Racial Disparities:
The Elderly Population in the Medicaid Program

AN ACTION REPORT SUBMITTED TO THE FACULTY OF THE COLLEGE OF SOCIAL SCIENCE IN CANDIDACY FOR THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION

REUBIN O’D. ASKEW SCHOOL OF PUBLIC ADMINISTRATION AND POLICY

BY

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Dear Dr. Ross:

I have the honor to submit to you Racial Disparities: The Elderly Population in the Medicaid Program. The report is the product of extensive research and analysis over the spring months of 2003. Racial disparities in the Medicaid program are important because the majority of Florida’s Medicaid recipients are minorities. Unfortunately, these racial disparities have gone undetected which has lead to a wide array of health disparities in the program. Furthermore, because the elderly population represents at least two-thirds of the recipients, the elderly minorities will suffer the greatly.

Having examined several options, my recommendation is to retain Florida’s current program. Currently, it is the strongest provider to eliminate racial disparities through performance reports, outreach programs and member satisfaction surveys. This policy alternative is recommended based on three criteria: administrative feasibility, political desirability, and member satisfaction.

The current program has a sound foundation and attainable objectives to eliminate racial disparities. The other two options need administrative reform and strategic policy objectives to make each alternative function well. The expansion of the current program did well on two of the criteria. The integrated comparative system that would perform an on-going analysis on various health outcomes scored the lowest for two of the criteria.

This recommendation has the potential to improve the overall program. Furthermore, state or federally funded programs provide health care services that are given to the majority of the elderly in this state. Therefore it is necessary to treat and provide all parties with an unbiased approach. The current program with its initiatives and policies
will help Florida effectively eliminate racial disparities in its Medicaid program for the elderly population.

Respectfully,

Danielle C.O. Foard
Legislative Analyst
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EXECUTIVE SUMMARY

America is witnessing dramatic improvements regarding health outcomes and scientific medicines. The ability to detect early stages for a particular medical condition has been the hallmark of scientific progress. Despite all the improvements and initiatives in health promotion and preventive medicine, racial and ethnic minorities have received less from these medical advances than others. Racial disparities were created due to unequal access, utilization, and quality of care. Unfortunately, as a result, health disparities have continued to exist.

Florida’s Medicaid program provides a health care safety net for all low-income indigent persons. It provides coverage for 1.8 million people of Florida’s population. While the elderly only represent one-third of Medicaid beneficiaries, they account for 69 percent of program spending. Furthermore, out of that 69 percent, two-thirds are minorities.

Information for this report was collected using three methods. First, popular media, surveys, and academic literature were analyzed to provide insight into the chronological background of current policy problems to eliminate racial disparities in the Medicaid program for the elderly population. Second, governmental publications, applicable laws, regulations, proposed legislation, policies, and planning documents were reviewed to determine statutory requirements and statistical data on various options to remedy the prevalence of racial disparities in the governmental program. Third, key agency leaders and staff members of the Agency of Health Care Administration, the Department of Health and Human Services, and the Regional Commissioner of Social Security Insurance were contacted to provide insight into pertinent issues.
This report presents three policy options for the elimination of racial disparities among the elderly population in the program: Maintain the Current Medicaid Program, Expand the Current Medicaid Program, and Develop an Integrated System for Comparative Analysis. Each option is evaluated against three criteria: administrative feasibility, political desirability, and member satisfaction.

Based on the assessment of alternatives using the three criteria, maintaining the current Medicaid system is recommended. Maintaining the current program is the most viable option to eliminate racial disparities among the elderly population. Overall the Agency of Health Care Administration (ACHA), the department that regulates Florida’s program, has the expertise and knowledge to effectively execute a program that eliminates racial disparities among the elderly (OPPAGA, 2001). The other two options are not as effective in accomplishing these goals. Even though ACHA has room for improvement, it has shown that it can efficiently develop methodologies, and policies to evaluate good health outcome, access and quality of care for Medicaid’s minority elder population.
I. PROBLEM STATEMENT

The problem that has emerged, in regards to the Medicaid program, is that between races, we find that elderly White Caucasians (statistically the minority) vs. elderly African-Americans and elderly Non-Whites (statistically the majority) utilize and benefit more from this federal and state funded program.

Currently, racial disparities are playing a major role in the “Quality of Care” for elderly enrollees in the Medicaid system. Some proponents suggest that clinical as well as non-clinical or psychological factors (physician/patient rapport) account for these disparities. Although elderly African Americans and Non-Whites make up the two-thirds of the majority of the Medicaid program, these minority groups are most likely found to receive less and inferior health-care than Whites (Edwards, 2001). Whites are more likely than African Americans to receive newer and higher technology services/procedures (Ayanian, Chasan, Epstein, and Weissman, 1999).

More specifically, this paper will focus on the elderly population that makes up Florida’s Medicaid constituents. By evaluating this current problem we will use race as our independent variable and socioeconomic/low-income/below poverty-level status as our dependent variable. In addition, the use of gender will be a bi-variate factor.

The purpose of this action report is to examine alternative solutions to combat Medicaid racial and ethnic disparities among the elderly. The benefits of solving and eliminating racial and ethnic disparities will result in preventing disease, promoting health and delivering appropriate care efficiently and effectively. Intervention and prevention are the key necessities to improve health-care and on the larger scale, to decrease health-care costs.
I. BACKGROUND & LITERATURE REVIEW

Background

This section discusses the historical evolution of Florida’s Medicaid program. First, the report describes the program in its entirety. The second and third component of this section explains who administers the program and who is eligible to receive it. Lastly, an overview is given to summarize all the topics that are examined. The topics examined are: past and current Medicaid program legislation; various types of managed-care programs; and the demographic make-up of the Medicaid program.

What is Medicaid?

