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Medicaid Reform: Legislature Should Delay Expansion Until More Information Is Available to Evaluate Success

at a glance

Medicaid Reform, implemented in August 2006, is intended to empower beneficiaries to take an active role in their health care. Medicaid Reform offers beneficiaries a choice among managed care options; guidance in selecting a health plan that meets their needs; and monetary incentives to increase healthy behaviors. Reform also is intended to encourage managed care plans to enroll sicker beneficiaries by paying plans based on the health status of the persons they serve. Overall, Reform is expected to improve beneficiaries' access to and quality of health care services.

Through December 2008, the state spent \$37.8 million to implement and administer Medicaid Reform. Most of these costs (94%) paid vendors to administer and operate the choice counseling, opt-out, and enhanced benefits components; to evaluate the pilot per waiver requirements; and to develop and manage other Medicaid Reform requirements such as health plan contracts, benefit package design, risk-adjusted payment rates, and other technical support. The remaining 6% paid for Agency for Health Care Administration personnel salaries and benefits associated with Reform activities.

To date, little data is available to demonstrate that Medicaid Reform has improved access to and quality of care. While AHCA has developed a system to track services provided to beneficiaries, this system will not have complete plan service data available until January 2010. In addition, little data is yet available on whether Medicaid Reform has produced cost savings or is more cost-effective than traditional Medicaid. We recommend that the Legislature not expand Medicaid Reform until more information is available to evaluate success.

Medicaid Reform

The 2005 Legislature authorized the Agency for Health Care Administration (AHCA) to reform the state Medicaid program with the intent of improving health outcomes of Medicaid beneficiaries and achieving budget predictability.¹ AHCA obtained a federal waiver and legislative approval to implement a managed care pilot program, which began providing services to Medicaid beneficiaries in Broward and Duval counties in September 2006. AHCA expanded the pilot to Baker, Clay, and Nassau counties in September 2007.² AHCA will need legislative approval to expand Medicaid Reform beyond these five counties.³

The major premise of Medicaid Reform is to improve health care services by giving managed care health plans flexibility to better meet the specific needs of Medicaid beneficiaries and to promote competition among these plans. Under Medicaid Reform, health plans can develop customized benefits packages for different beneficiary groups. Medicaid Reform is intended to empower beneficiaries by offering them more managed care options and encouraging them to

¹ Chapter 2005-133, *Laws of Florida*.

² AHCA received approval to implement an 1115 Research and Demonstration Waiver application from the Centers for Medicare and Medicaid Services in October 2005. The Legislature approved implementation of the waiver in December 2005 (Ch. 2005-358, *Laws of Florida*).

³ Chapter 2005-358, *Laws of Florida*, established a goal of statewide implementation by June 2011 in accordance with waiver requirements but requires AHCA to obtain legislative approval to expand implementation beyond the pilot sites.

take an active role in their health care. Medicaid Reform beneficiaries receive detailed information on their health plan choices and assistance from specially trained choice counselors to help them select a Reform plan that best fits their needs. Beneficiaries can earn monetary credits for participating in certain healthy behaviors that they can use to purchase health-related products.

Participation in Medicaid Reform in the pilot counties is mandatory for certain low income children and families and aged and disabled beneficiaries. These include families who have incomes at or below 23% of the federal poverty level, children who live in families that earn up to 200% of the federal poverty level (depending on the children's ages), and individuals who are age 65 and older or disabled and receive federal Supplemental Security Income.⁴ Other beneficiaries may choose to participate in Medicaid Reform, including children in foster care, individuals with developmental disabilities, and Medicare beneficiaries who are also eligible for Medicaid (dual eligibles).

As required by Ch. 2005-133, *Laws of Florida*, OPPAGA has issued a series of reports assessing the Medicaid Reform managed care pilot programs. Our prior reports, published in 2008, examined Medicaid Reform's opt-out component, plan benefits, enrollment patterns, enhanced benefits, choice counseling, risk-adjusted rates, Reform HMO preferred drug lists, and provider networks. (See Appendix A for a synopsis of each of these reports, including findings and updated information.)

This final report addresses four questions.

- How much has the state paid to develop and operate Medicaid Reform?
- What information is available to demonstrate whether Medicaid Reform has achieved its intent to improve quality of care?
- What information is available to demonstrate whether Medicaid Reform has increased plan competition?
- Is the Medicaid Reform pilot ready to expand to other areas of the state?

⁴ In 2009, 23% of the federal poverty level is \$4,211 per year for a family of three; 100% of the federal poverty level is \$18,310 for a family of three; and 200% of the federal poverty level for a family of three is \$36,620.

Questions and Answers —

How much has the state paid to develop and operate Medicaid Reform?

Through December 2008, the state spent approximately \$37.8 million to develop and operate Medicaid Reform in the pilot counties, in addition to the cost of providing health care services to beneficiaries. Most of these costs (\$35.6 million or 94%) paid for contracted services. The remaining costs were for AHCA personnel salaries and benefits associated with Medicaid Reform activities and responsibilities, although these costs exclude AHCA staff travel expenses.⁵

As shown in Exhibit 1, AHCA spent \$35.6 million in contracted services to develop and operate the major components or features of Medicaid Reform through December 2008. Of this amount, approximately two-thirds (\$23.4 million or 66%) funded the choice counseling program including training and certifying choice counselors, developing beneficiary materials, and maintaining the choice counseling call center.⁶ AHCA spent another \$8.3 million for a vendor to develop and manage other Medicaid Reform requirements such as health plan contracts, a software tool for assessing whether Medicaid Reform health plans' benefit packages meet state and federal requirements, risk-adjusted rates, and other technical support.^{7,8}

⁵ To estimate its personnel costs, AHCA apportioned Medicaid salaries and benefits associated with Medicaid Reform activities. AHCA reported that it could not provide travel costs associated with Medicaid Reform activities as it had not separately tracked travel costs related to Medicaid Reform.

⁶ This included contracts with Florida State University to develop and evaluate the choice counseling training curriculum and certification process as well as contracts with ACS to staff and maintain the choice counseling call center, provide local outreach, staff a special needs unit to assist beneficiaries with complex health care needs, mail information to beneficiaries, and to develop an electronic system that compares plans' preferred drug lists.

