Florida's Medicaid Reform Provider Workshop

Duval County

January 31, 2006

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Florida Medicaid Reform

Update

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Florida's Medicaid Reform

Choice Counseling

Chris Osterlund

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Enrolling in Medicaid Managed Care
How It Works Today

- *The Agency contracts with ACS State Health Care, LLC, to perform enrollment broker services.*
- *These services include:*
  - *mailing area-specific health plan information.*
  - *operating a call center.*
  - *answering questions about provider networks.*
  - *keeping updated provider files.*
  - *maintaining a recipient-specific historical data base.*

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What Will Change with Reform?

- *Comprehensive choice counseling.*
- *Education needs will dramatically change:*
  - *Differences between benefit packages.*
  - *New requirements on information provided.*
  - *Information on opting out of a Medicaid plan.*
- *Recipient will receive only emergency services until they enroll or are assigned to a plan.*

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Choice Counseling Requirements Under Reform

- *The Agency will:*
  - *Provide information to Medicaid recipients for the purpose of selecting a capitated managed care plan.*
  - *Ensure that at a minimum, the recipient is provided with:*
    - *a list and description of the benefits provided.*
    - *information about cost sharing.*
    - *plan performance data, if available.*
    - *an explanation of benefit limitations.*
    - *contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.*
    - *any other information the Agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.*

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Choice Counseling Requirements
(continued)

- *Ensure the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media.*
- *Develop a system to ensure that there is record of recipient acknowledgement that choice counseling has been provided.*
- *Develop contract standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.*
- *Promote health literacy and provide information to reduce minority health disparities throughout outreach activities for Medicaid recipients.*

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The Vision for Choice Counseling

- *Comprehensive choice counseling program to assist beneficiaries in making an important choice:*
  - *Strong face-to-face component.*
  - *Involvement of sister agencies and community organizations.*
- *Information provided at the time of eligibility:*
  - *Eligibility packet mailed by DCF.*
  - *Web-based application.*
- *Several modalities to effectively reach individuals.*
- *Information on choice will center on selecting a comprehensive care plan.*

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Status Update: Vendor Procurement

- *Agency released Invitation to Negotiate on December 28, 2005.*
- *Deadline for Receipt of Written Inquiries January 12, 2006.*
- *Vendor's Conference January 19, 2006.*
- *Anticipated date for Agency Responses to Written Inquiries January 30, 2006.*
- *Deadline for Receipt of Responses February 20, 2006*
- *Negotiations March 20 – 24, 2006.*
- *Anticipated Posting of Notice of Intent to Award April 10, 2006.*

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Status Update
Florida State University Contract

- *Develop educational and outreach materials:*
  - *Materials to be mailed to recipients.*
  - *Outreach DVDs.*
  - *Other items as needed.*
- *Focus groups will be used in development of materials.*
- *Develop Choice Counselor Certification program.*

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Role of Technical Advisory Panel

- *Review and make recommendations on:*
  - *Draft educational materials.*
  - *Draft DVD scripts.*
  - *Draft certification program materials.*
- *Make recommendations on how to structure face-to-face component.*
- *Recommendations on proposal elements panel deems to be critical to success of program.*

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Florida's Medicaid Reform

Update on Benefit Packages and Data Book

Roberta Kelley/Nick Simmons, F.S.A

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Customized Benefit Packages Plan Design Guidelines

- *Levels of amount, scope and duration flexibility:*
  - *Certain services must be provided at least to current State Plan coverage levels.*
  - *Other services must be provided at least to meet benefit sufficiency standards.*
  - *Remaining services must be offered, but amount, scope and duration are flexible.*
- *Reform plans can enhance any service above current State Plan levels.*
- *Reform plans can add services not currently covered under the State Plan.*

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Customized Benefit Packages Plan Design Guidelines *(continued)*

- *Required at least to current State Plan limits:*
  - *Emergency care.*
  - *Maternity care and other services to pregnant women.*
  - *EPSDT and other services to children.*
  - *Hospital inpatient care.*
  - *Transplant services.*
  - *Medical/drug therapies (chemo, dialysis).*
  - *Family planning.*
  - *Outpatient surgery.*
  - *Laboratory and radiology.*
  - *Transportation (emergent and non-emergent).*
  - *Outpatient mental health services.*
  - *Physician and physician extender services.*

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Customized Benefit Packages
Plan Design Guidelines *(continued)*

