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Justification Review

November 2001 **Report No. 01-61**

Expected Medicaid Savings Unrealized; Performance, Cost Information Not Timely for Legislative Purposes

at a glance

Over the past few years the Legislature enacted a number of cost reduction initiatives intended to curb Medicaid costs. Despite these initiatives, anticipated savings have not been realized, and expenditures continued to increase, surpassing appropriations in 1999-00 and 2000-01.

A weakness in the Medicaid program that has hindered the budgeting process is that the agency has not routinely provided the Legislature with information on the extent to which it has achieved the cost savings anticipated by cost reductions. Such reporting is necessary to keep the Legislature informed of the impact of its policy decisions and to assist the Social Services Estimating Conference in identifying budget needs.

The agency tracks and reports on PB² outcome measures that indicate the general health status of Medicaid clients. However, because of data delays and factors outside of Medicaid's control that can influence health status, these health outcomes are of limited usefulness for assessing program performance. They should be supplemented with key internal measures of processes and functions that affect health outcomes.

The Agency for Health Care Administration needs to provide better and more timely information to assist the Legislature in making budget and policy decisions. We, therefore, recommend that the Legislature direct the agency to

- **report quarterly on the status of legislative cost reduction initiatives and**
- **formally monitor key processes and functions that affect the health status of Medicaid clients.**

Purpose

Section 11.513, *Florida Statutes,* directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based program budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs. [1]

This report is the last of four that reviews the Medicaid program administered by the Agency for Health Care Administration. The other reports address cost control policies for prescription drug services; use of disease management organizations to improve health outcomes and reduce costs; and

[1] Chapter 92-249, *Laws of Florida* (see Appendix A for statutory requirements).

effectiveness of fraud and abuse prevention activities. [2] This report

- highlights the increasing costs of the Medicaid program;
- examines the success of recent Medicaid cost savings initiatives; [3]
- evaluates program performance based on health status outcomes; and
- recommends ways for the agency to improve its overall accountability.

Background

Purpose. Florida's Medicaid program, authorized by Title XIX of the United States Social Security Act, as amended in 1965, is among the largest in the country. [4] Its purpose is to improve the health of persons including children who might otherwise go without medical care. Medicaid provides health care services to around 1.9 million low-income persons each month who meet federal and state eligibility requirements. Medicaid serves mainly low-income families and children, elderly persons who need long-term care services, and persons with disabilities.

Clients and Services. To receive federal Medicaid funds, Florida must adhere to federal requirements related to eligibility and scope of medical services. For example, federal guidelines require Florida to provide health care coverage to low-income single parents and their children who receive cash assistance, children in foster care, and low-income elderly, blind, or disabled clients. Florida also elects to provide health care coverage to several optional groups including the medically needy, refugees, and other individuals such as certain persons needing long-term care services. [5]

Florida must also ensure that Medicaid clients receive the health care services required by federal guidelines. These mandatory services include physician visits, family planning, laboratory tests, health screening services for individuals under age 21, and hospital inpatient and outpatient services. Florida also provides a number of optional services, such as prescription drugs, hospice care, intermediate care facilities for the developmentally disabled, and children's dental services. Currently, Florida's Medicaid program covers 37 health care services. (See Exhibit 1.)

Exhibit 1
Florida's Medicaid Program Provides 37 Health Care Services Including 25 Optional Services

Mandatory Services (12)	Optional Services (25)
Advanced Registered Nurse Practitioner	Child Welfare Targeted Case Management
Early and Periodic Screening, Diagnosis, and Treatment	Intermediate Care Facility for the Developmentally Disabled
Family Planning	Adult Denture
Home Health Care	Adult Health Screening
Hospital Inpatient	Ambulatory Surgical Center
Hospital Outpatient	Assistive-Care
Independent Laboratory	Birth Center
Nursing Facility	Case Management
Physician	Children's Dental
Portable X-Ray	Chiropractic
Rural Health Clinics	Community Mental Health
Transportation	Dialysis Facility
	Durable Medical Equipment
	Healthy Start
	Hearing
	Home and Community-Based Care
	Hospice Care
	Intermediate Care Services
	Optometric
	Physician Assistant
	Podiatric
	Prescribed Drugs
	Registered Nurse First Assistant
	State Hospital
	Visual

Source: Sections 409.905 and 409.906, *F.S.*

[2] *Growth in Medicaid Prescription Drug Costs Indicates Additional Prudent Purchasing Practices Are Needed,* Report No. 01-10, February 2001; *Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed,* Report No. 01-27, May 2001; and *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed,* Report No. 01-39, September 2001.

[3] This report focuses on Medicaid cost reduction initiatives enacted by the Florida Legislature for 1997-98 to 2001-02; the Legislature also enacted initiatives for 1994-95 to 1996-97 that were anticipated to save Medicaid $490.5 million. The agency reported on the success of these initiatives in August 1998.

[4] According to the Health Care Financing Administration, in 1998, Florida ranked fourth nationally in the number of Medicaid clients served and seventh in Medicaid expenditures.

[5] Income eligibility limits vary from group to group up to 185% of the federal poverty level.

Service Delivery. Florida law requires that, to the extent possible, Medicaid clients enroll in a managed care delivery system. Depending on geographic availability, recipients have three managed care arrangements from which to choose. [6]

- **Medicaid Provider Access System (MediPass)**—The MediPass system is available statewide and is a primary care case management program. MediPass clients select or are assigned a primary care physician who is responsible for providing primary care and referring patients for specialized services. The state pays primary care physicians a $3 monthly case management fee for each client in addition to fee-for-service reimbursement for each service they provide to clients. In addition, MediPass clients with certain chronic conditions (e.g., hemophilia, asthma, HIV/AIDS) can receive intensive case management through the agency's disease management initiative.
- **Medicaid Health Maintenance Organizations (HMOs)**—Medicaid HMOs, available in 41 of the state's 67 counties, provide medical services to Medicaid clients on a prepaid basis. For each enrolled client, the state pays HMOs a monthly fee that is set at 92% of the expected cost to provide services to equivalent groups of fee-for-service clients. Besides the approved Medicaid services, HMOs are required to provide additional services including smoking cessation, pregnancy prevention, and domestic violence intervention services.
- **Provider Service Networks (PSNs)**—PSNs are currently available in only two counties, Broward and Miami-Dade. PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups. In 1997, the Legislature authorized the agency to contract with up to four PSNs. To date, only one PSN, the South Florida Community Care Network, is enrolling Medicaid clients.

As of June 2001, 1.2 million or 64% of the state's Medicaid clients were enrolled in one of these managed care options, including 635,000 clients enrolled in MediPass, 543,000 in Medicaid HMOs, and 24,000 in a PSN.

Organization. As the administrator of the state's Medicaid program, the Agency for Health Care Administration is responsible for managing and overseeing the Medicaid program. In fulfilling its responsibilities, the agency develops and carries out Medicaid policies and reimburses health care providers for medical services provided to Medicaid clients. The agency also develops and monitors the Medicaid budget, forecasts future funding needs, and develops long range plans for service delivery. In addition, the agency is responsible for monitoring contracts including individual provider contracts as well as the contract with Consultec, Medicaid's fiscal agent.

