

An Evaluation of the Pilot Project To Reform Florida's Medicaid Program

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Foreword

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Two factors caused Florida to act decisively in 2006 to reform its Medicaid program beginning with a pilot project in Broward County and the Jacksonville area. The purpose of the pilot project was to provide policy makers with an opportunity to obtain a fair evaluation the reforms being tested. The experiment was cleared to proceed after Florida officials obtained a waiver from the Federal government, which also has an interest in exploring ways to contain costs and improve the quality of care.

Of the two factors that prompted the state to act, cost was inarguably a major concern. The trend in state spending on Medicaid was simply unsustainable. Had it continued unabated, the program could have consumed roughly 60 percent of the projected state budget by 2015. This would have forced either (a) a large tax increase, (b) severe cutbacks in education, corrections, and other important programs the state funds from its finite supply of general revenue, (c) major reductions in the compensation paid to Medicaid's providers at a time when their costs were rising, further discouraging those providers from accepting Medicaid patients, or (d) some combination of all of the above.

Although money was a major factor in motivating the state to act, it was not the only factor. The other concern was the inconsistent quality of care provided to Medicaid's clients. Some patients have reported their extreme dissatisfaction with the care they or their children received through Medicaid. A chronic complaint is that the Medicaid clients who were dissatisfied have had little recourse.

One feature of the pilot project was to give Medicaid's clients as many choices as feasible, along with counseling to assist them in making a selection that best suits their needs. Another feature was an emphasis on the types of care that help patients maintain their "wellness" rather than merely treating them when they become ill. This method of reining in costs has multiple benefits beyond merely controlling costs.

After evaluating the evidence obtained thus far, we conclude that Florida's pilot project not only ought to be continued in the places where it is already underway, but also that the reforms instituted under this pilot project ought to be extended to the remainder of the state.

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I. Reform Summary

Florida's innovative Medicaid reform plan is now in its second year. This study examines how it seems to be working, based on the evidence collected thus far. What we can already safely conclude is that the reform has had numerous accomplishments and some start-up problems. According to the Agency for Health Care Administration (AHCA) the accomplishments include, but are not limited to, the following:

- Increasing the voluntary enrollment rate among beneficiaries.
- Increasing the number of health plans available to beneficiaries.
- Increasing the value of benefit packages as services that were not previously covered before the reform are now being offered to enrollees.
- In addition, as the reform plan's authors had hoped, the first specialty plan that serves the chronically ill has been established in both Broward and Duval counties.

To provide an accurate measure of the outcomes of the reform, Florida Medicaid (FM) has established 33 planned performance measures. FM also has developed business processes and initiated changes for the data system handling Medicaid encounters. The improved data system will allow greater transparency of the participating plans' performance and more accurate payments to the providers. Finally, the reform has been extended to Baker, Clay, and Nassau counties. Enrollment there began in the fall of 2007.

No bold reform will be totally free of problems during its initial phases, and Florida's experiment with Medicaid reform is no exception. FM has identified areas that could use improvement, including additional claims-processing training for provider service network (PSN) personnel. It is also apparent to FM that a single consolidated database for complaints and other issues will be needed to

better identify and track problems involving beneficiaries and providers.

In addition, client feedback has indicated that the Choice Counseling Program needed to restructure its public meetings to keep the focus on one or two elements of the program, to develop a calendar for regular public meetings, to enhance the field choice counselors' role by having them assist the call center in finding beneficiaries who were unenrolled, and to create a special program to help educate those beneficiaries who have multiple medical conditions. It was also determined that the Enhanced Benefit Program (EBP) needed to process health files more efficiently and to improve the delivery of the beneficiaries' monthly statements. In addition, more effort was needed to encourage individuals to use the credits they had earned in the EBP.

Finally, FM has determined that the formularies for prescription drugs were an issue for members enrolled in certain HMOs. The agency has worked with the HMOs in question to ensure that formulary information is available on each plan's website, and that each plan's member-services staff has easy access to the formulary and is able to answer beneficiaries' questions regarding drug availability and restrictions.

II. Reform = Competition And Choice

Florida has two broad goals in mind with regard to the reform of its Medicaid plan. One is to improve the quality of care and health outcomes for Medicaid beneficiaries. The other is to make the program fiscally sustainable within the state's long-term budget. Essentially, the program is a managed-competition model. This type of delivery system for health care was developed in response to problems identified in relation to insurance coverage for medical care. Insurance has significant effects on incentives. The occurrence of sickness and the cost of treatment are uncertain. Because most people prefer to avoid financial risks when they can, they want to have insurance to cover these

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events. But for most of the insured — and for Medicaid beneficiaries in particular — their amount of cost sharing is small or often zero. The end result is related to the long-standing law of supply and demand: People use more care than they would if they were directly paying with their own hard-earned cash.

Moreover, physicians who are compensated on a fee-for-service basis have significant economic incentives to treat every uncertain medical condition by providing more services. The combination of “free” health care, along with an increasing public awareness of medical specialties and new medical technology, significantly increases the effective demand for medical care and drives up usage and prices. In addition, given over 150 million fee-for-service claims in the Florida Medicaid program, it is probable that unneeded services are provided and that there is some outright fraud.

In response to the rising costs, new methods of delivering medical care have emerged. These include health maintenance organizations (HMOs) and provider service networks (PSNs). PSNs include contractual arrangements with selected physicians and other providers to offer a comprehensive benefit package for negotiated fees, with formal arrangements for quality assurance and utilization review. HMOs were designed to integrate into a single entity the insurance function and the provision of medical care. These prepaid plans provide an incentive to organize and deliver medical care more efficiently.

Yet it is crucial that effective competition exists for these managed-care organizations to produce high-quality care with limited price increases over time. In the absence of competition, the demand for health care is inelastic, that is, insensitive to price changes. Several factors can contribute to an inelastic demand. The first is when there are very few HMOs competing with each other. Conversely, the greater the number of good alternatives for medical consumers, including Medicaid beneficiaries, the greater the sensitivity of the HMO to the beneficiaries’ demands. **Increasing competition is one of the major goals of Florida’s Medicaid reform demonstration.**

Another aspect of health insurance and health plans that can generate an elastic

demand is product differentiation. Health plans offer a variety of different goods and services along with various cost-sharing schedules. Offering a complex package that significantly differs from those of other plans makes it difficult for beneficiaries to establish the true value of the package that they are being offered. Medicaid has traditionally dealt with this issue by establishing a broad-based plan under the assumption that one size can fit all needs of all beneficiaries. However, it is impossible for all enrollees in Medicaid to have the same medical wants and needs. So Medicaid’s traditional design naturally leads to redundancies in coverage, and it forces plans to offer services for which they may not have a comparative advantage. **A central part of reform is to allow for plans to differentiate their services while keeping them actuarially equivalent in terms of dollar value to beneficiaries.**

A crucial part of reform in Medicaid, as well as in the private sector, is to account properly for the health status of beneficiaries. If Medicaid pays its provider plans the same amount for each enrollee, regardless of that person’s health status, the carriers have a significant incentive to attempt to enroll healthier individuals because they’ll cost less to serve. Several other kinds of insurance — auto, life — function quite well because the risk is appropriately priced by plan actuaries. They base their decisions on credible cost projections formed from solid statistical analysis. For instance, older men pay much more for life insurance than younger women do. Younger male drivers pay much more for auto insurance than do middle-aged female drivers. With Medicaid, however, the history of paying the same amount for premiums for health plans — an approach known as community rating — means that the healthier are significantly overcharged to subsidize the sick. **For Medicaid, the simple solution to this problem is to risk-adjust the premium payments made to providers. Much progress has been made in implementing risk adjustment, and this is an integral part of Florida’s Medicaid reform.**¹

Another area that leads to effective inelastic demand for health plans is the lack of comparative information on the quality of the plans. This is an issue not only in Medicaid, but also in Medicare and private health plans. A useful

part of reform is the development of a way to provide beneficiaries with easy-to-understand information on plan quality and outcomes. In addition, many beneficiaries have established relationships with physicians and other medical providers. A key concern of beneficiaries who are in the process of choosing a plan to enroll in is the possibility that the physician they wish to use is not included in every plan available to them.

Under the law, the traditional Medicaid program must offer at least two managed-care plans in each enrollment area. In reality, however, there has been very little effective competition in this program because the list of providers participating in each of the respective “competing” plans is essentially the same. Under this reform, however, given intense competition among numerous plans, it should be expected that not every physician is available in every carrier. **Thus, in addition to the exact benefits design that the plan offers, the specific physicians who have signed onto the plan will be an issue that the beneficiaries will want to consider when they make their enrollment decision. This is another aspect of competition that should serve to make demand more elastic.**

What can be hoped for in the long run as a result of promoting forms of marketplace competition in Medicaid? The first result is that competing providers have an incentive, given current technology and knowledge, to provide excellent medical care at the lowest possible cost. This involves a combination of keeping all doctors and personnel actively engaged, paying no more than necessary to retain their services, using physicians’ assistants and other medical personnel when appropriate, and curtailing the use of unneeded medical services.

Over time, these plans would examine the delivery of medical care to evaluate critically the effectiveness of various substitutes in treatment. This would reduce the current practice of having wide variations in treatment patterns, with some of those costing many times others that produce essentially equivalent results. This would evolve toward the delivery of medicine and a best practices framework. This innovation would continue over time. **This continuous quality improvement would accelerate productiv-**

ity gains in medicine and slow the medical inflation rate to a more sustainable level over time. Just a one percent gain in efficiency over time would make the Medicaid expenditures half as large as they would otherwise be in 70 years.²

III. Reform Goals

According to FM, reform objective number one was to ensure that there is an increase in the number of plans an individual may choose, as well as an increase in different types of plans and an increase in patient satisfaction. 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.

At the end of the first year of the Medicaid reform’s implementation, the agency had established contracts for 10 HMOs and five PSNs for a total of 15 reform plans in Broward County and four HMOs and three PSNs for a total of seven health plans in Duval County. One of the plans is a specialty PSN plan serving children with chronic conditions in Broward and Duval counties. The number and types of health plans that beneficiaries can choose from in Broward in Duval counties increased considerably with the implementation of reform. Additionally, the agency approved the expansion of one HMO and one PSN in Baker, Clay, and Nassau counties during the last quarter of the first year, with the program beginning in September 2007. Unless otherwise stated all information in this report is taken from AHCA reform reports and/or direct communication with AHCA and legislative personnel.

Given that there were nine initial plans serving the two counties, it is apparent that Medicaid reform has, so far, succeeded in generating greater competition among provid-

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ers. Reform has also expanded to Baker, Clay, and Nassau counties. At this time, Florida Medicaid has contracted with United Health Care and Access Health Solutions for services in those counties. Both plans will offer a choice of an HMO and a PSN for four effective plan choices in those counties. This represents an increase in the number of providers in those counties. **Medicaid reform has obviously increased competition among plans in the five reform counties.**

Objective number two was to assure that there is access to services not previously covered and to improve access to specialists. Related to this is allowing plans to vary their benefit packages because one plan design cannot possibly meet the needs of every beneficiary. Many of the reform plans chose to expand benefits beyond those required by law. The most popular expanded benefits offered by the reform plans were an over-the-counter (OTC) drug benefit and adult preventative dental benefits. New expanded benefits to the beneficiaries during the first year of reform included over-the-counter drug benefits, adult preventative dental, circumcisions for male newborns, acupuncture, and medicinal massage. Additional benefits included adult vision, hearing services, and home-delivered meals for a period of time after surgery to provide nutrition essential for proper recovery for the elderly and disabled.

