

Florida's Experience with Medicaid Reform: What has been learned in the first two years?

Florida's Experience with

MEDICAID REFORM

Key Findings

- ❖ Beneficiaries and providers think the Medicaid program has become more complex with more paperwork as a result of reform, and there are signs that access to services is worsening.
- ❖ The state has not yet provided data on whether the reform has saved money. If savings are achieved, it is imperative to assess whether access to services is being compromised.
- ❖ Some key aspects of reform have not yet been implemented or assessed so it is too early to say if it is a success or failure. However, available data suggest that the reform has not achieved many of its objectives.

Background

Changes to Florida's Medicaid program were authorized by a federal Medicaid Section 1115 waiver approved on October 19, 2005. In July 2006, Florida launched Medicaid reform pilots in Broward and Duval counties. Beneficiary enrollment began in September 2006, and a year later the pilots were expanded into Baker, Clay, and Nassau counties, rural counties adjacent to Duval.

As of August 2008, two years after reform began, 196,860 beneficiaries are enrolled in the reform pilots. A total of 17 plans have participated in the pilots, including seven in Duval County, 16 in Broward County, and two serving the three rural counties.

When the reform pilots began, those already in Medicaid switched from their previous managed-care plans or from MediPass (the state's primary care case management program) over a several-month transition period. The state introduced a Choice Counseling service to help beneficiaries with the transition. New Medicaid enrollees, like those in MediPass, were asked to select a reform plan or were assigned to one if they did not.

The state continues to make adjustments to the reform pilots. In August and September 2008, scheduled changes in plan payment rates prompted several plans with a majority of reform enrollees to threaten withdrawal from the pilots. The state mostly averted trouble by reducing the scheduled cut. But three HMOs (Buena Vista, United Healthcare, and Vista South Florida), accounting for about 18 percent of the Broward County enrollment, are expected to leave the program November 2008. Enrollees in those plans will need to select a new plan. As of that date, other plans are scheduled to implement new benefit offerings for the program's third year.

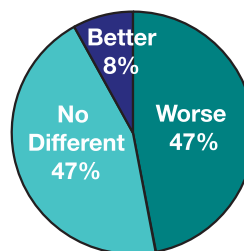
Has Reform Succeeded or Failed?

Success and failure must be considered in the context of both financial impact and effective provision of services. Because some key aspects of reform are yet to be implemented, it is difficult to conclude whether reform has succeeded or failed. However, many troubling signs have emerged.

On the financial side, it is fair to say that Florida's reform program has not yet experienced the full financial impact of reform. This is because financial changes have been phased in over time, with one class of health plan – the Provider Service Networks – not yet experiencing the most significant financial change. Provider Service Networks are still being paid on a fee-for-service basis for actual services delivered – the same payment structure as in traditional Medicaid.

Only HMOs so far are being reimbursed on a “per-person, risk-adjusted basis” – regardless of the actual cost of services. The risk-

Physicians' responses to the question: In your view, has Medicaid reform made the program:



Source: Georgetown analysis of 2008 physician survey. N = 210

In 2006, the Jessie Ball duPont Fund commissioned researchers at Georgetown University's Health Policy Institute to conduct an independent evaluation of the changes to Florida's Medicaid program in Broward, Duval, Baker, Clay, and Nassau counties. The researchers have reported findings in a series of six policy briefs, supplemented by webcasts and other presentations. This seventh policy brief reflects on the first two years of the Medicaid pilot program. (All materials are available at www.dupontfund.org and hpi.georgetown.edu/floridamedicaid.)

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adjustment system measures the health status of each enrollee and adjusts accordingly the per-person payment rate that each HMO receives. The idea is to ensure that plans whose mix of enrollees have more health conditions should receive higher per-person payments, thus reducing the incentive for plans to avoid sicker beneficiaries. (See The 'At-Risk' Dilemma, Page 4).

Until risk-adjusted per-person payments are fully in place, it is also too early to know how far plans will go in using their unprecedented flexibility to establish benefit limits. As margins tighten and plans feel their reimbursement is inadequate, they may feel compelled to limit benefits further.

To assess the non-financial impact of the reforms, Georgetown researchers conducted a total of four site visits to Broward and Duval counties in 2006 and 2008, before and after the implementation of the pilots. On these site visits, and in telephone conversations, the researchers interviewed dozens of stakeholders in the five pilot counties.

Throughout the two-year period, researchers also conducted 12 focus groups with a total of about 120 Medicaid beneficiaries. Researchers also conducted two surveys of physicians – the first in spring 2007 (reported in Briefing #2¹) and the most recent in summer 2008 (reported here). More details on research methods can be found in the methodological appendix.

