FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

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Suspicions Confirmed: Access to Care Plummeted in Medicaid Reform Experiment, Often to Dangerously Low Levels

Summary:

Five years of Florida's controversial Medicaid Reform experiment in managed care are already in the books. Approval of a three-year extension of the waiver that authorized the Reform Pilot is expected by next month. Meanwhile, the Florida Legislature has already set in motion its plan to build on the shaky foundation of Reform to expand an even more experimental version of Medicaid managed care statewide, passing House Bills 7107 and 7109. The state submitted the expansion proposal required by the legislation to federal officials in August, and it is currently under review.

The state's ability to shift virtually all recipients into capitated managed care plans with the unprecedented flexibility to vary benefits, medications, etc., has already been limited, however, because of problems with and unanswered questions about the Reform Pilot. But even the current authority that the state has to operate its current experiment would be imperiled if it became clear that patients' access to care had been undermined. From the outset (2005), permission to operate Reform was contingent upon the state's promise that access would be protected, as confirmed through ongoing analysis of patient-level "encounter data". Yet that data and any meaningful programmatic analysis of it remain inexplicably unavailable. As a result, questions about access to care in the five Reform Pilot counties have been sidestepped for more than five years.

From the outset, permission to operate Reform was contingent upon the state's promise that access would be protected, as confirmed through ongoing analysis of patient-level "encounter data". Yet that data and any meaningful analysis of it remain inexplicably unavailable. As a result, questions about access to care in the five Reform Pilot counties have been sidestepped for more than five years.

In the absence of patient encounter data for analysis, this report examines access to primary care in the Reform Pilot counties using alternative sources of available data. Although the data analyzed was not originally intended to answer questions about access to care, it ultimately served that purpose

effectively. In short, the primary care utilization statistics derived for this report corroborate the mounting anecdotal reports of problems with access in Reform. Specifically, during the 36-month period studied (January 2008 through December 2010):

- The extent to which Medicaid recipients had access to primary care varied significantly among plans.
- Overall, access to primary care in the Pilot counties was significantly and consistently worse than prior to the launch of Reform, and in the case of some plans, it was alarmingly worse. In particular, primary care utilization rates for a number of HMOs were deficient under any objective standard.
- Plans' business-driven maneuvers within the Reform experiment wreaked havoc on recipients' access to primary care.
- Provider service networks (PSNs) generally provided better access to care than their HMO counterparts.
- Primary care access in Reform improved over time, but remained disturbingly low.

In light of the vulnerability of Medicaid recipients and the barriers to access to care they face generally, these findings warrant suspension of efforts to expand and extend Florida's particular Medicaid managed care experiment to new areas and additional patient groups, pending further analysis.

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Background:

In 2006, Florida launched its controversial Medicaid Reform Pilot. Among other things, Reform participants in the five Pilot counties were required to enroll in managed care plans. In addition, each such plan was given the power to vary benefits, medications, administrative requirements, etc. The authority to operate this experiment and ignore many of the otherwise applicable Medicaid rules federal was granted under a broad federal waiver by the federal Centers for Medicare and Medicaid Services (CMS).

In Reform, access to care is controlled exclusively by managed care plans, most of which are for-profit and accept payment on a capitated basis (i.e., paid a fixed amount per enrollee). In recognition of the fact that such plans have a built-in incentive to divert funds from patient care to administration and profit, the state promised strong accountability and evaluation to protect access to care.

Nevertheless, throughout the Reform Pilot period, accounts of delays and denials of necessary care by many plans have proliferated. For their part, however, state officials have insisted that access has been preserved or even improved within the experiment. These conflicting assessments have confused both stakeholders and the public. Cutting through that confusion is essential, as the state is not only seeking to extend the Reform experiment, but legislation passed last spring (House Bills 7101 and 7109) calls for Reform to serve as the foundation for expanding an even more experimental version of Medicaid

managed care statewide to include virtually all Medicaid patients.

Central to the accountability and evaluation effort promised by the state was the development and extensive use of a "patient encounter" database that would allow detailed analysis of the types and amounts of services individual enrollees receive through their managed care plan. Florida's application to federal CMS in 2005 stated that, by 2008, "encounter data from the managed care plans [would] be available to use for program and evaluation purposes."[1]

Yet despite spending years and tens of millions of dollars on a new Medicaid Management Information System (FMMIS), the only encounter-data-based report examining access to care was an informal case study released in February 2009.[2] Even that limited case study added to mounting concerns about access problems in Reform. Nevertheless, millions of patient encounter records have already been collected, processed and stored in the FMMIS.[3]

Measuring Access to Care *Without* Encounter Data:

In response to the persistence of this inexplicable vacuum, this report draws from limited though relevant data available from alternative sources, particularly the quarterly and supplemental Claims Aging Reports[4] filed by managed care plans operating in the Reform Pilot.[5] In these reports, plans report the number of claims (bills for services submitted by health care providers) received as well as the payment status of those claims. Plans are required to pay providers in a timely manner, and these Claims Aging Reports are intended to reveal the extent to which plans are in compliance with those timeliness standards. When completing these reports, plans must assign claims to one of a few broad provider categories: primary care, specialty care, hospital, and other.

