

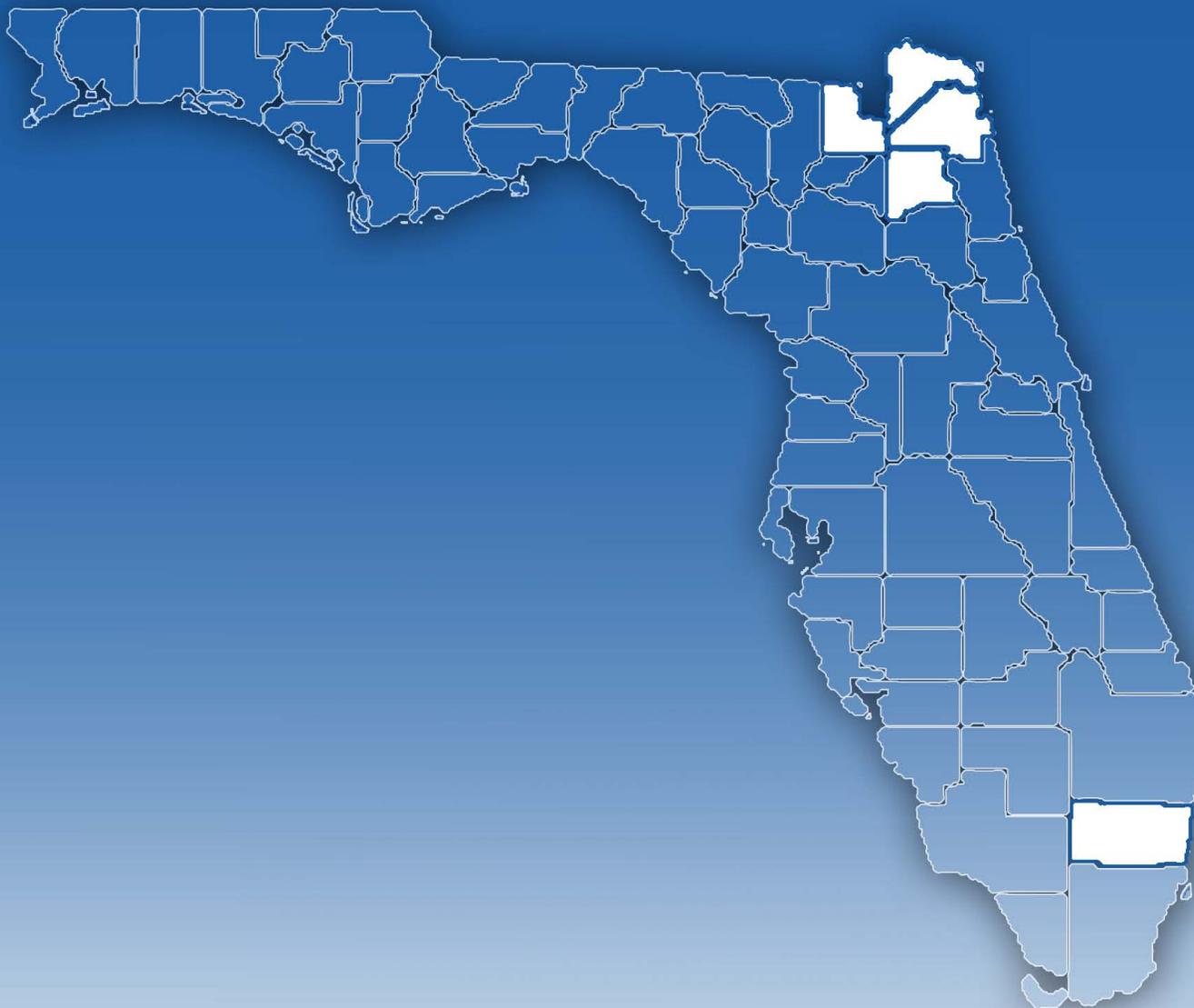


Evaluating Medicaid Reform In Florida



An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration

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**AN ANALYSIS OF MEDICAID EXPENDITURES BEFORE
AND AFTER IMPLEMENTATION OF FLORIDA'S
MEDICAID REFORM PILOT DEMONSTRATION**

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DELIVERABLE VIII.D
AN ANALYSIS OF MEDICAID EXPENDITURES BEFORE AND AFTER
IMPLEMENTATION OF FLORIDA'S MEDICAID REFORM PILOT DEMONSTRATION

