Medicaid pilots at one year: How is the new Medicaid marketplace faring?

Florida's Experience with
MEDICAID REFORM

Key findings:

- HMO benefit offerings have become less generous in year two.
- People with disabilities tend to choose different plans than families with children.
- It is too early to assess whether the state is saving money.

Overview of findings

HMOs benefit offerings have become less generous in year two. While plans have raised some limits on benefits, overall limits on benefits are tighter, copayments are rising, and extra services are being reduced.

People with disabilities tend to choose different plans than families with children. The majority of Medicaid beneficiaries (73 percent) are enrolled in HMOs with the largest player in the market being Wellcare. People with disabilities are more likely to enroll in provider-sponsored networks (PSNs), which currently are not permitted to limit benefits in the same way as HMOs.

It is too early to assess whether the state is saving money. Issues to watch include per person spending in the two counties as compared to similar groups in the rest of the state, the change in the way federal spending is flowing into the state, and whether administrative costs are higher than in regular Medicaid.

Introduction

As Medicaid pilots in Broward and Duval counties enter their second year of operation, some changes are under way. Although the pilots officially began in July 2006, the first enrollments were effective in September 2006. As of October 2007, 175,879 people were enrolled in the two-county pilot. Another 5,000 people have enrolled so far in the three rural counties (Baker, Clay, and Nassau) that are currently transitioning to the new system. There are two plans participating in each of those rural counties.

Effective September 1, 2007, plans operating in Broward and Duval counties were permitted to submit new benefit offerings. Plans' ability to offer differing benefits packages is one of the key features of the changes. This brief examines which plans are attracting the most enrollees and how the benefit offerings are changing. In addition we examine the way in which the financing of the waiver is operating, focusing on the calculations that will eventually show whether the pilots are saving the state money.

What kinds of plans are most prevalent in the Medicaid pilots?

Prior to implementation of the pilots, about half (51.6 percent) of the state's Medicaid beneficiaries received their services through managed-care plans. The share in Duval County was close to the statewide average, while in Broward County, the share was somewhat higher (65 percent).[1]

Under the Medicaid pilots in Broward and Duval counties, most beneficiaries – other than certain excluded groups – are required to enroll in one of the participating reform plans. At the end of the pilot's first year, total enrollment in the reform plans represents about 62 percent of the total Medicaid-eligible population in these counties. For those beneficiaries enrolled in the pilots, some stayed in the plan they were in prior to reform, while those in MediPass (a primary care case management program) or those new to Medicaid either selected a plan or were assigned to one. At present, there are 7 plans participating in Duval County and 15 in Broward County.[2] Nearly two-thirds of the participating plans are HMOs, while the remaining plans are provider-sponsored networks (PSNs). 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. While more than half of the plans participated in Medicaid in those counties prior to the changes, additional plans signed on as a result.

Overall, the majority of beneficiaries (73 percent) participating in the pilots are enrolled in one of the participating HMOs, while the remainder (27 percent) have selected a PSN. In Broward County, about three-fourths of enrollees (76 percent) are in one of the 10 reform HMOs, while the rest are in a PSN. The share enrolled in HMOs is

The Jessie Ball duPont Fund has commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program in Broward and Duval counties. This policy brief is the fourth in a series and examines some key questions that arise as the pilots began their second year of operation.

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Figure 1a. Broward County plan enrollment, September 2007

