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MEDICAID FACTS

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FLORIDA MEDICAID WAIVER: KEY PROGRAM CHANGES AND ISSUES

On October 19, 2005, CMS approved a Section 1115 waiver, allowing Florida to make fundamental changes in its Medicaid program. The state is seeking to improve predictability of Medicaid spending and reduce the rate of spending growth through the waiver. It is also looking to increase personal responsibility, market competition, and participation in private coverage.

Florida's approach could have significant national implications if it becomes a model for other states. Under the waiver, the program will move toward a defined contribution program in which the state will allot risk-adjusted premiums to beneficiaries to choose among different coverage options. Managed care plans will gain new authority to determine benefits for adults, subject to state approval, and the state will establish a new annual maximum benefit limit for adults. Beneficiaries will also be able to "opt-out" of Medicaid and use their risk-adjusted premium to subsidize the purchase of employer-sponsored or individual coverage if it is available.

Currently, Florida Medicaid operates as a defined benefit program under which beneficiaries are guaranteed a set of benefits established by the state within federal guidelines. They receive care from private providers through fee-for-service or capitated arrangements. About 34% of beneficiaries were enrolled in fully capitated HMO plans in June 2005. The state contracts with the HMOs to provide care for state-established covered benefits and plans are at financial risk if costs exceeded their capitated payments. (See Appendix A for a comparison of Florida's current Medicaid program and the waiver program.)

IMPLEMENTATION

The Florida Medicaid program is the country's fourth largest program in terms of enrollment and it ranks fifth in spending. It is financed jointly by the state and the federal government, which pays 59% of program costs. It covers some 2.2 million Floridians, including children, parents, and elderly and disabled people. The waiver will initially be implemented as a pilot in Duval and Broward counties and will require participation of the following eligibility groups: [1]

- *Disabled adults and children*: non-institutionalized elderly and disabled individuals receiving Supplemental Security Income, excluding those also on Medicare
- *Parents and pregnant women*: with incomes below 23% of poverty or about $300 per month for a family of three
- *Children:* age 0-1 under 200% of poverty, age 1-6 under 133% FPL, and age 6-21 under 100% of poverty

The state estimates that, by June 2007, 212,189 people in Broward and Duval counties will be enrolled in new plans under the waiver, representing about 9% of Florida's Medicaid beneficiaries.[2]

The state must obtain state legislative approval before implementing the pilot, which will be considered during a special session in early December. The five-year waiver period will begin by July 1, 2006, and the waiver outlines a plan to expand statewide and to encompass all beneficiaries and services within the waiver period, subject to several state legislative checkpoints.

CHANGES IN COVERAGE

Beneficiaries receive risk-adjusted premiums to choose among different plans. The state will establish risk-adjusted premiums based on individual risk scores developed using historical utilization data. It will allot the premiums to beneficiaries, who will use them to:

- Enroll in a Medicaid managed care plan contracted by the state, or
- "Opt-out" of Medicaid and use the premium toward the purchase employer-sponsored coverage or individual coverage that is not contracted by the state.

Coverage in Medicaid Managed Care Plans

New authority for Medicaid managed care plans to determine benefits for adults. Prior to the waiver, the state established a benefit package and then negotiated a capitated rate with the managed care plans to provide covered benefits. Under the waiver, the plans will determine the benefits they will offer for the state-established risk-adjusted premiums, subject to state approval. Approved benefit packages must meet the following requirements:

- *Cover all "mandatory benefits," but plans will have new authority to determine what "optional benefits" they provide.*[3] They will also determine the amount, duration, and scope of almost all benefits (mandatory

[1] During the initial phase, individuals with developmental disabilities, individuals eligible as part of a hospice-related group, pregnant women above 23% of poverty, foster care children, and children with chronic conditions will not be required to participate.

[2] Alker, J., "Understanding Florida's Medicaid Waiver Application," Winter Park Health Foundation, Sept. 2005.

[3] Under federal law, there are "mandatory" benefits states are required to offer in Medicaid. There are other "optional" benefits that states can choose to provide. The distinctions of "mandatory" and "optional" do not reflect the medical importance of a benefit. For example, prescription drugs and physical therapy are optional benefits.

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and optional).[4] For example, they can set limits on the number of visits for a particular service.

- *Be actuarially equivalent to the current program.* The state will determine actuarial equivalence by comparing the value of benefits in a proposed package to the value of the current Medicaid benefit package for the average member of the "target population," based on historical utilization of services.
- *Have benefits sufficient to "cover the needs of the vast majority of enrollees" within the target population.*

Because plans will have increased ability to determine benefits, the available benefit packages for adults may vary. Pregnant women and children will also receive risk-adjusted premiums and choose among plans. However, it appears plans are still required to provide all medically necessary care to pregnant women and children under the EPSDT benefit. Cost sharing will continue to be subject to the federal nominal limits with required exemptions for pregnant women, children, and certain benefits.

