

Florida's Proposal for Statewide Medicaid Managed Care Submitted to Federal CMS Frequently Asked Questions

What did the State of Florida submit to the federal Centers for Medicare and Medicaid Services (CMS) on August 1st?

The State - through the Agency for Health Care Administration (AHCA) - submitted several different documents which together seek to expand an experimental form of Medicaid managed care statewide:

1. Three proposed amendments to Florida's existing "Section 1115" "Medicaid Reform" Waiver seeking to modify and expand the current 5-county Medicaid managed care experiment.
2. An application for a new combination "Section 1915(b) & (c)" waiver seeking to create a mandatory managed care component for delivery of long-term care in Medicaid.
3. A proposed amendment to Florida's existing Section 1115 "MEDS-AD" Waiver seeking to add on a significantly modified version of the Medically Needy component of Medicaid.
4. A proposed amendment to Florida's Medicaid State Plan (not a Medicaid waiver) seeking to require recipients with access to job-based coverage to give up their Medicaid coverage.

What are all of these different mechanisms, and why were they used?

AHCA's submissions allow the State to seek the *greatest* possible amount of flexibility with the *least* possible amount of federal scrutiny. Splitting up the proposal into these different pieces allows each to be reviewed under the least burdensome process available.

At one end of the spectrum, amendments to the Medicaid State Plan are often used for changes within existing Medicaid rules, and public input isn't even required. By contrast, a wide range of Medicaid rules can be sidestepped or modified through a Section 1115 Waiver, but such broad authority is only granted after potentially extensive negotiations and federal sign-off. An 1115 Waiver is essentially a contract between the State and CMS that replaces portions of the federal Medicaid rules on the books.

How do these mechanisms relate to one another?

Most importantly, the current Medicaid Reform (1115) Waiver serves as the "foundation" for everything the State has proposed in its recent submissions. The other proposals are all built on top of that foundation, and could not stand on their own.

In particular, the State wants permission to build the statewide Medicaid managed care experiment onto that Reform foundation that today includes only five counties and a few patient groups. (The core of the Reform and new experiments are identical, namely mandatory enrollment in a capitated managed care plan where each plan can set its own benefit package.) Without the broad flexibility available through an 1115 Waiver, the State could not even attempt to force the most vulnerable patients to enroll in managed care plans, nor allow those plans to vary/reduce benefits in unique and confusing ways. Please refer to the figure on the next page.

Relationship Between Current and Proposed Medicaid Waivers

Medicaid Reform Experiment (Current)

- Mandatory enrollment in a capitated (HMO or HMO-like) plan
- Freedom for plans to vary amount, duration and scope of benefits
- "Opt out" to job-based coverage

**AHCA
Submissions
to CMS**

AHCA's submissions to federal CMS seek to accomplish four main objectives:

1. Expand the current Medicaid Reform experiment statewide to all counties and virtually all recipients.
2. Make some limited changes to the way the experiment works (competitive bidding by plans to serve regions is the biggest).
3. Add a managed long-term care component as part of the experiment for those who need such services.
4. Add a number of new extreme, punitive provisions.

Statewide Medicaid Managed Care

- Mandatory enrollment in a capitated (HMO or HMO-like) plan
- Freedom for plans to vary amount, duration and scope of benefits
- Competitive bidding to select plans to serve 11 regions, with plans negotiating contract terms behind closed doors

"Force-Out"
to job-based
coverage

"Opt-Out" to job-based coverage

**Managed
Long-Term
Care
component**
for recipients with
long-term
care needs

(eliminating most
of the current
HCBS Waiver

\$10 monthly
premium due
from each
recipient

Exorbitant
premiums due
from all Medically
Needy recipients

\$100 co-pay for
non-emergency
hospital ER visit

Why did AHCA propose amendments to the Medicaid Reform Waiver? Why three amendments instead of one?

