Medicaid Solutions:
Florida's Medicaid cure for Illinois' ailing program

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For more than a decade, Illinois' Medicaid program has failed to meet the needs of the state's most vulnerable residents. Access to high-quality care has deteriorated, even as record amounts of taxpayer dollars are spent on the ballooning program.

Over the years, eligibility standards have been loosened to increasingly include middle-class families. Today, only 40 percent of Medicaid patients are in poverty, meaning that scarce budget money is being siphoned away from those most in need. To cope with ballooning enrollment and higher costs, the state has opted to ration the fees it pays for each service.

Sadly, the state's mismanagement of the Medicaid program has forced many doctors to opt out of the Medicaid program altogether. These factors have created an environment in which Medicaid enrollees are given a medical card, but very little access to care.

In many cases, Medicaid patients have a more difficult time finding a doctor and suffer worse health outcomes than even the uninsured. The problems were so bad that a federal judge ordered state officials to study them. The results of that study, detailed more thoroughly later in this report, recently were published in the New England Journal of Medicine.

Illinois' Medicaid program is a one-size-fits-all model that's broken, and it's failing Illinoisans on three fronts: costs, access to quality care and health outcomes. Illinois should follow the lead of states such as Florida and Louisiana and fundamentally transform how the program operates. To address these problems, Illinois should:

- Give Medicaid patients meaningful choices for their health plans from a variety of provider service networks and managed care organizations.
- Allow plan providers to customize their plans to meet the individual needs of their enrollees, which will help ensure plans compete on value.
- Pay plan providers a fixed, risk-adjusted monthly rate based on enrollment in a particular plan.

Florida's reform pilot is a proven success. It has improved access to quality care and delivered better health outcomes to its patients than the traditional Medicaid program. Better yet, the reform pilot has seen average annual savings of more than 20 percent when compared to per-person spending in Florida's traditional program.

Although these reforms can be implemented without a waiver from the federal government, the Obama administration already has extended Florida's reform pilot and recently approved Louisiana's similar statewide reform plan.

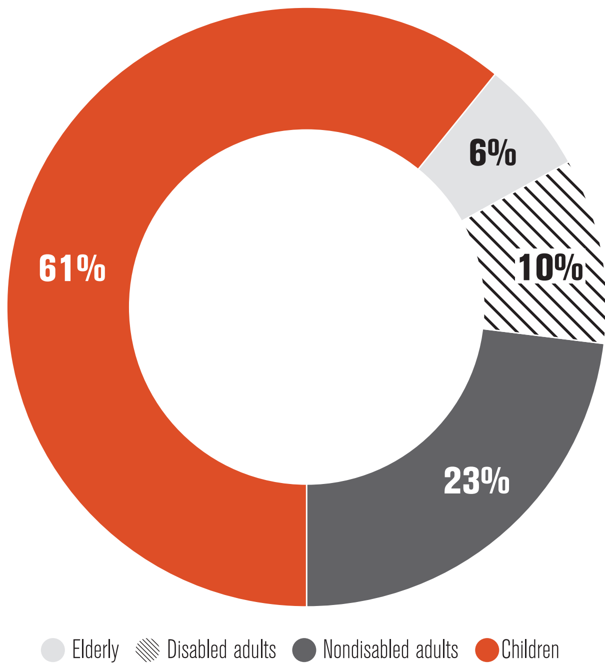
Transforming how Medicaid operates is the only solution that does right by both patients and taxpayers.

The Medicaid program was created as a temporary safety net for the poor and disadvantaged

Medicaid is a joint state and federal program that aims to provide medical care to the poor and disadvantaged. It is financed by federal, state and local taxes and is administered by state governments. Each state receives federal reimbursement of Medicaid expenditures according to their Federal Medical Assistance Percentage, or FMAP, rate. This rate can range from 50 percent to 83 percent of expenditures, depending upon the state's per capita personal income. Historically, half of all Medicaid spending in Illinois has been paid for with federal money.[1]

In Illinois, Medicaid serves both the nondisabled low-income population and the elderly, blind and disabled populations. While there might be some overlap between these two groups, each might require different policies tailored to their specific needs. Children and nondisabled adults account for 84 percent of enrollees in Illinois.[2]

Children and nondisabled adults make up a majority of Medicaid patients in Illinois



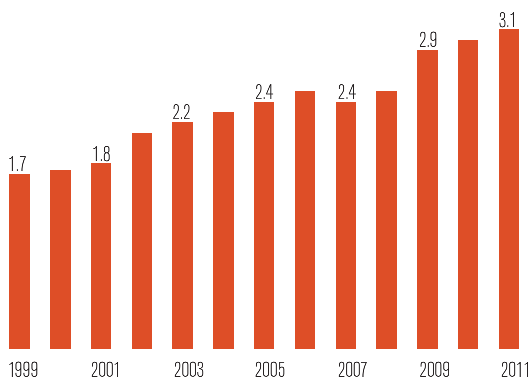
Source: Illinois Department of Healthcare and Family Services

The size of Illinois' Medicaid program has almost doubled since 2000

The number of people in Illinois' Medicaid program has increased significantly in recent years. In 2000, about 1.7 million people were enrolled in the program.[3] That number almost doubled to 3.1 million Illinoisans by 2011.[4] To put this in perspective, the state's population grew by only 3.5 percent during that same time period.[5]

