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New Medicaid Managed Care Law Imperils Patients to Accommodate Plans

Although Florida has spent the last five years struggling with a flawed Medicaid managed care experiment that could not be expanded beyond a few counties, the passage of House Bills 7107 and 7109 during the 2011 legislative session nevertheless accelerates and intensifies the statewide privatization of Florida Medicaid. The final legislation, while not as extreme as the proposal offered by the Florida Senate, imperils the health care of the three million Floridians who rely on Medicaid.

The justification for pressing forward consisted of inaccurate depictions of the key problems and concerns with the current Medicaid system, as well as of their root causes and of the best tools available to address them.

Legislators proceeded with expanding Medicaid managed care despite the disconcerting track record established by such plans in the "Medicaid Reform" experiment launched in 2006.

In particular, legislative leaders had insisted throughout the previous year that expanding capitated managed care statewide – building on the five-county "Medicaid Reform" experiment launched in 2006 – was critical to assuring the sustainability of Florida Medicaid. They proceeded despite the disconcerting track record established by Medicaid managed care plans in Florida, which casts serious doubt on their ability to achieve the desired cost savings without jeopardizing access to care for vulnerable Floridians. In fact, in their zeal to achieve Medicaid savings on a scale that could offset the effects of their unwillingness to generate sufficient revenue to meet the state's basic needs, the legislature extended the experiment to unprecedented lengths.

The state will face intense scrutiny by federal officials responsible for approval of the proposed expansion, however, as many rules and protections would need to be waived for Florida to implement the new legislation. That scrutiny is in fact already underway as part of federal review of the pending request for extension of the waiver authorizing Medicaid Reform, the foundation upon which the new legislation seeks to build. The brief reviews the flawed assumptions under which the legislation was approved and three particular elements of the proposal to be submitted to federal officials this summer: 1) extreme copayment and premium requirements, 2) siphoning of resources intended for patient care to plan profits and administration, and 3) unprecedented authority for plans to vary their benefit packages.

Using Total Medicaid Spending as a Distraction from Real Concerns

Legislative leaders justified the need for passage of this extreme legislation with claims of a historic crisis – a Medicaid budget spiraling out of control – and of a dire need for more predictability in Medicaid spending. Such claims were not only highly misleading, they also gave rise to "solutions" to false problems while distracting attention from the real concerns.

Although *total* Medicaid spending is the largest single spending category in the state budget, it is only because of the tremendous return the state reaps on its investment in Medicaid. Every dollar of state funding invested in Medicaid in 2011-12 will draw down an additional $1.27 in federal matching funds that would otherwise be lost to Florida and Florida's economy.[1] Even that figure understates the reality, however, because a portion of "state" dollars are generated locally and funneled to the state for the purpose of drawing down matching dollars. Thus every dollar of state general revenue invested in Medicaid will leverage more than another $3 in the next fiscal year.[2]

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Moreover, the primary factor driving recent Medicaid spending increases is the sharp increase in the number of the Floridians who have been forced to rely on it as a result of the job, income, and health coverage losses during the recession and its aftermath. The rate of enrollment growth has actually outpaced the rate of spending growth.[3] In fact, average total Medicaid spending per recipient in 2010-11 will be *less* than in 2007-08.[4]

The Misdirection of Medicaid Expansion

Legislative leaders also claimed that the urgency about "runaway" Medicaid spending is heightened by the "imminent" increase in enrollment resulting from the passage of the federal Patient Protection and Affordable Care Act (PPACA) and its impact on Florida's budget. Those claims are overstated on several counts.

By way of background, under PPACA, most Floridians with household incomes below 133 percent of the federal poverty level ($24,600 annually for a family of 3) will become Medicaid-eligible as of 2014.[5] This will be an increase in the income limit for all current eligibility groups in Florida except for children under age 6 and pregnant women. For example, unemployed parents and individuals with disabilities are currently eligible only up to 26 percent and 75 percent of the poverty level, respectively.[6] Additionally, childless, non-disabled adults who are too young to qualify for Medicare may qualify for the first time.

