HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1073 Medicaid Managed Care Pilot Program
SPONSOR(S): Traviesa
TIED BILLS: **IDEN./SIM. BILLS:** SB 1828

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council		Calamas	Gormley
2) Policy & Budget Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1073 repeals the current phase-in of the implementation of the risk-adjusted capitation methodology for plans that participate or will participate in the Medicaid managed care pilot. The bill amends the statutory schedule for phasing-in risk adjusted rates and requires the Agency for Health Care Administration (agency) to use an interim risk adjustment methodology with no more than 25 percent of the capitation based on this methodology until a functional comprehensive encounter data system is implemented.

The bill requires the agency to develop a new methodology to calculate risk-adjusted capitation rates contingent on several criteria for quality and completeness of encounter data, using a comprehensive encounter and diagnosis data system for acute Medicaid services. The new risk-adjusted capitation methodology must be phased-in over a 6-year period of time, and only after a fully functional encounter and diagnosis data system has been in operation for no less than 12 months. The bill specifies the capitation rate percentage that can be based on the new risk-adjusted methodology for each of the 6 years. Prior to implementing the new risk-adjusted capitation rate methodology, the agency must ensure that criteria are met as specified in this bill.

The bill also repeals the 2-year limit on the use of risk corridors in the Medicaid reform pilot, and extends the ten percent risk corridor indefinitely.

The bill has a significant fiscal impact.

The bill provides an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The bill does not appear to implicate any of the House principles

B. EFFECT OF PROPOSED CHANGES:

The Florida Medicaid Program[1]
Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The Agency for Health Care Administration (AHCA or agency) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[2] Other services are optional. A state may choose to provide optional services in its state Medicaid plan, however if included, such services must be offered statewide to all individuals who meet Medicaid eligibility criteria.[3] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, Florida Statutes. For FY 2006-07, the Florida Medicaid Program is estimated to cover 2.1 million people[4] at a cost of $14.6 billion.[5]

Medicaid Reform
On January 11, 2005, Governor Bush released a Medicaid reform proposal for consideration by the Legislature. The proposal was based on data at the time demonstrating that the Medicaid budget was growing at an unsustainable rate and that a comprehensive overhaul of the system was necessary to improve care and provide predictability in the state Medicaid budget.

The Governor's proposal centered on the concept of moving Medicaid recipients out of the current fee-for-service system into a mostly managed care environment. In this new system, managed care plans (including traditional Medicaid HMOs and new provider service networks) would receive actuarially-sound, risk-adjusted capitation rates to provide mandatory and optional services to Medicaid recipients.

The Legislature passed a Medicaid reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.). The provisions of the final bill offered opportunities to improve the current Medicaid program, while continuing a deliberative review of more comprehensive reform initiatives.

Medicaid Capitation Rates
The Florida Medicaid Program uses a capitated reimbursement model for Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion

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[1] Senate Analysis, March 22, 2007, on file with the Committee
[2] Section 409.905, F.S.
[3] Section 409.906, F.S.
[4] http://edr.state.fl.usconferences/medicaid/medcases
[5] http://edr.state.fl.us/conferences/medicaid/medhistory

programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated reimbursement systems since the early 1990s. Under the 2005 Medicaid reform proposal, capitated reimbursement will become the primary reimbursement methodology used within Medicaid reform pilot sites.

The HMOs are by far the largest of these provider types and receive the majority of reimbursements within the Medicaid managed care program. Medicaid HMOs in Florida are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the agency is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[6] The agency's methodology is established through the administrative rule process (59G 8.100, F.A.C) and is available to the public. The methodology is as follows:

• The capitation payment is the fixed amount paid monthly by the agency to an HMO for each enrolled HMO member to provide covered services during the month as specified in each contract.

• The agency uses two years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee for service program for the same service the HMO is responsible to deliver.

• These data are categorized into "rate cells" by age, gender, eligibility group, geographic region and forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may affect fee-for-service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates)

• After the adjustment for policy issues, the agency applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 8 percent and varies by rate cell depending on the geographic region and eligibility category.