By the end of the first year of operation, the agency had approved 28 health plan proposals customizing benefit packages from the HMOs and 13 different expanded benefits proposals from the fee-for-service PSNs. The proposed customized benefit packages and expanded benefits were submitted for the contract period running from September 1, 2007 through August 31, 2008. These submissions also included one HMO and one fee-for-service PSN for the reform expansion counties of Baker, Clay, and Nassau. **One of the significant changes in benefits for the upcoming contract is a continuation of reduced cost sharing from pre-reform levels.**

The 10 reform health plans that were approved during the first year of the reform included HMOs authorized to create customized benefit packages. Five plans elected to vary the amount of their services specific to the population. Six HMOs and one PSN chose to waive

cost sharing. Three HMOs imposed cost sharing for select services, and three PSNs charged cost sharing consistent with the fee-for-service limit. Finally, many plans chose to add services that are not currently covered by Medicaid. The expanded services include the following:

- Over-the-counter drug benefits from \$10-\$25 per household per month
- Adult preventative dental services
- Elective circumcisions
- Acupuncture
- Therapeutic massage
- Respite care
- Additional adult vision services – up to \$125 per year for upgrades such as scratch-resistant lenses
- Additional hearing services – up to \$500 per year for hearing aid upgrades
- Home-delivered meals following surgery

As stated above, FM received and reviewed 28 proposed customized benefit packages from the capitated plans and 13 different expanded benefits proposals from the fee-for-service plans. The proposals from ten HMOs and six fee-for-service PSNs included proposals for the reform expansion counties of Baker, Clay, and Nassau. The approved customized benefit packages were for September 1, 2007 to August 31, 2008. The two most popular expanded services offered are the same as last year's: over-the-counter drug benefits and adult preventative dental benefits. Four of the customized benefit packages increased the OTC value from \$10 to \$25, while another four added a \$25 OTC benefit. Many of the expanded services available in September 2007 are the same as those offered in September 2006.

For the second year of Medicaid reform, the 2007-2008 customized benefit packages added the following expanded benefits:

- Nutrition Therapy
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined)
- Adult Hospital Outpatient – Additional \$3,500/year for hospital outpatient services at Shands Jacksonville only (maximum \$5,000/year combined).

- The one benefit not offered for the 2007-2008 contract year is therapeutic massage.

The net impact from the inception of reform on benefits offered by capitated plans is as follows:

The number of plans increasing service, and/or waiving or reducing co-payments: 10 for behavioral health co-payments, nine for chiropractor co-payments, three for dental services co-payments, three for home health service co-payments, five for hospital outpatient co-payments, five for hospital outpatient surgery co-payments, three for lab and X-ray co-payments, three per outpatient mental health co-payments, five for physical health co-payments, nine for podiatrists co-payments. There were 18 expanded benefits provisions: four for chiropractor services, one for hearing services, four for podiatrist services, one for vision services, eight for outpatient pharmacy coverage, six for durable medical equipment, and 15 hospital outpatient services not otherwise specified.

Plans that reduced services or increased or added co-payments included one for dental services co-payments, one home health services co-payment, one outpatient mental health co-payment, one reduction of expanded benefits, six outpatient pharmacy service reductions, and two durable medical equipment reductions. **The net result is, after one year of reform, there have been 112 increases in services or co-payment reductions to beneficiaries and only 12 benefit reductions or co-payment increases. It is obvious that, on balance, enrollees have benefited from competition among reform plans.**

To make sure that beneficiaries receive appropriate access to care is a cornerstone of the Medicaid reform. The existing plan had a well-deserved reputation for low quality and poor access. Medicaid beneficiaries routinely have trouble accessing the system. This is the direct result of Medicaid fee-for-service payments being far below Medicare rates, as well as a lack of coordinated care for chronic illnesses. Basic economics indicates this will produce shortages of care that appear in three ways. One is outright inability to obtain treatment. This can lead to higher program costs as beneficiaries use

emergency rooms as their only point of access to treatment and/or relatively minor health issues expand into major medical problems.

Nationwide, only 65 percent of physicians are willing to accept new Medicaid patients vs. 96 percent for Medicare. The rejection rate for accepting new Medicaid patients is six times higher than for Medicare and five times higher than private coverage. This problem shows up as beneficiaries using the ER for non-ER treatments. The ER usage rate among Medicaid-eligible patients is almost double that of Medicare and four times the amount of the privately insured. The rate of non-urgent care provided by ERs to Medicaid patients is 50 percent higher than the uninsured. **It should be obvious that the Medicaid system that existed prior to reform had serious access issues.**³

FM was therefore very concerned about the impact of reform on enrollee access to care and treatment. In particular, the state was concerned about maintaining specialty networks that provide timely access and patient-centered services. Florida Medicaid identified five specialties — pain management, dental, orthopedics, neurology, and dermatology — as areas requiring access to care by beneficiaries under reform. To examine access to these areas Florida Medicaid compared specialty networks before and after the implementation of reform in Duval County.

The data involved June 2006 and June 2007 health plan provider files, June 2006 and June 2007 Medicaid fee-for-service (FFS) provider data, and June 2006 and June 2007 recipient files. Inclusion of Medicaid FFS providers in the baseline allows for a more accurate measurement of specialty access for MediPass recipients who were likely to be enrolled in a reform plan for the follow-up measurement. Medicaid FFS providers for MediPass recipients are determined by one or more paid claims for a MediPass recipient during the first half of 2006.

Measurement for June 2006 included specialists who were either identified by non-reform plans or who were active Medicaid FFS providers for MediPass recipients. In order to calculate the baseline, provider files for June 2006 from both active non-reform health plans and FFS were unduplicated and then

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	Pre-Reform (June 2006)						Post-Reform (June 2007)		Adequacy Benchmarks	
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	Specs per 100K	Health Plan Count	Specs per 100K	Estimate of Need per 100k (Low)	Estimate of Need per 100k (High)
Pain Mgmt	2	4.9	143	351.3	145	178.1	58	84.0	1.2	10.6
Dermatology	3	7.4	3	7.4	6	7.4	9	13.0	0.7	2.9
Neurology	21	51.6	44	108.1	54	66.3	67	97.0	1.2	3.4
Orthopedics	32	78.6	31	76.2	48	58.9	64	92.7	1.5	7.7
General Dentistry	14	34.4	32	78.6	45	55.3	31	44.9	17.5	30.8
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

“A major theme of Florida Medicaid reform is the placement of plan selection responsibility with beneficiaries.”

adjusted to per-100,000 enrollees to allow comparisons. Follow-up measurement for June 2007 included specialists who were identified by reform plans. In order to display reference ranges for adequate access based on published literature, Florida Medicaid incorporated adequacy benchmarks from AHCA's **Summer 2005 Access to Medicaid Physician Specialists Report**, and to ensure these ranges were applicable to the Medicaid population, they contrasted with George Washington University's database of other state Medicaid managed care plan requirements.

Assuming that plan provider files are complete and accurate, it appears that access to care for the five medical specialties in Duval County has either improved under reform or has been more than adequate to meet recipients' needs based on national benchmarks. Because of lack of encounter data from plans, plan provider files cannot be completely verified at this time by FM. Because of errors in both pre- and post- reform plan provider files, a significant number of specialists are withdrawn from this analysis. This error rate should decrease significantly in future analyses as plans were expected to improve the quality of their files starting in November 2007.

Another area of the reform that has been watched closely is the participation rate of primary care providers (PCPs) who had served in the original Florida Medipass program. Florida Medicaid has established that over 93 percent of original PCPs accepting MediPass in Broward County had signed on with reform plans. That

percentage is 97 in Duval County. Less than 3 percent of PCPs voluntarily left MediPass in Broward County, and the figure was the same for Duval County. The rest of the providers that left MediPass were removed from the program by Florida Medicaid for noncompliance issues. **Despite assertions by some critics of reform, there is little evidence that PCPs are not participating in competing reform plans.**

A major theme of Florida Medicaid reform is the placement of plan selection responsibility with beneficiaries. The idea is to make them informed consumers of health care. Related to this was the establishment of a Choice Counseling Program. It was not reasonable to expect beneficiaries to take on plan selection responsibilities without the support of Florida Medicaid. The goal was set at 65 percent of enrollees would make an active selection regarding the plan they entered. The Choice Counseling Program involves training at Florida State University for employees. Successful completion of this program involved the granting of a certificate required for employment by Florida Medicaid.

In addition, a special-needs unit was created as part of the counseling program for dealing with beneficiaries with medically complex situations. Enrollment packets and envelopes for both providers and beneficiaries were designed to make them easily recognizable. Related to this, an intensive advertising campaign was undertaken to alert interested parties to specific dates and deadlines regarding Medicaid reform enrollments. The field counseling program was also created to contact individuals who were

not reached by the mail, print, and media campaigns. According to FM, this program appeared to be successful as 30 percent of enrollments occurred at the local level.

The Choice Counseling Program established a call center for beneficiaries to obtain information regarding the reforms. In its first year of operation it received more than 169,000 calls regarding Medicaid reform. Every call was answered within four rings. Approximately 1 percent of callers hung up before a phone counselor could talk to them. During this year Florida Medicaid mailed more than 66,000 enrollment packets to the dually eligible and more than 119,000 packets for transition from old plans to new reform plans. Mail enrollments were significantly lower than enrollments via the phone or choice counseling visits. There were initial problems with errors in enrollment packages, preventing them from actually being used to enroll beneficiaries. It is unknown at this time if correcting this will increase the percentage of enrollments done by mail.

Mail packets appeared to cause some confusion among beneficiaries. This was related to the fact that packets included plan comparisons for both children and families, as well as aged and disabled beneficiaries. In response to this problem, mailings to beneficiaries were separated so that unique packets went out for each of these two groups. Another recurring problem was that beneficiaries sent enrollment packages back that had errors in them. This required counselors to contact the beneficiary in question to establish what their intent was with regard to registration for reform plans. The enrollment forms have been redesigned to make them easier to understand and fill out. Florida Medicaid continues to monitor these see if the error rates has declined.

Counselors have also worked on developing relationships with both providers and community-based organizations that either have relationships with or serve the Medicaid population. Over the first year of reform, counselors had staged between 187 and 320 public seminars per month. Private seminars range between 132 and 270 per month. In addition, visits to homes with no phone contact ranged in the several hundreds per month. Actual enrollments by field counselors increased from

148 in September of the first year of reform to almost 2,600 in June of the following year. At the end of the first year of reform around 40 percent of beneficiaries were being enrolled by counseling visits. **Florida Medicaid believes that the Choice Counseling Program has been a success and planned no major changes in the second year of reform.**

A central tenet of Medicaid reform is increasing health literacy among beneficiaries. Making informed decisions regarding different plans is crucial to making competition work. Counselors explain the concept of a primary care physician, the importance of that person directing uses of specialists, what network plans are, the use of formularies, and so forth. After enrollment information is received, counselors encourage beneficiaries to make an appointment to meet with their primary care physician. The beneficiaries' enhanced benefit account is discussed and the ability to earn credits in the account is carefully explained. In particular, the adoption of healthy behaviors by the beneficiary is reviewed.

A special-needs unit was created in November 2006, to assist enrollees with complex medical situations. This unit employs registered nurses in reviewing the health situation of beneficiaries and helping them to determine which plan best fits their needs. If needed, their counselor will arrange for three-way call between beneficiary, themselves, and the health plan. This is to establish that the particular provider in question is appropriate for this beneficiary. FM has determined that an additional nurse is needed to properly service this portion of the Medicaid population. It is obvious from beneficiary feedback that the nursing counselor program has reduced anxiety over enrollment in the newly created reform plans.

Because chronic diseases account for a disproportionate amount of Medicaid expenditures, the implementation of disease management programs is crucial to the reform success. Given the nature chronic illnesses, and the fact that more and more academic evidence suggests that many beneficiaries have multiple health problems, the special-needs unit must be relied upon in helping to implement disease management programs. Florida Medicaid announced its intention to significantly expand

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this aspect of reform in the second year. Because medical claims in Medicaid are so highly skewed toward beneficiaries with chronic illness, even a slowdown in expenditures among this group would produce significant long-term reductions in program growth.⁴

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. Note that these figures are for new eligibles only. The amount of new eligibles for both reform counties was in excess of 7,600 per month. Extrapolation of the first-year quarterly trend indicates a likelihood of meeting the 80 percent target for voluntary enrollments in year two.

