

FLORIDA'S HEALTH AT RISK

Fourth in a series of educational briefs on issues impacting Florida's families

Understanding Florida's Medicaid Reform Legislation

INTRODUCTION

On June 3, 2005 Florida Gov. Jeb Bush signed historic legislation aimed at reforming Medicaid, the health insurance program for more than 2.1 million low-income families, elderly and disabled Floridians. The legislation (Senate Bill 838 or SB 838) permits the state to submit a "Section 1115" Medicaid waiver proposal to the federal government and to implement his reforms on a pilot basis.¹

The bill makes many changes to the state's Medicaid program, some of which do and do not require a waiver of federal Medicaid law. This brief, however, examines only those sections of the legislation which relate to the Medicaid

1 The Medicaid Reform Act offers significant opportunities for the public to provide input into the reform process. See **Figure 4 on page 3**. The governor is encouraging public input into the process. It will be of vital importance for the public to examine the details of the state's Section 1115 Medicaid Reform Waiver proposal, as well as the various analyses required by SB 838, to understand the impact of the proposed changes. For more information on what a Section 1115 waiver is, see a previous Policy Brief in this series; "What Could a Waiver to Restructure Medicaid Mean for Florida?" *Winter Park Health Foundation*. April 2004. Available at <http://www.wphf.org/access/pubs/Medicaid.pdf>. For a national overview of recent Section 1115 waiver activity, see Artiga, S. and Mann, C. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) March 2005.

"Empowered Care" Section 1115 waiver proposal the state will soon be submitting to the federal government for approval.²

Gov. Bush has proposed a major restructuring of Florida's Medicaid program premised on the notion that fostering competition among private insurance carriers and provider networks would save the state money without compromising the quality and scope of services that Medicaid beneficiaries receive.³ To accomplish this goal, the governor has proposed developing individually risk-adjusted premiums for beneficiaries within an overall limit on Medicaid spending. Managed care plans

2 The authorization for a Medicaid managed care pilot program is found at Section 409.91211 as created by SB 838.

3 For more information on the governor's proposal, see the state's website www.empoweredcare.com. Also see a previous brief in this series: "Issues to Consider in Gov. Bush's Florida's Medicaid Modernization Proposal." *Winter Park Health Foundation*. March 2005. Available at www.wphf.org/access/pubs/Medicaid3.pdf

would be required to provide federally-mandated benefits, but plans would have the flexibility – at least for adult beneficiaries – to determine the amount, duration and scope of the benefits Medicaid beneficiaries will receive.⁴

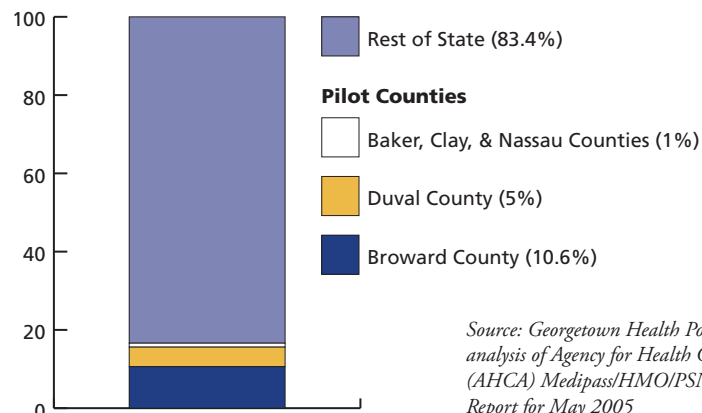
SB 838 permits the governor to seek a waiver from the federal government which generally conforms with the structure of the state's proposed "Empowered Care" reform, but provides for extensive legislative oversight and ongoing public input. (See **Figure 4 on page 3**). SB 838 requires the full Legislature to vote again twice on the issue - first to permit implementation of the waiver once it is approved by the federal government, and, second to permit statewide expansion of the pilot sites.

Even with the passage of SB 838 there are still many important details missing concerning the structure of the governor's proposal. For example, there is still no information on the budget and financing implications of the proposal. As such, it will be important for legislators and their constituents to examine the details of the waiver as they become available and the process moves forward.

4 See "Issues to Consider" as cited in previous footnote. Also see "Frequently Asked Reform Questions" on www.empoweredcare.com where it is stated "Plans will set varied benefit packages that will be tailored to meet individual needs of beneficiaries," on p. 4.