At the local level, the agency provides oversight through 11 area Medicaid offices located throughout the state. Staff in these offices provide technical assistance and training to providers, resolve claim disputes, assist in recruiting Medicaid providers, contract with local transportation coordinators, and assist in monitoring Medicaid HMOs and MediPass providers.

Resources. For Fiscal Year 2001-02, the Legislature appropriated $10.08 billion, including $2.97 billion in state general revenue, to operate the state's Medicaid program. Most of these funds (98.2%) will be used to pay for health care services for Medicaid clients. The other 1.8% (or $176.4 million) will pay for administrative functions such as program planning, data processing, and contract management. For Fiscal Year 2001-02, the Legislature authorized 693 full-time positions to fulfill Medicaid administrative functions.

In addition to general revenue, the Medicaid program receives funding from several trust funds. Exhibit 2 shows the sources of program funding for Fiscal Year 2001-02.

[6] Children with special health care needs may enroll in the Children Medical Services Network. Medicaid funds Children Multidisciplinary Assessment Teams that provide assessments, recommendations, and decisions for services for medically complex children.

Exhibit 2
Most Medicaid Program Funding Comes from Federal Matching Dollars Deposited in the Medical Care Trust Fund

Funding Source	Appropriations, FY 2001-02
General Revenue	$ 2,968,006,871
Medical Care Trust Fund (federal funds)	5,682,365,337
Grants and Donations Trust Fund	870,214,185
Public Medical Assistance Trust Fund	337,500,000
Administrative Trust Fund	104,747,235
Tobacco Settlement Trust Fund	100,208,270
Refugee Assistance Trust Fund	13,557,523
Health Care Trust Fund	560,382
Total	**$10,077,159,803**

Source: Agency for Health Care Administration operating budget, Fiscal Year 2001-02.

Findings

Reforms to Curb Medicaid Costs Not Fully Successful

Increased expenditures led to budget shortfalls in Fiscal Years 1999-00 and 2000-01

For the five Fiscal Years 1996-97 through 2000-01, Medicaid expenditures increased from $6.28 billion to an estimated $8.98 billion. While rate of increases averaged 5.2% through Fiscal Year 1998-99, this rate of increase more than doubled to an average 13.1% for the years after Fiscal Year 1998-99.

As shown in Exhibit 3, Florida's Medicaid expenditures have exceeded appropriations for the past two fiscal years. The Medicaid program experienced a budget deficit of $87.2 million and $640.1 million in Fiscal Years 1999-00 and 2000-01 respectively.[7] And, in February 2001, the Social Services Estimating Conference projected a Medicaid deficit of $1.5 billion for Fiscal Year 2001-02. The 1999-00 and 2000-01 deficits were funded from excess general revenue and unappropriated tobacco settlement payments. The projected 2001-02 deficit was offset by the Legislature increasing Medicaid health services appropriations by nearly $1.6 billion (or 18.5%) from the prior year's level.

Exhibit 3
Medicaid Expenditures Exceeded Appropriations In Fiscal Years 1999-00 and 2000-01

	Appropriations	*Expenditures*	*Under/(Over)*
1996-97	$6,730,225,017	$6,281,428,233	$ 448,796,784
1997-98	6,913,527,669	6,611,527,446	302,000,223
1998-99	7,007,490,975	6,946,629,422	60,861,553
1999-00	7,675,987,992	7,763,213,532	**(87,225,540)**
2000-01	8,340,329,081	8,980,454,227	**$(640,125,146)**

Source: Expenditures from the Social Services Consensus Estimating Conference; appropriations from LAS/PBS 10-year histories.

The Legislature has reduced the Medicaid budget by $1.1 billion since Fiscal Year 1997-98

In an effort to control costs and to improve the effectiveness of Florida's Medicaid program, the Legislature has enacted a number of policy and funding reforms since Fiscal Year 1997-98. These initiatives are intended to save $1.1 billion by the end of Fiscal Year 2001-02. Accordingly, the Legislature reduced the Medicaid budget by that amount in anticipation of achieving these cost savings. (See Exhibit 4.)

Exhibit 4
The Legislature Has Reduced Florida's Medicaid Appropriations by $1.1 Billion Since Fiscal Year 1997-98

Fiscal Year	Medicaid Reductions
1997-98	$ 44,991,761
1998-99	137,535,293
1999-00	114,165,051
2000-01	311,872,671
2001-02	479,786,150
TOTAL	$1,088,350,926

Source: General Appropriations Acts of 1997-98, 1998-99, 1999-00, 2000-01, and 2001-02.

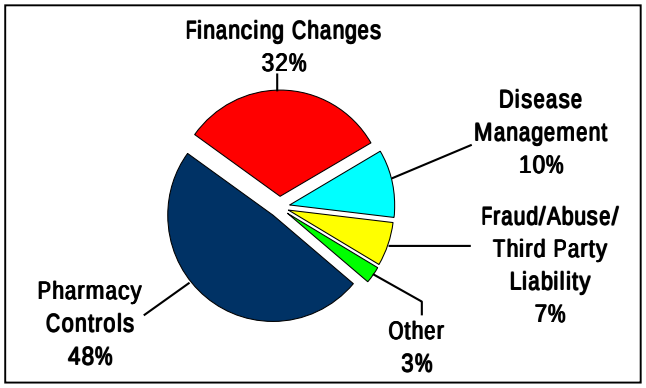
[7] In our prior Medicaid reports, we reported the 1999-00 deficit to be $78.7 million, an estimate provided us by the agency. The actual deficit was subsequently determined to be $87.2 million. Similarly, the estimated deficit of $546 million for 2000-01 reported in our prior reports was subsequently revised to $640.1 million.

As shown in Exhibit 5, most of these initiatives fall into four categories.

- Pharmacy cost controls. These initiatives include reducing drug dispensing fees, seeking additional generic drug rebates, using counterfeit-proof prescription pads, and implementing a drug formulary.
- Changes in financing. These initiatives include competitive bidding of independent laboratory, durable medical equipment, and transportation services; reducing Medicare crossover fees; and restricting nursing home rate adjustments associated with changes in ownership.
- Disease management strategies. These initiatives provide care management to Medicaid clients with certain chronic conditions, including diabetes, HIV/AIDS, and asthma.
- Fraud and abuse and third party liability. These initiatives focus on improving efforts to detect and recover overpayments due to pharmacy fraud and abuse and enhancing the ability to identify and bill other insurers before paying Medicaid claims.

Appendix B shows the individual legislative initiatives by categories for the fiscal year in which they were adopted.

Exhibit 5
Percentages of Dollar Value of $1.1 Billion Medicaid Cost Reductions Identified by the Legislature Since Fiscal Year 1997-98



Source: OPPAGA analysis.

Anticipated savings from cost reduction initiatives not fully realized

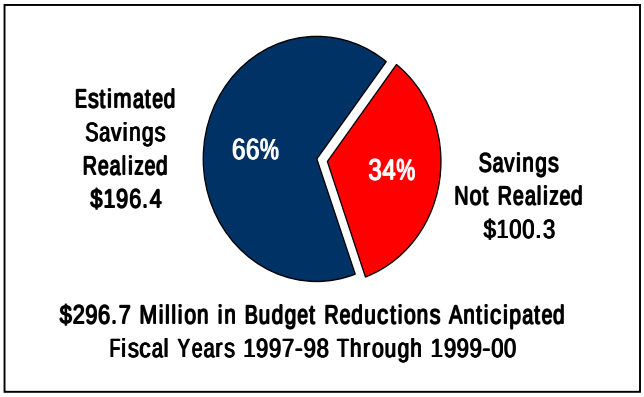
Of the $1.1 billion dollars in cost reductions identified since 1997-98, the Legislature anticipated that $608.6 million would be saved by the end of Fiscal Year 2000-01. However, based on agency information, the anticipated savings have not been fully realized. While the agency cites implementation delays as a primary reason for not achieving these savings, it has not routinely provided the Legislature with information related to the status of implementation or the extent to which it has achieved anticipated savings. Formal periodic reporting by the agency is necessary to assist the Legislature to make informed budget and policy decisions.

