Straw Man for New Rate Setting Method for Florida Medicaid Managed Care

Discussion Draft June 22, 2009

Introduction

There is a general consensus among AHCA, the health plans and stakeholders that the current Medicaid managed care rate setting methodology needs improvement and should be updated. Criticisms of the existing method include its over reliance on outdated fee-for-service data, which because of a combination of age and relevance, requires significant adjustments to make it an appropriate starting point for a rate setting effort. Indeed the existing method has been in use since before the new federal actuarial soundness regulations were promulgated in 2002 which allowed states to de couple their rate setting base from fee-for-service data.

Within the context of the legislatively required Commission on Managed care rates, AHCA requested the health plan representatives to create a straw man for discussion at the next scheduled commission meeting on June 30, 2009.

Basic Definitions and Building Blocks for Rate Setting

At the outset it is important to identify the key steps in the rate setting process as articulated in the actuarial soundness regulations

- Base data
- Trend from base year to rate year
- Program adjustments
- Administration and Profit

Our view is that it is best to work through the specifics of each item—treating them as building blocks so we do not confuse the implications of decisions and methods that apply to each of these.

Thus, the focus of this document and the straw man is on the first step: base data

Summary and Key Elements of the Straw man proposal

In recognition that the ultimate solution to rate setting will be a MCO based encounter data system, the work group created a bridge process to migrate the state from the current FFS data to encounter data over a three to four year period utilizing parts of the three acceptable rate setting methodologies (FFS, Financial and Encounter). Below is a summary of year 1 and 2 of that process:

Base Data

The most significant change envisioned to the rate method is to transition the source of the base data from fee-for-service to cost and utilization data derived directly from MCOs for members enrolled in the managed care program.
Beginning with the 2010 rate year, it is recommended that an MCO’s financial reports be used to create an interim rate setting database. Over time, there is general consensus that MCO generated encounter data is the ideal data set. Unfortunately, in the near term encounter data will not be available (although the state is building its capacity, conducting testing and working with the plans to accept the data). This situation is not unusual, indeed most states have used an interim data source for rate setting as they create and validate their encounter systems. As the encounter system comes online, plan financial data can be used to judge the completeness and accuracy of the encounter data.

Our vision is that use of MCO generated financial reports be a first step in a glide path to using encounter generated data.

*Specifics on the financial reports*

Currently AHCA collects financial information from managed care plans but it lacks the specificity needed for rate setting. Thus it is our recommendation that a specifically tailored “Florida Medicaid Managed Care Financial Report” (FMMCFR) be developed. This report would be modeled after those used in Maryland, New York and Pennsylvania. Key components of the report would include: Need to add a requirement for units, days, admits, etc… This is to build a transition into a tie into the encounter data.

- Data to be submitted for Medicaid managed care program only (current AHCA reports do not isolate the managed care line of business)
- Financial summary and detail data to be provided for TANF and SSI categories
- Regional reporting (specifics should follow more discussion with the state)
- Category of service level information (Inpatient, outpatient, physician, Rx, at a minimum)
- Administration expenses

The State and plans would create a common set of definitions for each grouping and category of service to assure comparability and to facilitate validation. This will be difficult task considering that ensuring the definitions are consistent within the program and among the MCOs, as well as providing for a standardized cross-walk and feed to the encounter data definitions for COS and COA will be required to provide the State’s actuaries with consistent data. AHCA would have to assist the PSNs in the gathering and reporting of their data.

*Rate setting base in 2010 and 2011*

With the collection and availability of the financial reports, and to create a reasonable transition as we move data sources, it is recommended that a blending method be created where the financial data and the fee-for-service data would be blended for a 2 year period. For example, in 2010, the blending would be 50/50 moving to 75% financial data and 25% FFS in 2011. Once we introduced a financial reporting model, we can move quickly to utilize the significance of the data versus the aging FFSE.

For the 2010 base, it is recommended that financial data for the calendar period 2008 be used. This will assure the data reported are largely complete and will significantly reduce adjustments for claims run out. (calendar 2008 year-end data with 6+ months of runout). The
State will need time to develop the format; the plans will need time to respond; and lastly, the State’s actuary will need time to consolidate and validate the submitted, self reported data. The State’s actuary will need time to consolidate the reported data and perform various validation exercises to be comfortable with weighting this source 50% or 75% of the total pool to be utilized to establish rates as described above.

Approach to Implementation

There are many important details to work through if such an approach is to be successful. We recommend that a small AHCA/Health Plan workgroup be created to in the next several months (or alternatively use this group to do so):

- Agree upon the format, level of detail and timing for the first report
- Gauge the plans ability to complete the reporting
- Create a training program for the health plans
- Identify validation tools
- Create the definitions for category of service, and what qualifies as administrative expenses

Next Steps

The workgroup should develop additional “straw man” proposals to the other components of the rate setting process to be vetted at future meetings.