Medicaid, also known as Title XIX of the Social Security Act, is a program that is jointly financed by the federal and state government. The federal government provides Florida with $5 billion or 55% of program cost, 34% from state revenue, 6% from grants and donations, 4% from Public Medical Trust Funds (PMATF), which is financed by taxes on hospitals, and 1% from the tobacco settlement and refugee assistance trust fund (FHA, 2001). Currently, the state of Florida’s budget is approximately $46.7 billion and $9.6 billion is appropriated for the Medicaid program for the fiscal year 2001-2002 (FHA, 2001). Medicaid spending represents 21% of the state’s budget. All persons that receive Medicaid must qualify based on assets and income, which must be below the threshold levels established by each state (Shi and Singh, 2001).

On January 10th 1970, Florida implemented the Medicaid program to provide health-care/medical services to indigent people. In 1989, the United State Congress mandated that all states must provide Medicaid services to those who are covered by the Social Security Act and to children under the age of 21. Currently there are two bodies that are covered and eligible to receive Medicaid benefits: low-income children and families, and the aged, blind or disabled.
Florida’s Medicaid program ranked 7th in the nation in Medicaid expenditures, however, ranked 4th in the nation for Medicaid recipients. The Medicaid program expends almost $12 million for health-care services for approximately 1.8 million clients each month (Agency of Health Care Administration, Medicaid Health Care Services, 2002). In order for Florida to receive federal Medicaid funds, it must uphold all federal regulations and guidelines. Some of these guidelines include mandatory physician visits, family planning, laboratory tests, x-rays, and health screening services for all Medicaid clients. The state of Florida is one of the few states that offer optional services, such as dental care for those under the age of 21, prescription drugs, hospice care and cover over 35 different health-care services.

Administration of Florida’s Medicaid

The Agency for Health Care Administration (AHCA) administers Florida’s Medicaid program. In 1992, the Florida Legislature created AHCA, a single entity of the state to govern the responsibilities for the Medicaid program (HCFA, 2001). The Department of Children and Families (DCF) and the Social Security Administration are authorized and determine all Medicaid recipient eligibility.

AHCA has overall and final authority in regards to Medicaid regulation, policy, and procedures. Some of AHCA’s duties and responsibilities fall under the umbrella of:

- Regulate and maintain Medicaid’s state plan by initiating and approving amendments before they are sent to Health Care Finance Administration (HCFA).
- Distribute state plan update to DCF and other concerned constituents.
- Coordinate with DCF on all administrative guidelines that pertain to the mission and goals, program, and budget of DCF.
- Approval of guidelines and regulations pertaining to the Medicaid program before implementation.
- Approval of all recommendations by DCF for Medicaid policy prior to implementation.
AHCA the agency is also the sole recipient of all federal funds which than is dispersed to various entities such as DCF and other governmental agencies that provide health care services to Medicaid beneficiaries. AHCA must comply with all state and federal regulations in regards to cash flow management and accountability for the funds to be allocated effectively.

Medicaid Eligibility

All Medicaid clients in the state of Florida must be enrolled in a managed-care program. Currently, Florida has two managed-care programs: Prepaid Health Plans (PHPs) and the Medicaid Provider Access System (Medi-Pass).

The PHPs program was implemented in 1982, which contracts out to private health plans that will provide prepaid medical services to the enrolled Medicaid client. Florida’s most common type of PHP provider is a Health Maintenance Organization (HMO) however, the Provider Service Network (PSN) also falls under a PHP. A monthly fee is paid out to the PHP for every Medicaid enrollee, which is set at a fixed rate of 92% of the expected cost for the providing services (Agency of Health Care Administration, Medicaid Health Care Services, 2002). Currently, there are 644,000 Medicaid recipients that were enrolled in 15 different types of private health plans that were distributed throughout 36 of the 67 counties in Florida (Agency of Health Care Administration, Medicaid Health Care Services, 2002). The Medi-Pass system was implemented in October 1991. It assigns a primary care physician who is responsible for providing the care that is necessary for the Medi-Pass clients. This system was built to ensure adequate efficiency and access to primary care by reducing moral hazard, and control program costs. This particular program differs from the PHP in several ways; (1) A Medi-Pass primary care physician is given a monthly case management fees vs. an HMO; (2) An additional fee-for-service reimbursement for each service provided to the client is paid out to the primary care
physician; and (3) The services that are provided, are provided through private contracts with private management organization (Agency of Health Care Administration, Medicaid Health Care Services, 2002). Currently, there are 637,000 Medicaid recipients that are enrolled in Medi-Pass (Agency of Health Care Administration, 2002).

Overview

On a national level, elderly women constitute most new cases and deaths from breast cancer, and minority women carry the bulk of this burden two-fold (Gold, Mandelblatt, and O’Malley, 1999). Despite Medicaid reimbursement for the services that were rendered, African-American women 65 years of age or older were less likely to have had a mammogram than their white counter-parts (Eggers, Fitternm an Gornick, Kucken, Mentnech, Reilly, and Vladeck; 1996). In 1996, the fifth leading cause of death for the elderly population was influenza and pneumonia. Between the Medicare and Medicaid population, Whites had been vaccinated more so than Hispanics and African-Americans (FHA, 2001). The low-income population of dually enrolled Medicare and Medicaid recipients are at a greater health risk due to disparities in contrast to other Medicare beneficiaries (Kaiser Commission, 1999).

According to the Health Plan Employer Data and Information Set (HEDIS), which is developed by the National Committee for Quality Assurance (NCQA), 62.9 percent of Blacks received breast cancer screening vs. 70.9 percent of Whites; eye exams were given to 43.6 percent of Blacks with diabetes compared to 50.4 percent of Whites; beta-blockers were administered after heart attacks to 64.1 percent of Blacks compared to 73.8 percent of Whites; post-op follow-ups after hospitalizations for mental illness were performed on 33.2 percent of Blacks compared to 54.0 percent of Whites (Epstein, Schneider, Zaslavsky, 2002). The research
that was done by HEDIS, had a sample pool of over 350,000 enrollees, 65 years of age or older in the lower-income bracket.