⁷ The federally approved Medicaid Reform waiver requires health plans to include all mandatory Medicaid services and AHCA requires that certain optional services must also be included at the same benefit levels as in the state plan. The waiver also requires that Reform plans provide all medically necessary services to pregnant women and children under age 21. For other beneficiary groups, AHCA allows plans flexibility to vary the amount, duration, and scope of 10 optional services; four of these services, however, must meet all the medical needs of at least 98.5% of each beneficiary group they serve.

⁸ Risk-adjusted rates enable the state to allocate funding so that plans with beneficiaries who are sicker and have greater health care needs (and thus, more costly to serve) receive higher payments than plans with healthier beneficiaries.

AHCA also spent approximately \$3.9 million for contracts with vendors to develop and implement the initiative's enhanced benefits and opt-out components, and for the contract with the University of Florida for evaluation activities required by the federal Medicaid Reform waiver.

Exhibit 1

AHCA Paid \$35.6 Million Between July 2006 and December 2008 to Develop and Operate Major Medicaid Reform Activities

Reform Activity	Contract Costs
Choice Counseling	\$23,414,481
Plan Development and Sufficiency, Risk-Adjusted Rates, and Technical Support	8,291,951
Enhanced Benefits Administration ¹	2,338,458
Mandated Waiver Evaluation	1,400,000
Opt-Out	151,050
Total Cost	\$35,595,940

¹ This excludes the funds beneficiaries earned for participating in healthy behaviors since AHCA pays for these incentives using service rather than administrative funding.

Source: OPPAGA analysis of cost information provided by AHCA.

During this timeframe, AHCA also spent \$2.2 million in agency personnel costs to support Medicaid Reform, which represented about 45% of the total personnel costs for its Medicaid managed care waivers.⁹ For the most part, AHCA used existing staff to carry out these responsibilities. In addition to maintaining their responsibilities for traditional Medicaid operations, staff assumed additional duties to develop and monitor Medicaid Reform contracts, provide support and direction to Medicaid Reform health plans, develop an encounter data system, provide community outreach and education, and reconcile the fee-for-service payments made to provider service networks with projected capitated payments.¹⁰ AHCA staff also worked closely with its contractors

and health plans to identify and address implementation issues. However, the \$2.2 million in AHCA staff costs does not include travel expenses, as the agency did not track these costs separately and could not apportion them between the traditional Medicaid program and its Medicaid Reform activities.¹¹

Data are not yet available to determine whether Medicaid Reform has produced cost savings or is more cost-effective than traditional Medicaid. AHCA has not centrally tracked expenditures associated with Medicaid Reform or developed a methodology to determine whether state administrative costs or per-beneficiary health care costs have changed under Medicaid Reform. As a result, we could not determine whether Medicaid Reform plans offer better care for less or the same costs, including agency administrative costs, as traditional Medicaid. While not a condition of the waiver, this information is important to assist decision makers to make fiscally sound budget recommendations especially given current revenue shortfalls.¹²

What information is available to demonstrate whether Medicaid Reform has achieved its intent to improve quality of care?

Even though a primary goal of Medicaid Reform is to improve the quality of care for beneficiaries by increasing their access to specialty care and improving their overall health status, little information is currently available to assess progress toward achieving this goal. While beneficiary satisfaction and plan performance data is available for the first year of Reform, this information is limited. Since Reform was implemented in September 2006, stakeholders and researchers, including OPPAGA, have noted concerns about beneficiaries' access to and quality of care. While

⁹ This estimate includes only costs for AHCA staff located at its Tallahassee headquarters office and does not include costs for other Medicaid staff such as those working in the area offices located in Broward and Duval counties.

¹⁰ For each provider service network, AHCA staff compare the annual amount spent under fee-for-service reimbursement to the amount the plan would have received using capitated risk-adjusted rates. Provider service networks that spend more under fee-for-service must reimburse AHCA a portion of their administrative fee. If they spend less, they can keep these savings. This process gives provider service networks the opportunity to assess spending patterns and risk prior to accepting capitated rates, as required after three years of operation.

¹¹ Staff traveled to the Medicaid Reform pilot areas prior to implementation and during the first two years of implementation to hold public meetings for informing and receiving feedback from provider groups, beneficiaries, and other stakeholders.

¹² Cost savings differs from budget neutrality which AHCA reports quarterly to the federal government as part of the waiver requirements. Budget neutrality ensures that actual total statewide Medicaid spending on Reform eligibles and services covered by the waiver do not exceed the projected statewide spending in absence of the waiver. In contrast, cost savings should be based on comparing the cost to serve the same groups of Medicaid beneficiaries before and after Reform in the pilot counties and/or comparing the cost to serve beneficiaries in Reform plans to similar groups in non-Reform counties.

AHCA is taking steps to address many of these concerns, the extent to which these efforts will be sufficient to improve access to and quality of care in Reform counties is still unknown. (See Appendix A for synopses of the prior OPPAGA reports on Medicaid Reform and AHCA's efforts to address concerns.)

The University of Florida recently reported on changes in Medicaid Reform beneficiaries' satisfaction in Broward and Duval counties prior to Medicaid Reform compared to the first year of Reform.¹³ The university reported few significant changes in beneficiary satisfaction under Medicaid Reform compared to before Reform. The only significant changes noted were that beneficiaries' overall satisfaction with their health care in Broward and Duval counties significantly decreased compared to before Medicaid Reform and that beneficiary ratings of personal physicians significantly increased in Broward County.¹⁴ While beneficiaries' satisfaction with their personal physicians also increased in Duval County, the increase was not statistically significant. In addition, the report noted that overall plan satisfaction had decreased slightly and satisfaction with specialists increased slightly compared to before Medicaid Reform, however, these differences also were not statistically significant.

