Medicaid Managed Care in Florida:
Federal Waiver Approval and Implementation

Florida's new Medicaid plan – *called the Managed Medical Assistance program – will move nearly all of the state's Medicaid beneficiaries into managed-care plans. This new plan, approved in June 2013, is the final chapter in a Medicaid reform effort that is almost a decade old. Drawing on experiences from that decade of experimentation, the new plan incorporates significant consumer protections, some unique to Florida. Most of these protections establish the need for ongoing oversight and public input, creating opportunities for stakeholder monitoring and comment.*

INTRODUCTION

On June 14, 2013, the federal Centers for Medicare & Medicaid Services (CMS) approved Florida's request to move almost its entire Medicaid program for acute care services into managed care.[1] The agreement was the culmination of many years of negotiations between the state and federal government.

The State of Florida began efforts to reform Medicaid in 2005, when it received a Section 1115 Medicaid waiver from the federal government. That waiver enabled the state to launch in 2006 a five-year pilot program in Duval and Broward counties to test reform strategies. (The next year, three suburban and rural counties – Baker, Clay and Nassau – were added to the pilot.) The pilot waiver was extended, with some modifications, in 2011.

Today's Managed Medical Assistance (MMA) program essentially extends statewide the Medicaid systems that were in place in the five pilot counties since 2006.

This move to statewide implementation of Florida's Section 1115 Medicaid managed care waiver not only was lengthy, but subject to much controversy.[2] Significant changes have occurred along the way in the state's vision for reforming its Medicaid program, and the growth of Medicaid managed care in Florida and nationally has continued during this period. Florida's agreement contains some unusual consumer protections, described below, that reflect the intensity of concerns about Florida's history with managed care. Many of the unique features of the original proposal have been dropped. The waiver is largely now about moving to risk-based managed care.

MEDICAID REFORM IN FLORIDA: KEY EVENTS

October 2005	Federal government approves waiver allowing Medicaid pilot programs in Florida.
July 2006	Pilot begins operation in Broward and Duval counties.
July 2007	Pilot expands to three suburban and rural counties: Baker, Clay and Nassau.
December 2011	Federal government approves a three-year extension of the pilot waiver, with modifications based on lessons learned during the first five years.
June 2013	Federal government approves taking the pilot program statewide, beginning in 2014.

This brief analyzes the terms of the agreement under which Florida's Medicaid program will operate going forward. It includes some suggestions for next steps in assuring that Florida's Medicaid program operates in a way that meets the needs of the millions of Floridians who rely on Medicaid for their health care, and ensures that responsible program management and oversight of managed care leads to cost-effective use of taxpayer dollars.

JESSIE BALL DUPONT FUND

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WHY WAS A SECTION 1115 MEDICAID WAIVER NEEDED?

Medicaid is a federal-state partnership, and states have many options under federal Medicaid rules that can be exercised simply by submitting state plan amendments. Section 1115 waiver authority is necessary when a state wishes to make changes to its program that eliminate or change certain federal requirements, or spend Medicaid dollars in a different way.

In Florida's case, some of what the state wanted to do could have been done without a waiver, as long as the state complied with existing federal consumer protections for managed care. In fact, states can require large groups of Medicaid beneficiaries to enroll in capitated managed care arrangements without special permission from the federal government. Children without disabilities (the single largest group of beneficiaries), parents, and adults who have disabilities can all be mandatorily enrolled in managed care without the authority of a federal waiver.

But Florida's scope of change was especially broad. Florida is moving most of its populations into managed care – including persons who are eligible for both Medicare and Medicaid, children who are receiving disability payments, and children in foster care arrangements, among others. The state's desire to move these more vulnerable populations into managed care necessitated special federal approval.

CURRENT MANAGED-CARE ENVIRONMENT

Even before the new program goes into effect, nearly half (47 percent) of Florida's Medicaid beneficiaries are enrolled in managed-care organizations (MCOs) – an optional program introduced in 1984.[3] (About one-third of the Medicaid beneficiaries not currently enrolled in managed care participate in Florida's MediPass program – a fee-for-service, primary care case management program that has been in place since 1991.)

