The Florida Senate

Issue Brief 2011-226 *November 2010*

Committee on Health Regulation

MEDICAID MANAGED CARE RATE-SETTING

Statement of the Issue

The Florida Medicaid program allows for the delivery of primary and acute health care services to Medicaid beneficiaries via various types of managed care organizations, also known as managed care plans. As of November 1, 2010, approximately 45.9 percent of the state's Medicaid beneficiaries were enrolled in some type of managed care plan for primary and/or acute health care services, including health maintenance organizations (HMOs), provider service networks (PSNs), minority physician networks (MPNs), and nursing home diversion (NHD) plans.[1] Many other Medicaid beneficiaries who are not enrolled in a managed care plan for comprehensive health coverage may receive certain specialty care services in a managed care plan setting.

Florida makes payment for services delivered by some Medicaid managed care plans on a "fee-for-service" (FFS) basis, i.e., payment is made for each service after the service has been rendered and the state has been billed. With other managed care plans, the state contracts to make payments on a prepaid basis, which results in a fixed, lump-sum payment per beneficiary, typically made on a monthly basis, designed to cover the cost of services in the aggregate for any given month in a 12-month period. Such a fixed, prepayment is known as a "capitation" and is sometimes referred to as a per-member-per-month payment, or a "pmpm." Managed care plans that are paid via capitation are sometimes referred to as "prepaid health plans." This issue brief focuses on Medicaid rate-setting for capitated managed care plans.

Medicaid managed care capitation rates are set once per year, effective September 1, for a number of different managed care models. The methodologies and data sources used by the Agency to calculate Medicaid managed care plan rates directly impact the cost of providing Medicaid services through managed care delivery mechanisms.

Discussion

Background

The federal Centers for Medicare and Medicaid Services (CMS) regulations allow states broad authority to develop Medicaid managed care rate-setting methodologies. States' processes for developing rates may vary in a number of ways, including the type and time frames of data they use as the basis for setting rates and what approach they use to negotiate rates with managed care plans.[2]

Florida Statutes currently require the Agency for Health Care Administration (Agency) to develop, by administrative rule, a Medicaid managed care rate-setting methodology that: uses fee-for-service expenditures; is certified as an actuarially sound computation of Medicaid fee-for-service expenditures for comparable groups of Medicaid recipients; and complies with applicable federal laws and regulations.[3] Florida Statutes allow the Agency to use a separate methodology that employs a risk-adjustment process to develop rates for Medicaid managed care plans participating in the Medicaid Reform demonstration pilot project (Medicaid Reform).[4]

---

[1] Medicaid Enrollment by Program Type, as of November 1, 2010, published by the Agency, available at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml>, (Last visited on November 29, 2010). This percentage excludes beneficiaries in MediPass, which is a managed care system but not a managed care organization.

[2] Report to Congressional Committees: CMS's Oversight of States' Rate Setting Needs Improvement, United States Government Accountability Office, August 2010, p. 4.

[3] *See* s. 409.9124, F.S.

[4] The Medicaid Reform pilot project, authorized under s. 409.91211, F.S., is currently in operation in Broward, Duval,

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitated entities sometimes assume full risk, i.e. the coverage is comprehensive with no mitigation factors for the risk assumed, and others assume partial risk, i.e. the coverage is limited, as opposed to comprehensive, and/or the risk may be mitigated by loss prevention or shared-savings arrangements. Capitation is designed to provide the state with less risk and more predictability for Medicaid spending and to incent capitated entities to manage the provision of services in a cost-effective manner.

Rate-Setting Methodology: Non-Reform Managed Care Plans

The Agency has adopted a rule to develop capitation rates for managed care plans that deliver comprehensive Medicaid health care services in non-Reform counties,[5] including HMOs and capitated PSNs. The rule is designed to produce capitation rates that, in the aggregate, represent roughly an 8-percent discount from what the state would otherwise pay for providing the same services on a fee-for-service basis to comparable groups of Medicaid recipients.

