The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health and Human Services Appropriations Committee

BILL: CS/SB 1828

INTRODUCER: Health and Human Services Appropriations Committee and Senator Fasano

SUBJECT: The Medicaid Managed Care Pilot Program

DATE: April 24, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Fav/2 amendments**
2.	Dull	Peters	HA	**Fav/CS**
3.				
4.				
5.				
6.				

I. Summary:

The bill specifies certain criteria that the Agency for Health Care Administration (the agency) must meet prior to the implementation of a risk-adjusted capitation rate methodology that uses a comprehensive encounter data system. Among these criteria is that the comprehensive encounter data system must be in place, and verified for accuracy before the new risk-adjustment methodology is phased-in. The bill allows the agency to use an interim risk adjustment methodology until the comprehensive encounter data system is fully operational.

The bill extends the full phase-in of the risk-adjusted capitation methodology for plans participating in the Medicaid reform pilot in Baker, Broward, Clay, Duval, and Nassau Counties from three years to five.

The bill revises the current statutorily required methodology used to calculate the risk adjusted rates for Medicaid reform plans during the phase-in period as follows:

- Maintains year 1 (September 1, 2006-August 31, 2007), to continue the current required methodology requiring that 25 percent of the calculation utilize risk adjusted data and 75 percent of the calculation utilize capitation methodology required under s. 409.9124, F.S. with a 10 percent risk corridor.
- Revises year 2 (September 1, 2007-August 31, 2008), to reduce the percentage of the calculation that requires risk adjusted data from 50 percent to 33 percent and increases the percentage of the calculation based on s. 409.9124, F.S. to 67 percent, while maintaining the current 10 percent risk corridor.
- Revises year 3 (September 1, 2008 – August 31, 2009), by repealing the requirement for a 100 percent risk adjustment calculation with no risk corridors, and replacing it with a

requirement to base 33 percent of the calculation on risk adjustment and 67 percent with the methodology required under s. 409.9124, F.S., including a 12.5 percent risk corridor.
- Creates year 4 (September 1, 2009-August 31, 2010), to require the agency to use a risk-adjusted methodology by which 50 percent of the calculation is based on comprehensive encounter data and 50 percent of the calculation is based on the methodology required in s. 409.9124, F.S. with a risk corridor of 15 percent.
- Requires 100 percent of managed care plan reimbursement to utilize a comprehensive encounter data methodology and eliminates risk corridors.
- Requires managed care organizations to pay noncontracted hospitals a reimbursement rate that is equivalent to the amount the agency would pay on a fee for service basis for services rendered to persons who are eligible for Medicaid, living within an area served by a Medicaid reform pilot program.

This bill amends s. 409.91211, F.S.

II. Present Situation:

The Florida Medicaid Program

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.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] 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[3] at a cost of $14.6 billion.[4]

Medicaid Reform

On January 11, 2005, Governor Bush released a Medicaid reform proposal (originally called Empowered Care) 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

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid program are found in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 22, 2007)
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 22, 2007)

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) will receive actuarially-sound, risk-adjusted capitation rates to provide all 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 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, if not sole, 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 AHCA, as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[5] 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 very complex, but can be summarized as follows:

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

- The AHCA 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 for delivering.

- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, 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

[5] S. 409.9124, F.S.

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 will begin 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 a sicker risk pool, and less of they have a healthier risk pool. Under the Medicaid reform demonstration program implemented in 2006, the AHCA began developing capitation rates utilizing a risk-adjusted capitation methodology that relies almost exclusively on pharmaceutical claims to identify the health status of the recipient. The use of pharmaceutical claims, however, can fail to accurately identify health risk for many reasons, including the large-scale practice of off-label prescribing.

For this reason, 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 generally acquired through the use of an encounter data system. However, the AHCA does not currently collect enough patient-specific information (specifically regarding diagnoses) through its current fee-for-service claims system to establish an extensive risk-adjustment methodology. The AHCA is currently transitioning to an encounter data system, but do not anticipating full implementation by September 2009. Therefore, it will be several years before it is fully implemented and its data can be validated.

