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THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

October 2008

Summary of
Florida Medicaid Reform Waiver: Early Findings and Current Status

What the Waiver Did: In 2006, Florida began pilot implementation of a Medicaid waiver that utilizes new approaches in Medicaid aimed at promoting consumer choice and market competition among private health plans and reducing the rate of spending growth. The waiver moved the program from a defined benefit to a defined contribution model in which the state allots risk-adjusted premiums to beneficiaries that are paid to managed care plans. The plans have new authority to determine benefits and cost sharing for non-pregnant adults, subject to state approval. Beneficiaries choose from managed care plans that provide varied benefit packages, with the state offering choice counseling to help in making a plan choice.

Implementation and Enrollment: The waiver was implemented in Duval (Jacksonville) and Broward (Ft. Lauderdale) counties in September 2006, and expanded into Nassau, Clay, and Baker counties the following year. The state legislature must approve any further expansion. Although debated in the 2008-09 budget negotiations, the final budget did not include an expansion. As of September 2008, 202,000 of Florida's 2.1 million Medicaid beneficiaries were enrolled in a reform plan, accounting for about 9% of the state's Medicaid enrollees. Most (84%) reform enrollees are children and parents; 16% are disabled individuals receiving SSI.

Early Findings: It is too early to determine the waiver's overall impacts on health access and outcomes and program costs. However, early analyses from various program evaluators find:

- The number of managed care plans increased after reform, but there was not a large influx of new commercial insurers to Florida Medicaid.
- Benefit packages vary across plans, but the differences among reform plans and between reform and non-reform plans are limited.
- In the first year, there were gaps in beneficiary knowledge of reform and many had difficulty choosing a plan due to problems understanding and obtaining plan information.
- Some beneficiaries had problems accessing prescription drugs after joining a reform plan or during the transition to reform.
- Reform may have negatively affected some providers' willingness to participate in Medicaid.
- There has been a lack of beneficiary awareness and understanding of the waiver's new "enhanced benefit" program designed to encourage healthy behaviors.
- Enrollment in the waiver's new premium assistance program has been very limited, which has contributed to high per capita administrative costs for this program.
- The state is reporting spending below the waiver's budget neutrality limit, but it is not clear whether it is achieving program savings from the waiver changes.

Issues to Consider: Continued assessment will provide insight into whether the challenges identified to date stem from the reform transition process or the program design. It will be important to continue to assess several key issues, including the stability of plan participation and value of benefits over time. There has been some recent uncertainty about continued participation of several plans, and, going forward, increased fiscal stress and the transition of Provider Service Networks to capitated payments could increase pressures on plans to reduce benefits or leave the reform market. It also will be important to continue to monitor beneficiaries' ability to actively and effectively choose a plan; the impacts on health access and outcomes; and the cost-effectiveness of the waiver and its impact on spending.

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Florida Medicaid Reform Waiver: Early Findings and Current Status

In 2006, Florida began pilot implementation of a Medicaid waiver program that made fundamental changes in the state's Medicaid program by allowing the state to waive certain federal program requirements. Through the waiver, the state is seeking to improve predictability of Medicaid spending and reduce the rate of spending growth. It is also looking to increase personal responsibility, market competition, and participation in private coverage. There has been interest in the waiver at both the state and national level, given that it utilizes new approaches in Medicaid aimed at promoting consumer choice and market competition among private health plans. This brief reviews the waiver changes and information available on the waiver experiences to date.

Who is Enrolled in the Waiver?

The October 2005 federal waiver approval gave Florida the authority to implement the waiver on a statewide basis for five years. The state legislature approved pilot implementation of the waiver in five counties, and it was initially implemented in Duval (Jacksonville) and Broward (Ft. Lauderdale) counties in September 2006. In September 2007, the waiver was expanded into three additional rural counties—Nassau, Clay, and Baker, which border Duval. The state legislature must approve further expansion to other areas.

Within the five reform counties, several groups of beneficiaries are required to participate in reform, including disabled beneficiaries receiving Supplemental Security Income (SSI) (excluding those in institutions or covered by Medicare), parents, and children. Other beneficiaries can participate on a voluntary basis. As of September 2008, 202,000 of Florida's 2.1 million Medicaid beneficiaries were enrolled in a reform health plan, accounting for about 9% of the state's Medicaid enrollees.[1] The bulk (84%) of reform enrollees are non-disabled children and parents; 16% are disabled individuals receiving SSI.[2] Over half (56%) of reform enrollees are in Broward County and 37% reside in Duval County.[3] The remaining 7% are in the more rural, new expansion counties of Baker, Clay, and Nassau.[4]

How did the Waiver Change Florida Medicaid?

