Florida Medicaid Reform

Quarterly Progress Report
April 1, 2010 – June 30, 2010

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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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 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.

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of allowing market-based approaches to assist the state in its service to Medicaid beneficiaries.

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;
- Catastrophic Component of the premium (i.e., state reinsurance to encourage development of provider service networks and health maintenance organizations in rural and underserved areas of the State); and
- Low Income Pool.

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, F.S., and Special Terms and Conditions # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 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 fourth quarterly report in Year Four of the demonstration for the period of April 1, 2010, through June 30, 2010. 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, one 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 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 11 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. If the demonstration extension is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, unless the PSN opts to convert to capitation earlier.

The Agency 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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. During this quarter, the initial on-site survey was conducted, which is Phase III of the application review process.

This quarter, AIDS Healthcare Foundation of Florida (AHF MCO), doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS,

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[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.

began providing services in Broward County. This is the second specialty plan in the demonstration, the first being the specialty plan for children with chronic conditions that became operational in 2006.

Table 1 provides a list of all health plan applicants, the date each application was received, the date of application approval, and each plan's county of operation, as well as the one pending application.

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
Health Ease***	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 dba 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 dba 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.	HMO	X		01/21/10	***Pending***

*During Fall of 2008, the plan amended its contract to withdraw from this/these counties.
**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.

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****		
Health Ease***	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 dba First Coast Advantage	07/01/06	PSN		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		
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO dba Positive Health Care	05/01/10	HMO	X		

*During Fall of 2008, the plan amended its contract to withdraw from this/these counties.
**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 this/these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.

Contract Amendments and Model Contracts

There was one general amendment during this quarter, the purpose of which was to add incentives and sanctions related to performance measures. Three health plans requested and received Agency approval during this quarter to increase their maximum enrollment levels in various counties.

Contract Conversions/Terminations

Simply Healthcare (HMO) purchased Total Health Choice (HMO) and purchased a minority share of Better Health Plan (FFS PSN). Total Health Choice ceased operations May 31, 2010. As a result, the Total Health Choice membership was transitioned to Better Health Plan this quarter. Prior to approving the transition, the Agency compared the plan's provider networks, including behavioral health providers, to ensure continuity of care and to ensure the continued availability of current primary care providers.

Total Health Choice enrollees were given written notification of the change and an opportunity to select another health plan. The health plan sent letters to their enrollees 60 days prior to the enrollment transition date and the Agency sent letters to the enrollees 30 days prior to the enrollment transition date. Beneficiaries impacted by the transition were given 90 days after the transition to change plans without cause.

In addition, the Agency required an amendment to Better Health's contract so that Better Health's benefit package aligned with benefit package offered by Total Health Choice, including Total's expanded services. Expanded services are those services a health plan offers above and beyond Medicaid State Plan services and for which they receive no extra compensation. This amendment ensured former Total Health Choice members continued to receive the same benefit package, including the expanded services and ensured those same expanded services were offered to all of Better Health's existing members. Effective June 1, the following expanded services became available to all Better Health members:

- Over-the-Counter Prescription Medication – $25 per household per month
- Circumcision – 0 to 3 months
- Adult Dental Cleanings up to 2 cleanings per year
- Adult Nutrition Therapy – 15 visits per year

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. If the demonstration extension is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, 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 have submitted conversion workplans and applications to the Agency in order to comply with the previous 5-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.

Table 3 provides the timeline for each step in the revised conversion process.

Table 3 PSN Conversion to Capitation Timeline	
Deadline for the FFS PSN to submit its conversion workplan to the Agency.	09/01/2011
Deadline for the FFS PSN to submit its conversion application to the Agency.	09/01/2012
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2013.	06/30/2013

FFS PSN Reconciliations

By the end of this quarter, the Agency completed work on the first and second contract year reconciliations[2] (September 2006 through August 2007, and September 2007 through August 2008) for all but two FFS plans. The Agency continues to work with the FFS plans that have requested additional time for reconciliation data analysis.

Systems Enhancements

With the conversion to the new Medicaid Fiscal Agent, systems changes continue to occur along with continued technical assistance being provided to the health plans (see Section K 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 beneficiaries 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

[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.

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 did 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 could 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 had to provide some coverage for the service, but had 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 four years of the demonstration. 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, and September 15, 2009, for Demonstration Year Four. All health plans are required to submit their 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) is typically completed during the last quarter of each state fiscal year. The verification process included 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 beneficiary, and the beneficiaries are getting new opportunities to engage in decision-making responsibilities relating to their personal health care.

The Agency, the health plans, and the beneficiaries can see the value of customization. The Agency has seen 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 average value of

the customized benefits package continues to exceed the Florida Medicaid State Plan benefit package in Year Three of the demonstration.

Current Activities

The benefit packages customized by the health plans for Demonstration Year Four became operational on January 1, 2010, and will remain valid at least until August 31, 2010. These benefit packages include 21 customized benefit packages for the HMOs and 13 benefit packages for the FFS PSNs.

The eight HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Four of the demonstration are Freedom Health Plan, Humana, Medica Healthcare, Molina Healthcare, Total Health Choice, Sunshine State Healthplan, United Health Care, and Universal Health Care. The four FFS PSNs are Better Health, Children's Medical Services, First Coast Advantage, and the South Florida Community Care Network. On May 1, 2010, Positive Healthcare, the first demonstration HMO specialty plan for beneficiaries with HIV/AIDS, began accepting voluntary enrollment, and it also offers a customized benefit package.

During this quarter, Total Health Choice (HMO) was acquired by Simply Healthcare (HMO) and ceased operations on May 31, 2010. The Total Health Choice Reform enrollees were transitioned into the Better Health Reform (PSN), of which Simply Healthcare is a minority owner, on June 1, 2010. Prior to approving the transition, the Agency compared provider networks, including behavioral health providers, to ensure continuity of care and the continued availability of current primary care providers. Total Health Choice members who were transitioned into Better Health were able to keep their expanded benefits originally offered by Total Health Choice. There was no change in benefit package or provider network for beneficiaries who transitioned from Total Health Choice to Better Health.

Table 4 lists the number of co-payments for each service type by each demonstration year. Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the beneficiaries of any reduction 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 Year Four. As such, 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 the third quarter of Demonstration Year Three and in December 2009, the second quarter of Demonstration Year Four.

During Demonstration Year Four, the total number of co-payments required by all health plans decreased from the first and second parts of Demonstration Year Three (from 104 to 33 and from 40 to 33). However, co-payments increased in Demonstration Year Four compared to December 2009 (29 to 33).

Table 4 Number of Co-payments by Type of Service by Demonstration Year						
Type of Service	Year One	Year Two	Year Three			Year Four
			(July-Dec 08)	(Jan-Nov 09)	(Dec 09)	
Chiropractic	10	0	8	4	3	3
Hospital Inpatient: Behavioral Health	11	1	8	4	3	4
Hospital Inpatient: Physical Health	7	1	8	4	3	4
Podiatrist	10	0	7	3	3	3
Hospital Outpatient Services (Non-Emergency)	7	1	7	3	3	2
Hospital Outpatient Surgery	7	1	8	4	3	2
Mental Health	7	3	6	2	1	4
Home Health	4	1	8	4	3	3
Lab/X-Ray	5	1	7	3	3	2
Dental	4	4	4	0	0	2
Vision	4	0	5	1	1	2
Primary Care Physician	0	0	5	1	0	0
Specialty Physician	1	1	6	2	1	0
ARNP / Physician Assistant	0	0	5	1	0	0
Clinic (FQHC, RHC)	0	0	6	2	1	0
Transportation	5	5	6	2	1	2
Total Number of Required Co-payments	**82**	**19**	**104**	**40**	**29**	**33**

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year. Year Four has now been separated into two sections, January 2010 and May 2010, to reflect the loss of the Total Health Choice benefit package as a choice.

Table 5 Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year							
	Year One	Year Two	Year Three			Year Four	
			July-Dec	Jan-Nov	Dec	Jan	May
Total Number of Benefit Packages	**28**	**30**	**28**	**24**	**20**	**20**	**19**
Total Number of Benefit Packages Requiring No Co-payments	**12**	**16**	**20**	**20**	**17**	**16**	**15**
Percent of Benefit Packages Requiring No Co-payments	**43%**	**53%**	**71%**	**83%**	**85%**	**80%**	**79%**

Table 6 displays the number of Demonstration Year Four benefit packages not requiring co-payments by population and area, and has been split into two time periods to reflect the loss of the Total Health Choice benefit package as a choice. The table 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 & Area 4th Quarter of Demonstration Year Four			
Target Population	List of Counties in Each Demonstration Area	Number of Benefit Packages Not Requiring Co-payments	
		Jan	May
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	3	3
SSI (Aged and Disabled)	Broward	6	5
TANF (Children and Families)	Duval, Baker, Clay and Nassau	1	1
TANF (Children and Families)	Broward	6	5

In Year Four 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 six different expanded services offered by the health plans during this contract year. The two most popular expanded services offered were the same as Demonstration Year Two and Three: the over-the-counter (OTC) drug benefits and the adult preventive dental benefits. The expanded services available to beneficiaries include:

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

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 percent.

The PET submission procedure for Demonstration Year Four was similar to that of the three previous years. The benefit packages for Year Three of the demonstration were extended until December 31, 2009. This extension was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's

benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Four of the demonstration. The updated version of the data book was released by the Agency on September 15, 2009, and the new PET was e-mailed to the health plans on September 17, 2009. The health plans' Year Four benefit packages had an effective date of January 1, 2010.

3. Grievance 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 beneficiary 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 for enrollees in a FFS PSN (as described below and on the following page). 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 beneficiaries face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in our quarterly reports. The Agency also uses this information internally, as part of the Agency's continuous improvement efforts.

Grievances & Appeals

Table 7 provides the number of grievances and appeals by health plan type for the third quarter of Demonstration Year Four.

Table 7
Grievances and Appeals
April 1, 2010 – June 30, 2010

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	76	28	56	135	275,832

*unduplicated enrollment count

The number of grievances reported by PSNs increased in the first and second quarter of Demonstration Year Four, from 62 in the fourth quarter of Demonstration Year Three, to 127 in the first quarter and to 189 in the second quarter of Demonstration Year Four. As noted in the second quarterly report for Demonstration Year Four, this increase was due to an increase in grievances for one PSN, whose membership increased significantly (by 45%) between June 2009 and September 2009, and by 9% between September and December 2009, and who had changed transportation vendors. There was a decrease in the number of grievances reported by both PSNs and HMOs in the third quarter of Demonstration Year Four, and the number of grievances continued to drop in the fourth quarter of Demonstration Year Four for the PSNs. It appears that the issues contributing to the large increase in grievances for one PSN in the first and second quarters have largely been resolved. These issues were closely monitored by the Agency to ensure timely resolution.

Medicaid Fair Hearings (MFHs)

Table 8 provides the number of MFHs requested during the quarter ending June 30, 2010. MFHs 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 MFH process. Of the 14 MFH requests, 11 were related to denial of benefits/services, one was related to denial of prescription medication, and two were related to the reduction/suspension/ termination of benefits/services. Seven hearings were held, four of which were favorable to the beneficiary and three of which upheld the health plans' decisions. The members withdrew from three hearings and four hearings were pending at the end of this quarter.

Table 8 Medicaid Fair Hearing Requests April 1, 2010 – June 30, 2010	
PSN	2
HMO	12

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances have been submitted to the SAP or the BAP for this quarter.

Table 9 provides the number of requests to BAP and SAP for the quarter ending June 30, 2010. The one request to the Subscriber Assistance Program that was received and pending at the end of the previous quarter was withdrawn.

Table 9 BAP and SAP Requests April 1, 2010 –June 30, 2010	
BAP	0
SAP	0

4. Complaint/Issue Resolution Process

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 beneficiaries, 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 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, implemented October 1, 2007, that was 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 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.

This quarter, the Agency received 7 complaints/issues related to PSNs and received 46 complaints/issues related to HMOs, for a total of 53 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO). 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.

During this quarter, all of the PSN complaints/issues were from members. Member issues included needing assistance in accessing providers and assistance in getting services authorized.

The majority of the HMO complaints/issues this quarter were related to member issues, with the majority being related to members needing assistance with finding/seeing a provider and getting authorization for services. Other complaints/issues included members needing assistance because they were being mistakenly billed or balance-billed. Provider issues included payment delays/denials. The Agency continues to monitor enrollment complaint issues related to enrollment data provided to the health plans by the Fiscal Agent.

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

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. On-Site Surveys & Desk Reviews

During this quarter, the Agency conducted on-site surveys of the health plans. The Agency survey staff consisted of health care analysts, nurses, and behavioral health care experts. The Agency staff approved initial networks for two health plan (HMO) applicants.

The Agency staff conducted reviews of two new health plan (HMO) applicants (Preferred Care Partners and Simply Healthcare Plans), and five current contracted health plans (HMOs). The reviews consisted of reviewing policies and procedures, interviewing health plan staff, observing member services, and claims review.

The Agency's Bureau of Medicaid Program Integrity conducted separate on-site Fraud and Abuse Compliance reviews of three current contract health plans (HMOs), and two health plan (HMO) applicants. The reviews consisted of review of policy and procedures and interviews with plan staff regarding on-going plan fraud and abuse activities.

The Agency continued to conduct desk-review health plan provider networks for adequacy, review medical and behavioral health policies and procedures, review and approve performance improvement projects, quality improvement plans, disease management programs, member materials, and handbooks.

The Agency's External Quality Review Organization (EQRO) vendor was contracted to strengthen the health plan contract review tool. This quater additional refinements were completed during the health plan on-site reviews. The health plan contract review tool was finalized this quarter.

Table 10 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 10 On-site Survey Categories
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Greivances & Appeals
➲ Financials

B. Choice Counseling Program

Overview

The demonstration has completed the fourth quarter of Year Four. A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health care by providing them with the information they need to make the most informed decisions about health plan choices.

The following are key events and efforts that have occurred during the fourth quarter:

- Implementation of the new Choice Counseling Vendor, Automated Health Systems (AHS), was successfully completed during this quarter. AHS assumed full responsibility of all duties effective June 18, 2010.
- The performance of the previous Choice Counseling Vendor contract, Affiliated Computer Services (ACS), improved during the first two months of the this quarter, but declined in the final month during the transition from ACS to AHS.
- Fiscal Agent Implementation Challenges & Resolutions: The Agency continues to work with the Florida Medicaid Fiscal Agent (HP Enterprise Services, LLC (HP)) on efforts to resolve system conflicts and errors related to data transfers to the new Choice Counseling Vendor.

Current Activities

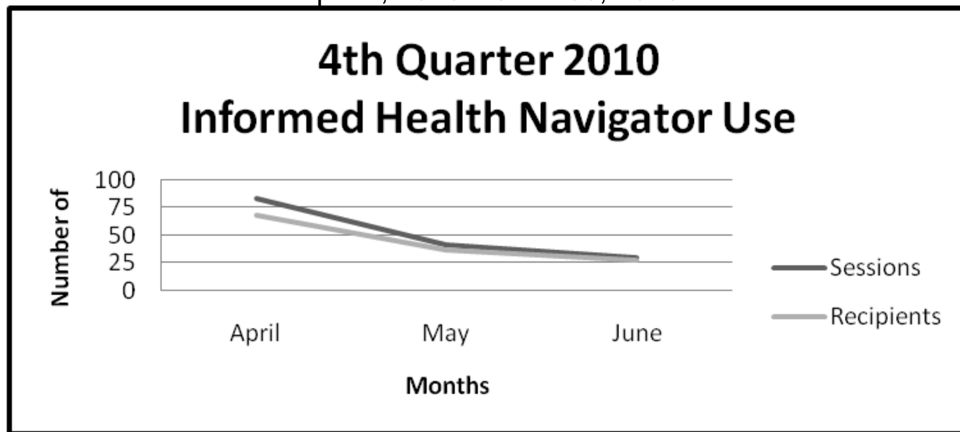
1. Informed Health Navigator Solution (Navigator)

Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets his or her prescribed drug needs. This additional information is provided to assist the beneficiary in making a plan selection. The Navigator system contains each health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator pulls the prescription data and provides detailed information on how each plan meets the beneficiary's current prescribed drug needs. This detail allows the counselor to provide more information to the beneficiary and does not require that the individual remember his or her current medications. The Navigator system also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries who do not have prior claims history or have received a new prescription not yet in their records. The Choice Counselor's role is to share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications.