The report also compares the satisfaction of Broward and Duval beneficiaries after the first year of Medicaid Reform on their awareness of the special features of Reform such as enhanced benefits and choice counseling. For example, slightly more than 60% of the beneficiaries in both counties had heard of choice counseling. Of these

beneficiaries, 53% of beneficiaries in Broward County and 49% in Duval County indicated they had used choice counseling to assist them with enrolling into a Reform plan.¹⁵ In addition, while the report compares beneficiaries' satisfaction on their ability to access needed specialty care and prescriptions, it does not address whether or not beneficiaries believed they were better able to access needed care and prescription drugs under Medicaid Reform than they could before Reform, both of which are critical to Medicaid Reform success. For example, the report notes there was a significant difference between the satisfaction of beneficiaries in getting prescription medicines in Broward and Duval counties but does not discuss whether performance was better or worse compared to before Medicaid Reform was implemented in those counties.¹⁶

AHCA also has collected and compiled data on 21 performance measures submitted by Reform plans and has posted plan ratings and scores for Calendar Year 2007 on its website.¹⁷ Although beneficiaries can use these ratings to compare reform plans, the ratings do not necessarily indicate acceptable or higher performance. These ratings have limited value for assessing actual plan performance because they compare individual plans to the average of all Medicaid Reform plans, which can compare plans to an average that does not represent good performance.¹⁸ For example, AHCA rated 'access to dental care' as average or above average for 13 of the 16 Reform plans, even though all Reform plans fell below the 50th percentile compared to national performance.¹⁹

¹³ AHCA contracted with the University of Florida to evaluate Medicaid Reform as required by the 1115 waiver requirements to have an independent evaluation. The university conducted a telephone survey based on the Consumer Assessment of Healthcare Providers and Systems survey, a national survey developed by the Agency for Healthcare Research and Quality. The university completed a baseline survey in Broward and Duval counties in 2006, just prior to Reform implementation and a second survey in early 2008 to determine whether satisfaction increased after one year of Medicaid Reform. The complete report can be found at <http://mre.phhp.ufl.edu/publications/Medicaid%20Reform%20Enrollment%20Satisfaction%20Year%20One%20Follow%20Up%20Survey.pdf>

¹⁴ These results are limited as they only capture differences in beneficiary satisfaction after the first year of Medicaid Reform. The university is currently surveying beneficiaries in Broward and Duval counties (as well as in Baker, Clay, and Nassau). Thus, these survey results for Broward and Duval beneficiaries will be based on longer experience with Medicaid Reform and may better detect differences.

¹⁵ These differences were not statistically different.

¹⁶ Duval County beneficiaries were significantly more satisfied with access to needed prescriptions than were beneficiaries in Broward County.

¹⁷ Nineteen of these measures are recommended by a national quality assurance organization, the National Committee for Quality Assurance. The other two measures were developed by the agency. These ratings and scores can be found at http://www.fdhc.state.fl.us/Medicaid/quality_mc/performance_measure.shtml

¹⁸ For each measure, AHCA first calculates the average (a weighted mean). AHCA gives two check marks to plans that are within one standard deviation of the average; three check marks for plans that score above one standard deviation from the average; and one check mark to plans that score one standard deviation below the average.

¹⁹ Access to dental care is assessed by calculating the percentage of plan members ages 2-21 who had at least one dental visit during Calendar Year 2007.

It would be more meaningful to decision makers if AHCA compared these measures to established benchmarks or targets. According to AHCA staff, the agency is taking steps to do this. Specifically, AHCA plans to assess health plan performance against the national Medicaid managed care performance, using the 75th percentile as the benchmark for plans to achieve. To accomplish this, AHCA is working with each plan to develop strategies to achieve performance goals. (See Appendix B for a comparison of 19 of the 21 measures reported by Medicaid Reform plans to national Medicaid managed care performance and how AHCA is working with the plans to achieve desired performance goals.)

Further, there is currently little information to compare the quality and quantity of health care services received by Medicaid Reform beneficiaries to beneficiaries served under the traditional Medicaid program or to assess whether these services meet beneficiaries' needs. While AHCA has developed a data system that will track service encounters and which could be used to evaluate access to and quality of care, this system is not expected to have complete and valid data before January 2010.²⁰ In addition, as of March 2009, plans had not ensured that all of their network providers had obtained unique identifying numbers. Unique provider numbers are necessary to accurately assess health plan network adequacy and to determine whether access to specialty care has improved under Medicaid Reform.²¹

What information is available to demonstrate whether Medicaid Reform has increased plan competition?

In addition to improving quality of care, another major premise of Reform is that giving capitated health plans flexibility to vary services will encourage more plans to enter the market and thus, will increase competition among plans. However, plans' benefits vary only minimally and

some Medicaid Reform plans have decreased or eliminated extra services since the first year of Reform. In addition, although the number of plans from which beneficiaries could choose initially increased under Medicaid Reform, in the last few months some plans have stopped enrolling Medicaid beneficiaries in the Reform counties and others have reorganized, potentially causing disruption in continuity of care for significant numbers of beneficiaries in the Medicaid Reform counties.

Although the intent of Medicaid Reform was to allow health plans to customize their benefits to better meet the needs of beneficiaries, the benefit packages offered by Medicaid Reform plans do not materially differ and are generally similar to benefits provided by HMOs serving beneficiaries under the traditional Medicaid program. This is, in part, due to federal and state policies that limit variation. Although Reform HMOs can vary the amount, duration, and scope of some services, federal and state policies allow plans to vary only 10 services; 4 of these services must meet the estimated need of at least 98.5% of beneficiaries. While health plans may vary the remaining 6 services without limitations, in practice they have tended to offer services similar to those available in the traditional Medicaid program. In addition, the services offered by plans available to children and families beneficiaries differ only slightly. Likewise the services provided by plans available to aged and disabled beneficiaries also vary only minimally.

In addition, some Medicaid Reform plans have decreased or eliminated extra benefits since the first year of Reform. For the current and third year of Reform, three of the eight Reform HMOs operating in Broward County (Staywell, HealthEase, and Preferred) no longer offer extra benefits to their children and families beneficiaries and three HMOs (Staywell, HealthEase, and AMERIGROUP) have decreased extra benefits for their aged and disabled beneficiaries. In Duval County, both Staywell and HealthEase no longer provide any extra services to their Medicaid Reform beneficiaries. In addition, United offers fewer extra services to beneficiaries in Duval, Baker, Clay, and Nassau counties than it did previously. Several HMOs that serve both Medicaid Reform beneficiaries and traditional

²⁰ Due to the lag times for claims submissions, complete service encounter information is not available for some time after services have been provided. For example, in January 2010, AHCA expects to have complete encounter data from July 2008 to June 2009.

²¹ AHCA's provider network files include information about individual providers multiple times both within single Reform plans and across several Reform plans within a pilot area. Because not all providers use a unique identifier, it is not possible to easily determine an accurate count of unique providers.

