The Florida Medicaid Reform Proposal

Proposal in Brief

Target population: Current Medicaid beneficiaries; not a coverage expansion.

Sources of Coverage: Medicaid managed care.

Coverage Incentives: Mandatory managed care enrollment; varied benefit packages.

Financing: Budget neutral.

Timing: Pilot project implemented in two counties in September 2006; full implementation expected by June 2010.

In March 2004, Gov. Jeb Bush released his proposal to reform the Florida Medicaid program. The plan creates a consumer-directed managed care model, under which beneficiaries would receive a risk-adjusted premium voucher to purchase health care from a private insurer. Medicaid managed care plans will be able to compete for enrollment by offering benefit packages that vary from the standard Medicaid benefits. This plan is intended only to change the way Medicaid benefits are delivered; it does not expand coverage to new populations. In May 2004, the state legislature approved implementation of the plan as a pilot program in two counties. The legislature will need to re-approve the plan before it can be implemented statewide. In October 2005, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 waiver, permitting the state to implement the reform proposal. Enrollment in Broward and Duval counties began in September 2006. In 2007, Gov. Charlie Crist took office; he has indicated that he will continue to support the Medicaid reform plan. Florida expects the plan to be fully implemented by June 2010.

PROPOSAL SUMMARY

***Managed Care Coverage*:** Assuming the legislature approves expansion of the plan statewide, Florida will enroll virtually all of its Medicaid beneficiaries into managed care plans by 2010. The state will contract with private managed care organizations and other insurers to enroll the Medicaid population. The state will pay each plan a risk-adjusted premium for each member based on gender, age, geographic location, and health status. The premium will be divided into "comprehensive" care, "catastrophic" care, and an enhanced benefit component. The comprehensive component will pay for covered services up to a defined catastrophic threshold. The catastrophic component will cover spending above the catastrophic threshold, up to a maximum benefit limit.[1] Florida is also pursuing a Senior Care waiver that would shift Medicaid beneficiaries over age 60 into comprehensive managed care plans to coordinate acute and long-term care services, including Medicare services.

***Benefit Packages*:** Plans participating in the Florida Medicaid program will have the option to offer varied benefit packages, instead of offering the standard Medicaid-covered services. Plans must cover all federal mandatory services, but can determine whether or not to cover optional or expansion services.[2] Plans may vary the amount, duration, and scope of all benefits. However, total plan bids must be actuarially equivalent to the current state Medicaid benefit package. Plans may impose cost-sharing requirements up to the federal nominal levels.

***Enrollment and Opt-Out*:** Florida Medicaid beneficiaries will be required to select a managed care plan when they apply for Medicaid eligibility. Individuals who do not select a plan within 30 days will be auto-enrolled into a plan. The state will coordinate an education and outreach campaign that will provide detailed consumer education about available plans' coverage and quality. The state has contracted with a vendor to employ choice counselors to assist beneficiaries, in person and by phone, with their plan selection. Plan vendors will be allowed to market directly to beneficiaries using materials approved by the state. Beneficiaries will be able

Florida Quick Facts

Population:
17.6M (US total: 292.9M)
4th largest state

No. and Percent Uninsured:
3.6M; 20% (US: 46.6M; 16%)
3rd highest uninsured rate

Median Household Income:
$42,079 (US: $44,684)
16th lowest

Undocumented Immigrants:
900,000; 5% (US: 9.3M; 3%)
3rd highest number of undocumented immigrants

Avg. Annual Cost of Employer-Sponsored Insurance (ESI) (individual per year):
$3,807 (US: $3,705)
17th highest

Medicaid Enrollment:
2.8M; 17% (US: 55.0M; 19%)
25th in % pop. covered

Medicaid Coverage of Working Parents
58% FPL (US avg: 65% FPL)

Sources: Kaiser State Health Facts; Urban Institute Estimates of Undocumented Immigrants, January 2004.

to change plans once a year during the open enrollment period. Medicaid beneficiaries may opt out of the Medicaid managed care system and use their premium value to subsidize employer-sponsored or other private insurance. If beneficiaries opt out, the state will not impose minimum benefit or cost-sharing requirements on these plans.

***Enhanced Benefits*:** The Florida plan includes an enhanced benefit component that rewards beneficiaries for positive health practices. Under the plan, beneficiaries who participate in specified healthy lifestyle programs (e.g., smoking cessation or weight loss) can earn contributions to their enhanced benefit account, similar to a Flexible Spending Account. Funds in this account may be used to purchase additional health care services (e.g., over-the-counter medications). Beneficiaries who become ineligible for Medicaid will be able to access their enhanced benefit accounts after their Medicaid coverage has ended. The state will contract with a private company to administer the enhanced benefit accounts.

OTHER KEY COMPONENTS

***Wellness, Prevention, & Care Coordination*:** The Florida Medicaid reform plan will emphasize beneficiary wellness through its enhanced benefit program. This program will create incentives for beneficiaries to make healthy lifestyle decisions and improvements. The state hopes these changes will improve overall beneficiary health and reduce health care costs.

***Quality*:** Florida's reform plan focus on shifting to a private delivery model, rather than improving quality through direct quality-related interventions. Most managed care plans conduct their own quality and care coordination programs. The state is responsible for ongoing monitoring and oversight of the plans to ensure that beneficiaries receive quality care.

***Health Information Technology (HIT)*:** The Florida plan does not include any provisions to expand HIT in the state.

BUDGET ESTIMATES

The Florida Medicaid reforms are projected to be budget neutral. Terms of the federal Medicaid waiver limit federal funding on a per capita basis to the pre-waiver levels. Because the private plans' benefit packages must be actuarially equivalent to current coverage, the state is not expected to save money as a result of the changes. However, by moving to a defined contribution model, the state hopes to gain additional predictability in its Medicaid spending.

NEXT STEPS FOR IMPLEMENTATION

Florida's Medicaid agency has successfully contracted with health plans, conducted beneficiary outreach, and enrolled members into managed care plans in its pilot areas. There are 11 plans available in Broward County and four in Duval County. Seven of these plans have no co-payment requirements and another nine are offering additional services to beneficiaries. Before the legislature approves the statewide expansion of the plan, the agency must demonstrate its overall effectiveness in these two counties. Florida will need to collect and analyze data on the availability of managed care plans, the adequacy of provider networks, and quality of care received by beneficiaries. Once it is approved, Florida will continue to expand contracting and enrollment efforts throughout the rest of the state.

SOURCES

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

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[1] The state will set a maximum benefit limit for each beneficiary. Any health care spending above the maximum benefit limit will become uncompensated care and will not be reimbursed by Medicaid. Most plans will be responsible for beneficiaries' comprehensive and catastrophic care. However, in some cases, plans may elect not to bear risk for the catastrophic coverage. In this case, the state will assume responsibility for catastrophic coverage.

[2] Expansion services refer to those benefits not currently covered by the state Medicaid plan. The most common expansion services included in the plan bids were over-the-counter drug benefits and adult preventive dental services.