Florida Medicaid Reform

1115 Research and Demonstration Waiver

3rd Quarter Progress Report
(January 1, 2012 – March 31, 2012)
Demonstration Year 6

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

This page intentionally left blank

Table of Contents

List of Tables

List of Charts

I. Waiver History

Background

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare and Medicaid Services (Federal CMS) on October 19, 2005. State authority to operate the program is located in section 409.91211, Florida Statutes (F.S.), which provides authorization for a statewide pilot program with implementation that began in Broward and Duval Counties on July 1, 2006. The program expanded to Baker, Clay and Nassau Counties on July 1, 2007.

On June 30, 2010, the Agency for Health Care Administration (Agency) submitted a three-year waiver extension request to maintain and continue operations for the period July 1, 2011 through June 30, 2014. Federal CMS approved the three-year waiver extension request on December 15, 2011. The waiver extension period is December 16, 2011 through June 30, 2014.

Florida expects to gain valuable information about the effects of allowing market-based approaches to assist the state in its service to Medicaid recipients.

Key components of Medicaid Reform include:

- Comprehensive choice counseling,
- Customized benefit packages,
- Enhanced benefits for participating in healthy behaviors,
- Risk-adjusted premiums based on enrollee health status, and
- Low Income Pool.

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Florida law, and the Special Terms and Conditions #19 and #20 of the waiver. Special Term and Condition (STC) #19 requires that the state submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to, approval and contracting with new plans, specifying coverage area, phase-in, populations served, benefits, enrollment, grievances and other operational issues.

This report is the third quarterly report in Year Six of the demonstration for the period of January 1, 2012 through March 31, 2012. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports, which can be accessed at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid health plan application. In 2006, a single application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas[1]: organizational and administrative structure, policies and procedures, on-site review, and contract routing and execution process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 6 through 9 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. The 2011 Florida Legislature also amended this area. Now, the FFS PSNs are required to convert to capitation no later than September 1, 2014, or within two years of operation, whichever comes later.

The Agency currently uses an open application process for health plans. This means there is no official due date for submission in order to participate as a health plan in Broward, Duval, Baker, Clay, or Nassau County. Instead, the Agency provides guidelines for application submission dates in order to ensure that applicants fully understand the contract requirements when preparing their applications.

Current Activities

Health Plan Applications and Requests to Expand to Additional Demonstration Counties

Since the beginning of the demonstration, the Agency has received 27 health plan applications (19 HMOs and eight PSNs) of which 23 applicants sought and received approval to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population. The application from Community Health Plan of South Florida to be a FFS PSN in Broward County is in Phase 2 of the review process. During the quarter, the following three new applications were received:

- Simply Healthcare applied to be an HMO in Broward County.
- Healthease applied to be an HMO in all five demonstration counties.
- Magellan Complete Care applied to be a specialty plan in Broward County.

These applications are in Phase I of the health plan application process.

[1] The health plan application process includes the following four phases: (I) organizational and administrative structure, (II) policies and procedures, (III) on-site review, and (IV) contract routing and execution, establishing a provider file in the Florida Medicaid Management Information System, completing systems testing to ensure the health plan applicant is capable of submitting and retrieving HIPAA-compliant files and submitting accurate provider network files, and ensuring the health plan receives its first membership.

The request from Children's Medical Services (Specialty Plan for Children with Chronic Conditions) to increase their maximum enrollment levels in Broward County was approved and the amendment continued through the execution process.
Table 1 provides a comprehensive list since the implementation of the demonstration of all health plan applicants, the date each application was received, the date each application was approved and the initial counties of operation requested by each applicant.

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
HealthEase	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista	HMO	X		04/14/06	06/29/06
Vista Health Plan SF	HMO	X		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center d/b/a First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	12/10/08
AHF MCO d/b/a Positive Health Care	HMO	X		01/28/08	02/18/10
Medica Health Plan of Florida	HMO	X		09/29/08	10/24/09
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		01/14/09	05/20/09
Preferred Care Partners, Inc. d/b/a CareFlorida	HMO	X		01/21/10	12/20/10
Community Health Plan of South Florida	PSN	X		06/14/11	*
Simply Healthcare	HMO	X		02/29/12	*
Healthease of Florida	HMO	X	X	03/23/12	*
Magellan Complete Care	HMO	X		03/30/12	*

*The application is under review.

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area.

Table 2
Medicaid Reform Health Plan Contracts

Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care	07/01/06	HMO	X****		
HealthEase	07/01/06	HMO	X***	X***	
Staywell	07/01/06	HMO	X***	X***	
Preferred Medical Plan	07/0106	HMO	X****		
United HealthCare	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista	07/01/06	HMO	X*		
Vista Health Plan SF	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center d/b/a First Coast Advantage	07/01/06	PSN		X	X******
Pediatric Associates	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X	X*****	X*****+
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO d/b/a Positive Health Care	05/01/10	HMO	X		
Preferred Care Partners, Inc. d/b/a CareFlorida	01/01/11	HMO	X		

*During Fall of 2008, the plan amended its contract to withdraw from this county.
**During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.
***During Spring of 2009, the plan notified the Agency to withdraw from these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.
*****Sunshine began providing services in these counties effective September 1, 2009.
******First Coast Advantage expanded into these counties effective December 1, 2010.
+Sunshine withdrew from Nassau and Baker Counties effective December 31, 2010.

Health Plan Capacity

Health Plan capacity is monitored on an ongoing basis. Health plans must supply an up-to-date provider network information file each month. The Agency uses the file to monitor the health plans' compliance with required provider network composition and primary care physician (PCP)-to-member ratios. In addition, the choice counseling/enrollment broker contractor loads

this information into its system for use in answering recipient questions and to enable PCP selection at the time of voluntary plan enrollment.

Additionally, the Agency monitors overall capacity to ensure recipients have a choice of at least two health plans in each demonstration county. There were no notable changes this quarter.

Contract Amendments and Model Contracts

During this quarter, there were no executed health plan amendments. Additional information regarding the contract amendment process is provided in Section J of this report.

Contract Conversions/Terminations

There were no conversions, terminations or acquisitions during this quarter, and no requests are pending.

FFS PSN Conversion Process

The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. The 2011 Florida Legislature also amended this area. Now, the FFS PSNs are required to convert to capitation no later than September 1, 2014, or within two years of operation, whichever comes later.

Current Reform FFS PSNs will be required to convert to capitation by September 1, 2014, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

While most FFS PSNs submitted conversion workplans and applications to the Agency in order to comply with the previous five-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications with the additional experience gained from the additional years of experience achieved. The Agency continued revising the conversion application based on the legislative changes and on changes in the health plan application process, and intends to release an updated version of the conversion application in April 2012. Table 3 provides the timeline for each step in the revised conversion process.

Table 3
PSN Conversion to Capitation Timeline

Deadline for current FFS PSNs to submit conversion applications to the Agency.	09/01/2013
Successful conversion of applicants and execution of capitated contracts for service begin date of 09/01/2014.	06/30/2014

FFS PSN Reconciliations

By the end of this quarter, the Agency completed work on the first, second and third contract year reconciliations[2] (September 2006 through August 2007, September 2007 through August 2008, and September 2008 through August 2009) for all plans, except two FFS PSNs. The

[2] Reconciliation is the process by which the Agency compares the per member per month (PMPM) cost of FFS PSN enrollees against what the Agency would have paid the FFS PSN had the PSN been capitated in order to determine savings or cost-effectiveness. The FFS PSNs are expected to be cost-effective and the Agency reconciles them periodically according to contract requirements.

Agency continues to work with the FFS PSNs that have requested additional time for reconciliation data analysis.

Systems Enhancements

With the conversion to the Medicaid fiscal agent, system changes continue to occur along with continued technical assistance to the health plans (see Section J of this report). As the new system has become fully operational, the Agency continues to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to be more innovative in their health care delivery and achieve efficiencies not currently available.

2. Benefit Package

Overview

Customized benefit packages are one of the fundamental elements of the demonstration. Medicaid recipients are offered choices in health plan benefit packages customized to provide services that better suit health plan enrollees' needs. The 1115 Research and Demonstration Waiver authorizes the Agency to allow capitated plans to create a customized benefit package by varying certain services for non-pregnant adults, varying cost-sharing, and providing additional services. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package, but could eliminate or reduce the co-payments and offer additional services.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages to ensure they were actuarially equivalent and sufficient coverage was provided for all services. To develop the actuarial and sufficiency benchmarks, the Agency defined the target populations as Family and Children, Aged and Disabled, Children with Chronic Conditions, and Individuals with HIV/AIDS. The Agency then developed the sufficiency threshold for specified services. The Agency identified all services covered by the plans and classified them into three broad categories: covered at the State Plan limits, covered at the sufficiency threshold, and flexible. For services classified as "covered at the State Plan limit," the plan does not have flexibility in varying the amount, duration or scope of services. For services classified under the category of "covered at the sufficiency threshold," the plan can vary the service so long as it met a pre-established limit for coverage based on historical use by a target population. For services classified as "flexible," the plan has to provide some coverage for the service, but has the ability to vary the amount, duration, and scope of the service.

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for all five years of the initial demonstration period. Interested parties were notified that the data book would be e-mailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were then released on May 23, 2007 for Demonstration Year Two, May 7, 2008 for Demonstration Year Three, September 15, 2009 for Demonstration Year Four and September 30, 2010 for Demonstration Year Five.

All health plans are required to submit their proposed customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006, and updated versions of the PET were released annually, shortly after the release of the latest data book. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial

equivalency and sufficiency tests before submitting a benefit package. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) are typically completed during the last quarter of each state fiscal year. The verification process includes a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

The health plans have become innovative about expanding services to attract new enrollees and to benefit enrollees by broadening the spectrum of services. The standard Florida Medicaid State Plan package is no longer considered the perfect fit for every Medicaid recipient, and the recipients are getting new opportunities to engage in decision-making responsibilities relating to their personal health care.

The Agency, the health plans, and the recipients can see the value of customization as shown in an increase in the percentage of voluntary plan choices. The health plans have used the opportunity to offer additional, alternative, and attractive services. In addition, the health plan enrollees are receiving additional services that were not available under the regular Florida Medicaid State Plan. The value of each customized benefit package continues to meet or exceed the Florida Medicaid State Plan benefit package in Year Six of the demonstration.

Current Activities

Customized Benefit Packages

The benefit packages customized by the health plans for Demonstration Year Five became operational on January 1, 2011 and remained valid until December 31, 2011, effectively overlapping Year Five and Year Six of the demonstration. These benefit packages include 20 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

Table 4 located on the following page lists the number of co-payments for each service type by each Demonstration Year and reflects the new benefit packages which went into effect January 1, 2011. Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the recipients of any changes in their current health plan's benefit package as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, in Tables 4 and 5, Demonstration Year Three has been divided into three columns: July 1, 2008 through December 31, 2008; January 1, 2009 through November 30, 2009; and December 2009. These different columns reflect the departure of health plans that ceased operations during Demonstration Year Three. Table 4 located on the following page has been updated to reflect the customized benefit packages effective January 2012.

Table 4 Number of Co-payments by Type of Service by Demonstration Year										
Type of Service	**Year One**	**Year Two**	**Year Three**			**Year Four**	**Year Five**		**Year Six**	
	July 2006-June 2007	July 2007-June 2008	July-Dec 2008	Jan-Nov 2009	Dec 2009	Jan-June 2010	July-Dec 2010	Jan-Aug 2011	July-Dec 2011	Jan-March 2012
ARNP/Physician Assistant	0	0	5	1	0	0	0	0	0	0
Chiropractic	10	0	8	4	3	3	3	5	5	6
Clinic (FQHC, RHC)	0	0	6	2	1	0	0	0	0	0
Dental	4	4	4	0	0	2	2	2	2	2
Home Health	4	1	8	4	3	3	3	3	3	4
Hospital Inpatient: Behavioral Health	11	1	8	4	3	4	4	6	6	6
Hospital Inpatient: Physical Health	7	1	8	4	3	4	4	6	6	6
Hospital Outpatient Services (Non-Emergency)	7	1	7	3	3	2	2	2	2	2
Hospital Outpatient Surgery	7	1	8	4	3	2	2	2	2	2
Lab/X-Ray	5	1	7	3	3	2	2	2	2	2
Mental Health	7	3	6	2	1	4	4	4	4	5
Podiatrist	10	0	7	3	3	3	3	5	5	6
Primary Care Physician	0	0	5	1	0	0	0	0	0	0
Specialty Physician	1	1	6	2	1	0	0	2	2	2
Transportation	5	5	6	2	1	2	2	2	2	2
Vision	4	0	5	1	1	2	2	2	2	2
Total Number of Required Co-payments	**82**	**19**	**104**	**40**	**29**	**33**	**33**	**43**	**43**	**47**

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year. During this quarter, the health plans' Year Six benefit packages became effective January 1, 2012.

Table 5 Number and Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year											
	Year One	**Year Two**	**Year Three**			**Year Four**		**Year Five**		**Year Six**	
	July 2006-June 2007	July 2007-June 2008	July-Dec 2008	Jan-Nov 2009	Dec 2009	Jan-April 2010	May-June 2010	July-Dec 2010	Jan-June 2011	July-Dec 2011	Jan-Mar 2012
Total Number of Benefit Packages	28	30	28	24	20	20	19	19	20	20	20
Total Number of Benefit Packages Requiring No Co-payments	12	16	20	20	17	16	15	15	14	14	13
Percent of Benefit Packages Requiring No Co-payments	43%	53%	71%	83%	85%	80%	79%	79%	70%	70%	65%

Table 6 displays the number of Demonstration Year Four and Year Five benefit packages not requiring co-payments by population and area. Table 6 shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments.

Table 6
Number of Benefit Packages Requiring No Co-payments by Target Population and Area
(Demonstration Years Four, Five and Six)

Target Population	List of Counties in Each Demonstration Area	Number of Benefit Packages Not Requiring Co-payments				
		Year Four		Year Five		Year Six
		Jan-April	May-June	July-Dec	Jan-June	July-March
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	3	3	3	1	1
SSI (Aged and Disabled)	Broward	6	5	5	6	6
TANF (Children and Families)	Duval, Baker, Clay and Nassau	1	1	1	1	1
TANF (Children and Families)	Broward	6	5	5	6	5

Expanded Services

In Year Six of the demonstration, many plans continue to provide services not currently covered by Medicaid in order to attract enrollees. In the health plan contract, these are referred to as expanded services. There are five different expanded services offered by the health plans during this contract year. The two most popular expanded services offered were the same as Demonstration Years Two, Three, Four, and Five: the over-the-counter drug benefits and the adult preventive dental benefits. The expanded services available to recipients include:

- Over-the-counter drug benefit – $25 per household, per month,
- Adult Preventive Dental,
- Circumcisions for male newborns, and
- Additional Adult Vision.

Plan Evaluation Tool

Since the implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006, to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Demonstration Year Three to a monthly script limit only. In Demonstration Year One and Year Two, plans had the option of having a monthly script limit or a dollar limit on the pharmacy benefit. This change was made to standardize the mechanism used to limit the pharmacy benefit. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF at 98.5%.

The PET submission procedure for Demonstration Year Six will be similar to that of the five previous years. The updated version of the data book and the new PET were released by the Agency during the second quarter of Demonstration Year Six. The health plans' Year Six benefit packages that were approved last quarter became effective January 1, 2012.

3. Health Plan Reported Complaints, Grievances and Appeal Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process and Medicaid Fair Hearing (MFH) system. In addition, plan contracts include timeframes for submission, plan response and resolution of recipient grievances. This is compliant with federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics and exclusive provider organizations; and to the Beneficiary Assistance Panel (BAP) for enrollees in a FFS PSN (described below). This provides an additional level of appeal.

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of the Health Plan to act within ninety (90) days from the date the Health Plan receives a Grievance, or 45 days from the date the Health Plan receives an Appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise his or her rights to obtain services outside the network.
- Appeal means a request for review of an Action, pursuant to 42 CFR 438.400(b).
- Grievance means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Under the demonstration, the legislature required that the Agency develop a process similar to the SAP as enrollees in a FFS PSN do not have access to the SAP. In accordance with Section 409.91211(3)(q), F.S., the Agency developed the Beneficiary Assistance Panel (BAP), which is similar in structure and process to the SAP. The BAP will review grievances within the following timeframes (same timeframes as SAP):

1. The state panel will review general grievances within 120 days.
2. The state panel will review grievances that the state determines pose an immediate and serious threat to an enrollee's health within 45 days.
3. The state panel will review grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee within 24 hours.

Enrollees in a health plan may file a request for a Medicaid fair hearing at any time and are not required to exhaust the plan's internal appeal process or the SAP or BAP prior to seeking a fair hearing.

Current Activities

In an effort to improve the demonstration, the Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. In an attempt to better understand the issues recipients face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in its quarterly reports. The Agency also uses this information internally as part of the Agency's continuous improvement efforts.

Plan-Reported Complaints

Beginning with the second quarter of Demonstration Year Four, the new health plan contract required the plans to report in their grievance and appeal reports the number of complaints that they received from members.

Table 7 provides the number of complaints reported by PSNs and HMOs for the third quarter of Demonstration Year Six. The health plan contract defines complaint as: any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day. The subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices or provision of services that relate to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system.

Table 7
Plan-Reported Complaints
(January 1, 2012 – March 31, 2012)

Quarter	PSN Complaints	HMO Complaints	HMO and PSN Enrollment*
January – March 2012	181	1,162	326,131

*unduplicated enrollment count

Grievances and Appeals

Table 8 provides the number of grievances and appeals by health plan type for the third quarter of Demonstration Year Six.