Despite the limitations of the data provided in the reports, they contain a wealth of information that can be used to shed light on access to care. For the sake of brevity, this report focuses on only one such use of data: estimation of primary care utilization. We focus on primary care for several reasons, including the facts that primary care access: 1) is the most fundamental and critical element of access to health care, and 2) is less likely to be impeded by utilization management tactics employed by managed care plans than other care components, making primary care utilization a more conservative measure of access than, for example, specialty care.

This report compares trends in primary care utilization (i.e., the number of primary care claims paid per enrollee) among managed care plans. Because the time period covered by each Claims Aging Report is a full calendar quarter, however, estimates can only be derived quarterly. More specifically, for any given plan, primary care utilization for a quarter is estimated as the number of primary care claims paid during the quarter, divided by the average quarterly enrollment[6] during the previous quarter. This estimate is presented as an annualized rate per 100 enrollees. For example, a rate of 270 reflects an average utilization of 2.7 primary care-related services per enrollee per year. A rate of 100 indicates that a majority[7] of enrollees would receive no primary care over the course of a year.

A more thorough discussion of the methods used can be found in the Appendix, but it should be noted

that the nature Claims Aging Report data is such that the rates presented in the report are an appropriate proxy measure of primary care access rather than a precise calculation of primary care utilization rates *per se*. In particular, claims data and enrollment data are staggered due to the lag in providers' submission of claims.

Findings:

1. Primary care utilization rates varied tremendously from plan to plan.

Table 1 lists selected plans and their primary care utilization rates for state Fiscal Years 2008-09 and 2009-10:

Table 1

Managed Care Plan	Primary Care Utilization Rate	
	2008-09	2009-10
Access Health Solutions (PSN)	439.5	**
Amerigroup (HMO)	127.9	**
Better Health (PSN)	*	370.4
First Coast Advantage (PSN)	474.0	***
Freedom (HMO)	160.7	262.3
WellCare - Healthease (HMO)	46.8	**
Humana (HMO)	74.0	44.1
Molina (HMO)	*	264.0
NetPass (PSN)	393.8	**
Preferred (HMO)	98.1	**
WellCare - Staywell (HMO)	84.0	**
Centene - Sunshine State(HMO)	*	395.1
United (HMO)[8]	167.9	235.9
Universal (HMO)	372.6	373.7

Notes:

* - Plan entered Reform on or after May 2009

** - Plan withdrew from Reform on or after May 2009

*** - Incomplete data

In 2008-09, for example, the primary care utilization rate for WellCare's Healthease plan was 46.8 services per 100 enrollees. By contrast, Access Health Solutions' rate was 439.5, more than 9 times higher. Similarly, in 2009-10, Humana's primary care utilization rate was 44.1 services per 100 enrollees. Sunshine's rate for the same period was 9 times higher, at 395.1.

Reasonable variation in primary care utilization is to be expected. A number of plan-specific factors may affect utilization as well, such as the mix of plan enrollees (families with children vs. SSI recipients, in particular) and geographic distribution (some plans operated only in Broward, for example). However, the magnitude of the differences among plan access rates is so pronounced as to preclude the possibility that they can be explained as reasonable variation.

2. Plans' business-driven maneuvers within the Reform experiment wreaked havoc on enrollees' access to primary care.

Although each individual plan's utilization rates remained relatively constant over time, there were a number of exceptions. These exceptions consistently corresponded with well-documented events in the timeline of the Reform experiment, and it is apparent that these events were primarily responsible.

a. The exodus of plans from Reform in 2008-09 massively disrupted access and imperiled patients.

In particular, as plans were in the process of withdrawing from one or more Pilot counties, primary care utilization rates plummeted – almost universally – to disconcerting levels. In some cases, these "business decisions" appear to have virtually eliminated primary care access for many enrollees. Most problematic of all, the reduction in access occurred not only after the plans withdrew, but *prior to withdrawal* as well, when plans were still being paid to assure the delivery of care to their enrollees.

Although this phenomenon can be observed throughout the Reform Pilot period, the system appeared to collapse during the exodus of plans from Reform that occurred in 2008 and 2009. A total of nine plans withdrew from Reform (including conversion) over a 12-month period.

For example, during the fall of 2008, the Medicaid HMO WellCare informed the state of its intent to withdraw its two plans – Staywell and Healthease – from the Reform Pilot.[9] During the third quarter of 2008, the primary care utilization rate for its 49,415 enrollees stood at 78.3 services per 100 enrollees per year. Although Staywell did not technically "drop" any enrollees before its contract ended, its primary care delivery while under contract fell dramatically from its already alarmingly low rate, to 39.1 for the first quarter of 2009, and finally to a negligible 6.2 during its final quarter of operation. WellCare's other plan, Staywell, officially lost only about 2,000 of its more than 32,000 enrollees between the fourth quarter of 2008 and the second quarter of 2009 (also its final quarter in Reform), but primary care utilization over the course of those four quarters dropped from 138.2 to 123.6 to 69.0 to a barely perceptible 4.2.

This turns any assertion that plan withdrawal did not produce upheaval or disruption of care for patients on its ear. Table 2 quantifies the drop-off in access to care as plans prepared to exit Reform.