INTRODUCTION

FLORIDA'S MEDICAID REFORM INITIATIVE

Medicaid is the principal state and federal program that finances the health and medical care of low-income families, the elderly, and people with disabilities who meet eligibility requirements, do not have health insurance, and otherwise cannot pay for their health care. Florida's Medicaid program, implemented on January 1, 1970, was modeled after the healthcare financing and delivery of the private sector at that time. However, the healthcare market in which Medicaid operates has experienced dramatic changes since the program's creation almost four decades ago, and the needs of the population it serves are constantly evolving. Medicaid has grown to become the single largest healthcare program in the United States. In Fiscal Year (FY) * 2006, Medicaid served 58.7 million people in the U.S.,¹ with expenditures of \$310.8 billion.^{2†} In FY 2006, Florida Medicaid served 3 million people,¹ with expenditures of approximately \$14 billion.³ For State Fiscal Year (SFY)0809,[‡] it is estimated that Florida Medicaid will spend approximately \$6,619 per eligible enrollee for a total of \$15 billion.^{4,5} Payments to hospitals, nursing homes, and Intermediate Care Facilities for the Developmentally Disabled, along with Low-Income Pool and Disproportionate Share payments comprise 45% of all Florida Medicaid expenditures. Twenty-three managed care plans and approximately 80,000 FFS providers serve Medicaid enrollees and are the recipients of the remaining expenditures.⁴

As a state, Florida has a history of making changes to its Medicaid program. These changes have varied in scope, intensity, and results. Some have been described in detail,[§] others are ongoing, and some have effectively been forgotten. However, each of these prior initiatives had its origin in an idea or cluster of ideas about how Medicaid might be improved. That is certainly the case in Florida's current Medicaid Reform initiative, in which Florida continues to develop innovative strategies to enhance the availability of quality healthcare services.

On May 6, 2005, the Florida Legislature authorized Medicaid Reform in Senate Bill 838. In accordance with Senate Bill 838, the Florida Agency for Health Care Administration (AHCA) formally submitted an application for an 1115 Research and Demonstration Waiver to the U.S. Department of Health and Human Service's Centers for Medicare and Medicaid Services (CMS) on October 3, 2005. That application was

* "FY" denotes Federal Fiscal Year which runs from October 1 through September 30. For example FY 2006 refers to the period October 1, 2005 through September 30, 2006.

† Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

‡ "SFY" denotes State Fiscal Year which runs from July 1 through June 30. For example SFY0809 refers to the period July 1, 2008 through June 30, 2009.

§ For an analysis of Florida's Medicaid Provider Service Network Demonstration, see Duncan, R. P., Lemak, C. H., Vogel, B., Johnson, C., & Porter, C. K. (2004). *Evaluating Florida's Medicaid Provider Service Network Demonstration Project*. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy.

approved by CMS on October 19, 2005. On December 8, 2005, the Florida Legislature passed legislation (House Bill 3B) to authorize the design and implementation of the reforms described in the waiver application.**

Effective July 1, 2006, AHCA began implementing Medicaid Reform by means of demonstration pilots in Broward and Duval Counties. Broward County is located in the southeast section of Florida and includes the city of Fort Lauderdale. Duval County is located in the northeast section of Florida and includes the city of Jacksonville. The transition of eligible enrollees to the demonstration started on September 1, 2006, and as of June 1, 2009, approximately 208,051 Floridians were enrolled in participating managed care organizations in these two counties.

At the end of the first year of implementation, the demonstration was extended to Baker, Clay, and Nassau Counties, all of which are somewhat more sparsely populated counties with extensive rural areas. All are in northeast Florida, adjacent to Duval County. As of June 1, 2009, approximately 17,698 Floridians were enrolled in Reform in the expansion counties. Overall, the total number enrolled in Medicaid Reform managed care organizations as of June 1, 2009, was 225,749.

As envisioned by those responsible for designing and implementing the changes, Medicaid Reform would transform Florida's Medicaid program by empowering consumers to take control of their health care, providing more choices for consumers, and enhancing the health status of Medicaid enrollees through increased health literacy and incentives to engage in healthy behaviors. Furthermore, a key objective of Medicaid Reform in Florida includes the goal of making the delivery of medical care in Medicaid more reflective of the processes and approaches operative in the private sector. The expressed principles governing Medicaid Reform are

- patient responsibility and empowerment,
- marketplace decisions,
- bridging public and private coverage, and
- sustainable growth rate.

These principles were manifested in several specifically identifiable activities. Participating Reform Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs) can offer customized benefit packages. The plans can design their own benefit package (within a specified amount, scope, and duration) subject to tests of actuarial equivalency and benefit sufficiency.†† These plan attributes are affirmed by contract with AHCA. Eligible Medicaid enrollees must enroll in a participating HMO or PSN, but may choose the plan that is best suited to meet their specific needs.

HMOs participating in Medicaid Reform are paid a capitation payment that is risk adjusted to reflect the relative healthcare status of their enrollees. Reform capitation rates are based on specific principles and policies of Reform applied to fee-for-service historical data in identifiable areas. That rate is then risk adjusted to reflect the medical circumstances of a particular plan's enrollees, based on their enrollees' age, gender, and use of prescription medications which serves as an indicator of certain chronic diseases. The

** For a summary of Florida's Medicaid Reform Section 1115 Waiver process, see Duncan, R. P., Lemak, C. H., McKay, N. M., Hall, A. G., & Bell, L. L. (2006). *Summary Report on Section 1115 Waiver Process*. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy.