Table 8
Grievances and Appeals
(January 1, 2012 – March 31, 2012)

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO and PSN Enrollment*
Total	12	33	50	122	326,131

*unduplicated enrollment count

During the third quarter of Demonstration Year Six, PSN grievances decreased from 28 to 12, and the number of PSN appeals increased from 31 to 33. Fifty (50) HMO grievances is a decrease from last quarter's count of 56, while 122 appeals for HMOs this quarter is higher than last quarter's 110.

Medicaid Fair Hearings (MFHs)

Table 9 provides the number of MFHs requested during the third quarter of Demonstration Year Six. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members; however, the Agency monitors the Medicaid Fair Hearing process. Of the 16 MFH requests relating to demonstration participants: six were related to the reduction/suspension/termination of benefits/services; five were related to denial/limitation of benefits/services; and one was related to the inability of the enrollee to change plans. An additional four had not yet progressed to being classified. In regards to outcomes, three cases were withdrawn, two cases were abandoned, and one was dismissed. In four cases, a hearing was held, but no decision was announced prior to the end of the quarter. Two cases had a hearing scheduled, and four had been acknowledged, but not yet scheduled.

Table 9 **Medicaid Fair Hearing Requests** (January 1, 2012 – March 31, 2012)	
PSN	9
HMO	7

BAP and SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level, as no grievances were submitted to the SAP or to the BAP during this quarter. Table 10 provides the number of requests to the BAP and SAP for the third quarter of Demonstration Year Six.

Table 10 **BAP and SAP Requests** (January 1, 2012 – March 31, 2012)	
BAP	0
SAP	0

4. Agency-Received Complaints/Issues Resolution Process

Overview

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on what is working and not working in managed care under the demonstration. Complaints/issues come to the Agency from recipients, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received by the Agency are as follows:

- Medicaid Local Area Offices,
- Medicaid Headquarters Bureau of Managed Health Care,
- Medicaid Headquarters Bureau of Health Systems Development, and
- Medicaid Choice Counseling Helpline. Health plan complaints received by the Choice Counseling Helpline are referred to the Florida Medicaid headquarters offices specified above for resolution.

The complaints/issues are worked by Florida Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. This tracking was previously accomplished through a consolidated automated database that was implemented October 1, 2007 and used by all Agency staff housed in the above locations to track and trend complaints/issues received. Beginning on October 1, 2009, Medicaid staff in the above locations started using the new Complaints/Issues Reporting and Tracking System (CIRTS), which allows real-time, secure access through the Agency's web portal for headquarters and Medicaid Local Area Office staff.

The Agency tracks complaints by plan and plan type (PSN and HMO) and continues to review particular complaint data on individual plans on a monthly basis and reviews complaint trends on a quarterly basis at the management level.

During this quarter, the Agency received 22 complaints/issues related to PSNs and received 45 complaints/issues related to HMOs, for a total of 67 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO) of this report. Attachment I provides the details on the complaints/issues related to PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

The majority of the PSN complaints/issues received this quarter were from members. The member issues included needing assistance in accessing providers and assistance in getting services authorized. The provider issues were regarding claims payment.

The majority of the HMO complaints/issues during this quarter were related to member issues, with the majority of those being related to members needing assistance with finding/seeing a provider, getting authorization for services, and obtaining medications. Provider issues included payment delays/denials.

The Agency's staff worked directly with the members and health plans (HMOs and PSNs) to resolve issues. For both PSN and HMO issues, education was provided to members and providers to assist them in obtaining the requested information/service. The health plans were informed of all member issues and, in most cases, the health plans were instrumental in obtaining the information or service the member or provider needed.

Agency staff will continue to resolve complaints in a timely manner and to monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

5. Medical Loss Ratio

On March 13, 2012, the Agency submitted to Federal CMS the draft Medical Loss Ratio (MLR) instructions and templates, the draft MLR reporting schedule and the draft report guide. This information is posted on the Agency's website and can be viewed at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/Special_Terms_Conditions_14_03-13-2012.pdf

During this quarter, the Agency received feedback from the plans on the draft MLR reporting schedule submitted to Federal CMS on March 13, 2012. Based on comments from the health plans, the Agency will be revising the draft MLR reporting schedule. The following draft plan

contract amendment language was provided to the health plans on February 17, 2012. In follow up, the Agency held a publicly noticed conference call with the plans on February 27, 2012, to discuss the draft changes to the health plan Contract Attachment II, Core Contract Provisions, Section II, General Overview, Item D., General Responsibilities of the Health Plan. The health plans submitted comments on the draft contract language in March 2012. The Agency has taken the plan's comments into consideration and has updated the Report Guide and Core Contract Provisions as follows:

> In accordance with the Florida's Section 1115 Demonstration Special Terms and Conditions, capitated health plans shall maintain an annual (July 1 through June 30) medical loss ratio (MLR) of eighty-five percent (85%) for operations in the demonstration counties beginning July 1, 2012. The health plan shall submit data to the Agency for Health Care Administration quarterly to show ongoing compliance. The Centers for Medicare and Medicaid Services will determine the corrective action for non-compliance with this requirement.
>
> The draft update to the Report Guide will be posted by April 2, 2012, and will be effective 90 days later on July 1, 2012. Health plans will be expected to submit quarterly and annual MLR reports using the Agency supplied template and in accordance with the filing instructions in the draft version of Chapter 39 of the Report Guide. Quarterly reports will be due to the Agency no later than 105 days following the close of the quarter. The first Annual MLR report, for the waiver Demonstration Year Seven (July 1, 2012 – June 30, 2013), is due to the Agency on December 1, 2013.

The calculation shall utilize uniform financial data collected from all capitated health plans operating in the demonstration areas and shall be computed for each plan on a statewide basis. For the purpose of calculating the MLR, "health care covered services" are defined as services provided by the health plan to Medicaid recipients in the demonstration area in accordance with the Health Plan Medicaid Contract and as outlined in Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I (see below).

> "The method for calculating the MLR shall meet the following criteria:
>
> a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 CFR Part 158.
> b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.
> c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period."

6. On-Site Surveys and Desk Reviews

During this quarter, the Agency did not conduct medical on-site surveys of the Medicaid HMOs and PSNs. The Agency continued to conduct desk reviews of health plan provider networks for adequacy; review financial reports; review medical, behavioral health, and fraud and abuse policies and procedures; and review and approve performance improvement projects, quality

improvement plans, disease management programs, member and provider materials and handbooks.

The Agency's External Quality Review Organization (EQRO) vendor continues to make refinements to the contract review tool based on the recommendations of the medical unit's reviews of the preceding year. The tool was utilized in on-site surveys beginning in April 2011. The vendor continues to make refinements to the behavioral health contract review tool, the clinical record review tool, and the targeted case management record review tool based on the recommendations of the Behavioral Health Unit during the course of the year. These tools will be used for health plan reviews in 2012.

Table 11 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 11
On-Site Survey Categories

➲ Services	➲ Provider Coverage
➲ Marketing/Community Outreach	➲ Provider Records/Credentialing
➲ Utilization Management	➲ Claims Process
➲ Quality of Care	➲ Grievances and Appeals
➲ Provider Selection	➲ Financials

B. Choice Counseling Program

Overview

A continual goal of the demonstration is to empower recipients to take control and responsibility for their own health care by providing them with the information and access needed to make the most informed decisions about health plan choices.

During the fourth quarter of Demonstration Year Four, Automated Health Systems (AHS) began rendering services for the Choice Counseling program. The implementation of the new choice counseling vendor was successfully completed and AHS assumed full responsibility of all duties effective June 18, 2010.

Current Activities

1. Choice Selection Tools

In October of 2008, the Agency implemented the Informed Health Navigator Solution (Navigator) as a Preferred Drug List (PDL) search system, under the previous choice counseling vendor, Affiliated Computer Services (ACS). The Navigator function allowed the choice counselor to provide basic information to the recipients on how well each plan meets his or her prescribed drug needs. This information was provided to assist the recipient in making a health plan selection.

Beginning June 18, 2010, the new enrollment system, referred to as Health Track, includes the same PDL comparison function, as well as Primary Care Physician (PCP), Specialist and Hospital search comparison options. Collectively, these new functions are now known as, "Choice Selection Tools."

A brief description of each choice selection tool is outlined as follows:

- **PDL Comparison**: Each health plan's PDL is compared against the recipient's prescribed drug claims history, as well as any additional list of medications provided to the choice counselor by the recipient.
- **PCP Comparison**: Each health plan's provider network file is searched simultaneously for the name of PCPs provided by the recipient.
- **Specialist Comparison**: Each health plan's provider network file is searched simultaneously for the name of specialists provided by the recipient.
- **Hospital Comparison**: Each health plan's provider network file is searched simultaneously for the name of hospitals provided by the recipient.

PDL information is updated quarterly, prescription claims information is updated daily and provider network files are updated monthly, at a minimum.

Upon entering the search criteria for each choice selection tool, the system returns the results in an easy to read format, which sorts the health plans by those that meet the most of the recipients' criteria to those that meet the least amount of criteria (see illustration located on the following page as an example).

Illustration of Choice Selection Tools in Health Track Enrollment System

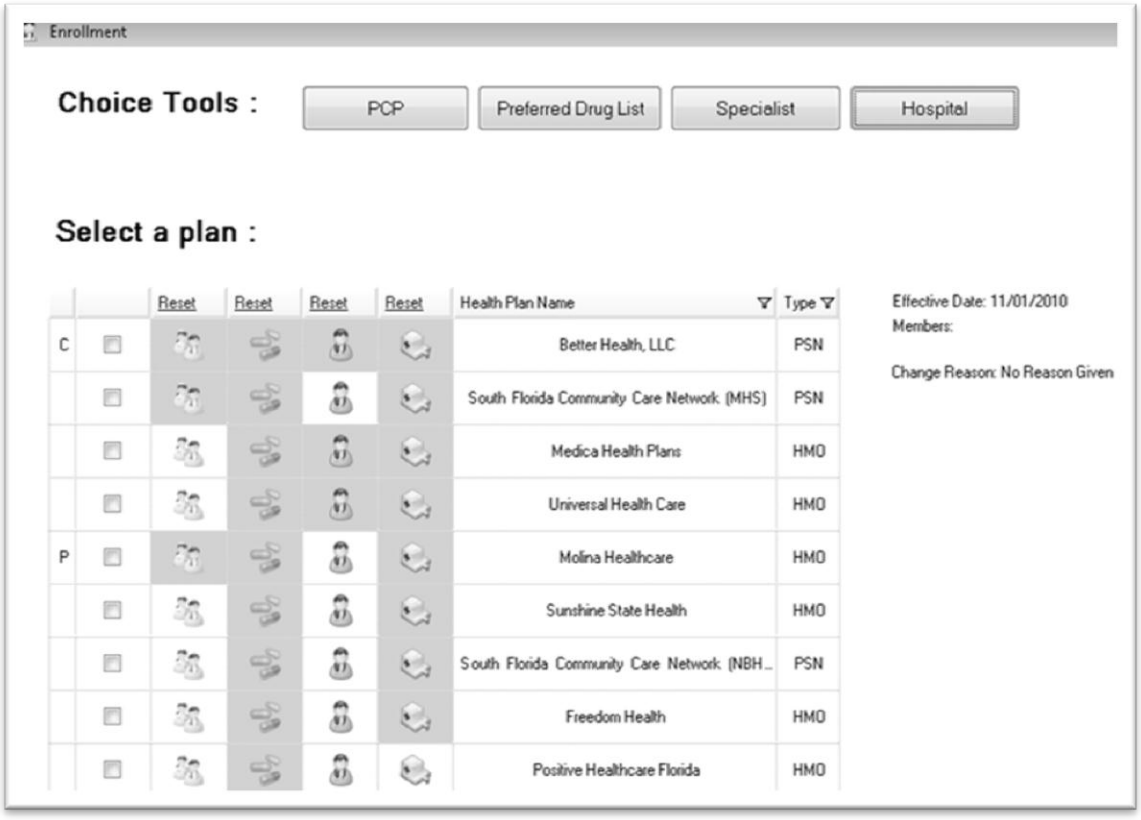
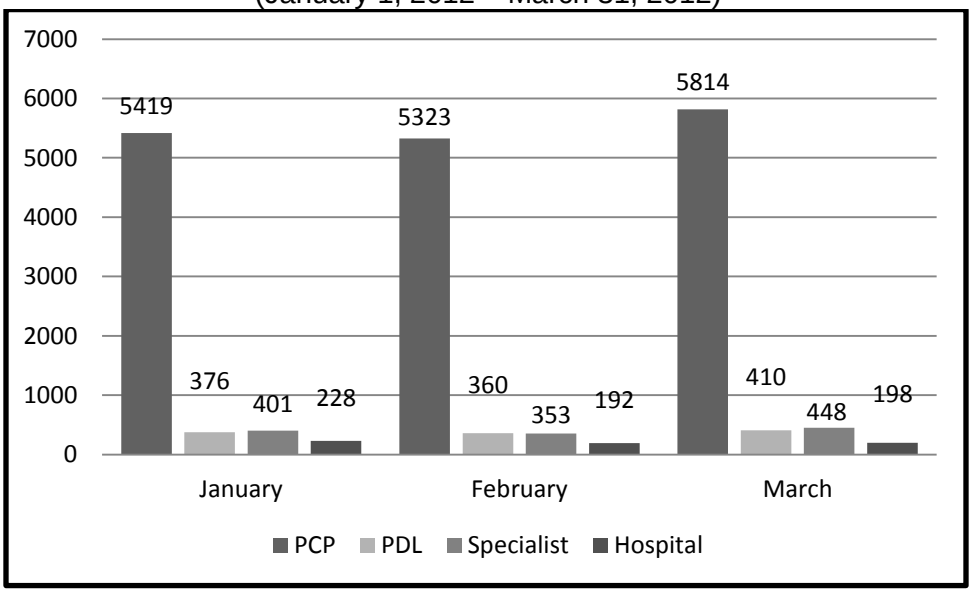


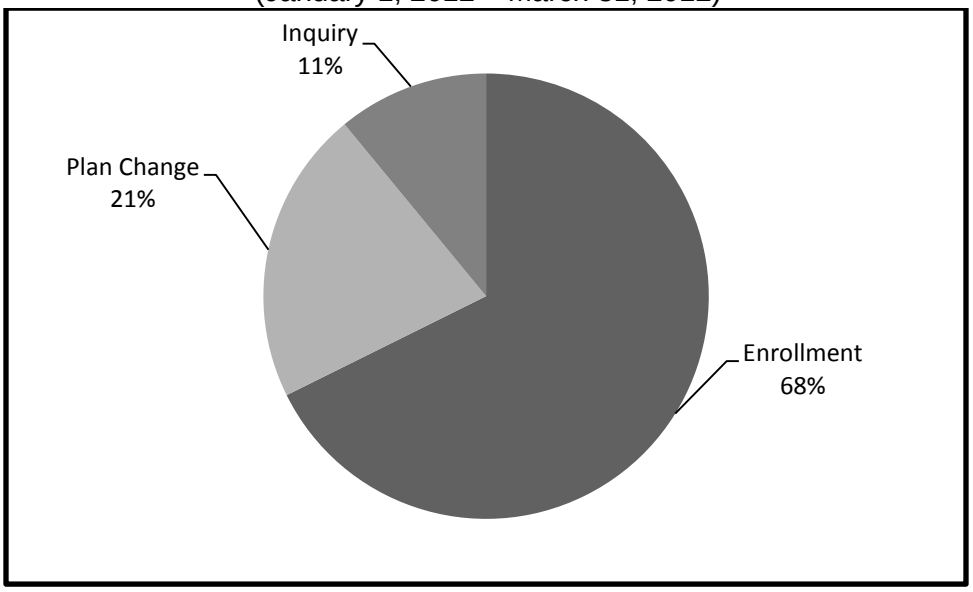
Chart A represents the number of times each choice selection tool was utilized during the enrollment or plan change process for this quarter. The results are broken out by choice tool type.

Chart A
Choice Tool Use by Type
(January 1, 2012 – March 31, 2012)



Choice counseling captures data to indicate whether a person is using the choice tools for an enrollment, plan change or an inquiry. Chart B shows (by percentages) what types of calls were received using this program as a choice driver during this quarter.

Chart B
Navigator Use by Call Type
(January 1, 2012 – March 31, 2012)



Recipient Customer Survey

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rank their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the survey to every recipient who calls to enroll in a plan or to make a plan change. A total of 1,343 recipients completed the automated survey this quarter.

Table 12 located on the following page shows a list of all questions that are asked during the survey and how recipients ranked their satisfaction (represented in percentages) with the choice counseling call center and the overall service provided by the choice counselors during this quarter. The number of recipients participating in the survey this quarter was as follows: January – 383, February – 409, and March – 551 (totaling 1,343).

Remainder of page intentionally left blank

Table 12 Choice Counseling Caller Satisfaction Results Percentage of Satisfied Callers Per Question		
January 2012	*February 2012*	*March 2012*
How helpful do you find this counseling to be		
89%	91%	88%
Amount of time you waited		
84%	94%	89%
Ease of understanding information		
80%	78%	78%
Likelihood to recommend		
95%	96%	95%
Overall service provided by Counselor		
95%	98%	95%
Quickly understood reason		
95%	98%	95%
Ability to help choose plan		
95%	96%	93%
Ability to explain clearly		
95%	96%	94%
Confidence in the information		
94%	97%	94%
Being treated respectfully		
97%	98%	97%

2. Call Center

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., Friday 8:00a.m. – 7:00p.m., and Saturday 9:00a.m. – 1:00p.m. During this quarter, the call center had an average of 31 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls.

The choice counseling call center received 46,772 calls during this quarter, which remains within the normal call volume.

