

FLORIDA'S HEALTH AT RISK

Fifth in a series of educational briefs on issues impacting Florida's families

Understanding Florida's Medicaid Waiver Application

KEY FINDINGS

- Financial risk to Florida's Medicaid program: The proposed budget neutrality agreement, which ensures that the federal government doesn't spend more dollars under a waiver than it would without one, is based on the participation of all counties in the state from day one, even though the program initially would be launched in just two counties. This could increase Florida's financial risk, because the more of the Medicaid program that falls under the agreement, the greater the risk for the state and its beneficiaries should the budget be exceeded.
- Plans have unprecedented flexibility with adults' benefits: Many adults – notably adults with disabilities – will be moved into reform plans where HMOs and other providers will have unprecedented flexibility to determine the benefits they will receive. This is an untested concept that poses more risk because the state is trying to reduce costs. These adults will also face new annual maximum benefit limits.
- Children's benefits remain the same: The proposal clarifies that most children are still assured of their current benefits.¹ The waiver's overall budget reduction goals, however, may pose a risk to the adequacy of the premium to ensure that children receive the services they need.

INTRODUCTION

On August 31st, 2005 the state of Florida made public its application for a Section 1115 "Florida Medicaid Reform" waiver from the federal government. The state has not officially submitted the waiver application to the federal government because state law requires that it be posted on the Internet for 30 days prior to submission.² There are still some unanswered questions about the waiver proposal, but the application provides important additional information on how Florida's Medicaid reform could change the way Medicaid services are paid for and provided.

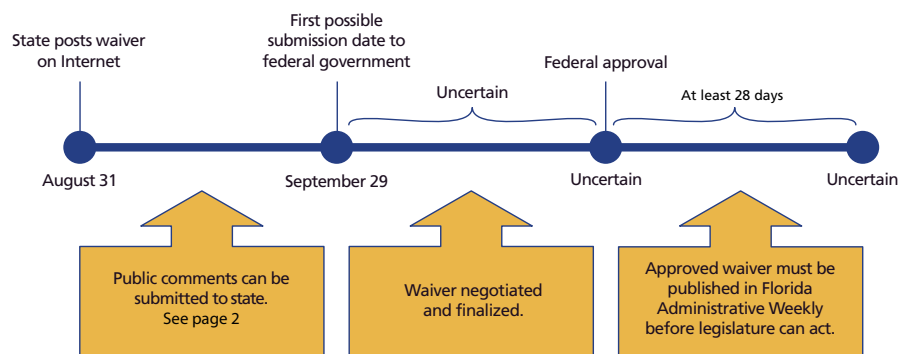
In its application, Florida specifies which provisions of federal law it is asking the federal government to waive.³ In exchange for this flexibility the state must agree to a "budget neutrality agreement" which changes the way the state receives its

federal Medicaid funding. This policy brief provides an overview of the state's waiver request and examines newly available information about the budget implications of the waiver. The brief does not attempt to address every issue raised by the waiver.

What are the next steps in the waiver process, and how can the public get involved?

During this pre-submission period, the state is requesting comments on its waiver application. The waiver application can be viewed at http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml. Following the public comment period, the waiver application is submitted to the Centers for Medicare and Medicaid Services (CMS) – the federal agency with primary responsibility for reviewing the waiver request. In addition to CMS, the Office of Management and Budget (OMB), which is located in the White House, plays an important role in determining the budget terms of the waiver. Once the waiver is officially submitted to the federal government, comments may be submitted to CMS. While there is no official process enabling this to occur, it is common for interested parties, including state and federal legislators, consumers, providers and others to do so. Subsequent to federal approval, the state must return to the Florida Legislature for approval before implementation can begin.

Figure 1: Florida Medicaid Waiver Process



Where can people submit comments?

Section 1115 waivers are subject to public process requirements.⁵ Interested parties often submit comments to both the state and federal governments at the following addresses:

AHCA/Florida

Mail: Medicaid Reform
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
Email: medicaidreform@ahca.myflorida.com

CMS/Federal Government

Mr. Dennis Smith
Director
Center for Medicaid and State Operations
The Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244-1850

Figure 1 (see page 1) outlines the next steps in the process, although the timing in many respects is uncertain.⁴ Waiver applications of this complexity generally take at least two months for the federal government to negotiate and approve. While many aspects of the waiver application appear to have been pre-negotiated, there are still likely to be changes made after the waiver is submitted. The final budget agreement and “terms and conditions” of the waiver, which provide important agreement details, will only become public if and when the waiver is approved.