Medicaid beneficiaries currently offer more extra services to their traditional beneficiaries than to Medicaid Reform beneficiaries.

Further, even though the number of plans from which beneficiaries could choose initially increased under Medicaid Reform, in the last few months some large plans have stopped enrolling Medicaid beneficiaries in the Reform counties and others have reorganized potentially causing disruption in continuity of care for significant numbers of beneficiaries in the Medicaid Reform counties. For example, several Medicaid Reform plans have left the pilot areas or plan to do so. Specifically, three health maintenance organizations (HMOs)—Buena Vista, Vista Health Plan of South Florida, and United—have stopped enrolling Reform beneficiaries in Broward County, and United has limited enrollment in Duval, Baker, Clay, and Nassau counties. In addition, two plans—Staywell and HealthEase—will stop serving Reform beneficiaries in Broward and Duval counties as of June and July 2009, respectively. As a result, based on March 2009 enrollment data, 33% and 44% of the beneficiaries in Broward and Duval counties, respectively, will need to select new plans. In addition, one of the PSNs operating in Broward County, NetPASS, was purchased by an HMO, called Molina Health Plan, which reduces the number of PSN options available to Broward County beneficiaries.^{22, 23}

Is the Medicaid Reform pilot ready to expand to other areas of the state?

Based on the lack of sufficient information to assess progress toward meeting quality of care and access goals, concerns raised by stakeholders and researchers, and symptoms of plan instability, we conclude that the Medicaid Reform pilot is not ready to expand to other areas of Florida. In addition, expanding the pilot would be costly to the state at a time when state revenues are experiencing significant shortfalls. According to AHCA's legislative budget request, it would cost an additional \$7.1 million in Fiscal Year 2009-10 to

expand Reform to Areas 1, 2, and 11.^{24, 25} Plans and service providers would also likely incur additional administrative costs.²⁶

Before the Legislature authorizes AHCA to expand Medicaid Reform to other areas in the state, AHCA should provide decision makers sufficient data to demonstrate that the initiative has improved the delivery of health care services to better meet the needs of Medicaid beneficiaries in the pilot counties. To do this, AHCA should use its Medicaid encounter data system to track the services that beneficiaries receive from providers to determine if quality of care and access to specialty care has improved under Medicaid Reform. In addition, to determine whether Medicaid Reform plans offer better care at the same or less cost, AHCA should track all expenditures associated with Reform and develop a methodology to compare total Medicaid Reform costs (administrative and per-beneficiary health plan costs) to traditional Medicaid.

Delaying expansion at this time also would give AHCA additional time to continue addressing areas needing improvement that OPPAGA identified in earlier Medicaid Reform reports, such as strengthening its managed care contract standards to include specific provider network requirements for specialty providers and using the Medicaid encounter data system to develop risk-adjusted rates for capitated plans based on diagnostic information. Further, delaying expansion would allow AHCA more time to seek specialty plans for providing services to additional special and hard to serve populations such as children in foster care and persons with developmental disabilities.²⁷ As of March 2009, only one specialty plan has been established in the

²⁴ This includes the costs for additional headquarters and field office staff as well as an increase to the choice counseling costs to serve an additional 290,000 beneficiaries.

²⁵ Area 1 includes Escambia, Okaloosa, Santa Rosa, and Walton counties; Area 2 includes Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jefferson, Jackson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington counties; Area 11 includes Miami-Dade and Monroe counties.

²⁶ Managed care organizations would need to develop new benefit packages to meet the specifications of Reform and providers that contract with multiple plans would have to become familiar with varying benefit limits and requirements which could be burdensome.

²⁷ These populations currently can voluntarily enroll in Reform; however, the waiver specifies that voluntary populations become mandatory after the initial implementation phase.

²² NetPASS is still accepting voluntary enrollments until June 2009. In August 2009, the agency will transition NetPASS beneficiaries to Molina Health Plan.

²³ Also, two other PSNs in Broward County, Pediatric Associates and Access Health Solutions have merged.

pilot counties, and the agency was in the process of approving a specialty plan for beneficiaries with HIV/AIDS.²⁸ While it may require legislative approval, this step is important to meet the intent of Medicaid Reform and is needed to demonstrate whether managed care plans are willing and able to develop benefit packages that will meet the needs of these vulnerable groups. Without these specialized plans, the state will continue serving approximately one-third of its Medicaid population in traditional fee-for-service.

²⁸ The Children's Medical Services (CMS) Network, administered by the Department of Health, developed a Medicaid Reform specialty provider service network to serve children with chronic conditions in Broward and Duval counties. The CMS Network coordinates services for children with chronic conditions in Baker, Clay, and Nassau counties as well as the rest of the state.

Agency Response ---

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

The Secretary's written response has been reproduced in Appendix C.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-9213), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

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Appendix A

Prior OPPAGA Reports Address Medicaid Reform and Identify Areas Needing Improvement

As part of our overall assessment of Medicaid Reform, OPPAGA earlier issued eight reports that address aspects of the Medicaid Reform pilot. These include reports addressing the opt-out component, Reform health plans' benefit packages, beneficiary enrollment patterns, enhanced benefits, choice counseling, risk-adjusted rates used to pay Reform capitated plans, preferred drug lists offered by Reform plans, and provider networks. Table A-1 summarizes these reports.

