Florida Medicaid Reform Waiver Application

SUMMARY

This is a summary of the waiver document Florida will be submitting to federal officials and the Legislature about Medicaid reform. It explains the highlights of the full waiver application. If you want details about a particular section, you can click on one of the links to go directly to that section of the waiver.

Sections I and II – Statement of Purpose and Florida Medicaid Reform

Medicaid provides health care coverage for low-income people. It uses both state and federal funds, and both the state and U.S. government have laws and rules that apply to Medicaid.

In Florida, the Agency for Health Care Administration is responsible for managing the Medicaid program. Other state agencies are also involved with Medicaid, either by providing services or handling Medicaid applications. The Department of Children and Families, for example, handles applications and makes decisions about who is eligible to receive Medicaid benefits. Other agencies manage programs that are funded by Medicaid. For instance, the Department of Elder Affairs manages long-term care programs for the elderly, while the Agency for Persons with Disabilities manages programs for the developmentally disabled. All of these programs require the cooperation of multiple state agencies.

Since Medicaid is jointly funded by the state and federal governments, both state and federal officials must agree on any major changes to the program. In Florida, this means that the Legislature must approve changes proposed for Medicaid. At the federal level, approval must come from the Centers for Medicare and Medicaid Services.

In May 2005 the Florida Legislature passed Senate Bill 838. It gives the Agency permission to change the Medicaid program. These changes are commonly referred to as “Medicaid reform.”

Every state has a Medicaid State Plan on file with the federal government. If a state wants to change the services it offers in ways that are different from the requirements for the State Plan, the state must ask federal officials to give special permission to set aside—or waive—those requirements. Florida has prepared an application it will submit to federal officials asking for permission to change the state’s Medicaid program. This is a summary of the waiver application Florida will submit.

Much of this summary is in question-and-answer form. It describes the major changes being planned and how those changes will affect you.

Why change the program?
Florida Medicaid began 35 years ago. It has made health care available to millions of Floridians. However, while Florida has changed—and the needs of its residents have changed—it has been difficult to make Medicaid change to meet those new challenges. The current system is based on illness. That is, providers get paid only when someone is very ill or needs costly services. The purpose of reform is to change the program so dollars are spent to keep people healthier. Such a program rewards delivery systems that do a good job of preventing illness by identifying chronic disease early, better managing those diseases, ensuring that children get preventive services, and helping our elders age in the dignity of their home or other community-based setting.

For a number of years Florida has operated some special programs under individual waivers of State Plan requirements. It is very complicated to operate so many waivers separate from regular State Plan services. The State Plan is not flexible enough to allow Medicaid to meet the needs of specific groups of enrollees.

As a result, too many people have to wait for special waiver services that they truly need, costs have been hard to predict, and access to care has become a growing problem. The proposed changes outlined in the waiver application are the result of months of study and discussion with people who are involved with Medicaid, including the Florida Legislature. Florida believes that through this new plan it can do a better job of serving Medicaid enrollees and make the best use of the state and federal dollars available to operate the Medicaid program.

Section III – Eligibility and Enrollment

Medicaid reform will not change who receives Florida Medicaid. The current eligibility categories and income and asset limits will be the same. If you want to receive Medicaid, you will still need to apply through the Department of Children and Families.

Do I have to be a part of Medicaid reform?
If you apply for Medicaid and your application is approved, you will receive a letter from the Department of Children and Families telling you that you are now on Medicaid. This letter will let you know if you will have to enroll in a reform plan.

During the first year, only Medicaid recipients who live in Broward and Duval Counties will be a part of reform. Some people on Medicaid will not be required to enroll in a reform health plan, but they may enroll in one voluntarily. The waiver application lists the required and voluntary categories in Appendix III.

I already have Medicaid; will I have to be part of reform?
If you are in a Medicaid managed care plan or on MediPass and live in Broward or Duval Counties, you probably will need to move to a reform plan. You will receive a letter when it is time for you to change to a reform plan. You do not need to do anything

until you are notified. People in Broward and Duval Counties who are not already in managed care or MediPass will be able to enroll in a reform plan if they choose.

I will need help choosing a plan.
Choice counselors will help you choose your plan. You may talk with a counselor by phone or in person. The choice counselors will have information on the benefits available in each plan, what providers are in the network, and a variety of other information helping you to compare the plans. They can answer your questions about any Medicaid plan. If you have health insurance available through your job, the counselors also can help you decide whether to enroll in employer-sponsored insurance or in a Medicaid plan, but you will need to bring information about any non-Medicaid plan with you when you talk with the counselor.