Medicaid enrollment almost doubled during the course of a decade

Total number of Medicaid enrollees in Illinois by year, in millions

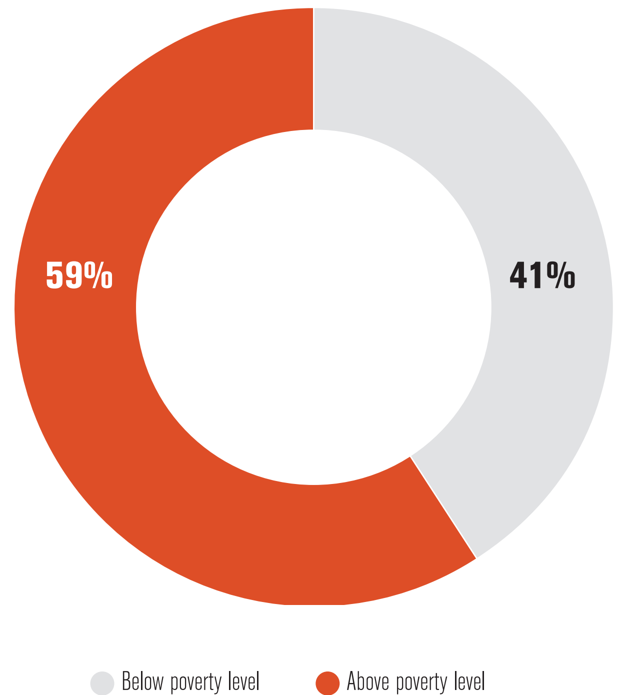


Source: Medicaid Statistical Information System

Additionally, as Medicaid grew, the composition of Medicaid enrollees changed. Medicaid historically has focused on individuals and families in poverty. As recently as 2003, a majority of Medicaid patients in Illinois had incomes at or below the federal poverty level.[6] But, over the years, eligibility standards were loosened to include more middle class families with higher incomes than previously allowed. Today, after years of expanding eligibility, almost 60 percent of Medicaid enrollees are above the federal poverty level.[7]

Most people on Medicaid are not in poverty

Enrollment in Illinois' Medicaid program by poverty level in 2012

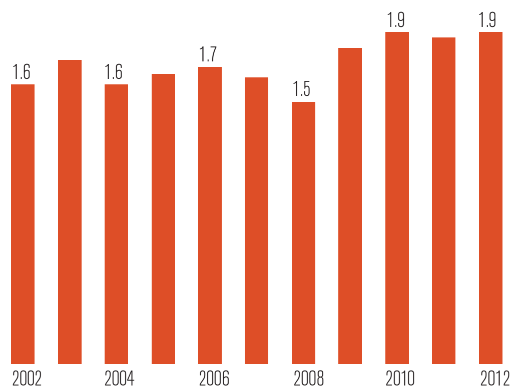


Source: U.S. Census Bureau

Ironically, even with these Medicaid expansions, the number of uninsured in Illinois continued to climb.[8] This suggests that rather than covering previously uninsured individuals, Medicaid expansions have crowded out private insurance coverage, leaving the uninsured population largely unaffected.[9-10] Sadly, eligibility expansions have diverted more Medicaid resources away from the poor and toward more middle-class families with access to private insurance.

Medicaid expansions have not reduced the number of uninsured

Number of uninsured people in Illinois, in millions



Source: U.S. Census Bureau

Medicaid patients often have 'coverage,' but lack access to quality care

The Medicaid program in Illinois operates on a fee-for-service basis. A fee-for-service system, as the name implies, means that the state reimburses doctors and hospitals at a specified fee for each service they provide.[11]

But ballooning enrollment in the Medicaid program has diverted more resources from the most vulnerable and toward middle-class families with access to private insurance. To cope with increasing enrollment and higher costs, the state is rationing the fees it pays for each service.

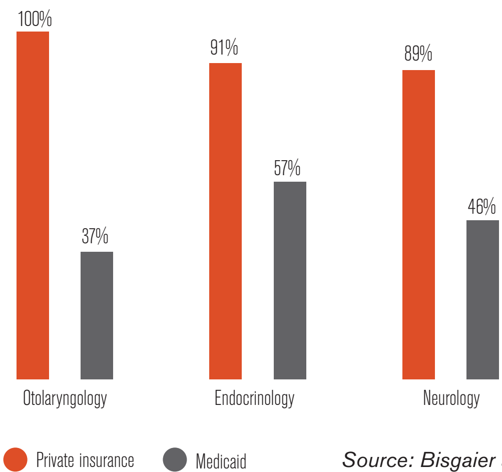
The fee-for-service structure incentivizes medical providers to perform more services, regardless of whether they are necessary, as a way to offset the low reimbursement fees offered by the state. As a result, patient care often is uncoordinated with other providers and health conditions are left unmanaged.

Sadly, the state's mismanagement of the Medicaid program has forced many doctors to opt-out of the Medicaid program altogether. These factors have created an environment in which Medicaid enrollees are given a medical card, but very little access to care.

