Florida's Medicaid Reform Demonstration: Year Three

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Funding Medicaid is currently a substantial and growing portion of many state budgets. Quality of care is another issue, and Medicaid is reputedly a low quality provider in care and accessibility. Reforms are necessary but the options appear limited. Florida is demonstrating that improvements and efficiencies can be obtained through market-based reforms. Since 2005, Florida incrementally moved toward managed competition and realized cost and utilization efficiencies. For the initial 3-year period, the data indicate that Florida's Medicaid reform initiatives are effective. A compelling question of whether such reforms can be expanded and even adopted by other states merits consideration.

INTRODUCTION

Medicaid, the joint Federal-State program that was created to provide health care for the poor, celebrated its 40th birthday in 2006. There was no party for the program (Business Week, 2005). In Florida and around the nation, Medicaid is growing at a long-term, unsustainable rate and threatens both state and federal budgets. It represented 2 percent of GDP in the year 2000 and is projected to rise to 9 percent by 2075. (Congressional Budget Office) This rate of growth, combined with other unfunded liabilities in Social Security and Medicare, could require a devastating doubling of Federal taxes and enormous increases in state funding. Indeed, the program is now larger than education in many state budgets. (State Coverage Initiatives, 2007) In fact, the latest estimate from the Medicare Trustees (Medicaid is legislatively part of Medicare) shows the present value of the nation's long-term unfunded liabilities to be $89,000,000,000,000.00. To spell it out, that's *eighty-nine trillion* dollars.

Over the past 17 years the Florida program has increased at approximately 10.4 percent annual rate versus around 6.6 percent for medical inflation generally. (Bureau of Labor Statistics, 2010) In 1990, Medicaid represented approximately10 percent of Florida's state budget. As of 2007, that total had increased to approximately 21 percent. Extrapolating these trends over 75 years or so would show Medicaid growing to over 200 percent of the state budget by 2085. Obviously, however, this trend is unsustainable and represents the major challenge to policymakers. In addition, there is a strong possibility that the expansions of Medicaid coverage mandated in pending Federal legislation will make the fiscal problem worse.

Unfortunately, the enormous fiscal problems facing Medicaid often overshadow its other major flaw. That is, Medicaid has a deserved reputation as a low quality provider of health care. It has been argued that the Medicaid population is sicker than the general population, which is probably true. What

proponents often fail to understand is that Medicaid's low quality of care is what makes some of the beneficiaries sick. The program delivers episodic treatment, poor preventative care, and a low quality of services to many of its beneficiaries. The plan also produces some tragic health outcomes for America's most vulnerable populations. Consider, for example, one of many academic findings concerning the quality of care provided under Medicaid:

> "Researchers evaluated data from over 37,000 patients younger than 65 years of age and over 59,000patients 65 years and older at 521 hospitals across the country. All patients had acute coronary syndromes. These symptoms occur when there is insufficient blood supply to heart muscle. If the blockage lasts long enough, the muscle dies causing a heart attack. The study measured the use of the recommended guidelines of the American College of Cardiology and American Heart Association. Those guidelines include recommended medications within the first 24 hours, medications and dietary advice to control cholesterol levels, counseling to stop smoking, and cardiac rehabilitation programs.
>
> "When compared to patients with HMO or private insurance, Medicaid patients were less likely to receive aspirin, beta-blockers, clopidogrel, and lipid-lowering agents. Medicaid patients were also less likely to receive dietary counseling, smoking cessation counseling, and referral for cardiac rehabilitation. Gaps also existed for acute care. Delays were observed for Medicaid patients in the time to first electrocardiogram and in time to cardiac catheterization and revascularization when these procedures were performed. Medicaid patients had higher in-hospital mortality rates (2.9 percent vs. 1.2 percent) and after adjustment, the risk for death was approximately 30 percent higher in Medicaid patients compared to those with HMOs and private insurances. Mortality rates were not significantly different for Medicare patients." (O' Shea, 2007)

Medicaid is rife with quality issues, including poor access and poor quality. Only 69.5 percent of physicians surveyed were willing to accept new Medicaid patients vs. the number willing to accept new privately insured patients (99.3 percent), Medicare patients (95.9 percent), and the uninsured (92.8 percent). This is for primary care physicians as well as medical and surgical specialists. Only 21 percent reported accepting no new Medicaid patients in 2004–05, which is six times higher than for Medicare patients and five times higher than for privately insured patients. This leads to expensive ER usage by beneficiaries. Medicaid beneficiaries' use of emergency department services (ER) for non-urgent problems is rampant in many states. The ER rate for Medicaid (80.3 visits per 100 persons) was almost twice as high as other medical groups. Assuming Medicaid beneficiaries gain access to providers, they receive inferior quality of care compared to other patients. Medicaid beneficiaries also face more difficulties scheduling adequate and timely follow-up care after initial treatment for an illness than those with private insurance.

Furthermore, Medicaid is also routinely abused by both providers and beneficiaries. This ranges from Medicaid "mills" to outright theft. There have been estimates that as much of 40 percent (over $100 billion) in Medicaid spending involves fraud and abuse. (Levy & Luo, 2005) Low estimates place fraud and abuse at 10 percent, with the higher figure of 40 percent being more accurate in urban areas.

