Lessons Learned from MLTSS Implementation in Florida

Where Have We Been and Where Are We Going?

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Statewide Medicaid Managed Care Program (SMMC) Overview

- Florida has implemented delivery system reform through the Statewide Medicaid Managed Care (SMMC) program.
- The SMMC program consists of two components:
  - Long-term Care program, and
  - Managed Medical Assistance (MMA) program.
- Now that the SMMC program is operational, program performance data is coming in, initial evidence shows…
  - Florida's Medicaid program is currently operating at the highest level of quality in its history, and that it is doing so at a substantial per person savings to Florida's taxpayers.

Two Components of Statewide Medicaid Managed Care

- Long-term Care (LTC) program:
  - Implemented August 2013 – March 2014.
  - Initially 83,000 enrollees in seven plans.
  - Currently 93,000 enrollees in six plans.
- Managed Medical Assistance (MMA) program:
  - Implemented May – August 2014
  - Initially 2.6 million enrollees in 20 plans.
  - Currently 3.9 million in 15 plans.
- Only a small percentage of recipients receive their services through the fee-for-service program.

SMMC Federal Authorities

- LTC program operates under a 1915(b) and 1915(c) combination waiver, initially approved February 2013.
- MMA program operated under a 1115 waiver, initially approved June 2013 as amendment to existing 1115.
- Waiver approvals predated HCBS and Managed Care Final Rules; but CMS approval resulted in requirements addressing:
  - HCBS settings,
  - Person-centered care planning,
  - Consumer support system,
  - Network adequacy, and
  - Readiness reviews.

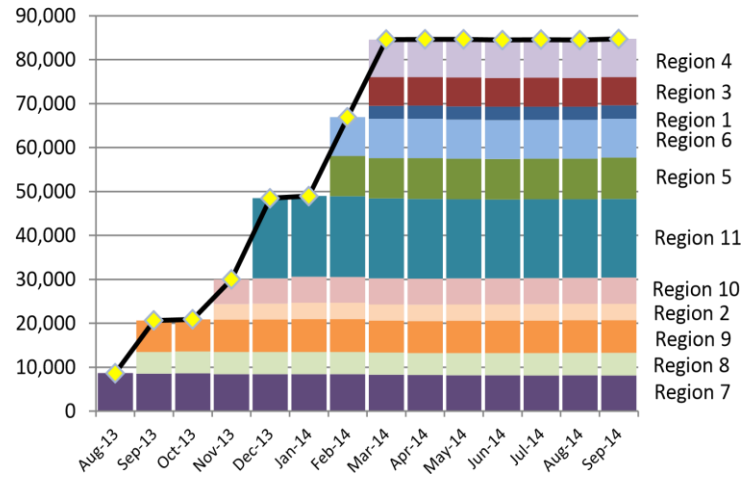
Enrollment in the LTC Program

- Recipients are mandatory for LTC enrollment 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.
- Recipients mandatory for LTC program enrollment if in the following pre-existing programs:
  - Aged and Disabled Adult Waiver (A/DA);
  - Consumer-Directed Care Plus for individuals in the A/DA waiver;
  - Assisted Living Waiver;
  - Channeling Services for Frail Elders Waiver;
  - Nursing Home Diversion Waiver;
  - Frail Elder Option.
- Nursing Home Diversion and Frail Elder Option were pre-existing MLTSS programs.

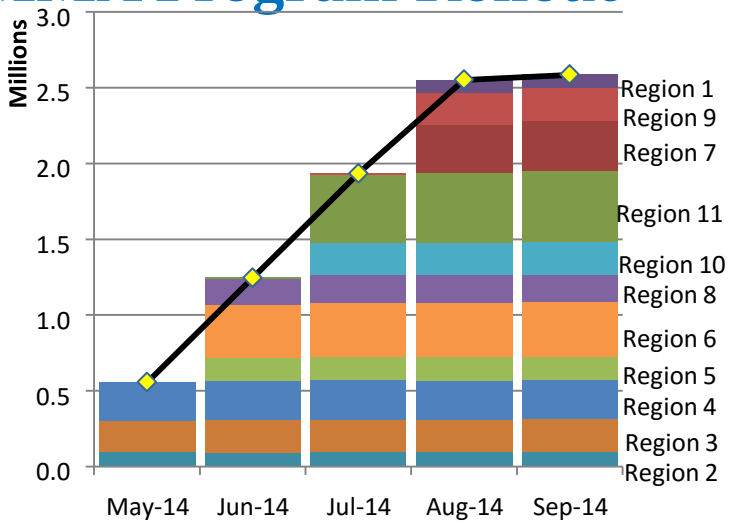
SMMC Implementation Timeline

- **JUN 2012** — LTC ITNs Released
- **DEC 2012** — MMA ITNs Released
- **JAN 2013** — LTC Contracts Awarded
- **SEP 2013** — MMA Contracts Awarded
- **FEB 2014** — SMMC Contracts Combined
- **JAN 2015** — D-SNP Contracts Rev isded

LTC Program Rollout



MMA Program Rollout



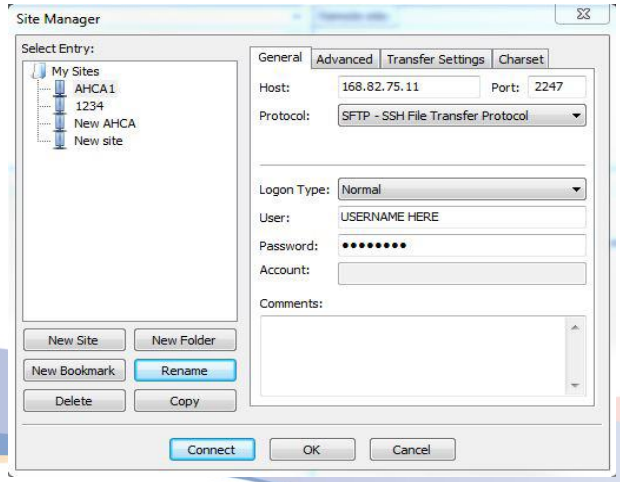
Continuity of Care (COC) in Transitions

- LTC plans were required to continue enrollees' pre-existing services for up to 60 days until a new assessment and care plan are complete and services are in place.
  - Same services
  - Same providers
  - Same amount of services
  - Same rate of pay (if the provider is not under contract)
- Pre-existing services were nursing facility, hospice, waiver (Diversion, Aged Disabled Adult, Assisted Living, Channeling), and Frail Elder.
- Case management providers were not included in this provision.

NOTE: Continuity of care provisions remained in effect after program roll-out for transitions between SMMC plans.

Data Exchange at Transition

- Data exchange process developed in order to ensure there is no disruption in services for pre-existing waiver recipients transitioning into LTC program.
- Pre-existing providers (case managers and related providers) were required to upload current care plans and service authorizations to the Agency.
- Each LTC plan retrieved the information and act to ensure and guarantee the continuation of each recipients' current services.
- The following recipient information was shared through Secure File Transfer Protocol (SFTP):
  - Care plan,
  - Service authorizations, and
  - Level of care assessment (optional).