Illinois' problems were so dreadful that in 2005 a federal judge ordered the state to study the access barriers the Medicaid program has created. The results of that study were published in the New England Journal of Medicine in 2011.[12] The study found that children on Medicaid were six times more likely than privately insured patients to be denied an appointment to see a specialist.[13] For some specialists, the barriers are even worse. Medicaid patients only have a one-in-five chance of seeing an orthopedic specialist, while privately insured patients are denied appointments only 2 percent of the time.[14] These same barriers exist when seeking new primary care physicians and urgent follow-up care.[15] A majority of doctors are taking few or no new Medicaid patients.[16] Indeed, Medicaid patients often are less likely to see a physician than uninsured patients, even in safety net clinics.[17-18]

Medicaid patients are far less likely to see a specialist

Likelihood of scheduling appointment, by insurance status and specialist type

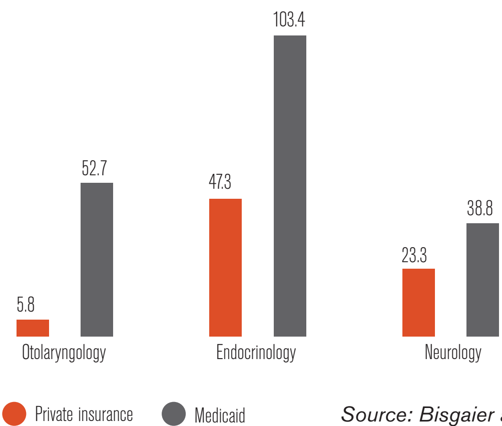


Source: Bisgaier and Rhodes

Even when doctors agree to see them, Medicaid patients often wait longer for services.[19] To see an endocrinologist, for example, children on Medicaid must wait an average of 103 days, more than twice as long as privately insured patients.[20] For all specialties, the average wait for Medicaid patients is 22 days longer than privately insured patients.[21]

Medicaid patients must wait longer to receive care

Length of wait times (days), by insurance status and specialty type

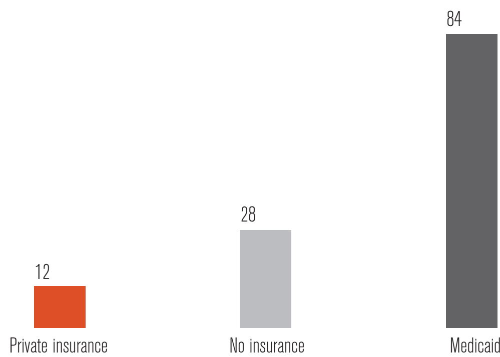


Source: Bisgaier and Rhodes

The access barriers Medicaid patients often face have forced many to seek nonurgent care from emergency rooms. Medicaid patients seek emergency room care about twice as often as both privately insured and uninsured patients.[22-23] This disparity is even larger for preventable conditions, such as hypertension, asthma and chronic obstructive pulmonary disease. Medicaid patients with preventable conditions seek hospital care seven times as often as privately insured patients, and three times as often as the uninsured.[24-25-26]

Access barriers force Medicaid patients to use emergency rooms for preventable conditions

Number of emergency department visits for preventable conditions per 1,000 people in 2007, by insurance status



Source: Tang et al.

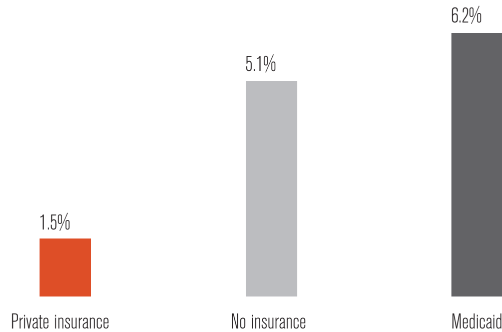
While this type of emergency room use steadily has declined for uninsured and privately insured patients, it has grown by 38 percent for Medicaid patients. Indeed, four out of five patients who seek emergency room care on a frequent basis are enrolled in either Medicare or Medicaid.[27] By segregating Medicaid patients into inferior care, the system ensures that when they're actually able to get care, usually from hospitals, it is at a much greater cost to the taxpayer.

Medicaid patients often face worse health outcomes

Medicaid's fee-for-service structure unfortunately has left patient care largely uncoordinated and conditions unmanaged. If and when Medicaid patients receive care, they frequently suffer worse outcomes than both privately insured and uninsured patients. Medicaid patients have the greatest risk of mortality during common surgeries and this greater risk remains even after discharge.[28-29] Medicaid patients experience the longest hospital stays and are more likely to have surgical complications.[30-31]

Medicaid patients are more likely to die after heart surgery

Likelihood of in-hospital death after percutaneous coronary intervention, by insurance type



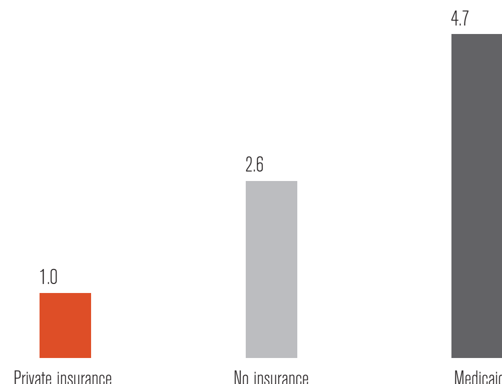
Source: Tang et al.