The Agency continues to work on strengthening the various methods used to inform recipients of their health plan choices and options to enroll in the plan that best meets their needs. Since the transition to the new Choice Counseling Vendor on June 18, 2010, the Agency has:

- Revised the new-eligible packet, open enrollment packet and auto-assignment letter,
- Implemented the Online Enrollment Application,
- Implemented the Choice Selection Tools, and
- Implemented the National Change of Address database to improve mail delivery.

Table 13 compares the call volume of incoming and outgoing calls during the third quarter of Demonstration Year Five and Year Six.

Table 13
Comparison of Call Volume for Third Quarter
(Demonstration Years Five and Six)

Type of Calls	Jan 2011	Jan 2012	Feb 2011	Feb 2012	Mar 2011	Mar 2012	Year 5 3rd Quarter Totals	Year 6 3rd Quarter Totals
Incoming Calls	20,669	15,912	16,507	14,855	20,148	15,804	**57,166**	**46,772**
Outgoing Calls	8,655	4,892	8,346	5,661	9,170	5,611	**26,171**	**16,164**
Totals	29,324	20,804	34,853	20,516	29,318	21,415	**83,337**	**62,936**

3. Mail

Outbound Mail

During this quarter, the choice counseling vendor mailroom mailed the following:

- New-Eligible Packets (mandatory and voluntary) 25,380
- Confirmation Letters 24,510
- Open Enrollment Packets 52,944
- Transition Packets (mandatory and voluntary) 1,907
- Plan Transfer Letters (mandatory and voluntary) 0

When return mail is received with no forwarding address from the post office, staff access the choice counseling vendor's enrollment system and the Florida Medicaid Management Information System to locate a telephone number or a new address in order to contact the recipient. The Outreach Team also assists in efforts to contact the recipient. The choice counseling mailroom staff re-addresses the packets or letters when possible, with the newly eligible mailings taking top priority.

As part of an Agency effort to improve recipient communication, the Agency no longer sends a separate mandatory health plan assignment letter. The pending health plan mandatory assignment information is now included within each new-eligible letter. A reminder notice is sent out to those who have not made a choice (self-selected a health plan) within the first 30 days of receiving their initial letter. If a choice is not made within the 30-day period following the reminder notice, the recipient is mandatorily enrolled into the assigned health plan on the first day of the following month; however, recipients still have 90 days to change, without cause, after the plan effective date.

Inbound Mail

During this quarter, the choice counseling vendor processed the following:

- Plan Enrollments 647
- Plan Changes 49

The percentage of enrollments processed through the mail-in enrollment forms is slightly less than the historical trend of 2 – 5%. This decline is expected to continue with the use of the Online Enrollment Application.

The Online Enrollment Application was implemented on September 1, 2010. Since implementation, 12,934 enrollments and 1,966 plan changes have been processed through the Online Enrollment Application. The Agency is working to increase recipient awareness of online access and expects the number of enrollments to increase. The Agency continues to evaluate whether the mail-in enrollment option will be maintained.

4. Face-to-Face/Outreach and Education

The field choice counseling outreach team enhanced the group sessions conducted this quarter by making additional field choice counselors available after the session to assist recipients in plan choices and, if needed, providing the option for a recipient to meet with a choice counselor one-on-one at the recipient's convenience. Table 14 provides the choice counseling outreach activities during this quarter:

Table 14
Choice Counseling Outreach Activities

Field Activities	3rd Quarter – Year 6
Group Sessions	410
Private Sessions	46
Home Visits and One-On-One Sessions	18
No Phone List*	796
Outbound Phone List	1,025
Enrollments	9,378
Plan Changes	258

*Attempts made by field counselors to contact recipients who do not have a valid phone number in the Health Track System.

On May 1, 2011, the field choice counseling outreach team implemented the flexible outreach schedule initiative (FOSI), designed to allow field choice counselors time to attempt to reach recipients after 5:00p.m., or on weekends. The goal of the FOSI is to reach recipients who are traditionally unreachable during normal business hours.

The Agency and the choice counseling vendor have revised the survey instrument used to monitor the field choice counselors' performance. The Agency is currently reviewing the changes. The survey statistics are not included in this quarter's report, but will be available by the fourth quarter of Demonstration Year Six.

<u>The Mental Health Unit</u>

The Mental Health Unit was created to provide more direct support to recipients who access mental health services. The ongoing initiatives and efforts to build relationships with the organizations that serve these individuals continue to yield positive results.

During August 2011, the vendor adjusted its staffing allocation to allow staff members of the Mental Health Unit to focus their time on building community relations and supporting the organizations and agencies servicing the special need communities.

During this quarter, the Mental Health Unit completed 35 private sessions for a total of 176 attendees and made 46 visits, as well as 99 calls to partners in an effort to strengthen and build relationships. Partner staff training was held on four occasions for a total of 16 staff members. Community Relations Specialists also completed an additional 11 private sessions for a total of 24 attendees and made 105 visits and 35 calls to our partners. They provided staff training to a total of 18 partner staff members and there were 60 referrals received and followed up on from various community agencies and organizations.

The vendor has also grown the community partner list to over 200 organizations and, as a result, the Mental Health Unit has established several key relationships and developed strong working partnerships including several large organizations:

- Susan B. Anthony Recovery Center in Broward County,
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County,
- Mental Health Resource Center and River Region Human Services in Duval County,
- Clay County Behavioral Health, and
- Wolfson's Children's Hospital/Community Health in Duval County.

These groups provide mental health and substance abuse services and have been very receptive to working with the field choice counselors.

5. Health Literacy

The choice counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse and a Licensed Practical Nurse who have both earned their choice counseling certification.

Summary of cases taken by the Special Needs Unit

A 'case referral' is when a choice counselor refers a case to the Special Needs Unit through the choice counseling vendor, enrollment system (Health Track) or verbally via phone transfer, for follow-up. The Special Needs Unit conducts the research and resolves the referral.

A 'case review' is when the Special Needs Unit helps with questions from a choice counselor as they are on a call. Most reviews can be handled verbally and quickly. Some case reviews may end up as a referral if there is more research and follow-up required by the Special Needs Unit.

During this quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as shown in Table 15 on the following page.

Table 15 Number of Referrals and Case Reviews Completed (January 1, 2012 – March 31, 2012)			
	January	**February**	**March**
Case Referrals	141	103	144
Case Reviews	98	97	114

The Special Needs Unit staff scope of work includes:

- Development of additional training for the choice counselors working with and serving the medically, mentally or physically complex,
- Enhancements to the scripts to educate recipients on how to access care in a managed care environment,
- Development of health related reference guides to increase the choice counselor's knowledge of Medicaid services (which is ongoing),
- Participation in the development of the navigator choice selection tool script, and
- Development and implementation of a tracking log to capture the number and type of counselor's verbal inquiries, which was completed during last quarter.

6. New Eligible Self-Selection Data[3]

On June 18, 2010, AHS began rendering services as the Agency's choice counseling vendor. Programming changes to the system have allowed the Agency to collect more reliable, yet not fully validated, data regarding self-selection and auto-assignment rates beginning in Demonstration Year Five. While provided, the self-selection rate and auto-assignment rate cannot be validated at this time.

From July 2010 to March 2012, 70% of recipients enrolled in the demonstration self-selected a health plan and 30% were auto-assigned. On average, the self-selection rate was 80% prior to July 2008. The high rate of the voluntary selection may be attributable to several factors including:

- Change in the choice counseling welcome packet, which may have resulted in recipients not calling to verify the preselected health plan as recipients are not required to do so. A description of the change in the welcome packet that was implemented during the fourth quarter of Year Four is provided below.
  - Prior to June 18, 2010, recipients received a packet of written materials (the choice counseling welcome packet) welcoming them to Medicaid, advising them of the need to select a plan by a specified date, and a brochure of covered services and available plans. In follow-up to the welcome packet, recipients were sent a pending auto-assignment letter. This letter notified recipients, who had not yet voluntarily selected a

[3] The Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate,"* the data is referred to as *"New Eligible Self-Selection Rate."* The term *"self-selection"* is now used to refer to recipients who choose their own plan and the term *"assigned"* is now used for recipients who do not choose their own plan.

plan, that they would be automatically enrolled in a health plan (plan name was specified in the letter) unless they voluntarily select a plan by the specified date.

- Beginning June 18, 2010, recipients receive a choice counseling welcome packet welcoming them to Medicaid, advising them of the need to select a health plan, the deadline for selecting a plan, and the name of the plan they will be assigned to if a self-selection is not made by the specified date. If the recipient is satisfied with the plan assignment provided in the choice counseling welcome packet, then the recipient does not need to take any action to select a plan. Should the recipient decide to select a different health plan, then they can refer to the brochure of covered services and available health plans that is also included in their choice counseling welcome packet.

Table 16 shows the current self-selection and auto-assignment rate for the current demonstration year.

Table 16
Self-Selection and Auto-Assignment Rate
(January 1, 2012 – March 31, 2012)

	January	February	March
Self-Selected	9,525	11,008	13,719
Auto-Assignment	5,789	3,968	5,701
Total Enrollments	15,314	14,976	19,420
Self-Selected %	62%	74%	71%
Auto-Assignment	38%	27%	29%

7. Complaints/Issues

A recipient can file a complaint about the Choice Counseling program either through the choice counseling call center, Medicaid headquarters, or the Medicaid area office. The choice counseling vendor's automated recipient survey allows complaints about the Choice Counseling program to be filed and voice comments can be recorded to describe what occurred on the call. There were no complaints received related to the Choice Counseling program during the third quarter of Demonstration Year Six.

The primary contributing factor to the limited number of complaints is directly tied to the community presence the field choice counselors provide to resolve issues before they become a complaint, as well as efforts taken by the Agency field staff.

8. Quality Improvement

A key component of the Choice Counseling program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the choice counseling vendor and the Agency improve customer service to Medicaid recipients. It is imperative for recipients to understand their options and make an informed choice. The survey results reporting the recipients' satisfaction, with the overall service provided by the choice counselors, indicate that more than 95% are satisfied with the choice counseling experience during this quarter. Survey results also indicate that 95% are satisfied with the choice counselor's ability to clearly explain health plan choices, and 97% felt they were treated respectfully. The choice counseling vendor continues to focus on improving communication

between the choice counselors and recipients, as well as evaluating comments left by recipients to improve customer service.

Survey scores and recipient comments are provided to supervisors and counselors. The positive comments encourage the choice counselor to keep up the good work and the negative comments help to point out possible weaknesses that may require coaching or training.

The Agency headquarters staff, the Medicaid area office staff, and the choice counseling vendor's staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between the Medicaid area office staff and the choice counseling vendor's field staff.

The choice counseling vendor's enrollment system has internal e-mail boxes, which enable the Agency staff and the choice counseling vendor's staff to share information directly to resolve difficult cases, and hold regularly scheduled conference calls. The choice counseling vendor has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the call center and field office have been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

C. Enrollment Data

Overview

In anticipation of Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population into the health plans located in the demonstration counties of Broward and Duval. The transition period for Broward and Duval lasted seven months, beginning in September of 2006 and ending in April of 2007. The plan staggered the enrollment of recipients who were enrolled in various managed care programs [operated under Florida's 1915(b) Managed Care Waiver] into demonstration health plans. The types of managed care programs that recipients transitioned from included Health Maintenance Organizations (HMOs), MediPass, Pediatric Emergency Room Diversion, Provider Service Networks (PSNs), and Minority Physician Networks (MPNs).

During the development of the transition plan, consideration was given to the volume of calls the Choice Counseling program would be able to handle each month. The Agency followed the transition schedule outlined below:

- **Non-committed MediPass[4]:** Phased in over 7 months (1/2 in Month 1, then 1/6 in each following month)
- **HMO Population:** 1/12 in Months 2, 3, and 4 and 1/4 in Months 5, 6, 7
- **PSN Population:** 1/3 in each of Months 2, 3, and 4.

During the first quarter of the Demonstration Year One, enrollment in health plans was based on this transitional process. Specifically, the July 2006 transition period focused on enrollment of newly eligible recipients as well as half of the MediPass population. Recipients were given 30 days to select a plan. If the recipients did not choose a plan, the choice counselor assigned the recipient to one. The earliest date of enrollment in a demonstration health plan was September 1, 2006. During the second, third and fourth quarters of Demonstration Year One, enrollment in the demonstration increased greatly as more existing Medicaid recipients were transitioned into health plans.

The Agency also developed a transition plan for the Year Two of the demonstration, which expanded the program into the counties of Baker, Clay, and Nassau. Due to the smaller population located in these counties, the transition plan was implemented over a four-month period with enrollment beginning in September of 2007 and ending in December 2007. This process was implemented to stagger the enrollment of existing managed care recipients into a demonstration health plan. The recipients were transitioned from HMOs, MediPass and MPNs. The transition schedule for Baker, Clay and Nassau Counties was as follows:

- **September 2007 Enrollment:** Non-committed MediPass located in Baker, Clay, and Nassau Counties.
- **October 2007 Enrollment:** Remaining recipients located in Baker and Nassau Counties.
- **November 2007 Enrollment:** Remaining recipients located in Clay County.
- **December 2007 Enrollment:** Clean-up period to transition any remaining recipients located in Baker, Clay, and Nassau Counties.

[4] Non-committed MediPass recipients are those who had a primary care provider that did not become part of a Medicaid Reform health plan's provider network.

The demonstration was not expanded in Year Six and continues to operate in the counties of Baker, Broward, Clay, Duval, and Nassau.

Current Activities

Monthly Enrollment Reports

The Agency provides a comprehensive monthly enrollment report, which includes the enrollment figures for all health plans in the demonstration. This monthly enrollment data is available on the Agency's website at the following link: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning January 1, 2012, and ending March 31, 2012. This section contains the following enrollment reports:

- Medicaid Reform Enrollment Report,
- Medicaid Reform Enrollment by County Report, and
- Medicaid Reform Voluntary Population Enrollment Report.

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 13 Medicaid Reform health plans – nine HMOs and four FFS PSNs.

There are two categories of Medicaid recipients who are enrolled in the demonstration health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the recipients' eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described on the following pages.

Remainder of page intentionally left blank

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the demonstration program for the quarter being reported. Table 17 provides a description of each column in Medicaid Reform Enrollment Report.

Table 17
Medicaid Reform Enrollment Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled – No Medicare	The number of SSI recipients who are enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled – Medicare Part B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Part B coverage
Number of SSI Enrolled – Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's recipient pool accounts for
Enrolled in Previous Quarter	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
Percent Change from Previous Quarter	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

The information provided in this report is an unduplicated count of the recipients enrolled in each Reform health plan at any time during the quarter. Please refer to Table 18 located on the following page for State Fiscal Year 2011-12, Third Quarter Medicaid Reform Enrollment Report.

Remainder of page intentionally left blank

Table 18 Medicaid Reform Enrollment (January 1, 2012 – March 31, 2012)									
Plan Name	**Plan Type**	**Number of TANF Enrolled**	**Number of SSI Enrolled**			**Total Number Enrolled**	**Market Share for Reform**	**Enrolled in Previous Quarter**	**Percent Change from Previous Quarter**
			No Medicare	**Medicare Part B**	**Medicare Parts A and B**				
Care Florida	HMO	2,775	533	1	69	**3,378**	**1.04%**	2,888	16.97%
Freedom Health Plan	HMO	3,913	581	1	91	**4,586**	**1.41%**	4,512	1.64%
Humana	HMO	2,803	1,227	1	211	**4,242**	**1.30%**	4,587	-7.52%
Medica	HMO	3,097	747	1	153	**3,998**	**1.23%**	3,823	4.58%
Molina Healthcare	HMO	25,734	3,885	5	670	**30,294**	**9.29%**	30,006	0.96%
Positive Healthcare	HMO	13	160	-	12	**185**	**0.06%**	172	7.56%
Sunshine	HMO	83,650	8,147	7	1,046	**92,850**	**28.47%**	92,372	0.52%
United Healthcare	HMO	8,668	1,201	2	116	**9,987**	**3.06%**	9,460	5.57%
Universal Health Care	HMO	18,279	2,607	-	431	**21,317**	**6.54%**	21,147	0.80%
HMO Total	**HMO**	**148,932**	**19,088**	**18**	**2,799**	**170,837**	**52.38%**	**168,967**	1.11%
Better Health, LLC	PSN	32,898	4,027	4	724	**37,653**	**11.55%**	36,251	3.87%
CMS	PSN	4,964	3,782	-	19	**8,765**	**2.69%**	8,473	3.45%
First Coast Advantage	PSN	59,404	8,448	3	1,278	**69,133**	**21.20%**	67,849	1.89%
SFCCN	PSN	34,694	4,334	2	713	**39,743**	**12.19%**	39,287	1.16%
PSN Total	**PSN**	**131,960**	**20,591**	**9**	**2,734**	**155,294**	**47.62%**	**151,860**	2.26%
Reform Enrollment Totals		**280,892**	**39,679**	**27**	**5,533**	**326,131**	**100.00%**	**320,827**	1.65%

The demonstration market share percentage for each plan is calculated once all recipients have been counted and the total number of recipients enrolled is known.

The enrollment figures for this quarter reflect those recipients who self-selected a health plan, as well as those who were mandatorily assigned. In addition, some Medicaid recipients transferred from non-demonstration health plans to demonstration health plans. There were a total of 326,131 recipients enrolled in the demonstration during this quarter. There were 13 demonstration health plans with market shares ranging from 0.06% to 28.47%.

2. Medicaid Reform Enrollment by County Report

During this quarter, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 19 located on the following page.