Figure 1: Florida Medicaid Enrollment

2.1 million as of May 2005



Source: Georgetown Health Policy Institute analysis of Agency for Health Care Administration (AHCA) Medipass/HMO/PSN Enrollment Report for May 2005



Who will be affected by the Legislature’s action?

SB 838 specifies that the state must first implement the reform in two counties – Broward and Duval. Then the state may proceed to expand the pilot sites to include Baker, Clay and Nassau counties – more rural counties adjacent to Duval County. Approximately 16 percent of Florida’s Medicaid beneficiaries live in these counties – 10 percent in Broward County alone (see Figure 1 on page 1).⁵

Broward County: Approximately ten percent of Florida’s population, as well as approximately 10 percent of its Medicaid enrollees, live in Broward County,⁶ which lies north of Miami. Broward is an ethnically diverse county with 20 percent of its residents being African-American (as compared to 15 percent statewide)⁷ and a large retiree community. Medicaid enrollment in Broward grew at roughly the same rate as in the state overall for the last year.⁸ Currently, Broward has seven capitated managed care plans operating with approximately 78,660 or 35 percent of its Medicaid population enrolled.⁹

Duval and surrounding counties: Approximately 5 percent of the state’s population and its Medicaid beneficiaries reside in Duval County – primarily in the city of Jacksonville. Duval is also diverse with 28 percent of its residents being African-American (15 percent statewide).¹⁰ However, unlike Broward County, Medicaid enrollment in Duval

5 It is unlikely, however, that all Medicaid beneficiaries will be enrolled in the pilots. See section below on *Who will be enrolled in the demonstration pilots?*

6 *Broward County QuickFacts from the US Census Bureau* available at quickfacts.census.gov/qfd/states/12/12011/html

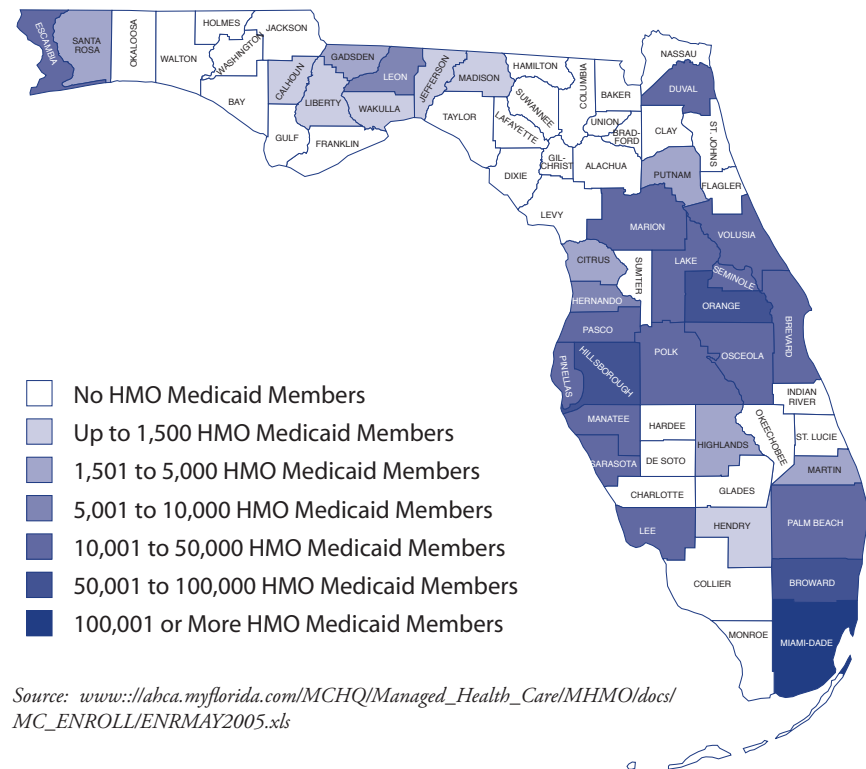
7 Ibid.

8 Center for Children and Families (CCF), Georgetown Health Policy Institute analysis of AHCA enrollment data from May 2004 to May 2005. Overall enrollment grew by 3.5 percent statewide and enrollment in Broward County increased 3.4 percent.