SMMC Care Coordination

- SMMC plans are responsible for care coordination and case management for all enrollees. LTC care coordination provides:
  - Assessment of the enrollee,
  - Development of the plan of care,
  - Assistance with maintaining Medicaid eligibility,
  - Monitoring of the enrollee's service delivery,
  - Coordination of transitions of care between settings/services.
- When a recipient is enrolled in both the LTC and MMA programs, SMMC plans must coordinate all services with each other to ensure "mixed" services are not duplicative.
  - When a recipient is enrolled in both LTC and MMA, the LTC plan is primary.
- SMMC plans must coordinate with other third party payor sources, including Medicare.

LTC, MMA & Comprehensive Plans

REGION	TYPE	AMERIGROUP	COVENTRY	HUMANA	MOLINA	SUNSHINE	UNITED
1	MMA			✓	✓		
	LTC			✓		✓	
2	MMA						
	LTC			✓			✓
3	MMA					✓	✓
	LTC			✓		✓	✓
4	MMA					✓	✓
	LTC			✓	✓	✓	✓
5	MMA	✓				✓	
	LTC			✓	✓	✓	✓
6	MMA	✓		✓	✓	✓	
	LTC		✓	✓	✓	✓	✓
7	MMA	✓			✓	✓	✓
	LTC		✓	✓		✓	✓
8	MMA					✓	
	LTC			✓	✓	✓	✓
9	MMA			✓	✓	✓	
	LTC		✓	✓		✓	✓
10	MMA			✓		✓	
	LTC	✓		✓		✓	
11	MMA	✓	✓	✓	✓	✓	✓
	LTC	✓	✓	✓	✓	✓	✓

Comprehensive Plans?

- SMMC plans that offer both LTC and MMA services.
- Cover <u>all</u> LTC and MMA services.
- Plan care coordinator(s) coordinates with all of the recipient's medical and long-term care providers.

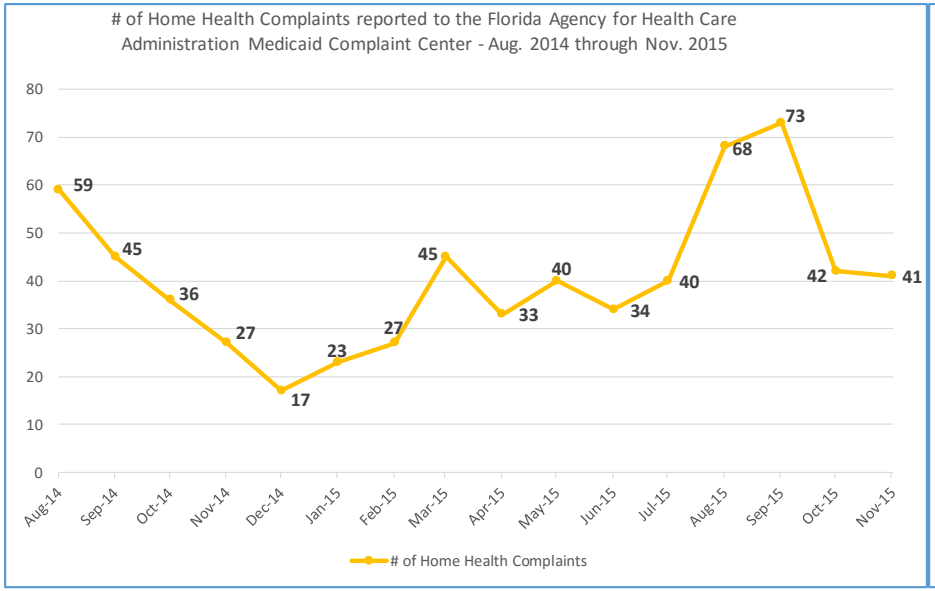
LTC and MMA Program Benefits

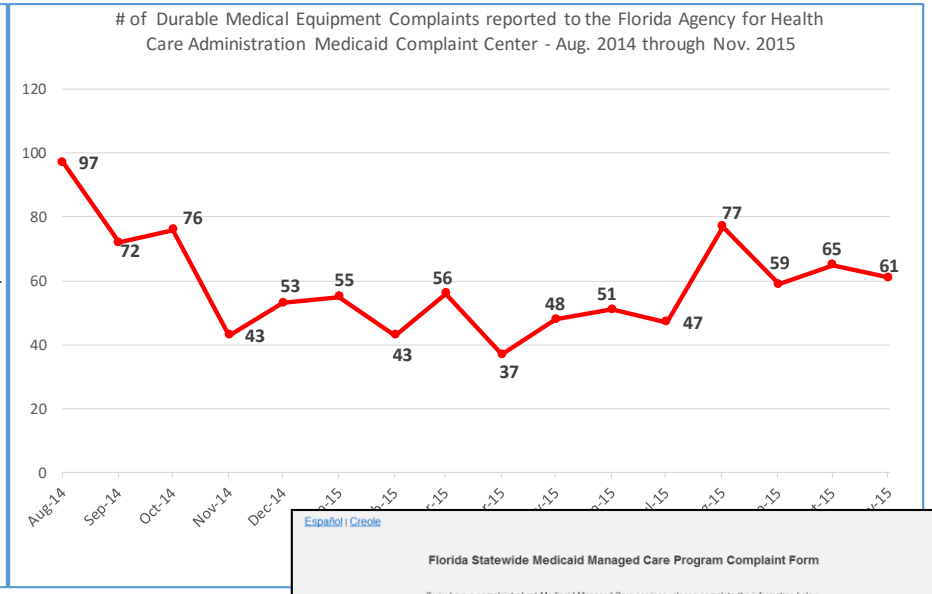
- LTC program covers Nursing Facility (NF) care and traditional Home and Community-Based Services (HCBS).
- MMA program covers primary care, acute care, dental, and behavioral health care services.
- Some "mixed" services are available under both LTC and MMA programs. These services are:
  - Assistive care services
  - Case management
  - Home health
  - Hospice
  - Durable medical equipment and supplies
  - Therapy services (physical, occupational, respiratory, and speech-language pathology)
  - Non-emergency transportation

Mixed Services Reimbursement

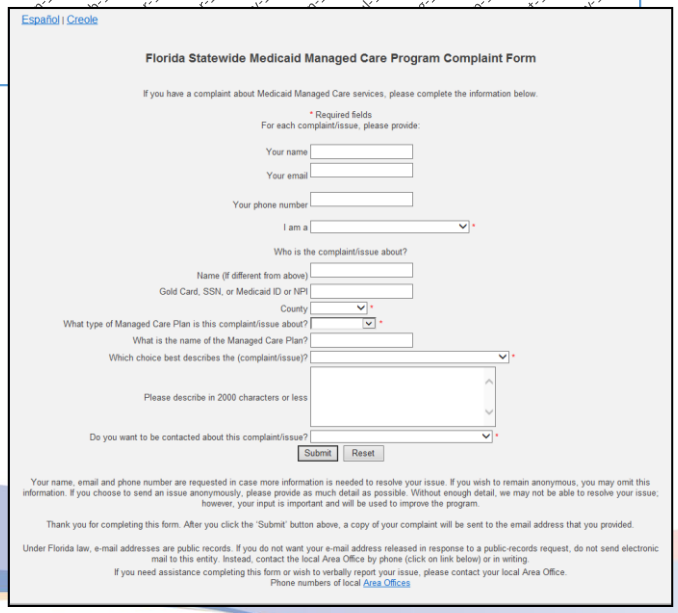
Recipient Coverage	Who Pays for Mixed Services
Medicare and Medicaid	Medicare (if a covered service)
Medicaid LTC and Fee-for-Service	Medicaid LTC Plan
Medicaid LTC and MMA Plan	Medicaid LTC Plan
Medicaid MMA Plan only (not enrolled in LTC)	Medicaid MMA Plan
Medicaid Fee-for-Service	Medicaid Fee-for-Service

SMMC Consumer Support





- Developed Independent Consumer Support Program with centralized complaint process:
  - Allows the Agency to streamline and better track and respond to all complaints and issues received; and
  - Provides a mechanism to review trends in related to specific issues, or complaints against SMMC plans.



