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Association for Community Affiliated Plans

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James Hooley, Chairman · Margaret A. Murray, Executive Director

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The Medicaid Managed Care's Perspective on Florida's Medicaid Waiver Proposals

Given the ever-rising costs of Medicaid, pressure is growing on state and federal policymakers to enact Medicaid reforms in a way that will hold down the costs of the nation's health care safety net in future years. As states seek to reform their Medicaid programs, many of them are issuing proposals that will require a waiver from the Centers for Medicaid and Medicare services to exempt them from several of the fundamental provisions of the Medicaid program. Florida Governor Jeb Bush (R) has issued one of the most far-reaching waiver proposals to date, which would result in tremendous changes to this state's program and its 2.1 million Medicaid beneficiaries.

Summary of Florida Medicaid Modernization Proposal

Re-Shaping the Marketplace

- Governor Bush's proposal would change Florida's Medicaid program to a premium-based program and establish maximum spending and benefit limits.
- Each year the state would set aside a fixed amount of money for Medicaid. Each Medicaid participant would be entitled to a preset share of the budgeted amount that varies according to medical need. The state would then pay premiums to HMOs, insurers and other groups to manage care. The state would not contract with a limited set of Medicaid HMOs but rather would essentially provide vouchers to clients to purchase their own insurance products in the open market.
- The government or private firms would perform oversight and regulation duties according to a rating system (to be developed). The government would also establish an information and choice counseling system.

Defining Medicaid Benefit Packages

- The new Medicaid proposal provides minimal guidance on the scope, amount and duration of benefits offered by vendors of insurance coverage or provider-based systems of care.
- Each vendor will determine the package of services they offer for the state's risk adjusted premium. Medicaid beneficiaries then use their fixed share of Medicaid dollars to select the type of coverage or the method of accessing services from options offered by managed care organizations, insurers, providers, and community-based systems.
- Participants can designate their premium in three categories – basic care, catastrophic coverage, and enhanced benefits – to different vendors. Medicaid participants could also "opt-out" and use their Medicaid premium to purchase employer-based coverage, thereby selecting a private plan.

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- By demonstrating healthy practices and personal responsibility, participants earn eligibility for additional benefits through flexible spending accounts.

Florida Waiver Undermines the Benefits of Medicaid Managed Care

Over the past decade, state Medicaid agencies have increased managed care enrollment to twenty-five million (59 percent of all Medicaid beneficiaries). Furthermore, most states incorporate some level of managed care in their Medicaid programs. Members of the Association of Community Affiliated Plans – comprised largely of non-profit, Medicaid–focused health plans –and similar Medicaid focused managed care organizations have made a major commitment to the Medicaid population that has allowed them to develop and maintain disciplined and responsive health care services and programs. And they have repeatedly responded to the changing health care marketplace.

Recent research has documented the expertise and services that Medicaid managed care plans offer to Medicaid enrollees and the advantages such plans bring to the marketplace. The Florida waiver proposal would undermine the quality and access protections that have been part of Medicaid managed care for the last ten years, would lead to higher costs and would diminish the improvements in public health that have been made under Medicaid managed care.

- **Eliminates Quality Oversight.** The current Florida proposal does not include the access and quality standards that many state agencies traditionally require or encourage health plans to pursue. Managed care organizations provide enrollees with a "medical home" and utilize physician's expertise to refer patients to the appropriate place in the system. These approaches have translated into benefits for Medicaid enrollees through improved quality of, access to, and continuity of care. To this end a forty-seven state study published in the December 2004 issue of *Health Affairs* documented more stringent quality measurement, feedback and improvement strategies – both voluntary and mandatory – in Medicaid managed care programs compared to Medicaid primary care case management programs (PCCM) programs.[1,2]

- **Removes Access and Quality Requirements.** In its present form, the Florida Medicaid proposal makes no mention of critical access and quality contracts that traditionally protect Medicaid's underserved enrollees. Medicaid MCOs provide a guarantee that those who rely on Medicaid will have access to critical health services. A December 2004 report from the Government Accountability Office study found that Medicaid MCOs perform as good or better than Medicare and private sector MCOs on access and quality requirements that specifically address the needs of managed care enrollees who are low-income or have special cultural or health care needs.[3] Specifically, neither Medicare nor private sector requirements treat the needs of low-income enrollees as distinct from those of other enrollees. Further, unlike private

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sector MCOs, Medicaid MCOs must take into account the means of transportation when developing their provider network and Medicaid's cultural and language competency requirements are more specific than private accreditation requirements.

- **Private Insurance Spending is Higher and Growing Faster than Medicaid Spending.** Health care costs are rising in the private and public sectors. However, on a per person basis Medicaid costs are lower than private insurance with Medicaid costs 30 percent lower for adults and 10 percent less for children.[4,5] Medicaid costs are also growing at a slower pace than growth rates for private insurance. Between 2000 and 2003, the average growth rate in acute care Medicaid costs per enrollee was 6.9 percent. This was lower than the 9 percent increase in per enrollee costs of the privately insured and substantially lower than the growth in employer-sponsored insurance premiums (12.6 percent).[6] Therefore retaining current Medicaid structure, including managed care, is more cost efficient for states.

- **Undermines Improvements in Public Health.** As states develop contractual relationships with Medicaid managed care plans, most contracts require plans to collaborate with local public health departments on specific services. In addition, contracts usually specify that prevention and treatment be included in the Medicaid managed care benefit package. For example, plans are required to report instances of diseases back to the local health department and EPSDT services have been largely shifted to health plans under Medicaid managed care.[7],[8] Commercial plans are not held to these same standards and may not have systems in place to monitor these issues.

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[1] Eric Schneider, Bruce Landon, Carol Tobias and Arnold M. Epstein. "Quality Oversight in Medicaid Primary Care Case Management Programs: As HMOs depart, are state Medicaid agencies ready to take the stage," Health Affairs December 2004, Volume 23, Number 6

[2] The Lewin Group. "Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies." Final Report Prepared for: America's Health Insurance Plans, July 2004

[3] United States Government Accountability Office. "Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees." Report to Senators Charles Grassley and Max Baucus and Congressmen Joe Barton and John Dingell, December 2004.

[4] John Holahan and Brian Bruen. "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2003?" Kaiser Commission on Medicaid and the Uninsured, September 2003, URL Accessed February 9, 2005: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22135

[5] Cindy Mann and Fouad Pervez, Georgetown University Health Policy Institute Policy Brief. "Medicaid Cost Pressures for States: Looking at the Facts."

[6] The Kaiser Commission on Medicaid and the Uninsured. News Release: "A Sharp Rise in Enrollment During the Economic Downturn Triggered Medicaid Spending to Increase by One-Third from FY2000-03," Information based on *Health Affairs* Article, " Understanding the Recent Growth in Medicaid Spending, 2000-2003," URL Accessed February 8, 2005: http://www.kff.org/medicaid/kcmu012605nr.cfm.

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[7] Rose Marie Martinez and Elizabeth Closter, Center for Studying Health System Change: Issue Brief No. 16 "Public Health Departments Adapt to Medicaid Managed Care," November 1998, URL Accessed February 9, 2005: http://www.hschange.com/CONTENT/65/?topic=topic02#top

[8] Managed Care Contracting Publications, George Washington University School of Public Health and Health Services, Health Policy Department. URL Accessed February 9, 2005: http://www.gwumc.edu/sphhs/healthpolicy/chsrp/managedcare_publications.html#onlinepubs