

## FLORIDA MEDICAID REFORM

Florida Medicaid serves just over 2 million individuals. Currently, the Florida Medicaid program has agreements with over 80,000 providers. There are over 47 different categories of Medicaid services and more than 140 million individual claims are processed each year. Florida has the fourth largest Medicaid program in the nation in terms of monthly enrollment, which in June 2004 was 2.09 million individuals, and the fifth largest in terms of total annual expenditures (over \$12.8 billion in 2004).<sup>1</sup> The Florida Agency for Health Care Administration (AHCA), which administers the Medicaid program, projected spending of \$14.7 billion in 2005.<sup>2</sup> If these trends continue, by 2015 AHCA projects that Medicaid would represent 59 percent of the state's total budget with expenditures over \$50 billion dollars. Actual caseload in December 2006 was over 2.1 million recipients. The Medicaid budget for 2006-2007 is \$15.9 billion and the projection for 2007-2008 spending is \$16.1 billion.

### **Reform Goals**

Medicaid reform in Florida is intended:

- To constrain growth in Medicaid expenditures;
- To foster patient responsibility through the use of enhanced choice and incentives to engage in healthy practices; and
- To open the Medicaid program to change through the application of marketplace decisions based on choice, competition, private administration, and the bridging of public and private coverage (“opt out” provisions).

Florida's model has been described as a “defined contribution” approach, rather than a “defined benefit” approach, because it is possible that the Florida legislature may restructure funding for the Medicaid program around a set dollar amount per person, rather than a prescribed set of benefits.

The Florida Medicaid program will utilize, upon full implementation of reform, a risk-based capitated system for all non-dual eligible recipients, which will encompass some or perhaps most long-term care benefits. A phased implementation approach that began in Duval and Broward counties was used by the state to introduce the new program. Medicaid reform will reduce the state's contact with individual providers and will shift the coordination tasks to managed care plans.

## **Objectives**

Florida expects to achieve the following objectives through Medicaid reform:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost.
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program.
- Improve health outcomes and reduce inappropriate utilization.
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve.
- Serve as an effective deterrent against fraud and abuse by moving from fee-for-services.
- Maintain strict oversight of managed care plans and adapt its fraud efforts to surveillance of fraud and abuse within the managed care system.
- Provide managed care plans with additional flexibility in creating benefit packages to meet the needs of specific groups.
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

## **Reform Process Background**

In late 2004, representatives of AHCA traveled the state holding a series of public meetings entitled "Florida Medicaid: A Case for Modernization." The presentations focused on the growth in spending and the complexity of the existing Medicaid program, and sought public input on reform concepts. In January 2005, Governor Bush proposed a reform of Florida's Medicaid program and the legislature enacted Senate Bill 838 in the 2005 legislative session directing the AHCA to complete a Medicaid reform waiver application. The legislation specified the features of the reform program and required that the waiver application be submitted to appropriate legislative committees for review prior to submission to the federal Centers for Medicare and Medicaid Services (CMS). The legislature also required that the federally approved waiver application receive full legislative approval prior to implementation. The draft 1115 waiver application was posted on AHCA's website on August 31, 2005 for public review and submission of comments. AHCA submitted the waiver application on October 3, 2005 to the federal CMS, after posting the draft application for thirty days as required by Senate Bill 838. The Florida legislature granted approval to implement Medicaid reform on December 8, 2005 following approval of the waiver by the federal CMS in late October 2005.

## **Implementation Strategy**

Florida's Medicaid reform program began in Duval and Broward counties for most low-income women and children (Temporary Assistance for Needy Families (TANF) group) and individuals with disabilities

(the non-dual Supplemental Security Income (SSI-non Medicare) group) in July 2006. Reform is now being implemented in three counties surrounding Duval County (Clay, Nassau and Baker counties). These counties are part of the original service area authorized by the legislature. The Florida legislature must authorize expansion of reform into other areas of the state. Current Florida law requires completion of an evaluation of the program in the two initial areas for review by the legislature prior to any decisions on expansion. This evaluation will occur after the program has been operational for two years. The legislative reporting entity (the Office of Program Policy Analysis and Government Accountability) will present a report to the legislature in 2008.

Medicaid beneficiaries in the two eligibility groups will be required to enroll in risk-bearing managed care plans (i.e., reform plans), which include Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), insurers, or Provider Service Networks (PSN). (EPOs and insurers are expected to operate similar to PSNs).

Reform will significantly impact Duval County, where 49 percent of recipients eligible for managed care enrollment were enrolled in the Medicaid Provider Access System (MediPass). MediPass is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. The choice to enroll in MediPass will be phased out under reform. In Broward County, a smaller proportion of recipients are enrolled in MediPass (37 percent in March 2006), and of these over 50 percent are enrolled in special networks including the Minority Physician Networks, the Pediatric Emergency Room Diversion network and a Provider Service Network. While all recipients enrolled in reform will experience changes, they will be less dramatic in Broward County where it is expected the existing special networks will become reform plans and the special network enrollees will likely stay with their existing health plan.

### **Program Highlights**

Eligible individuals who are covered by an employer-sponsored plan will have a new choice in Florida under reform: they may opt-out of Medicaid and be covered by their employer-sponsored health insurance plan with the Medicaid program paying up to what it would have paid a reform plan for that eligible.

