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 Policy Committee

BILL:	SB 1828
INTRODUCER:	Senator Fasano
SUBJECT:	The Medicaid Managed Care Pilot Program
DATE:	March 22, 2007
REVISED:	03/28/07

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

Please see last section for Summary of Amendments

- [X] Technical amendments were recommended
- [X] Amendments were recommended
- [ ] Significant amendments were recommended

I. Summary:

The bill repeals the current phase-in of the implementation of the risk-adjusted capitation methodology for plans participating in the Medicaid reform pilot in Baker, Broward, Clay, Duval, and Nassau Counties. The bill allows the Agency for Health Care Administration 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 and diagnosis system is in place. The bill requires the agency to develop a new methodology for calculating risk-adjusted capitation rates using a comprehensive encounter and diagnosis data system for all 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 percentage of the capitation rate that can be based on the new risk-adjusted methodology for each of the 6 years. Prior to the implementation of 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, requiring them to be used indefinitely, and requires that any risk-adjusted capitation paid by the agency be based on an aggregate risk score in accordance with this section as revised

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 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.

---

[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)

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 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.

[5] S. 409.9124, F.S.

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, however, it will be several years before it is fully implemented and its data can be validated. 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 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 subsection (8) of s. 409.91211, F.S.

Paragraph (a) requires the agency to develop a methodology for calculating risk-adjusted capitation rates using comprehensive encounter and diagnosis data pursuant to subparagraph (3)(p)4. for all acute Medicaid services. Prior to the implementation of the risk-adjusted capitation rate methodology, the agency shall ensure that all of the following criteria are met:

- Agency staff is sufficiently educated and trained regarding issues and methods related to compiling encounter data to implement and maintain the Florida Medicaid encounter data system.

- The Florida Medicaid Management Information System has the capacity to house, maintain, and manage the anticipated volume of encounter data records that will be produced.

- The agency has ensured that the encounter data system is secure, protects personal health information, and is in compliance with 45 C.F.R. ss. 160.102, 160.103, and 164, subpart A, commonly referred to as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation.

- The agency has implemented a validation system to ensure the encounter data is accurate; has been screened for completeness, logic, and consistency; and is standardized to facilitate the use of various models for the payment of claims and submission of data.

- The agency has compiled no less than 1 year's worth of complete encounter and diagnostic data to permit the adjustment of capitation rates for health risk differences and has ensured, through validation by an independent actuary, 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 the technical advisory panel regarding the development and implementation of the comprehensive encounter and diagnosis data system and sought input from the panel.

- The risk-adjusted capitation rates have been certified by an independent actuary and approved by the Centers for Medicare and Medicaid Services.

Paragraph (b) repeals the two-year limit on the use of risk corridors, requiring them to be used indefinitely, and requires that any risk-adjusted capitation paid by the agency be based on an aggregate risk score in accordance with this section as revised.

Paragraph (c) allows the agency to implement an interim risk-adjusted capitation rate methodology to be used before a fully functional encounter and diagnosis data system has been in operation for no less than 12 months pursuant to paragraph (a) in this subsection. If the agency implements an interim methodology, the capitation rates during the interim period shall be weighted so that 75 percent of each capitation rate is based on the methodology developed under s. 409.9124, F.S., and 25 percent is based on the interim risk-adjusted capitation rate methodology. 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.

Amends subsection (9) of s. 409.91211, F.S., to repeal the current phase-in of a risk-adjusted methodology and requires that only after a fully functional encounter and diagnosis data system has been in operation for no less than 12 months, risk-adjusted capitation rates for plans participating under this section shall be phased in, and this phase-in schedule shall be applied anew, in its entirety, in any county in which the risk-adjusted capitation rate methodology is implemented, as follows:

- For managed care plan contracts taking effect in the first and second state fiscal years after a fully functional encounter and diagnostic data system has been in operation for no less than 12 months, the capitation rates shall be weighted so that 75 percent of each capitation rate is based on the methodology developed under s. 409.9124, F.S., and 25 percent is based on the risk-adjusted capitation rate methodology developed under subsection (8), as revised.

- For managed care plan contracts taking effect in the third state fiscal year after a fully functional encounter and diagnosis data system has been in operation for no less than 12 months, the capitation rates shall be weighted so that 70 percent of each capitation rate is based on the methodology developed under s. 409.9124, F.S., and 30 percent is based on the risk-adjusted capitation rate methodology developed under subsection (8), as revised.

- For managed care plan contracts taking effect in the fourth state fiscal year after a fully functional encounter and diagnostic data system has been in operation for no less than 12 months, the capitation rates shall be weighted so that 50 percent of each capitation rate is based on the methodology developed under s. 409.9124, F.S., and 50 percent is based on the risk-adjusted capitation rate methodology developed under subsection (8), as revised.

- For managed care plan contracts taking effect in the fifth state fiscal year after a fully functional encounter and diagnostic data system has been in operation for no less than 12 months, the capitation rates shall be weighted so that 25 percent of each capitation rate is based on the methodology developed under s. 409.9124, F.S., and 75 percent is based on the risk-adjusted capitation rate methodology developed under subsection (8), as revised.

- For managed care plan contracts taking effect in the sixth state fiscal year after a fully functional encounter and diagnostic data system has been in operation for no less than 12 months, the risk-adjusted capitation methodology may be fully implemented.

Section 2. 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 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.

C. Government Sector Impact:

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. Calculating the 10 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 reform plan to another, including shifts from high cost reform counties to low cost counties. This may ultimately lead to some managed care plans operating in high-cost areas with high-risk membership to stop participating in the reform pilot.

The bill requires the AHCA 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 full time equivalents (FTEs) with associated information technology

equipment, as well as travel expenditures. The total for this would be $262,581 in FY 2007-08 and $250,131 in FY 2008-09. The validation system would initially require contractual arrangements with a third-party vendor at an estimated cost of $500,000 for each fiscal year. Total cost would be $762,581 ($346,741 in General Revenue) for FY 2007-08 and $750,131 ($340,516 in General Revenue) in FY 2008-09.

VI. Technical Deficiencies:

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. For this reason, it is recommended that line 26 on page 1 be deleted and the following inserted:

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

VII. Related Issues:

None.

VIII. Summary of Amendments:

Barcode 214694 by Health Policy:
This is a technical amendment clarifying that the risk-adjustment methodology relates to all Medicaid services specified under the Medicaid managed care pilot program.

Barcode 230330 by Health Policy:
This amendment reinstates current statutory language that specifies that the overall risk score for a Medicaid reform plan may not deviate by more than 10 percent from the mean of all plans in a Medicaid reform area.