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Progress Report

August 2004

Report No. 04-53

Medicaid Should Improve Cost Reduction Reporting and Monitoring of Health Processes and Outcomes

at a glance

While Medicaid expenditures have continued to increase, the annual rate of growth has slowed since Fiscal Year 2001-02. However, costs are expected to grow 9.67% in Fiscal Year 2003-04. In addition, expenditures have exceeded appropriations during four of the last five years. To control rising expenditures, the Legislature has enacted a number of cost reduction initiatives since Fiscal Year 1997-98, with the expectation that these initiatives would save $1.57 billion. The Agency for Heath Care Administration now reports realizing 81% of anticipated cost savings, an improvement over its past performance.

The agency has improved the frequency and quality of information on cost reductions that it provides to the Legislature. However, it could make further improvements that provide more detailed information on attained savings.

The agency's reporting on legislative outcomes for Medicaid is not timely enough to be of use in making decisions. In addition, the agency continues to lack meaningful information on health outcomes, in part because it still does not formally monitor processes that affect outcomes. The agency has improved its performance for some legislative outcome measures but only met the legislative standards for only 3 of 13 measures for Fiscal Year 2001-02.

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by Florida's Agency for Heath Care Administration (AHCA) in response to a 2001 OPPAGA review.[1,2] This report assesses the extent to which the agency has taken action to address the findings and recommendations in our prior review and reports on the effectiveness of these actions.

Background

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. Its purpose is to improve the health of persons including children who might otherwise go without medical care. Florida's Medicaid program provides health care services to around 2.1 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.

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

[1] Section 11.51(6), *F.S.*

[2] *Expected Medicaid Savings Unrealized; Performance, Cost Information Not Timely for Legislative Purposes,* OPPAGA Report No. 01-61, November, 2001.

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 Affiliated Computer Services, Inc., Medicaid's fiscal agent.

For Fiscal Year 2004-05, the Legislature appropriated $14.8 billion, including $4.3 billion in general revenue, to operate the state's Medicaid program. Most of these funds (98.6%) will pay for health care services for Medicaid recipients. The other 1.4% (or $212 million) will pay for administrative functions such as program planning, data processing, and contract management. For Fiscal Year 2004-05, the Legislature authorized 724.5 full-time positions to fulfill Medicaid administrative functions.

Prior Findings

At the time of our 2001 review, Florida's Medicaid expenditures had exceeded appropriations for the two prior fiscal years. Medicaid experienced a budget shortfall of $87.2 million and $640.1 million in Fiscal Years 1999-00 and 2000-01, respectively. The state was anticipating a Medicaid shortfall of $1.5 billion for Fiscal Year 2001-02. [3] In an effort to control costs and increase effectiveness, the Legislature had enacted a number of policy and funding reforms. However, at that time the agency had not routinely provided information to the Legislature on the extent to which it had achieved expected levels of savings. This lack of reporting hindered the budgeting process.

In addition, even though the agency reported on performance-based program budgeting (PB^2) outcomes, these measures alone were not sufficient to assess the effectiveness of Medicaid operations. To assist program managers and other policymakers, the agency needed to develop and formally monitor key processes and functions that affect health outcomes.

We recommended that the Legislature

- require the agency to report quarterly on the status of cost reduction initiatives and
- direct the agency to formally monitor key processes and functions that affect the health status of Medicaid clients.

[3] The Legislature offset this projected shortfall by increasing Medicaid Health Services appropriations by nearly $1.6 billion from the prior year's level.

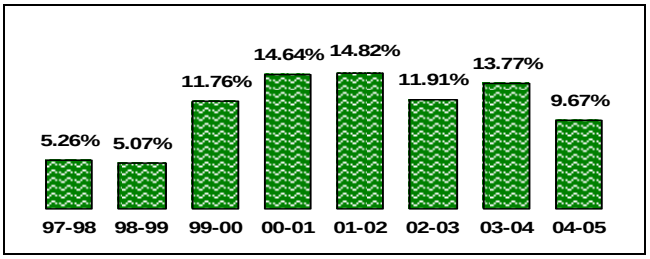
Current Status

In response to increasing expenditures, the Legislature has continued to enact reforms and has built the Medicaid budget based on expected savings. Since our last report, the program has achieved a larger proportion of the anticipated cost savings linked to these budget reductions. Even so, the program has continued to experience major annual shortfalls. While the agency has improved its reporting on the status of cost savings to the Legislature, it should make further improvements. In addition, performance on legislative measures for health outcomes has essentially remained at previous levels, and the agency still reports limited information on health outcomes, in part because it still does not formally monitor or link processes and functions that affect outcomes.

While the annual rate of increase has slowed, expenditures continue to contribute to budget shortfalls

From Fiscal Years 1996-97 through 2003-04, Medicaid expenditures more than doubled, increasing from $6.28 billion to an estimated $13.01 billion. While the annual rate of increase in expenditures almost tripled from Fiscal Year 1998-99 to 2001-02, peaking at 14.82%, the rate of growth over the past two fiscal years has been lower. For Fiscal Year 2004-05, the Medicaid Estimating Conference predicts that expenditures will grow at the lowest rate since Fiscal Year 1999-00. (See Exhibit 1.)

Exhibit 1
Annual Growth Rate of Medicaid Expenditures Has Slowed Since Fiscal Year 2001-02 [1]



[1] Expenditures for Fiscal Years 2003-04 and 2004-05 are estimates.

Source: Medicaid Estimating Conference, Office of Economic and Demographic Research, the Florida Legislature.

As shown in Exhibit 2, despite slowed growth, total expenditures have exceeded total appropriations in four of the past five fiscal years.

Exhibit 2
Total Medicaid Expenditures Have Exceeded Total Appropriations for Four of the Last Five Years

	Total Appropriations	Total 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	7,763,865,817	(87,877,825)
2000-01	8,340,329,081	8,900,820,394	(560,491,313)
2001-02	10,117,451,131	10,219,635,107	(102,183,976)
2002-03	11,731,350,948	11,436,644,237	294,706,711
2003-04	12,576,246,953	13,011,191,431[1]	(434,944,478)
2004-05	13,983,285,505	14,268,753,813[1]	(285,468,308)

[1] Estimated expenditures.
Source: Expenditures from the Medicaid Estimating Conference; appropriations from LAS/PBS 10-year histories.

In addition, the February 2004 Medicaid Estimating Conference reported general revenue shortfalls of $57.2 million and $205 million for Fiscal Years 2002-03 and 2003-04, respectively. This estimating conference also projected that, in order to continue operating the program at the previous year's level, the state would have to appropriate $655 million more in state funding for Fiscal Year 2004-05.

