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Executive Summary

The 2008 Legislature amended Section 409.908, Florida Statutes, relating to Reimbursement of Medicaid Providers, to create subparagraph 409.908 (23)(c), which specified the creation of workgroups to focus on the methodology in which Medicaid reimbursement is determined for certain provider types. With the creation of this language, the Agency for Health Care Administration (Agency) established the required Workgroups as specified under Section 409.908 (23)(c), Florida Statutes.

409.908 (23)(c) The Agency shall create a Workgroup on the hospital reimbursement, a Workgroup on nursing facility reimbursement, and a Workgroup on managed care plan payment. The Workgroup shall evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans, including prospective payment methodologies for hospitals and nursing facilities. The nursing facility Workgroup shall also consider price-based methodologies for direct and acuity adjustments for direct care. The Agency shall submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and House of Representatives by November 1, 2009.

The Agency requested nominations for Managed Care Reimbursement Workgroup members and appointed five members. Members are directly related to participating plans within the Florida Medicaid program. The Agency, as facilitator and staff for the Workgroup, created and submitted a charter to the Workgroup at the first meeting. The Workgroup adopted the charter, which specified purpose and scope, as the basis and direction of the Workgroup. (See Appendix A.)

During the initial meetings of the Workgroup, the Agency provided an overview of the Medicaid program and specific information related to the managed care services budget and current reimbursement methodology.

For State Fiscal Year 2009-10, the Medicaid program has an appropriation of $17.5 billion, of which $2.8 billion is appropriated for services provided through capitated managed care plan providers. As of September 1, 2009, there were 22 managed care plans participating in the Florida Medicaid program under both the 1915(b) Managed Care Waiver (non-Reform) and the 1115 Medicaid Reform Waiver (Reform). The plans included 17 capitated plans (16 HMO and one Provider Service Network (PSN)) and five fee-for-service (FFS) based PSNs. The 22 participating plans serve approximately 1,105,094 (1,002,499 capitated and 102,595 FFS) Medicaid recipients as of September 2009. Recipients enrolled in MediPass are not captured in these numbers.

The Workgroup focused on actuarially sound reimbursement for capitated managed care plans that serve as general health plans under Florida Medicaid as required by 42 Code of Federal Regulation (CFR) 438.6 (c) and consistent with the federal Centers for Medicare and Medicaid Services’ (CMS) rate setting checklist as revised July 22, 2003, or as subsequently revised.
Capitated managed care plans that participate in the Florida Medicaid Program are reimbursed in accordance with sections 409.9124 and 409.91211, Florida Statutes. The reimbursement for services provided to enrollees of FFS based plans is approved under the Medicaid state plan. The reimbursement for Nursing Home Diversion and Prepaid Mental Health plans were outside of the scope of the Workgroup.

The current reimbursement methodology for Medicaid capitated managed care plans is a FFS based prospective method. It uses historical paid claims data for populations eligible for managed care to establish the base for the capitation rates. The rates are then adjusted for inflation to establish capitation rates for subsequent rate periods.

General discussion of the current reimbursement methodology occurred throughout all Workgroup meetings with specific focus on the base data source and issues of concern related to reimbursement and the direction of the Workgroup. There was a general consensus among Workgroup members that consideration could be given to the use of alternative methodologies for establishing capitation rates for the managed care program within Florida Medicaid.

**Issues of Concern Related to the Current Reimbursement Methodology**

The members of the Workgroup identified issues of concern related to the continuation of the current methodology. Members expressed concern that, without modification, the current methodology could create negative outcomes for the managed care plans in the future. This could result in a reduction of participation of both plans and recipients of managed care within the Medicaid program. The following are the topics that received significant focus during the workgroup meetings as issues of concern related to the current method:

- Use of historical FFS data as base data for the rate setting methodology used to calculate Medicaid managed care plan capitation rates.
- Application of the 8% discount factor to adjust FFS claims base to account for the transition into a managed care environment.
- Use of a statewide inflation factor against the base data to project forward to the prospective payment period.
- Use of a single base methodology with differing adjustments for program policies or populations specific to the Reform or non-Reform managed care programs.

**Goals and Alternatives**

The Workgroup achieved a consensus that the primary goal of the Workgroup is to identify alternative data sources that could be used as base data to maintain an actuarially sound capitated managed care rate methodology and provide direction to the most ideal data source and methodology. The path to an ideal source and methodology should be a process that is transparent, data driven, and allows for collaboration of involved parties—the Agency and industry participants.

The Workgroup identified a transitional alternative that would use data from three data sources, --FFS data, plan financial data, and encounter data—to establish the base for capitated rate setting. Health plan reported financial data could serve as a bridge during a transition from the use of FFS data to the use of encounter and FFS data. The alternative would institute the use
of expanded or detailed financial reports from participating managed care plans as well as adjustments to the current methodology used to establish the capitated rates paid to the plans.

The transitional alternative would 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.

Closing Comments

The transitional alternative described above is a phased and blended approach that uses all three data sources--fee for service data, plan financial data, and encounter data--to establish the base for capitated rate setting. The method would address the issues identified above as areas within the current methodology that need improvement. It is anticipated that the transitional alternative would be used as a method each year, modified as needed, until the encounter data source is available to be used as a basis for the rate setting methodology.

In addition, the method and sources described above are consistent with processes and data sources found in other states. Contracted actuarial staff who participated in the Workgroup meetings as well as some Workgroup members are familiar with and have experience developing and implementing such rate changes in other states.