One-third of the anticipated savings from cost reduction initiatives for Fiscal Years 1997-98 through 1999-00 have not been realized. Agency data show that only two-thirds of the savings anticipated from the Medicaid initiatives were actually realized for Fiscal Years 1997-98 through 1999-00.[8] According to this data, the agency achieved cost savings of $196.4 million out of the $296.7 million savings anticipated by the Legislature (or 66%).[9] (See Exhibit 6.) We believe that these agency estimates of cost savings are overstated in a few instances. For example, the agency indicated that it saved $3 million due to implementing pharmacy fraud and abuse initiatives during Fiscal Year 1998-99. However, this $3 million represented the total amount identified for recoupment, not actual recoveries.

[8] *Summary on the Medicaid Cost Reduction Issues Identified in the General Appropriations Act for Fiscal Years 1997-98, 1998-99, and 1999-00,* Agency for Health Care Administration, September 2000.

[9] See Table C-1 in Appendix C for additional information related to these initiatives.

Exhibit 6
The Agency Achieved Only Two-Thirds of the Savings Anticipated by the Legislature for Fiscal Years 1997-98 to 1999-00



Source: OPPAGA analysis of information provided by the Agency for Health Care Administration.

The agency cited implementation delays as a primary reason for not attaining the full cost savings. The agency either did not implement or delayed implementing several initiatives due to problems negotiating contracts with some service providers, obtaining necessary permission from the US Health Care Financing Administration, and/or legal challenges. For example, although the Legislature directed the agency to implement disease management for nine diseases between 1997-98 and 1998-99, as of March 2001, programs existed for only five of the nine diseases and two of these programs did not cover the entire state. [10]

The Social Services Estimating Conference has recently begun to conduct periodic Medicaid impact conferences specifically focused on assessing the potential fiscal impact of proposed Medicaid reduction policies. The conference will discuss implementation dates for new Medicaid cost reduction initiatives and make adjustments to initial savings estimates based on expected implementation. This process should result in better annual estimates of cost savings due to Medicaid cost reductions.

The agency has not determined savings from Fiscal Year 2000-01 cost reduction initiatives. It is not yet clear whether the cost savings anticipated by the 2000 Legislature were realized during Fiscal Year 2000-01. The 2000 Legislature adopted several reforms for the agency to implement during Fiscal Year 2000-01, including prescribed drug spending controls. [11] In January 2001, the agency reported that the rate of growth of the average cost of prescriptions had slowed and that spending for prescription drugs was moving towards matching 2000-01 appropriations. [12] A recent agency report shows, that although the rate of growth increased during the latter half of Fiscal Year 2000-01, drug spending remained below projected spending in the absence of drug control initiatives. [13] We estimated that these controls yielded only 38% of the expected savings. The agency also has not reported on the success of the cost savings initiatives not related to controlling pharmacy costs.

Better and more frequent reporting on the status of cost reduction initiatives by the agency is needed. A weakness in the Medicaid program that has hindered the budgeting process is that the agency has not routinely provided the Legislature with information on the extent to which it has achieved anticipated cost savings. Agency reporting of actual savings from cost reduction initiatives is necessary to keep the Legislature informed of the impact of its policy decisions on this enormous program. The agency should provide this information quarterly to the Social Services Estimating Conference and annually as part of its legislative budget request so that it can be considered in the budget process.

The Legislature already requires the agency to report on the status of the Medicaid prescribed-drug spending control program. The 2000 Legislature directed the agency to report progress by January 15 of each year. The 2001 Legislature further required the agency to

[10] *Justification Review: Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed,* Report No. 01-27, May 2001

[11] See Table C-2 in Appendix C for a full list of the reforms to be implemented during 2000-01.

[12] *Annual Report Medicaid Prescribed Drug Spending Control Program*, Agency for Health Care Administration, January 2001.

[13] *Quarterly Report Medicaid Prescribed Drug Spending Control Program Initiatives for Quarter Ending September 30, 2001*, Agency for Health Care Administration.

prepare quarterly reports in a format prescribed by the Legislative Auditing Committee.

Similar quarterly reporting is needed for cost reduction initiatives that are not part of the prescribed-drug spending control program. These reports should include current implementation status, explanations of any delays in implementation, and to the extent possible, the fiscal impact of cost reduction initiatives. This will be particularly important for the 2001-02 initiatives as most of these initiatives affect services other than prescription drugs. [14]

Medicaid Not Meeting Legislative Standards for Program Results

Medicaid program performance met standards for only 3 of 10 PB² outcome measures for Fiscal Year 1999-00

The Medicaid program began operating under a performance-based budget (PB²) in Fiscal Year 1998-99. During Fiscal Year 1999-00, the agency tracked 10 PB² outcome measures for five Medicaid target groups: pregnant women, newborns, and women seeking family planning; children; non-disabled working age adults; disabled working age adults; and elders. Medicaid met legislative standards for only 3 of the 10 outcome measures for Fiscal Year 1999-00, the most recent year for which outcome data is available.

Health outcomes for pregnant women, newborns, and those seeking family planning services have improved slightly but lag behind the non-Medicaid population. As shown in Exhibit 7, Medicaid did not meet any of the legislative performance standards for the PB² measures for this group. Performance for all of the PB² measures has remained relatively unchanged since baseline year measures in Fiscal Years 1995-96 and 1996-97. See Appendix D, Table D-1.

While three of the four measures improved slightly in Fiscal Year 1999-00 over Fiscal Year 1998-99, the health outcomes for Medicaid clients remains substantially below that of the general population (non-Medicaid). For example, Exhibit 8 shows that while the percentage of Medicaid women who received adequate prenatal care improved to 83.6% in 1999, the percentage of non-Medicaid women who received adequate prenatal care was 96.1%.

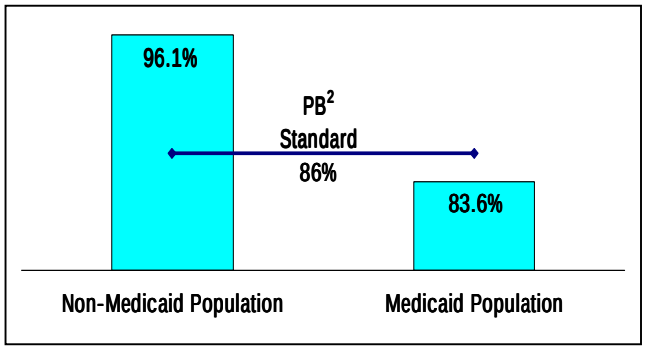
[14] See Table C-3 in Appendix C for a list of the 2001-02 Medicaid cost reduction initiatives.

