

Medicaid Changes: What will they mean for Broward and Duval counties, and beyond?

Florida's Experience with

MEDICAID REFORM

In January 2004 Florida Governor Jeb Bush announced his intent to seek broad and unprecedented changes to the State of Florida's Medicaid program. The goal of the reform, in Gov. Bush's words, is "to reinvent Medicaid to create a competitive health care market driven by educated consumers who are empowered to make purchasing decisions for themselves."¹

Almost two years later, in December 2005, the governor signed into law a bill passed by the Florida Legislature to proceed with implementation. As a result of concerns in the Legislature about the proposal, the changes are being implemented through pilots in two counties – Broward (Ft. Lauderdale) and Duval (Jacksonville) over two years.² At the end of the two years, the Legislature must vote to permit the changes to be implemented statewide.

Not only are people across Florida interested in the impact of these changes on Medicaid beneficiaries and the health system more broadly, but some policymakers around the country are asking whether Florida's plan offers a model for reform in other states. In his federal FY07 budget, President Bush, the governor's brother, cited Florida's waiver as a model that the federal government would like to encourage for other states. This heightened interest underscores the importance of identifying what does and does not work as implementation proceeds.

In the governor's vision, Medicaid reform entails moving from a "defined benefit" program, where a set of guaranteed benefits is available to all who are eligible, to a "defined contribution" model, where eligible beneficiaries receive a specific amount of "credit" to spend in the medical marketplace.³ Eligible beneficiaries choose one of a variety of plans offering different benefit packages. Based on their choice, the state pays a premium amount adjusted for the age, sex, and health status of each beneficiary. This vision reflects a fundamental shift in thinking about how the Medicaid program should work – shifting critical decisions about vulnerable people's access to medical services from government to private insurance companies, and limiting the amount of funding available for individuals' health care.

The reality of the new structure is far more complicated, however. For example, children and pregnant women will

continue to be guaranteed a comprehensive benefits package (a "defined benefit"). In the pilot counties, Medicaid beneficiaries – primarily parents and people with disabilities – will be required to choose (for themselves and/or their children) from a variety of health plans participating in the new system. If they do not make a choice, they will be assigned to a plan by the state.

In turn, plans have unprecedented, but not unlimited, flexibility to structure the benefits packages for non-pregnant adults.⁴ This new flexibility gives plans the ability to limit some Medicaid benefits – such as prescription drugs, physical therapy, and durable medical equipment – subject to certain tests the state has established. It also gives plans the option of adding certain extra benefits.

It is this ability to limit certain benefits that distinguishes Florida's changes from other states' transitions to more use of managed care. In fact, the provision to allow plans to limit benefits was one of the primary reasons that Florida was required to obtain a Section 1115 Medicaid waiver from the federal government to initiate its reform plan. A waiver would not have been needed if plans were only able to add benefits. Whether or not the full benefits flexibility afforded by the waiver is used by the plans may change over time.

Other key features of the changes include the creation of Enhanced Benefits Accounts to encourage Medicaid enrollees to engage in "healthy behaviors." Parents who take their child to well-child visits, or participate in a weight management program, for example, will be rewarded with a credit for health-related items such as bandages, aspirin, or dental floss at their local pharmacy. Families can accumulate up to \$125 a year in these accounts if their plan certifies that they are eligible for a credit.

The Jessie Ball duPont Fund has commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program in Duval and Broward counties. This policy brief is the first in a series and provides an overview of the changes that will be occurring and some of the key questions around how these changes may affect the experiences of families, people with disabilities, and others who receive their health care through Medicaid.

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Who will be affected by reform?

According to the state's most recent (July 2006) estimates, 207,077 current beneficiaries (126,616 in Broward and 80,461 in Duval) – or 73 percent of current enrollees in the two counties – will be required to participate by April 2007. The state estimates that another 48,544 newly eligible persons will be enrolled in the new system during this time. Children are the single largest group that will be required to participate.

While certain groups of beneficiaries will be required to participate in the new system, others may choose to participate, and some will be excluded from participating. In general, children, parents, and people with disabilities who are not in institutions will be required to participate. Children in foster care or receiving adoption assistance, people with developmental disabilities, persons with both Medicare and Medicaid (so-called “dual-eligibles”) may choose to enroll. Women who are eligible for Medicaid because they are pregnant, persons with high medical costs who “spend down” to become eligible, and persons residing in institutions will be excluded.