In retrospect, the evolutionary history of Florida’s Medicaid program initially began in the early 70’s to provide health-care services for indigent low-income people. This federally and state funded program currently accounts for two-third’s of the state budget (FHA, 2001). The administrative structure of Florida’s Medicaid program is based on the integrity of its two managed-care programs: PHP’s and the Medi-Pass. These programs aid and assist all who qualify under federal and state mandates for the Medicaid program. Unfortunately, these programs fail to represent all its members. A direct result of this failure leads to a misrepresentation that the minority is treated as the majority.

In summary, the Medicaid program disperses many different services and benefits. Before the inception of the Medicaid program, White elderly Americans were hospitalized 27% more frequent than elderly African Americans (David & Schoen, 1978). Therefore, one could say that the Medicaid program has opened the doors and remade the American health care system as well as creating better access for minorities. Due to the discretion that is afforded to states by the federal Medicaid laws, many states vary in their flexibility of providing options for Medicaid beneficiaries. However, pending on how a state designs its Medicaid program virtually all racial/ethnic disparities can be developed or eliminated regarding enrollment, access, delivery of care, and patient/doctor care. Furthermore, the Medicaid program has gradually converged with the private sector regarding health insurance in several ways. In one way is that Medicaid recipients are enrolling in plans that serve employer groups and corporations. Secondly, Medicaid eligibility now is provided to pregnant women and children regardless of
their income status. Therefore as a result, managed care programs and providers are showing high interest for the Medicaid market.
**Literature Review**

The pertinent literature on this topic addresses three themes: state-level management of Medicaid beneficiaries; individual managed-care provider\(^1\); and incentives that the payment model of capitation\(^2\) will provide not only the Medicaid elderly recipients but also managed-care providers.

First, it is important to discuss the discriminatory relationship between the state-level management that provides health care services. Often times state government regulations and statutes administer these institutions. According to a New England report (Benzeval, Judge, & Whitehead, 1995), there are four levels of intervention that state-level governments should address when tackling socioeconomic inequalities in the health-care system. The authors suggested that state-level governments should implement four strategic tactics; (1) improving the physical environment (including the adequacy of housing, working conditions, and pollution levels); 2) addressing social and economic factors (such as income and wealth, unemployment, and social support); 3) improving access to appropriate and effective health and social services; and 4) reducing barriers to adopting health care reform.

In one study done by Rosenblatt and colleagues (2001), states must provide provisions in practice applications and more local welfare offices to provide better assistance and access to care for Medicaid recipients. By 1999, according to a Rosenbaum and colleagues study (1999), all states by law implemented some form of mandatory managed care, encouraged by the Clinton Administration. The mandatory managed care was provided to Medicaid beneficiaries by two

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\(^1\) Manage care provider: the protocol in which they provide and deliver health services.

\(^2\) Capitation: A type of payment system in which providers receive a specific amount in advance to care for specific health care needs of a defined population over a specific period. Providers are usually paid on a per-member-per-month (PMPM) basis. A capitated provider assumes the risk of caring for the covered population for the PMPM amount. The capitation dollars are derived from premiums paid by the enrollees (Cameron & Cleverley, 2002).
styles: 1) risk style comprehensive managed care, and 2) primary care case management system. One author states that individuals who are enrolled in the Medicaid program are caught in a bind due to how states administer their programs (Stubert, 2000). The author continues to discuss how problems are often created due to the stigma or stereotyping that is perceived when individuals are enrolled in the Medicaid program or the health care providers that offered to them.

Second, the literature reviews certain methods for which individually managed-care providers (MOs, HMOs, PPOs and physicians) can delineate a system to assess the outcomes and satisfaction of their Medicaid minority-based beneficiaries.

According to the American Journal of Medicine (Epstein, Seage, & Taylor, 1985), previous research has concluded that many physicians have difficulties communicating to their “low socioeconomic patients” regarding preventive screenings or cardiac testing. Furthermore, physicians report less affluent or less educated Medicaid patients have more of a negative attitude/outlook versus their other patients. In a review of the literature for access in Hispanic elderly communities, Valdez and colleagues (1993) research found that poor patient-provider communication and cultural competency presented barriers to provide high quality care. To further support this point a study done by Morales and colleagues (1999), found that elder Hispanics were less satisfied than elderly Whites with provider communications. During a 1996 study using the Medical Expenditure Panel Survey (MEPS), racial/ethnic elderly minorities faced greater barriers to care in a managed care provider setting than their White counter-parts (Phillips, Mayer, & Aday, 1999). In addition, this study also found that Hispanics were twice as likely to any other racial group to have longer waits and perceive a poor rapport with their managed care provider who failed to listen and provide needed information (Phillips, Mayer, &
Aday, 1999). However, in another study done by Phillips and colleagues (1999), racial/ethnic elderly minorities enrolled in managed care plans did indeed report of greater continuity of care but less satisfaction with the care received.

The above studies suggest that despite recent advances in the health care industry, racial disparities in health status and quality of care persists. Reasons why these disparities continue are due to inadequate access to care (Andrulis, 1998). Language barriers account for the majority of the negative effects and outcomes in quality of care reports for elderly Hispanics. Furthermore, this section strongly suggests the importance for health care organizations to provide competent health care services in a culturally and linguistically diverse matter.