Objective number three of reform is to improve the overall health status of enrollees for select health indicators, reduce ambulatory sensitive hospitalizations, and decrease utilization of emergency room care. Florida Medicaid will monitor the Medicaid reform health plan enrollees through the HEDIS performance measures (see next page) and the plan’s disease management enrollees through Agency-defined disease management measures (see below). The Medicaid reform health plan contract specifies the performance measures that were to be collected from January 1, 2007 through December 31, 2007, and reported to FM by July 1, 2008, including the ones identified below.

Prior to implementation and during the first quarter of operation, FM reviewed the HEDIS measures and defined performance measures specified in the reform health plan contracts to ensure the measures were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable. FM also reviewed the disease-management performance measures used by health plans and disease-management

programs nationally and in Florida to determine which of those measures the plans would be required to collect and report to them.

After a full review of the measures along with input obtained through public meetings, FM identified a total of 33 proposed performance measures that would be applicable to the disease-management enrollees that are not currently listed in the contract. These measures will be collected over a three-year period. During the first year of reform, FM will collect 13 performance measures. The first set of performance measures will be reported to FM on July 1, 2008, for the measurement year beginning January 1, 2007 and ending December 31, 2007.

Florida Medicaid Disease Management Areas

HIV/AIDS
Asthma
Congestive Heart Failure
Diabetes
End Stage Renal Disease
Hemophilia

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.⁵ 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.⁶

Initially, the monthly statement for beneficiaries was apparently difficult to read. FM has revised it to include only the most relevant information. There were also issues with regard to the information system used by providers

2007 HEDIS Measures Required as Part of the NCQA Accreditation Process
for Medicaid Health Plans

- Adolescent Immunization Status (combination 2)
- Antidepressant Medication Management (all 3 rates)
- Appropriate Medications for People With Asthma
- Appropriate Treatment for Children With Upper Respiratory Infection
- Appropriate Testing for Children With Pharyngitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (combination 2)
- Cholesterol Management After Acute Cardiovascular Events (screening rate only)
- Comprehensive Diabetes Care (Eye Examination rate, Cholesterol Screening rate, HbA1c Screening rate, Nephropathy Monitoring)
- Comprehensive Diabetes Care—HbA1c Poorly Controlled (>9.0%)
- Controlling High Blood Pressure
- Follow-Up After Hospitalization for Mental Illness (7-day rate only)
- Medical Assistance With Smoking Cessation (Advising Smokers to Quit rate only)
- Prenatal and Postpartum Care (both rates)
- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

“Related to this, Florida Medicaid established an innovative Enhanced Benefits Account program (EBA). This is essentially a reverse health savings account.”

“At the end of the first year, reform beneficiaries had earned over \$4,300,000 in EBA credits.”

for the program. This was related to its initial use being for pharmaceuticals. The portal has been expanded and appears to be functioning in a more effective manner at this time. An additional technological advance will be the phase-in of a debit card for beneficiary use. Another option available to them will be the development of a mail-order system. When the program was initially developed, enrollees learned about it through choice counseling. Beneficiaries were provided with an EBA enrollment packet. In terms of information provided to beneficiaries enrolling in reform plans, EBA was not overly emphasized. The initial reasoning was to not overwhelm these individuals with too much information regarding the reform plans.

As the reform entered its second year, the marketing of the EBA was altered. This included the development of a user-friendly product list as well as a list of participating pharmacies that have not had issues with regard to EBA credit processing. An EBA outreach program was also created. Choice counselors have been specifically trained regarding all aspects of the EBA. This was done by an internally created team. The Enhanced Benefits Advisory Council is also solicited for thoughts and recommendations to make the program operate more effectively.

According to FM, some pharmacies had issues with regard to processing EBA credits. One of the reasons, not surprisingly, was lack of familiarity with the program. Another problem is a very large list of products that can be purchased with EBA credits. Related to this, pharmacists often found that there was an issue in helping beneficiaries to understand which items could be bought with EBA dollars. There were also some small issues with regard to products supposedly available not providing credits to pharmacies and other providers due to technical issues. **Despite these problems, a relatively low total of 29 complaints were filed regarding the EBA program.** FM has worked with these pharmacies and other providers on a case-by-case basis to make the program function more smoothly. Part of the resolution involves creating a code system for EBA eligible products. Each participating pharmacy has also been provided with a single page EBA reference sheet covering all aspects of the program.

At the end of the first year, reform beneficia-

ries had earned over \$4,300,000 in EBA credits. Over 91,000 beneficiaries had undertaken at least one healthy behavior. This is close to half of the reform population. A total 5,681 beneficiaries had used nearly \$149,000 worth of available program credits. The top healthy behaviors undertaken by enrollees were office visits for adults and children. Over 165,000 of these had occurred. The next highest behavior was childhood preventative care actions, with over 55,000 occurrences. Arranging for refills of maintenance drugs was next with 36,000 plus behaviors. Dental, eye care, and Pap smears were the next highly used healthy behaviors. At the bottom of the list were hypertension management, adult dental cleaning, and flu shots.

Florida Medicaid has also tracked what the credits have been used to purchase. Most used products were children's Motrin, Prilosec, children's Tylenol, baby wipes, several varieties of children's cold remedies, and non-aspirin purchases for adults. In terms of which plans are producing the most EBA credits, First Coast Advantage had over \$508,000 earned by enrollees. Pediatric Associates, Healthease, Staywell, and Amerigroup all had over \$350,000 worth of EBA earnings. The smallest use was with Universal Health Care of Broward County with only \$270 earnings.

The amount of EBA credits earned so far under the reform plan is within the range estimated by Florida Medicaid. However, the amount of funds actually used by beneficiaries to purchase the wide range of items eligible under reform is far below what was anticipated. The newly created EBA team has been working on this issue. One of the proposed changes involves giving beneficiaries a debit card for EBA fund expenditures. A mail-order program is also under consideration. This would work along the lines of private-sector plans like Medco. The team is also reviewing the list of products available for purchase under the reform plan. As health outcome data becomes available, the impact of EBA earned credits will be reviewed. Finally, the EBA outreach program will be expanded to encourage use of earned account dollars by beneficiaries.

The fourth objective of reforms is to determine why some individuals decide not to select a Medicaid reform plan that could provide greater value in coverage than the individual

otherwise could receive. 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? Based on information gathered in first-year of operation, some do so because their primary care physician isn't enrolled in a Medicaid reform health plan. Others do so because they or a family member have some kind of employer-subsidized coverage through their job. Conversely, individuals deciding against opting out were typically not employed or, if employed, nonetheless lack access to employer-sponsored insurance or, after hearing about it, preferred to stay in a Medicaid reform plan where there were no co-pays and deductibles.⁷

The reform's innovative opt-out program remains quite small. A total 36 beneficiaries contacted Florida Medicaid about the opt-out plan. Of these, it was determined that 16 did not have eligible employer-sponsored insurance to enroll in and were therefore denied access to the opt-out program. Another 15 were determined eligible, have been sent information, but have not followed up on enrollment. A total of five have used the program. A note of interest is that only one of the individuals who enrolled in the opt-out program had an employee health insurance premium greater than the cash value of their Medicaid benefit. **While the program remains disappointingly small, the reason does not appear to be a significant beneficiary cost-sharing requirement from their employer. JMI believes that adoption of our Small Group Insurance Exchange (SGIX) proposal would lead to a significant increase in private plans by beneficiaries.**⁸

Objective number five of reform is to ensure that patient satisfaction increases. It's too early to determine the impact on beneficiary satisfaction. However, FM has

contracted with the University of Florida to conduct a consumer assessment of health-care providers and systems surveys. The beneficiaries surveyed were enrolled in Florida's PSN and non-reform Medicaid HMOs in Broward and Duval counties to measure the level of patient satisfaction present prior to the implementation of Medicaid reform. Results of the survey will serve as a baseline against which to compare future surveys throughout the Medicaid five-year demonstration. The University of Florida will complete an evaluation of the five-year Medicaid demonstration. At this time, UF has completed three aspects of its study.

The first of these is a summary of the implementation and plan design. The second is a benchmark study of 5,767 enrollees in Broward and Duval counties. This will be used for a longitudinal study of health outcomes related to reform. The idea of the study is straightforward. Pre-reform experiences and levels of satisfaction will be contrasted annually with those the beneficiaries have received under reform plans. The pre-reform data was collected during the fall of 2006. The University of Florida used the consumer assessment of health providers and systems health plan survey to establish benchmark data. This is one of a group of standardized survey instruments widely used to assess beneficiary experiences and satisfaction with their health care. The initial sample of the survey was derived from Medicaid enrollees residing in the two pilot counties prior to the beginning of reform. Those surveyed had to have been enrolled in Medicaid for six months prior to the beginning of reform.⁹

The third study from the University of Florida is the summary of the preliminary findings from the baseline survey mentioned above.¹⁰ The survey identified key issues that researchers thought were worth noting and following through the demonstration. The first was how the control of health is influenced by individual belief, money and resources, and faith. Researchers were concerned that this might influence participation by the participants in the reform program. Second, relations with physicians are important to consumers. Third, Medicaid consumers actively pursue health and healthcare information. Fourth, and related to this, initially the Choice Counseling Program

“The University of Florida will complete an evaluation of the five-year Medicaid demonstration.”

“After sharing the results of the study with the Provider Access Systems, the Agency will then review the results of the cost-effectiveness study with the Federal Centers for Medicare and Medicaid Services...”

had not been used as a major source of health information but rather as a mechanism for selecting a health plan. **Fifth, experiences with the Medicaid health system are not always positive, particularly with regard to finding specialty providers.** This tells us that the program had access issues *before* reform. Finally, consumer knowledge of Medicaid reform is uneven. In the early stage of reform, enrollees may have heard about specific aspects of the program. Terms such as “choice counselors” and “enhanced benefits” were unfamiliar to many beneficiaries. It is important to note that these findings were based on a focus group of 37 beneficiaries from Broward and Duval counties. **The combination of an extremely small sample size and the fact that the enrollees did not have long-term experience with reform limits the usefulness of these findings.**

The agency also intends to evaluate patient satisfaction with the disease-management programs operated by the Medicaid reform plans. At a minimum, Medicaid reform health plans are required to have disease-management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. For Broward and Duval counties, the disease-management patient satisfaction surveys were conducted in September 2007, to ensure that the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for six months.

Objective number six of the reform is to evaluate the impact of the Low Income Pool on increased access for uninsured individuals. Before the Medicaid reform waiver, there was a hospital inpatient Upper Payment Limit (UPL) program that allowed for payments to hospitals for their services to Medicaid enrollees. The waiver eliminated the UPL program and created the Low Income Pool (LIP) program that provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The Provider Access Systems allows for increased access to services for the Medicaid, underinsured, and uninsured populations. Florida Medicaid cooperated with over 20 local governments and or health care taxing districts that provided 41 percent of the state’s non-federal share of the \$1 billion in LIP

funds. The services provided through these PAS entities include, but are not limited to, the implementation of case management for emergency room diversion efforts, chronic disease management, increased hours and/or medical staff to allow for increased access to primary care and pediatric services, and the inclusion of increased services for breast cancer and cervical screening services.

FM is conducting a study of the cost-effectiveness of the various Provider Access Systems. The University of Florida will conduct the evaluation of the LIP, including cost-effectiveness and the impact of the LIP on increased access to services for Medicaid, uninsured, and underinsured populations. The data required include encounters, patient days, patient discharges, and patient case mix. To obtain provider information in the most efficient manner, FM created a web-based reporting tool. This information-gathering was to be completed early in 2008.

