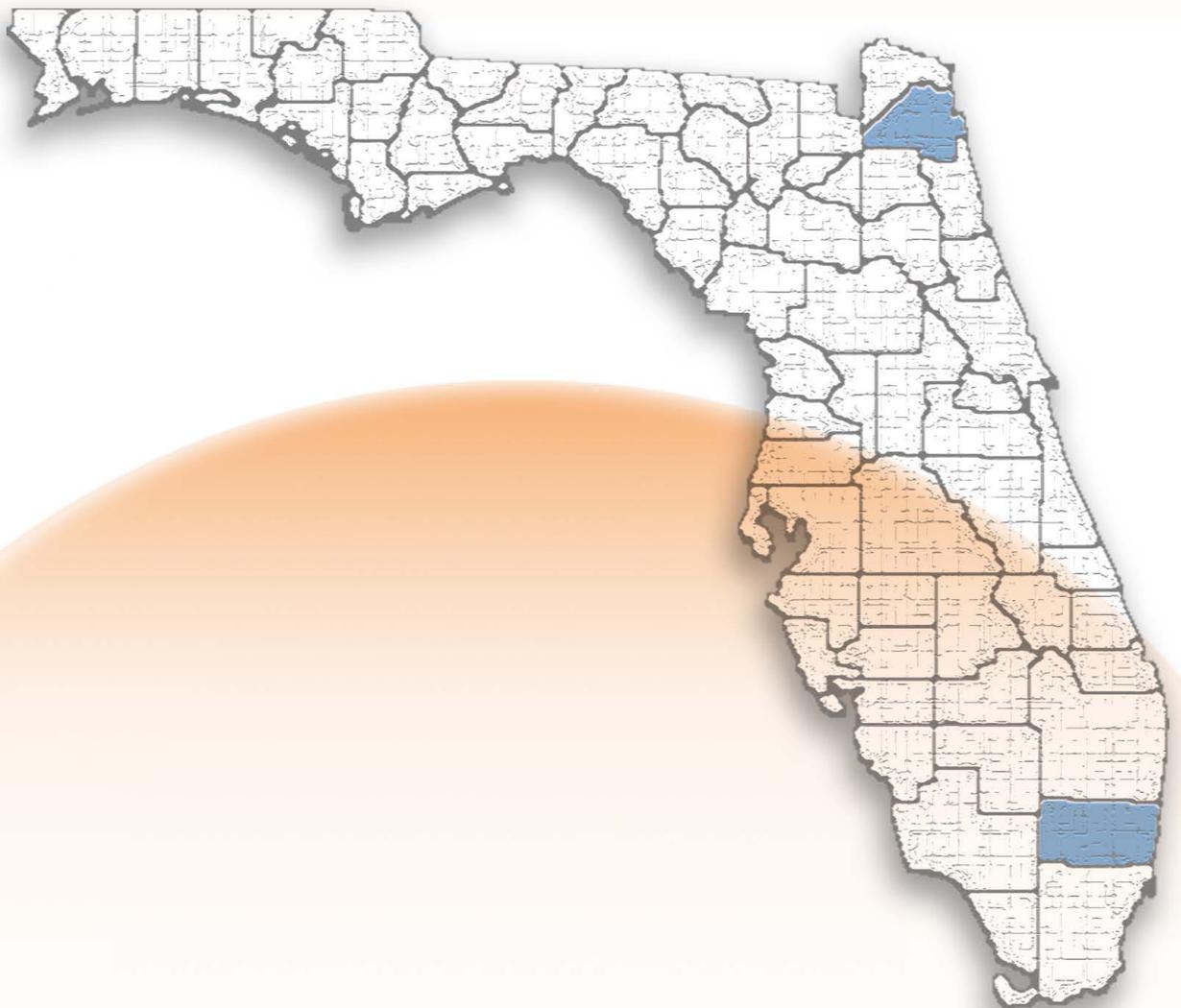




Evaluating Medicaid Reform in Florida



Summary Report on Section 1115 Waiver Process





SUMMARY REPORT ON SECTION 1115

WAIVER PROCESS

R. PAUL DUNCAN
LILLIANA L. BELL
CHRISTY HARRIS LEMAK
NICCIE L. MCKAY
ALLYSON G. HALL

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University of Florida

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SUMMARY REPORT ON THE MEDICAID REFORM SECTION 1115 WAIVER PROCESS

INTRODUCTION

Medicaid is the core financing program that pays for the health and medical care of people without insurance or other means to pay for that care. The program has existed since the United States Congress passed and President Lyndon B. Johnson signed Title XIX of the Social Security Act of 1965. Florida implemented its Medicaid program on January 1, 1970. Medicaid was explicitly intended to mirror the forms and mechanisms through which health care was financed and delivered in the private sector at that time—an approach that heavily emphasized fee-for-service payments and retrospective reimbursement. Medicaid has grown to become the largest single health care program in the nation. For fiscal year (FY) 2004, Medicaid served about 41 million people in the United States, expending about \$288 billion.^{1,2} At present Medicaid serves about 2.1 million people in Florida.² For the same fiscal year (2003-2004), Florida's Medicaid program expended approximately \$13 billion.¹ The Florida program is managed by the state's Agency for Health Care Administration (AHCA).

