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Florida Medicaid Modernization Proposal

Jeb Bush, Governor
State of Florida
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The Case for Medicaid Modernization

The multi-faceted growth of Medicaid has produced a nearly incomprehensible maze of multiple, even conflicting components. Management of these increasing complexities is nearly impossible. Despite Florida's aggressive efforts to curb spending, costs are still rising at double-digit rates and expenditures have exceeded budgeted amounts in each of the last four consecutive years requiring additional appropriations of $428 million in state funds and $616 million in federal funds.

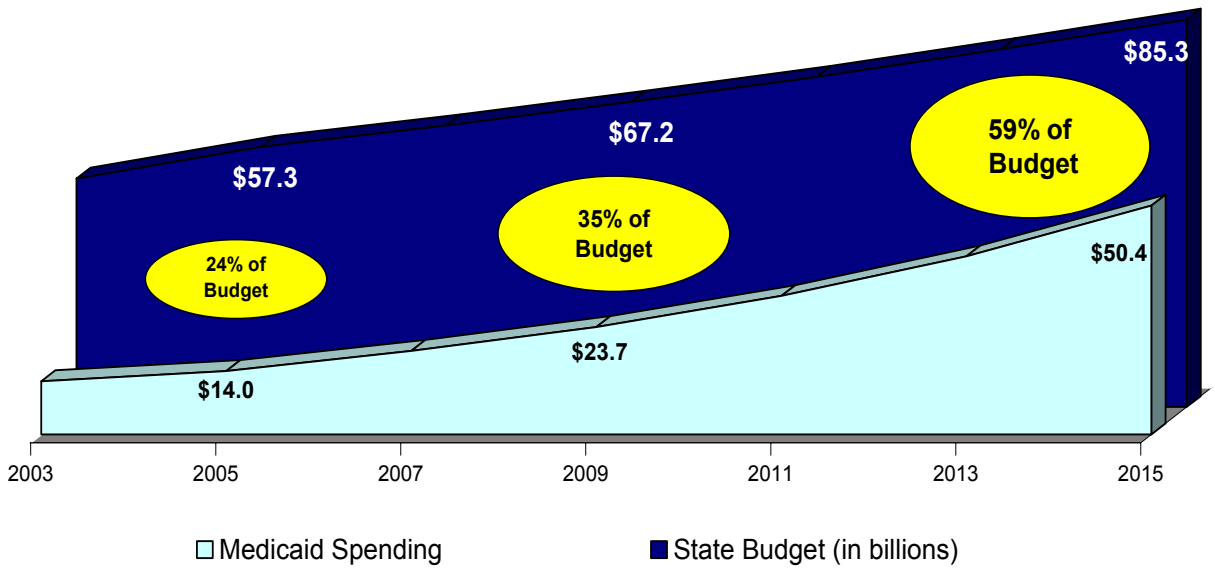
Each well-intentioned programmatic improvement or cost management strategy contributes to the piling-on effect. Participants are confused by the mandates and complexity; providers drop out due to red tape and payment restrictions; and, still, the state's financial obligation grows.

The Medicaid Maze

- *17 eligibility categories varied based on age, gender, income, and medical condition open the door to Medicaid benefits.*
- *47 different service types included in the Medicaid benefit package—more extensive than most workers receive through employment-based insurance.*
- *20 distinct waivers of federal regulations including one waiver that includes more than 20 different programs.*
- *224 state initiatives directing the Agency to develop and implement a broad array of vendor-driven projects.*
- *91 separate contracts with vendors and nearly 70,000 enrolled providers requiring Agency management and oversight.*

The spending increases exceed growth in the rest of the economy and overwhelm any increases in tax revenue. Between 1998 and 2004, growth in the economy allowed state tax revenues to increase by 24 percent, but the state's share of cost for the Medicaid program jumped by 88 percent. Total spending for Medicaid increased by 112 percent since 1999.

If Medicaid continues to grow at its current rate (13% average per year over the last six years) while the overall budget maintains its 4% per year average growth rate, the program will consume more than half of all state spending in just 10 years.