The waiver moves the program from a defined benefit to a defined contribution approach in which plans are paid risk-adjusted premiums and given new authority to determine benefits. Prior to reform, beneficiaries were guaranteed a set of benefits established by the state within federal guidelines. They received care from private providers through fee-for-service or capitated arrangements. In capitated arrangements, the state contracted with managed care plans to provide care for the state-established set of benefits. Under the waiver, the state now pays risk-adjusted premiums to plans, and the plans have new authority to determine the benefits they will offer to non-pregnant adults for the premium, subject to state approval. With this new authority, plans can make some benefits for these adults more limited compared to pre-reform. They can also offer additional benefits, although they had this authority pre-reform. Plans also can determine cost sharing for adults, subject to federal Medicaid cost sharing limits. The plans can change their benefits and cost sharing requirements each year, again subject to state approval.

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Two types of plans may participate as reform plans—HMOs and Provider Service Networks (PSNs). PSNs are plans organized by groups of providers. Unlike HMOs, the PSNs can choose to continue to be paid on a fee-for-service basis for the first few years of the waiver; they will begin to transition to capitated payments at the end of the third year of the waiver. Currently, all PSNs are receiving fee-for-service payments. While they are paid on a fee-for-service basis, PSNs must offer benefits at least to the level of the state-defined package in non-reform counties. Once a PSN transitions to capitated payments, it has the same benefit flexibility as the HMOs.

Under the waiver, beneficiaries are newly required to choose among health plans with varied benefit packages. Prior to reform, all beneficiaries were covered for the state-determined set of Medicaid benefits regardless of which plan or network through which they received care. Under reform, adult beneficiaries must now choose among a variety of HMOs offering different benefit packages and the PSNs. Children and pregnant women also choose among HMOs and PSNs, but remain covered for all medically necessary care. In choosing a plan, beyond evaluating differences in benefit packages, beneficiaries must also consider differences in preferred drug lists, pre-approval requirements, and provider networks.

The state offers "choice counseling" to assist beneficiaries in choosing a plan. Beneficiaries must make a choice within 30 days or the state assigns them to a plan. Individuals newly applying for Medicaid are only eligible for emergency and nursing home level care until they select and enroll in a health plan. After an initial 90-day period, beneficiaries are locked into their plan for 12 months, unless they can show "good cause" to change plans.

The state also established a new benefit limit for adults, created a wellness incentive program and a premium assistance program, and changed some hospital financing under the waiver. The waiver made a number of other changes including, creating a new annual maximum benefit limit for non-pregnant adults (over which neither the state nor the managed care plans are responsible for further costs), offering individuals that participate in state-defined healthy activities "enhanced benefit credits" that can be used for health-related purchases, allowing beneficiaries to choose to receive a premium subsidy to go toward the purchase of employer-sponsored coverage rather than receiving direct coverage through a plan, and replacing some hospital financing arrangements with a new "low-income pool."

What are the Early Findings on the Waiver's Impact?

There is significant interest in the waiver at both the state and federal level since it tests new private market approaches in Medicaid. As part of the waiver terms and conditions, the state must have the waiver evaluated. The state contracted with the University of Florida to conduct the evaluation; final results will not be available until the end of the five-year waiver term, but preliminary findings have been released to date. Separate from this evaluation, the Florida Agency for Health Care Administration Office of the Inspector General (AHCA OIG), the state legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA), and the federal Government Accountability Office (GAO) have reviewed aspects of the waiver.

Further, private foundations, academic institutions, and policy think tanks are studying the program. The Kaiser Family Foundation is conducting a study of the impact of Florida Medicaid reform on enrollees in Broward and Duval counties in collaboration with researchers from the Urban Institute and the University of Florida. An initial survey was completed during the first year of waiver implementation; a second follow-up survey is in process. Additionally, with support from the Jessie Ball duPont Fund, the Georgetown University Health Policy Institute is

conducting an evaluation that examines beneficiary and provider experiences under reform. The Center for Health Care Strategies, Inc., a non-profit health policy analysis center, and the James Madison Institute, a self-described free-market think tank, also have released Florida Medicaid reform analyses.