Table 19 Number of Reform Health Plans in Demonstration Counties (January 1, 2012 – March 31, 2012)		
County Name	**Number of Reform HMOs**	**Number of Reform PSNs**
Baker	**1**	**1**
Broward	**8**	**3**
Clay	**2**	**1**
Duval	**3**	**2**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 20 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 20 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
Number of SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan in the county listed and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan in the county listed; TANF and SSI combined
Market Share for Reform by County	The percentage of the demonstration population in the county listed that the plan's recipient pool accounts for
Enrolled in Previous Quarter	The total number of recipients (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
Percent Change from Previous Quarter	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, as shown in Table 21 located on the following page.

Table 21
Medicaid Reform Enrollment by County Report
(January 1, 2012 – March 31, 2012)

Plan Name	Plan Type	Plan County	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share For Reform by County	Enrolled in Previous Quarter	Percent Change from Previous Quarter
				No Medicare	Medicare Part B	Medicare Parts A and B				
United Healthcare	HMO	Baker	848	104	0	16	968	27.38%	977	-0.92%
First Coast Advantage	PSN	Baker	2,300	259	0	8	2,567	72.62%	2,468	4.01%
Baker			**3,148**	**363**	**0**	**24**	**3,535**	**100.00%**	**3,445**	**2.61%**
Freedom Health Plan	HMO	Broward	3,913	581	1	91	4,586	2.52%	4,512	1.64%
Humana	HMO	Broward	2,803	1,227	1	211	4,242	2.33%	4,587	-7.52%
Medica	HMO	Broward	3,097	747	1	153	3,998	2.20%	3,823	4.58%
Molina Healthcare	HMO	Broward	25,734	3,885	5	670	30,294	16.64%	30,006	0.96%
Positive Healthcare	HMO	Broward	13	160	0	12	185	0.10%	172	7.56%
Care Florida	HMO	Broward	2,775	533	1	69	3,378	1.85%	2,888	16.97%
Sunshine	HMO	Broward	36,315	3,088	6	346	39,755	21.83%	39,166	1.50%
Universal Health Care	HMO	Broward	10,485	1,622	0	283	12,390	6.80%	12,160	1.89%
Better Health, LLC	PSN	Broward	32,898	4,027	4	724	37,653	20.68%	36,251	3.87%
CMS	PSN	Broward	3,265	2,601	0	13	5,879	3.23%	5,717	2.83%
SFCCN	PSN	Broward	34,694	4,334	2	713	39,743	21.82%	39,287	1.16%
Broward			**155,992**	**22,805**	**21**	**3,285**	**182,103**	**100.00%**	**178,569**	**1.98%**
Sunshine	HMO	Clay	8,886	804	1	68	9,759	60.15%	9,535	2.35%
United Healthcare	HMO	Clay	2,201	208	0	23	2,432	14.99%	2,845	-14.52%
First Coast Advantage	PSN	Clay	3,703	305	0	26	4,034	24.86%	3,577	12.78%
Clay			**14,790**	**1,317**	**1**	**117**	**16,225**	**100.00%**	**15,957**	**1.68%**
Sunshine	HMO	Duval	38,449	4,255	0	632	43,336	36.77%	43,671	-0.77%
United Healthcare	HMO	Duval	4,003	708	1	58	4,770	4.05%	3,731	27.85%
Universal Health Care	HMO	Duval	7,794	985	0	148	8,927	7.58%	8,987	-0.67%
CMS	PSN	Duval	1,699	1,181	0	6	2,886	2.45%	2,756	4.72%
First Coast Advantage	PSN	Duval	49,235	7,467	3	1218	57,923	49.15%	57,295	1.10%
Duval			**101,180**	**14,596**	**4**	**2,062**	**117,842**	**100.00%**	**116,440**	**1.20%**
United Healthcare	HMO	Nassau	1,616	181	1	19	1,817	28.28%	1,907	-4.72%
First Coast Advantage	PSN	Nassau	4,166	417	0	26	4,609	71.72%	4,509	2.22%
Nassau			**5,782**	**598**	**1**	**45**	**6,426**	**100.00%**	**6,416**	**0.16%**
Reform Enrollment Totals			**280,892**	**39,679**	**27**	**5,533**	**326,131**		**320,827**	**1.65%**

As with the Medicaid Reform Enrollment Report, the number of recipients is extracted from the monthly Medicaid eligibility file and is then counted uniquely based on the most recent month in which the recipient was enrolled in a Reform health plan. The unique recipient counts are separated by the counties in which the plans operate.

During this quarter, there was an enrollment of 3,535 recipients in Baker County, 182,103 recipients in Broward County, 16,225 recipients in Clay County, 117,842 recipients in Duval County, and 6,426 recipients in Nassau County. There were two Baker County health plans with market shares of 27.38% and 72.62%, 11 Broward County health plans with market shares ranging from 0.10% to 21.83%, three Clay County health plans with market shares ranging from 14.99% to 60.15%, five Duval County health plans with market shares ranging from 2.45% to 49.15%, and two Nassau County health plans with market shares of 28.28% and 71.72%.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 22 and 23 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing recipients in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those recipients who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 22 provides a description of each column in this report.

Table 22
Medicaid Reform Voluntary Population Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
Foster, SOBRA and Refugee	The number of unique Foster Care, SOBRA, or Refugee recipients who voluntarily enrolled in a plan during the current reporting quarter
Developmental Disabilities	The number of unique recipients diagnosed with a developmental disability who voluntarily enrolled in a plan during the current reporting quarter
Dual-Eligibles	The number of unique dual-eligible recipients who voluntarily enrolled in a plan during the current reporting quarter
Total	The total number of voluntary population recipients who enrolled in Medicaid Reform during the current reporting quarter
Medicaid Reform Total Enrollment	The total number of Medicaid Reform recipients enrolled in the health plan during the reporting quarter

Table 23 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 23
Medicaid Reform Voluntary Population Enrollment Report
(January 1, 2012 – March 31, 2012)

Plan Name	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
		Foster, Adoption Subsidy and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
HMO's		New	Existing	New	Existing	New	Existing	Number	Percentage	
CareFlorida	Broward	4	20	-	1	18	52	**95**	**2.81%**	**3,378**
Freedom Health Plan	Broward	-	26	-	6	4	88	**124**	**2.70%**	**4,586**
Humana	Broward	-	35	-	24	-	212	**271**	**6.39%**	**4,242**
Medica	Broward	3	12	-	7	14	140	**176**	**4.40%**	**3,998**
Molina Healthcare	Broward	14	171	3	52	37	638	**915**	**3.02%**	**30,294**
Positive Healthcare	Broward	-	-	-	-	-	12	**12**	**6.49%**	**185**
Sunshine	Broward	27	222	-	31	18	334	**632**	**1.59%**	**39,755**
Sunshine	Clay	6	81	-	11	2	67	**167**	**1.71%**	**9,759**
Sunshine	Duval	15	471	1	65	12	620	**1,184**	**2.73%**	**43,336**
United Healthcare	Baker	-	9	-	2	-	16	**27**	**2.79%**	**968**
United Healthcare	Clay	-	13	-	2	-	23	**38**	**1.56%**	**2,432**
United Healthcare	Duval	2	62	1	16	11	48	**140**	**2.94%**	**4,770**
United Healthcare	Nassau	-	23	-	6	2	18	**49**	**2.70%**	**1,817**
Universal Health Care	Broward	9	71	1	15	14	269	**379**	**3.06%**	**12,390**
Universal Health Care	Duval	5	74	-	6	10	138	**233**	**2.61%**	**8,927**
HMO Total		**85**	**1,290**	**6**	**244**	**142**	**2,675**	**4,442**	**2.60%**	**170,837**
PSN's										
Better Health, LLC	Broward	15	228	5	70	27	701	**1,046**	**2.78%**	**37,653**
CMS	Broward	4	53	10	223	1	12	**303**	**5.15%**	**5,879**
CMS	Duval	22	153	-	122	-	6	**303**	**10.50%**	**2,886**
First Coast Advantage	Baker	4	26	1	2	2	6	**41**	**1.60%**	**2,567**
First Coast Advantage	Clay	4	29	-	3	4	22	**62**	**1.54%**	**4,034**
First Coast Advantage	Duval	20	669	4	141	33	1,188	**2,055**	**3.55%**	**57,923**
First Coast Advantage	Nassau	-	28	-	3	3	23	**57**	**1.24%**	**4,609**
SFCCN	Broward	18	403	1	79	29	686	**1,216**	**3.06%**	**39,743**
PSN Total		**87**	**1,589**	**21**	**643**	**99**	**2,644**	**5,083**	**3.27%**	**155,294**
Reform Totals		**172**	**2,879**	**27**	**887**	**241**	**5,319**	**9,525**	**2.92%**	**326,131**

D. Enhanced Benefits Account Program

Overview

The Enhanced Benefits Account program (EBA) component of the demonstration is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid recipients who enroll in a health plan are eligible for the EBA program. No separate application or process is required to enroll in the EBA program.

Recipients enrolled in a demonstration health plan may earn up to $125.00 of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Medicaid fiscal agent's [HP Enterprise Services, LLC (HP)] Pharmacy Point of Sale System, currently maintained and managed by the HP subcontractor, Magellan. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the recipient's Medicaid Gold Card or Medicaid identification number and a government issued photo ID.

The Agency approves credits for participation of approved healthy behaviors using date of service, eligibility, and approved behavior edits within a database referred to as the Enhanced Benefits Information System (EBIS). All health plans are required to submit monthly reports for their reform members who had paid claims for approved healthy behaviors within the prior month. These reports are uploaded into the EBIS database for processing and approval. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the HP subcontractor, Magellan, to be loaded in the pharmacy point of sale system.

Current Activities

1. Call Center Activities

The enhanced benefits call center, managed by the choice counseling vendor [Automated Health Systems (AHS)], located in Tallahassee, Florida, continues to operate a toll-free number as well as a toll-free number for the hearing impaired callers. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The hours of operation are Monday – Thursday 8:00a.m. – 8:00p.m., Friday 8:00a.m. – 7:00p.m., and Saturday 9:00a.m. – 1:00p.m.

The primary function of the call center is to answer all inbound calls relating to program questions, provide enhanced benefits account updates on credits earned/used, and assist recipients with utilizing the web based over-the-counter product list. AHS implemented the Automated Voice Response System (AVRS) on June 18, 2010 for recipients who need balance only information. In addition, the call center performs outbound calls to recipients who have not spent any of their enhanced benefits account credits.

Table 24 highlights the enhanced benefits call center activities during this quarter.

Table 24
Highlights of the Enhanced Benefits Call Center Activities
(January 1, 2012 – March 31, 2012)

Enhanced Benefits Call Center Activity	January	February	March
Calls Received	6,019	3,935	4,305
Calls Answered	5,674	3,865	4,218
Abandonment Rate	5.73%	1.78%	2.02%
Average Talk Time (minutes)	4:30	4:19	4:13
Calls Handled by the AVRS	8,560	4,809	5,758
Outbound Calls	94	49	10
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	11,246	10,028	9,730

2. System Activities

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day of each month. The EBIS continues to operate effectively and efficiently in processing the enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each recipient who has activity for the month.

The vendor of EBIS, Image Software Inc., continues to provide enhanced benefits account balance data to the choice counseling vendor's AVRS three times each week for each recipient who has an enhanced benefits account credit balance. Since the implementation of the new AVRS option, it continues to be a success as 19,127 calls were handled during this quarter.

3. Outreach and Education for Recipients

The mailing of the welcome letter and the recipient coupon statements continued during this quarter. There were 158,949 coupon statements mailed to recipients during this quarter. Along with the recipient coupon statements, there is either a flyer or pharmacy billing instructions included with the statement. The choice counselors continue to provide up-to-date information for recipients regarding their enhanced benefits account balances and the opportunity to earn healthy behavior credits. During this quarter, the choice counseling vendor continued to call recipients who have never utilized their enhanced benefits account balance. The number of outbound calls made during the quarter is listed above in Table 24.

4. Outreach and Education for Pharmacies

The pharmacy benefits manager, Magellan, provides ongoing technical assistance to pharmacies as needed related to all billing aspects of the EBA program.

5. Enhanced Benefits Advisory Panel

An Enhanced Benefits Panel meeting was held on February 11, 2012 where statistical updates were provided to the panel members. The next Panel meeting will be scheduled in June 2012.

6. Enhanced Benefits Statistics

As of the end of this quarter, 13,621 recipients lost EBA eligibility for a total of $615,301.64 and they no longer have access to those credits. Table 25 provides the Enhanced Benefits Account program statistics for this quarter.

Table 25
Enhanced Benefits Account Program Statistics

Third Quarter Activities – Year Six		January 2012	February 2012	March 2012
I.	Number of plans submitting reports by month in each county	27	27	27
II.	Number of enrollees who received credit for healthy behaviors by month	38,819	47,522	38,358
III.	Total dollar amount credited to accounts by each month	$938,565.00	$1,066,247.50	$861,927.50
IV.	Total cumulative dollar amount credited through the end each month	$48,711,716.16	$49,777,963.66	$50,639,891.16
V.	Total dollar amount of credits used each month by date of service	$761,042.86	$497,757.18	$512,945.65
VI.	Total cumulative dollar amount of credits used through the month by date of service	$26,249,609.32	$26,747,366.50	$27,260,312.15
VII.	Total unduplicated number of enrollees who used credits each month	26,991	18,564	19,080

7. Complaints

A recipient can file a complaint about the EBA program through the call center and those complaints are documented in the system utilized by the call center and reported to the Agency on a weekly basis. The Agency continues to review and resolve any complaints received regarding EBA program.

During this quarter, over 26,000 recipients purchased one or more products with their enhanced benefits credits, and there were two complaints recorded through the call center relating to the EBA program. The low number of complaints is attributed to improved call center staff training and direct problem resolution through the EB call center lead and the Agency EB staff person. Table 26 provides a summary of the two complaints received this quarter.

Table 26
Enhanced Benefits Recipient Complaints
(January 1, 2012 – March 31, 2012)

Recipient Complaint	Action Taken
1. Recipient was unhappy with service provided at the pharmacy.	Referred the recipient to another pharmacy.
2. Recipient was unhappy with service by the call center.	Supervisor resolved the issue by giving the recipient information.

E. Low Income Pool

Overview

Since the implementation of the 1115 Research and Demonstration Waiver, one of the fundamental elements of the demonstration is the Low Income Pool (LIP) program. The LIP program is established and maintained by the state to provide government support to safety net providers in the state for the purpose of providing coverage to the Medicaid, underinsured, and uninsured populations. The LIP program is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low-income populations, as well as increase access for select services for uninsured individuals.

The LIP funds are distributed to safety net providers that meet certain state and federal requirements outlined in the Special Terms and Conditions (STCs) of the waiver. The LIP program consists of a capped annual allotment of $1 billion total computable for each year of the demonstration. Availability of funds for the LIP program in the amount of $1 billion per year is contingent upon milestones being met during each demonstration year in order for the state and providers to have access to 100% of LIP funds. Funds in the LIP program are subject to any penalties that are assessed by Federal CMS for the failure to meet the milestones described in the STCs. The milestones established are intended to enhance the delivery of health care to low-income populations in Florida.

The LIP permissible expenditures, state authorized expenditures, and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document (RFMD). The RFMD limits LIP payments to allowable costs incurred by providers and requires the state to reconcile LIP payments to auditable costs. By February 1, 2012, and each successive February 1st of the renewal period of the waiver, the state must submit an RFMD protocol to ensure that the payment methodologies for distributing LIP funds to providers support the goals of the LIP and those providers receiving LIP payments do not receive payments in excess of their cost of providing services.

In addition, the Agency created a Low-Income Pool Council in accordance with s. 409.911(10), F.S. The Council's purpose is to advise the Agency and legislature on the financing and distributions of the LIP and related funds. The Florida Legislature amended the statutory provisions specific to the LIP Council during the 2009 legislative session. These provisions increased the number of members to be appointed to the Council, as well as specified criteria for the seats. The following is the language authorized in s. 409.911(10), F.S., for the LIP Council:

> "The Agency for Health Care Administration shall create a Medicaid Low-Income Pool Council by July 1, 2006. The Low-Income Pool Council shall consist of 24 members, including 2 members appointed by the President of the Senate, 2 members appointed by the Speaker of the House of Representatives, 3 representatives of statutory teaching hospitals, 3 representatives of public hospitals, 3 representatives of nonprofit hospitals, 3 representatives of for-profit hospitals, 2 representatives of rural hospitals, 2 representatives of units of local government which contribute funding, 1 representative of family practice teaching hospitals, 1 representative of federally qualified health centers, 1 representative from the Department of Health, and 1 nonvoting representative of the Agency for Health Care Administration who shall serve as chair of the council. Except for a full-time employee of a public entity, an individual who qualifies as a lobbyist under s. 11.045 or s. 112.3215 may not serve as a member of the council. Of the members appointed by the Senate

President, only one shall be a physician. Of the members appointed by the Speaker of the House of Representatives, only one shall be a physician. The physician member appointed by the Senate President and the physician member appointed by the Speaker of the House of Representatives must be physicians who routinely take calls in a trauma center, as defined in s. 395.4001, or a hospital emergency department. The council shall:

- Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.
- Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
- Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year."

Current Activities

LIP Council Meetings

During this quarter, the LIP Council held one meeting on the following date:

- January 5, 2012

During the January 2012 meeting, the LIP Council concluded their SFY 2011-12 activities. Agency staff provided updates on the ongoing compliance activities specified in the Special Terms and Conditions of the waiver. Among the LIP funding and distribution models presented to the LIP Council, the top three models were selected to be voted on. After the three selected models were reviewed, the Council voted on which LIP funding and distribution model would be recommended to the legislature for SFY 2012-13. Summaries of the LIP Council meetings can be viewed on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml.

The LIP Council anticipates holding meetings regarding SFY 2013-14 once the LIP Council meetings start up again in the first quarter of Demonstration Year Seven.