The Legislature has anticipated Medicaid savings of $1.567 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. The Legislature has continued to build the Medicaid budget with the expectation of achieving cost savings. The reductions were intended to save $1.567 billion by the end of Fiscal Year 2003-04. (See Exhibit 3.)

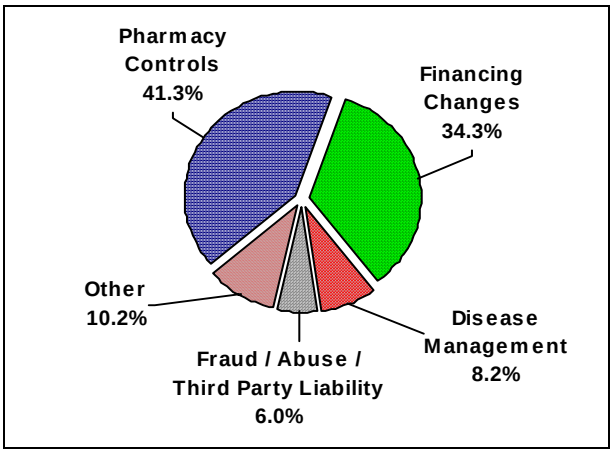
Most of these initiatives fall into four categories: establishing stronger pharmacy cost controls, changing program financing, establishing disease management initiatives, and strengthening fraud and abuse controls and third party liability. (Appendix A provides a brief description of these initiatives.) As shown in Exhibit 4, expected cost savings associated with prescription drug controls and program financing changes account for more than three-fourths of the expected cost reductions.

Exhibit 3
The Legislature Has Reduced Florida's Medicaid Appropriations by $1.567 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	332,614,778
2001-02	546,226,657
2002-03	121,579,907
2003-04	269,639,622
Total	$1,566,753,069

Source: General Appropriations Acts of 1997-98, 1998-99, 1999-00, 2000-01, 2001-02, 2002-03, and 2003-04.

Exhibit 4
Pharmacy Controls and Financing Changes Account for the Majority of Expected Savings



Source: OPPAGA analysis.

The agency has realized 81% of anticipated savings since Fiscal Year 1997-98

To avoid costly shortfalls, it is important that the agency effectively implement reforms and attain the cost savings anticipated by the Legislature. Since Fiscal Year 1997-98, the agency has realized savings of $1.277 billion, or 81% of the anticipated savings. This represents a substantial improvement, as our 2001 report found that at the time, the agency had attained only two-thirds of the anticipated savings. The agency reports achieving 91% ($910 million) of the expected $1 billion of savings from Fiscal Years 2000-01 through 2002-03.

As in our prior review, the agency cited implementation delays as the primary reason for not achieving full cost savings. These delays arose in obtaining approval from the federal Centers for Medicare and Medicaid Services, dealing with legal challenges, and issuing contracts to private vendors. The agency does not report cost-savings estimates for some initiatives, because it is too early to determine savings. In other situations, as with the agency's disease management initiative, estimated savings may be questionable. [4]

While some initiatives did not achieve the anticipated savings, a few saved more money than anticipated. For example, a Fiscal Year 1998-99 initiative related to third-party liability collections achieved 94% of $12.4 million anticipated savings in the first year and then achieved an additional $124.5 million in savings in the following three years, for a total savings of $136.2 million, which was more than 10 times that anticipated. Agency staff reported that the contractor's extensive electronic data capabilities aided in exceeding the anticipated cost savings.

The agency has taken steps to keep the Legislature better informed on cost impacts but should make further improvements. Medicaid impact conferences, which began just prior to the release of our previous report, specifically focus on assessing the potential fiscal impact of proposed Medicaid reduction policies. During these conferences, the agency provides the conference with information on implementation issues, including time frames and possible barriers, as well as cost-savings status and achievement. This allows the Legislature to better estimate cost savings and adjust budget and policy issues accordingly. The agency also now provides cost reduction updates to the Legislature more frequently than once a year.

However, the agency has not implemented our recommendation to issue formal quarterly reports on reduction initiatives other than prescribed drug spending as recommended by in our 2001 report. In addition, agency reports do not always provide a meaningful level of detail on cost savings. For example, in some instances the agency has reported that it has achieved or exceeded cost-savings expectations because actual expenditures were less than projected. However, the agency has not clarified whether this occurred due to cost savings or other factors such as lower than projected medical inflation or demand for services. The agency should enhance its reporting with more detailed information, such as the methods used to determine savings and in-depth reasons for achieving or not achieving anticipated cost savings. Finally, the agency also should produce an annual budget reduction report, which it has not done since September 2002.

Although the agency annually reports on Medicaid performance, information is not reported in a timely manner

During Fiscal Year 2001-02, the most recent year for which outcome data is available, the Legislature established 13 legislatively approved outcome measures for four Medicaid categories: Children's Special Health Care, Medicaid services to individuals, Medicaid long term care, and Medicaid prepaid health plans. In that year, Medicaid met the legislative standards for only 3 of the 13 outcome measures. [5] However, the agency's annual outcomes report lags by approximately 15 months and does not always provide meaningful information. As such, policymakers do not have current or meaningful information with which to assess agency performance and Medicaid health outcomes.

The agency does not report annual performance in a timely manner. There is a six-month to one year lag time for a majority of the performance data. Therefore, the annual report, typically released in the fall, provides performance information at a minimum of 15 months following the end of the fiscal year. One reason that the agency gives to explain time lags is that state Medicaid policy allows providers a full year from the date of service to submit claims. Thus, the agency waits an entire fiscal year before calculating performance for measures that rely on claims data. Other performance measures are not available until a full year following the fiscal year because contracted researchers do not submit final reports to the agency until this time.

In order for performance reporting to be useful to policymakers, the agency must provide it in a timelier manner. To address issues with data lag

[4] *Progress Report: Medicaid Disease Management Initiative Has Not Yet Met Cost-Savings and Health Outcomes Expectations,* Report No. 04-34, May 2004.

[5] We previously reported that for Fiscal Year 1999-00, the agency met 3 of the 10 legislative outcome measures.

times, the agency could shorten the time period for which providers must submit claims.[6] The agency also could require contracted entities to submit health outcomes research within six months of the end of fiscal year.[7] By making these changes, the agency could provide performance information within nine months after the end of a fiscal year.

Despite improvements on all measures, health outcomes for children fall short of legislative standards. As shown in Exhibit 5, Medicaid met only one of the five performance standards for children in Fiscal Year 2001-02. The program attained the expected percentage of compliance with standards established in the Guidelines for Health Supervision of Children and Youth for children eligible under the program. The program's performance on this measure has improved from Fiscal Year 1999-00 to 2000-01 and has exceeded the standard since that time.

While not meeting legislative standards, performance on the remaining four measures for Children's Special Health Care improved since Fiscal Year 1999-00. For example, the percentage of children with up-to-date immunizations improved from 74.2% in Fiscal Year 1999-00 to 80.1% in 2001-02 despite a slight decrease from Fiscal Year 1999-00 to 2000-01. In addition, the percentage of hospitalizations for conditions preventable by good ambulatory care for this group has decreased each year since Fiscal Year 1999-00. The agency reported that fewer admissions for pneumonia, an illness that is more prevalent among Medicaid children than the non-Medicaid population, accounted for most of this improvement.[8]

Health outcomes have improved for Medicaid services to individuals even though the agency met only one of the five performance standards. The program met the standard for percentage of hospitalizations for conditions preventable by good ambulatory care for all Medicaid recipients. Even though the agency did not meet standards for the remaining four measures, performance improved in three areas. For example, the percentage of eligible children receiving child health check-ups has shown steady improvement over time, increasing from 45% to 53%. The average number of months between pregnancies for women receiving family planning services has remained constant over the past three years.[9] (See Exhibit 6.)

[6] Texas and Pennsylvania require providers to submit claims in 95 days and 180 days, respectively.

[7] These contractors rely on vital statistics data, which are reported on the calendar year and have a six-month lag, to calculate some performance measures. However, according to Department of Health officials, vital statistics availability would not hinder earlier reporting.

[8] *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration, September 2003.

[9] Child Health Check-Ups, formerly known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, consist of comprehensive, preventive health screenings periodically performed on children under the age of 21.

Exhibit 5
Medicaid Met One of Five Legislative Performance Standards for Children's Special Health Care

	Fiscal Year			Legislative Standard	Standard Met?
	1999-00	2000-01	2001-02		
Percentage of hospitalizations for conditions preventable by good ambulatory care [1]	8.93%	8.41%	8.33%	7.30%	No / Above
Percentage of eligible uninsured children who receive health benefits coverage	77.00%	84.00%	78.32%	100.00%	No / Below
Percentage of children enrolled with up-to-date immunizations	74.20%	71.50%	80.10%	85.00%	No / Below
Percentage 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	82.70%	92.00%	92.00%	89.00%	Yes
Percentage of families satisfied with the care provided under the program	85.60%	85.10%	87.67%	90.00%	No / Below

[1]This measure only includes children enrolled in Medicaid, as the agency does not have access to medical claims of children enrolled in the other three KidCare programs. The remaining measures include the entire KidCare population.
Source: *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration, September 2003.

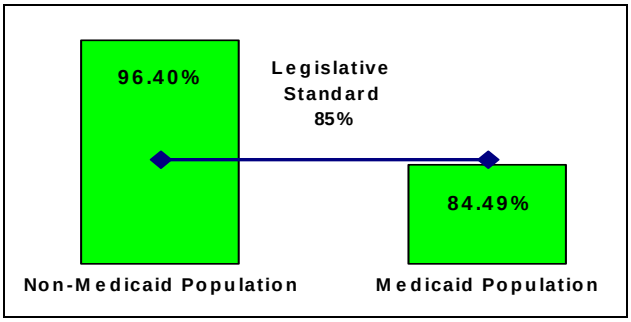
Exhibit 6
Medicaid Met One of Five Legislative Performance Standards for Services to Individuals

	Fiscal Year			Legislative Standard	Standard Met?
	1999-00	2000-01	2001-02		
Percentage of hospitalizations for conditions preventable by good ambulatory care	13.59%	13.04%	10.82%	16.3%	Yes
Percentage of women receiving adequate prenatal care	83.58%	83.80%	84.49%	85.00%	No / Below
Neonatal mortality rate (per 1,000)	5.05	4.83	5.00	4.70	No / Above
Average number of months between pregnancies for those receiving family planning services	33.5	33.5	33.6	37.4	No/Below
Percentage of eligible children who received all required components of EPSDT screen (Child Health Check-Up)	45.00%	48.00%	53.00%	64.00%	No / Below

Source: *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration, September 2003.

Health outcomes for Medicaid clients remain substantially below that of the non-Medicaid population. Exhibit 7 shows that the percentage of Medicaid women who received adequate prenatal care was substantially lower than the percentage of non-Medicaid women who received such care. A critical aspect of prenatal care is initiating care early in a pregnancy. Even though the agency collaborates with the Department of Health's Healthy Start program to identify women eligible for Medicaid, only 30% of the Medicaid women giving birth received prenatal care for more than 180 days.

Exhibit 7
Fewer Medicaid Clients Receive Adequate Prenatal Care Compared to the Non-Medicaid Population in Fiscal Year 2001-02



Source: *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration, September 2003.

Performance for Medicaid clients in long-term care did not meet the legislative standard, but has improved since Fiscal Year 1999-00. As shown in Exhibit 8, the percentage of hospitalizations for conditions preventable through good ambulatory care decreased from 15% in Fiscal Year 1999-00 to 12.89% in Fiscal Year 2001-02, but has not reached the legislative standard (12.6%). However, the agency only includes the developmentally disabled population for this indicator. When we brought this to the agency's attention, agency staff responded that, in the future, they will include all persons in long term care facilities for this measure. Doing this will provide the agency a more accurate assessment of long-term care performance.

Health outcomes are mixed for Medicaid clients in prepaid health plans. As shown in Exhibit 9, the agency met the legislative standard of 14.5% percentage of hospitalizations for conditions preventable by good ambulatory care for women and children in Medicaid prepaid health plans for Fiscal Year 2001-02. However, it did not meet the percentage of hospitalizations for conditions preventable by good ambulatory care for the total Medicaid population in prepaid health plans. While the agency asserts that the standard for this measure is set too high, it has not requested that the Legislature change the standard.

However, these two measures are not sufficient to assess the quality of care received by Medicaid HMO clients. To illustrate this, the two current measures look at virtually the same population. [10] As such, the Legislature should consider eliminating one of these measures and adding additional measures that mirror those for non-HMO clients. For example, if the Legislature added a measure for the percentage of children in Medicaid HMOs who received all required components of the Child Health Check-Up, the agency could compare HMO performance with non-HMO Medicaid clients.

[10] Agency staff told us that the only difference between these two measures is that the overall measure includes a small number of males. The measure for women and children is a subset of the overall measure.

Exhibit 8
Medicaid Did Not Meet Legislative Performance Standard for Long-Term Care

	Fiscal Year			Legislative Standard	Standard Met?
	1999-00	2000-01	2001-02		
Percentage of hospitalizations for conditions preventable by good ambulatory care (developmentally disabled)	15.00%	12.97%	12.89%	12.60%	No / Above

Source: *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration.

Exhibit 9
Medicaid Met One of Two Legislative Performance Standards for Prepaid Health Plans

	Fiscal Year			Legislative Standard	Standard Met?
	1999-00	2000-01	2001-02		
Percentage of hospitalizations for conditions preventable by good ambulatory care	19.57%	14.82%	14.88%	14.7%	No / Above
Percentage of women and children hospitalizations for conditions preventable with good ambulatory care	14.90%	15.41%	14.50%	14.50%	Yes

Source: *2003 Annual Report on Medicaid Outcome Measures*, Agency for Health Care Administration.

The agency places limited emphasis on assessing health outcomes and does not formally monitor key internal processes. The agency does not provide in-depth analyses of the legislative measures and what factors influence performance in the annual outcomes report. Instead the report provides only limited explanations for fluctuations and trends in performance over time. For example, it reports that the rate of hospital readmissions within 30 days of giving birth for women increased in 2001, reversing a three-year trend, without reporting possible factors for this change. A limited effort to understand performance changes also has prevented the agency from identifying and proposing alternative measures that might be better indicators of performance.

While agency staff track internal measures within program areas, the agency still does not formally monitor the effectiveness and efficiency of Medicaid program operations. Program operations include developing and implementing Medicaid policies, delivering cost-effective and quality health services, and ensuring adequate access to health care services. Monitoring key internal performance measures to assess program operations can serve to supplement and explain health outcome performance. For example, rates of hospitalizations for conditions treatable in an outpatient setting were higher for children enrolled in HMOs (15.7%) than they were for children enrolled in MediPass or fee-for-service (6.5%). Identifying and monitoring factors, such as availability of Medicaid providers, changes in benefit levels, and differences between delivery systems, that could influence outcomes will assist both program managers and policymakers to identify ways to improve Medicaid performance.

Agency staff reported that they are refocusing efforts to implement our previous recommendations to improve monitoring and performance information. Specifically, the agency is currently identifying internal measures that affect each legislative outcome and anticipates conducting more extensive data analysis to better understand performance and the factors that affect it. As part of its assessment, the agency should determine if outcome measures are adequate or if other measures would provide more useful performance information. In addition, the agency should assess whether standards are appropriate and propose changes to the Legislature, if needed.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes,* a draft of our report was submitted to the secretary of the Agency for Health Care Administration for his review and response.

The Agency for Health Care Administration provided a written response to our report. This response is not reprinted herein but is available in its entirety on our website.

Appendix A

Anticipated Savings from Medicaid Cost Reduction Initiatives by Category

Since Fiscal Year 1997-98, the Legislature identified initiatives to reduce costs primarily in 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.

As a result of these initiatives, the Legislature reduced the Medicaid budget by $1.57 billion from Fiscal Year 1997-98 through 2003-04 (see Table A-1).

Table A-1
The Legislature Reduced the Medicaid Budget by $1.57 Billion in Four Categories From Fiscal Year 1997-98 Through 2003-04

Initiative Description	Fiscal Year	Budget Reduction
Pharmacy Cost Controls		*$646,890,219*
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	213,836,853
Brand Name Drug Patent Expirations	2001-02	20,516,647
Implement Pharmacy Dispensing Fees	2001-02	3,952,268
Reduce Pharmaceutical Expense Assistance Program	2001-02	22,500,000
Continuation of Prescription Drug Cost Containment Initiatives	2002-03	12,000,000
Implement Pilot Program to Reduce Drug Diversion	2002-03	8,856,048

Initiative Description	Fiscal Year	Budget Reduction
Establish a Return and Reuse Program for Prescription Drugs Dispensed in Institutions	2003-04	14,110,139
Expand State Maximum Allowable Cost for Multi-Source Drugs	2003-04	11,750,515
Reduce Nursing Home Pharmacy Dispensing Fee (Not Restored)	2003-04	1,638,330
Expand Medicaid Beneficiary Pharmacy Lock-In Program	2003-04	797,399
Implement a 2.5% Prescribed Drug Co-Insurance	2003-04	26,801,883
Changes in Financing		***$538,174,649***
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 - This Was Restored in Special Session C	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
Prior Authorization 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
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
Competition/Privatization/Management FTE Reductions	2001-02	3,676,094
Reduce Meds/AD Program Income Eligibility from 90% to 88%	2002-03	64,088,150
Increase Managed Care Enrollment to 55% HMO and 45% MediPass	2002-03	3,552,049
Expand Prepaid Mental Health Program to Area 1	2002-03	765,884
Establish $15 Co-Payment for Non-Emergency Use of Emergency Room	2003-04	24,335,165
Reduce HMO Rates to Reflect on Average 91% of Fee for Service Rates	2003-04	14,423,331
Implement a 10% Decrease in Transportation Costs	2003-04	11,010,078
Include Third Party Administrators, Pharmaceutical Benefit Managers and Medicare Dually Eligible Beneficiaries as Liable Third Parties	2003-04	No net reduction
Delay Hospital Inpatient and Outpatient Rate Increase	2003-04	14,260,181
Implement Utilization Review of Physical, Speech, and Occupation Therapy	2003-04	10,695,567
Increase Managed Care Enrollment to 60% HMOs/Alternative Plans and 40% MediPass	2003-04	11,690,525
Eliminate Home Health Provider Fee Increase (not restored)	2003-04	3,005,094
Eliminate Nursing Home Rate Increase for Liability Insurance (not restored)	2003-04	26,925,842
Increase Enrollment in Prepaid Mental Health Plans	2003-04	3,517,159
Disease Management		***$128,756,677***
Disease Management Program—First Year	1997-98	4,167,060
Disease Management Program—Second 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
Guaranteed savings from Value-Added Contracts with Pharmaceutical Contracts	2003-04	16,034,275
Fraud and Abuse Prevention and Third Party Liability		***$93,671,063***
Enhanced Third Party Liability Detection	1997-98	10,000,000
Mental Health Provider Credentialing	1997-98	5,000,000

Initiative Description	Fiscal Year	Budget Reduction
Accelerated Third Party Liability Detection and Mental Health Utilization Management	1998-99	12,446,255
Pharmacy Fraud and Abuse Initiatives—First Year	1998-99	9,114,543
Pharmacy Fraud and Abuse Initiatives—Second Year	1999-00	34,498,620
Expand Fraud and Abuse Initiatives	2001-02	11,969,459
Expand Fraud and Abuse Initiatives to Prescribed Drug and Inpatient Services	2002-03	10,642,186
Other	*Total*	*$159,260,461*
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
Nursing Home Diversion/Assisted Living Waiver	2000-01	20,742,107
Shift General Nursing Home to Community-Based Waiver	2001-02	9,993,424
University of Florida Center for Orphan Autoimmune Disorders	2001-02	1,492,537
Pediatric Emergency Room Diversion Project	2001-02	1,480,000
Reduce Nursing Home Up or Out Project	2001-02	2,900,000
Reduce AIDS Waiver (PAC) Non-Essential Services	2001-02	5,000,000
Demonstration Project to Reduce Geriatric Falls	2002-03	503,156
Reduce Adult Dental Services to Emergency Only	2002-03	13,442,655
Eliminate Ticket to Work program	2002-03	7,729,779
Expand Nursing Home Diversion	2003-04	35,658,000
Eliminate Adult Dental, Vision, and Hearing Services (not restored)	2003-04	10,996,561
Reduce AIDS Waiver (PAC) Coverage (not restored)	2003-04	6,526,468
Limit Coverage of Circumcisions to Medically Necessary	2003-04	2,365,219
Eliminate Subacute Pediatric Transitional Care (not restored)	2003-04	1,882,086
Eliminate Lung Cancer Screening Project (not restored)	2003-04	1,744,186
Delay Nursing Home Staffing Increase	2003-04	19,471,619
Implement Nursing Home Transition Initiative	2003-04	No net reduction
TOTAL ALL INITIATIVES	ALL YEARS	$1,566,753,069

Source: General Appropriations Acts of 1997-98, 1998-99, 1999-00, 2000-01, 2001-02, 2002-03, and 2003-04.

Appendix B

Medicaid Cost Reduction Initiatives Fiscal Years 1997-98 Through 2003-04

In an effort to control costs and to improve the effectiveness of the Medicaid program, the Legislature has reduced the Medicaid budget by $1.567 billion since Fiscal Year 1997-98 through Fiscal Year 2003-04, enacting policy and funding reforms. As shown in Table B-1, the agency has realized $1.277 billion or 81% of these anticipated savings. For Fiscal Year 2004, the Legislature reduced the Medicaid budget by $576 million see Table B-2).

Table B-1
81% of Savings Expected from Implementing Cost Reduction Initiatives Identified for Fiscal Years 1997-98 Through 2003-04 Have Been Realized

Initiative Description	Budget Reduction	Estimated Savings	Comments
Fiscal Year 1997-98			
Enhanced Third Party Liability Detection	$10,000,000	$6,039,068	**Implementation delayed** in first year due to contract negotiations and operation problems with data systems.
Mental Health Provider Credentialing	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	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	4,167,060	Unknown	**Implementation delayed** because of contract negotiations with private disease management organizations. No documentation of savings.
Reduced Prescription Drug Dispensing Fee	6,174,066	0	**Not implemented due to legal challenges.**
Nursing Home Diversion Waiver	12,394,796	3,545,628	**Implementation delayed** due to protracted contract negotiations with providers. Estimated savings over three years.
Provider Service Networks	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.
Fiscal Year 1997-98 Total	**$44,991,761**	**$13,312,576**	
Fiscal Year 1998-99			
Accelerated Third Party Liability Detection and Mental Health Utilization Management	$12,446,255	$136,186,082	**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. Third party liability recoveries continued to increase as a result of enhanced data capabilities by a private contractor. Estimated savings are over four years.
Pharmacy Fraud and Abuse Initiatives - First Year	9,114,543	3,000,000	**Amount actually recovered not reported.** Identified potential recoveries only.
Disease Management Program - Second Year	39,414,987	Unknown	**Implementation delayed** because some disease states not covered by a contract. No documentation of savings.
Prescription Drug Rebate Recalculation	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	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	1,604,535	1,604,535	**Legislature eliminated funding.**
Fiscal Year 1998-99 Total	**$137,535,293**	**$266,852,637**	

Initiative Description	Budget Reduction	Estimated Savings	Comments
Fiscal Year 1999-00			
Pharmacy Fraud and Abuse Initiatives – Second Year	$ 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	40,733,198	3,509,019	**Initial intervention letters sent to identified physicians** in March 2000; first outcome measurement of interventions available January 2001. Savings based on evaluation of six-month interval comparisons of pre- and post-utilization changes.
Pharmaceutical Rebates in Managed Care Organizations	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	18,234,061	0	**Implementation awaiting approval** from the Centers for Medicare/Medicaid Services, formerly HCFA.
Fiscal Year 1999-00 Total	**$114,165,051**	**$ 44,237,884**	
Fiscal Year 2000-01			
Pharmacy Reforms	$242,732,316	$276,980,330	**Savings are based on a number of initiatives** (see Pharmacy Cost Controls for Fiscal Year 2000-01 on page 9), including the four-brand drug limit. The agency implemented most of these initiatives but did not provide specific information on the extent of savings by initiative.
Improve Disease Management Efficiency	23,046,785	8,114,623	**The agency continued the disease management initiative** but did not extend it to all diseases as directed by the Legislature.
Improve Case Management of MediPass Clients to Include Population-Based Disease Management	46,093,570	603,883	**The Legislature restored** this reduction to the budget in 2002. Savings are based on two physician-based case management organizations.
Nursing Home Diversion/Assisted Living Waiver	20,742,107	17,975,561	**The agency calculated $2,086 per month per case.** The waiver enabled an average monthly caseload diversion of 718 clients.
Fiscal Year 2000-01 Total	**$332,614,778**	**$303,674,397**	
Fiscal Year 2000-02			
Drug Formulary with Rebates and other Pharmacy Controls	$213,836,853	$214,643,665	While several pharmacy cost controls were introduced during Fiscal Year 2001-02, the agency attributes a substantial portion of the savings to the drug formulary and supplemental rebates from drug manufacturers. However, some of these savings include cost-saving arrangements, such as disease management, in lieu of supplemental rebates. The agency also has implemented benefits management programs aimed at unnecessary prescribing or use.
Brand Name Drug Patent Expirations	20,516,647	0	This reduction applied to four brand name drugs for which drug patents were expiring. The agency stated that there was no evidence to show an increased use of the generic versions of the drugs and that in some instances, after rebates, brand name drugs can be less expensive than the generic equivalent.
Implement Pharmacy Dispensing Fees	3,952,268	0	Due to an unexpected high level of compliance with the Medicaid Preferred Drug List, the agency decided not to implement any fee incentives, due to the concern that they might in fact increase program costs.
Reduce Pharmaceutical Expense Assistance Program	22,500,000	22,500,000	The agency implemented the Silver Saver program in August 2002.
Limit Medicaid Reimbursement for Hospital Outpatient and Nursing Home Medicare Crossover Claims	63,261,783	72,708,516	Prior to Medicaid's revision of outpatient payments, in Fiscal Year 2000-01 Medicare reduced its outpatient payments. Because Medicaid's crossover payment methodology is tied to Medicare's, Florida Medicaid outpatient costs were concurrently reduced by 42% in FY 2000-01, and declined an additional 51% with the Medicaid 2001-02 revisions. At the time the original reduction was projected, there was not enough information to assess the impact of the 2000-01 Medicare reduction.

Initiative Description	Budget Reduction	Estimated Savings	Comments
Adjust Health Maintenance Organization (HMO) Rates to Reflect the Net Cost of Drugs	$ 32,515,786	$ 46,848,921	In July 2001, Medicaid implemented changes to the HMO capitation methodology to include a reduction for the value of prescribed drug rebates.
Changes in Medicaid Choice Counseling	6,900,000	0	The Legislature partially restored these funds in the 2001 Special Session C. Agency has not reported information on this initiative.
Eliminate Administrative Costs Component Included In HMO Capitation Rate	3,828,782	3,828,782	Final Fiscal Year 2001-02 appropriations included a restoration of most of the costs previously used to fund the administrative component of the HMO rate for "rate equalization" for the rates of HMOs located in Broward, Miami-Dade, and Palm Beach counties.
Competitively Bid or Capitate Private Duty Nursing Services	3,467,807	0	The agency did not report savings because it delayed the procurement process.
Restrict Nursing Home Rate Adjustments Associated with Changes in Ownership	15,529,444	0	In September 2001, the nursing home per diem methodology was changed to eliminate the change in ownership "step up" provision. In the month before the methodology was changed, a large number of submissions for change of ownership were submitted and therefore savings were not achieved. The agency expects that savings would have been realized in Fiscal Year 2002-03.
Require Prior Authorization for and Concurrent Review of All Non-Emergency, Non-Psychiatric Hospital Inpatient Admissions	15,746,547	41,130,760	The agency's contract with KePRO, Inc., extends through June 2005. This estimate is based on limited claims data.
Prior authorization of Mental Health Services	9,977,681	8,450,941	Phase-in of the prior authorization program began in April 2002. The 2002E Legislature limited the prior authorization process to a targeted group of providers, however, and this was expected to substantially reduce savings from the program.
Reduce Hospital Provider Rates by 6%	88,143,227	88,295,574	Based on a legislative directive to reduce hospital inpatient and outpatient rates by 6% for a nine-month period; the reduction amount is composed of anticipated savings in hospital inpatient and outpatient services, as well as HMO rates.
Competitively Bid Independent Lab Services	849,084	0	Agency did not provide updated information on this cost reduction.
Competitively Bid Durable Medical Equipment	1,306,488	0	Implementation was delayed due to legal challenges related to RFP awards.
Competitively Bid Transportation	640,684	0	The agency reported that it would test a capitated transportation system. The agency did not provide updated information on savings achieved.
Increase Managed Care Enrollment to 50% HMO and 50% Medipass	6,742,062	6,742,062	For Fiscal Year 2001-02, the agency's automated assignment system allocated beneficiaries in accordance with the 50-50 policy, and the full cost reduction target was achieved.
Expand Fraud and Abuse Initiatives	11,969,459	7,558,049	Agency implemented this pilot project in Dade, Broward, Monroe, and Palm Beach counties. This estimate is based on projection of less than four months experience.
Shift General Nursing Home to Community-Based Waiver	9,993,424	3,820,800	Since the Department of Elder Affairs began transitioning qualified nursing home residents into waiver supported community living facilities in September 2001, the waiver monthly caseload has increased, as have its associated costs.
University of Florida Center for Orphan Autoimmune Disorders	1,492,537	Not determined	No documentation of savings.
Pediatric Emergency Room Diversion Project	1,480,000	Not determined	No documentation of savings.
Reduce Nursing Home Up or Out Project	2,900,000	2,900,000	This pilot project funded in the 2001 Regular Session was eliminated during the 2001 Special Session C.
Reduce AIDS Waiver (PAC) Non-Essential Services	5,000,000	4,769,247	Implementation of waiver service reductions occurred on March 1, 2002. Savings estimate based on projected expenditures for last four months of Fiscal Year 2001-02 and budget forecasts.
Competition/Privatization/Management FTE Reductions	3,676,094	3,676,094	Initial FTEs reduced by the 2001 Regular Session were eliminated on July 1, 2001. The remaining FTEs reduced by the 2001 Special Session C were eliminated on January 1, 2002.
Fiscal Year 2001-02 Total	**$546,226,657**	**$527,873,411**	

Initiative Description	Budget Reduction	Estimated Savings	Comments
Fiscal Year 2002-03			
Continuation of Prescription Drug Cost Containment Initiatives	$ 12,000,000	$ 49,173,595	The Medicaid preferred drug list and prior authorization initiatives continued to achieve savings. Actual pharmacy expenditures in Fiscal Year 2002-03 were less than projected.
Implement Pilot Program to Reduce Drug Diversion	8,856,048	0	Project began on April 15, 2002, in Dade, Broward, Monroe, and Palm Beach counties. Pharmacy costs initially decreased between April 2002 and June 2002, thereby achieving savings. However, Fiscal Year 2002-03 expenditures began to rise again in these counties.
Reduce Meds/AD Program Income Eligibility from 90% to 88%	64,088,150	0	Savings were not achieved because the affected population shifted to the Medically Needy category.
Increase Managed Care Enrollment to 55% HMO and 45% MediPass	3,552,049	3,628,013	Managed care enrollment increased by 22,856 in Fiscal Year 2002-03.
Expand Prepaid Mental Health Program to Area 1	765,884	813,527	416,913 claims were paid at the capitated rate in Fiscal Year 2002-03 at a savings of $1.95 per claim compared to fee-for-service claims.
Expand Fraud and Abuse Initiatives to Prescribed Drug and Inpatient Services	10,642,186	Not determined	While not readily identifiable, the agency states that excess savings from pharmacy cost-containment issues may be due to these measures.
Demonstration Project to Reduce Geriatric Falls	503,156	0	Project began on March 19, 2003 and operated until June 30, 2003. Savings not identified because previous contractor's lack of data.
Reduce Adult Dental Services to Emergency Only	13,442,655	17,302,805	Dental coverage for adults were reduced to emergency only beginning July 1, 2002. Actual expenditures were $17,302,805 less than projected expenditures.
Eliminate Ticket to Work Program	7,729,779	7,729,779	Program effectively eliminated on July 1, 2003.
Fiscal Year 2002-03 Total	**$121,579,907**	**$78,647,719**	
Fiscal Year 2003-04			
Establish a Return and Reuse Program for Prescription Drugs Dispensed in Institutions	$ 14,110,139	$ 0	Program implementation was delayed until April 2004 because of system programming and HIPAA implementation.
Expand State Maximum Allowable Cost for Multi-Source Drugs	11,750,515	0	The agency has not reported savings for this initiative nor successful implementation.
Reduce Nursing Home Pharmacy Dispensing Fee (not restored)	1,638,330	0	The agency updated the point-of-sale system to disallow dispensing fee addition.
Expand Medicaid Beneficiary Pharmacy Lock-In Program	797,399	2,442,972	This program was implemented. Upon review by the Medicaid Program Integrity unit, more than 600 recipients were "locked-in" to a specific Medicaid pharmacist as of February 2004.
Implement a 2.5% Prescribed Drug Co-Insurance	26,801,883	0	The agency has not reported savings for this initiative nor successful implementation.
5% Increase in Prescription Rebate	No net reduction	0	The agency reports that the generic manufacturers are reluctant to commit to any increase in generic rebates voluntarily and that they have no authority to require supplemental rebates for generics.
Establish $15 Co-Payment for Non-Emergency Use of Emergency Room	24,335,165	0	Implementation delayed because the agency had to amend the Medicaid state plan and obtain approval from the federal Centers for Medicare and Medicaid Services (CMS). CMS required copayment to be changed to coinsurance. Actual coinsurance was implemented on February 2, 2004 and established a 5% payment on first $300 of Medicaid cost per visit.
Reduce HMO Rates to Reflect on Average 91% of Fee for Service Rates	14,423,331	6,783,822	Rates were reduced July 2003.
Implement a 10% Decrease in Transportation Costs	11,010,078	0	The agency initially negotiated a contract with the Transportation Disadvantaged Commission (TDC) but the contract was voted down by the TDC board. The agency submitted a request for proposal in December 2003 and is reviewing responses.
Include Third-Party Administrators, Pharmaceutical Benefit Managers and Medicare Dually Eligible Beneficiaries as Liable Third Parties	No net reduction	1,722,350	This change has contributed to increased pharmacy recoveries by an average of 26.8% per month from an average monthly recovery of $941,288 prior to July 2003 to an average monthly recovery during the months of July 2003 through November 2003 of $1,285,758. The agency expects recoveries to increase as more eligibility files are forwarded to the third party liability contractor.

Initiative Description	Budget Reduction	Estimated Savings	Comments
Delay Hospital Inpatient and Outpatient Rate Increase	$ 14,260,181	$ 14,260,181	Delayed rate increases as planned until October 1, 2003.
Implement Utilization Review of Physical, Speech, and Occupation Therapy	10,695,567	0	Implementation delayed until May 1, 2004, because a potential contractor challenged the RFP award.
Increase Managed Care Enrollment to 60% HMOs/Alternative Plans and 40% MediPass	11,690,525	3,949,006	Mandatory assignment in effect since September 2003, earliest possible implementation since Governor signed bill. The agency expects to achieve the 60%/40% enrollment distribution by April 2005 with an average per member per month savings of $13.75.
Eliminate Home Health Provider Fee Increase (not restored)	3,005,094	0	Fee increase not continued in Fiscal Year 2003-04.
Eliminate Nursing Home Rate Increase for Liability Insurance (not restored)	26,925,842	0	Agency eliminated liability insurance from reimbursement methodology effective July 2003.
Increase Enrollment in Prepaid Mental Health Plans	3,517,159	0	The agency cites implementation delays as a result of differing interpretations by bill sponsors; specifically, what types of entities are eligible to provide services: should only one statewide entity provide services or should managed care plans that provide other services or are not statewide also be eligible to provide services. The agency requested the Attorney General's office to interpret the bill via letter on November 17, 2003.
Guaranteed Savings from Value-Added Contracts with Pharmaceutical Contracts	16,034,275	0	Disease management is an ongoing program. Savings have not been determined.
Expand Nursing Home Diversion	35,658,000	9,220,918	As of December 2003, 1,685 individuals were enrolled in diversion programs compared to 977 in June 2003. The agency expects an enrollment of at least 2,300 by June 2004. The agency reports a PMPM savings of $2,311 per month.
Eliminate Adult Dental, Vision, and Hearing Services (not restored)	10,996,561	2,646,747	Services terminated July 2003.
Reduce AIDS Waiver (PAC) Coverage (not restored)	6,526,468	0	Services terminated July 2003.
Limit Coverage of Circumcisions to Medically Necessary	2,365,219	1,057,185	Service eliminated effective July 2003.
Eliminate Subacute Pediatric Transitional Care (not restored)	1,882,086	0	Services terminated July 2003.
Eliminate Lung Cancer Screening Project (not restored)	1,744,186	0	Project terminated July 2003.
Delay Nursing Home Staffing Increase	19,471,619	0	The agency has not reported savings for this initiative nor successful implementation.
Implement Nursing Home Transition Initiative	No net reduction	0	The agency submitted a plan to the Legislative Budget Commission and received approval in October 2003. The agency issued an RFP and is reviewing responses and plans to begin transitions before the end of calendar year 2004.
Fiscal Year 2003-04 Total	**$269,639,622**	**$42,083,181**	
Total for Fiscal Years 1997-08 through 2003-04	**$1,566,753,069**	**$1,276,681,805**	

Source: General Appropriations Acts of 1997-98, 1998-99, 1999-00, 2000-01, 2001-02, and 2002-03; and Medicaid budget reduction reports, Agency for Health Care Administration.

Table B-2
The Legislature Anticipates That Implementing These Initiatives Will Save the State $576 Million During Fiscal Year 2004-05

Initiative Description	Budget Reduction
Eliminate special Medicaid payments to Area Health Education Centers	$ 10,394,940
Enroll recipients in managed care within 30 days of eligibility start date	12,083,270
Implement hospitalist program	26,581,905
Implement a comprehensive utilization management program for neonatal intensive care	1,582,964
Care coordination services and utilization management of inpatient psychiatric services for children	1,290,341
Reduce hospital rates	14,103,000
Implement physician lock-in program for recipients in the pharmacy lock-in program	924,375
Limits prescribed products to treat erectile dysfunction to one pill per month	3,904,000
Increase drug rebate threshold to a minimum of 29%	no net reduction
Implement Medicaid provider network controls	13,990,268
Eliminate value-added programs in lieu of supplemental rebates, prior authorization, and brand limitations.	85,158,151
Implement a behavioral pharmacy management system	33,819,951
Reduce pharmacy ingredient prices to the lesser of Average Wholesale price less 15.4% or Wholesaler Acquisition Cost plus 5.75%	25,740,000
Expand the state Maximum Allowable Cost (MAC) program	25,000,000
Postpone lifesaver prescription program until federal approval is received	28,906,110
Implement prior authorization for off-label prescribing of Neurontin	7,131,000
Decrease dosage frequency and amount of Zyprexa to dosage amount recommended by the federal Food and Drug Administration	6,000,000
Limit Cox II inhibitor utilization to once a day unless prescribed for an indication requiring more frequent dosing per the FDA approved product label	7,830,445
Implement a comprehensive utilization management program for private duty nursing services for children	8,565,000
Consolidate services included in the Aged and Disabled Waiver, the Channeling Waiver, Project Aids Care Waiver, and Traumatic Brain Injury and Spinal Cord Injury Waiver programs	6,857,968
Implement a utilization management program for Medicaid home and community-based service waiver programs	8,847,019
Reduce intermediate care facilities/developmentally disabled (ICF/DD) rate increases	4,788,000
Eliminate Medicaid bed hold days in nursing homes and ICF/DDs with reported occupancy levels less than 95%	14,523,568
Expand nursing home diversion programs	82,871,416
Implement demonstration project to reduce geriatric falls among at-risk community-based Medicaid beneficiaries in Broward and Miami-Dade counties	5,872,900
Delay nursing home staffing increase to 2.9 hours of direct care per resident per day until July 1, 2005	72,096,601
Reduce nursing home rates	66,689,094
Total	**$575,552,286**

Source: General Appropriations Act of 2004-05.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

August 4, 2004

Mr. Gary R. VanLandingham, Interim Director
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Tallahassee, FL 32399-1475

RE: OPPAGA Draft Progress Report

Dear Mr. VanLandingham:

Thank you for the opportunity to respond to your office's draft progress report entitled, *Medicaid Should Improve Cost Reduction Reporting and Monitoring of Health Processes and Outcomes.*

Enclosed is the Agency's response to several issues noted in the draft report. We appreciate the analyses performed by your staff and the opinions expressed in your report. AHCA continuously looks for opportunities to improve operations and is committed to providing cost effective and efficient health care services to the citizens of the state.

If you have any questions regarding this response, please contact Michael Bennett, Internal Audit Director, at 414-5419.

Sincerely,

Alan Levine
Secretary

AL/mb

Enclosure: Agency response to OPPAGA Draft Report

Agency for Health Care Administration
Response to OPPAGA's Draft Progress Report
Medicaid Should Improve Cost Reduction Reporting and Monitoring of Health Processes and Outcomes

Agency Response to OPPAGA Progress Report Conclusions:

Report Conclusion:
The Agency has taken steps to keep the Legislature better informed on cost impacts but should make further improvements.

Agency Response:
We are pleased OPPAGA recognizes many of the steps the Agency has implemented to keep the Legislature informed and involved with legislative directives. We also recognize the need for continued improvement in this area. Towards this end, the Agency has dedicated significant resources to quality assessments through outcome measurements. The Agency further uses almost all measures recommended for HMOs at a national level (NCQA) and publishes a comparative report card to further inform and educate the legislature and public with respect to specific performance benchmarks. Quality measurements are also gleaned from current claims data associated with Florida's Medipass program. Few other states utilize as expansive an array of outcome measurements as does the Florida Medicaid program.

Report Conclusion:
The Agency does not report on Medicaid annual performance in a timely manner.

Agency Response:
The Agency does not agree with the conclusion reached by OPPAGA as to the timeliness of reporting, and as evidence in support would note that a specific staff position is dedicated to the tracking of cost saving information for the Legislature. Reports are created and are regularly referenced at the Estimating Conferences. Furthermore, additional reporting is made through the Deputy Secretary for Medicaid through summaries provided to House and Senate Appropriations Committees during Session. Data is typically updated and refreshed twice yearly.

The perception of untimeliness may be due to factors that lie outside of the Agency's control. Because of delays inherent in the claims processing system, accurate measurement of savings typically requires six (6) months of data before an analysis can be performed on the initiative. For example, nursing home rate reductions occurred on 7/1/04, but claims for July dates of services will not be paid until mid-August. The first quarterly report (prepared 9/30/04) would only include approximately two months of actual expenditures. However, a six-month report, which would contain much more relevant data, would not be available until mid-January 2005.

Also complicating the timeliness issue is the fact many of the initiatives passed by the Legislature take up to six months (or longer) to implement. Many of these initiatives also require federal approval, which further delays implementation. Despite this recognized impediment, reporting timeframes are rarely extended. This results in the Agency being asked to report on issues with inadequate or non-existent records.

Report Conclusion:
Despite improvements on all measures, health outcomes for children fall short of legislative standards.

Agency Response:
Regarding certain measures of health outcomes for recipient children, the Agency's measurement of performance falls below that of non-recipient children. We believe this is largely due to differences in populations rather than specific deficiencies. The children of families with lower income levels often have worse outcomes and lower compliance with medical advice than their counterparts. The OPPAGA report fails to adjust for such a difference. A better comparison would be achievements in other states with similarly situated populations.

Florida Medicaid has one of the highest rates of immunizations for two-year-olds in the nation. The goal is to reach 84 percent for all groups, but OPPAGA fails to recognize and give credit for what has been accomplished to date. This year, the rate is dropping for the two-year old measure. However, this drop has occurred in the private sector as well as the public sector due to vaccine shortages. In fact, last year Medicaid's performance was not statistically different than the performance for the general population – a major achievement.

Report Conclusion:
Health outcomes have improved for Medicaid services to individuals even though the Agency met only one of the five performance standards.

Agency Response:
The Agency is pleased with the overall improvement in health outcomes recognized by OPPAGA in its report but realizes further improvements might be made. While the Agency is cited for not having met several of the performance targets set by the Legislature, this is likely due to increasing problems of specialty care and access issues in the program. The Agency has documented the availability of specialty care in Florida's Medicaid program is well below the national norm. Florida Medicaid is currently in the bottom tier of states with respect to its level of reimbursement to specialty care providers. Of course, any reimbursement increase would require legislative action.

Report Conclusion:
Performance for Medicaid clients in long term care did not meet the legislative standard, but has improved since Fiscal Year 1999-00.

Agency Response:
The difficulties associated with meeting legislative standards have been previously mentioned in our response (see above). However, the Agency remains committed to meeting such standards as well as additional measures that will positively impact Medicaid clients.

Report Conclusion:
Health outcomes are mixed for Medicaid clients in prepaid health plans.

Agency Response:
Mixed outcomes for Medicaid clients in prepaid health plans largely result from variations in the structure and management of these plans. While we encourage and welcome high standards, we want to ensure the standards set are achievable. The Agency agrees with OPPAGA that one of the two measures required by the Legislature could be eliminated and an additional measure reflecting non-HMO clients could be added. This modification would allow for better comparability between HMO and non-HMO populations.

Report Conclusion:
The Agency places limited emphasis on assessing health outcomes and does not formally monitor key internal processes.

Agency Response:
The Agency is formally committed to assessing health outcomes as part of its overall performance measurement structure. The Agency is currently redesigning its approach to quality indicators through performance measurements by contracting with an outside firm to assist in the design of such a system. Meanwhile, the OPAGGA report fails to mention internal monitoring measures such as those undertaken by the Agency's fiscal agent, Affiliated Computer Services, as part of physician profiling and utilization profiles. Additionally, the OPPAGA report fails to mention Provider Service Network evaluations and independent reviews and analyses are contracted through the state's universities.