Who will be required to participate?

The waiver application provides additional details on which Medicaid beneficiaries will be required to enroll under the proposed new structure. The vast majority of children, all parents, and most Supplemental Security Income (SSI) beneficiaries – persons with disabilities

who are not also enrolled in Medicare – will be required to enroll. While most pregnant women are exempt, those with the lowest incomes – below 23% of the poverty line – will be required to participate.

Persons who are enrolled in both Medicaid and Medicare (also referred to as “dual-eligibles”), children with chronic conditions, and persons with developmental disabilities will be required to participate at a later stage. Other groups (pregnant women at higher income levels, persons in institutions, etc.) can choose to participate.

The waiver application makes clear the state’s intent to broaden the scope of the waiver to encompass the “vast majority” of Medicaid beneficiaries. These include people with the most serious health care needs – persons in nursing homes and hospices, all seniors, and persons receiving inpatient psychiatric services.⁶ It is uncertain how the “Medicaid Reform” waiver will interact with the “Over 60” Section 1115 waiver, which the state is also developing, as the populations covered by the two waivers overlap.

When will people have to enroll?

As required by state law, the waiver application specifies that the reform must first be implemented in two counties – Broward and Duval. According to the timeline in the application,⁷ enrollment will be phased in over a fifteen-month period starting in April 2006. The state estimates that by June 2007, 212,189 persons in Broward and Duval counties will be enrolled in the new plans – just under nine percent of all of Florida’s Medicaid beneficiaries.⁸ In the following year, enrollment will be expanded to include three rural counties surrounding Duval – Baker, Clay and Nassau.

What benefits will beneficiaries be eligible for?

Changes to the benefits package are perhaps the most fundamental changes proposed in the waiver. The waiver application states that “one of the major principles the state seeks to test is the variation of amount, duration and scope”⁹ of benefits. The federal standard

ensures that each benefit category covered through Medicaid is “sufficient in amount, duration and scope to reasonably achieve its purpose.” Instead, the state will apply a new “actuarially equivalent” standard described below. The new design will only be applied to adults. Children will continue to be eligible for the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit – a comprehensive benefit that ensures that children receive all medically necessary services.¹⁰

Parents, people with disabilities and the lowest-income pregnant women could face a benefits design which is unprecedented in the Medicaid program nationwide. If granted, the waiver would allow HMOs and other providers significant new flexibility in determining benefits offered and how much of any one benefit individuals would receive. While plans could offer new and additional benefits, it is important to note that, in general, a waiver is not required to add benefits; a waiver is only required to reduce benefits.¹¹

The waiver application proposes that the Agency for Health Care Administration (AHCA) will develop a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans, but the full details of that strategy are not available.

Under the proposal, plans will have to offer all mandatory Medicaid benefits, but they will have flexibility to decide how much of such a service to offer, subject to the sufficiency test described below.¹² The only exception to this is for inpatient hospital care where the waiver application explicitly states that 45 days will be covered.

The situation is different for optional services. Plans will not be required to offer previously available optional services (e.g. prescriptions drugs, durable medical equipment, etc.) and they will have flexibility with respect to the amount, duration and scope for the optional benefits HMOs and other plans do choose to offer.¹³

In order to be approved to offer services, however, plans must offer an overall benefits package which is the actuarially equivalent of the value of the current State Plan package for the average member of the population. “Actuarial equivalency” is the value of the overall benefits package based on which benefits are offered, in what amount, and how much the beneficiary has to pay for them. In other words, the dollar value of the new benefits packages should be equivalent to the former combined package of mandatory and optional services for the average member of the population, but the composition of the package may change. For example, a plan might elect to cover more physician visits but less (or no) durable medical equipment. Linking the actuarial equivalency standard to the value of the package for the average member of the population raises questions about whether the package will be adequate for someone with above average needs in any given year. It is also not clear whether the value will erode over time.

How will the state assess the adequacy of the benefits package?