Enrollments in the pilot program are staggered over an eight-month period, with the first enrollments effective September 1. The transition emphasizes moving those beneficiaries who are currently enrolled in MediPass, a fee-for-service program, more quickly.

Finally, beneficiaries can choose to take their premium and use it to purchase employer-sponsored or other private coverage – a feature known as the “opt-out” program.⁵

A choice counseling system has been established by the state to help beneficiaries navigate the maze of new choices. In addition to a call center staffed by 43 counselors, there are six choice counselors working in Duval County and 10 working in Broward County. The state also is contracting with various community-based organizations. In July, the state mailed materials to the first wave of Medicaid beneficiaries and the call-in center began operations.

What does the Medicaid program provide today?

Florida's Medicaid program provides a diverse range of health and long-term care services to 2.1 million children, parents, people with disabilities, pregnant women, seniors and others.⁶ Currently, 109,458 individuals receive their health care services through Medicaid in Duval and 174,188 in Broward.⁷

Approximately 26% of Florida's children receive their health coverage through Medicaid and 44% of births in Florida are financed by Medicaid. The program is also the largest source of financing for HIV-AIDS care, and pays for 59% of nursing home care.⁸

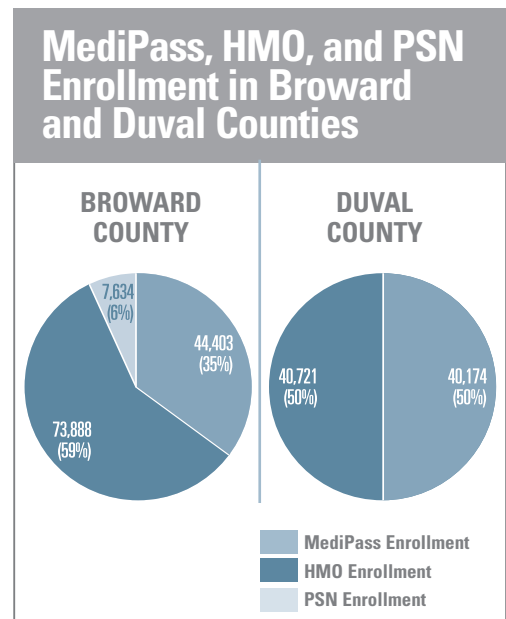
Beneficiaries currently receive their services by enrolling in one of three programs: MediPass (a fee-for-service program); an HMO (managed care); or a Provider Service Network (a managed-care plan operated by a provider). Just more than half (51.6%) of the state's Medicaid beneficiaries receive their services through HMOs.⁹ As the chart below illustrates, managed care is more established in Broward County than in Duval County.

Medicaid is a federal-state matching program and is the largest single source of federal dollars flowing into the state. The state's Section 1115 waiver changes the way a significant portion of the state's federal Medicaid spending enters the state through a complex financing arrangement known as a “budget neutrality agreement.” As a result of the agreement, growth in per-person federal spending is now limited to 8% annually for most of Florida's Medicaid beneficiaries statewide – not just those in the pilot counties.

What kinds of changes will beneficiaries see?

Changes that will affect all reform-eligible beneficiaries in Broward and Duval include:

- » *Pilot program enrollees no longer will have the option of enrolling in MediPass.* The MediPass program is a primary-care case-management program that reimburses participating providers on a fee-for-service basis with limited coordination by a primary care physician. Beneficiaries are not restricted to the network of a particular plan.
- » *New enrollees initially are eligible only for emergency services.* Individuals who are enrolling in Medicaid for the first time, or are re-enrolling after losing Medicaid coverage for a period of time, will be eligible only for emergency services until they execute a choice of plan. In addition, “retroactive” eligibility, which previously allowed for back payment of claims for up to 90 days prior to the date of application, no longer is available.



» *Everyone, but especially those not previously enrolled in a managed-care plan, is likely to experience some changes in the networks of providers that they see.* Plans currently are negotiating with hospitals, doctors, clinics and others to establish their networks.