LIP STCs - Reporting Requirements

The following is an abbreviated list of the LIP STCs that required action during this quarter. The complete list of STCs as approved by CMS on December 15, 2011, for the period December 16, 2011 to June 30, 2014, can be viewed at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/CMS_STCs_and_Authorities_12-15-2011.pdf

STC #52 – LIP Funds Distributed – All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.

STC #53 – LIP Reimbursement and Funding Methodology (RFMD)

- **DY1 – DY3 Reconciliations Finalized –** CMS and the Agency will finalize DY1-DY3 reconciliations within 60 days of the acceptance of the STCs (by March 14, 2012).

    - On March 8, 2012, the Agency received a written description from CMS outlining their findings of their review of DY1-DY3 reconciliations.

    - The Agency worked to resolve outstanding issues and discussed findings. The Agency anticipates submitting additional information to CMS in the next quarter to finalize DY1-DY3 reconciliations.

- **DY4 LIP Reconciliations –** The Agency will submit the LIP reconciliations for DY4 to CMS by May 31, 2012.

- **Finalize Modifications to RFMD –** By February 1 of each Demonstration Year, the Agency must submit a RFMD that ensures the payment methodologies for distributing LIP funds to providers supports the goals of the LIP.

    - During this quarter on January 31, 2012, the Agency submitted the revised RFMD for DY6 to CMS. The revised RFMD only included updated references since the results of CMS's review of DY1-DY3 reconciliations were not available prior to the February 1st submission due date specified in STC #53.

- **Claiming LIP Payments –** The state may claim LIP payments based on the existing methodology during the 60-day reconciliation finalization period. Claims after that period can only be made on the final RFMD for DY6 as approved by CMS. Changes to the RFMD requested by the state must be approved by CMS and are only approved for DY6 LIP expenditures.

    - As of the end of this quarter, the final RFMD for DY6 had not been approved by CMS. The state and CMS continue to work together to finalize the RFMD for DY6.

- **RFMD Protocol –** By February 1, 2012, and each successive February 1st of the waiver renewal period, the state must submit a RFMD protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP.

    - As noted above, the state submitted the revised RFMD for DY6 to CMS on January 31, 2012. The state and CMS continue to work on finalizing the RFMD for DY6. The state anticipates having all of the revisions completed in the fourth quarter of Demonstration Year Six.

STC #60 – Aggregate LIP Funding – At the beginning of each demonstration year, $1 billion in LIP funds will be available to the state. These amounts will be reduced by any milestone penalties that are assessed by CMS. Penalties will be determined by December 31st of each demonstration year and assessed to the state in the following demonstration year.

STC #61 – LIP Tier-One Milestone

- **61.a. – Allocation of Funds, Program Development, Implementation for DY7 – DY8**

  STC #61.a. references $50 million in LIP funds. A total of $35 million appears in the Other Provider Access System category, also known as the Non-hospital section, in the SFY 2012-13 General Appropriations Act (GAA) (Primary Care Initiatives per Tier-One Milestone). A total of $20 million will be used for the start-up of new primary care programs and the remaining total of $15 million will be used to meaningfully enhance existing primary care programs. There is a cap of $4 million per grant proposal. The Agency will determine the distribution and requirements for these programs.

  The remaining $15 million (Quality Measures) of the $50 million falls under the Special LIP for Hospital Provider Access System category listed in the GAA. This $15 million or Quality Measures category is broken down into three smaller amounts. Of the total, $400,000 is provided for the specialty children's hospitals to be distributed based on an allocation methodology incorporating quality measures that shall be developed by the Agency. The second amount is $7,300,000 and shall be allocated using the core measures as determined by CMS. The remaining amount of $7,300,000 shall be distributed equally using the following six outcome measures:

  1. Mortality Hospital Risk Adjusted Rate (HRAR) Acute Myocardial Infarction (AMI) without transfers.
  2. Mortality HRAR Congestive Heart Failure (CHF)
  3. Mortality HRAR Pneumonia
  4. Risk Adjusted Readmission Rate (RARR) AMI
  5. RARR CHF
  6. RARR Pneumonia

  Hospitals receiving an allocation in this Quality Measures category are required to enhance existing, or initiate new, quality-or-care initiatives to improve their quality measures and identified patient outcomes, and to provide required documentation of this to the Agency.

  - During the fourth quarter, the Agency will develop the distribution methodology for the $35 million and submit it to CMS.

- **61.b. – Proposed and Final Schedule for DY6 – DY8 Reconciliations –** The state will provide timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The state is required to submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the state on the reconciliation schedules within 30 days. The state will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

  - On January 14, 2012, the Agency submitted a proposed schedule to CMS. CMS accepted the proposed schedule with no edits on February 27, 2012.

- **61.c. – Timely Submission of Deliverables –** Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.

    - The Agency is on schedule for all deliverables specified in the STCs.

- **61.d. – Reporting Templates –** Within 60 days following the acceptance of the STCs, the state is required to submit templates for the development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report".

    - During this quarter on February 9, 2012, the Agency sent the draft templates for the above specified reports to CMS.
    - On March 13, 2012, the Agency submitted the final templates to CMS.

STC #62 – LIP Tier-Two Milestones – STC #62 requires the top 15 hospitals receiving LIP funds to choose three initiatives that follow the guidelines of the Three-Part Aim. These hospitals must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served. The three initiatives should focus on: infrastructure development; innovation and redesign; and population-focused improvement.

- During this quarter, the Agency worked with the top 15 hospitals in developing the Three-Tier Initiatives. Each of the 15 hospitals will submit three proposals to the Agency, for a total of 45 proposals.
- The Agency will submit the 45 proposals to CMS by April 9, 2012.

F. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved 1115 Medicaid Reform Waiver, Florida must monitor the status of the program on a fiscal basis. To comply with this requirement, the state will submit waiver templates on the quarterly CMS 64 reports. The submission of the CMS 64 reports will include administrative and service expenditures. For purposes of monitoring the Budget Neutrality of the program, only service expenditures are compared to the projected without-waiver expenditures approved through the 1115 Medicaid Reform Waiver.

MEGS

There are three Medicaid Eligibility Groups established through the Budget Neutrality of the 1115 Medicaid Reform Waiver. Each of these groups is referred to as a MEG.

MEG #1 – SSI Related
MEG #2 – Children and Families
MEG #3 – Low Income Pool program

It should be noted that for MEG 3, the Low Income Pool, there is no specific eligibility group and no per capita measurement. Distributions of funds are made from the Low Income Pool to a variety of Provider Access Systems.

Explanation of Budget Neutrality

The Budget Neutrality for the 1115 Medicaid Reform Waiver is based on five closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method which is required for 1115 waivers. Using the templates provided by the Centers for Medicare and Medicaid Services (CMS), the historical expenditures and case-months are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five year trend for each MEG. This trend is then applied to the most recent year (5^{th} year), which is known as the base year, and projected forward through the waiver period. Additional negotiations were involved in the final Budget Neutrality calculations set forth in the approved waiver packet.

The 1115 Medicaid Reform Waiver is a program that provides all services to the specified populations. If a person is eligible for the waiver, he or she is eligible to receive all services that would otherwise be available under the traditional Medicaid program. There are a few services and populations excluded from the 1115 Medicaid Reform Waiver.

To determine if a person is eligible for the 1115 Medicaid Reform Waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted Medicaid eligibility is assigned an eligibility category by the Florida Department of Children and Families. Specific categories are identified for each MEG under the 1115 Medicaid Reform Waiver. If the person has one of the identified categories and is not an excluded eligible, he or she is then flagged as eligible for the 1115 Medicaid Reform Waiver. Dual eligibles and pregnant women above the TANF eligibility may voluntarily enroll in a Medicaid Reform health plan. All voluntary enrollment member months and expenditures subject to the 1115 Medicaid Reform Waiver are included in the reporting and monitoring of Budget Neutrality of the waiver.

Excluded Eligibles:

- Refugee Eligibles
- Dual Eligibles
- Medically Needy
- Pregnant Women above the TANF eligibility (>27% FPL, SOBRA)
- ICF/DD Eligibles
- Unborn Children
- State Mental Facilities (Over Age 65)
- Family Planning Eligibles
- Women with breast or cervical cancer
- MediKids

All expenditures for the flagged eligibles are subject to the Budget Neutrality of the 1115 Medicaid Reform Waiver unless the expenditure is identified as one of the following excluded services. These services are specifically excluded from the 1115 Medicaid Reform Waiver and the Budget Neutrality calculation.

Excluded Services:

- AIDS Waiver Services
- DD Waiver Services
- Home Safe Net (Behavioral Services)
- Behavioral Health Overlay Services (BHOS)
- ICF/DD Institutional Services
- Family and Supported Living Waiver Services
- Katie Beckett Model Waiver Services
- Brain and Spinal Cord Waiver Services
- School Based Administrative Claiming
- Healthy Start Waiver Services

Expenditure Reporting:

The 1115 Medicaid Reform Waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to capture the expenditures by service type paid during the quarter that are subject to the monitoring of the Budget Neutrality. There are three MEGs within the 1115 Medicaid Reform Waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver, but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver, are subject to both the monitoring of the

1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, an additional five templates (one for each of the 1915(b) Managed Care Waiver MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

When preparing for the quarterly CMS 64 report, the following method is applied to extract the appropriate expenditures for MEGs 1 and 2:

I. Eligibles and enrollee member months are identified;

II. Claims data for included services are identified using the list created through 'I' above;

III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:

a. MEG #1 SSI- Related
b. MEG #2 Children and Families
c. Reform – Managed Care Waiver SSI – no Medicare
d. Reform – Managed Care Waiver TANF
e. Reform – Managed Care Waiver SOBRA and Foster Children
f. Reform – Managed Care Waiver Age 65 and Older;

IV. Using the paid claims data extracted, the expenditures are identified by service type within each of the groupings in 'III' above and inserted on the appropriate line on the CMS 64 waiver templates;

V. Expenditures that are also identified as Home and Community Based (HCBS) Waiver services are identified and the corresponding HCBS waiver template expenditures are adjusted to reflect the hierarchy of the 1115 waiver reporting.

All queries and work papers related to the quarterly reporting of waiver expenditures on the CMS 64 report are maintained by the Agency. In addition, all identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated and provided to the Agency's Finance and Accounting unit, which certifies and submits the CMS 64 report. This check sum process allows the state to verify that no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

Statistics tables below show the current status of the program's Per Capita Cost per Month (PCCM) in comparison to the negotiated PCCM as detailed in the Special Terms and Conditions.

Definitions:

- **PCCM** - Calculated per capita cost per month which is the total spend divided by the case months.
- **WOW PCCM** - Is the without waiver PCCM. This is the target that the state cannot exceed in order to maintain Budget Neutrality.
- **Case months** - The months of eligibility for the populations subject to the waiver as defined as included populations in the waiver. In addition, months of eligibility for voluntary enrollees during the period of enrollment within a Medicaid Reform health plan are also included in the case month count.

- **MCW Reform Spend** - Expenditures subject to the Reform Budget Neutrality for those not enrolled in a Reform Health Plan but subject to the Reform Waiver (currently all non dual-eligibles receiving services through the 1915(b) Managed Care Waiver).
- **Reform Enrolled & Non-MCW Spend** - Expenditures for those enrolled in a Reform Health Plan.
- **Total Spend** - Total of MCW Reform Spend and Reform Enrolled Spend.

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. Without the adjustment of drug rebates, the quarterly expenditure reform totals match the corresponding quarterly CMS 64 Report submission, which details the amount that will be used in the monitoring process by Federal CMS.

Current Activities

Budget Neutrality figures included in this report are through the third quarter (January 1, 2012 – March 31, 2012) of Demonstration Year Six. The 1115 Medicaid Reform Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For counties where the demonstration is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where the demonstration is not operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive their services through the Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and / or providers of 1915(c) Home and Community Based Waivers.

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by STC #108 is monitored using data based on date of service. The PMPM and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year.

In the following tables (Tables 27 through 33), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

Table 27 located on the following page shows the PCCM Targets established in the 1115 Medicaid Reform Waiver. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 27 PCCM Targets		
WOW PCCM	**MEG 1**	**MEG 2**
DY01	$ 948.79	$ 199.48
DY02	$ 1,024.69	$ 215.44
DY03	$ 1,106.67	$ 232.68
DY04	$ 1,195.20	$ 251.29
DY05	$ 1,290.82	$ 271.39
DY06	$ 1,356.65	$ 285.77
DY07	$1,425.84	$300.92
DY08	$1,498.56	$316.87

Tables 28 through 32 located on the following pages provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2012. Case months provided in Tables 28 and 30 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Remainder of page intentionally left blank

Table 28 MEG 1 Statistics: SSI Related					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
Q1 Total	737,829	$534,465,763	$13,022,287	$547,488,050	$742.03
Q2 Total	741,024	$656,999,737	$40,270,607	$697,270,344	$940.96
Q3 Total	746,739	$627,627,027	$74,363,882	$701,990,909	$940.08
Q4 Total	752,823	$627,040,703	$98,024,915	$725,065,618	$963.13
Q5 Total	755,417	$630,937,251	$101,516,732	$732,453,983	$969.60
Q6 Total	755,837	$648,757,106	$106,374,845	$755,131,951	$999.07
Q7 Total	758,014	$651,490,311	$111,968,931	$763,459,242	$1,007.18
Q8 Total	764,701	$661,690,100	$115,206,649	$776,896,750	$1,015.95
Q9 Total	818,560	$708,946,109	$116,393,637	$825,339,746	$1,008.28
Q10 Total	791,043	$738,232,869	$128,914,992	$867,147,861	$1,096.21
Q11 Total	810,753	$783,046,121	$125,741,442	$908,787,564	$1,120.92
Q12 Total	829,386	$676,381,576	$120,999,077	$797,380,652	$961.41
Q13 Total	822,396	$846,747,351	$153,763,674	$1,000,511,025	$1,216.58
Q14 Total	830,530	$769,968,776	$137,267,631	$907,236,407	$1,092.36
Q15 Total	847,324	$781,783,604	$141,815,963	$923,599,567	$1,090.02
Q16 Total	852,445	$811,240,631	$142,745,339	$953,985,969	$1,119.12
Q17 Total	868,873	$801,543,979	$150,327,146	$951,871,125	$1,095.52
Q18 Total	876,564	$823,362,358	$147,720,232	$971,082,591	$1,107.83
Q19 Total	851,488	$793,116,969	$137,115,775	$930,232,743	$1,092.48
Q20 Total	902,833	$730,735,500	$137,409,896	$868,145,395	$961.58
Q21 Total	933,661	$897,184,808	$165,500,587	$1,062,685,395	$1,138.19
Q22 Total	916,713	$780,812,437	$149,928,159	$930,740,596	$1,015.30
January 2012	290,381	$239,317,133	$49,116,158	$288,433,291	$993.29
February 2012	290,339	$389,776,652	$76,272,631	$466,049,284	$1,605.19
March 2012	290,330	$177,634,805	$35,812,556	$213,447,361	$735.19
Q23 Total	871,050	$806,728,589	$161,201,346	$967,929,935	$1,111.22
MEG 1 Total	18,840,449	$16,008,943,951	$3,408,478,022	$18,785,620,983	$997.09

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

Table 29 MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
Q1 Total	3,944,437	$491,214,740	$1,723,494	$492,938,235	$124.97
Q2 Total	3,837,172	$590,933,703	$21,021,285	$611,954,988	$159.48
Q3 Total	3,728,063	$559,579,323	$44,697,737	$604,277,060	$162.09
Q4 Total	3,653,147	$524,161,918	$57,096,383	$581,258,301	$159.11
Q5 Total	3,588,363	$520,316,242	$57,360,334	$577,676,576	$160.99
Q6 Total	3,648,832	$553,763,665	$63,871,154	$617,634,819	$169.27
Q7 Total	3,736,212	$570,477,394	$69,992,290	$640,469,684	$171.42
Q8 Total	3,856,584	$564,601,990	$70,899,271	$635,501,261	$ 164.78
Q9 Total	4,080,307	$586,455,736	$70,031,931	$656,487,667	$160.89
Q10 Total	4,174,698	$659,100,473	$71,936,704	$731,037,178	$175.11
Q11 Total	4,298,379	$708,620,481	$73,835,227	$782,455,708	$182.04
Q12 Total	4,541,456	$581,030,798	$60,822,514	$641,853,312	$141.33
Q13 Total	4,703,528	$824,013,811	$98,637,714	$922,651,526	$196.16
Q14 Total	4,959,454	$768,385,369	$89,723,473	$858,108,842	$173.02
Q15 Total	5,098,381	$773,609,163	$93,647,855	$867,257,018	$170.10
Q16 Total	5,203,143	$793,529,141	$90,471,922	$884,001,063	$169.90
Q17 Total	5,356,742	$766,604,001	$91,544,719	$858,148,719	$160.20
Q18 Total	5,470,396	$848,694,828	$99,937,769	$948,632,597	$173.41
Q19 Total	5,247,390	$787,922,115	$91,638,763	$879,560,878	$167.62
Q20 Total	5,611,671	$673,700,632	$90,712,877	$764,413,510	$136.22
Q21 Total	5,695,156	$965,461,910	$121,274,250	$1,086,736,159	$190.82
Q22 Total	5,773,020	$778,633,250	$99,802,883	$878,436,134	$152.16
January 2012	1,822,959	$252,551,795	$33,783,082	$286,334,877	$157.07
February 2012	1,811,968	$457,595,125	$63,262,036	$520,857,161	$287.45
March 2012	1,806,127	$150,429,478	$18,286,764	$168,716,242	$93.41
Q23 Total	5,441,054	$860,576,398	$115,331,882	$975,908,280	$179.36
MEG 2 Total	105,716,921	$15,751,387,083	$1,746,012,434	$17,497,399,516	$165.51

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 30), compared to WOW of $948.79 (Table 27), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 30), compared to WOW of $199.48 (Table 27), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 (Table 30), compared to WOW of $1,024.69 (Table 27), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 30), compared to WOW of $215.44 (Table 27), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.86 (Table 30), compared to WOW of $1,106.67 (Table 27), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 30), compared to WOW of $232.68 (Table 27), which is 71.76% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,077.22 (Table 30), compared to WOW of $1,195.20 (Table 27), which is 90.13% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.88 (Table 30), compared to WOW of $251.29 (Table 27), which is 66.41% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,094.35 (Table 30), compared to WOW of $1,290.82 (Table 27), which is 84.78% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.82 (Table 30), compared to WOW of $271.39 (Table 27), which is 61.47% of the target PCCM for MEG 2.