Given that the waiver was implemented just two years ago, it is too early to determine the waiver's overall impacts on health access and outcomes and program costs. However, available findings from these analyses provide insights into some of the waiver's early impacts.

Plan Participation and Variation in Reform Benefit Packages

The number of managed care plans increased after reform, but there was not a large influx of new commercial insurers to Florida Medicaid.[5] In each of the reform counties, the number of managed care plans available to beneficiaries increased after reform. However, the University of Florida evaluation of the waiver found that, as of March 2007, most plans joining the market were PSNs and that reform had not drawn any new commercial HMOs into Florida Medicaid.[6] More recent analysis by OPPAGA also concluded that, as of May 2008, the number of managed care plans had increased, but only one new HMO emerged that did not previously serve Medicaid beneficiaries in Florida.[7]

Beneficiary enrollment is concentrated among a small number of reform plans. As of September 2008, there were 17 reform plans operating across the five pilot counties—16 in Broward County, 7 in Duval County, and 2 in Baker, Clay, and Nassau Counties.[8] Eleven of the reform plans are HMOs; the remaining six are PSNs.[9] Most (72%) reform beneficiaries are enrolled in an HMO.[10] However, enrollment of disabled individuals receiving SSI is more concentrated among PSNs (41% of SSI enrollees are in a PSN) compared to children and parents (25% are in a PSN).[11] Although Broward County has 16 plans, about half (49%) of enrollees are in three plans.[12] Similarly, Duval County has seven health plans, but 84% of enrollees are in three plans.[13]

Benefit packages vary across plans, but the differences among reform plans and between reform and non-reform plans are limited. OPPAGA concluded that Medicaid reform plans have used some of the new flexibility to customize benefits, but "the services they offer differ minimally" from the benefits of non-reform plans.[14] Some plans now vary benefits by beneficiary group, such as covering more home health visits or having a higher limit on prescription drug coverage for elderly and disabled beneficiaries than children and families. Also, a number of the reform plans have used the option to provide "additional services," such as adult dental care and over-the-counter drugs. However, half of the additional services offered by reform plans are also offered by some HMOs in non-reform counties.[15] Four reform HMOs provide additional services not offered by any HMOs in non-reform counties.[16]

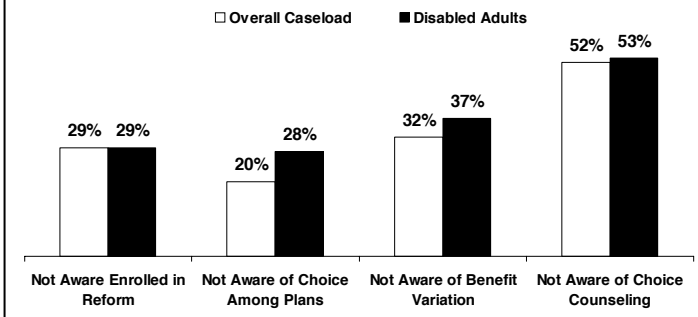
Beneficiary Experience with Consumer Choice

There were gaps in beneficiary knowledge of reform. Findings from the Kaiser Family Foundation survey of reform enrollees in Broward and Duval counties conducted during the first year of implementation show that, on average in the two counties, about 30% were not aware they were enrolled in reform (Figure 1).[17] Additionally, about one in five did not understand that they had a choice of health plans under reform, one in three did not know that plans may have different levels of benefits, and over half were not aware that choice counseling services were available.[18]

Similarly, focus groups with beneficiaries conducted by the Georgetown University Health Policy Institute found that some enrollees had not received the state's informational mailing about reform or were unaware that they needed to choose a health plan under reform.[19] Focus groups and interviews with beneficiaries conducted for the University of Florida evaluation also found that general understanding of Medicaid reform was limited.[20]

Figure 1

Gaps in Beneficiary Knowledge of Key Aspects of Florida Medicaid Reform

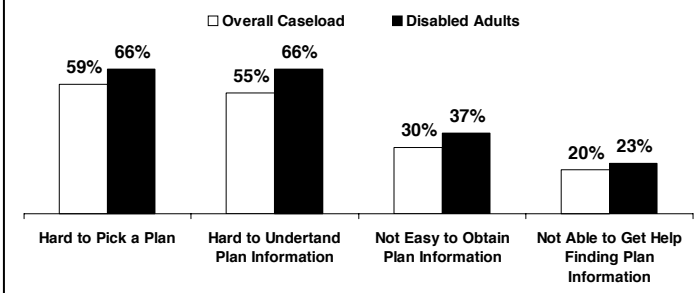


Source: 2006/2007 Kaiser Family Foundation Survey of Florida Medicaid Reform Beneficiaries
Data is an average of the effects in Broward and Duval counties.