Table A-1
OPPAGA Has Published Eight Prior Medicaid Reform Reports

Report	Summary
Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program (Report No. 08-37)	<p>Purpose: This report assesses the Medicaid Reform opt-out component and how beneficiaries learn about and enroll in employer-sponsored insurance.</p> <p>Findings: Medicaid Reform beneficiaries can opt out of the Medicaid program and enroll, instead, in their employer's health insurance plan using their Medicaid premium to purchase individual or family insurance. AHCA contracted with its third-party liability vendor, Health Management Systems, Inc. (HMS) to administer the opt-out program. The contract paid HMS a \$5,000 monthly fixed fee and \$50 per month per enrollee to process premium payments. As of the end of March 2008, AHCA had paid HMS \$110,050, representing a per enrollee cost of \$3,668.</p> <p>As of March 2008, only 19 individuals were enrolled in the opt-out program and only 30 beneficiaries had enrolled since September 2006. The 11 who disenrolled did so because they were no longer eligible for Medicaid or lost access to employer-sponsored insurance. We recommended that AHCA determine the reasons for low participation, including determining beneficiary access to employer-sponsored insurance, and identify ways to address barriers in order to increase program enrollment.</p> <p>Update: As of January 2009, participation remained low with 30 individuals opting to participate in employer-sponsored insurance and a total of 59 beneficiaries having done so since September 2006.</p> <p>AHCA has contracted with a new vendor, Affiliated Computer Systems (ACS), to serve as its new third-party liability vendor; this contract includes operating the opt-out program. This new contract has lower costs as it does not include fixed monthly fees and pays \$25.98 per month per enrollee.</p>
Medicaid Reform: More Managed Care Options Available; Differences Limited by Federal and State Requirements (Report No. 08-38)	<p>Purpose: This report assesses the extent to which differences in benefits offered by Medicaid Reform increased beneficiary choice by providing more managed care options and how differences in benefits offered by plans compared to traditional Medicaid and how these benefits have changed over time.</p> <p>Findings: Medicaid Reform seeks to provide beneficiaries with additional choices of managed care options tailored to meet their needs. While the number of managed care plans operating in the five pilot counties increased, the health services offered by the plans varied only minimally and were generally similar to managed care options offered in the state's traditional Medicaid program. In addition, at the time of our report, only one Medicaid Reform specialty plan (Children's Medical Services) was operating in Broward and Duval counties. However, Medicaid Reform plans had customized their offerings somewhat for different beneficiary groups, with some plans offering higher limits on certain medical services and providing additional extra services to aged and disabled beneficiaries. Medicaid Reform benefits packages had generally remained similar over the first two years of the initiative, with a few plans offering higher benefit levels, more extra services, and fewer co-payments in the second year.</p> <p>Update: Beneficiaries have fewer managed care options since several managed care plans have left Medicaid Reform and some continuing plans have reduced benefit levels. Three health maintenance organizations</p>

Report	Summary
	<p>(Vista, Buena Vista, and United) no longer serve beneficiaries in Broward County and Pediatric Associates, a provider service network operating in Broward County, merged with another entity (ACCESS) in February 2009, thereby decreasing the number of provider service network options in Broward County from four to three. While United, a health maintenance organization, is still serving beneficiaries in Duval, Baker, Clay, and Nassau counties, it has changed how it operates. In Baker, Clay and Nassau counties, to ensure that new Medicaid beneficiaries have two plans from which to choose, United will enroll beneficiaries who choose this plan, but will not accept beneficiaries who do not self-select the plan (AHCA will assign those beneficiaries to Access, the PSN serving these counties). Because Duval County has more than two plans from which beneficiaries can choose, United will continue to serve existing beneficiaries but will no longer take any new enrollees. In addition, one of the PSNs operating in Broward County, NetPASS, was purchased by an HMO, called Molina Health Plan. NetPASS is accepting voluntary enrollments until June 2009. In August 2009, the agency will transition NetPASS beneficiaries to Molina Health Plan. Further, HealthEase and Staywell will stop serving beneficiaries in Broward and Duval counties in June and July 2009, respectively.</p> <p>In addition, some Reform plans have decreased or eliminated extra services for beneficiaries. In Broward County, Staywell, HealthEase, and Preferred no longer offer extra services to their children and families beneficiaries; and Staywell, HealthEase and AMERIGROUP have decreased extra services available to their aged and disabled beneficiaries. In Duval County, Staywell and HealthEase no longer offer extra services to any Medicaid Reform beneficiaries; and United has decreased extra services for both children and families and aged and disabled beneficiaries. United has also decreased available extra services in Baker, Clay, and Nassau counties.</p>
<p>Medicaid Reform: Two-Thirds of the Initial Pilot Counties' Beneficiaries Are Enrolled in Reform Plans (Report No. 08-40)</p>	<p>Purpose: This report assesses AHCA's process for enrolling beneficiaries into Medicaid Reform plans in the five pilot counties, and provides data on the number of Medicaid beneficiaries enrolled in Reform plans and discusses differences in enrollment patterns by pilot areas and/or plan types.</p> <p>Findings: AHCA began enrolling beneficiaries into Medicaid Reform managed care plans in Broward and Duval counties in September 2006, and in Baker, Clay, and Nassau counties in September 2007. AHCA used a phase-in process to transition beneficiaries into Reform plans. In May 2008, about two-thirds (65%) of the Medicaid population in Broward and Duval counties were enrolled in Reform health plans as were 55% of the Medicaid population in Baker, Clay, and Nassau counties. Overall, most (73%) of these beneficiaries were enrolled in health maintenance organizations. In Baker, Clay, and Nassau counties, 64% of Reform beneficiaries were enrolled in provider service networks.</p> <p>Update: Enrollment patterns in Medicaid Reform health plans have remained similar. In March 2009, the percentage of all Medicaid beneficiaries in Broward and Duval counties enrolled in Reform plans remained unchanged at 65% while the percentage of the Medicaid population in Baker, Clay and Nassau counties who were enrolled in Reform plans had increased to 61% (compared to 55% one year previously). Overall, the percentage of Medicaid beneficiaries in the five Reform counties enrolled in health maintenance organizations had decreased to 64% (compared to 73% one year previously). In Baker, Clay and Nassau Counties 69% (compared to 64% one year previously) of the Reform beneficiaries were enrolled in provider service networks.</p>
<p>Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion (Report No. 08-45)</p>	<p>Purpose: This report assesses the enhanced benefits account program that rewards beneficiaries for participating in activities that can improve their health.</p> <p>Findings: The enhanced benefits component provides Medicaid Reform beneficiaries monetary credits of up to \$125 per year which they can redeem for health related products such as over-the-counter medications, first aid supplies, and personal care items. Beneficiaries earn these credits in a variety of ways including keeping doctor appointments, taking preventive measures such as mammograms and immunizations, and participating in disease management or other activities to improve their health such as smoking cessation and weight-loss programs.</p> <p>Through April 2008, Reform beneficiaries had earned credits totaling nearly \$13.8 million but only redeemed about \$1.6 million or 11.4% of this amount. Nearly 81% of these credits were earned for behaviors such as keeping primary and preventive care appointments rather than changing health related behaviors such as losing weight or stopping smoking. Stakeholders expressed concerns that some beneficiaries were unaware of the program or found it difficult to redeem earned credits. In addition, some stakeholders expressed concerns that the program may not motivate beneficiaries or adequately support them to make long-term changes that could improve their health.</p> <p>We reported that AHCA was taking steps to address concerns such as planning to change the name of the</p>