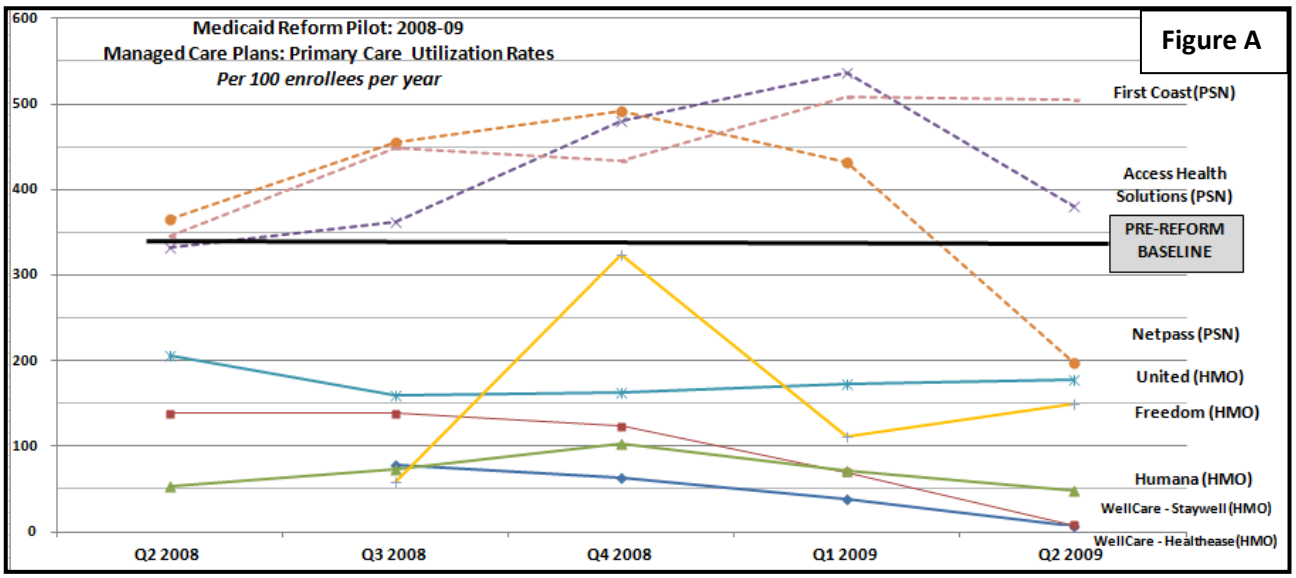
Table 2

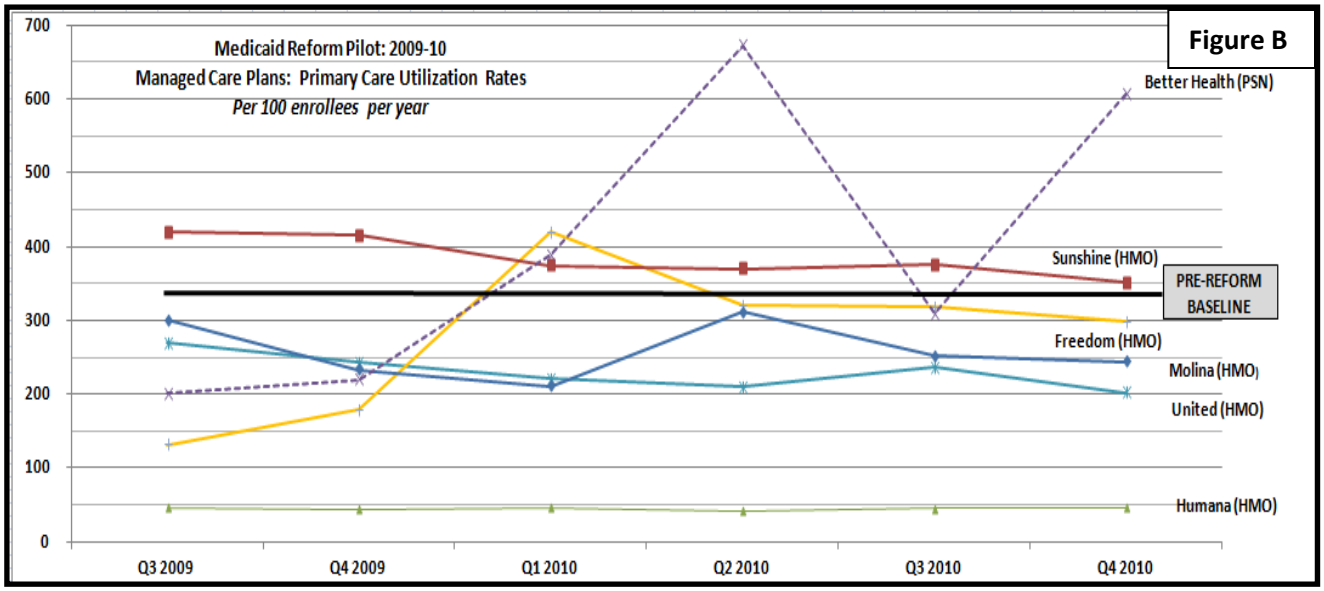
Managed Care Plan	Withdrawal Date[10]	Primary Care Utilization Rate PRIOR[11] to Withdrawal		
		3 Quarters Prior	2 Quarters Prior	1 Quarter Prior[12]
Amerigroup (HMO)	12/2009	315.4	216.2	19.0
Buena Vista (HMO)	12/2008	234.0	185.9	12.0
WellCare - Healthease (HMO)	7/2009	63.5	39.1	6.2
Preferred (HMO)	10/2008	88.3	66.9	15.5
WellCare - Staywell (HMO)	6/2009	123.6	69.0	5.1
United (HMO)[13]	11/2008	274.5	205.3	159.4

NetPass (PSN)	8/2009	431.4	197.6	116.3
Vista (HMO)	12/2008	228.6	155.9	7.7

Note: Three other plans have withdrawn from Reform for which complete data was not available: Pediatric Associates (10/2008), Access Health Solutions (9/2009) and Total Health Choice (6/2010).