Additional details relating to the issues, goals and alternatives are discussed later in this report.
Workgroup Overview

The Agency for Health Care Administration (Agency) Workgroup on Medicaid Managed Care Reimbursement was established under the authority of Section 409.908 (23)(c), Florida Statutes.

The responsibilities of this Workgroup were to evaluate, based on the above statute, alternative reimbursement and payment methodologies for Medicaid managed care plans. Based on this evaluation, the Agency developed this report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup evaluated and reported only on those health programs funded through the Florida Medicaid program. Discussions not covered by the description above (reimbursement and payment issues) are outside the scope of the Workgroup and were not to be included as topics of discussion.

This Workgroup consisted of five members appointed by the Deputy Secretary for Medicaid, based on the statute listed above. Agency staff served as facilitator and resources for, but not members of, the Workgroup.

Members of the Workgroup were:

**HMOs:**

- Thomas Wilfong  
  Chief Operating Officer  
  Amerigroup

- Alberto Arca  
  Chief Financial Officer  
  Preferred Medical Plan

- John Kaelin  
  Senior Vice President  
  State Program Development  
  AmeriChoice: A UnitedHealth Group Company

**PSNs:**

- Michael Lawton  
  Vice President, Managed Care and Network Development  
  Shands HealthCare

- Joe Rogers  
  Senior Vice President, Business Development/Managed Care  
  North Broward Hospital District
The duties of the Workgroup included the following:

1. Evaluation of alternative reimbursement and payment methodologies for Medicaid managed care including prospective payment methodologies.

2. Report findings to the Deputy Secretary for Medicaid as to the outcome of their fact finding.

The Workgroup met six times between January 2009 and September 2009 in order to accomplish the duties outlined above. Agency staff worked with members to develop supporting documentation of items for each meeting. All documentation and minutes of each meeting are posted online at:

http://ahca.myflorida.com/Medicaid/quality_management/workgroups/mcr_meetings.shtml

Please refer to Appendix A – Workgroup Charter for complete details of Workgroup membership, duties, meetings, etc.
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Florida Medicaid Overview

The Medicaid program is a state administered program that is funded by both the Federal Government and the state of Florida. There are federal requirements that must be met, and those are specified in the Florida State Plan as approved by the Centers for Medicare and Medicaid Services (CMS). There are mandatory and optional eligibility groups and service categories. In State Fiscal Year 2009-10, Florida Medicaid was appropriated $17.5 billion in funds. The federal share of funding is 67.64%, while the state share is 32.36%. Forty-five percent of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled, Low Income Pool and Disproportionate Share Payments. About 7% of expenditures are for prescribed medications. (See Figure – 1.)

Florida’s Medicaid budget is the fifth largest in Medicaid expenditures nationwide. There are 16 mandatory services that must be provided under the Medicaid program. These services account for a little over 41% of current year expenditures. Florida also provides 30 optional services, which account for almost 59% of current year expenditures. The Federal Medical Assistance Percentage (FMAP) is used in determining the amount of federal matching funds for state’s expenditures under the Medicaid program. Over time, Florida’s FMAP has generally been declining, except that the American Recovery and Reinvestment Act (ARRA) (Public Law 111-5) provided state fiscal relief for Medicaid funding for the period October 2008 through December 2010. During this time, Florida is receiving the enhanced Federal Medicaid Assistance Percentage (FMAP).

Figure - 1

Medicaid Expenditures by Section

The Medicaid budget for Managed Care Plans is $2.8 billion for State Fiscal Year 09-10. Over the past few years, there have been multiple legislative adjustments made to the Medicaid managed care reimbursement such as rate reductions. In addition to legislative changes that are specific to the reimbursement of the capitated managed care rates, policies and rate changes for services under the non-managed care Medicaid environment have been implemented. The changes that impact services that are identified as services covered under managed care contracts also directly impact the managed care plan administration and
reimbursement. For example, the coverage of adult vision policies has changed recently. This change is for a service that is covered under managed care. Therefore, the Medicaid managed care capitation rate is adjusted to reflect the change to the fee-for-service coverage. During the most recent legislative session, a reduction in the Medicaid managed care plan rate was authorized. However, due to the inability to achieve actuarial certification with the reductions, the reductions were not taken. The Agency worked closely with the actuaries and other parties involved and made necessary adjustments to the calculated rates to achieve certification. The Agency will continue to work with the actuaries and others to prepare for future rate setting periods.
Introduction

As of September 1, 2009, there were 22 managed care plans participating in the Florida Medicaid program. The current budget for Medicaid managed care is $2.8 billion.

Managed care plans that participate in the Florida Medicaid Program are reimbursed in accordance with section 409.9124, Florida Statutes.

There are currently two methodologies for calculating Medicaid managed care capitation rates: one for areas of the state that operate under the 1915 (b) Managed Care waiver (Non-reform) and the second for areas that operate under the 1115 Medicaid Reform waiver (Reform). The non-Reform rate methodology has been used for many years and has experienced very few significant changes since its inception. The Reform rate methodology uses the same base data and inflation factors as the non-reform but is adjusted in different areas to account for differences in the programs.

Medicaid Managed care rates are set once per year effective September 1. The Bureau of Medicaid Program Analysis within the Florida Division of Medicaid is the lead bureau for rate setting. The bureau contracts with actuarial firms for the certification of rates. Milliman is the contracted actuary for the non-Reform programs and Mercer is the contracted actuary for the Reform program. The bureau calculates draft rates and submits requests for certification of the draft rates to Milliman and Mercer. The authority for establishing capitated managed care rates is section 409.9124, Florida Statutes, relating to Managed Care Reimbursement, which requires the Agency to develop and adopt by rule a methodology for reimbursing managed care plans applying the use of fee-for-service (FFS) expenditures, actuarially sound rates for comparable recipients, compliant with federal laws and regulations, and which reflects changes based on removal of prior year adjustments that are not appropriate or for policies that have not been implemented.