The extent of Medicaid managed care in Florida varies considerably by geography. In six of the 11 administrative regions used by Florida's Agency for Health Care Administration (AHCA), home to about half of the state's population, managed-care penetration is between one-fourth and one-half of eligible beneficiaries. Although some regions with lower penetration today are the state's rural areas, Miami-Dade County has only about one-third of its Medicaid population in managed care. The highest penetration of managed care is in the counties that participated in the pilot (Broward, Duval, Baker, Clay, and Nassau), where managed-care enrollment is about two-thirds of the Medicaid population.[4]

Managed-care penetration also varies by population. About two-thirds (63 percent) of TANF beneficiaries (i.e., low-income children and parents) and half (47 percent) of SSI beneficiaries (i.e. persons receiving disability payments) are currently in managed care statewide. By contrast, only 9 percent of those dually eligible for Medicare and Medicaid and virtually none of those in highly specialized populations are in managed-care plans today. The dually eligible and other population groups comprise about one-fourth of the statewide Medicaid population.

WHO MUST PARTICIPATE?

In general, the waiver mandates managed care for most Medicaid beneficiaries.[5]

Beneficiaries in a few categories are not required to participate, but may choose to. These voluntary participants include anyone with some other source of health care coverage (other than Medicare), anyone age 65 or older who resides in a mental health treatment facility, anyone in an intermediate care facility for individuals with intellectual disabilities, and individuals with development disabilities who are enrolled in the home and community based waiver program or are on the waiting list for such services.[6]

Medicare beneficiaries who are fully eligible for both Medicare and Medicaid will be required to participate in the new program for their Medicaid services, but Medicare beneficiaries who get only premium and cost-sharing assistance from Medicaid are excluded.[7]

REGIONAL BREAKDOWN OF CURRENT MANAGED CARE

AHCA Region	Counties	Current Managed-CarePenetration	Plans Allowed Under New Waiver
1	Escambia, Okaloosa, Santa Rosa, Walton	28%	2
2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	34%	2
3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union	36%	3 to 5
4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	59%	3 to 5
5	Pasco, Pinellas	50%	2 to 4
6	Hardee, Highlands, Hillsborough, Manatee, Polk	55%	4 to 7
7	Brevard, Orange, Osceola, Seminole	53%	3 to 6
8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	38%	2 to 4
9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	42%	2 to 4
10	Broward	66%	2 to 4
11	Miami-Dade, Monroe	36%	5 to 10

WHAT MANAGED-CARE PLANS WILL PARTICIPATE?

Implementation of the new Managed Medical Assistance program will occur by region, based on AHCA's 11 administrative regions. The state is using a competitive procurement process to select managed-care organizations for each region. Several types of managed-care organizations, such as Health Maintenance Organizations (HMOs), Provider Service Networks (PSNs), or similar organizations are eligible to participate. Enrollees in each region will have a choice of at least two plans.

The invitation to participate was issued to managed-care organizations in December 2012; winning bids were announced in September 2013. Final awards could be delayed, however, if unsuccessful plans in any of the regions appeal the state's decisions. From a total of 27 plans that submitted bids in at least one region, 10 plans were selected to serve the general Medicaid population. These selected plans include 6 HMOs and 4 PSNs.[8] All of these organizations already participate in Florida Medicaid under the current system. None of the organizations was selected to participate in all 11 regions, but Sunshine Health Plan (operated by Centene) was selected in 9 regions.

The Provider Service Networks that were selected will be available in a subset of regions, based in part on the organization's provider networks. These PSNs typically are centered on a regional hospital system (e.g., First Coast Advantage, operated by Shands Jacksonville Medical Center) or on a primary care provider network (e.g., Prestige Health Choice, operated by 23 community health centers). At least one PSN was selected in each region.

In addition to the plans that will serve the general Medicaid population, five other companies were selected to offer specialty plans intended to serve individuals with specific conditions (e.g., HIV/AIDS or severe mental illness) or select eligibility groups (e.g., children in the child welfare system).[9]

Although all plans selected to serve the general Medicaid population already participate in Medicaid, *a substantial share of Medicaid beneficiaries enrolled in managed care today are enrolled in plans that were not selected to serve their regions*. The share of beneficiaries required to select a new plan varies considerably by region. For example, in Region 4, where Duval County and three nearby counties are participating in the pilot program, about 90 percent of participating beneficiaries in the pilot counties will be able to stay in the same plan if they wish to do so. By contrast, in Region 10 (Broward County), about half of those in managed-care plans will need to select a new plan.