- *Required and tested for benefit sufficiency:*
  - *Hospital outpatient services.*
  - *Durable medical equipment.*
  - *Home health care.*
  - *Prescription drugs.*

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Customized Benefit Packages Plan Design Guidelines *(continued)*

- *Required to be offered, but amount, scope and duration are flexible:*
  - *Chiropractic care.*
  - *Podiatry.*
  - *Outpatient therapy.*
  - *Adult dental services.*
  - *Adult vision services.*
  - *Adult hearing services.*

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Customized Benefit Packages Plan Proposals

- *AHCA will provide a standardized benefit template that plans can use to convey proposed benefit packages.*
- *Additional benefits proposed must be supported with PMPM projection and supporting documentation.*
- *DRAFT version in your handout today.*

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Florida's Medicaid Reform

Data Book

Nick Simmons, FSA

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Medicaid Reform Data Book

- *Goal: to provide health plans and interested PSNs with data about each Reform target population, organized in a way that facilitates use in designing customized benefit packages.*
- *Target release date: in early-to mid-March.*
- *Today: providing you as much information as early as possible so you can begin considering benefit package features and model-building.*

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Medicaid Reform Data Book

- *Types of tables to be provided:*
  - *Enrollment detail.*
  - *FFS claims experience.*
  - *Continuance tables for certain services.*
  - *Claim probability tables for certain services.*
- *Refer to today's handout for DRAFT specifications.*

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Florida's Medicaid Reform Rate Setting

Nick Simmons, FSA

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Guiding Principles

- *Budget Neutrality:*
  - *Does not cut the Medicaid budget, but Aggregate Costs will not increase.*
  - *Fair payment for improved access and outcomes.*
- *Provide best possible benefits for recipients:*
  - *Risk Adjustment used to increase/decrease base premiums based on health status of enrolled population.*
- *Risk Adjustment methodology:*
  - *Subject to corridor and phase-in per HB3.*

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Non-Reform and Reform

Non-Reform

- Capitation for HMOs at area discount percentages.
- Claims for some benefits carved out at 100% (e.g. Transportation, IP days over 45).
- Medipass claims at 100%.

Reform

- MCO premiums:
  - Fully risk adjusted for plans that exclusively serve specialty populations.
  - Partially risk adjusted for TANF/SSI.
- PSNs - FFS option with annual reconciliation
- Enhanced Benefits.

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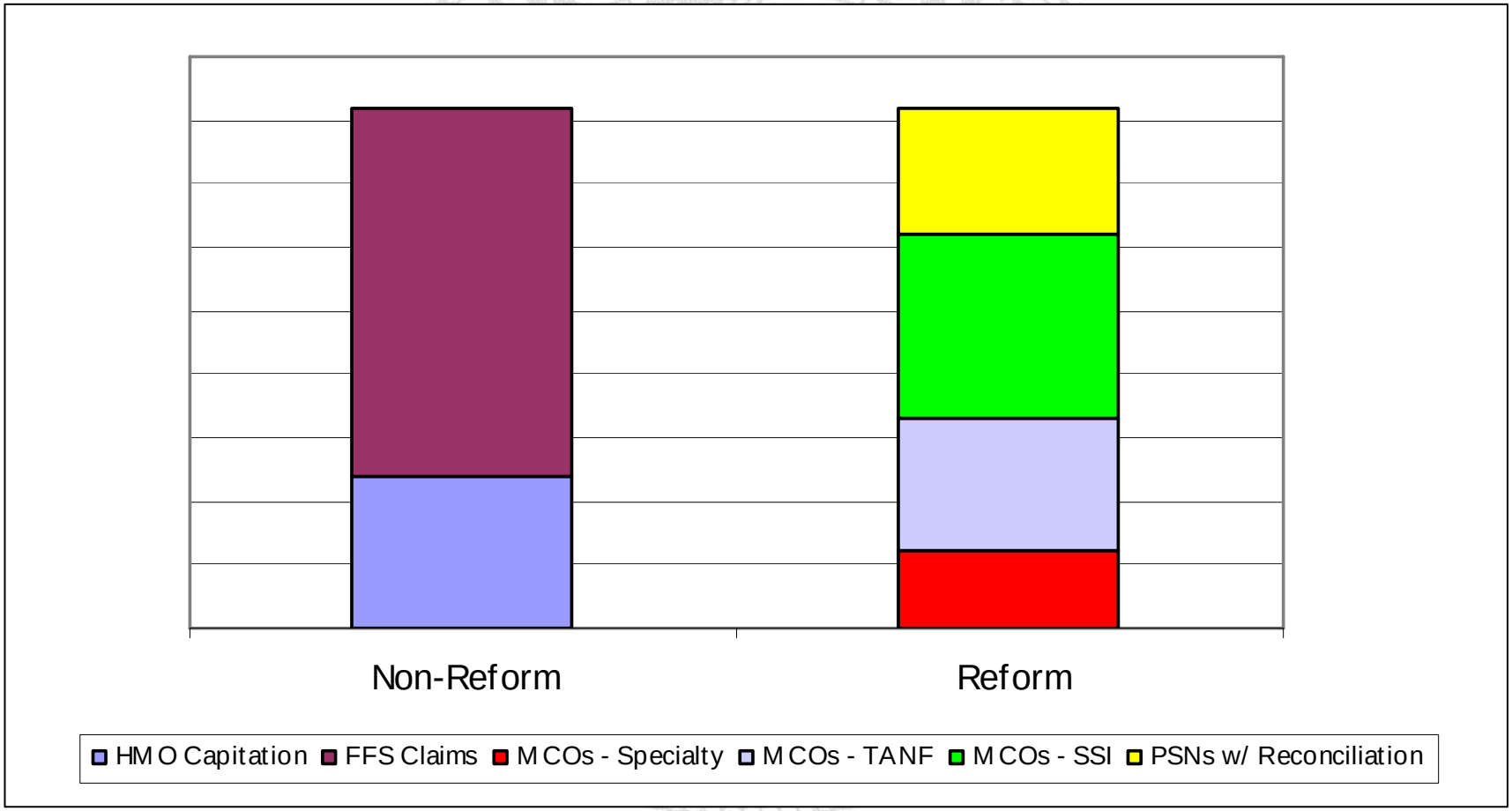
Estimated Non-Reform and Reform Spending for Mandatory Reform Populations