It is important to enroll with a plan as soon you are notified that you can receive Medicaid coverage. If you do not choose a plan within 30 days, you will be assigned to a plan. You know best what your health needs are, and you will want to make the choice of plans yourself.

In addition to information on choosing a plan, the choice counselors will help you understand how to receive services through the plan you choose. They will also have information on preventive health care services that you and your family should receive to maintain your health or, if you have a chronic condition, information that will help you manage your disease.

What if I don't like my plan after I enroll?
You will have 90 days to change plans if you want to. After 90 days you will not be able to change plans for the next 12 months unless you have an approved reason to change.

Section IV – Benefits

Not everyone needs the same health care services. One plan does not fit all. One of the goals of Medicaid Reform is to help people find the health care that best fits their needs.

Under reform every Medicaid health plan will offer a core set of required benefits. But the plans also will be able to adjust some benefits to meet the special needs of the people they hope will enroll in their plans. These are called "customized benefit packages."

The state will regulate all the Medicaid plans to make sure the benefits your plan offers are equal in value to the other plans available to you, and that the benefits are appropriate based on the needs of the population the plan is going to serve.

As a new option, instead of enrolling in a Medicaid plan, you may want to use your Medicaid premium, calculated by the state, to pay for coverage through a private plan or to pay your share of the premium for coverage available at your work. This option is

explained in more detail later. The section below discusses benefits available through Medicaid plans.

You can choose a customized benefit package.
When a plan is "customized," it means it has been adjusted to meet the needs of certain groups. Here is an example: A plan may decide it wants to focus on serving children with special health care needs. This plan might include case management, home care aides, respite services for caregivers, and other services not currently available outside special waiver programs. Or a plan may want to focus on serving the AIDS population. In addition to all required services such as hospitalization, this plan might include case management, expanded drug programs, and other services focusing on the specific needs of patients. Other specialty plans may include children's networks and general plans that provide a broad range of services without any focused population in mind. Ultimately, the decision about which plan to enroll in will be yours.

If the plan has to cover core Medicaid benefits, how can it customize a package?
Every plan must offer core Medicaid services, but, with state approval, a plan can change how much of each required service it provides. If a plan reduces one service, it must increase one or more other services because all plans must be of equal value.

All plans may be of equal value, but how do I know if a plan covers the services I need?
The state will regulate the Medicaid health plans. To receive approval for its benefit package, a plan will have to prove that the benefits it offers will meet the health care needs of the people it seeks to enroll. The state will review past Medicaid data on people like those the plan wants to enroll. It will compare their use of services against those the plan wants to offer. You will need to look at the services each plan offers and decide which plan is best for you. Medicaid will help you make that choice by providing counseling and information before you enroll. If you decide within the first 90 days after you enroll that you chose the wrong plan, Medicaid will help you change plans. After the first 90 days you will have to stay in that plan for one year.

Will all current Medicaid services be available?
Some Medicaid services are required under federal law. All of those will be offered by all plans. Other services are optional, meaning the Florida Legislature can choose which ones the state will offer. The state expects all plans to offer all the current mandatory and optional services, such as prescription drugs, behavioral health, transportation, hospitalization and all other services outlined in law. Plans may also decide to offer additional services you need that are not covered now by Medicaid. The level of those services will vary from one plan to another. This is why it is so important to study the plans available to you and make the choice that is best for you and your family.

What do the terms "comprehensive" and "catastrophic" mean?
These terms apply to the way the state pays the health plans for your care. The difference between the comprehensive level of care and the catastrophic level will not be important to you because it relates only to methods of financing the networks offering

care. No matter what, the network you choose will be responsible for providing the covered services.

Under Medicaid Reform the state will make a monthly payment to your health plan. It is basically an insurance premium. In exchange for that payment, your health plan will be responsible for making sure you get the health care you need under Medicaid.

Some people need a great deal of medical care; others need very little. If the cost of your medical care goes beyond a certain level, it becomes known as "catastrophic" care. When an enrollee is at a catastrophic level of care, the way the state and the health plan pay for that care may change. For example, the state may take over payment of the additional costs.

The payment arrangements will be taken care of between the health plan and the state. You will not need to worry about the change in the way the bills are paid. Because this is an important part of making sure that Medicaid Reform is built on sound business practices, these details must be included in the information Florida provides to the federal government, the Florida Legislature, and the participating health plans.

Is there a maximum benefit?

Medicaid, like other insurance programs, has service limits. These might be limits on the number of times you can receive a certain service in a year or limits on the kinds of service. For example, right now in today's Medicaid program, outpatient hospital services are limited to $1,500 per year for an adult; eyeglasses for adults are not covered; there are limits on home health visits and the types of other services you receive on an outpatient basis. Once the limit of the benefit is reached, Medicaid no longer pays for the service.