†† As a general principle, Reform plans must offer services consistent with the state Medicaid plan; variation is in the form of additional benefits.

technical approach to this adjustment is based on the calculation of risk scores using the Medicaid Rx risk adjustment model devised by researchers at the University of California San Diego.⁶ The risk adjustment work is performed under contract by an external, nationally prominent healthcare consulting and actuarial firm. For the first two years of Reform, a risk corridor was mandated so that risk adjustment was limited to plus or minus 10% of the original base rate noted previously.^{‡‡} PSNs are paid on a fee-for-service (FFS) basis.^{§§}

In order to facilitate enrollee selection of a health plan, a Choice Counseling process was created. Choice Counseling is a comprehensive counseling program designed to provide the education and outreach necessary to assist Medicaid enrollees with making a health plan choice that best fits their specific needs. Choice Counselors also provide information aimed at enhancing health literacy and the promotion of healthy lifestyles in order to reduce minority health disparities.

Another key element was the creation of an Enhanced Benefits Rewards (EBR) program. In this program, enrollees are offered financial incentives to participate in specific health promotion and illness prevention activities such as dental visits, vision exams, wellness visits, PAP screening, mammography screening, and colorectal screening.⁷ When enrollees complete an EBR activity, funds are placed in their account and can be utilized for purchasing certain over-the-counter items at any Florida Medicaid participating pharmacy.^{***}

EVALUATING MEDICAID REFORM IN FLORIDA

It is critically important that any program change of this magnitude be independently evaluated. Such assessment will assist in achieving an understanding of the Reform pilot, including the challenges of program design and implementation, costs, quality, the impact on program enrollees, and the like. Indeed, federal approval of the waiver includes a requirement for a comprehensive, independent evaluation. The evaluation is intended not only to provide information to assist the Florida Legislature as it considers possible expansion of Medicaid Reform, but also to inform Medicaid programs in other states and other interested parties as they pursue their own reform initiatives.

To accomplish these goals, the health services research team at the University of Florida is gathering data and conducting the research activities necessary to complete a series of analyses. In the first year of the evaluation, the research team examined the evolution of Medicaid Reform, including the earliest expressions of interest, the initial legislation, the waiver application process, the subsequent legislation, the program design, and the initial implementation in Broward and Duval Counties. Through the evaluation process, the research team will continue to pursue answers to the questions included in Florida's "Application for 1115 Research and Demonstration Waiver."⁸

^{‡‡} Further technical details on the underlying mathematical and statistical processes involved are available online at <http://ahca.myflorida.com/Medicaid/meds/index.shtml>

^{§§} AHCA also develops risk scores for each PSN and compares the amount the plan was paid using the FFS payment methodology, to what they would have been paid had they been paid a risk adjusted capitated rate. On May 27, 2009, Florida Governor Charlie Crist approved CS/SB 1658 which delays the requirement that PSNs move from FFS to risk adjustment capitated payment by two years (or the 6th year of the demonstration: 2011).

^{***} This program has been described in detail in Greene, J. (2007). *Medicaid Efforts to Incentivize Health Behaviors*. Hamilton, New Jersey: Center for Health Care Strategies, Inc.

The research team is conducting its analysis through inquiry in five major project areas: (1) organizational analyses, (2) enrollee experiences analyses, (3) fiscal analyses, (4) Low-Income Pool program analysis, and (5) mental health analyses. The organizational analyses are focused on the Reform implementation process, the Reform health plans, and the Choice Counseling organization. The enrollee experiences analyses are measuring the changes in enrollee experiences, primarily their satisfaction with care. The fiscal analyses are assessing pre- and post-Reform Medicaid utilization and expenditures for both Reform and non-Reform plans. The Low-Income Pool analysis is examining the impact of the new financing mechanism that provides reimbursement for the provision of services to the uninsured and underinsured. The mental health analyses are examining the impact of the demonstration pilot on mental health services and experiences.