The published methodology calculates capitation rates separately for ten Agency service areas, four service categories, and eight age and gender bands. The service categories include hospital/medical services, dental services, transportation services, and prescription drug rebates. The rule's managed care plan capitation rate methodology consists of the following basic steps:

1. Identify age and gender bands for each eligibility category.
2. Calculate statewide age and gender factors by age and gender band and eligibility category.
3. Calculate estimated FFS costs by eligibility category and service area for the upcoming contract year.
4. Adjust for incurred but not reported (IBNR) claims, third party liability (TPL) recoveries, and trend factors.[6]
5. Apply statewide age and gender factors calculated in Step 2 to the estimated FFS costs by service area calculated in Steps 3 and 4 to calculate fee-for-service equivalent (FFSE) estimates for the upcoming contract year by age and gender band, service area, and eligibility category.
6. Apply managed care discounts to the FFSE estimates to calculate the capitation rates by age and gender band, service area, and eligibility category.

The methodology results in separate capitation rates for Agency service areas and eligibility categories, and the methodology applies various discount factors to each capitation rate depending on the service area and eligibility category in question.

Statutory Authority for Managed Care Capitation Rates

The requirement for the Agency to adopt a rule on managed care rate-setting methodology was created in 1996.[7] The statute originally directed the Agency to: adopt a rule requiring managed care plans to report certain pieces of financial information; and examine the financial condition of each managed care plan and its performance in serving Medicaid patients. The statute has been substantively amended four times since 1996, as follows:

- Chapter 2004-270, LOF, directed the Agency to:
    - Publish final managed care capitation rates annually prior to September 1 of each year;

Nassau, Baker, and Clay counties.

[5] The payment methodology, entitled "Agency for Health Care Administration, Payment Methodology for Participating Medicaid Managed Health Care Plans, July 2005," is incorporated by reference in Rule 59G-8.100(17), FAC.

[6] Florida's Social Services Estimating Conference develops detailed projections, i.e., inflation factors, by type of Medicaid service and eligibility category to reflect trends anticipated prospectively. Actuaries who set managed care capitation rates review the impact of the inflation factors for reasonableness and appropriateness to the rate-setting process and apply them to the methodology.

[7] *See* s. 9, ch. 96-199, LOF, and s. 409.9124, F.S.

- Calculate actuarially sound rates based on Medicaid's fee-for-service expenditures for comparable groups of Medicaid recipients and to include all fee-for-service expenditures;
- Comply with all applicable federal laws and regulations, including the requirement to include an allowance for administrative expenses; and
- Review all prior year adjustments for changes in trend and to reduce or eliminate those adjustments deemed to be unreasonable and reflective of policies or programs not in effect.

- Chapter 2005-60, LOF, directed the Agency to:
  - Make adjustments for policy reductions only when such policy reductions would be applicable to the fiscal year for which the rates would be in effect; which could be accurately estimated and verified by an independent actuary; and which had been implemented prior to or would be implemented during the fiscal year;
  - Pay managed care plan capitation rates designed to equal, but not exceed, the amounts allowed for in the General Appropriations Act; and
  - Amend the rate methodology to develop two rates for children under one year of age, one of which would represent the month of birth through the second complete month following the month of birth, and a second rate to represent the remainder of the months through the 11th complete month following the birth month. (The methodology had previously calculated one rate for children under one year of age. This change was designed to more accurately reflect the risk assumed by capitated managed care plans for covering such children.)

- Chapter 2005-133, LOF:
  - Revised amendments to the statute that had been made earlier in the 2005 Regular Legislative Session in what became ch. 2005-60, LOF, to direct the Agency to pay managed care plan capitation rates that would not exceed the amounts allowed for in the General Appropriations Act. This revision removed the requirement that the payments must equal the amounts allowed for in the GAA;
  - Directed the Agency to make an additional, non-recurring adjustment to the 2005-06 rates for capitated managed care plans providing comprehensive Medicaid coverage in order to result in an average increase of 2.8 percent to the capitation rates in effect for the 2005-06 fiscal year only.

- Chapter 2008-143, LOF, eliminated the requirement that the Agency must pay managed care plan capitation rates that do not exceed the amounts allowed for in the General Appropriations Act.

Medicaid Managed Care Reimbursement Workgroup

In 2008, the Legislature directed the Agency to create a workgroup on managed care plan payment for the purpose of evaluating alternative reimbursement and payment methodologies.[8] The Agency was directed to submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and the House of Representatives by November 1, 2009. The Agency created the Workgroup on Medicaid Managed Care Reimbursement[9] (the Workgroup), and members of the Workgroup represented Medicaid HMOs and PSNs under contract with the Agency. The Agency also invited its third-party actuaries to participate.[10] The Workgroup focused on actuarially sound reimbursement for capitated managed care plans that provide comprehensive health services to Florida Medicaid beneficiaries.