Regulatory and management responsibility for Medicaid is jointly held by the federal and state governments.³ In general, the federal role is (a) to establish core program guidelines and responsibilities (setting the minimum attributes and characteristics of the program that must be followed by all states) and (b) to manage the federal financial contribution to the program. The states are responsible for program design, including eligibility, covered services, implementation and management, and for the appropriation of the state financial share. The federal/state partnership aspect of Medicaid has long been touted as an important positive attribute that allows each state's program to vary somewhat in order to meet its unique needs, while ensuring a national foundation of minimum program characteristics and a sharing of the financial responsibilities.

The federalist aspect of the program has also been viewed as a feature that might allow Medicaid to be flexible, adaptable, and innovative in the face of rapid changes in the organization and delivery of medical care. Ideally, the states would serve as laboratories, exploring different means of accomplishing program goals and learning lessons that can be applied (or avoided) in other states.

However, the same joint management and financing responsibilities that create such potential for flexibility introduce significant complexities in program administration and implementation. General actions taken by the federal government must be managed and implemented in all states, so proposals for change must be vetted with care. In recent years, many "trial balloons" referring to potential changes in Medicaid have been floated at the national level. Relatively few have resulted in significant changes to the program. Similarly, individual states are constrained by the minimum program requirements and the fact that state-level changes may impact the federal fiscal obligations. Since the state

and federal objectives may not always be fully congruent, a regulatory environment at both levels has evolved. Over the forty-plus years of the Medicaid program's life, this regulatory environment has become increasingly detailed and complex, adding a substantial layer of difficulty to the contemplation or enactment of changes, even those that seem to be quite reasonable.

SECTION 1115 WAIVERS

Although other means are available, the principal mechanism by which states can implement changes in their Medicaid programs, and thus pursue the intended experimentation and innovation, is specified in Section 1115 of the Social Security Act. Section 1115 was enacted in 1962 prior to the creation of Medicaid. It authorizes potential changes to several federal programs.³ In effect, the section acknowledges that there may be circumstances in which states should be granted the flexibility to modify programs, even in a manner that might appear to diverge from the "minimum" federal standards, if the proposed modification shows promise for overall improvement in the program.

Section 1115 outlines the mechanism for states to follow if they wish to pursue the available flexibility. This has come to be known as "The Waiver Process" because the core attribute is a federal agreement to "waive" one or more federal requirements, thus granting a particular state increased flexibility to modify its [Medicaid] program in pursuit of some identified improvement. Waivers are more precisely known as "Research and Demonstration Waivers" because they are expected simultaneously to (a) establish a program that demonstrates how the alternative approach sought by the state would operate in the real world and (b) conduct observations and evaluation (research) to confirm or test the degree to which the program achieves the intended benefits. Analysts have noted that in many Section 1115 Waivers, the "research" part of the process is given minimal attention, thus reducing the confirmable value of the demonstration project. Indeed, as recently as March 14, 2006, the Honorable Don Sundquist, serving as Chair of the National Commission on Medicaid, noted the value of states serving as laboratories, but bemoaned the fact that "we aren't getting the lab reports."⁴

Section 1115 Waiver applications are expected to follow a set of principles and guidelines as distinct from a prescribed process regarding content and format. Medicaid waiver applications are reviewed by staff in the federal Centers for Medicare and Medicaid Services (CMS), the agency responsible for the federal portion of the Medicaid program, with fiscal support from the Office of Management and Budget. There are few rules regarding such elements as the length of the review period, the reasonableness of requests for additional information, specific review criteria, and the like. In the practical world, the process includes a great deal of both formal and informal negotiations between the state's Medicaid Agency and CMS. The existence, as well as some elements in the content, of Florida's current Medicaid Reform initiative derives in part from the Section 1115 Waiver process.

MEDICAID REFORM IN FLORIDA, 2005–2010

As a state, Florida has a significant history of making changes to its Medicaid program. In fact, according to Florida's Section 1115 Waiver application, Florida operated 20 distinct waivers including 13 home and community-based waivers, two 1115 Research and Demonstration Waivers and five 1915(b) waivers.⁵ The changes have varied in their scope, intensity, and results, including the degree to which those results are fully documented and understood. Some demonstration projects have been described in detail,⁶ and others are ongoing. But each of these prior initiatives had its origin in an idea or cluster of ideas about how Medicaid might be improved. That is certainly the case in Florida's current Medicaid Reform initiative.

It is clear that there exists no single "eureka" moment at which interest in the current Medicaid Reform and the content of the proposed changes came to exist as a unified proposal. However, medical liability issues and the cost/quality of nursing home care occupied a central place in Florida's health policy conversation for much of the period from 1998 through 2004. The discussions and resulting legislative actions revealed some of the key health care financing issues facing Florida. Governor Jeb Bush's interest in issues of health insurance coverage was reflected in "The Governor's Health Care Summit" of 2000 and the subsequent creation in 2004 of the "Governor's Task Force on Affordable Health Insurance." The economic downturn following September 11, 2001, resulted in an understandable spike in Florida's Medicaid program expenditures and serious concern about the fiscal implications of continuing growth in the cost of the program. Together these circumstances and activities indicate an ongoing level of interest in health and healthcare policy and, hence, an environment in which Medicaid Reform might be contemplated. While the interest certainly extended to key legislators and legislative staff, the primary locus of these early conversations was in the executive branch, primarily in the governor's office and in AHCA.