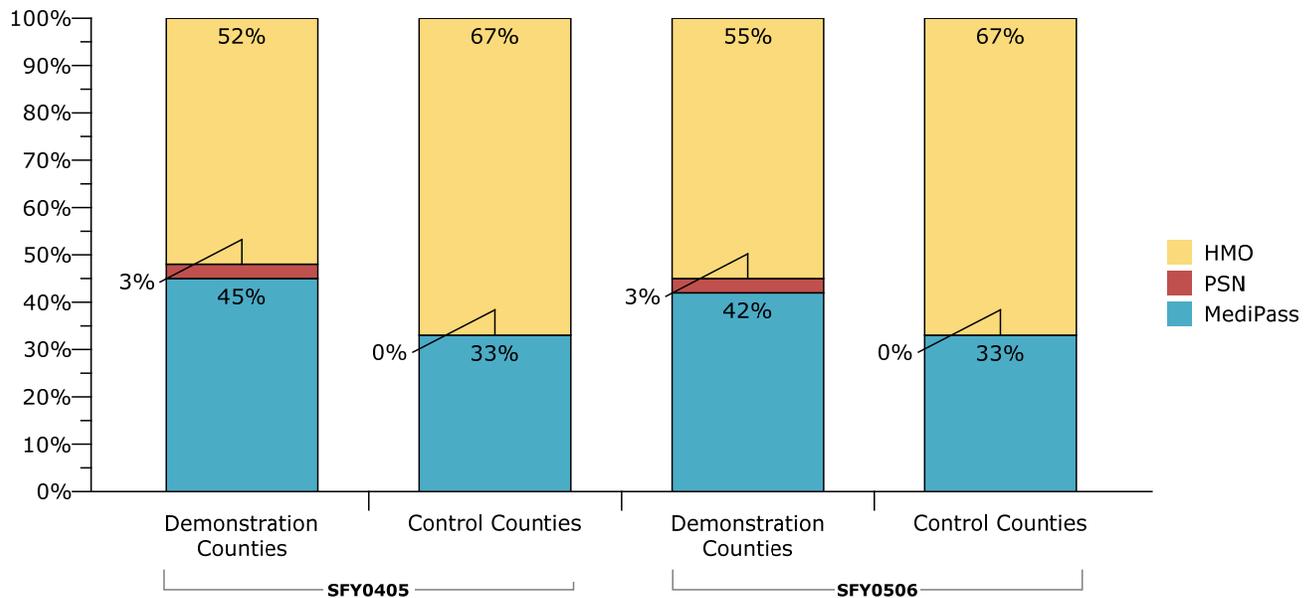
This report is focused specifically on one component of the fiscal analyses. It describes the Florida Medicaid program's expenditures in Broward and Duval Counties immediately prior to and during the first two years of the demonstration.

BACKGROUND

A key goal of the demonstration has been to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate objective of improved capacity to manage program costs.^{8,9} The first step in determining the degree to which this goal is being achieved is to compare expenditures before the Reform began to those experienced in the demonstration. For such a comparison to be helpful, it must take into account changes in Medicaid expenditures that may have been occurring in Florida regardless of the demonstration. To accomplish this, changes in expenditures in the demonstration counties of Broward and Duval are measured and compared with changes in two other Florida urban counties. The comparison counties (also called control counties throughout this report) are Hillsborough and Orange Counties. Hillsborough County is located in the central west section of Florida and includes the city of Tampa. Orange County is located in central Florida and includes the city of Orlando. The urbanity, population size, and demographics of Hillsborough and Orange Counties are generally similar to those of Broward and Duval Counties. A summary of select general population statistics for each county is provided in Appendix 1.

The comparison counties were also reasonably comparable in terms of their Medicaid programs and enrollment characteristics during the period immediately preceding the demonstration. Figure 1 (next page) shows HMO, PSN, and MediPass enrollments for the demonstration counties (Broward and Duval) and the control counties (Hillsborough and Orange) for SFY0405 – SFY0506. Hillsborough and Orange Counties do not have any PSN market penetration, so in the comparisons, MediPass enrollment is used as a proxy for PSN enrollment. Enrollees in Duval did not have a PSN plan option until Medicaid Reform was implemented in September 2006. For the two years prior to the demonstration, the HMO market penetration rate for both the demonstration and control counties was over 50%, with the control counties having a slightly higher HMO presence. Compared to the control counties, the demonstration counties had a slightly higher MediPass/PSN enrollment, partly due the absence of PSNs in the control counties. In general, the proportion of HMO and PSN/MediPass enrollment for the demonstration counties compared to the control counties was similar for both years prior to the pilot program initiation.

Figure 1: Comparison of HMO, PSN, and MediPass Enrollment for the Demonstration Counties Compared to the Control Counties for SFY0405 – SFY0506*



* Demonstration counties include Broward and Duval and the control counties include Hillsborough and Orange.

The current study is focused on early evidence regarding one aspect of the fiscal outcomes of the Reform initiative in Broward and Duval Counties. It compares the Medicaid program’s per member per month (PMPM) expenditures for all Reform eligible services provided to Reform eligible enrollees during the two fiscal years prior to implementation of the demonstration (SFY0405, SFY0506) to the PMPM expenditures on behalf of enrollees in Reform HMOs and PSNs during the first two fiscal years of Reform (September 1, 2006 – June 30, 2007, and July 1, 2007 – June 30, 2008). Expenditures do not include administrative costs incurred by AHCA.^{†††}

It is important to emphasize that this analysis is not intended to measure budget neutrality. Budget neutrality refers specifically to the Section 1115 Waiver process and is measured according to specifications outlined in the special terms and conditions.^{9,10} Because it is focused on expenditures, this analysis touches on only one aspect of the overall fiscal consequences of the demonstration. AHCA is working with health plans to collect and process encounter data, and once those data are comprehensive, it will be possible to determine precisely what services were purchased with these expenditures.