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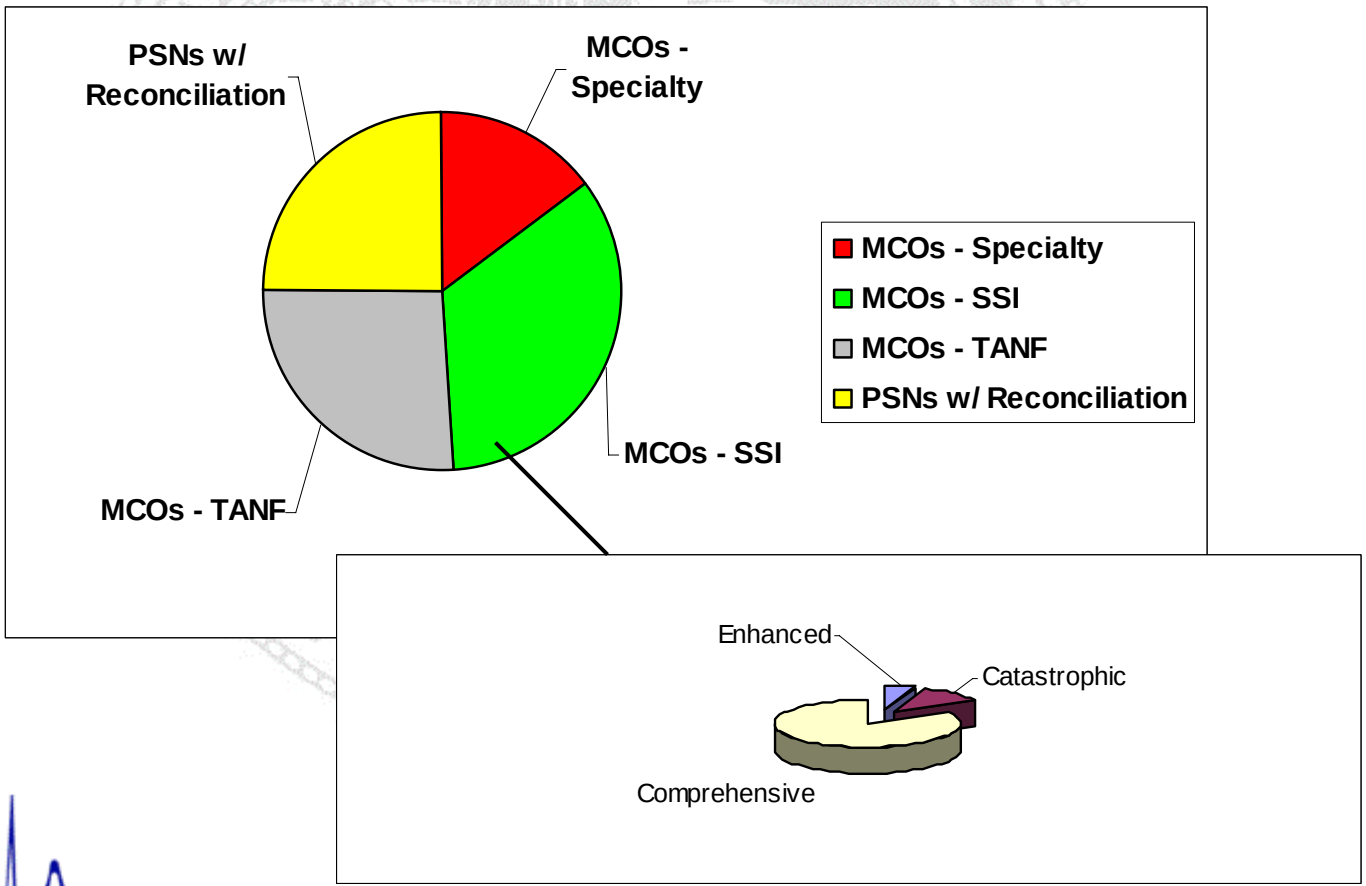
Overall Funding includes Comprehensive, Catastrophic and Enhanced Benefits