Expressed in terms of concerns or issues, those responsible for Medicaid policy and programs in Florida concluded that the Medicaid program was not as effective as it should be in meeting the needs of its enrollees; it was too expensive, costs were rising at such steep and rapid rates that the program might overwhelm other valued elements of the state's budget, and the unpredictability of projected increases in program costs made thoughtful planning for both Medicaid and other state programs impossible. For instance, Florida's Medicaid spending grew an average of 13.5 percent per year: from \$418 million in FY 1980 to \$12.7 billion in FY 2004. In addition, Florida Medicaid's share of the state budget grew to 23.6 percent in 2004 from only 5.9 percent in 1980.⁷

The Reform proponents generally held the view that at least part of these difficulties derived from the reality that the current Medicaid approach to health care was inconsistent with contemporary financing and delivery mechanisms in the private sector. Medicaid's slow response to changes in the healthcare environment derives in part from the static nature of federal regulations. In this perspective, despite the development of a primary care case management program (MediPass) and a significant commitment to Health Maintenance Organizations (HMOs) in the provision of services to Medicaid enrollees, Florida's Medicaid program had not sufficiently evolved and changed with the

times; it had retained features of the original (1970) program while other segments of medical care, especially in the private sector, had significantly and fundamentally changed. Most notably, a major part of Medicaid expenditures were in a fee-for-service model, which did not incorporate sufficient elements of care management. Not surprisingly, several commentators noted that the track record of the private sector in containing healthcare costs while improving quality over the same period of time was considerably short of stellar. Several health services researchers have pointed out that over the past 10–15 years, the overall rates of increase in Medicaid expenditures were, in fact, lower than the rates of increase in spending for private health insurance.⁸

Nevertheless, there emerged a general theme that Medicaid Reform was necessary, that it must address the overall costs of the program, and that the thrust of the reformed program would be to better serve Medicaid enrollees while ensuring that the program's activities would be more closely comparable to medical care delivery in the private sector. On March 30, 2004, AHCA issued a letter requesting public comment on Governor Bush's intention to seek waiver authority from CMS to reform the Medicaid program. Considerable conversation, comment, and debate ensued.

Clearly, the announcement of administration interest in a waiver application created consternation among some individuals and organizations. In part, these concerns reflected a fear that Florida might seek a so-called "super waiver" that would fundamentally change even the most basic tenets of the Medicaid program. Specific concerns were expressed that the state might agree to a "cap" on the federal fiscal obligation in exchange for an unusual level of flexibility in program design and management. Such a cap would effectively transfer the entire risk for all cost increases (beyond the cap) to the state, a possibility that was of great concern to some legislators who worried about the budget implications and to various advocacy groups who worried that the state might find itself forced to cut services.

In June 2004, Alan Levine became AHCA's Secretary. In his previous role as Governor Bush's Deputy Chief of Staff with responsibilities for health issues, Secretary Levine had been a very active participant in the executive branch's conversations regarding health policy in general and Medicaid Reform in particular. His appointment as Secretary was interpreted as a clear signal that the Medicaid Reform conversation would move forward. During the summer and fall of 2004, Secretary Levine and other senior AHCA officials traveled the state of Florida extensively; addressing community and other groups about health policy issues and emphasizing the administration's interest in reconsidering numerous aspects of Medicaid. Public controversy regarding a 2003 freeze on enrollment in Florida's KidCare (SCHIP) Program was an impetus for some of these conversations.⁹ Secretary Levine also took steps to visit many state legislators in their home districts to discuss Medicaid funding and the implications of growth in the Medicaid budget for other initiatives in Florida, and to explore the range of politically feasible reforms.

Various informal workgroups and conversations also began to occur, both within state government and in wide-ranging interest and advocacy groups. Networks were tapped, activities in other states were reviewed, and numerous and diverse experts were consulted. A wide diversity of opinions was expressed in an equally wide range of forums and mechanisms. Conferences took place. Written expressions of opinion were

prepared, disseminated, and, in some cases, delivered to AHCA. In some instances, the exchange of ideas was passionate. There is good reason to believe that all participants in these conversations learned from the others, and that ideas genuinely evolved and developed over the period from late spring through summer and fall of 2004.

These relatively informal processes converged in the fall of 2004 with a thorough briefing for Governor Bush and receipt of his ideas on potential elements of Medicaid Reform. The result was his approval to develop the ideas further, prepare a policy statement, and begin the complex series of steps that would be required to obtain a Section 1115 Waiver and pursue a significant reform of Florida's Medicaid program. A team was identified to render the ideas into a more manageable format and to specify the necessary "next steps." Although others would contribute in material ways, the key executive branch participants at this stage were Alan Levine (AHCA Secretary), Tom Arnold (Deputy Secretary for Medicaid), Carol Gormley (then Policy Coordinator for Health and Human Services, Florida Governor's Office), and Mike Hansen (Budget Director, Florida Governor's Office of Policy and Budget).

The Governor's White Paper

The initial concrete step in the process was to formulate the core ideas in a manner that was clearly understood to be a proposal, subject to ongoing discussion and development, and yet reasonably precise about the basic outlines and expected direction of the proposed reforms. The latter was intended to establish some key Medicaid reform attributes—characteristics that would be necessary if a proposal hoped to garner the support of a popular governor. On January 11, 2005, Governor Bush released "Florida Medicaid Modernization Proposal" (originally called "Empowered Care") for consideration by Florida's citizenry and legislature. This document is sometimes referred to as "The Governor's White Paper." The Governor's proposal clearly indicated concerns that the Medicaid budget was growing at an alarming and unsustainable rate. It noted the need for reform to provide stability in Florida's Medicaid budget, and to modernize the provision of healthcare services to the program's enrollees.¹⁰ For instance, Medicaid averages 13 percent per year expenditure growth and at present equals 24 percent of Florida's budget. Current total Medicaid expenditures exceed \$14 billion. The White Paper notes that if the present growth rate were to continue, Medicaid would comprise 59 percent of the state budget and exceed \$50 billion in expenditures by 2015.⁵

In response to the Governor's Medicaid Reform proposal, the Speaker of the House and the President of the Senate established Select Committees on Medicaid Reform on January 19, 2005. The Select Committees met routinely during the early months of 2005 and conducted five public hearings in the cities of Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. The public hearings allowed hundreds of Medicaid stakeholders, including Medicaid enrollees, providers, HMO representatives, advocacy groups, and others, to express their opinions on Medicaid Reform to legislators and key legislative staff. Again, there is no doubt that some of the ideas and suggestions gleaned from these public hearings were considered during the 2005 Legislative Session.