Much of this disparity stems from poor access to care. Because access to the very best providers is limited severely, Medicaid patients often are forced to use lower quality doctors, hospitals and specialists. High-volume surgical centers, for example, generally provide the best care.[32] Unfortunately, Medicaid patients are the least likely group to use these high-volume hospitals, ultimately leading to lower quality care.[33]

Limited access to early screening and treatment also contributes heavily to their poorer outcomes. Medicaid patients are more likely to be diagnosed with diseases at later, less treatable stages. The odds of being diagnosed with a late-stage melanoma, for example, are almost twice as high for Medicaid patients than for the uninsured, and almost five times greater than for those who are privately insured.[34] There are similar disparities in late-stage diagnosis for other types of cancer.[35-36]

Medicaid patients are diagnosed at later, less treatable stages

Odds ratio of being diagnosed with late-stage melanoma by insurance type



Source: Roetzheim et al.

Florida fundamentally has transformed how Medicaid operates

For years, Florida's Medicaid program was plagued with many of the same problems as its counterpart in Illinois. But in 2005, Florida enacted a bipartisan plan to fundamentally restructure its Medicaid program.[37-38]

In the traditional Medicaid program, patients are all dumped into the same health plan without regard to their diverse conditions and unique needs. Patients are lumped together in the same plan whether they have autism, diabetes or breast cancer.

But rather than impose a one-size-fits-all model on Medicaid patients, the Florida reform pilot created a new, patient-centered approach.[39] This approach allowed patients to choose from as many as 11 insurance plans offering a wide variety of benefits and providers networks.

The state contracts with the plan providers to buy fully capitated health plans. These plans are paid a flat monthly rate for each enrolled individual, which is then risk-adjusted for that individual's health status. The fixed monthly rate is paid in exchange for the health plan to provide all Medicaid-covered services for individual patients. This framework shifts the risk of waste, fraud and abuse from the taxpayer back to the health plans that are managing and coordinating patients' care. This payment arrangement also provides health plans with financial incentives to identify and treat health conditions earlier. By risk-adjusting the rates, these fixed rates provide plans with an incentive to compete for sicker patients and manage their care more effectively.

The reform pilot, which has been in place since 2006, covered low-income families, the elderly and the disabled in both urban and rural counties with a combined population of almost 3 million residents. In 2011, Florida passed legislation to launch the reforms statewide.[40-41]

Florida's reforms empower patients with real choices

The Florida reforms were designed to empower patients by giving them meaningful choices for their health plans. Health plan providers compete for patients based on value. If patients are unhappy with their plan, they can choose a new plan that provides them with better value based on their individual needs and situation.

One way these plans compete is by customizing their benefits to better meet the needs of their patients. This has allowed plans to include benefits not typically covered by the traditional Medicaid program, including over-the-counter drugs, vision and preventative dental coverage, nutrition therapy and respite care. The reform pilot even includes specialized plans for Medicaid patients who are HIV positive or have AIDS. In 2012, plan providers offered 31 customized benefit packages from which to choose.[42]

When given meaningful choices, patients are empowered to take more control over their health care decisions. Indeed, between 70 and 80 percent of patients in the reform pilot selected their own health plan.[43]

The reform pilot also launched a choice counseling program to help patients select plans that met their own needs and situations. The choice counseling program provides patients with comparisons of primary care and specialist networks, hospital networks and preferred drug lists, among other things.[44]

Surveys offered to all patients who use choice counseling to enroll or make a plan change show that this counseling is very helpful to patients. More than 90 percent found the counseling services helpful and 95 percent would recommend the counseling to a friend.[45]

Patients also generally seem to be satisfied with their plan choices. In 2012, the Florida agency that oversees Medicaid received just 6 complaints for every 10,000 patients. [46] The plans seem to be successfully resolving these complaints, as no unresolved grievances were filed in 2012. [47]

When surveyed, patients in the reform pilot reported high satisfaction with their plans. In both the urban and rural counties, patients generally reported that they had no problem finding personal doctors whom they liked.[48] They also reported that their personal doctor usually or always listened to them, explained things easily and spent enough time with them.[49-50-51]

Florida's reforms improve health outcomes for Medicaid patients

The Florida reform pilot isn't just delivering greater choices to patients, it's delivering better results. Florida can measure plan performance by using the Healthcare Effectiveness Data and Information Set, or HEDIS, which is a set of metrics used by more than 90 percent of health plans in the United States.

