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Ms. Stacey Lampkin, FSA, MAAA
Acting Assistant Deputy Secretary for Medicaid Finance
Agency for Health Care Administration
2727 Mahan Drive – Building 3
Tallahassee, FL 32308-5407

Re: High Level Analysis of Medicaid Benchmark Plan for Potential Adult Medicaid Expansion

Dear Stacey:

The Florida Agency for Health Care Administration (AHCA) retained Milliman to model the financial impact of the Medicaid Benchmark Plan as defined by the Affordable Care Act (ACA). The ACA gives states the option to expand Medicaid eligibility to most individuals with annual incomes below 138% of the Federal Poverty Level (FPL) and under the age of 65. States have the option of offering this "expansion population" the state's standard Medicaid State Plan benefit package or a Medicaid Benchmark Plan benefit package.

This letter is intended to provide AHCA with the estimated relative actuarial value of a Medicaid Benchmark Plan as compared to the Florida Medicaid State Plan benefits. We understand AHCA may use the information in this letter as part of its internal evaluation of the optional ACA Medicaid expansion. Milliman has not analyzed other components of the potential cost of the ACA Medicaid expansion.

At AHCA's request, we performed a high-level comparison of the relative actuarial value of the Medicaid Benchmark Plan options for the potential adult Medicaid expansion population. A more detailed modeling approach may produce a different conclusion. The scope of our analysis did not include a detailed comparison of Florida Medicaid State Plan covered services to Benchmark Plan and Essential Health Benefit covered services. In addition, we did not reflect the impact of changes in demographics or expected acuity of the expansion population in our analysis.

Summary of Results

Selecting a Medicaid Benchmark Plan would reduce the cost of providing healthcare to the Medicaid expansion population compared to using the Florida Medicaid State Plan benefit. Table 1 summarizes the relative actuarial value of the Medicaid Benchmark Plan compared to the Florida Medicaid State Plan benefit.

Table 1
Medicaid Benchmark Plan Relative Actuarial Value
Based on High-Level Analysis

Benefit Plan	Estimated Relative Actuarial Value
Florida Medicaid State Plan	100%
Medicaid Benchmark (0-100% of FPL)	97%
Medicaid Benchmark Plan (100-138% of FPL)	94%

AHCA may incur increased administrative costs associated with the design and implementation of a Medicaid Benchmark Plan, but it is not within our scope to estimate these potential administrative costs.

Medicaid Benchmark Plan Cost Sharing

The modeled Medicaid Benchmark Plan was based on two cost-sharing scenarios that divided the population by two levels of FPL. The first covers household incomes below 100% of FPL and the second covers the range from 100-138% of FPL. Nominal charges for out-of-pocket expenses are subject to a cap not exceeding 5% of family income.

Table 2 shows the schedule of cost sharing we assumed for the Florida Medicaid State Plan benefits and the Medicaid Benchmark Plan.

Table 2
Summary of Modeled Benefit Plan Member Cost Sharing

Service	Florida Medicaid State Plan Cost Sharing	Medicaid Benchmark Maximum Cost Sharing (0-100% of FPL)	Medicaid Benchmark Maximum Cost Sharing (100-138% of FPL)
Inpatient Hospital Stay	$2.00 / admission	$3.80 / admission	10%
Inpatient Mental Health	$0.00	$3.80 / admission	10%
Emergency Room	$0.00	$3.80 (waived if admitted)	$3.80 (waived if admitted)
Outpatient Surgical Procedures	$3.00 / visit	$3.80 / visit	10%
Physician Office	$2.00 / day	$3.80 / visit	10%
Chiropractor	$2.00 / visit	$3.80 / visit	10%
Eye Exam	$2.00 / exam	$3.80 / exam	10%
Physical Therapy	$2.00 / visit	$3.80 / visit	10%
Prescription Drugs	$0.00	$3.80 / script	$3.80 / script
Emergency Services	$0.00	$0.00	$0.00
Pregnancy Related Services	$0.00	$0.00	$0.00
Out-of-pocket Maximum (5% of family income)	N/A	$279	$662