The disruption was also visible in utilization trends for the plans that remained in Reform and continued to accept new enrollees. In a number of instances, as plans withdrew following a period during which they provided diminished access, other plans observed a spike in primary care as new plans tried to accommodate the pent-up need. The upswing was often further delayed by the inaccessibility of the choice counseling service that was to assist recipients with enrollment.
Figures A and B illustrate the trends discussed above.





b. Withdrawal from the Reform Pilot was by no means the only action taken by plans that adversely impacted access.

Even as newer arriving plans Sunshine State (Centene) and Better Health achieved primary care utilization rates approaching 400 (claims per 100 enrollees per year) in 2009-10, longer tenured plans that did not withdraw from Reform nevertheless used approaches that assured adequate profitability by keeping primary care utilization rates consistently low.

For one, although United Healthcare withdrew from Broward County in 2008, the plan continued operating in the four counties in Northeast Florida, at least in part because withdrawal would have left only one operational plan in the three smaller counties for an extended period. United's primary care utilization rate fell to 159.3 during its final quarter in Broward County; if a Broward-only rate could be isolated, it would clearly be comparable to those of its withdrawing counterparts. However, United's contract dispute and other factors resulted in low access rates in its remaining counties also. United's primary care utilization rate was only 167.9 for 2008-09, climbing only to 235.9 in 2009-10.

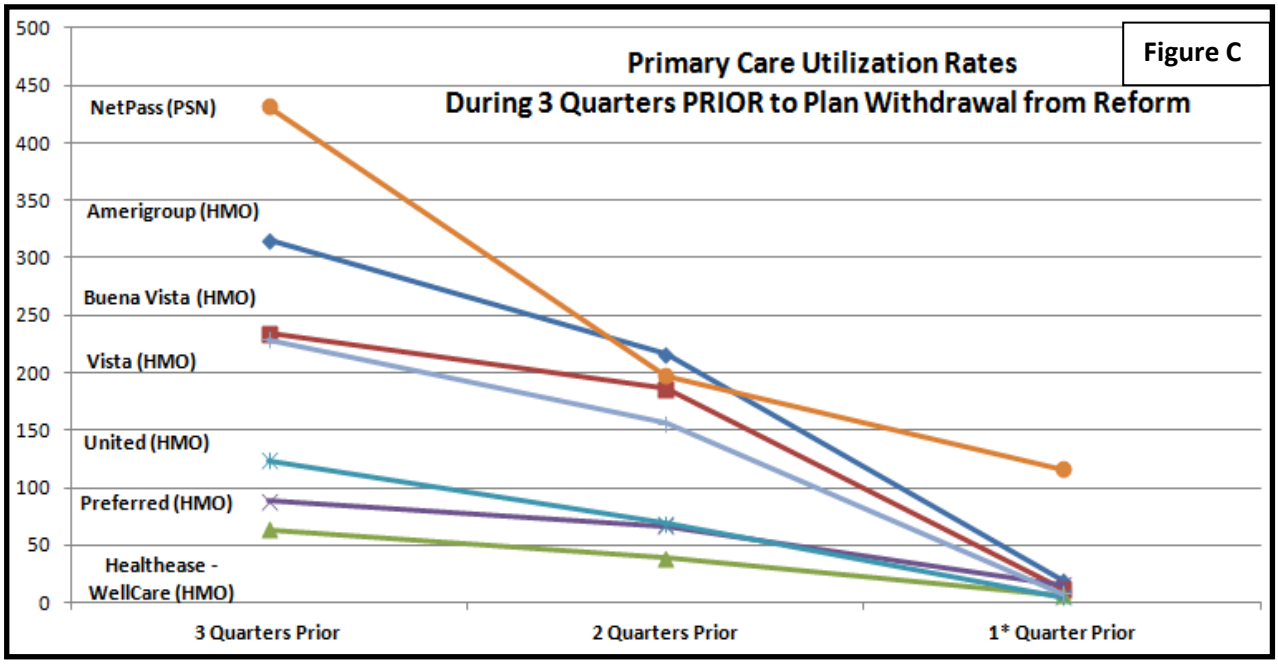
Humana's performance was even more problematic, as it only reached the 100.0 threshold once over 12 quarters. Humana's rate was 74.0 in 2008-09, and an alarmingly low 44.1 in 2009-10. Put another way, assuming year-round enrollment, fewer than half of those enrolled during the year would have received any primary care services through Humana. Not coincidentally, Humana's enrollment plummeted by 63 percent over the most recent six quarters studied.

c. Additional Considerations

i. Access plummeted *while* plans were being paid to ensure that their enrollees had access.