[8] *See* s. 5, ch. 2008-143, LOF.
[9] Workgroup charter and final report to the Legislature available at: <http://ahca.myflorida.com/Medicaid/quality_management/workgroups/mcr_meetings.shtml>, (Last visited November 30, 2010).
[10] The Agency has contracted with Milliman, Inc., for actuarial services related to non-Reform capitation rates and with Mercer Health & Benefits, LLC, for actuarial services related to Medicaid Reform capitation rates.

The Workgroup identified issues of concern about the Agency's rate-setting methodology. These concerns were largely related to the use of historical FFS data as the methodology's base data, the roughly 8-percent discount factor applied during the rate-setting process, the inflation factors used to project forward into the prospective payment period, and the fact that managed care plans report financial data to the Agency in the aggregate while the Agency employs different payment methodologies in Medicaid Reform counties versus non-Reform counties, as well as among the different types of managed care plans, e.g., capitated HMOs versus fee-for-service PSNs.

The Workgroup determined that its primary goal was to identify data sources to be used as an alternative to FFS base data for the purpose of maintaining an actuarially-sound managed care rate methodology. Workgroup members envisioned the path to an ideal data source and methodology as a process that would be transparent and data-driven and would allow for collaboration between the Agency and Medicaid managed care plans.

The Workgroup achieved a consensus that the ideal data source would be Medicaid encounter data that could be verified as valid and complete. Realizing that the ideal data source and methodology would take time to develop, the Workgroup identified a transitional alternative that could use data from three sources – FFS data, managed care plan financial data, and encounter data – to establish the base for a transitional rate-setting methodology. Expanded or detailed health plan-reported financial data could serve as a bridge during a transition from the exclusive use of FFS data to the use of encounter data combined with FFS data.

The transitional methodology could include:

- The use of plan financial data to serve as a test source and add perspective to the FFS and encounter data to identify major differences or shifts across data sources;
- Adjustments to the base data source to account for trends and inflation, policy changes, benefit changes, or trends identified specific to managed care enrolled recipients and health plan administration;
- Risk-adjustment based on aggregate plan enrollment; and
- Use of specialty rates and kick payments.[11]

The Workgroup anticipated that a transitional methodology could be implemented and modified each year, as needed, until statewide encounter data became verifiably valid and complete enough to be used exclusively as the basis for a new rate-setting methodology.[12]

The Agency submitted its report from the Workgroup to the Legislature in November 2009. However, the 2010 Legislature did not use the findings and recommendations contained in the report to amend s. 409.9124, F.S., nor were changes made to the administrative rule promulgated by the Agency that governs the methodology for non-Reform managed care capitation rates.

Rate-Setting Process for 2010-11: Non-Reform Managed Care Plans

Following the report of the Workgroup, the Agency changed its non-Reform rate-setting methodology for Medicaid prepaid health plans, effective for 2010-11. The Agency incorporated recommendations from the Workgroup into the 2010-11 methodology, which, for the first time, utilized data other than FFS data for the rate calculations.

The methodology for 2010-11 used a combination of non-pharmacy FFS data, health plan financial data, and managed care plan pharmacy encounter data. The methodology weighted the data as follows: for the non-pharmacy components of the capitation, FFS data was weighted at 75 percent while financial data was weighted at 25 percent; for the pharmacy component of the capitation, managed care plan pharmacy encounter data was used exclusively, with no utilization of FFS data.

---

[11] A "kick payment" is a method of reimbursing capitated managed care plans in the form of a separate, one-time, fixed payment for a specific service, such as transplants or obstetrical delivery services.

[12] Medicaid Managed Care Reimbursement Workgroup Report, November 2009, published by the Agency, available at: <http://ahca.myflorida.com/Medicaid/quality_management/workgroups/managed_care/mcr_final_report_november_2009.pdf>, (last visited November 30, 2010).