Exhibit 7
Medicaid Did Not Meet Legislative PB² Performance Standards for Women and Newborns

	Fiscal Year			PB² Standard	Standard Met?
	1997-98	1998-99	1999-00		
Percentage of women receiving adequate prenatal care	83.7%	83.10%	83.60%	86.00%	No / Below
Percentage of vaginal deliveries with no complications	69.5%	69.20%	67.60%	73.10%	No / Below
Number of months between pregnancies for those giving birth funded by Medicaid	33.05	33.08	33.50	37.40	No / Below
Neonatal mortality rate (per 1000)	5.00	5.32	5.05	4.86	No / Above

Source: *The 2001 Annual Report on Medicaid Outcome Measures,* Agency for Health Care Administration.

Exhibit 8
A Smaller Proportion of Medicaid Clients Receive Adequate Prenatal Care Compared to the Non-Medicaid Population



Source: The 2001 Annual Report On Medicaid Outcome Measures, Agency for Health Care Administration.

Health outcomes for children need improvement. The Medicaid program met the legislative performance standard for one of the three PB² outcome measures for children who receive Medicaid. As illustrated in Exhibit 9, while the ratio of children hospitalized for mental health care to all children who received mental health services has met the legislative standard since Fiscal Year 1997-98, it worsened in Fiscal Year 1999-00.

Preventive care is an important component of children's health care, and thus, it is important for the agency to carefully monitor the delivery of child health check-ups.[15] While the percentage of eligible children who received a child health check-up remained at 45% for Fiscal Years 1998-99 and 1999-00, this represents a sharp decline in performance from 71% in 1997-98.

The agency asserts that the decline in performance may be a function of decreased reporting by physicians of well child visits rather than an indication of worse performance. Proper reporting and performance measurement on this outcome is important, as child health check-ups are critical for ensuring that children's health problems are identified and corrected as early as possible. The Division of Child Health Services, the agency entity responsible for this information, should examine this issue and correct any reporting deficiencies by the end of this current fiscal year.

Performance for disabled adults and for elderly persons achieved legislative standards. As shown in Exhibit 10, the Medicaid program has met the legislative standard for the percentage of hospital stays for elder clients exceeding length of stay criteria since Fiscal Year 1997-98.

Exhibit 10 also shows that the percentage of hospitalizations for conditions preventable with good ambulatory care met the legislative standard for disabled adults in Fiscal Year 1999-00. Performance for non-disabled adults was close to meeting the standard for the same measure and has shown improvement since Fiscal Year 1997-98. The 2000-01 Legislature revised these measures and reset the standards with the expectation that performance can be further improved and that ambulatory care should prevent unnecessary hospitalizations.

[15]Child health check-ups, formerly known as Early and Periodic Screening, Diagnosis, and Treatment (EPSTD) services, consists of comprehensive, preventive health screenings periodically performed on children under the age of 21.

Exhibit 9
Medicaid Met One of Three Legislative PB² Performance Standards for Children

	Fiscal Year			PB² Standard	Standard Met?
	1997-98	1998-99	1999-00		
Ratio of children hospitalized for mental health care to those receiving mental health services	5.10	4.70	5.30	6.80	Yes
Percentage of eligible children who received a Child Health Check-Up	71.00%	45.00%	45.00%	64.00%	No / Below
Percentage of hospitalizations for conditions preventable with good ambulatory care	8.96%	8.24%	8.93%	7.53%	No / Above

Source: *The 2001 Annual Report on Medicaid Outcome Measures,* Agency for Health Care Administration.

Exhibit 10
Medicaid Met Two of Three Legislative PB² Performance Standards for Elders and Disabled Adults

	Fiscal Year			PB² Standard	Standard Met?
	1997-98	1998-99	1999-00		
Percentage of hospital stays for elder recipients exceeding length of stay criteria	9.8%	11.1%	9.9%	26.0%	Yes
Percentage of hospitalizations for conditions preventable with good ambulatory care for disabled adults	14.3%	14.9%	13.9%	13.9%	Yes
Percentage of hospitalizations for conditions preventable with good ambulatory care for non-disabled adults	14.4%	13.8%	13.8%	13.3%	No / Above

Source: *The 2001 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration.

The agency is acting to improve performance. The agency is pursuing strategies to improve program performance, especially related to prenatal care and reducing hospital stays of children that are preventable with good ambulatory care. In addition, Medicaid's disease management initiative, intended to provide care management to persons with chronic diseases, could reduce hospitalizations for conditions that are preventable with good ambulatory care.

The 2000 Legislature reorganized the agency's PB² measures into new groups. The 2000 Legislature identified two major programs for the agency, the Health Care Regulation Program and the Health Care Services Program. The Health Care Services Program contains four new categories: *children with special health care needs, Medicaid prepaid health plans, Medicaid long-term care, and health care services to individuals.*[16] The 2001 Legislature maintained this organization, revised some of the 2000-01 measures, and added two new measures. See Appendix D, Table D-2.

Health outcomes do not provide enough information on the effectiveness of Medicaid operations

The PB² outcome measures indicate the health status of Medicaid clients. It is important to monitor these measures over time to determine if the health status of this population is improving or worsening. However, delays in the availability of outcome data hinder policymakers and program managers from relying solely on PB² outcome measures to make program decisions. Complete health outcome data from the numerous information systems are not available until one to two years after Medicaid service because providers can file claims up to one year after providing services and the agency needs time to collect and validate data accuracy.

In addition, factors outside the Medicaid program influence health outcomes. For example, the federal government and non-profit organizations finance and deliver services to the same populations that the Medicaid program serves. This makes it time-consuming and complicated to determine the effect that Medicaid services have on health outcomes. To attribute performance to the Medicaid program would require using statistical analyses to adjust for the effects of these influences.

The agency needs to formally monitor internal operations that affect health outcomes. In addition to the PB² measures, the agency should formally monitor the processes and functions that affect the cost of, quality of, and access to Medicaid health care services and ultimately, the health outcomes of Medicaid clients. Key internal measures can serve to supplement and explain health outcome performance and can provide insight into the effectiveness and efficiency of Medicaid program operations. Such measures can also assist program managers and policymakers in identifying ways to improve the delivery of health care services.

For example, access to client services directly affects health outcomes. Measuring the number of clients who access a provider within a certain

[16]The category, *children with special health care needs,* includes all children enrolled in the state's KidCare program, of which Medicaid is one component.

time period or the number of Medicaid providers in a specific geographic area can inform program managers if access to services needs improvement. Program changes to improve access to client services will improve health outcomes.

In addition to tracking processes directly related to the delivery of health services, the agency should develop measures for and routinely report on the effectiveness of program functions such as third party liability, program integrity, and contract management as these functions also influence the ability of the Medicaid program to deliver quality health care that is accessible and cost-effective.

Conclusions and Recommendations

As the administrator of the state's Medicaid program, the Agency for Health Care Administration is responsible for effectively managing the program, safeguarding Medicaid funds, and providing timely and useful information that policymakers and stakeholders can use to make informed policy and budget decisions. Based on our review of the agency's reporting on cost reduction initiatives and on performance-based budgeting (PB^2) outcome measures, we concluded that the agency needs to provide more timely information to the Legislature to assist it in making policy and budget decisions.