9 Agency for Health Care Administration (AHCA) *Medipass/HMO/PSN Enrollment Report* for May 2005.

10 *Duval County QuickFacts from the US Census Bureau* available at quickfacts.census.gov/qfd/states/12/12031.html

Figure 2: Current Medicaid HMO Enrollment, May 2005



Source: [www://abca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/ENRMAY2005.xls](http://abca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/ENRMAY2005.xls)

County actually declined over the last year.¹¹ Duval currently has only one HMO with 40,274 persons – or 43 percent of its Medicaid eligible population – enrolled in capitated managed care.¹² The surrounding predominantly rural counties currently have no capitated

managed care operating for their Medicaid beneficiaries. Figure 2 displays the counties where HMOs currently enroll Medicaid beneficiaries, including MediKids.

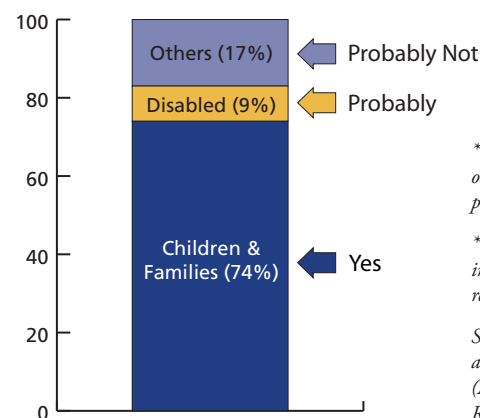
Who will be enrolled in the demonstration pilots?

Under SB 838, the governor and the Agency for Health Care Administration (AHCA), which administers Florida’s Medicaid program, are authorized to determine which populations

11 CCF analysis of AHCA enrollment data from May 2004 to May 2005 shows a decline of 1,011 enrollees in Duval County.
12 abca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/ENRMAY2005.xls

Figure 3: Who Will Be Required to Participate in Broward County?

Total Medicaid Enrollment in Broward County = 224,743



*Revised June 27, 2005

* People with disabilities who are not on Medicare or institutionalized will probably be required to participate.

** Others, including people on Medicare and in nursing homes, are probably unlikely to be required to participate.

Source: Georgetown Health Policy Institute analysis of Agency for Health Care Administration (AHCA) *Medipass/HMO/PSN Enrollment Report* for May 2005

will be required to participate in the demonstration programs. Based on available information from the state, it is likely that all children (both those in Medicaid and the state's Title XXI Healthy Kids program), their parents, pregnant women and disabled persons who are not institutionalized will be required to participate.¹³ These groups comprise the vast majority of persons eligible for Medicaid. In Broward County, for example, children and parents comprise 74 percent of Medicaid enrollees (see Figure 3 on page 2). Persons with Medicare coverage who receive financial assistance with their premiums, the so-called "dual-eligibles," will likely not be required to participate.

Special populations: SB 838 requires the state to address certain special populations in the waiver proposal. The state must "develop and recommend a *service delivery alternative* for children having chronic medical conditions."¹⁴ In addition, SB 838 requires the state to "develop and recommend *service delivery mechanisms within capitated managed care plans*" for Medicaid-eligible children in foster care and persons with developmental disabilities.¹⁵ It will be important to examine the precise details in this area when the waiver proposal is released.

Persons over 60: One area that will also await further details from AHCA relates to Medicaid beneficiaries who are over 60. In a separate section of the bill, SB 838 grants the state authority to seek Section 1115 waiver authority from the federal government to establish an "integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older," also on a pilot basis in two areas of the state.¹⁶ The 60+ waiver is not the subject of this brief, and the program is likely to be structured differently,

13 See *Empowered Care: A Proposed Concept for Florida Medicaid* March 14, 2005, pps. 6-7. It is possible that children with chronic medical conditions will be exempted. See section on Special Populations.