Issues to monitor: Are PSNs prepared to operate under capitation? How do transitions work out for those currently enrolled in managed-care plans not selected for the new program? How will the specialty plans operate?

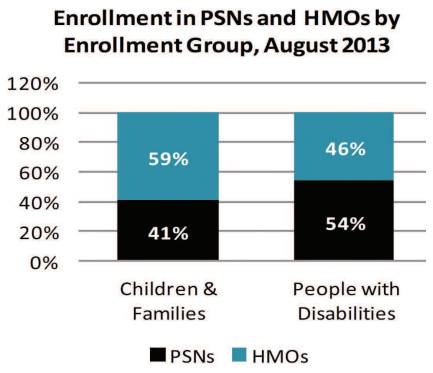
WHAT IS THE TIMELINE?

A key feature of Florida's agreement with the federal government is the requirement that implementation be staggered and that a readiness plan must be approved by CMS before individual regions can go forward with implementation.

According to the waiver agreement, the state must submit an implementation plan to the federal government by October 31, 2013. This plan must include the state's plans for conducting a "readiness review" and a solvency assessment for participating plans. Readiness reviews must include assurances that there is adequate capacity in the system, a means for access to care outside of plan networks, and additional attention to access to care for enrollees with special health care needs and cultural considerations.

CHANGES AHEAD FOR POPULAR PROVIDER SERVICE NETWORKS

Provider Service Networks have had the option of being paid using a per-person capitation rate or a fee-for-service rate. Throughout the history of the five-county pilot, PSNs that chose to operate on a fee-for-service basis have not been moved to a capitated system, even though such a move was anticipated from the inception of the pilot. Every year, the transition was delayed.



These PSNs in the pilot counties have been popular with enrollees – especially those with disabilities. A higher share of people with disabilities, compared to children and families, have opted to enroll in PSNs, perhaps because of existing relationships with the sponsoring provider systems.

Going forward, AHCA reports that all PSNs bidding to remain in Medicaid will do so by accepting risk and moving out of fee-for-service reimbursement.[10] It is unclear how this will affect beneficiaries, but given the high proportion of persons with disabilities and chronic health conditions that will be moving into a fully capitated environment, this development will be worth monitoring. In the past, while there have not been many complaints submitted as a percentage of the overall Medicaid population, a disproportionate proportion of the complaints filed have been with HMOs as opposed to PSNs. In the year that ended June 30, 2013, HMOs had 52 percent of total Medicaid enrollment but garnered 75 percent of all complaints, while PSNs had 48 percent of enrollment and 25 percent of complaints. [11]

Enrollment, which will be staged across the 11 AHCA regions, will begin no earlier than January 1, 2014, and the transition of all regions in theory will be complete by October 31, 2014. According to the Governor's office, implementation might begin April 1, 2014.[12] A broad-based outreach and education campaign is required to begin 90 days before the start of enrollment in any particular region.

A key factor in the timeline is a careful review both by the state and the federal government to ensure that the state and the plans are ready for implementation. Furthermore, as implementation phases in by region, the state must report to the federal government on the record of implementation in each region – including stakeholder feedback and how any problems were resolved. Agreement to proceed to the next phase is contingent on submission of all required reports and a plan to address any problems identified.

Issues to monitor: What information is made available about readiness? What stakeholder input is solicited about the implementation record? Are "pauses" deemed necessary by CMS after the initial rounds of implementation?

HOW WILL MANAGED CARE BE OPERATED?