It is important to note that these utilization rates are evidence of reductions in access even while recipients remained enrolled in the plan, and so the plans were still responsible for assuring the delivery of patient care through their contracted provider networks. The disruptions in access to care about which advocates were concerned were those pertaining to the period following disenrollment and subsequent enrollment in a new plan. Those disruptions certainly occurred, but these rates show that they were preceded by disruptions even while plans were being paid under contract specifically to sustain continuity of care.

Figure C below depicts the pre-withdrawal loss of primary care access that recipients faced in Reform.



ii. Plans that failed to ensure primary care access have been linked to other financially motivated improprieties.

In particular, for-profit HMOs that are ultimately accountable to investors or shareholders have accounted for the bulk of the upheaval in Medicaid Reform. Eight of the 11 plans to withdraw from one or more counties in the Pilot area were for-profit HMOs. Notably, these include the HMOs with a checkered history in Florida's Medicaid managed care program, including significant fraud and poor performance. It was these plans that also exhibited the greatest disruption in access to care, with sharp drop-offs in primary care utilization rates. Table 3 below lists five HMOs with significant market share that generated the lowest primary care access rates during their participation in Reform, identifying the many other aspects of their track record that have been problematic.

Table 3

Managed Care Plan	Withdrew from Reform Pilot[14]	Showed Significant Reductions in Primary Care Access in Reform	Management Indicted for Defrauding Medicaid[15]	Required to Repay Funds Improperly Diverted from Patient Care[16]	Fined for Denial of Services or Failure to Report Fraud[17]	Refused to Allow NCQA To Publish Performance Data[18]
Staywell (WellCare)	X	X	X	X	X	X
Healthease (WellCare)	X	X	X	X	X	X
Amerigroup	X	X		X	X	X
United	X (Broward)	X		X	X	X
Humana		X		X	X	

iii. Plans that fled Reform nevertheless continue to profit from Medicaid managed care elsewhere in Florida.

It should also be noted that all of the HMOs that pulled out of the Medicaid Reform Pilot account for the majority of enrollment in managed care in the *non*-Reform counties.[19] The decision to withdraw from Reform has been attributed to disparity between payment rates in Reform vs. outside of Reform. Under statewide Medicaid managed care, the baseline method of calculating payment rates would be uniform and many of these plans would likely seek to return to the counties from which they previously withdrew.

3. PSNs generally provided better access to primary care than HMOs.

In 2008-09, Provider Service Networks, which have not been required to operate on a capitated basis, attained primary care utilization rates many times higher than their HMO counterparts. A reduction in the number of PSNs in 2009-10 and limitations in the PSN data makes drawing conclusions more difficult, but primary care access among PSNs remains higher, although the gap appears to have closed to some extent. The gap closure appears to be attributable in part to the access rates attained by HMOs that acquired and converted PSNs. In particular, Access Health Solutions strong primary care access (439.5 claims per 100 enrollees in 2008-09) appears to have been sustained upon its conversion by HMO Centene to Sunshine State Health Plan (395.1 in 2009-10).

4. Access to primary care in the five Pilot counties was significantly and persistently worse than prior to the launch of the Reform experiment, and in the case of some plans, alarmingly worse. In particular, primary care utilization rates for many HMOs were deficient under any objective standard.

Although relative comparison of primary care access rates among plans and over time is informative, assessment of how access within the Reform compares to a baseline level may be even more important. In this case, primary care utilization rate for the five Reform counties prior to the launch of the Reform Pilot provides just such a baseline. The specific (and conservative) benchmark to which utilization is compared is total primary care-related claims per 100 recipients in some form of managed care, including the MediPass program,[20] for the two-year period prior to the launch of the Reform experiment (2004-05 and 2005-06).

Specifically, the blended primary care utilization rate for all recipients during that period was, at a minimum, 340 claims per 100 enrollees. In other words, the average Medicaid recipient[21] received 3.4 primary care-related services per year immediately prior to the implementation of Reform. (Refer to the Appendix for further discussion of the methodology used to calculate the baseline.)

Comparing this baseline with utilization rates in 2008-09, with the exception of one then-small plan (Universal at 372.6), no HMOs in Reform even approached this baseline level of access in 2008-09, while all PSNs achieved rates above the baseline.

In 2009-10, access improved within HMOs to some extent. Two had primary care access rates above the baseline level (Universal at 373.7 and Sunshine State at 395.1), and they had combined enrollment

exceeding 100,000 enrollees. However, several HMOs continued to post rates far below the baseline.

5. Primary care access in Reform improved during the latter part of the period, but remains disturbingly low.

With some notable exceptions, Reform plans have provided better access to primary care in the aftermath of the massive withdrawal by HMOs in 2008-09. This can be attributed largely to the performance of a few newer HMOs that have significantly outperformed their predecessors. In general, however, primary care utilization rates remain significantly lower than the pre-Reform baseline.

With a more manageable number of plans from which to choose, however, it may be that recipients are better able to identify the plans that provide better access. Alternatively, as pressure to provide better access has intensified, which in turn could affect profitability, some plans have reduced enrollment levels. For instance, Humana, with its persistently low access rate, saw its enrollment drop by 63 percent in less than two years, even as overall Medicaid enrollment surged. Even after United had withdrawn from Broward County, its enrollment in the remaining Pilot counties plummeted by more than 50 percent over roughly the same period. By contrast, HMO Sunshine State and PSN Better Health – the plans of their respective type with the highest utilization rates – have each seen their enrollment levels increase by more than 20,000.