During the beginning of this quarter, there was a decrease in Navigator usage compared to the last month of the previous quarter. However, usage of the Navigator continued to decline over the remainder of this quarter. The decrease in call volume was a contributing factor to the decreased usage of Navigator.

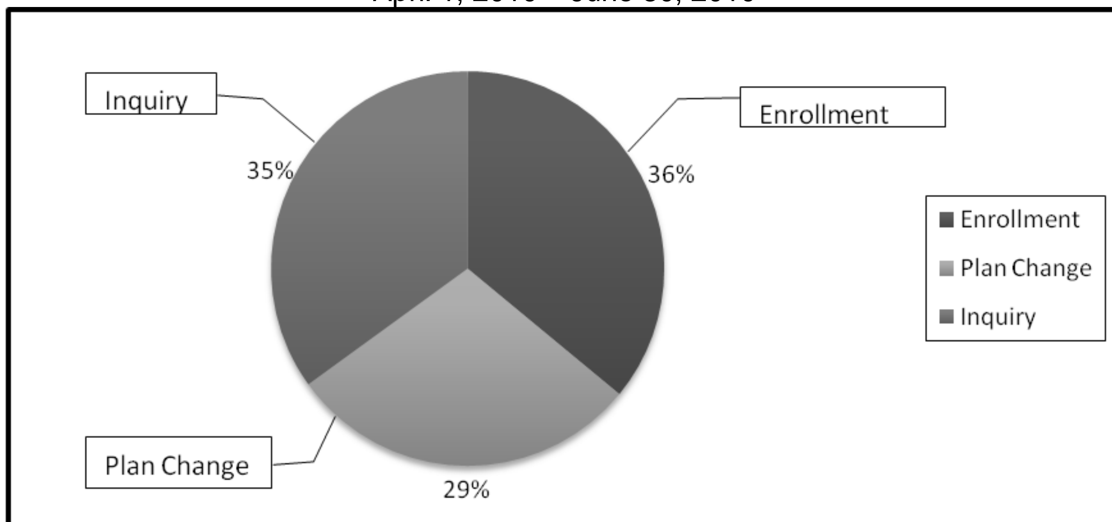
Chart A provides the Navigator statistics for the fourth quarter of Demonstration Year Four. “Sessions” represents the number of times the Navigator program was utilized, and “Recipients” represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate session and recipient. This quarter, the total usage of the Navigator was 154 sessions and 131 unique recipients utilized the system.

Chart A
Navigator Use by Session & Unique Recipient
April 1, 2010 – June 30, 2010



Choice Counseling captures data to indicate whether a person is using the Navigator 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 over this quarter.

Chart B
Navigator Use by Call Type
April 1, 2010 – June 30, 2010



Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The Call Center does have a set day of the week when the Choice Counselors offer the survey to callers. This helps to reach the goal of at least 400 completed surveys each month. During this quarter, a total of 876 beneficiaries completed the automated survey.

The Customer Survey ratings consider 100% to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. 100% or 9 reflects a truly satisfied caller. The scoring range translates into the following percentages:

Rating	%	Rating	%	Rating	%
1	00.00%	4	37.50%	7	75.00%
2	12.50%	5	50.00%	8	87.50%
3	25.00%	6	62.50%	9	100%

If a beneficiary scores a category between 1 and 3, the caller has the ability to leave a comment about why they left a low score. The caller also has the ability to request a supervisor call back so the beneficiary can provide even more feedback on his or her experience.

The scores for the amount of time the beneficiary had to “wait on hold” improved during the first two months of this quarter, but declined during the final month. The decline in June is directly related to the ACS to AHS transition efforts. The survey results were primarily based on ACS’s performance as the new Choice Counseling Vendor assumed full responsibility of all duties effective June 18, 2010. The Agency expects to see significant improvement over the next few months.

Table 11 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) during this quarter. The number of beneficiaries participating in the Survey this quarter was as follows: April - 430, May - 378, and June - 68 (totaling 876).

The top three survey categories for this quarter were: “Being treated respectfully,” “Quickly understood reason” and “Ability to explain clearly.” The three lowest scoring survey categories were: “Amount of time you waited,” “Ease of understanding information” and “How helpful do you find this counseling to be.”

Table 11 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
April	**May**	**June**
How helpful do you find this counseling to be		
83.7%	84.9%	79.4%
Amount of time you waited		
79.5%	82.5%	48.5%
Ease of understanding information		
75.7%	80.3%	57.4%
Likelihood to recommend		
91.4%	94.4%	83.8%
Overall service provided by Counselor		
94.7%	94.2%	85.3%
Quickly understood reason		
95.6%	96.0%	86.8%
Ability to help choose plan		
91.4%	91.0%	80.9%
Ability to explain clearly		
93.5%	95.2%	88.2%
Confidence in the information		
90.5%	92.3%	85.3%
Being treated respectfully		
95.8%	96.6%	89.7%

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. and Friday 8:00a.m. – 7:00p.m., providing no Saturday hours. The Call Center had an average of 28.8 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls during this quarter. The change in staffing was related to the ACS to AHS transition, as several of the Choice Counselors were hired by the new vendor. On June 18, 2010, AHS began operations with 43 FTE employees in the Call Center.

The Choice Counseling Call Center received 61,686 calls during this quarter. This represents approximately a 6% increase in call volume from the previous quarter. The Choice Counseling Call Center continued to show improvement in performance during this quarter. The average call talk time decreased slightly from 8.8 minutes to 8.2

minutes, which is consistent with the historical average of 8 minutes. The call abandonment rate decreased from 9.3% during the third quarter to 7.3% for this quarter. During the implementation of the new vendor, AHS, the Agency took several steps to assure future call center performance remains consistent.

- The new system, Health Track, was designed to improve counselor efficiency, by automating several routine processes.
- System coding was implemented to address some file transfer issues to reduce enrollment and data failures which contribute to duplicate calls to the center.
- Saturday hours were implemented to allow an additional day for inbound calls, as well as conducting proactive outbound campaigns to reach identified beneficiaries.
- The use of Field Counselors has been modified to gain efficiencies in group and individual sessions, freeing them to engage in being more proactive in outreach.
- The National Change of Address (NCOA) database is now used to improve address verification for beneficiary communication.

Table 12 compares the call volume of incoming and outgoing calls during the fourth quarter of Demonstration Year Three and Year Four.

Table 12
Comparison of Call Volume for Fourth Quarter
(Demonstration Year Three & Year Four)

Type of Calls	Apr. 2009	Apr. 2010	May 2009	May 2010	Jun. 2009	Jun. 2010	Year 3 4th Quarter Totals	Year 4 4th Quarter Totals
Incoming Calls	25,206	21,833	24,163	20,583	33,250	19,270	**82,619**	**61,686**
Outgoing Calls	3,963	3,191	3,090	2,515	6,016	1,107	**13,069**	**6,813**
Totals	29,169	25,024	27,253	23,098	39,266	20,377	**95,688**	**68,499**

3. Mail

Outbound Mail

During this quarter, the Choice Counseling Vendor mailroom mailed the following:

- New-Eligible Packets (mandatory and voluntary) 21,399
- Auto-Assignment Letters 18,361
- Confirmation Letters 15,926
- Open Enrollment Packets 29,999
- Transition Packets (mandatory and voluntary) 381
- Plan Transfer Letters (mandatory and voluntary) 0

The amount of returned mail increased this quarter to 5.6%, which is slightly above the estimated 3-5% contract standard. When return mail is received, the Choice Counseling staff accesses the Choice Counseling Vendor‘s enrollment system and the Florida Medicaid Management Information System (FMMIS) to try to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team also assists in efforts to contact the beneficiary. The Choice Counseling staff re-address the packets or letters when possible, with the newly eligible mailings taking top priority. The implementation of the National Change of Address database should assist with decreasing the volume of return mail.

Inbound Mail

During this quarter, the Choice Counseling Vendor processed the following:

- Plan Enrollments 1,004
- Plan Changes 141

The percentage of enrollments processed through the mail-in enrollment forms has remained 2-5% of total enrollments. The Agency is reviewing the enrollment form to evaluate whether the mail-in enrollment option is viable or not. The Agency expects to implement an online enrollment application during the first quarter of demonstration Year Five.

The fourth quarter update of Florida Medicaid's Welcome Brochures and Open Enrollment flyers was completed during this quarter and distribution began on June 18, 2010.

4. Face-to-Face/Outreach and Education

During this quarter, the Field Choice Counseling Outreach Team continued to be available in the Area Offices to assist those beneficiaries that are having trouble reaching the Call Center or have additional questions.

Table 13 provides the Choice Counseling Field activities for the fourth quarter of Demonstration Year Four:

Table 13
Choice Counseling Outreach Activities

Field Activities	4th Quarter – Year 4
Group Sessions	552
Private Sessions	69
Home Visits & One-On-One Sessions	106
No Phone List	471
Outbound Phone List	3,018
Enrollments	2,992
Plan Changes	145

The Field Choice Counseling Outreach Team efforts during this quarter continued to focus on face-to-face counseling to provide more opportunities for Medicaid beneficiaries to meet with Field Choice Counselors.

Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff randomly calls beneficiaries who were served by Field Choice Counselors. The monitors ask four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 14 provides the responses, in percentage, from 102 beneficiaries who participated in the surveys from April – June 2010. The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 14 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	99.67%
Felt the information provided by the Choice Counselor helped them make an informed decision	99.67%
The information was explained in a way that made it easy to understand	99.67%
The Choice Counselor was friendly/courteous	100.00%

The Field Choice Counselors continued their efforts to better reach the special needs population. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups have included providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities, and other types of community based organizations that serve these population groups.

The Mental Health Unit

During the second quarter of Demonstration Year Three, the Outreach/Field team created the Mental Health Unit to provide more direct support to beneficiaries who access mental health services. Those beneficiaries in the special needs community remain a high priority within the unit. The efforts made earlier to build relationships with the organizations and people who serve these individuals are yielding positive results. The Mental Health Unit continues to expand its efforts, now acting in a community relations role promoting community partnerships and taking the lead on event planning.

The Mental Health Unit completed 28 staff presentations for the community partners.

This quarter was highlighted by 7 Health Fairs, resulting in 517 contacts at the events.

To date, over 120 organizations have been identified and a contact attempt was made by a Field Choice Counselor. As a result, the Mental Health Unit has established

several key relationships and developed strong working partnerships. Some of the large organizations include:

- Susan B. Anthony Recovery Center (Broward);
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County;
- Mental Health Resource Center and River Region Human Services in Duval; and
- Clay County Behavioral Health.

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 supervisor, and a Licensed Practical Nurse that have both earned their Choice Counseling certification.

Summary of cases taken by the Special Needs Unit

Case referrals and review requests/inquiries decreased during this quarter. Only ten (10) new case referrals were received and processed by the Special Needs Unit during this quarter.

A 'case referral' is when a Choice Counselor refers a case to the Special Needs Unit through the Choice Counseling Vendor , ACS, enrollment system (BESST) 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.

This quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as noted in Table 15.

Table 15
Number of Referrals and Case Reviews Completed
April 1, 2010 – June 30, 2010

	April	May	June
Case Referrals	4	1	5
Case Reviews	0	0	0

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 beneficiaries on how to access care in a managed care environment;
- Development of health related reference guides to increase the Choice Counselors knowledge of Medicaid services (which is ongoing);
- Participation in the development of the Navigator Choice Counseling script; and
- Development and implementation of a tracking log to capture the number and type of counselor's verbal inquiries, which was done during the first portion of this quarter.

6. New Eligible Self Selection Data[3]

The new eligible numbers for self-selection have not been reported since July 2008 due to issues with daily file and month end processing transfers from Florida Medicaid's Fiscal Agent (HP Enterprises) and the Choice Counseling Vendor. The Agency, the Choice Counseling Vendor (ACS) and HP have identified and created Customer Service Requests (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with FMMIS and the Choice Counseling Vendor's enrollment system (BESST). HP will continue to work through the program changes. Some improvements have been made to the daily and monthly files that transfer from HP to the Choice Counseling Vendor and some issues have been resolved. When the program changes are complete, and the month end information comes through consistently and correctly, it will allow the Vendor to determine the new eligible's and ensure the enrollment will be more successful. Prior to the Fiscal Agent transition, the Choice Counseling Vendor exceeded the self-selection standard. The Agency fully expects when the corrections are in place, the Choice Counseling Vendor will not only meet, but exceed the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the Call Center, Medicaid headquarters or the Medicaid Area Office. In August of 2007, the Agency and the Choice Counseling Vendor implemented an automated beneficiary survey where complaints against the Choice Counseling Program can be filed and voice comments can be recorded to describe what occurred on the call.

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[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 beneficiaries who choose their own plan and the term *"assigned"* is now used for beneficiaries who do not choose their own plan.

During this quarter, there was one (1) complaint received related to the Choice Counseling Program. The complaint was related to an enrollment processing error, where the enrollment requested by the beneficiary was not completed by the system. The case was referred to the Agency for resolution. The Agency requested that the Fiscal Agent perform file maintenance to fulfill the beneficiaries original enrollment request and report the update to the Choice Counseling system. The request was completed successfully.

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 beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Choice Counselor's ability to explain health plan choices indicate that more than 96% are satisfied with the Choice Counseling experience (both Field and Call Center). The Choice Counseling Vendor continues to focus on improving communication between the Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

The Choice Counseling Vendor distributes individual report cards to each Choice Counselor on their performance. Survey scores and beneficiary comments are also 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 requiring coaching or training.

In addition to external feedback, the Choice Counseling Vendor has implemented an employee feedback e-mail system that allows call center Choice Counselors and Field Choice Counselors to provide immediate comments on issues or barriers that they encounter as part of their daily work. It may be hard at the end of a shift to remember the issues they encountered and this anonymous e-mail box allows the Choice Counselors to send information, which is reviewed by management and shared with the Agency.

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 e-mail boxes, which enables the Agency staff and vendor's staff to share information directly from the system to resolve difficult cases, and 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.

9. Summary

The Agency, the Choice Counseling Vendor and HP remain committed to identifying, prioritizing and resolving challenges related to the Fiscal Agent transition and new data transfer issues. Additional staffing resources were added to the HP systems team, with the sole purpose of correcting identified issues and continuing a root cause analysis, as it relates to the demonstration.

The Choice Counseling Vendor continues to work hard to provide excellent customer service to the beneficiaries and has continued to play a key role in identifying and resolving issues as they come up in all areas of their organization. The beneficiary is treated with the highest regard and given the opportunity to make plan selections and changes through whatever process is necessary to help them (including Good Cause plan changes).

The completion of transitioning the Choice Counseling Program to the new vendor has helped restore consistency in operational performance. All Service Level Agreements are being met or exceeded.

The Agency will continue to conduct periodic public meetings to gain beneficiary and community input. Also, during Year Five of the demonstration, the Agency will partner with the new vendor to conduct training on the new web enrollment application that can be used by beneficiaries to learn about available plan options and complete enrollments.

The Agency has been in contact with federal CMS to discuss the Fiscal Agent transition changes as it relates to Choice Counseling Self-Selection rates. The Agency will continue to communicate with federal CMS as progress is made.