There are substantial protections built in to Florida's waiver intended to address many of the problems that have emerged with managed care operating in Florida. Some of these are unique to Florida's agreement and some are reflected in other recent waiver agreements CMS has reached with states such as Kansas, New Mexico and Oregon. Still others merely restate what federal law has required for many years. Key features of the agreement intended to protect consumers and improve plan performance include:

MEDICAL-LOSS RATIO:

A medical-loss ratio measures the percentage of premium dollars that an insurer spends on medical care vs. administrative costs, advertising and profits. The Affordable Care Act imposed a medical-loss ratio on plans operating in the private insurance market, and at least 11 states have enacted medical-loss ratios on some or all of their Medicaid dollars.[13] However, federal law does not generally require a medical-loss ratio for Medicaid insurers and they are not subject to the new ACA requirements.

CMS included a medical-loss ratio requirement of 85 percent in Florida's December 2011 agreement extending the five counties' pilot programs, and the recent waiver agreement extends this statewide. *This appears to be the first time that CMS has required a medical-loss ratio as part of a Section 1115 Medicaid waiver agreement.*

All plans providing acute care services (not long-term care services) will need to spend 85 percent of premium revenues on medical care and report quarterly on their medical-loss ratios. CMS will determine what corrective action will be taken if plans do not meet their ratios. This will be an important issue for ongoing monitoring.

While medical-loss ratios are not intended to be a proxy for plan performance, they do provide an important floor for how much a plan actually spends on meeting the health needs of its enrollees. A national study (which included Medicaid HMOs in Florida) found that insurers who were publicly traded spent more money on administrative costs, had lower medical-loss ratios and performed worse on clinical quality measures.[14] The clinical quality measures examined included preventive care, treatment of chronic conditions and consumer satisfaction. Publicly traded plans are the dominant carriers in Florida's Medicaid program.

Issues to monitor: Which plans have higher medical-loss ratios and are spending more on patient care? How is the ratio being calculated – what counts as a medical expense? Are plans with higher medical-loss ratios performing better on quality measures?

COMPREHENSIVE QUALITY STRATEGY, PLAN REPORTING MEASURES:

The special terms and conditions accompanying the Florida waiver include a set of requirements on quality of care. A key component is that the state must adopt and implement a comprehensive state quality strategy that focuses on quality improvement at state, plan and provider levels. The state is expected to adopt a set of quality metrics for this purpose and to set targets on the metrics that equal or exceed the 75th percentile national Medicaid performance level. In addition, these metrics would be used to establish plan performance improvement projects focusing on areas such as improved prenatal care and well-child visits in the first 15 months and better preventive dental care for children.

The state is also required to create consumer health plan report cards to be available to consumers and other stakeholders on an annual basis – a feature unique to Florida's waiver.

Issues to monitor: What quality metrics are selected? What information does the state provide on quality metrics? When are consumer health plan report cards made available? Are the report cards reasonably transparent and easy for consumers to understand? Are report card ratings used by beneficiaries? Are appropriate actions taken by the state if plans fail to meet quality targets?

NETWORK ADEQUACY:

Concern about an inadequate number of physicians and other providers for Medicaid beneficiaries has been an ongoing issue in Florida. In our analysis of the pilot program, we identified provider participation as an ongoing concern and presented evidence that provider participation had declined in counties where the pilots were located.[15] We found that there was a net decline in the pool of physicians serving Medicaid patients in Duval and Broward counties and that participating providers were seeing fewer patients. In the new program, the competitive procurement invitations to plans included a number of requirements around network adequacy, consistent with the special terms and conditions in the federal waiver. These include policies on network capacity, travel time and distance standards, and availability of appointments. In addition, plans are expected to have networks with the capacity to serve a substantial share of the region's Medicaid population, and the state intends to validate provider network listings on a regular basis. The state must report on its policies to CMS by 90 days after the waiver approval.

Issues to monitor: Are providers who have traditionally served Medicaid beneficiaries satisfied with their ability to be included in plan networks? Is there any decrease in the overall number of providers treating Medicaid beneficiaries? Are beneficiaries having difficulty in accessing primary care providers or specialists? Is the state making information available (for example, analysis of plan encounter data) to demonstrate access? Are "secret shopper" studies being conducted to see if providers really are accepting new Medicaid patients?