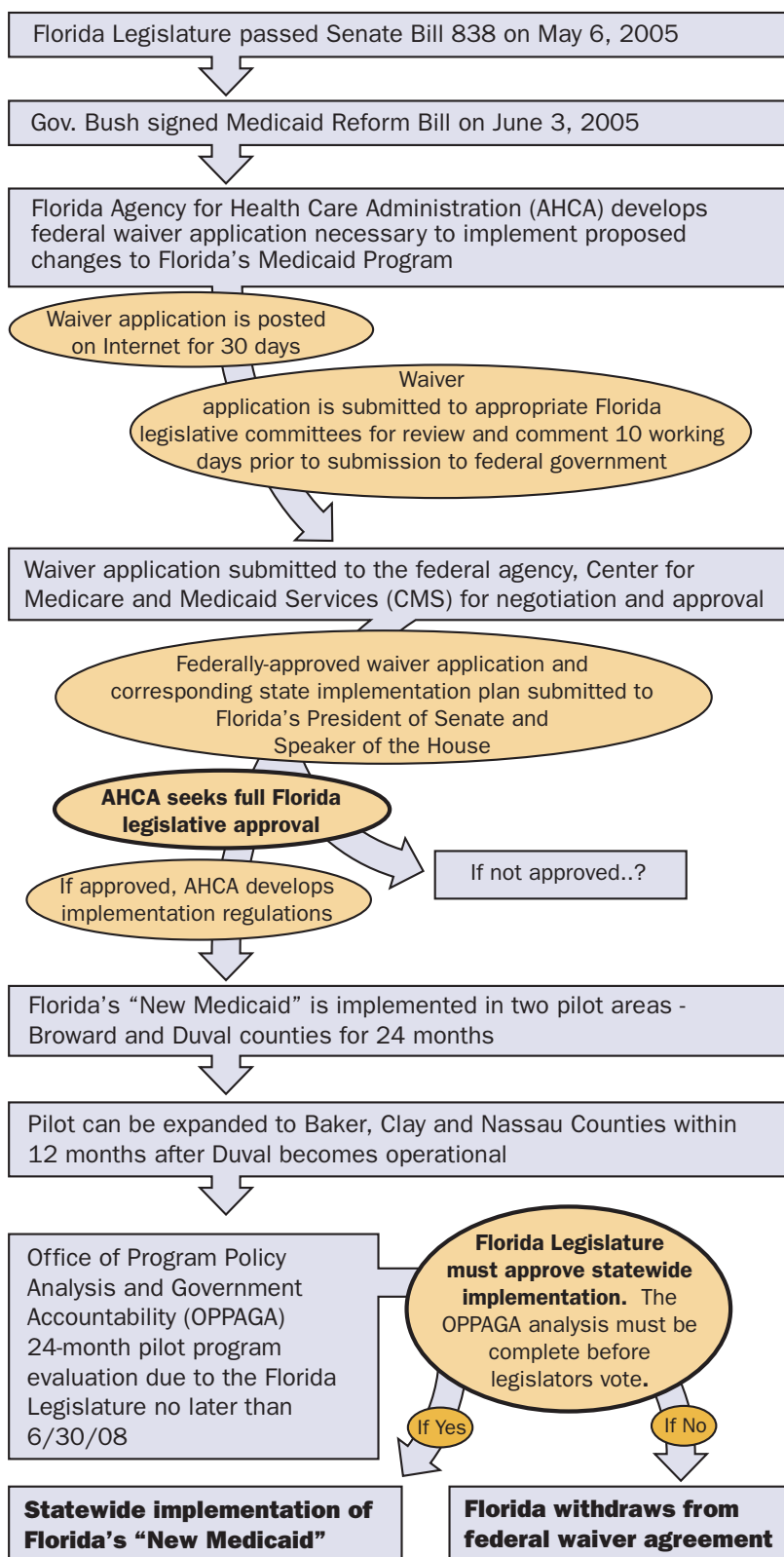
14 Section 409.91211 (3)(bb) found in SB 838 at p. 66 lines 24-25. Emphasis added.

15 Section 409.91211 (3)(cc) and (dd) found in SB 838 at p. 67 lines 4-16. Emphasis added.

16 Section 409.912 (5) found in SB 838 at p. 16.

Figure 4: Florida Section 1115 Medicaid Reform Waiver Process

The circles indicate opportunities for public input. Suggestions or comments can be emailed to empoweredcare@ahca.myflorida.com.



POLICY BRIEF

but there are many questions about how the two waivers will interact. For example, will Medicaid beneficiaries over 60 be excluded from the “Empowered Care” pilot sites? Will the programs be implemented in different counties? Will the financing structures be similar in the two waivers? All of these questions will need to be addressed and considered when the waiver proposals become available.

What is the process and timeline established by the Legislature?

As mentioned above, the Legislature incorporated many checks and balances to provide oversight as the proposal moves forward. **Figure 4 (on page 3)** provides an overview of the process as established by SB 838.

How does the federal waiver process work?