After sharing the results of the study with the Provider Access Systems, the Agency will then review the results of the cost-effectiveness study with the Federal Centers for Medicare and Medicaid Services to “define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the Low Income Pool for demonstration year 3 through 5.” By the end of demonstration year 2, June 30, 2008, the state was to “develop a plan for the statewide implementation of the demonstration by the end of waiver year 5.”

For this fiscal year, FM has received over \$358 million from over 30 local funding sources for operation of the LIP. A total of over \$966 million was distributed to providers approved by the LIP council. Because of lags in distribution, some of the above amount was being distributed during the second fiscal year of reform. For that second fiscal year of the reform, another \$1 billion has been approved for distribution to eligible parties. The University of Florida will be examining the impact of the LIP, including its cost-effectiveness. It is possible, based on the conclusions of this research, that some providers will be dropped from the program for falling too far short of the goals outlined in their program application.

IV. Budget Neutrality

As with all 1115 waivers, the Florida Medicaid reform plan must be budget neutral. This is defined as not increasing the cost to the Federal government given the reforms that have been undertaken. This neutrality is arrived at by the reform plans not expending more than would have been spent in the absence of the 1115 waiver. The mechanics of this neutrality is for program expenses and the federal matching portion of the funding 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 total expenditure of \$1 billion per year.

The budgeted amounts for SSI, and children's 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 program 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. It is this amount that represents the upper bound for the maintenance of budget neutrality. **For the first year reform budget neutrality has been attained.** The SSI population had a PCCM of \$875.74, compared to a WOW of \$948.79. This is 7.7 percent below the budget-neutral figure for this part of the reform. Children's and Families had a PCCM of \$158.80 relative to a WOW of \$199.48. This represents an amount more than 20 percent below the budget neutral total. For the overall program reform, the budgeted amount in year one was \$328.24. The actual PCCM for the entire reform was \$281.99. Thus, for those two parts of the reform, the actual per capita expenditures were more than 14 percent below the budgeted amount. Program reform PCCM targets are shown in Table 2. The budget growth rate for both categories of enrollment is 8 percent per annum. Expenditures are calculated on a cash basis. **While it is far too early to establish a trend in expenditures under reform, the first year's results are encouraging. Actual PCCM for the SSI population declined by .32 percent in the first year of reform. The Children and Families PCCM declined by 14.0%. Total reform per capita expenditures declined by 7.2%.**

Due to an oversight in reporting on rolled reform eligible expenditures, FM reported expenditures for non-enrolled dual eligibles in the CMS 64 for the first two quarters of year one of the reform plans. These expenditures have been identified and the prior data have been adjusted for the CMS 64 reporting process. Ending June 30, 2007 the third quarter report included the correct amounts for the impact of those

"Budget neutrality for the Low Income Pool portion of the reform is straightforward. It cannot exceed total expenditure of \$1 billion per year."

months and therefore no changes are required. Expenditures reported in the third quarterly report were net of rebates. Since the PCCM as provided in the special terms and conditions of waiver were not calculated net of rebates, the PCCM targets reported in the report were revised to include the collection of rebates. No

changes were made the CMS 64 report as rebate amounts are provided in the CMS 64 templates for each group of the reform.

The LIP expenditures are contingent upon securing the state, not Federal, share through local governments in health-care taxing districts. Since LIP is a new program to many local

TABLE 1 SSI BUDGETED AND ACTUAL EXPENSES			
ACTUAL	CASE MONTHS	EXPEND	PCCM
JULY	261,613	109,990,268	
AUG	260,641	292,808,939	
SEPT	258,963	153,549,828	
OCT	260,493	222,817,252	
NOV	259,752	326,135,309	
DEC	260,065	173,573,994	
JAN	260,390	320,970,221	
FEB	261,186	236,712,797	
MAR	266,681	170,199,159	
APR	267,563	230,450,788	
MAY	268,130	329,748,114	
JUN	268,522	162,900,912	
ACTUAL	3,153,999	2,762,090,155	875.74
BUDGET		2,975,596,229	948.79
SAVINGS			-7.70%

TABLE 2 C&F BUDGETED AND ACTUAL EXPENSES			
ACTUAL	CASE MONTHS	EXPEND	PCCM
JULY	1,295,214	116,586,290	
AUG	1,286,292	275,168,632	
SEPT	1,276,974	101,989,233	
OCT	1,273,251	195,498,611	
NOV	1,252,855	312,006,740	
DEC	1,246,544	125,045,515	
JAN	1,216,944	305,786,936	
FEB	1,219,671	205,509,650	
MAR	1,296,192	125,333,531	
APR	1,289,543	199,822,438	
MAY	1,277,379	302,609,053	
JUN	1,270,325	112,430,095	
ACTUAL	15,201,183	2,413,915,950	158.8
BUDGET		3,902,199,885	199.48
SAVINGS			-20.39%

TABLE 3 TOTAL PROGRAM BUDGETED AND ACTUAL EXPENSES			
ACTUAL	CASE MONTHS	EXPEND	PCCM
ACTUAL	18,355,182	4,966,500,417	281.99
BUDGET		6,877,796,114	328.24
SAVINGS			-14.09%

governments, the executing of letters agreement for the state, nonfederal share took slightly longer than anticipated. The agency did not release any LIP payments to provider access systems until the appropriate documents were secured. By the end of the first year of operation, all letters of agreement were executed and provider access system distributions from it were made accordingly.

V. Risk-Adjustment Phase In

A central tenet of reform is the creation of a risk-adjusted payment mechanism to health plans. The logic of this is twofold. First, an across-the-board equal payment to plans significantly increases the incentive of those carriers to attempt to enroll “healthier” individuals. While Medicaid’s “guaranteed issuance” prevents plans from excluding high medical risks, it cannot completely stop practices designed to enroll relatively healthy beneficiaries. These include offering benefits of dubious medical value in order to attract healthier enrollees. Another major reason for risk-adjustment is to provide the incentive necessary for innovative providers to develop niche products for those Medicaid enrollees who have significant health issues. These “special needs” plans would seek to enroll the sick rather than shun them. They would likely be clinical type providers with groups of specialists working together to coordinate the care needed to treat the very ill with multiple chronic issues in a proper and cost-effective manner. These small numbers of chronically sick beneficiaries account for a disproportionate amount of Medicaid spending. The existence of actuarially fair payments is expected to lead to the creation of such specialized plans. Indeed, risk-adjustment in the Medicare program has already led to such plans.

Interim pharmacy data and medical services encounter data will be used to support a risk-adjusted methodology for setting capitated payments to reform health plans. Risk adjustment is to be phased in over a period of three years beginning with the Medicaid Rx model and transitioning to a diagnostic based model such as the Chronic Illness and Disability Payment System.¹¹ Medicaid Rx is a pharmacy-based, risk-adjustment model that serves as the basis

for risk-adjusting payments to Medicaid health plans. The Medicaid Rx model includes patient characteristics and pharmacy data that can be used to predict future health care expenses. The Medicaid Rx drug classification and predictive weights were recently derived from California data from 1995-2004 by the University of California at San Diego. The data must be periodically updated for changes in pharmacological treatments of various health issues. Next page is a summary of health issues covered by Medicaid Rx:

In order to determine the value related to each of the above items, a process was established to classify patients into one or more of the prescriptions. A beneficiary needed to use a drug only once to establish a particular disease category. Enrollees with multiple conditions are counted if the illnesses are correlated by combining various categories into one. If illnesses are not interrelated, the Rx model simply presumes an increased cost based on additional health problems. In order to improve the model’s predictive ability, patient demographic characteristics are also examined for issues not covered above. This produces 11 additional medical categories.

The pharmacy-based model will be replaced by the Chronic Illness and Disability Payment System (CDPS).¹² The transition includes an interim phase of pharmacy encounter data from all health plans capitated for these services. The second and third phases involve the statewide collection of encounter data from health plans for all Medicaid-covered services. The second phase occurs with the incumbent fiscal agent, and the third phase occurs with the new fiscal agent for FM. CDPS essentially uses a set of diagnosis data related to medical conditions to assign risk factors by diagnosis categories. This methodology has more predictive power than the Rx model but requires additional experience data. This is the reason for the phase-in over time. FM will use the data to develop individual beneficiary risk scores.

Assume, for example, three hypothetical beneficiaries one, two, and three. The initial age/sex rate might pay \$150 per month for enrollee one, \$100 for enrollee two, and \$50 for enrollee three. The total payment then is \$300 per month or an average of \$100 per

“Another major reason for risk-adjustment is to provide the incentive necessary for innovative providers to develop niche products for those Medicaid enrollees who have significant health issues.”

The Medicaid Rx (MRX) Disease Categories with Summary Drug Descriptions

MRX Category	MRX Descriptions	Summary Drug Descriptions
MRX1	Alcoholism	Anti-alcoholic preparations
MRX2	Alzheimers	Cholinesterase inhibitors, NMDA receptor antagonists
MRX3	Anti-coagulants	Coumarin, Heparin
MRX4	Asthma/COPD	Beta-adrenergic agents, glucocorticoids
MRX5	Attention Deficit	CNS stimulants
MRX6	Burns	Topical sulfonamides
MRX7	Cardiac	Ace inhibitors, beta blockers, calcium channel blockers, diuretics, vasodilators
MRX8	Cystic Fibrosis	Pancreatic enzymes, mucolytics
MRX9	Depression/Anxiety	Anti-depressants, anti-anxiety
MRX10	Diabetes	Hypoglycemics, Insulin
MRX11	Ears, Eyes, Nose, & Throat (EENT)	Anti-inflammatory steroids, anti-infectives for EENT related conditions
MRX12	ESRD/Renal	Electrolyte depleters, hematinics
MRX13	Folate Deficiency	Folic acid
MRX14	CMV Retinitis	Eye anti-virals
MRX15	Gastric Acid Disorder	Gastric acid secretion reducers
MRX16	Glaucoma	Miotics
MRX17	Gout	Purine inhibitors, colchicine
MRX18	Growth Hormone	Growth Hormones
MRX19	Hemophilia/von Willebrands	Factor IX concentrates
MRX20	Hepatitis	Hepatitis tx agents
MRX21	Herpes	Anti-virals, general
MRX22	HIV	Anti-virals, HIV specific
MRX23	Hyperlipidemia	Lipotropics
MRX24	Infections, High	Aminoglycosides
MRX25	Infections, Medium	Macrolides
MRX26	Infections, Low	Penicillins, cephalosporins
MRX27	Inflammatory/Autoimmune	Glucocorticosteroids
MRX28	Insomnia	Sedative-hypnotics
MRX29	Iron Deficiency	Iron replacement
MRX30	Irrigating Solution	Irrigants
MRX31	Liver Disease	Ammonia inhibitors
MRX32	Malignancies	Anti-metabolites
MRX33	Multiple Sclerosis/Paralysis	Skeletal muscle relaxants
MRX34	Nausea	Anti-metics
MRX35	Neurogenic Bladder	Parasympathetic agents
MRX36	Osteoporosis/Pagets	Bone resorption inhibitors
MRX37	Pain	Narcotics
MRX38	Parkinsons/Tremor	Anti-parkinsonism
MRX39	Prenatal Care	Prenatal vitamin preparations
MRX40	Psychotic Illness/Bipolar	Anti-psychotics, anti-mania
MRX41	Replacement Solution	Calcium, potassium replacements
MRX42	Seizure Disorders	Anti-convulsants
MRX43	Thyroid Disorder	Thyroid hormones
MRX44	Transplant	Immunosuppressives
MRX45	Tuberculosis	Anti-mycobacterium agents

beneficiary. The CDPS risk scores from the above methodology are 3, 1.5, and .3 respectively for these three individuals. Patient one now is subsidized for \$300 (their risk score times the initial average plan payment) while patients two and three receive \$150 and \$30, respectively. The total payment to the plan is now \$480, or 60 percent higher than before because of the poor health status of beneficiaries one and two. The initial phase-in will not have a risk-adjustment greater than 10 percent of the mean. The phase-in occurs with 25 percent new methodology in year one, 50 percent in year two, and complete phase-in for year three. After the complete phase-in of the new risk-adjustment methodology, individual scores will be recalculated semi-annually, and total plan scores will be adjusted quarterly.