MEASURES TO ENSURE PLAN STABILITY:

In the five-county pilot program, 11 of the 14 HMOs that participated in the first year of the pilot later withdrew (by contrast, only one of the participating eight PSNs withdrew). Representing well over half of all program enrollees in these counties, these withdrawals have resulted in significant disruptions for Medicaid beneficiaries. An involuntary change of plans, at minimum, means dealing with a different plan and can lead to changes in health care providers and coverage of prescription drugs.

Under the terms of the new program, provisions have been added with the goal of increasing program stability.

The procurement for plan participation under the new waiver requires a five-year commitment to the program. Plans that leave a region before the end of a contract term will face penalties and will be required to pay AHCA for the cost of various transition activities. In addition, a plan that elects to withdraw from one region must terminate its participation in all other regions. The rules also establish a maximum number of plans per region, based on population, with the intent of ensuring adequate enrollment for all participating plans.

Issues to monitor: What is the distribution of enrollment across participating plans? Are there any threats to withdraw during the program's first year? Are the new requirements effective deterrents to plans to withdraw?

ENROLLMENT PROCEDURES:

As the rollout occurs in each region, eligible beneficiaries will receive a letter with enrollment information. They will have 30 days to select a plan and another 90 days after enrollment to change that selection. Choice counseling resources are available as in the past. Those beneficiaries who do not select a plan will be enrolled automatically into a plan – a common practice known as "auto-enrollment."

The program will take into account both individual circumstances and plan capacity in making auto-enrollments. Those in a managed-care organization under the current system will be assigned to that plan, if possible. For those in fee-for-service Medicaid or MediPass, the state must use its data to match the individual to a plan where the network includes the person's primary care provider. Where no record of a provider exists, the state should determine whether a plan's primary care providers are geographically accessible for the beneficiary.

Auto-enrollments also should ensure that family members are placed together in the same plan to the extent possible. For beneficiaries who already are participating in the managed long-term care program, the intention is to assign them to plans offered by the same company to the extent possible.

Issues to monitor: Do beneficiaries generally understand the plan choices? How many beneficiaries make voluntary plan selections, and how many are auto-enrolled? Do counts of voluntary selections include those rolled over from plans under the current system? For those who are auto-enrolled, are they accurately assigned to plans where their providers are in the network? Are family members placed in the same plan?

THE ENHANCED BENEFITS PROGRAM

A unique feature of Florida's Medicaid changes since inception has been the Enhanced Benefits Program, intended to encourage Medicaid beneficiaries to engage in "healthy behaviors," such as obtaining preventive care, participating in smoking cessation programs, etc. Credits earned through this program are redeemable by participants at local drug stores for approved products. A waiver has been needed to spend federal Medicaid dollars in this way.

The program was slow to get off the ground with high administrative costs. (Alker and Hoadley, Briefing #6, July 2008)

While popular with beneficiaries, there is little evidence that it has been altering their behavior.

The new agreement terminates the current program starting on July 1, 2014 and instead requires plans to develop their own incentive programs.

OPPORTUNITIES FOR PUBLIC INPUT:

Another unique feature of Florida's waiver agreement is the creation of some new opportunities for public and beneficiary input, referred to as "stakeholder engagement processes."

Every state is required as part of its Medicaid program to have a Medical Care Advisory Committee or MCAC. As part of the waiver agreement, Florida's MCAC must have a minimum of four beneficiaries – positions that must be filled at all times unless CMS grants an exception. And the state must also convene smaller advisory committees that meet at least quarterly to focus on subpopulations, including at a minimum: persons with HIV/AIDS, children with a special focus on those in foster care and the provision of dental care to all children, and persons receiving behavioral health or substance use disorder services.[16]

While additional opportunities for consumer input are valuable, it is often difficult for beneficiaries and their advocates to participate in discussions in a meaningful way if the information presented is highly technical, there is a lack of transparency, or both. Often technical assistance and support is needed to ensure that beneficiaries are able to provide meaningful input and are even able to participate.

Issues to monitor: Are issues presented to the advisory committees in a way that facilitates meaningful input? Do concerns expressed by beneficiaries and their advocates result in meaningful actions to address them?

CONCLUSION

Florida's move to risk-based managed care is far-reaching and will require careful monitoring going forward. In each section of the brief, we have highlighted issues that will be important to monitor.

