Florida Medicaid Reform

Year 6
Annual Report
(July 1, 2011 – June 30, 2012)

1115 Research and Demonstration Waiver

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Letter from the Medicaid Director

Florida's 1115 Medicaid Reform Waiver is a comprehensive demonstration designed to improve the Medicaid delivery system by integrating the increased use of managed care principles with innovative approaches like customized benefit packages and health-related incentives for recipients. The demonstration was initially implemented in Broward and Duval Counties on July 1, 2006, and expanded into Baker, Clay, and Nassau Counties on July 1, 2007.

On December 15, 2011, the Centers for Medicare and Medicaid Services (Federal CMS) approved the demonstration waiver extension request to maintain and continue the demonstration until June 30, 2014. The approval letter and amended Special Terms and Conditions (STCs) of the waiver are posted on the Agency's website and can be viewed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

The demonstration continues to generate an environment that encourages recipients to actively participate in the management of their health care and incentivizes health plans to provide care centered on the person's individual needs. The following are highlights from Demonstration Year Six. A more in-depth review of these highlights can be found in the body of the report.[1]

Highlights of Demonstration Year Six

- Enhanced plan contract requirements for encounter data to ensure accuracy and completeness.
- Performance of the health plans was above the national mean on several components of the of the Comprehensive Diabetes Care measure and on Well-Child Visits in the 3rd-6th years of life, along with several other Healthcare Effectiveness Data and Information Set (HEDIS) measures. The health plans had a weighted mean that was above the National Mean [as published by National Committee for Quality Assurance (NCQA) for the Medicaid product line] for 11 HEDIS measures reported in 2011.
- Significantly increased select health plan HEDIS measure performance over time: Childhood Immunization Status increased 9% for Combo 2 and 11.9% for Combo 3, between 2009 and 2011 reporting. Adult BMI assessment increased 10.8% from 2010 to 2011 reporting. Annual Dental Visits increased 18.8% between 2008 and 2011.
- Implemented a statistical analysis initiative for monitoring the association between plan medical services and pharmacological treatments within clinical practice guidelines. This follows the HEDIS measures, which are coupled with managed care populations having targeted conditions. Preliminary results for the two measures related to Chronic Obstructive Pulmonary Disease (COPD) and Asthma have been completed and are under Agency review.
- Developed a methodology using encounter data to analyze specialty care and used the methodology to produce baseline data for three types of specialty care: orthopedics, neurology and dermatology for this demonstration year. The Agency will use the analyses to initiate an encounter data performance improvement project focusing on specialty access in the next demonstration year. The project will measure health plans' access to specialty

[1] Prepared by the Agency for Health Care Administration in accordance with Section 409.91213(1)(b), F.S. This report covers the sixth operational year of the waiver demonstration (July 1, 2011 through June 30, 2012).

care and common encounter data transaction errors. The error analysis will be used to improve data quality moving forward.

- Enhanced the online enrollment website to increase readability and user friendliness. Seven percent of the total recipient self-selected plan enrollments for this year occurred online (processing 9,829 enrollments online and 1,655 plan changes).
- Conducted 14 targeted on-site surveys of the plans that addressed: provider services, provider networks and covered services, prior authorization/quality improvement, utilization management, member services, complaints, and grievances and appeals.
- Approved an increase in the maximum enrollment level for the Children's Medical Services specialty plan in Broward County.
- Received fewer grievances: Provider service networks had a lower number of grievances in Demonstration Year Six (71) than in Years Five (143) or Four (483 grievances). The health maintenance organizations had a lower number of grievances in Year Six (213) than Year Five (245), remaining lower than the 242 grievances reported in Year Four.
- Extension of the LIP Primary Care Grant ($34 million) by the 2012 Florida Legislature for an additional two years; for a total of three years (Demonstration Year Five, Six and Seven). Grants awarded to the same 38 applicants as the previous year.
- Met the Low Income Pool (LIP) deliverables as required by the STCs including establishing the 15 hospitals quality initiatives to implement new/enhanced programs.

The Agency gratefully acknowledges the Florida Legislature, recipients, providers and other key stakeholders for their assistance in making this demonstration a success. We continue to search for future opportunities for improvement as we gain more data and experience. The Florida Medicaid community is leading the way in improving care for all Florida residents.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

I. Waiver History

Background

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

On June 30, 2010, the Agency submitted a three-year waiver extension request to maintain and continue operations of the demonstration waiver for the period of July 1, 2011 through June 30, 2014. Federal CMS granted temporary extensions of the waiver from July 1, 2011 until December 15, 2011, at which time they approved the waiver extension request for the period of December 16, 2011 through June 30, 2014.

On August 1, 2011, the Agency submitted an amendment request to Federal CMS to implement the Managed Medical Assistance (MMA) program as specified in Florida law. The Agency continues to work with Federal CMS to obtain approval. The amendment request, correspondence with Federal CMS, additional information about the amendment and the MMA program can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA.

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Florida law, and STCs #19 and #20 of the waiver. Special Term and Condition #20 requires that the state submit an annual report for each operational year documenting the events occurring during the year or anticipated to occur in the near future that affect health care delivery including, but not limited to, accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the waiver.

This report is the annual report for Year Six of the demonstration for the period of July 1, 2011 through June 30, 2012. For detailed information about the activities that occurred during previous periods 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[2]: organizational and administrative structure; policies and procedures; on-site review; and the contract execution process. In addition, capitated health plans are required to submit a customized benefit plan to the Agency for approval as part of the application process. Customized benefit packages are described in Section A.2 on pages 9 through 13 of this report 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. In the last two years, the Florida Legislature amended Section 409.91211(3)(e), F.S., to allow FFS PSNs to convert to capitation no later than September 1, 2014, or within two years of operation, whichever comes later.

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

Since the implementation of the demonstration, the Agency has received 28 health plan applications [20 health maintenance organizations (HMOs) and eight FFS PSNs], of which 23 applicants sought and received approval to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population. One health plan application from Community Health Plan of South Florida, to become a FFS PSN in Broward County, is currently on hold at the request of the applicant.

During the sixth year of the demonstration, four new applications were received and are in various phases of review:

- Simply Healthcare HMO (Broward County)
- Healthease HMO (all five demonstration counties)
- Magellan Complete Care (Broward County)
- Simply Healthcare d/b/a Clear Health Alliance specialty plan for individuals living with HIV or AIDS (Broward County).

[2] 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.

Table 1 provides a comprehensive list, from the implementation of the demonstration, of all health plan applicants, the date each application was received, the date each application was approved, and the initial counties of operation requested by each applicant.

Table 1
Health Plan Applicants

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

*The application is under Agency review.

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

Table 2
Medicaid Reform Health Plan Contracts

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

*During Fall of 2008, the plan amended its contract to withdraw from this county. The United withdrawal was effective November 1, 2008. The Vista / Buena Vista withdrawal was effective December 1, 2008.

**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. The withdrawals for both Healthease and Staywell were effective July 1, 2010.

****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county. The withdrawals for both Amerigroup and Preferred were effective December 1, 2009.

*****Sunshine began providing services in these counties effective September 1, 2009.

******First Coast Advantage expanded into these counties effective December 1, 2010.

+Sunshine withdrew from Nassau and Baker Counties effective December 31, 2010.

Contract General Amendments

In Demonstration Year Six, one general amendment to the health plan contracts was completed. This amendment implemented plan rates effective September 1, 2011 through August 31, 2012, with corresponding benefit packages.

Expansion or Maximum Enrollment Increase Requests

Sunshine State Health Plan (HMO) requested expansion into Baker and Nassau Counties and the request remained under Agency review at the close of Demonstration Year Six.

The Agency approved a request from Children's Medical Services (CMS) specialty plan to increase its maximum enrollment level in Broward County.

Contract Conversions/Terminations

Terminations

There were no plan conversions, terminations or acquisitions during Demonstration Year Six and no requests are pending as of the end of Demonstration Year Six.

FFS PSN Conversion Process

Over the last two years, the Florida Legislature amended Section 409.91211(3)(e), F.S., to allow FFS PSNs to convert to capitation no later than September 1, 2014, or within two years of operation, whichever comes later. Florida law requires the FFS PSNs to convert to capitation by September 1, 2014 unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. The Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

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

Table 3
PSN Conversion to Capitation Timeline

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

FFS PSN Reconciliations

By the end of Demonstration Year Six, the Agency completed work on the first, second and third contract year reconciliations[3] (September 2006 through August 2007, September 2007 through August 2008, and September 2008 through August 2009) for all plans, except two FFS PSNs. The Agency continues to work with the FFS PSNs that have requested additional time for reconciliation data analysis.

Systems Enhancements

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

Demonstration Year Six at a Glance

The following summarizes this year's accomplishments regarding the health plan contracting process.

- The Agency received four new health plan applications, which remain under Agency review.
- The Agency received one plan request to expand into Baker and Nassau Counties, which remains under Agency review.
- The Agency approved the CMS specialty plan's request to increase its maximum enrollment level in Broward County.
- The Agency provided technical assistance to demonstration health plans over the year.

Lessons Learned

The following summarizes the lessons learned and opportunities for improvement that were identified during Demonstration Year Six regarding the health plan contracting process. Additional information regarding lessons learned is provided in Section J of this report.

- Trouble-shooting new Florida Medicaid Management Information System (FLMMIS) issues and staying up-to-date on previously identified FLMMIS issues was time intensive. Conveying appropriate information to the plans was dependent on expert communication by all parties.
- As the Agency works to refine provider network standards, reliance on manual processes to confirm accuracy and adequacy has become time consuming and cumbersome; therefore, the Agency is working to develop an automated network verification tool.

Looking Ahead to Demonstration Year Seven

The Agency will continue to look to the successes of the specialty plan for children with chronic conditions and the specialty plan for persons living with HIV/AIDS for more information on how

[3] 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.

to effectively provide care to these specialized populations. The Agency anticipates learning best practices from the plans that have remained successful throughout the demonstration and from the plans that have entered the market and are performing well.

The Agency will continue to work with the plans to define new ways to improve health plan performance, enhance fraud and abuse activities, and further augment provider access. For instance, the 2012-2015 health plan contract added cardiovascular surgery, orthopedics and orthopedic surgery, rheumatology, and physical, respiratory, and speech therapies as pediatric specialist requirements for the provider network, and will allow health plans with the option of providing certain dental and behavioral health services through telemedicine. Health plans will also have to develop mechanisms for confirming services billed by providers were actually rendered to plan members, and will have to maintain an 85% medical loss ratio.

FLMMIS training and technical assistance to the health plans will continue during Demonstration Year Seven. The Agency will communicate with all health plans about known systems issues and the progress of requested modifications. In particular, the Agency intends to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to continue to refine their health care delivery and achieve additional efficiencies.

2. Benefit Package

Overview

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

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

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

Year Two, May 7, 2008 for Demonstration Year Three, September 15, 2009 for Demonstration Year Four, and September 30, 2010 for Demonstration Year Five. The data book for Demonstration Year Six was released on October 28, 2011.

All health plans are required to submit their proposed customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006, and updated versions of the PET were released annually, shortly after the release of the latest data book. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) are typically completed during the last quarter of each state fiscal year. The verification process includes a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

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

Demonstration Year Six at a Glance

Customized Benefit Packages

The benefit packages customized by the health plans for Demonstration Year Five became operational on January 1, 2011 and remained valid until December 31, 2011, effectively overlapping Year Five and Year Six of the demonstration. The benefit packages for Demonstration Year Six became operational on January 1, 2012 and will remain valid at least until August 31, 2012. These benefit packages include 21 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

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

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

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year.

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

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

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

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

Expanded Services

In Year Six of the demonstration, many health plans continue to provide services not currently covered by Medicaid in order to meet the needs of new 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 in previous demonstration years: over-the-counter drug benefits and the adult preventive dental benefits. The expanded services available to recipients include:

- Over-the-counter drug benefit – $25 per household, per month;
- Adult preventive dental;
- Circumcisions for male newborns;
- Additional adult vision;
- Wellness and nutrition therapy; and
- Respite care.

Plan Evaluation Tool

Since the implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006 to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Demonstration Year Three to a monthly script limit only. In Demonstration Years One and 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 sufficiency threshold level of pharmacy benefit for SSI and TANF of at least 98.5%. In addition, the Agency will ensure each plan's customized benefit package meets or exceeds, and maintains, a minimum threshold of 98.5% for benefits identified as sufficiency tested benefits as required by STC #39.

The PET submission procedure for Demonstration Year Six was similar to that of the five previous demonstration years. The updated version of the data book was released by the Agency on October 28, 2011 and the PET was e-mailed to the health plans on November 15, 2011. The health plans' Year Six benefit packages were approved during the second quarter and became effective January 1, 2012.

3. Plan-Reported Complaints, Grievances and Appeal Process

Overview

The grievance and appeals process specified in the 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, health plan contracts include timeframes for submission, plan response and resolution of recipient grievances. These requirements are compliant with federal grievance system requirements located in Subpart F of 42 Code of Federal Regulation (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) as specified in Section 408.7056, F.S., for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel (BAP) for enrollees in a FFS PSN (described below). This provides an additional level of appeal.

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Health Plan to act within ninety (90) days from the date the Health Plan receives a Grievance, or forty-five (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 Florida Legislature required that the Agency develop a process similar to the SAP for enrollees in a FFS PSN who do not have access to the SAP. In accordance with Section 409.91211(3)(q), F.S., the Agency developed the 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 MFH 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.

Demonstration Year Six at a Glance

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

Plan-Reported Complaints

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

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

Table 7
Plan-Reported Complaints
(July 1, 2011 – June 30, 2012)

Quarter	PSN Complaints	HMO Complaints	HMO & PSN Enrollment*
July – September 2011	306	477	321,111
October – December 2011	187	451	323,920
January – March 2012	369**	1,162	329,137
April – June 2012	374	2,111	337,311
July 1, 2011 – June 30, 2012	**1,048**	**4,201**	**413,602**

*unduplicated enrollment count
**One health plan under-reported the number of complaints by 188 during the 3rd quarter. The Agency worked with the PSN health plan and determined they had entered 188 complaints into the wrong reporting form. The PSN complaints for the 3rd quarter reflect the amended number of complaints.

Grievances and Appeals

In an attempt to better understand the issues recipients face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level this annual report. The information included in this section is plan-reported grievances and appeals. These are grievances and appeals filed by enrolled members or providers utilizing the plan's internal

grievance and appeal process. The Agency also uses this information as a part of continuous improvement and quality oversight.

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

Table 8
Grievances and Appeals
(July 1, 2011 – June 30, 2012)

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO and PSN Enrollment*
July – September 2011	16	31	50	84	321,111
October – December 2011	28	31	56	110	323,920
January – March 2012	12	33	50	122	329,137
April – June 2012	15	38	57	98	337,311
July 1, 2011 – June 30, 2012	**71**	**133**	**213**	**414**	**413,602**

*unduplicated enrollment count

The number of plan-reported grievances and appeals fluctuated during Year Six of the demonstration. The PSNs had fewer grievances in Demonstration Year Six (71) than in Years Five (143) and Four (483). The number of PSN appeals ranged from 31 to 38 per quarter. The number of HMO grievances was lower in Demonstration Year Six (213), compared to Year Five (245) and Year Four (242). The number of HMO appeals increased during Demonstration Year Six, and the total number (414) is higher than Years Five (406) and Four (315), although this number is still relatively low given the total enrollment in the HMOs and PSNs, which grew over Demonstration Year Six.