The state proposes a two-part test to assess the benefits package. First, the benefit package must be actuarially equivalent to the “value of the current State Plan package” for the average member of the population as described above. Second, the plan must demonstrate “sufficiency of benefits.” The state will evaluate whether certain benefits are provided at an adequate level “to cover the needs of the vast majority of enrollees.” Precisely how this test will be administered is not yet clear.

How will the premiums be determined?

A critical determinant of how generous the benefits package is likely to be, and how aggressively managed care plans manage care, is the adequacy of the premium. The state plans to develop “individual risk scores” where possible, and readjust these in a timely manner. Presumably these individual risk scores will be used to place each Medicaid beneficiary in some kind of larger category

People with Disabilities Face Risks

While all participants will face changes in the way services will be delivered if the waiver proceeds, the changes will be especially acute for adults with disabilities for a number of reasons. First, persons with disabilities are less likely to be enrolled in capitated managed care arrangements today than low-income families – approximately half of low-income families in Medicaid are currently enrolled in HMOs, as compared to one-third of persons receiving SSI.¹⁴ Secondly, adults with disabilities or other chronic health conditions will face greater risks if the benefits package is inadequate since they use more services. While the premiums will presumably be higher for persons with disabilities, it appears they will be based on historical expenditures for the *average* member of the population. Thus a certain number of people will fall above the average in any given year, and the services offered may be insufficient to meet their needs. Another concern is that access to prescription drugs may be further restricted by plans since it is an optional service. Finally, people with disabilities are most likely to run up against the maximum benefit limit because they are high service users.

or rate band that will determine their premium level. In other words, if the Medicaid enrollee is determined to be a healthy three-year-old, the family would receive the premium amount based on average historical costs for healthy three-year-olds.

While developing individual risk scores is a laudable goal, this is an enormously complex and challenging task and AHCA acknowledges that it may have inadequate data to do so in the initial phases of implementation. Important questions about the feasibility of doing so include whether adequate data is available on previous claims history etc. – a particular challenge when many Medicaid beneficiaries come on and off the program – and whether AHCA will be nimble enough to adjust premiums in a timely manner should someone’s health status change. It is possible that some Medicaid beneficiaries will end up at the wrong premium level – either too high or too low.

The waiver states that the premiums will be based on 100 percent of historical Medicaid expenditures for mandatory and optional services “less any applicable discount.” The state may “adjust” these expenditure levels to reflect anticipated savings as a result of managing care. Presumably this means that the state may lower premium levels. The state’s desire to reduce spending and the budget neutrality agreement raise the risk that funding will be inadequate to support premium

levels that incentivize HMOs and other providers to provide rich benefits packages.

Will Medicaid beneficiaries pay more?

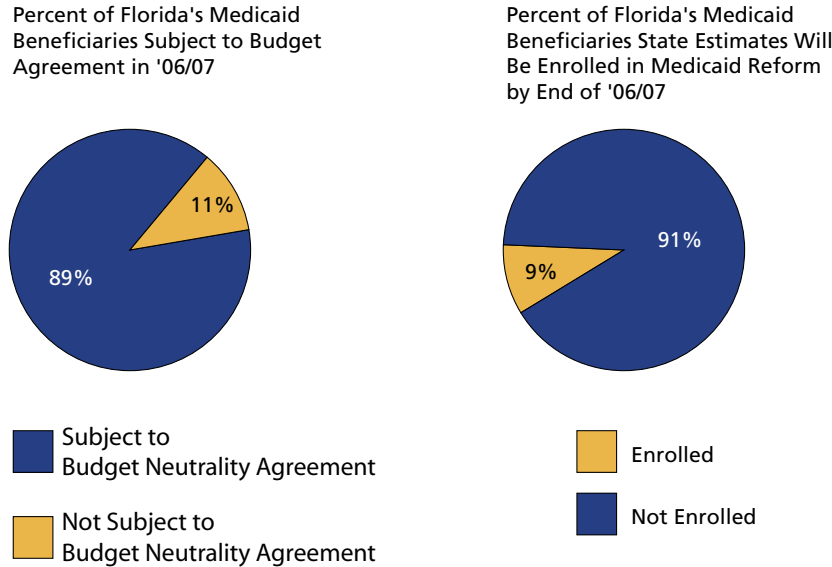
The state is proposing to raise copayments for adults, but not for children and pregnant women. In general, the proposal does not seek to charge higher cost-sharing than what is now permitted under federal law.¹⁵ However, adult Medicaid beneficiaries (except pregnant women) will face an annual maximum benefit limit once a certain dollar threshold is reached. This means that the beneficiary will be responsible for any additional costs above the limit. Because most Medicaid beneficiaries have very little disposable income, these costs are likely to become uncompensated care for the provider (as the waiver acknowledges) and/or bad debt for the families. Alternatively Medicaid beneficiaries may avoid care once the limit is reached. Research is clear that any level of additional costs restricts access for low-income people.¹⁶