Initial data show the average number of prescription medications (scripts) per user under reform for HMOs appears to be consistently higher than for non-reform HMOs. This could be due to coverage of former fee-for-service beneficiaries with greater utilization patterns and higher burdens of illness, or increased access to pharmacy services under reform. Data for Duval County also show increased growth of encounters under reform. As is the case for Broward County, the average is slightly higher among enrollees in reform HMOs, at about 3 scripts per user. The overall average scripts per user, however, remained very close to the pre-implementation, non-reform HMO utilization level.

VI. Reform Evaluations

Evaluation of the Florida Medicaid reform plan is crucial in determining whether the goals set out for it are actually being attained. This includes a six-objective evaluation specified above through the entire demonstration ending June 30, 2010. Evaluation will be conducted by the Medicaid reform evaluation or (MRE). The MRE team consists of University Florida professors and of the staff in charge of the contract in various aspects of evaluation. Evaluation involves a five-year longitudinal study of the impact of reform, with the findings summarized in 2010. Many individuals and organizations, including the Florida Legislature, were interested

in reviewing the results much sooner than 2010. So Florida Medicaid and several other entities are conducting evaluations to look at specific issues described below.

First there is an agency internal review. As requested by the Secretary of the Agency for Healthcare Administration, the AHCA Office of the Inspector General conducted a review of the implementation of the 1115 Medicaid reform waiver. The review objectives are to document the current status of Medicaid reform impact using input from the stakeholders and available performance data; to provide recommendations as indicated that will assist executive leadership and decision-making regarding expansion of the 1115 Medicaid reform waiver; and to provide recommendations regarding self-evaluation of activities for new projects. This report was completed in September 2007 and will be summarized later in this report.

The Urban Institute established a sub-contract with University of Florida to study the early impact of transitioning individuals enrolled in the 1115 Medicaid reform waiver. A total of 1,800 reviews were completed. All data sets were delivered in May 2007. Following its examination, a report will be disseminated by the Kaiser Family Foundation. The University of Oregon also contracted with UF to study the impact of incentivizing healthy behaviors of Medicaid beneficiaries. Data collection was done by means of focus groups and telephone surveys. All data sets were delivered earlier this year and, following normal review procedures, reports will be disseminated by the University of Oregon. Florida State University evaluated the choice-counseling program materials given to individuals eligible to enroll in the 1115 Medicaid reform waiver. This evaluation is part of a contract with Florida Medicaid. The federal Government Accountability Office is conducting a review of Florida's 1115 reform waiver. The report, titled "Medicaid Demonstration Waivers: Lack of Opportunity for Public Input During Federal Approval Process Still a Concern," was released in July 2007 and will be referred to later in the study. The University of Florida will continue all evaluation activities for a second year. In addition to the studies already initiated, the agency expects a study by the Florida Mental Health Institute at the

“As requested by the Secretary of the Agency for Healthcare Administration, the AHCA Office of the Inspector General conducted a review of the implementation of the 1115 Medicaid reform waiver.”

“Florida State University evaluated the choice-counseling program materials given to individuals eligible to enroll in the 1115 Medicaid reform waiver.”

University of South Florida from a subcontract between UF and USF. The study will evaluate the mental health aspects of Medicaid reform in the reform counties.

As of this writing, there appear to be three formal outside critical studies of Florida Medicaid reform. These were conducted by the General Accountability Office (GAO), the Georgetown Health Policy Institute Center (HPI), and AHCA Inspector General’s Office (AIG). The GAO studies are primarily related to the legality of the opt-out provision of the Florida Medicaid reform plan. As discussed above, Florida Medicaid reform allows eligible beneficiaries to opt out of reform plans, and use the actuarial value of their benefit to buy into employer-based health insurance. The logic of this reform was to make it easier for beneficiaries to move from public to private insurance plans. Related to this is a significant amount of literature that suggests that the quality and/or availability of treatment under Medicaid is deficient relative to private plans.

Beneficiaries enrolling in private health insurance plans under the approved waiver receive the benefits package that is provided to all other employees under the health plan in question. In some instances, it is possible that the benefits covered by the private plan may not be as broad as those legally required for Medicaid beneficiaries in reform plans serving the state. The legal issue raised is whether individuals selecting the opt-out provision have effectively declined Medicaid eligibility when they chose to enroll in a private plan. This is the position taken by CMS and Florida Medicaid. GAO argues that legally this is not the case.

JMI believes the issue is trivial for two reasons. First, given the wide literature on Medicaid’s low quality, a beneficiary enrolling in a private health insurance plan that offers less coverage than the minimum mandated by Medicaid does not necessarily receive inferior coverage. Enrollment in a Medicaid plan that is generous on paper but which has contracted with lower quality providers may in fact be inferior to private coverage. Second, the number of individuals who have expressed an opinion in the opt-out provision is very small, and the actual number who are either enrolled or have used the provision is even smaller.

Another GAO concern is that the waiver also waives statutory limits on cost-sharing requirements on beneficiaries. Again, this was to enable enrollment in private health plans with the actuarial value of a Medicaid plan being used to pay the private plan premium. Cost sharing in Medicaid plans is extremely limited. It has a low dollar limit when allowed at all, and it’s prohibited for a variety of services including enrollees under 18 and services to pregnant women. Enrollment in private health plans under the reform brings with it the various co-pays, co-insurances, and other cost-sharing aspects of the private plan that other employees are required to cover. This issue also seems trivial. This is related to the finding that in most of the instances of private enrollment under reform, the actuarial value available to the beneficiary is greater than the plan costs at the employer in question.

GAO also raised concerns about the absence of public input during the design of the plan. It specifically cites concerns about the lack of employer involvement. It notes that Florida provided opportunities for public input by holding public hearings and posting drafts of the demonstration proposal in the state’s websites. But it cites complaints by stakeholders in Florida and at the national level that they lacked access to specific information about various aspects of the reform proposal that had an impact on beneficiaries or that they were not given enough time to review, comment on, and criticize the proposals. Specifically, stakeholders complained that the information provided about the proposal was insufficient to understand its possible implications, and that Florida Medicaid did not provide documents related to budget and demographic information. Given numerous instances of allegations about problems with reform by stakeholders in Florida and their inability to provide evidence of such allegations, these concerns also seem trivial.¹³

The Florida Medicaid reform demonstration has also been criticized by Georgetown University’s Health Policy Institute (HPI). HPI had criticized the reform plan in January 2005 in the form of numerous questions about the plan. Most of the answers to these were easily available to parties willing to examine the reform proposal. HPI produced a May 2007

briefing titled “Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida’s Medicaid Changes.” This report reaches negative conclusions about the reform in a two-part analysis. The first were comments from focus groups interviewed by the project’s researchers. According to HPI, fewer than half of focus group participants said they had spoken with choice counselors. They found that virtually all focus group participants were aware of the changes that were underway in the Florida Medicaid plan but that a significant minority reported not having received the state’s information mailing regarding enrollment or were unaware that they needed to make a plan selection under the reform.

Focus group participants stated that their top priority was the ability to keep their current doctors when enrolling in a reform plan. Many beneficiaries reported to researchers that they had problems keeping some or all of their doctors. Plan selection based on coverage of specific medications was also a concern for some focus group participants, especially the disabled. According to HPI, a number of problems were reported in this area, and participants expressed frustration about choice counselors not having access to the plans’ drug formulary.

Participants did not appear to be making choices based on the ability of plans to offer differing benefits packages. A notable exception to this was the possibility of obtaining an adult dental benefit. It appeared that some parents might have selected a plan for themselves that offers adult dental benefits. Most of the focus group participants, according to HPI, reported frustration with the number of plan choices and the differing benefits packages that were available. When the focus group members were quizzed about available plans and their coverage, HPI reported that they exhibited significant problems in understanding what was available. Finally, HPI found that virtually all participants stated they would like the choice of the state’s existing fee-for-service plan instead of enrollment in one of the new plans.

The second part of the HPI study involved how physicians were reacting to the demonstration program. An attempt was made to measure

this by surveying physicians in Broward and Duval counties. The survey was distributed by e-mail and fax for the Broward County Medical Association and Duval County Medical Association to their membership lists. Of the responses obtained by HPI, approximately half were specialists and half were primary care physicians. HPI interpreted the results as indicating that physician participation in Medicaid was declining. According to HPI, 27 percent of the responding physicians who previously participated in Medicaid said that they did not intend to join any of the new reform plans.

HPI argued that these findings correlated with focus group concerns about the inability to find their existing physicians in the reform plans. They further argued that this is most problematical for beneficiaries with multiple health conditions who see different physicians. Some focus group beneficiaries say they discovered that their doctors are scattered across different plans so that they cannot access all of their original providers. HPI suggests that the reform, therefore, has the opposite effect of its intention to increase access to providers. This is especially true with regard to specialists, according to their briefing. As further evidence of this, HPI cites survey results that show about 40 percent of physicians had half or fewer of their patients since reform.

HPI argues that supposedly declining participation by physicians after the implementation of reform is related primarily to two issues. The survey HPI conducted indicates that about one-third of responding physicians stated that payments for services have declined. In addition, managed-care paperwork requirements of physicians also led to less provider interest in participating in reform. According to the HPI survey, 42 percent of the responding physicians said that the paperwork requirement for claims was more burdensome than in the past. In addition, physicians who treat children indicated that it would become more difficult to provide services to the EPSDT group due to approval issues related to plans. Approximately half of responding physicians reported difficulty in providing “needed” services to beneficiaries due to plan limitations.

Further examination of the HPI findings leads to considerable questions about their

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validity. First is the extremely limited size of the focus groups in question. According to HPI, four focus groups were conducted in each county by the project’s researchers. The participants were recruited by an unnamed professional focus group firm. The combined total of beneficiaries interviewed in both counties was 80. The fact that there is no information as to how focus group participants were selected and that an extremely small sample of enrollees was questioned by HPI casts serious doubt on the appropriateness of extrapolating the supposed problems to the entire reform population. Finally, the actual number of complaints registered with regard to various parts of the reform is very small given the total number beneficiaries involved. And, as stated above, the fact that not one formal program level grievance was filed by enrollees in the first year of the reform casts serious doubt on assertions that the quantity and quality of medical services provided has declined in a measurable way.

Similar validity questions are raised with regard to the physician survey undertaken by HPI. The unsolicited e-mail and fax survey conducted by HPI received a total of 186 responses. This represents approximately 8 percent of surveys sent. In addition, responding physicians did not answer every question. HPI admits that because of the low response rate, the survey findings should not be considered generalizable to the entire membership of these organizations. Indeed, actual physician participation in Medicaid has not changed markedly since the implementation of reform. Limited evidence on the participation of specialists shows a similar pattern. These initial findings, along with the very limited number of complaints by beneficiaries, casts serious doubt on assertions that there has been a substantial decline in participation by doctors since reform began.¹⁴

HPI also claims that cost sharing had increased significantly as the reform entered its second year. They also allege that benefit packages are shrinking from year one levels. For HMOs, supposedly 58 co-payments have been added or increased while only one has decreased. They also state that 52 other plans’ benefits have been reduced or eliminated along with just 16 increases in benefits. So this analysis

reports a total of only 17 benefit increases and/or co-pay reductions in contrast with 110 benefit decreases and/or co-pay increases.