Report	Summary
	<p>program to Enhanced Benefits Reward\$, to use a coupon format instead of a account statement to inform beneficiaries of their credits, and to reduce the credit received for office visits. To better target wellness types of behaviors, we recommended that AHCA consider adding credits for behaviors such as completing prenatal laboratory and diabetes screening tests and to target persons with specific chronic conditions, women who have neglected annual screenings, and/or children who should receive preventive dental care.</p> <p>Update: As of February 2009, Medicaid beneficiaries had earned \$19.6 million in enhanced benefits credits since the start of Reform. Redemption of these credits continued to increase; beneficiaries had spent \$7.4 million (37.9% of earned credits) suggesting that AHCA's efforts to better inform beneficiaries about their credits and how to redeem them has been effective. However, beneficiaries continued to earn most credits (71.6 %) for primary and preventive care appointments, despite a program change that reduced credits earned for keeping office visits to \$7.50 once per year from \$15 up to twice per year.</p>
<p>Medicaid Reform: Choice Counseling Goal Met, But Some Beneficiaries Experience Difficulties Selecting a Health Plan That Best Meets Their Needs (Report No. 08-46)</p>	<p>Purpose: This report assesses the Medicaid Reform choice counseling process, how AHCA monitors this process, and how successful choice counseling has been in helping beneficiaries select plans that best fit their health care needs.</p> <p>Findings: The Medicaid Reform choice counseling program provides beneficiaries with materials describing available health plans and access to certified counselors to help them select and enroll in a health plan. As of May 2008, AHCA had consistently met or exceeded its goal that 65% of newly eligible beneficiaries select a health plan after receiving choice counseling. However, information from stakeholders and disenrollment data indicated that some beneficiaries had experienced problems selecting a health plan that met their needs from among the available plans. Commonly cited concerns were that beneficiaries found enrollment packets and materials confusing and difficult to read and understand, and that some beneficiaries have difficulty comparing Reform health plans using the comparison charts provided to them. In addition, Reform disenrollment data from October 2006 to April 2008 showed that approximately 24% of the 40,508 beneficiaries who voluntarily disenrolled or requested a plan change did so because their primary care or specialist physicians were not in the plan in which they enrolled.</p> <p>AHCA had made a number of changes to improve choice counseling materials and procedures based on public and stakeholder feedback. However, these changes did not fully address the difficulties that beneficiaries were experiencing when selecting among Medicaid Reform health plans. To further address these difficulties, we recommended that AHCA consider making the plan comparison materials easier to understand and continue to make the materials more user-friendly by ensuring that the materials are written at the fourth-grade reading level.</p> <p>Update: AHCA has worked to improve its special needs unit that was designed to assist beneficiaries with medically complex conditions. For example, to address the needs of beneficiaries with mental health issues, in the last quarter of 2008, AHCA field offices assigned experienced choice counselors to work with community level mental health providers so providers can better assist clients to enroll in Reform health plans. In addition, AHCA has revised plan comparison choice counseling materials to make them easier for beneficiaries to use.</p>
<p>Medicaid Reform: Risk-Adjusted Rates Used to Pay Reform Health Plans Could Be Used to Pay All Medicaid Capitated Plans (Report No. 08-54)</p>	<p>Purpose: This report assesses AHCA's methodology for paying Reform capitated managed care plans and the benefits of using risk-adjusted payments for other Medicaid capitated plans.</p> <p>Findings: As required by state law, AHCA phased in a method that pays Medicaid Reform capitated plans monthly rates that are risk-adjusted to reflect the health status of plans' beneficiaries. By risk adjusting rates, AHCA pays plans that serve beneficiaries who are sicker and have greater health care needs more than it pays plans that serve healthier beneficiaries. AHCA currently uses the Medicaid Rx, a statistical model that uses prescription drug information and demographic data, to adjust Reform capitated plans' base rates. In 2009, AHCA expects to begin phasing in another model, most likely the CDPS that will assess risk using diagnostic data captured by its encounter data system (expected to be implemented in late 2009) and may continue using pharmacy data as well.</p> <p>Because risk-adjusted rates better match capitated plans' payments to the health status and costs of their beneficiaries, once AHCA gains experience using encounter data to set risk-adjusted rates, the Legislature should consider directing the agency to also use risk-adjusted rates to pay non-Reform capitated plans.</p> <p>Update: AHCA has continued to assess the validity of the encounter data provided by plans. On July 1, 2009, AHCA expects to begin collecting encounter data for services provided from July 2008 – June 2009</p>

