

Looking Ahead to 2012, What Changes Are In Store for Florida's Medicaid Program?

Florida's Experience with

MEDICAID REFORM

Floridians may see significant changes in the state's Medicaid program in 2012 due to a combination of factors: A desire to extend the state's five-year pilot program now operating in Broward, Duval and three rural counties; a proposed statewide expansion of a modified version of this pilot; and significant changes to the delivery of long-term care services approved by the Florida Legislature in May 2011. Many of these changes must be negotiated with the federal government.

BACKGROUND

Florida's Medicaid program is an essential component of the state's health care system, covering more than 3.1 million people, the majority of whom are children. Florida Medicaid also is the largest source of long-term care services, covers a substantial number of the state's births, and provides critical support for mental health services and care for people with HIV and other persons with disabling or chronic conditions.

As a federal-state partnership, Florida Medicaid receives federal funds based on the amount of money the state spends. This "matching rate" is determined by a national formula. In the next three fiscal years, it is estimated that for every \$1 Florida spends on Medicaid, the federal government will give the state 58-59 cents.⁽¹⁾ Currently, annual costs for Florida Medicaid are slightly less than \$20.3 billion.⁽²⁾

In exchange for this open-ended source of federal funding, federal law establishes certain requirements and options regarding who must be covered, what services they receive and how those services are provided. When a state wants to test a new approach or idea and use federal matching funds to do so, the state must request a waiver of existing federal Medicaid rules. The broadest statutory authority through which a state may make such a request is known as a Section 1115 Research and Demonstration waiver. Section 1115 waivers also contain "budget neutrality" agreements, which prohibit states from developing new programs that are more costly. States also may seek more limited waiver authority to implement managed care for some populations and to expand home and community-based care options through what are known as 1915 waivers.

On May 6, 2011, the Florida Legislature passed a far-reaching statute, House Bill (HB) 7107, authorizing the

state to make changes to Florida's Medicaid program. Some program changes that the state is seeking require waiver authority from the federal government and others do not.

Principal among the changes is a desire to move much of Florida's acute and long-term care services into capitated managed care. Capitated managed care means that a managed care company receives a monthly payment to cover most or all of the services that a beneficiary receives, rather than providers being paid on a fee-for-service basis. As of June, 2009 just fewer than 1 million of Florida's Medicaid beneficiaries were enrolled in capitated managed care.⁽³⁾

HB 7107 seeks to build on a Medicaid pilot program operating in five Florida counties that was launched in 2006. The pilot has a unique variant of managed care, and the bill would expand that statewide, despite limited evidence that this pilot has saved money or improved the quality of care.⁽⁴⁾

On an even faster timeline, the state is seeking to move long-term care services into managed care. Other changes covered by HB 7107 include increased beneficiary cost-sharing in the form of new premiums and copayments. They are described below.

MEDICAID'S BUDGET: PUTTING MEDICAID COSTS IN CONTEXT

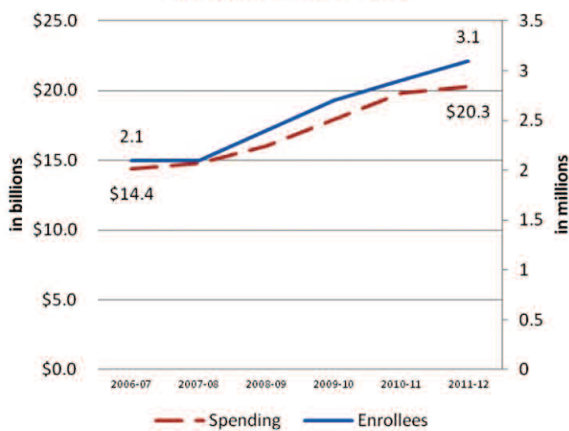
Much of the impetus for changes to the Medicaid program emanates from a desire to control costs. Florida, like other states, faces a budgetary shortfall as a result of poor economic conditions and state policy choices.

Florida's general fund revenues have declined 10.3 percent over the past five years⁽⁵⁾ while enrollment in the state's Medicaid

program has grown by approximately 1 million persons. Increases in Florida's Medicaid costs are very closely correlated to this increase in enrollment, as Exhibit 1 shows below.