• Upon completion, the rates are reviewed and certified by and independent actuarial firm. Upon actuarial certification, and confirmation by the Centers for Medicare and Medicaid Services, the agency begins reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

The division of individuals into rate cells is based on age, sex, eligibility category, or location and can capture differences in average spending for entire population groups. However, rate cells cannot predict the level of risk represented by individual enrollees. This has two consequences. First, in states in which managed care enrollment is voluntary, individuals choosing to enroll may have better or worse health status than individuals choosing to remain in the fee for service system. If capitation rates are based on fee for service experience, overall payments to managed care organizations (MCOs) might not reflect the level of risk they are actually assuming. Second, when multiple MCOs are competing, any one entity may be over paid or under paid, depending on the health status of the beneficiaries it enrolled. This creates incentives for MCOs to market to healthier beneficiaries and/or to promote disenrollment by sicker individuals, often called "cherry picking."

Risk-Adjusted Capitation Rates

One way to reduce or eliminate this incentive to "cherry pick" is to pay MCOs more if they have

[6] Section 409.9124, F.S.

a sicker risk pool, and less of they have a healthier risk pool.

For this reason, accurate measurement of risk is essential. It is widely understood that quality utilization data for all services is critical in order to implement a risk-adjusted capitated rate methodology. This type of data is may be acquired through several methods, including drug utilization generally acquired through the use of an encounter data system. However, the agency, pre-reform, did not collect enough patient-specific information (specifically regarding diagnoses) through its fee-for-service claims system to establish an extensive risk-adjustment methodology. The agency is currently transitioning to an encounter data system, however, it is unlikely that sufficient encounter data for risk adjustment will be available for at least a year after implementation.

The Legislature addressed these problems by including a provision in the Medicaid reform implementing law (ch. 2005-358, L.O.F.) passed during the 2005 Special Session requiring a phase-in of the risk-adjustment methodology over three years. During this phase-in period, the agency is using historical prescription drug claims as a proxy for diagnostic codes as a way to implement the risk adjustment in reform demonstration sites. The prescription drug data currently being used to generate risk-adjusted rates for the phase-in period was chosen via consensus by the members of the Technical Advisory Panel.[7] The agency will also limit the percentage of the capitation rate that is based on the risk-adjusted methodology to 25 percent in the first year (75 percent of the capitation rate would be based on the old methodology), 50 percent in the second year, and 100 percent in the third year of implementation. The Year 2 phase-in to 50 percent would be implemented in September 2007.

The Medicaid reform implementing law also attempted to reduce the risk of providers accepting this new capitation rate by requiring "risk corridors." Risk corridors are a mechanism that takes some of the natural error out of the risk-adjusted methodology. Risk corridors, as established in the implementing law, ensure that plans' overall risk scores do not deviate by more than 10 percent from the average (or mean) of all plans in the reform pilot sites. However, to the extent the interim, drug utilization-based methodology for measuring risk is accurate, risk corridors could prevent plans from being accurately paid for the risk they bear.[8] These risk corridors would be used for two years while implementing the pilot, and then discontinued in September 2008.

Effect of Proposed Changes:

The bill requires the agency to develop methodology for calculating risk-adjusted capitation rates using comprehensive encounter and diagnosis data. Prior to implementing the rate methodology, the agency is required to ensure several safeguards, including ensuring that agency staff is educated and trained regarding encounter data compilation; ensuring that the Florida Medicaid Management Information Systems has the capacity to maintain and manage encounter data records; and ensuring that the encounter data system protects personal health information and is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation. [9]

According to the agency, the bill will delay full implementation of the Medicaid Encounter Data System (MEDS), and the full implementation of risk adjusted rates in Medicaid reform pilot areas. According to the agency, a delay in MEDS implementation removes the incentive for plans to develop and submit accurate encounter data. As of January 2007, the MEDS has been developed by the

[7] The Technical Advisory Panel is established pursuant to s. 409.91211, F.S., and its membership includes representatives of PSNs and HMOs.

[8] Some evidence exists suggesting the drug utilization-based methodology does not assess risk accurately. A study by Milliman, funded by the Florida Association of Health Plans (a HMO association) found that the drug-based methodology is best at measuring the SSI-disabled population, but is not as accurate when measuring the TANF population. The study estimated a 7 percent loss in revenue to the HMOs if risk adjustment is phased-in according the statutory schedule and if the drug-based methodology is used. See, *Florida Association of Health Plans Research Paper on Risk Adjustment in the Florida Medicaid Reform Program*, January 26, 2007, prepared by Robert M. Damler, Milliman, Inc.