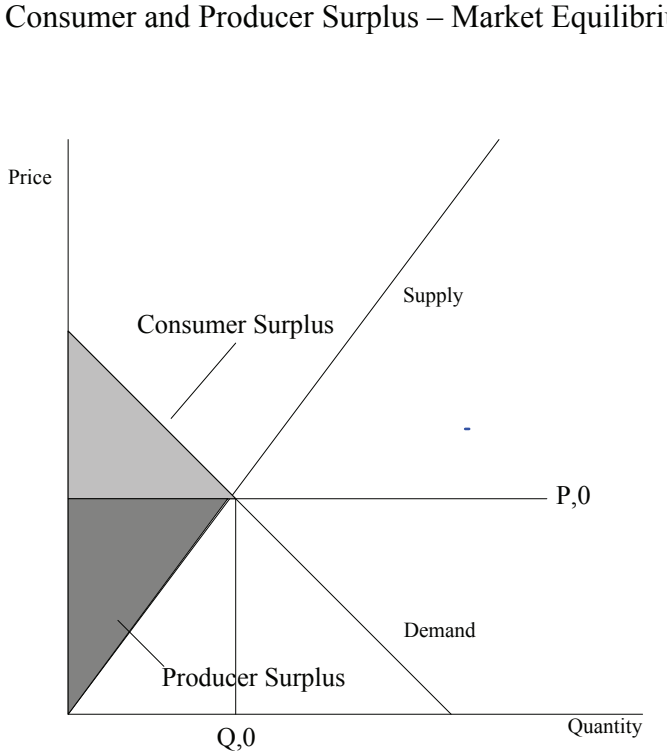
How did a well-meaning government attempt to provide quality health care for the poor end up as an actuarially bankrupt plan that delivers poor quality care? While the problems facing Medicaid are indeed complex, in one way the problem is actually quite simple: There is no real marketplace for the vast majority of health care in the United States. Any economic product and/or service where buyers have no incentive to economize and the sellers have no incentive to be efficient will face ever escalating costs. This is the fundamental problem of Medicaid and, for that matter, Medicare and much of the private medical sector. Failure to design a program with proper incentives to be cost efficient is doomed to fail.

WHAT'S WRONG WITH MEDICAID?

How does Medicaid work? Medicaid is responsible for providing medical services and care to three major groups: acute care for the poor and near-poor, for the disabled population, and for long-term care recipients. Some of these individuals would not be able to obtain coverage in the traditional health market because of their low incomes and/or the chronic nature of their health needs.

In Florida, approximately 16 percent of Medicaid's medical services funds are spent on coverage for children, with another 10 percent on health coverage for adults. Of these funds, around 32 percent is for hospital care, 7 percent for physician care, 8 percent for outpatient services, and 7 percent for drugs with the remainder for other services and Medicare "claw backs." This includes 23 percent for managed care plans. About 24 percent of the program is for coverage for the elderly, with the remaining 39 percent or so for the disabled. Of these expenditures, around 57 percent is for nursing home coverage, around 36 percent for in-home care, and the remainder for ICF. (Kaiser Family Foundation, 2010) Medicaid thus serves as a needed program for those who would fall "between the cracks" in our healthcare system. This is grounded in the American tradition of helping the less fortunate. Unfortunately, a system that bankrupts the State of Florida and the Federal Government while providing a low quality of care serves no one's interests. (Kaiser Family Foundation, 2010)

FIGURE 1
CONSUMER AND PRODUCER SURPLUS – MARKET EQUILIBRIUM



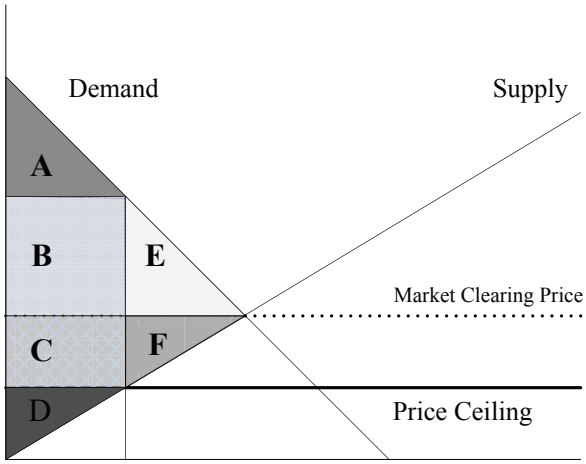
The fundamental problem of Medicaid is a flawed program design. Medicaid does not rely on a market in the traditional sense of buyers and sellers acting in their own interest in a decentralized marketplace. Instead, it is an "administered pricing" system where various schemes are used to determine reimbursements. This system ranges from cost-based reimbursement for nursing homes to prospective

payments for acute care. We believe this is the Achilles Heel of the current program. Any efforts to fix Medicaid need to address this payment system.

FIGURE 2
IMPACT OF PRICE CEILING ON EFFICIENCY

Impact of Price Ceiling on Efficiency

A+B+C – New CS
A+B+E – Old CS
D – New PS
C+D+F – Old PS



E+F is the *Deadweight Loss* Associated with Price Ceiling

All administered pricing schemes are fundamentally flawed due to the "information problem." Centralized systems and price determination often appear attractive. In reality, they suffer from this basic problem: In order to know where resources should be directed, the central planners and price setters need to know both what goods and services people want and how they can be most cheaply produced. But this knowledge is held in the minds of individual consumers, businesses, and providers, not in the filing cabinets or computers of a government planning agency such as Medicaid. The only practical way for consumers and providers to relay this knowledge to each other is through a decentralized system of market-determined prices. (Hayek, 1945)

These price-control schemes produce myriad problems: They result in shortages of the goods or services subject to control. They lead to reductions in the quality of the goods or services subject to control. They divert economic activity and investment from heavily controlled sectors into less controlled, or uncontrolled, sectors. They benefit well-connected and richer consumers at the expense of others. They encourage black markets. In addition, the longer they are in effect, the worse shortages of goods and services become, and the more painful the adjustment process back to market prices. They lead to costly and unpopular methods of allocating goods and services, such as queuing, rationing, and bribes. They reduce the penalties for discrimination by sellers and reward those sellers who game the system. (Haislmaier,1993)

An example of the negative impact of price controls is shown in Figures 1 and 2. A free market exists in Figure 1, where supply and demand determine the good or service in question. The benefits to consumers are the triangle called "consumer surplus," and the profits to producers are shown as "producer surplus." In Figure 2, the government imposes a "price ceiling" in the market. There are several impacts. First, there is a shortage of the good or service. Second, there is a decline in the profit/income of

producers. Third, there is a possible dollar decline in the benefit to consumers. This graphical analysis cannot show quality declines which are particularly important in medical care. In the real world, from above, price controls produce low quality health care.

FIXING THE PROBLEM

The solution to the quality and cost problems in government-run plans such as Medicaid and Medicare, as well as some of the markets in the private sector, involves "opening the markets and leveling the playing field." Employers should band together and create "insurance exchanges" where employees can choose from numerous competing plans. Employers would provide funding for employees to spend at these "marts." This is also the solution to the problems facing Medicaid.