The 2005 Legislative Session and Senate Bill 838

In order to pursue a Section 1115 Waiver aligned with the principles noted in the Governor's White Paper, action by the Florida Legislature would be required, although the degree to which legislative action was a technical legal necessity remains the subject of some debate. Most analysts agreed that AHCA could legally submit a Waiver application without prior legislative approval. However, the ideas being proposed were substantial variations from current practice, and federal approval would not likely be obtained in the absence of clear evidence that the state legislature was supportive. Further, legislative action would almost certainly be required to implement any changes consequent to an approved waiver. Thus, for practical purposes, prior legislation became a necessity.

The Governor's White Paper articulated the core ideas of the executive branch, but it was not, and was not intended to be, proposed legislation. However, the mechanism for creating a bill, managing the legislative processes of committee review, discussion, amendment, and similar steps in both houses of the legislature required a starting point.

Achieving the required starting point created the first of many intersections where political/policy strategy and tactics are added to philosophy and the actual content of a proposal. How to proceed with an idea becomes inextricably entangled with the idea itself and both aspects become important elements in the process. It would certainly be possible for executive branch participants to craft a fully developed bill and arrange for its introduction in one or both houses of the legislature. Such an approach frequently occurs in the federal government and in many state governments. In the case at hand, it would ensure that the bill, at least in its initial form, would reflect the intentions and ideas of Governor Bush and others involved in preparing the White Paper. On the other hand, members and staff in the legislative branch have their own interests and preferences, including an appropriate belief in legislative prerogative: They generally prefer that legislation be developed by the legislature.

It has been well documented that the flow of a legislative initiative from an idea to final passage and signature into law is a subtle, complex, and arcane process, involving placeholder bills, substitutions, committee assignments, hearings, amendments, deals, and lobbying, as well as numerous technical requirements of language, format, and timing.¹¹ This paper is not intended to describe every detailed step and nuance of the process in which Florida's legislature enabled Medicaid Reform. It is important, however, to understand the key stages and to appreciate the numerous situations in which even slight changes in events might have resulted in a very different outcome.

In the Florida House of Representatives, Anna Holliday "Holly" Benson serves as Chair of the Health and Families Council, which includes the Elder and Long-Term Care Committee, the Future of Florida's Families Committee, the Health Care General Committee, and the Health Care Regulation Committee. Representative Benson was instrumental in conducting hearings and workshops and drafting bill ideas over the course of summer and fall 2004. These preparatory efforts would ultimately result in HCB 6003 which was filed on April 8, 2005, and sponsored by Representative Holly Benson and the four committees of the Health and Families Council. The bill was co-sponsored by

Representatives Aaron Bean, Frederick “Fred” Brummer, Bill Galvano, Rene Garcia, Audrey Gibson, Gayle Harrell, Ed Homan, and Mark Mahon. Substantial staff leadership was provided by Mary Pat Moore, who was the Staff Director of the Florida House of Representatives’ Select Committee on Medicaid Reform. Many analysts identify this filing as the legislative starting point for the current Medicaid Reform initiative in Florida because this is the path most closely aligned with the Governor’s White Paper.

It is important to bear in mind that one of the key attributes of the proposed legislation was to provide the state’s executive branch with clear authority to seek a Section 1115 Waiver from the federal government. It was thus critical that the bill successfully balance three potentially inconsistent agendas. It must describe the breadth and nature of the waiver authority. No legislature would casually grant a “blank check” authority allowing the relevant state agency wide-open authority to seek federal approval for an unknown list of reforms. Also, in stating the boundaries of waiver authority, the governor’s views and those of the executive branch entity that would actually prepare and submit the waiver application (AHCA), and eventually have to manage any resulting programmatic initiatives, had to be fairly represented. Finally, the bill had to describe a potential waiver application that would have some reasonable probability of achieving the necessary federal approval. Balancing these three objectives required extensive conversation and negotiation, which by this stage included participants from the Florida House of Representatives, the Florida Senate, the Governor’s office, AHCA, Florida’s Washington, DC office, and, of course, federal officials, including two successive Secretaries of the U.S. Department of Health and Human Services as well as leadership and staff in CMS.

After multiple amendments, HCB 6003 was passed as amended (Yeas 81, Nays 34) on May 2, 2005. The Senate received the bill on May 3, 2005, and referred it to the Health Care, Health and Human Services Appropriations, Ways and Means, and Rules and Calendar Committees.

