BRIEFINGS

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Understanding Florida Medicaid Reform

On June 3, 2005 Governor Bush signed SB 838—Florida's Medicaid reform bill aimed at containing costs and providing greater individual choice in the 40-year old health insurance program. Medicaid is important to Florida, as the following fact sheet outlines.

Medicaid Fact Sheet

- Medicaid is a joint federal state entitlement program that provides health care for the economically disadvantaged who are children, disabled people, and the elderly as well as needy people covered by optional state services.
- Medicaid is different from Medicare. Medicare is financed entirely by the federal government from Congressional appropriations, employer and employee contributions, and covers all Social Security recipients regardless of income.
- States administer Medicaid under guidelines set by the federal government that offer states options concerning the types of medical services covered, who is covered for those services, and if states may charge recipients a share of costs, called "co-payments." Consequently, Medicaid programs vary among the states.
- A state may apply to the federal government for a "waiver" from the state's approved Medicaid plan to vary the state's administration and service delivery structures.
- Florida's Medicaid program covers 2.2 million people including 27% of Florida children, 44% of pregnant women, and 52% of people with AIDS.[1]
- Medicaid pays for 66% of patient days in Florida nursing homes.[1]
- Medicare and Medicaid consume 20% of the federal budget and have doubled in budget share in twenty years.
- With a total budget of over $15.5 billion in FY 2005-06, Florida's Medicaid program is the fourth largest in the nation because of Florida's relatively large and growing population and Florida's higher concentration of elder citizens.[2]

[1] Thomas W. Arnold, Agency for Health Care Administration: *Medicaid Waiver and Reform*, House Health Care General Committee presentation, March 9, 2005.
[2] The Florida Senate Committee on Health Care: *Identification and Prevention of Fraud and Abuse in Medicaid Managed Care*, November 2005.

- Medicaid consumes about 16% of the state's own general funds annually, a percentage second only to public education. Medicaid is also the largest source of federal funds in the state budget.[3]
- State and federal funds combined, Medicaid's share of the Florida state budget jumped to 24.4% in 2005, from only 5.9% in 1980.[4]
- Medicaid spending grew 13.5% on average every year in Florida between 1980-2004, far exceeding the annual 8.8 % growth of the state budget during the same period.[4]
- If the overall state budget increases by 7% while Medicaid spending continues increasing by 13.5%, Medicaid will consume 32.8% of the state budget in 2010. If major changes do not occur, this rate will jump to 79.5% in two decades.[5]
- It is unlikely that the federal government will be able or willing to fund the increasing cost of Medicaid. The U.S. Government Accountability Office has observed that the rate of growth in Medicare and Medicaid spending cannot be sustained.[6]

Florida Senate Bill 838[7] begins with a pilot project in Broward and Duval counties, which adds Baker, Clay and Nassau counties a year after implementation in Duval county. The pilot will test the comprehensive and bold form of Medicaid "managed care" for possible statewide expansion.[8] The 2005 Legislature added an evaluation of the pilot to note any administrative changes needed, determine cost savings and measure effects on patient care.[9] The proposed changes if implemented statewide will affect millions of people and be a model for other states if successful. The reform has garnered national attention because of its potential statewide scale and effects on Florida's relatively large and diverse Medicaid population that is the fourth largest in the US. The U.S. Center for Medicaid and Medicare (CMS) approved the waiver for Medicaid reform on October 19, 2005[10] and the Governor has called a special session for December 5 to receive the necessary final approval for the pilots.

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[3] The Florida Senate Ways and Means Committee and The Office of Economic and Demographic Research: *State of Florida Three Year Revenue and Expenditure Outlook*, Winter 2005, page 29.

[4] Michael Bond: Reforming Florida's Medicaid Reform with Consumer Choice and Competition, Backgrounder, The James Madison Institute, February 2005.

[5] FY 2004-05 Florida Social Services Estimating Conference, February 25, 2005. Florida's E-budget website.

[6] United States Government Accountability Office: *21st Century Challenges: Reexamining the Base of the Federal Government*, Report Number GAO-05-325SP.

[7] It is important to note that the reform bill also requires a major change in long-term care. The bill mandates ACHA in partnership with the Department of Elder Affairs "to create an integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older." The changes will be implemented on a pilot basis in two areas of the state. In one area, participation will be mandatory while in the other area, it will voluntary. This reform is beyond the scope of this Briefing.

[8] For the full text of the reform legislation, see: http://election.dos.state.fl.us/laws/05laws/ch_2005-133.pdf. The reform law is codified in FS 409.91211. See: www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0409/SEC91211.HTM&Title=->2005->Ch0409->Section%2091211#0409.91211

[9] Section 3, Ch. 2005-133 of the reform law (Committee Substitute for Committee Substitute of SB 838) requires a comprehensive evaluation of the pilots by the Legislature's Office of Program Policy Analysis and Government Accountability (OPAGA) in consultation with the Auditor General.

[10] For the full text of the approved waiver, see: www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/index.shtml.