While this model may seem worlds away from Florida's current Medicaid program, it is actually a reform within the state's grasp. The State of Florida received approval from the Federal Government to begin converting its Medicaid plan to the exchange model. Although these reforms are still in their early stage, they are working well.

What would happen under broad-based market reforms in Florida? We can surmise that competition and innovation would bend down the long-run growth rate of the Florida Medicaid Plan. Given that productivity growth has accelerated from essentially zero to around 2 percent in the service sector since 1995, efficiency gains in the health sector should result from the creation of a real marketplace. If the Medicaid Reform could produce the same productivity gain as the private service sector, Medicaid would be only 25 percent as large as currently projected in the year 2085.

REAL MEDICAID REFORM: FLORIDA'S DEMONSTRATION

The State of Florida received CMS approval for the broadest reform in the history of Medicaid in October 2005. The plan involves real managed competition as well as an innovative health savings account devised for beneficiaries. It will allow for much more predictability in Medicaid spending, and is unprecedented in allowing providers flexibility in designing benefits packages for the diverse needs of enrollees. The plan is initially a demonstration in Broward and Duval Counties.

Under this waiver, beneficiaries will receive a risk-adjusted credit to purchase health care from competing prepaid plans. The fee-for-service approach will be effectively eliminated. This is important, because fee-for-service plans cannot effectively control utilization without significant cost sharing, which is obviously impractical in plans for low income groups. This is a major improvement over Medicaid's existing managed-care programs. The credit is used to purchase two types of coverage, comprehensive care and catastrophic care. The beneficiary only sees a particular plan and its benefits.

Comprehensive care is essentially the routine care needed by most individuals. Catastrophic coverage is used to pay for very high medical bills. The purpose of the split is to encourage a host of providers to enter the marketplace and compete for beneficiary credits. Large HMOs in urban areas enrolling tens of thousands of beneficiaries will receive little or no catastrophic payment since they are well capitalized and, due to the law of large numbers, are able to reasonably predict the costs of providing such services. Smaller groups will receive a much higher credit for catastrophic coverage because a few very sick individuals could quickly bankrupt them since they must operate as prepaid plans.

This will help produce real managed competition. Providers will have an incentive to enroll any part of the Medicaid population, whether healthy or sick, because the payments are risk adjusted. Furthermore, the catastrophic coverage portion of the plan will allow smaller groups of health care innovators to enter the marketplace. Competition, in turn, will spur efficiency gains that will slow the cost inflation in Medicaid. Just as important, the ability of beneficiaries to switch providers if they are unhappy with their care will give providers a strong incentive to "treat their customers well" or lose actuarially fair payments from them. This, in effect, creates a real marketplace for health care.

Since everyone will have a gatekeeper physician whose group has an incentive to control costs, the providers may be expected to focus resources on preventative care that could reduce or eliminate

Medicaid's major cost drivers. Unlike the Medicare population, which by definition is older, many of Medicaid's large costs are behavioral in nature. For example, the inability to obtain good prenatal care sometimes results in low birth-weight babies with huge expenses. Another factor in Medicaid's growing costs is obesity and the health problems it can cause. Current Medicaid managed care gives providers an incentive to "cherry pick" rather than manage diseases and prevent them when possible. The risk adjusted, competitive model that Florida has developed will reduce those perverse incentives.

Another incentive for healthy behavior among beneficiaries involves the establishment of an enhanced benefits program. This is essentially a "reverse health savings account" where enrollees receive credits into their account if they follow healthy practices. These may include obtaining immunizations, blood pressure checks, diabetes spot checks, and other preventative treatments that have documented payoffs in terms of reducing major problems down the road. These funds may be used to purchase additional medical services or may be used to buy employer or individual health insurance upon leaving Medicaid.

A further innovative aspect of the Florida plan is the ability of prepaid providers to design different benefits packages. In all previous Medicaid plans the state must provide a minimum benefits package as established by the Federal Government and to expand that based on state choices. But once the plan is established, all providers must offer the entire package. This "one size fits all" approach is a great impediment to the efficient, low cost delivery of medical care.

Under Florida's new approach, providers will have great flexibility in designing packages for specific parts of the Medicaid population. One group may wish to enroll the mentally ill, another for those afflicted with AIDS, and a third focusing on providing OB/GYN services. Since their payments from Medicaid are related to the risk of enrolling beneficiaries, there will be little incentive to discretely "cherry pick." Recalling the catastrophic portion of the plan (essentially reinsurance above certain cost amounts) will allow very small, niche providers to specialize in offering care to some of Medicaid's most challenging beneficiaries such as the mentally disabled. Florida has also mandated a prepaid plan for long-term care for the elderly. This waiver has been approved by CMS.

While other states have used aspects of their Medicaid plans to subsidize employer-based health care for non-Medicaid individuals, Florida's proposal goes a step further and allows those enrolled to purchase health care from their employers using the value of their risk-adjusted credit. This plan will move some individuals back into the labor market, and, in some instances, into better jobs that offer health coverage to employees. The prepaid nature of the program may be expected to reduce fraud and abuse that is rampant in Medicaid. Finally, like all private sector coverage, there is an overall limit on benefits limit to beneficiaries. This, along with the defined contribution nature of the plan, will increase the predictability of Florida's Medicaid spending in the future. (Bond, 2005)

CAN FREE MARKETS IMPROVE QUALITY AND REDUCE HEALTHCARE COSTS?

Would the free enterprise system really help Medicaid's beneficiaries and improve Medicaid's fiscal situation? Or is the purchase of health care simply too sophisticated for most people to deal with, especially the poor? Fortunately, we have some answers to these questions based upon recent experience.

It is true that broad market-based reforms are virtually non-existent in Medicaid. In the past, Federal bureaucrats have looked unfavorably on significant, free-market reforms. While attempts have been made to utilize HMOs, these continue to suffer from administered pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system. Recently, however, a more receptive attitude in Washington may permit more experimentation with changes in the system.