### Consumer Choice

Medicaid beneficiaries residing in reform areas will be required to select a reform plan, which will provide most of their Medicaid services. If a beneficiary does not select a reform plan within 30 days, the

state will automatically assign the beneficiary to a plan. In order to assist beneficiaries with this requirement, a choice counselor will be contracted by the state to inform every current eligible and each new eligible of the reform plan choices they have. Until eligibles are enrolled into a reform plan they will be provided emergency services, nursing facility services or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) services only.

### Customized Benefit Packages

Reform plans will be permitted to offer customized benefit packages, subject to certain limitations and approval by the state. However, reform plans will be required to offer the same benefits as existed before reform to children and pregnant women.

Customized benefit packages must include all existing mandatory Medicaid services such as physician services and inpatient hospital services. However, reform plans may offer different optional service packages, which will be evaluated in “two groups.” Reform plans are expected to offer optional services such as durable medical equipment (DME) and outpatient hospital services and these services must be determined to be “sufficient” based on an assessment by the state. Other optional services such as chiropractic care or physical therapy may be offered, and are not subject to a sufficiency test. In addition, the AHCA has defined four target populations that reform plans may serve: mandatory groups, voluntary groups, children with chronic conditions (CCCs) and people with AIDS (PWA). Reform plans will propose a customized benefit package for each of these groups they plan to serve. All benefit packages must be actuarially equivalent to the current benefits package and most of the benefits will also be tested for actuarial sufficiency.

### Enhanced Benefit Accounts

Beneficiaries participating in reform will be provided with an opportunity to earn money to purchase “enhanced benefits.” Plans administer the benefits. Money will be earned when a beneficiary participates in a specified list of “healthy behaviors” being developed by the state, such as smoking cessation and exercise. Funds will be deposited in an “Enhanced Benefits Account” and may be used to purchase health-related items such as over-the-counter drugs and weight reduction items not covered by Medicaid. A total of \$125 a year may be accumulated per recipient. The list of qualifying activities and qualifying expenditures has been posted on the Florida Medicaid Reform website.

Reform HMOs will be paid a risk-based capitation rate for their members and PSNs may be paid fee-for-service for up to three years before being mandated into a risk-based capitation rate system for payment, receiving the same payment as the HMOs at that time. In order to track and evaluate the implementation

of reform and identify the specific services that reform plans offer their enrollees, HMOs and PSNs will be required to supply encounter data, on a phased approach, beginning in state fiscal year (SFY) 2006-2007.

### **UPL Program**

One of the special terms agreed to by the federal CMS when approving Florida's reform waiver, was to continue Florida's upper payment limit (UPL) program as a low-income pool (LIP). Under reform a LIP will be established and maintained by the state to provide direct payment and distributions to safety net providers for the purpose of providing coverage to the uninsured. Funds will be distributed to safety net providers that meet certain state and federal requirements. Recommendations for the reimbursement and funding methodology for the LIP will be developed by the Disproportionate Share Hospital (DSH) Council, which was renamed the Medicaid Low-Income Pool Council effective July 1, 2006, and submitted to the legislature for review and approval. However, the recently released proposed revisions to the UPL program may have a dramatic impact on this arrangement. CMS is proposing limitations on intergovernmental transfers (IGTs) and government hospitals will be limited to cost when calculating the UPL. The proposed rules specifically note they will be applicable to all prior UPL arrangements, including those authorized under Medicaid waivers (as in the case of Florida's Medicaid Reform UPL arrangement).

### **Long-Term Care Services**

One final change expected under reform following the initial period of implementation is the gradual inclusion of long-term care (LTC) services. The AHCA expects to add additional services and groups to the demonstration before the end of the five-year period. Upon full implementation, Medicaid reform will serve the vast majority of Medicaid enrollees and include most services, including LTC services.

The inclusion of persons who typically use LTC services (e.g., persons with developmental disabilities, children with special health care needs, and dual eligibles) is dependent upon the state's development and implementation of networks to meet their special needs.

The eventual inclusion of LTC services is likely to include development of one or more models similar to Florida's existing Nursing Home Diversion Waiver program and to the proposed Florida Senior Care program. These programs encompass acute and LTC services, including nursing facility services. The contracted entity receives a monthly capitation payment, which has been developed to incentivize the

provision of home and community-based services rather than nursing facility services. The contracted entity is responsible for ensuring enrollees have access to all covered services and must have a network of providers in place before enrollment can begin.

More details regarding Florida Medicaid Reform are available on the AHCA's website at:

[http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml).

#### **Endnotes:**

<sup>1</sup> Kaiser Family Foundation. State Health Facts. <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>. Retrieved April 11, 2006.

<sup>2</sup> Florida Medicaid. Presentation to Florida State Medical School. Tom Arnold, Deputy Director, Florida Agency for Health Care Administration. October 24, 2005.

This fact sheet was produced for the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City by Health Management Associates (HMA) and is available online at [www.mffh.org](http://www.mffh.org) or at (314) 345-5576. HMA is a national health care research and consulting firm whose senior professionals work with Medicaid, SCHIP, Medicare, and other public programs and with the local, state and federal government agencies that develop and administer them, as well as the providers and others who participate in those programs and foundations that evaluate the outcomes the programs achieve.



2700 East 18th Street, Suite 220 Kansas City, MO 64127 877.241.7006 [www.healthcare4kc.org](http://www.healthcare4kc.org)

**Missouri Foundation for Health** 1000 St. Louis Union Station, Suite 400 St. Louis, MO 63103 800.655.5560 [www.mffh.org](http://www.mffh.org)