Medicaid Fair Hearings

Table 9 provides the number of MFHs requested and the number of fair hearings held during Demonstration Years One through Six. The MFHs are conducted through the 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.

Table 9
Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held
(July 1, 2006 – June 30, 2012)

Demonstration Period		Medicaid Fair Hearings Held	Medicaid Fair Hearing Requests
Year One	Quarter 1: July 2006 – August 2006	No Plan Enrollment	
	Quarter 2: September 2006 – December 2006	1	1
	Quarter 3: January 2007 – March 2007	0	0
	Quarter 4: April 2007 – June 2007	0	0
Year Two	Quarter 1: July 2007 – September 2007	1	4
	Quarter 2: October 2007 – December 2007	0	0
	Quarter 3: January 2008 – March 2008	1	3
	Quarter 4: April 2008 – June 2008	1	3

Table 9 Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held (July 1, 2006 – June 30, 2012)			
Year Three	Quarter 1: July 2008 – September 2008	0	5
	Quarter 2: October 2008 – December 2008	1	5
	Quarter 3: January 2009 – March 2009	0	2
	Quarter 4: April 2009 – June 2009	2	6
Year Four	Quarter 1: July 2009 – September 2009	2	7
	Quarter 2: October 2009 – December 2009	0	2
	Quarter 3: January 2010 – March 2010	4	7
	Quarter 4: April 2010 – June 2010	7	14
Year Five	Quarter 1: July 2010 – September 2010	6	11
	Quarter 2: October 2010 – December 2010	9	15
	Quarter 3: January 2011 – March 2011	2	14
	Quarter 4: April 2011 – June 2011	1	8
Year Six	Quarter 1: July 2011 – September 2011	7	12
	Quarter 2: October 2011 – December 2011	3	8
	Quarter 3: January 2012 – March 2012	4	16
	Quarter 4: April 2012 – June 2012	2	7
Total		**54**	**148**

There were a total of 43 MFHs requested during Demonstration Year Six; 23 for PSNs and 20 for HMOs. Of the 43 MFH requests, 21 requests were related to denial of benefits/services, 12 requests were related to reduction of benefits, two requests were related to denial of prescription medication, two were related to the inability to change plans, one was related to substandard medical care, and five have not progressed to being classified. Twenty-one (21) MFHs were held, although, in six of the cases, the recipient did not show or abandoned the hearing. Out of the remaining 15 hearings, two were dismissed, one was withdrawn and one plan action was confirmed as accurate and the plan having provided services appropriately. The outcome is pending in 11 cases. Of the 22 MFH requests that did not have hearings, seven were abandoned or withdrawn by the member, one was rejected by the Department of Children and Families due to an incomplete form and 14 were still pending at the end of the demonstration year.

BAP and SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances were submitted to the BAP or SAP in Demonstration Year Six. The low number of MFHs and SAP and BAP requests indicate that the plans are resolving these issues internally as enrolled members are not requesting further review. Table 10 located on the following page provides the number of requests to BAP and SAP for Demonstration Year Six.

Table 10 BAP and SAP Requests (July 1, 2011 – June 30, 2012)		
	BAP	**SAP**
July – September 2011	0	0
October – December 2011	0	0
January – March 2012	0	0
April – June 2012	0	0
Total	**0**	**0**

Please note *that Florida legislation was passed in 2012 that amended the statutory requirements for the Subscriber Assistance Program (SAP). The amendment revised which recipients' unresolved grievances can be referred to the SAP to include only those that belong to prepaid health clinics certified under Chapter 641, Florida Healthy Kids plans, and health plans that meet the requirements of 45 CFR 147.140. Therefore, the managed care organization recipients' unresolved grievances will now be referred to the BAP instead of the SAP. In the first quarter of Demonstration Year Seven, the description and reporting of the SAP and the BAP will be modified to reflect this change.*

4. Agency-Received Complaints/Issues Resolution Process

Overview

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on what is working and not working in managed care under the demonstration. Complaints/issues come to the Agency from recipients, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received 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 majority of complaints/issues are referred to the health plan for resolution and are tracked in the Agency's Complaints/Issues Reporting and Tracking System (CIRTS) to ensure resolution.[4]

The complaints/issues received by the Agency regarding health plans are listed in the quarterly reports. Please note, the complaints/issues received during Demonstration Years Four and Five were related to managed care in general and not specific to the demonstration. The Agency's complaints/issues resolution process addresses recipient and provider complaints/issues, and the review of complaint data has led to several revisions in health plan contracts (general amendment effective January 1, 2008).

[4] A detailed description of the process the Agency followed to create the consolidated automated database referred to as CIRTS can be found in previous quarterly and annual reports.

Demonstration Year Six at a Glance

During Demonstration Year Six, the Agency received a total of 260 complaints/issues regarding health plans. The volume of complaints is low relative to the number of recipients enrolled in the demonstration. Table 11 provides a summary of the complaints/issues received compared to enrollment during Demonstration Years One through Six.

Table 11
Agency-Received Health Plan Complaints/Issues
(Demonstration Years One – Six)

Year One

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year One Total	Complaints per 10,000
PSN	0	0.00	1	0.19	18	3.28	10	1.78	29	4.28
HMO	0	0.00	6	0.99	18	1.41	37	2.65	61	3.87
TOTAL	0	0.00	7	0.62	36	1.97	47	2.40	90	3.99
Enrollment*										
PSN		488		52,620		54,925		56,194		67,836
HMO		7,116		60,701		127,606		139,408		157,745
TOTAL		7,604		113,321		182,531		195,602		225,581

Year Two

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Two Total	Complaints per 10,000
PSN	10	1.87	16	2.63	13	2.15	6	0.99	45	5.85
HMO	16	1.18	48	3.17	72	4.59	48	2.93	184	8.76
TOTAL	26	1.32	64	3.07	85	3.92	54	2.41	229	7.98
Enrollment*										
PSN		53,664		60,913		60,516		60,091		76,978
HMO		143,776		151,282		156,583		163,961		210,037
TOTAL		197,440		212,195		217,099		224,052		287,015

Year Three

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Three Total	Complaints per 10,000
PSN	7	1.12	3	0.41	5	0.59	6	0.48	21	1.48
HMO	46	2.83	67	4.34	74	4.89	59	4.82	246	14.5
TOTAL	53	2.36	70	3.09	79	3.34	65	2.63	267	8.57
Enrollment*										
PSN		62,276		72,374		85,003		124,773		141,679
HMO		162,554		154,280		151,372		122,491		169,884
TOTAL		224,830		226,654		236,375		247,264		311,563

Year Four

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Four Total	Complaints per 10,000
PSN	11	1.1	8	0.8	15	1.6	7	0.6	41	2.7
HMO	81	5.0	60	3.4	57	3.1	46	2.8	244	12.0
TOTAL	92	3.5	68	2.5	72	2.6	52	1.8	285	8.1
Enrollment*										
PSN		96,526		94,240		96,277		125,911		150,437
HMO		162,647		178,209		183,267		161,542		202,949
TOTAL		259,173		272,449		279,544		287,453		353,386

Table 11
Agency-Received Health Plan Complaints/Issues
(Demonstration Years One – Six)

Year Five

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Five Total	Complaints per 10,000
PSN	19	1.5	17	1.3	25	1.8	19	1.3	80	4.6
HMO	37	2.2	44	2.6	45	2.7	38	2.2	164	7.7
TOTAL	56	1.9	61	2.0	70	2.3	57	1.8	244	6.3
Enrollment*										
PSN		127,084		128,225		140,295		146,150		175,800
HMO		166,653		171,423		169,695		172,187		213,936
TOTAL		293,737		299,648		309,990		318,337		389,736

Year Six

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Six Total	Complaints per 10,000
PSN	17	1.1	14	0.9	22	1.4	20	1.2	73	3.7
HMO	43	2.5	47	2.7	48	2.8	49	2.8	187	8.6
TOTAL	60	1.9	61	1.9	70	2.1	69	2.0	260	6.3
Enrollment*										
PSN		150,355		152,729		156,173		161,025		194,955
HMO		170,756		171,191		172,964		176,286		218,647
TOTAL		321,111		323,920		329,137		337,311		413,602

**Enrollment is enrollment of last month of quarter and year end.*

All complaints/issues were worked and addressed with the health plans and providers, resulting in no sanctions. Issues regarding policy were discussed with the health plans in monthly technical and operational issues conference calls, policy transmittals, and by e-mail. As noted earlier, the majority of complaints/issues are related to managed care in general and not specific to the demonstration. Agency staff will continue to resolve complaints in a timely manner and monitor the complaints received for contractual compliance, plan performance and trends that may reflect policy changes or operational changes needed.

In Demonstration Year Six, the major reasons for complaints/issues were related to services (e.g., referral to a specialty provider and authorization of services) and claims processing (including payment delays). Charts A and B located on the following page provide the total HMO and PSN complaints by complaint type (claims, customer service, services, and other) for Demonstration Year Six.

Complaint type descriptions are as follows:

Claims	Claims complaints include, but are not limited to, timely provider payment, eligibility denial (claim denied because service was not eligible for payment or recipient was not eligible at the time of service), and issues regarding inpatient provider payment.
Customer Service	Customer Service complaints include, but are not limited to, issues regarding enrollment, disenrollment, member verification, provision of incorrect information by a customer service representative, and inability to obtain member materials.

Services	Service complaints include, but are not limited to, complaints received from providers and recipients regarding timely service authorization requests, participating provider availability, and authorization denials.
Other	Other complaints include those that don't fall into other general categories. For example: a provider called to ask for assistance in negotiating a payment rate with a health plan. The Agency maintains a neutral position regarding plan-provider negotiations.

Chart A
HMO Complaints by Type
(Demonstration Year Six)

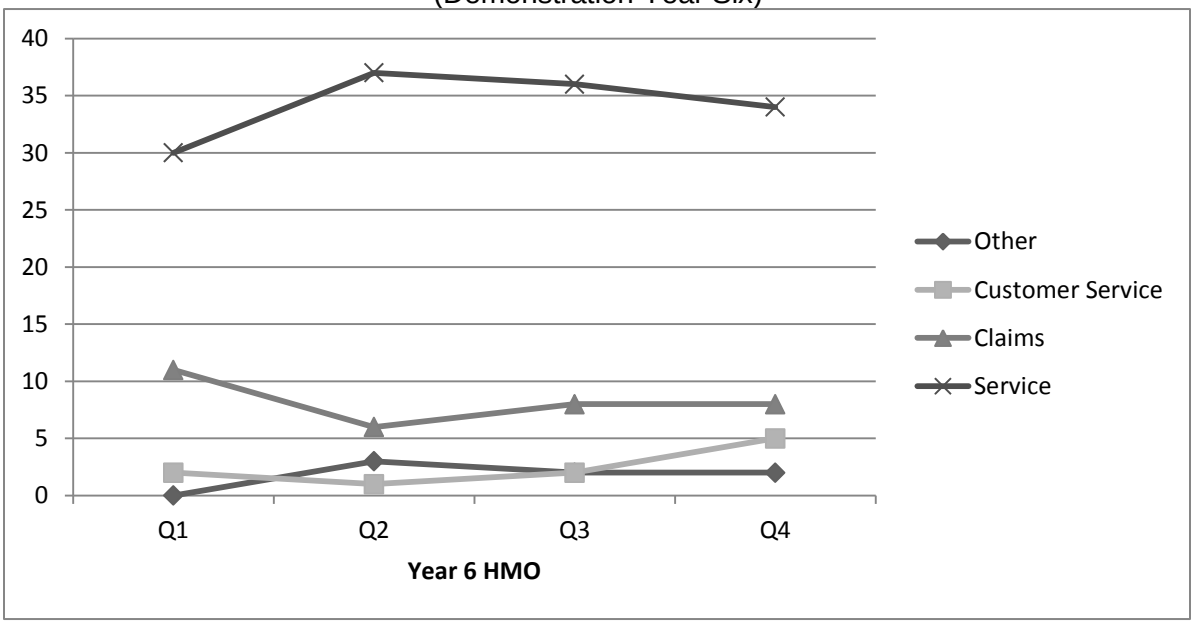
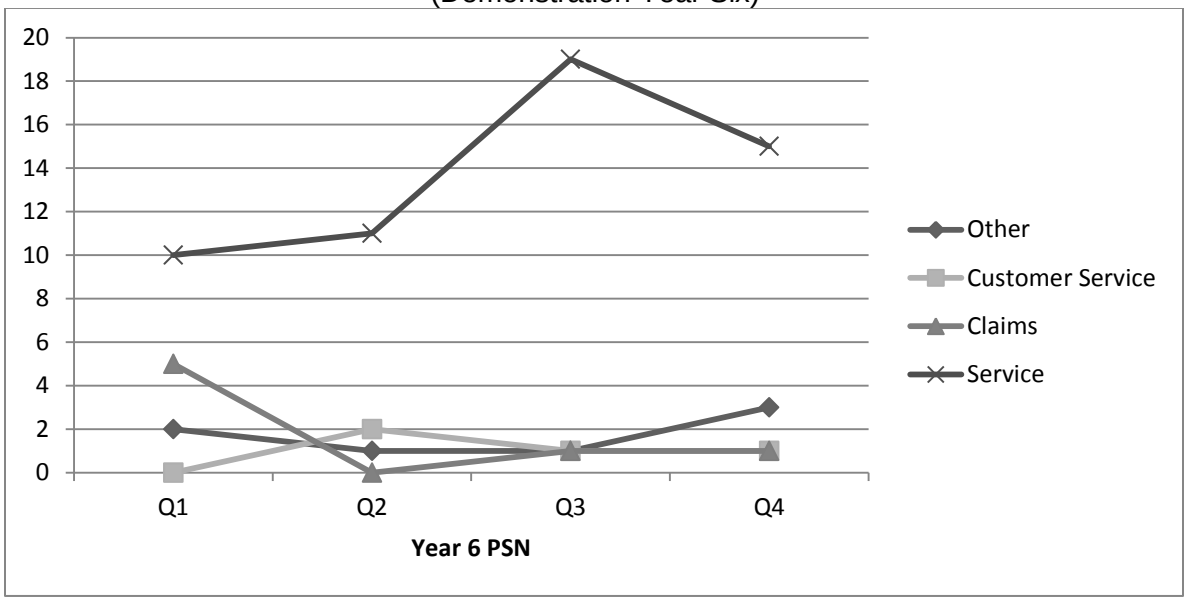


Chart B
PSN Complaints by Type
(Demonstration Year Six)



Trending reports on HMO and PSN complaints in Demonstration Year Six are provided in Charts C and D. There were fewer complaints received related to PSNs in Demonstration Year Six (73) than in Year Five (80). The number of complaints received related to HMOs increased in Demonstration Year Six (187) relative to Year Five (164). The average rate of issues reported remained the same from Demonstration Year Five (6.3 per 10,000 recipients) to Year Six (6.3 per 10,000 recipients). In Demonstration Year Six, the Agency continued reviewing complaints on a monthly basis and looking at complaints by health plan and issue type on a quarterly basis.