While the private sector suffers from many of the same problems as the public sector, we can see how a free market in medical care would operate. Most people did not have prescription drug coverage until the 1980s and 90s. They paid out of pocket. The result was a 34 percent increase in drug costs between 1960 and 1980 contrasted with a 236 percent increase in the general cost of medical care. After prescription drug coverage became much more commonplace, prescription drug costs rose 336 percent vs. 281 percent for general health care from 1980 through 2002.

In cash medical markets, such as cosmetic care, the results are what would be expected. Along with continuing advances in quality, innovations, and comfort, the discipline of the market serves to control costs. Cosmetic care rose at a lower rate than general inflation between 1992 and 2001, while general medical inflation was three times greater. Eye-care costs -- where there is not nearly as much third-party payment -- increased 33 percent between 1990 and 2002, while general medical costs increased 75 percent. This occurred during a period when there were dramatic advances in eye-care technology and services such as LASIK. In addition, the cost of other types of medical services, such as podiatry and chiropractic care (which are often not insured) rose at only 43 percent between 1990 and 2002 vs. that general medical inflation rate of 75 percent. (Herrick, 2003)

HOW IS BROAD BASED MEDICAID REFORM WORKING? MORE COMPETITION IN PLANS

Before reform, Medicaid contracted with various managed-care programs including eight HMOs, two PSNs, a pediatric emergency room diversion program, and two minority physician networks (MPNs) for a total of 12 managed-care programs in Broward County. Medicaid had contracted with two HMOs and one MPN for a total of three managed-care programs in Duval County. The pediatric emergency room diversion and minority physician networks in Broward and Duval counties prior to implementation of Medicaid reform operated as prepaid ambulatory health plans.

Currently, there are 15 plans operating in Broward County. These include 10 HMOs and five PSN plans. There also two HMO plans currently pending, which would increase the total in Broward to 17 plans. In Duval County, there are now four HMOs and three SPN Plans operating, with an additional PSN completing its application for a total of eight plans. It is obvious that reform has increased the number of competing plans in these counties. This is despite the withdrawal of five plans from the reform. Their withdrawals appear unrelated to reform but rather to a state-mandated reduction in payments based on the difficult budget situation. In addition, a second special needs plan (for HIV/AIDS patients) is nearing approval. Contrast this with the nearly 90 percent of private businesses that offer only one health plan to their employees.[1]

MORE COMPETITION IN BENEFITS PACKAGES

While the reform plans may not discriminate among enrollees in the actuarial value of the benefit packages they offer, they are allowed to offer different coverage items and co-pays. In terms of co-pays, after the withdrawal of several plans in year three, the number of services/procedures with co-pays has declined from 82 in year one to 40 in year three. The specific co-pays are listed in Table 1.

In the third year of reform, in order to attract enrollees, many plans continued to provide services not currently covered by Medicaid. There were 11 different expanded services offered by the health plans during Year Three. The two most popular expanded services offered were the same as Year Two: the over-the-counter (OTC) drug benefits and the adult preventive dental benefits. Thirteen of the customized benefit packages decreased their OTC value, while one added a $25 OTC benefit. The expanded services available to beneficiaries include an over-the-counter drug benefit ranging from $20 to $25 per household, per month; adult preventive dental care; circumcisions for male newborns; acupuncture; additional adult vision care, up to $125 per year for upgrades such as scratch-resistant lenses; additional hearing care, up to $500 per year for upgrades to digital, canal hearing aids; respite care; and nutrition therapy.

MORE ENROLLEE INVOLVEMENT

A major goal in the reform is to make beneficiaries active participants in their own health care. As part of the plan of increasing health literacy among enrollees, Florida Medicaid established a target of 65 percent of voluntary enrollments in the first year of the reform. In the second year of reform the goal was

increased to 80 percent. The actual enrollment amount done voluntarily by beneficiaries in Year One was more than 67 percent. Thus, the program achieved its first-year goal. Further, the voluntary enrollment trend was upward. The amount was 62 percent in the second quarter, 66 percent in the third quarter, and close to 75 percent in the fourth quarter. These figures are for new eligibles only.

TABLE 1
NUMBER OF CO-PAYMENTS BY TYPE OF SERVICE BY DEMONSTRATION YEAR

Type of Service	**Year One**	**Year Two**	**Year Three**
Chiropractic	10	0	4
Hospital Impatient: Behavioral Health	11	1	4
Hospital Inpatient: Physical Health	7	1	4
Podiatrist	10	0	3
Hospital Outpatient Services (Non-Emergency)	7	1	3
Hospital Outpatient Surgery	7	1	4
Mental Health	7	3	2
Home Health	4	1	4
Lab/X-Ray	5	1	3
Dental	4	4	0
Vision	4	0	1
Primary Care Physician	0	0	1
Specialty Physician	1	1	2
ARNP/Physician Assistant	0	0	1
ClinicFQHC, RHC	0	0	2
Transportation	5	5	2
Total Number of Required Copayments	82	19	40

TABLE 2
NUMBER AND PERCENT OF TOTAL BENEFIT PACKAGES REQUIRING NO CO-PAYMENTS BY YEAR

	Year One	**Year Two**	**Year Three**
Total Number of Packages	28	30	24
Total Number of Packages - No Copayments	12	16	20
Percent of Packages - No Copayments	43 percent	53 percent	83 percent

The new eligible numbers for self-selection have not been reported since June 2008, due to issues with daily filing and month-end processing transfers between the new fiscal agent and the state‘s choice counseling vendor. According to Florida Medicaid (FM), this should be complete within six months. When the corrections are in place, FM anticipates that reform will not only meet but will exceed the 80 percent minimum standard set in the self-selection rate for Year Four. Direct survey of enrollees (below) seems to confirm this view.

A significant amount of health problems in the United States and in Florida may be related to individual behavior. This is particularly true with regard to the Medicaid population. (Thorpe, 2004) Related to this, Florida Medicaid established an innovative Enhanced Benefits Account program (EBA). This is essentially a reverse health savings account. Upon enrollment, each beneficiary receives an EBA with a zero balance. The enrollee may then earn dollar credits by undertaking "healthy behaviors." These are included in a list of practices and medical protocols that have been determined to be beneficial to enrollee health outcomes and cost-effective for the Medicaid program. These funds may then be used to purchase a wide variety of products related to all aspects of health.