What are the Enhanced Benefits Accounts?

The state is seeking to establish Enhanced Benefits Accounts for all beneficiaries. Beneficiaries who participate in “healthy behaviors” such as (among other things) annual check-ups, gym membership, or signing a living will, would receive points.¹⁷ The application does not specify if families with very low-incomes will

Figure 2: Budget neutrality agreement applies to larger proportion of Medicaid program than the pilot counties.

Waiver application budget assumes statewide implementation.



Source: Georgetown University Center for Children and Families analysis based on Florida's August 31, 2005 waiver application and enrollment data from Social Services Estimating Conference Medicaid Caseload data, February 24, 2005

receive assistance for costs associated with things like gym memberships, gymnastics classes, etc. Beneficiaries could redeem points for non-covered services or retain the funds for up to three years to pay for private health insurance if their Medicaid eligibility terminates and their income stays below 200 percent of the federal poverty level.¹⁸ Funding for these accounts, according to the application, will come out of savings garnered through Medicaid restructuring.

What is the "opt-out" provision?

The state seeks to establish an "opt-out" program whereby families receive a voucher they can use to purchase private coverage. The state has requested a waiver from federal benefits standards, including EPSDT, for families that choose to participate in this program. If the waiver request is granted, the purchased coverage would not be required to meet any federal or state Medicaid benefits or cost-sharing standards, nor would beneficiaries retain other protections such as grievance procedures. Participation in the opt-out

program is voluntary, and because it is almost certain that families will face higher costs and reduced benefits in the private market, it is very important that participants fully understand the pros and cons of such a choice.

A potential advantage of this program may be that some uninsured parents might receive coverage if subsidies for their children enable them to pay the employee share of coverage they could otherwise not afford. This may be useful in a state like Florida where eligibility for parents is relatively low. Experience from other states suggests, however, that these programs typically have very low enrollment, and initial start-up administrative costs are likely to be high.¹⁹

FINANCING

What is "budget neutrality"?

All Section 1115 waivers establish a budget neutrality agreement which ensures that the federal government does not spend more federal dollars under a waiver than it would have without

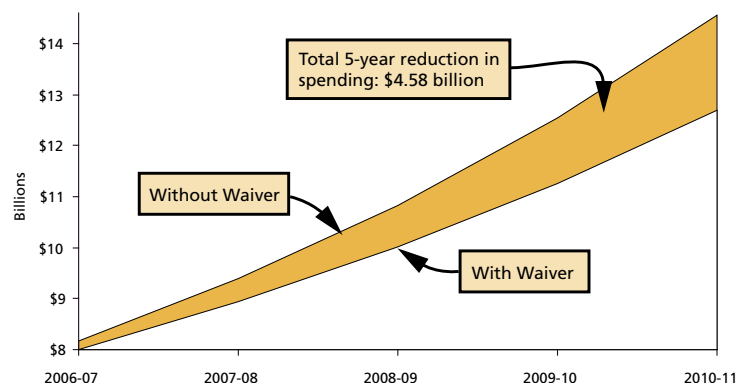
the waiver. To guarantee this happens, the federal government negotiates an agreement with the state that estimates future spending with and without the waiver. This formula is used to establish a cap on the amount of federal funding that will be provided to the state over the life of the waiver.

There are many important questions that arise about any budget neutrality agreement. The first focuses on the kind of cap the federal government will establish. This could be a "global" (flat cap) or a per-person ("per capita") cap. Per capita caps establish a per-person spending limit, but overall federal funding rises and falls with enrollment changes. It is still unknown what kind of cap (i.e., per capita or global) will be established in Florida's waiver agreement, but it appears that the state is negotiating a per capita cap.