To explain this change, Milliman, Inc., included the following passage in its certification document for the 2010-11 managed care plan capitation rates:[13]

> *In general, AHCA wishes to move away from a rate setting methodology that is based on FFS data and toward a rate setting methodology that relies on HMO experience data. The rate setting methodology for September 2010 – August 2011 is the first major step in the direction of relying more on HMO data. While AHCA recognizes the advantages of relying more on HMO data, it also recognizes that a multi-year phase-in approach will provide a more stable rate environment as well as more time to validate that the data collected from the HMOs is accurate and complete. It is common actuarial practice to phase in the use of new data into a rate calculation.*

Another noteworthy change took place in the 2010-11 rate-setting process. There was a shift in responsibility for the rate calculation. The following passage is from the Milliman certification document for 2009-10:[14]

> *AHCA developed the HMO capitation rates using the methodologies described in this report. Milliman did not calculate the HMO capitation rates. AHCA's rate setting methodology is set by rule according to Florida state statute. Milliman's role is to certify the September 1, 2009 - August 31, 2010 capitation rates produced by the current rate setting methodology are actuarially sound to comply with CMS regulations.* [emphasis added]

The following passage is from the Milliman certification document for 2010-11:[15]

> *The Florida Agency for Health Care Administration (AHCA) retained Milliman, Inc. (Milliman) to develop and certify its non-reform HMO and PDHP capitation rates. Milliman's role is to calculate and certify actuarially sound September 2010 – August 2011 capitation rates to comply with CMS regulations and the CMS rate setting checklist.* [emphasis added]

This change means that the 2010-11 non-Reform capitation rates were both calculated and certified as actuarially sound by the same entity. Prior to the 2010-11 rate-setting process, AHCA developed the non-Reform rates, and the certification was performed independently.

Rate-Setting Methodology: Medicaid Reform Managed Care Plans

The Agency has developed a separate rate-setting process for capitated managed care plans participating in the Medicaid Reform pilot project.[16] The Reform statutes require a managed care plan's capitation to be risk-adjusted based on an assessment of the health status of the plan's enrollees, but the Agency is not required to adopt a rule for the Reform rate-setting methodology.

Risk-adjusted rates are designed to pay managed care plans that serve beneficiaries who are sicker and have greater health care needs more than plans that serve healthier beneficiaries. This differs from non-Reform in that AHCA pays non-Reform capitated plans monthly rates that take into account eligibility categories and age and gender bands but are not adjusted based on an assessment of beneficiary health status.

The Agency has contracted with Mercer Health & Benefits LLC to both calculate the capitation rates for the Reform project and to certify them as actuarially sound. The Reform methodology was designed to utilize managed care plan encounter data for pharmacy services in order to risk-adjust the capitation based on the health status of Medicaid beneficiaries. This approach was phased-in over a 3-year period beginning in 2006-07. During the first 2 years, capitation rates in the Reform pilot were a blend of the non-Reform methodology and the risk-adjusted methodology,

---

[13] State of Florida Agency for Health Care Administration September 2010 - August 2011 Capitation Rate Development For Non-Reform HMO Program and Prepaid Dental Health Program, Milliman, Inc., September 14, 2010, p. 6.
[14] State of Florida Agency for Health Care Administration September 1, 2009 - August 31, 2010 Capitation Rate Development For Non-Reform HMO Program and Prepaid Dental Health Program, Milliman, Inc., September 23, 2009, p. 1.
[15] Supra, note 13, p. 1.
[16] Supra, note 4.

and risk corridors were utilized to prevent extreme outliers during the phase-in.[17] In the third year and subsequent years, the risk-adjustment methodology was used exclusively, without risk corridors.

The Agency selected a tool called "Medicaid Rx" (MedRx) to perform risk-adjustment for Reform capitation rates. MedRx uses prescription drug information to gauge beneficiary health status. The Agency selected MedRx because Reform prescription drug information was readily accessible and up to date. Once full encounter data become verifiably complete and valid, the Agency has expressed intent to use a diagnosis-based model to calculate risk-adjusted rates. The Agency may test the feasibility of risk-adjusting Reform rates using a combined model that uses both diagnostic information and pharmacy encounter data.[18]

For the 2010-11 Reform capitation rates, Mercer, like Milliman, developed the rates utilizing managed care plan financial data and pharmacy encounter data in combination with FFS data. For the pharmacy component of the rate, pharmacy encounter data was utilized exclusively. For the non-pharmacy components, FFS data and financial data were weighted at 50 percent apiece.

Health maintenance organizations participating in Reform are paid via the risk-adjusted capitation methodology. PSNs in Reform have the option to be capitated or to be paid case management fees and administrative allocations while health care services for their members are paid on a fee-for-service basis. Currently, no PSNs in the Reform pilot have opted to be paid via capitation.