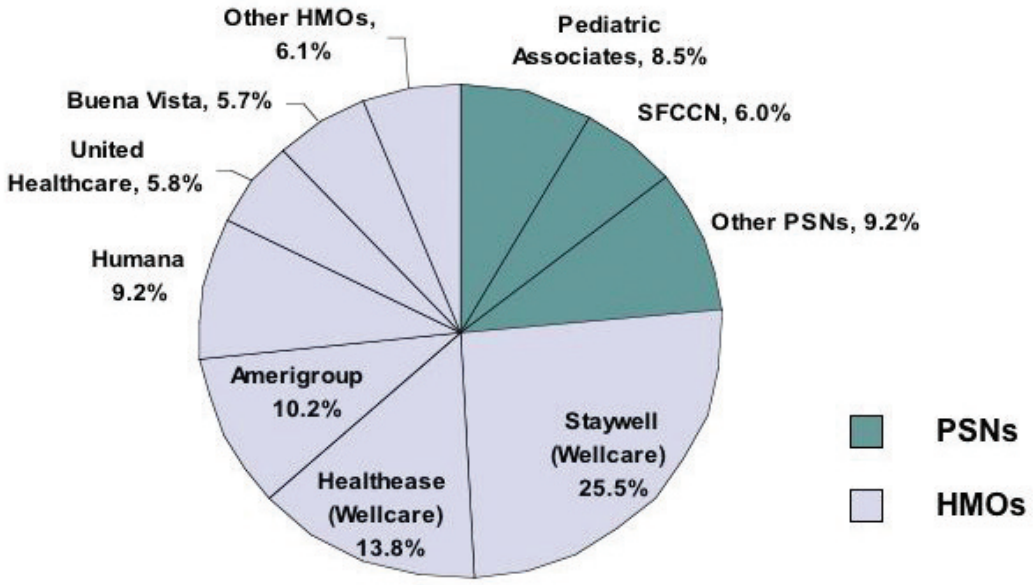
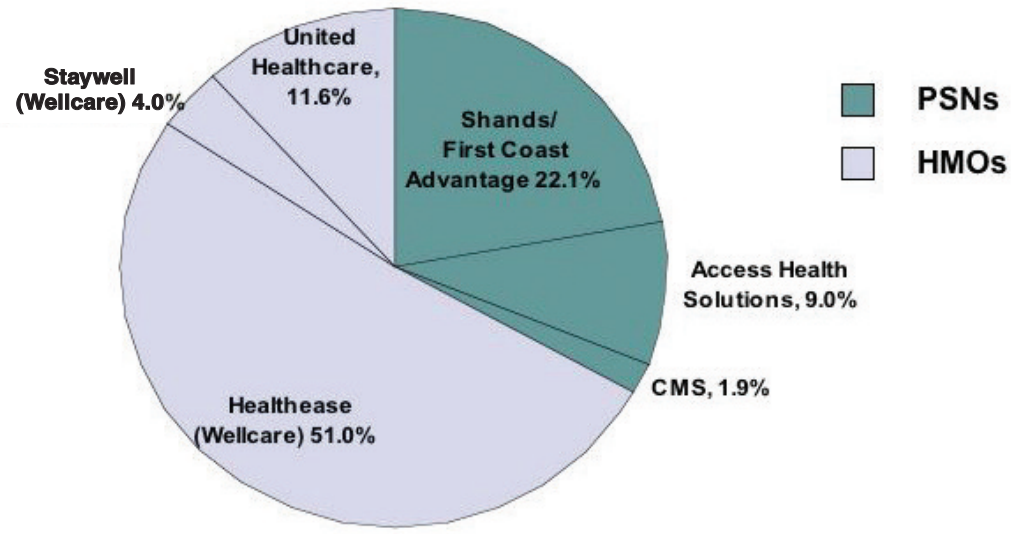


Figure 1b. Duval County plan enrollment, September 2007



Source: September 2007 Florida Medicaid Reform Enrollment Report, AHCA

slightly smaller in Duval County, with 67 percent in four HMOs and 33 percent in three PSNs (See Figures 1a and 1b on overleaf).

Wellcare is the largest player in each county, drawing just over half the Duval County enrollment and 39 percent in Broward County to its two plan offerings (Healthease and Staywell).[3]

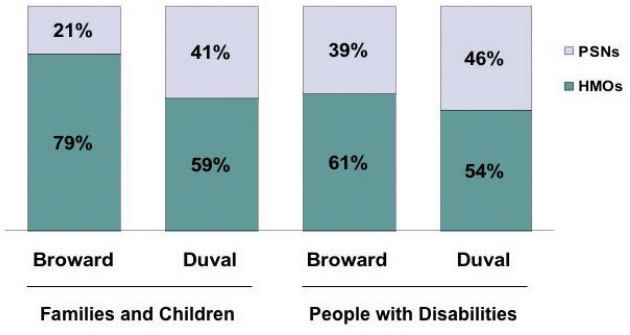
In Duval County, the PSN organized by Shands Jacksonville (First Coast Advantage) is the second largest player with nearly one-fourth of the county's enrollees. United Healthcare's HMO and the PSN created by a group of minority physicians (Access Health Solutions) split most of the remaining enrollment.

In Broward County, six plans – two PSNs and four HMOs – vie for runner-up status to Wellcare's two plans. Each has between 5 percent and 10 percent of the county's enrollees, while eight additional plans have smaller numbers of enrollees. The South Florida Community Care Network, a PSN organized by the largest hospitals in the county, acquired only 6 percent of overall enrollment in the county, despite its affiliation with Broward Health and the Memorial Healthcare System, the major county-financed hospital systems.