The claims data used is the Medicaid FFS and PSN FFS utilization data (exclusions apply based on services). Two complete years of data is used as the base of the rate calculation. Inflation factors are calculated to be used to inflate the historical data to the current budget.

Capitated Rates are based upon:

- 25 service categories (e.g. hospital inpatient, lab, x-ray, prescribed medicine, etc.);
- Prescribed medicine is computed net of rebates;
- A series of adjustments specific to:
  - Claims incurred but not reported,
  - Third party liability claims, and
  - Area discount factors.
Elements specific to the Medicaid Reform pilot program capitation rate methodology are:

- Risk Adjustment.
- Kick Payments.
- Enhanced Benefits.

Service Areas are composed of the following counties:


Service Area 5. -- Pasco and Pinellas Counties.

Service Area 6. -- Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

Service Area 7. -- Seminole, Orange, Osceola, and Brevard Counties.

Service Area 8. -- Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

Service Area 9. -- Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

Service Area 10. -- Broward County.

Service Area 11. -- Monroe and Miami-Dade Counties.

Eligibility Group with Age/Gender Bands

**TANF/AFDC**

Months 0-2  
Months 3-11  
Years 1 - 5  
Years 6 - 13  
Years 14 - 20 Male  
Years 14-20 Female  
Years 21-54 Male  
Years 21-54 Female  
Years 55 and over

**SSI - no Medicare**

Months 0-2  
Months 3-11  
Years 1 - 5  
Years 6 - 13
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Years 14-20
Years 21-54
Years 55 and over

SSI Medicare Part A and B

Under 65 years
65 years and over

SSI Medicare Part B only

All ages combined

Current Methodologies:

The current methodology for the non-Reform managed care rate setting is provided in Rule through the Florida Administrative Code (59G-8.100, FAC).

Additional detail of the method and adjustments for the non-Reform and Reform managed care rates can be found in the Actuarial Certification Reports provided annually by the actuarial firms.
Findings and Issue Identification

The Workgroup on Medicaid Managed Care Reimbursement met six times during the period of January 2009 through September 2009. During the meetings, the Workgroup discussed the purpose and goals of the Workgroup and reached consensus regarding potential changes to the Medicaid managed care reimbursement methodology.

The Workgroup identified issues where improvement to current Medicaid reimbursement policy, discussed in the previous section, could be made. The following issues were than raised and discussed by the Workgroup during the course of its deliberations. Only those issues which are prime for consideration of policy modification are included in this report.

General discussion of the current methodology occurred throughout all Workgroup meetings with specific focus on the base data source and issues of concern related to reimbursement and the direction of the Workgroup. There was a general consensus among Workgroup members that the current reimbursement methodology is no longer the most appropriate method for establishing capitation rates for managed care plans.

Issues of Concern Related to the Current Reimbursement Methodology

The members of the Workgroup identified issues of concern related to the continuation of the current methodology. Members expressed concern that without modification, the current methodology could create negative outcomes for the managed care plans in the future. This could result in a reduction of participation of plans and enrollment of recipients of managed care within the Medicaid program. The following are the topics that received significant focus during the Workgroup meetings as issues related to the current reimbursement methodology:

- Use of fee-for-service data as base.
- Discount factor.
- Statewide inflation factor process.
- Varying methods for plan and contract type:
  - Non-reform.
  - Reform.
  - PSN and other FFS based plans.

Fee-For-Service Base Data Source:

With the implementation of mandatory enrollment into managed care in some counties and a growing managed care enrollment in others, there is a consensus that sufficient recent FFS data is no longer available to support the financial base. Indeed, the CMS actuarial soundness regulation and corresponding check list provides guidance on the sources of base data and states that the data should be appropriate for the Medicaid population. This is the primary concern related to the current methodology as it does not include data directly related to the services provided to the enrolled recipients of managed care plans. The FFS data does not account for actual utilization or claims data that are specifically for recipients enrolled in the managed care plan. Therefore, the method assumes that the population served through the FFS environment is reflective of that served through capitated managed care plans. Without actual data for the enrollees, there is potential for not capturing trends that may be only attributable to the population enrolled in capitated plans.
The workgroup requested that the Agency work with the actuaries to identify pros and cons of using an FFS base for reimbursement as well as to provide alternative data sources and best practice information regarding capitated reimbursement programs about which the actuarial firms had experience or knowledge. (See Appendix B for created list and Appendix C for additional detail.) Consistent with the Actuarial Soundness Regulation and check list, three sources were identified: FFS data, plan financial data, and Encounter data.

1) Fee-For-Service data is reflective of the costs incurred by the state for services provided to recipients. Florida has used this data as the base for rates since the inception of managed care. Changes in enrollment, utilization and policy changes can be identified and tracked. However, the claims are for recipients and services provided outside capitated managed care enrollment.

2) Plan financial data is aggregate data that is specific to the plans’ Medicaid managed care product and provides insight of costs and trends experienced by all managed care plans. This data source allows for the methodology to capture the expenses incurred for the population enrolled in the plans in aggregate.