This is in stark contrast, however, with the 12 co-pay reductions and 112 benefit expansions, respectively, that have been reported by FM for the entire group of plans. The HPI assertions cannot be correct given those results. **HPI needs to clarify its research methodology for these declining benefit assertions.**¹⁵

The AHCA Inspector General’s Office (AIG) conducted a program review of Florida Medicaid reform at the request of the Secretary of the AHCA.¹⁶ AIG recognized that there was a paucity of performance data at this initial stage in the reform demonstration. To evaluate reform they conducted interviews with Florida Medicaid staff, providers, advocates, and plan representatives. They also attended informational meetings held by Florida Medicaid for beneficiaries in Clay and Baker counties, and they listened to telephone exchanges between enrollees and choice counselors. In addition, they reviewed beneficiary telephone exchanges and complaint data and examined the availability of health plan preferred drug listings. The review was conducted between April and August of 2007.

Among the conclusions reached by AIG were the following:

1. Florida Medicaid implemented the Medicaid reform demonstration project within timelines set by the executive and legislative branches of government with few additional resources.
2. The expedited implementation timeframe of the demonstration produced many of the challenges faced by the reform.
3. Given the expedited timeline, Medicaid staffing levels were inadequate to undertake the implementation of the demonstration.
4. Internal communication and information sharing and availability were hampered by a lack of widespread access to key documents, although this appears to have improved over time.
5. Characteristics of Medicaid that existed prior to reform, such as limited access to specialists, continued to be a concern.
6. The accuracy of information available to

choice counselors has been compromised by high rates of errors in the provider network reports.

7. For most plans and provider service networks, drug formularies and specific drug coverage information is not available online or through customer service phone numbers.
8. The enhanced benefits program has encountered serious implementation problems.
9. Managed care has not ended Medicaid fraud and abuse and simply changes its character and methods, which requires modification of the state's detection and prevention strategies.
10. Subpopulations such as the severely and persistently mentally ill and those with complex mental conditions may have serious challenges in adapting to managed care.
11. Reform expansion has the potential of negatively impacting the financial viability of county health departments.

AIG then makes the following recommendations, among others:

1. Florida Medicaid should develop standardized policies and procedures describing how health plans will be approved in the future. Policy should address such areas as plan approval steps, on-site visits, system readiness testing, claims processing, and any problems encountered in readiness and provider network adequacy.
2. Further expansion of Medicaid reform should be delayed until such time as those improvement benchmarks are met.
3. Future audits or evaluations of cost-effectiveness should examine indicators of possible cost shifting, as well as outsourcing and administrative costs.
4. Implement a web-based information technology system for document sharing.
5. Continue to adopt a consolidated, real-time complaint tracking system, with features to promote a coordinated response and analytical capabilities for producing trend reports. Include in the system a means to track indicators of inappropriate denial of care by health plans.
6. Continue to work with plans or provider

service networks on obtaining accurate provider network reports. Regularly audit those reports by comparing them with enrollee handbooks for discrepancies, contacting a sample of providers to ensure accuracy.

7. Pursue alternatives to ensure beneficiaries have easy access to health plan drug formularies and pharmacy benefit information prior to choosing a health plan.
8. Ensure that the choice counseling special-needs unit is adequately staffed.
9. Expedite internal preparations to deal with the changing character of Medicaid fraud and abuse in a managed-care environment.

A review of the AIG study of Medicaid reform leads to one obvious observation. The basis for most of these conclusions was direct interviews and anonymous surveys of AHCA employees. As limited as the HPI study was, it did at least attempt to ascertain the impact of reform by questioning beneficiaries and physicians. An underlying theme of the AHCA employee survey's findings was that there were not enough resources made available to implement the reform demonstration. **This ignores the fact that the Legislature appropriated \$35 million for choice counseling, actuarial analysis, plan evaluation, and management of enhanced benefits. Related to this was the employment of over 11 new full-time equivalent employees to assist in implementing reform.** The failure to report this portrays Florida Medicaid officials in an unnecessarily negative light with regard to the manpower needed to properly implement reform demonstration.

It should also be recognized that the decision to implement Medicaid reform was a political one made by the Legislature and the Governor. It was not arrived at by a democratic vote of AHCA employees. It seems reasonable to assume that at least some of these individuals were opposed to the decision by elected individuals to implement the Medicaid demonstration. This can certainly be expected to influence their comments on, and opinions of, reform. It is not unreasonable to expect that this is especially true when they're able to submit these views via anonymous questionnaires and surveys. That does not mean that all of the AHCA employees'

“An underlying theme of the AHCA employee survey’s findings was that there were not enough resources made available to implement the reform demonstration.”

“But the findings by AIG of problems and negative outcomes related to reform would carry more weight if backed up by actual evidence rather than opinion.”

criticisms and negative comments on reform are necessarily inaccurate or should be dismissed. **But the findings by AIG of problems and negative outcomes related to reform would carry more weight if backed up by actual evidence rather than opinion.**

For example, AIG’s conclusion that pre-reform problems such as limited access to specialists continue to be a concern stands in contrast to evidence cited above that reform plan access to this group has, in some cases, increased. A statement that the enhanced benefits plan has significant implementation problems does not correspond with the data showing that nearly half of beneficiaries are undertaking “healthy behaviors.” It is also argued that managed care competition has not ended fraud but only changed its nature. This flies in the face of an outright drop in per capita plan expenditures. AIG needs to update its report to include actual evidence on expenditures, provider access, legislated resources, and other issues related to reform.

Both HPI and AIG raise concerns about drug formularies of HMOs. They argue that beneficiaries are reporting problems getting access to “needed” drugs and that a significant number of HMOs limit either the dollar or specific number of prescriptions that can be obtained. While admitting that this dollar limit is set at a very high level, they also argue that most HMOs have a drug list that is less inclusive than the existing Medicaid formulary. Finally, they assert that finding what types of drugs are on the various lists is difficult to do for enrollees.¹⁷ They do admit, however, that controlling drug costs is a reasonable goal in controlling overall Medicaid inflation. But they argue that the HMO formularies may be too limited to properly serve beneficiaries.

These arguments are based on three findings. First, it is pointed out that HMOs in the reform may limit the number or dollar amount of prescriptions available to beneficiaries while there is no such restriction in PSNs. HPI examines the availability issue of 50 drugs “commonly used” by Florida Medicaid beneficiaries. According to them, Medicaid’s state formulary covers 48 of these (96 percent). They point out that only one HMO has a drug list as extensive as the state’s. The other HMOs in question have comparable

rates between 74 percent and 90 percent of the state formulary. This is presented as evidence of a problem in this area.

JMI finds this argument unconvincing. JMI does agree that HMOs need to provide more transparency in which drugs are available under their plan without an exception. Indeed, FM has recognized this problem and worked with plans to solve it. But that does not imply that HMO formularies are causing significant issues for beneficiaries. First, a disproportionate amount of “sicker” beneficiaries are enrolled in PSNs at this stage of reform, so the HMO formulary is irrelevant to those individuals. Second, HPI does not define their “top 50” list.¹⁸ Third, it should be no surprise that the state formulary is broader than most HMO lists. Pharmaceutical firms exert enormous political pressure on traditional fee-for-service Medicaid to have their products listed. Since the only bargaining power available to the state in this instance is exclusion of patented medicines, it should not be surprising to find broad (and expensive) formularies at that level.¹⁹ This is not true among competing plans. Fourth, while dismissed in these critical reports, access to non-formulary drugs involves a non-onerous process of “prior authorization” that involves the attending physician making a request for an exception (of course the plan is not required to make an exception but, from individual cases shown below, sometimes does). No data are provided by critics with regard to this issue. Fifth, the allegation of an access problem is (again) based on HPI’s extremely limited focus group in the early part of 2007.

The numerous concerns raised by the HPI and AIG reports must be contrasted with the actual results that have been obtained in the first year of Medicaid reform. Only 90 complaints were received from Medicaid reform beneficiaries. **This implies a complaint rate of only .0174 percent for all plans. The rate is .0412 percent for HMOs, and .0079 percent for providers service networks. It does not seem logical that the existence of significant reform problems would be producing these extremely low complaint rates. In addition, not one formal grievance was actually filed by enrollees at the program level in the first year of reform.** The choice-counseling program, which is a crucial part of the reform, received

a total of 52 complaints during the first year run operation. There were a total of only 29 complaints regarding the enhanced benefits program. **Again, the existence of significant widespread problems in the reform would seem to imply far higher complaint rates than have been received during the first year of the demonstration.**

In addition, an important aspect of reform is to make Medicaid function like a private marketplace. In this situation, enrollees unhappy with the care they receive from the plan they selected may switch during a reenrollment period. The limited survey conducted by Florida State University regarding the choice-counseling plan indicated that nearly 80 percent of respondents had no intention of changing to a different carrier.²⁰ While the small sample size of 275 does not allow for this to be generalized to the entire reform population, these initial results are encouraging. Some participants in the AHCA survey question if any value had been obtained by implementing the reform. While the early stage of the reform does not allow for a robust evaluation of changes in health outcomes, data are available on the fiscal aspect of the reform. As previously established, per capita expenditures for both the children and families population and the SSI group are significantly below the required amount for the maintenance of 1115 budget neutrality.

VII. Summary and Conclusions

Florida's Medicaid reform demonstration is now in its second year. It now operates in five counties. The reform has unambiguously led to greater competition in all of the participating counties. It has also increased services and products available from many plans and has led to differing benefits packages provided by plans. The most popular expanded benefits offered by reform plans are over-the-counter drug benefits and adult preventative dental benefits. In addition, there is little evidence that primary care physicians are leaving the Medicaid program, with the voluntary non-renewal rate being around 3 percent in the two initial reform counties. Extremely limited data available on selected specialists in the program also do not indicate a problem with specialists participating

in Medicaid, relative to free reform levels.

As part of the reform, a choice-counseling program was created to assist beneficiaries in plan selection and with regard to various questions related to the demonstration. Counselors have answered almost 170,000 calls from beneficiaries and have run hundreds of public and private seminars to disseminate information about the program. A measure the success of this program is the percentage of new beneficiaries who have made a voluntary enrollment selection as opposed to automatic assignment. Florida Medicaid established a target of 65 percent of voluntary enrollments in the first year of the reform and met the goal, as the actual figure was 67 percent. In the second year of reform the target was increased to 80 percent. 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. Extrapolation of the first year's quarterly trends indicates a likelihood of meeting the 80 percent target for voluntary enrollments during year two.

A third reform goal was to increase the quality of the medical care and health outcomes in Medicaid. Data are not yet available on changes in health status of beneficiaries. Some results are available on an aspect of this program, however. Specifically, it is to encourage healthy behavior among beneficiaries given that a significant part of poor health status is related to issues such as obesity. All beneficiaries are given enhanced benefit accounts, where they essentially earn spendable dollars by engaging in healthy behaviors. At the end of the first year, reform beneficiaries had earned over \$4,300,000 in EBA credits with over 91,000 beneficiaries having undertaken at least one healthy behavior. This is close to half of the reform population. The top healthy behavior undertaken by enrollees was office visits for adults and children. Less successful was the effort to encourage beneficiaries to use their credits; some 5,700 enrollees spent about \$150,000 in earned credits. A major disappointment of the reform is the low utilization of the reform's "opt-out" provision, with fewer than ten beneficiaries using the actuarial value of their benefit to buy into an employer-sponsored plan.

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“The demonstration must be ‘budget neutral,’ which means it can cost the Federal government no more than what the match would have been in the absence of reform.”

The demonstration must be “budget neutral,” which means it can cost the Federal government no more than what the match would have been in the absence of reform. For the overall program reform, the budgeted amount per capita in year one was \$328.24. The actual expense was \$281.99. The allowable budget growth rate for both categories of enrollment is 8 percent per annum. **Total reform per capita expenditures declined by 7.2 percent.** In addition, the reform established a Low Income Pool (LIP) to distribute one billion dollars a year to “safety net” providers and other groups serving Medicaid, the uninsured, and underinsured populations. For this fiscal year, Florida Medicaid has received over \$358 million from over 30 local funding sources for operation of the LIP. A total of more than \$966 million was distributed to providers approved by the LIP council. For the second fiscal year of the reform, another \$1 billion has been approved for distribution to eligible parties. The University of Florida will be examining the impact of the LIP, including its cost-effectiveness.