Are people with disabilities enrolling in different plans than families with children?

The two major categories of beneficiaries participating in the pilots are low-income families with children (called the "TANF" group) and people with disabilities who are not on Medicare or in institutions (the "SSI" population). Enrollment data show that people with disabilities are disproportionately enrolling in the PSNs, especially in Broward County. In Broward, 39 percent of SSI beneficiaries are in PSNs, compared to only 21 percent of TANF beneficiaries (similar shares in Duval County are 46 percent and 41 percent, respectively).

Figure 2. Enrollment in PSNs and HMOs by county and enrollment group, September 2007



Source: September 2007 Florida Medicaid Reform Enrollment Report, AHCA

As the name suggests, PSNs are organized by providers – typically either a hospital system or a group of physicians – and the rules treat them somewhat differently than participating HMOs. In the first three years of the pilots, PSNs may opt not to take on financial risk, and all participating PSNs have made that choice. Thus, they are paid by the state based on actual costs incurred. By contrast, HMOs are paid on a per-enrollee basis and can profit if expenses are less than projected or lose money if expenses are higher. When plans are paid on a per-enrollee basis, these payments are risk-adjusted for the health status of their enrollees.[4] When PSNs choose not to operate on an at-risk basis, they are not permitted to vary their benefit offerings – in particular, they may not restrict any benefits below the state-provided levels and may not substitute their own preferred drug list for the state list. PSNs, however, may add benefits or impose co-payments within the limits of law.[5]

Although no definitive evidence exists, the sense among Florida observers is that more disabled beneficiaries select PSNs because of their close relationships with certain providers and because they do not limit any of the benefits below state levels. Thus the state is covering on a fee-for service basis the full cost of the care for what is presumably a more expensive set of beneficiaries. By the end of the pilot's third year, PSNs will be paid on a per-enrollee basis putting them at risk for the health costs incurred. To the extent that the risk-adjusted payments measure accurately the differences in health status of their enrollees, the PSNs will receive higher average payments. But some stakeholders have raised concerns that at least some PSNs will not be prepared to go at risk at that time. If risk-adjustment factors are not adequate, the challenge faced by PSNs will be greater.

Furthermore, the disabled beneficiaries who enroll in PSNs are sheltered from some of the changes that have faced other beneficiaries who are in HMOs. They are not experiencing some of the benefit reductions or gaps in the preferred drugs lists seen by some HMO enrollees.[6] PSN enrollees may also be having an easier time finding physicians, including getting referrals to specialists, because the networks are based in provider communities, although documentation of this is hard to come by. It remains to be seen whether these broader networks will be sustained when the PSNs go at risk and start paying providers at something other than the state Medicaid rates.

How are plan offerings changing in year two?

One of the unique features of the Medicaid pilots is the ability of managed care plans to offer "customized benefits packages" for non-pregnant adult Medicaid beneficiaries. The claim has been made by proponents of the pilots that competition induced by consumer choice would result in plans offering more generous benefits than the regular Medicaid program. As the pilot's second year began, plans were able to submit new benefit packages for approval by the state; plans must keep their benefit packages consistent for one year. We analyzed 28 different benefit packages offered by all participating HMOs for year two and compared them to those offered in the program's first year.[7]

The federal Medicaid waiver under which the pilots are operating allows plans to limit the amount of certain benefits they offer subject

to constraints established in state law. These constraints apply differently across three tiers of benefits. The first tier includes "mandatory" Medicaid benefits (e.g., inpatient hospital services, physician visits) that plans must offer at the same level as the rest of Florida's Medicaid program. The second tier includes "optional" Medicaid benefits (e.g., prescription drugs, home health services, durable medical equipment, and outpatient hospital services) that plans must offer but can vary the amount subject to a state-established sufficiency test[8]. In the final tier (e.g., adult dental, vision, and physical therapy benefits), plans have unfettered flexibility as to whether or not to offer the benefit at all and in what amount.

Overall, new offerings by plans are less generous than in the first year – with lower limits on specific benefits, higher copayments, and fewer extra services.