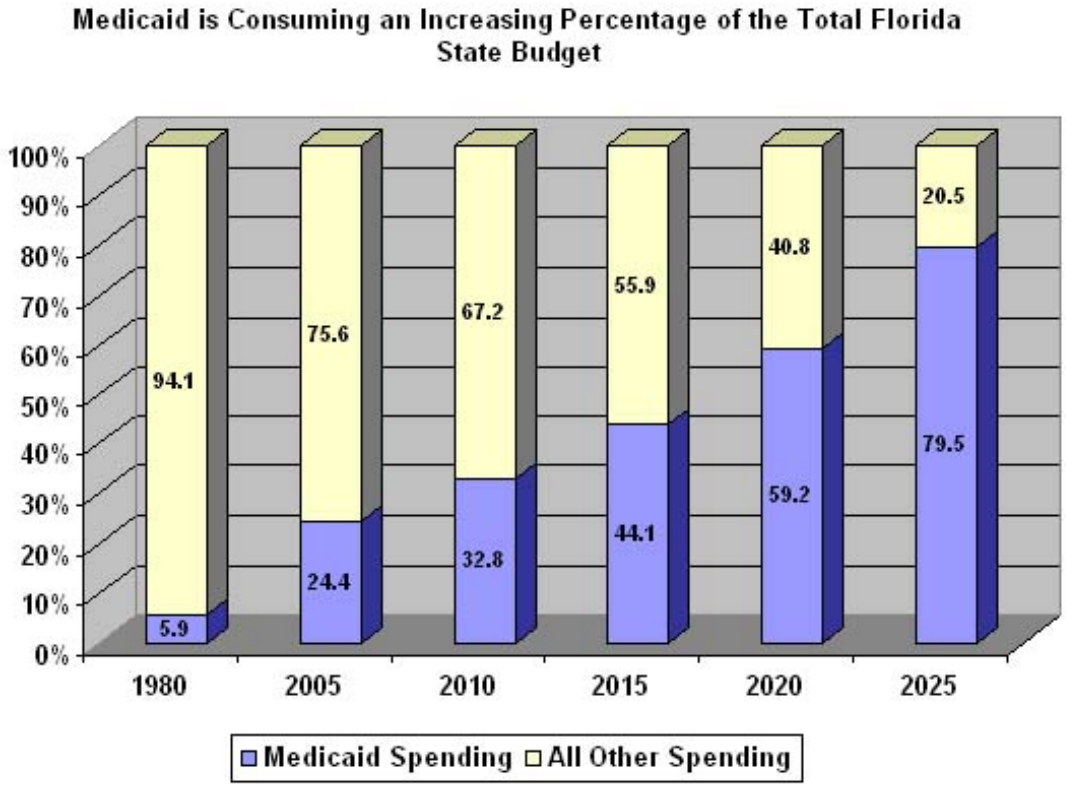
A comprehensive evaluation of the Medicaid reform is beyond the scope of this briefing. Since the reform will have impact on many taxpayers, Florida Tax Watch will continue to monitor the progress of the reform. This second briefing on Medicaid reform seeks to inform stakeholders about the nature of the current and new Medicaid systems, to increase public awareness on the matter, and to raise some questions about the reform.

I. Florida's Current Medicaid System

Medicaid, along with Medicare, was created in 1965 by an amendment to the federal Social Security Act. The objective was to provide broad heath care coverage to lower income, disabled and elderly populations. Medicaid consists of several different programs. First, it is an insurance program for low-income, uninsured children, parents and pregnant women. Second, it is a long-term care program for people with chronic disease or disabilities. Third, it supplements gaps in Medicare coverage for low-income people. Fourth, it is a program funding safety net for hospitals and community health centers with disproportionate share of uninsured patients.[11] Medicaid is financed by state and federal government. States have to provide mandatory services described by the federal government in order to receive federal funding.

Ominously, the U.S. Government Accountability Office has warned that all federal public health finance programs including Medicaid are not sustainable by the federal government at current rates of cost growth. Medicare and Medicaid consume 20% of the federal budget and have doubled in budget share in twenty years.[12] Florida Medicaid spending grew 13.5% on average every year between 1980-2004, far exceeding the annual 8.8% growth of state budget during the same period. Medicaid's share of the Florida state budget jumped to 24.4% in 2005, from only 5.9% in 1980. This share will be much higher when baby boomers reach retirement age.[13] As shown in the figure below, if the overall state budget increases by 7% while Medicaid spending increases by 13.5%, Medicaid will consume 32.8% of the state budget in 2010. Worse than that, if major changes do not occur, this rate will jump to 79.5% in two decades. With a large retiree population, Florida is expected to face even a bigger increase in the number of Medicaid recipients when baby boomers retire.

[11] Smith, Vernon K. & G. Moody: Medicaid in 2005: Principles & Proposals for Reform, Health Management Associates, February 2005.
[12] United States Government Accountability Office: 21st Century Challenges: Reexamining the Base of the Federal Government, GAO-05-325SP.
[13] Michael Bond: Reforming Florida's Medicaid Reform with Consumer Choice and Competition, Backgrounder, The James Madison Institute, February 2005.