Conclusion:

A proposal approved by the Florida Legislature to use the Medicaid Reform experiment as the foundation for expanding the Medicaid managed care experiment to all Florida counties and almost all Medicaid patient groups is currently under federal review.

Perhaps the most basic question asked throughout the Reform experiment, and one that was to have been a priority for state administrators and evaluators, was whether requiring enrollment in for-profit managed care plans while relaxing basic protections and rules would undermine access to care. Yet even as anecdotal accounts of dire problems with access have compounded, quantitative data, particularly the patient-level encounter data that was to allow for a comprehensive analysis of which recipients receive how much of which services from which providers, somehow remains wholly unavailable for that purpose.

In an effort to examine access to care using limited but most relevant information available, we reviewed claims payment and enrollment reports from Reform. Using this data in a non-traditional but appropriate means of examining primary care utilization, we found reduced access to primary care within the five-county Reform Pilot, both in absolute and relative terms, in many cases to dangerously low levels. Given the vulnerability of Medicaid recipients, these findings warrant suspension of efforts to expand and extend Florida's particular Medicaid managed care experiment pending further analysis.

Appendix: Discussion of Methodology

Measuring Access to Care:

This report aims to examine primary care access – as measured by service utilization - within the five-county Medicaid Reform experiment, including both access trends over time as well as differences among plans with respect to access afforded during the same time periods. In particular, for the enrollees of a given managed care plan for a given calendar quarter, primary care utilization is estimated by the total number of primary care claims paid by the plan during the following quarter, divided by the average monthly number of plan enrollees during the current quarter. That statistic, multiplied by four, yields a proxy for an annualized rate of primary care service utilization per plan enrollee. The proxy primary care utilization rate is not the only potential measure of access to care. However, absent the availability of patient encounter data, this was the best data available to us and we took the most reasonable approach available to interpreting it.

Time Period:

The 36-month period for which utilization data was reviewed included all of calendar 2008, 2009, and 2010. This period corresponds to the last half of the second year through the first half of the fifth year of the Reform Pilot. The Reform experiment was not fully implemented prior to the start of this period and, more importantly, the quality of reporting in Reform was too poor to permit credible analysis. In an abundance of caution, rates for the last half of calendar 2010 were not discussed in this report, as supplemental Aging Claims Reports may be filed by plans up to 105 days after the end of the quarter to which they pertain.

The period used for purposes of calculating the pre-Reform baseline was state Fiscal Years 2004-05 and 2005-06, the two years immediately preceding the launch of the Reform experiment in September 2006.

Data Sources:

The source of the primary care claims data used in calculating utilization rates were the Claims Aging Reports submitted by plans to AHCA for each quarter of activity. Under the requirements of their contracts with the state, Medicaid managed care plans are required to submit these reports, classifying claims submitted by contracted providers by provider type and payment status. Plans operating both within and outside of the five-county Reform Pilot area must file separate reports for their Reform and "non-Reform" activity.[22]

Claims Aging Reports must be submitted within 45 days of the end of the quarter, at which time some claims may be pending. Plans may also submit Supplemental Claims Aging Reports within 105 days of the end of the quarter. Whenever these supplemental filings were available, we used them in place of the original.

When preparing Claims Aging Reports, plans must classify each claim using a short list of broad categories (primary care, specialty care, etc.) No specific parameters for making such classifications were found in the instructions for the reporting form itself or any other contract-related document,

however.

Proxy primary care utilization rates for a given quarter were calculated as the quotient of the number of primary care claims paid by the plan during the next quarter and the number of plan enrollees during the current quarter. Although primary care claims are reported by quarter, AHCA issues enrollment reports by month. To reconcile the units, we averaged monthly enrollment totals to derive a quarterly enrollment average, except that only data from those months during which the plan was operational during the quarter were included in the average.

To develop a pre-Reform baseline for comparison with the proxy utilization rates derived from the claims and enrollment data, we used the 2007 Medicaid Reform Data Book, which is a compilation of utilization statistics used to assess whether Reform plan benefit packages are actuarially equivalent and medically sufficient.[23] The Data Book includes actual utilization rates for all categories of Medicaid services for 2004-2005 and 2005-2006 in the five Reform Pilot counties.

Adjustments to the Estimate:

As discussed in the body of this report, between 2008 and 2010, numerous managed care plans either withdrew from the Reform Pilot entirely or were converted to an entirely different plan following a change of ownership. An adjustment to the proxy utilization rate calculation was therefore necessary to accommodate post-withdrawal claims payments. Although relatively few claims were paid subsequent to withdrawal/conversion, such claims *were* added to the base number of claims in the calculation of the utilization rate for the plan's final quarter of operation in the Reform Pilot. In other words, if a plan withdrew following the 4th quarter of 2008, its utilization rate included not only the claims paid during the first quarter of 2009, but rather *all* claims paid after the 4th quarter of 2008.