Changes that will affect adults (other than pregnant women):

- » *Adults will be subject to a new annual maximum benefit limit.* The state has set this limit at \$550,000.¹⁰ While this is likely to affect only a handful of individuals, this new kind of limit is unprecedented in the Medicaid program nationwide.
- » *Adults will see variations in their benefits.* Services that are deemed “mandatory” (such as inpatient care and doctor visits) under Medicaid rules will be subject to the same limits as in the rest of the state’s Medicaid program. Other benefits, even if they are medically necessary, are subject to new limits that may vary by plan. Overall, the value of the benefits package must meet an “actuarial equivalency test” (in other words, the dollar value of the new benefit packages should be equivalent to the value of the old Medicaid benefit package for the average member of the population). Plans have some flexibility to limit durable medical equipment, home health services, outpatient hospital services, and prescription drugs, but must meet a “sufficiency test.”¹¹ Finally, plans must cover physical and respiratory therapy, podiatry, chiropractic, dental, vision and hearing services, but have total flexibility in how much of a benefit to offer (subject to the overall actuarial equivalency). Plans may also offer additional or enhanced services, as in the rest of the Medicaid program.

How many plans have signed up to participate?

As of August, five plans had been approved to participate in Duval County. Of these, three are HMOs – two of which are new or relatively new to the marketplace.

Two are Provider Service Networks, one organized by Shands Jacksonville, part of the University of Florida health care system, and one organized by a group of minority physicians. Thirteen plans

PLANS APPROVED IN BROWARD & DUVAL COUNTIES		
	HMOs	PSNs
BROWARD COUNTY	Buena Vista*	South Florida Community Care Network*
	HealthEase*	
	Humana Family*	Access Health Solutions*
	Preferred Medical Plan*	Florida NetPASS*
	Staywell*	Pediatric Associates*
	Total Health Choice	
	United Healthcare*	
	Vista Healthplan	
Amerigroup Community Care		
DUVAL COUNTY	HealthEase*	First Coast Advantage
	Staywell	Access Health Solutions*
	United Healthcare	

*operating in the county prior to 2006

have been approved for Broward County, where more managed care plans have been operating. Four of the Broward plans are PSNs.

Evaluating the pilot program

To understand better the impacts of reform, the Jessie Ball duPont Fund has engaged researchers at Georgetown University to conduct an independent evaluation of the two-year pilot program in Broward and Duval counties. Five central themes are at the core of this evaluation and will form the basis of future policy briefs.¹²

1) WILL INTRODUCING MARKET-BASED CONCEPTS, SUCH AS CONSUMER CHOICE AND COMPETITION AMONG PRIVATE COMPANIES, SAVE MONEY WITHOUT REDUCING ACCESS TO CARE?

The principle of choice is a central theme and raises many issues.

What kinds of choices are available? Do beneficiaries feel that they have good choices? How many are choosing to opt out of Medicaid into private insurance? How does the number of participating plans change over time?

Are beneficiaries being equipped with good tools to make these choices? Is the choice counseling program working?

Are beneficiaries actually making choices? How many are being auto-assigned? How many are simply staying with plans they already are in?

Are beneficiaries newly eligible for Medicaid able to make plan choices reasonably quickly? Is there increased use of emergency rooms because only emergency services are covered during the transition?

2) ARE HEALTH CARE PROVIDERS PARTICIPATING WITH THE NEW HEALTH PLANS?

For most beneficiaries, ensuring continuity of care with existing providers is a primary concern. Other key questions include the impact of the new system on providers’ financial viability and the related availability of safety-net providers and services.

Is there strong participation by providers? Are primary care doctors typically signing up with just one plan or with several? Are they able to keep their current patients? Are more specialists available to beneficiaries than in the current system?

How has reform affected access to hospitals? Are hospitals broadly available in most plan networks? What are hospitals doing when beneficiaries from other plans show up in the emergency room?

What is the impact on the safety net? Are safety net providers, including county health departments and community health centers, participating in all plan networks? If not, are they still providing services to beneficiaries enrolled in other plans? What is the financial impact?

What are the consequences of moving to many payors in

What are the consequences of moving to many payors in the system? Do providers have smooth relationships with the plans? Are administrative issues better or worse with private plans than with Medicaid?