Sources: FY 2004-05 Social Services Estimating Conference, February 25, 2005. Florida's E-budget website.

Medicaid fiscal problems burden every state. Indeed, most states have implemented policies to prevent a foreseeable crisis such as reducing or freezing provider payments, controlling prescription drug costs, reducing or restricting eligibility, reducing benefits and increasing co-payments by beneficiaries.[14]

The Florida reform must be considered in the context of Medicaid's history, which along with Medicare, greatly influenced state government health and fiscal policy as well as the behavior of medical professionals and Medicaid recipients. Medicaid originally paid for services on a "fee-for-service" basis whereby providers received fees fixed on the state level for each unit of service delivered (e.g. physician visits, per day of nursing home care, etc.). A government controlled fee-for-service system, coupled with the entitlement nature of Medicaid, had many unintended but worrisome and costly consequences:

- Medicaid facilitated service delivery and units of care delivered, but failed to provide incentives for better health habits or comprehensive primary care that lead to better long-term outcomes.
- The federal and some state governments expanded Medicaid eligibility to more groups or made eligibility less restrictive—but failed to anticipate corresponding long-term actuarial liabilities.

[14] Florida Agency for Health Care Administration, *The Current Program and Proposed Framework for Modernization*, April 18, 2005.

- More poor, elderly, and disabled Medicaid recipients entered the system already in poor health, were at high risk for developing chronic conditions, or whose poor health behaviors contributed to health problems in infants and children (e.g. failure to seek pre-natal care, smoking, or use of alcohol during pregnancy).
- State governments opted for more federally-authorized services (dental, vision, nursing services, etc.) because of compassion and the availability of federal matching funds.
- Providers and drug companies developed effective negotiating and lobbying skills to achieve higher fees for services and drugs.
- Companies invested in capacity to earn more Medicaid revenue (e.g. nursing home beds)—correctly anticipating that society was becoming more dependent on Medicaid to provide long-term care for elderly and disabled populations.
- Certain trends in U.S. medical care in general affected Medicaid too. Generally accepted medical treatment modalities for all patients including Medicaid patients increasingly entailed very effective but costly technology or procedures. Tort liability abuses and defensive medicine increased the incidence of redundant tests and more costly treatment modalities.
- Physicians had no incentive to prescribe lower-cost, equally-effective approved generic drugs if Medicaid paid for higher cost drugs preferred by Medicaid patients.
- State-imposed attempts to control fee-for-service costs, such as restrictions on physician visits, co-payments and monthly prescription limits, often created unintended side effects when they caused patients with chronic conditions such as elevated cholesterol, hypertension or diabetes to avoid treatment, which increased far more costly emergency room admissions, hospitalizations, and higher incidence of deaths or long-term debilitating conditions such as heart attacks, strokes, or amputations.
- Fraud and abuse increased as increasingly savvy dishonest providers and recipients took advantage of poor controls and inadequate audit and investigation procedures and received billions in illegal payments for fake billings, kickbacks, prescription selling, and an assortment of schemes.[15]
- State Medicaid agencies lagged in obtaining sophisticated computer technology, which contributed to delay in responding to fraud and abuse, failure to detect legal, but costly utilization patterns, and hindered accurate and timely modeling and forecasting of actuarial cost consequences of policy changes. Alan Levine, Secretary of the Agency for Healthcare Administration, has called the current system "a pay and chase" system, because it pays claims first and identifies fraud later, which could amount to as much as 20% of costs in certain areas.[16]

"Managed care" through health maintenance organizations, provider networks, disease management, case management, or utilization review is an alternative approach that is commonly suggested as a cost savings measure and a way of ensuring access to health care without many of the deleterious side effects of fee-for-service. Premium and cost arrangements between the state and the providers in a managed care system vary from full-risk or fully-capitated plans to limited or partially-capitated plans to no-risk or primary case management plans. These terms require further explanation.

Under a defined contribution or "capitated" arrangement, the state limits payments to the managing organization to a fixed amount per Medicaid recipient similar to an insurance premium. Under a fully-capitated plan, the "risk" of paying costs above anticipated or average levels shifts "fully" to the managing organization. A partially-capitated plan provides for the state and managing care organization to share costs above anticipated levels. Under a "no-risk" or "case management plan," the state pays only for the managed

[15] For a discussion of fraud schemes affecting both Medicare and Medicaid, see National Center for Policy Analysis: *Fraud in Medicare* available at www.ncpa.org/~ncpa/health/pdh5.html
[16] Interview with Florida TaxWatch, November 2005.

care organization's "gatekeeping" expertise in authorizing medical services delivered by providers selected by the state with the state setting fees that it will pay providers while assuming all of the financial risk for utilization of services.