Under reform there will still be limits, and there will be a maximum dollar amount of coverage each year per person. The maximum amount will be very high, and very few people will ever reach the maximum benefit amount. The maximum dollar amount will not apply to children or pregnant women.

Will I have to pay more of the cost myself?

Medicaid already has two kinds of cost sharing. Medicaid providers can either collect the cost sharing fee or they can choose to waive the fee. Some services require a copayment, which is a set amount per service. For example, a visit to the doctor requires a $2 copayment. Some services require coinsurance, which is a percentage of the cost of the service. For example, visits to the emergency room for a non-emergency reason require a payment of 5 percent of the first $300. That is coinsurance. A complete list of current Medicaid cost sharing requirements is on page 25 of the waiver application.

Under reform, Medicaid health plans can require cost sharing that does not exceed the current amounts. The plan will also have the flexibility to not require any cost sharing. People who choose not to enroll in a Medicaid plan, and instead enroll in private plans

or in a health plan through their jobs, may have different copayment and coinsurance requirements.

What are enhanced benefits?
Medicaid wants to encourage people to make healthy choices and engage in activities that will help keep them from getting sick. People in Medicaid plans will be eligible for enhanced benefits if they take part in specific activities. The goal is to reward healthy behavior.

You will receive information on the activities that will earn enhanced benefits for you. When you complete one of the activities, money will be deposited in an account for you. You will be able to use the money in that account to pay for health services that are not already covered by Medicaid. This could include over-the-counter medicines like aspirin and vitamins or payment for routine adult dental care, for example. If you leave Medicaid coverage, you still will be able to use the remaining funds in your enhanced benefit account to help pay for other health insurance. The state may contract with a company to operate the enhanced benefits program.

Section V – Opt-Out: Private or Employer Sponsored Insurance

For the first time, Medicaid recipients will be able to choose between enrolling in a Medicaid plan or in a health insurance offered where you work. If you have insurance at your work and have not enrolled because you felt you could not afford the premium, Medicaid may be able to help you with the cost of the premium. Instead of paying your monthly Medicaid premium to a Medicaid plan, the state would pay it to the employer or private insurer. Through employer-sponsored insurance, the state may be able to pay for coverage for your whole family.

If I opt-out of Medicaid, does that mean I am no longer a Medicaid recipient?
Medicaid will pay all or part of your premium as long as you are eligible for Medicaid. However, you will receive health insurance through the same insurer as all of your coworkers. Your benefits will be different from the benefits you would have in a Medicaid plan. You would receive health care under the benefit plan offered by your employer's health plan. You would use that plan's doctors, pharmacies and other providers to receive the health care that you need. They would not have to be Medicaid providers.

How do I know if my employer's health insurance is right for me?
Choice counselors will be available to help you understand the differences between the Medicaid plans and other health insurance available to you. It is very important to understand the differences in the plans so you can make an informed decision about which plan is best for you and your family. You need to get information from your employer or private insurer so you can make the right choice. Your choice counselor can help you.

If I choose my health insurance at work, but don't like it can I change my mind?
You can make a change in employer-sponsored insurance only at certain times. These times include the annual open enrollment period and when you have what is known as a "qualifying event." A qualifying event includes marriage, divorce, and the loss of coverage, either because you are no longer working or because your employer stops offering insurance.

Will I get all the same services if I choose a plan outside of Medicaid?
You may or may not get the same services. Just as Medicaid requires that certain services be available, the state requires private insurers to offer certain benefits, but the total benefit package will be different for each plan. That is why it is so important to work with the choice counselors so they can help you understand these differences.

Will I pay more out of my pocket if I choose my health insurance at work?
The health insurance plan offered at your work will probably have different cost sharing than Medicaid. The amount of cost sharing will vary among employers. If you are thinking about enrolling in the health insurance plan at your work, you will want to find out what the cost-sharing requirements are. Your choice counselor can help you understand cost sharing.

Section VI – Delivery Systems

If you already participate in Medicaid, you may already be enrolled in a managed care program. It may be a health maintenance organization (HMO), MediPass, or one of several localized networks of providers serving Medicaid enrollees. Medicaid reform will increase the number of managed care programs that offer Medicaid health plans.

People who live in Broward and Duval Counties will have the first chance to select from the new range of Medicaid health plans. The goal is to improve your ability to find the health care you need, and to give you more choices in how you get your care.