Principles of Medicaid Modernization

To accomplish the transformation of Florida's Medicaid program, the Governor proposes a new structure—one that empowers participants, creates flexibility for providers, and facilitates program management for government. In this model, the people receiving Medicaid coverage will gain control over the use of the resources allocated on their behalf. Medicaid participants will choose the types of plans and the methods of accessing services. The choices available to them will be meaningful because the system will offer new flexibility in determining the programs and services that can be purchased using the contribution from the Medicaid program. This added flexibility will permit diversification of products and services offered to participants and will generate a dynamic competitive environment. When patients are empowered with choice and providers are encouraged to innovate, the Medicaid program will be capable of improving services, outcomes, and delivery of better value for Florida's Medicaid participants and taxpayers. In moving from today's Medicaid to Florida's new Medicaid, this transformation will put people first.

Today's Medicaid		***Florida's New Medicaid***
Government as consumer	→	***Patients as participants***
Complex programs mandated by government	→	***Clear choices made by participants***
Centralized planning	→	***Marketplace decisions***
"Blank Check"	→	***Defined investment***
Unsustainable growth	→	***Predictable growth***

Patients as Participants

Floridians in today's Medicaid program have little control over their health care. By the time an individual enrolls in Medicaid, government decisions have already determined the type and amount of services that are available as well as the sources of that care.

In Florida's new Medicaid, the people served by the program will be active participants in the Medicaid marketplace. Persons insured through Medicaid will direct the use of the Medicaid resources allocated on their behalf. They will select the type of coverage or the method of accessing services from options offered by managed care organizations (MCOs), insurers, providers, and community-based systems. Additionally, they will have the opportunity to earn enhanced benefits by demonstrating healthy practices and personal responsibility. These enhancements will be provided through flexible spending accounts which can be used in a variety of ways to purchase additional services or coverage.

Marketplace Decisions

The current Medicaid program functions without the benefit of a viable market and many of the program's cost-control strategies further erode the potential for competition. Today's Medicaid program is one in which centralized government decisions determine which products and services are purchased, which plans and providers supply the services, what prerequisites limit access, and what prices are paid.

The state's healthcare investment will be used more effectively when spending occurs within a more rational economic system.

The vision for the future of Florida's Medicaid relies on competition among vendors of coverage and services to inspire innovation and efficiency. Creating this competitive environment depends upon minimizing government regulation and encouraging diversification and distinctiveness among the products and services that can be purchased with Medicaid dollars.

Competing to produce value will place new emphasis on prevention, early diagnosis and effective treatment of illness and injury. New information technologies will provide transparency for both plan selection and accountability—supplying participants with added tools for effective decision-making. In this competitive environment, plans and provider based systems will succeed only by serving satisfied participants and demonstrating their expertise through improving patients' outcomes.

Sustainable Growth Rate for Medicaid

The costs of today's Medicaid program are spiraling out of control. Double-digit increases in expenditures persist in spite of many years of aggressive cost control efforts. These trends are found not only in Medicaid, but in private insurance and Medicare. Controlling costs while maintaining access requires a broad and bold change in the economic foundation of health care.

The objective of these changes is not to reduce spending below current levels, but to achieve a more manageable and predictable rate of growth in Medicaid expenditures.

The bold proposal for Florida's Medicaid program is to transform the system into a premium-based plan. In this model, the state will set aside a specific amount of money for each person enrolled in Medicaid. The amount of the assistance will be risk-adjusted to reflect the medical needs of each participant. Additionally, Florida will establish a maximum benefit limit similar to private insurance.

Bridging Public and Private Coverage

Additional flexibility and choice is offered in Florida's new Medicaid program by an "opt-out" provision. Participants should be able to use their Medicaid premium to purchase employer-based coverage, thereby selecting a private plan instead of any of the Medicaid-approved plans and services. This provision may be exercised during the period of Medicaid eligibility, using the entire premium to support the employee's share of cost. Alternatively, Medicaid premiums deposited into flexible spending accounts may be saved and used in the future to assist the participant to purchase employment-based coverage.