The Agency believes that the Choice Counseling Program is well on the way to resuming its exceptional performance standards.

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 beneficiaries 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 beneficiaries 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, enrollment in health plans was based on this transitional process. Specifically, the July 2006 transition period focused on enrollment of newly eligible beneficiaries as well as half of the MediPass population. Beneficiaries were given 30 days to select a plan. If the beneficiary did not choose a plan, the Choice Counselor assigned them to one. The earliest date of enrollment in a demonstration health plan was September 1, 2006. During the second, third, and fourth quarters of operation (Demonstration Year One), enrollment in the demonstration increased greatly as more existing Medicaid beneficiaries 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 beneficiaries into a demonstration health plan. The beneficiaries were transitioned from HMOs, MediPass, and MPNs. The transition schedule for Baker, Clay and Nassau Counties was as follows:

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

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

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

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 URL:

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 April 1, 2010, and ending June 30, 2010. This section contains the following enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- 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 (9) HMOs and four (4) fee-for-service PSNs. Total Health Choice was acquired by Simply Healthcare, and its Reform HMO in Broward County ceased operations on June 1, 2010. Total Health Choice Reform enrollees were transitioned into the Better Health Medicaid Reform PSN, of which Simply Healthcare is a minority owner. In addition, a new specialty plan for Medicaid Reform enrollees with HIV/AIDS, Positive Healthcare, began accepting voluntary enrollments on May 1, 2010.

There are two categories of Medicaid beneficiaries 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 beneficiaries' eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 16 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 16 Medicaid Reform 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)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled – Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled – Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Increase From Prev. Qtr.	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 beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 17 on the following page for the Fiscal Year 2009-10, Fourth Quarter Medicaid Reform Enrollment Report.

Table 17 Medicaid Reform Enrollment Report (Fiscal Year 2009-10, 4th Quarter)									
Plan Name	Plan Type	Number of TANF Enrolled	# SSI Enrolled			Total Number Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	Percent Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A and B				
Freedom Health Plan	HMO	1,835	314	1	49	**2,199**	**0.76%**	1,008	118.15%
Humana	HMO	6,906	1,870	6	217	**8,999**	**3.13%**	10,492	-14.23%
Medica	HMO	1,283	197	0	41	**1,521**	**0.53%**	988	53.95%
Molina Healthcare	HMO	18,496	3,156	14	320	**21,986**	**7.65%**	20,300	8.31%
Positive Healthcare	HMO	1	21	0	0	**22**	**0.01%**	0	N/A
Sunshine	HMO	87,230	8,685	10	657	**96,582**	**33.60%**	89,908	7.42%
Total Health Choice	HMO	3,047	133	2	29	**3,211**	**1.12%**	33,637	-90.45%
United Healthcare	HMO	7,917	985	0	52	**8,954**	**3.11%**	9,545	-6.19%
Universal Health Care	HMO	15,723	2,048	8	289	**18,068**	**6.29%**	17,389	3.90%
HMO Total	**HMO**	**142,438**	**17,409**	**41**	**1,654**	**161,542**	**56.20%**	**183,267**	**-11.85%**
Better Health, LLC	PSN	30,722	4,360	11	541	**35,634**	**12.40%**	8,092	340.36%
CMS	PSN	3,817	3,184	0	13	**7,014**	**2.44%**	6,884	1.89%
First Coast Advantage	PSN	42,380	6,425	3	858	**49,666**	**17.28%**	49,468	0.40%
SFCCN	PSN	29,264	3,827	6	500	**33,597**	**11.69%**	31,833	5.54%
PSN Total	**PSN**	**106,183**	**17,796**	**20**	**1,912**	**125,911**	**43.80%**	**96,277**	**30.78%**
Reform Enrollment Totals		**248,621**	**35,205**	**61**	**3,566**	**287,453**	**100.00%**	**279,544**	**2.83%**

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

The enrollment figures for this quarter reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-demonstration health plans to demonstration health plans. There were a total of 287,543 beneficiaries enrolled in the demonstration during this quarter. There were thirteen (13) demonstration health plans with market shares ranging from 0.01 percent to 33.60 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter, the demonstration remained operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 18 on the following page.

Table 18 Number of Reform Health Plans in Demonstration Counties April 1, 2010 – June 30, 2010		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**0**
Broward	**8**	**3**
Clay	**2**	**0**
Duval	**3**	**2**
Nassau	**2**	**0**

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 19 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 19 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)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	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, shown as in Table 20 and located on the following page.

Table 20
Medicaid Reform Enrollment by County Report
(Fiscal Year 2009-10, 4th Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Sunshine	HMO	Baker	2,607	233	0	13	**2,853**	**83.42%**	2,800	1.89%
United Healthcare	HMO	Baker	482	78	0	7	**567**	**16.58%**	622	-8.84%
Total Reform Enrollment for Baker			**3,089**	**311**	**0**	**20**	**3,420**	**100.00%**	**3,422**	**-0.06%**
Freedom Health Plan	HMO	Broward	1,835	314	1	49	**2,199**	**1.41%**	1,008	118.15%
Humana	HMO	Broward	6,906	1,870	6	217	**8,999**	**5.76%**	10,492	-14.23%
Medica	HMO	Broward	1,283	197	0	41	**1,521**	**0.97%**	988	53.95%
Molina Healthcare	HMO	Broward	18,496	3,156	14	320	**21,986**	**14.08%**	20,300	8.31%
Positive Healthcare	HMO	Broward	1	21	0	0	**22**	**0.01%**	0	N/A
Sunshine	HMO	Broward	30,515	2,625	5	170	**33,315**	**21.33%**	30,952	7.63%
Total Health Choice	HMO	Broward	3,047	133	2	29	**3,211**	**2.06%**	33,637	-90.45%
Universal Health Care	HMO	Broward	9,585	1,459	4	203	**11,251**	**7.20%**	11,037	1.94%
Better Health, LLC	PSN	Broward	30,722	4,360	11	541	**35,634**	**22.82%**	8,092	340.36%
CMS	PSN	Broward	2,340	2,074	0	11	**4,425**	**2.83%**	4,338	2.01%
SFCCN	PSN	Broward	29,264	3,827	6	500	**33,597**	**21.51%**	31,833	5.54%
Total Reform Enrollment for Broward			**133,994**	**20,036**	**49**	**2,081**	**156,160**	**100.00%**	**152,677**	**2.28%**
Sunshine	HMO	Clay	9,392	861	0	61	**10,314**	**73.44%**	8,868	16.31%
United Healthcare	HMO	Clay	3,473	245	0	13	**3,731**	**26.56%**	3,744	-0.35%
Total Reform Enrollment for Clay			**12,865**	**1,106**	**0**	**74**	**14,045**	**100.00%**	**12,612**	**11.36%**
Sunshine	HMO	Duval	40,299	4,544	5	377	**45,225**	**41.93%**	42,718	5.87%
United Healthcare	HMO	Duval	2,995	549	0	23	**3,567**	**3.31%**	4,057	-12.08%
Universal Health Care	HMO	Duval	6,138	589	4	86	**6,817**	**6.32%**	6,352	7.32%
CMS	PSN	Duval	1,477	1,110	0	2	**2,589**	**2.40%**	2,546	1.69%
First Coast Advantage	PSN	Duval	42,380	6,425	3	858	**49,666**	**46.05%**	49,468	0.40%
Total Reform Enrollment for Duval			**93,289**	**13,217**	**12**	**1,346**	**107,864**	**100.00%**	**105,141**	**2.59%**
Sunshine	HMO	Nassau	4,417	422	0	36	**4,875**	**81.74%**	4,570	6.67%
United Healthcare	HMO	Nassau	967	113	0	9	**1,089**	**18.26%**	1,122	-2.94%
Total Reform Enrollment for Nassau			**5,384**	**535**	**0**	**45**	**5,964**	**100.00%**	**5,692**	**4.78%**
Reform Enrollment Totals			**248,621**	**35,205**	**61**	**3,566**	**287,453**		**279,544**	**2.83%**

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

During this quarter, there was an enrollment of 3,420 beneficiaries in Baker County, 156,160 beneficiaries in Broward County, 14,045 beneficiaries in Clay County, 107,864 beneficiaries in Duval County, and 5,964 beneficiaries in Nassau County. There were two (2) Baker County health plans with market shares ranging from 16.58 percent to 83.42 percent, eleven (11) Broward County health plans with market shares ranging from 0.01 percent to 22.82 percent, two (2) Clay County health plans with market shares ranging from 26.56 percent to 73.44 percent, five (5) Duval County health plans with market shares ranging from 2.40 percent to 46.05 percent, and two (2) Nassau County health plans with market shares ranging from 18.26 percent to 81.74 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 21 and 22 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 beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those beneficiaries who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 21 provides a description of each column in this report.

Table 21
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 beneficiaries who voluntarily enrolled in a plan during the current reporting quarter
Developmental Disabilities	The number of unique beneficiaries diagnosed with a developmental disability who voluntarily enrolled in a plan during the current reporting quarter
Dual-Eligibles	The number of unique dual-eligible beneficiaries who voluntarily enrolled in a plan during the current reporting quarter
Total	The total number of voluntary population beneficiaries who enrolled in Medicaid Reform during the current reporting quarter
Medicaid Reform Total Enrollment	The total number of Medicaid Reform beneficiaries enrolled in the health plan during the reporting quarter

Table 22 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 22
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2009-10, 4th Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations: Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		Medicaid Reform Total Enrollment
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Freedom Health Plan	HMO	Broward	9	7	2	1	24	26	**69**	**3.14%**	**2,199**
Humana	HMO	Broward	0	66	0	30	0	223	**319**	**3.54%**	**8,999**
Medica	HMO	Broward	3	5	1	4	21	20	**54**	**3.55%**	**1,521**
Molina Healthcare	HMO	Broward	16	126	7	39	62	272	**522**	**2.37%**	**21,986**
Positive Healthcare	HMO	Broward	0	0	0	0	0	0	**0**	**0.00%**	**22**
Sunshine	HMO	Baker	1	34	0	2	3	10	**50**	**1.75%**	**2,853**
Sunshine	HMO	Broward	23	137	3	15	44	131	**353**	**1.06%**	**33,315**
Sunshine	HMO	Clay	12	67	0	4	11	50	**144**	**1.40%**	**10,314**
Sunshine	HMO	Duval	47	461	8	59	77	305	**957**	**2.12%**	**45,225**
Sunshine	HMO	Nassau	2	40	0	4	12	24	**82**	**1.68%**	**4,875**
Total Health Choice	HMO	Broward	1	43	1	0	4	27	**76**	**2.37%**	**3,211**
United Healthcare	HMO	Baker	0	4	0	1	0	7	**12**	**2.12%**	**567**
United Healthcare	HMO	Clay	2	29	0	5	1	12	**49**	**1.31%**	**3,731**
United Healthcare	HMO	Duval	0	97	0	13	0	23	**133**	**3.73%**	**3,567**
United Healthcare	HMO	Nassau	0	6	2	7	0	9	**24**	**2.20%**	**1,089**
Universal Health Care	HMO	Broward	5	67	0	11	27	180	**290**	**2.58%**	**11,251**
Universal Health Care	HMO	Duval	13	57	0	4	20	70	**164**	**2.41%**	**6,817**
HMO Total	**HMO**		**134**	**1,246**	**24**	**199**	**306**	**1,389**	**3,298**	**2.04%**	**161,542**
Better Health, LLC	PSN	Broward	13	212	3	60	42	510	**840**	**2.36%**	**35,634**
CMS	PSN	Broward	2	53	7	168	0	11	**241**	**5.45%**	**4,425**
CMS	PSN	Duval	5	56	3	89	0	2	**155**	**5.99%**	**2,589**
First Coast Advantage	PSN	Duval	23	675	3	141	51	810	**1,703**	**3.43%**	**49,666**
SFCCN	PSN	Broward	24	433	6	69	44	462	**1,038**	**3.09%**	**33,597**
PSN Total	**PSN**		**67**	**1,429**	**22**	**527**	**137**	**1,795**	**3,977**	**3.16%**	**125,911**
Reform Enrollment Totals			**201**	**2,675**	**46**	**726**	**443**	**3,184**	**7,275**	**2.53%**	**287,453**

D. Opt Out Program

Overview

In January 2006, the Agency began developing a process to ensure all beneficiaries who have access to employer sponsored insurance (ESI) are provided the opportunity to opt out of Medicaid and select an ESI plan. The Agency decided to contract with Health Management Systems, Inc. (HMS), to administer the Opt Out Program. HMS submitted its proposal on March 31, 2006, which included a description of the Opt Out process for contacting beneficiaries, contacting employers, establishing the premium payment process and maintaining the Opt Out Program database. The Agency entered into a contract with HMS to conduct the Opt Out Program on July 1, 2006.

In April 2006, the Agency began planning outreach activities for employers located in Broward and Duval Counties. The Agency mailed letters to major employers in the pilot counties beginning in June 2006, notifying them of the Medicaid Reform Opt Out Program and providing them a summary of the Opt Out process. The Agency conducted nine conference calls with several large employers to answer questions and request they accept premiums on behalf of Opt Out enrollees.

An Invitation to Negotiate was released during the third quarter of Demonstration Year Two on January 22, 2008, for Third Party Liability Recovery Services that included the Opt Out Program. ACS State Healthcare, LLC (ACS) was awarded the contract and took over administration of the Opt Out Program effective November 1, 2008. The contract with the former vendor, HMS, expired on October 30, 2008. In conjunction with ACS, the Agency ensured that the vendor transition was smooth and seamless for all program participants.

Description of Opt Out Process

Medicaid beneficiaries interested in the Opt Out Program are either referred to the current vendor by the Choice Counseling Program or they contact the vendor directly. The beneficiary is provided the toll-free number for the Opt Out Program so he or she may follow-up directly with the vendor if preferred. A new Referral form requesting employer information is completed over the phone with an Opt Out specialist or is sent to the beneficiary for completion. A release form is also sent to the beneficiary, giving the vendor permission to contact their employer.

After the signed release is received from the beneficiary, an Opt Out specialist sends the employer an Employer Questionnaire requesting the following information: Is health insurance available? Is the individual eligible for health insurance? What is the plan type? What is the insurance company? What is the premium amount and frequency? When is the open enrollment period?

After the required information from the employer is received, the Opt Out specialist follows up with the beneficiary to discuss the insurance that is available through their employer, how much the premium will be and how payment of the premium will be

processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the employer. After enrollment into the Opt Out Program, the beneficiary is sent an Enrollment Letter that confirms the beneficiary is enrolled in the Opt Out Program. The vendor then begins to process the premiums according to the required frequency. If the beneficiary is unable to enroll in the Opt Out Program (e.g., not open enrollment), the beneficiary is sent an Opt Out denial letter. The Opt Out database is then flagged to contact the beneficiary when he or she is eligible for the Opt Out Program.

The Opt Out database has been designed to comply with the Special Terms and Conditions of the waiver. The database tracks enrollee characteristics such as eligibility category, type of employer-sponsored insurance and type of coverage. The database will also track the reason for an individual disenrolling in an ESI Program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Current Activities

During this quarter, the vendor has continued to monitor program participants, ensuring that they continually meet the established eligibility requirements.

The Agency monitored the Opt Out process on a regular basis to ensure that it continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified during this quarter that required the Agency to make any changes to the process.

Opt Out Program Statistics

- 75 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 61 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the fourth quarter of Demonstration Year Four, there are currently 14 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

1. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the second quarter of Demonstration Year One on October 1, 2006. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.