Reform plans outperformed the traditional Florida Medicaid program on 19 of 30 health performance measures.[52] Among the remaining 11 performance measures, the scores for reform plans were within 3 percentage points of those for the traditional program.[53] Among the performance measures that were tracked regularly during the pilot, 82 percent have improved since 2008.[54] The reform plans outperform Illinois on several, although not all, performance measures, as well.[55] Florida's reform patients, for example, were 1.7 times more likely than Illinois Medicaid patients to be screened for breast cancer every two years and 1.4 times more likely to control high blood pressure and diabetes through proper disease management.[56]

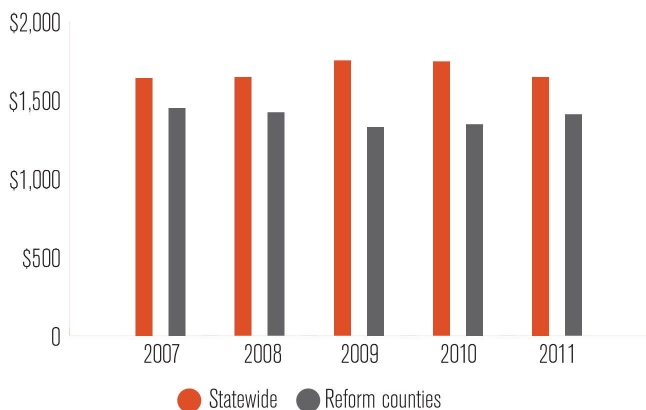
Florida's reforms save money

Florida has seen substantial savings from its Medicaid reform pilot. The reform pilot's capitated rates consistently have been lower than the state's per-person spending on similar populations statewide.

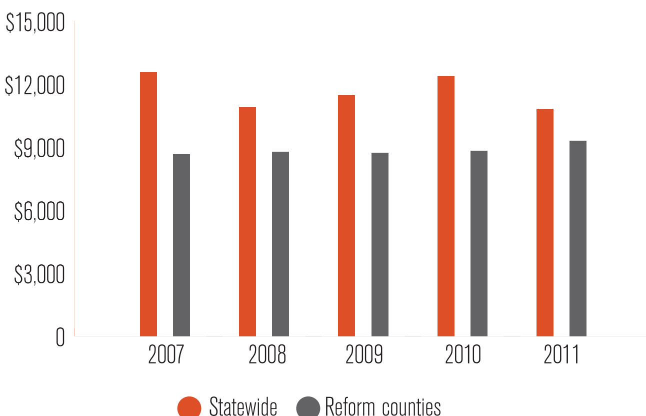
In 2011, for example, Florida spent $1,647 a person to provide medical care to low-income children and families in its traditional Medicaid program.[57] On the other hand, the capitated rates in the reform pilot were just $1,406 a person.[58] Likewise, Florida spent $10,801 a person to provide medical care to the elderly and disabled populations in its traditional Medicaid program.[59] In the reform counties, however, the capitated rates for this population were just $9,300 a person.[60] Altogether, the reform pilot's capitated rates were 14.3 percent lower than spending in the traditional program during 2011.[61] Historically, these capitated rates averaged 20.8 percent lower than spending in the traditional program.[62]

Florida's Medicaid reform pilot spends less than traditional Medicaid

Spending per-person in reform counties and statewide
Children and families



Spending per-person in reform counties and statewide
Elderly and disabled



Source: Medicaid Statistical Information System; Florida Agency for Health Care Administration

Illinois could see significant savings by implementing the Florida reforms. In 2011, for example, Illinois spent $1,575 a person to provide medical care to low-income children and families in its traditional Medicaid program.[63] It also spent $14,131 a person to provide care to elderly and disabled patients.[64]

If Illinois were to match the savings that Florida's reform pilot has seen, taxpayers would be able to give greater control to millions of Illinoisans while capturing $1.1 billion in annual budget savings.[65-66]

Illinois could have saved $1.1 billion if it had implemented Florida's Medicaid cure in 2011

Illinois' actual Medicaid spending in 2011 and estimated spending based on the Florida reform pilot's historical savings

	Without reform	With reform	Savings
Targeted populations			
Total spending	$5.22 billion	$4.13 billion	$1.09 billion
Spending per person	$2,367	$1,874	$493
Non-targeted populations			
Total spending	$6.66 billion	$6.66 billion	-
Spending per person	$7,192	$7,192	-
Combined			
Total spending	$11.88 billion	$10.79 billion	$1.09 billion
Spending per person	$3,795	$3,447	$348

Source: Medicaid Statistical Information System; Florida Agency for Health Care Administration; Illinois Policy Institute

Illinois can implement reforms without federal waivers

Illinois can implement Florida's Medicaid reforms statewide without going through the burdensome waiver process, as federal law already permits mandatory assignment for these populations.[67]

Instead, the state simply would need to file a state plan amendment. While the federal government has wide discretion to reject waiver requests, it must generally approve any state plan amendment that meets statutory requirements. The federal government only has 90 calendar days from submission to act on the state plan amendment.[68] In late 2011, the Obama administration approved Louisiana's state plan amendment to implement similar reforms.[69] The administration also approved Florida's request for a three-year extension of its reform pilot in 2011.[70]

In addition to the state plan amendment, Illinois should seek greater flexibility by asking to receive a federal matching block grant. This block grant should be accompanied by a global waiver, freeing the state from much of the federal micromanagement the current program faces. In exchange for giving the state more freedom, the federal government would receive budget certainty and, ultimately, long-term savings. Illinois should seek a block grant equal to what it could be expected to receive under the current state plan.

Why this works

Illinois' Medicaid system does not provide its patients with true access to care despite its enormous price tag for taxpayers. Instead of continuing to pour money into a failing system, Medicaid needs to be fundamentally restructured.