3) Encounter data is claim-specific data that is provided by the plan for services provided to recipients enrolled in the plans. The Agency resumed collecting plan encounter data on a statewide basis in July 2009. However, this data will require a thorough analysis and validation, some of which is already occurring, before it can be relied upon as the primary source of base data for rate setting.

The actuaries stated that having the most current data available was key to any method of rate setting. Adjustments will be required for any method chosen as the base. However, fewer adjustments are required if the base data appropriately and directly reflects the claims and population served through managed care programs. Please see attached document provided by Mercer (Appendix C).

General consensus of the Workgroup is that all three data sources provide the basis for valid rate setting methodology. However, establishing a capitated managed care reimbursement methodology utilizing encounter data as the base data source which incorporates supplemental financial data and FFS data would be an ideal methodology. The Workgroup also addressed the timeline and concerns of adopting and implementing an ideal methodology in the immediate future. A transitional alternative method would be needed to bridge the conversion from an FFS data based methodology to achieving the ideal Encounter data based methodology. The implementation of a transitional alternative would allow for some of the issues with the current methodology to be addressed via the use of plan financial data.

Discount Factor:

A second issue relates to the discount factor and the application under the current methodology. The discount factor was established to adjust the FFS claims base to account for the expected decrease in utilization of services due to increased care management that would occur with the transition to managed care. The general assumption is that there is an estimated 8% savings due to transitioning a recipient from a FFS environment to a managed care program. The assumption of the discount that can be achieved is based on demographics and utilization. Due to these variables, the resulting discount must be adjusted to account for differences found in areas of the state. Therefore, the discount factor is applied at a percentage less than 8% for specific areas of the state where maximum savings cannot be achieved.

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Discount Factors by Service Area and Eligibility Category (non-Reform)

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<th>SSI- Medicare Part A and B</th>
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The analysis that was used to establish the discount factors is dated and has not been updated as a whole since the original implementation in the late 1990s. Since the implementation of the discount factor, many cost effective measures, programs and other changes have been implemented. A significant change is the implementation of FFS based managed care plans such as Minority Physician Networks (MPN) and Provider Service Networks (PSN). These programs provide managed care, however, the contractual risk factors and payment method is not the same as that for a capitated plan. The data that is used as the base data source (FFS) is made up of claims that are for those for whom FFS was paid for recipients not enrolled in FFS managed care as well as those claims for recipients enrolled in FFS managed care plans.

The rational for the use of a discount factor is to adjust for the anticipated change in expenditures as a result of transitioning a population from a FFS environment to a capitated managed care environment. Implementation of an encounter data based methodology would minimize the need for a specific discount factor as the data used would represent a population already transitioned to a managed care environment. A general consensus that the discount factor should be analyzed was achieved during the workgroup meetings. The Agency has begun discussions with staff of the contracted actuarial firms regarding an updated analysis.

Inflation Factor:

A third issue relates to the statewide utilization and unit cost inflation factor process. Under the current methodology, the base data is projected forward to the prospective payment period using inflation factors specific to each of the 25 service categories. A statewide inflation factor is calculated for each service to align the base data with the approved General Appropriations Act (GAA) for the prospective payment period. The Workgroup expressed the concern that applying the inflation factors equally statewide assumes that all areas of the state have and will be impacted equally by changes driving the inflation factors when actual changes and impacts may differ by area of the state.
The assumptions of the Medicaid Social Services Estimating Conference (SSEC) are used as a basis for inflation projections for each of the 25 services included in the rate methodology. The SSEC estimates are projected and tracked on a service level and do not account for area or facility specific changes. Therefore, changes in projections or expenditure trends are seen on an aggregate basis. There is currently no method or basis for utilization and unit cost inflation factors to be applied in any manner other than on a statewide basis. The inclusion of financial data and/or encounter data would address concerns related to the inflation factors.

Varying Methods for Plan and Contract Type:

Currently there are different rate calculation methods for the Reform and non-Reform programs. However, the financial reports that are submitted for the participating managed care plans are reported for the plan as a whole and do not provide detailed information for the different programs. Therefore, the current financial reports submitted to the Agency will not suffice as a source of base data for capitated managed care rate setting purposes.

Another issue relates to the varying reimbursement methods for plan and contract type. Managed care plans may participate in Florida Medicaid as a capitated non-Reform or Reform plan or an FFS based non-reform or Reform plan. Reform plans are authorized and participate under the 1115 Medicaid Reform Demonstration waiver and the Non-Reform plans are authorized and participate under the 1915(b) Managed Care waiver. The types of plans are as follows:

- Non-Reform HMO
- Reform HMO
- Reform PSN (Capitated or FFS)
- Non-Reform PSN (Capitated or FFS) and other FFS based plans

Goals and Alternatives

The Workgroup achieved a consensus that the primary goal of the Workgroup is to identify alternative data sources that could be used as base data to maintain an actuarially sound capitated managed care rate methodology that would provide direction to the most ideal data source and methodology. The path to an ideal source and methodology should be a process that is transparent, data driven, and allows for collaboration of involved parties—the Agency and industry participants.

During the discussions related to the issues of concern with the current managed care reimbursement methodology, areas of focus were identified that could be used to develop alternatives or modifications to the current method that would address the issues. These areas of focus are as follows:

- Base Data Source (Please see Appendix B and C):
  - Fee-For-Service paid claims.
  - Financial data and reports submitted by plans.
  - Encounter data claims.
- Application of base data source.
- Adjustments to base data source.
- Timeline for conversion of base data source.
Medicaid Managed Care Reimbursement Workgroup Report

- Statewide Risk adjustment.
- Statewide Carve outs/ Kick payments.