Throughout the research period, the Georgetown researchers heard from most stakeholders that the pilots had left the Medicaid program either the same or worse than before the reforms were implemented. Only a few saw improvements. For example, nearly half of the 210 physicians responding to a 2008 survey question reported that things were worse as a result of the reform pilots, while 8 percent thought that the pilots had made the program better. Focus group participants, when asked in 2008 about their overall evaluation of the reform, gave mixed responses. Some preferred the flexibility offered before reform to choose doctors in MediPass,

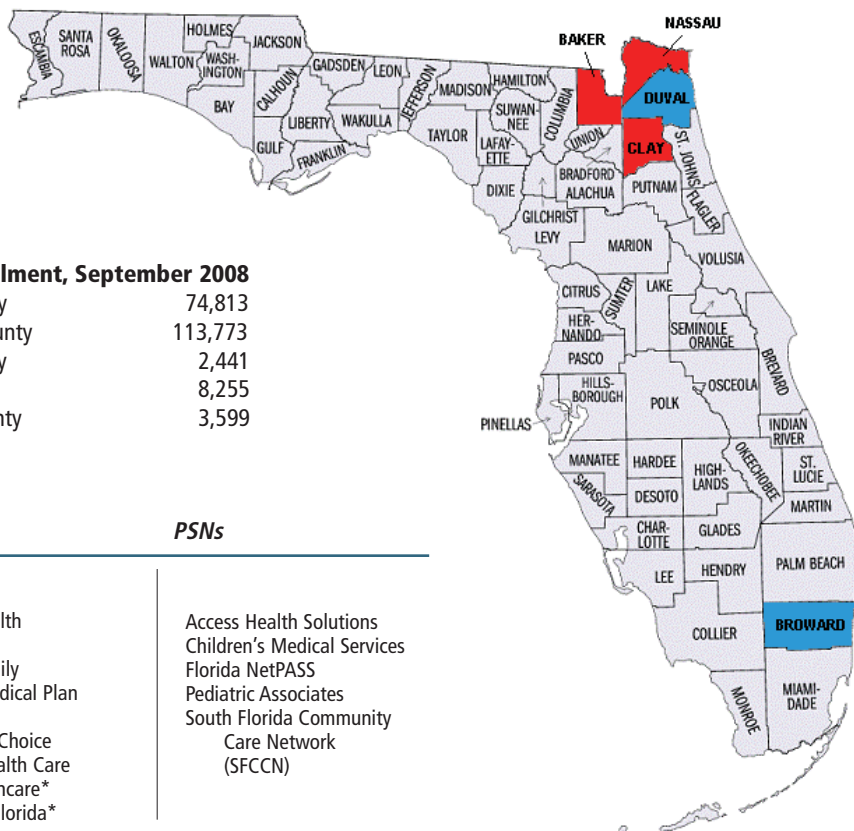
Florida's Experiment with Medicaid Reform

Key Dates

Waiver Signed	October 2005
Reform Launched	July 2006
Enrollment Began	September 2006
Expansion Began	July 2007

Total Enrollment, September 2008

■ Duval County	74,813
■ Broward County	113,773
■ Baker County	2,441
■ Clay County	8,255
■ Nassau County	3,599



Plans Operating In Reform Counties

County	HMOs	PSNs
Broward	Amerigroup Buena Vista* Freedom Health HealthEase Humana Family Preferred Medical Plan Staywell Total Health Choice Universal Health Care United Healthcare* Vista South Florida*	Access Health Solutions Children's Medical Services Florida NetPASS Pediatric Associates South Florida Community Care Network (SFCCN)
Duval	HealthEase Staywell United Healthcare Universal Health Care	Access Health Solutions Children's Medical Services First Coast Advantage/Shands
Baker, Clay & Nassau	United Healthcare	Access Health Solutions

*Scheduled to leave program in late 2008

and many wanted to see more accurate lists of available network physicians. Others thought little overall had changed. Many emphasized the importance of Medicaid coverage whether before or after the start of the pilots and wanted to make sure coverage remains available to them.

Emphasis on Consumer Choice: Patient Responsibility and Empowerment

One of the fundamental principles of the Medicaid pilots, as described in Florida's waiver application, was consumer responsibility and empowerment.