^{†††} For SFY0708, AHCA spent \$14.2 million to administer the demonstration pilot. These expenditures included the cost of administering the Choice Counseling program (\$8.7 million), EBR program (\$1.2 million), Medicaid Encounter Data Systems/Risk Adjustment/Actuarial Services (\$3.3 million), Reform evaluation (\$750,000), Opt-Out program (\$81,000) and Project Management (\$182,000).⁹

METHODOLOGY

To calculate pre-Reform expenditures, all facility, medical, and pharmacy claims or analogous HMO capitation payment amounts were obtained for all Medicaid enrollees who lived at least one month in Broward or Duval County and were in an eligibility category that would have made them eligible to participate in the demonstration had it existed during SFY0405 or SFY0506. According to the special terms and conditions of the waiver, three eligibility categories referred to as Medicaid Eligibility Groups (MEGs) were established: MEG #1 includes individuals with eligibility based on Supplemental Social Security Income (SSI), MEG #2 includes Children and Families with eligibility through Temporary Assistance for Needy Families (TANF), and MEG #3 refers to the Low-Income Pool program.^{10†††}

Individuals categorized as either MEG #1 or MEG #2 are considered mandatory participants in the demonstration pilot. Certain individuals, including dual eligibles (participating in both Medicaid and Medicare) and pregnant women above the TANF eligibility level, could voluntarily participate. To ensure genuine comparability, those enrollee months where individuals were voluntarily eligible for the waiver and/or special services (e.g., AIDS waiver, Statewide Inpatient Psychiatric Program [SIPP] services, etc.) or included retroactive eligibility were not included in the calculations. In addition, children who received services through CMS were excluded from the calculations. Because many individuals moved in and out of Duval and Broward Counties and/or changed eligibility during this time, only those months where the individual lived in one of the pilot counties and was in a Reform eligible category were used to calculate baseline PMPM expenditures and utilization. A detailed description of the sample selection/exclusion criteria is provided in Appendix 2.

The analysis uses a person-month approach, meaning each observation corresponds to expenditures by a person in a month (or member months). Therefore, each individual could contribute up to 24 member months used in the calculations (one for each month of the two fiscal years). Using this method, the final pre-Reform sample from Broward and Duval Counties included 5,160,860 member months from SFY0405 and SFY0506 combined.

To calculate Reform expenditures all payments made to HMOs and PSNs for Reform enrollees who were enrolled for at least one month during SFY0607 and SFY0708 (the first two years of the demonstration) were included. Months where individuals were eligible for waiver and/or special services or included retroactive eligibility were not included in the calculations. As with the pre-Reform sample, each observation corresponds to expenditures for a person in a month, meaning each individual could contribute up to twenty-two member months in the calculations.^{§§§} In the first year of Reform, the Medicaid population in the Reform counties was transitioned over a period of several months into Reform health plans. The transition was completed in April 2007.¹¹ This resulted in a final Reform sample of 2,947,075 member months from SFY0607 and SFY0708 combined.

††† MEG #3 does not include any specific eligibility group as it refers to the payments distributed through the Low-Income Pool program. For a detailed analysis of the Low-Income Pool program see McKay, N. L. (2008, June). *Supplemental Analysis of the Low-Income Pool Program Using Milestone Data: SFY 2005–06 and SFY 2006–07*. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy.

§§§ Reform enrollment began in September 2006; therefore SFY0607 includes 10 member months.

As indicated above, overall time trends for the Medicaid expenditures are accounted for by including expenditures for enrollees in the control counties (Hillsborough and Orange). The same selection criteria for enrollees and services used for the calculation of PMPM expenditures in the demonstration counties (Broward and Duval) (e.g., MEG #1 or MEG #2, no waiver services, no CMS, etc.) were used to calculate PMPM expenditures for enrollees in the control counties. This resulted in a final control sample of 4,777,221 member months from SFY0405 and SFY0506; and 3,990,311 member months from SFY0607 and SFY0708.

Differences in average PMPM expenditures between the Reform period and the pre-Reform period were calculated for the Reform counties and the non-Reform counties, and then the difference in the difference (Reform counties difference minus non-Reform counties difference) was calculated. **** These differences were calculated separately for MEG #1 and MEG #2. Additionally, calculations of differences in PMPM expenditures were broken down by enrollees in Reform HMOs and PSNs as well as HMO vs. MediPass for the non-Reform counties and pre-Reform period for the Reform counties.

The analysis is based on data referring to all Medicaid enrollees who meet the inclusion and exclusion criteria as described. Hence the subjects included here represent a complete database of the eligible enrollees germane to this analytic question, as distinct from a random sample. It is important to understand that this analysis does not examine an individual's change in expenditure over time, but the change in average expenditures for all enrollees in the Reform and non-Reform counties, in the pre-Reform period and Reform period (i.e., there will be individuals in the pre-Reform periods calculations who are not included in the Reform period calculations and vice versa).