Chart C
HMO Overall Complaint Trends
(Demonstration Year Six)

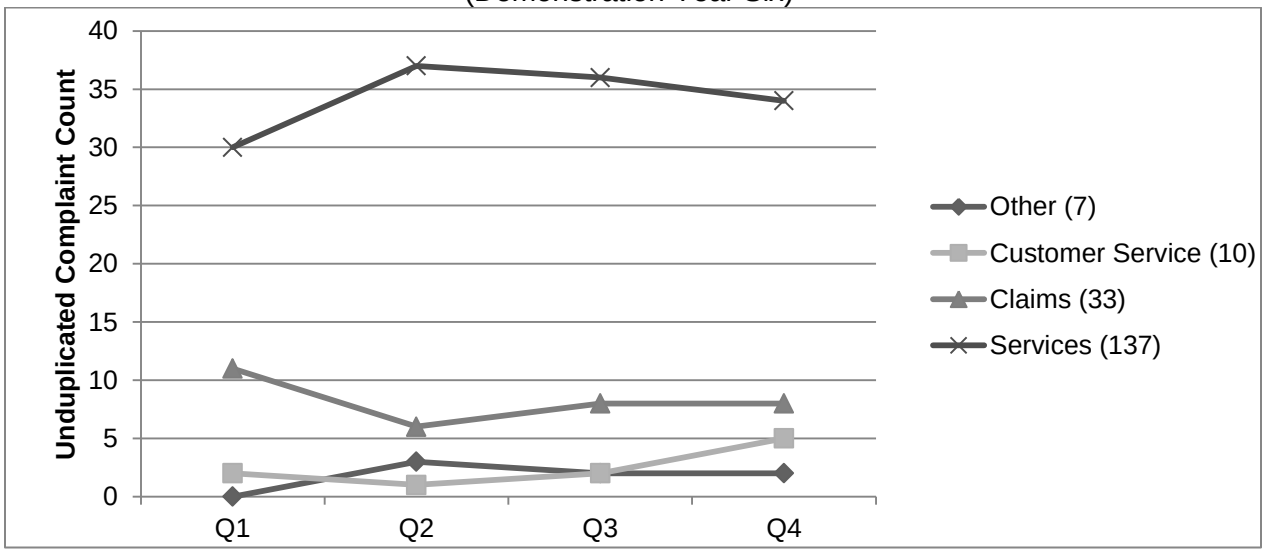
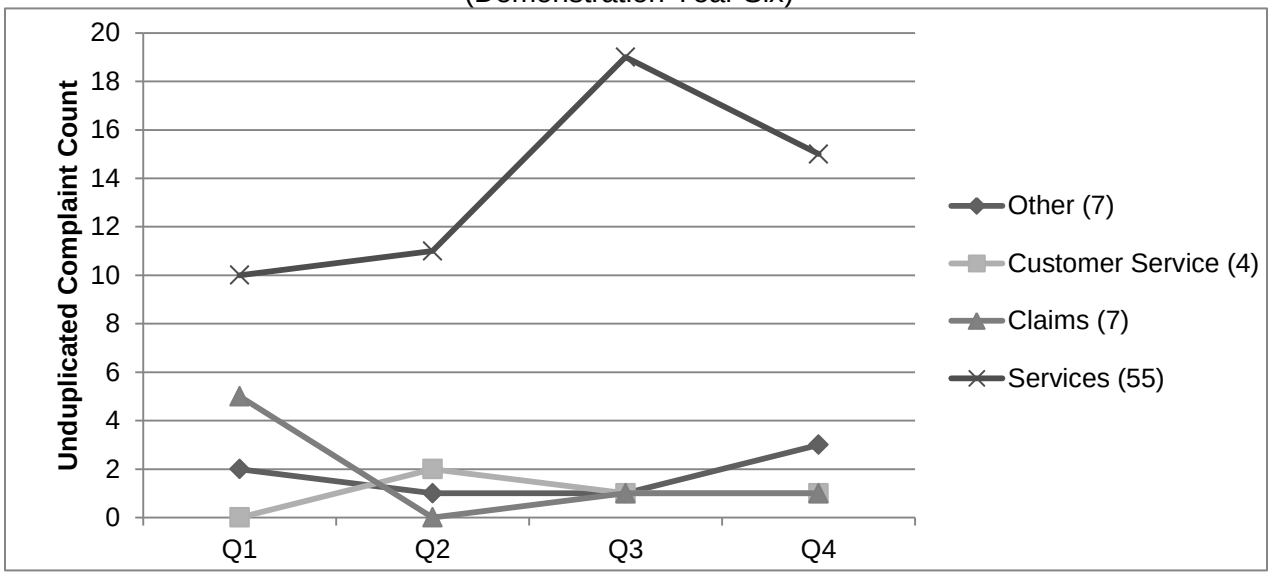


Chart D
PSN Overall Complaint Trends
(Demonstration Year Six)



5. Medical Loss Ratio

Demonstration Year Six at a Glance

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

On June 25, 2012, the Agency submitted to Federal CMS the revised MLR instructions and templates, MLR reporting schedule and the report guide that incorporated comments from the health plans and Federal CMS. The substantive change made to this policy was to extend the reporting deadline from 45 days to seven months after the end of each quarter or year for which the health plan is reporting. This change was made based on comments received by Federal CMS on June 15, 2012 to allow for the initial claims filing and claims adjudication to conclude so that the incurred but not reported (IBNR) ratio is lower. The revised MLR reporting schedule is outlined in Table 12, and is scheduled to become effective October 1, 2012.

Table 12
Health Plan Medical Loss Ratio Reporting Schedule

Demonstration Year	Quarter	Due to Agency	Due to CMS
Demonstration Year 7 (07/01/12 – 6/30/13)	**Q1:** 07/01/12 – 09/30/12	04/30/2013	05/15/2013
	Q2: 10/01/12 – 12/31/12	07/31/2013	08/15/2013
	Q3: 01/01/13 – 03/31/13	10/31/2013	11/15/2013
	Q4: 04/01/13 – 06/30/13	01/30/2014	02/14/2014
	DY 7 Annual Report	01/30/2014	02/14/2014
Demonstration Year 8 (07/01/13 – 06/30/14)	**Q1:** 07/01/13 – 09/30/13	04/30/2014	05/15/2014
	Q2: 10/01/13 – 12/31/13	07/31/2014	08/15/2014
	Q3: 01/01/14 – 03/31/14	10/31/2014	11/15/2014
	Q4: 04/01/14 – 06/30/14	01/30/2015	02/14/2015
	DY 8 Annual Report	01/30/2015	02/14/2015

In addition, the following draft plan contract amendment language was posted on the Agency's Managed Care website and will be provided to the health plans on July 1, 2012. The Agency has reviewed comments from Federal CMS and the health plans and updated the Report Guide and Core Contract Provisions as follows:

> In accordance with the Florida's Section 1115 Demonstration STCs, capitated health plans shall maintain an annual (July 1 through June 30) MLR of eighty-five percent (85%) for operations in the demonstration counties beginning July 1, 2012. The health plan shall submit data to the Agency quarterly to show ongoing compliance. The

Federal CMS will determine the corrective action for non-compliance with this requirement.

The update to the Report Guide will be posted by July 1, 2012 and the contract amendment will be effective 90 days later on October 1, 2012. Health plans will be expected to submit quarterly and annual MLR reports using the Agency supplied template and in accordance with the filing instructions in the draft version of Chapter 38 of the Report Guide. Quarterly reports will be due to the Agency no later than 7 months following the close of the quarter. The first Annual MLR report, for the waiver Demonstration Year Seven (July 1, 2012 – June 30, 2013), is due to the Agency on January 30, 2014.

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

"The method for calculating the MLR shall meet the following criteria:

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

The Agency will review all MLR reporting requirements to determine if changes are needed during Demonstration Year Seven.

6. On-Site Surveys and Desk Reviews

Demonstration Year Six at a Glance

During Demonstration Year Six, the Agency completed both desk reviews and on-site surveys of all Reform HMOs and PSNs. Demonstration Year Six spanned two parts of the on-site survey process. On-site surveys consisted of health plan staff interviews, demonstrations of health plan processes, and review of selected parts of the health plan contract. The behavioral health on-site survey consisted of a comprehensive review of the health plans' operations for compliance with the specific provisions of the contract related to behavioral health and all applicable federal and state laws and regulations.

<u>Desk Reviews</u>

The desk reviews focused on new and revised policies and procedures, including medical, fraud and abuse, and behavioral health. Provider network reviews were performed upon the health

plan's request for expansion of the service areas and/or increases in enrollment in existing service areas. In addition, the desk reviews consisted of reviewing member and provider materials and a review of complaints received concerning the recipients and/or providers.

On-Site Surveys

The Agency continued to further refine and strengthen the health plan survey process and monitoring tools with the assistance of Florida's External Quality Review Organization, Health Services Advisory Group, Inc. (HSAG). All monitoring tools and functions are compliant with state and federal regulations.

Table 13 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 13
On-Site Survey Categories

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

Each of the health plans received an on-site survey during this demonstration year. The on-site surveys consisted of medical and care/case management record reviews; review of complaints, grievances and appeals; prior authorization denials; provider credentialing and re-credentialing; provider services; provider contracts and subcontracts; access and availability; covered services; immunizations; pregnancy; drugs; transportation; member services; quality improvement; and utilization management processes. For this reporting period, only one health plan received a comprehensive behavioral health on-site survey. Desk reviews of provider networks, websites, member materials, policies and procedures, and clinical records were conducted on the other health plans.

The survey process was consistent across health plan types. The survey team consisted of a team leader and at least two team members and lasted an average of two days. The survey teams consisted of analysts and Registered Nurses from the bureaus of Health Systems Development and Managed Health Care. Behavioral health and program integrity reviews were done separately. The behavioral health survey teams included licensed clinical mental health professionals and consisted of a team lead and at least one team member. Health plan policies and procedures were reviewed prior to the on-site visit. Health plan staff were interviewed to make sure the plan processes were consistent with written procedures and plan staff were cognizant of the health plan responsibilities and how the various committees worked together to provide quality services to enrollees. The results of these surveys showed that all health plans are currently in good standing with the state and there were no sanctions administered as a result of desk and on-site reviews.

B. Choice Counseling Program

Overview

The Choice Counseling program continued to operate successful during Demonstration Year Six by providing information that helps recipients select the plan that bests meets their needs. A continual goal of the demonstration is to empower recipients to take responsibility for their own health care by providing information needed to make the most informed decisions about health plan choices.

During Demonstration Year Six, the following changes were implemented:

- Enhancements to the online enrollment website to increase readability and user friendliness.
- Refinements were made to the new file format for transfer of data between the Medicaid fiscal agent, HP Enterprise Services, LLC (HP), and the choice counseling vendor, Automated Health Systems (AHS).
- Implementation of systems logic to aide in maintaining continuity when recipients change counties.
- Increase in the Choice Counseling program's community partners.

Details on these and other components of the Choice Counseling program are described on the following pages.

1. Choice Selection Tools

Demonstration Year Six at a Glance

One primary goal of the demonstration is to increase the active participation of recipients in their health care. The Agency responded to feedback from recipients and other interested stakeholders and implemented, in October 2008, the Informed Health Navigator Solution (Navigator) as a Preferred Drug List (PDL) search system, under the previous choice counseling vendor, Affiliated Computer Systems (ACS). The Navigator function allowed the choice counselor to provide basic information to the recipients on how well each plan meets his or her prescribed drug needs. This information was provided to assist the recipient in making a health plan selection.

Since implementation of the Navigator program in 2008, the Agency has continued to evaluate recipient's needs and use patterns and identified primary care physician (PCP), physician specialist, and hospital as other primary drivers in plan selection. Beginning in June 18, 2010, the new enrollment system, referred to as Health Track, which includes the same PDL comparison function as well as primary care physician (PCP), specialist and hospital search comparison options, was implemented. Collectively, these new functions are now known as "Choice Selection Tools."

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

- **PDL Comparison**: Each health plan's PDL is compared against the recipient's prescribed drug claims history, as well as any additional list of medications provided to the choice counselor by the recipient.

- **PCP Comparison**: Each health plan's provider network file is searched simultaneously for the name of PCPs provided by the recipient.
- **Specialist Comparison**: Each health plan's provider network file is searched simultaneously for the name of specialists provided by the recipient.
- **Hospital Comparison**: Each health plan's provider network file is searched simultaneously for the name of hospitals provided by the recipient.

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

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

Illustration of Choice Selection Tools in Health Track Enrollment System

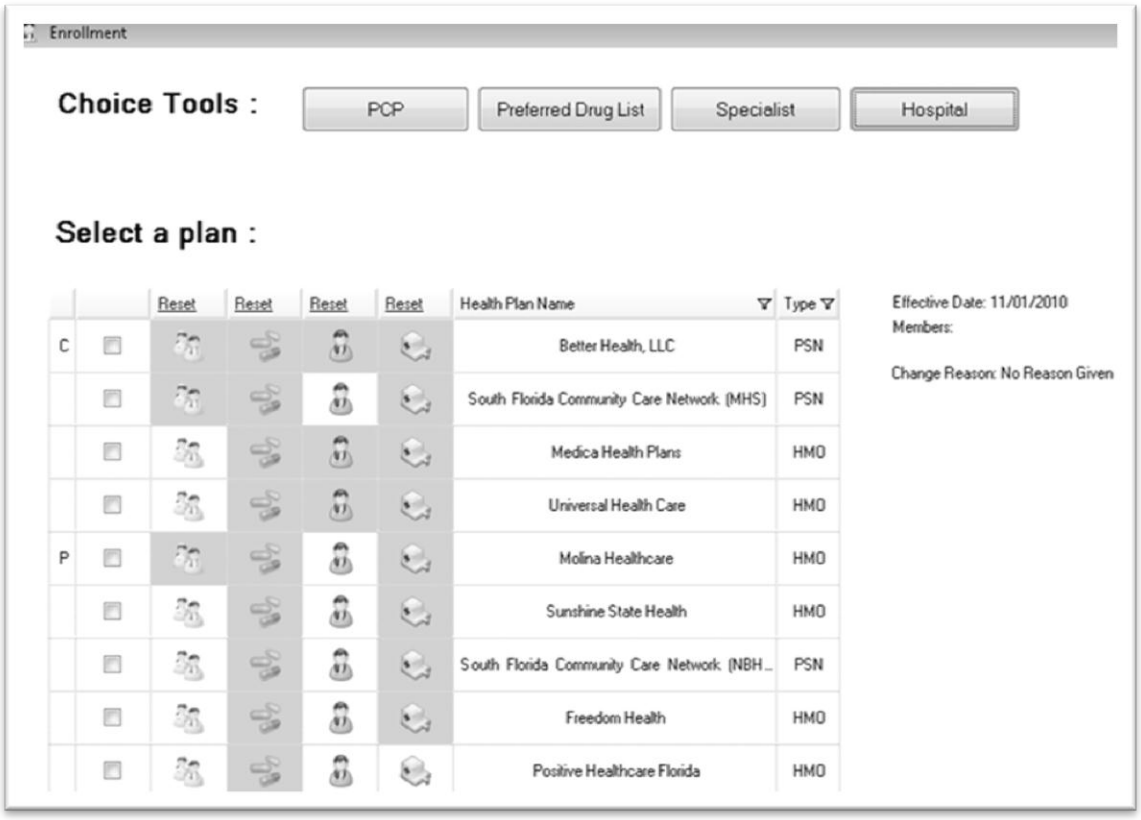
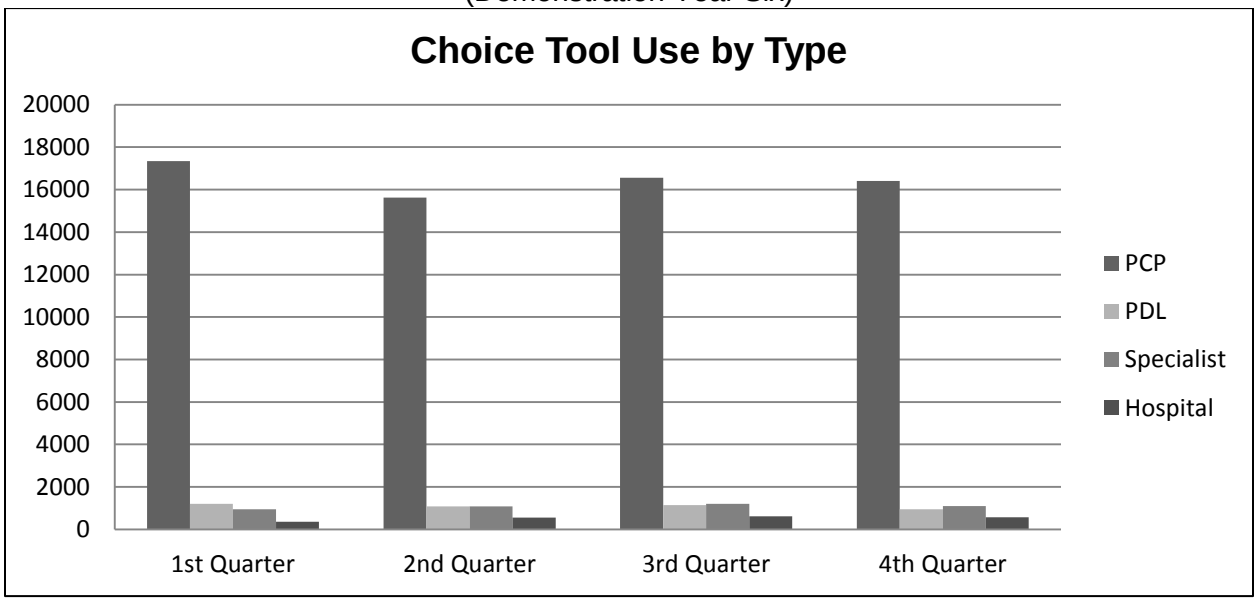