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Reform and Non-reform Plans Run Concurrently During Transition

- *Mandatory enrollment in reform is phased in based on eligibility redetermination dates (with some exceptions).*
- *Auto assignment if choice not made within 30 days of redetermination date.*
- *Recipients can opt to enroll in reform early.*
- *New Medicaid recipients enroll in reform.*
- *Therefore AHCA must develop both reform and non-reform rates in pilot areas.*

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Reform Enrollment

- *Plans would expect to retain the bulk of their pre-reform members:*
  - *Auto assignment algorithm reflects pre-reform plan membership.*
- *Remainder of reform membership will come from fee-for service and from new Medicaid enrollees.*
- *Risk adjustment protects plans if they get an enrollee mix with higher cost due to health status.*

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Reform Premiums

- *MCOs (HMOs and capitated PSNs) exclusively serving specialty populations fully risk adjusted.*
- *MCOs serving non-specialty populations partially risk adjusted:*
  - *Year 1:25% risk adjusted; 75% "current methodology".*
  - *Year 2:50% risk adjusted; 50% "current methodology".*
  - *Thereafter: 100% risk adjusted.*
- *MCOs that serve non-specialty TANF/SSI are subject to a 10% risk corridor for first 2 years.*
- *PSNs can elect FFS payment with annual reconciliation.*

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Rate Setting Process

- *Many of the reform Rate Setting steps correspond to steps in the existing non-reform process:*
  - *For example, still based on FFS claims for 2-year base period.*
- *Modified as needed where reform and non-reform environments are different, for example:*
  - *Different sets of capitated services.*
  - *Inclusion of kick payment methodology for labor/delivery and certain transplants.*
  - *Enhanced Care benefit in reform environment.*
  - *Phase out of area discounts as risk adjusted rates phased-in.*

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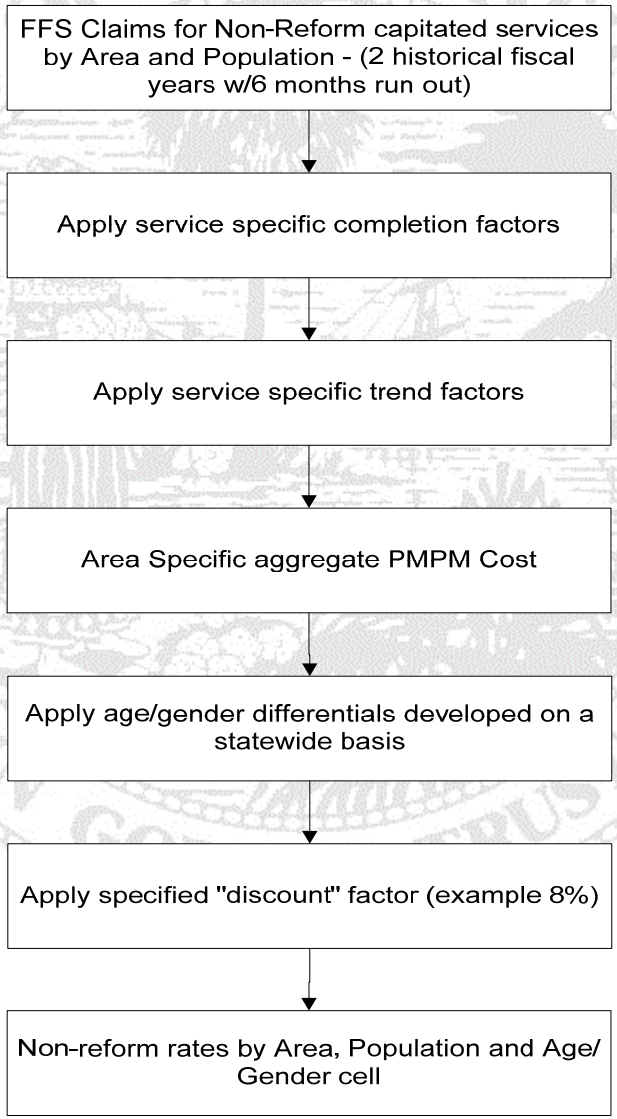
Non-Reform Methodology