Interim pharmacy data and medical services encounter data will be used to support a risk-adjusted methodology for setting capitated payments to reform health plans. Risk adjustment is to be phased in over a period of three years beginning with the Medicaid Rx model and transitioning to a diagnostic-based model such as the Chronic Illness and Disability Payment System. A major reason for risk adjustment is to provide the incentive necessary for innovative providers to develop niche products for those enrolled in Medicaid with significant health issues. These “special needs” plans would seek to enroll the sick rather than shun them. They would likely be clinical type providers with groups of specialists working together to coordinate the care needed to properly and cost effectively treat the very ill with multiple chronic issues. Innovation in this area is crucial to reducing medical inflation in the program.

Finally, reform outcomes are being reviewed by the University of Florida and other researchers. Specific outside reviews that have been critical of reform include the GAO, The Georgetown Health Policy Institute (HPI) and the AHCA Inspector General (AIG). The

GAO report focuses primarily on the legality of the reform’s “opt-out” availability. HPI critically comments on availability of providers and of drugs from HMO formularies, among other issues. Its study’s credibility is very limited, given the extremely small focus group sample (80 individuals) as well as a very low response rate to its physician survey. In addition, HPI’s claims of declining benefit packages and/or increasing co-pays in year two is suspect. Meanwhile, the AHCA’s AIG report raises concerns based primarily on an anonymous survey of AHCA employees. It also discounts the significant financial resources that were put in place to implement reform.

VIII. Appendix: Beneficiary and Provider Complaints

HMO Complaints

This is a list of complaints registered by beneficiaries and/or providers in the first year of reform. A review of them indicates that the vast majority of the issues were resolved satisfactorily. The small number of complaints and the low severity of the issues in question do not appear to correspond to major problems in the reform demonstration.

1. Member needs vision referral. Area office was contacted to get demographics on client and confirm with the Plan to respond on the outcome. Member was seen at provider. Arrangements for service and reimbursement were made.
2. Member cannot find pediatric dentist that sees children under the age of five. Sent an e-mail to member requesting identifying information. Also, requested that the plan check into this issue with dental provider and locate pediatric dental providers. The plan has non-participating pediatric dentists who see children under the age of five. They are working on contracting with these providers.
3. Authorization for drugs denied and requesting to see specialist. The plan was contacted by phone and e-mail and agreed to provide the member with the requested medication and referral to an orthopedic specialist. Client has been

- encouraged to contact PCP. The plan's customer service representative contacted member. Member no longer wanted the medication. Member contacted her PCP and scheduled an appointment for 12/28/06. Drug Evaluation forms were faxed to the PCP for approval. Member was also given the name, address, and number of an orthopedic doctor.
4. Problem obtaining authorization for drugs, and problems with current plan PCP. After plan was contacted, case manager provided member with list of alternative PCPs to select from. Case manager spoke with client on several occasions to resolve issue. After a few denials of different drugs, PCP prescribed Diltia XT. Member had paid out of pocket for 30-day supply, but was reimbursed.
 5. Member was transferred from MediPass to an HMO plan and is now being denied for the same drug she has used for many years. Member filed appeal with plan on 11/1/06 and denial was upheld. AHCA was informed by the plan that the PCP did not provide necessary clinical documentation to support the medical necessity for Buprenex. Member was sent the denial letter advising her of her rights to a Medicaid Fair Hearing.
 6. Problems finding dental service in local area. Plan was contacted. A Dental Provider Relations representative spoke with the member's mother to discuss her issues. Member's mother indicated that this was no longer an issue and that she already had made an appointment with the same dentist her child had seen before.
 7. Member is having problems obtaining authorization to see psychiatrist. Member was enrolled in Medipass, but was transferred to a Reform PSN plan. His current psychiatrist was offered a contract with the plan, but did not accept. Member has not been able to see a psychiatrist or get medication since 11/06. The Director of Client Relations for the plan was contacted. He immediately approved a six-month authorization for the member to see his psychiatrist. Appointment was made for 3/21/07.
 8. Problem obtaining authorization for circumcision. The Plan was contacted to make arrangements with the member for medical services. The child was over one year of age, and the plan only covers circumcisions for babies up to one year of age. The plan's medical director reviewed the provider's authorization request and denied it for lack of medical necessity. An elective circumcision after one year of age is not a covered benefit.
 9. Neurologist and ophthalmologist do not accept member's current health plan. Plan was contacted. Operations Specialist spoke to member to inform her that her neurologist is not in the plan's network. Plan authorized, for continuity of care purposes, to continue treatment from 1-12-07 through 2-2-07. Member has agreed to subsequently transfer to a provider within the network. Member was informed that ophthalmologist accepts the member's plan.
 10. Member requested information on dental care. Dental provider indicated that they did not have member in their system. Confirmation letter was faxed to dental provider so member could make appointment.
 11. Dental Provider alleged that claims for patients under 21 are being denied by Reform plan. Plan was contacted and subsequently requested provider to fax all denied claims for reconsideration.
 12. Member was confused about enrollment requirements into Nursing Home Diversion Program. Member was contacted and provided with the necessary information. Member was enrolled into the program effective 4/1/07.
 13. Provider alleged that the plan denied payment of claims for immunizations. After plan was contacted, the plan agreed to pay for all outstanding immunization claims.
 14. Member has pending application for different plan. Member is currently in regular HMO plan and has been unable to receive home health care. Overall, member was confused about the enrollment process. Member was informed that he has to

- be disenrolled from regular HMO plan before being enrolled into the new plan. Member was segmented out of HMO plan to facilitate immediate enrollment into the new plan. This should provide the member with the necessary care.
15. Father of beneficiary indicated that authorizations for mental health drugs necessary to keep son out of hospital were frequently denied by plan; that assigned PCP refuses to see member; and also requested plan change. Plan was contacted. AHCA staff requested that member receives intensive case management as well as evaluation for day treatment. The plan agreed to re-evaluate the beneficiary and reconsider the denial for various prescription drugs. In the meantime, beneficiary has been changed to another plan effective 4/1/07 based on the father's request.
 16. Provider alleged that the dental provider did not provide fee schedule to dental office. Dental office was contacted by a Provider Relations Supervisor with the dental provider. A copy of the fee schedule was faxed to the provider's office.
 17. Problems accessing dental services. Member was contacted and given the phone number for the dental provider to schedule an appointment.
 18. Diabetic test strips are being denied by pharmacy. The plan was contacted. The plan contacted the pharmacy to resolve issue. Apparently the pharmacy did not process the diabetic supplies correctly. However, they are now processed correctly, and member was able to receive requested test strips.
 19. Beneficiary requested assistance with Enhanced Benefits Account. The plan was contacted by the Agency to send appropriate information to member. Plan sent member the requested information.
 20. Member was sent letter to enroll in HMO Reform plan although member was enrolled in another plan. Member was inadvertently sent a letter to pick a Reform plan and was changed to a regular HMO Reform plan. Member was reenrolled in the original plan.
 21. Provider indicated that payment for transplant services was denied by plan. Provider was called and was informed of the reimbursement process for transplant services by the plan. The plan was advised to educate providers on the documentation needed to receive payment.
 22. Member was auto-assigned to wrong plan. Member was contacted and reassigned to plan of his choice.
 23. Member requested plan change because assigned PCP was too far away. Member was assisted in changing healthcare plan.
 24. Provider having problems getting payment from the plan. The plan was contacted and agreed to pay the provider.
 25. HMO member's mother wants to enroll her child into another plan because her PCP does not accept her current plan. HMO member's current HMO was contacted and has authorized two visits with member's PCP and agreed to give more if needed. Child will be enrolled into mother's plan of choice effective 5/1/07.
 26. HMO member has been waiting enrollment into plan since January, 2007. HMO member was enrolled in the plan effective 4/1/07.
 27. HMO member is having issues receiving a referral to see a specialist. Member also wants to file a grievance with the plan. The HMO contacted member to assist in finding a specialist. An out-of-network provider was offered, but member did not want to travel that far. A grievance with the health plan was never filed.
 28. HMO member is unable to finish ongoing treatment to his teeth because provider stopped accepting Medicaid. The HMO was contacted and they instructed the member to file a grievance with the dental network. The dental network was contacted and stated they did receive the grievance and are working on the issue.
 29. HMO member needs authorization to go to Texas Children's Hospital for heart/lung transplant. The HMO was contacted and agreed to cover case management and transportation.
 30. Hospital is having issues getting an authorization on an HMO member;

- member is not showing on the HMO's enrollment system. The HMO was contacted and stated that the member was in their system and the issue was human failure. Authorization for services has been approved.
31. HMO claim is being denied. The HMO was contacted and stated the member was not enrolled with them. Our records indicate the member is enrolled in the plan, and they were asked to update the member's file. The plan has updated its records and the claim was paid.
 32. HMO member is in need of a liver transplant. The HMO was contacted and the member has been approved for a transplant and is currently the first on the transplant list.
 33. HMO member is in need of a liver transplant. The HMO was contacted and confirmed that the member has been authorized and is in case management.
 34. HMO member claims she was mistreated by her HMO and had questions about over-the-counter drugs and reimbursement. An HMO representative contacted the member and assisted her with ordering her over-the-counter items and provided information about reimbursement.
 35. HMO member was denied drugs. The HMO was contacted and agreed to provide enough medication to get the member through until his appointment. The doctor will then write a full prescription.
 36. Complaint against transportation provider's phone line. A wrong number was being dialed in order to get in touch with transportation provider. The HMO member was sent the correct number and was able to get through.
 37. HMO member is in need of a liver transplant. The HMO was contacted and confirmed that the member has been authorized and is in case management.
 38. HMO member mother needs dental care for her children and is being denied by their current HMO because of county change. The HMO member's mother called Choice Counseling for a plan change, but they were unable to process the request. We e-mailed Choice Counseling to look into this issue because the current plan is not covered in the member's new county. Member was contacted by Medicaid Options, and a plan change has been made so they will be able to receive the dental care.
 39. HMO member is having problems receiving drugs from his plan. The HMO was contacted and provided limited authorization for the medication, with instruction for member to receive further evaluation. A representative from the plan contacted the guardian of the member about the concerns with the medication prescribed.
 40. HMO member having issues getting authorization for dental needs. The HMO was contacted and sent a copy of the dental contract.
 41. HMO member is not showing as being enrolled with the HMO. The HMO was contacted and has corrected its system to show member as enrolled.
 42. HMO member has high-risk pregnancy, and the hospital does not accept her plan. The HMO member has changed her plan.
 43. HMO member needs to see a specialist, and none is available in the area. The HMO member does not want to travel out of the area to see a specialist. The HMO was contacted and has found a specialist within the area for the member to see.
 44. HMO member wants to enroll into plan but is being declined. The HMO member was enrolled into desired plan effective June 1, 2007.
 45. HMO member is being billed for services that should be covered by plan. The HMO was contacted and corrected eligibility, reprocessed the claims, and contacted the member for closure.
 46. HMO member is having problems receiving drugs. The prescribing physician did not obtain the prior authorization for the increase in the medication. The HMO was contacted and stated that the authorization is good for a year. The HMO contacted member's mother to inform her that the medication was ready for pick up at the pharmacy.