To assist the Legislature in budget decisions, the agency should report periodically on the status of all cost reduction initiatives. While the Legislature expected the initiatives identified in 1997-98 through 2000-01 to save $608.6 million by the end of 2000-01, these savings have not been fully realized. According to agency information, the agency achieved 66% of the cost savings anticipated by the Legislature for Fiscal Years 1997-98 through 1999-00 (or $196.4 million out of $296.7 million). And, it is not clear from agency information how much of the $311.9 million expected in cost savings for 2001-02 has actually been realized. Formal periodic reporting by the agency is necessary to assist the Legislature to make informed budget and policy decisions.

To assist program managers and other policy-makers, the agency should develop measures and formally monitor key processes and functions that affect health outcomes. While the Medicaid PB^2 health outcomes indicate the general health status of Medicaid clients, their usefulness is limited because outcome data are not timely and factors outside the influence of Medicaid can affect health outcomes.

We therefore recommend the Legislature take the actions described below.

- Require the Agency for Health Care Administration to report quarterly on the status of cost reduction initiatives. These reports should, to the extent possible, include the fiscal impact of the initiatives. By reporting quarterly, the agency will be in a position to assist the Social Services Estimating Conference to adjust and project Medicaid funding needs. The agency should also include in its annual legislative budget request information detailing the status of cost reduction initiatives and actual savings realized.
- Direct the agency to formally monitor key processes and functions that affect the health status of Medicaid clients. In addition to the PB^2 measures, the agency should identify and routinely monitor key internal measures that affect the cost of, quality of, and access to Medicaid services. Program managers can use these measures to explain performance on health outcomes and to improve the effectiveness and efficiency of program operations. The agency should track measures quarterly so that agency staff can respond to inquiries by the Legislature.

Agency Response

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration to review and respond.

The Secretary's written response is reprinted herein beginning on page 20.

Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513(3), *Florida Statutes*, provides that OPPAGA program evaluation and justification reviews shall address nine issue areas. Our conclusions on these issues as they relate to the Agency for Health Care Administration's Medicaid Services Program are summarized below.

Table A-1
Summary of the Program Evaluation and Justification Review of the Medicaid Services Program

Issue	OPPAGA Conclusions
The identifiable cost of the program	For Fiscal Year 2001-02, the Legislature appropriated $10.08 billion for the Medicaid Program. This includes $2.97 billion in general revenue.
The specific purpose of the program, as well as the specific public benefit derived therefrom	Florida's Medicaid Program pays for medical assistance for the poor and disabled. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. On average, the Medicaid program provides services to 1.9 million low-income people per month, including families with children in the Temporary Assistance for Needy Families (TANF) program; children in foster care; children in low-income families; low-income pregnant women; and low-income elderly, blind, or disabled persons.
Progress towards achieving the outputs and outcomes associated with the program	In Fiscal Year 1999-00, the most recent year for which outcome data is available, the Medicaid program met the legislative standards for 3 of 10 PB² outcome measures: the ratio of children hospitalized for mental health care to those receiving mental health services; the percentage of hospital stays for elder clients exceeding length of stay criteria; and the percent of hospitalizations for disabled adults for conditions preventable with good ambulatory care. While there was some fluctuation on individual measures, the overall performance remained relatively stable with Medicaid achieving one more standard in 1999-00 than it did in 1998-99.
An explanation of circumstances contributing to the state agency's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, *F.S.*, associated with the program	According to agency staff, meeting the performance standard for hospital stays for children with mental illness could be attributed to a relatively new practice involving review of care and prior authorization of psychiatric hospital inpatient stays for those clients who are heavy users of behavioral health services. The continued poor performance in providing Child-Health Check-Ups could reflect a provider reporting/billing problem, rather than be a true indication of poor performance in this area.
Alternative courses of action that would result in administering the program more efficiently and effectively	The following summarizes the alternative courses of actions recommended to the Agency for Health Care Administration by OPPAGA in each of the four reports that comprise OPPAGA's program evaluation and justification review of the Medicaid program. Implementation of these recommendations should improve the efficiency and effectiveness of the state's Medicaid program. Growth in Medicaid Prescription Drug Costs. To help control rapid increases in the cost of Medicaid prescriptions and to promote effective drug therapies for least cost, the agency should develop a mandatory preferred drug list and negotiate supplemental rebates, develop and implement strategies to encourage compliance with using the preferred drug list, and competitively bid contracts for Medicaid pharmacy networks. These steps could save up to $306.1 million annually in Medicaid prescription drug costs, of which $113.1 million would be state general revenue savings. The 2001 Legislature enacted legislation allowing the agency to develop a preferred drug list and to negotiate supplemental rebates. Medicaid Disease Management Initiative. The disease management initiative was implemented to improve health outcomes and decrease health care costs for chronically ill Medicaid clients. However, current initiative design creates inefficiencies and impedes program success. Further, due to methodology issues, the agency has been unable to show whether the initiative has achieved cost savings. The agency should redesign the initiative from a disease-specific to a patient-focused approach and contract with fewer companies. In addition, the agency should establish an effective methodology to determine cost savings and report on progress in meeting performance expectations, including health outcomes and cost savings.

Issue	OPPAGA Conclusions
	Medicaid Fraud and Abuse. The agency needs to improve its efforts to detect and deter Medicaid fraud and abuse and its methods of assessing the effectiveness of program integrity functions. To assist in detecting and deterring fraud and abuse the agency should develop and use more sophisticated methodologies that take into account changing abuse patterns and schemes; conduct comprehensive follow-up reviews of providers with a history of overpayment; and institute a policy to fine providers that are particularly egregious. To aid stakeholders in understanding the extent of Medicaid fraud and abuse and to be more accountable, the agency should contract with a firm to calculate the amount of fraud and abuse in the Medicaid program; develop measures and standards that more accurately assess program integrity's performance; and annually report performance to stakeholders. Meeting Legislative Cost Reductions and Performance Standards. Despite enacting a number of cost control initiatives to curb Medicaid spending, expenditures exceeded appropriations in 1999-00 and 2000-01. A lack of routine reporting by the agency on the status of these initiatives has been a weakness of the program that has hindered the budgeting process. Further, data delays and factors outside of Medicaid's control limit the usefulness of the agency's PB² outcome measures for decision-making. To assist the Legislature and other policymakers in making informed budget and policy decisions, the agency should report quarterly on the status of all cost reduction initiatives, including the extent to which cost savings have been achieved; and formally monitor key processes and functions that affect the health status of Medicaid clients, and track them on a quarterly basis.
The consequences of discontinuing the program	Florida's Medicaid program provides low-income and disabled people access to and payment for medical services, including preventive and primary care services for adults and children, inpatient and outpatient hospital services, and prescription drugs. Discontinuing the program would increase the number of Floridians without access to health care and result in poor health outcomes for this population. In addition, discontinuing the program would increase use of expensive health care services such as the emergency room and in-patient hospitalization. These costs would ultimately be passed on to other private payers.
Determination as to public policy; which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or part	The Medicaid program provides beneficial services to clients and is a cost benefit to taxpayers. The four reports that review the Medicaid program identify alternatives for improving program effectiveness and efficiency.
Whether the information reported pursuant to s. 216.03(5), *F.S.*, has relevance and utility for the evaluation of the program	Two factors limit the Legislature's use of health outcome measures for annual Medicaid budget discussions. First, the outcome data are not available until one to two years after Medicaid services have been provided. Second, because multiple factors outside Medicaid's influence can affect performance, it is difficult to attribute success to the program without using statistical techniques to adjust for the effect of these influences. Even with these limitations, tracking health outcomes can alert the Legislature to declines or gains in the health status of individuals eligible for Medicaid. Evaluations of the causes of declines or gains can provide the Legislature with information to guide policy decisions.
Whether state agency management has established control systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports	The agency's inspector general reviewed data control systems and validated agency performance data. The most recent audit of the Medicaid program's PB² measures and supporting data, published in February 2000, reported that due to data delays, the program sometimes reports prior year outcome information in documents such as the legislative budget request. The audit recommended that the Medicaid program update such documents once actual outcome data becomes available. The audit further recommended that the program develop processes to review and update outcome data prior to finalizing the legislative budget request.