Florida, like other states, has already engaged in extensive negotiations with the federal government to shape its waiver proposal.¹⁷ After the waiver is formally submitted to the federal government, both the Center for Medicare and Medicaid Services (CMS) and the White House’s Office of Management and Budget (OMB) will consider the application and the budget for the state’s proposal. There is no formal procedure for the public or local, state and federal elected officials to submit comments to CMS once the waiver is submitted, but this often occurs. Approval from the federal government, assuming it is given, could come in as little as a few months.¹⁸ If the state receives approval from the federal government, the state is required by SB 838 to submit the approved waiver, along with an implementation plan, for approval

17 Letter from U.S. Secretary of Health and Human Services, Michael O. Leavitt to Governor Bush, April 1, 2005. Available at www.empoweredcare.com/docs/cms_medicaid_letter.pdf

18 For information on timelines from formal submission of Section 1115 waivers, see Table 1 in *Section 1115 Waivers at a Glance: Summary of Recent Medicaid and SCHIP Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) April 2003.

by the full Legislature before AHCA can begin developing regulations and move to implement the plan.

Under SB 838, pilot programs will be established in the chosen counties for up to 24 months during which time they will be comprehensively evaluated by the Legislature’s auditing arm, the Office of Program Policy Analysis and Government Accountability (OPPAGA), and the Auditor General. According to SB 838:

*The evaluation must include assessments of cost savings; consumer education, choice, and access to services; coordination of care; and quality of care by each eligibility category and managed care plan in each pilot site.*¹⁹

The evaluation must also describe legal and administrative barriers encountered in the pilot sites and make recommendations regarding statewide expansion of the program. The evaluation must be submitted to the Legislature no later than June 30, 2008, and once the evaluation has been completed, the state can seek approval from the full Legislature to take the program statewide.

19 Section 3 of SB 838, p. 72 lines 3-7.

What did the Legislature say about benefits?

The governor’s “Empowered Care” proposal includes a complex three-tiered system of benefits: 1) “Comprehensive Care,” a basic package of benefits that beneficiaries will choose but is likely to vary by plan (at least for adults); 2) “Catastrophic Care,” for beneficiaries who run out of their “comprehensive” benefits; and 3) “Enhanced Care,” an account reserved for those beneficiaries who engage in “healthy” behaviors.²⁰ Many questions exist about what these benefits will consist of, as well as how the different tiers will interact. The governor’s proposal would require participating plans to offer federally-mandated benefits, such as inpatient hospital care, but the plans would have flexibility to decide how much of such a benefit to offer (i.e.; how many days of inpatient care would be covered).²¹ In fact, the ability of the plans

20 See March 14th *Empowered Care* proposal and Winter Park Health Foundation brief “Issues to Consider.”

21 This is technically referred to as the “amount, duration and scope” of benefits.

What will happen to the children’s EPSDT benefit under SB 838?

Under federal Medicaid law, all children enrolled in Medicaid are eligible for the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit. This is a comprehensive benefit endorsed by the American Academy of Pediatrics¹ and has strong bipartisan support in Congress. EPSDT is especially important for children on Medicaid as they are more likely to have chronic or special health care needs which require services that are often not covered in private insurance packages, and their families have little income to pay for services not covered by Medicaid. EPSDT requires that all medically-necessary services for children be covered, and limits on benefits are not permissible.

If plans are allowed to determine the amount, duration and scope of benefits as the governor proposes, children may or may not receive the EPSDT benefit. The governor has proposed a “maximum expenditure limit” for each Medicaid beneficiary, and if this limit is applied to children, the guarantees provided by the EPSDT benefit could be undermined. Federal officials have publicly stated that CMS will not approve waivers that sought to waive the EPSDT benefit for children who are required to be covered by Medicaid (i.e.; “mandatory children”).

Information from Florida officials on whether the maximum expenditure limit will apply to children and how the EPSDT guarantee will be preserved is unclear. SB 838 requires the state to develop a credentialing system for plans that wish to participate. Plans that wish to participate, among other things, must ensure “compliance with federal EPSDT requirements under federal law.”²

1 See Medicaid Policy Statement by the American Academy of Pediatrics *Pediatrics* May 16, 2005.

2 Section 409.91211 (3)(h)(2)

to determine the benefits that Medicaid beneficiaries will receive is one of the unprecedented features of the governor's plan.