Table 3 shows the activity in the EBA Program through the first three years. A total 272,424 health activities have been undertaken with recipients earning a cumulative $21,804,814. Approximately 41 percent of these credits have been spent by beneficiaries. Table 4 shows the types of health activities engaged in so far. The vast majority involve office visits for adults and children and child and adult preventative care. Uses of the earned credits are shown in Table 5 with child rearing items being the most prevalent. At this time it is not known whether the EBAs have positively influenced health outcomes and/or reduced costs. The impact of the EBA program on reducing total Medicaid expenditures will be completed in demonstration Year Five.

TABLE 3
ENHANCED BENEFITS PROGRAM

Year	Number	$ by Date Created	$ by Date of Service	Purchases	%Part
1	91, 564	$4,317,999	$5,005,381	$113,172	0.02%
2	178,494	$10,737,460	$10,718,877	$2,432,729	23%
3	272,424	$6,748,755	$6,079,955	$6,384,497	105%
TOTAL		$21,804,214	$21,804,214	$8,930,398	41%

HOW HAS THE OPT OUT PROGRAM WORKED?

For individuals who chose to opt out of Medicaid reform plans, Florida Medicaid established a database that captures their employer's health-care premium information and whether the premium is for individual or family coverage. The goal was to allow FM to compare it to the premium Medicaid would have paid. In addition, the agency enters in the opt-out programs database the reason why an individual who initially expressed an interest in and was provided information on the program from a choice counselor decided not to opt out of Medicaid.

Why do some individuals opt out? According to FM, there are several reasons, including their primary care physician not being enrolled in a Medicaid reform health plan or because they or a family member have some kind of employer-subsidized coverage through their job. Conversely, individuals deciding against opting out did not have a job or, if they did, were not eligible for the firm's plan. Some also preferred Medicaid plans due to the availability of no co-pays and deductibles.

So far the program has been a major disappointment in terms of the number who have participated. A total of 61 individuals have enrolled in the Opt Out Program since its inception. Of these, 40 individuals have ended their disenrollment from the Opt Out Program due to loss of job, loss of Medicaid eligibility, or disenrollment from commercial insurance. This leaves just 21 individuals enrolled in the Opt Out Program.

TABLE 4
HEALTHY BEHAVIOR COUNTS AND $
(September 2006 - June 2009 by date of Service)

Procedure	Count of Procedure Code	Sum of Granted Credit Amount
Office Visit - Adult/Child	477,571	$8,678,465.00
Childhood/Adult Preventative Care	360,018	$8,796,447.50
Maintenance Drug	185,978	$1,393,587.50
Dental	52,878	$1,314,635.00
Eye Adult/Child	28,427	$708,167.50
Pap Smear	29,000	$723,067.50
Mammogram	2,986	$73,630.00
Colorectal Screening	126	$42,692.50
Hypertension Disease	1,034	$25,312.50
Management Program - Diabetes Disease	744	$21,622.50
Management Program - Asthma Disease	628	$15,530.00
Management Program - HIV/AIDS Disease	299	$7,422.50
Management Program - Congestive Heart Failure	117	$2,857.50
Administrative Credit	10	$151.16
Adult Dental Cleaning (preventive service)	3	$45.00
Other Disease Management Program	21	$515.00
Flu Shot	2	$50.00
Smoking Cessation 6 months Success	1	$15.00

TABLE 5
TOP 10 BENEFICIARY PURCHASES

#	Description	Count	Sum	Average
1	Huggies Ultratrim	93143	-$931141.98	-$10.00
2	Pampers Baby-Dry	61238	-$611,121.04	-$9.98
3	Huggies Pull-Ups	57270	-$556,854.25	-$9.72
4	Huggies Baby Wipes	105166	-$412,393.2	-$3.92
5	Listerine Antiseptic	41825	-$171,192.2	-$4.09
6	Huggies Baby Wipes Nat Care	33240	-$143,175.41	-$4.31
7	Huggies Ultratrim Step 4	8413	-$102,762.26	-$12.21
8	Huggies Supreme	9669	-$92,453.08	-$9.56
9	Blood Pressure Monitor	4425	-$89,033.39	-$20.12
10	Comfort-Stretch	12519	-$87,317.63	-$6.97

ARE ENROLLEES SATISFIED WITH THEIR REFORM PLANS?

One of the goals of reform was to increases the quality of medical care obtained by Medicaid beneficiaries. Implicit in this is the level of satisfaction among plan enrollees. The University of Florida has been surveying reform plan members to determine the impact of the change on member satisfaction. (Duncan, P., et. al., 2009) An initial survey conducted in 2006 was updated with another survey in 2008. The findings were generally positive. The majority of enrollees in the original reform counties stated that they had not had a problem finding a doctor or nurse they were satisfied with, that they communicated well with their providers, that they selected their own health plan, and that their overall plan satisfaction was very high (9 or 10 on a scale of 1 to 10, with 10 being the best).

More than 80 percent of those surveyed reported that it was not a problem to see their personal physician, and around 50 percent stated that it was easy to be seen by a specialist. These findings were basically the same in both Broward and Duval counties. There did not appear to be significant differences in satisfaction based on enrollment in HMOs vs. PSN plans. However, satisfaction levels were somewhat lower for SSI beneficiaries. Those enrolled in reform plans in the expanded counties of Baker, Clay, and Nassau also gave plans high marks.

The updated survey in Duval County revealed no significant changes in satisfaction related to overall plan rating, satisfaction with care, personal doctor ratings, and specialist ratings. In Broward County, there was a decline in overall plan rating at the highest level, but personal doctor ratings increased. SSI member ratings declined by seven points in Broward County and by three points in Duval County. The researchers also point out that it seems reasonable to expect some decline from patients switching from "unmanaged" to "managed" care. In this light, the beneficiary ratings are primarily positive. Survey results are shown in Table 6 (Appendix 1).