For Demonstration Year Six, MEG 1 has a PCCM of $986.89 (Table 30), compared to WOW of $1,356.65 (Table 27), which is 72.74% of the target PCCM for MEG 1. MEG 2 has a PCCM of $161.69 (Table 30), compared to WOW of $285.77 (Table 27), which is 56.58% of the target PCCM for MEG 2.

Tables 30 and 31 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 31 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 31 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific

actual PCCM as provided in Table 31 is $309.27. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 31 is $297.53. Comparing the calculated weighted averages, the actual PCCM is 76.93% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 31 is $295.70. Comparing the calculated weighted averages, the actual PCCM is 71.59% of the target PCCM.

For Demonstration Year Six, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 31) is $434.23. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 31 is $276.08. Comparing the calculated weighted averages, the actual PCCM is 63.58% of the target PCCM.

Remainder of page intentionally left blank

Table 30 MEG 1 and 2 Annual Statistics					
DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 Total	3,033,969	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,937,427,184	$500,344,974	$3,437,772,158	$1,057.86
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(158,619,822)	
% of WOW PCCM MEG 1					95.59%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,572,390,668	$281,844,467	$2,854,235,134	$166.96
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,123,392,237)	
% of WOW PCCM MEG 2					71.76%

Table 30 Continued MEG 1 and 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	3,357,141	$3,066,211,465	$550,184,219	$3,616,395,684	$1,077.22
WOW DY4 Total	3,357,141			$4,012,454,923	$1,195.20
Difference				$(396,059,239)	
% of WOW PCCM MEG 1					90.13%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	20,033,842	$2,991,610,295	$351,568,768	$3,343,179,063	$166.88
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,691,125,093)	
% of WOW PCCM MEG 2					66.41%
DY05 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY05 Total	3,499,758	$3,241,595,446	$588,363,062	$3,829,958,508	$1,094.35
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(687,599,114)	
% of WOW PCCM MEG 1					84.78%
DY05 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY05 Total	21,686,199	$3,220,627,211	$397,006,974	$3,617,634,185	$166.82
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,267,783,362)	
% of WOW PCCM MEG 2					61.47%
DY06 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY06 Total	2,721,424	$2,256,858,569	$428,878,645	$2,685,737,214	$986.89
WOW DY6 Total	2,721,424			$3,692,019,870	$1,356.65
Difference				$(1,006,282,656)	
% of WOW PCCM MEG 1					72.74%
DY06 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY06 Total	16,909,230	$2,419,031,570	$314,941,049	$2,733,972,618	$161.69
WOW DY6 Total	16,909,230			$4,832,150,657	$285.77
Difference				$(2,098,178,039)	
% of WOW PCCM MEG 2					56.58%

Table 31 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.27
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,057,821,760	$901,752,987	$6,959,574,747	$297.53
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,087,184,332)	
% Of WOW					76.93%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,462,222,656	$985,370,036	$7,447,592,693	$295.70
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,955,382,476)	
% Of WOW					71.59%
DY 06	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	19,630,654	$4,675,890,138	$743,819,694	$5,419,709,832	$276.08
WOW	19,630,654			$8,524,170,527	$434.23
Difference				$(3,104,460,694)	
% Of WOW					63.58%

Table 32 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Q19	**$180,732,289**
Q20	**$353,499,776**
Q21	**$57,414,775**
Q22	**$346,827,872**
Q23	**$175,598,167**
Total Paid	**$5,575,590,004**

Table 33 shows that the expenditures for the first twenty-three quarters for MEG 3, the Low Income Pool (LIP), were $5,575,590,004 (69.69% of the $8 billion cap).

Table 33 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$579,840,814	$1,000,000,000	57.98%
DY07		$1,000,000,000	
DY08		$1,000,000,000	
Total MEG 3	$5,575,590,004	$8,000,000,000	69.69%

*DY totals are calculated using date of service data as required in STC #108.

During Demonstration Year Three, the Florida Legislature directed the Agency to carry forward approximately $123 million dollars from the Demonstration Year Three LIP appropriation until an amendment of the STC #105 could be negotiated. Upon approval of the amendment, approximately $123 million dollars in carry forward funding was provided to the Agency through appropriations for Demonstration Year Four. The appropriations for Demonstration Year Four totaled $1,001,250,000 plus the $123,577,163 of carry forward LIP funds for a grand total of $1,124,827,163. Due to the payment process and the reporting period, payments made after June 30, 2010 were not captured in the Fourth Quarter report of Demonstration Year Four or the Year Four Annual Report. The report for the first quarter of Demonstration Year Five included the final LIP payment totals for Demonstration Year Four.

G. Encounter and Utilization Data

Overview

The Agency is required to capture medical services encounter data for all Medicaid covered services in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes. In addition, Section 409.91211(3)(p), Florida Statutes, requires a risk-adjusted methodology be a component of the rate setting process for capitated payments to the demonstration health plans. Risk adjustment was phased in over a period of three years, using the Medicaid Rx (MedRx) model. The Agency plans to eventually transition to a diagnosis-based model such as the Chronic Illness and Disability Payment System (CDPS).

Current Activities

The following are the highlights for this quarter:

Encounter Data

- Analytic validation continues for all encounter data received to date. Analytical measures designed to report the completeness, accuracy, and timeliness of encounter data submissions continue to be postponed until July 2012 pending health plans' readiness for submission of 5010 versions of X12 encounter claims and pharmacy encounters in the National Council for Prescription Drug Programs (NCPDP) D.0 format.
- The Agency is working with plans, providing technical assistance and guidance for capturing the required additional 5010 data elements. A team of staff from multiple bureaus meets weekly for focused reviews of MMIS edits on encounter claims. The reviews result in reconsideration of the disposition of certain edits and the expected remediation actions.
- The Agency is preparing existing data to be used in a predictive analysis model designed to determine if Medicaid contracted Managed Care Organizations (MCOs) are reliably submitting encounter data. Currently, the model and preliminary results are in the final stages of review within the Agency. The plan is for the model to analyze all MCOs using 24 data points (months) to compute predicted encounter volumetrics and conduct trend analyses. Additional peer review will be undertaken prior to implementation.
- The Agency is conducting preliminary analyses for monitoring compliance with clinical practice guidelines. Health Effectiveness Data and Information Set (HEDIS) methodology provides a basis for defining populations with targeted conditions. Two measures, Chronic Obstructive Pulmonary Disease and Asthma, are being reviewed.

Risk Adjustment

The following are highlights for this quarter regarding the collection, validation, and utilization of quarterly pharmacy encounter data for risk adjustment purposes:

- Provided NCPDP pharmacy encounter claims for the July 1, 2010 – June 30, 2011, measurement period (paid through September 30, 2011) to the Agency's actuary for use in the MedRx model to generate risk scores.

- Incorporated encounter inpatient data and encounter pharmacy data for rate setting purposes. Inpatient and Pharmacy encounter data continued to be utilized for the rate setting process.

During this quarter, risk adjustment factors were calculated for the health plans operating in the demonstration counties.

H. Demonstration Goals

Objective 1: *To ensure there is an increase in the number of plans from which an individual may choose, an increase in the different type of plans, and increased patient satisfaction.*

Prior to the implementation of the demonstration, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, and two Minority Physician Networks (MPNs), for a total of 12 managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of the demonstration operated as prepaid ambulatory health plans offering enhanced medical management services to recipients enrolled in MediPass, Florida's primary care case management program.

The Agency currently has contracts with eight HMOs and three PSNs, for a total of 11 health plans in Broward County; three HMOs and two PSNs, for a total of five health plans in Duval County; and two HMOs and one PSN, for a total of three health plans in Baker, Clay, and/or Nassau Counties.

Since the beginning of the demonstration, the Agency has received 27 health plan applications (19 HMOs and eight PSNs) of which 23 applicants sought and received approval to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population. The application from Community Health Plan of South Florida to be a FFS PSN in Broward County is in Phase 2 of the review process. During the quarter, the following three new applications were received:

- Simply Healthcare applied to be an HMO in Broward County.
- Healthease applied to be an HMO in all five demonstration counties.
- Magellan Complete Care applied to be a specialty plan in Broward County.

These applications are in Phase I of the health plan application process

Patient satisfaction was also examined and is addressed in Objective 4.

Objective 2: *To ensure that there is access to services not previously covered and improved access to specialists.*

Access to Services Not Previously Covered

All of the capitated health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year Five of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter drug benefits and adult preventive dental benefits. The expanded services available to recipients in Demonstration Year Six include:

- Over-the-counter drug benefit $25 per household, per month,
- Adult Preventive Dental,
- Circumcisions for male newborns, and
- Adult Vision Services.

For Demonstration Year Five, the Agency approved 20 benefit packages for the HMOs and 10 benefit packages for the FFS PSNs. The benefit packages customized by the health plans for Demonstration Year Five became operational on January 1, 2011, and remain in effect in Demonstration Year Six.

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for recipients. Through the contracting process, each health plan is required to provide documentation to the Agency of a network of providers (including specialists) that will guarantee access to care for recipients. As Year One of the demonstration ended, the Agency began the first intensive review of the health plan provider network files to evaluate the effectiveness of the demonstration in improving access to specialists. The analysis includes the following steps:

1. Identifying the number of unduplicated providers that participate in Reform,
2. Identifying providers that were not fee-for-service providers, but now serve recipients as a part of Reform,
3. Comparison of plan networks that were operational prior to Reform with the Reform health plan networks at the end of Year One of the waiver, and
4. Comparison of Reform provider networks to the active FFS providers.

During the second quarter of Demonstration Year Two, the Agency began additional provider network analysis of the Medicaid health plans, including each Medicaid Reform health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on recipient access to providers (e.g., if the provider only accepts current patients, or if they only treat children and women, etc.).

Also in October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 34 located on the following page shows the results of these analyses.

Remainder of page intentionally left blank

Table 34
Results of Analyses of Access to Specialty Care in Duval County
(Pre and Post-Reform)

	Pre-Reform (June 2006)						Post-Reform (June 2007)		Adequacy Benchmarks	
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	Specs per 100K	Health Plan Count	Specs per 100K	Estimate of Need per 100k (Low)	Estimate of Need per 100k (High)
Pain Mgmt	2	4.9	143	351.3	145	**178.1**	58	**84.0**	**1.2**	**10.6**
Dermatology	3	7.4	3	7.4	6	**7.4**	9	**13.0**	**0.7**	**2.9**
Neurology	21	51.6	44	108.1	54	**66.3**	67	**97.0**	**1.2**	**3.4**
Orthopedics	32	78.6	31	76.2	48	**58.9**	64	**92.7**	**1.5**	**7.7**
General Dentistry	14	34.4	32	78.6	45	**55.3**	31	**44.9**	**17.5**	**30.8**
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

After factoring in estimates of need for each specialty, the Agency concluded that access to care for the five identified specialties in Duval County has either improved under Medicaid Reform or is more than adequate to meet recipient needs based on national benchmarks.

In November 2007, Agency staff began to improve the process of validating the accuracy of the health plans' provider network files. The Agency worked with contractors to create a survey tool aimed at measuring whether providers are indeed under contract with the health plans that report them as part of the health plan's networks and, if so, whether the providers' restrictions match those reported in the health plan files. Agency staff were trained to use this survey tool to call provider offices and verify provider participation and restrictions in Medicaid health plans.

In December 2007, the Agency pulled a random sample of 713 providers, 39 from each health plan's provider network file that was submitted to the Agency. This sample was divided among 21 Agency staff, who conducted the surveys in the middle of the month. Of the 713 providers in the sample, 58.5% participated in the survey. Of those who participated, 84.4% of the providers confirmed participation in the health plans. Agency staff followed-up with the health plans to see if they had a provider contract on file for those providers whose office managers did not confirm participation. This follow-up resulted in a finding that 99% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

During the second half of Demonstration Year Two and in Demonstration Year Three (March 2008 through March 2009), the Agency conducted 11 monthly surveys. These surveys included both a sample of 300 providers across the state, 15 from each health plan, and a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist). Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. The results of these surveys are provided in Table 35 located on the following page.

Table 35 Results of Provider Network Validation Surveys (March 2008 – March 2009)			
Survey Month/Year	**Statewide Accuracy Rate**	**Geographic Medicaid Area**	**Medicaid Area Accuracy Rate**
March 2008	88%*	10	95%*
April 2008	88%*	4	84%*
May 2008	97%	11	99%
June 2008	96%	9	97%
August 2008	97%	6	100%
September 2008	99%	3	99%
October 2008	100%	5	100%
November 2008	100%	8	100%
January 2009	99%	7	100%
February 2009	99%	2	100%
March 2009	99%	1	100%

*The follow-up process for the March and April 2008 survey results was different than for the May 2008 surveys onward.

As of the March 2009 survey, each of the 11 Medicaid Areas had been the focused geographic area of the survey once. Since each geographic area had been sampled, the Agency has moved to quarterly provider network surveys, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) when possible. The survey focus is on statewide samples rather than the Medicaid area-focused samples each quarter. The quarterly survey results that have been analyzed to date are in Table 36.

Table 36 Results of Provider Network Validation Surveys (July 2009 – April 2011)	
Survey Month/Year	**Statewide Accuracy Rate**
July 2009	95%
October 2009	98.4%
January 2010	96.6%
May 2010	97.4%
October 2010	96%
April 2011	91%

In April 2011, the Agency conducted a semi-annual provider network validation survey. Follow-up and analysis of the results for that survey were completed during this quarter. A sample of 690 providers was selected for survey (30 providers for each of 23 health plans). Of the 690 providers, 585 providers agreed to participate in the survey. Of those providers, 543 reported that they accepted the health plan in question. For those providers in the sample who were not agreeable to participating or who were unable to be reached, the Agency contacted the health plan and requested evidence of an active contract with the provider. This process resulted in an additional 84 providers from the sample being considered confirmed for an overall accuracy rate of 91%.

In December 2011, the Agency began the second semi-annual survey of 2011. Follow-up activities are underway. Analysis for that survey is expected to be reported during the first quarter of Demonstration Year Seven. The next survey is planned for June 2012.

Objective 3: *To improve enrollee outcomes as demonstrated by: (a) improvement in the overall health status of enrollees for select health indicators, (b) reduction in ambulatory sensitive hospitalizations, and (c) decreased utilization of emergency room care.*

(3)(a) Improvement in the overall health status of enrollees for selected health indicators.

During the first quarter of Demonstration Year Six, the Agency received the fourth year of performance measure submissions from the health plans. In most cases, the statewide average results for the demonstration plans continued in a steady upward trend, although there were some exceptions. It is important to note, when reviewing this year's results, that the measurement year for submissions was 2010. A number of health plans left the demonstration in late 2009 and early 2010; therefore, they were present in the statewide calculations last year, but not this year. Additionally, this year's submission included several health plans reporting complete data for the first year, which is a time when data issues may negatively impact rates. Nevertheless, the overall trends were generally positive. Results can be viewed in Attachment III of this report.

During this quarter, the Agency received Performance Measure Action Plan (PMAP) quarterly progress reports from the health plans. PMAPs are required for all measures that scored below the 50th percentile as identified in the National Committee for Quality Assurance's National Means and Percentiles. Agency staff reviewed the initial PMAPs and began reviewing the PMAP quarterly reports.

The Agency continues to move forward in the development of an incentive program to reward higher performing health plans with enhanced auto-assignments. The Agency finalized a draft methodology for assigning recipients who fail to actively choose a health plan during the enrollment period. The methodology includes both HEDIS performance measures and other reporting metrics. In October 2011, the Agency had a conference call with the health plans to review this methodology. The health plans then submitted some additional questions and comments to the Agency regarding the process, which the Agency is currently reviewing. Once finalized, the Agency will pilot the methodology in one non-demonstration county and then expand to both demonstration and non-demonstration counties in 2012.

(3)(b) Reduction in ambulatory sensitive hospitalizations.

The Agency used Preventative Quality Indicators identified by the Agency for Healthcare Research and Quality (AHRQ) to analyze the prevalence of Ambulatory Care Sensitive Conditions. The Agency also began preliminary analysis of the AHRQ Inpatient Quality Indicators. Additional fields must be collected to run the full models, although descriptive statistics are generated using their extraction criteria.

To date, reports have been generated for designated Florida counties possessing similar Standard Metropolitan Statistical Areas (SMSA) characteristics, which are classified by small rural, medium rural, medium urban, large urban using SFY 2009-10 encounter data. The reports presented to the Florida Legislature during the 3rd quarter of Demonstration Year Six have provided the foundation for follow-up analysis, which is ongoing at this time.

(3)(c) Decreased utilization of emergency room care.

The Agency continued its collaborative emergency department reduction project through the External Quality Review Organization, Health Services Advisory Group (HSAG). The project, operating in Duval and Broward Counties, is a voluntary collaborative project involving health plans and community partners, facilitated by HSAG. The project is based on a modification of a model developed by the Institute for Healthcare Improvement.