SB 838 does little to shed light on the structure and scope of the benefits package, but creates opportunities for the Legislature to continue to monitor this issue closely. It establishes that the demonstrations must ensure access to "medically necessary services" and that AHCA must develop and recommend a system that delivers all the current mandatory and optional services currently provided under Florida's Medicaid program, but it is silent on the question of the "amount, duration and scope" of benefits. Rather, SB 838 requires that the agency develop and recommend a data-based system to monitor the "utilization and quality of health care services" to establish whether or not beneficiaries enrolled in the demonstrations receive medically-necessary services.²² In addition, as described below, SB 838 requires the state to provide analyses of anticipated benefit designs under three different fiscal models.

What did the Legislature say about how Medicaid will be funded?

SB 838 makes clear the intent of the pilot is to "stabilize Medicaid expenditures under the pilot program as compared with Medicaid expenditures in the pilot area for the 3 years before implementation."²³ Again, instead of establishing any specific requirements with respect to the financing structure, SB 838 requires AHCA to provide the Legislature with more information. In particular, SB 838 requires analysis which describes the effect on capitation rates and what benefits will be offered in the pilot program under three different budget scenarios for a prospective five-year period. These scenarios include: a) limiting the growth rate in Medicaid to the growth rate in general revenue (See Text Box on right), b) linking Medicaid's growth to increases in Medicaid's per-person costs and

²² Section 409.91211(3)(p)
²³ Section 409.91211 (2)(b)

c) using Medicaid's current financing structure for a previous year (state fiscal year 02-03 to 03-04).²⁴

AHCA has not provided any specific budget projections for the state's proposal. However, recent information clearly indicates that the state wishes to restrict the rate of growth in Medicaid funding by linking Medicaid's growth rate to the growth rate in state revenues.²⁵ This would fundamentally alter the financing structure of the Medicaid program in a way that has not occurred anywhere in the country.²⁶ Currently, Medicaid funding increases or decreases reflect changes in health care costs and changes in enrollment, as well as state choices about provider reimbursement, drug pricing methodologies, optional services and optional beneficiaries.²⁷ Under the

²⁴ Section 409.91211 (3)(x)
²⁵ The state says "annual increases will allow a reasonable rate of growth commensurate with the growth in state revenue." *Frequently Asked Reform Questions* on the state's Empowered Care website. Available at www.empoweredcare.com/faqMedRef.aspx
²⁶ The Governor of Tennessee has proposed a similar concept for Tennessee's Medicaid program known as TennCare.
²⁷ For more information on how federal financing of Medicaid operates with and without Section 1115 waivers, see "What Could a Waive to Restructure Medicaid Mean for Florida?"

current Medicaid structure, states have flexibility to control costs by changing provider reimbursement or clamping down on prescription drug expenditures, for example, but the state must cover medically necessary expenditures incurred by any eligible Medicaid beneficiary. If, for example, a recession occurs, Medicaid enrollment and expenditures are likely to go up as more children whose parents lose their jobs become eligible. If a recession occurred, however, state general revenue would likely go down.

Under the current reform proposal, the nature of this financing system would fundamentally change. If expenditures were linked to the growth of state revenue, overall spending levels would no longer be determined by changes in enrollment or changes in health care costs. In a recession, for example, enrollment in Medicaid would likely increase as unemployment rose, state revenues would likely slow down, and total state revenues could even shrink. As described in the box below, this would likely lead to considerable funding shortfalls for Medicaid, if Medicaid funding was tied to the growth in state revenues.

What is the impact of limiting Medicaid spending to the rate of growth in state revenue?

The governor has proposed restricting the rate of growth in Medicaid to the rate of growth in state revenue.¹ This would mean that increases in Medicaid spending would be limited to the same percentage growth rate as the state's general revenue. Growth in Medicaid costs would no longer be driven by increases in enrollment or changes in the costs of health care services.

If this proposal had been in place for a recent fiscal year, what would this have meant in dollar terms? Between FY 02-03 and FY 03-04, Medicaid spending grew at a rate just over 14 percent. Net general revenue growth for the same period was 8.4 percent.² If Medicaid spending growth had been restricted to 8.4 percent, the state would have had to implement cuts in its Medicaid program of \$653 million.³ Cuts of this size would have had a dramatic impact on the program. For example, the state's expenditure for **all** of its Medicaid Home and Community Based Services that year was \$776 million.