The trends shown in Exhibit 1 are important because, by contrast, cost growth in the private-sector health system is primarily due to the cost of services going up – rather than more people being covered, as is the case in Florida's Medicaid program. Florida's Medicaid program is in fact already more efficient than the private sector in containing costs – in large part due to low provider reimbursement rates. Health care cost growth has been much more pronounced in the private sector (Exhibit 2). Premiums for family coverage provided through employer-sponsored insurance nationally have increased more than 31 percent in the past five years, while per-person costs in Florida's Medicaid program have actually decreased almost 5 percent over the same period.

EXHIBIT 1: Growth in Florida Medicaid Enrollment and Spending, 2006-2011

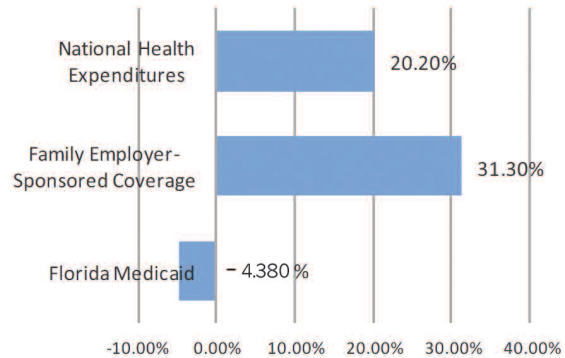


Source: Georgetown University calculations of "Social Services Estimating Conference - Medicaid Services Expenditures" (March 1, 2011); and "Social Services Estimating Conference - Basic Medicaid Caseloads, Historical and Forecasted" (September 9, 2011) and "Social Services Estimating Conference – Medicaid Services Expenditures" (October 17, 2011).

WHAT'S IN THE 2011 LEGISLATION AND HOW DOES IT BUILD ON THE PILOT WAIVER?

The recently passed HB 7107 outlines a far-reaching expansion of managed care and other components of the five-county pilot waiver. Following is a look at key components of the law, and whether those components would or would not require a new waiver.

EXHIBIT 2. Per Person Five-Year Growth in Health Care Costs 2006-2011



Source: Georgetown University calculations of Kaiser Family Foundation & Health Research & Educational Trust, "Employer Health Benefits 2011 Annual Survey" (September 2011); 2006-2009 and Projected 2010-2011 National Health Expenditure Data;"Social Services Estimating Conference - Medicaid Services Expenditures" (March 1, 2011); and "Social Services Estimating Conference - Basic Medicaid Caseloads, Historical and Forecasted" (January 24, 2011).

Managed Care: The new law would require the enrollment of the vast majority of Medicaid beneficiaries statewide into managed care (See Exhibit 3 on page 5). The state does not need a waiver to enroll many Medicaid beneficiaries (i.e. most children who are in Medicaid as a result of their income being low, their parents, and adults with disabilities who are not in long-term care settings) as long as certain consumer protections are observed.

Children who are in foster care or are receiving Medicaid because they are disabled may not be placed in managed care without a waiver.

As described in more detail in the box on Page 3, the state is seeking to expand to new populations its unique approach to managed care, which for non-pregnant adults gives plans unprecedented flexibility to determine the benefits package. This issue and many others have been closely examined by the federal Centers for Medicare & Medicaid Services in the context of the five-county pilot waiver and any decisions made in that context are likely to carry over to a statewide expansion (See box, Page 3).

Monthly Premiums: The law includes a proposal to charge every person enrolled in managed care a \$10 monthly premium regardless of income or age. No other state has sought such expansive premiums – especially for children – at such low income levels, and this proposal, if approved, is likely to result in major declines in enrollment.

(See Brief #2, “Proposed Medicaid Premiums Challenge Coverage for Florida’s Children and Parents” for more details.) This change would require a waiver.

Special Charges: The legislation also includes a provision to charge beneficiaries a \$100 copayment for non-emergency use of the emergency room. States have some flexibility under existing Medicaid law to charge a copayment for non-emergency use of the ER⁽⁶⁾, but a charge this high would require waiver authority from the federal government. New Jersey recently proposed a copay of \$25 for non-emergency use of the ER as part of its Section 1115 waiver request, but dropped this proposal after public comments were negative.

Long-Term Care: A key component of HB 7107 is the Long-Term Care Managed Care Program, which requires that the Florida Agency for Health Care Administration, in partnership with the Department of Elder Affairs, implement the program beginning July 1, 2012 and reach full implementation by October 1, 2013. The plan is to enroll beneficiaries over a nine-month period beginning January 2013. The proposal suggests a competitive procurement process to select long-term care managed-care organizations, also called plans, for each of 11 regions in the state. Health Maintenance Organizations, Provider Service Networks, and similar organizations are eligible to participate. Beneficiaries in each region would have a choice of plans.

