



***Florida's
Medicaid Reform***

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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).

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.*

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.*

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.*

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.*

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.*

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.*

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 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.*

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.*

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.*

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.*

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*



Questions and Answers

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