Florida’s Experience with Medicaid Reform
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Abstract

Florida’s Medicaid reform demonstration seeks to control costs by increasing the role of private managed care providers, encouraging marketplace efficiencies, and capping state contributions. This brief examines the market-based plan and its potential impact on access to affordable care for Florida’s vulnerable populations, and comes to the following conclusions:

- The project does not mandate or implement specific quality measures to assure quality of care; rather, managed care entities are expected to implement these independently.
- Because the plan was established through a Section 1115 Waiver, federal contributions to the state’s MA cannot be increased, a major impediment to increasing access. The state has expressed no intention to change eligibility requirements to allow the uninsured to qualify for MA.
- Under the old system of defined benefits, subscribers received all benefits appropriate for a particular diagnosis. Under the new system of defined contributions that caps state expenditures, subscribers may have to pay greater amounts out of pocket to receive equivalent levels of care. The plan also does not address costs of long term care, the largest single component of the current system.

Surveys suggest bureaucratic obstacles reduce access to providers and prescription drugs, and benefit offerings may be less generous in the second year of the demonstration than the first. It is too soon to tell whether or not the state is saving money. Until all these issues can be resolved, statewide rollout of the program should be postponed.