Identified Transitional Alternative:

Assuming the capitated managed care reimbursement methodology base data source was to change from FFS based to encounter based, the process would not be immediate. Health plan reported financial data can serve as a bridge or transitional alternative during the transition from the use of FFS data to encounter data (See Figure 2). The alternative would institute the use of expanded or detailed financial reports from participating managed care plans as well as adjustments to the current methodology used to establish the capitated rates paid to the plans.

**Figure 2**

The following steps outline the alternative identified by the Workgroup through its deliberations:

**Step 1: Identifying base data source**

The transitional alternative method would continue the use of two years of historical data. However, the data that would be used would be FFS based as well as financial data reported by the plans. Encounter data will be phased into the transitional alternative as valid testing and milestones are met. A standardized financial report for participating managed care plans would be submitted to the Agency for the base period that provided data at a level that provided details of services, expenditures, population, for the business line that could be used for rate setting purposes. This detail is much greater than the current reporting standards for financial data that the industry is required to submit to the Agency. Additional benefits of detailed financial reporting would allow for the Agency and other interested parties to see indicators related to the business line and performance of the plan which are not available today.

**Step 2: Application of base data source**

Due to the nature of Florida Medicaid rate setting and the limitations of available data sources, the application of a base data source cannot be a predetermined process. The Agency is currently receiving and testing plan submitted encounter data. Additional tests and milestones are required before the Agency or actuaries can determine the validity, completeness and
soundness of the encounter data to be used for rate setting purposes. The Agency will continue to receive and test the data which will be incorporated into the rate setting process at levels that maintain an actuarially sound method for reimbursement.

The choice and use of each data source should be determined based on the availability and validity of the data. Assuming all three data sources as described above are available, the validity of each may vary. Therefore, a blending of the available sources should be considered. The introduction of financial data as described above can serve as a test source and add perspective of the FFS and encounter data sources to identify major differences or shifts across data sets.

**Step 3: Adjustments to base data source**

Regardless of the method chosen as the base data source, the available data will represent a period of time in the past and therefore should be adjusted to account for trends and inflation required for a prospective payment. Adjustments could be based on policy changes, benefit changes, plan financial data, or trends identified that are specific to managed care enrolled recipients.

The FFS data will be adjusted for any differences in population demographics, geographic cost and utilization variation, or eligible services. Such adjustments should be data driven and achievable by the majority of health plans in a Medicaid managed care setting. These adjustments will be determined through a contracted actuarial review comparing the FFS data to the plan-reported financial data and other actuarial valuation techniques applicable to a similarly situated Medicaid population. A review of regional variations in unit cost and utilization should be conducted periodically by a contracted actuary to determine what regional grouping of counties should be used to establish the managed care rates.

After encounter data is available to replace FFS data as the data base, the encounter data may need to be adjusted based on plan reported financial data or other sources to ensure the encounter data fully reveals all health care activity and reflects health care cost components not fully reported in encounter data such as claim adjustment activity and incurred but not reported claims (IBNR).

**Step 4: Additional Adjustments:**

Since the base data is established from historical data, the unit cost and utilization is currently, and should continue to be trended forward to the prospective payment period. Trends should be valid and comply with requirements of the state as well as maintain an actuarially sound methodology for rate setting.

Health plan administration is another variable for the methodology. The rate methodology should provide adequate funding to perform contracted Medicaid managed care functions and allow appropriate risk and contingencies including cost of capital. Administration, risk and contingencies load should be targeted at a level that maintains an actuarially sound rate methodology.

**Step 5: Statewide Risk adjustment**

Risk adjustment is not a reimbursement method in itself. It is a component of a reimbursement methodology for distributing adjusted capitation payments based on risk factors and health
indicators for the population as a whole being served and managed by a plan. The higher the average the risk for the population, the larger the adjustment to increase the capitation rate should be. However, if the risk is lower than the average, the capitation should be reduced. Risk adjustment should not be used as a method to solve reimbursement concerns or inefficiencies when the base data source is the driving factor for the inefficiencies. In addition, specific goals should be analyzed and set prior to implementing the use of risk adjustment. Risk adjustment is currently, and should continue to be, based on aggregate plan enrollment and not at the individual enrollee level.

The Reform plans are currently subject to risk adjusted rates, but the non-Reform plans are not. A composite rate is established for the Reform areas and is adjusted to account for risks that the plan enrollees bring to the plan. Risk adjustment is based on demographics as well as individual medical conditions. For non-Reform, area differentials are established to account for age and gender but individual conditions are not accounted for based on plan enrollment.

The Workgroup achieved a consensus that the use of risk adjustment contributes to appropriate rate reimbursement. However, the base data is a priority prior to the application of risk adjustment.

**Statewide Carve outs / Kick payments**

The reimbursement process for Reform plans currently allows for individual payments made in addition to capitation payments, known as kick payments, for labor and delivery and for transplants. Specialty rates for the HIV/AIDS population are also established. There may be other populations for which it may be appropriate to establish specialty rates or kick payments. The workgroup achieved a consensus that the use of specialty rates and kick payments contribute to appropriate rate reimbursement. However, the base data is a priority prior to application.

**Timeline for conversion of base data source**

Currently the Agency only has FFS data available as a valid source of data. States that have converted to use of encounter data, including Florida for the Prepaid Mental Health Plans and Nursing Home Diversion programs, have required several years before the data was at a level where the reimbursement methodology could be based on the encounters as the sole source for base data.