Español | Creole

Florida Statewide Medicaid Managed Care Program Complaint Form

If you have a complaint about Medicaid Managed Care services, please complete the information below.

* Required fields
For each complaint/issue, please provide:

Your name
Your email
Your phone number
I am a *

Who is the complaint/issue about?

Name (If different from above)
Gold Card, SSN, or Medicaid ID or NPI
County *
What type of Managed Care Plan is this complaint/issue about? *
What is the name of the Managed Care Plan?
Which choice best describes the (complaint/issue)? *
Please describe in 2000 characters or less
Do you want to be contacted about this complaint/issue? *

Submit Reset

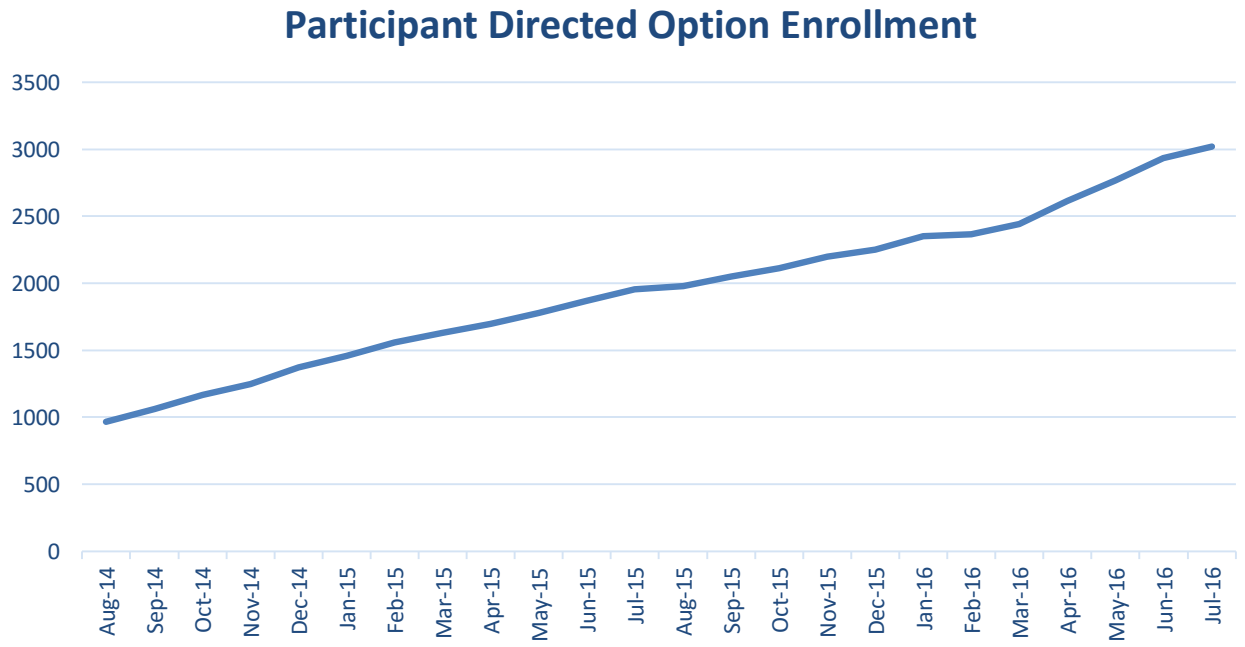
Your name, email and phone number are requested in case more information is needed to resolve your issue. If you wish to remain anonymous, you may omit this information. If you choose to send an issue anonymously, please provide as much detail as possible. Without enough detail, we may not be able to resolve your issue; however, your input is important and will be used to improve the program.

Thank you for completing this form. After you click the 'Submit' button above, a copy of your complaint will be sent to the email address that you provided.

Under Florida law, e-mail addresses are public records. If you do not want your e-mail address released in response to a public-records request, do not send electronic mail to this entity. Instead, contact the local Area Office by phone (click on link below) or in writing.
If you need assistance completing this form or wish to verbally report your issue, please contact your local Area Office.
Phone numbers of local Area Offices

Participant Direction

- Participant Direction Option (PDO) initial rollout was limited to select LTC plans.
- PDO is small but growing component of LTC program.



D-SNPs and SMMC Alignment

- Dual-Eligible Special Needs Plans (D-SNPs) receive capitated payments from the state to provide the same covered benefits provided under the MMA program for the applicable eligibility categories – Full Benefit Dual Eligible (FBDE).
  - D-SNP can include Special Low Income Medicare Beneficiaries (SLMBs) and Qualified Medicare Beneficiaries (QMBs).
  - D-SNP excludes Institutional Care Program (ICP) eligible recipients during the enrollment month.
- Beginning 2015, FBDE recipients enrolled in a D-SNP (or other fully liable Medicare Advantage health plan) not enrolled in a SMMC MMA health plan.
- D-SNP not required to provide expanded benefits beyond MMA program services.
- Only D-SNPs with companion LTC plans provide all MLTSS services including NF and HCBS waiver services.

LTC Provider Networks

- SMMC plans generally limit the providers in their networks based on credentials, quality indicators, and price; plans were required to offer initial contracts to certain providers within their region.
- Each LTC plan must offer a network contract to all nursing facilities, hospices and aging network services providers in their region.
  - LTC plans required to pay nursing homes an amount equal to the nursing facility-specific payment rates set by the Agency; may negotiate higher rates for medically complex care.
  - LTC plans pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the Agency.
  - HCBS Example: LTC plans required to offer contract to any ALF that was billing for Medicaid waiver services as of July 2012.
- Nursing facilities and hospices enrolled in Medicaid must participate in all LTC plans selected in the region in which the provider is located.

SMMC Network Adequacy & COC

- SMMC program enhancements to network adequacy include:
  - Provider network contractual standards,
  - Robust Provider Network Verification (PNV) system,
  - Provider Network File (PNF) submitted weekly, and
  - On-line provider directories updated weekly.
- When an SMMC plan makes a change to their provider network the plan must:
  - Notify impacted providers and enrollees in active care sixty days before suspension or termination, and
  - Allow enrollees to continue receiving medically necessary services for a minimum of sixty days (continuity of care period).
- Recipients impacted can change plans through a “good cause” plan change.

