The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Policy Committee

BILL:	SB 1830
INTRODUCER:	Senator Fasano
SUBJECT:	Medicaid Reimbursement for Managed Care
DATE:	March 24, 2007 REVISED:

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

I. Summary:

The bill requires the Agency for Health Care Administration (AHCA or agency) to amend its rule pertaining to the methodology for reimbursing Medicaid managed care plans to increase the percentage of the payment limit for capitation rates by 3.9 percentage points from the percentage of the payment limit specified in the rule applicable to the 2006-2007 fiscal year (approximately 9 percent), which would result in an overall rate increase for Medicaid managed care plans. This change is effective for Medicaid managed care contracts beginning in the 2007-08 fiscal year and thereafter.

The bill also repeals the provision in current law that ensures per member; per month average capitation rates paid by the agency do not exceed the amounts allowed for in the General Appropriations Act. The current provision essentially requires the agency to make additional reductions to the managed care capitation rates if the rate methodology would result in expenditures greater than the appropriation in the General Appropriations Act.

This bill amends s. 409.9124, F.S.

II. Present Situation:

The Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state

agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S.

For FY 2006-07, the Florida Medicaid program is estimated to cover 2.1 million people[3] at a cost of $14.6 billion.[4]

Medicaid Capitation Rates

The Florida Medicaid program uses a capitated reimbursement model for Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated reimbursement systems since the early 1990s.

The HMOs are by far the largest of these provider types and receive the majority of reimbursements within the Medicaid managed care program. Medicaid HMOs in Florida are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the AHCA, as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[5] The agency's methodology is established through the administrative rule process (59G 8.100, F.A.C) and is available to the public. The methodology is very complex, but can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by AHCA to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- The AHCA uses two years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee-for-service program for the same service the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid program are found in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 22, 2007)
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 22, 2007)
[5] s. 409.9124, F.S.

affect fee-for-service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates).

- After the adjustment for policy issues, the agency applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 9 percent and varies by rate cell depending on the geographic region and eligibility category.
- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by the Centers for Medicare and Medicaid Services, the agency will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

The current discount factor is set at approximately 9 percent by rule, although it varies by rate cell depending on the geographic region and Medicaid eligibility category.

Appropriation Limits on Medicaid Capitation Rates

Florida law also includes a provision to ensure that this capitation calculation methodology ultimately remains within budget. Section 409.9124(2), F.S., specifies:

> "…The agency shall pay rates at per-member, per-month averages that do not exceed the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect."

The effect of this provision is to require the agency to make additional reductions to the managed care capitation rates if the rate methodology would result in expenditures greater than the appropriation in the General Appropriations Act.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.9124, F.S., requiring the agency to amend its rule pertaining to the methodology for reimbursing Medicaid managed care plans to specify that, for each agency area and eligibility category, the percentage of the payment limit shall be increased by 3.9 percentage points from the percentage of the payment limit specified in the rule applicable to the 2006-07 fiscal year. The percentage of the payment limit may not exceed 100 percent in any agency area or eligibility category. This change is effective for Medicaid managed care contracts beginning in the 2007-08 fiscal year and thereafter.

The bill also repeals the provision in current law that ensures per member, per month average capitation rates paid by the agency do not exceed the amounts allowed for in the General Appropriations Act. The current provision essentially requires the agency to make additional reductions to the managed care capitation rates if the rate methodology would result in expenditures greater than the appropriation in the General Appropriations Act

Section 2. Provides that the bill takes effect on July 1, 2007.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Medicaid managed care health plans will benefit from higher reimbursement rates.

C. Government Sector Impact:

The bill would have a substantial fiscal effect on the Florida Medicaid program.

On March 9, 2007, the Medicaid Impact Conference estimated that changing the discount factor by 4 percent would result in a cost of $79,666,002 ($34,328,080 in General Revenue) in FY 2007-08.

The AHCA provided similar estimates. The agency estimates that the total fiscal impact of the 3.9 percent increase over the percentage of the base FY 06-07 payment limit for HMOs and prepaid behavioral health plans in FY 2007-08 will be $87,624,971 and in FY 2008-09 will be $92,006,219. The difference in the estimates with the Medicaid Impact Conference is the inclusion of the prepaid behavioral health plans.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.