¹ *Frequently Asked Reform Questions* op cit.
² Medicaid growth rate from Social Services Estimating Conference – Medicaid Services Expenditures 2/25/05. General revenue growth from 4/11/05 Revenue Estimating Conference General Revenue Fund.
³ Georgetown Health Policy Institute analysis based on Medicaid and General Revenue growth rates cited above.

What are the legislative guidelines regarding managed care protections?

The state has sought to allow entities that wish to participate to be exempt from current state licensing and other requirements.²⁸ SB 838 permits AHCA to develop a new credentialing system with certain requirements for entities that wish to participate, but requires that applicable licensing laws must prevail. This means that for example, an HMO wishing to participate in the new system would have to meet state solvency laws, but a provider-sponsored network that sought to take on risk would be exempt.

²⁸ See for example “Bush Plan May Boost No-Bid HMOs” *The Tallahassee Democrat* March 27, 2005.

SB 838 requires that AHCA’s new credentialing system address certain issues such as the establishment of a grievance system for both consumers and providers, restrictions on marketing practices the plans may engage in, and the establishment of certain requirements with respect to consumer choice counseling.

In addition, SB 838 establishes certain procedures for enrollment and assignment to plans in instances where beneficiaries do not choose a plan, as well as procedures for beneficiaries wishing to disenroll from a plan. **Figure 5** provides an overview of the process as specified in SB 838.

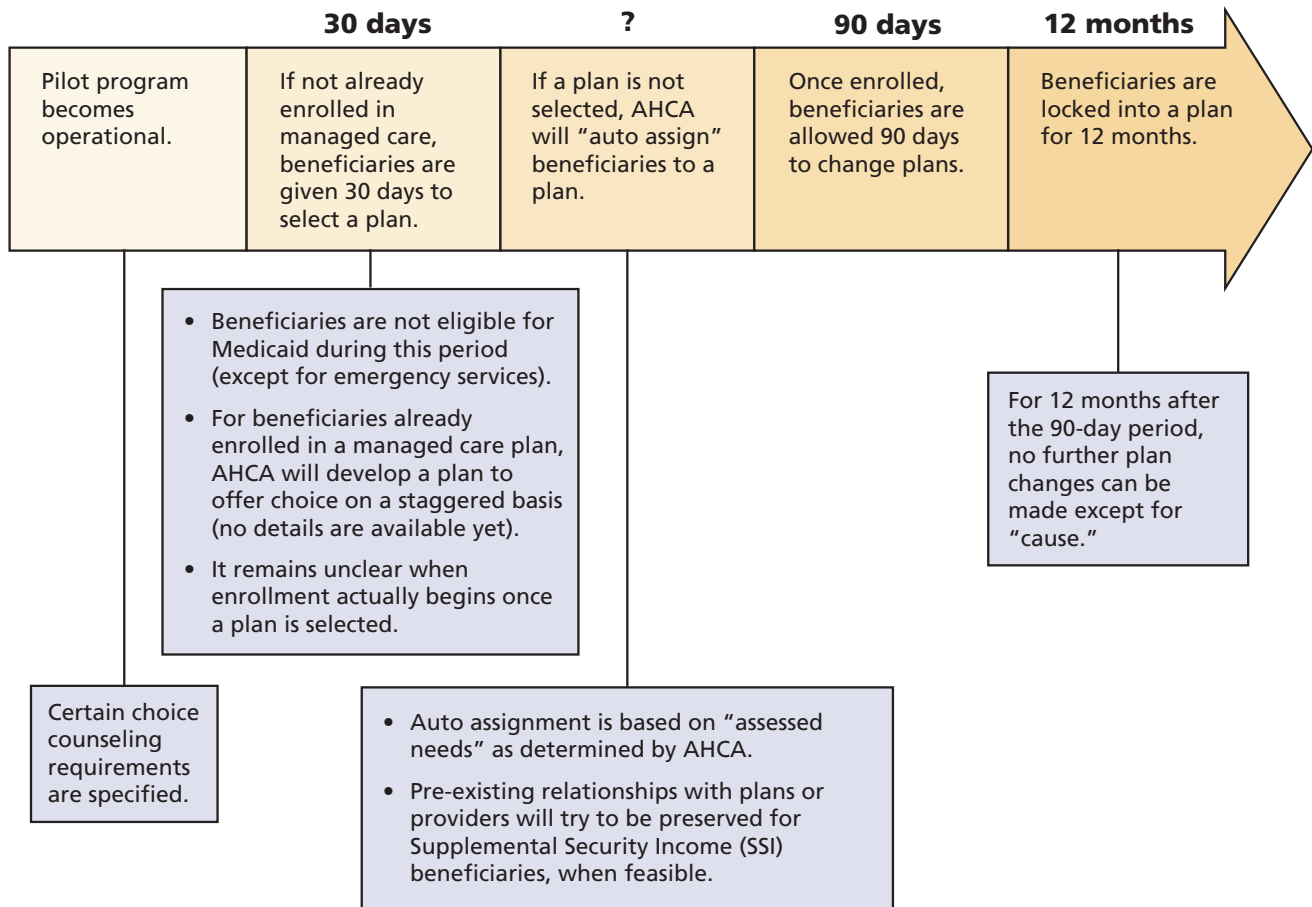
Premium subsidy for private insurance or “Opt-out”: SB 838 authorizes AHCA to request federal waivers to eliminate Medicaid cost-sharing protections and benefits requirements to allow the state to offer families a premium subsidy for