Third, capitation provides incentives to the primary care physicians, the HMOs, and the Medicaid recipients. The payment model of capitation contains no incentives to over-provide expensive care, but rather offers the long-run incentive to provide preventive care. A capitated system can run the risk of under-care, so quality must be monitored at all times. A gatekeeping effect helps to minimize the risk of over-referrals. Studies have been done at the state-level that show capitation systems provide greater flexibility for the physician and patient in delivering long-term care (Held & Holahan, 1985). A RAND Health Insurance Study was done evaluating Florida’s HMOs (staff model vs. group, network, and individual practice association) and found that low capitation rates did indeed have an effect on the number of Medicaid enrollees (Wells, Manning and Benjamin, 1986; Frank & McGuire, 1997; Goldman, McCullough & Strum, 1998). Furthermore, it was discovered that these low rates had indeed deterred members’ utilization (Gomes, 2002). According to Leigh and colleagues study (1999), capitation is the most common method of payment for managed care providers and primary physicians. Over 61% of HMOs rely on capitation fees versus 25% on fee-for-service (FFS) and only 14% on salary
Leigh et al., 1999). The Leigh et al. (1999) study compared capitation rates versus FFS outcomes for enrollees in Florida, Tennessee, and Texas. The study found that elderly African Americans are more likely to report problems with access to care and elderly Hispanics with provider/patient care, than their White counter-parts.

On the other hand, a 1997 study done by RAND Health Insurance Experiment concluded that racial/ethnic minorities are harmed by cost containing methods such as capitation (Frank & McGuire, 1997). According to Evan and colleagues (1993):

The primary effect of substituting user fees for tax finance is cost shifting –the transfer of the burden of paying for health care from taxpayers to users of care…People pay taxes in rough proportion to their incomes, and use health care in rough proportion to their health status or need for care. The relationships are not exact, but in general sicker people use more health care, and richer people pay more taxes. It follows that when health care is paid for from taxes, people with higher incomes pay a larger share of the total cost; when it is paid for by the users, sick people pay a larger share…The wealthy and healthy gain, the poor and sick lose (Evan et al., 1993, p.4).

Several authors also stated that racial and ethnic minorities are less likely to have or to enroll in some type of insurance plan due to the fact that on average, minorities have a lower income than Whites (Copper & Schone, 1997; Kronick & Gilmer, 1999). Furthermore, Buchmueller, (1998) stated that when manage care providers, physicians, or insurance companies raise premiums, it forces a disproportionate number of racial/ethnic minorities to choose health plans that are of lower quality.

In summary, the literature review uncovers pertinent information that can be analyzed and pursued for alternatives to alleviate the racial disparities that exist in the Medicaid program. In the following report specific recommendations will be made to aid Medicaid beneficiaries and local/state policy and community leaders to determine the most appropriate alternative.
III. METHODOLOGY & EVALUATION CRITERIA

Methodology

The information for this report was collected using the following methods:

- An analysis of research dating from 1985 to 2002 from several academic databases: Agency Health Care Administration, Lexis-Nexis, JAMA, ABI Inform, and The National Academies Press;
- A review of proposed legislation, governmental publications, applicable laws, regulations; and
- Structured interviews and telephone contacts (n=five), with staff from the Agency of Health Care Administration (AHCA), the Chief Medicaid Researcher for AHCA, and a representative of the United States Health and Human Services (HHS) Regional Commissioner for SSI office.

The popular media, surveys and academic literature provided insight into the chronological background of current policy problems. The literature was also able to give insight to establish support for the various alternatives to remedy the racial disparities that presently exist in the Medicaid program for elderly beneficiaries. The review of federal and state proposed legislation, governmental publications, and applicable laws to analyze the biases that create racial disparities for the Medicaid elderly.

Structured interviews were conducted to explore the options of proposed legislation and initiatives, as well as to gain more detailed information from expert professionals. The interviews consisted of 45 minutes-to an hour of general questions to explore proposed legislation and state-level initiatives to rectify the racial disparities that currently exist in the Medicaid program. The researcher knew some of the interviewees, which allowed additional information to be required after formal interviews. Administrators and staff provided viability and support of current proposed legislation and the initiatives that state government has
implemented for the Medicaid program. Finally, expert information was collected from legislative updates on current bills that were filed during last session.

**Evaluation Criteria**

Three criteria were used to evaluate the proposed policy options: administrative feasibility, political desirability, member satisfaction.

- **Administrative feasibility** rates whether or not the organizations made strategic steps to obtain adequate amount of staff as well as to properly train staff to combat and eliminate racial biases for Medicaid elderly recipients. Data sources include interviews, surveys, utilization reviews and performance reports.

- **Political desirability** assesses the political community and its perspectives in achieving policy options. The political community constitutes as legislative committee staff research directors and employees, as well as state employees from various agencies. Data sources entail interviews with employees at Agency Health Care Administration, Social Security Insurance employees, and the Center for Economic Forecasting & Analysis.

- **Member satisfaction** means access to care, timeliness of care, provider communication, staff helpfulness, and plan services. The data sources for the quality outcome measures are surveys, HEDIS measures, interviews, and performance reports.

These criteria were selected as the best possible to evaluate racial disparities among the elderly in the Medicaid program. Other criteria such as administrative cost, environmental factors, and biological factors (behaviors and psyche) could not be evaluated or measured due to the lack of data. Each option will be assigned a rating of high, average, or low based on how well they meet the criteria.

One limitation of this study is the lack of complete public opinion of quality of care. However, sufficient and measurable outcomes were provided so the necessary information would be analyzed. Despite this constraint the recommendations and the most significant criteria in this
report are believed by the analyst to be the most viable options available. Furthermore, the criteria were evaluated using available resources such as organizational data and interviews.
IV. MANAGEMENT POLICY OPTIONS

This section explains three of the most promising options to eliminate racial disparities for Medicaid elderly recipients. Each alternative is evaluated using the three criteria stated previously: administrative feasibility, political desirability, and member satisfaction. Although the policy options are designed to guide policy makers toward the most viable policy, utilization reviews and community-based initiatives are other possible options that could have been evaluated. Due to unavailable data they could not be evaluated.