*The fundamental basis of the reform rests upon two critical inputs: transparency and consumer empowerment ... [Beneficiaries] will purchase or select a managed care plan directly. They will have the flexibility to choose from a variety of benefit packages and be able to choose the package that best meets their needs. Additionally, they will be rewarded for demonstrating healthy practices.*²

In assessing success, a key question is whether consumers are being offered the types of choices they most want. As reported in Briefing #2, participants in focus groups were most interested in a choice of doctors, rather than a choice of plans or benefits packages (with the exception of a strong interest in more adult dental services). But some beneficiaries reported difficulties in locating a plan that included all of their current doctors. The state reports that a high proportion of newly eligible beneficiaries (83 percent) in a recent three-month period chose a plan voluntarily rather than being assigned by the state.³ According to the state, 92 percent of all current enrollees chose a plan themselves rather than being assigned, but data are not divided between those already enrolled in Medicaid (the larger group) and those new to Medicaid. This is an important distinction because, under the terms of the waiver, those newly deemed eligible for Medicaid have a strong incentive to make a choice since they are not eligible for full Medicaid benefits until they select a plan. Furthermore, the state classifies as self-selection those already in Medicaid who took no action and were assigned to the same plan they were enrolled in prior to reform. Those previously in MediPass were assigned to a plan based on their primary care physician being in the plan's network.

Two features highlighted by the state as introducing more individual choice were the "opt-out" program, whereby individuals may choose to use their premium subsidy to purchase employer-sponsored insurance, and the enhanced benefits accounts intended to provide incentives to Medicaid beneficiaries to pursue healthy behaviors and lifestyle choices.⁴ Neither has been very successful. As reported in Briefing #6, participation in the enhanced benefits program has been low, and many focus group participants were unaware that the program existed. Many beneficiaries are accumulating credits, but only one in four had spent their credits as of June 2008 (although the number is up from one in eight as of March 2008). Only 17 percent of all credits earned have been spent.⁵ Participation in the opt-out program has been more limited. Only 42 individuals have ever enrolled over the two years of the pilots, with 19 of them ultimately disenrolled for a variety of reasons.⁶ Low enrollment is consistent with the experience of other states; although Florida's enrollment is

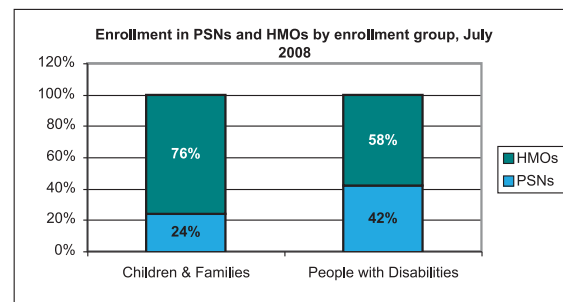
especially low.⁷ Focus group participants were universally unaware of this program. When the program was described to them, most said they were not likely to participate because of the additional costs that private insurance entails.

These results suggest that efforts at enhancing consumer empowerment and engagement should be reconsidered in a framework that incorporates information and feedback from consumers and their providers regarding the kinds of choices consumers desire.

Provider Service Networks: Big Questions Lie Ahead

Another basic principle outlined in Florida's waiver application was that of "marketplace decisions" – the idea that the state would move from a centralized decision maker to a purchaser looking at systems of care delivery. Provider service networks – PSNs – were expected to play a large role in this new framework.

PSNs are networks that are operated by a health care provider or group of providers and that deliver a substantial proportion of services directly through those providers. Although a majority of the plans participating in the reform pilots are HMOs, provider service networks are among the choices available in each of the pilot counties. Briefing #4 reported that 27 percent of beneficiaries in the pilot counties were enrolled in one of the participating PSNs as of September 2007. That overall proportion was unchanged in July 2008.



Source: July 2008 Florida Medicaid Reform Enrollment Report, AHCA

Some distinct trends are evident within the PSN enrollee population, a key trend being that people with disabilities have enrolled in PSNs more often than children and families. This trend has grown stronger in the pilots' second year. Across the five pilot counties, 42 percent of people with disabilities have enrolled in PSNs, compared with 24 percent of children and families. This difference may reflect, in part, the closer relationship people with disabilities have with their providers and the relative predictability of benefits compared with HMOs.

Medicaid reform rules treat PSNs somewhat differently than HMOs. In the pilots' first three years, the PSNs could choose, and have opted, not to take on financial risk, a choice not available to HMOs. Thus, PSNs are paid by the state based on actual costs incurred (i.e., fee for service), whereas HMOs are paid on a risk-adjusted per-enrollee basis. HMOs profit if expenses are less than

projected and lose money if their expenses are higher. PSNs, however, are guaranteed that their actual costs are covered – albeit at Medicaid reimbursement levels. Unlike HMOs, PSNs that are paid on a fee-for-service basis are not permitted to restrict benefits below state-provided levels (though they may add benefits or impose copayments within the limits of law).