Forty-seven states, excluding Alaska, New Hampshire, and Wyoming, utilize managed care approaches to some extent. As of June 30, 2004, 61% of all U.S. Medicaid eligibles were enrolled in some form of managed care. In Florida, the current Medicaid law, FS 409.9121,[17] requires that, to the extent possible, Medicaid beneficiaries must be enrolled in a managed care delivery system.[18] Indeed, as of June 2005, 68% of all Medicaid beneficiaries were enrolled in one of the following managed care programs: 1) MediPass, 2) Medicaid Health Maintenance Organizations (HMOs), and 3) Provider Service Networks (PSNs). The MediPass system is a statewide primary care case management program that provides primary care and refers patients for specialized services. The state pays a $3 monthly fee for each recipient in addition to fee-for-service reimbursement. Medicaid HMOs are available in most of the state's counties. The state pays a discount off of fee-for-service costs for a similar population. There is only one PSN in the state, which provides service in two counties. Florida's and other states' experiences with fee-for-service and managed care arrangements have largely determined the nature of the proposed reform.

The key elements and timeline of proposed changes are discussed below.

II. Key Elements of the Florida Medicaid Reform

1. **Creating a Private Marketplace for Medicaid Services:** The essence of proposed reform is to shift more of the state's Medicaid cost risk to managed care networks. The premise behind the proposal is that managed care organizations will be willing to accept higher cost responsibility in exchange for making a profit. Beneficiaries will shop for and then choose a managed care plan, be assigned one by the state by default, or be compensated for insurance provided by the recipient's employer. Managed care entities will serve as counselors and function as a gateway before participants receive services from providers who participate in the managed care organization's provider network. Participating managed care organizations will find medical professionals who accept Medicaid and coordinate many aspects of health care services. The proposed changes are expected to create a more competitive market among private provider networks and insurance carriers as they compete for participants by offering a wider and more attractive array of services. It is anticipated that this will encourage participants to be more selective, eliminate unnecessary treatments and prescriptions, steer participants to more cost-effective treatment modalities, and reduce Medicaid expenditures without compromising the quality and scope of services. To accomplish this, the reform legislation authorizes

[17] To review the text of the statute, see http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0409/SEC9121.HTM&Title=->2005->Ch0409->Section%209121#0409.9121 .

[18] The Florida Senate Committee on Health Care: *Identification and Prevention of Fraud and Abuse in Medicaid Managed Care*, November 2005 citing Office of Program Policy Analysis and Government Accountability FGAR profile: http://www.oppaga.state.fl.us/profiles/5009/ .

the Florida Agency for Health Care Administration (AHCA) to develop standards and credentialing requirements for managed care networks. AHCA may contract with multiple types of managed care providers in order to increase competition and choice.

2. **Creating Three Different Benefit Components:** Similar to private health insurance plans that offer customers coverage options that vary in what is covered and what costs must be borne by customers, the legislation includes a three-tiered system for Medicaid beneficiaries.

    a. **Comprehensive Benefits** is a basic benefit package, which will cover all mandatory services and needed optional services. This benefit plan may vary in terms, amount, duration and scope of services. The bill encourages different benefit plans that meet the diverse needs of individual participants.

    b. **Catastrophic Care** covers those who deplete their comprehensive benefits. Individuals who pass a threshold amount in one year will be re-insured up to a maximum benefit limit for all medically necessary services.

    c. **Enhanced Benefits** is an incentive to Medicaid beneficiaries who demonstrate healthy practices. Qualified recipients may use accumulated funds in their accounts to purchase additional health care services that are not covered by their plan or use them for employer-sponsored insurance when they become ineligible for Medicaid.