All agreements are enforced at the end of the five-year waiver agreement. If the state's total Medicaid spending in the aggregate over the five-year period exceeds the amount established by the budget neutrality agreement, the state must assume 100 percent of any excess cost or seek to renegotiate the terms of the agreement. Under the current Medicaid matching system, Florida is assured of a 59 percent federal match for any authorized Medicaid expenditures.

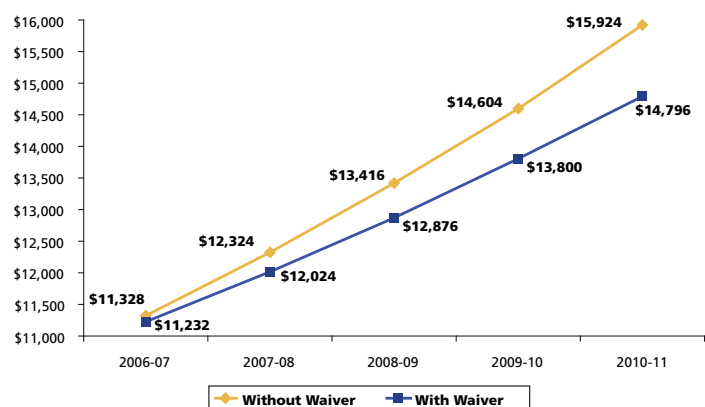
A second critical question focuses on how much of Florida's Medicaid program will come under the cap. Florida's application suggests a very broad application of the cap – both in terms of Medicaid eligibility groups and areas of the state. The application makes clear that the state is basing the budget neutrality agreement on statewide application of the waiver, even though state law requires that the waiver be implemented initially in just two counties. In addition, it appears that the state is seeking to include children in the budget neutrality agreement even though most of the intended changes for children do not require a federal waiver. Thus, as **Figure 2** demonstrates, the budget neutrality agreement will apply to a much larger proportion of the Medicaid program than the waiver

Figure 3: State's Estimate of Medicaid Savings From Waiver



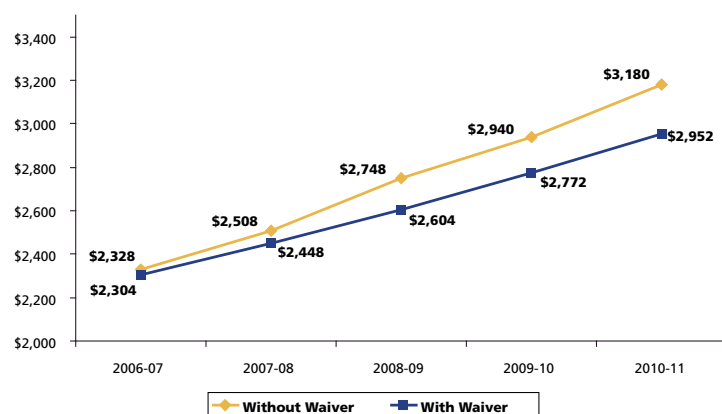
Source: Georgetown University Center for Children and Families analysis of Tables 4 and 5 from Florida Medicaid Reform Section 1115 Waiver Application, August 31, 2005.

Figure 4: Annual Medicaid Cost per SSI Beneficiary, With and Without Waiver



Source: Georgetown University Center for Children and Families analysis of Tables 4 and 5 from Florida Medicaid Reform Section 1115 Waiver Application, August 31, 2005.

Figure 5: Annual Medicaid Cost per Family Member, With and Without Waiver



Source: Georgetown University Center for Children and Families analysis of Tables 4 and 5 from Florida Medicaid Reform Section 1115 Waiver Application, August 31, 2005.

reforms – especially in the early years of the waiver. The more of the Medicaid program that falls under the budget neutrality agreement, the greater the risk for a state and its beneficiaries should the cap be exceeded at the end of the five years.

The state is seeking a budget neutrality agreement whereby it preserves its Upper Payment Limit (UPL) arrangement (renamed the Low Income Pool in the waiver application) with a growth factor as mandated by state law. This aspect of the financing agreement is clearly under intense discussion,²⁰ and state officials have publicly expressed their concerns over the ability of the state to receive adequate financial terms on this issue under the budget neutrality agreement.