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

AHCA will use historical prescription drug claims as a proxy for diagnostic codes as a way to implement the risk adjustment in reform demonstration sites. The AHCA 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 will 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. These risk corridors were to be used for two years while implementing the pilot, and will be discontinued in September 2008.

III. Effect of Proposed Changes:

Section 1 amends subsections (8 and 9) of s. 409.91211, F.S., as follows:

Subsection 8 is amended to repeal language describing the two-year limit on the use of risk corridors. (This language is rewritten and moved to other sections of the bill)

Subsection 8(a) is created to require the agency to develop a methodology for calculating risk-adjusted capitation rates using comprehensive encounter data pursuant to subparagraph (3)(p)4. for all Medicaid services specified in the section. Prior to the implementation of the risk-adjusted capitation rate methodology, the agency must ensure that all of the following criteria are met:

- The agency has validated that the encounter data are accurate; have been screened for completeness, logic, and consistency.
- The agency has compiled no less than 1 year's worth of complete encounter data to permit the adjustment of capitation rates for health risk differences and has ensured, that the data are of sufficient integrity to be used for risk-adjustment purposes in accordance with actuarial standards of practice that are generally recognized as sound and appropriate.
- The agency has consulted with and sought input from the technical advisory panel regarding the development and implementation of the comprehensive encounterdata system.

Subsection 8(b) is created to require the agency to implement an interim risk-adjusted capitation rate methodology to be used before a fully functional encounter data system has been operating for 12 months. This allows the agency to continue using their current risk-adjusted methodology until the encounter data system is operational and a new risk-adjusted methodology is implemented.

Subsection (9)(a) is amended to insert the 10 percent risk corridor language that was removed from subsection (8). The subsection maintains the phase-in risk adjustment methodology for the first year of the pilot, where 75 percent of the calculation is based on the methodology used in s. 409.9124, F.S. and 25 percent of the calculation is based on the interim risk adjusting methodology.

Subsection (9)(b) is amended to revise the second year (September 1, 2007-August 31, 2008) of the interim risk adjustment methodology by reducing the percentage of the calculation that requires risk adjusted data from 50 percent to 33 percent and increases the percentage of the calculation based on s. 409.9124, F.S. to 67 percent, while maintaining the current 10 percent risk corridor.

Subsection (9)(c) is amended to revise the third year (September 1, 2008 – August 31, 2009) of the interim risk adjustment methodology, by repealing the requirement for a 100 percent risk adjustment calculation with no risk corridors, and replacing it with a requirement to base 33 percent of the calculation on risk adjustment and 67 percent with the methodology required under s. 409.9124, F.S., with a 12.5 percent risk corridor.

Subsection (9)(d) is created to add a fourth year (September 1, 2009-August 31, 2010), requiring the agency to use a risk-adjusting methodology where 50 percent of the calculation is based on comprehensive encounter data and 50 percent of the calculation is based on the methodology required in s. 409.9124, F.S. with a risk corridor of 15 percent.

Subsection (9)(e) is created to require the agency to reimburse managed care plans with a methodology that uses 100 percent comprehensive encounter data and risk corridors are eliminated.

Section 2 requires managed care organizations to pay noncontracted hospitals a reimbursement rate that is equivalent to the amount the agency would pay on a fee for service basis for services rendered to persons who are eligible for Medicaid, living within an area served by a Medicaid reform pilot program.

Section 3 provides that the bill takes effect July 1, 2007.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill extends the phase-in of the comprehensive risk-adjusted capitation model in Medicaid reform until after an encounter database is operational for at least 24 months. During the phase-in period, risk corridors based on the "aggregated weighted mean of all managed care plans" for "TANF and SSI" in reform area may limit payments to plans with high cost patients and overpay plans with low cost patients. Although the purpose of the risk corridors are to limit the fluctuation in capitation rates while encounter data is being developed, this may adversely affect the financial viability of some managed care plans with high-risk populations.

C. Government Sector Impact:

There is no direct impact to the state budget because of Medicaid reform waiver budget neutrality requirements.

VI. Technical Deficiencies:

None

VII. Related Issues:

None.

VIII. Summary of Amendments:

This Senate Professional Staff Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.