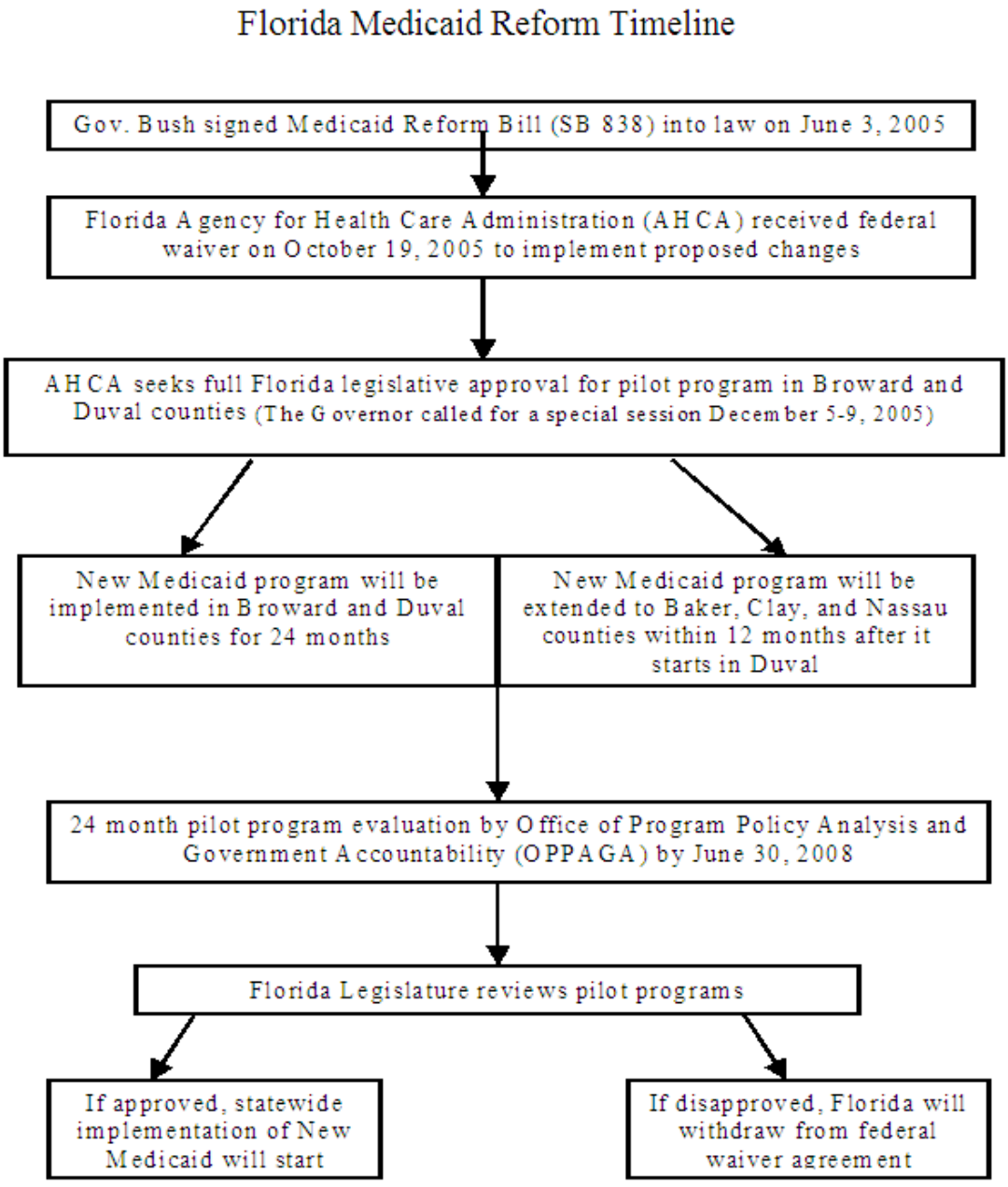
        The Medicaid reform will reward beneficiaries for healthy behaviors such as making and keeping all primary care appointments; adult age-sex appropriate preventative practices; and for participating in childhood wellness visits, preventive care, vision and annual dental exams; alcohol and/or drug treatment; smoking cessation programs; and weight loss programs. The enhanced plan will cover medical services such as adult routine dental, alcohol and drug treatment, bandages, contact lenses, dental treatment, eyeglasses, hearing aids, OTC or brand-name drugs, and healthy behavior programs such as stopping smoking and weight-loss.

3. **Creating A Risk Adjusted Premium-based Capitation System:** AHCA is authorized to develop risk-adjusted premiums to cover three proposed benefit components. Managed care providers will be paid a monthly, risk-adjusted premium for Medicaid enrollees. In exchange, the providers will accept responsibility for delivering all medically necessary services mandated by the contract with the state.

4. **Creating An Opportunity for Medicaid Recipients to Opt-Out of the Medicaid System:** Medicaid participants will be able to enroll in employer-sponsored health insurance instead of a Medicaid certified plan by using their state-paid premium. They can also use enhanced benefits in their account to purchase a private insurance plan. They can opt back into Medicaid if they become unemployed.

III. Timeline of Medicaid Reform

The Agency for Healthcare Administration (AHCA) recently received a waiver from the U.S. Centers for Medicaid and Medicare (CMS) in order to implement the reform program in Broward and Duval counties, with authority to expand into Baker, Clay, and Nassau counties within one year after the Duval county program becomes operational. The statewide expansion of the program will require Legislative approval after the pilots. The program will initially start with targeted Medicaid eligibility groups. As seen in the flowchart below, the statewide implementation will be possible in the 2009 fiscal year if everything goes as planned.



IV. New Medicaid System: Questions and Concerns

There are several important questions and concerns about the Florida Medicaid Reform discussed below.

1. How will the state assess the sufficiency of the benefit plans?

The waiver states that the benefit packages offered by managed care organizations must be actuarially equivalent to the value of the current state plan package. It also requires the providers to demonstrate sufficiency of benefits. The state needs to establish a clear guideline for the actuarial equivalence and sufficiency test of benefit plans. If the state does not address all expected issues in the contract with a managed care organization and does not monitor the implementation, Medicaid recipients may not receive the proper services intended by the Legislature. There is a serious concern that all the people who now rely on Medicaid might not receive adequate service through a managed care system. A Medicaid Director cautioned in 1995 against viewing a managed care system as a cost containment strategy alone:

> In Wisconsin, we started using HMO's in 1983 with the goal of saving money….That was the first goal and there wasn't a second or third goal….But we lost sight of quality and access issues and community involvement….If you do the right things actuarially and set your rates appropriately and you do competitive bidding, you will save money, but that becomes a secondary goal, because unless you assure access and quality, and look and pound away at those areas, the system falls apart eventually and you're not serving the ultimate needs.[19]