47. HMO member wants to change plans. The HMO was contacted and will be going to member's home to assist in the application process.
48. HMO member was removed from transplant list due to change in plan. The new HMO is case managing the member and is awaiting reactivation on the waiting list. At this point, no further action is required.
49. HMO member wants to change plans. The HMO member has been enrolled into a new plan effective June 1, 2007
50. HMO member is having problems continuing his care from a specialist. The HMO spoke with the specialist, and he has agreed to continue treating patients that he was seeing prior to implementation of Medicaid reform.
51. HMO provider's claims are being denied. HMO claims were adjusted by plan and paid.
52. HMO member was in the process of dental care when provider was banned from participation in Medicaid. The HMO member was unable to get in contact with the dental provider in the middle of his dental care. The dentist has been banned from participation in Medicaid or Medicare per Emergency Suspension Order on August 13, 2002. Member filed for a Medicaid Fair Hearing, but withdrew his request. The HMO member stated that he has gone through the grievance process with the plan, but the plan ended the process and retained counsel. The HMO member is considering a medical malpractice suit, but really just wants appropriate dental care. The dental network has referred this case to Medicaid Fraud.
53. HMO member wants clear fillings from dental provider. The HMO was contacted and explained that clear fillings are not covered. The dental network then contacted the member to explain what types of fillings are covered.
54. HMO member is having issues getting dental network to fund his procedures. The HMO was contacted and per dental network, the services the HMO member is seeking are not covered under the HMO. Member is no longer concerned with his dental issues and will be switching back to his previous plan.
55. HMO member needs ID card. The HMO contacted the member and verified address to send another ID card. The HMO also faxed member's eligibility verification to their PCP.
56. HMO member is having issues finding an Ob/Gyn that specializes in cancer treatment. The HMO member has filed a grievance with the HMO. The HMO contacted the member to refer her to an Ob/Gyn, but they do not specialize in her condition. The HMO found another Ob/Gyn that the member will be seeing.
57. HMO member is seeking a good cause plan change because current plan cannot provide a specialist. The HMO contacted member via letter and informed her that there is no authorization on file and to contact her PCP. The HMO also contacted the member by phone and explained to her that they need an authorization request from her PCP. Information was forwarded to Choice Counseling to make final determination.
58. HMO member needs ID card and a member handbook. The HMO contacted the member and left several messages. The HMO has sent member a new ID card and member materials.
59. HMO member has reached his prescription cap and is in need of more medication. The pharmacy has re-run all of the claims and has contacted the member. For the entire month of May 2007, the member received case management and had his/her prescriptions filled. The recipient changed plans with an effective date of June 1, 2007.
60. HMO member needs to see a doctor and wants to file a grievance with her plan. The HMO contacted the member and informed her that she does not have a PCP (even though there is a name on her ID card) and to go to the emergency room. The member asked to speak to a supervisor to complain and was told no

one was there and they would not let her speak to someone to file a grievance. The Agency HQ staff contacted the HMO and they stated the issue has been handled and resolved and the member reported she was satisfied.

61. HMO member is having issues getting drugs authorized. The HMO member's mother stated that she has submitted all necessary paperwork to the HMO in order for her son to receive this medication. E-mail was sent to the HMO requesting that it honor a 30-day prescription until further evaluation can be conducted. The HMO did honor the 30-day prescription, and the authorization will be good for one year unless the doctor changes the dosage. Mother is satisfied with ending results.

Specific PSN Complaints

1. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. One PSN updated its trading partner information to ensure rapid processing by the Medicaid fiscal agent. Another PSN corrected a system mapping error and resubmitted claims that had previously denied. Both PSNs also educated provider on how to properly and fully complete claim forms.
2. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with each PSN. One PSN found no evidence that provider had submitted claims. Another PSN educated the provider on how to properly and fully complete claim forms and service authorization requests.
3. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Area Office staff attended meetings between provider and PSNs. Two PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms. One PSN found no evidence that provider had submitted claims.
4. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Based on research, provider educated on how to properly and fully complete claim forms. Medicaid fiscal agent resolved issue related to claim submitter IDs.
5. Provider issue regarding PSN lack of timely claims payment. HQ staff facilitated review with PSN and provider. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms.
6. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. Medicaid fiscal agent resolved issue related to claim submitter IDs. Provider educated on how to properly and fully complete claim forms and how to request service authorization.
7. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. Medicaid fiscal agent resolved issue related to claim submitter IDs. One PSN corrected a system mapping error and resubmitted claims that had previously denied. Provider educated on how to properly and fully complete claim forms.
8. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with each PSN, provider, and Medicaid Contract Management staff systems staff. HQ staff hosted multiple conference calls. PSN assisted provider in updating her billing system. Provider educated on how to properly and fully complete claim forms.
9. Provider issue regarding PSN timely authorizations and payments. HQ staff facilitated review with PSN and provider. Based on research, provider was educated on how to properly and fully complete claim forms and service authorization requests.

10. Provider issue regarding PSN lack of timely claims payment. HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Area Office staff, PSN, and local fiscal agent representative met with provider. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms. Medicaid fiscal agent reprocessed some claims that should have paid as submitted.
11. Provider issue regarding PSN timely payments. HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Meeting between PSNs' TPA and provider attended by Area Office staff. PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms.
12. Provider issue regarding PSN lack of timely claims payment. HQ staff facilitated review with PSN and provider. Provider educated on how to properly and fully complete claim forms.
13. Provider issue regarding multiple PSNs' lack of timely claims payment. HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Provider meetings with PSNs attended by Area Office staff. PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms.
14. Provider issue regarding PSN timely authorizations and payments. HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider educated on how to properly and fully complete claim forms and service authorization requests. Medicaid fiscal agent reprocessed some claims that should have paid as submitted.
15. Provider issue regarding PSN delays in authorizing services. HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. One PSN gave the provider the correct phone number for requesting authorizations and resubmitted claims that had denied due to a PSN keying error. Another PSN found no evidence that provider had ever requested service authorization.
16. Provider issue regarding PSN delays in authorizing services and payments. HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms and service authorization requests. PSN providing weekly progress reports to HQ until all outstanding claims are paid.
17. Provider issue regarding multiple PSNs' authorizations and lack of timely claims payment. HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Based on research, provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms and service authorization requests. Two PSNs found no evidence that provider had submitted claims. Each PSN worked with provider to expedite processing of claims. One PSN updated its trading partner information to ensure rapid processing by the Medicaid fiscal agent.
18. PSN provider issue regarding PSN lack of timely claims payment. At the PSN's request, the Agency's Headquarters (HQ) staff submitted a customer service request (CSR) to allow provider to submit claims directly to Florida Medicaid's Fiscal Agent. The provider was advised to correct tax ID information on his Florida Medicaid provider file. HQ staff periodically checked with Medicaid Contract Management staff until CSR was implemented. Then, notified PSN and Area Office staff, who notified provider.
19. PSN provider issue regarding multiple PSNs' lack of timely claims payment. The Agency's HQ staff facilitated review with each PSN and provider. The Agency's HQ and PSNs educated provider on how to properly reconcile payments received. Both PSNs educated the provider on how to properly

and fully complete claim form. The Agency's HQ staff provided information on how to order new CMS-1500 claim forms.

20. PSN provider issue regarding PSN lack of timely claims payment. The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider was educated regarding timelines by which the PSN submits claims to Florida Medicaid's Fiscal Agent. Provider revised its billing process accordingly.
21. PSN provider issue regarding PSN lack of timely claims payment. The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms.
22. PSN provider issue regarding multiple PSNs' lack of timely claims payment. The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms. PSNs submitted corrective action plan to ensure proper education and processing by their subcontracted claims managing entities.
23. PSN provider issue regarding multiple PSNs' lack of timely claims payment. The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Florida Medicaid's Fiscal Agent reprocessed claims impacted by a recent system issue. PSNs identified keying errors and resubmitted impacted claims.
24. Provider issue regarding PSN lack of timely claims payment. HQ staff facilitated review with PSN and provider. Provider educated on how to properly and fully complete claim forms.
25. PSN provider issue regarding PSN lack of timely claims payment. The Agency's HQ staff facilitated review with PSN and provider. Provider educated on

how to properly reconcile payments received. PSN identified keying errors and resubmitted impacted claims.

26. PSN provider issue regarding PSN lack of timely claims payment. The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms.
27. Member complained about her PCP. Member referred to Area 10 office for assistance.
28. Member general complaint about lack of providers for authorizations. Referred to PSN for reference and network review.

References

- 1 Risk adjustment is being done in Medicare Advantage Plans. See Verdier, J., "Medicare Advantage Rate Setting and Risk Adjustment," Center for Health Strategies, October 2006.
- 2 See the nonpartisan Congressional Budget Office for long run fiscal estimates on Medicaid. www.cbo.gov/ftpdocs/88xx/doc8877/12-13-LTBO.pdf
- 3 O' Shea, J., "More Medicaid Means Less Quality," The Heritage Foundation, #1402, March 2007.
- 4 Summers, A., and Cohen, M., "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" Medicaid and the Uninsured, Kaiser Family Foundation, March 2006.
- 5 In 2004 it was estimated that 11% of Medicaid expenditures were directly related to obesity. See [Finkelstein E.](#), [Fiebelkorn I.](#), and [Wang G.](#), "State-level estimates of annual medical expenditures attributable to obesity," *Obesity Research*, 2004 Jan;12(1):18-24.
- 6 Private sector HSAs may not be advisable in Medicaid because of limits on cost sharing in Medicaid. These "reversed" HSAs eliminate that issue and also generate a "reverse" working capital effect.
- 7 The GAO is concerned that enrollment in private plans may not offer beneficiaries the same level of benefits as the minimum Medicaid package. This is discussed critically later in this report.
- 8 See Bond, M., "Expanding Opportunities for Health Insurance in Florida," The James Madison Institute, Backgrounder No. 51, February 2007.
- 9 See Duncan, P., et. al., "Medicaid Enrollee Reform Satisfaction: Baseline CAHPS Survey in Broward and Duval Counties," Department of Health Services Research, University of Florida, July 2007.

- 10 See Hall, A., et. al., "Medicaid Reform Preliminary Baseline Findings from Longitudinal Study," Department of Health Services Research, University of Florida, July 2007.
- 11 Gilmer, T., et. al., "The Medicaid Rx Model: Pharmacy-based Risk Adjustment for Public Programs," *Med Care*, 2001 Nov;39(11):1188-202.
- 12 Kronick, R., et. al., "Improving Health Based Payment for Medicaid Beneficiaries: Chronic Illness and Disability Payment System," *Health Care Financing Review*, 21, Spring 2000, pp. 29-64.
- 13 See www.gao.gov/new.items/d07694r.pdf
- 14 See Alker, J., and Hoadley, J., "Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes," *Florida's Experience With Medicaid reform, Briefing #2*, May 2007, Georgetown Health Policy Institute.
- 15 See Alker, J., and Hoadley, J., "Medicaid Pilots at One Year: How Is the New Medicaid Marketplace Fairing? Briefing #4, December 2007, Georgetown Health Policy Institute.
- 16 See "Program Review of the Medicaid Pilot Project," Office of the Florida Inspector General, September 2007.
- 17 See Alker, J., and Hoadley, J., "Uncertain Access to Needed Drugs: Florida's Medicaid reform creates challenges for patients" *Florida's Experience With Medicaid reform, Briefing #3*, July 2007, Georgetown Health Policy Institute.
- 18 JMI has been told by AHCA officials that HPI did not define or provide this list to Florida Medicaid.
- 19 This is similar to the argument that a Federal formulary for Part D drug coverage will lower costs. The argument is fallacious. See Enthoven, A., and Fong, K., "Medicare: Negotiated Drug Prices May Not Lower Costs," *Brief Analysis #575*, National Center for Policy Analysis, December 2006.
- 20 From the Florida Agency for Health Care Administration.

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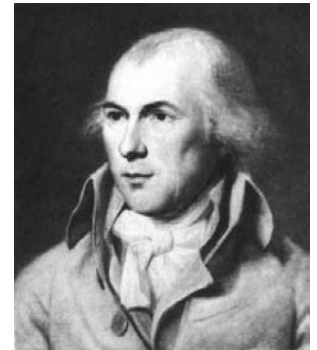
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