During this quarter, the health plans continued to review their data and identified a number of target groups, referred to as "patient streams," which appear to be high drivers of avoidable emergency department services. An algorithm developed by New York University is used to identify conditions for which an emergency department visit may have been avoided, either through earlier primary care intervention or through access to non-emergency department care settings.

Collaborative groups will continue developing interventions targeted to the particular issues of each patient stream and will strengthen community partnerships and infrastructure to reduce unnecessary utilization. The patient streams are in the process of being finalized for the next quarter.

Objective 4: *To ensure that patient satisfaction increases.*

The Agency contracted with the University of Florida (UF) to conduct patient satisfaction surveys throughout the five-year demonstration period, and will be contracting with UF to conduct these surveys during the three-year extension period as well. The survey instrument used by UF is based on the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) *Survey*. The CAHPS Survey is one of a family of standardized instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care. The UF has adapted the CAHPS telephone survey component by adding questions specific to the demonstration.

During the first quarter of Demonstration Year Six, the Agency forwarded revisions to UF for the report, *Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey, Volume 3: Enrollee Characteristics,* which assesses enrollee satisfaction differences by enrollee subgroup (race/ethnicity demographics). The UF made revisions to the report at the end of the first quarter and it has gone through final routing. Minor revisions are being made prior to posting the report in the fourth quarter of Demonstration Year Six.

During the fourth quarter of Demonstration Year Five, the Agency received the report, *Medicaid Reform Enrollee Satisfaction Year 3 Follow-Up Survey*. This report includes descriptions of enrollee satisfaction ratings for their health care, health plan, personal doctor, and specialists. The Agency has reviewed this report and continues to provide feedback to UF to finalize the report for review by management. Findings from this report were included in the Final Evaluation Report, which the Agency submitted to Federal CMS last quarter on December 15, 2011.

The results of past reports and all other evaluation reports conducted by UF can be viewed at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

Objective 5: *To evaluate the impact of the low income pool on increased access for uninsured individuals.*

Prior to the implementation of the Medicaid Reform Waiver, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The Medicaid Reform Waiver created the Low Income Pool (LIP) program, which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of these new Provider Access Systems allows for increased access to services for the Medicaid, underinsured and uninsured populations.

During the first year of the LIP, the following Provider Access Systems received State appropriations for LIP distributions: Hospitals, County Health Departments (CHDs), the St. John's River Rural Health Network (SJRRHN), and Federally Qualified Health Centers (FQHCs). During the first two quarters, the state approved a PAS distribution methodology and has worked with these PAS entities establishing agreements with the local governments or health care taxing districts.

The services utilized through these PAS entities include, but are not limited to, the implementation of case management for emergency room diversion efforts and/or chronic disease management, increased hours and medical staff to allow for increased access to primary care services and pediatric services, and the inclusion of increased services for breast cancer and cervical screening services.

As required under STC #102 in Demonstration Year Two, the state conducted a study of the cost-effectiveness of the various PASs (hospital and non-hospital providers). The state has contracted with the University of Florida (UF) to conduct the evaluation of LIP, including cost-effectiveness and the impact of LIP on increased access for uninsured individuals. During the second quarter of Demonstration Year One, the state held meetings with UF's Medicaid Reform Evaluation team in preparation for the study required in Year Two of the demonstration.

Special Term and Condition #102, Demonstration Year Two Milestones, states that, “the State will conduct a study to evaluate the cost effectiveness of various provider access systems.” This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost-effectiveness study to the Agency by the third quarter of Demonstration Year Two (January 2008). The cost-effectiveness study is based on the measurements of the LIP Milestone reports provided by the PAS entities. A sample of the LIP Milestone report is provided in the Reimbursement and Funding Methodology document. It should be noted that the LIP Milestone reports represent a snapshot of a 12-month period of time.

The LIP Milestone data collected includes data for hospital PAS entities and non-hospital PAS entities. All PAS entities completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Demonstration Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PAS entities with fiscal years different than July 1 – June 30 had to create data system extracts in order to comply with the Agency’s request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges
- Case Mix Index
- Hospital Inpatient Days
- Hospital Emergency Department Encounters (categorized by HCPC codes)
- Hospital Outpatient Ancillary Encounters (includes services such as diagnostic, surgical, therapy)
- Affiliated Services (includes services such as hospital owned clinic encounters, home health care, nursing home)
- Prescriptions Filled

The non-hospital PAS LIP Milestone report data includes the following, also separated by Medicaid populations and uninsured/underinsured populations:

- Primary Care Clinic Encounters
- Obstetric/GYN Encounters
- Disease Management Encounters
- Mental Health/Substance Abuse Encounters
- Dental Service Encounters
- Prescription Drug Encounters
- Laboratory Service Encounters
- Radiology Services
- Specialty Encounters
- Care Coordination Encounters

The PAS entities input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the UF LIP Evaluation team. The UF LIP Evaluation team will use the data (along with data previously submitted such as pre-LIP payments, Intergovernmental Transfers (IGTs), charge, cost, and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports were used for the cost-effectiveness study. The UF provided a "Plan for Evaluation of the Low Income Pool Program" to the Agency. The cost-effectiveness will be measured in the method described below.

> "In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost / Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in 'natural units' (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome."

The UF LIP Evaluation was received from UF on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to

the PAS entities. This document includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost-effectiveness study (STC #102).

On June 30, 2008, in accordance with STC #102 of Florida's 1115 Medicaid Reform Waiver, the Agency submitted a letter to Federal CMS along with the LIP Program Highlights: Year 1 (SFY 2006-07) as prepared by UF. The LIP Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to Federal CMS.

In accordance STC #23, paragraph three, the State is submitting the following information for provider qualitative and quantitative data, which describes the impact on the Low Income Pool:

> "The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted to CMS.
>
> "Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.
>
> "Beginning with the annual report for demonstration year four, the State must include a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the demonstration."

The Agency received the "*Evaluation of the Low-Income Pool Program Using Milestone Data: SFY 2008-09*" provided by the University of Florida during the first quarter of Demonstration Year Five. The report can be found on the Agency's Low Income Pool website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

This report provided several key findings for SFY 2008-09:

- A total of 221 PAS in Florida received LIP funding – 162 hospitals and 59 non–hospital providers.
- Total LIP funding for SFY 2008-09 was approximately $876.3 million.
- Reporting hospitals receiving LIP Payments served a total of approximately 3.4 million Medicaid, uninsured, and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served a total of approximately 692,000 Medicaid, uninsured, and underinsured individuals.
- On average, hospitals received $167 in LIP payments for each Medicaid, uninsured, and underinsured individual served.
- On average, non-hospital providers received $73 in LIP payments for each Medicaid, uninsured, and underinsured individual served.
- LIP payments supported a variety of Florida Department of Health Emergency Room Alternative projects.

The UF report also included key findings comparing SFYs 2005-06, 2006-07, 2007-08, and 2008-09:

- The number of hospitals receiving LIP funding increased in comparison to those receiving funding from the SMP program: 87 hospitals received Special Medicaid Payments (SMP) funding in SFY 2005-06, with 163, 160, and 162 hospitals receiving LIP funding in SFY 2006-07, 2007-08, and 2008-09, respectively.
- Non-hospital providers began receiving funding under the LIP program: 43 and 44 non-hospital providers received LIP payments in SFY 2006-07 and SFY 2007-08, respectively, increasing to 59 non-hospital providers receiving LIP payments in SFY 2008-09.
- Total funding increased under the LIP program in comparison to the SMP program: total SMP payments were approximately $666.9 million in SFY 2005-06, with total LIP payments being approximately $998.7 million in SFY 2006-07, approximately $1 billion in SFY 2007-08, and approximately $876.3 million in SFY 2008-09.
- When adjusted for inflation (2005=100), total SMP payments were approximately $666.9 million, with total LIP payments being approximately $967.2 million in SFY 2006-07, approximately $941.7 million in SFY 2007-08, and approximately $807.8 million in SFY 2008-09.
- Hospitals receiving LIP payments served an estimated total of approximately 3.6 – 3.8 million Medicaid, uninsured, and underinsured individuals in each of the first three years of Medicaid Reform.
- Non-hospital providers receiving LIP payments served an estimated total of approximately 800,000 – 1 million Medicaid, uninsured, and underinsured individuals in the first three years of Medicaid Reform.
- For hospitals, the average (SMP or) LIP payment received for each Medicaid, uninsured, and underinsured individual served declined during Medicaid Reform in comparison to the year prior to Medicaid Reform: in nominal terms, $ per individual was $267 in SFY 2005-06, $176 in SFY 2006-07, $166 in SFY 2007-08, and $167 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $267 in SFY 2005-06, $171 in SFY 2006-07, $156 in SFY 2007-08, and $154 in SFY 2008-09.
- For non-hospital providers, the average LIP payment for each Medicaid, uninsured, and uninsured individual served declined between SFY 2006-07 (first year in which non-hospital providers received funding) and SFY 2008-09: in nominal terms, $ per individual was $102 in SFY 2006-07, $91 in SFY 2007-08, and $73 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $98 in SFY 2006-07, $85 in SFY 2007-08, and $67 in SFY 2008-09.
- Results based on individuals served must be used with caution given that they are based only on data for hospitals and non-hospital providers that reported milestone data in a given year. The percentage of providers receiving payments that reported milestone data varied across years from 84 – 96% for hospitals and from 63 – 89% for non-hospital providers. Particularly in years with a low reporting percentage, results might demonstrate a different pattern if all providers had reported milestone data.

Current Activities

During the second quarter of Demonstration Year Six, the Agency received and reviewed the SFY 2009-10 LIP Milestone data results received from the LIP evaluation team at UF. The Milestone data tracks the number of individuals and types of services provided through LIP. The following is some of the key data included in the results:

- A total of 217 Provider Access Systems in Florida received LIP funding – 162 hospitals and 55 non-hospital providers.
- Total LIP funding was approximately $1.1 billion (including rolled over funding from previous year).
- Reporting hospitals receiving LIP payments served a total of approximately 4 million Medicaid, uninsured and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served a total of approximately 1 million Medicaid, uninsured and uninsured individuals.
- On average, hospitals received $168 in LIP payments for each Medicaid, uninsured and underinsured individual served.
- On average, non-hospital providers received $96 in LIP payments for each Medicaid, uninsured and underinsured individual served.

During this quarter, the Agency returned comments to UF after reviewing the SFY 2009-10 LIP Milestone data and report, and looks forward to receiving the updated version from UF during the fourth quarter of Demonstration Year Six.

Currently, the Agency is designing a report regarding STC #61, #62 and #80. The report will analyze the processes and outcomes that relate to the Three-Part Aim of better care, better health and reducing cost. Also provided in the report will be an analysis of the Tier-One Milestone from STC #61 and Tier-Two Milestone from STC #62. The Agency anticipates the report to be finalized in the upcoming SFY 2012-13. See Section E of this report for more information.

I. Evaluation of Medicaid Reform

Overview

The evaluation of Medicaid Reform is an ongoing process to be conducted during the life of the demonstration. In November 2005, the Agency contracted for this required 1115 Medicaid Reform Waiver evaluation with an independent entity, the University of Florida (UF). This evaluation was designed to incorporate criteria in the waiver, plus those in the Special Terms and Conditions (STCs). The Agency developed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to the Federal Centers for Medicare and Medicaid Services (CMS) on February 15, 2006. The Agency incorporated comments from the Federal CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to Federal CMS on May 24, 2006. Federal CMS approval was received on June 13, 2006.

The initial Medicaid Reform Evaluation was a five-year "over-arching" study that presented its major findings in the Final Evaluation Report that was submitted to Federal CMS on December 15, 2011. The report can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/FL_1115_Final_UF_Eval_Report_12-15-11.pdf

Current Activities

The Agency will submit a draft evaluation design to CMS by April 13, 2012 as specified in STC #80. The draft evaluation design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the demonstration.

During this quarter, Agency staff drafted research questions to address the nine domains of focus that STC #80 requires be included in the draft evaluation design of the demonstration. In addition, the Agency reached out to several public state universities to solicit interest in conducting the evaluation for the waiver renewal period (December 16, 2011 – June 30, 2014). The Agency will review university proposals to select a vendor to begin conducting the evaluation during the next quarter.

J. Policy and Administrative Issues

Current Activities

The Agency continues to identify and resolve various operational issues for capitated health plans and FFS PSNs. During this quarter, the Agency's internal and external communication processes continue to play a key role in managing and resolving issues effectively and efficiently.

Policy, administrative, and operational issues are generally addressed by six different processes:

- Technical Advisory Panel regular meetings,
- Policy transmittals and "Dear Provider" letters and e-mails,
- Health Plan Technical and Operational Issues conference calls,
- PSN Systems Implementation monthly conference calls,
- General amendment/contract overview calls, and
- Fraud and abuse meetings.

These forums continue to provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our "Dear Provider" letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement. In conference call forums, the focus during this quarter has been on operational updates and information exchange.

Medicaid Reform Technical Advisory Panel

The Technical Advisory Panel (TAP) was created by the 2005 Florida Legislature, and appointed by the Agency with the directive of advising the Agency on various implementation issues relative to the demonstration. The seven-member TAP held one meeting during this quarter on March 19, 2012. Items discussed included updates on the demonstration (including demonstration extension), update on Florida's Statewide Medicaid Managed Care program initiative (including update on waiver amendment requests), choice counseling and enhanced benefits update, budget and legislative update, and discussion of capitation rate setting and process.

Policy Transmittals and "Dear Provider" Letters

During this quarter, there were no "Dear Provider" letters and one policy transmittal released to the health plans. The policy transmittal advised health plans of the Agency's process for health plan expansion into a new county in order to streamline the expansion process through set documentation requirements.

There were also several "Dear Provider" e-mails sent to provide updated information on the Medicaid program. Issues addressed in the "Dear Provider" e-mails included the following:

- Information regarding fraud and abuse,
- Information regarding changes in Medicaid fee schedules and updates regarding enrollment and payment file transmissions,

- Changes in the provider mass registration process and encounter data updates,
- Information regarding quarterly changes to the electronic Report Guide for the contract covering the period January 1, 2009 through August 31, 2012,
- Informational updates on the newborn/unborn enrollment process,
- Information on health plan capitation rate development for the September 1, 2012 through August 31, 2013 contract year, and
- Notice regarding upcoming general amendment, amendment draft, comment period and review conference call.

Technical and Operational Issues Conference Calls

The purpose of these calls is to communicate the Agency's response to issues addressed at a higher level in the TAP meetings and to respond to plan questions posed through e-mail, telephone inquiries and previous technical calls. Previously, these calls occurred biweekly, but with the demonstration being fully operational, the need for biweekly calls has significantly lessened. As discussed with the health plans in June 2010, a decision was made to change to monthly calls beginning in July 2010. Unless a particular need arises for calls to occur more often, the Technical and Operational Issues conference calls are now monthly. During this quarter, the Agency conducted three Technical and Operational Issues conference calls with health plans and health plan applicants.

All health plans are invited to participate, whether they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of the demonstration and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers, and health plan subcontractors.

Approximately 20 participants attended in person and the popularity of these calls continues to be shown by over 100 phone lines in active use on the calls. The agenda items discussed on this quarter's calls were as follows:

- Health information technology update.
- General amendment update,
- 5010 implementation and encounter data update,
- Encounter data threshold reports,
- Managed care organization/Pharmacy benefits manager testing, and
- Databook release.

FFS PSN Systems Implementation Issues Conference Calls

The purpose of these calls is to provide a forum to discuss claims processes and enrollment file issues that are unique to the FFS PSN model. The PSNs are encouraged to submit questions and/or issues in advance in order for systems research to occur internally at the Agency (or between the Agency and the Agency's Medicaid fiscal agent). Agency participants included management and key technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Bureau of Contract Management, Area Office staff, and Bureau of Managed Health Care

staff responsible for monitoring the health plans. PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs' contracted TPAs. Unresolved issues include those that are in the systems change queue for implementation and anecdotal issues pending examples to be submitted from PSNs for Agency research. While these calls were originally bi-weekly, then monthly, they now occur on an as-needed basis. If there is nothing new to report or discuss, then the monthly call is cancelled. There were two calls during this quarter.

A summary of key items addressed through this process included the following:

- Medicaid fiscal agent transition issues relative to PSN enrollment and claims processing,
- Revisions requested by the PSNs in terms of the electronic remittance advice that they receive, and
- Claims processing changes in the queue until their priority status for systems change reaches a higher priority level.

In addition to these calls, the Agency continued to coordinate technical assistance between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, it has been needed only occasionally. Modification of the current claims process (to streamline the claims processing function) for FFS PSNs remains under consideration.

General Amendment/Contract Overview/Training Calls and Meetings

During this quarter, one conference call/meeting was held on February 27, 2012 with health plans regarding the last general amendment for the 2009 – 2012 contract period. The Agency provided the health plans with an advance copy of the draft amendment and reviewed the draft with the health plans on the conference call. In addition, the Agency provided the health plans with a template upon which they could submit comments or questions regarding the draft amendment. The general amendment draft covered the following major items:

- Requiring health plans to comply with MLR and reporting requirements, as specified in the Special Terms and Conditions as approved by the Federal CMS on December 15, 2011, beginning July 1, 2012,
- Allowing plans the option of providing dental and behavioral health services through telemedicine if approved by the Agency,
- Providing specifications for telemedicine equipment, service limitations and documentation,
- Specifying that the health plan submit, with its preferred drug list (PDL), copies of its committee meeting minutes and decision points that support the choice of medications on the PDL and requiring notice to providers regarding deleting drugs,
- Requiring the health plan's assistance in dispute resolution between the Agency and the drug manufacturer regarding federal drug rebates,
- Updating psychotropic medication consent requirements,
- Updating nicotine replacement therapy requirements,
- Revising accreditation requirements for subcontracted managed behavioral health organizations,

- Revising encounter data reporting requirements for pharmacy services,
- Updating social networking requirements based on new Agency-wide contractual requirements,
- Clarifying requirements for plans requesting assignment, transfer, withdrawal or termination to ensure the Agency receives the data needed to ensure adequate transition planning and maintenance of existing case/care coordination and facilitate continuity of care, and
- Implementing Florida statutory revisions in the FFS PSN reconciliation process and in the conversion to capitation requirements.