2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on January 1, 2007. The father has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.
3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer’s health insurance plan effective December 31, 2007. As a result, the children were disenrolled from the Opt Out Program. The mother subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Demonstration Year Two on January 1, 2008. The children’s Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program (Item Number 11).
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. One of the children’s Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program. The mother re-enrolled the child in the Opt Out Program during the fourth quarter of Demonstration Year Three on May 1, 2009 (Item Number 36).
6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child’s Medicaid Opt Out medical premium to pay the employee

portion for their family coverage. The child's Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
8. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended on September 30, 2009. As a result, the children were disenrolled from the Opt Out Program. The mother re-enrolled her children in the Opt Out Program during the fourth quarter of Demonstration Year Four on April 1, 2010 (Item Number 45).
9. The caller began the process to enroll her two children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.
10. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.
11. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.
12. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for

enrollment was during the third quarter of Demonstration Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's Medicaid eligibility ended March 31, 2009 and as a result has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the fourth quarter of Demonstration Year Two and subsequently re-enrolled in the Opt Out Program effective May 1, 2008. The child's Medicaid eligibility ended March 31, 2009, and as a result, has been disenrolled from the Opt Out Program (Item Number 26).

13. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on February 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on February 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out Program.

16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on March 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The father lost his job effective September 26, 2008. As a result, the child has been disenrolled from the Opt Out Program.

17. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on March 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

18. The caller began the process to enroll his two children in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The father lost his job effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.
19. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual's Medicaid eligibility ended September 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended May 31, 2008. As a result, the child has been disenrolled from the Opt Out Program.
21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2010. As a result, the child has been disenrolled from the Opt Out Program.
22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended November 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
23. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.
25. The caller began the process to enroll in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.
27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2009. As a result, the children have been disenrolled from the Opt Out Program.
28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.
29. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on October 1, 2008. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual

coverage. The individual's Medicaid eligibility ended February 28, 2010. As a result, the individual has been disenrolled from the Opt Out Program.

30. The caller began the process to enroll her five children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on December 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The caller elected to disenroll her five children from the Opt Out Program due a change in health insurance companies offered through her employer. As a result, the children have been disenrolled from the Opt Out Program effective January 19, 2010.

31. The caller began the process to enroll her child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child's Medicaid eligibility ended November 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.

32. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended July 31, 2009. As a result, the children have been disenrolled from the Opt Out Program.

33. The caller began the process to enroll herself and her two children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended effective June 30, 2009. As a result, the mother and child were disenrolled from the Opt Out Program. The other child remained eligible and enrolled in the Opt Out Program. The mother has now discontinued her employer's health insurance plan due to high cost and now she is looking into private insurance. As a result, the other child has also been disenrolled from the Opt Out Program effective January 27, 2010.

34. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

The individual’s Medicaid eligibility ended December 31, 2009. As a result, the individual has been disenrolled from the Opt Out Program.

35. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on March 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

36. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the fourth quarter of Demonstration Year Three on May 1, 2009. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

37. The caller began the process to enroll in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on July 1, 2009. The individual has health insurance available through her employer. The individual has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual’s Medicaid eligibility ended May 31, 2010. As a result, the individual has been disenrolled from the Opt Out Program.

38. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on July 1, 2009. The father has health insurance available through his employer. The father elected to use his child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

39. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on August 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child’s Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.

40. The caller began the process to enroll in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on August 1, 2009. The individual has health insurance available through her employer. The individual elected to use her Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual is still enrolled in the Opt Out Program.

41. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on September 1, 2009. The

child's legal guardian has health insurance available through her employer. The child's legal guardian elected to use the child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

42. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on September 1, 2009. The father has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
43. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on September 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2009. As a result, they have been disenrolled from the Opt Out Program.
44. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the third quarter of Demonstration Year Four on January 1, 2010. The father has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
45. The caller began the process to enroll her three children in the Opt Out Program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the fourth quarter of Demonstration Year Four on April 1, 2010. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.

Table 23 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2010. Current Opt Out enrollment, as of June 30, 2010, is 14.

Table 23
Opt Out Statistics
September 1, 2006 – June 30, 2010

Eligibility Category	Effective Date of Enrollment	Type of Employer Sponsored Plan	Type of Coverage	Number of Beneficiaries Enrolled	Effective Date of Disenrollment	Reason for Disenrollment
C & F	10/01/06	Large Employer	Individual	1	02/28/07	Loss of Job
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/2010	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	02/28/10	Loss of Medicaid Eligibility
C & F	12/01/08	Large Employer	Family	5	1/19/2010	Disenrolled from Commercial Insurance
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	2 1	06/30/09 01/27/10	Loss of Medicaid Eligibility Disenrolled from Commercial Insurance
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	05/31/2010	Loss of Medicaid Eligibility
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	09/30/2009	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Small Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	3	12/31/2009	Loss of Medicaid Eligibility
SSI	01/01/10	Large Employer	Family	1	Still Enrolled	N/A
C & F	04/01/10	Large Employer	Family	3	Still Enrolled	N/A

*C & F - Children & Family
*SSI - Supplemental Security Income

E. Enhanced Benefits Account Program

Overview

The Enhanced Benefits Account Program (EBAP) component of Reform is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid beneficiaries who enroll in a Medicaid Reform Health Plan are eligible for the program. No separate application or process is required to enroll in EBAP.

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 worth of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (HP Enterprise Services, LLC (HP)) Pharmacy Point of Sale System currently maintained and managed by the HP subcontractor, Magellan (formally First Health). 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 beneficiary'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 Medicaid Reform 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

During this quarter, the Enhanced Benefits Call Center, located in Tallahassee, Florida, continued 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 operation hours are 8:00a.m. – 8:00p.m., Monday – Thursday, 8:00a.m. – 7:00p.m. on Friday, and 9:00a.m. – 1:00p.m. on Saturday.

The primary function of the call center is to answer all inbound calls relating to program questions, provide EBA account updates on credits earned/used, and assist beneficiaries with utilizing the web based OTC product list. Again this quarter, the majority of the calls (at ACS) were related to beneficiaries requesting information regarding their EBA account balances. Implementation of Automated Health Systems (AHS) as the new choice counselor and EB call center vendor included creation of an Automated Voice Response System (AVRS) which provides beneficiaries with their

balance after the beneficiary provides certain identifying information. On June 18, 2010, this feature was implemented successfully.

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

Table 24
Highlights of the Enhanced Benefits Call Center Activities
April 1, 2010 – June 30, 2010

Enhanced Benefits Call Center Activity	ACS April 2010	ACS May 2010	ACS June 1 – June 17, 2010	AHS June 18 – June 31, 2010	4th Quarter Totals
Calls Received	7,725	6,268	4,137	2,237	20,367
Calls Answered	7,452	6,011	3,687	2,174	19,324
Abandonment Rate	3.50%	4.10%	10.87%	2.80%	5.32%
Average Talk Time (minutes)	4.3	4.1	4.1	4.7	4.4
Calls Handled by the AVRS				1,618	
Enhanced Benefits Mailroom Activity					
EB Welcome Letters	10,952	10,792	27,039	11,220	60,003

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 Enhanced Benefits Information System (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 beneficiary who has activity for the month and a separate statement, sent at least once per year for beneficiaries who have a balance with no new activity.

System activities this quarter surrounded implementation of AHS as the new EB call center vendor. EBIS provides EBA balance data to AHS AVRS three times each week for each beneficiary that has an EBA credit balance. Implementation of the new AVRS option began on June 18, 2010; this new feature was successful and continues to be used by more beneficiaries each week.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during this quarter. There were 132,143 coupon statements mailed to beneficiaries. Seventy-three percent of calls received this quarter by ACS were primarily related to beneficiaries seeking current balance information. The counselors are able to provide up-to-date information to each beneficiary, covering the latest weekly balances.

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 Program.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel meeting was held on May 6, 2010. Program updates were provided to panel members. The next Panel meeting will be scheduled in August 2010.

6. Enhanced Benefits Statistics

As of June 30, 2010, 5,879 beneficiaries lost EBA eligibility for a total of $223,431.76 and no longer have access to those credits.

Table 25 provides the Enhanced Benefit Account Program statistics beginning April 1, 2010, and ending June 30, 2010.

Table 25
Enhanced Benefit Account Program Statistics

Fourth Quarter Activities – Year Four		April 2010	May 2010	June 2010
I.	Number of plans submitting reports by month in each county*	34 of 35	35 of 35	35 of 35
II.	Number of enrollees who received credit for healthy behaviors by month	37,055	31,563	34,512
III.	Total dollar amount credited to accounts by each month	$720,220.00	$644,857.50	$746,780.00
IV.	Total cumulative dollar amount credited through the end each month	$29,062,463.66	$29,707,321.16	$30,454,101.16
V.	Total dollar amount of credits used each month by date of service	$537,430.39	$474,398.62	$454,530.17
VI.	Total cumulative dollar amount of credits used through the month by date of service	$14,133,189.21	$14,607,718.19	$15,062,291.87
VII.	Total unduplicated number of enrollees who used credits each month	21,712	19,591	19,106

*Count includes Health Plan who have recently merged and exited Reform

7. Complaints

A beneficiary can file a complaint about the EBAP 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 complaints are reviewed and worked by the Agency to resolve the issue the beneficiary is having regarding the program.

During this quarter, over 21,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 68 (less than .5%) complaints were recorded through

the call center related to the EBAP. Table 26 provides a summary of the complaints received this quarter and outlines the actions taken by the EB Call Center, the Agency, or HP (through Magellan) to address the issues raised.

Table 26 **Enhanced Benefit Beneficiary Complaints** April 1, 2010 – June 30, 2010	
Beneficiary Complaint	**Action Taken**
1. Twenty-six beneficiaries called to complain the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program. The call center also refers beneficiaries to an actively participating pharmacy in their area.
2. Thirty-two beneficiaries complained about healthy behaviors not submitted by the health plan on behalf of the beneficiary.	➲ The Agency researches with each health plan regarding healthy behaviors not submitted. In most cases, the health plan submitted the behaviors in the next report submission. In a few cases, some beneficiaries had already reached occurrence limits on some of the behaviors; therefore, credit would not have been credited to the beneficiary account.
3. Ten beneficiaries complained about the balance in their account, either regarding pricing of products or duplicate pricing of one item.	➲ The Agency researched along with the pharmacy vendor regarding these complaints. The vendor was able to resolve issue with the pharmacy.

F. Low Income Pool

Overview

In accordance with the Special Term and Condition (STC) #100 of the Florida Medicaid 1115 Research and Demonstration Waiver, the Agency has met all the specified pre-implementation milestones. The availability of funds for the Low Income Pool (LIP) in the amount of $1 billion is contingent upon these pre-implementation milestones being met.

On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to federal CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. On March 16, 2006, federal CMS requested additional information of these sources and the Agency submitted a revised source of non-Federal share funding to be used to access the LIP funding to federal CMS on April 7, 2006.

On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement. Federal CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006.

On June 27, 2006, Florida submitted a State Plan Amendment (SPA) # 06-006 to federal CMS to terminate the current inpatient supplemental upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid eligible's to Medicaid cost as defined in the CMS 2552-96. In the event of termination of the Florida Medicaid 1115 Research and Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State has agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

On June 30, 2006, the Agency received confirmation from federal CMS stating that "as of July 1, 2006, the State of Florida is permitted to make expenditures from the Low Income Pool (LIP) in accordance with the Special Terms and Conditions (STCs) approved October 19, 2005."

Current Activities

<u>May 24, 2010, LIP Council Meeting</u>

On May 24, 2010, a LIP Council meeting was held at the Agency for Health Care Administration in Tallahassee, Florida.

At the meeting, an update was given for the LIP distribution and the General Appropriations Act. The Agency provided a chart which illustrated the LIP Council

recommendations for SFY 2010-11 compared to what was adopted in the General Appropriations Act (GAA), as well as an adjustment to the LIP funding for SFY 2010-11 if Congress were to adopt an extension of the Federal Medical Assistance Percentage (FMAP), a contingency provided in the GAA.

A more in depth discussion took place on the waiver extension process, timeline and Special Terms and Conditions. Provided to the Council members and the attending AHCA staff was an excerpt from the legislation that was adopted, by the Legislature, Senate Bill 1484. The Legislature has directed the Agency to seek a 3-year extension of the 1115 Demonstration Wavier, under which authority the Low Income Pool exists. Also noted, the Agency was to report and have approved by the Legislative Budget Commission any changes to the Special Terms and Conditions of the wavier which are specific to the Low Income Pool. In regards to the Special Terms and Conditions, although it is a renewal, no changes were proposed to the wavier itself. The request for the one-billion dollar per year in the extension period remained without any changes or increases of additional funds.

A presentation by the Agency made to the Senate and House as part of the Legislative Committee meetings regarding a Low Income Pool and Upper Payment Limit comparison was explained to the Council. Also included in the provided materials for the LIP Council meeting was a document titled, "Amended Special Term and Condition 105 Reconciliation Draft Review Tool and Written Procedures for Reconciliation of LIP Expenditures to Allowable Provider Costs." This document provided instructions on the updated LIP Cost Limit and quarterly reporting tool. It also aids in the Agency's compliance with the modified STC 105 (1)(a).

Presented before the Council, was a brief update on the Letters of Agreements (LOAs). This process of distribution of LOAs was halted until the Governor approved the GAA for the new fiscal year. Once the GAA was acted on, the Agency's goal was to have the LOAs to the communities within 30 days of the signing.

Another focus of the LIP Council meeting was directed to the provided document of Senate Bill 1484. Section 2 of this document explained the Agency's current task of developing a methodology to ensure the availability of intergovernmental transfers (IGTs) in the expansion of prepaid managed care in the Medicaid program. An overview was given of this section of the Senate Bill which explained the need to create an IGT Technical Advisory Panel. The Secretary of the Agency would be in charge of selecting representatives to serve on this panel. Council members were also given the authority to nominate anyone who could be beneficial to this Technical Advisory Panel.

Other Activities

In accordance with STC 105, sections (1)(a), (1)(b), (2)(a) and (2)(b) were submitted to federal CMS as follows:

- STC 105 (1)(a) was submitted to federal CMS on April 30, 2010, and resubmitted to make a grammatically correction on June 14, 2010. The purpose of Amended STC

105 (1)(a) is to provide a review tool and instructions to be used for the reconciliation of the LIP expenditures to allowable provider costs. This milestone was set with a deadline submission of April 30, 2010. The purpose of this document is to meet Milestone (1)(a) requirements of the terms of the amendment by providing a review tool and instructions to be used for the reconciliation of the LIP payments to provider costs limits.

- STC 105 (1)(b) was submitted to federal CMS on June 30, 2010. This amendment was to provide CMS a schedule for the completion of provider reconciliations statewide for Demonstration Years One, Two, Three, and Four by June 30, 2010.
- STC 105 (2)(a) was submitted to federal CMS on May 31, 2010. The purpose of this document is to meet Milestone (2)(a) requirement of the terms of the amendment by providing a baseline report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for SFY 2009-10 to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings. This report will provide a baseline assessment of current administrative capabilities Also, Milestone (2)(a) would develop a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventive care settings.
- STC 105 (2)(b) was submitted to federal CMS on June 30, 2010. This document is to provide an update with SFY 2010-11 projections for LIP dollars allocated to participating providers by June 30, 2010. This update will include descriptions of increases to allocations and changes to current allocations.

All submissions can be found on the Agency's Low Income Pool (LIP) website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

G. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved 1115 Demonstration 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 Medicaid Reform 1115 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 Demonstration 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, 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 (5th 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)
- 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 (STC #116).

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 the Centers for Medicare and Medicaid Services.

Current Activities

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 will 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 32), 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 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC #116. 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

Tables 28 through 32 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2010. Case months provided in the Tables 28 and 29 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.