During the same legislative session, an alternative approach had been emerging in the Florida Senate. In general, the Senate was more cautious about the proposed reforms and less willing to grant the breadth of Waiver authority sought by Governor Bush. Specifically, the Senate wanted to avoid an almost immediate statewide research and demonstration waiver, preferring a smaller number of pilot projects. The Senate approach was manifested in CS/CS/SB 838-Medicaid, which was filed by the Senate Committees on Ways and Means and Health Care on January 25, 2005. The bill was sponsored by Senator Durell Peaden and co-sponsored by Senators Jeffrey Atwater, Walter Campbell, Lisa Carlton, Nan Rich, Burt Saunders, and Evelyn Lynn. Staff leadership was under the supervision of Michael Garner, who was the Staff Director of the Florida Senate’s Select Committee on Medicaid Reform. On March 8, 2005, the bill was introduced and referred to the Senate Committees: Health Care, Health and Human Services Appropriations, Ways and Means, and Rules and Calendar. On April 7, 2005, the bill was placed on the Health Care Committee agenda, read the first time, and received votes of Yeas 10 and Nays 0. On April 13, 2005, the bill was placed on the Ways and Means Committee Agenda and received votes of Yeas 15 and Nays 0.

On May 6, 2005, the house bill (HCB 6003) was withdrawn from the Senate Committees and replaced by CS/CS/SB 838. This bill (CS/CS/SB 838) amended ss.409.912,

409.9122 and 409.13, Florida Statutes, and created s.409.91211, Florida Statutes, and 11 undesignated sections of law. On the same day, the Senate approved the bill (Yeas 39, Nays 1). The bill was returned to the House (still on May 6, 2005) and passed on the third reading (Yeas 88, Nays 24). It should be noted that May 6 was the final day of the 2005 legislative session, and the final vote on the bill occurred at 9:00 p.m. On May 24, 2005, CS/CS/SB 838 was signed by officers of both houses and presented to the Governor. On June 3, 2005, CS/CS/SB 838 was signed into law (Chapter 2005-60) by Governor Bush.

Key provisions of CS/CS/SB 838 for Medicaid Reform are summarized in Figure 1 below.

Key Provisions of CS/CS/SB 838 for Medicaid Reform Managed Care Pilot Program

- Authorization for AHCA to submit a Medicaid Reform waiver application to CMS. Dependent on federal approval and legislative authorization, Medicaid Reform will take place in Broward and Duval Counties. The reform will expand into Clay, Baker, and Nassau Counties one year after the Duval County reform becomes operational.
- Requirement for AHCA to submit an implementation plan that outlines the activities associated with the Reform process and evaluates the impact of Medicaid Reform on the total Medicaid budget for FY 2006-2007 through FY 2009-2010.
- Legislative approval is contingent on the preservation of the hospital upper payment limit and hospital disproportionate share program. In the demonstration areas, for most Medicaid eligibility groups the Fee for Service and MediPass systems would be replaced by managed care pilot programs.
- The Managed Care Pilot Program will
 - include all mandatory and optional services including behavioral health services;
 - offer choice of plans;
 - establish a process for risk-adjusting capitation rates;
 - phase in provider service network risk over a three-year period;
 - permit the use of stop-loss provisions and catastrophic coverages;
 - establish a managed care plan credentialing process;
 - implement beneficiary choice counseling and grievance resolution programs;
 - authorize the development of network provider participation criteria;
 - ensure coordination with school-based health programs;
 - authorize the development of a service delivery alternative for children with chronic medical conditions;
 - authorize AHCA to recommend service delivery alternatives within capitated managed care plans for developmentally disabled individuals and foster care children;
 - permit the assignment of beneficiaries to managed care plans if they have not chosen a plan within 30 days, provide for a 90-day voluntary disenrollment period, and permit disenrollment for cause;
 - authorize beneficiary opt out and enrollment in employer-sponsored plans;
 - require AHCA to post the federal waiver application on its website 30 days in advance of waiver submission to the federal government;
 - require evaluation of the pilot programs;
 - establish a process for beneficiaries to opt-out of Medicaid and participate in an employer-sponsored plan; and
 - establish enhanced benefits accounts.

On balance, the passage of SB 838 is a pretty clear example of the manner in which significant legislation frequently occurs. Both before and during the legislative session, many organizations and entities took steps to participate and provide input at numerous stages of the process. There is good reason to conclude that virtually all interested participants were heard. In some cases, provisions in support of expressed interests were added to the bill. Some interested groups succeeded in deleting or preventing the inclusion of ideas they found especially problematic. It is clear that none of the participants achieved everything they preferred.

No doubt, the law reflects a reality that Florida's governor and majorities in both legislative chambers are relatively conservative Republicans with a preferential orientation that favors the private market as a driving force in health policy and the delivery of health care. Within that reality, it would appear that the proponents of extensive reform (in the sense of more dramatic change and a statewide breadth for the proposed changes, as well as a shorter time line for implementation) had to settle for less—two counties immediately, with three more to follow soon. Statewide expansion can occur, but not until sometime after June 30, 2008, and only with legislative approval.

On the other hand, core philosophical elements of the extensive reform proponents' point of view were enacted. These included formal legislative approval to pursue the waiver, specific program elements clearly derived from proposals in the Governor's White Paper, demonstrations of significant size in large counties, a much more contemporary "managed" approach to care, and greater enrollee responsibility, including the opt-out and enhanced benefit provisions. Conversely, those who feared and/or opposed the reform ideas were unable to simply block the process, but did obtain geographic concessions, some program limitations, and new opportunities for review.