New annual maximum benefit limit for adults. Once expenditures for a beneficiary reach this limit, neither the state nor the managed care plans will be responsible for further costs. The state has not yet specified the limit level or how it will be defined. Because the limit will enable the state to control maximum expenditures for each adult, it will influence the amounts of the risk-adjusted premiums allotted to beneficiaries. Pregnant women and children are exempt from the limit.

"Enhanced benefits." Individuals that participate in state-defined healthy activities may receive enhanced benefit credits up to an unspecified maximum dollar amount, which they can use for uncovered health services or for premium costs of private coverage if they lose Medicaid eligibility. The credits will remain available to individuals for up to three years after losing Medicaid eligibility, so long as their incomes remain below 200% of poverty. The state plans to finance these benefits with savings from the waiver and is authorized to receive federal matching payments for them.

Coverage for Beneficiaries who "Opt Out" of Medicaid

No benefit or cost sharing standards for subsidized employer-sponsored or individual coverage. If beneficiaries "opt-out" and use their premium toward the purchase of employer-sponsored or individual coverage there are no benefit or cost sharing requirements for the coverage. The maximum amount a beneficiary can receive to purchase coverage is his or her risk-adjusted premium. Beneficiaries (including pregnant women and children) will be responsible for premium costs in excess of their risk-adjusted premium, all cost sharing (e.g., deductibles, copays), and costs of uncovered benefits.

[4] Plans will be required to provide 45 days of inpatient hospital care.

CHANGES IN HOSPITAL FINANCING

New "Low-Income Pool" replaces some hospital financing arrangements. The waiver authorizes a new "Low-Income Pool" that will be capped at $1 billion each year and financed with state and federal matching funds. The state can use the pool funds to provide direct payment and distributions to safety net providers for the purpose of providing coverage to the uninsured through provider access systems. Availability of the funds is subject to CMS approval of pool operations and the sources of state funds.

CHANGES IN FEDERAL AND STATE FINANCING

Per capita caps on federal funds. Under longstanding administrative policy, the federal government caps federal funds under waivers to ensure that federal costs under a waiver do not exceed what federal costs would have been without the waiver. The Florida waiver establishes per capita caps that limit the amount of federal funds the state can receive per beneficiary for the eligibility groups covered by the waiver. These caps apply on a statewide basis even through the waiver initially will be implemented in only two counties.

State spending under waiver not specified. Prior to the waiver, the state paid for covered benefits for fee-for-service beneficiaries and made capitated payments to managed care plans. Thus, state spending levels were driven by enrollment, utilization of care, and the cost of services. The waiver gives the state more ability to set its spending since it will now consist of risk adjusted premiums for each beneficiary. Thus, state spending will be driven by enrollment and the premium amounts. Under the waiver, the state does not necessarily have to spend the full amounts allowed under the federal caps.

KEY ISSUES

The waiver represents a broad experiment that applies to a very poor population with significant health care needs. Many details remain unknown, including the risk-adjusted premium amounts, the maximum benefit limit for adults, and the state spending levels. Further, the state currently lacks sufficient data to develop the risk scores that will be used to determine the risk-adjusted premiums. In assessing the waiver, some key issues to consider are:

Accuracy of the risk-adjusted premiums. Florida's waiver moves away from the traditional insurance concept of shared risk to individual risk. The state plans to use historical utilization data to develop individual risk scores to reflect health care needs to derive the premiums allotted to individuals. Therefore, the accuracy of the scores will be critical to assuring whether individuals can access adequate coverage. As noted, the state currently has

insufficient data to develop the risk scores. Once developed, a critical issue is how well the risk scores will reflect actual health needs, given the inherent problems associated with using historical data to predict future needs. The state notes that, during the waiver's initial phase, it will update risk scores on a timely basis; these updates may be critical for ensuring their accuracy.

Actuarial value of the adult benefit package over time. The waiver specifies that, initially, benefit packages must be actuarially equivalent to the value of the current benefits for the average member of the target population. However, the waiver does not specify whether this actuarial value will be adjusted over time for inflation. Without adjustment, the actuarial value will effectively fall each year.

Changes in financial risk for state and managed care plans. Prior to the waiver, the state was at risk for the costs of covered services for fee-for service beneficiaries and the capitated payments to plans. Plans were at risk for the costs of covered services that exceeded their capitated payments. Under the waiver, the state has increased protection from financial risk and greater ability to set spending levels because its spending will be driven by the risk adjusted premiums and enrollment. The state and the managed care plans will also be protected by the new annual benefit limit for adults.

Changes in financial risk for beneficiaries. Adults who enroll in Medicaid managed care plans will be subject to nominal copays, costs for uncovered services, and costs beyond the new benefit limit for adults. Beneficiaries who "opt-out" of Medicaid and use their premium toward the purchase of employer-sponsored or individual coverage will be at risk for premium costs in excess of their risk-adjusted premium amount, cost sharing, costs of uncovered benefits, and costs of care in excess of benefit limits. These costs could be significant given that there are no benefit or cost sharing standards for purchased coverage.