While the agreement reached with CMS provides multiple pathways to monitor, regulate and oversee the performance of the managed-care plans, it remains to be seen whether these pathways will provide meaningful opportunities for feedback and improvement of plan performance. With both federal and state employees stretched thin with multiple demands, oversight and enforcement may be limited. Education about what protections consumers have is essential to ensure that consumers are aware of them and that they are enforced.

There are reasons to be concerned as commercial risk-based insurers expand their reach into vulnerable populations in Florida's Medicaid program. Because these populations have higher health care needs, they tend to be more expensive and thus are sometimes targets for cost-cutting. Although managed care carries the potential to coordinate the many care needs experienced by vulnerable populations and thus improve that care, the need for commercial managed-care plans to control costs and generate profits for shareholders may come into conflict with the cost of providing high-quality care.

Florida's stakeholders will need to keep a careful eye on how the myriad issues identified in this brief unfold as implementation moves statewide.

ENDNOTES

(1) Separate legal authority to move Medicaid long-term care services into managed care was granted by the federal government February 1, 2013, through another Medicaid authority – Sections 1915(b) and 1915(c) of the Social Security Act. A forthcoming brief will address this program, in which the initial enrollments began in August 2013.

(2) Previous work in this series of issue briefs, as well as a prior series by Joan Alker for the Winter Park Health Foundation on the original waiver proposal in 2004 and an evaluation of the pilot county programs by Joan Alker and Jack Hoadley for the Jessie Ball duPontFund are all available at hpi.georgetown.edu/floridamedicaid, http://www.dupontfund.org/catgories/reports/, or http://www.wphf.org/research-publications/issue-policy-briefs/.

(3) AHCA, Florida Medicaid Managed Care and Medicaid Pilot Enrollment Reports, August 2013.

(4) Ibid.

(5) Medically needy beneficiaries will be required to participate in managed care under the waiver, although there is a separate waiver request pending that could change the coverage for this population prior to the start of the new program.

(6) A few groups are entirely excluded: Those eligible only for emergency services based on immigration status, participants in the family planning waiver program, those eligible as women with breast or cervical cancer, and children receiving services in a prescribed pediatric extended care facility.

(7) The excluded groups are Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs).

(8) The HMOs with winning bids are: Amerigroup Florida (2 regions), Humana Medical Plan (5 regions), Preferred Medical Plan (1 region), Sunshine State Health Plan (9 regions), United Healthcare of Florida (2 regions), and Wellcare of Florida (7 regions). PSNs with winning bids are: Better Health (3 regions), First Coast Advantage (1 region), Integral Health Plan (2 regions), and Prestige Health Choice (7 regions).

(9) The organizations with winning bids for specialty plans are: AIDS Healthcare Foundation (HIV/AIDS population in 2 regions), Florida MHS, operated by Magellan (people with severe mental illness in 8 regions), Freedom Health (4 separate plans in 8 regions, serving people with cardiovascular disease, chronic obstructive pulmonary disease, congestive heart failure, and diabetes), Simply Healthcare Plans (HIV/AIDS population in 10 regions), Sunshine State Health Plan (child welfare population in 11 regions).

(10) Telephone Interview with AHCA Director Justin Senior, August 29, 2013.

(11) A total of 2990 complaints were filed during the period examined. Georgetown University HPI analysis of complaint and enrollment data from the four most recent AHCA Quarterly reports available at http://www.fdhc.state.fl.us/medicaid/medicaid_reform/quarterly.shtml

(12) Office of the Governor, "Gov. Rick Scott Announces Florida Receives Final Waiver Approval for Managed Medical Assistance Program," June 14, 2013. http://www.flgov.com/2013/06/14/gov-rick-scott-announces-florida-receives-final-waiver-approval-for-managed-medical-assistance-program/

(13) Gifford, K et al. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* Kaiser Commission on Medicaid and the Uninsured, September 2011, page 23.

(14) McCue, M. and Bailit, M. *Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide* Commonwealth Fund, June 2011.

(15) Alker and Hoadley, Briefing #7, October 2008.

(16) Special Terms and Conditions of June 14, 2013 #43 found at p. 25. http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_MMA_STCs_CMS_Approved_06-14-2013.pdf

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