The one-size-fits-all system has not worked. By transforming Medicaid into a program that provides patients with meaningful choices from a variety of private plans, the state can improve health outcomes while spending less taxpayer money.

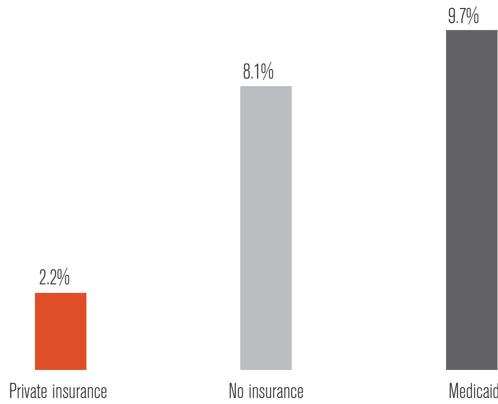
These reforms will stabilize spending through strong competition on value and market forces. They would give the most vulnerable residents the freedom to choose health plans that meet their needs, rather than the requirements imposed by bureaucrats in Springfield or Washington. The freedom to select plans based on price, range of options and quality would foster a competitive market that creates more value for less money.

Transforming Medicaid into a program that provides patients with meaningful choices also would give Medicaid enrollees a vested interest in making sure that their health care dollars are spent efficiently by empowering them to find the best value in plans and providers. By providing patients with choice counseling and support, we can empower them to take more control over their health care decisions.

This program also would ensure that the most vulnerable members of society have real access to quality care, have their care properly coordinated and their conditions managed more appropriately. Doctors no longer will need to limit the number of Medicaid patients they see because of low and late reimbursements from state bureaucrats. Instead, Medicaid patients will look like any other patients with a private plan. With these changes, Medicaid can be a program that offers actual access to health care, not just meaningless coverage.

Medicaid patients are more likely to die or have another heart attack after heart surgery

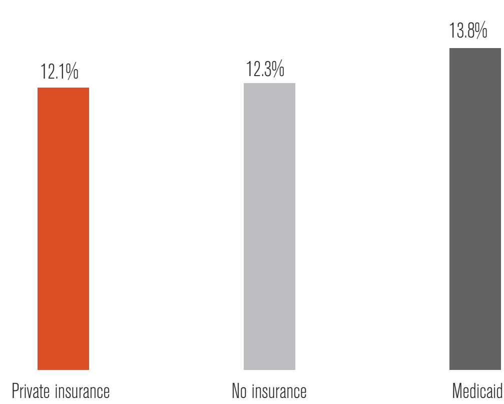
Likelihood of major adverse cardiac events within 30 days after percutaneous coronary intervention



Source: Gaglia et al.

Medicaid patients experience the most complications

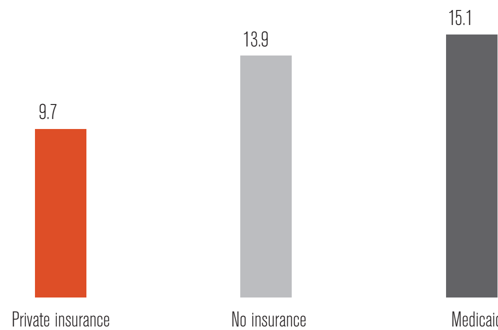
Likelihood of pulmonary complications after cardiac valve operations, by insurance type



Source: LaPar et al.

Medicaid patients experience the longest hospital stays

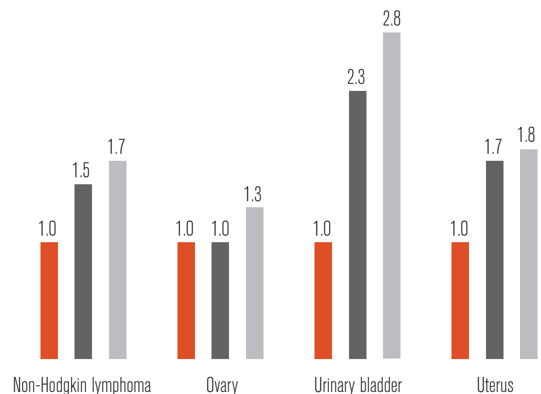
Number of days spent in hospital for cardiac valve operations, by insurance type



Source: LaPar et al.

Medicaid patients are diagnosed at later, less treatable stages

Odds ratio of being diagnosed with late stage cancer, by cancer type



Source: Halpern et al.

Florida's Medicaid reform plans outperform Illinois' plans on several measures

Comparison of select HEDIS measures for the Medicaid program in Florida and Illinois

Performance measure	Florida (traditional)	Florida (reform)	Illinois
Childhood immunization (combo 2)	71.4%	70.0%	71.6%
Childhood wellness visits (3-6 years)	74.9%	72.7%	74.6%
Adolescent wellness visits	45.7%	46.3%	41.6%
Adult access to preventative care (20-44)	67.9%	71.2%	66.9%
Adult access to preventative care (45-64)	81.2%	84.9%	68.1%
Breast cancer screening	50.1%	56.9%	33.8%
Postpartum care	52.7%	52.1%	44.3%
Blood pressure control	53.0%	53.4%	38.0%
Diabetes management (HbA1c testing)	76.4%	82.8%	69.3%
Diabetes management (LDL screening)	77.9%	83.5%	60.6%
Appropriate asthma medications	87.0%	87.6%	87.4%

Source: Florida Agency for Health Care Administration; Illinois Department of Healthcare and Family Services

ENDNOTES

[1] Author's calculations based upon annual FMAP rates for fiscal years 1961 through 2011. See, e.g., Assistant Secretary for Planning and Evaluation, "Federal percentages and federal medical assistance percentages, FY 1961 - FY 2011," Department of Health and Human Services (2011), http://aspe.hhs.gov/health/fmapearly.htm.