The initial period when PSNs may be paid based on actual costs ends in September 2009, when PSNs are scheduled to go “at risk.” Because beneficiaries with disabilities tend to be more expensive than other beneficiaries, the PSNs likely will experience higher per-person costs than the HMOs. One PSN manager said that the transition process to fully risk-adjusted per-person payments has allowed the large HMOs “to avoid sick patients and gobble up healthy patients.... The sick patients go to the PSNs, since there’s no fee-for-service Medicaid.” During the transition, plans are presumably somewhat overpaid for healthy enrollees and underpaid for sicker enrollees. Although fully risk-adjusted payments are intended to ensure that the per-person payments are appropriately higher for those sicker patients, some are concerned that it will be difficult for PSNs to sustain their operations on an at-risk basis. “We have serious concerns as we get closer to the contractual obligation to go to risk,” said another PSN official. “In the current environment, we have serious concerns about the ability to gather the membership to make this a profitable, successful organization.”

Has Provider Participation Improved?

Provider participation is an ongoing challenge for the Medicaid program in Florida and nationwide. Indeed, one goal of Medicaid reform was to improve access to specialists.⁸ Yet Briefing #2 reported that provider participation in Medicaid appeared to decline as the pilots were implemented.

This question was re-examined in a 2008 survey after physicians and plans had more time to negotiate contracts and become accustomed

The ‘At-Risk’ Dilemma

The world of insurance – whether life insurance, auto insurance or health insurance – is based upon risk and the law of large numbers. If 100 people are insured and paying premiums, the prudent insurer wants the smallest number possible to incur problems and file claims, and wants those claims that are filed to be as small as possible, thus minimizing financial risk. The premiums from those who do not file claims provide the financial “cushion” that enables the insurer to pay the large claims of those who do file, and still make a profit. Large numbers help make this work by minimizing the effect of the random occurrence of expensive claims.

Health plans operate in much the same manner. The government pays the plan – for example an HMO – a set fee per person. The fees for those who do not get sick provide the cushion needed to pay the bills of those who do, and provide a profit for the HMO. Further protection is offered by a system of risk adjustment where the per-person payment is adjusted based on the “risk profile” of the client pool. Thus if one plan enrolls a higher share of patients with existing health conditions, it receives a higher average per-person payment. Part of the risk is random, since everyone has a chance of needing health services, but the risk adjustment helps since those with existing conditions are more likely to need services.

Since the beginning of Medicaid reform, HMOs operating in the reform counties have operated “at-risk,” that is, they receive a per-patient fee based on the risk profile of their client pool. It is up to the HMO to ensure that there is enough money to pay claims and turn a profit.

PSNs, on the other hand, have not operated at risk to date. They are reimbursed for their actual costs for each patient. (This is the same manner in which the state’s MediPass program previously operated.) In September 2009, however, PSNs will be required to go at risk, operating in the same manner as HMOs.

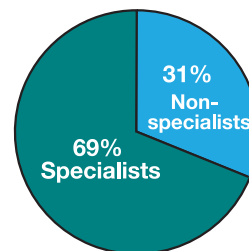
This distinction is critical to any evaluation of the Medicaid reform pilots to date. With more than a quarter of reform enrollees choosing to enroll in a PSN – and that quarter being disproportionately people with disabilities, who typically have higher medical needs – the state has not experienced the full impact of a Medicaid population being managed 100 percent at risk.

to the new arrangements. Today, the story is somewhat better, but departures by physicians from Medicaid still outnumber those participating for the first time through the reform plans.

Among respondents to our 2008 physician survey, there was a 10 percent net decline in the pool of physicians serving Medicaid patients in Duval and Broward counties. About one-fourth of the physicians who participated in Medicaid before the onset of reform reported that they are not in the networks of any reform plans. These departures were partly offset by new participants. Those dropping out of the program were disproportionately specialists, a result that mirrors the 2007 findings.

Similar to what was reported in Briefing #2, providers who have remained in Medicaid are seeing fewer Medicaid patients. *About 38 percent of physicians surveyed in 2008 reported that they retained half or fewer of their patients.* In some cases, physicians dropped plans after bad experiences. One physician in Broward County said his frustration with some plans led to withdrawing from their networks. “I’ve let go of one or two of [the plans] – it is the most difficult experience that you can have. You are coupling low payments with a high threshold [in terms of prior approval] to get care and diagnostic testing. Coupling the worst things you can do!”

What kind of doctors are leaving Medicaid?