Implementation on this timeframe is a major undertaking that could be challenging for a state that has limited experience with comprehensive managed long-term care. State officials must establish policies and procedures for a new program that targets not only the most costly, but also the most vulnerable Medicaid beneficiaries.

Individuals who are 65 years of age or older or who are 18 years of age or older and are eligible for Medicaid by reason of a disability must enroll in the new program if they now participate in any of five of the Elder and Disabled waiver programs that Florida currently operates or if they receive nursing facility or hospice care⁽⁷⁾. Individuals currently enrolled in Disease-Specific or Developmental Disability long-term care waivers are not required to enroll in the new managed-care program.

The state must obtain waiver authority from the federal government to operate the new program. Uncertainty about the timing of waiver proposal negotiations and approval also complicates plans for implementation.

Enhanced Benefits: One aspect of the five-county pilot waiver that was featured in much of the discussion around the original program is the Enhanced Benefits program – designed to encourage healthy behaviors on

THE FIVE-COUNTY PILOT WAIVER: WHAT ABOUT THE REQUESTED EXTENSION?

The five-county Medicaid pilot that began in 2006 operated under a Section 1115 Medicaid Research and Demonstration waiver from the federal government. On June 30, 2010 – a year prior to its expiration, as is common practice – the State of Florida submitted a request to the federal Centers for Medicare & Medicaid Services (CMS) to extend its waiver for three more years.

The pilot enables the provision of services through managed care in Broward and Duval counties and three rural counties surrounding Duval. As discussed in our other studies of the pilot, Florida’s managed care in these counties is unusual because plans have unprecedented flexibility to determine the benefits package for most adults and limit and adjust benefits in ways that are not usually permitted in Medicaid⁽⁸⁾.

While managed care is the heart of the request, the state also originally sought to extend other features of its waiver, including the enhanced benefits program, which provides rewards to encourage certain healthy behaviors, and the opt-out program, which permits families to enroll in their employer-sponsored insurance in these counties, though they must pay additional costs.

Another high stakes issue is the Low Income Pool which has been providing Florida with an additional \$1 billion annually in federal funds to compensate providers who see a large volume of uninsured persons. Whether this revenue stream continues and, if so, at what level, is obviously of great concern to the state and providers.

The request is still under discussion with federal CMS and the waiver currently is operating under a series of 15- or 30-day extensions. Official correspondence between the state and CMS is available at http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/index.shtml.

According to press reports, most issues have been resolved except for financing questions related to the Low Income Pool and the application of a Medical/Loss ratio to participating managed-care plans.⁽⁹⁾ Draft terms that have been obtained suggest that CMS will no longer permit the state to limit children’s benefits, known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT), in the limited circumstances in which they had been waived previously. Some changes to the adult benefit package appear to be under consideration as well. It is likely that changes made to the terms and conditions of the five-county pilot waiver will carry over to the new waiver.

the part of beneficiaries by giving them credits for certain behaviors, such as keeping a doctor's appointment and receiving preventive care such as immunizations. Currently, in the five pilot counties beneficiaries earn credits that are redeemed at drugstores to buy health related products. This program appeared to be popular with beneficiaries, but there was little evidence that it was changing behaviors⁽¹⁰⁾. It appears that the Enhanced Benefits program in its current form has been dropped and replaced with a requirement that managed-care plans include smoking cessation, weight loss and substance abuse treatment programs in their package of services.

Opt-out: The "opt-out" program, approved for the five pilot counties, permits families to choose to use the value of their Medicaid coverage as a subsidy to purchase their employer-sponsored insurance.

The state has submitted and received federal approval to convert the opt-out program to a "Section 1906" premium assistance program through a state plan amendment. Section 1906 allows Medicaid funds to be used to purchase employer-sponsored insurance but families must not face higher cost-sharing or more limited benefits as a result. In the past, families who participated in the opt-out were required to pay all copayments and deductibles associated with the cost of private coverage. Enrollment has been extremely low. In the new Section 1906 program, families can be required to participate if the state deems that this approach will be cost-effective, but families should face no additional cost burden, and children will continue to be guaranteed the Medicaid "EPSDT" benefits package, which had been waived in the past.

WHAT IS THE FEDERAL GOVERNMENT'S PROCESS FOR REVIEW?