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Reform Process

- *Phase in process requires parallel calculations of "current methodology" and "risk adjusted" rates.*
- *However, several of the initial steps are common to the two calculations:*
  - *Development of Area and Population specific aggregate PMPM amounts.*
  - *Kick payment calculations.*

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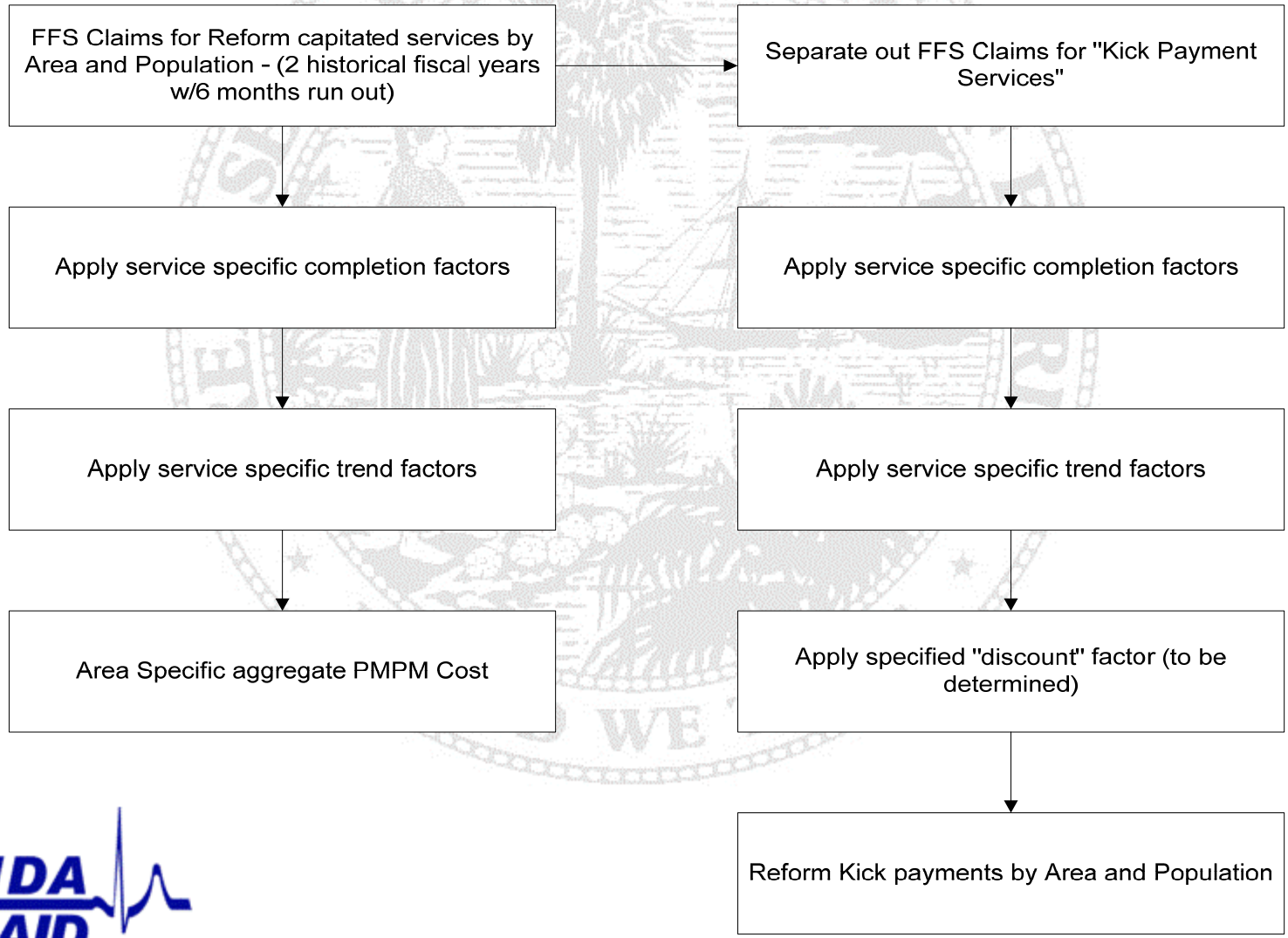
Reform Methodology - Elements Common to Both "Current" and "Risk Adjusted" Methodologies