Methodology and Assumptions

We used the following methodology and assumptions to develop the high-level estimates presented in this letter:

1. We used data from the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Data Book to establish the baseline utilization and medical cost for the adult TANF population. We chose the adult TANF population as a reasonable proxy to evaluate benefit relativities for the expansion population. We used the following information from the MMA Data Book:
    a. Financial data collected from the capitated managed care plans
    b. Fee-for-service (FFS) data for the services covered on a FFS basis for capitated plan enrollees
    c. Non-emergency transportation funding

We assumed any non-MMA services would not materially impact our analysis because they are expected to be rarely used by the expansion population (e.g., nursing home, home and community based services, etc).

2. We used the utilization and medical cost data compiled in step 1 to calibrate an actuarial cost model based on the Milliman Health Cost Guidelines. We used this actuarial cost model to evaluate the impact of differences in covered benefits and member cost sharing.

3. We evaluated the difference between the Florida Medicaid State Plan benefits and the Medicaid Benchmark Plan

    a. We removed the Medicaid State Plan benefits that are clearly not in the Medicaid benchmark plan (dental services and non-emergency transportation). We assumed any other differences in covered services would not materially impact our analysis.
    b. We evaluated the impact of differences in member cost sharing between the Medicaid State Plan benefits and the Medicaid Benchmark Plan benefits. The impact includes the value of the higher cost sharing plus changes in induced utilization of services caused by the higher cost sharing amounts.

CAVEATS AND LIMITATION ON USE

This letter is intended to provide AHCA with the estimated relative actuarial value of a Medicaid Benchmark Plan compared to the Florida Medicaid State Plan benefits. We understand AHCA may use the information in this letter as part of its internal evaluation of its option to expand Medicaid under the ACA. This information may not be appropriate for other purposes. We understand this letter may be shared with other interested parties.

In preparing this information, we relied on information provided by AHCA and the participating health plans, including health plan financial data and AHCA's FFS data. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

This information should not be relied upon by anyone other than AHCA. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This letter assumes that the reader is familiar with the Florida Medicaid program and the Affordable Care Act.

I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The terms of Milliman's contract with AHCA signed on July 24, 2012 apply to this report and its use.

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If you have any questions, please contact Steve Hanson (262-796-3442) or me (262-796-3434).

Sincerely,

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

Implications of Benchmark Packages for ACA Expansion Populations under Managed Care

BACKGROUND

The Affordable Care Act allows states to use a benchmark benefit package (also known as "Alternative Benefit Plan") to most adults who are newly covered under Medicaid expansion. The benchmark package has at its core a popular commercial benefit set, but must also include certain specified items such as coverage of FQHC/RHC services, EPSDT for 19- and 20-year olds, and non-emergency transportation. It must also include all services in the essential health benefits. For adults over 100% FPL, higher cost sharing is allowed. The attached 2012 article by Manatt provides a good summary of this state option, although it was prepared prior to the November 2013 Essential Health Benefit rule promulgation. A recent relevant State Medicaid Director letter is also attached for reference.

SERVICE EXPENDITURES

Use of a benchmark benefit package allows states to offer a Medicaid expansion program at lower overall costs than using their standard Medicaid benefit packages. Some states are able to achieve more savings than others, depending on the richness of their standard benefit package. AHCA asked its contracted actuary, Milliman, to evaluate the potential cost reduction that Florida could achieve by using a benchmark package. Due to available timing, Milliman's analysis was necessarily very high-level, but it does show that a benchmark package could produce lower costs in Florida's program. Milliman compared the benchmark package to Florida's current State Plan benefits and found the benchmark for populations below 100% FPL could be 3% lower cost and the benchmark package available for populations over 100% FPL (with higher cost sharing) could be 6% lower cost.[1] See the attached March 8, 2013 letter from Milliman for more information. AHCA has evaluated those results in light of the characteristics of the Florida expansion population, including income distribution as well as which expansion enrollees might be eligible for a benchmark package, and estimates that overall savings available with this option could be 3% - 4%. Thus, using the March 8, 2013 consensus ACA "optional expansion" estimate of $3.63 billion for SFY 2014-2015, use of a benchmark package with maximum recipient cost sharing could save $109 - $145 million in that year.