2. How will the state measure health outcomes of Medicaid recipients in the pilot counties?

The focus of the reform is largely on cost and administration, which is understandable given Medicaid's increasing share of the state budget. However, if AHCA does not establish comprehensive performance standards for health care outcomes of Medicaid participants in the pilot areas, it will not be possible for the state to determine if the reform maintained or improved the health of participants. A major assumption is that participants and managed care providers will behave differently than they would under a fee-for-service system. One advantage of a pilot project is that with the smaller size of the population involved, it should be more practical to establish health outcome hypotheses and then test those hypotheses. Without evaluation, the state may not know whether any health outcomes achieved resulted from the reform or if they occurred by accident or would have occurred anyway without the reform.

3. How will the state determine the adequacy of the adjusted premiums?

[19]Kevin Piper in remarks to the 1995 NCSL Annual Meeting quoted by Martha P. King, National Conference of State Legislatures, *Medicaid Survival Kit,* 2001 update*,* Chapter 8, page 8-1.

One of the key merits of the reform, as mentioned in the waiver, is to bring "marketplace decisions" into the Medicaid program in order to increase quality and efficiency while stabilizing cost. However, in a free market, price (premium) is determined by supply and demand, not by government intervention or rate setting. The waiver states that the premiums for comprehensive and catastrophic plans will be determined by ACHA based on "individual risk scores." According to ACHA, "Premiums will be established based on eligibility groups, age, and gender for a specified geographic area and risk adjusted for health status."[20] In other words, historical claims for Medicaid enrollees will be used to determine the premiums. For instance, if a Medicaid enrollee is determined to be healthy for the last three years, the premium for the next year will be based on the average cost of those years. ACHA will estimate health care expenses based on historical data and distribute capitation payments across health plans based on the health risk of the enrollees.

There are problems in such determination. First, in order to accurately determine the premiums, ACHA has to have adequate and accurate historical data, which might not exist for some enrollees. Second, the premiums could be high to the extent that fraud and abuse are attributable to past participants and providers who have abused the system in the past and will affect the risk group to which the enrollee belongs. The advocates of the reform claim that the reform will reduce fraud and abuse substantially. However, since the premiums will be determined by historical cost data, the costs to the state will not change until there is a future decline in Medicaid fraud. Third, if the premiums were too low, these would discourage some providers from participating in the program or cause them to offer inadequate benefits. If the premiums were too high, these would not help the state to realize the desired goal of stabilizing the cost of Medicaid. In short, determining a correct premium level will be a major challenge to ACHA and a key factor to the success of the reform.

4. Will the reform bring extra financial burden to Medicaid enrollees or to the state?

The waiver clearly states that there would be no cost-sharing for the enrollees due to the reform. However, since the benefit plans, including catastrophic care, will have an annual maximum benefit limit, the Medicaid enrollees will be responsible for any costs above the limit. As discussed before, the Medicaid beneficiaries generally do not have sufficient income to cover such cost. This means that either beneficiaries would avoid care after passing the limit or the costs would become charity cost absorbed by providers and ultimately passed along to other payers with the side effect of raised private insurance rates as well as future managed care premiums paid by the state. Since the federal government pays more than half of the Medicaid cost, it is very important for the state to determine an adequate upper limit level.

5. Will managed care organizations be as administratively efficient as the current state-administered Medicaid system?

The reform will be cost-effective for the state if managed care providers spend less per enrollee compared with a fee-for-service system. Some studies found that Medicaid has

[20] Florida Agency for Health Care Administration, DRAFT *Empowered Care: A Proposed Concept for Florida Medicaid,* p.10.

been more efficient than private HMOs due to a relatively low administrative cost. A study prepared for the National Governor's Association concluded (emphasis added by Tax Watch):

> Medicaid has done an excellent job of holding down the per capita growth in spending. Over the period from 2000 to 2003, Medicaid per capita growth in the cost of acute care was just 6.9 percent. This compares with per capita growth for all Americans with private insurance coverage of 9.0 percent, and with the per capita growth in employer‐sponsored health insurance of 12.6 percent. Medicaid programs have achieved this level of performance with administrative costs that are among the lowest of any health care payer in the country, typically in the range of four to six percent of claims paid. **By comparison, a health maintenance organization (HMO) with administrative costs of eight to twelve percent of claims paid would be regarded as efficient and a well‐run commercial health insurer typically would have administrative costs of 15 to 20 percent of claims paid. No program has done a better job than Medicaid at controlling health care spending, and no program has more limited administrative costs**.[21]

This issue warrants consideration by the Legislature during the upcoming special session and by the Office of Program Policy Analysis and Government Accountability during its evaluation of the pilot project. The state could adjust premiums downward to prevent paying managed care organizations for less efficient administration.

