Medicaid and Health Plan Information

Overview of Low Income Pool Distributions and Intergovernmental Transfers

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Managed Medical Assistance (MMA) Rates

Managed Care Plan Rate Setting

- Plans are paid a capitation rate for each recipient enrolled in their plan.
- Rates paid to the health plans must be actuarially sound.

Managed Care Plan Rate Setting

- Capitation rate is the per-member-per-month amount (PMPM), including any adjustments, that is paid by the Agency to a health plan for each Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment period.
- The capitation rates reflect historical utilization and spending for covered services projected forward and are adjusted to reflect the level of care profile (risk) for enrollees in each health Plan.

Managed Care Rate Setting

- Rates must be approved by CMS.
- "Actuarial Soundness" required by 42 CFR 438.6(c).
- Rates must be certified; changes to rates must be accompanied by documentation from the actuary.
- Florida contracts with an actuarial firm for rate setting: Milliman.

Managed Care Plan Rate Setting

- Actuarial Soundness:
- Developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract.
  - Benefit costs
  - Administrative expenses
  - Fees and taxes
  - Cost of capital

MMA Capitation Rates

- Competitive procurement (2014-2015)
  - "Best value" to the state included negotiated capitation rates for the period May 1, 2014 – Aug 31, 2015
  - Detailed Data Book & sample methodology in ITN
  - Bidders submitted cost proposals, methodology, and actuarial certification
  - Negotiations resulting in a rate schedule of common rates for all awarded standard plans in each region
- State Established (remaining contract years)

MMA Rates – Year 2

- Will be effective from September 2015 – August 2016
- Established by the Agency's contracted actuarial firm, Milliman, with significant input and feedback from the plans
- Target distribution of draft rates for plan review: June 5

Low-Income Pool Program Overview

Low-Income Pool Program

- The Low Income Pool (LIP) program was initially established as part of the Florida Medicaid Reform Demonstration Waiver which began operation in 2006.
- The Low Income Pool is a way to provide more funding to providers, mainly hospitals, for providing care to Florida's vulnerable population.
- The current LIP program will end on June 30, 2015.

Low-Income Pool Program

- Local government entities, such as taxing districts, put money into the Pool using a mechanism called an Intergovernmental Transfer, or IGT.
- The Agency then draws federal Medicaid funding from the federal government in the amount of the Federal Medical Assistance Percentage, or FMAP.
- The current FMAP is 59.56 (for SFY 2014-2015). Therefore, if a local entity puts up $40.44, they will get back $100.00 (which includes $59.56 in federal funds)

Low-Income Pool Program

- The current LIP program total computable dollar limit for expenditures in DY9 (SFY 2014-2015) is $2,167,968,341. This total includes the following elements:
  - $1 billion (for DY1 - DY8, LIP funding had a capped allotment of $1 billion disbursed in quarterly payments to providers);
  - $963,184,508 (historical spending amount for self-funded hospital rate exemptions and buybacks, conditional on the state's assurance that no such rate exemptions or buybacks will be executed apart from LIP in DY9);
  - $204,533,833 (historical supplemental payment amount for physician groups with medical school affiliation, conditional on the state's assurance that no such supplemental payments will be made apart from LIP in DY9).

Low-Income Pool Program Participation Requirements for Hospitals

- Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;
- Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,
- Participate in the Florida Event Notification program.

Where do LIP dollars come from? (in millions)

State General Revenue	$9.1
Local Taxes & Other Agencies	$867.6
Federal Funds	$1,291.2
Total	**$2,167.9 billion**

LIP Distribution
(in millions)

LIP 4	$764.0
LIP 5	$2.4
LIP 6	$963.2
Special LIP	$116.5
Other Provider Programs	$321.8
Total	**$2,167.9**

LIP Allocated and Proportional Distribution

Funding of $1,729.6 million

- Allocation factor is 8.5%
- Increased $963.2 million due to the addition of the LIP 6 distribution.

LIP 4 and LIP 5

Total Funding $766.4 million

- Funds in LIP 4 ($764.0 million) are first allocated to hospitals where local government funds are transferred to the State of Florida for use in the LIP program and former exemption programs.
- The designated hospital will receive a LIP 4 distribution equal to the IGT plus an 8.5% allocation factor.
- Funds in the LIP 5 category ($2.4 million) are provided to statutorily defined rural hospitals that ensure access to medical care for those individuals in the rural parts of Florida.
- Quarterly LIP payment contingent on the non-federal share of matching funds provided by local governmental entities based upon a Letter of Agreement (LOA) between the Agency and the local government.

LIP 6

Total Funding $963.2 million

- Existing funding but new to the LIP.
- Based on the SFY 2013-14 spending amount for self-funded Inpatient hospital DRG Add-on and Outpatient hospital rate exemptions and buybacks.
- Quarterly LIP payment contingent on the non-federal share of matching funds provided by local governmental entities based upon a Letter of Agreement (LOA) between the Agency and the local government.

Special Hospital LIP

Funding $116.5 million for the following initiatives:

– Rural	$ 5.6 m
– Primary Care	$ 12.0 m
– Specialty Pediatric	$ 1.4 m
– Trauma	$ 8.8 m
– Tier One Quality Measures	$ 15.0 m
– Safety Net	$ 73.1 m
– Independent Report	$ 0.5 m
Total Special LIP	**$ 116.5 m**

Questions?