Source: OPPAGA analysis.

Appendix B

Anticipated Savings from Medicaid Cost Reduction Initiatives by Category

Table B-1
Since Fiscal Year 1997-98, the Legislature Identified Initiatives to Reduce Costs Primarily in Four Categories: Pharmacy Cost Controls, Financing Strategies, Disease Management, and Fraud and Abuse Prevention and Third Party Liability Detection

Initiative Description	Fiscal Year	Budget Reduction
Pharmacy Cost Controls	***Total***	***$ 531,013,488***
Reduced Prescription Drug Dispensing Fee	1997-98	6,174,066
Prescription Drug Rebate Recalculation	1998-99	11,314,777
Pharmaceutical Rebates in Managed Care Organizations	1999-00	20,699,172
Physician Profiling and Prescription Drug Utilization Review	1999-00	40,733,198
Counterfeit-Proof Prescription Pads	2000-01	18,000,000
Monthly Brand Drug Limit and 34-day Supply Limit	2000-01	70,000,000
Drug Ingredient Cost Adjustment	2000-01	24,126,993
Drug Benefit Management of High Users	2000-01	41,000,000
Limit Pharmacy Network	2000-01	22,585,849
Additional Generic Rebates	2000-01	2,996,082
Enforce Drug Therapy Limits	2000-01	10,000,000
Establish Drug Use Standards Based on Federal Food and Drug Administration Guidelines	2000-01	17,500,000
Voluntary Preferred Drug List	2000-01	25,000,000
Drug Formulary with Rebates and other Pharmacy Controls	2001-02	206,336,853
Brand Name Drug Patent Expirations	2001-02	14,546,498
Changes in Financing	***Total***	***$ 346,229,530***
Competitive Bidding Lab, X-Ray, and Durable Medical Equipment Services	1997-98	3,922,506
Medicare Crossover Fee Reductions	1998-99	63,640,196
Enroll Pregnant Women in Managed Care Programs	1999-00	18,234,061
HMO Capitation Rate Adjustment	2000-01	11,523,392
Limit Medicaid Reimbursement for Hospital Outpatient Medicare Crossover Claims	2001-02	59,211,457
Adjust Health Maintenance Organization (HMO) Rates to Reflect the Net Cost of Drugs	2001-02	32,515,786
Changes in Medicaid Choice Counseling	2001-02	6,900,000
Eliminate Administrative Costs Component Included In HMO Capitation Rate	2001-02	3,828,782
Limit Medicaid Reimbursement for Nursing Home Medicare Crossover Claims	2001-02	4,050,326
Competitively Bid or Capitate Private Duty Nursing Services	2001-02	3,467,807
Restrict Nursing Home Rate Adjustments Associated with Changes in Ownership	2001-02	15,529,444
Require Prior Authorization for and Concurrent Review of All Non-Emergency, Non-Psychiatric Hospital Inpatient Admissions	2001-02	15,746,547
Preauthorization of Mental Health Services	2001-02	9,977,681
Reduce Hospital Provider Rates by 6% effective July 1, 2001, and Restore April 1, 2002	2001-02	88,143,227
Competitively Bid Independent Lab Services	2001-02	849,084

Initiative Description	Fiscal Year	Budget Reduction
Competitively Bid Durable Medical Equipment	2001-02	1,306,488
Competitively Bid Transportation	2001-02	640,684
Increase Managed Care Enrollment to 50% HMO and 50% Medipass	2001-02	6,742,062
Disease Management	***Total***	***$ 112,722,402***
Disease Management Program—1st year	1997-98	4,167,060
Disease Management Program—2nd year	1998-99	39,414,987
Improve Disease Management Efficiency	2000-01	23,046,785
Improve Case Management of MediPass Clients to include population based disease management	2000-01	46,093,570
Fraud and Abuse Prevention And Third Party Liability	***Total***	***$ 71,059,418***
Enhanced Third Party Liability Detection	1997-98	10,000,000
Mental Health Provider Credentialing	1997-98	5,000,000
Accelerated Third Party Liability Detection and Mental Health Utilization Management	1998-99	12,446,255
Pharmacy Fraud and Abuse Initiatives—1st Year	1998-99	9,114,543
Pharmacy Fraud and Abuse Initiatives—2nd Year	1999-00	34,498,620
Other	***Total***	***$ 27,326,088***
Nursing Home Diversion Waiver	1997-98	12,394,796
Provider Service Networks	1997-98	3,333,333
Eliminating Adult Cardiac Transplants	1998-99	1,604,535
Shift General Nursing Home to Community-Based Waiver	2001-02	9,993,424
TOTAL ALL INITIATIVES	**ALL YEARS**	**$1,088,350,926**

Source: General Appropriations Acts of 1997-98, 1998-99, 1999-00, 2000-01, and 2001-02.

Appendix C

Medicaid Cost Reduction Initiatives Fiscal Years 1997-98 Through 2001-02

Table C-1
Only Two-Thirds of the Savings Expected from Implementing Cost Reduction Initiatives Identified for Fiscal Years 1997-98 Through 1999-00 Have Been Realized

Initiative Description	Fiscal Year	Budget Reduction	Estimated Savings	Comments
Enhanced Third Party Liability Detection	1997-98	10,000,000	6,039,068	**Implementation delayed** in first year due to contract negotiations and operation problems with data systems. Estimated savings for one year.
Mental Health Provider Credentialing	1997-98	5,000,000	3,727,880	**Unable to determine savings** due to dis-enrolling non-credential providers. Estimated savings from inappropriate payments to mental health providers. Estimated savings over three years.
Competitive Bidding Lab, X-ray, and Durable Medical Equipment Services	1997-98	3,922,506	Unknown	**Competitive bidding not implemented.** Agency estimated savings over one year of $6,990,000 realized through fraud investigations and prior authorization.
Disease Management Program —First year	1997-98	4,167,060	Unknown	**Implementation delayed** because of contract negotiations with private disease management organizations. No documentation of savings.
Reduced Prescription Drug Dispensing Fee	1997-98	6,174,066	0	**Not implemented due to legal challenges.**
Nursing Home Diversion Waiver	1997-98	12,394,796	$3,545,628	**Implementation delayed** due to protracted contract negotiations with providers. Estimated savings over three years.
Provider Service Networks	1997-98	3,333,333	Unknown	**Implementation delayed** due to Health Care Financing Administration (HCFA) waiver approval, contract negotiations, and legal challenges. PSN contracts became operational in March 2000
Total for	**1997-98**	**$44,991,761**	**$13,312,576**	
Accelerated Third Party Liability Detection and Mental Health Utilization Management	1998-99	12,446,255	11,691,083	**Fiscal Year 1998-99 third party liability recoveries increased** over Fiscal Year 1997-98; mental health **utilization management reduced** average length of inpatient hospital days. Estimated savings over one year.
Pharmacy Fraud and Abuse Initiatives—First Year	1998-99	9,114,543	3,000,000	**Amount actually recovered not reported.** Identified potential recoveries only.
Disease Management Program —Second Year	1998-99	39,414,987	Unknown	**Implementation delayed** because some disease states not covered by a contract. No documentation of savings.
Prescription Drug Rebate Recalculation	1998-99	11,314,777	61,850,324	**Estimates of drug rebates were considerably under actual rebates collected.** Estimated savings over one year.
Medicare Crossover Fee Reductions	1998-99	63,640,196	64,211,696	**Full implementation delayed** due to complexity of changes to claims processing data system. Estimated savings over two years.
Eliminating Adult Cardiac Transplants	1998-99	1,604,535	1,604,535	**Legislature eliminated funding.**
Total	**1998-99**	**$137,535,293**	**$142,357,638**	