The five-county pilot operated under a Section 1115 Medicaid Research and Demonstration waiver that expired in June 2011, and the state has requested an extension of that waiver (See box, Page 3). On August 1, 2011, in accordance with a state statutory deadline included in HB 7107, the state submitted its request to implement features of HB 7107 and go statewide through an amendment to that pilot waiver-extension request.⁽¹¹⁾

Section 1115 waivers have no official timelines on the federal side and negotiations often take many months – sometimes years when issues are complex. However, as mentioned above, some aspects of the waiver have been negotiated already in the context of the five-county pilot

renewal, while some aspects of HB 7107 are new and will require careful scrutiny on the part of the federal government. Public participation is a required component of the Section 1115 waiver process.

For the Long-Term Care Managed Care Program, Florida submitted 1915(b) and (c) waivers, relying on a waiver combination approach that has been used historically to provide managed long-term services and supports. CMS has determined in the past that waivers to section 1915 (b) of the Social Security Act permit states to mandatorily enroll beneficiaries in Medicaid managed-care plans and to contract selectively with certain service providers. Waivers to section 1915(c), sometimes called home and community-based service (HCBS) waivers, allow states to provide services in a community-based setting to select groups of individuals who otherwise would require institutional services reimbursable by Medicaid. These waivers are subject to a federal clock of 90 days, although requests for more information do stop the clock.

ENDNOTES

- (1) "Florida Medicaid Caseload and Expenditures," Social Services Estimating Conference, October 17, 2011.
- (2) Ibid.
- (3) Kaiser State Health Facts, "Florida Enrollment by Medicaid MC Plan Type. Includes Commercial and Medicaid only MCOs." Available at statehealthfacts.org.
- (4) Georgetown's previous research included an extensive evaluation of this pilot, for more information see project papers at hpi.georgetown.edu/floridamedicaid.
- (5) Georgetown University Center for Children and Families analysis based on National Governors Association and National Association of State Budget Officers, "The Fiscal Survey of States: Spring 2011" (Spring 2011); and National Governors Association and National Association of State Budget Officers, "The Fiscal Survey of States: Spring 2008" (Spring 2008).
- (6) Federal Register: "Medicaid Program; Premiums and Cost Sharing" 42 CFR Parts 447 and 457.
- (7) The five waivers to be incorporated in the LTCMC program include the Adult Day Health Care, Aged and Disabled, Assisted Living for the Frail Elderly, Channeling for Frail Elders, and Nursing Home Diversion waivers.
- (8) See project findings at hpi.georgetown.edu/floridamedicaid.
- (9) In this context, Medical/Loss Ratio refers to the proportion of managed care dollars that must be spent on patient care as opposed to items such as administration and marketing.
- (10) See Joan Alker and Jack Hoadley, "The Enhanced Benefits Rewards Program: Is it changing the way Medicaid beneficiaries approach their health?" Policy Brief, July 2008.
- (11) The state's submission is available at http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf

EXHIBIT 3. WHO MUST GO INTO MANAGED ACUTE CARE?

STATUS UNDER HB 7107	ELIGIBILITY GROUP
Mandatory Populations	Children and parents who are eligible because of their incomes Aged and Disabled persons receiving SSI disability (except those with developmental disabilities) Children eligible because they are disabled (SSI) Pregnant women* Children with chronic conditions who participate in Children's Medical Services Network* Children in foster care and/or receiving adoption subsidies* Individuals eligible for hospice-related services* Individuals eligible for both Medicaid and Medicare ("dual eligibles")* "Medically Needy"*
Voluntary Populations	Individuals residing in an institution, such as a nursing home, sub-acute inpatient psychiatric facility for those under the age of 21, or an Intermediate Care Facility for the Developmentally Disabled Individuals with developmental disabilities Individuals that have other creditable health care coverage, excluding Medicare* Individuals residing in residential commitment facilities, operated through the Department of Juvenile Justice or mental health treatment facilities* Refugees* Individuals with developmental disabilities enrolled in the home and community based services waiver program, those on the waiting list for this program, or those who are residents of developmental disabilities centers*
Exempt Populations	Women who are eligible for family planning services Women who are eligible through the breast and cervical cancer program Persons who are eligible for emergency Medicaid only Children receiving services in a pediatric extended care facility
* indicates a new population not included in the current five-county pilot waiver.	

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Copies may be found at www.dupontfund.org, www.wphf.org and at hpi.georgetown.edu/floridamedicaid.

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