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**
April 2010	280,909	$253,666,997	$48,259,799	$301,926,796	$1,074.82
May 2010	283,942	$174,652,397	$31,571,736	$206,224,133	$726.29
June 2010	287,594	$303,907,266	$49,657,712	$353,564,978	$1,229.39
Q16 Total	**852,445**	**$732,226,661**	**$129,489,247**	**$861,715,907**	**$1,010.88**
MEG 1 Total	**12,614,821**	**$11,076,341,065**	**$1,715,134,511**	**$12,791,475,577**	**$1,014.00**

* 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**
April 2010	1,720,938	$253,484,728	$30,906,075	$284,390,803	$165.25
May 2010	1,737,239	$137,689,965	$11,390,819	$149,080,785	$85.81
June 2010	1,744,966	$285,875,642	$31,065,785	$316,941,426	$181.63
Q16 Total	**5,203,143**	**$677,050,335**	**$73,362,678**	**$750,413,013**	**$144.22**
MEG 2 Total	**67,052,156**	**$9,953,315,142**	**$1,018,660,047**	**$10,971,975,189**	**$163.63**

* 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 $1,054.83 (Table 30), compared to WOW of $1,106.67 (Table 27), which is 95.32% of the target PCCM for MEG 1.

MEG 2 has a PCCM of $166.66 (Table 30), compared to WOW of $232.68 (Table 27), which is 71.63% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,004.26 (Table 30), compared to WOW of $1,195.20 (Table 27), which is 84.02% of the target PCCM for MEG 1. MEG 2 has a PCCM of $159.01 (Table 30), compared to WOW of $251.29 (Table 27), which is 63.28% of the target PCCM for MEG 2.

Tables 29 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 $308.53. Comparing the calculated weighted averages, the actual PCCM is 82.87% 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 $387.01. 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 $280.55. Comparing the calculated weighted averages, the actual PCCM is 72.49% of the target PCCM.

Table 30 MEG 1 & 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	$2,929,166,025	$498,754,183	$3,427,920,209	$1,054.83
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(168,471,771)	
% of WOW PCCM MEG 1					95.32%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,567,544,536	$281,489,731	$2,849,034,267	$166.66
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,128,593,104)	
% of WOW PCCM MEG 2					71.63%

Table 30 Continued MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY04 Total	**3,352,695**	**$2,860,428,027**	**$506,557,483**	**$3,366,985,511**	**$1,004.26**
WOW DY4 Total	**3,352,695**			**$4,007,141,064**	**$1,195.20**
Difference				**$(640,155,553)**	
% of WOW PCCM MEG 1					**84.02%**
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 Total	**19,964,506**	**$2,838,043,266**	**$336,519,140**	**$3,174,562,407**	**$159.01**
WOW DY4 Total	**19,964,506**			**$5,016,880,713**	**$251.29**
Difference				**$(1,842,318,306)**	
% of WOW PCCM MEG 2					**63.28%**

Table 31 MEG 1 & 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	$5,496,710,561	$780,243,914	$6,276,954,476	$308.53
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,297,064,875)	
% Of WOW					82.87%
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	23,317,201	$5,698,471,293	$843,076,624	$6,541,547,917	$280.55
WOW	23,317.201			$9,024,021,777	$387.01
Difference				$(2,482,473,860)	
% Of WOW					72.49%

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

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**
Total Paid	**$3,749,408,365**

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	$873,476,332	$1,000,000,000	87.35%
Total MEG 3	$3,749,408,365	$5,000,000,000	74.99%

The expenditures for the first sixteen quarters for MEG 3, the Low Income Pool (LIP), were $3,749,408,365 (74.99% of the $5 billion cap).

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, are not captured in this quarter's report or the Year Four annual report. However, payments for each demonstration year are allowed to be processed for payment through September 30, 2010. The first quarter of Demonstration Year Five report will provide the final payment totals for Demonstration Year Four.

H. 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, 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 transition to a diagnosis-based model such as the Chronic Illness and Disability Payment System (CDPS).

The Medicaid Encounter Data System / Risk Adjustment Team (MEDS Team) is comprised of internal subject matter experts and external consultants with experience in risk adjustment and medical encounter data collection. The MEDS Team continues to support the operational activities of the Medicaid Encounter Data System (MEDS).

Current Activities

Encounter data collection in FMMIS is operational and plans are making regular monthly submissions. Current day encounter claims are routinely processing in the claims systems and move to claims history (Decision Support System/DSS) as they are processed. The Agency continues to reconcile monthly data submissions to the encounter data certifications provided by the plans. The Agency has processed in excess of 69 million encounter records (medical services and pharmacy). Encounter records reflect the level of services provided to beneficiaries in Medicaid capitated managed care plans.

At present there are two concurrent encounter data collection efforts:

- The collection of medical and pharmacy encounter data for all Medicaid-covered services within FMMIS. (Planned uses for these data include, but are not limited to, health plan capitation rate setting, services and utilization analysis, supporting health plan quality and performance metrics, and supporting managed care fraud and abuse prevention and detection.)
- The collection of quarterly pharmacy encounter data in a proprietary format for risk adjusting demonstration health plans' capitation rates.

<u>Data Validation – Internal</u>

Data validation is essential to identifying statistical anomalies and evaluating data integrity and reasonableness. The submission process itself includes a number of data validation steps.

1. Initial data validation is performed by the plans using Edifecs Ramp Manager, which checks encounter claim formatting and HIPAA compliance. The plans are given

access to Ramp Manager in order to check their encounter data validity before submitting the encounter claims to the fiscal agent. Theoretically, files approved by Ramp Manager should pass all inbound file system edits. Once the encounter data receive Ramp Manager approval, they can be submitted to the fiscal agent.

2. Inbound file system edits examine file format and overall data validity. They check for such things as: monetary field entries are formatted correctly; beneficiary Medicaid identification (Medicaid ID) numbers are included and are the correct length; diagnosis codes and/or procedure codes are included in the claims; file structure meets HIPAA requirements, etc. Files that do not pass all inbound system edit checks are rejected and must be corrected and resubmitted. Each of the 69 million encounter records in claims history has successfully passed this validation step.
3. Subsequent validation edits occur at the transaction level as the system processes the claims. Threshold claims processing edits are designed to completely reject the encounter claims and prevent them from moving to the next processing step. These failed claims are reported to the health plans and must be corrected and resubmitted. Examples include:

- **General validity** - Initial checks are made against central tables, including diagnosis code and dates of service, to determine if those required elements are present in the claim and are valid values.
- **Beneficiary Medicaid ID** - Checks are performed to determine whether the beneficiary Medicaid ID is a valid value and is on file with Florida Medicaid.
- **Duplication of records** - Each encounter claim record is checked against those already accepted into the system to ensure that the same encounter data exists only once. If a record has already been processed, any record containing identical information is rejected.

A separate set of system edits are considered repairable. These edits allow the encounter claims to continue processing but are labeled on the claims and reported to the plans for correction and resubmission. Examples of repairable edits are:

- **Provider eligibility** - Provider numbers are checked against the provider file to determine whether the provider is registered with Florida Medicaid and was part of the plan's network at the time of service.
- **Beneficiary eligibility** - Checks are performed to determine whether the beneficiary was both eligible for Medicaid and enrolled in the plan at the time of service.

The Agency is augmenting the system validation by performing analytic procedures on the encounter data to help determine its reliability by pinpointing possible gaps or other deficiencies that should be corrected. These procedures are designed to instill confidence in the data's ability to accurately describe the services provided by the health plans. Examples of analytic validation procedures are listed below:

- Key data elements submitted within each encounter claim, i.e., diagnosis and procedure codes, provider types reported, services by counter, and beneficiaries receiving services, are examined across time and by plan to identify correlations and trends.
- Time series analyses of each plan's historical submissions are used to forecast future encounter claim submission volumes. Actual submission volumes are compared to forecasts and variances analyzed.
- All data are evaluated by key data fields to identify and interpret any possible data gaps within encounter claims, such as missing plan payment information, place of service, EPSDT indicator, etc., that could impact analyses and conclusions drawn.
- Provider Medicaid IDs and National Provider Identifiers (NPIs) within the encounter data submissions are compared to each plan's Provider Network File to identify invalid NPIs, providers not registered with the State, network providers not submitting encounter data, and specialty services provided by the plans by areas of the State.

Analytic validation will be performed for all encounter data received to date and for all future submissions by plan by month. For each set of analytic procedures, a feedback loop allows the Agency to communicate results from the procedures to the health plans using a series of standard reports, including a dashboard. These reports are currently under development. Analytic procedure results may require the plans to respond formally to questions from the Agency and/or to perform corrective action, such as when the variance between forecast and actual submissions for a particular claim type and month is more than 2 standard deviations (a 95% confidence interval).

Validation Reports:

- In January 2010 the Agency initiated a preliminary analysis of encounter data with dates of service during SFY 2008-2009. Encounter claims were extracted from claims history and the following comparisons were made across all capitated health plans:

    - Submission volume by MCO
    - Total volume by claim type (medical, inpatient, outpatient, and pharmacy)
    - Claim type distribution by MCO

  From this preliminary analysis, the Agency identified data submission issues that were subsequently researched and corrected.
- During the 2010 Legislative session, staff completed a very specific comparative analysis of the performance of Medicaid managed care plans to the MediPass program. Specific requirements for the analysis were provided, which compared four service delivery models, MCO-Non Reform, MCO-Reform, MediPass, and Provider Service Networks, for six specified disease states. Also requested was the

frequency of hospitalizations/re-hospitalizations as well as the top five surgical CPT codes for the service delivery models.

- In May 2010, the Agency distributed to the plans an initial provider report that compared their Provider Network Files to providers included in the plans' encounter data submissions. The report identified invalid NPIs, providers not registered with the State, network providers not submitting encounter data, and specialty services provided by the plans by areas of the State. Plans will use this information to identify providers not registered with the State and then register them; plans may use the report for other analysis as well.

Data Validation – External

In addition to the analytic validation procedures performed within the Agency, three external vendors, Mercer, Milliman, Inc., and Health Services Advisory Group (HSAG), will assist the Agency. Mercer and Milliman are the Agency's contracted actuaries and HSAG is the Agency's External Quality Review Organization (EQRO). Mercer and Milliman will perform validation procedures to help determine the encounter data completeness and accuracy and to what extent (percentage) they will be used as part of the base data for setting the health plan capitation rates. The Agency is in discussions with HSAG about their role in validating encounter data and anticipates agreement on a methodology by the end of August 2010.

As part of a larger project, Mercer has developed data intake processes and sets of general validation reports that summarize the quality and completeness of the various data sources. Validation activities include, but are not limited to, the following:

- Using eligibility and encounter claims to determine the percentage of beneficiaries who used services within the period. A lower than normal user percentage could indicate underreporting by the plans.
- Analyzing the dollars paid by month of service and month of payment to determine if there are any missing encounter data.
- Analyzing the percentage of diagnosis codes populated by position (Dx1, Dx2, etc.) on the encounter claims, as well as the average number of diagnoses populated per encounter across the health plans.
- Analyzing the missing values in encounter claims and the percentage of total encounter claims this represents to determine the completeness of the encounter data.

A report describing the results of Mercer's validation activities is due to the Agency by the end of July 2010.

Using Encounter Data

The Agency's confidence in using the encounter data is dependent upon complete and accurate submissions of historical and current ongoing encounter data by the health

plans. As confidence in the data increases, the Agency will use the data extensively to monitor health plans through fiscal and quality analyses. Current and projected encounter data uses are described below:

Current encounter data uses:

- Health plan capitation rates for SFY 2010-2011 will use encounter claims data as a portion of the base data used in the rate setting process, in conjunction with FFS claims data and enhanced plan financial data. The Agency provided the SFY 2008-2009 encounter data to two independent actuaries for review and validation by July 2010, as part of the rate-setting process. The percentage of encounter data used for the capitation rates will be determined after the actuaries review the encounter data in conjunction with the health plan financial information and comparable FFS claims data. A public meeting was conducted in June 2010 to discuss the Agency's approach to using encounter data in the rate-setting process.
- MEDS NCPDP-format pharmacy data for SFY 2008-2009 were given to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use. The comparison is to see if the risk scores are similar between the two data sources.
  - Preliminary analysis indicates the results are tracking well except for a volume discrepancy between the two data sources for one plan.
  - If the scores remain substantially equivalent during parallel testing, the Agency will transition to NCPDP pharmacy data for risk adjusted rates in the Reform counties while testing the CDPS model using diagnosis-based encounter data.
  - The comparison is now being run monthly using both data sources to increase confidence in the risk scores' integrity.
- To test and perform a dry run of the CDPS model using diagnosis-based encounter data for comparison to results from the current pharmacy-based Medicaid Rx model results. (The Agency plans to transition to a diagnosis-based model.)

Examples of expected encounter data uses in the future:

- To risk-adjust the demonstration county capitation rates using a diagnosis-based model such as CDPS.
- To analyze the services and utilization across the health plans in comparison to one another.
- For comparative analysis of the services reported on encounter claims to services on the FFS claims.
- To support the electronic health record.
- To analyze the overall volume of services per beneficiary and service utilization for specific diagnoses.

- To verify health plan compliance with contract requirements, such as tracking History and Physical procedure codes in the plan encounter claims to verify automatic beneficiary disenrollment if the initial primary care physician visit does not occur within 180 days of plan enrollment.
- To support managed care fraud and abuse prevention and detection, including but not limited to:

  - Comparative analysis of managed care plan utilization, performance, outcomes, referrals, and disenrollment;
  - Profile managed care plan practice patterns as compared to their peers;
  - Compare managed care plan services to fee-for-services to identify potential access barriers and under-utilization; and
  - Detect practices that could inflate rate setting, e.g., upcoding, unbundling services.

The following are the highlights for this quarter:

- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans, i.e., MEDS and NCPDP Companion Guides, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions.
- Provided outreach and technical assistance with health plans to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Held weekly update meetings for Medicaid management to discuss the progress of encounter data submission and receipt and any system issues that may impact processing and reporting.
- Conducted weekly MEDS Team meetings to discuss project progress, risks, and issues that needed to be addressed to keep the team on track.
- Continued meeting with the Agency Encounter Data Utilization Team and identified some uses for the managed care encounter data.
- Continued performing the encounter data analytic validation procedures.
- Worked with external vendor to determine the status of their validation activities.
- Conducted weekly update meetings with Agency senior management to discuss the progress of the encounter data analytic validation (internal and external).
- Worked with EQRO vendor to develop validation activities.
- Began transition of operational aspects of encounter data validation to the fiscal agent.
- Initiated planning of provider mass enrollment effort.

Quarterly Pharmacy Encounter Data Collection For Risk Adjustment

To comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed to calculate individual risk scores for both the Medicaid fee-for-service and managed-care populations. Using the MedRx model, the health plans were assigned plan risk factors for both TANF and SSI based on the aggregate risk scores of their enrolled populations in those categories under the demonstration.

Health plan factors, budget neutrality, and the derived risk corridor plan factor were applied to capitated premium rates for Medicaid-enrolled populations in the demonstration counties monthly from October 2006 through June 2008. As mentioned in previous reports, Legislation required that capitation premiums be fully risk-adjusted and health plan corridor factors were no longer to be applied effective in Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting demonstration capitation rates was October 1, 2008, through September 30, 2009, paid through December 31, 2009. This measurement period was used to generate risk-adjustment factors for the health plans operating in the five demonstration counties.