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Two Methodologies

- *The current (age and gender based) and risk-adjusted methodologies diverge after the aggregate area population and area-specific rates are established:*
  - *Current methodology (75% weighting in year one for non-specialty plans) applies existing area discounts and age/gender differentials.*
  - *Risk Adjusted methodology (25% weighting in year one for non-specialty plans) allocates premium to Enhanced Care benefit, then applies normalized plan and population specific risk adjustment factors.*

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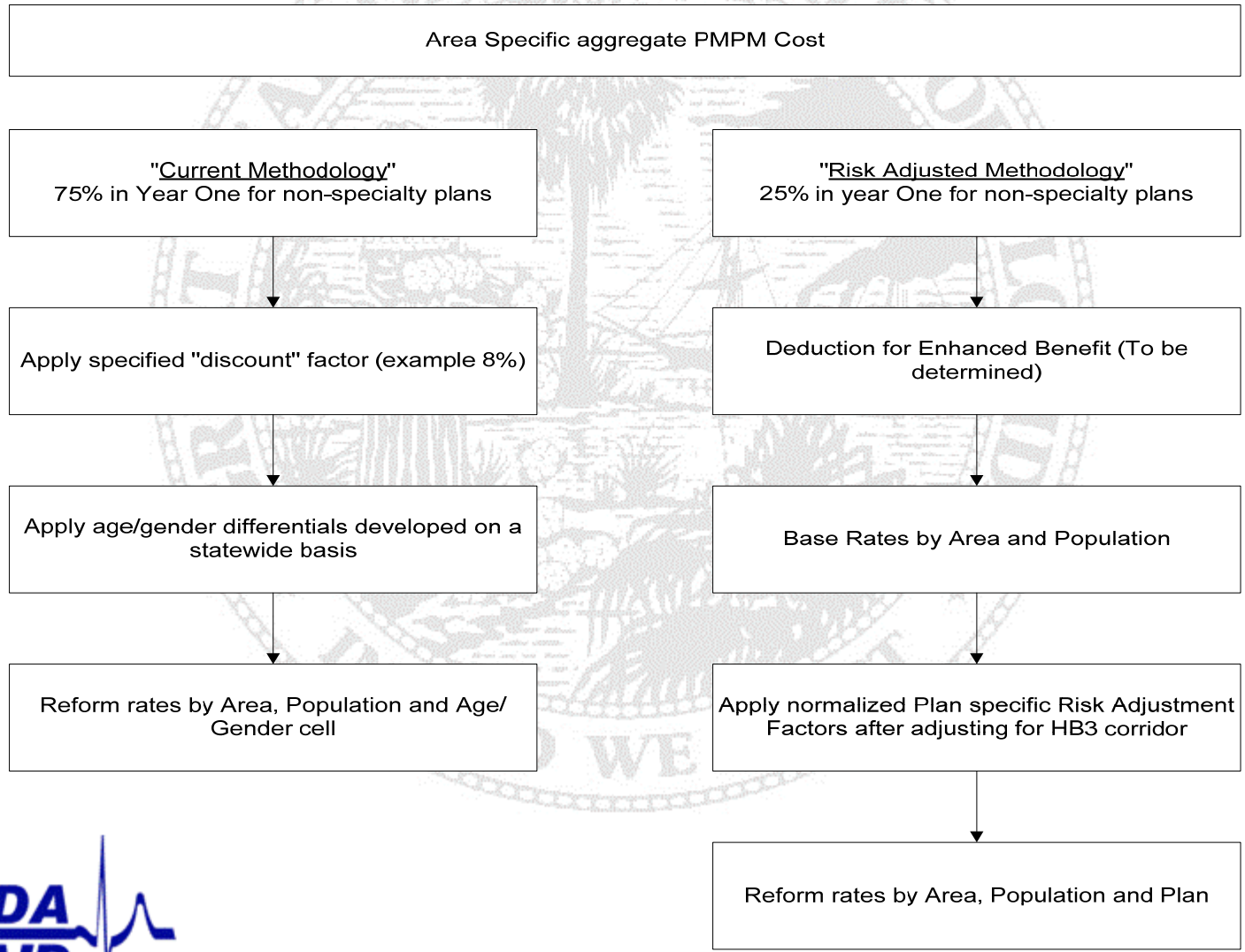
Reform Methodology - "Current" and "Risk Adjusted" Methodology