Creating a Medicaid Marketplace

Competitive markets are the most efficient means for achieving optimal allocation of resources. The current Medicaid program functions without the benefit of these market forces. With no choice, participants lack incentives to use resources wisely. Providers lack incentives to control costs. Participating plans lack incentives or even the freedom to modify benefits to entice participants. The transformation of Medicaid is built on the introduction of competitive forces and choice.

Active Involvement

- ✓ Medicaid participants will have a ***variety of options*** including MCOs, insurance plans, provider service networks, or community-based care systems.
- ✓ Participants will be able to earn eligibility for ***additional benefits***.
- ✓ Additional or enhanced benefits will be offered through ***flexible spending accounts.***
- ✓ Flexible accounts will allow participants to ***expand the amount of coverage or purchase special services***.
- ✓ Participants can ***save the funding in their accounts*** for allowable future uses even after their Medicaid eligibility ends.
- ✓ Participants will be allowed to ***contribute to the cost of their care*** in order to select and help pay for additional plans or services.

Choice

Highly competitive markets feature multiple options with many buyers and sellers. The new Florida Medicaid seeks to mobilize the power of participants and avoid concentration of the market in the hands of a few vendors. Active and involved participants are critically important to achieving the advantages of a competitive market. Florida's new Medicaid involves participants in several ways and offers them opportunities for wise choices.

The aim of Florida's transformed Medicaid program is to give participants enough options for using their Medicaid premium to purchase the types of services they need and want the most. Therefore, the new Medicaid provides only 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.

Participants' choice is also enhanced by designating the available premium in three distinct categories and allowing participants to select their coverage from vendors offering plans and services in one, two, or all three categories. In this way, participants can mix and match the plans or care systems they select in order to obtain the type of coverage they most need and want.

Competition

The transformed Medicaid program will allow a new level of flexibility that is not found in the current system. Most importantly, this flexibility will provide a new platform for competition based on the forms of coverage as well as the methods of service delivery. MCOs, insurers, and providers will be encouraged to specialize and diversify in ways that effectively manage how participants access and use services. Three key strategies are intended to promote innovation and manage risk:

1) Vendors offering coverage and services in return for the Medicaid premium will be allowed to define the amount and scope of benefits they will offer;

2) The redesigned benefit structure will provide for further flexibility allowing participants to direct different portions of their Medicaid premium to different vendors; and

3) An upper limit will be established on Medicaid benefits, similar to the maximum benefit limits found in private insurance.

The choices available to participants will not be limited to MCOs or insurance plans, although these selections will be among those offered and likely to be preferred by many participants. Other options will include provider service networks and community-based health systems, which can serve as alternative means of organizing access to medical services. The competition among these various types of coverage and access systems will spur innovation in the methods of interacting with patients and managing methods for meeting their health needs.

Role of Government

One of the factors limiting competition in the current Medicaid program is the extent of government intervention and control. Today's Medicaid program is driven by a broad array of centralized decision-making in which elected officials and federal and state bureaucrats debate and decide everything from provider payment levels to clinical therapies. The transformed Medicaid program focuses government's role in just three areas.

Consumer Protection. Government oversight and regulation is essential to promote quality of care and assure the integrity of the options offered to Medicaid participants. The scope of the regulations should avoid restricting choice, but still be sufficient to certify that each choice is presented by a reliable company or network with the ability to deliver the services offered.

Creation of a rating system is a related function, which may be performed by government or by private firms. This system may be comparable to the bond rating system that classifies quality and measures performance risk. One approach would be to base the ratings on the medical loss ratio of the plan or service network. The more of the premium dollar spent on services for the patients, the higher the rating. In this way, participants would be encouraged to select the most patient-centered choice with the lowest administrative overhead.