[2] Author's calculations based upon Title XIX and Title XXI enrollment data provided by the Department of Healthcare and Family Services.

[3] In 2000, there were 1,736,185 unique individuals with personal identification numbers in Illinois' Medicaid program. Approximately 1,519,313 of these had a paid amount adjudicated during the fiscal year. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2000 Quarterly Cube," Department of Health and Human Services (2001), http://msis.cms.hhs.gov/.

[4] In 2011, there were 3,130,791 unique individuals with personal identification numbers in Illinois' Medicaid program. Approximately 2,917,389 of these had a paid amount adjudicated during the fiscal year.

See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Department of Health and Human Services (2001), http://msis.cms.hhs.gov/.

[5] Author's calculations based upon federal population estimates from the U.S. Census Bureau. According to census data, Illinois had 12.4 million residents in 2000 and nearly 12.9 million residents in 2011.

[6] Author's calculations based upon 2003 census data disaggregated by Medicaid enrollment and by income-to-federal poverty level ratio. See, e.g., Census Bureau, "Current Population Survey's Annual Social and Economic Supplement," Department of Commerce (2003).

[7] Author's calculations based upon 2012 census data disaggregated by Medicaid enrollment and by income-to-federal poverty level ratio. See, e.g., Census Bureau, "Current Population Survey's Annual Social and Economic Supplement," Department of Commerce (2012).

[8] Author's calculations based upon 2003-12 census data disaggregated by health insurance status. See, e.g., Census Bureau, "Current Population Survey's Annual Social and Economic Supplement," Department of Commerce (2012).

[9] The crowd-out effect is further evidenced by the fact that the number of impoverished Illinoisans who are employed increased over the same time period, that employer-sponsored insurance offer rates remained relatively stable and that the number of Illinoisans with private insurance decreased in each of these income brackets.

[10] Author's calculations based upon 2003-12 census data disaggregated by health insurance status, income-to-poverty ratio and employment status. See, e.g., Census Bureau, "Current Population Survey's Annual Social and Economic Supplement," Department of Commerce (2012). See also, Gary Claxton et al., "Employer health benefits: 2011 annual survey," The Kaiser Family Foundation (2011), http://ehbs.kff.org/pdf/2011/8225.pdf.

[11] In fiscal year 2011, approximately $10.4 billion of the state's $11.9 billion Medicaid budget was billed as fee-for-service. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html.

[12] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[13] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[14] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[15] Katherine Iritani, "Most physicians serve covered children but have difficulty referring them for specialty care," Government Accountability Office (2011), http://www.gao.gov/new.items/d11624.pdf.

[16] Only 45 percent of primary care physicians are accepting most or all new Medicaid patients. See, e.g., Center for Studying Health System Change, "Health tracking physician survey, 2008," Inter-university Consortium for Political and Social Research (2010), http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/27202.

[17] Brent R. Asplin et al., "Insurance status and access to urgent ambulatory care follow-up appointments," Journal of the American Medical Association 294(10): 1248-54 (2005), http://jama.ama-assn.org/content/294/10/1248.

[18] Approximately 77 percent of primary care physicians accept at least some uninsured patients who are unable to pay for services, while 46 percent accept all or most of them. See, e.g., Center for Studying Health System Change, "Community tracking study physician survey, 2004-2005," Inter-university Consortium for Political and Social Research (2008), http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/4584.

[19] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[20] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[21] Joanna Bisgaier & Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," New England Journal of Medicine 364: 2324-33 (2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.

[22] Amy B. Bernstein et al., "Health, United States, 2010: With special feature on death and dying," National Center for Health Statistics (2011), http://www.cdc.gov/nchs/data/hus/hus10.pdf

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[48] More than 86 percent of reform pilot patients in urban counties and more than 82 percent of reform pilot patients in rural counties reported having no problem finding a personal doctor that they liked. Approximately 8.5 percent of reform pilot patients in urban counties and 10 percent of reform pilot patients in rural counties reported minor problems finding a doctor that they liked. See, e.g., R. Paul Duncan et al., "Medicaid reform enrollee satisfaction: Year two follow-up survey," Florida Agency for Health Care Administration (2010), http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol1_County_Estimates.pdf.

[49] Approximately 91 percent of reform pilot patients in urban counties and nearly 93 percent of reform pilot patients in rural counties reported that their personal doctors usually or always explained matters to them in a way that was easy to understand. See, e.g., R. Paul Duncan et al., "Medicaid reform enrollee satisfaction: Year two follow-up survey," Florida Agency for Health Care Administration (2010), http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol1_County_Estimates.pdf.