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Actuarial Soundness

- *Actuarial certification of both reform and non-reform rates.*
- *Rates and risk-adjustment process must be actuarially sound.*
- *Resulting blended rates intended to be adequate to provide actuarially equivalent benefits but will not increase program costs.*

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Risk Adjusting Rates

Jeff Smith

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Risk Adjusted Rates - What is it?

- *A process to predict health care expenses based on chronic diagnoses.*
- *Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.*
- *Captures adverse selection without using experience rating (health status, not health use).*
- *Rate allocation, not rate setting.*

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Why Risk Adjust?

- *Addresses the real and imagined perceptions of fairness:*
  - *Non-specialty plans "cherry pick" low risk – paid too much?*
  - *Specialty plans enrolling high risk cases – paid too little?*
- *Better matches payment to risk:*
  - *Pay for the risk enrolled.*
  - *Help control payment escalation.*

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Risk Adjustment Methods

- *Age/Gender – easily obtained but not a good indicator of risk.*
- *Prior Cost – good predictor of risk but subject to gaming.*
- *Health Risk Assessments – can help identify case management opportunities but expensive to administer.*
- *Health Based Risk Adjustment – big improvements in prediction, moderate cost to administer, data intensive.*

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Health-Based Risk Adjustment

- *Uses historical diagnosis codes and/or pharmaceutical utilization available on individual's claims records as basis for risk assessment.*
- *Certain conditions (heart disease, asthma, diabetes, etc.) and use of particular pharmaceuticals to treat them have strong link to future health care costs.*
- *Statistical models correlate historical diagnoses/pharmaceutical utilization to likelihood of future health care cost.*

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Health-Based Risk Adjustment
(continued)

- *Pharmacy-Based Models (Medicaid Rx):*
  - *Data necessary to support easier to obtain.*
  - *Less predictive than diagnostic-based approaches.*
  - *Long-term use could alter prescribing patterns.*
- *Diagnostic-Based Models (CDPS):*
  - *Most commonly applied risk adjustment method.*
  - *More predictive than pharmacy-based approaches.*
  - *Data necessary to support more challenging to obtain.*

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Medicaid Rx vs. CDPS

- *Model developers at UCSD found Medicaid Rx performed similarly to CDPS for the TANF population but slightly less well for SSI.*
- *2001 CHCS paper by Cheri Rice, et al, also found predictive results similar to that of UCSD.*
- *Each model has strengths and weaknesses - Medicaid Rx does a better job in predicting costs for mental illness (due to underreporting of diagnosis) but not as well for diabetes (often managed by diet and exercise, not drugs).*
- *Pharmacy data is generally much more complete and available than diagnostic data.*

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Risk Adjustment Steps

- *Individuals assigned a "risk score".*
- *Individual risk scores generate premium based on recipient's predicted needs.*
- *Health plans credited with risk score/premium of each individual enrolled.*
- *Collective risk scores/premiums of members generate health plan revenues/capitation tied to expected health costs.*

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Risk Adjusted Rates Illustration

	Plan A	Plan B	Plan C	Total
Before	$1,000,000	$1,000,000	$1,000,000	$3,000,000
RAR Factor	1.04	.95	1.01	1.00
After	$1,040,000	$950,000	$1,010,000	$3,000,000

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Risk Adjustment Under Reform