**** For a detailed explanation of the difference in difference methodology, see Abadie, Alberto. "Difference-in-difference estimators." *The New Palgrave Dictionary of Economics*. Second Edition. Eds. Steven N. Durlauf and Lawrence E. Blume. Palgrave Macmillan, 2008. *The New Palgrave Dictionary of Economics Online*. Palgrave Macmillan. 04 June 2009 <http://www.dictionaryofeconomics.com/article?id=pde2008_D000245> doi:10.1057/9780230226203.0390

RESULTS

As can be seen in Table 1, average PMPM expenditures for MEG #1 enrollees were \$26 lower in the first two years of Reform (SFY0607 – SFY0708), compared to SFY0405 – SFY0506. In the control counties, average PMPM expenditures for MEG #1 enrollees were \$150 higher in SFY0607 – SFY0708, compared to SFY0405 – SFY0506. Thus, relative to the control counties, expenditures for MEG #1 enrollees in the Reform counties were lower by \$176 PMPM during the first two years of Reform, compared to the two years immediately before implementation of Reform (SFY0405 – SFY0506). For MEG #2 enrollees in Reform counties, average PMPM expenditures were \$4 higher in the first two years of Reform compared to the two years prior to Reform. However, for MEG #2 enrollees in control counties, average PMPM expenditures were \$10 higher in SFY0607 – SFY0708 compared to SFY0405 – SFY0506. Therefore, relative to control counties, Medicaid expenditures in the Reform counties were \$6 PMPM less during the first two years of Reform compared to the two years prior to Reform.

Table 1: Average PMPM Expenditure for All Enrollees (in Dollars)

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control minus Reform)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Reform Period	809	127	683	126		
Reform Period	783	131	833	136		
Reform minus Pre-Reform	-26	4	150	10	176	6

Pre-Reform Period is SFY0405 and SFY0506

Reform Period is SFY0607 and SFY0708

Next, differences in average PMPM expenditures for HMO enrollees were calculated (Table 2). For these calculations, only person-months by individuals enrolled in an HMO were used in both the pre-Reform period (SFY0405, SFY0506) and the Reform period (SFY0607, SFY0708). In the demonstration counties, average PMPM expenditures for MEG #1 enrollees was \$104 higher in the first two years of Reform, compared to the two years prior to Reform. In the control counties, average PMPM expenditures for MEG #1 enrollees were \$111 higher in the first two years of the pilot compared to the two years prior to the pilot. Therefore, relative to the control counties, Reform expenditures of HMOs participating in the demonstration were lower by an average of \$7 PMPM in the first two years of Reform compared to the two years prior to Reform. For MEG #2 enrollees in the Reform counties, average PMPM expenditures were \$12 greater in the first two years of Reform compared to the two years prior to Reform. In the control counties, PMPM expenditures for MEG #2 enrollees were \$3 greater in the first two years of Reform compared to the two years prior to Reform. Therefore, relative to the control counties, Medicaid payments to participating HMOs on behalf of MEG #2 enrollees were greater by an average of \$9 PMPM in the first two years of Reform compared to the two years prior to Reform.

Table 2: Average PMPM Expenditure for HMO Enrollees (in Dollars)

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control minus Reform)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Reform Period	668	126	512	118		
Reform Period	772	138	623	121		
Reform minus Pre-Reform	104	12	111	3	7	-9

Pre-Reform Period is SFY0405 and SFY0506

Reform Period is SFY0607 and SFY0708

Finally, differences in PMPM expenditures were calculated separately for MediPass enrollees and PSN enrollees (Table 3). Because PSN enrollment was extremely limited pre-Reform in the pilot counties and not available at all in the control counties, expenditures by MediPass enrollees are used for comparison. On average, MEG #1 enrollees in PSNs in the Reform counties had PMPM expenditures that were \$95 less in the first two years of Reform compared to the two years prior to Reform. MEG #1 enrollees in the control counties had \$178 greater PMPM expenditures during the first two years of Reform compared to the two years prior to Reform. Thus, relative to the control counties, Florida Medicaid expended an average of \$273 PMPM less on behalf of MEG #1 enrollees in PSNs in the first two years of the Reform demonstration compared to the two years prior to Reform. For MEG #2 enrollees in Reform counties, average PMPM expenditures in PSNs were \$16 less in the first two years of Reform compared to the two years prior to Reform. For MEG #2 enrollees in the control counties, average PMPM expenditures were \$18 greater in the first two years of Reform compared to the two years prior to Reform. So, relative to the control counties, Medicaid’s expenditures for MEG #2 enrollees in PSNs was an average of \$34 PMPM lower in the first two years of Reform compared to the two years prior to Reform.