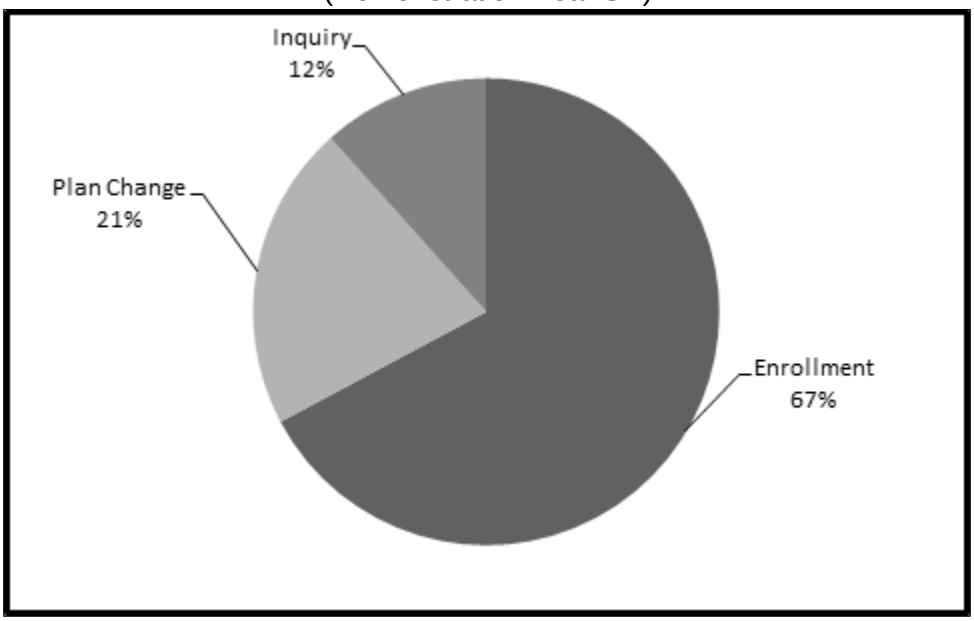
Chart E represents the number of times each Choice Selection Tool was utilized during the enrollment or plan change process for Demonstration Year Six. The results are broken out by choice tool type.

Chart E
Choice Tool Use by Type
(Demonstration Year Six)



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

Chart F
Navigator Use by Call Type
(Demonstration Year Six)



Recipient Customer Survey

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rank their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the survey to every recipient who calls to enroll in a plan or to make a plan change. During Demonstration Year Six, a total of 5,252 recipients completed the automated survey.

Table 14 shows a list of all questions that are asked during the survey and how recipients ranked their satisfaction (represented in percentages) with the choice counseling call center and the overall service provided by the choice counselors for Demonstration Year Six (by month).

Table 14
Choice Counseling Caller Satisfaction Results for Demonstration Year Six
Percentage of Satisfied Callers Per Question

Jul	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
How helpful do you find this counseling to be											
92%	89%	90%	92%	92%	91%	89%	91%	88%	90%	89%	87%
Satisfaction with the amount of time you waited to speak with a counselor											
90%	88%	87%	92%	91%	88%	84%	94%	89%	88%	87%	90%
How easy it was to understand the information											
78%	78%	76%	78%	81%	80%	80%	78%	78%	76%	74%	80%
How likely are you to recommend Choice Counseling helpline to friend or relative											
96%	94%	96%	96%	96%	94%	95%	96%	95%	95%	94%	94%
Overall service provided by Counselor											
97%	96%	98%	96%	97%	95%	95%	98%	95%	96%	94%	95%
How quickly the Counselor understood why you called today											
98%	97%	98%	97%	97%	97%	95%	98%	95%	96%	96%	97%
The Counselor's ability to help you choose your health plan											
97%	95%	98%	96%	96%	94%	95%	96%	93%	95%	95%	94%
The Counselor's ability to explain things clearly											
96%	96%	97%	96%	97%	95%	95%	96%	94%	96%	95%	95%
The confidence you have in the information given to you by the counselor											
97%	97%	98%	96%	95%	94%	94%	97%	94%	95%	93%	94%
Satisfaction with being treated respectfully											
99%	99%	99%	98%	98%	97%	97%	98%	97%	98%	96%	97%

2. Call Center

Demonstration Year Six at a Glance

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., Friday 8:00a.m. – 7:00p.m., and Saturday 9:00a.m. – 1:00p.m. During Demonstration Year Six, the call center had an average of 33 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls.

The primary function of the choice counseling call center is to handle inbound calls from Medicaid recipients and assist them in the enrollment process. The secondary function is to

place calls to recipients in their 30-day choice window, who need to make a health plan choice and have not yet contacted choice counseling.

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

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

Table 15 provides the choice counseling call center statistics for Demonstration Year Six.

Table 15
Choice Counseling Call Center Statistics
(Demonstration Year Six)

Type of Calls	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Inbound Calls Received	48,647	43,811	46,772	47,979	187,209
Average Speed of Answer (seconds)	:21	:24	:16	:8	:17
Abandoned Calls	943	870	952	426	3,191
Abandonment Rate[5]	1.94%	1.99%	2.03%	0.89%	1.70%
Calls Answered	47,704	42,941	45,820	46,553	183,018
Calls Answered in <180 seconds	97.0%	96.2%	98.1%	98.5%	97.5%
Outbound Calls	18,303	14,936	16,164	13,330	62,733

3. Mail

Demonstration Year Six at a Glance

In Demonstration Year Six, there was an increase in all mailings compared to Demonstration Year Five. The increase in mailings is in line with enrollment and growth trends.

Table 16 located on the following page highlights the volume for the largest mailings completed during the demonstration. Mailings are grouped by family or case. This means if there are two children in one case, only one mailing will be sent to the household instead of two; therefore, the number of individuals is higher than the number of mailings.

[5] The call abandonment rate is calculated by dividing the total number of calls abandoned by the total number of calls received.

Table 16 Mail Room Statistics Per Demonstration Year						
Type	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
New Eligible Packets	66,832	84,696	95,178	87,702	93,547	87,005
Transition Packets	119,002	17,730	3,221	2,045	5,543	8,206
Auto-Assignment Reminder Letters	49,390	48,147	129,456	84,384	64,846	56,097
Confirmation Letters	49,029	57,537	106,634	84,489	94,700	93,121
Open Enrollment Packets	2,641	74,412	166,227	137,648	172,684	220,096

During Demonstration Year Six, enrollments completed through the mail consistently remained around 1% each month. Mail-in enrollments remain significantly lower than the enrollments completed through the choice counseling call center, by the field choice counselors or online.

During Demonstration Year Six, the choice counseling vendor mailed 21,396 annual reminder notices to those who are exempt from open enrollment. The reminders are to inform recipients, who are exempt from open enrollment, that they may change their health plan at any time.

4. Face-to-Face/Outreach and Education

Demonstration Year Six at a Glance

Looking back over the results of the outreach efforts through Demonstration Year Six, there are important points that should be considered:

- The field choice counseling team has increased the number of community partners for approximately 120 to 205, 79 of which specifically serve and support recipients with mental health related diagnosis.
- Outbound call enrollment efforts continue to be a key activity, urging recipients to take an active role in their health care decisions.

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

The field choice counselors also have a presence on four different local committees:

- Regional Health Services Advisory Committees;
- Medical Home for Homeless Children Project;
- Clay Mercy Network; and
- Children's Counsel Services in Broward County.

Maintaining this type of presence in the community assures that the community is aware of the demonstration and the valuable point of access.

Minimizing complaints from recipients regarding either the choice counseling call center or the outreach/field team is another area that has great significance. The choice counseling vendor

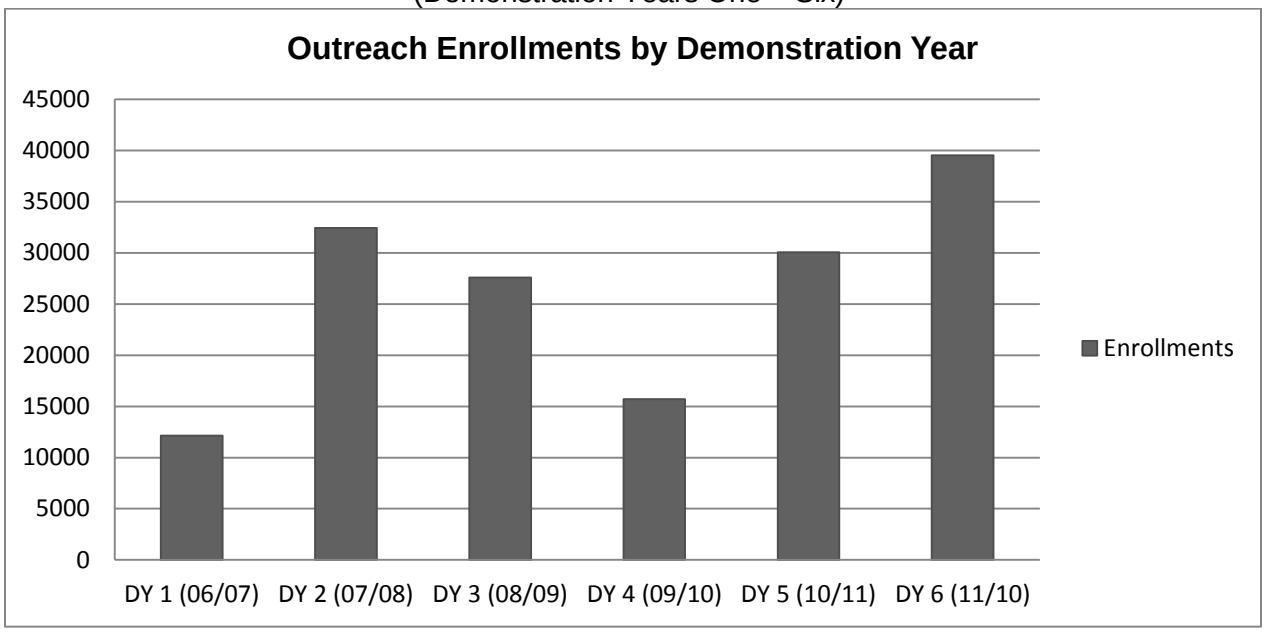
and the Agency's commitment to resolving issues in a timely manner made a positive impact. In the call center and in the field, if a recipient has a concern, then the concern is handled with expediency and care. The choice counselors have resources available such as the Special Needs Unit, choice counselors available in the field to meet someone face-to-face if needed, and supervisors (both in the field and the call center) who give guidance and assistance. The availability of these services alleviates most complaints, because the issues are resolved quickly. The efforts of the program to provide choice counseling services to recipients has taken away many of the concerns recipients have and empowered them with the information they need to select the best health plans for themselves and their families.

Table 17 lists the type and volume of outreach/field choice counselor activities during Demonstration Year Six, and Chart G shows the number of enrollments over the six years of the demonstration.

Table 17
Choice Counseling Outreach Activities
(Demonstration Year Six)

Field Activities	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Public Sessions	348	325	410	438	1,521
Private Sessions	74	53	46	56	229
Home/No-Phone Visits	534	793	814	488	2,629
Outbound List Calls	12,576	8,303	1,025	9,376	31,280
Outreach Enrollments	11,199	9,241	9,378	9,697	39,515

Chart G
Choice Counseling Outreach Enrollments
(Demonstration Years One – Six)



Mental Health Unit

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

During Demonstration Year Six, the vendor adjusted its staffing allocation to allow staff members of the Mental Health Unit to focus their time on building community relations and supporting the organizations and agencies servicing the special need communities. The Choice Counseling program continued to make dedicated efforts to contact community based organizations serving Medicaid recipients. This effort to establish a partnership and a line of communication between the local community and the field staff is of great benefit in reaching the most vulnerable of the Medicaid recipients.

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

- Susan B. Anthony Recovery Center in Broward County,
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County,
- Mental Health Resource Center and River Region Human Services in Duval County,
- Wolfson's Children's Hospital/Community Health in Duval County,
- Clay County Behavioral Health,
- Broward Addition Recovery, and
- Vocational Rehabilitation with the Florida Department of Education.

These groups provide mental health and substance abuse services and have been very receptive to working with the field choice counselors. The private sessions held in mental health and assisted living facilities allow the field choice counselors to work closely with case managers or family members to help these individuals transition as smoothly as possible. The field choice counselors have developed a reputation as being knowledgeable, compassionate and dedicated among the partners that have been established.

5. Health Literacy

Demonstration Year Six at a Glance

The choice counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit staff scope of work includes:

- Development of additional training for the choice counselors' on working with and serving the medically, mentally or physically complex;
- Enhancement of the scripts to educate recipients on how to access care in a managed care environment;
- Development of reference guides to increase the choice counselor's knowledge of Medicaid services, and information about diseases;

- Participation in the revising of the choice counseling script; and
- Development of a tracking log to capture the number and type of choice counselor's verbal inquiries, case referrals and reviews.

Summary of Cases Taken by the Special Needs Unit

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

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

During Demonstration Year Six, there were 1,494 new case referrals and 1,080 case reviews received and processed by the Special Needs Unit.

