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September 28, 2005

Alan Levine, Secretary
Agency for Health Care Administration
2727 Mahan Dr. MS #8
Tallahassee, Fl. 32308

Re: Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver,
August 30, 2005

Dear Secretary Levine:

This letter is submitted to you on behalf of Florida Legal Services, Inc. (“FLS”). FLS is a nonprofit organization which provides civil legal services to low income individuals and families, including Medicaid beneficiaries. We appreciate the opportunity to provide comments on the recent Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver (hereafter “the Waiver Application” or “the Application”).

While we vigorously support efforts to give Medicaid beneficiaries greater access to quality care, *we urge the state to move slowly and carefully* in implementing significant changes to the current program. When the state acts too quickly to implement major changes, Medicaid beneficiaries get hurt and increased health care costs are incurred, as well as cost shifts to safety net providers, local government and taxpayers. *See Profits From Pain* series, December 10, 1994-November 26, 1995, Fred Schulte, Jenni Bergal, Ft. Lauderdale Sun Sentinel series (excerpts enclosed). Further, the state’s recent experiences with increased privatization of governmental services and the new prescription drug restrictions underscore the need for a cautious approach, including sufficient resources for strong governmental oversight (*See* enclosed articles).

After reviewing the Waiver Application, we have the following questions and concerns:

Budget Neutrality Agreement:

Of greatest concern is that the budget for the Waiver proposal is not limited to the pilot counties designated in SB 838. This means that nearly 2 million Florida Medicaid recipients statewide will be subject to a single, statewide budget cap from day one of the Waiver. For those recipients outside of the pilot counties, the Waiver Application lacks any assurances that the

current benefit package for recipients outside the pilot areas will not be cut, particularly when overall program funding is capped and the state needs more dollars for the pilot areas to “ensure success.”

The exact financial risk that the state will be taking on remains unclear. The Application does not say whether the state is seeking a global cap on spending and/or a per capita cap. Either way, the state is taking a gamble that it will be able to pay for health care for our most vulnerable citizens over the next five years, regardless if the federal funding runs out, while this type of gamble requires caution, the Waiver Application is taking a very “high-stakes” approach by immediately making nearly all Florida Medicaid recipients subject to a statewide funding cap.

Children’s Services

We are pleased that state officials have indicated they are not seeking to waive EPSDT services mandated in federal Medicaid law. However, the terms and conditions in the Waiver Application must unambiguously reflect this position. We are concerned about the blanket request on page 61 of the Application to waive amount, duration, scope and comparability protections in federal Medicaid law which fails to specifically exclude recipients under age 21 from this waiver. Therefore, we suggest that the state include language specifying that this waiver request is sought only for Medicaid recipients 21 or older and for recipients younger than 21 who have opted out of Medicaid and enrolled in an employer-sponsored or private plan.

Over half of Florida’s Medicaid population are children. Despite the fact that children who do not opt out of the program will retain the EPSDT benefit, under the Application all of these children will nonetheless be subject to an 1115 federal funding cap. The state will have the legal responsibility to provide all EPSDT services to Medicaid-eligible children with no guarantee that federal funding over the next five years will be sufficient to meet those responsibilities. If the state’s goal is to move more children into capitated care plans, for most Medicaid-eligible children, this can be achieved without an 1115 waiver or its accompanying funding cap. We urge the state to try this option before putting Florida children’s health care at risk due to insufficient funding.

In addition to an overall Medicaid program funding cap, we are concerned about how the “individual dollar threshold” as described on page 22 of the Waiver Application will impact access to EPSDT services. (*“The state will establish the individual dollar threshold which will be in effect for all enrollees of the plan.”*) While the Application states that children will not be subject to an overall maximum benefit level, what will happen to children who exceed their individual dollar threshold? Will the state or plans be responsible for providing all EPSDT services (including unlimited hospital inpatient days) beyond the dollar threshold? Which entity will manage the child’s care when they have exceeded the “catastrophic care component?”