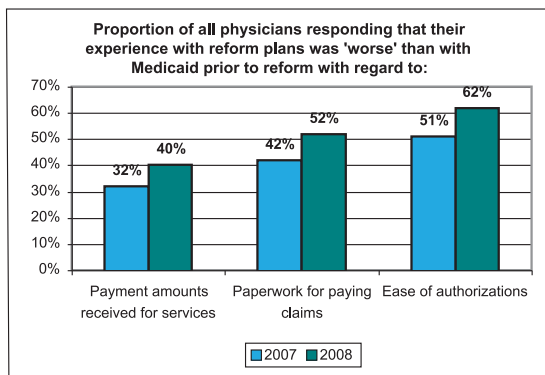


Note: Non-specialists include doctors in emergency medicine, family/general practice, general surgery, internal medicine, OB/Gyn and pediatrics.

Source: Georgetown analysis of 2008 physician survey. N-31

Source of Concern for Physicians: Increased Administrative Burden and Low Reimbursement Rates

To explain what might be causing changes in physician participation, the 2007 survey results suggested that low reimbursement levels and increased administrative burden were key factors. Prior to the implementation of reform, several physicians in Duval County told Georgetown researchers they were frustrated with the low reimbursement levels in Medicaid, but liked the fact that Medicaid was a prompt and efficient payer. Since reform, however, a common theme and concern heard from patients and providers is the growing complexity of the Medicaid program.



Source: Georgetown analysis of 2007 and 2008 physician surveys
N=99/103/101 (2007) N=167/168/175 (2008)

The 2008 physician survey asked, “How would you compare your experience with the Medicaid reform plans relative to your experience with the traditional Medicaid program prior to reform?” The proportion of physicians who thought that payment for services has become worse under reform increased from 32 percent in 2007 to 40 percent in 2008. “Reimbursement is too low for the increased work required by physicians and staff to care for these often complex and very ill patients,” one respondent stated. Another reported: “I continue to participate in Medicaid because, as a pediatrician, I feel it is ethically necessary to provide services to all children. The reform has actually cost us money due to the loss of the \$3 per child per month, which MediPass paid.”

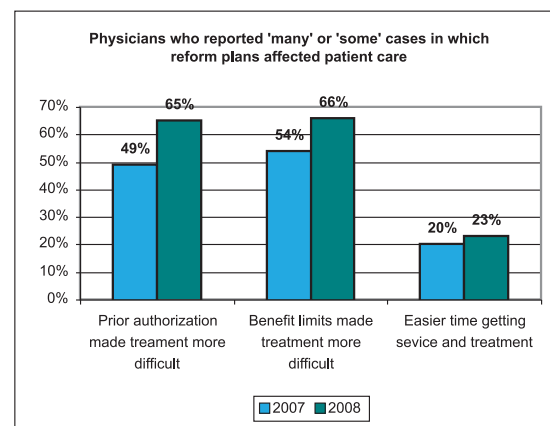
Similarly, the number of surveyed physicians who thought “paperwork for paying claims” had gotten worse under reform increased to 52 percent in 2008. One physician interviewed in Broward County showed an inch-thick stack of paperwork that was part of a network contract. He noted that the plans offer payment rates that are 80 to 90 percent of Medicaid rates with lots of paperwork. Another physician suggested that her paperwork had tripled since reform. One said he had claims going back more than a year that are still unpaid, a problem he never had faced with Medicaid or MediPass. Few physicians (5 percent) thought claims paperwork had improved under reform.

The number of physicians who felt that the “ease of authorizations for needed services” by the plans had worsened also rose – from 51 percent to 62 percent. One Broward obstetrician said, “My staff spends hours on the phone trying to get authorizations. I’ve delivered patients for whom I haven’t had authorization yet, and you just wait to get paid.” The same physician suggested that he regularly gets turned down, but eventually gets the go-ahead. “You might get the authorization 2 or 3 days later. You scream enough, you’re going to get it.” One pediatrician reported having stopped accepting a specific plan due to its “failure to honor pre-approvals, even with a pre-approval number.”

The Impact of Reform on Patients’ Access to Services

The frequency of cases where physicians report that some of their patients had problems getting access to needed services has increased. In 2008, two-thirds of surveyed physicians reported that “some” or “many” of their patients are having difficulty with access to needed treatments because the plan either limits their benefits or requires prior authorization that has not been received. Only about one-fourth of physicians said they were having an easier time getting treatments for some or many of their patients.