What are the anticipated state/federal spending levels under the waiver?

The waiver application provides new information on the state's projections for Medicaid spending over the next five years. The document underscores that the state believes sharp reductions in the rate of growth in Medicaid spending levels are desirable and achievable. Overall, as **Figure 3** demonstrates, the state estimates that \$4.58 billion in federal and state Medicaid funds can be saved in the next five years.

There are few details provided about how this would be accomplished – although the waiver application documents point to lowered spending levels on a per person basis for families and persons with disabilities as a result of the proposed waiver. **Figures 4 and 5** illustrate these reductions – as **Figure 4** shows, annual spending for a person receiving SSI is expected to be \$14,796 with the waiver, but according to the state, would have been \$15,924 without the waiver. Savings targets for the waiver will not be binding on the state with respect to levels of federal funding in the budget neutrality agreement – it is the estimates without a waiver that are binding. The numbers do suggest that the state believes the new reform design will result in lower per-person spending.

CONCLUSION

The state's Section 1115 waiver proposal raises many questions about the way services will be delivered and financed. Key questions include whether parents and people with disabilities receiving Medicaid services will be given choices that provide them with broad enough coverage – especially should a serious health crisis or an ongoing disability require extensive care. The adequacy of the premiums, especially over time and in light of the state's desire to reduce spending, raises questions for children and adults in Florida's Medicaid program. In addition, the state appears to have constructed the budget neutrality agreement with the federal government in the broadest way possible, raising the state's financial risk should Medicaid spending exceed the levels projected.

ENDNOTES

- 1 Except for children in families that choose to participate in the "opt-out" program. See details on page 4.
- 2 For more information on what state law requires, see a previous brief in this series Understanding Florida's Medicaid Reform Legislation (June 2005) available at www.wphf.org
- 3 It is important to note though that a number of the changes the state is seeking to make to Florida's Medicaid program do not require a federal waiver.
- 4 The 28 day posting in the Florida Administrative Weekly is required by 409/912(11), Fla. St.
- 5 See most recently Dear State Medicaid Director Letter of Dennis Smith available at www.cms.hhs.gov/states/letters/smd50302.asp
- 6 See Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver p. 44.
- 7 It is important to note that the timeline in the application is dependant on a number of factors that AHCA does not have control over such as federal approval and action of the Florida legislature.
- 8 Georgetown U. Center for Children and Families analysis based on Social Services Estimating Conference Medicaid caseload projection for 2006-07 as estimated on 2/4/05 with adjustments for 2005 session action.
- 9 Waiver application, p. 18.
- 10 One exception is for children participating in the "opt-out" provision described on page 4.
- 11 The state is also seeking waivers of the "comparability" and "statewideness" rules. These standards are designed to ensure that different groups of Medicaid beneficiaries are not treated differently based on their eligibility category or where they live. For an explanation of these terms, see Chapter 2 of The Medicaid Resource Book (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) July 2002.
- 12 See p. 22 of the waiver application.
- 13 The waiver states that it is "expected that they (i.e. plans) will cover most optional services."
- 14 Georgetown U. Center for Children and Families analysis of AHCA Medipass/HMO/PSN Enrollment Report for September 2005.
- 15 Again an exception applies to families that voluntarily choose to participate in the "opt-out" program.
- 16 See Artiga, S and O'Malley, M. Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) May 2005.
- 17 Some of the referenced activities such as gym memberships, gymnastics, etc. classes for kids, advance directives involve some costs for families. This raises questions about their feasibility especially for the lowest income families.
- 18 Since children should retain access to all medically necessary services it is unclear what uncovered services they could use the accounts for.
- 19 See Alker, J. Serving Low-Income Families Through Premium Assistance: A Look at Recent State Experience (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) October 2003.
- 20 See for example "Conflict Could Delay Medicaid Changes" The Orlando Sentinel September 15, 2005.

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Author
Joan Alker, Center for Children and Families
Health Policy Institute
Georgetown University
P.O. Box 571444
Washington, DC 20057
202-687-0880
jca25@georgetown.edu
ccf.georgetown.edu

Publisher
Winter Park Health Foundation
1870 Aloma Avenue, Suite 200
Winter Park, FL 32789
407-644-2300
Lisa Portelli
lportelli@wphf.org
www.wphf.org



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