6. What profit levels will managed care organizations receive?

Another consideration is whether the state will benefit from savings achieved by managed care organizations. Cost stability to the state is a goal of the proposed reform. The National Conference of State Legislatures (NCSL) noted based upon a study by Robert Hurley from Virginia Commonwealth University that managed care produces typical cost savings per beneficiary in the 5 to 15% range annually and that Arizona's experience with a statewide managed care system suggests those savings will grow as the program matures. If the state's total cost levels off, but managed care organizations' costs for care decline at a faster rate, unless the state adjusts premiums downward and prospectively, the organizations will achieve profits at that faster rate. Reasonableness of profits is a matter of opinion. However, if managed care organizations net relatively large profits from Medicaid program premiums, the Legislature may be urged to cap profits and set state policy on what profit level would be sufficient to attract investment capital. Arizona imposed a profit cap when one of its Medicaid health maintenance organizations reported a $25 million profit.[22]

If the state were to consider a profit cap, the state would need to define "profit" and "expense" carefully as well as assure regular independent financial audits of managed care

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[21] Vernon K. Smith & G. Moody: *Medicaid in 2005: Principles & Proposals for Reform*, Health Management Associates, February 2005, p.8. Available at www.nga.org/Files/pdf/0502MEDICAID.pdf . Smith and Moody cited data from John Hollahan and Arunabh Ghosh: *Understanding the Recent Growth in Medicaid Spending*, 2000-2003, HEALTH AFFAIRS, January 26, 2005 available at: www.content.healthaffairs.org/cgi/content/full/hlthaff.w5.52/DC1

[22] Martha P. King, *Medicaid Survival Kit*, National Conference of State Legislatures, August 2001, p. 8-11.

organizations to prevent organizations from overstating administrative expenses and understating profit.

7. Are managed care organizations capable of handling larger numbers of long-term care, elder, or disabled populations?

According to AHCA, elder (over-65), blind and disabled groups constituted 30% of Florida's Medicaid enrollees, but accounted for 71% of 2003-04 Medicaid expenditures. To achieve cost stability for the state, participating managed care organizations will have to address the higher utilization and cost rates associated with these populations. A publication by The National Conference of State Legislatures listed several questions posed by advocates for these groups, including:

- Will the state ensure that a beneficiary's primary care physician is included in the network?
- Can specialists serve as primary care physicians?
- Do the HMOs have a full range of providers and services in the network, including rehabilitation technology services, durable medical equipment suppliers, prosthetics services, personal assistance services and communication specialists?
- How will the HMOs coordinate Medicaid services with other programs, such as individualized education programs and individualized family service plans?
- How will capitation arrangements affect the provision of key assistive technology devices and services?
- What type of case management does the state Medicaid agency require the HMOs to provide?
- In what ways can implementation of a Medicaid managed care system affect people being served by state developmental disability systems?
- Should the state create an ombudsman or consumer advocacy service as a liaison between the beneficiary and the HMO to provide education about the new system and to assist with grievances?[23]

8. Is ACHA ready for the implementation of the reform?

There are several issues regarding the readiness of ACHA in order to successfully implement the reform. These include monitoring contracts with managed care organizations, establishing adequate premiums based on relevant data, retraining staff for the changes in the organizational responsibilities. Before the implementation of the reform, ACHA needs to have a broad public education effort, develop a counseling program regarding program choices to help beneficiaries select a managed care plan, and determine the premiums for each plan. The success of Medicaid reform largely depends on the ability of ACHA to monitor managed care providers to ensure the quality of services. Indeed, all states that have a managed care program have used an enrollee survey or focus group to ensure service quality and opened an enrollee hotline to gather user feedbacks.

[23] King, *Medicaid Survival Kit*, NCSL, p. 8-10.

9. What is the plan to educate Medicaid beneficiaries and to increase public awareness about the reform?

The proposed reform if implemented statewide will be the biggest privatization project in the state's history, and it will have lasting impact on millions of current and future Medicaid beneficiaries. Therefore, it is very important to educate the public and to increase their awareness about the content and impact of the reform.

The problem now is that Medicaid is so complex and the terminology so obtuse and confusing, that only Medicaid experts can understand the program. What is needed is a "dashboard" type document to clarify and provide transparency to the reform. ACHA should develop educational materials to cover the premise of the reform, a list of changes from the status quo, major reform goals, and quantitative benchmarks for success (graphically portrayed numbers, dollars and timelines), which the general public could use to determine if the reform is succeeding.

10. What are the strategies for full enrollment?

The waiver states that each enrollee will be given 30 days to select a managed care plan after being accepted into Medicaid. Enrollees who fail to choose a plan within the deadline will be automatically assigned to a plan. It is important that the state follow the auto-enrollment criteria established in the waiver in order to prevent any disruption in care or serious under-use of care due to the lack of knowledge regarding the coverage. If problems exist with enrollment, the state might pay managed care premiums to the providers for enrollees who do not receive services. A counseling program is very important in order to assist beneficiaries in making the right choice. ACHA needs to develop effective strategies to reach all beneficiaries.