Rate-Setting Methodology for Behavioral Health Care

The Agency has developed a separate managed care rate-setting methodology for non-Reform behavioral health care delivered on a capitated basis. No rule has been adopted for this rate-setting methodology. Prior to 2005, behavioral health care was delivered on a fee-for-service basis for the large majority of Medicaid beneficiaries, including those enrolled in capitated managed care plans. The Legislature first authorized a pilot program for delivering Medicaid behavioral health care via capitated managed care plans in 1996,[19] and the pilot was expanded statewide between 2005 and 2007.

Currently, with the exception of most children receiving child welfare services from the Department of Children and Families,[20] Medicaid HMOs are capitated to provide behavioral health care to their own members. Behavioral health care for MediPass beneficiaries and non-Reform PSN members is delivered on a capitated basis by prepaid behavioral health plans (PBHPs), also known as prepaid mental health plans (PMHPs), contracted by the Agency on a regional basis throughout the state. The 2010 Legislature required capitated PSNs to provide behavioral health services to their own members,[21] and the Agency has set a target date of January 2011 to begin implementing that provision.

Prior to the 2006-07 fiscal year, the non-Reform rate-setting methodology for prepaid behavioral health care used FFS data exclusively as the methodology's base data. The Agency first began using encounter data collected from HMOs and PBHPs to set capitation rates in 2006-07. The switch to encounter data was phased-in, beginning with a blend of 90 percent FFS data and 10 percent encounter data, gradually relying more on encounter data and less on FFS data in subsequent years. Currently, the non-Reform behavioral health capitation is calculated using encounter data exclusively.

---

[17] "Risk corridors" were required under s. 409.91211(8), F.S., to provide that no managed care plan providing comprehensive benefits in a Reform area would have an aggregate risk score that varied by more than 10 percent from the aggregate weighted mean of all such managed care plans in that area.

[18] Report No. 08-54, Office of Program Policy Analysis & Government Accountability, September 2008, p. 4.

[19] *See* s. 6, ch. 96-199, LOF.

[20] Most Medicaid-eligible children statewide who are receiving child welfare services are provided enhanced behavioral health services via a specialty prepaid behavioral health plan operated by community-based lead agencies. *See* s. 409.912(4)(b)8., F.S.

[21] *See* s. 15, ch. 2010-144, LOF.

The methodology for behavioral health capitation shares a number of elements with the methodology for non-Reform managed care plans providing comprehensive health care, including the use of age bands and eligibility categories, but is specialized for Medicaid behavioral health services.[22]

The Agency contracts with Milliman, Inc., to develop and certify the capitation rates for behavioral health care in non-Reform counties. For capitated managed care plans participating in the Medicaid Reform pilot project, behavioral health care is included in the Reform rate-setting methodology.

Rate-Setting Methodology for Nursing Home Diversion Plans

The Nursing Home Diversion (NHD) program is a managed care option designed to provide community-based services to people who would qualify for Medicaid nursing home placement. The objective of the program is to provide elders with community-based care to avoid nursing home placement at a cost less than Medicaid nursing home care.

The NHD program, administered primarily by the Department of Elder Affairs (DOEA), differs from other home and community based waiver programs in that it covers both medical and long-term care services under Medicaid and the services are provided by managed care plans that receive a capitated rate for all covered services.

The rate-setting methodology for NHD uses encounter data exclusively.[23] The Agency and DOEA have retained Milliman, Inc., for developing the encounter data-based methodology to calculate the rates and certify the rates as actuarially sound.

---

[22] *See* State of Florida Agency for Health Care Administration September 2010 - August 2011 Capitation Rate Development For HMO Mental Health Add-On, Milliman, Inc., August 26, 2010, for a full description of the rate-setting process for HMOs and capitated PSNs. *See* State of Florida Agency for Health Care Administration September 1, 2010 - August 31, 2011 Prepaid Mental Health Plan Capitation Rate Development, Milliman, Inc., August 19, 2010, for a full description of the rate-setting process for PBHPs. Draft versions available at: <http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/index.shtml>, (Last visited December 3, 2010).

[23] *See* State of Florida Agency for Health Care Administration and Department of Elder Affairs September 1, 2010 – August 31, 2011 Capitation Rate Development for Nursing Home Diversion Health Program, Milliman, Inc., August 3, 2010, for a full description of the rate-setting process for NHD plans, on file with the Senate Health Regulation Committee.