Plan financial data reports are not available to the state in the detail that would be needed to use as a data source for rate setting. However, changes and collection of financial data can be achieved much more quickly than encounter data, and the Workgroup deliberations illustrated that plan financial information could be reported within one year. The transitional alternative described above could be implemented for the rate setting period following the adoption and submission of the described financial data source.

Through the Workgroup deliberations and discussions on creating and submitting health plan financial reports, there was a consensus that such a process could be in place within one year to support a new rate setting method. Likewise, the process changes described in this report, notably a transparent and data driven rate method, could also be implemented within a similar time frame (See Figure 2).
Closing Comments

The transitional alternative described in this report is a phased and blended approach that uses all three data sources--fee for service data, plan financial data, and encounter data--to establish the base for capitated rate setting. The method would address the issues of concern identified as areas within the current methodology that need improvement. It is anticipated that the transitional alternative would be used as a method each year, modified as needed, until the ideal encounter data source is available to be used as the primary basis for the managed care rate setting methodology.

In addition, the method and sources described above are consistent with processes and data sources found in other states. Members of the Workgroup as well as contracted actuarial staff who participated in the Workgroup meetings are familiar with, and some have actual experience, developing and implementing such changes in other states.
**Glossary**

**Area Discount Factors** - An adjustment to the Fee-for-Service claims base to account for the expected decrease in utilization of services due to increased care management that would occur with the transition from fee-for-service care to managed care.

**Carve-outs** - Groups of individuals or services which will not be a part of a managed care plan or will be paid under a different arrangement.

**Encounter Data System** – Also known as the Medicaid Encounter Data System (MEDS), which has been designed to collect, process, store, and report on managed care service activities and prescription drug utilization for all Florida Medicaid capitated health care providers and support specific information requests.

**Fee-for-Service (FFS) reimbursement** – Method of reimbursing Medicaid providers for every Medicaid eligible service rendered to the recipient.

**Capitated reimbursement** -- Under the managed care plan method, a managed care plan receives a monthly capitated payment for each Medicaid recipient enrolled in the plan and is responsible for ensuring that the enrollees have access to a comprehensive range of medical services.

**IBNR: Incurred but not reported** – A rate setting adjustment that reflects an estimate of claims that will be paid after the state fiscal year of data is summarized, which is six months after each state fiscal year.

**Kick payments** – A lump sum payment made to Medicaid Reform health plans for select organ transplants and obstetrical delivery services rendered to recipients. A kick payment is paid in addition to the capitated per member per month rate.

**Non-Reform** – Refers to the managed care plans operating outside the Reform counties (see Reform) under the 1915(b) federal waiver.

**Reform** – Through a federal waiver, Florida is conducting a managed care pilot in Broward, Duval, Baker, Clay and Nassau counties. Some characteristics of this program include an Opt Out program, Enhanced Benefits program and enhanced choice counseling. This pilot operates under an 1115 Research and Demonstration Waiver.

**Risk Adjustment** – The process of adjusting capitation payments to Medicaid managed care organizations (MCOs) to reflect cost differences resulting from their recipients’ health conditions.

**Third Party Liability (TPL)** - Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State Plan. The Medicaid program by law is intended to be the payer of last resort, that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
Appendices

Appendix A

Workgroup on Managed Care Reimbursement

This body shall be known as the Agency for Health Care Administration (Agency) Workgroup on Managed Care Reimbursement and is established under the authority of Section 409.908 (23)(c), Florida Statutes.

Purpose/Scope

The responsibilities of this Workgroup shall be to evaluate, on behalf of the Agency, alternative reimbursement and payment methodologies for managed care. Based on these evaluations, the Agency will develop a report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup will evaluate and report only on those health programs funded through the Agency.

Discussions not covered by the description above (Reimbursement and Payment Issues) are outside the scope of the Workgroup and will not be included as topics of discussion. This Workgroup will not include discussion of pre-paid plans or carve outs from the Medicaid state plan.

Membership

- The Workgroup shall be composed of five members appointed by the Deputy Secretary for Medicaid. Three members will represent the HMOs and two members (one from North Florida, one from South Florida) will represent the PSNs.

- Agency staff will be the Facilitator and resources for, but not members, of the Workgroup.

- Members of the Workgroup shall be appointed by the Deputy Secretary for Medicaid to serve a term of one year, or until all information for the aforementioned report is obtained.

- Resignation/Vacancies:
  - A member wishing to resign prior to the end of his/her term shall submit a letter of resignation to the Agency Facilitator of the Workgroup and the Deputy Secretary for Medicaid. The Deputy Secretary for Medicaid shall fill each vacancy on the Workgroup for the balance of the unexpired term, if appropriate. Priority consideration must be given to the appointment of an individual whose primary interest, experience, or expertise lies with clients of the Agency.
  - Nominations for member vacancies will be submitted to the Agency Facilitator of the Workgroup. If an appointment is not made within 120 days after a vacancy occurs on the Workgroup, the vacancy may be eliminated at the will of the Agency.
• The Agency shall appoint a Facilitator of this Workgroup. The term of the Facilitator shall be for one year, or until the Workgroup is disbanded. The Facilitator will be an employee of the Agency and selection is at the discretion of the Deputy Secretary for Medicaid.

• Four members shall constitute a quorum.

Duties of the Workgroup

The Workgroup’s fact finding should be limited to those health programs funded through the Agency for Health Care Administration. The Agency will author a report on the workgroup’s findings and retains control of its content.

The duties of the Workgroup shall include the following:

1. Evaluation of alternative reimbursement and payment methodologies for managed care including prospective payment methodologies.