6. New Eligible Self-Selection Data[6]

Demonstration Year Six at a Glance

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

From July 2010 to June 2012, 70% of recipients enrolled in the demonstration self-selected a health plan and 30% were auto-assigned. On average, the self-selection rate was 80% prior to July 2008. The high rate of the voluntary selection may be attributable to several factors including a change in the choice counseling welcome packet, which may have resulted in recipients not calling to verify the preselected health plan as recipients are not required to do so. A description of the change in the welcome packet that was implemented during the fourth quarter of Demonstration Year Four follows:

- Prior to June 18, 2010, recipients received a packet of written materials (the choice counseling welcome packet) welcoming them to Medicaid, advising them of the need to select a plan by a specified date, and a brochure of covered services and available plans. In follow-up to the welcome packet, recipients were sent a pending auto-assignment letter. This letter notified recipients, who had not yet voluntarily selected a plan, that they would be automatically enrolled in a health plan (plan name was specified in the letter) unless they voluntarily select a plan by the specified date.
- Beginning June 18, 2010, recipients receive a choice counseling welcome packet welcoming them to Medicaid, advising them of the need to select a health plan, the deadline for selecting a plan, and the name of the plan they will be assigned to if a self-selection is not made by the specified date. If the recipient is satisfied with the plan

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

assignment provided in the choice counseling welcome packet, the recipient does not need to take any action to select a plan. Should the recipient decide to select a different health plan, then they can refer to the brochure of covered services and available health plans that is also included in their choice counseling welcome packet.

Table 18 shows the current self-selection and auto-assignment rate for Demonstration Year Six.

Table 18
Self-Selection and Auto-Assignment Rate
(Demonstration Year Six)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Self-Selected	34,673	37,735	34,252	35,171
Auto-Assignment	9,746	17,841	15,458	17,442
Total Enrollments	44,419	55,576	49,710	52,613
Self-Selected %	78%	68%	69%	67%
Auto-Assignment %	22%	32%	31%	33%

7. Complaints/Issues

Demonstration Year Six at a Glance

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

8. Quality Improvement

Demonstration Year Six at a Glance

A key component of the Choice Counseling program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the choice counseling vendor and the Agency improve customer service to Medicaid recipients. It is imperative for recipients to understand their options and make an informed choice. The survey results reporting the recipients' satisfaction with the overall service provided by the choice counselors indicate that more than 96% are satisfied with the choice counseling experience for Demonstration Year Six. The Agency continues to focus on improving communication between choice counselors and recipients, as well as evaluating comments left by recipients to improve customer service.

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

In addition to external feedback, the choice counseling vendor has implemented an anonymous, employee feedback e-mail system that allows call center choice counselors and field choice

counselors to provide immediate comments on issues as part of their daily work. This information is reviewed by management to ensure issues are addressed.

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

Lessons Learned and Looking Ahead to Demonstration Year Seven

During Demonstration Year Six, the Choice Counseling program identified and implemented several improvements. The following provides a description of the lessons learned and steps to be taken during the upcoming Demonstration Year Seven.

System Enhancements

The Agency will continue to evaluate the enrollment system, Health Track, to make all possible improvements in efficiency and effectiveness for recipient use in plan selection. During Demonstration Year Six, the following improvements were made:

- Integration of mass transfer processing within the system to allow greater control by the Agency during any transfer or transition process;
- Improvement to the online enrollment website to allow enrollment into specialty plans online; and
- Improved data transfer process between the choice counseling vendor and the Agency's Medicaid fiscal agent, allowing quicker resolution of any enrollment or disenrollment errors.

Public Feedback

The Agency will continue public interaction to provide opportunities for feedback in Demonstration Year Seven, as it is vital for the success and continued development of the Choice Counseling program.

C. Enrollment Data

Overview

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

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

- **Non-committed MediPass[7]:** 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 and 7
- **PSN Population:** 1/3 in each of Months 2, 3 and 4.

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

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

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

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

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

Demonstration Year Six Enrollment by Plan

Table 19 contains the quarterly enrollment for each health plan during Year Six of the demonstration, and shows how enrollment in the demonstration increased over this time period. The quarterly enrollment for each of the HMOs is displayed in Charts H and Chart I located on the following page shows the quarterly enrollment for each of the PSNs.

Table 19
Quarterly Medicaid Reform Enrollment by Plan
Demonstration Year Six

Plan Name	Plan Type	Number of Enrollees by Quarter – Year 6			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Care Florida	HMO	2,251	3,040	3,589	3,880
Freedom	HMO	4,510	4,635	4,645	4,657
Humana	HMO	5,065	4,615	4,263	5,501
Medica	HMO	3,753	3,936	4,173	4,278
Molina Healthcare	HMO	30,555	30,427	30,665	31,098
Positive Healthcare	HMO	155	176	186	196
Sunshine	HMO	94,383	93,184	93,541	94,994
United Healthcare	HMO	8,504	9,576	10,148	9,402
Universal Health Care	HMO	21,580	21,602	21,754	22,280
HMO Totals		**170,756**	**171,191**	**172,964**	**176,286**
Better Health, LLC	PSN	35,955	36,512	37,937	39,302
CMS	PSN	8,324	8,500	8,801	9,011
First Coast Advantage	PSN	66,920	68,135	69,407	72,369
SFCCN	PSN	39,156	39,582	40,028	40,343
PSN Totals		**150,355**	**152,729**	**156,173**	**161,025**
Medicaid Reform Totals		**321,111**	**323,920**	**329,137**	**337,311**

Chart H
Quarterly Medicaid Reform Enrollment for HMOs
(Demonstration Year Six)

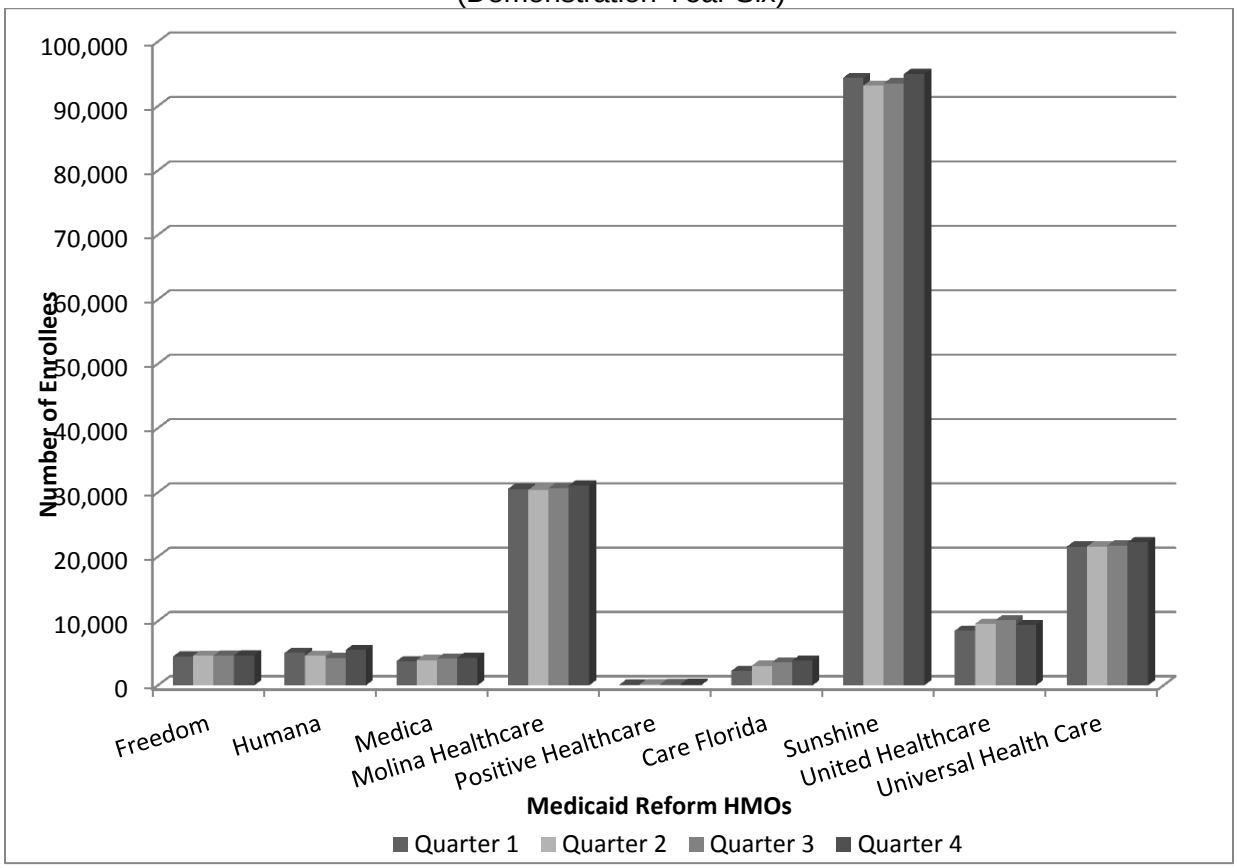
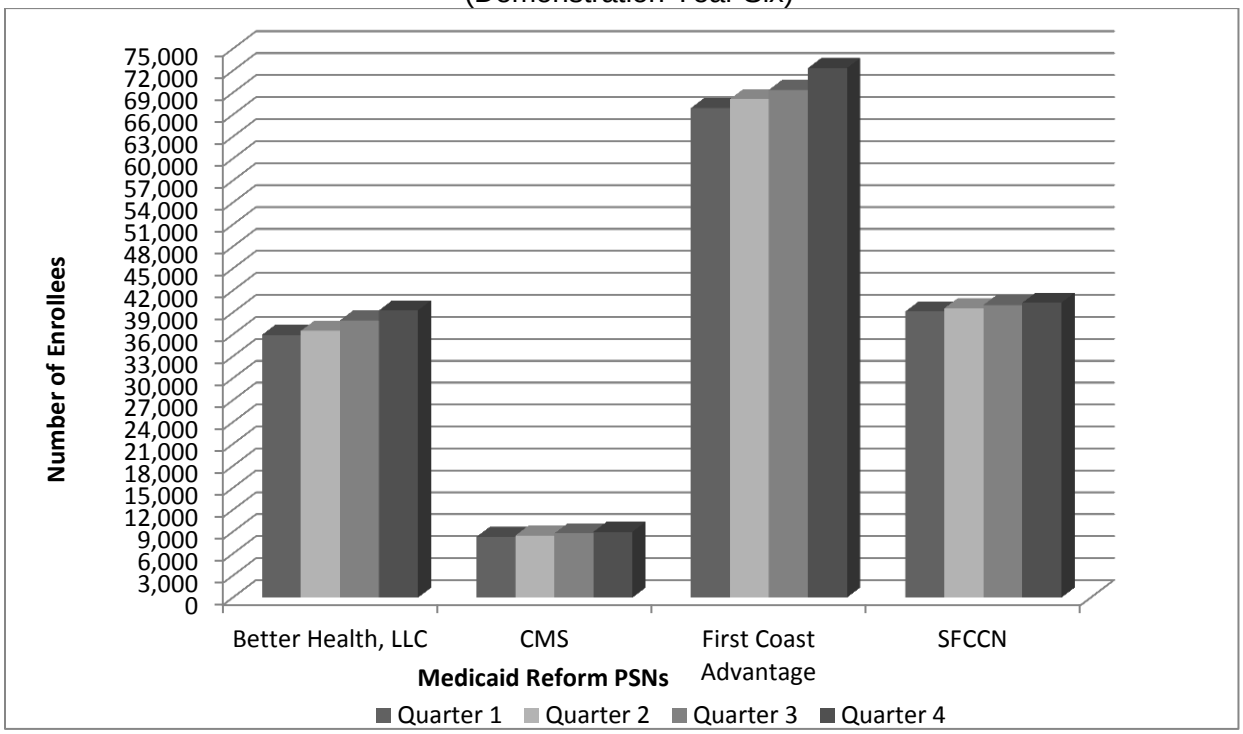


Chart I
Quarterly Medicaid Reform Enrollment for PSNs
(Demonstration Year Six)



Demonstration Year Six at a Glance

Monthly Enrollment Reports

The Agency provides a monthly enrollment report for all Medicaid Reform health plans. This monthly enrollment data is available on the Agency's website at the following link: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml

Below is a summary of the annual enrollment for Demonstration Year Six. 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 Demonstration Year Six, beginning July 1, 2011 and ending June 30, 2012, there were a total of 13 health plans – nine HMOs and four FFS PSNs. There are two categories of Medicaid recipients who are enrolled in health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the recipients' eligibility for Medicare. Each enrollment report for Demonstration Year Six and the process used to calculate the data they contain are described in this section.

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1. Medicaid Reform Enrollment Report

The annual Medicaid Reform Enrollment Report is a complete look at the entire enrollment (unduplicated count) for the demonstration for the year being reported. Table 20 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 20
Medicaid Reform Enrollment Report Column Descriptions

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

The information provided in this report is an unduplicated count of the recipients enrolled in each Reform health plan at any time beginning July 1, 2011, and ending June 30, 2012. Please refer to Table 21 located on the following page for the annual Medicaid Reform Enrollment report for Year Six of the demonstration.

Table 21 Medicaid Reform Enrollment (July 1, 2011 – June 30, 2012)									
Plan Name	**Plan Type**	**Number of TANF Enrolled**	**Number of SSI Enrolled**			**Total Number Enrolled**	**Market Share for Reform**	**Enrolled in Previous Year**	**Percent Change from Previous Year**
			No Medicare	**Medicare Part B**	**Medicare Parts A and B**				
Care Florida	HMO	3,978	739	3	135	**4,855**	**1.17%**	1,422	241.42%
Freedom Health Plan	HMO	5,288	692	0	137	**6,117**	**1.48%**	5,648	8.30%
Humana	HMO	4,358	1,429	4	280	**6,071**	**1.47%**	6,833	-11.15%
Medica	HMO	4,321	971	2	223	**5,517**	**1.33%**	4,430	24.54%
Molina Healthcare	HMO	33,790	4,594	15	968	**39,367**	**9.52%**	36,865	6.79%
Positive Healthcare	HMO	18	192	0	14	**224**	**0.05%**	149	50.34%
Sunshine	HMO	105,642	9,505	13	1,371	**116,531**	**28.17%**	120,106	-2.98%
United Healthcare	HMO	10,163	1,326	1	149	**11,639**	**2.81%**	11,608	0.27%
Universal Health Care	HMO	24,502	3,234	10	580	**28,326**	**6.85%**	26,875	5.40%
HMO Total	**HMO**	**192,060**	**22,682**	**48**	**3,857**	**218,647**	**52.86%**	**213,936**	**2.20%**
Better Health, LLC	PSN	41,731	4,707	10	945	**47,393**	**11.46%**	43,441	9.10%
CMS	PSN	6,097	4,201	0	27	**10,325**	**2.50%**	9,452	9.24%
First Coast Advantage	PSN	76,103	10,093	6	1,617	**87,819**	**21.23%**	75,067	16.99%
SFCCN	PSN	43,407	5,093	9	909	**49,418**	**11.95%**	47,840	3.30%
PSN Total	**PSN**	**167,338**	**24,094**	**25**	**3,498**	**194,955**	**47.14%**	**175,800**	**10.90%**
Reform Enrollment Totals		**359,398**	**46,776**	**73**	**7,355**	**413,602**	**100.00%**	**389,736**	**6.12%**

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

The enrollment figures for Demonstration Year Six reflect those recipients who self-selected a health plan, as well as those who were mandatorily assigned. In addition, some Medicaid recipients transferred from non-demonstration health plans to the demonstration health plans. There were a total of 413,602 unique recipients enrolled in the demonstration during Year Six. There were 13 demonstration health plans with market shares ranging from 0.05% to 28.17%.

2. Medicaid Reform Enrollment by County Report

During Year Six of the demonstration, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 22 located on the following page.