[50] Nearly 85 percent of reform pilot patients in urban counties and nearly 88 percent of reform pilot patients in rural counties reported that their personal doctors usually or always spent enough time with them. See, e.g., R. Paul Duncan et al., "Medicaid reform enrollee satisfaction: Year two follow-up survey," Florida Agency for Health Care Administration (2010), http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol1_County_Estimates.pdf.

[51] Nearly 93 percent of reform pilot patients in both urban and rural counties reported that their personal doctors usually or always listened to them. See, e.g., R. Paul Duncan et al., "Medicaid reform enrollee satisfaction: Year two follow-up survey," Florida Agency for Health Care Administration (2010), http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol1_County_Estimates.pdf.

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[55] Health Services Advisory Group, "External quality review technical report: HEDIS 2010 Medicaid rates," Illinois Department of Healthcare and Family Services (2010), http://www2.illinois.gov/hfs/ManagedCare/Documents/112811_hedis.pdf.

[56] Author's calculations based upon reported HEDIS measures.

[57] Author's calculations based upon federal data from the Medicaid Statistical Information System. Statewide spending per person includes individuals and expenditures for patients who are over the age of 1 with a basis of eligibility of children, adults, unemployed adults, children of unemployed adults and foster care children. Statewide spending per person excludes individuals and expenditures for patients who are under the age of 1, dual-eligibles or medically needy. Statewide spending per person also excludes individuals and expenditures for patients receiving medical care at intermediate care facilities for individuals with mental retardation. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html.

[58] Author's calculations based upon capitated monthly rates for low-income children and families in the five reform counties, weighted by each counties' enrollment in the pilot. See, e.g., Justin Senior, "Medicaid Reform HMO capitation rates by area, age and eligibility category/population," Florida Agency for Health Care Administration (2010), http://www.fdhc.state.fl.us/mchq/managed_health_care/mhmo/docs/MCAID/1011_Rates/Attach-I_Exhibit2-R_rates-effective_2010-09-01.pdf.

[59] Author's calculations based upon federal data from the Medicaid Statistical Information System. Statewide spending per person includes individuals and expenditures for patients who are over the age of 1 with a basis of eligibility of aged, blind or disabled. Statewide spending per person excludes individuals and expenditures for patients who are under the age of 1, dual-eligibles or medically needy. Statewide spending per person also excludes individuals and expenditures for patients receiving medical care at intermediate care facilities for individuals with mental retardation. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html.

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[61] Author's calculations based upon federal data from the Medicaid Statistical Information System and from the capitated rates in the Medicaid reform pilot.

[62] Author's calculations based upon federal data from the Medicaid Statistical Information System and from the capitated rates in the Medicaid reform pilot for fiscal years 2007 through 2011.

[63] Author's calculations based upon federal data from the Medicaid Statistical Information System. Statewide spending per person includes individuals and expenditures for patients who are over the age of 1 with a basis of eligibility of children, adults, unemployed adults, children of unemployed adults and foster care children. Statewide spending per person excludes individuals and expenditures for patients who are under the age of 1, dual-eligibles or medically needy. Statewide spending per person also excludes individuals and expenditures for patients receiving medical care at intermediate care facilities for individuals with mental retardation. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html.

[64] Author's calculations based upon federal data from the Medicaid Statistical Information System. Statewide spending per person includes individuals and expenditures for patients who are over the age of 1 with a basis of eligibility of aged, blind or disabled. Statewide spending per person excludes individuals and expenditures for patients who are under the age of 1, dual-eligibles or medically needy. Statewide spending per person also excludes individuals and expenditures for patients receiving medical care at intermediate care facilities for individuals with mental retardation. See, e.g., Medicaid Statistical Information System, "State Summary Datamart: FY 2011 Quarterly Cube," Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html.

[65] Author's calculations based upon federal data from the Medicaid Statistical Information System and Florida's reform pilot savings. If these reforms had been enacted in fiscal year 2011, the state could have seen savings of $1.09 billion.

[66] For a similar estimate of savings, see Tarren Bragdon and Christie Herrera, "Florida's Medicaid cure: Big taxpayer savings for every state," Foundation for Government Accountability (2012), http://www.medicaidcure.org/wp-content/uploads/2013/01/Medicaid-Cure-Policy-Brief-1.pdf.

[67] States may generally require individuals to enroll with a managed care entity as a condition of receiving Medicaid assistance. Federal law exempts patients who are eligible for both Medicare and Medicaid, certain children with special needs and members of Indian tribes from this requirement. See, e.g., 42 U.S.C. 1396u–2(a)(1)(A).

[68] The federal government can file a formal request for additional information, which stops the 90-day clock until the state provides a written response. The federal government is then given up to an additional 90 calendar days to act upon the state plan amendment.

[69] Bill Brooks, "Letter to Louisiana Department of Health and Hospitals regarding State Plan Amendment Transmittal No. 11-21," Centers for Medicare and Medicaid Services (2011), http://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/LA-11-21-Ltr.pdf.

[70] Cindy Mann, "Letter to Florida Agency for Health Care Administration regarding Project No. 11-W-00206/4," Centers for Medicare and Medicaid Services (2011), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/CMS_Approval_Letter_12-15-2011.pdf.

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