completed)
- MC rates would be calculated based on Non Exempt rates, then adjusted individually for Exempt and Buy Back
- Rates determined by County; PMPMs calculated based on current membership % and utilization % based on historic data
- Utilization trend in base underwriting added to IGT adjustment rate.

County IGT Distribution (cont.)

III. Determine if Results are Within Corridor

	Original Distribution	80% Minimum	120% Maximum	Adjusted Distribution	Are results In Corridor	Amount (Above)/Below	Percentage to Adjust	New OP Per Line	New IP Per Line
Hospital A	73,591,977	58,873,582	88,310,373	44,155,186	BELOW	14,718,395	33%	73.49	1,698.52
Hospital B	6,692,542	5,354,033	8,031,050	8,700,304	ABOVE	(669,254)	-8%	50.89	636.21
Hospital C	60,650,391	48,520,313	72,780,469	60,650,391	WITHIN	-	0%	41.38	771.20
	<u>140,934,910</u>	<u>112,747,928</u>	<u>169,121,892</u>	<u>113,505,881</u>		<u>14,049,141</u>	<u>12%</u>		

IV. Final Distribution Amounts

	New OP Per Line	New IP Per Line	Resulting Utilization		Distribution		Total Distribution
			OP	IP	OP	IP	
Hospital A	73.49	1,698.52	52,463	32,392	3,855,699	55,017,882	58,873,582
Hospital B	50.89	636.21	21,864	10,875	1,112,627	6,918,422	8,031,050
Hospital C	41.38	771.20	293,143	62,917	12,128,970	48,521,421	60,650,391
			<u>367,470</u>	<u>106,183</u>	<u>17,097,297</u>	<u>110,457,726</u>	<u>127,555,023</u>

V. PMPM to Health Plans

Member Months	Market Share	Facility Utilization			Dollars Distributed				PMPM to Health Plan	
		Hospital A	Hospital B	Hospital C	Hospital A	Hospital B	Hospital C	Total		
Health Plan A	429,959	38.0%	20%	25%	33%	11,774,716	2,007,762	20,216,797	33,999,276	79.08
Health Plan B	328,127	29.0%	40%	41%	33%	23,549,433	3,292,730	20,216,797	47,058,960	143.42
Health Plan C	373,386	33.0%	40%	34%	33%	23,549,433	2,730,557	20,216,797	46,496,787	124.53
	<u>1,131,472</u>	<u>100.0%</u>				<u>58,873,582</u>	<u>8,031,050</u>	<u>60,650,391</u>	<u>127,555,023</u>	<u>112.73</u>