Table 22 Number of Reform Health Plans in Demonstration Counties (July 1, 2011 – June 30, 2012)		
County Name	**Number of Reform HMOs**	**Number of Reform PSNs**
Baker	**2**	**1**
Broward	**8**	**3**
Clay	**2**	**1**
Duval	**3**	**2**
Nassau	**2**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 23 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 23 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
Number of SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan in the county listed and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan in the county listed; TANF and SSI combined
Market Share for Reform by County	The percentage of the demonstration population in the county listed that the plan's recipient pool accounts for
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, as shown in Table 24 located on the following page.

Table 24
Medicaid Reform Enrollment by County Report
(July 1, 2011 – June 30, 2012)

Plan Name	Plan Type	Plan County	Number of TANF Enrolled	# SSI Enrolled			Total Number Enrolled	Market Share for Reform by County	Enrolled in Previous Year	Percent Change from Previous Year
				No Medicare	Medicare Part B	Medicare Parts A and B				
First Coast Advantage	PSN	Baker	3,077	337	0	11	**3,425**	**75.84%**	2,680	27.80%
Sunshine	HMO	Baker	-	-	-	-	**0**	**0.00%**	537	-
United Healthcare	HMO	Baker	958	115	0	18	**1,091**	**24.16%**	1,242	-12.16%
Baker			**4,035**	**452**	**0**	**29**	**4,516**	**100.00%**	**4,459**	**1.28%**
Better Health, LLC	PSN	Broward	41,731	4,707	10	945	**47,393**	**20.41%**	43,441	9.10%
Care Florida	HMO	Broward	3,978	739	3	135	**4,855**	**2.09%**	1,422	241.42%
CMS	PSN	Broward	3,982	2,893	0	19	**6,894**	**2.97%**	6,203	11.14%
Freedom Health Plan	HMO	Broward	5,288	692	0	137	**6,117**	**2.63%**	5,648	8.30%
Humana	HMO	Broward	4,358	1,429	4	280	**6,071**	**2.61%**	6,833	-11.15%
Medica	HMO	Broward	4,321	971	2	223	**5,517**	**2.38%**	4,430	24.54%
Molina Healthcare	HMO	Broward	33,790	4,594	15	968	**39,367**	**16.95%**	36,865	6.79%
Positive Healthcare	HMO	Broward	18	192	0	14	**224**	**0.10%**	149	50.34%
SFCCN	PSN	Broward	43,407	5,093	9	909	**49,418**	**21.28%**	47,840	3.30%
Sunshine	HMO	Broward	46,197	3,709	8	515	**50,429**	**21.72%**	47,893	5.30%
Universal Health Care	HMO	Broward	13,617	1,920	5	378	**15,920**	**6.86%**	15,633	1.84%
Broward			**200,687**	**26,939**	**56**	**4,523**	**232,205**	**100.00%**	**216,357**	**7.32%**
First Coast Advantage	PSN	Clay	5,549	473	0	38	**6,060**	**27.95%**	2,441	148.26%
Sunshine	HMO	Clay	11,215	899	1	95	**12,210**	**56.31%**	12,279	-0.56%
United Healthcare	HMO	Clay	3,099	278	0	35	**3,412**	**15.74%**	5,227	-34.72%
Clay			**19,863**	**1,650**	**1**	**168**	**21,682**	**100.00%**	**19,947**	**8.70%**
CMS	PSN	Duval	2,115	1,308	0	8	**3,431**	**2.34%**	3,249	5.60%
First Coast Advantage	PSN	Duval	61,885	8,765	6	1,526	**72,182**	**49.18%**	65,437	10.31%
Sunshine State Health Plan	HMO	Duval	48230	4897	4	761	**53,892**	**36.72%**	58,334	-7.61%
United Healthcare	HMO	Duval	4072	717	1	72	**4,862**	**3.31%**	2,599	87.07%
Universal Health Care	HMO	Duval	10,885	1,314	5	202	**12,406**	**8.45%**	11,242	10.35%
Duval			**127,187**	**17,001**	**16**	**2,569**	**146,773**	**100.00%**	**140,861**	**4.20%**
First Coast Advantage	PSN	Nassau	5,592	518	0	42	**6,152**	**73.01%**	4,509	36.44%
Sunshine	HMO	Nassau	-	-	-	-	**0**	**0.00%**	1,063	-
United Healthcare	HMO	Nassau	2,034	216	0	24	**2,274**	**26.99%**	2,540	-10.47%
Nassau			**7,626**	**734**	**0**	**66**	**8,426**	**100.00%**	**8,112**	**3.87%**
Reform Enrollment Totals			**359,398**	**46,776**	**73**	**7,355**	**413,602**		**389,736**	**6.12%**

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

During Demonstration Year Six, there was an enrollment of 4,516 recipients in Baker County, 232,205 recipients in Broward County, 21,682 recipients in Clay County, 146,773 recipients in Duval County, and 8,426 recipients in Nassau County. There were two Baker County health plans with market shares from 24.16% to 75.84%, 11 Broward County health plans with market shares ranging from 0.10% to 21.72%, three Clay County health plans with market shares ranging from 15.74% to 56.31%, five Duval County health plans with market shares ranging from 2.34% to 49.18%, and two Nassau County health plans with market shares ranging from 26.99% to 73.01%.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 25 and 26 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing recipients in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those recipients who were not part of Medicaid Reform for at least six months prior to the start of the demonstration year. Table 25 provides a description of each column in this report.

Table 25
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 26 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 26
Medicaid Reform Voluntary Population
(July 1, 2011 – June 30, 2012)

Plan Name	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
		Foster, Adoption Subsidy and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
HMOs		New	Existing	New	Existing	New	Existing	Number	Percentage	
Care Florida	Broward	31	11	2	1	107	31	**183**	**3.77%**	**4,855**
Freedom Health Plan	Broward	16	29	4	6	27	110	**192**	**3.14%**	**6,117**
Humana	Broward	5	40	2	27	17	267	**358**	**5.90%**	**6,071**
Medica	Broward	7	19	5	5	90	135	**261**	**4.73%**	**5,517**
Molina Healthcare	Broward	74	251	13	48	223	760	**1,369**	**3.48%**	**39,367**
Positive Healthcare	Broward	0	1	0	0	1	13	**15**	**6.70%**	**224**
Sunshine	Broward	88	293	16	28	126	397	**948**	**1.88%**	**50,429**
Sunshine	Clay	29	124	4	10	15	81	**263**	**2.15%**	**12,210**
Sunshine	Duval	118	604	11	62	92	673	**1,560**	**2.89%**	**53,892**
United Healthcare	Baker	1	10	0	1	2	16	**30**	**2.75%**	**1,091**
United Healthcare	Clay	0	28	3	4	5	30	**70**	**2.05%**	**3,412**
United Healthcare	Duval	31	65	3	14	26	47	**186**	**3.83%**	**4,862**
United Healthcare	Nassau	4	30	0	7	4	20	**65**	**2.86%**	**2,274**
Universal Health Care	Broward	37	85	4	15	78	305	**524**	**3.29%**	**15,920**
Universal Health Care	Duval	34	98	6	5	73	134	**350**	**2.82%**	**12,406**
HMO Total		**475**	**1,688**	**73**	**233**	**886**	**3,019**	**6,374**	**2.92%**	**218,647**
PSNs										
Better Health, LLC.	Broward	102	308	21	80	116	839	**1,466**	**3.09%**	**47,393**
CMS	Broward	3	46	28	190	1	11	**279**	**5.75%**	**4,848**
CMS	Broward	2	20	7	57	1	6	**93**	**4.55%**	**2,046**
CMS	Duval	70	257	10	130	0	8	**475**	**13.84%**	**3,431**
First Coast Advantage	Baker	167	822	22	147	185	1,347	**2,690**	**3.73%**	**72,182**
First Coast Advantage	Clay	27	36	1	4	16	22	**106**	**1.75%**	**6,060**
First Coast Advantage	Duval	19	39	1	4	5	6	**74**	**2.16%**	**3,425**
First Coast Advantage	Nassau	9	46	2	2	17	25	**101**	**1.64%**	**6,152**
SFCCN	Broward	94	479	10	76	127	791	**1,577**	**3.19%**	**49,418**
PSN Total		**493**	**2,053**	**102**	**690**	**468**	**3,055**	**6,861**	**3.52%**	**194,955**
Reform Totals		**968**	**3,741**	**175**	**923**	**1,354**	**6,074**	**13,235**	**3.20%**	**413,602**

D. Enhanced Benefits Account Program

Overview

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

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

The credits earned may be carried forward each state fiscal year so the recipient does not lose access to accrued credits. Any recipient who earned credits prior to December 2011 and loses Medicaid eligibility for three consecutive years will lose access to their credits. Beginning January 2012, any recipient who has earned credits and loses Medicaid eligibility for one year will lose access to their credits.

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

Demonstration Year Six accomplishments for the EBA program include:

- Continued increased use of the Automated Voice Response System (AVRS) at the Enhanced Benefits Call Center and a significant decrease in complaints by recipients regarding the EBA program.
    - Total number of calls to the AVRS were 91,239 and 64,866 calls were handled by an agent.
    - Total number of complaints for Demonstration Year Six was four compared to 22 complaints during Demonstration Year 5.

<u>Administration of the Enhanced Benefits Accounts</u>

The EBA program is administered through two separate systems; the EBIS and the pharmacy point of sale system through the HP subcontractor, Magellan. The EBIS acts as a data repository that houses healthy behavior activity information of recipients (as reported by their health plans), EBA purchases (as recorded in the Agency’s Pharmacy Point of Sale System), and EBA balances. The EBIS also is a means for the enhanced benefits call center as well as internal Agency resources to view the EBA information of recipients in a central location via the

Internet. The EBIS was created and is contracted with an outside vendor, Image Software Inc., which performs administrative and maintenance duties that include monthly statement generation, transaction testing, application recovery plan, participation project status meetings, database/website monitoring/maintenance, system backups, and AHCA phone support. Image Software Inc., also provides all users of the EBIS with customer support, secures hosting services/support, provides all equipment, maintains office space/work stations, and provides needed enhancements to the system all in a secure environment.

The Agency's pharmacy point of sale system through the HP subcontractor, Magellan, is the system where recipients can access their credits through their Medicaid Gold Card at any Medicaid participating pharmacy. The pharmacy system also is the official system which receives the credits from EBIS and where all the debit transactions are recorded and later transmitted to EBIS three times per week.

Participation Rates and Assessment of Expenditures

Table 27 compares the credits earned each month, by date of service for earned credits and purchases each month by date of service, and the number of recipients actively participating. Mailing of the monthly insert, which focuses on health related products and outbound calls to recipients who have not used their credits, continues to be very successful in increasing the spending of earned credits at the pharmacy and creation of opportunities to educate recipients about the program.

Table 27
Enhanced Benefits Information System Summary
(July 1, 2011 – June 30, 2012)

Month of Claims	Number Credited***	Earned by Date of Service*	Amount of Credits Earned Each Month**	Purchases by Date of Service	Recipients Actively Participating by Month
July 2011	64,392	$1,276,395.00	$1,052,595.00	$569,518.78	22,005
August 2011	59,855	$1,313,070.00	$1,378,510.00	$495,013.93	20,503
September 2011	51,331	$1,099,390.00	$1,031,657.50	$636,560.70	24,018
October 2011	46,346	$1,043,655.00	$885,917.50	$772,890.05	27,997
November 2011	38,810	$890,100.00	$1,255,952.50	$734,680.75	26,617
December 2011	36,639	$850,472.50	$841,067.50	$674,406.75	23,882
January 2012	42,412	$993,592.50	$938,565.00	$760,024.28	26,995
February 2012	38,627	$916,112.50	$1,066,247.50	$492,697.61	18,569
March 2012	39,918	$977,852.50	$861,927.50	$511,490.25	19,085
April 2012	35,727	$884,147.50	$1,076,470.00	$609,704.61	22,021
May 2012	34,424	$869,660.00	$1,132,645.00	$625,765.17	23,113
June 2012	18,212	$414,917.50	$961,930.00	$626,428.81	22,167
Year 6 Totals	**270,715**	**$11,529,365.00**	**$12,483,485.00**	**$7,509,181.69**	**276,972**

* Health Plans may submit healthy behaviors up to one year after the date of service.
** This is the amount of credits earned when the EB reports are due by the 10th of each month.
*** This is the number of recipients who were credited unduplicated.

1. Call Center Activities

Demonstration Year Six at a Glance

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

The primary function of the call center is to answer all inbound calls relating to program questions, provide enhanced benefits account updates on credits earned/used, and assist recipients with utilizing the web based over-the-counter product list. AHS implemented the Automated Voice Response System (AVRS) on June 18, 2010 for recipients who need balance only information. The AVRS handles the majority of recipient calls for balance only information and is available 24 hours a day. In addition, the call center performs outbound calls to recipients who have not spent their enhanced benefits account credits.

During Demonstration Year Six, the number of inbound calls handled by an agent in the call center was 64,866 compared to the reported 65,977 inbound calls in Year Five. There were 91,239 that were handled by the AVRS in Demonstration Year Six compared to 81,732 in Year Five. The reason for the decrease in inbound calls for Demonstration Year Six is due to an increase of calls handled by the AVRS. Additional detail regarding call center activity can be found in the remainder of this section. Table 28 highlights the enhanced benefits call center activities during Demonstration Year Six.

Table 28
Highlights of the Enhanced Benefits Call Center Activities
(July 1, 2011 – June 30, 2012)

Enhanced Benefits Call Center Activity	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Total
Calls Received	18,969	17,847	14,259	15,742	**66,817**
Calls Answered	18,346	17,256	13,757	15,507	**64,866**
Abandonment Rate	3.28%	3.30%	3.20%	1.49%	**2.82%**
Average Talk Time (minutes)	4:12	4:30	4:16	3:52	**4:13**
Calls Handled by the AVRS	25,629	25,001	19,127	21,482	**91,239**
Outbound Calls	617	354	153	152	**1,276**
Enhanced Benefits Mailroom Activity					
EB Welcome Letters	11,864	13,760	19,852	37,378	**82,854**

The AVRS continues to be used and was a good step towards assisting recipients more efficiently. In Demonstration Year Six, the call center has primarily handled calls related to recipient EBA balances. The call center is well below its standard abandoned rate of 5% with an average 2.82% abandonment rate during Demonstration Year Six. The Agency continues to evaluate call center activities to bring additional improvements for the EBA program.

2. System Activities

Demonstration Year Six at a Glance

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

3. Outreach and Education for Recipients

Demonstration Year Six at a Glance

There are many occurrences when recipients receive information about the EBA program. Every recipient enrolled in a demonstration health plan has access to the EBA Program. The first instance is through the choice counseling script. When a recipient is going through the choice counseling process, the EBA program is explained and promoted to the recipient. The second instance is once a recipient is enrolled in a plan, the recipient then receives an EBA program welcome letter. Lastly, as a recipient earns credits or purchases items, monthly statements are mailed to keep the recipient up-to-date with their account balance. The quarterly statement mailing has discontinued due to the high volume. The Agency continues to mail flyers to promote specific products recipients may purchase. The Agency also continues to mail flyers to promote a healthy activity and preventive procedures.