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

- Continued to collect and process pharmacy encounter data on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated, and any significant changes from the previous quarter’s submission are reported to the health plans for corrective action, if necessary.
- Provided MEDS NCPDP-format pharmacy data for SFY 2008-2009 to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use. Continued parallel testing and comparison between the two data sources.
- Worked with MCOs and the risk adjustment vendor to resolve data anomalies between fourth quarter of SFY 2009-10 and first quarter of SFY 2010-11 encounter submissions.
- Provided MEDS diagnosis-based encounter data for SFY 2008-2009 to the risk adjustment vendor on March 31, 2010, for use in a dry run comparison of the Chronic Illness & Disability Payment System (CDPS) model risk score results to the MedRx risk score results based on pharmacy encounter data.
- For this period, risk adjustment plan factors were calculated for the following health plans:

Better Health Plan	Medica Healthcare Plan	Total Health Choice
Children’s Medical Services, Florida Department of Health	SFCCN – Memorial Healthcare System	United Healthcare
Freedom Health Plan	SFCCN – North Broward Hospital Districts	Universal Health Care
Humana	Shands Jacksonville Medical Center d/b/a First Coast Advantage	
Molina Health Plan	Sunshine	

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the ‘Under 1 year old’ population, or specialty plans/populations such as HIV/AIDS and CMS. Enrollment in the demonstration counties for the month of June 2010 for risk adjustment purposes totaled 232,826 and was distributed as follows:

June 2010	Broward	Duval, Baker, Clay, and Nassau
Children & Families	108,625	95,567
SSI	15,965	12,669
Totals	**124,590**	**108,236**

- Pharmaceutical data to support risk adjustment capitation rate premium calculations will be collected and processed through MedRx until encounter data in FMMIS are of sufficient quality and completeness for a transition to NCPDP pharmacy data in MedRx, and/or a diagnostic risk-adjustment model such as CDPS.

The process of providing plan risk factors for the demonstration rate setting and budget neutrality will continue into the next quarter. A dry run of the CDPS model using diagnosis-based encounter data will occur next quarter and the results will be analyzed. The Agency will continue to test and compare results between CDPS and MedRx until the quality and completeness of the diagnosis-based encounter data support transitioning to a diagnostic risk-adjustment model, such as CDPS. Scheduled activities in the MEDS project plan associated with the collection and processing of encounters will also continue. These activities include providing technical support to capitated health plans, reviewing end-to-end processing results, reporting on encounter submission adjudication results, and analyzing and reporting on encounter data validation results.

I. 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, two Minority Physician Networks (MPNs), for a total of twelve 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 beneficiaries enrolled in MediPass, Florida's primary care case management program.

The Agency currently has contracts with 7 HMOs and 3 PSNs for a total of 10 health plans in Broward County; 3 HMOs and 2 PSNs for at total of 5 health plans in Duval County; and 2 HMOs for at total of 2 health plans in Baker, Clay, and Nassau Counties.

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. During this quarter, the initial on-site survey was conducted, which is Phase III of the application review process.

This quarter, AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS, began providing services in Broward County. This is the second specialty plan in the demonstration, the first being the specialty plan for children with chronic conditions that became operational in 2006.

Patient satisfaction was also examined and is addressed in Objective 5.

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 Four of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter (OTC) drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Demonstration Year Four include:

- Over-the-counter (OTC) drug benefit $25 per household, per month;
- Adult Preventive Dental;
- Circumcisions for male newborns;
- Adult Vision Services;
- Wellness and Nutrition Therapy; and
- Respite Care.

For Demonstration Year Four, the Agency approved 21 benefit packages for the HMOs and 13 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010, to August 31, 2010, for eight HMOs and four PSNs. Positive Healthcare, the first Reform HMO specialty plan for beneficiaries with HIV/AIDS, began accepting enrollment on May 1, 2010. In addition, Total Health Choice was acquired by Simply Healthcare and ceased operations on May 31, 2010. The Total Health Choice Reform enrollees were transitioned to the Better Health Reform PSN, of which Simply Healthcare is a minority owner, on June 1, 2010.

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for beneficiaries. 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 beneficiaries. As Year One of the demonstration ended, the Agency had begun 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 beneficiaries 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 fee-for-service 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 beneficiary 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 33 shows the results of these analyses.

Table 33
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 beneficiary 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 members 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 members, 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, the Agency finished analyzing the March 2008 and April 2008 survey data and continued to conduct surveys. In each month, the Agency pulled a sample of 300 providers across the state, 15 from each health plan, to be surveyed. Additionally, a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist) was pulled from Area 10 (Broward County) in March 2008 and from Area 4 (Duval, Baker, Clay, Nassau, St. Johns, Flagler, and Volusia counties) in April 2008.

In the March 2008 statewide survey, 258 of the 300 providers were surveyed or could not be surveyed due to inaccurate information (e.g., the provider phone number was incorrect or disconnected). Of these 258 providers, 79% confirmed participation with a health plan. Agency follows-up with the health plans resulted in a finding that 88% of the providers sampled were in fact contracted with the health plan for which they were surveyed. The March 2008 survey focusing on Area 10 included 117 providers, 82% of which confirmed participation with a health plan. Agency follow-up with the health plans resulted in a finding that 95% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

In the April 2008 statewide survey, 273 of the 300 providers were surveyed or could not be surveyed due to inaccurate information (e.g., the provider phone number was incorrect or disconnected). Of these 273 providers, 79% confirmed participation with a health plan. Agency follow-up with the health plans resulted in a finding that 88% of the providers sampled were in fact contracted with the health plan for which they were surveyed. In the April 2008 survey focusing on Area 4, 103 of the 117 providers were surveyed or could not be due to inaccurate information. Of the 103 providers, 83% confirmed participation with a health plan, and Agency follow-up indicated that 84% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

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. In the May 2008 statewide survey, the combined results from the survey and the follow-up indicate that 292 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 11 in May 2008, 116 (99%) had current contracts with the health plans from which they were sampled.

During the second quarter of Demonstration Year Three, the Agency followed-up on and analyzed the June 2008 survey results. As mentioned above, the Agency's follow-up now includes all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the June 2008 statewide survey, the combined results from the survey and the follow-up indicate that 288 (96%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 9 in June 2008, 114 (97%) had current contracts with the health plans from which they were sampled.

Surveys were conducted in August, September, October, and November 2008. During the third quarter of Demonstration Year Three, the Agency followed-up on and analyzed the August and September surveys. In the August 2008 statewide survey, the combined results from the survey and follow-up indicate that 291 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk Counties) in August 2008, all 117 (100%) had current contracts with the health plans from which they were sampled. The September survey results were very similar, with 297 (99%) of the 300 providers in the statewide sample having current contracts with the health plan; and with 99 (99%) of the 100 providers in the Medicaid Area 3 sample having current contracts with the health plans for which they were surveyed. The Medicaid Area 3 (Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, and Sumter Counties) sample contained 100 provider records rather than 117 due to there being 22 provider records for dentists rather than 39.

During the fourth quarter of Demonstration Year Three, the Agency followed-up on and analyzed the October and November 2008 surveys and the January through March 2009 surveys. In the October 2008 survey, the combined survey results and follow-up by Agency staff indicate that 100% of the sampled providers had current contracts with the health plans for which they were surveyed, in both the statewide (300 providers) and Area 5 (115 providers from Pasco and Pinellas counties) samples. The November 2008 survey had the same results, with 100% of the statewide sample (283 providers) and 100% of the Area 8 sample (95 providers from Sarasota, DeSoto, Charlotte, Glades, Lee, Hendry, and Collier Counties) confirmed as participating in the health plans from which they were sampled.

In January 2009, there was an increase in the number of health plans and thus, the number of providers that we sampled and surveyed statewide. In the January, February, and March surveys, the combined survey results and follow-up by Agency staff indicated that 99% of the providers sampled statewide had current contracts with the health plans for which they were surveyed, while 100% of the providers in the focused Medicaid Area samples had current contracts with the health plans. The focused areas in January, February, and March 2009 were Area 7, Area 2, and Area 1, respectively.

As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area has 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 month.

During the second quarter of Demonstration Year Four, Agency staff followed-up on and analyzed the results of the first quarterly provider network survey, which was conducted in July through September 2009. A total of 651 providers were sampled from the health

plan provider network files. The survey results and follow-up by Agency staff indicated that 95% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. The second quarterly provider network survey was conducted during the second quarter of Demonstration Year Four as well, from October through December 2009.

During the third quarter of Demonstration Year Four, Agency staff followed-up on and analyzed the results of the second quarterly provider network survey. A total of 630 providers were sampled from the provider network files, and 98.4% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. The third quarterly provider network survey was conducted during the third quarter as well, from January through March 2010.

During the fourth quarter of Demonstration Year Four, Agency staff followed-up on the results of the January survey, and the May quarterly survey was conducted.

During the first quarter of Demonstration Year Five, Agency staff will finish the January survey follow-up and analysis. Agency staff will also prepare for the next survey, which will be fielded in October 2010.

The Agency is also working on the National Provider Identification and provider matching initiatives. When completed, these two initiatives will result in the provider files containing unique identifiers for each provider. This information will shorten the timeframes to collect these necessary data and improve the accuracy of the information. As the encounter data system is fully implemented, this unique identifier will allow the Agency to take additional steps in identifying active providers, as well as determining how many unduplicated providers are participating in the demonstration.

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 this quarter, the Pay-for-Performance and Value-Based Purchasing Team held workshops with Medicaid health plans to obtain input on a methodology for enhanced auto-assignments to reward high performing health plans. Two workshops were held. The first, on May 19, 2010, offered an opportunity for participating health plans to suggest data sources that should be included in the methodology and to raise issues that should be considered to ensure all plans are treated equitably. The health plans requested that metrics other than the required performance measures be included and suggested indicators such as claims processing and payment timeliness and Child Health Check Up rates, among others. Participants raised concerns about how a methodology could affect new plans, small plans, and plans who served a disproportionate number of enrollees with serious illnesses.

The second workshop, on June 8, 2010, was dedicated to HEDIS measures. The plans requested that a subset of the full list of required performance measures be selected for the incentive methodology to allow the health plans to target resources to improve the selected measures. The group reached consensus to recommend the following list:

- Diabetes – rotate the 4 screening measures
- Childhood Immunizations – Combo 3
- Follow-up after Hospitalization for Mental Illness – 30 days
- Breast Cancer Screening
- Well Child 3-6 Years of Life
- Asthma Medications
- Lead Screening in Children
- Postpartum Care

The Agency's internal workgroup is reviewing the recommendations made in the health plan workshops. In the next quarter, the Agency's team will develop several suggested assignment algorithms and scoring methodologies. These options will then be presented in a workshop for the health plans to provide review and comment.

This quarter also included frequent dialogue between the Agency, health plans, and HEDIS vendors and auditors as the July 1, 2010, deadline for performance measure submission came near.

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

The Ambulatory Sensitive Hospitalization analysis will be updated when hospital data is available.

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

No new data was available this quarter on utilization of emergency rooms. Data from the Ambulatory Care HEDIS measure will be available next quarter.

Objective 4: *Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).*

For individuals who chose to opt out of the demonstration, the Agency, through its vendor, established a database that captures the employer's health care premium information and whether the premium is for individual or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the vendor enters in the Opt Out Program's database the reason why an individual, who initially expressed an interest in and was provided information on the Opt Out Program from a Choice Counselor, decided not to opt out of Medicaid.

The reasons individuals have chosen to opt out of demonstration include:

(1) elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance

(2) primary care physician was not enrolled with a Medicaid Reform health plan

The individuals who decided not to opt out:

(1) were not employed,

(2) did not have access to employer sponsored insurance, or

(3) after hearing about opt out decided to remain with their Medicaid Reform health plan where there were not co-pays and deductibles.

Objective 5: *To ensure that patient satisfaction increases.*

The Agency has contracted with the University of Florida to conduct patient satisfaction surveys throughout the five-year demonstration period. 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 University of Florida has adapted the CAHPS telephone survey component by adding questions specific to the demonstration.

Enrollee Satisfaction: Year Two Follow-Up Survey Report - Volumes 1, 2, and 3 (2009), are scheduled to be submitted to the Agency in the first quarter of Demonstration Year Five. Volume 1 is currently being finalized by the Agency and presents survey results by county. Volume 2 will address enrollee satisfaction differences by plan type, and Volume 3 will assess enrollee satisfaction differences by enrollee subgroup.

During this quarter, UF began fieldwork for the next iteration of this survey. Telephone interviews began on Wednesday, May 12, 2010, and will conclude on Monday, July 12, 2010.

Past surveys can be viewed on the Agency's website at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

Objective 6: *To evaluate the impact of the low income pool on increased access for uninsured individuals.*

Prior to the implementation of the demonstration, 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 demonstration 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 the non-hospital PAS entities allows for increased access to services for the Medicaid, underinsured, and uninsured populations.

During the Year One of the LIP, the following PASs 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 of Demonstration Year One, the State approved a PAS distribution methodology and worked with these PAS entities establishing Letters of Agreement with the local governments or health care taxing districts.

The services realized 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 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.

During the third quarter of Demonstration Year One, the Agency continued its work with UF’s Medicaid Reform Evaluation team. On January 30, 2007, the Agency received a request for pre-LIP information from UF 's Medicaid Reform Evaluation team. On February 20, 2007, the Agency responded, via e-mail, with the electronic data requested. The data requested included information from the hospital Upper Payment Limit (UPL) program, Disproportionate Share Hospital (DSH) program, and the hospital reimbursement exemption costs. In addition, data from the Florida Hospital Uniform Reporting System and hospital Medicaid audited DSH data were provided. A conference call was held on March 6, 2007, to review the data provided.

During the fourth quarter of Demonstration Year One, the Agency received a letter on June 8, 2007, from UF LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to UF LIP Evaluation team along with the pre-LIP Milestone data (SFY 2005-06) by July 31, 2007. The LIP Milestone data for Year One of LIP (SFY 2006-07) was due to the Agency from all PAS entities no later than August 15, 2007. This information was shared with the UF LIP Evaluation team in September 2007. The University of Florida and the Agency are using the LIP Milestone data for the 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).

During the first quarter of Demonstration Year Two, the Agency and the UF LIP Evaluation team continued their work together regarding the overall LIP evaluation, with an emphasis on STC #102. During this quarter, the Agency provided the UF LIP Evaluation team the detail of prior years' Intergovernmental Transfers (IGTs) beginning with SFY 2003-04 through SFY 2005-06. The UF LIP Evaluation team prepared two pre-LIP reports and shared the drafts with the Agency. These reports summarized hospital provider costs for the Medicaid, uninsured, and underinsured populations for SFY 2003-04 and SFY 2004-05.

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 PASs 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. PASs with fiscal years different than July 1st – June 30th 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 Demonstration 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, 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 University of Florida 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." (pp 10-11)

The final 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 Demonstration Waiver, the Agency submitted a letter to federal CMS along with the LIP Program Highlights: Demonstration 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 the fourth quarter of Demonstration Year Three, the Agency submitted the SFY 2007-08 Milestone data to UF. The Milestone data will be used in accordance with STC #102 of the waiver. The SFY 2007-08 Milestone in report from UF will include 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).

During the first quarter of Demonstration Year Four, the Agency reviewed the SFY 2007-08 Milestone report from UF. The Agency provided additional feedback to the UF LIP evaluation team during this quarter. The Agency looks forward to the final review the first quarter of Year Five. The Agency will share the Demonstration Year Three data with UF evaluation team to allow for the evaluation on Demonstration Year Three to begin.

Current Activities

The Agency is scheduled to receive the final SFY 2008-09 Milestone report from UF during the first quarter of Demonstration Year Five. The report will illustrate the qualitative impact on the implemented indicators in Demonstration Year Three on uninsured individuals as referenced in STC# 104.

J. 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. The Agency developed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to federal CMS on February 15, 2006. The Agency incorporated comments from the CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to CMS on May 24, 2006. Federal CMS approval was received on June 13, 2006.

The Medicaid Reform Evaluation is a five-year "over-arching" study that will present its major findings in 2010-2011. Descriptions of the evaluation reports that were received or approved by the Agency during the fourth quarter of Demonstration Year Four are provided below.