2. Report findings to the Deputy Secretary for Medicaid as to the outcome of their fact finding.

Meetings

• The Workgroup shall meet at least quarterly or upon request of the Facilitator or the Deputy Secretary for Medicaid. The length of each meeting will be three hours, or whatever is agreed upon by the Facilitator and the members of the Workgroup.

• Meeting materials shall be coordinated through the Facilitator. The Facilitator will work with the individual members to develop an agenda that is inclusive of their related topics; however the Agency will retain control of the final contents of the agenda. Staff will work with members to develop supporting documentation of their items for each meeting.

• As part of the agenda, technical resource persons may present information to the Workgroup.

• Audience participation shall be limited to attendance. The Workgroup meetings will not be open for public comment. However, items for the Workgroup’s agenda can be submitted to the Facilitator for consideration by the Agency.

Absences

Members shall inform the Facilitator if they are unable to attend a scheduled meeting. In the event that a quorum will not be met, the Deputy Secretary for Medicaid will determine if the meeting is to be rescheduled or proceed without quorum.

Remuneration

Members shall receive no compensation or reimbursement for time or travel.
Parliamentary Authority

Rules of Order: Except where there is conflict with this document, the rules contained in the current edition of “Robert’s Rules of Order” shall govern the Workgroup in all cases to which they are applicable. Any special rules of order that the Workgroup or Agency may promulgate shall take precedence over “Robert’s Rules of Order.”

Facilitator

The Facilitator of the Workgroup on Managed Care Reimbursement is responsible for providing necessary support to enable the Workgroup to accomplish its mission. In addition to facilitating the meetings of the Workgroup, the Facilitator will be responsible for the following: planning, organizing meetings; processing nomination and appointment papers; assisting in the implementation of plans, preparing status reports, implementation plans and progress reports; preparing summaries of meetings; and other activities as appropriate. The Facilitator shall not be a member of the Workgroup. The Facilitator shall be an employee of the Agency.
Appendix B

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-For-Service (FFS)</td>
<td>Credible base to adjust rates</td>
<td>Population is not accurately represented</td>
</tr>
<tr>
<td></td>
<td>Calculable and has financial controls</td>
<td>Data becoming increasingly dated</td>
</tr>
<tr>
<td></td>
<td>Currently acts with edits in place and closely reflects Medicaid FFS</td>
<td>Reimbursement may fluctuate</td>
</tr>
<tr>
<td></td>
<td>Useful and solid data set that is currently available</td>
<td>Difficult to adjust to various utilization methods and changes that occur</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May not be comparable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequency and intensity of services are not equal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delivery systems are not parallel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are various independent payment methodologies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Penetration rates vary in counties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arbitrarily low FFS reimbursement may result in reduced utilization, which may drive down capitation rates.</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>Ideally as solid a base as FFS and will require less adjustment</td>
<td>Time and coordinated effort needed to get solid encounter data base</td>
</tr>
<tr>
<td></td>
<td>Population would be accurately represented both universally and within each health plan</td>
<td>Potentially incomplete where providers are capitated by the managed care plans</td>
</tr>
<tr>
<td></td>
<td>Risk adjustment can be applied</td>
<td>Florida has two intermediaries processing encounter data, the fiscal agent for medical services and a pharmacy benefits manager for pharmacy services</td>
</tr>
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</table>


<table>
<thead>
<tr>
<th>Data Source</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>Will provide a representative and current picture of HMO world</td>
<td>Possibility of incomplete data and under reporting</td>
</tr>
<tr>
<td>Data Source</td>
<td>Considered ‘Gold standard’ for rate setting</td>
<td></td>
</tr>
</tbody>
</table>

**Financial Reporting**

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences between plans are not as critical and may minimize the under or over reporting that may be created in Encounter data</td>
<td>Summary claims data not as detailed as Encounter data</td>
</tr>
<tr>
<td>Get costs regardless of delivery systems</td>
<td>Self reported</td>
</tr>
<tr>
<td>Get reporting from HMOs</td>
<td>Financial burden on additional reporting and some plans</td>
</tr>
<tr>
<td>Validating challenges</td>
<td></td>
</tr>
<tr>
<td>Tie to financials</td>
<td></td>
</tr>
<tr>
<td>PSNs not same level of reporting as FFS</td>
<td></td>
</tr>
<tr>
<td>Problem with multitude of plans and categorizations and variations of services, smaller plans may not be able to get meaningful data when broken down</td>
<td>Need to build bridging documents to financials</td>
</tr>
<tr>
<td>Method must be validated</td>
<td></td>
</tr>
</tbody>
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Appendix C

Mercer Rate Setting Data Sources Document
Rate Setting Data Sources

Several data sources can potentially be used to set actuarially sound rates for capitated Medicaid managed care programs. The primary requirement is that the actuary and the state consider the resulting rates to be appropriate and that any differences between the data source and the anticipated program experience have been adjusted appropriately.