LTC Network Performance Measures

- After 12 months of active participation in a health plan's network, the plan may exclude any of the providers from the network for failure to meet quality or performance criteria.
- Nursing facility performance measures based of CMS Nursing Home Compare Star Ratings.
- At a minimum, LTC plans must use these performance measures when re-credentialing a nursing facility provider.
- LTC plans are not required to exclude a nursing facility that does not meet performance measures.

MMA Program Quality: Health Plan Report Cards

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2014

(•) Medicaid Health Plan Report Card
To view individual measures in a category, click one of the following:

( ) Pregnancy-related Care
( ) Keeping Kids Healthy
( ) Keeping Adults Healthy
( ) Living with Illness
( ) Mental Health Care

Sorting Options:

Sort By Column | (•) Ascending (A-Z, 0-9) | ( ) Descending (Z-A, 9-0)

View Results

Statewide Information for Plans Currently Operating in Florida Counties

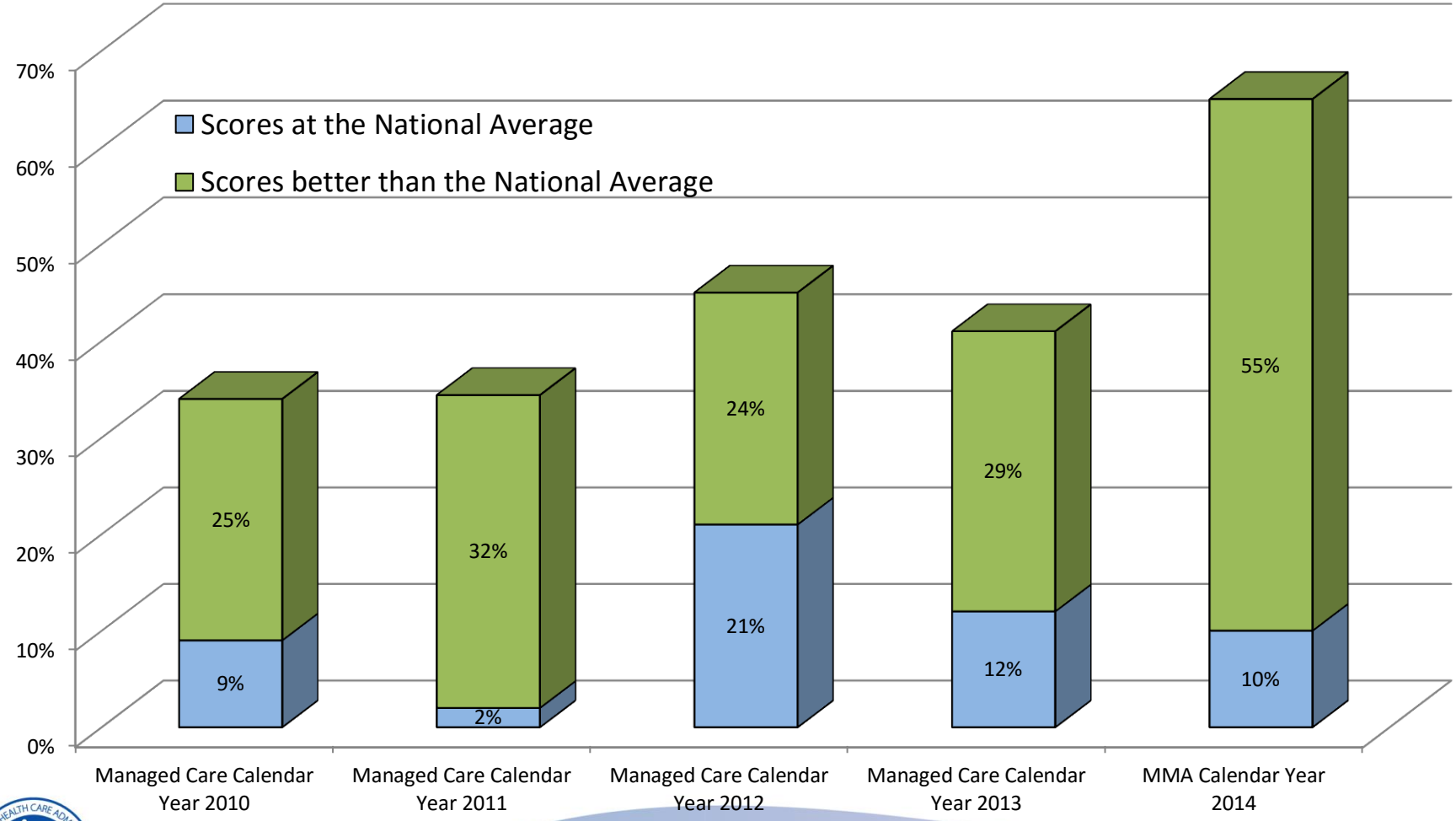
Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Keeping Adults Healthy	Living with Illness	Mental Health Care
Amerigroup Florida, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★★☆
Better Health, LLC	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆	★★★☆☆
Children's Medical Services	N/A	★★★★☆	N/A	★★★★★	★★★★☆
Clear Health Alliance	N/A	N/A	★★★★★	★★★☆☆	★☆☆☆☆
Coventry Health Care of Florida	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★☆☆☆☆
Florida MHS (Magellan)	★☆☆☆☆	N/A	N/A	N/A	★☆☆☆☆
Humana Medical Plan, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★☆☆☆
Molina Healthcare of Florida, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★☆☆☆	★★★☆☆
Positive Healthcare Florida	N/A	N/A	★★★★★	★★★☆☆	★★☆☆☆
Prestige Health Choice	★★★★☆	★★☆☆☆	★★★☆☆	★★★☆☆	★★☆☆☆
Simply Healthcare Plans, Inc.	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆	★★☆☆☆
South Florida Community Care Network	★★☆☆☆	★★★★☆	★★☆☆☆	★★★★☆	★★☆☆☆
Staywell	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★☆☆
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆
Sunshine State Health Plan, Inc. - Child Welfare	N/A	★★★☆☆	N/A	N/A	★★★★☆
United Healthcare of Florida, Inc.	★★★★☆	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆

Ratings Key:

★★★★★ **Best**	at or above 50% of all Medicaid health plans' scores
★★★★☆ **Good**	better than at least 40% of all Medicaid health plans' scores
★★★☆☆ **Fair**	better than at least 25% of all Medicaid health plans' scores
★★☆☆☆ **Poor**	better than at least 10% of all Medicaid health plans' scores
★☆☆☆☆ **Very Poor**	worse than 90% of all Medicaid health plans' scores
N/A	Not Measurable/Small Population

Change Health Plan Type | Change Location / County | Print | Save to Excel | Start Over

MMA Program Quality: Overall HEDIS Scores Trend Upward



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%.

LTC Program Quality:
LTC Plan Report Cards

LTC Program Quality

- The LTC program was designed with incentives to ensure patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs.
- Three measures apply to the LTC Program:
  - Transition of individuals who wish to go home from institutional care such as nursing facility care to the community.
  - Patient Satisfaction survey results.
  - LTC Evaluation Report.