1. Evaluations Affiliated with the Agency or its Contractors

During this quarter of the reporting period, there was one "external" report on the demonstration submitted for publication by UF. The article, "Successful Implementation in the Public Sector: Lessons Learned from Florida's Medicaid Reform Program," was submitted to The Journal of Public Health Management and Practice for publication in a future issue. A list of current articles for the Journal can be found on their web site at:

http://journals.lww.com/jphmp/pages/default.aspx

2. Evaluations Commissioned by Governmental Agencies

During this reporting period, there were no new studies commissioned by governmental agencies.

3. Independent Evaluation by the University of Florida

UF continues to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency.

During this quarter, the following areas of UF's independent evaluation conducted and/or produced reports.

University of Florida – Progress Reports on Key Aspects of the Evaluation

These semi-annual administrative reports provide summary and status information about the Medicaid Reform Evaluation. Progress is reported for all associated tasks identified in the work plan categorized by major evaluation subprojects. During this quarter, there were two draft progress reports submitted to the Agency for review. One of these progress reports (July – December 2009) is available on the Agency's website at:

http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_x-a_progress_report_final_06-17-2010.pdf

The remaining report (January – June 2010) is under review and will be submitted to federal CMS once the Agency has approved it.

University of Florida – Mental Health Analysis

This series of studies evaluates mental and behavioral health services provided in the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). The mental health analysis has three primary objectives to:

1. Evaluate health plan satisfaction by enrollees with severe mental illness (SMI) or severe emotional disturbances (SED),
2. Assess the association of the Reform pilot on involuntary commitment of enrollees with SMI or SED through Baker Act data, and
3. Assess pharmacotherapy provided to enrollees with SMI or SED by examining rates of drug switching and rates of adequate pharmacotherapy treatment.

Execution: Studies for Objectives 1 and 3 are being conducted by UF, and Objective 2 of the mental health analysis is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF.

Objective 1: A second draft for the Objective 1 report was submitted to the Agency by the researcher during the current quarterly reporting period. An approved report should be submitted to federal CMS for review towards the end of the first quarter of Demonstration Year Five.

Objective 2: The final report for Objective 2: *Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services – The Effect of Medicaid Reform on Baker Act and Criminal Justice Encounters* is scheduled to be approved by the Agency during the first quarterly reporting period of Demonstration Year Five.

Objective 3: This report is being reviewed by the Agency. UF and the Agency are working through methodological issues. There is no anticipated date for this deliverable at this time.

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. This report, *An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*, addresses two years pre- and two years post implementation, and can be found on the Agency's website at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_viii_d_fisca_analysis_report_07-10-09.pdf.

In follow-up to the first fiscal analyses, a preliminary draft of the multivariate analyses report: *Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analyses,* was delivered to the Agency for review during the second quarterly reporting period of this demonstration year. This report provides an update to the univariate report findings, and also looks at demonstration data by various subgroups (gender, race, etc.) against specific controls. During that review, some methodological problems were identified and addressed. It is anticipated that the Agency will have this report in its final stages by the end of the first quarterly reporting period of Demonstration Year Five.

University of Florida – Low Income Pool (LIP)

In July 2006, the State of Florida introduced broad-ranging reform of the Florida Medicaid Program, with the establishment of the Low-Income Pool (LIP) Program being one of several components of the demonstration. The LIP consists of a capped annual allotment of $1 billion (the "pool"), with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.[5] The conditions of the LIP are discussed in the Special Terms and Conditions (STC's) of the waiver, as approved by the federal Centers for Medicare and Medicaid Services (CMS).[6]

The *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2006-2007 Florida Hospital Uniform Reporting System (FHURS) Data* is currently being finalized by the University of Florida. The report evaluates the link between payments from the LIP-related programs and the provision of services to Medicaid, underinsured, and uninsured populations using data from FHURS. This evaluation measures services along four dimensions—adjusted days, gross revenue, net revenue, and operating expense, in order to gain a more complete picture of the amount of services obtained from a given amount of LIP-related payments. This report is one of a series of reports that will evaluate the LIP Program throughout the demonstration period. All evaluation

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[5] State of Florida, Agency for Health Care Administration (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml, accessed September 12, 2009).

[6] *CMS Special Terms & Conditions* (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf, accessed October 26, 2007).

studies will use data on LIP-related payments as provided by the Agency, but two different data sets will be used to assess the amount of services provided—data from FHURS and data from the LIP Milestone Reporting Requirements for CMS. These studies will cover periods both before Reform was implemented and during implementation and operation for purposes of comparison. Evaluations of the LIP utilizing Milestone data (for SFYs 2007-2008 and 2008-2009) and FHURS data (SFY 2006-2007) will be available in separate reports before the end of the first quarter of Demonstration Year Five.

University of Florida – Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[7]) study designed to help understand demonstration enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. The qualitative study did achieve its objective during the demonstration's implementation period, but due to the nature of qualitative research the study could not successfully be sustained over time. With this particular component of the evaluation reaching its conclusion, the independent evaluator will now move forward with conducting an analysis from another area of the demonstration that needs to be assessed in order to further enhance the demonstration. The Agency has approved a summary report of these activities and is available on the Agency's website at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_x_c_qualitative_studies_summary_report_final_06-08-2010.pdf

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state's hospital and managed care industries, the medical association, other health professional groups, advocacy organizations, legislative leadership, or other entities. A list of the FAC members and their demographic information can be found on the following website:

http://fdhcdev/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

There was no FAC meeting held during this quarter; however, a meeting will be scheduled during Demonstration Year Five.

[7] This study was originally intended to be longitudinal; that is, it would follow the same recipients over time from before implementation through the end of the study period. However, maintaining the true longitudinal nature of the study was difficult because enrollees were hard to reach or decided they did not wish to continue study participation.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. A list of the TAC members and their expertise can be found on the following website:

http://mre.phhp.ufl.edu/advisorycommittees/index.htm#tac

The purpose of this committee is to, over the five-year demonstration period, provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The UF research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary or requested. The TAC meets annually over the five years of the project. There was no TAC meeting held during this quarter; however, a meeting will be scheduled during Demonstration Year Five.

In addition to the TAC representatives, all project areas of the evaluation are represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day-to-day basis. The information exchange between the UF evaluators and the national experts focuses on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

K. Policy and Administrative Issues

Current Activities

The Agency continues to identify and resolve various operational issues for both prepaid 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 five different processes:

- Technical Advisory Panel regular meetings;
- Policy Transmittals and Dear Provider Letters and E-mails;
- Health Plan Technical and Operations Conference Calls;
- PSN Systems Implementation Monthly Conference Calls; and
- General Amendment/Contract Overview Calls.

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

There was only one Technical Advisory Panel (TAP) meeting that took place this quarter. The nine-member TAP created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration, met in June and discussed the following topics:

- Medicaid encounter data collection and processing, including the focus on submission of current encounter data, compliance and validation efforts and the different uses for the data;
- Health plan risk-adjusted capitation rate setting timeline for September 2010 rates, including discussion on what portion may be based on encounter data and how rates would be affected by enhanced benefits credits;
- Choice counseling update, including reports on the beneficiary survey results, call statistics and the transition to the new Choice Counseling Vendor (with discussion on the new online choice process and security efforts);
- Enhanced benefits update on credits earned, credits spent and services for which the most credits were earned (childhood preventive care);

- Legislative update, including proposed budget reductions and LIP funding changes across categories;
- Medicaid Reform evaluation update, including enhanced benefit program participation, comparisons between demonstration and non-demonstration counties, and enrollee satisfaction; and
- Update on extension request for the 1115 waiver demonstration, including creation of an e-mail in-box for receipt and tracking of public comments and the five public meetings.

The TAP continued to be helpful through their provider and plan insight – ensuring Agency processes and procedures are well thought out and properly vetted.

Policy Transmittals and Dear Provider Letters

During this quarter, there was one policy transmittal and one Dear Provider letter released to the health plans. The policy transmittal covered the removal of the minority participation reporting requirement. The one Dear Provider letter provided information regarding prescription encounter data changes required by changes in national health reform.

In addition, there were several Dear Provider e-mails providing updated information relative to the Medicaid program during this quarter. Issues addressed included:

- Changes in Medicaid physician and practitioner fee schedules;
- Extensions for the submission of benefit change requests for the 2010-11 health plan contract year; and
- Notice of changes to the 2009-2012 Medicaid Health Plan Contract Report Guide, effective July 1, 2010.

Technical and Operations Calls

This quarter, the Agency conducted six biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants. 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.

All health plans are invited to participate, whether or not 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 is shown by over 100 phone lines in active use on the calls. Items that have made an appearance at almost all calls include updates on Medicaid encounter data submissions and choice counseling updates. During June, the health plans were advised that due to the decrease in issues reported and general topics, the calls would occur monthly rather than biweekly.

Other agenda items included:

- External Quality Review Organization meeting/conference call/webinar updates;
- Payment for county health department services;
- Provider fee schedule posting;
- Medicaid Program Integrity fraud and abuse reporting;
- Performance measures and related action plans;
- Legislative updates;
- Report guide updates; and
- Benefit and rate amendment timeline.

Feedback from call participants continues to indicate that the calls are well received, a good forum for discussion of technical and operational issues, and an avenue for quick discussion and feedback on identified operational issues.

Fee-for-Service PSN Systems Implementation Issues 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. During this quarter, the PSN Association requested an additional forum for unresolved issues and the Agency responded by scheduling an additional call with association members. 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. Additional items related to Medicare crossover claims and chiropractic claims were also discussed.

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

- Medicaid fiscal agent transition issues relative to PSN enrollees, claims remittance advice, and enrollment file formats; and
- Claims systems 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 with a few repeat providers. Modification of the current claims process (to streamline the claims processing function) for FFS PSNs remains under consideration.

General Amendment/Contract Overview Calls

During this quarter, the Agency held one workshop/conference call with the health plans to discuss an auto-assignment algorithm to reward high performing health plans. Specific topics discussed included the following:

- Amending the existing round-robin assignment process to favor high performing health plans;
- Criteria to include in the determination of high performing health plans; and
- Exceptional scenarios that must be considered when developing policy (e.g., new health plans entering the market).

L. Waiver Extension Request

Legislative Direction

On April 30, 2010, the Florida Legislature passed Senate Bill 1484 and Governor Crist signed the bill into law (Chapter 2010-144, Laws of Florida) on May 28, 2010. Within this bill, the Florida Legislature directed the Agency to seek approval of a three-year waiver extension in order to maintain and continue operation of the 1115 waiver in Baker, Broward, Clay, Duval and Nassau Counties. The Agency was directed to submit the extension request by no later than July 1, 2010.

Development of Waiver Extension Request

In preparing the waiver extension request document, the Agency held a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver as authorized by the Florida Legislature. The agenda items for the public meetings included: description of the legislation passed during the 2010 Florida Legislative Session which impacts the waiver, an overview of the existing waiver, and a description of the draft extension request. There was an opportunity for public comment during the meetings.
The location, date and time of the public meetings that were held are provided below. In addition, the Agency accepted written comments on the waiver extension request via mail or e-mail. A complete summary of the public notice and public process used in the development of the wavier extension request is included in the final document and posted on the Agency's website.

Schedule of Public Meetings				
Location	**Date**	**Time**	**FAW Notice**	**Agenda/Presentation**
Tallahassee 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL	5/21/10	1:00p.m. – 3:30p.m.	Notice	Final Agenda Final Presentation Meeting Video
Duval County The Arc Jacksonville 1050 North Davis Street Jacksonville, FL 32209	6/8/10	1:00p.m. – 3:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Broward County Broward County Health Department Main Auditorium 780 SW 24 Street Fort Lauderdale, FL 33315	6/9/10	10:00a.m. – 12:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Nassau County Nassau County Children and Family Education Center 86207 (479) Felmor Road Yulee, FL 32097	6/10/10	2:00p.m. - 4:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Clay County Clay County Agricultural Center 2463 SR 16 W Green Cove Springs, FL 32043	6/11/10	10:00a.m. - 12:00p.m.	Notice	Final Agenda Final Presenation Meeting Video

Schedule of Public Meetings				
Location	**Date**	**Time**	**FAW Notice**	**Agenda/Presentation**
Baker County Baker County Health Department 480 W. Lowder Street Macclenny, FL 32063	6/11/10	2:00p.m. - 4:00p.m.	Notice	Final Agenda Final Presentation Meeting Video

Schedule of Agency Advisory (Public) Meetings				
Meeting	**Location**	**Date**	**Time**	**FAW Notice**
Medical Care Advisory Committee	Tallahassee, FL (AHCA)	5/18/10	1:00p.m. - 3:30p.m.	Notice
Low Income Pool Council	Tallahassee, FL (AHCA)	5/24/10	1:00p.m. - 3:00p.m.	Notice
Technical Advisory Panel	Tallahassee, FL (AHCA)	6/2/10	10:00a.m. - 12:00p.m.	Notice

Submission of the Waiver Extension Request

On June 30, 2010, the Agency submitted a three-year waiver extension request to federal CMS as directed by the Florida Legislature in SB 1484 and in compliance with federal regulations. The waiver extension request document can be viewed by visiting the Agency's website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Public comments related to the waiver extension request can be mailed to:

1115 Medicaid Reform Waiver
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
Or e-mailed to: medicaidreform@ahca.myflorida.com

The Agency will post federal CMS's request for additional information relating to the waiver extension request on the Agency's website (see above) along with the Agency's responses.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues April 1, 2010 – June 30, 2010	
PSN Informal Issue	**Action Taken**
1. A PSN member's parent reported that the PSN is unwilling to provide a referral to a specialist near their home and that the referrals provided are inconvenient.	➲ The PSN contact provided the Agency with a detailed report on the plan's efforts to provide an acceptable referral to the family. The member's parent rejected the first two referrals that the PSN provided. The member's parent requested that the member be referred to a non-participating provider, which the PSN attempted to do, but the provider does not participate in Medicaid at all and would not be able to be paid. The PSN referred the member to a specialist in North Miami, but the family said it was too far away and then requested a specialist in West Palm Beach, which is even farther away. The PSN attempted to find a specialist for the member in West Palm Beach, but could not find a provider who would accept the patient. After the PSN's multiple attempts, the family decided to work with the plan and accept one of the referrals that the PSN made. The member's parent is very pleased with the provider.
2. A PSN member reported to the Agency that he is unable to obtain a good specialist referral from the PSN.	➲ The PSN contact reported to the Agency that an authorization to see a specialist was already in place. The PSN member was apparently unaware of this so the PSN contacted him and made sure he knew how to get to the provider's office. The member is satisfied.
3. A PSN member reported to the Agency that her primary care provider is not giving her the help she needs.	➲ The PSN contact reported to the Agency that it arranged for her to see a new primary care provider and get the medications she needs. The member is satisfied.
4. A PSN member's parent reported to the Agency that she has been unable to get authorizations from the PSN so that the member can have necessary procedures.	➲ The PSN contact reported to the Agency that they had spoken with the member's parent and advised her that the primary care provider assigned by the PSN could give authorizations for a network specialist after seeing the member. The member's mother notified the PSN that she is switching the member to a different plan, in which her preferred providers participate. The member said she would wait to schedule the services under the new plan.