Option One: Maintain Current Medicaid Program

The first option is to leave the Medicaid program as it is. State and governmental bodies will continue to administer the Medicaid program with its current policy and initiatives. AHCA coordinated the efforts and hired managerial staffs from the Department of Medicaid Bureau of Research to develop two initiatives that help alleviate current biases in the Medicaid program for the elderly population. The first initiative is “The Florida Health and Human Service Access Act” work plan. The Florida HHS Access Act objectives are to implement and evaluate a comprehensive automated eligibility system, which will improve and provide easy access to health human services. The Florida 211 Network Provider system provides 24-hour coverage 7 days a week to answer and monitor phones (N. Ross, personal interview, March 14, 2003). The 211 system mandates that staff members must all be Alliance of Information and Referral System (AIRS) certified and have at least 25% or more referral specialists or resource specialists accessible for calls.

The second initiative is “Disease Management.” AHCA contracts out with various disease management organizations to aid recipients enrolled in Medi-pass. They provide
information that promotes healthier outcomes (improving health, reducing inpatient hospitalization, reducing emergency room visits, and reducing Medicaid costs) (N. Ross, personal interview, March 14, 2003). The main goal for the program is to provide high quality health care coverage to indigent persons unable to afford health insurance. For many years the program has been successful in accomplishing its mission; however health care costs are on a rise due to population growth causing a more expanded and overworked system. In the case of the Medicaid program, elderly minorities tend to get left behind because the system is so overworked.

Administration Feasibility: AHCA currently has 11 area offices, which provide services to the local Medicaid recipients in that area. The $8.3 billion dollar program administers 105 million claims each year-- nearly 300,000 claims a day (FHA, 2001). AHCA staff uses in-house staffing as well as contracts out to process claims and data for Medicaid beneficiaries. To help expedite claims, AHCA uses a computer database system called Florida Medicaid Management Information System (FMMIS). FMMIS has a direct link up communication to FLORIDA another database system however to access information that cuts down staffing efforts. AHCA also contracts with Contract Management\(^3\) staff in regards to billing information to alleviate overhead costs. This past January, AHCA provided its staff with effective methods and communication skills for provider billing training and implementation.

To create a more stable and efficient work environment, in 1998 AHCA contracted out with Benova Incorporated to provide services to help enroll and choice council Medicaid beneficiaries. Case management and updating enrollment (mandatory or voluntary) status were some of the many duties that Benova provided to AHCA staff and Medicaid recipients.

\(^3\) Contract Management is a particular body of management that provides information of recent updates and explanations of benefits to Medicaid beneficiaries.
Administrative feasibility is rated high because AHCA completes all tasks and responsibilities that have been mandated by the state and federally to ensure equity among Medicaid beneficiaries (Agency of Health Care Administration, Medicaid Health Care Services, 2002). AHCA does indeed have adequate amounts of staff and has gone to the proper lengths to ensure adequate training for its employees.

**Political Desirability:** There are many supporters that wish to eliminate racial disparities in the Medicaid program, specifically Governor Jeb Bush, Florida Secretary of Health John Agwunobi, M.D, and Monica Almas, Southeast Region Market Director for Aetna (HMO) (Agency of Health Care Administration, 2002). The Florida legislature in 1999-2000 appropriated $5 million dollars to the Department of Health to administer and implement the reduction of racial and ethnic disparities: “Closing the Gap,” grant program. Under Florida statues (section 381.7353(3)) the Secretary of Health has authority to appoint an ad hoc advisory committee to aid legislative policy. To support the current program, the Racial and Ethnic Health Disparities Advisory Committee was appointed to examine different approaches that could eliminate racial disparities (public awareness, education, research on why health disparities exist, and increase access to care and transportation). Another piece of legislation that had been introduced to the Florida legislature was the Medicaid Co-payments for Transportation Senate bill no. 644 and House bill no. 903. Governmental agencies such as AHCA, and HHS were used as resources to advise legislators. Unfortunately this particular bill did not pass in this past session. If the bill did pass it would have deleted the provisions that require a co-payment for transportation services for all Medicaid recipients.

AHCA’s Chief of Medicaid Research commended the efforts of policy makers for setting forth attainable goals, however dissatisfied with the slow progression regarding their outcomes.
As a whole racial disparities among the elderly population is decreasing, however one can not give sole credit to legislative acts of policy. It is the external factors that really must be weighed. For example, when the economy is down racial disparities are up. Or, why is it that Hispanics have better outcomes than African Americans, but worst access to care? Just because we have the funds does not necessarily mean we can use them effectively (N. Ross, personal interview, March 14, 2003).

Strategic steps have been taken to achieve policy options to support the elimination of racial disparities. Legislative committees have been assigned to address all issues that surround equity for minority elderly. The “Closing the Gap” grants created by the Florida legislature provided funds to initiate programs that would increase quality of care. Political desirability is rated average because the Medicaid Co-payments for Transportation bill that is much needed to accomplish a main objective of access and the delivery of care was denied.