The most common benefit being reduced is physical and/or respiratory therapy. One quarter (seven) of HMO offerings reduced therapy benefits – both for adults who are disabled and parents. No HMO improved its benefit. Plan offerings in this area are minimal – in some cases limiting therapy services to only $100 annually. Limits on durable medical equipment, an important benefit for people with chronic and disabling conditions, were reduced by six HMOs and improved by just one.

Figure 3. Benefits are decreasing

Service	Eliminating or Decreasing Benefits	Adding or Increasing Benefits
Pharmacy	8	6
Outpatient Therapy (physical/respiratory)	7	0
Durable Medical Equipment	6	1
Outpatient Hospital Services (non-emergency)	5	1
Chiropractor	3	0
Podiatrist	2	0
Hearing Services	1	0
Vision Services	1	0
Extra Services (some plans made both adds and drops)	19	8
Total	**52**	**16**

Note: Counts indicate the number of benefit packages where changes occurred out of the total of 28 different packages across two counties (Broward and Duval) and across the two beneficiary populations (persons with disabilities and parents).

Source: Georgetown Health Policy Institute analysis of AHCA Benefit Comparison Charts for Broward and Duval Counties.

Another important area where HMOs made changes is the pharmacy benefit. Plans are permitted to establish an overall dollar limit or monthly limit on the number of prescriptions a beneficiary can receive (subject to the state's sufficiency test). Here there was more variety, with six plans improving the benefit, and eight reducing the benefits. However, much of the change in this area is accounted for by the two plans offered by Wellcare, which reduced the pharmacy benefit for people with disabilities from a limit of 17 drugs a month to 16 and increased the benefit for the healthier parent population by removing the previous limit of nine prescriptions a month.

Other benefit reductions included the scope of hospital outpatient services, chiropractor and podiatry services.

As noted above, plans can choose to offer extra services such as over-the-counter medications, circumcision for infants, or additional adult dental services. Here the trend was also downwards with eight plans adding at least some services and 19 reducing or eliminating extra services (of these, three both added and reduced services). In some instances, plans may have made changes to several different extra services.

Copayments are going up.

Plans have less flexibility to raise copayments because the state did not seek permission under the waiver to allow increases above what is permitted under federal Medicaid law. All plans are allowed to charge nominal copayments, and our analysis found that this is increasingly the case. For year two, *copayments were increased or added in 58 instances across all services and reduced or eliminated in one case.* The most common services for which copayments were added were inpatient hospital services, podiatry, and chiropractor services. Notably, Wellcare's plans (the largest in the program) did not raise copayments, while other plans with large market share including Amerigroup, Shands, and UnitedHealth, did.

Figure 4. Copayments are going up

Service	Adding or Increasing Copayments	Eliminating or Decreasing Copayments
Chiropractor	10	0
Hospital Inpatient	10	0
Podiatrist	10	0
Outpatient Hospital Services (non-emergency)	6	0
Hospital Outpatient Surgery	5	0
Mental Health Services	5	1
Home Health Services	4	0
Lab/X-ray	4	0
Vision Services	4	0
Total	**58**	**1**

Note: Counts indicate the number of benefit packages where changes occurred out of the total of 28 different packages across two counties (Broward and Duval) and across the two beneficiary populations (persons with disabilities and parents).Only categories where changes occurred are listed.

Source: Georgetown Health Policy Institute Analysis of AHCA Benefit Comparison Charts for Broward and Duval Counties.

Will Florida's Medicaid reform save money?

Sound data are not yet available to determine conclusively whether or not the state is saving money in these two counties.[9] To come closer to answering this question it is important to examine some of the complexities of Medicaid financing

How does Medicaid financing generally work?

The federal and state governments finance Medicaid jointly. Normally states are assured of open-ended federal matching funds for Medicaid expenditures that meet federal guidelines. Under regular Medicaid rules, for every dollar Florida spends on approved Medicaid services, it receives 57 cents back in federal funding.[10] In the absence of a waiver, the federal government pays 57 percent of increased costs if spending or enrollment goes up. Florida's Medicaid enrollment declined in 2007, while per person spending appears to be on the rise.

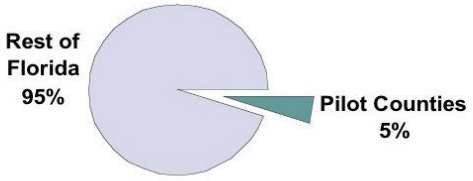
How does the waiver affect Florida's federal Medicaid funding?