Many beneficiaries had difficulty choosing a health plan. Multiple analyses have found that the state met its first year goal of a 65% voluntary plan selection rate among reform enrollees.[21] However, this rate is among individuals newly applying to the program and does not reflect the rate among existing Medicaid beneficiaries who were transitioned to reform. The Kaiser survey of existing Medicaid beneficiaries found that, on average in Broward and Duval counties, about 44% were likely assigned a plan by the state, suggesting a voluntary selection rate of about 56%. The Kaiser survey also found that, on average in the two counties, over half of reform enrollees and two-thirds of disabled reform enrollees who had selected a plan or thought about selecting a plan found picking a plan difficult (Figure 2).[22] Similar percentages said it was hard to understand plan information.[23] Further, about a third said it was not easy to obtain plan information, and about one in five said they had tried, but had been unable to get help finding health plan information.[24]

Figure 2

Reported Difficulties Choosing a Health Plan in Florida Medicaid Reform



Data is an average of the effects in Broward and Duval counties. Limited to persons who reported that they were told they needed to select a plan, those who had volunteered to enroll in a plan, and those who had thought about plan selection prior to the time of the interview.
Source: 2006/2007 Kaiser Family Foundation Survey of Florida Medicaid Reform Beneficiaries

Several other analyses also found that beneficiaries had difficulty understanding and obtaining plan information. Focus groups conducted by Georgetown University found that some beneficiaries were unable to understand key differences in the plans, and a number expressed frustration with the complexity of plan choices and benefit packages.[25] Further, some

beneficiaries said they did not have access to plan formularies and prior authorization procedures and that choice counselors were unable to provide this information.[26] Similarly, beneficiary focus groups and interviews from the University of Florida evaluation found that choice counselors were not a major source of information for beneficiaries.[27]

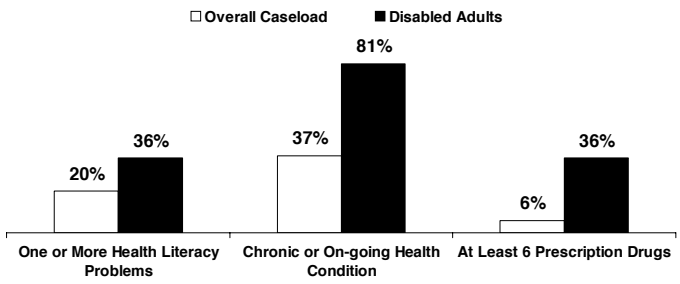
Additionally, in its analysis, OPPAGA found that some beneficiaries had difficulty selecting a plan, and the most commonly cited concerns were that the enrollment materials and plan comparison charts were confusing and difficult to read and understand.[28] Other concerns included choice counselors' inability to answer specific benefit questions and choice counselors' lack of accurate information on participating providers.[29] Further, OPPAGA concluded that plan disenrollment data suggest that information beneficiaries received was confusing, outdated, or inaccurate as about 24% of voluntary disenrollees between October 2006 and April 2008 said they changed plans because their primary care or specialist physician was not in their plan.[30]

Results from the Florida AHCA OIG review were consistent with these beneficiary experiences, finding that choice counselors referred beneficiaries to individual health plans for specific drug information but that most plans did not have preferred drug lists and/or specific drug information available online or through customer service numbers.[31] The AHCA OIG also found high rates of error in the provider network information provided to the state by the plans, and noted that these errors compromise choice counselors' ability to provide accurate information to beneficiaries.[32] The state is taking steps to try to address some of these problems and improve the information provided by choice counselors, but the impact of these efforts is not yet known.