Member Satisfaction: Member satisfaction includes outcome measures that evaluate access to care, timeliness of care, provider communication, helpfulness, and plan of service. In order to create better access, 25-field choice counselors and four field supervisors are stationed in North Florida (Tallahassee), Central Florida (Tampa), and South Florida (Miami). The goal of this outreach program is to increase collaboration with community-based organizations to increase awareness for the need of the elderly Medicaid recipient to make a voluntary choice in regards to their health status and plan. Benova reports however, that timeliness of care is often impeded upon due to the lack of information provided to their employees/brokers (OPPAGA, 2001). For three years AHCA has tried to get information such as phone numbers included on the Medicaid eligibility transmittal forms. If these changes were made costs for staffing, resources, and efforts to get phone numbers would be greatly reduced.
ACHA currently has initiatives and practices that will help facilitate provider communication. In Florida’s Medicaid program AHCA has set up a cultural and linguistic program. Materials are written at a 4th grad-6th grade reading level, back translated by local groups and materials are available in 13 languages. Regarding staff recruitment, 37% of local staff is bilingual and 32% of service staff is bilingual (N. Ross, personal interview, March 14, 2003). The mission for the outreach program is to encourage elderly as well as other beneficiaries to learn and help select the best managed care plan (service plan) and primary physician for their needs. Therefore, outreach brokers are available to Medicaid recipients face-to-face to assist in the selection process of choosing a plan (OPPAGA, 2001). Furthermore, telecommunications between Benova outreach brokers and recipients are currently at a 66% success rate regarding help and information that is provided to them (OPPAGA, 2001).

In summary, the member satisfaction criteria scores high on the entire criterion. The administration feasibility was well received but rated average because AHCA completed all tasks that were required by law and agency staffing was fully trained and operating at full capacity. Political desirability was rated high regarding current policies and initiatives alternatives. Overall, this alternative would be relatively inexpensive to implement because most of the components already exist and are in place.

Option 2: Expanded Medicaid Program

The second option is to expand the current program by implementing incremental changes to ensure a better system to assess racial biases for elderly recipients. In this option it is recommended for AHCA to use cost containment strategies and obtain resources to establish partnerships with accreditation agencies and organizations. Currently, it does not have an
evaluating method to ensure that Medicaid recipients receive the up most care. HEDIS (quality indicators) measures are used, however they are not required. AHCA would partner with the National Committee of Quality Assurance (NCQA) and the Joint Commission of Accreditation (JCA) to ensure accountability for managed care organizations to provide quality healthcare to Medicaid elderly recipients.

Administration Feasibility: Strategically, AHCA is in the best position to regulate protocol-assessing, accreditation and cost containment for managed care organizations that receive Medicaid funds. It would have to adopt new responsibilities to assure that its overall mission to provide quality health care coverage to indigent persons is still accomplished. Requirements and training procedures would have to be modified to incorporate mandatory quality measures and cost-saving techniques. Agency staff would develop quality measures (such as HEDIS) stratified by the terms of one’s socioeconomic position and race/ethnicity. By requiring inclusion of socioeconomic position and race/ethnicity in performance reports for providers, staff can then submit approval to NCQA or JCA for accreditation. In addition to training staff and adapting new responsibilities, research would have to be done. Such efforts were suggested in 1999 when AHCA was allocated $4.5 million dollars to set up grants to conduct research in understanding and eliminating minority health disparities (HCFA, 2001). The applicant pool was derived internally from AHCA employees in the research department and externally from other agencies.

Other administrative duties that AHCA would have to re-regulate would be their accounting offices. It may have to hire strategic financial officers to employ effective cost-cutting strategies for current staff. Financial techniques such as freezing provider rates,
increasing capitation rates, withhold(s)$^4$, and bonuses$^5$ would be taught to employees as cost containing measures. The agency has also considered developing a risk adjusted capitation rates. In doing so, capitation rates would reflect risks incurred by certain racial/ethnic groups (HCFA, 2001). In the long-term, risk adjusted rates would reduce the rates that Medicaid is currently paying for their healthy elders and only increase rates slightly for those who require intense health services.

In short, implementing this recommendation will be more costly than the current Medicaid system. Costs can be determined by the amount of additional staff, which is needed, or to train for specific managerial tasks or duties. The estimated costs to implement this program for AHCA divisional managers would be $278.00 per person (The Twentieth Century Fund, 1995). Although this recommendation may be costly in the short-term, the long-term effects would prove to be cost effective (OPPAGA, 2001). Therefore the recommendation for this criterion is average.

**Political Desirability:** In 2000, AHCA had requested to the legislature a 40% increase in physicians fees regarding Medicaid recipients. Unfortunately however, the state of Florida only requested a 4% increase. A quarter or less of Medicaid enrolled physicians received reimbursements greater than ten thousand dollars (HCFA, 2001). It is highly likely that if more funds are not allocated to fees or increase capitation rates, physicians and managed care organizations will cease to participate in the program or reduce the number of recipients that they see (N. Ross, personal interview, March 14, 2003). An action of this sort would have an adverse and rippling effect to the elderly minority population in the Medicaid program. Furthermore, in

$^4$“Withholds” refers to the situation where some of the physician’s revenue is withheld and paid back only if cost containment measures are met, such as reduced referrals, and hospitalization.

$^5$“Bonuses” are extra payments rewarded to the physician based on meeting utilization goals or patient satisfaction set by the agency.
the fiscal year of 2000-2001 Florida’s Legislative Appropriations Act authorized for no new funding for an increase of Medicaid HMO’s capitation rates (OPPAGA, 2001). Currently today, no action has been brought forth to the legislature in regards to capitation rates.

Thus, political desirability is viewed unfavorably due to the increase of capitation rates (Rivera, 2001). According to many of the interviewees, this particular recommendation is logical, but very unlikely to reach the floor in the legislature. Many AHCA employees and staff feel that the reason why this recommendation would be so unfavorable to the legislature is due to Medicaid funds being cut at the federal level (Rivera, 2001). This recommendation is rated low because even though there is a high degree of interest in state level agencies and managed care organizations, policy makers remain uninterested. Furthermore, it would be quite costly for the state government and state taxpayers.