First, Medicaid expansion under PPACA will not even begin for another two and a half years, well into a period when Medicaid enrollment levels are expected to level off as Florida's economic recovery continues.[7]

An estimated 1.1 million uninsured Floridians will become Medicaid-eligible for the first time as a result of expansion[8], and a much smaller group of low-income Floridians with unaffordable or inadequate coverage might also sign up for Medicaid. However, the number who will enroll, the pace at which they will enroll, and the resulting cost borne by the state have been drastically inflated.

Second, Florida will pay *nothing* to provide coverage for newly eligible recipients through 2016.[9] The entire cost of expansion will be federally funded for the first three years. After that, the state will make a small contribution to the cost of expansion. In 2017, for example, the state share of expansion cost will be 4 percent, less than one-tenth of Florida's traditional match rate. Florida will not begin paying its "full share" of Medicaid expansion costs – 10 percent (10 cents of every dollar) – until 2020.

The Illusion of Managed Care Expansion as Patient-Centered

Another stated impetus for making changes to Medicaid was concerns about quality of and access to care delivered through the Medicaid system. Sponsors of bills to shift Medicaid to a managed-care program repeatedly cited the need to create a more "patient-centered" system. Yet the legislation places little emphasis on patients and their interaction with health care providers or their relationship to the health care system. Rather, the focus is placed squarely on managed care plans and the need to make turning over the responsibility for the direct administration of Medicaid attractive to and safe for them.

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The disconnect between the legislators' stated interest in a patient-centered approach and the actual content of the legislation is apparent from a review of the process by which medical practices can be recognized as "patient-centered medical homes" by the National Center on Quality Assurance (NCQA).[10]

The NCQA's project reflects the growth of a national movement promoting the use of the patient-centered medical homes model. NCQA-recognized medical homes demonstrate patient-centeredness through incorporation of specific elements that include "team-based care", reliance on patient level data to inform care, use of evidence-based guidelines, support of patients and families with information and tools, and the tracking and coordination of testing, referrals and transitions of care.[11]

By contrast, the new Florida law is based on principles that differ from the patient-centered approach, in particular the assertion that "managed care [in and of itself] holds the most promise for better patient outcomes and more sustainable growth" in Medicaid.[12] With respect to patient-centered care, the same set of principles states only that this includes "customized benefits packages and plan choice." "Patient empowerment", by contrast, is described simply as the ability to use Medicaid funds to purchase forms of health coverage *other than Medicaid*.

In fact, almost nothing in the legislation itself addresses the configuration of the Medicaid system and the delivery of care at the patient level. Plans do receive a competitive advantage, albeit an unspecified one, in the plan-selection process for implementing patient-centered medical homes. However, plans can seemingly define a patient-centered medical home as they see fit. Further, this is the *only* reference to patient-centered care in the legislation.[13]

The Alignment of the Demand for Predictability With the Push for Profit

Citing the arguments discussed above – like spiraling Medicaid costs – legislative leaders have insisted that they must secure "predictability" in the Medicaid budget, and that this is only possible by shifting oversight responsibility for the delivery of care from the state through privatization. To implement this agenda, legislators had a natural and supportive group of allies in for-profit managed care plans.

In general, "managed care" is a broad term that could apply to any of a wide range of approaches to organize, coordinate, and/or regulate the use of health care services to achieve certain system-wide goals (such as increased access to care or improved health outcomes) in a manner that also controls costs. A basic tenet of the managed care model is that system changes result in cost containment, not vice versa.

Medicaid HMOs are placed at financial risk to deliver the care that their enrollees need. If providing the necessary care costs more than the contracted payments they receive, Medicaid HMOs (and their investors or shareholders) agree to take a loss. More realistically, however, their sustained participation in Medicaid is contingent upon their profitability. Consequently, Medicaid HMOs have a strong incentive to limit spending on patient care.

Almost two-thirds of the nearly three million recipients in Florida Medicaid today are enrolled in some form of managed care.[14] That statistic was cited by sponsors of the legislation in an attempt to make the case that the proposed expansion of mandatory enrollment in a managed care plan would not be a drastic change for Medicaid recipients.