IS THE REFORM BUDGET NEUTRAL?

As with all 1115 waivers, the Florida Medicaid reform plan must be "budget neutral." This form of neutrality is defined as not increasing the cost to the Federal Government by spending more than would have been spent in the absence of the 1115 waiver. The mechanics of this neutrality provide that program expenses and the Federal matching portion of the funding may not to exceed a budget amount agreed to by Florida Medicaid and CMS. According to the waiver from CMS, there are three groups impacted by the reform. These include SSI related individuals, temporary assistance to needy family individuals or the

children and families portion of Medicaid, and Low Income Pool individuals. Budget neutrality for the Low Income Pool portion of the reform is straightforward. It cannot exceed a total expenditure of $1 billion per year.

The budgeted amounts for SSI and for children and families is based on five years of historical expenditure per program. The trend for this amount is then applied to the fifth historical year of the data and extrapolated out five years to establish benchmarks for the program's budget neutrality. These future budget benchmarks are allowed some flexibility by CMS, and this was negotiated by Florida Medicaid in the waiver that was approved. For the most part, Medicaid services available under the old plan are available under the reform. Thus, the budgeting is essentially an apples-to-apples comparison. Eligibility in the two groups is determined upon application for Medicaid. When an application is approved, FM determines which program an individual should be enrolled in. There are a few eligible individuals were waived from enrolling in reform plans. Expenditures on them are obviously not counted as part of the reform budgeting neutrality. However, some of these may, if they choose, enroll in reform plans. These include dual eligibles and pregnant females. In addition, refugee eligibles, the medically needy, institutionally cared and developmentally disabled individuals, unborn children, state mental facilities, family planning individuals, women with breast cancer or cervical cancer, and Medikids do not have to enroll in reform plans. There are certain services that are also excluded from reform plans, and, last, do not enter into budget neutrality calculations. These include but are not limited to AIDS waiver services, developmentally disabled services, home behavioral services, behavioral health overlay services, supported living waiver services, spinal cord waiver services, and school based and Healthy Start waiver services. The major statistics used for calculation of budget neutrality is the calculated per capita cost per month (PCCM). This is total expenditure divided by the case months. Next is the "WOW PCCM." This is the per capita cost per month that would have existed "without the waiver" (WOW). It is this amount that represents the upper limit for the maintenance of budget neutrality. These are shown in Table 7 for Medical Eligibility Group 1 (SSI) and Medical Eligibility Group 2 (Children and Families):

TABLE 7
PER CAPITA COST PER MONTH ANALYSIS (PCCM)

	MEG 1	**MEG 2**
PCCM Targets WOW PCCM		
DY01	$948.79	$199.48
DY02	$1,024.69	$215.44
DY03	$1,106.67	$232.68
DY04	$1,195.20	$251.29
DY05	$1,290.82	$271.39

Table 8 (Appendix 2) compares the annual actual PCCM with the WOW PCCM. The key number here is % of WOW PCCM, which represents the actual expenditure by medical group relative to the negotiated budget neutral amount. With the exception of Year 1 MEG 1 where PCCM was 2.46% above budget the reform for both groups has been budget neutral. In addition, as shown in Table 9 (Appendix 3), the combined medical groups have been budget neutral in all three years of reform.

It should be noted that actual PCCM for both medical groups declined from Year One to Year 3 of reform. MEG 1 decreased from $972.13 to $962.75 while MEG 2 declined from $160.23 to $154.04.

HAS THE REFORM REDUCED COSTS?

The above decline in PCCM could be interpreted as the reform having reduced costs. However, a better measure of cost reduction is to compare expenditures in reform counties with those of counties with similar characteristics that are not in the reform demonstration. University of Florida researchers compared expenditure patterns in Duval and Broward Counties with non-reform Hillsborough and Orange Counties. (Duncan, et. al., 2009) Hillsborough includes the city of Tampa while Orange includes Orlando. These counties are reasonably similar to the two reform counties. They are also similar in terms of health plan types with 55 percent enrollment in HMOs in Broward and Duval and 67 percent in the control counties. The control counties did not have PSN plans, so traditional fee-for- service Medicare (Medipass) was used as a proxy. The results are shown in Tables 10, 11, and 12. Table 10 shows average HMO PCCM:

TABLE 10
PCCM EXPENDITURE FOR HMO ENROLLEES

	Broward/Duval		Control Counties		Difference	
	MEG 1	**MEG 2**	**MEG 1**	**MEG 2**	**MEG 1**	**MEG 2**
Prereform	668	126	512	118		
Reform	772	138	623	121		
Change	104	12	111	3	7	-9

TABLE 11
PCCM EXPENDITURE FOR MEDIPASS/PSN ENROLLEES

	Broward/Duval		Control Counties		Difference	
	MEG 1	**MEG 2**	**MEG 1**	**MEG 2**	**MEG 1**	**MEG 2**
Prereform	894	128	860	139		
Reform	799	112	1038	157		
Change	-95	-16	178	18	273	34

TABLE 12
PCCM EXPENDITURE FOR ALL ENROLLEES

	Broward/Duval		Control Counties		Difference	
	MEG 1	**MEG 2**	**MEG 1**	**MEG 2**	**MEG 1**	**MEG 2**
Prereform	809	127	683	126		
Reform	783	131	833	136		
Change	-26	4	150	10	176	6

Has the reform reduced costs? The initial, cautious answer appears to be yes. During the first two years of reform, expenditures in Broward and Duval Counties were lower on per member per month basis. Enrollees, as above, are broken into Medical Eligibility Groups. Group 1 consists of those who assess Medicaid through SSI, and Group 2 consists of those who access through Children's and Women TANF.

The MEG 1 appears to have higher savings than the MEG 2 group. This is true for both HMO and PSN plans. PSNs appear to be saving somewhat more money, especially for the MEG 1 group. Expenditures were slightly higher for the MEG 2 group enrolled in HMOs. It should be noted that these numbers may not be directly comparable as the group of enrollees in the pre-reform period in all counties is not necessarily the same beneficiaries in the post reform period. If relatively healthier enrollees were signing up in the reform counties, then the lower cost assertion would not be valid.