Report	Summary
<p>Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved; Information Difficult for Beneficiaries to Locate and Compare (Report No. 08-55)</p>	<p>and plans to use this information to help set risk-adjusted rates starting in January 2010.</p> <p>Purpose: This report assesses prescription drug coverage under Medicaid Reform, including AHCA's requirements for Reform plan's drug coverage, how this differs from coverage under Medicaid's traditional fee-for-service system, and challenges beneficiaries have faced in accessing information about Reform plans' drug coverage.</p> <p>Findings: Under Medicaid Reform, capitated health plans have more flexibility than traditional Medicaid plans. Although AHCA expects Reform beneficiaries to have access to the same drugs that would be available to them under traditional Medicaid, it primarily relies on assurances that the plans will provide the drugs needed by their beneficiaries. AHCA does not impose the requirement that preferred drug lists include two drugs per therapeutic category that it imposes on non-Reform Medicaid managed care plans.</p> <p>Our analyses found that Medicaid Reform capitated plans' preferred drug lists do not contain all of the drugs or therapeutic classes of drugs available through Medicaid fee-for-service. While not listing a drug does not necessarily mean the plan will not cover the drug, beneficiaries may have to go through additional steps such as obtaining prior authorization or step therapy before they can receive the drug.</p> <p>Despite the importance of prescription drug coverage to many Medicaid beneficiaries, they experienced difficulty locating and comparing Medicaid Reform health maintenance organizations' drug offerings and prior authorization requirements. To address this issue, AHCA established a special needs unit to help beneficiaries determine which plans cover the drugs they need. In addition, at the time of our report, AHCA was in the process of developing an electronic tool for choice counselors to use to help beneficiaries compare prescription drug coverage among the plans.</p> <p>To better assist beneficiaries who seek information from plans' websites, we recommended that AHCA develop guidelines for Reform plans to ensure that drug coverage information is easy to find on their websites and require plans to display information related to prior authorization, step therapy, and other restrictions using common symbols or abbreviations.</p> <p>Update: In October 2008, AHCA implemented an electronic tool, the Navigator, to assist choice counselors in providing beneficiaries with comparative information about Medicaid Reform plans' preferred drug lists. From October through March 2009, the Navigator tool was accessed by 2,251 Reform beneficiaries. In addition, AHCA continues to work to improve its special needs unit that was designed to assist beneficiaries with medically complex conditions.</p>
<p>Medicaid Reform: Reform Provider Network Requirements Same As Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers (Report No. 08-64)</p>	<p>Purpose: This report assesses AHCA's requirements for ensuring that Reform plans have adequate provider networks, including specialty providers, to meet the needs of their beneficiaries. The report also discusses the accuracy of information received by beneficiaries about provider networks and presents data from a telephone survey OPPAGA conducted of endocrinologists, ENTs, and dentists in Duval and Broward counties.</p> <p>Findings: Even though access to providers is expected to improve under Medicaid Reform, AHCA used the same contract requirements governing provider networks for both Medicaid Reform and non-Reform managed care plans. For the most part, the agency also monitored provider network adequacy the same way for both types of plans.</p> <p>We found that information available to Medicaid Reform beneficiaries about providers participating in Reform plans is not always accurate and some beneficiaries have experienced difficulty making appointments to see specialty providers. Our survey of endocrinologists, ENTs, and dentists confirmed that some providers listed in plan directories were not accepting new patients, and that some that were limited their practice to certain beneficiaries, such as children only. We also found that beneficiaries might have to wait from 4 months to up to 11 months for an appointment.</p> <p>To better ensure that Medicaid Reform provider networks can meet the needs of beneficiaries, we recommended that AHCA develop additional contract requirements as well as enhance its oversight of provider networks, including taking additional steps to ensure that provider information available to beneficiaries is accurate.</p> <p>Update: While AHCA has not developed additional Reform contract requirements, it has continued to assess the accuracy of provider network information that the Reform plans report to the agency and has continued its monthly contract management oversight meetings.</p>

Source: OPPAGA reports.

Appendix B

For 2007, Medicaid Reform Plans Often Did Not Meet the 50th Percentile for National Performance on Measures AHCA Uses to Assess Quality

AHCA requires Medicaid Reform plans to report on performance measures related to beneficiaries' health status and outcomes. For calendar year 2007, Reform contracts specify that health plans collect information on 21 measures including 19 that were established by the National Committee for Quality Assurance. The other two measures were developed by AHCA.²⁹ Plans were required to submit data on these measures by July 2008. In January 2009, AHCA posted information about Reform plan performance for 20 of these measures.³⁰

While informative, the available information is of limited value to stakeholders wishing to assess plan performance because AHCA compares individual plan performance to the mean performance for all Medicaid Reform plans.³¹ This, in essence, compares plans to an average that may not represent acceptable performance. For example, AHCA rated 'access to dental care' as average or above average for 13 of the 16 Medicaid Reform plans, even though all plans fell below the 50th percentile compared to national performance.

It would be more meaningful for AHCA to compare performance to an established benchmark. AHCA staff told us that they plan to use the 75th percentile for the 2007 national Medicaid HMO performance as a benchmark for both Medicaid Reform and non-Reform health plans to work towards over the next three years. To accomplish this, the agency has begun working with individual health plans to identify areas for improvement, develop corrective action plans, and propose strategies for improvement. As shown in Table B-1, in 2007, most Reform plans did not meet the national 50th percentile performance for Medicaid managed care programs. For 15 of the 19 Healthcare Effectiveness Data and Information Set (HEDIS) measures, more than half of the plans that reported performance were below the 50th percentile. In addition, for 6 of the measures, none of the Medicaid Reform plans that reported performance data met the national 50th percentile for 2007.

²⁹ The agency-defined measures relate to the use of beta agonists, which are a therapeutic group of medications used to treat cardiovascular conditions, and the number of enrollees admitted to a state mental health hospital.

³⁰ AHCA did not present the ambulatory care measure on the website because the measure is a rate, not a percentage like the other measures.

³¹ For each measure, AHCA first calculates an average. AHCA gives two check marks to plans that are within one standard deviation of the average; three check marks for plans that score above one standard deviation from the average; and one check mark to plans that score one standard deviation below the average.

Table B-1
Medicaid Reform Plans Reported on 19 National Performance Measures for 2007

Measure	Number of Plans Reporting This Measure ¹	Number of Plans Exceeding 50th Percentile	National 50% Percentile Performance
Annual Dental Visits - The percentage of members age 2-21 who had at least one dental visit during the measurement year.	16	0	(42.8%)
Adolescent Well Care - The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	15	6	(42.1%)
Controlling Blood Pressure - The number of members with hypertension whose most recent BP is <140/90.	12	2	(55.4%)
Cervical Cancer Screening - One or more Pap tests during the measurement year or the two years prior to the measurement year.	13	0	(66.5%)
Comprehensive Diabetes - HbA1c Testing - HbA1c test was performed during the measurement year.	12	5	(79.3%)
Comprehensive Diabetes - HbA1c Poor Control - The most recent HbA1c level is >9.0% or is missing or was not done during the measurement year.	12	5	(46.7%)
Comprehensive Diabetes - Good Control - The most recent HbA1c level is <7.0%.	12	5	(31.3%)
Comprehensive Diabetes - Eye Exam - A retinal or dilated eye exam by an eye care professional was done during the measurement year OR a negative retinal exam was done by an eye professional in the year prior to the measurement year.	12	1	(53.6%)
Comprehensive Diabetes - LDL Screening - An LDL-C test was performed during the measurement year.	12	10	(72.8%)
Comprehensive Diabetes - LDL-C Control - The most recent LDL-C level performed during the measurement year is <100 milliliters.	12	4	(31.3%)
Comprehensive Diabetes - Nephropathy - A urine micro-albumin test was done during the measurement year OR there is evidence of nephropathy during the measurement year.	12	7	(76.6%)
Follow-up after Hospitalization for Mental Illness - 7 days - The percentage of discharges for members 6 years and older who were hospitalized for a mental health disorder and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days.	11	0	(35.8%)
Follow-up after Hospitalization for Mental Illness - 30 days - The percentage of discharges for members 6 years and older who were hospitalized for a mental health disorder and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 30 days.	11	0	(57.3%)
Prenatal Care - The percentage of deliveries that received a prenatal care visit as a member of the plan in the first trimester OR within 42 days of enrollment in the plan.	10	0	(84.2%)
Postpartum Care - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	10	3	(59.7%)
Well-Child 0 Visits - The percentage of children who turned 15 months old during the measurement year who had zero well-child visits with a PCP.	9	0	(1.4%)
Well-Child 6+ Visits - The percentage of children who turned 15 months old during the measurement year who had six or more well-child visits with a PCP.	9	1	(56.6%)
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - The percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.	15	8	(67.5%)
Ambulatory Care - ER Visits - The number of emergency room visits for every 1000-member months.	16	11	(57.1%)