11. Will the state cut any optional services provided through the current Medicaid system?

State officials repeatedly have said that the Medicaid reform will not reduce services, but instead it will increase quality and efficiency. However, Medicaid beneficiaries are still concerned whether there would be any cut in some of the optional services provided by the current plan. It is important to note that almost two-thirds of Medicaid services are optional, not mandatory, including the services of dentists, optometrists, podiatrists; prescription drugs; and ambulance transports.[24] Medicaid recipients may also worry whether they will be forced to change their doctors or to travel greater distances for care.

12. Will managed care organizations offer catastrophic care benefits?

All Medicaid beneficiaries will have both comprehensive and catastrophic benefits in their plans. The comprehensive benefit will cover the costs of most services up to a set threshold. After that, catastrophic care will take effect. However, the Medicaid reform does

[24] Vernon K. Smith: *Medicaid in 2005: Principles & Proposals for Reform*, Health Management Associates, February 2005.

not mandate managed care providers themselves to cover the catastrophic component. According to the state Department of Children and Families, in 2004, 46% of the Medicaid budget went to 47.5 thousands recipients who are likely to be under a catastrophic plan. There is a concern that managed care organizations may not want to cover chronically ill people or those with catastrophic diseases. This might create a serious burden for the state due to adverse selection in the health care market. In other words, managed care providers might prefer to offer services to less risky enrollees while the state might end up covering more risky enrollees.

13. How will the reform prevent fraud and abuse in Medicaid?

The Medicaid reform bill mandates ACHA "to develop and recommend a system to oversee the activities of pilot program participants, health care providers, capitated managed care networks, and their representatives in order to prevent fraud or abuse, over utilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of participants and to recover overpayments as appropriate."

The National Health Care Anti-Fraud Association estimates that the cost of fraud and abuse in health care expenditures ranged between 3 to 10% in 2003. The proposed reform is expected to lower the rate based on the assumption that managed care organizations are better able to reduce fraud and abuse. The waiver states that "moving from fee-for-service to a premium-based environment will serve as an effective deterrent against fraud and abuse." However, a recent Florida Senate report indicates that this assumption might be faulty.[25] The report states that Medicaid fraud and abuse still occur in managed care systems—they simply change form. Potential areas of fraud and abuse include procurement of the managed care contract; marketing and enrollment fraud and abuse; underutilization; claims submission and billing procedures. As recommended by the Senate report, the Medicaid reform should collaborate with managed care organizations to develop a comprehensive fraud and abuse prevention and identification system.

14. How will the reform change the current Medicaid delivery system?

Given the fact that 68% of Florida Medicaid recipients are already enrolled in managed care programs, the state needs to explain to the stakeholders what would be different with the proposed reform.

15. Will there be independent monitoring and assessment of the reform as it is developing?

There should be a mechanism established to monitor implementation of the reform as well as to provide a summative evaluation. The implementation of the proposed changes will not be like throwing a switch. Negotiations between the Governor and state agencies with the federal government about the reform are ongoing. The reform will be phased in and may change from its original form. Elements of the reform will be developed after the

[25] The Florida Senate Committee on Health Care, *Identification and Prevention of Fraud and Abuse in Medicaid Managed Care*, November 2005.

reform commences. Timely and objective monitoring is necessary to detect looming fiscal problems or recipient service failures.

As previously noted, the Medicaid reform bill mandates the Florida Legislature's Office of Program Policy Analysis and Government Accountability to conduct a comprehensive evaluation of the two managed care pilot programs covering "assessments of cost savings; consumer education, choice, access to services; coordination of care; and quality of care by each eligibility category and managed care plan in each pilot site." The findings and recommendations by OPPAGA will help the Governor and Legislature decide on the statewide expansion of the reform.

It may be useful for OPPAGA to issue six-month updates on the progress of the reform because the reform will be taking form well before OPPAGA issues the required two-year summative evaluation. Regular monitoring may detect building concerns and unanticipated side effects that could be corrected by immediate administrative and legislative action.

Conclusion

Medicaid is the cornerstone of the state's system to help Florida's most vulnerable people. However, the program is not sustainable and may suffer severe fiscal problems if strong reforms are not undertaken in the near future. This is a very difficult and complicated task because the program is very large and complicated. Therefore, there has not been an attempt toward reform in the Medicaid system of this novelty and scale. Florida could set a good example if it implements the proposed changes successfully and documents how success was achieved so that other states might replicate Florida's reform. Given the scope and importance of the program, it is critical to increase public awareness about the proposed changes. It is important to have sufficient public debate and appropriate legislative oversight as the AHCA develops the details of the reform and implements it in pilot counties.

The sufficiency of benefit plans and the precision and adequacy of the premiums are very crucial for the success of the reform in terms of the state's desire to control spending and assure quality services. While there is consensus among policy experts that there is a great need for changes in Medicaid, there are concerns that the proposed changes may not produce savings and cost stability without serious reductions in services or degradation of health outcomes.

This *Briefings* was written by Dr. Necati Aydin, Senior Research Analyst and John Turcotte, Research Consultant, under the direction of Mary Lou Rajchel , Senior VP for Research & Development.

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