3) HOW ARE BENEFITS CHANGING? Key questions include how plan benefit packages vary, and if so, whether the changes are causing problems for beneficiaries.

Are plans changing benefits from what Medicaid traditionally has offered? To what degree are plans using their flexibility to limit certain benefits? Are plans adding new benefits that people want? How does this change over time?

Are the new plan benefit packages adequate for the needs of the beneficiaries – especially those with chronic or disabling conditions? Are limits on the pharmacy benefit causing problems for beneficiaries? Are children still maintaining full access to Early Periodic Screening Diagnosis & Treatment services?

Is the new maximum benefit limit affecting many beneficiaries? If so, how are these beneficiaries meeting their health care needs?

4) ENHANCED BENEFITS ACCOUNTS: ARE THEY RESULTING IN MORE HEALTHY LIFESTYLE CHOICES? Key questions center on whether these accounts encourage behavior changes and who decides if patients are “doing the right thing.”

How are the enhanced benefit accounts working?

Is there any evidence that beneficiaries are responding to the incentives to engage in healthy behaviors? What types of purchases are they making with their credits? How are they administered, and are they administered fairly?

5) WHAT DO WE KNOW ABOUT THE IMPACT ON COST AND QUALITY OF CARE? This question is among the most important and probably the most difficult to evaluate.

Is there evidence that the reform is saving or costing money? Is more or less money being spent on administrative costs?

Are plans being paid adequately? Is the risk-adjustment system working? Do providers and beneficiaries see any evidence that plans are skimping on services to reduce costs?

Are measures on the quality of care available for the new plans? Do they suggest that quality and access to care is improving or worsening?

Policy briefs addressing these questions will be forthcoming in 2007. The Georgetown evaluation period is April 2006 through April 2008.

ENDNOTES

- ¹ Bush, Governor Jeb. “Market Principles: The Right Prescription for Medicaid,” *Stanford Law & Policy Review*, Volume 17:1, Spring 2006.
- ² During the second 12 months of the implementation period, the state may expand the pilots to three rural counties (Baker, Clay and Nassau) near Duval. For more on what state law requires, see Alker, J. “Understanding Florida’s Medicaid Reform Legislation” (Orlando: Winter Park Health Foundation) June 2005.
- ³ Bush, Governor Jeb. “Market Principles: The Right Prescription for Medicaid.”
- ⁴ For more background on the Medicaid waiver, see *Florida’s Medicaid Waiver: Key Program Changes and Issues* (Washington: Kaiser Family Foundation) December 2005, and Alker, J. “Understanding Florida’s Medicaid Waiver Application” (Orlando: Winter Park Health Foundation) September 2005.
- ⁵ This kind of “premium assistance” program has been tried in a few other states and has had some success, but has generally had small enrollment. See *Premium Assistance Programs: How are they Financed and do States Save Money?* (Washington: Kaiser Family Foundation) October 2005.
- ⁶ AHCA MediPass/HMO/PSN Enrollment report for July 2006.
- ⁷ *Ibid.*
- ⁸ All data from Kaiser StateHealthFacts online; birth data is from 2002; children’s coverage data from 2003-2004; and nursing home care is from FFY2004.
- ⁹ *Ibid.*
- ¹⁰ See AHCA Health Plan Model Contract, Attachment 2 July 2006, p. 2 of 259.
- ¹¹ The sufficiency test is based on past service use and is set a level that is designed to meet the service needs of 98.5% of beneficiaries.
- ¹² This evaluation relies on data collected through such methods as structured interviews with key stakeholders, focus groups with beneficiaries and review and analysis of other materials. For more information on methods, please contact the authors.

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It may be found online at www.dupontfund.org and at www.hpi.georgetown.edu/floridamedicaid

For more information:

Sherry P. Magill
President
Jessie Ball duPont Fund
One Independent Drive
Suite 1400
Jacksonville, Florida

32202
904-353-0890



AUTHORS

Joan Alker
Jack Hoadley
Health Policy Institute
Georgetown University
3300 Whitehaven St. NW
Suite 5000, Box 571444
Washington, D.C. 20057
202-687-0880