PROGRAM

This remainder of this document provides some comments on operational implications of a benchmark benefit package on the Medicaid program.

- All federal managed care regulations (i.e., BBA) would apply
    - Standard 30-day choice, choice between at least two plans, 90-day change and open enrollment applies

[1] These values may be slightly inflated, as Milliman removed non-emergent transportation from the benchmark calculation, when in fact it appears to be required in the benchmark package. However, this effect should be small and AHCA has included a range of overall adjustment value to accommodate this effect and in acknowledgement that there could be other effects associated with a high-level analysis such as this.

- 1932 SPA can be used to mandatorily assign mandatory populations to Managed Care Organizations. Waiver authority would be needed to assign to FFS PSNs (classified as PIHPs).

- Policy established through rule, handbook and fee schedules would have to be amended.

- Increased system and program complexity related to dual service provision under both the benchmark benefit package and the SMMC and State Plan (FFS) benefits package will require both systems and policy updates.

- Outreach and implementation strategies would need to be developed for recipients, providers and other stakeholders (plans, sister state agencies).

- Determination on how this might affect Florida KidCare programs may need to be considered (for the Agency, particularly MediKids).

- DCF would need the capacity to enroll a large number of recipients in a very short time period.

- AHCA would need to beef up its choice counselor's operations to handle a rapid influx of new Medicaid recipients.

POLICY

Rules/ Handbooks and Fee Schedules

- The Bureau of Medicaid Services is responsible for over 100 rules, many of which of would need to be updated if the State chose to offer a limited benchmark benefit to the newly eligible Medicaid recipients under the Affordable Care Act expansion. Our current rules include handbooks and fee schedules that identify the services, including coverage and limitations, that are available to Medicaid eligible recipients. We would need to clarify the services that this newly covered population is eligible for.

- Multiple Medicaid handbooks (policy and reimbursement) and fee schedules may need to be revised via rule promulgation depending on benchmark package.

- If new services not covered under Medicaid are added, including new provider types, then rule promulgation would be necessary and provider enrollment applications, handbooks, fee schedules, etc., would need to be revised or developed. Habilitation is a required covered service for benchmark plans that is not covered by Florida Medicaid under the state plan today.

- The rulemaking process can generally take anywhere from 9 – 12 months. Here are the steps in the rulemaking process:

Notice of Rule Development

- Notice of rule development (NORD) documents route within the Agency for Health Care Administration
- Once approved, the NORD is submitted to the Office of Fiscal Accountability and Regulatory Reduction (OFARR)
- The NORD is published in the Florida Administratively Weekly.
- A workshop can be held 14 days after the NORD is published.
- Another week is generally to the public to submit comments.

Proposed Rulemaking

- Notice of proposed rulemaking (NOPR) documents route within the Agency for Health Care Administration
- Once approved, the NOPR is submitted to the Office of Fiscal Accountability and Regulatory Reduction (OFARR)
- Once the OFARR completes its review, the NOPR is published in the Florida Administratively Weekly.
- The rule documents are also submitted to the Joint Administrative Procedures committee (JAPC).
- A hearing can be held 21 days after the NOPR is published.
- If a notice of change is needed, the Agency must wait 20 days after the notice of change is published before it can proceed to adoption.

Rule Adoption

- Reference material is finalized and documents route within the Agency
- JAPC is notified and the Agency must wait 7 days before filing the documents with the Department of State
- The Agency must wait 20-days before the rule is adopted.