AHCA actually proposed only one meaningful amendment: the one that proposes to “build onto the Reform foundation” and make some limited changes to its design required by the legislation passed last spring. The other two amendments are separated out because they propose extreme measures that face outright rejection, at least in their current form. One is a requirement that a premium of \$10 per month be paid for every recipient in a family, regardless of income or hardship. The other is a requirement that recipients make a \$100 co-payment when seeking non-emergency care in a hospital emergency room, regardless of circumstances or lack of access. If the two extreme amendments are rejected as anticipated, they can simply be discarded.

What is the other waiver amendment proposed by AHCA? Why is that amendment proposing to modify the MEDS-AD Waiver, not the Reform Waiver?

This amendment proposes perhaps the most extreme new measure of all, requiring that Medically Needy recipients, who incur catastrophic medical expenses, pay exorbitant monthly managed care premiums of up to thousands per month. (The few who somehow manage to pay can have up to 6 months of continuous coverage, however.) This component would then be tacked on to the existing MEDS-AD (Aged and Disabled) Waiver, which provides Medicaid coverage for selected seniors and people with disabilities with incomes slightly above the SSI level. One explanation for the addition of the new Medically Needy experiment to MEDS-AD is that both programs are perpetually on the chopping block in Florida. If Congress were ever to permit the Legislature to cut eligibility, both programs could be axed upon ending the single waiver. Ultimately, however, there are so many questions about the proposal that AHCA submitted this proposal in concept form only.

Where does the new proposed long-term managed long-term care component come in?

This is the focus of the only new Medicaid waiver applications submitted by AHCA: the combination 1915(b)/(c) waiver. Again, because of the Medicaid Reform foundation, seniors and people with disabilities who need long-term care - whether in a nursing home or a home/community-based setting as an alternative to nursing home placement - would be enrolled in managed care plans for their primary care, specialty care, etc., like other Medicaid recipients. Beyond that, however, most will also be enrolled in plans that will manage their access to long-term care services (including a financial incentive to keep them out of nursing homes).

The 1915(c) waiver would allow the State to provide long-term care services only to eligible recipients, as happens with all the current Home- and Community-Based Services Waivers. Most of those successful programs will be eliminated, however, and replaced by this experimental managed long-term care program. The 1915(b) would then allow the State to require recipients to enroll in managed care plans that would regulate access to those long-term care services. At least the State could not allow plans to reduce long-term care benefits below the Medicaid State Plan standard under the 1915(b)/(c) waiver.

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What would the proposed State Plan amendment do?

This would implement yet another of the extreme provisions added in the new legislation: forcing recipients with access to job-based coverage out of Medicaid as their primary coverage. Under this amendment, if recipients have access to coverage through an employer, no matter how limited or inaccessible, they would have to accept it as their main form of coverage, as long as the State determines that this is “cost-effective.” This “Force-Out” proposal would theoretically allow recipients to access other Medicaid services their plan does not cover through Medicaid providers they find on their own, but this is an arrangement that works much better on paper than in real life. Although this amendment is permissible in concept, the proposal is neither complete nor fully thought out, and so may be a “throw-away” like several other proposed waiver amendments.

Could all of the State’s proposals be approved? On the other hand, could CMS deny all of them?

Again, the ones that are the most problematic are separated out. For example, two of the proposed amendments add requirements that recipients start to pay premiums (unreasonable premiums at that) are specifically prohibited by the “Maintenance of Effort” (MOE) requirement of the Affordable Care Act. MOE prevents states from tightening or restricting Medicaid eligibility to protect the Medicaid safety net. The State cannot use a waiver to get around MOE.

As far as the overall Medicaid managed care experiment is concerned, again, the authority for much of what is proposed exists *already* through the Medicaid Reform Waiver, although only in 5 counties and for certain groups of recipients. CMS and AHCA are just finishing up negotiations on a multi-year extension of that Reform Waiver. In recognition of the problems with the 5-county Pilot, CMS has required a number of changes, however. Those changes are significant, and the modified requirements will carry over directly to the new experiment. Since a number of aspects of AHCA’s new proposal do not meet these modified requirements either, negotiations may become slow or stall, and the Legislature may need to make changes. At a bare minimum though, the Reform Waiver will remain in place for the foreseeable future.

8/10/11