

# SNOWBIRD NEWS

## Governor Bush Signs Bill Forcing Many Florida Medicaid Recipients Into Managed Care Plans

By Howard S. Krooks

On December 9, 2005, the Florida legislature approved a sweeping change to Florida's Medicaid program that will force many of the state's 2.2 million-plus recipients into managed care plans over the next several years. Governor Jeb Bush has been arguing for quite some time that changes in the State's Medicaid program are needed. He signed the bill into law on December 16, 2005. Under the new law, a handful of big HMOs will be in charge of the long-term care of thousands of elderly Floridians.



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Florida received approval from the Center for Medicare and Medicaid services on October 19, 2005, for its Section 1115 waiver application, which gives the State greater flexibility to implement this type of program. After receiving federal approval, it was up to the State legislature and the Governor to pass legislation implementing the waiver. However, in exchange for the waiver approval, the State was required to sign a budget neutrality agreement limiting the amount of federal dollars that will come into the State. This agreement requires the State to limit growth in Medicaid expenditures to 8% annually for each person during the five-year period of the waiver. While the State may save some money by cutting back on care, there will actually be fewer federal dollars coming in to the State of Florida as a result.

Initially, the State will implement the new program in only two counties: Broward (Hollywood/Fort Lauderdale area) and Duval (Jacksonville area). Eventually, however, the new program may be implemented statewide. This could have a devastating effect on Florida's Medicaid program. As more of its program falls under the neutrality agreement, if expenditures increase at a higher rate than anticipated, the State will not receive any increase in federal dollars to meet the increased costs. Rather, the State will be forced to use its own funds or cut back on the services it will provide. Because the State of Florida has already underfunded the other existing Medicaid waivers, there is little likelihood of there being enough dollars.

The waiver granted to Florida by the Center for Medicare and Medicaid Services provides details on which Medicaid beneficiaries will be required to enroll under the new structure. Many children and parent Medicaid recipients, and most SSI beneficiaries who are not also enrolled in Medicare, will be required to enroll. While most pregnant women are exempt, those with the lowest incomes will be required to participate. Dual eligibles (those enrolled in both Medicare and Medicaid), children with chronic conditions, and persons with developmental disabilities will be required to participate at a later date. **While persons receiving long-term care in nursing homes are not currently covered under the new law**, the State has made it clear in its waiver application that it intends to broaden the scope of the waiver to encompass the vast majority of Medicaid beneficiaries, including individuals in nursing homes and hospices, all seniors, and persons receiving inpatient psychiatric services.

According to the timeline specified in the waiver application filed by the Florida legislature, enrollment will be phased in beginning in July 2006. The State estimates that by sometime in mid- to late 2007, more than 200,000 persons in Broward and Duval Counties will be enrolled in the new plans. This represents just under 9% of Florida's Medicaid recipients. In 2008, the program will be expanded to include three rural counties surrounding Duval—Baker, Clay and Nassau.

One of the fundamental changes which the State will implement through the waiver is a variation in the federal standard that requires states to ensure that each benefit category covered through Medicaid is sufficient in "amount, duration and scope to reasonably achieve its purpose." Under the waiver, managed care plans will be required to offer all mandatory Medicaid benefits; however, they will have flexibility to determine how much of such a service to offer provided that the plans offer an overall benefits package which is actuarially equivalent to the value of the current State Plan package for the

average member of the population. Thus, a plan might elect to offer more doctor visits, but less durable medical equipment. This new approach will apply *only* to adults and will not affect children receiving Medicaid benefits.

Non-institutionalized adults, people with disabilities and pregnant women with low incomes will be hardest hit by this new approach. The waiver allows the HMOs tremendous new flexibility in deciding which benefits will be offered and how much of any one benefit an individual would receive. While it is possible for a plan to offer new and additional benefits, generally waivers are not required to add benefits but rather to reduce benefits. In particular, persons with disabilities will face the harshest changes since they are less likely to be enrolled in a capitated managed care arrangement compared with low-income families. Also, adults with disabilities face greater risk under the waiver if the benefits package is inadequate since they tend to use more services.

Naturally, other states will be looking at the Florida waiver to see how it performs and to make its own determination as to whether such an approach might

work elsewhere. We will keep the New York State Bar Elder Law Section updated on any developments in the Florida waiver.

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