Reform impacted a poor population with health literacy problems and significant health needs. By virtue of qualifying for Medicaid, reform enrollees are low-income. The Kaiser survey also found that, on average in Broward and Duval counties, about one in five reform enrollees had at least one health literacy problem and over one in three had an ongoing health condition (Figure 3).[33] Health literacy problems were more prevalent among disabled reform enrollees and almost all disabled reform enrollees had an ongoing health condition.[34] These characteristics put individuals at a disadvantage in choosing a plan, as health literacy problems can impede an individual's ability to understand plan information and an individual with health problems may have difficulty identifying a plan that covers all needed services, prescription drugs, and providers. Further, because of enrollees' low incomes, it is important for them to enroll in a plan that meets their health needs since they have limited or no resources to pay for uncovered care.

Figure 3

Health Literacy Problems and Health Needs Among Florida Medicaid Reform Enrollees



Literacy problems include reported frequent difficulty reading or understanding: a newspaper, directions for taking medicine, forms or letters from doctors or health plans, or numbers in a table or chart. Data is an average of the effects in Broward and Duval counties.
Source: 2006/2007 Kaiser Family Foundation Survey of Florida Medicaid Reform Beneficiaries

Access to Care

Early experiences suggest some access barriers for beneficiaries. Georgetown University's focus groups with beneficiaries found that some beneficiaries, particularly disabled beneficiaries, reported problems accessing prescription drugs under their reform plans or during the transition to reform.[35] Some found their drugs were not covered; others had to switch to

alternative medications.[36] Further, Georgetown University's analysis of plans found that almost all of the reform HMOs had more restrictive preferred drug lists than the state's list for non-reform Medicaid enrollees, and half of the HMOs limited the number or dollar value drug coverage, although these limits were high.[37] Plans adjusted their benefit packages in the second year of reform, and they generally made them more generous by raising benefit limits, eliminating or reducing copayments, or adding extra services.[38] However, changes in prescription drug coverage were more mixed—more than half of HMOs raised limits on drugs while others imposed stricter limits.[39]

Reform may be negatively affecting some providers' willingness to participate in Medicaid. In a survey of physicians conducted with the local medical societies, Georgetown University found that some physicians did not intend to participate in any of the new Medicaid plans under reform, and most physicians reporting this were specialists.[40] In that survey, providers' key concerns about reform were increased paperwork demands and administrative complexity stemming from working with different plans.[41] Physicians also reported difficulty providing needed care due to plan benefit limits or prior authorization requirements.[42] In contrast, the James Madison Institute concluded that provider participation data suggest that access to some specialists has increased since reform.[43] However, they note that this analysis is based on plan provider files, which cannot be completely verified for accuracy.[44] The AHCA OIG also examined provider participation, but concluded that it could not make valid pre- and post-reform provider participation comparisons due to the high rates of error in health plan provider network reports.[45]

Enhanced Benefits

Separate from the "additional services" managed care plans can choose to offer as part of their benefit packages, the state created a new "enhanced benefits" program under the waiver. Reform enrollees can earn up to $125 per year in enhanced benefit credits for participating in state-defined "healthy behaviors" such as keeping appointments; receiving preventive care, screenings, and immunizations; and participating in activities to improve health such as smoking cessation, weight loss, and disease management programs. The credits can be redeemed at participating pharmacies to purchase state-approved health-related products.

OPPAGA's analysis of the enhanced benefit program found that the state will spend $2.17 million to administer the program over its first two years.[46] It also found that about 190,000 beneficiaries had earned credits totaling nearly $13.8 million as of the end of April 2008 and that over eight in ten (81%) were earned by keeping primary and preventive care appointments; less than 1% were for participating in disease management programs or health improvement activities.[47] However, beneficiaries had only used about 11.4% of earned credits valuing $1.6 million through the end of April 2008.[48] They were most commonly used for baby care products and over-the-counter medications.[49]

Several analyses have identified a lack of beneficiary awareness and understanding of the enhanced benefit program.[50] Multiple studies concluded that some beneficiaries had difficulty understanding the monthly statement summarizing their credit levels, with some mistaking it for a bill.[51] The state has since taken steps to try to make the statement easier to read and understand. Analyses also identified problems with beneficiaries redeeming their credits—both in terms of beneficiaries understanding how to redeem them and pharmacies' ability to process the redemptions.[52] Further, researchers from OPPAGA and Georgetown found that while there is a level of enthusiasm among both beneficiaries and providers about the program, there is also skepticism about how effective it will be at actually leading to changes in behavior.[53] In

addition to citing stakeholder remarks in this regard, both analyses noted that the majority of credits have been earned for routine physician visits and/or immunizations that beneficiaries likely would have obtained regardless of the credit incentive.[54]