LTC Program Quality: Satisfaction

- Survey developed by the Agency/Used by all plans.
- Satisfaction regarding:
  - LTC plan
  - Case manager
  - Services
  - Overall health
- Agency-approved independent survey vendor must be used.
- Results must be used by the plans to develop and implement activities to improve member satisfaction.
- The survey was completed in 2015.

LTC Program Quality: Satisfaction (cont.)

- Survey respondents reported the following experience with the LTC program:
  - 79.7% of respondents rated their Long-term Care plan an 8, 9, or 10.
  - 83.4% of respondents reported it usually or always being easy to get in contact with their case manager.
  - 84.4% of respondents rated their case manager an 8, 9, or 10.
  - 90% of respondents reported their long-term care services are usually or always on time.
  - 83.3% of respondents rated their LTC services an 8, 9, or 10.
  - 59.5% reported that their overall health had improved since enrolling in their LTC plan
  - **77.4% reported that their quality of life had improved since enrolling in their LTC plan**

LTC Program Quality:
LTC Evaluation Report

- Access to Care Findings:
  - Diligent outreach conducted
  - Complex effort was coordinated successfully with no large scale access to care failures
  - Complaints related to access to care were fairly uncommon
  - Network of willing LTC providers appears to be robust.
- Quality of Care Findings:
  - Overall, quality levels remained the same or improved
  - 75 % of satisfaction survey respondents indicated that their quality of life had improved since enrolling in the LTC program

LTC Program Quality: HCBS Incentives

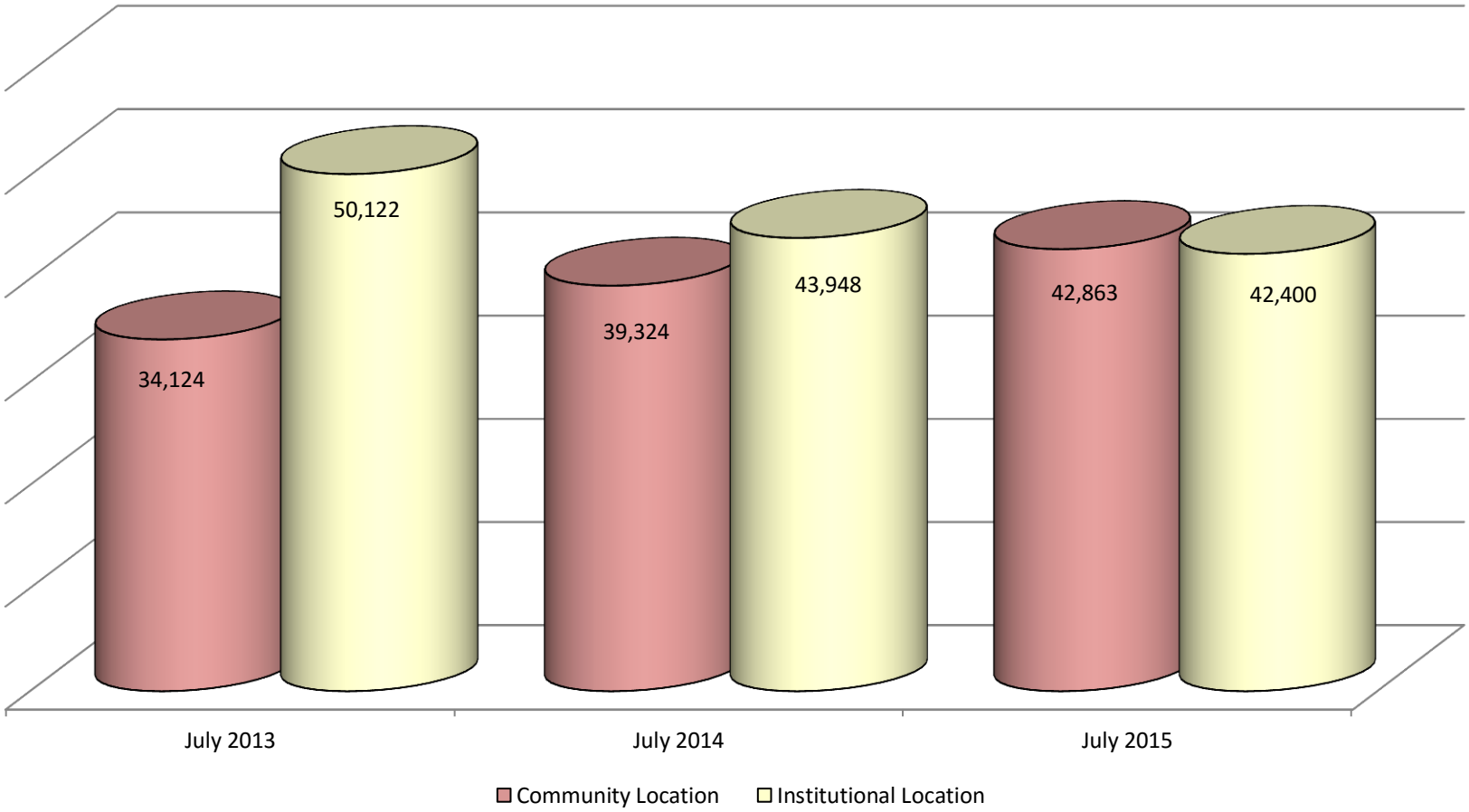
- The LTC program was designed with incentives to ensure patients are able to reside in the least restrictive setting possible and have access to home and community based providers and services that meet their needs.
  - The law requires AHCA to adjust managed care plan rates to provide an incentive to shift services from nursing facilities to community based care.
  - Transition percentages apply until no more than 35% of the plan's enrollees are in nursing facilities.

- An enrollee who starts the year in a nursing home is treated as being in a nursing home for rate purposes for the entire year, even after transition.

- Plans "win" financially if they beat the target, "lose" if they do not meet the target.