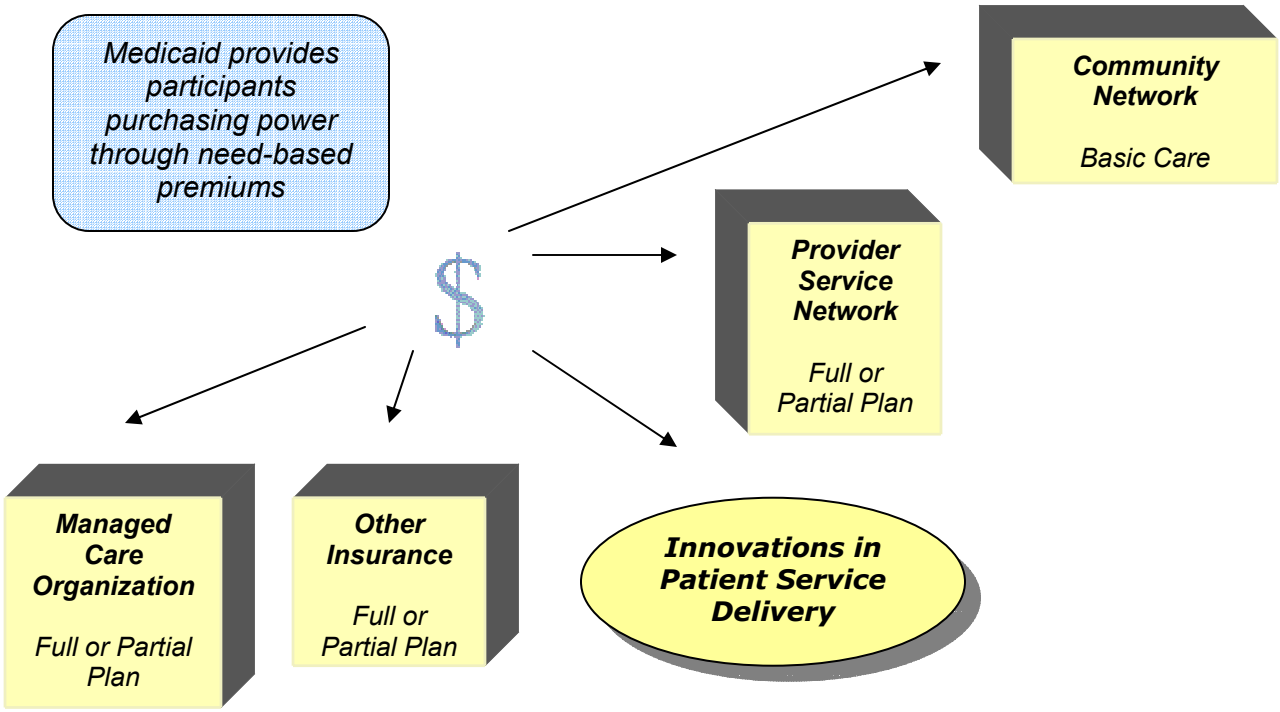
Information Infrastructure. Government actions are needed to establish an information infrastructure and choice counseling system that educates and empowers participants to select the plan or system most suited to their individual medical needs. Information available to participants should include profiles of each company or sponsoring organization. Additionally, participants should be able to access information on practitioner and plan credentials, disease-specific outcomes, and customer satisfaction data.

Special personalized assistance must also be provided for those Medicaid participants and families who may need extra help in evaluating the available options and selecting the one most suitable for them.

Budget. In the transformed Medicaid program, setting the spending level is the primary governmental function. From this aggregate budget, funding is earmarked for the three components of the benefit structure—basic care, catastrophic coverage, and enhanced benefits. Each Medicaid participant is entitled to a specific share of the budgeted amount—a monthly premium—that varies according to medical need. These risk adjusted premiums are used to purchase coverage or services. Through these selections, budgeted funds follow the patients and the choices they make.

Medicaid Marketplace Financial Flow Chart

- *Participants select plans or provider-based services*
- *Information infrastructure helps participants make choices*
- *Plans compete for participants based on quality/coverage*



Portions of the premiums for participants selecting partial plans are directed to designated funds for future use.