There are multiple examples confirming that numerous participants got comparably mixed outcomes. Providers of care, especially the teaching hospitals and other healthcare safety-net organizations providing a substantial level of care for Medicaid enrollees, sought some protections against the prospect of payment rate reductions or dramatic increases in uncompensated care. The legislation includes a requirement that any waiver approval must include federal concurrence that a key hospital financing mechanism known as the Upper Payment Limit (UPL) would be preserved. Groups concerned with cultural competency, health literacy, and reducing minority health disparities obtained a commitment that waiver demonstration projects would focus attention on those issues. Some organizations voiced especially strong concerns that the proposed level of enrollee participation in choosing among multiple plans could be successful only if there were substantial investment in a patient education program and the commitment to an energetic choice counseling program is evident. In sum, no participants got everything they wanted, but a consensus emerged that was sufficient to obtain the required majority vote, such that many contributors to the process achieved at least some elements of their preferred outcome.

THE WAIVER APPLICATION AND APPROVAL

With final passage of CS/CS/SB 838,¹² AHCA was clearly empowered to prepare and submit a Section 1115 Waiver application.¹³ Section 409.91211(6), F.S. of the legislation (SB 838) also required AHCA to submit a Medicaid Reform Implementation Plan¹⁴. A team was assembled and work began, again with significant collaboration among AHCA (including consultants), the Governor's office, and Florida's Washington, DC, office, augmented by continuing input from legislative leadership and staff as well as interest/advocacy organizations.

AHCA assumed the appropriate leadership role in preparing the Waiver application. Secretary Levine's participation is well documented, but during this phase his role and that of senior officials in the governor's office moved toward a focus on process, evident especially in the conversations and negotiations with CMS. Deputy Secretary for Medicaid Tom Arnold and Roberta Kelley, Bureau Chief of Medicaid Health Systems Development, became the de facto AHCA leadership team on the process of actually crafting the waiver application. Technical and financial issues were the focus of Dyke Snipes, Assistant Deputy Secretary for Finance, and Robert Butler who was Bureau Chief of Program Analysis at the time but has since left the Agency. External consultation was obtained. Such support varied from brief ad hoc consultations involving as little as a telephone conversation or chance meeting at a conference to substantial contractual engagements. Some of this consultation was sought by AHCA while some was obtained by legislative participants or the executive office of the Governor. Such informal consultations are extremely difficult to precisely enumerate, and it is impossible to specify the exact nature of any resulting influence.

Among the more extensive and formal consultations, a small number merit specific mention. Mercer Human Resources Consulting provided detailed actuarial services and technical assistance that were critical to such questions as determining the catastrophic threshold, the concept and application of actuarial equivalence (for premium/rate setting), risk adjustment, and related issues. Alicia Smith and Associates is a Washington, DC-based consulting firm with known expertise on technical issues associated with the waiver application process. Ms. Smith (who is a former Florida Medicaid director) and her associates provided support services and technical assistance in preparing the waiver application. Similarly, a Washington law firm (Covington and Burling) assisted in crafting legal language that met the needs of both Florida and CMS.

Three elements of this phase are noteworthy. First, it is clear that the waiver application was prepared in a context of extensive, active consultation and negotiation with the federal government, specifically CMS. Second, it is comparably clear that a complex, technical, and arcane financial issue became central to the conversation with federal officials and would remain a potential deal-breaker until the very end. Third, it seems certain that Florida's unique circumstance as a controversially pivotal state in both the 2000 and the 2004 presidential elections, combined with the reality of a Governor and President who are brothers, played a role in the process. Each of these elements merits brief discussion.

The very nature of waiver application and approval creates a strange process. States do not want to request waivers unless they are reasonably confident the request will be approved by CMS. The federal government does not want to pre-judge a waiver request that has not yet been fully prepared and hence is absent the detailed documentation that may be required for a thorough and thoughtful review. Both state and federal administrative officials are wary of pursuing/approving waiver applications that may then not be implemented because a state legislature takes or fails to take some action that is essential to the proposed demonstration. The preparation of Florida's waiver application included extensive conversations between state and federal officials and careful attempts to be sure that state legislative leadership was fully informed. The process involved numerous trips to Washington. Conceptual meetings were arranged with two successive Secretaries of the U.S. Department of Health and Human Services (first with Secretary Tommy Thompson and later with Secretary Mike Leavitt) to ensure that the ideas were within the general policy perspective of the federal Bush administration. Multiple detailed meetings at the state leadership level were also held. Florida team leadership included Tom Arnold, Secretary Levine, and Roberta Kelley from AHCA/Medicaid, as well as Carol Gormley from the Governor's office. Key support was provided by Florida's Washington office (Nina Oviedo, Deputy Chief of Staff, Florida Washington, DC, office, and Karen Hogan, Federal Liaison, Florida Washington, DC, office). Liaison to the Florida Legislature was primarily through Mary Pat Moore and Representative Benson, although other legislative leadership (especially Representative Gayle Harrell and Senator Durell Peaden) were actively involved. The key CMS participants were Dennis Smith (Director, Center for Medicaid and State Operations) and, for some issues, Jean Sheil (Director, Family and Children's Health Programs Group).

The fiscal issue of key interest became clear as the conversations developed. Over the course of time, two financing mechanisms to support safety-net hospitals had evolved in Florida. Collectively these mechanisms are referred to as the UPL and the Disproportionate Share (DSH) programs. As noted above, SB 838 required that these programs be protected and preserved in any demonstration program approved by waiver. On the other hand, Section 1115 Waivers must be "budget neutral" from a federal perspective, meaning that approval could not put the federal government at risk for higher contributions to a state's Medicaid program than those which would be expected to occur in the absence of the waiver. Protecting Florida's UPL/DSH financing for safety-net hospitals while implementing the other proposed changes to Medicaid in a manner acceptable to CMS became difficult. The establishment and allocation of funding (\$1.0 Billion) to a Low-Income Pool (LIP) became the solution. The consulting services of Dr. Bruce Greenstein (former regional director of CMS) were useful as these discussions between Florida and the federal government unfolded.