Table 3: Average PMPM Expenditure for MediPass/PSN Enrollees (in Dollars)

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control minus Reform)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Reform Period	894	128	860	139		
Reform Period	799	112	1038	157		
Reform minus Pre-Reform	-95	-16	178	18	273	34

Pre-Reform Period is SFY0405 and SFY0506

Reform Period is SFY0607 and SFY0708

SUMMARY AND CONCLUSIONS

In summary, it appears that Medicaid expenditures in Broward and Duval Counties were lower on a PMPM basis during the first two years post Reform than would have been the case in the absence of the demonstration project. The observed differences are greater among MEG #1 enrollees. The differences occurred among both HMO enrollees and PSN enrollees. It appears that the differences are greater among the latter, especially among those eligible through MEG #1. There were slightly higher PMPM expenditures among MEG #2 enrollees in HMOs. Because this analysis is limited to the first two state fiscal years of Reform, it is not known whether these savings are sustainable over time. As noted above, only data from the first two state fiscal years of Reform were available at the time of this report and used in the calculations. More analyses are needed to determine whether the initial reductions are in fact sustained in subsequent years of the Reform Pilot.

It is critically important that the limitations of this analysis be understood. This analysis does not measure changes in expenditures for individual enrollees, pre- and post-Reform implementation. The PMPM expenditure calculations during the pre-Reform period refer to enrollees during that time period, a different group of individuals than those who are the basis for calculating PMPM expenditures in the post-Reform period. It is possible that the case-mix varies over these periods, thus some observed differences in expenditures may be due to variations in case-mix and not due to the Reform. Additionally, the expenditures were calculated from either claims or from monthly capitated premiums. The PSNs under Reform are still operating on a fee-for-service basis while the HMOs are paid monthly risk adjusted premiums directly from AHCA. Therefore, the expenditure amounts attributed to the HMO enrollees do not necessarily measure expenditures for direct care provided to enrollees. Clearly, expenditures for direct care provided to capitated enrollees cannot be calculated until complete encounter data are available for all HMOs participating in the demonstration. Because of the absence of encounter data at this time, it is difficult to determine the source of the observed decreases in expenditures and whether this is attributable to appropriate management of care by the plans or other factors such as a possible reduction in services (e.g., specialty care, emergency room, hospitalizations, etc.). This will be important to know in order to determine whether observed decreases in expenditures are due to a more efficient provision of care by the HMOs and PSNs, or from reduced access to care. It is also important to note that the Reform expenditures noted in this analysis do not include expenditures incurred to administer Reform activities such as the Choice Counseling Program nor the EBR program.

APPENDIX 1: GENERAL POPULATION CHARACTERISTICS FOR STUDY COUNTIES

	DEMONSTRATION COUNTIES		CONTROL COUNTIES		FLORIDA TOTAL
	Broward	Duval	Hillsborough	Orange	
Population, 2008 estimate	1,751,234	850,962	1,180,784	1,072,801	18,328,340
Population change, April 1, 2000, to July 1, 2008	7.9%	9.3%	18.2%	19.7%	14.7%
Population estimates base (April 1) 2000	1,623,016	778,866	998,943	896,346	15,982,813
Persons under 5 years old, 2007	6.5%	7.7%	7.2%	7.6%	6.3%
Persons under 18 years old, 2007	23.6%	25.9%	24.8%	25.3%	22.2%
Persons 65 years old and over, 2007	14.3%	10.5%	11.7%	9.6%	17.0%
Female persons, 2007	51.4%	51.5%	50.7%	50.2%	50.9%
White persons, 2007 ^a	69.6%	64.5%	78.2%	72.3%	80.0%
Black persons, 2007 ^a	25.3%	29.9%	16.6%	20.8%	15.9%
American Indian and Alaska Native persons, 2007 ^a	0.4%	0.4%	0.5%	0.5%	0.5%
Asian persons, 2007 ^a	3.0%	3.5%	3.0%	4.4%	2.3%
Native Hawaiian and Other Pacific Islander, 2007 ^a	0.2%	0.1%	0.1%	0.2%	0.1%
Persons reporting two or more races, 2007	1.4%	1.6%	1.6%	1.8%	1.3%
Persons of Hispanic or Latino origin, 2007 ^b	23.4%	6.0%	22.4%	24.3%	20.6%
White persons not Hispanic, 2007	48.1%	59.5%	57.6%	50.4%	60.8%
Living in same house in 1995 and 2000, 5 years old & over	47.1%	48.9%	46.0%	42.3%	48.9%
Foreign born persons, 2000	25.3%	5.9%	11.5%	14.4%	16.7%
Language other than English spoken at home, age 5+, 2000	28.8%	9.5%	20.9%	25.4%	23.1%
High school graduates, percent of persons age 25+, 2000	82.0%	82.7%	80.8%	81.8%	79.9%
Bachelor's degree or higher, percent of persons age 25+, 2000	24.5%	21.9%	25.1%	26.1%	22.3%
Persons with a disability, age 5+, 2000	310,454	149,290	197,799	165,831	3,274,566
Mean travel time to work (minutes), workers age 16+, 2000	27.4	25.2	25.8	26.6	26.2
Households, 2000	654,445	303,747	391,357	336,286	6,337,929
Persons per household, 2000	2.45	2.51	2.51	2.61	2.46
Median household income, 2007	\$52,504	\$49,175	\$50,485	\$50,988	\$47,804
Per capita money income, 1999	\$23,170	\$20,753	\$21,812	\$20,916	\$21,557
Persons below poverty, 2007	11.4%	12.4%	11.6%	11.6%	12.1%
Land area, 2000 (square miles)	1,205.40	773.67	1,050.91	907.45	53,926.82
Persons per square mile, 2000	1,346.9	1,006.3	950.5	988.3	296.4