Emergency Rulemaking

- The Agency can explore the use of expedited, emergency rulemaking for rules that must be in place on January 1, 2014.

CONTRACTING

- 2012-15 Contracts would need to be amended to include the benefit packages, rate development, reporting, enrollment, handbook, network adequacy requirements, performance measures (including HEDIS), possible changes to PIPs, enrollee materials, etc., related to this implementation. For any new provider types, this may include determining network standards for provider types we haven't covered before. Habilitation is a required covered service for benchmark plans that is not covered by Florida Medicaid under the state plan today.

- 2012-15 Report Guide and various report layouts may need to be revised regarding inclusion of this population/benchmarks/provider network file layouts (inclusion of habilitation services, if this population would need to be uniquely tracked for any reason).

- SMMC MMA Contract would need to be revised to include this population and benchmark in the final contract for execution. (There is ITN language that specifies that the contracts will be amended for changes in law, etc.; however, full impact of adding this population and benchmark package to the MMA competitive procurement would need to be reviewed for the following components: benefit packages, rate development, reporting, enrollment, handbook, network adequacy requirements, performance measures (including HEDIS), enrollee materials, etc., related to this implementation.)

- SMMC Report Guide and various report layouts may need to be revised regarding inclusion of this population/benchmarks/provider network file layouts (inclusion of habilitation services, if this population would need to be uniquely tracked for any reason).

- Revision of monitoring tools and plan readiness tools would be needed for this population/benchmark package. Inclusion of the additional benefit package would result in an increased workload to monitor network adequacy, provider and enrollment materials, quality initiatives, and any added performance measures and reporting that would be required from the plans for this population.

- The code of federal regulations requires states to ensure appropriate utilization controls over its Medicaid program. Florida Medicaid maintains prior authorization/utilization management contracts for certain Medicaid services that are provided to fee-for-service recipients. There are currently four contracts that provide these services. These contracts would need to be amended to reflect any scope changes related to the newly eligible population. We may also need to amend our transportation contract with the Commission for Transportation Disadvantaged if these available benchmark options offer limited transportation services.

- All of the contracts have a clause that allows for modifications based on state or federal law changes. Therefore, additional competitive procurements would not be necessary.

IMPACT ON MANAGED CARE PLANS

- Managed care plans would need to develop and implement contractually required provider networks, internal systems for service authorization and claims payment, practice protocols, complaints, appeals and grievance processes, fraud and abuse procedures, encounter data reporting, and outcomes reporting for the expansion population as well as extensive provider outreach/education.

- Managed care plans would need to develop new enrollee and provider materials; such as enrollee and provider handbooks, provider directories; potentially hire additional staff and staff with different skill sets to handle complex troubleshooting,

- Managed care plans would need to revise current enrollment and disenrollment procedures and file processing for these new populations.

SYSTEMS

- Current managed care programming would need to be revised to include this population, benchmark services, new provider types and enrollment, managed care eligibility criteria

(mandatory, voluntary, assignment policy), payment methodology, (rate cells), components would need to cover service provision in FFS Medicaid (if this population received benchmark services while in choice process), FFS PSN authorization and claims processing, and service exclusions if in a capitated plan.

- MMA managed care programming would need to be revised to identify this population, create benchmark services inclusions/exclusions, create new provider types and enrollment, revise managed care eligibility criteria (mandatory, voluntary, assignment),include additional payment methodology, (rate cells),

- FFS programming would need to be revised to include: service provision if this population received benchmark services while in choice process, FFS PSN authorization and claims processing, and service exclusions if in a capitated plan.

- Identifying populations that would be exempt from the benchmark package would be difficult; i.e., the medically fragile population, and the substance abuse population (if it is added as an exempt population).

- Choice process and choice enrollee materials/brochures, scripts, letters would need to be revised or new letters and materials/brochures would need to be created.

- There would be impact to both the Medicaid fiscal agent and choice counseling contracts.

- Interface with DCF and/or hospitals would be needed.