There has been speculation regarding any impact from the unusual circumstance of brothers occupying the offices of Florida Governor and U.S. President. The range of opinion spans from the view that these circumstances were completely without a shred of relevance to Florida's waiver application all the way to the alternative extreme: that the outcome of Florida's waiver application was fixed from the beginning, and Florida would obtain approval for whatever waiver authority it might request. All evidence to date suggests that neither of these extreme views has merit. Participants in the process uniformly acknowledge their belief that Florida was in a unique position. Some suggest this may have created more scrutiny than the norm. The more common view is that

Florida may have had some advantages, perhaps including somewhat greater access and the capacity to successfully press for timely federal decisions. It is undoubtedly clear that the Medicaid policy views of the federal administration, perhaps especially as described in President Bush's FY 2005 Budget Proposal, emphasized increased state flexibility in managing both Medicaid and SCHIP programs.¹⁵ While the proposed block-grant approach did not receive support from the nation's governors, it opened a "policy window" for Florida. Apart from these general contextual circumstances, no knowledgeable participant has to date even contended that any advantages Florida may have enjoyed were sufficient to overwhelm the substantive issues or procedural norms that are a part of the waiver application and review processes.

The waiver application itself was completed in late August 2005. Following state and federal requirements, the application was officially disseminated and public comment was invited by posting the document on AHCA's website on August 31, 2005. The waiver and legislative processes require that an interval of not less than 30 days must be provided for public response. During the period from August 31 through the month of September, AHCA received 92 public comments, some of which did not relate to Medicaid Reform. A formal letter was issued to address each comment on Medicaid Reform. Some comments were quite specific while others were very general. Some comments provided the agency with ideas that did not directly pertain to the waiver application itself, but suggested steps that might be taken during program implementation, if the waiver was granted and reform took place.

Conversation during the review and comment period included a discussion regarding the process and any consequences that might ensue from changing the waiver application. Posting the proposed application and inviting responses certainly implied an interest in the responses and the possibility that they would be incorporated. On the other hand, if the proposed application were changed to reflect one or more expressions of public input, did the revised application then have to be posted for another 30-day period? AHCA decided to retain the comments and suggestions with the intent of using those it found valuable in the program design process.

The waiver application was formally submitted to CMS on October 3, 2005. On October 19, 2005, 16 days after formal submission, CMS approved Florida's Medicaid Reform waiver application with special terms and conditions. The number, detail, specificity, and thoroughness of the special terms and conditions (11-W-00206/4) illustrate the full nature, character, and extent of federal involvement in the waiver process. They outline Florida's responsibilities to CMS throughout the life of the waiver.

The duration of the final CMS review period was unusually short and came as a surprise to some observers. There is no official standard for the duration of CMS review of waiver applications. Technically, some waivers have been approved in a period as short as nine days, but this seems to occur only when an application is being resubmitted with changes requested by CMS after a prior review.¹⁶ Other waiver applications have been approved after review periods ranging from two to six months, although some have languished in a review process for years.

For some observers, the short review period experienced by Florida gave credence to the proposition that the state had a special inside track or that it may not have received the level of scrutiny that would typically occur. On balance, it seems more likely that the short period of review reflected two realities. First, CMS had been significantly involved in the conversations that led up to the formal waiver submission over a period of several months. Because of this extensive consultation between Florida and CMS, it was well understood that the Florida request fell within the confines of CMS' statutory authority and that the final waiver application would not ask CMS to waive something that could not be waived according to the statutes. This obviated any need for the kind of detail, line by line review that would be necessary if a waiver application was being examined *de novo*. Second, CMS also had full access to the final version of the application during the 30 days of posting. As a result, some elements of the CMS review had effectively been under way for several weeks, so it is reasonable that relatively little remained to be accomplished during the first two weeks of October. In a very real sense, all that remained for CMS to accomplish during its final "formal" review was determination that the waiver application in fact reflected the conversations to date. Notwithstanding the noted circumstances, there is no doubt that CMS was under substantial pressure (some have characterized it as relentless pressure) from Florida to expedite and finalize its review and decision. A special legislative session would be required to formally approve the movement from waiver approval to program design and implementation. That session had to be called and completed before the end of calendar year 2005 if program design, planning, procurement, and other steps were to be accomplished for an implementation date set for July 1, 2006.

As specified in section 409.91211(6), F.S., AHCA submitted the "Florida Medicaid Reform Implementation Plan" to the Florida legislature for approval on November 29, 2005. This Implementation Plan is a template for the rollout of Medicaid Reform in Broward and Duval Counties and compares the cost of Medicaid benefits without Medicaid Reform to the costs of Medicaid benefits with Medicaid Reform. It also served as the core focus of the legislative review that would occur in the special session.

With formal approval of the Section 1115 Waiver application and submission of the Implementation plan, legislative approval was the final step required before attention could turn from proposal to program design and, ultimately, program implementation.

The 2005 Special Legislative Session and House Bill 3B

Governor Bush called the Florida Legislature into a special session, scheduled for five days beginning December 5, 2005. While the session included consideration of a number of items, the focus requested by the Governor was Medicaid Reform and the recently approved waiver.