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Enhanced Benefit Bank

Funds for enhanced benefits are held until participant qualifies.

Qualified participants access funds through flexible spending accounts (FSA) which can be used to purchase:

- *More coverage*
- *Additional services*
- *Employment-based health insurance*

Catastrophic Fund

When costs of care exceed a defined dollar threshold, claims can be paid by the catastrophic fund. The fund is:

- *Financed by risk-adjusted premium*
- *Managed by state or contractor*
- *Used to pay claims for catastrophic care*

Benefit Framework

In the private sector, consumer-driven health care generally refers to a high deductible plan accompanied by a funded personal account. Florida's proposal adapts that model in order to respond to the characteristics of the Medicaid population. Medicaid participants, generally, have low incomes and limited disposable resources. These financial circumstances make it unlikely for them to manage the first-dollar coverage of many basic services necessary for maintaining good health. Nevertheless, the creation of a personal stake in their healthcare spending is an essential component of the transformed Medicaid model. For this reason, the new Medicaid program establishes a category of enhanced benefits that eligible participants will earn, own, and use or save as they see fit.

The benefit framework consists of three distinct components. These components are not defined by the type of services covered—any service may be covered in any category. Rather, they are defined by explicit expenditure thresholds that are based on historic utilization experience. A variety of sources will be able to provide these benefits to participants. Full plans will offer all three categories. Partial plans may function in only one or two of these categories. The choices offered for accessing benefits in any of the three categories will include MCOs and other insurer offerings, such as preferred provider organizations. Provider networks or community based systems may also offer a system of accessing medical care in any of these categories.

Proposed Benefit Structure

Basic Care

Services in this category include:

- *Professional services*
- *Pharmaceuticals*
- *Diagnostic Care*
- *Emergency services*
- *Hospital care*
- *Transportation*

The amount and scope of basic care services should be sufficient to meet most patients' medical needs.

Additional services should include health advice and counseling, preventive care, disease management, etc.

Plans may vary on the specific amount, scope and conditions of services offered.

Enhanced Benefits

Flexible spending accounts are offered to qualified participants. Funds may be used to purchase additional services or retained for use in purchasing employer-based insurance.

Catastrophic Coverage

Patients utilize catastrophic coverage when expenses exceed a certain dollar threshold. All medically necessary services are covered up to a specific maximum benefit.

Coverage provided may be subject to a variety of utilization management programs including:

- *Prior authorization*
- *Pharmacy benefit management*
- *Provider network management*

Basic Care. This category is not a minimal level of service, but includes most of the services most people need most of the time. The amount of the premium directed to this category will be based on an analysis of historic spending patterns. Basic services will include professional services, diagnostic services, hospitalization, and transportation—all of the mandatory services required under federal law and such other services as may be offered by the vendor. However, the amount, duration and scope of services will be determined by each plan or provider-based system, with government oversight to assure that the amount of coverage offered is sufficient to meet patients' medical needs. The distinctiveness of these offerings will provide the basis for competition and consumer choice.

All Medicaid participants will receive a risk-adjusted premium to purchase basic care from a certified vendor. Vendors will be obligated to deliver the amount and scope of services detailed in their offering. Government-authorized rating systems will compare their offering to an expected standard or level of care and the results will be used to advise participants of the "value" of the proposed coverage in each option.

Catastrophic Coverage. This category of spending is defined by a minimum dollar threshold. Persons who require healthcare services costing more than a certain amount in one year would be covered for medically necessary care up to a maximum benefit limit.

All Medicaid participants will receive catastrophic coverage. When participants have not selected a plan or provider-based system offering full or comprehensive coverage, the portion of their premium allocated for catastrophic care will be held in a fund to be used by the state in reimbursing their care up to the established maximum limit.