- *Use risk adjustment model to vary plan payment based on expected risk of enrolled population:*
  - *Start-up (Medicaid Rx):*
    - *Use pharmacy data in conjunction with a pharmacy-based risk adjustment model.*
    - *Phase-in per HB3 (Yr 1 – 25%, Yr 2 – 50%, Yr 3 – 100%; subject to 10% corridor).*
    - *Develop encounter data collection and validation system*
    - *Next 2 to 3 years.*
  - *Mature (CDPS):*
    - *State receiving validated encounter data.*
    - *Use diagnoses present on both fee-for-service claims and encounters.*

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Risk Score Example

- *Sample Individual Risk Score Development.*

Component	Category	Weight
Demographic	Female age 25 to 44	0.5
Diagnostic	Hypertension Diabetes	0.4 2.4
Risk Score (Sum of Weights)		**3.3**

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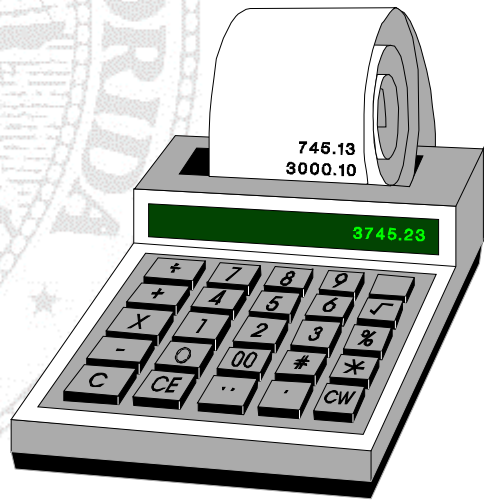
Assign a Case Mix Score for Each Health Plan

ABC Health Plan	
Jo Smith	*3.30*
Betty Jones	*.43*
Doug Brown	*.66*
Charlie Williams	*.37*
Brad Wilson	*.45*
Case Mix Score	*1.04*



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Rate Methodology Comparison

			Current Methodology	Risk Adjustment Methodology	
Member	Sex	Age	Age/Sex Rate	Risk Adj. Factor	Risk Adj. Rate
Jo Smith	F	27	$225.00	3.30	$330.00
Betty Jones	F	6	65.00	.43	43.00
Doug Brown	M	11	95.00	.66	66.00
Charlie Williams	M	3	50.00	.37	37.00
Brad Wilson	M	6	65.00	.45	45.00
Total			$100.00	1.042	$104.20

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Phase-In

- *HB3 requires risk adjustment be phased-in over 3 years:*
  - *Individual risk scores generated.*
  - *Individuals assigned to MCO, PSN, or FFS.*
  - *Budget neutrality adjustment calculated and applied.*
  - *Plan scores generated.*
  - *Phase-in adjustment applied.*
  - *10% corridor applied.*

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Risk Adjustment Phase-In

- *Based on $100 PMPM Aggregate MCO Rate and a plan risk score of 1.042.*

Phase-In Period	Age/ Sex %	Risk Adj. %	Age/ Sex $	Risk Adj. $	Paid Rate
Year 1	75%	25%	$75.00	$26.05	$101.05
Year 2	50%	50%	$50.00	$52.10	$102.10
Year 3	0%	100%	$0.00	$104.20	$104.20

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Program Specifics

- *Risk Adjustment Update Schedule:*
  - *Recipient risk scores to be updated quarterly during the phase-in, otherwise semi-annual updates.*
  - *Plan case mix scores to be updated monthly during the phase-in, otherwise quarterly updates.*

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Program Specifics (continued)

- *Scoring Criteria:*
  - *Recipients must be eligible for some minimum period of time in order for their claims to enter the system and generate a risk score.*
  - *For CDPS, 6 months is generally considered the minimum time required before risk scores stabilized.*
  - *For Medicaid Rx, less time (because pharmacy data completes more quickly) may be required for risk scores to stabilize.*
  - *An analysis of Florida's FFS data will be performed to determine the most appropriate period.*

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Rx to DX Transition

- *All Dx risk adjustment models (including CDPS) require complete and accurate encounter data.*
- *MEDS currently under development.*
- *Encounter data will be used to test FL's CDPS model.*
- *AHCA will perform simulations using MCO encounter data.*
- *CDPS may be phased-in alongside Medicaid Rx.*
- *CDPS will be fully implemented once encounter data is available.*

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Summary

- *Risk adjusting better matches payment to risk.*
- *Addresses perception of fairness.*
- *Helps control budget pressures by adequately paying providers for risk assumed.*
- *In the long term, mature program requires complete and accurate encounter data to be effective.*

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Questions and Answers

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