Opt Out Option:

Individualized and careful choice counseling will be critical in ensuring that families who choose this option are not harmed. Most private plans will have fewer benefits than the current Medicaid package and will require significantly more cost-sharing. This could have disastrous consequences for low income families who experience an unexpected illness or accident. The Waiver Application (pp. 31-32) expresses a preference for enrollees opting out of Medicaid (e.g. recipients can opt out at any time). However for most families, this is not a good option, and if selected enrollees will be locked in for at least one year. Will there be special protections in the choice counseling program for Medicaid beneficiaries with disabilities? For example, under Florida law, private insurance policies may exclude coverage, as provided through a preexisting condition clause, for HIV infection or AIDs. *See* p. 106 of the Application. What happens if a family with an HIV-infected child selects the opt-out option without fully understanding a pre-existing condition exclusion in their private plan? Under the waiver proposal the child may not be able to get any medical treatment for HIV for up to a year. Another likely scenario is after a family chooses to opt-out, their child becomes very ill, the private insurance benefit package is insufficient to meet the child's needs, but they are locked out of the Medicaid program for a year. We recommend that the state have some provision for families to opt back into the Medicaid program in these types of circumstances.

Based on the experience of other states which have implemented premium assistance programs, it is expected that enrollment in such a program in Florida will be very low. Has the state made any projections of what the enrollment will be in this program and the costs associated with running the program? What is the minimum enrollment needed to justify the costs of administering such a program?

We recommend that the evaluation component of the Waiver Application include research questions directed to determining the impact on children's access to medically necessary health care services when their families opt-out of the Medicaid program and lose access to the EPSDT benefit.

Services for Persons with Disabilities:

Under the Waiver Application, plans are given flexibility to vary the current Medicaid benefit package and it is expected that "[s]uch packages will more closely resemble private plans." p. 16. The effort to promote Medicaid benefit packages that look more like private insurance is a concern. Historically, private plans have not enrolled persons with significant disabilities (such as SSI recipients) and their benefit packages have not been tailored to meet the needs of this population. It is likely that SSI recipients will be disproportionately adversely impacted by this change because they require more services than other target populations. Since plans are not able to vary benefit packages for children and pregnant women, savings will likely come from benefit packages for adults with disabilities.

It is unclear how the "actuarial equivalence" or "sufficiency" standards specified in the

Application will ensure that adults with severe disabilities get medically necessary services. Both of these standards appear to be based on what is needed for the “average member” of the population or the “vast majority” of enrollees. *See* p. 18 of the Application. Where does that leave individuals in the minority who need an “above average” level of services? Currently SSI recipients who have severe illnesses and need an extraordinary level of services have a guarantee of coverage and are not limited by a dollar threshold. Under the Waiver Application, those individuals who are the frailest and sickest are most at risk of not getting medically necessary care because their medical needs fall outside of the “average” range of service needs.

It appears that not all reform plans will have to offer a benefit package for SSI recipients. If this is true, will SSI recipients in each demonstration area have a choice of at least two plans? What happens when a healthy adult suddenly becomes disabled? Will they have an opportunity to disenroll from their plan and select a plan that better meets their newly increased medical needs?

Once a plan adopts a benefit package for SSI recipients will the plan be permitted to change the package during a recipient’s lock-in period? If so, this will create additional problems for recipients who have selected a plan based on their particular medical needs and the array of services offered.

MediPass & Enrollee Choice:

The waiver application states: “Enrollees in the demonstration sites will initially have the choice of enrolling in a reform plan or to opt out of Medicaid. At a minimum, an individual in a demonstration area will have a choice of the following: One reform plan and MediPass or two or more reform plans. p. 12

We are uncertain of the definition of a “demonstration area” for the purposes of this section. Does it mean that for each county, there must be at least two reform plans available in that county before the MediPass option will be eliminated for recipients? Will there have to be a minimum of two reform plans that have benefit packages for each target population?

It is unclear whether the reference to MediPass in this section is a reference to the MediPass program that currently exists (a fee-for-service primary care case management program). Also, the Application does not address what will happen to the MediPass program over the life of the waiver. We urge AHCA to maintain the current MediPass option, particularly for SSI recipients. If the MediPass option is eliminated, in the initial demonstration counties alone (Duval and Broward), there are nearly 60,000 SSI recipients who will be forced to switch plans and possibly treating physicians. This disruption in care may be life-threatening for some SSI recipients with severe and chronic illnesses.

