

## SOME PRELIMINARY QUESTIONS ON FLORIDA'S "MEDICAID MODERNIZATION" PROPOSAL

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**Overview:** On January 11, 2005 Governor Bush released an outline of a plan to restructure Florida's Medicaid program. The document suggests a far-reaching and radical restructuring of Florida's Medicaid program, but it lacks many important details. Many of the concepts proposed have not been tested anywhere even on a pilot basis, and it appears that the Governor intends to apply them on a very broad scale. Yet many key questions are left unanswered by the document – perhaps chief among them who will be affected by the changes and what the budgetary implications are.

The document itself is not a Section 1115 federal waiver proposal, although such a waiver will be needed to implement much of the proposal. There is no information about what the scope of such a waiver would be or when it will be submitted.

Florida's Medicaid program serves approximately 2.2 million persons. Over half of these beneficiaries are children – most of whom are covered through federal "mandatory" coverage categories. In general, Florida has few optional beneficiaries and is a low per capita spender as compared to other states -- ranking 39<sup>th</sup> nationally.<sup>1</sup>

### Selected Key Issues:

**Financing:** Again, while details are sketchy it appears that the Governor's proposal *intends to cap the amount of money spent by the Medicaid program on a per person (per capita cap) basis and on an overall or global cap basis as well.* According to the proposal:

*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 benefits structure ... Each Medicaid participant is entitled to a specific share of the budgeted amount.<sup>2</sup> (Emphases added)*

### Questions on financing:

1. How would this affect federal dollars? It is impossible to discern from the document how federal funding would flow to the state. Such a decision would arise in the context of Section 1115 waiver budget negotiations, but the greater the scope of the waiver (i.e. the more of Florida's Medicaid program that is encompassed by the waiver) the more federal dollars that are at stake. Any Section 1115 waiver includes a cap – either a per capita or

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<sup>1</sup> For more information, see Alker, J. and Portelli, L. "Florida's Medicaid Budget: Why are Costs Going Up?" Winter Park Health Foundation, July 2004, available at [www.wphf.org](http://www.wphf.org).

<sup>2</sup> Florida Medicaid Modernization Proposal, p. 5.

global cap on federal funding.<sup>3</sup> There is no way of knowing at this juncture what kind of cap would be applied.

2. How much money does the state plan to spend per person? Again the document provides no information on how much money the state is trying to save or how much it intends to spend per beneficiary. These are critical questions which are likely to determine if beneficiaries – particularly those with high medical needs – are likely to receive adequate care under the new system.

3. What happens when the state hits its aggregate spending limit? Again no information is provided. Will the state close enrollment? Will hospitals, nursing homes, community clinics, counties and other providers have to absorb greater levels of uncompensated care? Will families receiving Medicaid be charged with costs that they can't afford likely leading to bad debt and possibly bankruptcy?

4. What will happen to existing payment arrangements like the Disproportionate Share Hospital (DSH) program or the "FQHC" reimbursement structure for community health centers?

5. Another issue to consider is that capping state funding will also cap federal funding since this funding is provided on a matching basis. What will the economic impact of the loss of federal dollars mean in terms of lost jobs and business activity?<sup>4</sup>

**Benefits:** It appears that under the waiver, *private insurers, HMOs and other vendors would have extraordinarily broad flexibility to determine what benefits Medicaid beneficiaries would get.* Beneficiaries would receive a set premium amount that would be risk-adjusted – although it is not clear how. According to the proposal:

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.<sup>5</sup>

According to the proposal, there would be a three-tiered benefit system: Basic Care, "Enhanced Benefits" and Catastrophic Care. *These tiers would not be defined by the types of benefits but rather by the amount of money that is allotted to each person in each category.* As the proposal says:

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.<sup>6</sup>

*Because the amount of money is the determinative factor rather than any set benefits package, this appears to undermine most if not all of the benefits standard that currently exist in Medicaid.* For example, the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit for children it appears would be compromised by the cap on spending.

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<sup>3</sup> For more information, see Alker J. and Portelli, L. "What Could a Waiver to Restructure Medicaid Mean for Florida?" Winter Park Health Foundation Policy Brief April 2004, available at [www.wphf.org](http://www.wphf.org).

<sup>4</sup> See Sampath, P. "Penny Wise and Pound Foolish: Why Cuts to Medicaid's Economy Hurt Florida's Economy" (Miami: Human Services Coalition), October 2003.

<sup>5</sup> Proposal, p. 8

<sup>6</sup> Proposal p. 7.

No state has sought to limit this benefit for children covered in “mandatory” coverage categories.

How would it work? Plans would compete for beneficiaries by offering them different choices for the “Basic Care” services. Beneficiaries could then use their fixed sum to decide which plan to purchase. Once beneficiaries reach a minimum dollar threshold and require more healthcare services they would move into the catastrophic coverage category. It is not clear how this source of funding will function, but it is clear that there will be a maximum benefit limit.

Finally, Medicaid beneficiaries who “exercise personal responsibility” and participate in “established healthy practices” will be eligible for “enhanced benefits.” This would be money in a flexible spending account that can be used to purchase additional services.

*Questions on benefits:*

1. What benefits, if any, would beneficiaries be guaranteed? Will the state seek a waiver of the EPSDT benefit for children? Given that HMOs and other participating private insurers will need to make a profit, the state’s desire to control costs, and the fact that Florida is a low per capita spender already it seems inevitable that services will be cut.
2. What happens to people with a disability or a serious illness when they reach the benefit limit? For example what happens to someone in a persistent vegetative state who reaches their benefit limit? Who will absorb these costs?
3. Who will decide if beneficiaries are engaging in healthy behaviors? Will infants, children, people with severe mental illness, or people in nursing homes be expected to engage in healthy behaviors?
4. What protections will there be to ensure that plans do not “cherry-pick” or structure benefits to attract healthy individuals?

**Cost-sharing:** The proposal states “Participants will be allowed to contribute to the cost of their care in order to select and help pay for additional plans or services.”<sup>7</sup>

There is no further information on who this would apply to – for example, would it apply to children who are the bulk of Florida’s Medicaid beneficiaries which is not permitted under federal law. Also how much would people would be asked to pay and what protections would exist to protect people with disabilities and seniors who tend to use a lot of services. The vast majority of Florida’s Medicaid beneficiaries have very low incomes, and research is clear that imposing costs on low-income populations reduces the use of needed services.

**Consumer protections:** The proposal provides virtually no information on what will happen to important consumer protections that exist in the Medicaid program. Some questions include:

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<sup>7</sup> Proposal, p. 4.

1. Will the state seek the authority through a federal waiver to allow people to receive different benefits based on where they live? It would appear so since vendors will determine the scope of benefits. This is a particular concern for rural areas.
2. What consumer protections will exist with respect to managed care? Nursing home quality?

**Long term care:** The proposal provides very few details about what would happen to long term care. This is a key area of Medicaid given the high level of services needs in this population and the concomitant high proportion of spending. The proposal does little to clarify where to state intends to go in this area or whether long term care is even included in the proposal. Much is at risk for these beneficiaries in a capped system.