Because the changes to Florida's Medicaid program were made through a federal Section 1115 waiver, a budget-neutrality agreement is required. The federal government insists that no more federal dollars are spent under a waiver than without one. By agreeing to the terms of the waiver, the state is saying that the waiver's policy changes will result in spending no more federal dollars – and possibly fewer if savings are achieved.[11] In order to enforce this principle, a budget-neutrality agreement, or cap, is negotiated to estimate how much a state would have spent in the absence of the waiver.

The budget neutrality agreement in Florida's Medicaid waiver establishes a per person or "per capita" cap of 8 percent growth annually on the federal dollars the state can receive for certain groups (people receiving SSI but not Medicare and families with children) and certain services (acute care services). The cap allows the state to receive increased federal funding if Medicaid enrollment goes up but puts the state at 100 percent risk for increased spending per person that may result from increases in health-care costs. For example, if a bird flu epidemic struck or the state increased provider reimbursements, per person spending may increase substantially. One reason Florida might wish to make improvements, such as raising provider reimbursement levels, is that its program is relatively under-funded compared to other states. A recent study found that Florida's spending on Medicaid as a share of the state's total health care spending was only 12.4 percent, compared to a national average of 17.4 percent, and even well below the average of 16.4 percent average for states in the Southeast.[12]

Florida's Medicaid budget-neutrality agreement is premised on immediate statewide implementation of the waiver even though state law requires that implementation proceed initially on a pilot basis in a limited set of counties. In other words, the state must meet spending targets established by the waiver for eligibility groups included in the waiver *for the entire state*, not just those residing in the two counties. Indeed, as figure 5 shows, for the first year of the waiver's budget neutrality agreement, the state reported to the federal government that *only 5 percent of spending governed by the waiver was attributable to Medicaid beneficiaries in the Broward and Duval pilot programs.* This statewide reach may compel state legislators to expand the pilots if they are saving money and curtail them if they are not, regardless of the impact on beneficiaries' health. Recently, state officials have cited the need to "ensure waiver budget neutrality" as a reason to expand the pilots quickly into other counties with large Medicaid enrollment.[13]

Figure 5. Most waiver spending is outside the pilot counties

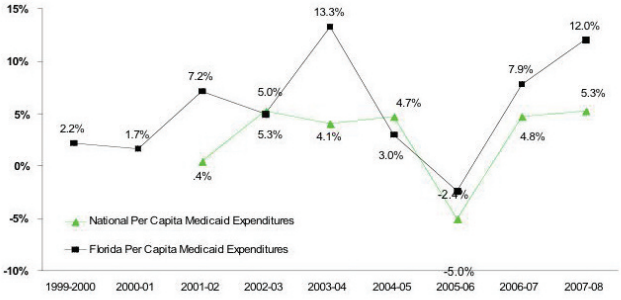


Source: Georgetown Health Policy Institute analysis of data from AHCA's *Florida Medicaid Reform Quarterly Progress Report, April 1, 2007 – June 30, 2007.*

Of the spending reported to the federal government under the budget-neutrality agreement so far, the state indicates it has spent considerably less on Medicaid beneficiaries than it would have in the absence of the waiver – just under 86 percent.[14] One important question that has not been answered is how has per person spending differed in the pilot counties versus the rest of the state for the same eligibility groups? More information is needed to disentangle these critical questions.

Like most states, Florida's overall per capita Medicaid spending fluctuates from year to year. Because Florida's Medicaid enrollment is declining, the growth of spending in the state's budget has been limited. But the potential of hitting the budget neutrality cap grows. As shown in Figure 6, Florida's per capita spending is on the rise and is projected to grow by 12 percent next year. This does not mean that Florida will necessarily violate the waiver's budget neutrality cap of 8 percent because this analysis includes all Florida Medicaid spending – much of which is outside the waiver. But it does highlight the need for detailed information on trends in the Medicaid spending governed by the waiver and outside of it.

Figure 6. Annual percentage changes in per capita Medicaid expenditures, Florida and U.S.



Source: Georgetown Health Policy Institute analysis of CBO March Medicaid Baselines 2002-2007; and Florida Social Services Estimating Conference Medicaid Caseload Data (10/19/2007) and Medicaid Expenditure Data (7/31/2007).
Note: National Medicaid expenditures do not include DSH, other payments to providers, or vaccines for children.

Potential for high administrative costs.