In focus groups conducted in 2008, beneficiaries described their experiences getting services. One woman in Duval County reported that she was able to get appointments for her diabetes, but had more difficulty getting appointments for asthma treatment. Several beneficiaries had found plan provider lists to be inaccurate or insufficient. One mother’s children were enrolled in different plans so that the youngest could continue to see a doctor who did not participate in the same Medicaid plan as the older children. Access to dentists was a particular concern. One Broward participant had problems finding a dentist that accepted Medicaid: “When I call up my insurance, they give me a list of dentists and clinics.... Half the numbers they give you are disconnected, or don’t take insurance. They’d give me 50 numbers, and maybe three of them work.” But a few had better stories to tell; one woman said she had an easier time seeing a psychiatrist under Medicaid reform than when she was on regular Medicaid.



Source: Georgetown analysis of 2007 and 2008 physician surveys
N=111/108/108 (2007) N=202/204/203 (2008)

Experiences obtaining referrals for specialists were uneven as well. One beneficiary in Broward County said that “referrals are the number one problem.... Two of the doctors that I was seeing are no longer in the network. [So you] wait weeks for referrals.” But one mother reported that it was easier to obtain specialist referrals for her child after she switched from one Medicaid plan to another.

Finally, some beneficiaries reported that the problems accessing a physician were adversely affecting their health. “You never know [when your] doctors might leave the program,” one woman said. “I’m supposed to be on heavy-duty medication, and I’m not taking it, because who knows when my doctor’s not going to be there? When you have to be tested every three weeks, you’re afraid to do it.” The mother of a child with cerebral palsy said, “My son was going to have surgery – the doctor found out that it was on reform and said that he wouldn’t perform it after reform, because they wouldn’t reimburse him what the surgery cost. And it took me so long to find this wonderful doctor.” Ultimately, the doctor performed the surgery, but did not provide the follow-up care.

Prescription Drugs: A Key Benefit for Consumers

Participants in the focus groups regularly pointed to prescription drugs as one of the key benefits they care about when considering whether a plan meets their needs. But under the terms of the federal waiver, the state allows plans to limit drug coverage as long as it meets the state’s sufficiency test and the limits do not apply to children. Briefing #3 reported that half of the participating HMOs were using that flexibility to limit their drug benefits.

In the pilots’ second year, 10 of 15 HMOs limited either the number of prescriptions allowed each month or the total dollar amount of drugs that can be covered. For example, the two plans with the largest overall enrollment, both offered by Wellcare, apply limits of nine prescriptions per month for adults without disabilities and 17 per month for those with disabilities. Effective in November 2008, all HMOs and PSNs, except those serving only children, will have monthly limits on prescriptions.⁹ According to the state, about 60 beneficiaries have reached their plan’s drug limits during the first two years. In some cases, plans have opted to waive the limits.¹⁰

In 2007, the Georgetown researchers reported that many beneficiaries were having problems getting access to needed drugs. Based on focus groups in 2008, the situation seemed to have improved somewhat, but problems remain. Participants in Broward County generally had fewer problems obtaining prescription drugs than those in other counties. One Broward beneficiary noted, “My doctor has to send medications to [the plan] and say they’re medically necessary,” but her medications were not delayed. Although one parent commented that “drugs won’t come through,” another expressed gratitude that Medicaid “paid for everything.” Another mother reported that she had no problems obtaining asthma medication for her three children.

By contrast, beneficiaries in Duval County focus groups recounted numerous problems. One woman said she had relied on samples from her doctor for the past two years, as her plan would not cover her blood pressure medication. Three other beneficiaries were concerned that their doctors had prescribed drugs that were not on their plans’ preferred drug lists and were trying to manage with less effective alternatives. One mother described problems coordinating the multiple medications needed to treat her daughter’s different medical conditions: the plan did not pay for one drug and switched her to one that interacted poorly with other drugs; it took two months and multiple calls from physicians to straighten out the problem.

Physicians responding to the 2008 survey reported similar concerns for their patients. About two-thirds (68 percent) responded that “reform plan formularies prevented a patient from obtaining needed drugs” in many or some cases. Only about one-fifth said they had not seen cases where formularies created a problem. One physician wrote that he had experienced “significant difficulties,” saying that “prior approval ... results in delays or non-medication for indicated conditions.” A pediatrician called the difficulties of formulary restrictions “ridiculous,” while another said that formularies cause patients to “go without drugs because drugs on the standard Medicaid list are not covered or require special authorization or paperwork.”

Is Reform Saving Money?

There are many complex issues surrounding the question of how the waiver has affected Medicaid financing.

All Section 1115 waivers – the federal provision that allowed the State of Florida to create the reform pilots – require a budget neutrality agreement with the federal government. This agreement establishes limits on the amount of federal matching funds that a state can draw down. The idea is to prevent states from launching alternatives to “traditional” Medicaid that are more costly than traditional Medicaid.