Source: US Census Bureau State & County QuickFacts

a. Includes persons reporting only one race.

b. Hispanics may be of any race, so also are included in applicable race categories

APPENDIX 2: FISCAL ANALYSIS INCLUSION ALGORITHM

This analysis includes all enrollees living in one of the two demonstration counties (Broward, Duval) or one of the two control counties (Hillsborough, Orange) for at least one month in the pre-Reform period (July 2004 – June 2006) and all claims were extracted for these enrollees for this pre-Reform period as well as the post-Reform period (September 2006 – June 2008).

Inclusion criteria (pre-Reform)

- Enrolled in Medicaid for at least one month during July 1, 2004 – June 30, 2006, in Broward, Duval, Hillsborough, or Orange Counties

AND

- Eligible for Medicaid through MEG #1 or MEG #2 (MEG category descriptions are provided in the table on the next page)
 - MEG #1 (SSI-related) → r_asst_cat = MS, MT A, MT C, MT D, MT S, MT W, or MX
 - MEG #2 (TANF-related) → r_asst_cat = MA I, MA R, MA U, ME C, ME I, ME T, MM C, MM I, MN, MO A, MO D, MO P, MO S, MO T, MO U, MO Y, MP C, MP N, MP U
- All claims for drugs and services that are required to be covered by Reform HMOs and PSNs used in PMPM calculations

Exclusion criteria (pre-Reform)

- Received services through SIPP (provider type = 16)
- Children enrolled in CMS (There will be a separate analysis on this group.)
- Retrospective claims payments are not included in PMPM calculations

Inclusion and exclusion criteria (post-Reform)

- All individuals (and claims) identified using the pre-Reform inclusion and exclusion criteria who were enrolled for at least one month in a Reform plan (HMO or PSN) in Broward or Duval County between September 1, 2006, and June 30, 2008

OR

- All individuals (and claims) identified using the pre-Reform inclusion and exclusion criteria who were enrolled for at least one month between September 1, 2006, and June 30, 2008, in Hillsborough or Orange County

MEG Category Descriptions

MEG	ELIGIBILITY GROUP	ELIGIBILITY CATEGORY	DESCRIPTION
MEG # 1	SSI-Related	MS	SSI Medicaid (Eligibility for Medicaid & usually SSI cash assistance determined by SSA Emergency MICs and retroactive Medicaid coverage on FLORIDA Medicaid)
		MT A	Protected Medicaid for Widows I & kids (disab. defin. change)
		MT C	Regular protected Medicaid (COLA)
		MT D	Protected Medicaid for Disabled Adult Children
		MT S	Protected Medicaid Due to SSI Disability Definition Change
		MT W	Protected Medicaid for Widows II
		MX	SSI Children with continuous coverage
MEG # 2	Children & Families	MA I	Low Income Families (LIF) Medicaid (Incapacitated Parent)
		MA R	Low Income Families (LIF) Medicaid (Deprived Child)
		MA U	Low Income Families (LIF) Medicaid (Unemployed Parent)
		ME C	Extended Medicaid Due to Child Support
		ME I	Transitional Medicaid Due to Caretaker Earned Income
		ME T	Transitional Medicaid Due to Loss of \$30 or 1/3 Disregard
		MM C	MEDS for Children Born after 9/30/83
		MM I	MEDS for Infants Under One
		MN	Presumptively Eligible Newborn Medicaid (PEN)
		MO A	"AFDC" Failed Due to Alien Status Medicaid
		MO D	"AFDC" Failed Due to Deemed Income Medicaid
		MO P	"AFDC" Failed Due to Project Independence Sanctions Medicaid
		MO S	"AFDC" Failed Due to Sibling Income Medicaid
		MO T	"AFDC" Failed Due to Transfer of Assets Medicaid
		MO U	LIF Medicaid for Pregnant Women Below TANF (8 months – 9th Month in MA R)
		MO Y	LIF Medicaid for Age 18–21 Deprived Children
		MP C	PMA for Children Under 21 in an Intact Family
		MP N	PMA for Children Born After 9/30/83 Living with Non-relatives
MP U	PMA for Unemployed Parents with Children Under 18		

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