With respect to the timeline, both the time allotted for submission of claims by providers to plans and payment to providers by plans must be considered. This is where the "snapshot" intent of the estimate was compromise. Although the standard requirement in Medicaid is that claims be submitted within twelve months after the provision of the service[24], providers must generally submit within six months. From there, claims payment requirements for HMOs and PSNs are different. For example, HMOs must either pay or contest an electronically submitted claim within 20 days of receipt, and then pay or ultimately deny the claim within 90 days of receipt.[25] PSNs operate on a slightly different timetable, claims often must be forwarded to and ultimately processed by a third-party fiscal agent.

The methods used in this report essentially equate to an assumption that payment for approved claims was remitted at some point during the quarter following the quarter in which the service was provided. Under this assumption, the total time elapsed between service delivery and claim payment falls within a range of 1 and 180 days, with a weighted average of 90 days. Although making such an arbitrary assumption is by no means ideal, it is a reasonable and the best available option. Most importantly, rates derived using staggered and non-staggered claims are generally similar, and any error resulting from an inaccurate assumption about the quarter in which a claim is paid is "zero sum" in the aggregate (any resulting rate increase in one quarter will correspond with an offsetting decrease in another

quarter).

Development of the Baseline Utilization Rate:

To derive a conservative baseline to which primary care utilization rates could be measured, we examined actual utilization rates for four particular Medicaid services among the dozens listed in the Data Book that are most clearly primary care-related. Two services appear to correspond without exception to the Primary Care provider classification on the Claims Aging Reports, and two other appear to correspond in virtually every case. The four services are: primary care physician services; Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children, advanced registered nurse practitioner (ARNP)/physician assistant (PA) services, and Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) services. We note that of these four services contributing to the baseline level, 95 percent of the total was contributed by primary care physician and EPSDT services.

The Data Book reports annualized utilization rates for each Medicaid service per 1,000 recipients by enrollment group, region, age and gender. In order to compare primary care utilization with the single estimate derived from each plan's Claims Aging Report, we calculated an aggregate (weighted) primary care utilization rates for all Medicaid recipients included in the Data Book calculation for the five counties.

The coarsest (i.e., most aggregated) utilization rates provided in the Data Book were totals that were rolled up for all ages and genders, but not for Medicaid regions (4 and 10) or enrollment groups (SSI or TANF-related). In order to arrive at a Reform Pilot-wide baseline utilization rate, we therefore manually computed a weighted average of the four constituent utilization rates (i.e., Region 4 + SSI, Region 4 +TANF, Region 10 + SSI and Region 10 + TANF). We computed such a weighted utilization rate for each of the four identified services. The sum of those rates then served as the pre-Reform baseline primary care utilization rate.

Limitations and Potential Sources of Error:

Although we attempted to review a complete set of Claims Aging Reports from all Reform plans over the course of 36 months, data was not available for some quarters for all operational plans. In some cases, the data appeared to be incomplete. In other cases, the data was not available because the plan apparently did not provide it to AHCA.

As noted previously, the high level of aggregation of the available data was such that the shortest period for which we could attempt to calculate the proxy utilization rate was a calendar quarter. In particular, it is impossible to determine with precision the month in which the primary care service that gave rise to any particular claim paid in a given quarter was delivered.

Finally, for the sake of completeness, it is necessary to mention some other potential sources of error, that is, factors that may explain differences between pre-Reform and Reform utilization rates other than changes in access itself. These include, but are not necessarily limited to:

1. Changes in the regional mix among Reform participants.
2. Changes in the overall SSI-TANF mix among Reform participants, particularly those resulting from recession-driven increases in Medicaid enrollment.
3. Variation within and among plans with respect to the average time elapsed between service delivery and the payment of the associated claim.

Final Notes Regarding Selection of Method:

Comparison of quarterly aggregate utilization rates was by no means the preferred method of gauging the impact of the Reform experiment on primary care access. Although many stakeholders have sought access to or analysis of patient encounter data, in its absence, we could only rely on the only data that has been made available.

It should be noted that the proxy primary care utilization rate only includes consideration of paid claims. Many plans with low utilization rates also had disconcertingly high claim denial rates. However, such denials may have resulted in providers' delivery of an unspecified amount of primary care services to recipients for which they were not reimbursed. Such provision amounts to charity care that is in effect not provided through or paid by Medicaid.

In addition, the proxy primary care utilization rate only includes consideration of whether or not a service is provided. The rate does not factor in the extent to which access to services has been denied, delayed, or discouraged. Although this may be less relevant in the primary care realm, allegations of denials of, delays in, or impediments to access are rampant in Reform. However, services that were never provided do not give rise to a claim, and therefore do not factor into utilization rates. Consequently, there are other barriers to access that have anecdotally been rampant in Reform that are not captured by this analysis.

Future Investigation:

As limited as this data and the statistics derived from them are, more investigation would shed additional light on access in Reform. In particular, we were only able to review Claims Aging Reports from Reform; undertaking similar analysis of non-Reform reports would be useful, although we would need to include data from MediPass in order to even attempt a comparison.

Analysis of specialty care utilization rates would also be instructive. This report focuses on primary care because specialty care provider participation is lacking, not only within the Reform Pilot, but in Medicaid as a whole. The view of the relationship between managed care plans' practices and utilization rates should therefore be less obstructed for primary care than for specialty care.

