

Key Features of House Medicaid PCB – Council on Health and Family Services

- 1. Addresses and anticipates problems with the Medicaid encounter data system.**
 - Requires contracted Medicaid providers to agree to “fully comply” with the Medicaid encounter data system.
 - Requires AHCA to annually report to Governor and Legislature summarizing available encounter data and status of implementation.
 - Requires AHCA to collect encounter data from all Medicaid managed care plans (not just Reform).
 - Requires advisory panel (see #2 below) to assess whether the encounter data needed for risk-adjustment is complete and accurate.
- 2. Expands risk-adjustment throughout Medicaid managed care.**
 - Requires that AHCA, beginning in September 2011, begin to shift towards a risk-adjusted payment system for all Medicaid managed care plans (it’s currently only in Medicaid Reform).
 - Calls for the transition to risk-adjustment to occur in the same way as occurred with Medicaid Reform:
 - 3-year phase-in to full risk-adjustment: 25%, 50% and then 100%
 - Imposes “risk corridors” for 2 years to ensure that no plan’s payment rates fall more than 10% below the overall average.
 - Requires that AHCA convene an advisory panel to advise them on the transition to risk-adjustment.
- 3. Establishes “Medical Home Pilot Project”**
 - Creates new pilot program in 4 counties: Alachua (Gainesville), Hillsborough (Tampa), Miami-Dade and Orange (Orlando) to test “the potential for coordinated and cost-effective care in a fee for service environment and to compare performance...with other managed care models.” (*Deadline unclear*)
 - Provides for at least one “medical home network” in each pilot area. That baseline network will consist of community health centers (for primary care), medical schools (for specialty care) and participating hospitals, which must provide “efficient and effective” access to all necessary Medicaid services.
 - Requires that the networks adhere to key principles, such as an interdisciplinary team – led by a primary care provider – with shared responsibility for the ongoing care of specific patients.
 - Changes the “auto-assignment” process in the 4 counties: recipients who don’t choose will be assigned to a medical home network, until at least 65% of recipients are enrolled in such a network.
 - Requires calculation of cost savings over managed care. Savings may be awarded to network as a bonus.
 - Requires University of Florida to evaluate pilot: preliminary evaluation (2012) and final evaluation (2015).
- 4. Tweaks the Medicaid Reform Pilot**
 - Requires hospitals receiving LIP funding to serve Medicaid recipients regardless of county of residence.
 - Extends the time allotted to PSNs to switch from fee-for-service to capitation from 3 to 5 years (the first PSNs would not need to switch until September 2011 as a result).
 - Keeps HIV/AIDS patients in their current disease management or specialty plan unless they opt out.
 - Neither expands nor seeks to repeal the Pilot.
- 5. Troubleshoots Problems in Medicaid Managed Care**
 - Creates “monitored negotiation” program to allow AHCA to mediate contract disputes between plans and providers.
 - Requires that AHCA report at least annually regarding financial conditions and trends in Medicaid managed care in order to allow Governor/Legislature to assess plan viability, identify risks and make necessary changes.
- 6. Allows for Some Evaluation and Investigation of Alternatives in Real Time**
 - Requires AHCA to convene a workgroup to evaluate the current status and future viability of Medicaid managed care and report by January 2010, including plan performance with respect to access, quality and cost, as well as the potential availability of other models that may improve performance.
- 7. Miscellaneous:** Requires AHCA to set aside up to 2% of plan payments to provide enhanced benefits for healthy behaviors throughout Medicaid managed care (currently only in Medicaid Reform), etc.