Further, there are over 30 Florida counties which do not currently have a Medicaid

managed care plan and it remains highly uncertain that plans will initiate business in many of those counties. MediPass must remain a viable option for those areas of the state. However, MediPass is already woefully underfunded and if case management fees and provider reimbursement rates remain the same, doctors will continue to drop out of the program and it will no longer be a viable option. A statewide plan for Medicaid reform must include increased funding for MediPass providers.

Choice Counseling/Plan Assignments:

Implementation of the choice counseling plan in the Waiver Application is impractical within the specified time frames, and punitive for beneficiaries who are not currently enrolled in a capitated plan. We know of no other state in the country that terminates a recipient's Medicaid eligibility during the time period in which the recipient is attempting to make an "informed choice" of health plans. Instead of promoting responsible decision-making, this proposal forces recipients to make any "choice" as quickly as possible just to have their coverage reinstated.

Notably, the individuals who disproportionately will be impacted by this loss of Medicaid benefits are the elderly and/or recipients with disabilities who are more likely to have ongoing treatment regimens disrupted due to a loss of Medicaid eligibility. What does this mean for the recipient in the midst of a course of chemotherapy for cancer, or the recipient with a severe psychiatric illness who needs daily medication to stay out of the hospital?

Further, the time frame for providing "choice counseling" is completely unrealistic. In previous years, Medicaid recipients had a 60 day window in which to pick a plan. When that window was reduced to 30 days, the demands on the choice counseling Medicaid Options phone line substantially increased, more calls went unanswered and default auto-assignment rates went up. The face to face counseling option is critical, particularly for Medicaid recipients with disabilities. However, given the number of recipients needing this service, as well as the complexity of sorting out multiple benefit plans and matching them with individual recipient needs, a 30 day choice counseling window is not sufficient.

The choice counseling program envisioned by the Waiver Application and SB 838 is more comprehensive than what currently exists and will require additional resources and staff. Has the state projected the costs for implementing this more comprehensive program? Have these costs been factored into the projected costs of the waiver?

The Waiver Application indicates that the state will use certain criteria to make assignments to plans for Medicaid recipients who do not voluntarily choose a plan, including assigning SSI recipients to providers with whom they have an ongoing relationship. p. 10. These assignment criteria have been in Florida law for almost a decade. *See* 409.9122, Fla. Stat. However, despite repeated efforts, we have never received confirmation that the state has actually operationalized implementation of these criteria. In fact, we periodically hear from SSI recipients who have been auto-assigned to a managed care plan and can no longer see their ongoing treating physician because that physician is not in the plan.

Cost-sharing:

We are pleased that the state is not seeking to waive the cost-sharing limits included in current federal Medicaid law. However, we think the Waiver Application is somewhat misleading in suggesting that Medicaid HMOs currently have cost-sharing requirements for their enrollees. *See* pp. 24-25. Under Florida law, Medicaid HMOs are expressly prohibited from imposing any cost-sharing on Medicaid enrollees. *See* 409.9081(3)(f), Fla. Stat. Under the Waiver, plans will now be able to charge these enrollees copayments. This is a cut in the current benefit package for Florida Medicaid HMO enrollees. Also, the Waiver Application should clarify that plans charging co-payments will be required to abide by the federal requirement that services cannot be denied to Medicaid beneficiaries who are unable to pay the co-payments. *See* 42 U.S.C. 1396o(e).

Quality Strategy:

This section of the Application (p. 53) specifies that AHCA will rely, in part, on encounter data and external quality reviews to ensure the appropriateness of care delivered by managed care plans. However, in response to a recent public records request, FLS confirmed that the state is not currently collecting encounter data from plans or providing for external quality reviews of any of its Medicaid capitated care providers. We understand that AHCA has plans to contract with an external quality review organization (EQRO) in 2006 and intends to implement an encounter data system through its new fiscal agent EDS. However, that contract will not be in effect until 2007 and the state's complete lack of experience in these critical areas underscores the need to proceed cautiously and slowly.

Encounter data is essential to adequately gauging whether Medicaid recipients are well served through capitated plans. The state's own 2004 Medstat report acknowledges the limitations of the current data collected by AHCA and the importance of encounter data:

While the current MCOs submit a number of summary level reports to support performance monitoring, detailed service-level information is not currently available. AHCA needs a more comprehensive, detailed, objective, and flexible information source to fulfill its fiduciary responsibilities and monitor the quality of and access to care, especially as its contracting relationships and the types of MCOs under contract continue to change and expand.

