# Florida Medicaid Reform
# EXCEL Plan Evaluation Tool

Florida Medicaid Reform allows capitated health plans to offer customized benefit packages to enrolled Medicaid recipients, as long as the benefit packages meet two tests, both of which are based on the historical medical service utilization patterns of the target population. The two tests are:

- Actuarial equivalence to the State Plan benefits covered under Reform; and
- Benefit sufficiency for certain types of services.

To assist health plans in designing customized benefit packages that will satisfy these tests, AHCA has provided an extensive Data Book that illustrates the historical medical service utilization patterns of each of the target populations. In addition, the Agency has provided the Plan Evaluation Tool (PET) for health plans to test proposed benefit packages before submitting them to AHCA for approval.

**Note: Use of the PET does not convey any information to AHCA. Benefit packages must be submitted to AHCA as described in the Reform application**. Once the benefit package has been reviewed and approved by AHCA, it will be incorporated into the health plan's contract and will form the basis of the formal commitment to covered benefits for the health plan's enrollees.

**Important References for Designing Reform Benefit Packages and Using the PET**

- Florida Medicaid Reform Health Plan Application. The application shows what flexibility is available in Reform packages.
  http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/yeartwo.shtml

- Summary of Services. The Summary of Services outlines the current State Plan benefits and copay levels. http://ahca.myflorida.com/Medicaid/beneficiary.shtml

- Information about requesting the Data Book. The Data Book provides definitions of service categories shown in the PET.
  http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/yeartwo.shtml

## USER INSTRUCTIONS

**INPUT** Identification Information
The first input fields on the Plan Evaluation Tool are for identification purposes: the health plan should:

- enter the name of the health plan
- enter any name associated with the benefit package to be tested, and
- use the drop down menus to identify the target population and Medicaid Reform area for which the package is to be available.

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***As the packages are evaluated specifically for a target population in the selected area, the plan must submit a separate benefit package for each population in each area.***

- Target Populations: there are three available Target Populations for which customized benefit packages may be offered: Aged and Disabled, Children and Families, and HIV-AIDS. Select one from the drop-down box. (There is a fourth Reform target population, Children with Chronic Conditions, for which benefits cannot be defined to be less than current State Plan levels, so these tests do not apply.)

- Reform Areas: there are currently two Medicaid Reform demonstration areas: Duval, Baker, Clay and Nassau Counties (part of AHCA Area 4) and Broward County (AHCA Area 10). Select one Reform demonstration area from the drop-down box. Tests on Area 4 are identical whether your plan will be serving Duval County only, Baker, Clay, and Nassau Counties only, or all Reform counties in Area 4. However, please label your benefit grid specifically with the specific counties your plan will cover.

**INPUT** Proposed Benefits for Flexible Services

The "User Input" worksheet of the PET allows health plans to define benefits for services that are flexible *for non-pregnant adults* under Reform (i.e., can differ from the State Plan level of coverage). Health plans may also apply copayments to benefits where the State Plan authorizes a copay, although the Reform copay may not exceed the copay authorized in the State Plan. Use the "tab" key to navigate user entry fields.

- Coverage levels of most flexible services can be defined in terms of a maximum annual dollar value. ***If a maximum annual dollar value of benefits is used, plans must apply the benefit using the Medicaid fee schedule (i.e., "reprice" services for the purpose of applying any dollar limit) so that plans using dollar-based benefit definitions can be accurately compared by prospective enrollees. Because negotiated rebates are likely to vary between the State and health plans, pharmacy dollar limits are evaluated at a pre-rebate level.***

- Coverage levels of some flexible services can be defined in terms of the maximum number of visits or prescriptions covered. Most of these are measured only on an annual basis, with the exception of pharmacy, which can be defined on either a monthly or annual basis.

- To set the coverage level of a benefit at the State Plan level, leave the input cell blank. Do not use zeros.

- To customize the coverage level, enter the visit/script or annual dollar benefit into the input cell using whole numbers and no commas. **NOTE**: For services that allow definition either as visits or dollars, leave the input cell for the unused category blank.

- The input fields for copayments are pre-populated with the State Plan authorized copays. To define a customized copay for a benefit (which may include waiving the copay), enter the proposed copay in the appropriate input cells. Copays can be incorporated into the package design only on the same basis as authorized under the State Plan (e.g., per admit rather than per day for inpatient services, and coinsurance for dental services rather than a flat dollar copay).

- ***If a copay is used for Outpatient Mental Health, it can be levied on Community Mental Health Services only; it cannot be applied to Targeted Case Management Services.***
- ***Varying copays can be applied to Primary Care Services and Specialist services, but cannot be higher than the current State Plan physician copay.***

**INPUT** Expanded Benefit PMPM
This section of the PET allows health plans to include benefits that are not State Plan covered services – either brand new benefits or expansions of benefits that have limited coverage under the State Plan. As specified in the application, health plans proposing expanded benefits must submit with their application a projected PMPM value for the target population and supporting actuarial justification. The justification must be developed in accordance with 42 CFR 438.6.

- Expanded benefits need not be offered to the entire target population (e.g., adult dental), but the estimated PMPM must be based on the entire membership.

- To include one or more expanded benefits for testing purposes, enter the benefit name and the estimated PMPM for the target population in the input fields.

**REVIEW** the results of the proposed package on the “Report” worksheet. Results are displayed on the screen and show Pass/Fail for the Actuarial Equivalence Test and the Benefit Sufficiency Test. Both tests must receive “PASS” in order for the entire plan to pass.

**Note**: receiving a PASS on a proposed package through the PET does not guarantee AHCA approval. Although the Agency uses the same algorithms as available in the distributed tool, the PMPMs estimated for expanded benefits could be questioned. In addition, while the Agency has made every effort to ensure the accuracy of the PET, it is provided only as a service to health plans. If results differ from the Agency’s evaluation, it is the Agency’s evaluation that will prevail.