Florida Medicaid Reform

Medicaid Commission Meeting
March 15, 2006
Atlanta, Georgia

Jeb Bush
Governor

FLORIDA

Medicaid Reform

- *Authorized by Florida Legislature in SB 838 – passed on May 6, 2005.*
- *Posted on website August 31, 2005.*
- *Agency received a number of comments on the waiver.*
- *Waiver was submitted to CMS October 3, 2005, after posting it for 30 days.*
- *Reached agreement on Terms & Conditions, including UPL program, with Centers for Medicare and Medicaid Services (CMS).*
- *Waiver was approved by CMS on October 19, 2005.*
- *Approved by the Legislature December 8, 2005.*
- *Will begin in Duval and Broward Counties on July 1, 2006.*

What Medicaid Reform Is NOT

- *Reform will NOT change who receives Medicaid. Eligibility does not change.*
- *Reform will NOT "cut" the Medicaid budget. The budget will continue to grow each year.*
- *The state will NOT limit medically necessary services for pregnant women.*
- *The state has NOT asked to waive Early and Periodic Screening Diagnosis and Treatment (EPSDT) for children. This means children will be able to access all medically necessary services.*
- *The state will NOT increase cost sharing requirements.*

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):*
    - *HMOs are capitated.*
    - *PSNs are Fee-for-Service up to three years, then capitated.*

Customized Plans

- *Benefits for Medicaid Eligible Individuals:*
  - *Variety of plan choices.*
  - *Increased access to care.*
  - *Ability to select a plan that best meets their needs.*
    - *Must provide coverage of all mandatory services and all optional services required by plan enrollees.*
    - *May vary in scope, amount and duration for some benefits.*
    - *May cover services not traditionally covered by Medicaid.*
- *All medically necessary services for children and pregnant women will be provided.*

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 people in the population.*
- *Actuarial equivalence and sufficiency are data driven.*

Opt-Out

- *Recipient can choose to enroll in employer-sponsored health insurance instead of 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.*

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.*

Risk-Adjusted Rates

- *Certain conditions (AIDS, asthma, diabetes, etc.) and use of particular pharmaceuticals have strong link to future health care costs.*
- *Statistical models correlate historical diagnoses/ pharmaceutical utilization to likelihood of future health care cost.*
- *Individuals assigned a "risk score."*
- *Individual risk scores generate premium, based on recipient predicted needs.*
- *Health plans 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.*

Risk Adjustment Phase In

- *Requires phasing in of risk adjusted rates during the first two fiscal years:*
  - *In the first year, the capitation rates will be weighted so that 75% of each capitation rate is based on current methodology and 25% is based on a new risk-adjusted capitation rate methodology.*
  - *In the second year, the capitation rates will be weighted so that 50% of each capitation rate is based on current methodology and 50% is based on a new risk-adjusted capitation rate methodology.*
  - *In the following fiscal year, the risk-adjusted capitation methodology may be fully implemented.*

Risk Adjustment
Risk Corridor

- *Requires the Agency ensure that during the first two fiscal years:*
  - *No reform plan providing comprehensive benefits to TANF and SSI recipients have an aggregate risk score that varies more than 10 percent from the aggregate weighted mean of all reform plans providing comprehensive benefits to the same population in a reform area; and*
  - *The Agency's payment to such a reform plan will be based on such revised aggregate risk score.*

State Reinsurance Component
(Catastrophic Component of Premium)

- *A single set of benefits:*
  - *Recipients review their chosen set of benefits.*
  - *Transition between Comprehensive and Catastrophic component is transparent to the recipient.*
  - *Continuous coverage of benefits.*
- *All Plans must provide both Comprehensive and Catastrophic Services.*
- *Comprehensive Care covers the cost of most services for most Medicaid recipients:*
  - *Plan is financially responsible up to a set threshold.*
  - *Represents approximately 90% of total premium in aggregate.*

Next Steps

- *Pre-Implementation activities:*
  - *Continued outreach and education.*
  - *Procurement of plans.*
  - *Plan readiness review.*
  - *Choice Counseling Development.*
  - *Enhanced Benefits Development.*
  - *Opt-Out Development.*
  - *Payment Systems.*
  - *CMS Pre-implementation milestone.*
- *July 1, 2006, implementation in two counties.*