Recognizing that the waiver impacts some of the state's poorest and most vulnerable residents, these costs could contribute to difficulties accessing needed care and increased financial burdens. Those with the highest health care needs will be at the greatest risk as they are the most likely to have needs beyond the new maximum benefit limit in Medicaid managed care plans and to experience access and affordability problems due to a private plan's benefit limits and cost sharing requirements.

Shift of control to private plans. Under the waiver, the state shifts some decision making and control to the private plans. The state believes that this will breed innovation and efficiency in Medicaid coverage. It is not yet known how many plans will participate in the waiver program and how they will react to their new authority to determine benefits. It also will be important to consider how this shift in control will impact the state's accountability for and oversight of coverage. The state's ability to monitor the benefits provided as well as utilization of care will likely be more limited, particularly for beneficiaries who "opt out" into private plans that are not contracted with the state.

Impact of increased plan choice on beneficiaries. There may be new variation in benefit packages since plans will have increased ability to determine benefits. Thus, beneficiaries will choose a plan not only based on providers and location, but also on covered benefits. Enrollment counselors will be available to help beneficiaries choose plans. The state anticipates that this choice will increase beneficiaries' satisfaction and improve health outcomes by increasing individuals' role in managing and understanding their health care needs.

However, beneficiaries may have difficulty navigating the options, even with assistance from enrollment counselors, particularly given their limited resources and significant health needs. Further, beneficiaries will face competing pressures to make a plan choice both quickly and carefully. After being determined eligible for Medicaid, they will only be covered for emergency and nursing home services until they select and enroll in a plan. It is only after they enroll in a plan that they will be covered for broader benefits. Further, after an initial 90-day period, beneficiaries generally will be locked into their plan for 12 months, increasing the importance of choosing a plan well suited to their needs and of plans not changing benefits midstream.

Impact of budget neutrality agreement on the state. The waiver limits federal funding on a per capita basis for the eligibility groups covered by the waiver. Unlike an aggregate cap, the per capita caps do not put the state at risk for costs due to enrollment growth. The state will be at risk for the full cost of any per capita spending in excess of the caps. The caps will apply on a statewide basis even though the waiver will first be implemented as a pilot in two counties. This places a larger portion of the state's program under the budget neutrality cap than will initially be impacted by the waiver changes.

CONCLUSION

The Florida Medicaid waiver authorizes broad programmatic and financing changes that could have significant implications for some of the state's poorest and most vulnerable residents. The waiver's impacts should be closely monitored and evaluated to assess the impacts on access to care and the health of beneficiaries. The waiver requires the state to complete an evaluation by 2011, but an independent federally-funded evaluation is not required.

Appendix A
Florida Medicaid: Comparisons Between Current Program and Waiver Program

	Medicaid Prior to Waiver	Medicaid After Waiver	
	Fee-for-Service and Managed Care	*Medicaid Managed Care Plans*	*"Opt-Out" of Medicaid into Employer-Sponsored or Individual Coverage*
Benefit Package	A state-defined benefit package within federal benefit and cost sharing guidelines	Plans determine benefits subject to state approval based on actuarial equivalence and sufficiency tests Plans must cover all mandatory benefits but have new flexibility over optional benefits and amount, duration, and scope of almost all benefits (mandatory and optional) New annual maximum benefit limit for adults Beneficiaries may be able to earn "enhanced benefits" by participating in "healthy activities"	Employer-sponsored and individual plans available on the private market with no state-established benefit or cost sharing standards
Protections for Pregnant Women & Children	Covered for all medically necessary care under EPSDT benefit	Exempt from overall annual benefit limit and appear to be covered for all medically necessary care	None; subject to benefit limits and cost sharing requirements of plan
State Role	Establish benefit package Reimburse fee-for-service providers for medically necessary covered services Contract with plans and pay a capitated rate for covered benefits	Establish individual risk-adjusted premiums that are allotted to beneficiaries Approve benefit packages offered by managed care plans	Establish individual risk-adjusted premiums that are allotted to beneficiaries No controls over benefit package
State Financing	Expenses for all covered benefits for fee-for-service beneficiaries and capitated payments to plans Driven by enrollment, utilization, and cost of services	Pre-determined risk adjusted premiums for beneficiaries Driven by enrollment and premium amounts	
Federal Financing	Open-ended matching payments	Limited on a per capita basis for the waiver period	
Financial Risk for:			
State	Costs of care of medically necessary covered services for fee-for-service beneficiaries and the capitated payments to plans	Cost of the risk-adjusted premiums	
Plans	Costs of care for medically necessary covered services that exceed the capitated payments	Cost of covered services up to the maximum benefit limit for adults	Cost of covered services subject to any benefit limits or cost sharing requirements of the plan
Individuals	Copays (subject to federal limits) and costs of uncovered services	Copays (subject to federal limits), costs of uncovered services, and costs for care beyond the maximum benefit limit for adults	Premiums in excess of the risk-adjusted premium they receive from the state, all required cost sharing (e.g., deductibles, copays), costs of uncovered benefits, and costs of care in excess of benefit limits

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