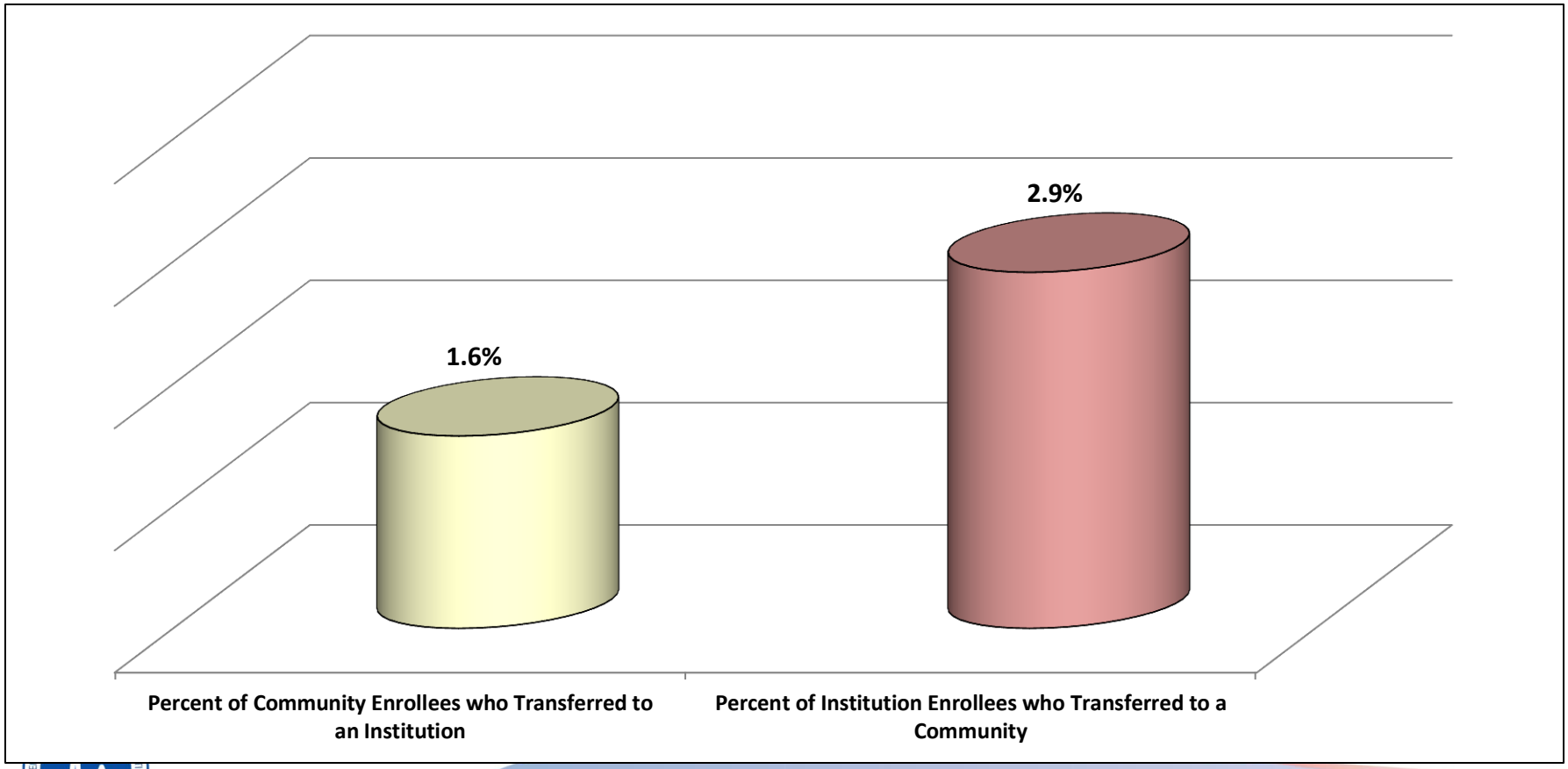
Florida's Experience: HCBS Incentives

Number of enrollees, July 2013, July 2014 and July 2015, by Residential Setting

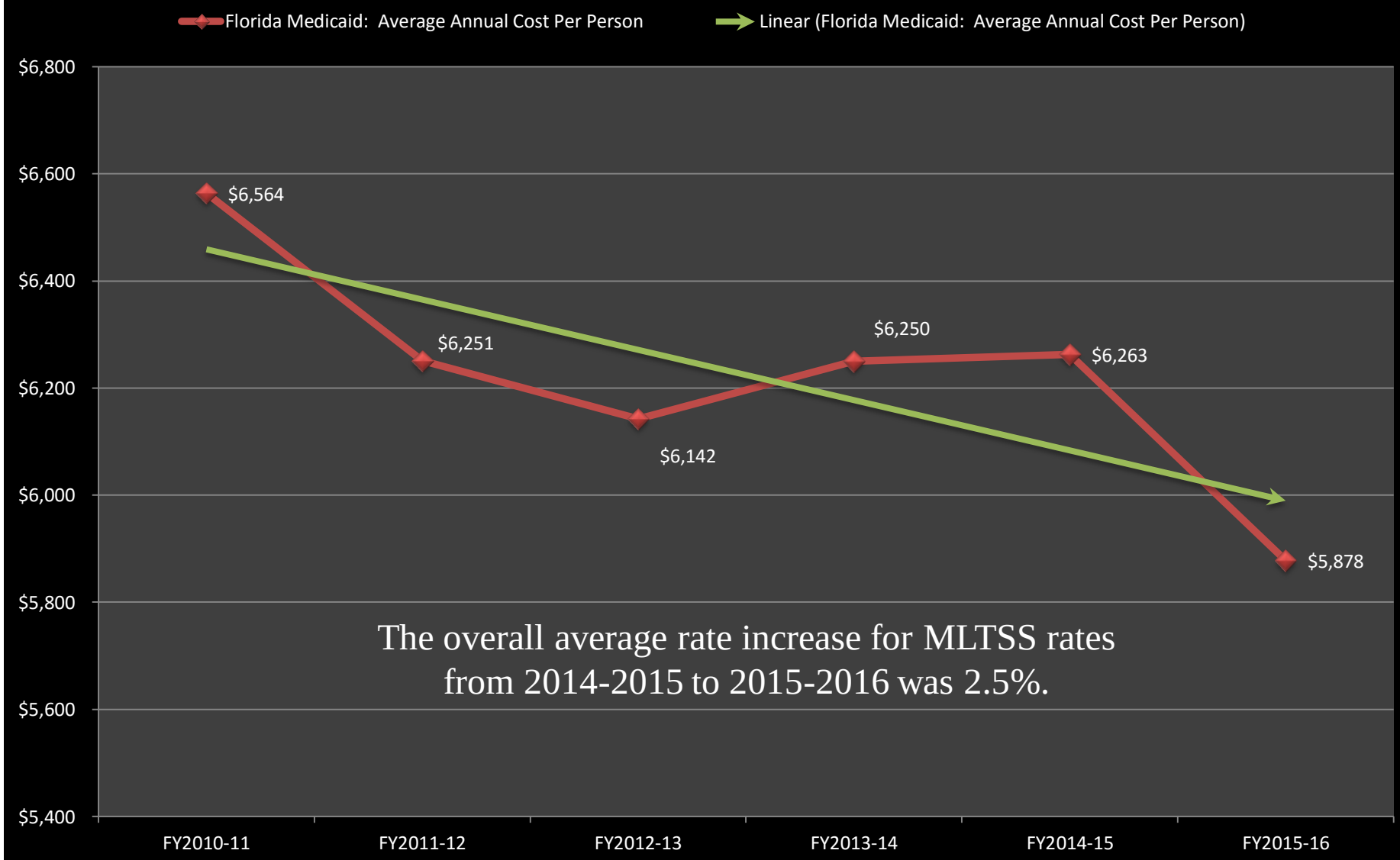


LTC Program Performance: Transitions

Percent of LTC Enrollees Who Transferred from One Residential Setting to Another, July 2014 - June 2015