In anticipation of the formal onset of the special session, HB 3B¹⁷ was filed in the House of Representatives on Friday, December 2, 2005. The bill was sponsored by Representative Holly Benson and co-sponsored by Representatives Aaron Bean, Frank Farkas, Bill Galvano, Rene Garcia, Hugh Gibson, J. Dudley Goodlette, Gayle Harrell, and Ed Homan. It was read the first time on Monday, December 5, 2005, and sequentially referred to the Health Care Regulation Committee, the Fiscal Council, and the Health and Families Council. On the same day (December 5, 2005), the bill was

added to the Health Care Regulation Committee's agenda, found favorable with the Committee Substitute, and reported out. On Tuesday, December 6, 2005, the bill was found favorable and reported out by both the Fiscal Council and Health and Families Council. On Tuesday, December 6, 2005, the bill was added to the Special Order Calendar (12/7/2005). Within the next two days, 40-plus amendments were filed and either withdrawn, failed, or adopted. On Wednesday, December 7, 2005, the bill was read for a second and third time. The bill passed on the third reading as amended (Yeas 83, Nays 36) and was sent to the Senate. On Thursday, December 8, 2005, the Senate received the bill and referred it to the Health Care and Ways and Means Committees.

The Senate's comparable Medicaid bill, CS/CS 2B, was also filed on Friday, December 2, 2005. CS/CS 2B was sponsored by the Health Care Committee and Senator Durell Peadar and co-sponsored by Senators Lisa Carlton and Jeffrey Atwater. On Monday, December 5, 2005, it was referred to the Health Care and Ways and Means Committees. By Thursday, December 8, 2005, the bill had been successfully amended once and read for the third time. It was at this point that the Senate received HB 3B. CS/CS 2B was immediately withdrawn from the two Senate committees and substituted by HB 3B. On the same day, HB 3B was read for the third time in the Senate and passed as amended (Yeas 26, Nays 14). On Thursday, December 8, 2005, the bill was added to the Senate Message list where amendment 660548 was added and sent to the House. The House accepted amendment 660548 and HB 3B passed as amended (Yeas 87, Nays 31). That same day the bill was ordered engrossed and enrolled as an act. On Wednesday, December 14, 2005, the bill was signed by officers of both houses and presented to the Governor. On December 16, 2005, the bill was signed by the Governor and became law (Chapter No. 2005-358).

Key provisions of HB 3B for Medicaid Reform are summarized in Figure 2 on the following page.

Key Provisions of HB 3B for Implementation of Medicaid Reform

- Authorizes AHCA to implement the Medicaid capitated managed care pilot program in the Broward and Duval Counties and to expand the waiver to Baker, Clay and Nassau Counties within one year of becoming operational in Duval County.
 - Specifies the process for statewide expansion in accordance with the special terms and conditions of the approved waiver, with the goal of full statewide implementation by June 30, 2011.
 - Requires the matching funds for UPL/LIP program be provided by local governmental entities.
 - Requires AHCA to distribute UPL, disproportionate share hospital funds, and LIP funds according to published federal statutes, regulations, and waivers.
 - Provides legislative intent with respect to the LIP plan required under the waiver.
 - Specifies AHCA's powers, duties, and responsibilities with respect to implementing reform.
- Revises Legislative intent to include Children's Medical Services Network as an entity authorized by the state under reform.
- Requires AHCA to implement reform plan standards relating to quality assurance and performance improvement in the reform areas.
- Requires AHCA to establish an encounter database to collect data on health services provided by health care providers who provide health care services to individuals enrolled in reform managed care plans.
- Requires AHCA to implement procedures to reduce the risk of Medicaid fraud and abuse in all reform plans.
- Requires AHCA to organize a technical advisory panel to advise AHCA on risk-adjusted rate setting, benefit design, and choice counseling.
- Specifies the phase-in process for risk adjustment.
- Indicates that if any conflicts exist between the reform law and other provisions related to Medicaid Reform, the Reform law will take precedence.

With these events, AHCA turned its attention to program design, with a view to the fast-approaching "go live" date of July 1, 2006, for the state's Medicaid Reform research and demonstration project. Those parts of the process will be explored in a future paper.

Table 1: Chronology of selected key events

Date	Activity
March 30, 2004	AHCA issued letter requesting public comment on Governor Bush's intention to seek a waiver from CMS.
May 12, 2004	Governor Bush named Alan Levine as the Secretary of AHCA.
January 11, 2005	Governor Bush released "Florida Medicaid Modernization Proposal" for consideration by the Legislature.
January 19, 2005	House Speaker and Senate President established Select Committees on Medicaid Reform.
May 6, 2005	Florida Medicaid Reform authorized by Florida Legislature in SB 838.
June 3, 2005	Governor Jeb Bush signed Medicaid Reform legislation (CS/CS/SB 838) into law.
August 31, 2005	Florida Medicaid Waiver posted on State website for 30 days for public comment.
September 29, 2005	First possible submission date of waiver to the Federal Government.
October 3, 2005	Governor Jeb Bush announced the formal submission of Florida's Medicaid Reform waiver application to CMS for approval.
October 19, 2005	United States Department of Health and Human Services Secretary Michael O. Leavitt and Governor Jeb Bush announced federal approval of Florida's Medicaid Reform plan.
November 29, 2006	AHCA submitted Medicaid Reform Implementation Plan to the Legislature as mandated by SB 838.
December 8, 2005	Florida Legislature passed legislation to transform Medicaid in state of Florida.
December 15, 2005	AHCA appointed a Medicaid Reform Technical Advisory Panel.
December 16, 2005	Governor Jeb Bush signed Medicaid Reform Legislation (HB 3B) into law.

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