the purchase of employer-sponsored insurance. This is a program that would operate separately from the Medicaid managed care pilot, and would likely be similar in structure to Illinois’ KidCare Rebate program which is currently operating under a federal Section 1115 waiver.²⁹ Because the program is voluntary for families, CMS is likely to permit a waiver of federal cost-sharing and benefits requirements.³⁰

²⁹ For a quick overview of Illinois’ waiver see *Factsheet on Illinois Section 1115 Waiver* (Kaiser Commission on Medicaid and the Uninsured) August 2003, available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14357

³⁰ See Alker J. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) October 2003.

Figure 5: Proposed Enrollment Process for Medicaid Beneficiaries



What does SB 838 say about the role of safety-net providers in the new system?

Health care providers that serve a large number of Medicaid beneficiaries, such as public and children's hospitals, community health centers, county clinics and others, have much at stake in any major restructuring of the Medicaid delivery system. These providers receive a large share of their funding through Medicaid, and also provide essential services to the uninsured in their communities. SB 838 includes a few provisions which recognize the importance of this funding stream for certain safety-net providers. First, the bill makes clear that the waiver authority granted is "contingent upon federal approval to preserve the upper-payment limit funding mechanism for hospitals."³¹ The upper-payment limit (known as "UPL") allows hospitals to receive certain payments in excess of their per-beneficiary cost, up to an established limit.³² States' UPL arrangements have recently come under increased scrutiny by the federal government.

In addition SB 838 requires that "to the extent possible" the pilot programs authorized by the bill include any "federally qualified health center, federally qualified rural health clinic, county health department, or other federally state or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate."³³

31 Section 409.91211(1)

32 For more on UPL and related financing arrangements, see the fact sheet on *Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity* (Washington, DC: Kaiser Commission on Medicaid) February 2005.

33 Section 409.91211(3)(h)

Conclusion

Medicaid is the cornerstone of the nation's health care safety-net. Begun in 1965, Medicaid now provides health and long-term care services to more than 2.1 million low-income families and elderly and disabled individuals in Florida. Medicaid's responsibilities are far-reaching – it is a health insurance program for low-income adults and children, a comprehensive source of medical and long-term care coverage for people with disabilities, and a supplement to Medicare for the elderly, providing assistance with prescription drugs, long-term care, Medicare premiums and other cost-sharing obligations.

The Medicaid Reform Act signed into law by Florida Gov. Jeb Bush June 3, 2005 enables the state to submit a "Section 1115" Medicaid Waiver proposal to the federal government. The process and the legislation offers the public multiple opportunities to provide input and comment on proposed reforms.

Given the scope and unprecedented nature of the proposals, and the number of Florida residents who depend on Medicaid for vital medical services and long-term care, it is critical that the public be aware of and capitalize on these opportunities. It will be important for Florida residents to examine the details of the state's Section 1115 Medicaid Reform Waiver proposal, as well as the various analyses required by SB 838, to fully understand the impact of proposed changes.

UNDERSTANDING FLORIDA'S MEDICAID REFORM LEGISLATION

Fourth in a series of educational briefs on issues impacting Florida's families – Florida's Health at Risk. Published by the Winter Park Health Foundation.

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