Addendum

On December 7, 2011, AHCA presented what was described as a preliminary analysis of Medicaid patient encounter data to the House Health and Human Services Committee.[26] The summary data provided were described as service utilization rates for FY 2009-10, specifically including "primary care" utilization rates, aggregated at the county level for each of the five Reform counties as well as for

selected non-Reform counties. These county-level rates were then compared with a 2009-10 statewide average utilization rate, which in the case of primary care was purported to be 486.0 services per 1,000 enrollees.

First, it seems clear that the rate in question is in fact 486 services per *100* enrollees, as statewide primary care access among this group could not have been so low as to have precluded the majority from accessing *any* primary care services during the course of an entire year.

Second, even assuming the rate indicated is per 100 enrollees, this statistic itself is not directly comparable to the primary care utilization rate discussed in this report, nor does it provide additional information about access to care in the Pilot counties. For its calculation, AHCA includes patient encounters pertaining to any among a range of 143 different procedure codes (mainly Current Procedural Terminology codes[27]) that pertain to the Evaluation and Management component[28] of Florida Medicaid-funded services. In particular, many of these procedure codes pertain to services such as provider office visits, which could be provided by either primary care providers or specialists. Although specialists certainly provide services that are procedurally unique to their specialty area, a high percentage of the services they bill must be classified as Evaluation and Management-related.[29] By contrast, the classification of services/claims for purposes of the Medicaid Data Book and the Claims Aging Reports used in this analysis is a function of the provider rather than the general nature and scope of the service provided. In short, AHCA's "primary care" utilization rates are inflated as a result of the inclusion of some care provided by specialists, and therefore over-report the actual provision of primary care, perhaps significantly.

More appropriate calculation of primary care utilization rates using encounter data will require factoring in diagnostic and perhaps provider codes into the analysis as well.

This report was researched and written by Greg Mellowe. The report and its findings do not necessarily reflect the views of the FCFEP Board of Directors.

Endnotes

[1] Florida Agency for Health Care Administration (AHCA), Application for 1115 Medicaid Research and Demonstration Waiver, August 2005, p. 60

[2] AHCA, Preliminary Comparative Analysis of Medicaid Encounter Data System (MEDS) Data, March 2010

[3] See, e.g., AHCA, Medicaid Reform Technical Advisory Panel, Medicaid Encounter Data System (MEDS) Update, August 2010, pp.8.1-8.3

[4] See AHCA, 2009-2012 Medicaid Managed Care Contract**,** Contract-Required Forms, Templates and Instructions

[5] Managed care organizations operating outside the Reform Pilot are required to file reports as well. Those operating both within and outside of Reform must file both reports.

[6] See AHCA, Comprehensive Medicaid Managed Care Enrollment Reports

[7] A primary care utilization of 100.0 equates to an average of precisely one primary care claim per recipient for the year. Therefore, if any recipients use more than one primary care service in a year, mathematically, a majority must therefore generate no claims at all (i.e., receive no primary care).

[8] United withdrew from Broward County in October 2008.

[9] At the same time, WellCare did not provide (or the state did not make available) claims summary reports until the third quarter of 2008, when the company's plans' withdrawal from Reform was already underway.

[10] Withdrawal dates can be determined, for example, from managed care enrollment reports.

[11] The "quarter prior to [a plan's] withdrawal" refers to any portion of the calendar quarter that includes the final date of participation in Reform during which the plan was operational.

[12] The utilization rate calculation for a plan's final quarter in Reform includes consideration of claims paid in ALL quarters subsequent to withdrawal. See Appendix.

[13] Refers to date of withdrawal from Broward County

[14] See Table 2

[15] See, e.g., Federal Bureau of Investigation, "Five Former Executives Indicted on Health Care Fraud Charges", March 2011

[16] See. e.g., Associated Press, "WellCare, United, other insurers cheat Florida kids program", July 2011

[17] See, e.g., AHCA, Final Orders (*database query of named insurers, executed November 2011*)

[18] See, e.g., National Center for Quality Assurance, 2010-11 Managed Care Plan Rankings, October 2011

[19] See, e.g., AHCA, Comprehensive Medicaid Managed Care Enrollment Report, November 2011

[20] The MediPass program is a form of primary care case management. Although considered a form of "managed care", it is substantially different from the from the managed care model used by managed care plans, and particularly from Medicaid HMOs that are paid on a capitated basis and bear financial risk.

[21] Not all Medicaid recipients and their service utilization are incorporated into the compilation of the Data Book. The Data Book population includes the groups of recipients who would be participants in the Reform Waiver for comparability purposes.

[22] See, e.g., AHCA, Health Plan Report Guide (effective 10/1/2011), p.67

[23] Such assessments are required because, in Reform, managed care plans are permitted to vary the amount, duration, and scope of certain benefits, subject to these actuarial equivalence and medical sufficiency requirements.

[24] AHCA, Medicaid Provider Reimbursement Handbook, UB-04 (July2008), pp.1-5

[25] AHCA, Medicaid Health Plan Contracts (5/1/2011), Attachment II, Exhibit 10, p.38

[26] Florida House of Representatives, Health and Human Services Committee, Meeting Packet, December 2011, pp. 102-111

[27] The American Medical Association defines, maintains and owns the copyright for the CPT coding set.

[28] See AHCA, Physician Evaluation and Management Fee Schedule, January 2011

[29] See, e.g., Codapedia, Top CPT Codes by Specialty for 2009, Date unknown (*last visited December 2011*)