Initiative Description	Fiscal Year	Budget Reduction	Estimated Savings	Comments
Pharmacy Fraud and Abuse Initiatives – Second Year	1999-00	34,498,620	40,405,746	**Cost avoidance due to terminating pharmacies** identified in Medicaid Fraud Control Unit investigations and additional AHCA contracted pharmacy audits that began in January 2000. Estimated savings for one year.
Physician Profiling and Prescription Drug Utilization Review	1999-00	40,733,198	Unknown	**Initial intervention letters sent to identified physicians** in March 2000; first outcome measurement of interventions available January 2001; outcome measurement does not include cost savings estimates
Pharmaceutical Rebates in Managed Care Organizations	1999-00	20,699,172	323,119	**Most pharmaceutical drug companies refused paying additional rebates**; HCFA determined drugs dispensed by managed care organizations are not subject to Medicaid rebates
Enroll Pregnant Women in Managed Care Programs	1999-00	18,234,061	0	**Implementation awaiting approval** from the Centers for Medicare/Medicaid Services, formerly HCFA.
Total for Fiscal Year 1999-00		**$114,165,051**	**$ 40,728,865**	
Total for Fiscal Years 1997-98 to 1999-00		**$296,692,105**	**$196,399,079**	

Source: General Appropriations Acts of 1997-98, 1998-99, and 1999-00; and *Summary on the Medicaid Cost Reduction Issues Identified in the General Appropriations Act for Fiscal Years 1997-98, 1998-99, and 1999-00,* Agency for Health Care Administration, September 2000.

Table C-2
Although the Agency Has Reported That Growth in the Average Cost of Prescriptions Has Slowed, It Has Not Yet Determined the Extent to Which the Savings Anticipated for Fiscal Year 2000-01 Have Been Realized

Description	Budget Reduction	Estimated Savings	Comments
Counterfeit-Proof Prescription Pads	18,000,000	To be determined	**Implementation began** in February 2001
Improve Disease Management Efficiency	23,046,785	To be determined	**New disease management contracts require annual 6.5% savings guarantee.**
Improve Case Management of MediPass Clients to include population based disease management	46,093,570	To be determined	**Not yet implemented.** Disease management contracts will require annual 6.5% savings guarantee.
Monthly Brand Drug Limit and 34-day Supply Limit	70,000,000	To be determined	**Gradual implementing of limit on brand name drugs** with state wide implementation occurring September 2000; 34-day supply limit implemented July 2000
Drug Ingredient Cost Adjustment	24,126,993	To be determined	**Implemented** July 2000
Drug Benefit Management of High Users	41,000,000	To be determined	**Implemented** September 2000
Limit Pharmacy Network	22,585,849	To be determined	**Surety bond required** as of February 2001
Additional Generic Rebates	2,996,082	To be determined	**Implemented** July 2000
Enforce Drug Therapy Limits	10,000,000	To be determined	**Prior authorization established** for certain drugs in August and October 2000
Establish Drug Use Standards Based on Federal Food and Drug Administration Guidelines	17,500,000	To be determined	**Prior authorization established** for certain drugs in August and October 2000
Voluntary Preferred Drug List	25,000,000	To be determined	**Implemented** September 2000
HMO Capitation Rate Adjustment	11,523,392	To be determined	**Implemented** July 2000
Total	**$311,872,671**		

Source: General Appropriations Act of 2000-01; and *Medicaid Prescribed Drug Spending Control Program Annual Report,* Agency for Health Care Administration, January 2001.

Table C-3
The Legislature Anticipates That Implementing These Initiatives Will Save the State $480 Million During Fiscal Year 2001-02

Initiative Description	Budget Reduction
Drug Formulary with Rebates and other Pharmacy Controls	$ 206,336,853
Brand Name Drug Patent Expirations	14,546,498
Limit Medicaid Reimbursement for Hospital Outpatient Medicare Crossover Claims	59,211,457
Adjust Health Maintenance Organization (HMO) Rates to Reflect the Net Cost of Drugs	32,515,786
Changes in Medicaid Choice Counseling	6,900,000
Eliminate Administrative Costs Component Included In HMO Capitation Rate	3,828,782
Limit Medicaid Reimbursement for Nursing Home Medicare Crossover Claims	4,050,326
Competitively Bid or Capitate Private Duty Nursing Services	3,467,807
Restrict Nursing Home Rate Adjustments Associated with Changes in Ownership	15,529,444
Require Prior Authorization for and Concurrent Review of All Non-Emergency, Non-Psychiatric Hospital Inpatient Admissions	15,746,547
Preauthorization of Mental Health Services	9,977,681
Reduce Hospital Provider Rates by 6% effective July 1, 2001, and Restore April 1, 2002	88,143,227
Competitively Bid Independent Lab Services	849,084
Competitively Bid Durable Medical Equipment	1,306,488
Competitively Bid Non-Emergency Transportation	640,684
Shift General Nursing Home to Community-Based Waiver	9,993,424
Increase Managed Care Enrollment to 50% HMO and 50% MediPass	6,742,062
Total	**$479,786,150**

Source: General Appropriations Act of 2001-02.

Appendix D

Medicaid Health Services Performance-Based Budgeting(PB²) Outcome Measures, Fiscal Years 1995-96 through 2001-02

The Agency for Health Care Administration adopted PB² measures for the Medicaid Health Services Program in Fiscal Year 1998-99. Table D-1 presents performance for Fiscal Years 1995-96 through 1999-00 and the standards set by the 1999-00 Legislature.

The 2000 Legislature identified two major programs for the agency, the Health Care Regulation Program and the Health Care Services Program. The Health Care Services Program includes KidCare as well as Medicaid. The 2000 Legislature added measures for the KidCare program. The 2001 Legislature maintained these categories, revised some of the measures added the previous year, and added two new measures. Table D-2 lists the health outcome measures and standards set by the 2001 Legislature.