HAS THE REFORM IMPROVED MEDICAL CARE?

Has the increase in plan choices and larger benefits packages improved beneficiary health? Continued delays in the collection of patient encounter data have made a more detailed analysis of this issue problematic. But some initial evidence suggests that the answer is yes. Table 13 shows ambulatory sensitive hospitalizations per 1,000 enrollees. Prior to reform, the rates were 2.09 and 1.85 for non-HMO and HMOs, respectively. In both years 2007 and 2008 reform HMOs and reform PSNs had lower rates than traditional coverage.

Data on 28 different health outcome measures (ranging from blood pressure screening to prenatal care) indicate that 14 are above national averages for reform plans as opposed to nine for non-reform enrollees. Further, reform plans have better outcomes in 20 of the health categories vs. eight for non-reform plans. In addition, health quality seems to be improving over time in the reform plans. In the 17 categories where data are available for two years, reform plan outcomes have improved in all but one category. This contrasts with 10 categories improving in non-reform plans. These results are shown in Table 14 (Appendix 4).

TABLE 13
AMBULATORY SENSITIVE HOSPITALIZATION COMPARISON OF AVERAGE INPATIENT ADMISSION RATES PER 1,000 ENROLLEES

	Prereform	2007	2008
Average	2.09	2.07	2.07
Non-Reform HMO	1.85	1.94	1.99
Reform HMO		1.8	1.76
Reform PSN		1.7	1.7

THE IMPACT OF PROPOSED REFORM ON MEDICAID

As of this writing, conferees in the U.S. House and Senate are working to reconcile their different health reform bills. These proposals will have significant impacts on Medicaid in Florida and the whole nation. These include but are not limited to the following:

- *Medicaid Income Eligibility* – The House Bill expands Medicaid income eligibility to 150 percent of the poverty level while the Senate expands to 133 percent.
- *Determining Income Eligibility* – House Bill has no financial resource or asset test and requires separate SCHIP coverage to enroll in Medicaid. Senate Bill has no income, asset, or financial resource test (with the exception of the elderly and SSI enrollees).
- *Childless Adult Eligibility* – Under both bills coverage is extended to childless adults up to the 150 percent and 133 percent of poverty income, respectively.
- *Fiscal Impact* – The House Bill increases Medicaid coverage by 20 million individuals and increases costs by $425 billion in the first 10 years. Given state matching funds, it is estimated state Medicaid spending will increase by $34 billion in the first 10 years. The Senate Bill also increases enrollment by 20 million and increases costs by $395 billion in the first ten years.

Estimated state spending will increase by $26 billion. DSH are reduced by $10 billion under the House Bill and $18.5 billion under the Senate Bill.

- *Benefit Requirements* – House Bill prohibits enrollment of childless adults in managed care programs unless the state demonstrates these plans meet "minimum" standards of care. It also requires podiatric and optometrist services. Both plans require a benefits package of services no less than newly created "health exchanges" require for private enrollees.
- *Provider Payments* – House Bill requires states to increase primary care payments to those of Medicare with states ultimately covering 9 percent of the increase. Both bills expand Federal authority to experiment with regulatory and payment changes to improve care quality and reduce medical inflation. Both bills establish seed funding and Federal match of funds for demonstrations related to supposed innovative programs.
- *Long-Term Care* – Both bills establish national, voluntary long-term care insurance program (CLASS).

Estimates of the fiscal cost of these programs are tremendously understated as reviews from the Congressional Budget Office are limited to 10 years and are back loaded because benefits will not begin for several years. Further, because of the state's high uninsured rate, the current total of 2.7 million beneficiaries could grow by almost 50 percent. The estimated cost of the 9 percent state pick up on new enrollees is in excess of $400 million per year. (Florida AHCA, 2010)

SUMMARY AND CONCLUSION

Florida's Medicaid Reform has entered its fourth year. While it's still early, the initial results are encouraging. The reform has increased competition among health plans, reduced co-pays, and expanded and diversified patient benefits.

ENDNOTES

1. Unless stated otherwise, all data is from the Agency for Health Care Administration publications or direct communication with AHCA officials. Private employment data is from the Kaiser Family Foundation.

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APPENDIX 1

TABLE 6
BENEFICIARY SURVEY RESULTS
Select Satisfaction Measures: Broward and Duval Counties

Percent Rating 9 or 10 (Highest Satisfaction Level)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.10	57.37
Overall Satisfaction with Care	66.54	59.63
Personal Doctor Rating	70.19	73.41
Specialist Rating	60.39	63.32

Select Satisfaction Measures: SSI (Broward Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	53.39	45.76
Overall Satisfaction with Care	56.41	48.68
Personal Doctor Rating	67.09	67.01
Specialist Rating	64.56	64.35

Select Satisfaction Measures: Non-SSI (Broward Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	59.88	60.10
Overall Satisfaction with Care	68.98	62.53
Personal Doctor Rating	70.97	76.64
Specialist Rating	60.29	62.58

Select Satisfaction Measures: SSI (Duval Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	55.91	53.12
Overall Satisfaction with Care	59.19	55.38
Personal Doctor Rating	69.41	68.82
Specialist Rating	63.80	58.65

Select Satisfaction Measures: Non-SSI (Duval Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	57.57	58.74
Overall Satisfaction with Care	68.40	60.87
Personal Doctor Rating	70.29	71.88
Specialist Rating	55.0	65.88

Select Satisfaction Measures: PSN (Broward Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	57.96	56.11
Overall Satisfaction with Care	63.67	60.82
Personal Doctor Rating	70.56	76.19
Specialist Rating	61.93	62.72

Select Satisfaction Measures: HMO (Broward Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: PSN (Duval Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: HMO (Duval Only)

Percent Rating 9 or 10 (Highest Level of Satisfaction)	Benchmark Survey	Year 1 Follow-Up Survey
Overall Plan Satisfaction	55.33	56.72
Overall Satisfaction with Care	64.01	59.54
Personal Doctor Rating	66.98	69.67
Specialist Rating	49.11	62.07