The waiver includes two special features: enhanced benefits accounts, which aim to encourage healthy behaviors, and an "opt-out" program, which allows Medicaid beneficiaries to receive a premium subsidy to purchase their employer sponsored coverage. The state has used a variety of private vendors to administer these programs. So far, both of these programs have had very low participation rates and very high administrative costs. Only $260,691 (4 percent) of almost $6 million earned in credits for the enhanced benefit accounts has been redeemed to date.[15] Yet initial administrative costs associated with the program have been $1.1 million.[16] Similarly, enrollment of fewer than 10 persons in the opt-out program has led to extraordinarily high administrative costs – an annualized cost of $9,171.48 per participant.[17]

These high administrative costs compare unfavorably with low administrative costs typically associated with the Medicaid program. They constitute an important consideration in determining the value of these elements of the waiver.

Issues to consider going forward

As the Medicaid pilot program moves into its second year, it is important to continue examining key questions. A look at the second year of plan competition suggests that benefit offerings by participating HMOs are becoming less generous. Many important issues need to be monitored in year two, such as whether access to needed services is limited by more restrictive benefit plans and higher copayments, whether the eventual shift of PSNs to at-risk status will have an adverse effect on the persons with disabilities who have enrolled disproportionately in them, and how ongoing expansion to the three new rural counties fares. Furthermore, a critical concern for policymakers will be the impact of the changes on federal and state Medicaid spending in Florida. Much more detailed information is needed on overall Medicaid spending trends and on administrative costs associated with the pilot to be able to examine cost issues.

ENDNOTES

[1] See our earlier brief, *Medicaid Changes: What will they mean for Broward and Duval counties, and beyond?* (Briefing #1, September 2006).
[2] Enrollment is currently suspended for one of the plans (Universal) approved in each county. It has about 100 enrollees total in each county.
[3] Wellcare is currently under investigation for possible Medicaid fraud by Florida's Medicaid Fraud Control unit and several federal agencies. Few details of the investigation have been released.
[4] In the pilot's first years, limits are applied to the application of the risk-adjustment factors, thus limiting the range of payments plans get for sicker beneficiaries versus healthier beneficiaries.
[5] The different rules applying to PSNs and HMOs are spelled out in the state's waiver application at http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml
[6] See previous briefs in this series, *Waiving Cautionary Flags: Initial reactions from doctors and patients to Florida's Medicaid changes* (Briefing #2, May 2007) and *Uncertain Access to Needed Drugs: Florida's Medicaid reform creates challenges for patients* (Briefing #3, July 2007).
[7] In each county, HMOs offer two different packages: people with disabilities and parents. Plan descriptions are made available to Medicaid beneficiaries through comparison charts developed by AHCA. Our analysis is based on AHCA materials dated July 2007.
[8] The sufficiency test sets a level that meets the service needs of 98.5 percent of beneficiaries, based on past usage.
[9] This point is made in *Program Review of the Medicaid Reform Pilot Project*, Office of the Inspector General, AHCA, September 2007.
[10] Matching rates are available in *Federal Register*, November 30, 2006 (Volume 71, Number 230) pp. 69209-69211
[11] A primary motivation for the Medicaid waiver, according to state officials, was to control the rate of growth in Florida's Medicaid spending.
[12] A. Martin et al. "Health Spending by State of Residence, 1991-2004" *Health Affairs* 26, no. 6 (2007), w651-663, see Exhibit 2.
[13] "Florida Medicaid Reform," presentation by Tom Arnold, Deputy Secretary of Medicaid, to the Senate Health Policy Committee, October 2, 2007.
[14] *Florida Medicaid Reform, Quarterly Progress Report, April 1, 2007 – June 30, 2007.* For the two groups included in the waiver, families with children are coming in at just under 80 percent of what would have been spent, and people with disabilities at 92 percent.
[15] "Florida Medicaid Reform," presentation by Thomas W. Arnold, October 2, 2007.
[16] "Agency's Response to Questions from Marc Ryan Regarding the Funding of the Enhanced Benefits Account Program," Medicaid Reform Technical Advisory Panel Meeting., September 14, 2007.
[17] This calculation assumes an average of seven enrollees for 12 months. Georgetown Health Policy Institute analysis of OPPAGA Medicaid Reform Implementation Memorandum No. 2 March 2007.

This report is made possible through the generous support of the Jessie Ball duPont Fund, The Community Foundation in Jacksonville and United Way of Northeast Florida.

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

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The authors would like to thank Jen Thompson and Lauren Bakios for their research assistance on this report.