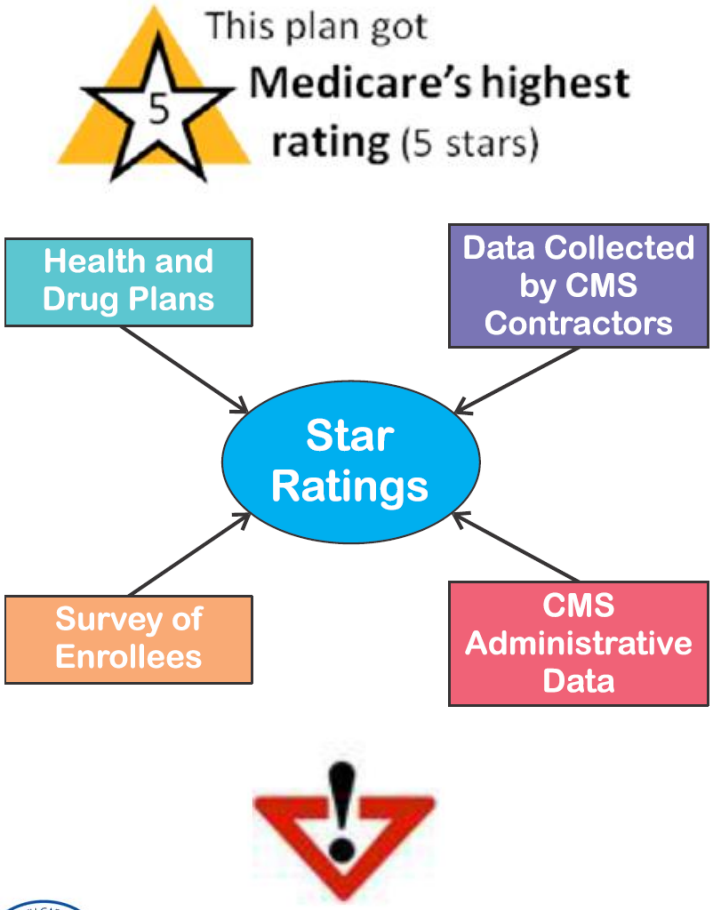
Florida Medicaid: Average Annual Cost Per Person



The overall average rate increase for MLTSS rates from 2014-2015 to 2015-2016 was 2.5%.

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

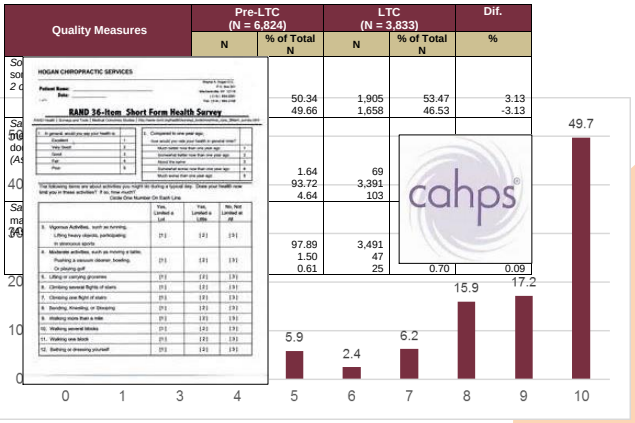
Medicare Part C Star Ratings



- Enrollee Satisfaction
  - Care Coordination (CAHPS)
  - Getting Needed Care (CAHPS)
  - Rating of Health Care Quality (CAHPS)
  - Rating of Health Plan (CAHPS)
- Care Measures
  - Diabetes Care (HEDIS)
  - Colorectal Cancer Screening (HEDIS)
  - Care for Older Adults – Functional Status Assessment (HEDIS)
- Process Measures
  - SNP Care Management
- Enrollee Experience
  - Complaints about the Health Plan (CTM)
  - Beneficiary Access and Performance Problems (Admin. Data)
  - Reviewing Appeals Decisions (IRE / Maximus)
  - Members Choosing to Leave the Plan (MBDSS)

Not a comprehensive listing.