In drafting this budget neutrality agreement, the federal government uses a formula to project Medicaid spending in the absence of the waiver (known as the “without waiver” baseline). This amount becomes the upper limit – the ceiling – for federal funding on a per person basis.

The budget neutrality agreement for Florida’s waiver is based on affected populations in the entire state. But Medicaid reform is in place in only five of the state’s 67 counties. Thus, much of the spending under the budget neutrality agreement is unrelated to reform. According to spending reports submitted by the state to the federal government, *spending on persons enrolled in reform constitutes only 10 percent of the spending reported under the budget neutrality agreement.*¹¹ The reports do not show, however, how spending is changing in the reform counties compared with other areas of the state.

According to these reports, Florida is significantly below the ceiling or “without waiver” limit.¹² In Year 1 (2006-2007) the reports show the state spent 91 percent of the “without waiver” limit, and in Year 2 (2007-2008) just 81 percent. It is worth noting that an 8 percent year-to-year growth rate was incorporated into the budget neutrality agreement – a very generous growth rate, according to an investigation by the U.S. Government Accountability Office.¹³ Because of this high growth rate and the challenging fiscal climate the state is operating under, it is unlikely that the state would hit the current budget neutrality limit.

The budget neutrality agreement will have to be renegotiated with the federal government at the end of the five-year waiver period (July 2011) should the state seek to extend the waiver.

Whether or not the state is saving money in the reform counties is a different question. A more relevant comparison is to look at whether spending on a per-person basis in the affected counties has changed since implementation of the reform pilots, or how spending in the pilot counties compares with that on similarly situated persons elsewhere in the state. Only a limited answer is yet available for the first question, and the state has not reported information on the second question even though it clearly has some data.

A preliminary analysis done by the University of Florida Medicaid Reform Evaluation project found a 3 percent decrease in expenditures in the pilot counties after reform was implemented. However, as the study noted, this did not account for increased spending on enhanced benefits, which are funded by an initial reduction of 2 percent in plan premiums, and other administrative expenses such as for Choice Counseling.¹⁴

Thus there is not yet clear evidence on the impact of the reform pilots on state Medicaid spending. Should savings be demonstrated by future data, some key questions should be addressed:

- Are new administrative costs, including the enhanced benefits accounts, included in the calculations? As reported in Briefing #4, administrative costs have been very high so far for these accounts, as well as for the “opt-out” component of the waiver.
- If savings are demonstrated, do these savings represent efficiencies that plans are making, or simply reduced access to necessary care? This question is especially important in light of the benefit flexibility that plans have and the recent threat by the largest HMOs participating to withdraw from reform. If plans are making less money, the likelihood that benefits packages will be reduced or that more onerous authorization procedures will be imposed is great. The switch of PSNs to risk-adjusted per-person payments may lower state costs if risk-adjusted payments are lower than paying full cost of fee for service. But for PSNs to remain in the program, they may be forced to use their new benefit flexibility to make reductions.
- How does spending in the reform counties compare to spending in other counties around the state for similar populations?

Conclusion

To proclaim Medicaid reform either a success or a failure would be premature. In some respects, Medicaid has not changed as radically as many proponents or opponents said it would, in part because some of the changes are not yet fully implemented. PSNs, still operating on a fee-for-service basis, provide something of a safety valve for sicker beneficiaries. The pressure on HMOs to use their benefit flexibility in ways that limit access to needed services is likely to grow over time given the state’s fiscal pressures.

But, to the extent change has occurred, it appears to be moving in the wrong direction. The complexity of the program has grown, causing confusion and increased administrative burdens for consumers and providers. Access to needed services appears to be worsening according to both physicians and beneficiaries, and provider participation is declining.

It may be that many of the goals of reform and the methods to achieve them were unrealistic. Achieving savings without reduced access to care by relying on the dynamics of market competition might be a questionable assumption when Medicaid already spends much less than private insurance on a per-person basis.¹⁵ Consumer engagement and empowerment are important and laudable goals. But progress in this area seems to have been limited, perhaps in part because reform was not designed to give consumers the choice they really want. Although proponents hoped that reform would help eliminate fraud and abuse, there is little or no evidence that this has happened. For all of these reasons, continued evaluation of the program’s accomplishments and limitations is vital so that policymakers will have the information they need to make decisions about the future of Florida’s Medicaid program.