¹ Although 16 Reform health plans reported performance data to AHCA, not all health plans reported on each indicator. Plans did not report on a measure if the number of beneficiaries affected by that measure was small or if the measure was not applicable to a plan. For example, a plan that serves only children would not report on measures, such as controlling blood pressure, that apply to adult populations.

Source: AHCA website and National Committee for Quality Assurance.

Appendix C

CHARLIE CRIST
GOVERNOR



HOLLY BENSON
SECRETARY

June 3, 2009

Gary R. VanLandingham, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. VanLandingham:

The Agency for Health Care Administration (Agency) appreciates the opportunity to review the final draft of the Office of Program Policy Analysis and Government Accountability (OPPAGA) report titled "*Medicaid Reform: Legislature Should Delay Expansion Until More Information is Available to Evaluate Success.*" This is the final report in the series of nine reports OPPAGA has completed on Medicaid's managed care pilot program. The Agency appreciates the efforts of your staff in researching, analyzing and compiling the written report. There are a few items in the report which could be enhanced and we offer the following clarifications regarding these key issues:

Budget Neutrality compared to Cost Savings

The report appears to focus on the Medicaid managed care pilot providing cost savings. As an 1115 Research and Demonstration Waiver, the pilot program is required to be budget neutral. Budget neutrality is achieved if the total cost of the pilot does not exceed the cost that would have been incurred without implementing the demonstration. The assumption of the program is that by providing services under the designed demonstration, the growth of the Medicaid program expenditures would be predictable and would achieve a stable level of growth. The growth rate for the waiver is 8 percent per year. As outlined in the quarterly and annual reports, the demonstration program is budget neutral.

Additionally, the waiver requires the Agency to have an independent evaluation that evaluates multiple components of the demonstration, including a financial component that will evaluate cost effectiveness (not cost savings). The cost effectiveness of the program will be determined by analyzing the pre-reform expenditures for the operating counties to the post reform expenditures for the operating counties. The evaluation will look at non-demonstration counties to identify trends and impacts that are driven by variables outside of the demonstration.

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June 3, 2009
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Patient Satisfaction

While the OPPAGA Report references some results in the University of Florida's assessment of patient satisfaction under Reform compared to before Reform, it is important to acknowledge that the University of Florida's evaluation states "In 2008, Medicaid Reform enrollees' satisfaction with their health care experiences was generally high."¹ and "In general, Medicaid Reform beneficiaries tended to rate their health care experiences positively and to have a generally high level of satisfaction with their health care."²

It is also important to acknowledge that some negative shift in satisfaction is to be expected during any transition from an unmanaged care environment to a managed care situation, such as we have with moving fee-for-service populations into Reform. Specifically, the University of Florida has reported "Therefore, a normal expectation would be to see a decline in satisfaction levels when Medicaid patients move from the fee-for-service MediPass program to the "managed" Reform demonstration."³ Finding such few significant differences in beneficiaries' satisfaction after being enrolled in Reform may actually indicate a more positive satisfaction than would have been anticipated.

Increased Plan Competition

Where the OPPAGA report addresses whether Medicaid Reform has succeeded in its intent to increase competition by providing more health plan options, it includes narrative regarding some health plans that are ceasing enrollment and some plans that are reorganizing. As in non-Reform counties, the number of managed care plans participating is expected to change over time due to market driven forces that produce acquisitions, withdrawals, and expansions. The number and type of managed care plans available in the Reform areas has in fact increased since before Reform. Even with plans recently withdrawing from certain Reform service areas, we also note the entrance of new health plans. Especially given current revenue shortfalls that have resulted in health plan capitation rate reductions, the entrance of new health plans is a significant achievement.

An improvement of the demonstration is that financial incentives are directed to managed care organizations to manage the chronically ill and to keep people healthy. Capitation payments are adjusted for acuity of the plan enrollees, thus directing resources based on need rather than a distribution based on the population as a whole regardless of the acuity of plan enrollment. As in non-Reform counties, a few plans have adjusted their enrollment capacity and are not enrolling new members at this time. It is important to note that all services continue for the currently

¹ Evaluating Medicaid Reform in Florida, Medicaid Reform Enrollee Satisfaction: One Year Follow-Up Survey, Release Date: March 20, 2009 by the University of Florida, Executive Summary, page 1

² Ibid., Summary and Conclusions, page 47

³ Ibid., Executive Summary, page 2

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enrolled members, and that plans are allowing reinstatements, thus preserving continuity of care for the Reform beneficiaries who have lost and regained Medicaid eligibility within a 180 day period.

In a reference to whether the pilot is ready to expand to other areas of the state, the report infers that these normal market place changes (health plans leaving, coming in, reorganizing) are a "... symptom of plan instability..." (page 6, first column second full paragraph). This wording appears to link a normal business process with instability and includes this as a rationale not to expand the pilot. Regardless of whether or not the pilot should expand, this rationale does not appear to be appropriate.

We appreciate the opportunity to respond and look forward to working with OPPAGA again in the future.

Sincerely,

A handwritten signature in cursive script, appearing to read "Holly Benson".

Holly Benson
Secretary

HB/lam