Enhanced Benefits. A portion of the Medicaid premium for each participant is allocated to a flexible spending account. Persons must earn eligibility for these enhanced benefits by exercising personal responsibility and participation with established healthy practices. The funding for the enhanced benefit may be managed by an MCO or insurer or held in reserve by the state for future use. Examples of how the accounts may be used by consumers include:

- Purchase of specific types of services not available through the basic coverage; for example, various rehabilitative therapies or a variety of home and community based services;
- Upgrading of basic plans in order to purchase more services than originally offered;
- Purchase of specialty service plans such as dental or vision care; and,
- Saving the account for use in purchasing employment-based insurance after Medicaid eligibility expires.

Long Term Care

More than 30 percent of all Medicaid expenditures are made on behalf of persons age 65 and older. The medical needs of this population are significant and varied. Traditionally, nursing facilities have been the major providers of Medicaid long term care, but over the last 20 years, home based alternatives have developed. Florida's Medicaid program has developed 12 such programs through approved waivers of federal Medicaid rules. These home and community

based services programs are preferred by elders over nursing home care, but the availability of services is limited. The proliferation of waiver programs leads to confusion among Medicaid participants and providers, making the options for care difficult to understand. Additionally, most waivers do not attempt to coordinate primary and acute care with long term care leading to further fragmentation.

Under legislation enacted in 2004, the Florida Medicaid program, in conjunction with the Department of Elder Affairs, has drafted a plan for integrated long term care. The proposed plan recommends a managed care approach for providing all Medicaid services for a participant age 65 and older, including long term care, if needed. The range of services includes physician care, hospitalization, prescription drugs, durable medical equipment, transportation, mental health services and other services. The MCOs selected to operate these integrated systems would have considerable flexibility in the service menu they may offer.

Florida's reform proposal will build on this integrated long term care plan in order to increase coordination and management of care. Gradually, the plan will be modified to increase consumer choice and flexibility, consistent with the overall framework for Medicaid reform in Florida.

Summary

Medicaid must change. The current system is often incapable of meeting participants' needs; it is costly, and inefficient. The change cannot be timid or tentative. It must fundamentally transform relationships, responsibilities and economic incentives.

The transformation of Medicaid in Florida will build a competitive market in which participants are empowered to make choices and rewarded for responsible behavior. The transformation of Medicaid in Florida will inspire providers, insurers, and MCOs to invent new methods and processes for serving patients and through these innovations, Florida's Medicaid participants will derive greater value for the investment made on their behalf. The Governor's proposal for Medicaid initiates a broad range of reforms to the very foundation of the financing and delivery system for health care services. The benefits of these changes will be shared by participants, providers, insurers, and taxpayers.

Florida must be capable of setting its investment level in health care. While that objective might be achieved in the existing system with strict limits on eligibility, services and spending, the extent and scope of such measures would be draconian and, inevitably, some Medicaid participants would be unable to obtain the care they need. Florida's proposal seeks to do more than limit spending—it strives to create a bold new Medicaid program that will better serve the state's vulnerable residents.

This proposal constitutes not a final product, but a broad framework that will require considerable effort to put into action. The involvement and commitment of legislative leaders as well as federal partners will be critical to achieving success as the need for waivers, statutory changes, and plan amendments is determined. Input is needed from many quarters including MCOs, insurers, providers, advocates and participants. Change will not be quick or easy, but it must be accomplished if we are to preserve our capacity for protecting the health of Floridians.

