Florida's Medicaid Reform

National Medicaid Congress

June 5, 2006

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Key Elements of Reform

- *New Options / Choice:*
  - *Customized Plans.*
  - *Opt-Out.*
  - *Enhanced Benefits.*
- *Financing:*
  - *Premium Based.*
  - *Risk-Adjusted Premium.*
  - *Comprehensive and Catastrophic Component.*
- *Delivery System:*
  - *Coordinated Systems of Care (PSN and HMOs).*

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Types of Reform Plans: FFS vs. Capitated

What will be the different types of managed care organizations participating in reform?

- *Provider Service Networks (PSNs):*
  - *Capitated PSNs.*
  - *Fee-for-Service (FFS) PSNs.*
- *Health Maintenance Organizations (HMOs).*
- *Other licensed insurers.*

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What Medicaid Reform will NOT do?

It will NOT:

- *Change who receives Medicaid.*
- *"Cut" the Medicaid budget.*
- *Waive Early and Periodic Screening, Diagnosis and Treatment for children.*
- *Limit medically necessary services for pregnant women.*
- *Permit Reform health plans to charge higher cost sharing.*

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What Medicaid Reform Will Do?

It will:

- *Increase recipient choice.*
- *Empower recipients to participate in health care.*
- *Encourage benefits that better meet recipient needs.*
- *Allow access to services not traditionally covered by Medicaid.*
- *Reward recipient healthy behavior and choices.*
- *Bridge the gap to private insurance.*

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Reform Timeline

- *Authorized by Florida Legislature in SB 838 – passed on May 6, 2005.*
- *Draft waiver request posted on AHCA website August 31, 2005.*
- *Agency received a number of comments on the draft.*
- *Agency reached agreement on UPL program with Centers for Medicare and Medicaid Services (CMS).*
- *Waiver request submitted to CMS on October 3, 2005, after 30-days posting*
- *Waiver request approved by CMS on October 19, 2005.*
- *Approved by the Legislature on December 8, 2005.*
- *Begins in Duval and Broward Counties on July 1, 2006.*

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Customized Benefit Packages
Plan Design Guidelines

- *Levels of amount, scope and duration flexibility:*
  - *Certain services must be provided at or above current coverage levels.*
  - *Other services must be provided to meet sufficiency standards for the population.*
  - *Remaining services must be offered, but amount, scope and duration are flexible.*
- *Reform plans can enhance any service above current levels.*
- *Reform plans can add services not currently covered.*

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Evaluation of Customized Plans

- *Two components of AHCA benefit plan evaluation:*
  - *Actuarial equivalence:*
    - *How does the value of proposed benefits compare to historical Medicaid for the target population?*
      - *Ensures the overall financial value of benefits is appropriate.*
  - *Sufficient to meet medical needs:*
    - *Are medical services provided at sufficient levels to serve the target population?*
      - *Must cover medical service needs of the population being served.*
- *Actuarial equivalence and sufficiency are data driven.*

Opt-Out

- *Recipient can choose to enroll in employer-sponsored health insurance instead of a Medicaid-certified plan.*
- *Self-employed individuals may purchase private insurance.*
- *Medicaid will pay the employee share of the employer-sponsored premium on behalf of the recipient.*
- *Individuals with access to employer-sponsored insurance may opt-out at any time.*

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Enhanced Benefits

- *A pool of funds is set aside to encourage recipients to engage in "Healthy Behaviors."*
- *Individual Medicaid recipients earn access to "credit" dollars from the pool by completing defined healthy practices and / or behaviors.*
- *Once credits are earned, they may be used to purchase health-related services and products.*
- *Earned credits may be used during or within three years following cessation of Medicaid eligibility.*

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Risk-Adjusted Premium

- *Statistical models correlate historical diagnoses / pharmaceutical utilization to the likelihood of future health care cost.*
- *Individuals are assigned a "risk score."*
- *Individual risk scores generate premium, based on recipient's predicted needs.*
- *Health plans are credited with risk score / premium of each individual enrolled.*
- *Collective risk scores / premiums of members generate health plan revenues / capitation tied to expected health costs.*

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State Reinsurance Component

- *A single set of benefits:*
  - *Recipients see their chosen set of benefits.*
  - *Transition between Comprehensive and Catastrophic component is transparent to the recipient.*
  - *Continuous coverage of benefits.*
- *Comprehensive risk is always borne by the health plan; catastrophic risk may be borne by the plan or the state:*
  - *All care continues to be managed by the health plans.*
  - *Whether a plan accepts catastrophic risk is transparent to the recipient.*
- *If the plan does not cover catastrophic risk:*
  - *State pays all claims that exceed the threshold at Medicaid fee-for-service cost.*

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Choice Counseling

- *Comprehensive choice counseling program to assist recipients in making the right choice:*
  - *Strong communication component.*
  - *Involvement of sister agencies and community organizations.*
- *Information on choice will focus on selecting a benefit package.*
- *Information provided at eligibility:*
  - *Eligibility packet mailed by DCF.*
  - *Web-based application.*
  - *Choice counselor notified of new eligibility.*
  - *Choice counselor reaches out to recipients.*

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Low-Income Pool

- *Under Medicaid Reform, the Upper Payment Limit (UPL) becomes the Low Income Pool (LIP).*
- *Low-Income Pool Funding:*
  - *$5 billion available over the five-year waiver period.*
  - *$1 billion per year, for five years.*
    - *Roll over provision allows state to exceed $1 billion in a given year.*

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Reform Implementation Status

- *As of May 1, 2006, 16 Reform Health Plan Applications Received*
  - *5 Fee-for-Service Provider Service Networks*
  - *11 HMOs*
- *Benefit Sufficiency Tool on the Web*
- *Risk-Adjusted Rates developed*
- *Choice Counselor selected*
- *Model health plan contracts developed*
- *Application review in process*

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Questions and Answers

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