Opt-Out Premium Assistance Program

Under the waiver, the state also created a new "opt-out" premium assistance program. This program allows reform beneficiaries to choose to receive a premium subsidy (equal to the premium amount that would have been paid if they enrolled in a Medicaid reform plan) to put toward the cost of employer-sponsored coverage rather than enrolling in a Medicaid reform plan. To date interest and enrollment in the program has been very low. OPPAGA found that less than 1% of Medicaid reform enrollees have enrolled or even expressed interest in the program.[55] Since the program's inception, 30 individuals have enrolled in the program, and as of March 2008 there were 19 active enrollees.[56] As a result of low enrollment, the program has high per capita administrative costs, recently calculated at nearly $3,700 per enrollee.[57]

Waiver Budget Neutrality and State Cost Savings

Under longstanding federal policy, Medicaid waivers must be budget neutral to the federal government, meaning that a waiver must not result in greater federal Medicaid spending than would have occurred without the waiver. The Florida waiver did not expand Medicaid coverage and one of the state's primary goals of the waiver is to reduce the rate of spending growth. However, it is still subject to a budget neutrality cap that limits the amount of federal financing available under the waiver. Florida's budget neutrality cap is a per capita cap, which limits the amount of federal funds the state can receive for people covered under the waiver based on pre-set per person costs and an annual growth rate. The cap applies statewide even though the waiver has only been implemented in five counties.

In setting the budget neutrality cap, the state and federal government estimated how much the state would have spent over the five-year waiver period without the waiver. To date, the state is reporting lower spending under the waiver than these "without waiver" projections.[58] However, a recent GAO report found that the spending limits the Department of Health and Human Services (DHHS) agreed to for Florida are higher than what should have been granted based on currently stated policy for determining budget neutrality.[59]

Further, the lower spending amounts reported by the state to date are for the entire state; only about 10% of the reported spending under the agreement is related to reform enrollees.[60] As such, it is not clear if the state is achieving program savings from the waiver changes. It will be important to continue to monitor per person spending under the waiver, and, if savings are determined to occur from the waiver, to evaluate whether they accrue from efficiencies achieved by the plans or if they reflect lower utilization due to access problems. Additionally, it will be important to continue to monitor the administrative costs under the waiver, including costs for choice counseling as well as the enhanced benefit and premium assistance programs.

What is the Status of the Waiver?

The waiver is currently operating in five counties. The state legislature must approve expansion of the waiver to other areas of the state. In September 2007, the AHCA OIG recommended that the state delay expansion of reform into additional areas until certain improvements were met. In December 2007, the state Agency for Health Care Administration announced that it would not recommend expansion of reform during the 2008 legislative session, stating that the reform plan

required further study. As part of the 2008-2009 budget negotiations, the state legislature debated expanding the waiver into additional counties, including the heavily-populated area of Miami-Dade. However, the final budget released by the legislature at the end of April 2008 did not include any expansions to other areas of the state.

In late August 2008, four HMOs (Healthease, Staywell, United Healthcare, and Amerigroup) that together cover 60 percent of Medicaid reform enrollees notified the state that they would be withdrawing from Medicaid reform in December 2008 and asked that they stop receiving new enrollees.[61] The withdrawal appeared prompted by financial concerns, following the state's announcement of a five percent rate cut for the reform plans.[62] About one week later, three of the plans (Healthease, Staywell, and Amerigroup) rescinded their plans to withdraw from reform, after the state reduced the payment cuts from five to three percent.[63] Going forward, there may be continued uncertainty around plan participation in reform. Growing fiscal pressures could increase pressures on plans to either reduce benefits or leave the reform market. It also is not clear what will happen when the PSNs transition to a capitated payment structure and whether this will have any impact on their participation in reform or the benefits they offer.

It will be important to continue to monitor the waiver to allow insight into whether the challenges identified to date are reflective of issues related to the transition to reform, or if they stem from the basic program design. As the waiver continues to be studied it will be important to assess:

- How stable plan participation and benefit packages are over time;
- The scope of benefit packages offered by the plans each year and whether they meet beneficiaries' health care needs;
- Whether beneficiaries are able to actively and effectively choose a health care plan, and if some beneficiaries are at a disadvantage in navigating the plan choices;
- The overall impacts of the waiver changes on health access and outcomes; and
- If the waiver is cost-effective and whether it achieves savings.

This brief was prepared by Samantha Artiga, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

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