**Member Satisfaction:** AHCA has room for improvement regarding satisfaction. In 2001, the “Real Choice Systems Change Grant” is to be introduced over a two to three year span. This option strongly recommends implementation of this grant. The main objectives and activities for this grant satisfy the criterion. The grant will provide funding through state Medicaid waivers to remove all barriers in receiving and or providing health services; improve access to care for all Medicaid elderly persons through aid from community-based resources; improve delivery of services to Medicaid recipients by developing a statewide educational campaign and referral procedures; implementation of an outreach program in local areas to link Medicaid recipients who are most at-risk; have Medicaid beneficiaries assigned to culturally appropriated providers; and encourage public agencies such as AHCA, DCF, DOEA, and DOE to participate in local cultural events.
In summary, the recommendation of the “Real Choice System Change Grant” scores high on member satisfaction. Administrative feasibility rated average because the costs to provide adequate staffing and training does not out-weigh AHCA’s long-term agenda to eliminate racial disparities and provide good quality care to elderly Medicaid recipients. Political desirability rated low because even though there is a high interest within state level agencies and managed care organizations, the policy makers remain uninterested because it would be too costly for the state (OPPAGA, 2001).

Option 3: Develop an integrated system for comparative analysis

The third option is for AHCA is to integrate its Florida Medicaid Management Information System (database for Medicaid services), Florida (database for Medicaid eligibility), and performance outcomes systems to establish an ongoing comparative analysis system. It would do analysis of costs, complaints, performance measures and reports, and health outcomes. Unfortunately, AHCA does not have the capability to develop this type of system.

According to OPPAGA (2001), AHCA is incapable of tracking and evaluating the quality of care and service delivered to beneficiaries. As a result, the technological gap has made it harder to remedy racial disparities for Medicaid elderly. The system would yield data that is beneficial to managerial staff at AHCA. The data would be informative regarding managed care plans, customer satisfaction, and the cost analysis of the Medicaid population.

Administrative Feasibility: AHCA currently has two systems that verify claims and coverage, processes, certifies and carries out policies that are related to Medicaid providers and the Medicaid program. These systems of information would integrate all information that is gathered regarding Medicaid recipients. The system would provide AHCA with statistical data
on enrollment data and the type of plan an individual has. The agency also contracts out with the University of Florida to evaluate PNS information regarding managed care options and the quality of access to care (OPPAGA, 2001). For this criterion to be viable, staff employees would have to be trained to become more efficient with the computerized system. Since information can be easily attained from Benova brokers, there is currently no significant literature that suggests obtaining this data would be costly. The only costs that would incur are the initial set up cost for operational staff, and equipment.

It is viable for AHCA to implement such a program. This recommendation scores average for administrative feasibility because administrative costs that would be incurred to initially set up operational staff, procedures, and equipment would be inexpensive.

**Political Desirability:** By designing an integrated system, it would analyze managed care organizations, performance measures, health outcomes, and cost analysis. Therefore, the integrated system meets the criterion for political desirability. This alternative provides the best way to eliminate racial disparities for Medicaid elderly. In regards to information systems, statistical error is far less than human error. Therefore, information is less biased and tainted that will be processed by the database system. The overall effect of the system will enable policy makers, government agencies and legislators to make effective decisions to help eliminate racial disparities. Furthermore, there are no political drawbacks to this system. It will provide in-depth knowledge for cost-saving strategies that will alleviate the burdens of high expenditures in the program. In short, political desirability scores high and meets all criteria.

**Member Satisfaction:** An integrated comparative system will provide the knowledge to help obtain better measures to provide easier access to care, shorten waiting periods between visits, better provider care that are culturally and linguistically sensitive to the beneficiary
(Rivera, 2001). HEDIS measures used to evaluate quality of service for the applicants can be implemented into the system to create a user-friendly environment for employees (N. Ross, personal interview, March 14, 2003). Another benefit that this system creates is time management. Furthermore, there are potential benefits that a system like this could provide when updates are given regarding the types of care that may not on typical basis be realized unless the system is constantly monitored (Rivera, 2001). Often times, though, recipients do not get processed in a timely fashion because of the monumental amounts of paper work that agency staff must sort through and process. AHCA could rectify this situation by installing the integrated system.

In summary, member satisfaction in this option scores average. Although the entire criterion is met, the data that is processed is one step further away from the Medicaid recipient. Face-to-face interaction is very important for quality care and member satisfaction (N. Ross, personal interview, March 14, 2003). Administrative feasibility scores average because of initial start-up costs incurred. It would also be timely to train staff and to implement operational procedures. Political desirability was rated high because it enabled policy makers, governmental agencies and legislators to make more effective decisions to help eliminate racial disparities that exist in the program. Many indicators that would help eliminate racial disparities in the Medicaid program for elderly persons can be discovered when using this system. Overall, this integrated comparative system is a sound and strong option however has only one real drawback that would hinder its performance if implemented. The drawback as stated earlier would be the financial costs to set up the integrated system and operationally maintain them for 11 area offices (FHA, 2001).
V. CONCLUSIONS

The report presented three alternatives to eliminating Racial Disparities in the Medicaid Program. Each policy was evaluated based on administrative feasibility, political desirability, and member satisfaction. Table 1 summarizes the results.

Table – Summary of Alternatives and Evaluation Criteria

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<th>CRITERIA</th>
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<tr>
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<td>Maintain Current Medicaid Program</td>
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<tr>
<td>Administrative Feasibility</td>
<td>High: AHCA completed all tasks and responsibilities that were required by law. Agency staffing was fully trained and capacitated.</td>
</tr>
<tr>
<td>Political Desirability</td>
<td>Average: Appropriate legislative committees and policies have been assigned and formulated to address all issues that may help create racial disparities</td>
</tr>
<tr>
<td>Member Satisfaction</td>
<td>High: AHCA currently has initiatives, practices, and outreach programs that will ensure quality of care, access to care, provider communication and plan of service.</td>
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Ranking Scale: Low – does not meet or apply to the needs of the option.  
Average – meets the minimal needs of the option.  
High – meets all the needs of the option.
All three options provide insight on how to eliminate racial disparities for the elderly population in the Medicaid program. The report discusses the nature of each option and the agencies and organizations that provide vital services for the state in making sure that various government entities are effective and efficient in delivering health services.