Evolution: Meaningful Metrics

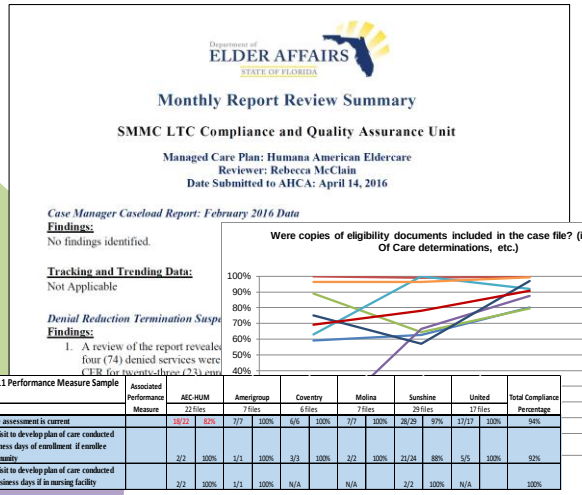


Satisfaction

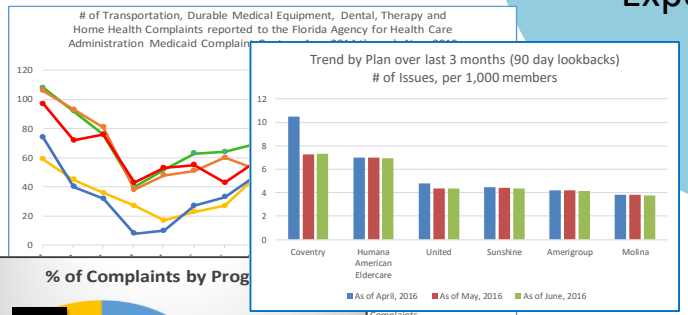
Process

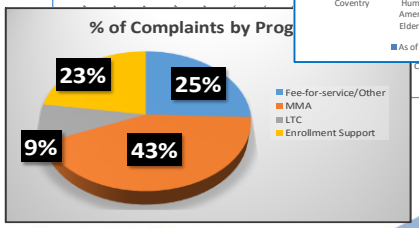
Experience

Care Outcomes



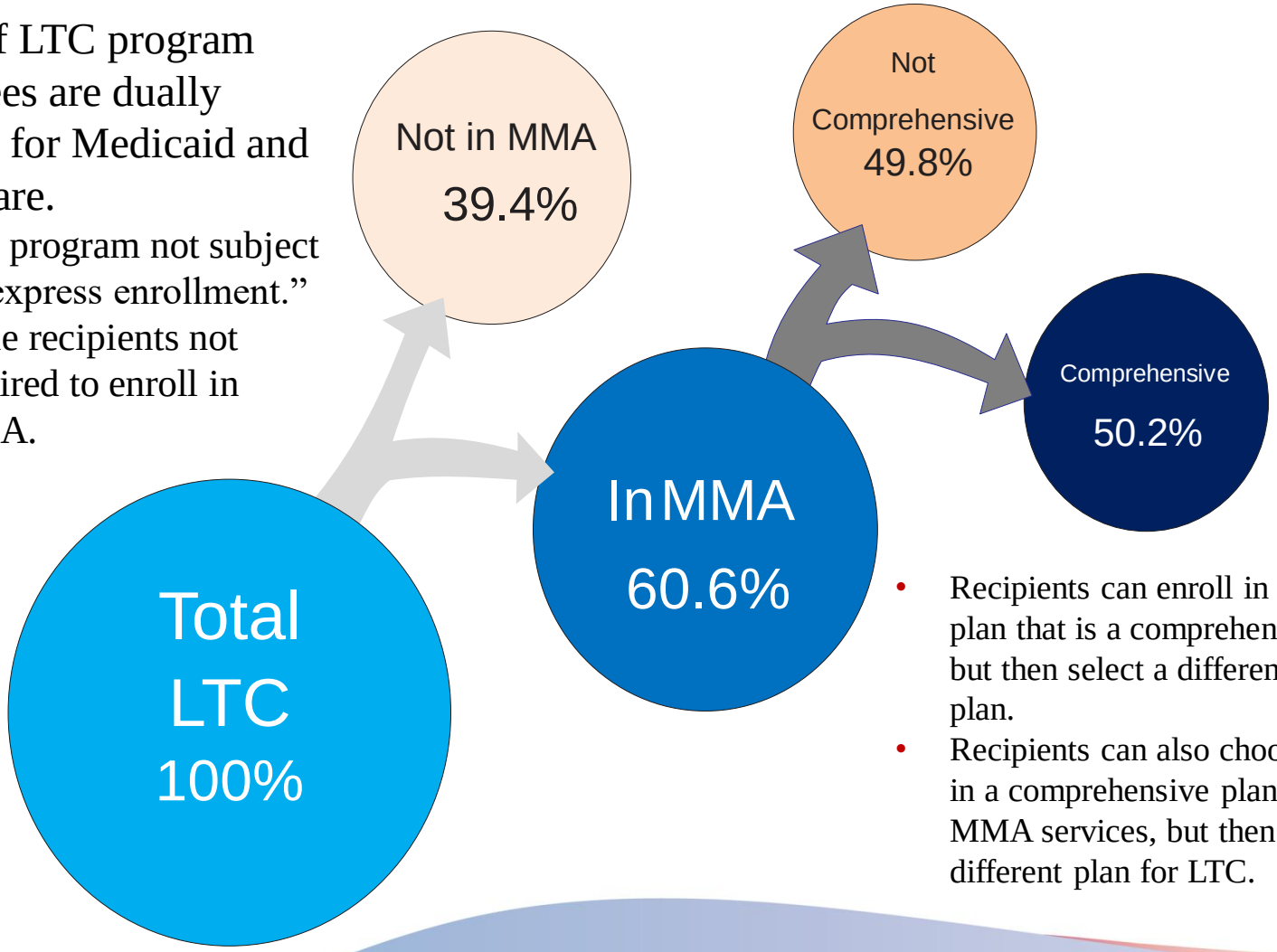
Submission 11 Performance Measure Sample Review	Associated Performance Measure	AEC-HUM		Amerigroup		Coventry		Molina		Sunshine		United		Total Compliance Percentage
Total Files		22 files		7 files		6 files		7 files		29 files		17 files		
Comprehensive assessment is current		18/22	82%	7/7	100%	6/6	100%	7/7	100%	28/29	97%	17/17	100%	94%
Initial on-site visit to develop plan of care conducted within five business days of enrollment if enrollee resides in community		2/2	100%	1/1	100%	3/3	100%	2/2	100%	21/24	88%	5/5	100%	92%
Initial on-site visit to develop plan of care conducted within seven business days if in nursing facility		2/2	100%	1/1	100%	N/A		N/A		2/2	100%	N/A		100%





LTC, MMA & Comprehensive Plans

- 95% of LTC program enrollees are dually eligble for Medicaid and Medicare.
  - LTC program not subject to “express enrollment.”
  - Some recipients not required to enroll in MMA.



- Recipients can enroll in an LTC plan that is a comprehensive plan, but then select a different MMA plan.
- Recipients can also choose to enroll in a comprehensive plan for their MMA services, but then select a different plan for LTC.

Alignment: Integration with Medicare

REGION	TYPE*	AMERIGROUP	COVENTRY	HUMANA	MOLINA	SUNSHINE	UNITED
1	MMA			✓	✓		
	LTC			✓		✓	
	MA			✓			✓
2	MMA						
	LTC			✓			✓
	MA			✓			✓
3	MMA					✓	✓
	LTC			✓		✓	✓
	MA		✓	✓			✓
4	MMA					✓	✓
	LTC			✓	✓	✓	✓
	MA		✓	✓			✓
5	MMA	✓				✓	
	LTC			✓	✓	✓	✓
	MA		✓	✓			✓
6	MMA	✓		✓	✓	✓	
	LTC		✓	✓	✓	✓	✓
	MA		✓	✓			✓
7	MMA	✓			✓	✓	✓
	LTC		✓	✓		✓	✓
	MA			✓			✓
8	MMA					✓	
	LTC			✓	✓	✓	✓
	MA		✓	✓			✓
9	MMA			✓	✓	✓	
	LTC		✓	✓		✓	✓
	MA		✓	✓			✓
10	MMA			✓		✓	
	LTC	✓		✓		✓	
	MA		✓	✓			✓
11	MMA	✓	✓	✓	✓	✓	✓
	LTC	✓	✓	✓	✓	✓	✓
	MA		✓	✓			✓

* If a Medicare Advantage Plan is indicated, it is present in at least one county in the Region

REGION	TYPE*	AMERIGROUP	COVENTRY	HUMANA	MOLINA	SUNSHINE	UNITED
1	MMA			✓	✓		
	LTC			✓		✓	
	D-SNP			✓			✓
2	MMA						
	LTC			✓			✓
	D-SNP			✓			✓
3	MMA					✓	✓
	LTC			✓		✓	✓
	D-SNP			✓		✓	✓
4	MMA					✓	✓
	LTC			✓	✓	✓	✓
	D-SNP			✓		✓	✓
5	MMA	✓				✓	
	LTC			✓	✓	✓	✓
	D-SNP		✓	✓	✓	✓	✓
6	MMA	✓		✓	✓	✓	
	LTC		✓	✓	✓	✓	✓
	D-SNP	✓	✓	✓	✓	✓	✓
7	MMA	✓			✓	✓	✓
	LTC		✓	✓		✓	✓
	D-SNP	✓		✓		✓	✓
8	MMA					✓	
	LTC			✓	✓	✓	✓
	D-SNP			✓			✓
9	MMA			✓	✓	✓	
	LTC		✓	✓		✓	✓
	D-SNP		✓	✓	✓	✓	✓
10	MMA			✓		✓	
	LTC	✓		✓		✓	
	D-SNP		✓	✓	✓	✓	✓
11	MMA	✓	✓	✓	✓	✓	✓
	LTC	✓	✓	✓	✓	✓	✓
	D-SNP	✓	✓	✓	✓	✓	✓

* If a D-SNP is indicated, it is present in at least one county in the Region

**Amerigroup D-SNP includes affiliated Simply Healthcare

Where Are We Going?

- Evolving Program Quality
  - Move from MLTSS process-based measures to comprehensive and relevant outcome-based measures.
  - Leverage disparate program information to create consistent and meaningful measures for all stakeholders, especially consumers.
- Aligning Program Structure
  - Move from separate and non-concurrent procurements to comprehensive program of medical and LTSS services.
  - Leverage Medicare Advantage plans, particularly D-SNP agreements, to integrate Medicaid and Medicare.

Questions?