PSN Complaints/ Issues April 1, 2010 – June 30, 2010	
PSN Informal Issue	**Action Taken**
5. A PSN member reported to the Agency that the PSN will not authorize services previously approved by her prior plan.	➲ The PSN contact reported that PSN staff needed to review the member's medical records before approving continued therapy sessions and the member's provider was slow in furnishing the records. The PSN approved continued therapy sessions and scheduled an appointment for the member. At first, the member was not happy about going to a new therapy provider, but the member is accepting of it now.
6. A PSN member reported to the Agency that she was referred to an out-of-network facility for treatments and needs authorization from the PSN.	➲ The PSN contact reported to the Agency that the necessary treatments are available at a facility in the network. The PSN contacted the specialist to get a new referral for the member. The specialist provided a new referral to a network facility and an appointment was made for the member.
7. A PSN member reported to the Agency that he was unable to obtain authorizations for necessary medications through Medicaid Pharmacy Services.	➲ Agency staff worked with the PSN and the member's specialist to resolve the issue. The Agency authorized the medications and the specialist agreed to obtain and administer the medication to the member. Protocols were put in place to ensure that the member is able to get his medications without delay in the future. The member is satisfied.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
1. A dental provider reported to the Agency that the HMO approved the provider's treating of the child, but that after the member changed plans, the provider is having problems getting claims paid by the HMO's subcontracted dental provider.	➲ The member's previous health plan sent documentation to the HMO member's current plan showing the previously approved dental procedure plan and showing that continuity of care is contractually required. The HMO reported to the Agency and the member that it would provide the dental care for the member.
2. A dental provider reported to the Agency that the HMO approved the provider's treating the child, but after the member changed plans, the dental provider is having problems getting claims paid by the HMO's subcontracted dental provider.	➲ The member's previous health plan sent documentation to the HMO member's current plan showing the previously approved dental procedure plan and showing that continuity of care is contractually required. The HMO reported to the Agency and the member that it would provide the dental care for the member.
3. A provider reported to the Agency that they had been paid for providing services to an HMO member and that the monies were later recouped. The provider reported being told by the HMO that the member was not assigned to the health plan when services were provided.	➲ HMO staff reported to the Agency that they researched this case and concur that the member was in the health plan and there should not have been a recoupment. The HMO contacted the provider and notified them that the appropriate payment would be made and that the provider should contact the HMO if payment was not received within 2 weeks.
4. A provider contacted the Agency to report being unable to get claims paid because an HMO member's Medicaid eligibility category was changed and she was assigned to an HMO in which the provider does not participate.	➲ An HMO contact reported to the Agency that the provider had not submitted any claims for the member. The HMO asked the provider to submit the claims for HMO staff to evaluate. Agency staff reviewed the member's Medicaid file and determined that assignment to the new aid category was correct. The HMO contact reported to the Agency that HMO staff reviewed and denied the provider's claims (and notified the provider of this) because the provider had either not checked the member's eligibility or saw the member even though the member had been assigned to the HMO for several months. The issue was closed.
5. A provider contacted the Agency to report that claims are being denied because the HMO says the former member was not active on the dates of service.	➲ The HMO contact reported to the Agency that the former member's file was updated to reflect the actual period of enrollment. The HMO notified the provider that the claims would now process and pay.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
6. A former HMO member's parent says the HMO is denying that he was enrolled in the plan and will not pay provider claims.	➲ The HMO contact reported to the Agency that the HMO's membership database has been updated and that the former member now shows as being active on the date of service. The HMO asked the provider to re-submit the claims for payment.
7. A former HMO member's family reported to the Agency that they are being balance billed by a provider because the HMO denied a claim.	➲ The HMO contact reported to the Agency that they had contacted the provider, who agreed to cease attempts to bill the former member's family. The HMO's subcontractor will not pay the provider because the provider did not obtain proper authorization. The HMO explained this to the provider and the provider understands and will not dispute the decision.
8. An inpatient facility provider reported to the Agency that the HMO wanted to discharge a member from the facility before the member was ready.	➲ Agency staff contacted HMO staff, who reported that the member had used his 45 available inpatient days. The HMO contact reported that the member was discharged to a group home, where he will receive day treatment and medication management. The HMO continued to monitor the member through case management.
9. An HMO member's parent reported being very unhappy with the pediatric dental services being provided to the member. The parent wants the child to get a better provider and dental services in the area.	➲ The HMO reported to the Agency that it contacted the member's mother to provide alternative dental specialist names, phone numbers, and office hours.
10. An HMO member's parent reported that the member was switched to another plan without the parent's knowledge. The parent wants to make sure that appointments and medications for the child will be available, as the member suffers from a special medical condition. The parent would like to switch the member back to the previous plan.	➲ The HMO reported to the Agency that it worked out the appointment and medication needs for the member until he is back in his previous plan. The member's mother indicated that no further assistance was needed.
11. An HMO member's parent contacted the Agency to request assistance for the child to see a specialist out-of-network for a broken arm. The member is now in a different county with a different parent due to a change of custody.	➲ The HMO reported to the Agency that it has approved and arranged for the member to see a specialist out of network.
12. An HMO member contacted the Agency to report that she wanted to see a surgeon who previously performed hip surgery as she is having problems after surgery. She said she has contacted the plan, but has been unable to get access to the proper specialist.	➲ The HMO reported to the Agency that it contacted the member and provided her contact information for both a primary care provieder and a surgery specialist who are in the HMO's network. The member scheduled an appointment with the surgery specialist.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
13. An HMO member's parent reported to the Agency that she wants the HMO to approve a referral for the member to a non-participating specialist.	➲ The HMO reported to the Agency that the member's primary care provider had not followed the proper referral process. The HMO contact reached out to the provider and clarified how to get the referral process going, so this should now go smoothly.
14. An HMO member reported to the Agency that the HMO would not approve necessary services.	➲ The HMO contact reported to the Agency that HMO staff have been working with the member for several weeks and that it was determined that the member qualified for a nursing home diversion waiver program and was referred to several alternatives. The member is deciding on a program and is satisfied.
15. An HMO member reported to the Agency that she scheduled a procedure with an out-of-network provider and wants the HMO to authorize it on short notice.	➲ The HMO contact reported to the Agency that HMO staff are working with the provider and that the provider agreed to postpone the procedure until the HMO can get all the information. The HMO authorized post-procedure follow-up visits.
16. An HMO member was assigned to the wrong plan and the member's specialist does not participate with that plan. The member's parent reported that the enrollment issue is being addressed but that services are needed now. The provider is balance billing the parents for previously rendered services.	➲ The HMO contact reported to the Agency that the hospital where the provider practices will not cooperate with the plan and will not send the bill to the HMO. The HMO asked the member's parent to forward the bill to the HMO and the plan worked on an out-of-network authorization. The HMO contact reported that the provider's bill was paid in February and notified the provider of this. The HMO authorized out-of-network care for the member through June 1, 2010.
17. A provider contacted the Agency to report that an HMO member was unable to obtain necessary services due to the HMO's requirement for monthly prior authorizations.	➲ The HMO contact reported to the Agency that the member received the necessary medication for the month. The HMO requested prior authorization for this medication because HMO staff wanted to monitor the interaction of this medication with the other medications that the member uses. The HMO told the provider that they would contact her later in the month to see how the member is doing on the medication. If the member is doing all right, the HMO will end the prior authorization requirement. The provider is satisfied and will work with the member to ensure compliance.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
18. An HMO member reported to the Agency that he cannot get necessary medications because the HMO is denying all prior authorization requests.	➲ The HMO contact reported to the Agency that the pharmacy was trying to get authorizations from the wrong health plan. The HMO authorized all the requested medications and notified the member that he could pick them up.
19. An HMO member's parent reported to the Agency that they are being balance billed by a non-participating provider.	➲ The HMO contact reported to the Agency that HMO staff discussed the issue with the parent and the parent agreed she was responsible for the bill and would pay it. The member's parent has already switched the member to a new plan in which the provider participates.
20. An HMO member's parent reported being balance billed by a non-participating provider because the HMO denied the claims.	➲ The HMO contact reported to the Agency that HMO staff contacted the provider and asked the provider to submit the claims to the HMO for out-of-network payments. The HMO advised the parent that she would not have to pay the claims.
21. An HMO member's parent reported to the Agency that she is being balance billed because the HMO denied the claim based on eligibility.	➲ The HMO contact reported to the Agency that the HMO updated its member files and they show that the member was active on the date of service. The HMO contacted the provider and advised them to resubmit the claim for payment. The family is satisfied.
22. An HMO member's parent reported to the Agency that the HMO does not have the correct payee in its files.	➲ The HMO contact reported to the Agency that they have updated their files so that they now match the State's files.
23. An HMO member moved to another county and is in need of seeing a provider immediately.	➲ The HMO contact reported to the Agency that the HMO's Regulatory Affairs Specialist called a couple of provider offices in the member's new county and found a provider that could see the member within a few days. HMO staff called the member and gave her the information for the provider and called to make an appointment.
24. A provider reported to the Agency that the HMO denied a prior authorization request for medication for a member.	➲ The HMO contact reported to the Agency that its Provider Relations Representative contacted the provider and explained that the prescription was denied because the request was missing required information. The provider stated that she would submit the missing information. An HMO case manager contacted the member's mother and advised her that the HMO will review the medication request as soon as they receive the required information from the provider and that they will follow-up with the parent regarding the outcome.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
25. An HMO member reported to the Agency that she was erroneously assigned to an HMO and cannot see her regular primary care provider for necessary services.	➲ The HMO contact reported to the Agency that an HMO case manager worked with the member. Authorizations for two visits to the primary care provider were given for the month, as well as an authorization for an outpatient procedure. The member is satisfied.
26. An HMO member reported to the Agency that she was unable to get necessary authorizations from the HMO.	➲ The HMO contact reported that a case manager worked with the member and the durable medical equipment provider. All authorizations are now in place and the member will receive the specialized equipment she needs. The HMO also authorized out-of-network office visits to the provider that the member requested.
27. An HMO member reported to the Agency that the HMO denied a transplant evaluation for the member.	➲ The HMO contact reported to the Agency that it reversed its decision and assisted the member with the requested medical care.
28. An HMO member's mother reported to the Agency that the HMO denied requests for physical, occupational, and speech therapy for the member.	➲ The HMO contact reported to the Agency that the original request was denied because clinical information was not submitted supporting the request. The HMO sent denial letters explaining this to the provider and to the member's parent. The HMO's special needs case manager worked with the member's mother to coordinate care for the member, and the case manager and provider relations staff reached out to the provider to obtain the necessary clinical information so that the services may be approved.
29. An HMO member reported to the Agency that the HMO refused to cover a transplant procedure and advised the member to disenroll and seek care elsewhere.	➲ The HMO contact reported to the Agency that plan staff was in error in their communications with the member. HMO staff were retrained on proper policy interpretation and the HMO contacted the member to advise him that the HMO will cover the procedure. The HMO coordinated a plan of care with the member and the providers involved.
30. An HMO member reported to the Agency that she wants to disenroll from the HMO so she can see a non-participating provider.	➲ The HMO contact reported to the Agency that the HMO authorized the specialist and plan of care requested by the member. The member is satisfied.
31. A provider reported to the Agency that the HMO paid her claim but then recouped the money.	➲ The HMO contact reported to the Agency that the claim was adjusted to be repaid to the provider based on the HMO's eligibility update. The HMO sent a letter notifying the provider of this and attempted to reach the provider by phone.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
32. An HMO member reported to the Agency that a specialist will no longer see her because the specialist reports not having claims paid by the HMO.	➲ The HMO contact researched the claims and reported to the Agency that the provider was promptly paid by the plan for all outstanding claims. The provider's office manager confirmed that the claims were paid. The HMO and the provider notified the member that she could continue treatment with the same provider. The member is satisfied.
33. A provider reported to the Agency that the HMO has not followed their agreement and is not paying the provider's claims at the agreed upon rate. This has happened since September 2009.	➲ The HMO reported to the provider and the Agency that they will pay the claims. Agency staff will follow-up with the provider to ensure they have been paid.
34. An HMO member's parent reported to the Agency that she has been paying for her son to continue seeing a specialist with whom he is established since the specialist is not participating with the HMO.	➲ Agency staff asked the HMO whether the member's mother or the provider had submitted claims to the HMO. The HMO reported to the Agency that since the member's mother chose to pay the specialist, the provider has not submitted any claims. The HMO designated a primary care provider for the member to coordinate any other health care needs. HMO staff called the member's mother and provided orientation.
35. An HMO member's parent reported to the Agency that the member has been unable to obtain services because the HMO says he is no longer an active member.	➲ The HMO contact reported to the Agency that the member's file was corrected and HMO staff notified the member's parent that she may proceed to obtain necessary services for the member.
36. An HMO member reported to the Agency that she has a high risk pregnancy and tried to go to a local hospital but found that it does not participate in the HMO. The member needs access to a specialist or specialty care.	➲ The HMO contact reported to the Agency that the HMO case manager contacted the member and helped her select a primary care provider. The case manager arranged a home visit for the member. The member is satisfied with the resolution.
37. An HMO member reported to the Agency that he has not been able to find pain management specialists in his area and has not been able to obtain prescriptions that he needs for his health condition.	➲ The HMO contact reported to the Agency that they have contacted the member and have assigned him a case manager who will assist him with his needs. The HMO's pharmacy department ran a utilization report and found that the member has received all of his medications and that no medications have been denied to date. The member is satisfied with the outcome.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
38. A provider reported to the Agency its concern about an HMO member who had liver problems. The provider reported having problems providing services to the member due to the HMO's failure to properly approve services.	➲ Agency staff contacted the HMO and the member's mother. Both confirmed that the member has been receiving the services needed since the member's enrollment in the HMO. The HMO contact reported that it has approved and covered the member's care. The member's mother is satisfied and had not been aware that the provider called to complain.
39. A provider reported to the Agency its concern about an HMO member with liver problems. The provider reported that the HMO has not properly approved services.	➲ Agency staff contacted the HMO and the member's mother. Both confirmed that the member has been receiving the services needed since the member's enrollment in the HMO. The HMO contact reported that it has approved and covered the member's care. The member's mother is satisfied and had not been aware that the provider called to complain.
40. A provider reported to the Agency its concern about an HMO member with liver problems. The provider reported that the HMO has not properly approved services.	➲ Agency staff contacted the HMO and the member's mother. Both confirmed that the member has been receiving the services needed since the member's enrollment in the HMO. The HMO contact reported that it has approved and covered the member's care. The member's mother is satisfied and had not been aware that the provider called to complain.
41. An HMO member's parent reported to the Agency that the HMO has not provided an acceptable specialist referral for the member.	➲ The HMO contact reported to the Agency that a case manager arranged an appointment with a participating specialist for the member. The case manager advised the parent of the appointment and she was very pleased.
42. An HMO member reported to the Agency that he was unable to obtain necessary medications and that the HMO has not referred him to a primary care provider in his area.	➲ The HMO contact reported to the Agency that a case manager made arrangements for the member to get medications and arranged an appointment with a primary care provider near his home. The member missed the appointment due to being ill, so HMO staff scheduled a new appointment for the member. The member's family is satisfied and the HMO is continuing to monitor the member's case.

HMO Complaints/Issues April 1, 2010 – June 30, 2010	
HMO Informal Issue	**Action Taken**
43. An HMO member's mother reported to the Agency that the HMO's subcontractor denied services that the member urgently needs.	➲ The HMO contact reported to the Agency that according to the information submitted by the provider, the procedure is not medically necessary. The HMO advised the provider to redo the prior authorization request to make a case for why the procedure is necessary. The HMO advised the member's parent that the provider will resubmit the request.
44. A community case worker reported to the Agency that the HMO denied specialized services to an HMO member.	➲ The HMO contact reported to the Agency that the authorization request was missing CPT codes. The HMO called the provider for the proper codes, then authorized the services and notified all parties.
45. An HMO member reported to the Agency that he has an appointment for a procedure with a specialist in an adjoining county and has obtained all authorizations from the HMO, but the transportation provider is refusing to authorize the trip.	➲ The HMO contact reported to the Agency that HMO staff worked with the member and transportation subcontractor to ensure that the member was picked up for his appointment. The member is satisfied.
46. An HMO member reported to the Agency that she needs a surgical procedure at an out-of-town facility which does not participate with the HMO.	➲ The HMO contact reported that the HMO has worked with the facility and has approved the procedure if evaluation by the specialist shows that the procedure is medically necessary. The HMO scheduled an evaluation for the member and the member is satisfied.

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