While many other states with large Medicaid programs have been successfully collecting and using encounter data for some time, Florida remains one of the few states yet to implement an encounter data system.¹

Setting up a reliable encounter data system is at least a 2-3 year project. Under Florida's

¹Florida Agency for Health Care Administration, Medicaid Encounter Data System (MEDS) Strategic and Implementation Plan, prepared by Medstat, submitted June 30, 2004, p.1.

projected time line, this project will not even begin until 2007 which means that at best a reliable data collection system will not be in place until 2009-2010, the end of the demonstration project.

The state's lack of encounter data or any external reviews will obviously impair Medicaid consumers' capacities to make "informed" plan selections. In addition, it will be very difficult for the Legislature to perform its fiduciary duty of adequately overseeing this demonstration and assessing whether the investment of millions more of public dollars into Medicaid capitated plans is money well spent.

Unlicensed HMO Certification:

The proposal indicates that capitated plans which are not licensed HMOs (PSNs) will have a different set of requirements to meet in order to be certified. Those requirements are not specified in the proposal. Although the state currently has some PSN contracts, it is not clear how those standards differ from licensed HMO standards; whether PSNs will be required to meet the standards that exist in the current PSN contracts; or whether the state intends to adopt some other standards.

We fear that creating different standards for licensed and unlicensed HMOs could lead to a re-play of the problems Florida Medicaid beneficiaries encountered during the early 90's when the Medicaid agency, eager to increase capitated plan enrollment statewide, permitted unlicensed HMOs into the Medicaid market. The ensuing fraud and scandals which accompanied these "fly-by-night" plans created a "black-eye" for the entire Medicaid managed care field of players. Similarly now, in a rush to expand capitated care plans statewide, the state should not make the same mistake of adopting "lesser" quality, access, fiscal or oversight standards for these unlicensed entities.

Evaluations and Implementation Time Frames:

It is critical that a thorough, objective and independent evaluation be done of Phase I of the demonstration *before* moving to statewide implementation. It is anticipated under SB 838 that OPPAGA will complete an evaluation within 24 months after implementation of Phase I. Under the Application projected time frames, this will occur no later than June 2008. The concern is that this evaluation will be done *before* the state has a reliable encounter data system in place.

Additionally, PSNs are not subject to capitated rates until three years into the project and *after* the Phase I evaluation is due. Capitated PSNs are totally new players in the Medicaid managed care arena and will not be subject to HMO licensing requirements. The Waiver proposal heavily relies on the PSN concept, particularly for those areas of the state currently without any Medicaid HMOs. It is essential that the initial evaluation include information about PSNs' performance under a capitated system.

Clearly, a longer period of time is needed to complete evaluation of Phase 1. Such an

evaluation *must occur before* statewide implementation of a reform plan that fundamentally re-structures the entire Florida Medicaid program.

Consumer Advisory Function:

The Waiver Application emphasizes the importance of “empowering” Medicaid consumers. One way to do this is by complying with the federal Medicaid law which requires the state to have an active Medical Care Advisory Committee (MCAC). The MCAC must include Medicaid consumers. *See* 42 U.S.C. 1396a(a)(4); 42 C.F.R. 431.12 Although federal law requires that the MCAC have the opportunity to participate in program policy development, the Florida MCAC has not met since 2000, well before the State started to promote the Medicaid reform 1115 waiver.

State law also requires that the agency consult with Medicaid consumers and their representatives on an ongoing basis regarding Medicaid managed care services *See* 409.9122(10). Again, while the Advocacy and Consumer Workgroup on Managed Care Issues was established by AHCA for this purpose during the late 90's, in recent years, that group has met only very sporadically and not for the purposes of “consultation” but merely to report agency decisions and policies that have already been adopted.

Although the Agency is holding various public meetings on its Medicaid Reform proposal, this is not the same as empowering specific consumers who are committed to developing expertise about the Florida Medicaid program and providing the Agency with ongoing consumer perspectives and input on program issues. Now, more than ever, it is imperative for the agency to put a priority on developing this Medicaid consumer resource.

We appreciate the opportunity to provide these comments and look forward to continuing our discussions with you on Medicaid Reform.

Sincerely,

Anne Swerlick
Deputy Director