CMS Requirements

CMS’ requirements generally support the “appropriateness” and “adjustment” process above. The following are extracts from CMS’ specific requirements for rates subject to 42 CFR 438.6(c) as set out in their rate-setting “checklist”:

- The state must provide the actuarial certification of the capitation rates and payments under the contract.
  - All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound … means … rates developed in accordance with generally accepted actuarial principles and practices, … appropriate for the populations to be covered, and the services to be furnished under the contract.
  - Actuaries can create either rates or rate ranges so long as the methodology (including all assumptions) to get to the actual rates in the contract are specified and meet CMS requirements.
- Base utilization and cost data that are derived from the Medicaid population or, if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.
- Examples (emphasis added) of acceptable databases … are: Medicaid FFS databases, Medicaid managed care encounter data, State employee health insurance databases, and low income health insurance program databases. Note: some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases.
- Except in the case of FQHCs … CMS does not regulate the payment rates between entities and subcontracting providers. Payment rates are adequate to the extent that the capitated entity has documented the adequacy of its network.
- Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the state. … There is no stated or implied requirement that entities be reimbursed the full cost of care at billed charges.
- Adjustments are often needed to remove from the base period covered months – and their associated claims – that are not representative of months that would be covered by an entity. For example, many newborns are retrospectively covered by FFS Medicaid at birth and will not enroll in an entity (even in mandatory enrollment programs) until a few
months after birth…. If retrospective eligibility periods are not removed … the state could be substantially over-estimating entities’ average PMPM costs in the under-1 age cohort. Similar issues exist with the mother’s costs …. and with retrospective eligibility periods in general.

- The state must document that the utilization and cost data assumptions for a voluntary program were analyzed and adjusted to ensure they are appropriate … if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates were set). … Note: this analysis is needed whenever the population enrolled in the managed care program is different than the data for which the rates were set (e.g. beneficiaries have a choice between a fee-for-service program (PCCM) and a capitated program (MCO) and the rates are set using FFS data).

**Typical Data Sources**

Medicaid managed care rates are typically set using one of the following four data sources, or a combination of them.

- **FFS Claims data:**
  This is the most common data source for relatively new managed care programs with relatively current FFS data available.

  For Florida’s non-reform population rates have historically been based on recent FFS data from the recipients in an Area who have selected the FFS alternative. This data continues to be available.

  For Florida’s reform population, recent FFS history for the same geographical Area may be somewhat limited, consisting largely of those recipients who are, for one reason or another, not in managed care or have selected a Provider Service Network (PSN). However, FFS data from an earlier period, or from a different geographical area, might be adjusted.

- **HMO Encounter data:**
  This is often considered the gold standard for those managed care programs that have been in place for a period of time, sufficient to collect a volume of reasonably complete and accurate encounter data. The collection process, however, is complex and often requires at least one or two years’ of cooperative effort from HMOs and the Medicaid agency.

- **HMO Financial and summary encounter data:**
  This is often the intermediate step when a program has been in place long enough that prior FFS data is of questionable relevance but, for one reason or another, encounter data still appears unreliable. It is also a valuable basis for estimating the extent to which
related encounter data may be incomplete. Encounter data for particular services is often incomplete in situations where a subcapitation payment in made to providers instead of fee-for-service payments.

- Other data sources:
  For example, the sources mentioned in the CMS checklist include state employee data and low income insurance data. This is probably a relatively infrequently used source, except for programs that expand coverage beyond traditional Medicaid and S-CHIP populations.

Data Sources available to AHCA

As noted, all of the above mentioned data sources are available to AHCA and its actuaries, with the exception that, for 2009 at least, there is not yet a credible volume of HMO encounter data.

Using the various Data Sources

Again, providing the encounter data is present, there are no particular difficulties using any of the data sources, and no particular preferences for one over another. However, more recent data would generally be preferred over older data, and data for the population and benefits like those for which rates are to be developed would be preferred over data which would need extensive adjustment for population or coverage differences. Each of the data sources will require some adjustment, as prescribed by CMS guidelines and by generally accepted actuarial practice, in order to make it “appropriate” for Medicaid managed care rate setting. Generating appropriate adjustments may be challenging, but is within the capabilities of a qualified and experienced actuary.

The following are some of the more important adjustments that must (explicitly or implicitly) be made for each data source:

**FFS Data for Non-reform:**

- Incurred but not paid adjustment
- Time period (projected trend in utilization and cost per unit of service between the base data period and rate effective period)
- Program changes, if any
- Provider payment differences, if any, perhaps due to economic, political and/or contracting environment
- Risk and selection differences between FFS and HMO members
- Managed Care utilization differences from FFS
- Plan administrative expenses and margin for cost of capital
**FFS Data for Reform**
- All of the same items as listed for Non-reform
- Additional differences between base and projection populations may include the following (depending upon the choice of FFS data)
  - PSN/HMO differences and/or
  - Longer time gap between base and projection periods and/or
  - Geographical and/or risk differences between base and projection populations

**HMO Encounter Data**
- Incurred but not paid adjustment
- Potential incompleteness of encounter data (particularly if subcapitation is used)
- Time period (projected trend between base data period and rate effective period)
- Program changes, if any
- Provider payment differences, if any, perhaps due to economic, political and/or contracting environment
- Risk and selection differences over time
- Incremental managed care efficiencies
- Plan administrative expenses and margin for cost of capital

**HMO Financial Data**
- Incurred but not paid adjustment
- Potential incompleteness of data (particularly if subcapitation is used)
- Time period (projected trend between base data period and rate effective period)
- Program changes, if any
- Provider payment differences, if any, perhaps due to economic, political and/or contracting environment
- Risk and selection differences over time
- Incremental managed care efficiencies
- Potential changes in plan administrative expenses and margin for cost of capital
- Allocation of costs between geographies and entities

**Recommendation**
We recommend that AHCA consider all of the available data sources, and consider performing calculations under several of them, as appropriate. It will then be important for AHCA and the actuaries to understand as fully as necessary the differences between results under each method selected. Based on that understanding, an informed decision can be made as to which method or methods to incorporate in rate development and how to weight them.