APPENDIX 2

TABLE 8
MEG 1 AND 2 ANNUAL STATISTICS

DY 01 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total		2,978,415	$2,825,890,368		$948.79
Difference					$69,527,564
% of WOW PCCM MEG 1					**102.46%**
DY01 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total		15,162,819	$3,024,679,134		$199.48
Difference					($595,158,233)
% of WOW PCCM MEG 2					**80.32%**
DY02 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
MEG 1 - DY02 Total	3,033,969	$2,632,920,981	$441,425,660	$3,074,346,641	$1,013.31
WOW DY2 Total		3,033,969	$3,108,877,695		$1,024.69
Difference					($34,531,053)
% of WOW PCCM MEG 1					**98.89%**

DY02 – MEG 2	Actual CM	MEG 1 & 2 Actual Spend	Total	PCCM	
MEG 2 - DY02 Total	14,829,991	$2,246,768,250	$264,010,165	$2,510,778,415	$169.30
WOW DY2 Total		14,829,991	$3,194,973,261		$215.44
Difference					($684,194,846)
% of WOW PCCM MEG 2					**78.59%**
DY03 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
MEG 1 - DY03 Total	**3,249,742**	$2,681,127,304	$447,570,779	$3,128,698,083	$962.75
WOW DY3 Total		**3,249,742**	$3,596,391,979		$1,106.67
Difference					($467,693,896)
% of WOW PCCM MEG 1					**87.00%**
DY03 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
MEG 2 - DY03 Total	**17,094,840**	$2,369,832,024	$263,413,450	$2,633,245,474	$154.04
WOW DY3 Total		**17,094,840**	$3,977,627,371		$232.68
Difference					($1,344,381,897)
% of WOW PCCM MEG 2					**66.20%**

APPENDIX 3

TABLE 9
MEG 1 AND 2 CUMULATIVE STATISTICS

DY 01	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW		18,141,234	$5,850,569,502		$322.50
Difference					**($525,630,669)**
% Of WOW					**91.02%**
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
Meg 1 & 2	17,863,960	$4,879,689,231	$705,435,825	$5,585,125,056	$312.65
WOW		17,863,960	$6,303,850,956		$352.88
Difference					**($718,725,900)**
% Of WOW					**88.60%**
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend**	**Total**	**PCCM**	
Meg 1 & 2	**20,344,582**	$5,050,959,328	$710,984,229	$5,761,943,557	$283.22
WOW		**20,344,582**	$7,574,019,350		$372.29
Difference					($1,812,075,794)
% Of WOW					**76.08%**

APPENDIX 4

TABLE 14
2009 PERFORMANCE MEASURE RESULTS

	Non-Reform			Reform			
Measure	**2008**	**2009**	**Difference**	**2008**	**2009**	**Difference**	**National Mean**
Annual Dental Visit	n/a	n/a	n/a	15.20%	28.50%	13.30%	42.50%
Adolescent Well-Care	41.90%	46.00%	4.10%	44.20%	46.50%	2.30%	43.60%
Controlling Blood Pressure	52.70%	51.60%	-1.10%	46.30%	55.90%	9.60%	52.90%
Cervical Cancer Screening	56.60%	53.80%	-2.80%	48.20%	52.20%	4.00%	65.70%
Diabetes - HbA1c Testing	74.70%	75.10%	0.40%	78.90%	80.10%	1.20%	78.00%
Diabetes - HbA1c Poor Control INVERSE	48.50%	51.70%	3.20%	48.30%	46.80%	-1.50%	48.70%
Diabetes - Eye Exam	36.30%	41.90%	5.60%	35.70%	44.00%	8.30%	51.40%
Diabetes - LDL Screening	75.60%	76.30%	0.70%	80.00%	80.20%	0.20%	71.10%
Diabetes - LDL Control	29.50%	29.40%	-0.10%	29.30%	35.90%	6.60%	30.60%
Diabetes - Nephropathy	77.10%	76.10%	-1.00%	79.20%	80.30%	1.10%	74.60%
Follow-up after Mental Health Hospital - 7 day	30.50%	37.20%	6.60%	20.60%	29.30%	8.70%	39.10%
Follow-up after Mental Health Hospital - 30 day	47.00%	51.70%	4.80%	35.50%	46.60%	11.10%	57.70%
Prenatal Care	71.70%	69.10%	-2.60%	66.60%	67.40%	0.80%	81.20%
Postpartum Care	58.50%	50.10%	-8.40%	53.00%	51.50%	-1.50%	59.10%
Well-Child First 15 Months - Zero Visits INVERSE	2.80%	3.00%	0.20%	4.90%	1.60%	-3.30%	3.80%
Well-Child First 15 Months - Six Visits	44.00%	51.00%	7.00%	44.40%	49.30%	4.90%	55.60%

Well-Child 3-6 years	71.10%	72.50%	1.50%	71.30%	75.70%	4.40%	66.80%
Adults' Access to Preventive Care - 20-44 years	n/a	69.30%	n/a	n/a	71.80%	n/a	76.80%
Adults' Access to Preventive Care - 45-64 years	n/a	82.20%	n/a	n/a	84.70%	n/a	82.40%
Adults' Access to Preventive Care - 65+ Years	n/a	74.70%	n/a	n/a	83.60%	n/a	78.80%
Antidepressant Medication Mgmt – Acute	n/a	45.60%	n/a	n/a	52.00%	n/a	42.80%
Antidepressant Medication Mgmt – Continuation	n/a	31.20%	n/a	n/a	29.80%	n/a	27.40%
Appropriate Medications for Asthma	n/a	87.00%	n/a	n/a	83.60%	n/a	86.90%
Breast Cancer Screening	n/a	47.50%	n/a	n/a	51.40%	n/a	50.00%
Childhood Immunization Combo 2	n/a	61.80%	n/a	n/a	63.60%	n/a	72.30%
Childhood Immunization Combo 3	n/a	52.00%	n/a	n/a	53.80%	n/a	65.60%
Frequency of Prenatal Care	n/a	51.60%	n/a	n/a	52.60%	n/a	59.30%
Lead Screening	n/a	46.00%	n/a	n/a	54.80%	n/a	61.50%
• Bold = Better than the national mean							