

# *Florida Medicaid Reform*

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# *Florida Medicaid Reform*

- ❖ *Will begin in Broward and Duval Counties.*
- ❖ *Expand to Baker, Clay and Nassau counties within one year of Duval implementation.*
- ❖ *Expand statewide upon Legislative approval.*
- ❖ *Initially begin with targeted Medicaid eligibility groups.*
- ❖ *Utilize a Medicaid encounter data system.*
- ❖ *Include performance measures, provider network controls, recipient grievance procedures and quality oversight functions.*

# *Key Elements of Reform*

- ❖ *Defined Contribution.*
- ❖ *Comprehensive and Coordinated Delivery System.*
- ❖ *Three Components to the Benefit Structure – Comprehensive Benefits, Catastrophic Care and Enhanced Benefits.*
- ❖ *Risk Adjusted Premiums.*
- ❖ *Consumer Choice.*
- ❖ *Opt-Out to Employer Sponsored Insurance.*

# *Defined Contribution*

- ❖ *Most Medicaid recipients in capitated managed care.*
- ❖ *Slows growth of Medicaid expenditures by reducing reliance on inefficiencies associated with the fee-for-service system.*
- ❖ *Medicaid expenditures become more predictable through:*
  - *Reducing misutilization of services.*
  - *Care coordination of recipient's health.*
  - *Reduction in Fraud and Abuse*

*Outcome: Medicaid stays within Legislative appropriation; expand access and care coordination; and improve health outcomes.*

# *Coordinated Delivery System*

- ❖ *Coordinated system of care for recipients and providers:*
  - *Care management of recipients.*
  - *Improved access.*
  - *Comprehensive provider networks.*
  - *Better outcomes.*
  - *Providers have access to information about care patient is receiving.*
- ❖ *Easy for providers and recipients to navigate:*
  - *Eliminates administrative layers for providers.*
  - *Simplified system of receiving care for recipients.*

# *Coordinated Delivery System*

## *(continued)*

- ❖ *Efficient to administer and oversee:*
  - *Eliminates oversight of 80,000 providers.*
  - *Eliminates multiple payment systems.*
- ❖ *Strong fraud and abuse program:*
  - *Provider network controls.*
  - *Oversight of managed care plans by the Agency.*

*Outcome: Seamless, care managed delivery system which offers increased access to quality health care services.*

# *Comprehensive Benefits*

*Benefits most recipients need most of the time*

- ❖ *All plans will cover comprehensive care:*
  - *Comprehensive care will cover all mandatory service and needed optional services.*
- ❖ *Eliminates the “One Size Fits All” Benefit Plan:*
  - *Plan may vary amount, duration and scope of services.*
  - *Benefit packages must be actuarially equivalent to the state premium.*
  - *Benefit packages must be sufficient to meet needs of enrolled clients.*
- ❖ *Flexibility with benefits will encourage plan participation.*
- ❖ *Encourage innovation in the marketplace.*

# *Catastrophic Care*

- ❖ *Individuals who incur health care services costing more than a threshold amount in one year could be re-insured up to a maximum benefit limit:*
  - *Transition to catastrophic will be defined by a dollar threshold and will be seamless to recipient.*
  - *Plans will continue to care manage recipients.*
- ❖ *Plans will choose whether to offer catastrophic care.*
- ❖ *The state will reimburse plans for catastrophic care.*
- ❖ *Ability to limit risk will encourage plan participation.*

# *Enhanced Benefits*

- ❖ *Incentives to recipients who demonstrate healthy behaviors:*
  - *Encourages personal responsibility.*
  - *Helps recipients understand the importance of healthy behaviors.*
- ❖ *Dollars will be deposited into an account for recipients who qualify:*
  - *Recipients may purchase additional health care items and services or use it for employer sponsored insurance when no longer Medicaid eligible.*
  - *Recipients maintain access to account for up to three years after losing eligibility.*
  - *Bridge to private insurance.*

# *Premiums*

- ❖ *Rates will be risk adjusted for health status:*
  - *Better align premiums with medical need of enrolled recipients.*
  - *Increase access for all recipients.*
- ❖ *Premiums will be separated into comprehensive care and catastrophic care:*
  - *Plan will receive only the premium for the level of benefits they provide.*
  - *Benefit package must be actuarially equivalent to the state premium.*
  - *Benefit package must be sufficient to meet the needs of the enrolled population.*

# *Premiums*

## *(continued)*

- ❖ *PSN's allowed to phase-in risk over 3 years:*
  - *Pay initially through fee-for-service.*
  - *Encourage participation of innovative networks.*
  - *Assist in transition to capitation.*

# *Consumer Choice*

- ❖ *Our goal is all 67 counties will have managed care plan participation:*
  - *Currently only 33 counties offer choice of plans.*
  - *Only 2 counties have a PSN.*
  - *Increased plan participation will increase access for beneficiaries.*
- ❖ *Recipient will have a choice between benefit packages:*
  - *Allows recipient to choose a plan that best meets their health care needs.*
  - *Recipient chooses the plan, the plan does not pick the recipient.*

# *Consumer Choice*

## *(continued)*

- ❖ *Recipient will have the choice of joining a Medicaid plan or opting-out to employer sponsored insurance:*
  - *Empowers the recipient to make choices about how they receive their health care services.*
  - *Promotes independence.*
- ❖ *Strong choice counseling program to assist recipient in choosing a plan:*
  - *Counseling will be provided fact-to-face, via telephone and in writing.*
  - *Ensure there is a recipient's acknowledgement of choice counseling.*
  - *Requires that choice counselors represent the state's diverse population.*

# *Consumer Choice*

## *(continued)*

- ❖ *Recipient has 30 days to make a plan choice:*
  - *New beneficiaries eligible for only emergency services until enrolled in plan.*
  - *After plan choice, have 90 days to change their plan.*
  - *After 90 days, stay in their plan for 12 months.*
- ❖ *Limits marketing by plans:*
  - *No inducements to recipients.*
  - *No prejudicing recipients against other plans.*

# *Opt-Out of Medicaid*

- ❖ *Recipient can choose to enroll in employer-sponsored health insurance instead of Medicaid certified plan:*
  - *Bridges the gap between Medicaid and private insurance.*
- ❖ *Opt back into Medicaid:*
  - *Recipient will have 90 days to change their mind and enroll in a Medicaid certified plan.*
  - *If recipient loses employment.*
  - *During employers open enrollment period.*



# *Next Steps*

❖ *Waiver Submission:*

- *Draft waiver.*
- *Post draft waiver on Internet website for 30 days.*
- *Submit to Senate and House for at least 10 working days.*

❖ *Waiver Approval:*

- *The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole.*

❖ *Implementation:*

- *Implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature.*