[9] See 45 C.F.R. ss 160.102, 160.103, and 164, subpart A

Agency and managed care plans have been testing their data submissions. According to the agency. it is understood that the validity and completeness of a new data system is low and increases over time and when accurate data submission is tied to monetary incentives. Current statute ties risk adjusted rates to submitting plan encounter data. In this way, according to the agency, the plans have an incentive to submit complete and accurate data to ensure that risk adjustment is calculated correctly for their population because plans realize that failure to do so could adversely impact their rate payments. According to the agency, the bill could result in a longer period of data inaccuracy as the consequence of poor data would not have as great of an effect in early years.

The proposed legislation extends the phase-in schedule of risk-adjusted rates to six years before full implementation is achieved, and extends use of the risk corridors indefinitely. It also requires a new phase-in schedule to be followed upon implementation of the risk-adjusted capitation rate methodology in any county. According to the agency, tracking multiple risk adjustment methodologies could be administratively difficult to implement. In addition, according to the agency, delaying risk-adjusted rates will disadvantage plans serving sicker populations and result in overpayments to plans serving healthier populations.

The bill could have the adverse affect of discouraging the development of PSNs and specialty plans due to the lack of risk adjusted rates based on actual encounter data and due to the possible, artificial, suppression of rates in the interim by risk corridors. Current statute provides for additional required funding to plans serving a sicker population in year 3 by eliminating the ten percent risk corridor, when plans will be fully reimbursed based on their risk scores. The bill will delay risk-related funding until full implementation is achieved by year 6, which is after the 5-year federal waiver pilot period is over. The delay could negatively affect plans that carry sicker populations, causing these plans to leave the program if payment for actual risk is delayed.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.91211, F. S.; relating to Medicaid managed care pilot program.

Section 2. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

	2007-08	**2008-09**
Federal Title XIX Match (Medicaid)	$72,898	$266,773

2. Expenditures:

The proposed legislation requires Agency staff to be sufficiently educated and trained in encounter data systems and methods. It also requires implementation of a validation system to ensure accuracy, completeness, and consistency of encounter data. These criteria would require three additional FTEs with associated information technology equipment as well as additional travel expenditures (as provided in the bill, staff would be required to provide training and education resulting in additional travel need for six months in year one and 12 months in year two). Because of the highly technical nature of these positions, the agency is requesting funding to hire the individuals at 15% above the minimum salary base. The validation system would initially require contractual arrangements with a third party vendor at an estimated cost of $500,000 and would be reduced to $300,000 in year two.

	2007-08	2008-09
AHCA (3.0 FTE)	$245,796*	$233,546
Contractual Services	$500,000	$300,000
Total Expenditures	$745,796	$533,546

*Fiscal Year 2007-08 includes $13,200 in non-recurring funding for equipment for the new staff positions. Contractual service funding would be reduced to $300,000 in year two.

General Revenue Fund	$372,898	$266,773
Administrative Trust Fund	$372,898	$266,773

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will slow the implementation of the risk-adjusted capitation model in Medicaid reform until after an encounter database is operational for at least 12 months. This will limit the risk for private managed care plans participating in the Medicaid reform initiative of being paid capitation rates that do accurately reflect the health status of a plan's members.

D. FISCAL COMMENTS:

According to the Agency for health Care Administration, although there is no direct overall impact to the state budget because of Medicaid Reform Waiver budget neutrality requirements, there could be significant potential for local impact. The ten percent corridor based on the "aggregated weighted mean of all managed care plans" for "TANF and SSI" on a statewide basis will likely cause shifts of Medicaid payments from one plan to another, including shifts from high cost reform counties to low cost counties. This may generate disparate subsidies amongst the plans. This may ultimately lead to some managed care plans operating in high cost areas with high risk membership to drop out of the program leaving Medicaid beneficiaries to cope with limited choices for health care, and Medicaid to potentially face higher fee-for-service costs.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On page 1, line 26, the term “acute” refers to non long-term care services; however, the term can also be interpreted as making a distinction between primary care services and acute services. See recommended amendment. It is recommended that line 26 on page 1 be deleted and the following language be inserted:

“for all Medicaid services specified under this section. Prior to implementation”

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES