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Follow-Up Report on Medicaid Managed Care Options

Abstract

- **The Agency for Health Care Administration has taken some of the actions we recommended. The Agency (1) revised its method for setting monthly prepaid health plan fees, which has resulted in annual state savings of $74.3 million; (2) contracted with an independent entity to evaluate MediPass and its impact on Medicaid costs; and (3) implemented choice counseling to inform Medicaid clients of their managed care options.**
- **However, the Agency has not established performance objectives for judging the success of Medicaid managed care in improving access to and the quality of health care services and in containing costs. Also, the Agency has not compared the relative effectiveness of MediPass, prepaid health plans, and traditional fee-for-service.**

Purpose

In accordance with s. 11.45(7)(f), F.S., this follow-up report informs the Legislature of actions taken by the Agency for Health Care Administration in response to Report No. 94-18 and Report No. 94-47. This report presents our assessment of the extent to which the Agency has implemented our recommendations.

Background

Section 409.902, F.S., and Title XIX of the United States Social Security Act authorize Florida's Medicaid Program. The Agency for Health Care Administration administers the Program and provides medical assistance to clients who meet prescribed federal and state eligibility criteria. Clients include low-income parents and children, children in foster care, persons with disabilities, and elders who need nursing home care. In fiscal year 1996-97, the Program expended around $6.9 billion. These expenditures paid for medical care for approximately 1.5 million clients per month.

In an effort to contain costs while improving access to health care for Medicaid clients, Florida has implemented two managed care systems: prepaid health plans (PHPs); and MediPass, a primary care case management system.

- **The PHP system** - PHP clients enroll in plans that contract with Florida's Medicaid program to provide comprehensive medical services. The most commonly recognized type of PHP provider is a Health Maintenance Organization. For each enrolled client, PHPs are paid a monthly fee that is set at 92% of the expected cost of providing services to equivalent groups of fee-for-service Medicaid clients.[1]
- **The MediPass system** - MediPass clients select or are assigned a primary care physician who is responsible for providing primary care and referring patients for specialized services. MediPass primary care physicians receive a $3 monthly case management fee for each client in addition to fee-for-service

[1] Under fee-for-service, health care providers are reimbursed for each service provided to clients.

reimbursement for each service they provide to clients.

Enrollment of Medicaid clients in managed care has increased significantly over the past few years. In January of 1994, approximately 25% of Florida's Medicaid clients were enrolled in either MediPass or a PHP. By May 1997, nearly two-thirds (around 66%) of the state's Medicaid clients had enrolled in a managed care option.

Prior Findings

At the time of our reviews, 36 states were operating managed care programs for Medicaid clients. Most of these states offered only a single managed care option. Florida was one of nine states that operated two types of managed care options for its Medicaid Program, prepaid health plans and primary care case management. Our reports noted several areas that if modified, could improve the effectiveness and efficiency of Florida's managed care programs.

Method of setting PHP monthly fees. The Agency's method for setting monthly PHP fees did not ensure that payments to PHPs did not exceed the state's average cost for providing similar services through fee-for-service providers.[2] For example, in fiscal year 1992-93, the Agency set PHP fees at 95% of estimated average Medicaid fee-for-service costs. However, in making its estimates, the Agency did not adjust for changes in fee-for-service utilization rates. As a result, the statewide average monthly fee paid to PHPs for Aid to Families with Dependent Children (AFDC) clients was $3.36 or 3.2% higher than the state's average fee-for-service costs for AFDC clients.

Although in fiscal year 1993-94, the statewide average PHP fee for AFDC clients was lower than average fee-for-service costs, the lower PHP fees may not have resulted in cost-savings due to favorable selection. Favorable selection occurs when clients who enroll and remain in PHPs are, on average, healthier and use fewer services than fee-for-service clients.[3] From fiscal year 1992-93 to 1993-94, enrollment of AFDC clients in PHPs grew by around 37%. During that same time, fee-for-service utilization rates also increased. Although other factors can cause increases in Medicaid fee-for-service utilization rates, when these rates increase at the same time PHP enrollment is increasing, favorable selection could be occurring.

Method of estimating MediPass cost-savings. While the MediPass option appeared to have reduced health care use and costs, the Agency's method of estimating cost-savings by comparing MediPass and traditional fee-for-service use and costs did not provide valid estimates of these savings. Agency estimates did not consider the effects of client and geographic characteristics that could have had a differential effect on service use and costs. Estimates also did not take into account all costs associated with providing services to MediPass clients.

Informing Medicaid clients of managed care options. Prior to enrolling Medicaid clients in MediPass, district MediPass staff were not informing clients of their managed care options and rights or helping them select the type of managed care that would best fit their needs. Well informed clients are more likely to select the managed care option that best meets their families' needs. We noted that other states with both types of managed care systems provided information to clients through brochures or other written documents. Some states also had staff to counsel clients and help them make a suitable choice.

Establishing managed care performance objectives. The Agency had not identified and included in its Strategic Plan outcome measures for assessing whether Medicaid managed care was meeting its goals of reducing unnecessary use of

[2] Federal guidelines require that PHP fees not exceed the state's average cost of providing similar medical services on a fee-for-service basis to equivalent groups of clients.

[3] Favorable selection can occur if PHPs attempt to attract healthier clients or discourage less healthy clients from enrolling. Client choice can also result in favorable selection if sicker clients avoid enrolling in PHPs.

high cost health care services, while improving access to and quality of health services.

Evaluating the overall performance of Medicaid managed care systems. The Agency was not using routinely collected information about managed care services to assess the overall performance of its MediPass and PHP systems. We noted that the Agency could compile and use available information to identify areas needing improvement or further study. Also, the Agency had not evaluated the differential effectiveness of the MediPass, PHP, and traditional fee-for-service delivery systems. The Agency could periodically conduct client satisfaction surveys and focused studies of key health care services designed to compare the quality of health care services provided through MediPass, PHPs, and traditional fee-for-service delivery systems.

Current Status

The Agency has taken steps to address most of our concerns. The Agency changed its method of setting PHP monthly fees, contracted with a private entity to evaluate MediPass cost-savings, and implemented a choice-counseling program for Medicaid clients. However, additional steps are needed to enable policy makers to assess whether Florida's Medicaid managed care systems are meeting their intended goals.

Actions Taken or Not Taken

Method of setting PHP monthly fees. As we recommended, the Agency revised its method for setting monthly PHP fees. In 1995, the Agency began to use age-bands and geographic regions in addition to eligibility categories in setting rates. According to the Agency, these adjustments resulted in a 14% decrease in PHP payments during fiscal year 1995-96. This resulted in an annual Medicaid cost-savings of about $74.3 million.

The Agency anticipated saving an additional $16.9 million in fiscal year 1996-97 by establishing PHP fees through competitive bidding. However, the Agency ran into protracted legal difficulties with the procurement process and decided to abandon this effort. Instead, the Agency decided, effective April 1, 1997, to reduce PHP rates from 95% to 92% of projected fee-for-service expenditures.[4] Additional Medicaid savings due to this rate reduction are expected to approach $5.6 million for fiscal year 1996-97. PHP fiscal year 1997-98 contracts have been set at 92% of the projected fee-for-service expenditures for that year.

Method of estimating MediPass cost-savings. The Agency took steps to improve the precision of MediPass cost-savings estimates. The Agency contracted with Florida State University's Policy Sciences Center to evaluate the impact of MediPass on Medicaid costs. The study design took client and geographic characteristics into account when assessing cost-savings. The study concluded that except for pharmacy services, MediPass enrollees used fewer Medicaid services than fee-for-service clients. Cost-savings between MediPass and fee-for-service, over a 27-month period, ranged from 8.5% to 19.1% per client per month. The study also reported preliminary results of MediPass client and provider satisfaction surveys that were generally favorable. However, response rates were low (around 10% for clients and 25% for providers) and may not accurately reflect client and provider satisfaction.

The Agency has again contracted with the Policy Sciences Center at Florida State University to evaluate the MediPass program. Results of this evaluation are expected to be available in October 1997 and will address cost-savings attributable to Medicaid managed care for Supplemental Security Income (SSI) clients as well as other groups.[5]

Informing Medicaid clients of managed care options. The Agency has implemented a choice-counseling program to inform Medicaid clients of

[4] In both reports, we offered several alternatives that would improve the Agency's ability to ensure that PHP fees do not exceed fee-for-service costs. These included establishing fees that vary by client characteristics, setting fees at less than 95% of predicted fee-for- service costs, competitively bidding, and using actuarial or regression models.

[5] The prior evaluation conducted by the Policy Sciences Center did not address SSI clients as MediPass was not available for SSI clients during that evaluation period.

their managed care choices. The 1996 Legislature appropriated $1 million to the Agency for choice counseling. The Agency used this money to publish brochures explaining managed care for distribution to new Medicaid clients. Funds were also used to create a choice-counseling call center that currently receives from 2,000 to 3,000 calls each week from Medicaid clients.

The 1997 Legislature appropriated $15.3 million to the Agency to provide a comprehensive choice-counseling program. The Agency is currently preparing a request for proposal for choice-counseling services to be administered by an independent contractor. The Agency is specifically looking for a contractor to provide face-to-face choice-counseling, hotline choice-counseling, managed care brochures and mailings, managed care video tapes, information kiosks, and community outreach activities.

Establishing managed care performance objectives. Although it has not established performance objectives for Medicaid managed care, the Agency reports that it is currently expanding its performance-based budgeting efforts to include Medicaid managed care. The Agency plans to clearly identify performance measures that will provide useful information to the Legislature about the progress of Medicaid managed care in improving access and quality of health care service and in containing costs.

Evaluating the overall performance of Medicaid managed care systems. While the Agency reports that beginning with fiscal year 1996-97, it directed the Keystone Peer Review Organization to review MediPass medical records in addition to PHP medical records, comparative information was not available for our review. We encourage the Agency to use the results of these peer reviews to compare the relative quality of care of the MediPass and PHP systems. As we recommended, the Agency also has contracted with an independent firm to conduct satisfaction surveys of Medicaid clients enrolled in managed care. According to the Agency, the results of this survey should be available in August of 1997. However, since only managed care enrollees were surveyed, the results cannot be compared to traditional fee-for-service clients.

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302). Web site: http://www.state.fl.us/oppaga/

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