Endnotes

- ¹ Copies of all Briefing Papers are available at www.dupontfund.org and hpi.georgetown.edu/floridamedicaid.
- ² Florida Medicaid Reform Approved Application for 1115 Research and Demonstration Waiver, October 19, 2005, p. 3.
- ³ AHCA, Florida Medicaid Reform Quarterly Progress Report April 1, 2008 – June 30, 2008, Table 9 p. 25.
- ⁴ See Florida Waiver Application.
- ⁵ AHCA, Florida Medicaid Reform Quarterly Progress Report April 1, 2008-June 30, 2008, see Table 20 p. 45.
- ⁶ *Ibid.*, p. 37.
- ⁷ See Table 1 in Alker, J. *Choosing Premium Assistance: What Does State Experience Tell Us?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) May 2008.
- ⁸ Florida Waiver Application, p. 56.
- ⁹ Based on benefit comparisons charts (dated October 2008) on the Choice Counseling website. The PSNs that serve only children are not permitted to impose limits.
- ¹⁰ Telephone interview with Mr. Carlton D. Snipes, AHCA Medicaid Director, September 19, 2008.
- ¹¹ Georgetown University analysis of Table 26 (p. 56), AHCA, Florida Medicaid Reform Quarterly Progress Report April 1, 2008 – June 30, 2008.
- ¹² AHCA, Florida Medicaid Reform Quarterly Progress Report April 1, 2008 – June 30, 2008.
- ¹³ Government Accountability Office, “Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act,” GAO-07-694R, July 24, 2007.
- ¹⁴ Harman, J. et al “Comparison of Medicaid Per Member Per Month Expenditures One Year Prior to Reform to First Four Months of Reform,” University of Florida Medicaid Reform Evaluation Draft Issue Brief No. 4 January 2008.
- ¹⁵ For example, the cost of covering a family through private employer-sponsored insurance in 2004 was \$9,950 whereas through Medicaid it was \$7,418. Source: Kaiser/HRET, “Survey of Employer Health Benefits, 2004,” and Georgetown Center for Children and Families and Center on Budget and Policy Priorities analysis of 2004 Medical Statistical Information System (MSIS) data.

Methodology

Research for the project consisted of four major elements:

- ❖ Interviews with stakeholders,
- ❖ Focus groups with Medicaid beneficiaries,
- ❖ Surveys of physicians,
- ❖ Analysis of various program materials and data.

Stakeholder Interviews – Georgetown researchers conducted interviews with approximately 75 stakeholders in Florida, many of these occurring

as part of four site visits. Two site visits were conducted to each of the two major pilot counties (Broward and Duval), one set of visits occurring before reform was implemented (June and July 2006) and the second set of visits near the end of the pilots’ second year (April and May 2008). In addition, researchers visited Baker County, one of the expansion counties, in spring 2008. A three-person team of researchers conducted interviews with representatives of hospitals, health plans, consumer organizations, physicians and other health care providers. Additional interviews were conducted at various other times during the project’s two-year period.

Beneficiary Focus Groups – The project conducted three series of focus groups in Broward and Duval counties:

- ❖ In June and July 2006, before implementation of reform;
- ❖ In January and February 2007, approximately six months after the start of initial enrollment;
- ❖ In April and May of 2008, about 18 months after the start of the pilots.

During each series, two focus groups – one with beneficiaries with disabilities, and one with parents of children enrolled in Medicaid – were held in each county. About 120 beneficiaries participated in the 12 focus groups. They were recruited by professional research firms in the two counties and received \$75 as compensation for their time. All focus groups were moderated by two senior Georgetown researchers using a standard protocol. All procedures and materials were approved by Georgetown University’s Institutional Review Board.

Physician Surveys – The researchers conducted two anonymous, confidential surveys of physicians in the two original reform counties. The first survey was conducted between December 2006 and April 2007; the second in June through August 2008. The surveys were distributed to the membership of the Broward County Medical Association and the Duval County Medical Society via fax and email by the respective medical societies. In total, 186 physicians responded to the 2007 survey, and 276 physicians responded to the 2008. Approximately one quarter of respondents filled out the 2008 survey online by following an e-mailed link, while the remainder filled out paper copies. The survey instrument was approved by Georgetown University’s Institutional Review Board.

Other Analysis – A variety of Medicaid reform program materials were reviewed and analyzed by Georgetown researchers during the two years of the project. These included choice counseling materials, plan contracts and benefit offerings, prescription drug formularies used by plans, quarterly reports by the Agency for Health Care Administration, data on enhanced benefit accounts, risk-adjustment methodology, and enrollment data.

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It may be found online at www.dupontfund.org and at hpi.georgetown.edu/floridamedicaid



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