Option one is recommended as the strongest provider for elimination of racial/ethnic disparities for recipients not just in the elderly population but the whole applicant pool. The criteria of administrative feasibility and political desirability demonstrate how important the roles of racial disparities play in the program. AHCA and the legislature have made it a point to tackle this issue. AHCA is currently leading the forefront has developed effective forms of methodology, outreach programs, and cultural and linguistic programs to provide recipients better quality and access to care. By addressing the issues of access and provider care; AHCA can enforce the delivery of better quality of care, which in turn, will maximize member satisfaction.

Option two, the expansion of the current program through incremental change, was highly recommended regarding member satisfaction and the guarantee for quality of care. For the agency to establish a partnership with the National Committee of Quality Assurance or the JCA for accreditation purposes would provide a profound increase in accountability for individual managed care providers to ensure the best quality of care to their clients. Additionally, to implement financial withholds, bonuses or increases in capitation rates, would provide incentives for managed care providers and physicians to ensure quality and access to care. The political desirability for this option was non-existent. Although state agencies such as AHCA and powerful organizations such as manage care organizations support the notion to increase capitation rates, it is not an issue that policy makers wish to get involved in. Grants
whether they are state or federally funded will always provide a quick fix for the issue at hand; the “Real Choice System Change Grant” did just that and provided funds for outreach programs, community-based clinics, and hot-lines to provide education regarding manage care plans, customer service and better access and delivery of care.

Option three a developed integrated system for comparative analysis, was the least favorable of the three. Administrative feasibility requires a considerable amount of costs to set up and train staff as well as obtain the equipment. However, since AHCA contracts out to monitor member satisfaction, and currently has two up and running systems internally, the costs would not be too great. Therefore, administrative feasibility received an average score. This option did, however, receive a high score in political desirability because it enables policy makers, government agencies, and legislators to make more precise and effective decisions to help eliminate racial disparities for the elderly. Member satisfaction scored average because a computerized system cannot provide a one-on-one type of interaction that an AHCA employee can. Despite the fact that this system would yield a magnitude of helpful and beneficial information, an automated system is no substitute for person-to-person interaction.

An assessment of the alternatives using three evaluative criteria indicates that maintaining the current program to eliminate racial disparities is the most viable option to provide quality health care, access to and delivery of care, and customer satisfaction for recipients. AHCA is considered the organization that regulates the Medicaid program for policy, procedures, and rules. Even though it has room for improvements regarding options to enforce better health care for the elderly minorities in the Medicaid program. It has also demonstrates that the agency has the expertise and knowledge required to develop a program to eliminate racial disparities for the elderly. The other two options were not as effective in accomplishing
the goal to eliminate racial disparities for the elderly population as option one. AHCA, however, has demonstrated efficiency in developing methodologies and policies to evaluate health care, health outcomes, and the quality of care that is provided to the Medicaid elderly population in the state of Florida.
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About the Author

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PRESS RELEASE

Elderly Minorities and Health Care - Do They Mix or Are They Like Vinegar and Oil?
Racial Disparities in the Medicaid Program

Tallahassee, FL- April 24, 2003- According to the new report of legislative analyst Danielle C.O. Foard released today, Racial Disparities: The Elderly population in the Medicaid Program, striking disparities still exist for racial and ethnic minority Americans.

There was a time when a Medicaid card worked more or less like a Blue Cross card: got patients into many private doctors’ offices. Not anymore. Funding cuts are tighter than ever and have largely turned Medicaid into a separate, unequal system for the poor and the elderly. Minorities, of course, are disproportionately caught there.

The literature review in this report places some what of the blame on the bias or stereotyping nature by doctors, manage-care providers, and the refusal to increase capitation rates for primary care physicians. This is a startling and courageous assertion no one dares to talk or confront the issue in a forthright matter until now.

Access to quality of care is a specific goal of the Agency of Health Care Administration (AHCA). AHCA administers Florida’s Medicaid program. The agency uses the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), for quality indicators to measure access to care. Furthermore, HEDIS measures are used to ensure access to quality healthcare which is essential for the elimination of health disparities and achieving the objectives within AHCA’s mission.

In addition to eliminating racial disparities among the elderly population in the Medicaid program, the analyst discusses how community support and outreach programs helps create healthy individuals.

The first recommendation in this report for eliminating racial disparities among the elderly in the program is the general awareness of public, doctors, insurance companies, and policy makers. The Institute of Medicine recommends a two-tier approach
to eliminate racial disparities in the health care industry: Medicaid recipients should get the same services; and the same protection, as privately insured patients receive. The report also urges AHCA to help to bring stability to doctor-patient relationships. Many of these efforts have been trampled by budget cuts and other changes in the program. Despite the instability of the doctor-patient relationship, AHCA devotes considerable efforts, initiatives, policy decisions to build a consistent goal for equal and quality medical care for Medicaid recipients.

America has a long way to go to eliminate racial disparities, however, the report applauds the ongoing efforts of AHCA. Furthermore, the analyst suggested that if the agency helps to push several pieces of legislation that would increase capitation rates for physicians and a program that provides transportation to and from the medical facility for the elderly, the race to eliminate racial disparities would pick up tremendous pace.

The report concludes by proposing broad courses of action of which are currently being carried out by AHCA, to improve the quality of health care available to racial and ethnic minority elderly populations. They include continuing to build the science base research, improving access to treatment and care, to improving the quality of health services by reducing barriers among primary physicians and managed care organizations, and supporting culturally relevant programs and leadership opportunities.