References

- Health Insurance/Uninsured*, The Commonwealth Fund, Health Services Research Vol. 39, No. 4, Part II, August 2004*
- Medicaid and State Budgets IN FY 2004: Why Medicaid Is So Hard To Cut*, Fossett, W., James, and Burke, E., Courtney, Rockefeller Institute of Government Federalism Research Group, July 2004*
- Heritage Foundation Backgrounder- The Future of Medicaid: Consumer-Directed Care*, Frogue, James, January 16, 2003*
- What Goes Up May Not Go Down: State Medicaid Decisions in Times of Plenty*, American Legislative Exchange Council, Health Care, Spring 2003*
- Giving Patients More Control, *National Center for Policy Analysis*, *Bachman, E. Ronald, Monday, June 17, 2002*
- Defined Contribution Health Insurance*, National Center for Policy Analysis, Scandlen, Greg, Policy Backgrounder No. 154, October 26, 2000*
- Abolishing the Medicaid Ghetto: Putting 'Patients First'*, American Legislative Exchange Council -The State Factor, Teske, Richard, April 2002*
- Reforming Medicaid In Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes*, Buckeye Institute for Public Policy Solutions, Bond, T., Michael, Goodman, C., John, and Lindsey, Ronald, March 2003*
- Redefining Competition in Health Care*, Harvard Business Review OnPoint Article, Porter, E., Michael and Teisberg, O., Elizabeth, June 2004.*
- Do Children Receiving Supplemental Security Income Who Are Enrolled in Medicaid Fare Better Under a Fee-for-Service or Comprehensive Capitation Model?*, Pediatrics Vol. 114 No. 1, Mitchell, M., Jean and Gaskin, J., Darrell, July 2004*
- Competition In Imperfect Markets: Does It Help California's Medicaid Mothers?*, National Bureau Of Economic Research, Working Paper 10429, Aizer, Anna, Currie, Janet, and Moretti, Enrico April 2004*
- Does Medicaid Pay Too Much For Prescription Drugs? Evidence From Medicaid HMOs*, National Bureau of Economic Research, Working Paper 9626, Duggan, G., Mark, April 2003*
- Does Contracting Out Increase the Efficiency of Government Programs? A Case Study of Atypical Anti-Psychotics*, National Bureau of Economic Research, Working Paper 9091, Duggan, G., Mark, August 2002*
- Medicaid Expansions and the Crowding Out Of Private Health Insurance*, National Bureau of Economic Research, Working Paper 6527, Yazici, Y., Esel, and Kaestner, Robert, April 1998*
- Does Public Insurance Crowd Out Private Insurance?*, National Bureau Of Economic Research, Working Paper 5082, Cutler, M., David, and Gruber, Jonathan, April 1995*
- How Managed Care Affects Medicaid Utilization A Synthetic Difference-in-Differences Zero-Inflated Count Model, *Freund*, *A., Deborah, Kniesner, J., Thomas, and LoSasso, T., Anthony, April 18, 1996*

- Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, Duke University School of Law, Richman, D., Barak, Winter 2004*
- Expanding Care Versus Expanding Coverage: How To Improve Access To Care, *(The two strategies should be viewed as complements, not competitors), Cunningham, Peter and Hadley, Jack, Data Watch, July/August 2004*
- Consumer-Directed Services At Home: A New Model for Persons With Disabilities*, Health Affairs, Volume 20, Number 6, Benjamin, A. E., November/December 2001*
- Providing Long-Term Care Benefits In Cash: Moving To A Disability Model *(The cause of patient autonomy is well served by cash benefit programs, although challenges reman) Stone, I., Robyn, Health Affairs- Volume 20, Number 6, November/December 2001*
- Improving the Quality of Medicaid Personal Assistance through Consumer Direction*, Data Watch, Foster, Leslie, Brown, Randall, Phillips, Barbara, Schore, Jennifer, and Carlson, L., Barbara, March 26, 2003*
- The Effects Of Cash And Counseling On Personal Care Services And Medicaid Costs In Arkansas*, Data Watch, Dale, Stacy, Brown, Randall, Phillips, Barbara, Schore, Jennifer, and Carlson L., Barbara, November 19, 2003*
- Can Managed Care Solve the Medicaid Crisis?*, National Center for Policy Analysis, Monday, April 10, 1995*
- Reforming Medicaid*, National Center for Policy Analysis, Fantwel, R., James, Policy Report No. 197NCPA, August 1995*
- Medicaid Managed Care Cost Savings – *A Synthesis of Fourteen Studies, Lewin Group 358016, Prepared for: America's Health Insurance Plans, July 2004*