However, current managed care enrollment includes almost a million recipients served through the MediPass program, a form of "primary care case management" in which access to services is coordinated by a primary care physician, but not restricted by a managed care plan.[15] Furthermore, the recipients not in any form of managed care today are particularly vulnerable and therefore intentionally exempted or excluded from the requirements of managed care.

The new law shifts Medicaid from a "fee-for-service" system – one that allows each health provider to receive reimbursement from the state for each Medicaid-eligible service provided – to a system of "capitated managed care." Capitated managed care is a form of managed care in which the payer (in this case, Medicaid) contracts with managed care plans[16] to ensure that health care services are delivered to their enrollees for a fixed price (in this case, a monthly payment). The managed care organization is paid a set amount for each enrollee in its plan, whether that enrollee receives care or not.

The legislation requires that most Medicaid recipients enroll in a capitated managed care plan.[17] In Florida Medicaid, capitated managed care has historically been virtually synonymous with HMOs.[18] As capitated plans, Medicaid HMOs are placed at financial risk to deliver the care that their enrollees need. Under financial risk, if providing the necessary care costs more than the contracted payments they receive, Medicaid HMOs (and their investors or shareholders) agree to take a loss. More realistically, however, their sustained participation in Medicaid is contingent upon their profitability. Consequently, Medicaid HMOs have a strong incentive to limit spending on patient care.

As sponsors emphasized, the legislation *does* allow other types of managed care plans to compete for managed care contracts, particularly provider service networks (PSNs), in which one or more health care providers hold a majority ownership.[19] However, these PSNs will be required to operate like HMOs in short order, as they must shift to operating on a capitated basis after two years.[20]

Breaking New Ground in Prioritizing Profits Over Patients

Although they are charged with assuring delivery of care to their enrollees, managed care plans can employ a variety of tactics to reduce spending and thereby increase profit, some of which the state would not or could not utilize directly in the past. Many of these methods are designed to yield cost savings through direct or indirect reductions in access to care. The legislation employs several such methods, three of which include:

1. Extreme Cost-Sharing Requirements

The legislation includes a number of unprecedented measures that would for the first time place a tremendous financial burden on most recipients. Although some adult recipients are charged smaller co-payments for certain Medicaid services now[21], the legislation calls for recipients to pay well beyond their limited means. Although the new requirements were described as a way to encourage recipients to take personal responsibility, the provisions would drastically reduce access to care for large numbers of recipients. Three of these include:

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a) **A requirement that recipients pay a monthly premium of $10 or lose coverage.**[22] The language in the legislation in fact requires that a premium be paid for each recipient, regardless of how low their income, and even if there are multiple recipients in the same family. For example, an unemployed single mother with two children is currently eligible to receive unemployment or cash assistance of about $300 per month. Ten percent of her household income would be due for Medicaid premiums or she would be subject to loss of Medicaid eligibility.

b) **A requirement that recipients who seek care for non-emergency conditions in a hospital emergency room pay a $100 co-payment.**[23] This co-pay would be due regardless of the recipient's attempts to obtain care elsewhere within the system, the availability of alternatives (e.g., night and weekend access), the extent to which a recipient has a choice of plans or access to the plan's providers, or the recipient's particular circumstances. Without evaluation of any of these factors, a typical recipient would risk having to pay more than half of his or her family's average weekly income to seek care to which he or she might have no other timely access.

c) **A requirement that recipients in the Medically Needy component of Medicaid pay monthly premiums that could absorb the overwhelming majority of family income.**[24] Medically Needy recipients have chronic medical needs but incomes that are too high for regular Medicaid. Currently they receive short-term coverage for months in which they have catastrophic medical expenses. To qualify in a given month, a recipient must show that he or she owes medical bills that could not be paid without taking all but a few hundred dollars per month. Although the change has been represented as an improvement allowing

recipients to have much-needed continuous coverage, recipients would need to actually pay that same amount – called the "share of cost" – in the form of a premium *every month*. For example, a disabled worker in a family of three at the poverty level (with a monthly income of $1,500) would be required to pay a monthly premium of almost $1,200 for the family. In fact, many Medically Needy recipients will be forced to pay in excess of 90 percent of their annual household income to sustain coverage.[25]