During Demonstration Year Six, there were 1,276 outbound calls made to recipients who have never utilized their EBA credits. Every other Saturday, depending on other choice counseling activities, agents reach out to recipients to encourage them to use their credits, explain some of the nuances at the pharmacy when using their earned credits, and how they can earn additional credits by participation in a healthy behavior. The call center's outreach to recipients about their earned EBA credits may have contributed to the increase in utilization of credits. Purchases continue to be stabilized with a slight increase.

Continuation of grass roots efforts, through mail, field choice counseling and partnerships with health agencies will be used to inform recipients about the EBA program. The call center will increase the outbound calls to recipients who have never spent their EBA credits and education will continue to be provided to those recipients about the EBA program. The EBA script will continue to be updated as needed.

4. Outreach and Education for Pharmacies

Demonstration Year Six at a Glance

The Agency continues to provide outreach and education to pharmacies regarding the design and billing process for the program as needed. Although there are still complaints from recipients regarding some product availability or treatment at some pharmacies, this has significantly decreased as more and more pharmacies are familiar with the EBA program. The Agency has also continued use of a "Network Pharmacy List," which lists pharmacies that are actively participating in the EBA based on monthly sales. The call center refers recipients to these pharmacies if they call and complain about a particular pharmacy. The over-the-counter product list is updated on a quarterly basis. The Agency has continued to work with these pharmacies on a one-on-one basis to address the issues they are encountering and to make system changes as needed.

5. Enhanced Benefits Advisory Panel

Demonstration Year Six at a Glance

The Enhanced Benefits Advisory Panel is a seven-member, Agency-appointed panel. The EB Charter was updated to have two-year time limits for serving and to have representation of both HMO's and PSN's. The Enhanced Benefits Advisory Panel is responsible for adding additional healthy behaviors and setting the credit amount. During Demonstration Year Six, the panel met once on February 11, 2012, and there were no changes or additions suggested by the Panel. The Enhanced Benefits Advisory Panel will meet and receive statistical updates regarding the status of the EBA program.

Enhanced Benefits Statistics

Table 29 located on the following page provides a cumulative count of healthy behaviors and the sum of granted credit amounts for the demonstration. Since implementation of the program in September 2006 through June 30, 2012, a total of 499,209 recipients have earned $53,810,936.16 in EBA credits; 277,531 recipients have spent $29,512,502.90 in credits.

Through Demonstration Year Six, 13,699 recipients lost EBA eligibility for a total of $616,956.63 and they no longer have access to those credits. Programming is in process to address the recent FLMMIS EBA customer service request fix that should increase the three-year EBA expiration counts. As of July 5, 2012, there are 221,024 individuals who continue to retain access to funds ($14,051,700.00) in an account, but have never made a purchase with their earned credits; the call center does outbound calls on some Saturdays to these individuals.

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Table 29 Healthy Behavior Counts and Credit Amounts (September 2006 - June 30, 2012)		
Healthy Behavior	**Count of Procedure Code**	**Sum of Granted Credit Amount**
Childhood Preventive Care	974,258	$24,256,427.50
Office Visit-Adult/Child	1,084,764	$13,236,262.50
Dental Preventive Services-Adult/Child	242,587	$6,033,025.00
Compliance with prescribed maintenance drugs	459,646	$3,417,857.50
Vision Exam-Adult/Child	109,586	$2,729,165.00
Pap Smear	75,075	$1,871,972.50
Child and Adult Preventive Care	57,235	$1,041,510.00
Diabetes Management	24,732	$369,845.00
Adult Preventive Care	17,502	$261,430.00
Mammography	8,592	$211,975.00
Colorectal Screening	4,551	$112,722.50
Prostate Specific Antigen PSA	6,318	$94,392.50
Healthy Start Screen - 1st Trimester	3,581	$53,715.00
Hypertension Disease Management Program	1,487	$36,157.50
Diabetes Disease Management Program	1,064	$25,732.50
Asthma Disease Management Program	817	$20,170.00
Adult BMI Assessment	749	$18,632.50
HIV/AIDS Disease Management Program	465	$11,572.50
Congestive Heart Failure Disease Management Program	153	$3,712.50
Other Disease Management Program	141	$3,470.00
Flu Shot	11	$275.00
Dental Preventive Services-Adult/Child	16	$237.50
Exercise Program	8	$200.00
Administrative Credit	10	$151.16
Weight Management	3	$75.00
Weight Management 6 Months Success	5	$75.00
Smoking Cessation Program	2	$50.00
Exercise Program 6 Months Success	3	$45.00
Smoking Cessation 6 Months Success	2	$30.00
Alcoholics Anonymous Program	1	$25.00
Narcotics Anonymous Program	1	$25.00

Table 30 compares credits earned and used (by date of service) since implementation of the program in September 2006.

Table 30 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2012)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Demonstration Year 1		
Sep-06	$40,202.50	0
Oct-06	$249,542.50	0
Nov-06	$366,097.50	$203.87
Dec-06	$487,102.50	$840.55
Jan-07	$631,890.00	$3,424.90
Feb-07	$621,636.16	$8,716.25
Mar-07	$722,477.50	$17,574.09
Apr-07	$647,160.00	$13,992.22
May-07	$653,342.50	$28,306.64
Jun-07	$585,930.00	$40,113.83
Year 1 Totals	**$5,005,381.16**	**$113,172.35**
Demonstration Year 2		
Jul-07	$943,790.00	$44,331.82
Aug-07	$982,095.00	$70,911.44
Sep-07	$872,717.50	$62,306.52
Oct-07	$1,113,220.00	$80,148.38
Nov-07	$897,445.00	$50,068.93
Dec-07	$834,907.50	$96,201.45
Jan-08	$996,050.00	$192,498.60
Feb-08	$922,135.00	$201,446.46
Mar-08	$892,452.50	$309,259.55
Apr-08	$850,625.00	$352,972.35
May-08	$721,262.50	$471,300.40
Jun-08	$692,177.50	$500,229.37
Year 2 Totals	**$10,718,877.50**	**$2,431,675.27**
Demonstration Year 3		
Jul-08	$836,270.00	$388,020.48
Aug-08	$691,197.50	$549,953.65
Sep-08	$649,355.00	$399,659.71
Oct-08	$610,170.00	$447,058.34
Nov-08	$510,127.50	$621,601.81
Dec-08	$497,597.50	$686,935.39

Table 30 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2012)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Jan-09	$575,282.50	$756,374.59
Feb-09	$369,185.00	$537,483.98
Mar-09	$621,027.50	$490,736.08
Apr-09	$616,705.00	$497,179.36
May-09	$572,660.00	$518,645.42
Jun-09	$630,025.00	$491,292.11
Year 3 Totals	**$7,179,602.50**	**$6,384,940.92**
Demonstration Year 4		
Jul-09	$920,607.50	$440,893.08
Aug-09	$942,385.00	$382,324.35
Sep-09	$702,145.00	$574,278.21
Oct-09	$678,590.00	$708,707.76
Nov-09	$574,665.00	$652,294.50
Dec-09	$546,220.00	$617,914.57
Jan-10	$550,725.00	$484,714.36
Feb-10	$519,765.00	$344,644.76
Mar-10	$731,987.50	$460,177.80
Apr-10	$711,135.00	$537,418.41
May-10	$646,965.00	$474,325.31
Jun-10	$792,142.50	$454,480.64
Year 4 Totals	**$8,317,332.50**	**$6,132,173.75**
Demonstration Year 5		
Jul-10	$1,193,995.00	$451,960.36
Aug-10	$1,289,937.50	$549,826.34
Sep-10	$951,010.00	$645,491.64
Oct-10	$828,962.50	$705,524.23
Nov-10	$761,742.50	$655,928.61
Dec-10	$768,330.00	$757,988.83
Jan-11	$878,912.50	$383,469.03
Feb-11	$807,900.00	$383,252.35
Mar-11	$984,875.00	$473,448.95
Apr-11	$862,497.50	$455,209.66
May-11	$855,545.00	$540,680.37
Jun-11	$876,670.00	$524,077.61
Year 5 Totals	**$11,060,377.50**	**$6,526,857.98**

Table 30 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2012)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Demonstration Year 6		
Jul-11	$1,276,395.00	$578,636.42
Aug-11	$1,313,070.00	$497,622.76
Sep-11	$1,099,390.00	$637,629.14
Oct-11	$1,043,655.00	$774,340.58
Nov-11	$890,100.00	$736,175.86
Dec-11	$850,472.50	$675,502.05
Jan-12	$993,592.50	$761,022.47
Feb-12	$916,112.50	$497,691.91
Mar-12	$977,852.50	$512,650.27
Apr-12	$884,147.50	$610,344.97
May-12	$869,660.00	$626,498.86
Jun-12	$414,917.50	$627,371.88
Year 6 Totals	**$11,529,365.00**	**$7,535,487.17**
Cumulative Total*	**$53,810,936.16**	**$29,124,294.06**

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Table 31 highlights the Demonstration Year Six amount of credits submitted by each health plan for recipients as of June 30, 2012 (date of service).

Table 31
Amount of Credits Submitted by Health Plan
(July 1, 2011 – June, 30, 2012)

County	Health Plan Company Name	Granted Credit Amount
Baker	Access Health Solutions	$159,697.50
Baker	First Coast Advantage - Baker	$136,320.00
Baker	Sunshine State Health Plan, Inc.-Baker	$102,095.00
Baker	United Healthcare of Florida, Inc.	$139,047.50
Broward	Access Health Solutions	$648,542.50
Broward	AMERIGROUP Florida, Inc.	$1,928,780.00
Broward	Better Health	$3,512,390.00
Broward	CareFlorida	$105,037.50
Broward	CMS Network Broward North	$890,965.00
Broward	CMS Network Broward South	$298,427.50
Broward	Florida NetPass, LLC	$763,020.00
Broward	Freedom Health Plan	$302,027.50
Broward	HealthEase	$1,468,065.00
Broward	Humana Inc.	$2,084,957.50
Broward	Medica Health Plans of Florida, Inc.	$199,310.00
Broward	Molina	$2,112,185.00
Broward	Pediatric Associates PSN, LLC	$1,069,322.50
Broward	Positive Healthcare Florida	$12,475.00
Broward	Preferred Medical Plan, Inc.	$156,912.50
Broward	South Florida Community Care Network	$2,834,643.66
Broward	South Florida Community Care Network	$2,845,680.00
Broward	Staywell	$2,951,117.50
Broward	Sunshine State Health Plan, Inc.-Broward	$3,562,327.50
Broward	Total Health Choice, Inc	$1,071,057.50
Broward	United Healthcare of Florida, Inc.	$753,315.00
Broward	Universal Health Care Broward	$983,082.50
Broward	Vista Healthplan of South Florida, Inc.	$575,345.00
Broward	Vista Healthplan, Inc. (Buena Vista)	$753,525.00
Clay	Access Health Solutions	$407,962.50
Clay	First Coast Advantage - Clay	$159,802.50
Clay	Sunshine State Health Plan, Inc. - Clay	$694,710.00
Clay	United Healthcare of Florida, Inc.	$623,610.00
Duval	Access Health Solutions	$1,040,637.50
Duval	CMS Duval/Ped-I-Care	$468,302.50
Duval	First Coast Advantage - Duval	$8,665,635.00
Duval	HealthEase	$3,404,717.50
Duval	Staywell	$259,832.50

Table 31 Amount of Credits Submitted by Health Plan (July 1, 2011 – June, 30, 2012)		
County	**Health Plan Company Name**	**Granted Credit Amount**
Duval	Sunshine State Health Plan, Inc. -Duval	$3,046,142.50
Duval	United Healthcare of Florida, Inc.	$1,398,940.00
Duval	Universal Health Care Duval	$512,622.50
Nassau	Access Health Solutions	$135,357.50
Nassau	First Coast Advantage - Nassau	$171,712.50
Nassau	Sunshine State Health Plan, Inc.-Nassau	$147,260.00
Nassau	United Healthcare of Florida, Inc.	$254,020.00

Table 32 provides the top 25 purchases in terms of dollar amount, made by recipients, during Demonstration Year Six.

Table 32 Top 25 Recipient Purchases (July 1, 2011 – June, 30, 2012)				
	Description*	**Count**	**Sum**	**Average**
1	HUGGIES	119864	$1,125,046.56	$9.39
2	HUGGIES BABY WIPES	111927	$431,332.77	$3.85
3	HUGGIES PULL-UPS	36020	$365,879.38	$10.16
4	PREMIUM BABY DIAPER	42731	$359,917.14	$8.42
5	SUPREME DIAPERS	47802	$311,413.25	$6.51
6	LISTERINE ANTISEPTIC	43408	$208,134.76	$4.79
7	KOTEX	27147	$139,970.75	$5.16
8	PAMPERS BABY-DRY	12946	$126,867.36	$9.80
9	BABY WIPES	44859	$107,307.76	$2.39
10	CHILDREN'S IBUPROFEN	18585	$97,746.70	$5.26
11	CETAPHIL	13237	$84,044.58	$6.35
12	SENSODYNE	16587	$79,168.49	$4.77
13	TRAINING PANTS	9014	$77,787.75	$8.63
14	AVEENO	10510	$76,188.19	$7.25
15	KIDPANT	9516	$73,821.94	$7.76
16	IBUPROFEN	13731	$68,943.18	$5.02
17	PREMIUM TRAINING PANTS	8720	$68,013.24	$7.80
18	BABY SHAMPOO	17888	$66,008.37	$3.69
19	FLINTSTONES MULTI-VIT GUMMIES	7311	$62,847.24	$8.60
20	ISOPROPYL ALCOHOL	19799	$45,910.90	$2.32
21	GUMMY SWIRLS	8045	$41,621.44	$5.17
22	AQUAFRESH	15645	$41,514	$2.65
23	CHILDREN'S PAIN RELIEF	8610	$40,774.99	$4.74
24	LUBRIDERM DAILY MOISTURE	6157	$40,729.01	$6.62
25	ADVIL	6353	$40,247.01	$6.34

*Includes purchase/return combinations

Table 33 provides the EBA program statistics for Demonstration Year Six.

Table 33
Enhanced Benefits Account Program Statistics

Year Five Activities		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
I.	Average number of plans submitting reports by quarter.	27	27	27	27
II.	Number of enrollees who received credit for healthy behaviors by quarter (not unduplicated by date of service as of July 2011).	170,595	112,024	111,325	84,158
III.	Total dollar amount credited to accounts by each quarter (as of July 2011, by date of service).	$3,688,855.00	$2,784,227.50	$2,887,557.50	$2,168,725.00
IV.	Total cumulative dollar amount credited through each quarter (not based on date of service).	$44,790,213.66	$47,773,151.16	$50,639,891.16	$53,810,936.16
V.	Total dollar amount of credits spent each quarter by date of service.	$1,713,888.32	$2,186,018.49	$1,771,364.65	$1,864,215.71
VI.	Total cumulative dollar amount of credits used through the quarter by date of service.	$23,302,695.21	$25,488,713.70	$27,260,078.35	$29,124,294.06
VII.	Total cumulative number of enrollees who used credits through the quarter (not unduplicated – by date of service through July 2011).	66,526	78,496	64,649	67,301

6. Complaints

Demonstration Year Six at a Glance

As the EBA program was implemented, the Agency had no historical information to predict what type of complaints would be received on the program. It was anticipated that there would be some processing problems with the pharmacies as they adjusted to the program and that recipients would have questions about their account balance. While no formal evaluation of this has been conducted, the Agency can report that the health plans are submitting healthy behaviors to the Agency on a very timely basis so that recipients can earn credit dollars.