Table D-1
The Medicaid Program Only Met 3 of the 10 Health Outcomes PB² Measures in Fiscal Year 1999-00, the Most Recent Year for Which Outcome Data Is Available

Outcomes	*Fiscal Year*					*1999-00 PB² Standard*	*Standard Met in 1999-00*
	1995-96	*1996-97*	*1997-98*	*1998-99*	*1999-00*		
Health Services to Pregnant Women, Newborns, and Women Who Want Family Planning Services							
Percentage of women receiving adequate prenatal care	83.5%	83.6%	83.7%	83.1%	83.58%	86.0%	No
Neonatal mortality rate per 1,000	5.18	5.05	5.00	5.32	5.05	4.86	No
Percent of vaginal deliveries with no complications	N/A	70.7%	69.5%	69.2%	67.6%	73.1%	No
Average length of time between pregnancies for those receiving family planning services (months)	32.14	32.84	33.05	33.08	33.5	37.4	No
Health Services to Children							
Percentage of eligible children who received all required components of EPSTD screen	64%	56%	71%	45%	45%	64%	No
Percentage of hospitalizations for conditions preventable with good ambulatory care	9.04%	8.85%	8.96%	8.24%	8.93%	7.53%	No
Ratio of children hospitalized for mental health care to those receiving mental health services	7.2	6.8	5.1	4.7	5.3	6.8	Yes
Health Services to Working Age Adults (Non-Disabled)							
Percentage of hospitalizations for conditions preventable with good ambulatory care	13.9%	13.2%	14.4%	13.8%	13.8%	13.3%	No
Health Services to Disabled Working Age Adults							
Percentage of hospitalizations for conditions preventable with good ambulatory care	14.5%	14.3%	14.3%	14.9%	13.9%	13.9%	Yes
Health Services to Elders							
Percentage of hospital stays for elder recipients exceeding length of stay criteria	N/A	11.0%	9.8%	11.1%	9.9%	26%	Yes

Source: Chapter 99-226, *Laws of Florida*.

Table D-2
The 2001-02 PB² Health Outcome Measures and Standards Address the Health Care Services Program, Which Includes KidCare and Medicaid

Outcomes	*Fiscal Year 1999-00*	*Standard*
Children's Special Health Care (KidCare)		
Percent of eligible uninsured children who receive health benefits coverage	77.0%	100.0%
Percent of children enrolled with up-to-date immunizations	80.0%	85.0%
Percent of compliance with the standards established in the Guidelines for Health Supervision of Children and Youth as developed by the American Academy of Pediatrics for children eligible under the program	82.7%	89.0%
Percent of families satisfied with the care provided under the program	85.6%	90.0%
Percent of Hospitalizations for conditions preventable by good ambulatory care	8.9%	7.3%
Medicaid Services to Individuals		
Percent of eligible children who received all required components of EPSTD screen	45%	64%
Percent of hospitalizations that are preventable with good ambulatory care	No data	12%
Percent of women receiving adequate prenatal care	83.58%	85.0%
Neonatal mortality rate per 1,000	5.05	4.7
Average number of months between pregnancies for those receiving family planning services	33.5	37.4
Number of children ages 1-20 enrolled in Medicaid	No data	1,425,747
Medicaid Long Term Care		
Percent of hospitalizations for conditions preventable with good ambulatory care	15.0%[1]	12.6%
Medicaid Prepaid Health Plan		
Percent of hospitalizations for conditions preventable with good ambulatory care	14.6%[1]	14.7%
Percent of women and child hospitalizations for conditions preventable with good ambulatory care	14.9%	14.5%

[1] Data from 1999-00 for analogous 1999-00 PB² measures.

Source: Conference Approved Agency Performance Measures and Standards for Fiscal Year 2001-02 and *The Annual Report on Medicaid Outcome Measures,* Agency for Health Care Administration. August 2001.

Appendix E

Response from the Agency for Health Care Administration

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration to review and respond.

The Secretary's written response is reprinted herein beginning on page 21.

JEB BUSH, GOVERNOR RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

November 20, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank you for the opportunity to respond to the preliminary and tentative recommendations included in your justification review of Medicaid cost reduction initiatives and performance measures.

The Florida Legislature has granted the Agency the authority to pioneer innovative health care initiatives with the goal of controlling costs and improving health of Medicaid recipients. In our efforts to measure the planned results of these initiatives, we have provided a variety of reports to the Legislature, the Executive Office of the Governor, and the Social Services Estimating Conference. As you are aware, the Social Services Estimating Conference is the formal consensus mechanism required in section 216.136, Florida Statutes. The Agency is a principal in the Conference and as such provides information used by the principals for purposes of the state planning and budgeting system.

In addition to the information reviewed by the Conference on the cost control measures, the Agency prepares quarterly and annual reports for the largest cost control initiative, the Prescribed Drug Cost Control program. These reports are submitted to the Legislature routinely. Additionally, costs versus appropriations are tracked weekly for this initiative. The Disease Management Initiative is more difficult to measure due to its long-term nature and the transient nature of the Medicaid population. However, the Agency has provided reports to the Legislature on this initiative. Many of the Agency's reports on the results of the initiatives are located on the Agency's website. Additionally, we have attached a list of some of the more recent reports with this response.

The Agency has also reported on the 30 Medicaid performance measures required by the Legislature in the fiscal year 2000-2001 General Appropriations Act, plus an additional 24 performance measures that are tracked and reported internally. This data and analysis of the

Mr. John W. Turcotte
November 20, 2001
Page 2

Medicaid performance measures tracked by the Agency have been reported in each of the last three years, with the most recent report published in September 2001. This Annual Report on Medicaid Outcome Measures is also available on the Agency' s web site.

The Agency will continue its efforts in monitoring and reporting on the results of the Medicaid Program, and will continue to enhance the value and usefulness of Medicaid data that is gathered and reported. We will be happy to provide data as necessary to ensure that the Legislature and program managers can make informed decisions.

If you have any questions regarding this response please contact Rufus Noble at 921-4807 or Kathy Donald at 922-8448.

Sincerely,

/s/
Rhonda M. Medows, M.D.
Secretary

RMM/kd
Enclosure

Agency Reports Addressing the Results of Cost Reduction Initiatives

Medicaid Prescribed Drug Program, A Status Report, presented to the House Committee on Health Promotion October 23, 2001

Quarterly Report to the Joint Legislative Auditing Committee: Medicaid Prescribed Drug Spending Control Program Initiatives, Quarter Ended September 30, 2001 (Format and content approved by Committee Chairperson.)

2001 Annual Report, Medicaid Outcome Measures, September 2001

Annual report, Medicaid Prescribed Drug Spending Control Program, January 15, 2001

Florida Medicaid Cost Reduction Initiatives (FY 1994/95, 1995/96, 1996/97). (Detailed analysis on the success of previous reduction issues prepared for the Social Services Estimating Conference, December 1997.)

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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- Performance-based program budgeting (PB^2) reports and information offer a variety of tools. Program evaluation and justification reviews assess state programs operating under performance-based program budgeting. Also offered are performance measures information and our assessments of measures.
- Florida Government Accountability Report (FGAR) is an Internet encyclopedia of Florida state government. FGAR offers concise information about state programs, policy issues, and performance. Check out the ratings of the accountability systems of 13 state programs.
- Best Financial Management Practices Reviews of Florida school districts. In accordance with the *Sharpening the Pencil Act*, OPPAGA and the Auditor General jointly conduct reviews to determine if a school district is using best financial management practices to help school districts meet the challenge of educating their students in a cost-efficient manner.

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Florida Monitor: http://www.oppaga.state.fl.us/

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