How can I tell the difference between the types of health plans?
A choice counselor will help you understand the differences among the plans available to you. While plans may have different names, no matter what a Medicaid health plan is called, you can be sure that it has been approved by the state, offers all the Medicaid benefits needed to serve its enrollees, is financially sound, has enough providers, and is being reviewed regularly by the state.

The important decision you will need to make is what health plan offers the benefits that best fit your needs. The technical or legal designation for your Medicaid health plan is not a major part of deciding which plan to choose, so do not be confused when you hear terms like "HMO" or "PSN." You should carefully review the services offered by each plan. While the value of the overall benefit package in each plan will be equal, the benefits themselves may be different from one plan to another. For example, a plan designed to serve elders might have a benefit package that is somewhat different from

a plan designed to serve children. A unique new benefit of the choice counseling will be that the state will begin to measure the performance of each plan. When that data is gathered, you will get information about consumer satisfaction with access to doctors, the effectiveness of the plan in providing children's preventive health services, vaccinations and preventive dental care, and other measures important for you to know before you select a plan. The state believes having this information available to potential customers will give the plans even more reason to make their services responsive to your needs.

If you do have a problem with your health plan, you will be able to have your problem reviewed by health plan officials. If the problem is not resolved there, a state panel will be available to you. You also have the right to request a separate Medicaid Fair Hearing.

What if I have special health care needs and need a lot of care?
If you have a chronic health condition, such as diabetes or heart disease, are disabled, or have other serious health problems, being able to see people who specialize in treating your condition is very important. Under reform, health plans will be encouraged to develop specialty plans to serve specific health conditions. These specialty plans must meet additional requirements to make sure they can handle the complex needs of their enrollees. These plans will be paid a premium that is adjusted to take into account the higher cost of your care.

Can I enroll in a health plan that is not a Medicaid plan?
Yes. If the place where you work offers health insurance, your Medicaid premium can be paid to that insurer instead of to a Medicaid plan. Most employers who offer health insurance require the worker to pay part of the cost. Medicaid would pay that cost for you up to the limit of the premium it would have paid to a Medicaid plan. If your share of the insurance through your job is more than the Medicaid premium, you would have to pay the difference. You might be able to get coverage for your entire family in a work-based insurance plan. Offering people a way to get maximum coverage for their families is one of the goals of Medicaid reform.

Choice counselors will be available to answer your questions so you can decide whether to enroll in a Medicaid plan or to enroll in a plan outside of Medicaid. If you do enroll in a plan outside of Medicaid, you will have time to change your mind and enroll in a Medicaid plan instead. It is important to understand that private plans and work-based plans will have benefits that are different from Medicaid. Copayments, coinsurance, and deductibles also will be different. You will want to study the differences very carefully before you make a choice.

Section VII – Implementation Timeline

Senate Bill 838 starts Medicaid reform in Broward and Duval Counties. That will happen as early as April 2006. Within one year, the program will expand to Baker, Clay and

Nassau Counties. In this waiver application, the Agency outlines some of the key points that will be addressed in planning for expansion to the rest of Florida.

Sections VIII and IX – Accountability, Monitoring and Evaluation

Medicaid reform will have many safeguards to make sure people get the care they need under the new system. These safeguards also will measure whether the changes make the program better. The state will review each Medicaid plan regularly to check on access to care and the quality of that care. Plans will be required to meet a set of standards and will be penalized if they do not meet the standards.

What if my plan denies a health care service?
Each plan must have a way for its enrollees to appeal if a service is denied. If you do not get the result you want by appealing to the plan, you will be able to bring your appeal to a state panel for a further hearing, and there will be procedures to speed up this review when necessary. You also will continue to be able to ask for a Medicaid Fair Hearing, just as you can do today. Importantly, the Agency for Health Care Administration will be monitoring Medicaid plans. If a plan accepts the payment from the state, and then refuses to provide medically needed services covered by the plan, the Agency will move quickly to take action against the plan, up to and including termination from the Medicaid program or prosecution. It is the intent of the state to ensure Medicaid consumers receive the services they need and that they may reasonably expect from the plan they have chosen.

Section X – Waivers

The Medicaid program is governed by many different sections of federal law. To make changes to the program, the Agency must identify each section of law it is asking to have waived. Section X lists all the sections of federal law that Florida wants to be waived.

Section XI – Budget Neutrality

The state estimates that Medicaid Reform will cost no more than the program would cost if it continued to operate in its present form. Budget neutrality is one of the keys to meeting federal requirements for approval of a waiver. The waiver provides details on how cost estimates were calculated for the waiver. It projects reductions in the rate of increase of both use of services and payment rates. The waiver assigns the savings to a Low Income Pool that will be available to provide access to health care services for uninsured low-income people who do not qualify for Medicaid.