The Agency continued to review health plan feedback received in March regarding the amendment.

Fraud and Abuse Meetings

During this quarter, the Agency held a fraud and abuse meeting on March 15, 2012, for all health plans. The training was located in Tallahassee at the Agency. The fraud and abuse meeting included the following:

- Government agencies sharing about processes that are integral to the health plans' anti-fraud efforts,
- Health plans sharing concerns or needs about more effectively addressing fraud, and
- Presentations by various health plans regarding fraud schemes seen or anticipated, and discussion on how best to address them (prevention, detection, investigation, enforcement, and prosecution).

Over 40 persons attended the training, with representation from most Medicaid health plans. The next meeting is tentatively scheduled for June 2012.

Attachment I
PSN Complaints/Issues

PSN Complaints/Issues (January 1, 2012 – March 31, 2012)	
PSN Informal Issue	**Action Taken**
1. A recipient was assigned to managed care in error and required access to her specialist.	The PSN agreed to authorize access to the specialist until the recipient could be disenrolled the following month.
2. An adult PSN enrollee exhausted his outpatient benefit and was in need of additional care.	The PSN and the Agency worked with the provider community to locate a resource.
3. The parent of a PSN enrollee complained of rudeness from a transportation provider.	The PSN's transportation provider submitted an incident report related to the transport in question. The PSN contacted the parent to discuss the incident and to plan for future transportation needs.
4. A PSN enrollee requested mental health services.	The PSN arranged mental health services.
5. The parent of a PSN enrollee complained of not being able to access services.	The PSN assisted the parent in obtaining services.
6. The parent of a PSN enrollee with complex medical needs complained about being enrolled in a PSN.	The PSN worked with the parent to resolve each of her issues.
7. A PSN enrollee complained that the PSN would not authorize access to a pain management specialist.	The enrollee's neurologist did not recommend pain management. The PSN authorized care from a specialist recommended by the neurologist.
8. The parent of a PSN enrollee needed assistance accessing dental care.	The dental provider did not show the enrollee as active. The PSN sent confirmation that the enrollee was covered.
9. A PSN enrollee requested assistance with specialty care.	The PSN provided the enrollee with a list of in-network specialists and offered assistance if he had difficulty scheduling an appointment.
10. The parent of a PSN enrollee contacted the Governor's Office complaining that the PSN had denied access to cochlear implants for her child.	The PSN upheld the denial as not medically necessary due to the child already having functioning cochlear implants per the physician. The mother requested a newer model, which is not indicated while the current implant is functional.
11. The parent of a PSN enrollee requested assistance with accessing a pediatric specialist.	The PSN assisted with accessing the pediatric specialist.

PSN Complaints/Issues (January 1, 2012 – March 31, 2012)	
PSN Informal Issue	**Action Taken**
12. The parent of a PSN enrollee requested assistance with accessing specialty care.	The PSN assisted with arranging specialty care.
13. A PSN enrollee's attempt to refill medication was denied.	The enrollee attempted to get a refill too early. The PSN informed him of the date he could fill his next prescription.
14. The parent of a PSN enrollee requested access to a pediatric urologist.	The PSN authorized out-of-network care with a pediatric urologist.
15. The parent of a PSN enrollee complained about termination of home health services for her child.	The parent followed the grievance and appeal procedures and was instructed on the process for pursuing a Medicaid Fair Hearing.
16. A PSN enrollee requested assistance in accessing an orthopedic surgeon.	The PSN assisted the member in obtaining an appointment.
17. A PSN enrollee requested confirmation of his enhanced benefits credits.	The PSN provided documentation of their submissions for the enrollee's credits.
18. The parent of a PSN enrollee was unable to obtain medications from CVS Pharmacy.	Agency staff worked with CVS Pharmacy to correct a billing error.
19. A PSN enrollee could not obtain authorization for an organ transplant.	The transplant provider was not cooperating with the PSN's authorization procedures. The PSN worked with the enrollee and providers to obtain the documentation required to authorize the transplant.
20. A PSN enrollee complained that he was hospitalized and was not receiving appropriate care.	The PSN attempted to contact the enrollee, but he was not hospitalized as he claimed and could not be located.
21. A PSN enrollee requested assistance with obtaining a primary care physician (PCP).	The PSN enrollee assisted the enrollee with the PCP issue. The PSN also noted that the enrollee was in need of an eligibility update and referred the enrollee to the Department of Children and Families. The enrollee maintained her eligibility.
22. A PSN enrollee requested assistance with Durable Medical Equipment (DME).	The PSN provided the DME as requested.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues (January 1, 2012 – March 31, 2012)	
HMO Informal Issue	**Action Taken**
1. An HMO enrollee reported that he did not have a PCP.	The HMO contacted the enrollee to advise him of his PCP. There was evidence that the enrollee had chosen his PCP in the health plan's system.
2. An HMO enrollee complained that she was unable to see her current doctors after being assigned to an HMO.	The HMO attempted to contact the enrollee, but the recipient had been disenrolled from the plan prior to making contact.
3. An HMO enrollee requested assistance obtaining medication.	The HMO assisted the enrollee in obtaining the medication.
4. The parent of an HMO enrollee complained that her request for insulin pens for her child had been denied.	The HMO authorized the insulin pens.
5. An HMO enrollee requested assistance obtaining a provider for dentures.	The HMO provided an appointment for the enrollee.
6. An HMO enrollee requested assistance obtaining greater than 10 prescriptions per month and a brain MRI.	The HMO reported that there was no record of medication denials in the system. Assistance was provided with scheduling the brain MRI.
7. An HMO enrollee complained that the HMO was denying her pain medication.	The HMO contacted the enrollee and offered a pharmacy pick-up option. The enrollee was satisfied with the outcome.
8. An HMO enrollee complained about a denial of service authorization for vision services.	The enrollee's Medicaid eligibility ended prior to resolution. However, the Agency is looking into the HMO's authorization timeliness.
9. An HMO enrollees' guardian requested a list of therapy providers.	The guardian was provided the list of therapy providers.
10. An HMO enrollee's parent reported that his child was unable to access dental care because the dental vendor was not aware of the child's eligibility.	The HMO worked with the vendor to update the eligibility file and obtained an appointment for the child.
11. An HMO wanted to access an out-of-network OB/GYN.	The HMO authorized the out-of-network care. The enrollee was scheduled for disenrollment the next month.
12. An HMO enrollee requested out-of-network care.	The HMO approved the out-of-network care.

HMO Complaints/Issues (January 1, 2012 – March 31, 2012)	
HMO Informal Issue	**Action Taken**
13. A provider reported being denied claims for a billing code.	The HMO and the provider have on-going disagreements about how the code is being billed. The Agency continues to work with both parties toward resolution.
14. An HMO enrollee reported difficulty obtaining an oxygen tank.	The HMO enrollee received the oxygen tank.
15. An HMO enrollee was denied a request for surgery by an out-of-state specialist.	The enrollee was sent for several out-of-state consultations. Upon the recommendation of those physicians, she is being evaluated locally for an organ transplant.
16. An HMO enrollee requested out-of-network care for imaging services.	The enrollee was instructed to use in-network providers or to self-pay.
17. An HMO enrollee reported denial of services through the plan.	There was confusion with the enrollee and the plan about services that would be provided through a waiver program and those services that must be provided through the plan. Services have been authorized and delivered.
18. An HMO enrollee requested authorization for out-of-network authorization and complained of difficulty obtaining medication.	Authorization was granted. The medication issue was with the supplier. The HMO changed suppliers and the medication was provided.
19. An HMO enrollee requested a PCP closer to her home.	A new PCP was provided.
20. An HMO enrollee was being told she would have a co-pay for dental services.	The provider was not in-network. The HMO arranged in-network care.
21. An HMO enrollee did not have a PCP.	The HMO assisted her with selecting a PCP and arranged an appointment.
22. A provider reported that claims were being denied.	The HMO is reprocessing the claims.
23. An HMO enrollee reported that her request for an MRI was denied.	Current medical documentation was not provided. The HMO assisted the enrollee with scheduling an appointment for an updated evaluation.
24. An HMO enrollee requested assistance in getting a PCP.	The HMO assisted the enrollee with selecting a PCP and scheduled an appointment.
25. An HMO enrollee requested assistance in obtaining dental services.	The HMO assisted the enrollee in obtaining services.

HMO Complaints/Issues (January 1, 2012 – March 31, 2012)	
HMO Informal Issue	**Action Taken**
26. An HMO enrollee complained to an advocacy organization that the plan was not providing care. The advocacy organization referred the complaint to the Agency.	The HMO contacted the enrollee and explained how to access benefits. The enrollee expressed understanding.
27. A provider reported that payments were sent to a wrong address and were lost. The HMO would not issue new checks.	The HMO sent one check to the provider to cover all missing payments.
28. An HMO enrollee complained that asthma medications were being denied.	The HMO had no record of having the medication being denied or requested. The HMO worked with the enrollee's physician to authorize medication going forward. The physician reported having previously provided samples, but had not given a prescription because the medication was not on formulary. The HMO provided the physician forms to request authorization for the medication.
29. An HMO enrollee reported difficulty obtaining an appointment with a neurologist.	The HMO scheduled an appointment for the enrollee with an in-network neurologist.
30. An out-of-state provider contacted the Agency regarding a recipient's health plan eligibility status.	The HMO contacted the provider to confirm eligibility and provide billing information.
31. An HMO enrollee reported that her HMO was unresponsive to her requests for an authorization to see a specialist.	The HMO contacted the provider. The provider had not yet sent the request for authorization paperwork.
32. A provider complained of lack of payment.	The provider had filed a claim with errors. The HMO assisted the provider in filing a clean claim.
33. A provider was denied payment due to the enrollee not being eligible for the date of service.	The HMO updated enrollment files to show the enrollee was eligible. The enrollee will submit bills she received to the HMO for payment.
34. A provider was denied payment for drug administration.	The provider was not aware of the process to request payment for injectibles. The provider was educated on the process.
35. The caseworker for an HMO enrollee reported difficulty obtaining medication.	The HMO had evidence that prescriptions were filled. The caseworker could not be reached for follow-up.
36. An HMO enrollee could not obtain medication.	A systems error denied payment due to third party liability. The error was fixed and the enrollee received his medication.
37. An HMO enrollee reported difficulty accessing a specialist.	The HMO provided a list of available specialists and changed the PCP per her request.

HMO Complaints/Issues (January 1, 2012 – March 31, 2012)	
HMO Informal Issue	**Action Taken**
38. An HMO enrollee's parent complained of difficulty obtaining medication for her child.	The HMO upheld the denial of the medication as its use is considered experimental for children.
39. An HMO enrollee's parent was billed for services.	The HMO paid for the services.
40. An HMO enrollee complained about access to medication and transportation.	The HMO worked with the enrollee on issues related to prior authorization and addressed his transportation concerns.
41. An HMO enrollee requested assistance in getting a PCP and behavioral health provider.	The HMO assisted the enrollee with both providers. Their care managers will continue contact with him to ensure he is getting needed care.
42. A provider complained about an HMO's reimbursement rate for chemotherapy drugs.	The provider had previously agreed to the rate in contract.
43. An HMO enrollee requested assistance with medication and transportation.	The HMO authorized all medication and assisted with transportation.
44. An HMO enrollee complained about access to medication.	The HMO had no record of denials. All attempts to contact the enrollee, including certified mail, were unsuccessful.
45. A provider complained that an HMO is paying at the adult rates rather than the pediatric rates.	The HMO confirmed that they were paying incorrectly and was working with the provider to correct the error.

Attachment III
2011 Managed Care Performance Measures

	Non-Reform*					Reform*					
Measure	2008	2009	2010	2011	Trend	2008	2009	2010	2011	Trend	National Mean**
Annual Dental Visit	n/a	n/a	***	16.1%	n/a	15.2%	28.5%	33.4%	34.0%	+	45.7%
Adolescent Well-Care	41.9%	46.0%	45.7%	**49.2%**	+	44.2%	46.5%	46.3%	46.2%	-	47.7%
Controlling Blood Pressure	52.7%	51.6%	53.0%	**54.7%**	+	46.3%	55.9%	53.4%	46.3%	-	55.3%
Cervical Cancer Screening	56.6%	53.8%	55.3%	55.6%	+	48.2%	52.2%	50.8%	53.2%	+	65.8%
Diabetes – HbA1c Testing	74.7%	75.1%	76.4%	79.6%	+	78.9%	80.1%	82.8%	**81.9%**	-	80.6%
Diabetes – HbA1c Poor Control INVERSE	48.5%	51.7%	46.4%	42.5%	+	48.3%	46.8%	44.9%	**48.6**%	-	44.9%
Diabetes – Eye Exam	36.3%	41.9%	48.3%	52.1%	+	35.7%	44.0%	45.4%	49.3%	+	52.7%
Diabetes – LDL Screening	75.6%	76.3%	77.9%	**80.0%**	+	80.0%	80.2%	83.5%	**81.8%**	-	74.2%
Diabetes – LDL Control	29.5%	29.4%	**33.8%**	32.8%	-	29.3%	**35.9%**	36.1%	**36.9%**	+	33.5%
Diabetes – Nephropathy	77.1%	76.1%	77.1%	**79.0%**	+	79.2%	80.3%	81.9%	**83.1%**	+	76.9%
Follow-Up after Mental Health Hospital – 7-day	30.5%	37.2%	24.2%	28.4%	+	20.6%	29.3%	25.4%	23.1%	-	42.9%
Follow-Up after Mental Health Hospital – 30-day	47.0%	51.7%	41.4%	47.9%	+	35.5%	46.6%	41.3%	44.3%	+	60.2%
Prenatal Care	71.7%	69.1%	69.5%	71.7%	+	66.6%	67.4%	75.2%	68.4%	-	83.4%
Postpartum Care	58.5%	50.1%	52.7%	54.6%	+	53.0%	51.5%	52.1%	49.3%	-	64.1%
Well-Child First 15 Months – Zero Visits INVERSE	2.8%	3.0%	4.2%	3.2%	+	4.9%	1.6%	6.0%	3.0%	+	2.3%
Well-Child First 15 Months – Six Visits	44.0%	51.0%	46.1%	51.4%	+	44.4%	49.3%	35.4%	46.5%	+	59.4%
Well-Child 3-6 years	71.1%	72.5%	74.9%	**74.8%**	-	71.3%	75.7%	72.7%	**75.0%**	+	71.6%
Adults' Access to Preventive Care – 20-44 Years	n/a	69.3%	67.9%	68.1%	+	n/a	71.8%	71.2%	71.2%	flat	80.5%
Adults' Access to Preventive Care – 45-64 Years	n/a	82.2%	81.2%	81.5%	+	n/a	84.7%	84.9%	**85.5%**	+	85.3%
Adults' Access to Preventive Care – 65+ Years	n/a	74.7%	66.9%	69.9%	+	n/a	83.6%	83.7%	84.2%	+	84.7%
Antidepressant Medication Mgmt – Acute	n/a	45.6%	46.8%	47.0%	+	n/a	52.0%	56.3%	**56.3%**	flat	49.6%
Antidepressant Medication Mgmt -- Continuation	n/a	31.2%	29.2%	31.4%	+	n/a	29.8%	43.8%	**44.0%**	+	33.0%
Appropriate Medications for Asthma	n/a	87.0%	87.0%	86.6%	-	n/a	83.6%	87.6%	86.0%	-	88.6%

	Non-Reform*					Reform*					
Measure	2008	2009	2010	2011	Trend	2008	2009	2010	2011	Trend	National Mean**
Breast Cancer Screening	n/a	47.5%	50.1%	50.9%	+	n/a	51.4%	56.9%	**59.2%**	+	52.4%
Childhood Immunization Combo 2	n/a	61.8%	71.4%	73.8%	+	n/a	63.6%	70.0%	72.6%	+	74.3%
Childhood Immunization Combo 3	n/a	52.0%	63.7%	67.9%	+	n/a	53.8%	62.7%	65.7%	+	69.4%
Frequency of Prenatal Care	n/a	51.6%	54.3%	**60.6%**	+	n/a	52.6%	46.9%	44.0%	-	61.6%
Lead Screening	n/a	46.0%	53.1%	53.5%	+	n/a	54.8%	52.0%	54.1%	+	66.4%
Adult BMI Assessment	n/a	n/a	31.2%	**48.3%**	+	n/a	n/a	41.9%	**52.7%**	+	34.6%
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	n/a	n/a	37.8%	**37.1%**	-	n/a	n/a	43.6%	**44.5%**	+	36.6%
Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance	n/a	n/a	46.6%	**46.7%**	+	n/a	n/a	n/a	n/a	n/a	41.7 %

Bold = Better than the national mean

* Data are submitted to the Agency by HMOs and PSNs and are audited by NCQA-Certified HEDIS auditors. Data do not include Medicaid FFS or MediPass.
** National Mean as published by NCQA, Medicaid product line. The National Mean that the 2011 submission is compared against is the National Mean for 2010.
*** Data from Sunshine remains outstanding pending the result of an appeal to the auditor.

This page intentionally left blank