**Issues for Rate-Setting**

*Non-reform*

- Discuss importance of budgeting FY 2008-09 budgeted unit costs to preserve managed care in as many counties as possible for FY 2009-10 and beyond.
- When can we receive the raw data used in establishing rate base in each Area? – the earlier the better.
- What to do about the non-reform and reform rate base in areas 4 and 10 due to no FFS data left – just six months of unreliable data in FY 2006-07.
- What is the agency’s view of the medical service component increases/trends incorporated in the November SSEC for the FFS program? What is state’s view on ultimate trends in FFS program that may appear in Feb/March SEC? If HMOs see higher trends for any number of reasons, would agency support higher trend assumption?
- What is the agency’s estimate on the Rx rebate percentage to be used in the coming rate cycle? Cap percentage assumed in rate-setting.
- Discussion of expected industry margins for CY 2008 and CY 2009 compared with current certification analysis for 7/1/07 to 3/31/08.
- Certification did not have traditional discussion of MLRs or margins. What is Milliman’s assessment of such for the current contract year?
- Discussion of new/updated data expected to be supplied by the association to the agency and its actuaries.
- When will the July 1 exempt hospital rates be posted? We need to understand the statewide aggregate impact and how this ties to the inflation factors assumed in the FY 2008-09 rate process.
- By exempt hospital, how far back in time did the buy backs go? What were the impacts of prior year buy backs vs. 1/1/08 reduction vs. current year reductions?
- Discuss impact of the buy back/exempt rate increase impact on managed care costs for prior and current contract year. Higher trend than FFS. Additional adjustments needed to support moving to 100% of exempt rate in aggregate.
- What is the status of January rate process for hospitals?
- Will the agency support another adoption of a buy back provision in the legislature?
- Does the agency have a view on the timeline for the coming contract year rate process?
- The association’s actuary studied the impact of including MPN/PSN/pilot claims in the rate base calculation. When analyzing the MPN/PSN impact, Milliman engaged in “normalizing” the lives in question via risk-adjustment, removed the retro claims, and appeared to remove all non-retro claims for anyone who’d had retro claims. We continue to believe that the so-called “double discount” that results from including the other managed care lives in the rate base calculation is an important issue that needs to be thoroughly discussed with the agency and Milliman/Mercer in the coming rate cycle. In general, we do not believe the lives in question should be “normalized” via risk-adjustment. On retro claims, proviso
in the budget said retro claims should not be removed if rates came in below budgeted amounts.

- The association continues to be concerned about the fact that the rate-setting system did not support payment of exempt rates and that the rate-setting system needs to recognize higher managed care trends due to the increased share of the aggregate exempt costs being covered by plans. Discussion as to how this is handled needs to occur.
- With rate contraction and consistent managed care discount being applied, need to discuss changing physician factor and admin load to above 1 in methodology.
- Discuss behavioral health encounter rate process. Return to system? Phase-in in each area?
- IP vs. OP calculation in current BH rates.
- Transportation rate-setting for Dade 11 and reform areas.
- Children’s dental rate-setting.
- Concern about proposals to remove retroactive claims from rate base.
- Discuss status of managed care trend factor of 1.0622% for contract year 2009-10.
- Discuss brevity of Milliman exempt discussions compared with FY 2006-07 and FY 2007-08 certifications, as well as lack of discussion on IGT buy back. Milliman indicated that it would include two projections on financial results – one with exempts paid in full and the other assuming current payment levels.
- Certification says rates drop by about 1.9%, but agency indicates statewide reduction of 3%. Discussion. Timeframe looked at (7/1/07 – 3/31/08?)
- AA.3.12 Page 22 – if Milliman is not aware of a material difference between HMO and FFS lives, why would it take the position of risk scoring alternative managed care lives?
- What data was and will be used to calculate hospital days over 60 for duals given state plan change? Is the data credible? What about for NH days and certain physician impacts?
- Mercer assumed a trend assumption from base year to contract year of between 4.67% and 7.38% annually. This is much higher than the SSEC assumptions – true? How did Mercer calculate this? What impact would these assumed trends have on the actual rate-setting process done by AHCA?
- Did Milliman do any independent (from SSEC) calculation on anticipated trends from base period to contract year?

Reform

- Has the agency discussed the MLR study with Mercer? What data would be needed? Can we meet with agency and Mercer on this?
- Continued concern and need for discussion on impact of retroactive claims adjustments.
- Discussion on 45 day IP add on to rate.
- Analysis of labor and delivery reduction to ensure amount taken from rate cells is in aggregate amount of kick payments.
- Look at HIV/AIDS reduction and premiums.
- Look at adequacy of transplant kick.
- Issues related to understanding what the trans, dental, and MH components are. Important for subcap vendor agreements.
- Discussion of appropriate caseload period for calculation of discounted vs. undiscounted lives for budget neutrality
- Enhanced benefit reduction of 2%. Alternatives.
- How often are NDCs updated for risk model? When were they last?
- Can we obtain individual risk scores for our members and backup?
- Certification -- Kicks – says the agency modified its approach and now allows submission of relevant codes in a P and I format. This has not been discussed with plans? Did this change in approach impact the amount of the carveout? What impact did it have on the rate cell reduction?
- What were the managed care adjustments calculated by Mercer by service category? What were the PCP increase assumptions? What were the specialist reductions? What were the rx rebate assumptions? What were Milliman’s assumptions if any beyond the rate rule?
- How can the managed care aggregate adjustments plus admin be reconciled with the rate-setting discounts applied?
- Why assume lower admin on labor and delivery premium?
- Discussion of comprehensive vs. catastrophic breakout.
- Mercer says it considered expected financial viability of the current HMOs under the proposed rates. Can details be provided?