2. Diversion of Resources from Patients to Plans

One of the most-discussed ideas as the bill wound its way through the legislative process was whether to include a requirement for a "medical loss ratio" (MLR), which requires that a minimum percentage of state payments to a managed care plan be spent on direct patient care.[26]

An MLR requirement is recognized as a key accountability mechanism for appropriately limiting the amount of Medicaid payments to managed care plans that can be spent on overhead and administration or paid out to investors or shareholders. One draft of the legislation would have required that plans achieve an MLR of at least 90-percent.[27]

One of the most-discussed ideas was whether the Medicaid bill should include a requirement for a "medical loss ratio", which requires that a minimum percentage of state payments to a managed care plan be spent on direct patient care. The legislation ultimately enacted did not, but used instead another mechanism that doesn't protect patients and taxpayers as well.

The legislation ultimately enacted, however, requires the use of a related mechanism referred to as "achieved savings rebates." Under the achieved savings rebate (ASR), plans essentially may take 5 percent of their income as profit off the top, assuming they are otherwise in good standing as contractors.[28]

The key distinction is that an MLR essentially requires that a minimum amount be spent on patient care, while the ASR limits only the amount of profit a plan may earn. The MLR requirement better protects patients and taxpayers, as a limit on profit is built into the definition of the MLR. The ASR shifts the emphasis from the patient to the plan.

Another problematic aspect of this ASR approach is its failure to adequately control other types of excessive plan spending, namely administration, marketing and overhead. Plans can divert any amount to executive compensation that they see fit, provided that actuaries find it reasonable.[29]

To illustrate the potential impact, during a recent quarter, Medicaid HMOs reported spending 13 percent of state payments they received for administrative costs.[30] Although the bases for the two calculations are slightly different, the ASR for that quarter would be equivalent to an MLR of less than 80 percent. As a result, during the first year after full statewide managed care implementation, plans will receive capitated payments totaling at least $15 billion.[31] Consequently, a bare minimum of $1.05 billion more would be diverted from patients to plans in that year alone as a result of using the ASR instead of the MLR.[32] Finally, it should be noted that many of these HMOs are based outside of Florida, meaning that a significant portion of those diverted funds will immediately flow out of Florida's economy.

3. Shift from "Defined Benefit" to "Defined Contribution"

Perhaps the aspect of the legislation with the greatest potential to undermine Medicaid is the least well understood: the partial transformation of Medicaid from a program of "defined benefit" to one of "defined contribution."

The legislation expands the experiment authorized through the broad waiver of federal Medicaid regulations first sought by then-Governor Jeb Bush in 2005. The experiment, often referred to as Medicaid Reform, gives Florida several unique types of flexibility in managed care. Medicaid currently guarantees the availability of a specific benefit package. In Medicaid Reform, each plan is permitted to vary the "amount, duration and scope" of many benefits. Instead of a requirement to offer a consistent set of benefits, plans are subject to only two vague state-monitored restrictions: (1) actuarial equivalence (i.e., the expected total spending on the benefits used by plan enrollees is no less than the amount that would have been spent on the benefits used by enrollees under the standard Medicaid benefits package), and (2) medical sufficiency (i.e., the benefit level is sufficient to meet the needs of most Medicaid recipients).[33]

The idea is that, while the structure of the Medicaid program remains intact, plans are given flexibility to squeeze access in diverse ways that cannot be easily traced, as they are determined by actuaries and analysts behind closed doors. Furthermore, the challenge in assuring any level of accountability or transparency under such a system is compounded under the new legislation by the fact that there will be dozens of different plans for the state to attempt to evaluate and for recipients to attempt to sort out.

The shift toward defined contribution is specifically intended to allow the legislature to exert greater control over the growth in Medicaid spending. Instead of overtly eliminating benefits, plans may be able to arbitrarily reduce benefit levels without direct, visible action on the part of the legislature.

Conclusion

The ultimate fate of the changes outlined in the newly enacted Medicaid managed care legislation is uncertain, but a clear understanding of what is proposed and who will benefit/suffer most will be essential as implementation progresses. Florida Medicaid is both a vital health care safety net as well as a massive economic development engine. If implemented, these changes stand to undermine both functions, placing the poorest and sickest patients' care as well as taxpayers' investment at unacceptable risk, all while diverting billions from Florida's economy.

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Endnotes

1 Derived using information from Florida Legislature, Office of Economic and Demographic Research (EDR), Social Services Estimating Conference (SSEC), Official FMAP Estimate, March 2011, p.1

2 Conservative lower bound derived using EDR,SSEC, Long-Term Medicaid Forecast, March 2011, p.2

[3] Florida Center for Fiscal and Economic Policy (FCFEP), Addressing Misconceptions in Florida Medicaid, November 2010, p.2

[4] Derived using information from various Social Services Estimating Conference reports

[5] See Section 2001(a), Patient Protection and Affordable Care Act (PPACA)

[6] FCFEP, pp. 4-5

[7] EDR, SSEC, Medicaid Caseloads, January 2011, p. 2

[8] Derived from estimates taken from Urban Institute, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, May 2010, pp. 36, 41 and 45

[9] All references to state matching requirements under Medicaid expansion are taken from Section 2001(a), PPACA

[10] National Center for Quality Assurance (NCQA), Patient Centered Medical Homes, January 2011

[11] NCQA, p. 6

[12] For all references to principles incorporated into the legislation, see Florida House of Representatives, Medicaid Memorial Background, November 2010. Note: The Legislature ultimately adopted the memorial as SM 4-A (2010A).

[13] The legislation does address aggregate standards at the plan level, but not expectations that impact individual recipients and their interactions with individual providers.

[14] Derived from Agency for Health Care Administration(AHCA), Comprehensive Medicaid Managed Care Enrollment Report, May 2011

[15] AHCA, MediPass program (website last visited June 2011)

[16] More precisely, the state contracts with "managed care organizations" which administer one or more plans. However, "managed care plan" is the term in common use.

[17] Sections 409.965 and 409.972(2), Florida Statutes (2011). As the 2011 Florida Statutes are not yet published, see also sections 6 and 13, Chapter 2011-134, Laws of Florida.

[18] Based on review of all AHCA Comprehensive Medicaid Managed Care Enrollment Reports dating back to 2000

[19] s. 409.962(13), F.S. (also s. 3, Ch. 2011-134, L.O.F.)

[20] s. 409.968(2), F.S. (also s. 2, Ch 2011-134, L.O.F.)

[21] See e.g., AHCA, Florida Medicaid: Copayments and Coinsurance, June 2010

[22] s. 409.972(4), F.S. (also s. 13, Ch. 2011-134, L.O.F.)

[23] s. 409.9081(1)(c), F.S. (also s. 13, Ch. 2011-135, L.O.F.)

[24] s. 409.975(7), F.S. (also s. 16, Ch. 2011-134, L.O.F.)

[25] If the state intends to seek federal approval to modify the method of calculating a recipient's share of cost, that intent is in no way apparent from the legislation.

[26] U.S Department of Health and Human Services, What Is A Medical Home and Why Does It Matter?, October 2010

[27] See section 40, CS/CS/CS Senate Bill 1972 (2011)

[28] s. 409.967(3)(f), F.S. (also, s. 8, Ch. 2011-134, L.O.F.)

[29] s. 409.967(3)(h), F.S.

[30] Florida Office of Insurance Regulation, Medicaid Prepaid Plans – Medicaid Profit and Loss Report, 4th Quarter 2009

[31] $15 billion in payments made to prepaid plans is a conservative placeholder. A more precise estimate is forthcoming.

[32] Uses an 80% MLR as a very conservative substitute for assumptions of diversion of the maximum 10% of income that can be diverted under the ASR along with reservation of 13% of premiums for administrative costs. Also recognizes that the effective MLR requirement under CS/CS/CS SB 1972 would have been 87%, not 90%. $15B x (87% - 80%) = $1.05B.

[33] U.S. Centers for Medicare and Medicaid Services, Florida's Medicaid Reform (1115) Waiver, Special Terms and Conditions, #55 and #56, 2006