During Demonstration Year Six, there were only four recipient complaints. The decrease in complaints (compared to 25 complaints in Demonstration Year Five) is attributed to improved call center staff training and direct problem resolution through the EB call center lead and the Agency EB staff person. Table 34 located on the following page provides a description of the complaints received during Demonstration Year Six.

Table 34 Enhanced Benefits Recipient Complaints (July 1, 2011 – June 30, 2012)	
Recipient Complaint	**Action Taken**
1. Three recipients called to complain they were unhappy with the services provided at the pharmacy.	➲ The pharmacy process was explained to one recipient. ➲ Two recipients were referred to another pharmacy.
2. One recipient was unhappy with the service provided by the EB call center.	➲ Supervisor resolved the issue by giving the recipient information and an apology.

More frequent updates of the over-the-counter product list posted onto the EB website are planned for Demonstration Year Seven. In addition, training efforts for pharmacy personnel will continue, when applicable.

Table 35 lists the dollar amount and count of recipients during Demonstration Year Six who have lost EBA eligibility and credits because they have not been Medicaid eligible for three consecutive years. There is a decreased number during Demonstration Year Six. A Customer Service Request was submitted and completed by the Fiscal Agent to correct the three-year calculation related to Medicaid EBA eligibility. This fix will eventually effect Magellan point of sale data in reporting recipients who have lost EBA eligibility.

Table 35 Count of Recipients Who Lost EBA Eligibility and Credits (July 1, 2011 – June 30, 2012)		
Month	**Recipient Count**	**Total Dollar Amount**
July 2011	171	$9,117.64
August 2011	45	$2,608.83
September 2011	29	$1,079.03
October 2011	40	$1,481.86
November 2011	46	$1,525.24
December 2011	37	$1,012.97
January 2012	30	$1,029.52
February 2012	101	$5,032.42
March 2012	32	$1,155.63
April 2012	21	$637.57
May 2012	32	$743.56
June 2012	25	$911.43
Total	**609**	**$26,335.70**

E. Low Income Pool

Overview

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

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

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

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

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

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

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

Demonstration Year Six at a Glance

LIP Council Meetings

The LIP Council held eight meetings between the first, second, and third quarters of Demonstration Year Six to prepare recommendations for Demonstration Year Seven, on the following dates.

- August 17, 2011
- September 14, 2011
- October 5, 2011
- October 26, 2011
- November 8, 2011
- November 29, 2011
- December 13, 2011
- January 5, 2012

The LIP Council meeting history can be viewed on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml

The LIP Council anticipates beginning meetings regarding SFY 2013-14 in the first quarter of Demonstration Year Seven.

LIP Council Recommendations for SFY 2012-13

The LIP Council recommends continued full utilization of the federally authorized funding level of $1 billion for SFY 2012-13. Detailed schedules, which show the distributions and calculations by Provider Access Systems, are included in Attachment C of the *LIP Council Report for SFY 2011-12 with Recommendations for SFY 2012-13*. For the programs related to LIP, the LIP Council recommended: maximize funding through the Disproportionate Share Hospital (DSH) program at $260.0 million; continue the Exemptions Program at a level of $648.5 million (which

includes $9.9 million for liver transplants); and provide the "buy-back" program with a funding level of $130.5 million. In order to accomplish this level of funding, an appropriation of $18.7 million in state General Revenue (GR) is continued and a decrease of $31.5 million of local Intergovernmental Transfers (IGTs) is proposed. A detailed description of each LIP component is presented in the following pages of this report.

Table 36 provides a brief financial summary by component (in millions) of the LIP Council's recommendations for SFY 2012-13 compared to SFY 2011-12 appropriations as modified by the Legislative Budget Commission:

Table 36
Comparison Summary of LIP Council Recommendations
for SFY 2012-13 and SFY 2011-12 Appropriations as Modified by the Florida LBC

	Modified Appropriation SFY 2011-12	LIP Council Recommendations SFY 2012-13	Appropriations SFY 2012-13
Low Income Pool:			
LIP Hospital	$821.50	$771.50	$771.50
Special LIP	98.40	113.40	113.40
LIP Non-Hospital	80.30	115.30	115.30
Total LIP	**$1,000.30**	**$1,000.30**	**$1,000.30**
Related Programs:			
Disproportionate Share Hospital	$260.00	$260.00	$246.60
Exemptions	655.40	638.60	638.60
Medicaid "Buy-Back" Program	125.00	130.50	130.60
Total LIP Related	$1,040.40	$1,029.10	$1,015.80
Total LIP and Related Programs	**$2,040.70**	**$2,029.40**	**$2,016.10**

The LIP Council reviewed several options and approaches for consideration of LIP funding at each LIP Council meeting. Models which utilized no additional state funds and maximized the use of local IGTs were considered. A summary of every model considered by the LIP Council is included in the *LIP Council Report for SFY 2011-12 with Recommendations for SFY 2012-13*. Major LIP Council recommendations include a comprehensive proposal which:

- Fully allocates the $1 billion of the federally-approved LIP allocation authorized by the Florida 1115 Medicaid Reform Waiver;
- Requests $18.7 million in continued state GR funding;
- Partially funds, via a tiered approach, the Exemption Program (including global liver fee) using SFY 2011-12 policy guidelines at a level of $648.5 million;
- Uses a 10% Medicaid, charity, and bad debt threshold for general distributions; an 8.5% allocation factor; and a $2.4 million charity distribution pool for rural hospitals;
- Fully distributes available federally allotted DSH funding of $260 million;
- Continues the currently authorized self-exemption policy for public hospitals, which can provide qualified IGTs and continues the same self-exemption policy to allow for the buy-

back of the cost margin between the current exempt rate and 100 percent of Medicaid allowable costs for public hospitals;

- Authorizes maximizing exemption and buy-back authority for all qualifying hospital providers with access to qualified IGT matching funds; and
- Allocates $50 million to fulfill the new LIP Tier-One Milestone requirement as specified in STC #61. Of the $50 million:
  - $15 million of these funds are distributed to hospitals based on the hospital meeting specific Quality Measures collected by the Agency and Core Measures collected by Federal CMS. A detailed description of these measures is provided in Attachment E of the *LIP Council Report for SFY 2011-12 with Recommendations for SFY 2012-13*.
  - The remaining $35 million will be distributed via an open, competitive process to be administered by the Agency.

Additional information regarding the LIP Council Recommendations including detailed recommendations by program and distribution tables can be found under the title, "LIP Council Recommendations to Governor and Legislature for SFY 2012-13" on the Agency's LIP website at the following link:
http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/LIP_Report_Feb_2011.pdf

On April 17, 2012, the Governor signed the SFY 2012-13 General Appropriations Act that included $1,000.30 million in LIP distributions and funding. The SFY 2012-13 LIP distributions and funding recommended by the Florida Legislature and signed by the Governor are similar to the LIP Council recommendations, with the biggest difference being a decrease of $24 million in the disproportionate share category.

Good News Stories

One Problem Clinic at the Okaloosa County Health Department

At the time this report was compiled, the One Problem Clinic at the Okaloosa County Health Department at the time of this report had been open for approximately nine months and is a clinic designed to provide individuals with primary medical care for any one health problem they may have. The One Problem Clinic's goal is to provide affordable health care and provide a service that will divert non-emergency care away from hospital emergency rooms for patients of all ages. After being open for approximately nine months, the One Problem Clinic staff set out to answer questions about the clinic and those who sought care in the clinic: Who are the clients that access care from the One Problem clinic and why are they coming to the clinic (Demographics and Diagnosis)? Why do they use the One Problem Clinic rather than another source of medical care? Where would they go for care if the One Problem Clinic was not available? To view the results of this report, please refer to Attachment I.

LIP STCs – Reporting Requirements

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

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

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

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

    - On March 8, 2012, the Agency received a written description from CMS outlining their findings of their review of DY1-DY3 reconciliations.
    - The Agency worked to resolve outstanding issues and discussed findings. The Agency anticipates submitting additional information, if required by CMS, to finalize DY1-DY3 reconciliations in the first quarter of Demonstration Year Seven.

- **DY4 LIP Reconciliations –** The Agency submitted the LIP reconciliations for DY4 to CMS on May 30, 2012.

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

    - During the third quarter, on January 31, 2012, the Agency submitted the revised RFMD for DY6 to CMS. The revised RFMD only included updated references since the results of CMS's review of DY1-DY3 reconciliations were not available prior to the February 1st submission due date specified in STC #53.
    - The state submitted another revised RFMD for DY6 to CMS on May 5, 2012, and again on June 6, 2012.

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

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

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

    - As noted above, the state submitted the most recent revised RFMD for DY6 to CMS on June 6, 2012. The state and CMS continue to work on finalizing the RFMD for DY6. The state anticipates having all of the revisions completed in the first quarter of Demonstration Year Seven.

STC #60 – Aggregate LIP Funding – At the beginning of each demonstration year, $1 billion in LIP funds will be available to the state. These amounts will be reduced by any milestone

penalties that are assessed by CMS. Penalties will be determined by December 31st of each demonstration year and assessed to the state in the following demonstration year.

STC #61 – LIP Tier-One Milestone

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

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

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

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

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

  - On June 29, 2012, during the fourth quarter, the Agency posted the LIP Primary Care Application for the $35 million (SFY 2012-13) up for bid on the Agency's LIP website: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

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

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

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

  - On May 31, 2012 the Agency submitted all deliverables on schedule as specified in the STCs.

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

  - During third quarter on February 9, 2012, the Agency sent the draft templates for the above specified reports to CMS.
  - On March 13, 2012, the Agency submitted the final templates to CMS.
  - On March 14, 2012, CMS had no comments and the STC 61.d. submission. The letter to CMS and corresponding templates were posted to the Agency's website.

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

- During the third quarter, the Agency worked with the top 15 hospitals in developing the Three-Tier Initiatives. Each of the 15 hospitals submited three proposals to the Agency, for a total of 45 proposals.
- During the fourth quarter, the Agency submitted 44 proposals to CMS by April 9, 2012; the forty-fifth was exempt. CMS approved the 44 proposals on June 29, 2012.

Summary

Throughout Demonstration Year Six, the Agency has collected information from hospitals related to budgeted uninsured and medical items outside of inpatient care. During the third quarter of Demonstration Year Five, the Agency provided the SFY 2009-10 Milestone data for further research and evaluation with the LIP evaluation team at the University of Florida. The Agency has received and reviewed the results from UF during SFY 2011-12, and continues to work with UF on completion of the report.

During Demonstration Year Six, $929,016,020 in Low Income Pool funding was released to the participating providers.

On April 17, 2012, the Governor signed into law the *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2012-2013 Conference Committee Report on SB 2000*, a supplemental

document accompanying the General Appropriations Act for SFY 2012-13. This document provides instructions for the funding and distribution of SFY 2012-13 Low Income Pool funds.

Additional information regarding the *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2012-2013 Conference Committee Report on SB 2000*, including detailed recommendations by program and distribution tables, can be found under the title *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2012-2013 Conference Committee Report on SB 2000* on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

F. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved Florida 1115 Medicaid Reform Waiver, the state 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 waiver.

MEGS

There are three Medicaid Eligibility Groups established through the Budget Neutrality of 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 waiver is based on 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 Federal CMS, the historical expenditures and case-months are inserted into the appropriate fields.

Florida's 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 waiver.

To determine if a person is eligible for the 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 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 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 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 waiver unless the expenditure is identified as one of the following excluded services. These services are specifically excluded from the waiver and the Budget Neutrality calculation.

Excluded Services:

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

Expenditure Reporting:

The 1115 Medicaid Reform 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 waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of the waiver, 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 the waiver 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 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 demonstration 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 STC #76.

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. The quarterly totals match the expenditures reported on the CMS 64 report, which is the amount that will be used in the monitoring process by Federal CMS.

Demonstration Years One, Two, Three, Four, Five, and Six at a Glance

The 1115 Medicaid Reform Waiver is budget neutral as required by the Special Terms and Conditions (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 Medicaid Reform is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where Medicaid Reform 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 #64, 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 following tables (Tables 37 through 41), 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 37 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC #76. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 37
PCCM Targets

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

Tables 38 through 42 provide the statistics for MEGs 1, 2 and 3 for the period beginning July 1, 2006 and ending June 30, 2012. Case months provided in the tables 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 38
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$109,209,309	$909,045	$110,118,354	$446.18
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$204,666,715	$9,068,294	$213,735,009	$864.97
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$279,485,810	$29,362,800	$308,848,610	$1,245.10
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$198,742,236	$31,793,702	$230,535,938	$919.18
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$188,079,271	$31,056,750	$219,136,021	$871.08
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$298,437,791	$47,839,499	$346,277,290	$1,372.13
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$287,896,155	$50,059,242	$337,955,397	$1,338.26
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$111,968,931**	**$763,459,242**	**$1,007.18**
April 2008	254,500	$302,204,899	$52,469,635	$354,674,534	$1,393.61
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
July 2008	277,846	$192,176,160	$32,392,732	$224,568,891	$808.25
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**

Table 38 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
October 2008	266,157	$232,318,022	$41,009,801	$273,327,823	$1,026.94
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
July 2009	277,093	$319,718,390	$52,941,079	$372,659,469	$1,344.89
August 2009	274,819	$168,336,551	$33,437,914	$201,774,466	$734.21
September 2009	270,484	$358,692,409	$67,384,681	$426,077,090	$1,575.24
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
October 2009	275,733	$169,233,974	$30,153,422	$199,387,395	$723.12
November 2009	277,577	$252,330,497	$45,182,664	$297,513,161	$1,071.82
December 2009	277,220	$348,404,305	$61,931,546	$410,335,851	$1,480.18
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
January 2010	282,575	$159,062,482	$29,470,651	$188,533,134	$667.20
February 2010	283,235	$249,307,944	$44,581,877	$293,889,821	$1,037.62
March 2010	281,514	$373,413,178	$67,763,434	$441,176,612	$1,567.16
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**
July 2010	289,450	$166,097,229	$32,548,825	$198,646,054	$686.29
August 2010	288,959	$257,400,660	$50,362,126	$307,762,786	$1,065.07
September 2010	290,464	$378,046,090	$67,416,195	$445,462,285	$1,533.62
Q17 Total	**868,873**	**$801,543,979**	**$150,327,146**	**$951,871,125**	**$1,095.52**
October 2010	290,791	$178,740,566	$32,141,420	$210,881,986	$725.42
November 2010	292,081	$259,494,453	$49,145,534	$308,639,987	$1,054.89
December 2010	293,692	$385,127,339	$66,518,308	$451,645,646	$1,537.11
Q18 Total	**876,564**	**$823,362,358**	**$147,720,232**	**$971,082,591**	**$1,107.83**

Table 38 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
January 2011	286,758	$169,087,404	$30,705,047	$199,792,451	$696.73
February 2011	283,891	$254,801,466	$45,756,956	$300,558,423	$1,058.71
March 2011	280,839	$369,228,098	$60,653,771	$429,881,870	$1,530.71
Q19 Total	**851,488**	**$793,116,969**	**$137,115,775**	**$930,232,743**	**$1,092.48**
April 2011	302,990	$172,927,438	$34,444,241	$207,371,679	$684.42
May 2011	301,388	$262,943,250	$48,035,560	$310,978,811	$1,031.82
June 2011	298,455	$294,864,812	$54,930,094	$349,794,906	$1,172.03
Q20 Total	**902,833**	**$730,735,500**	**$137,409,896**	**$868,145,395**	**$961.58**
July 2011	312,416	$259,712,742	$48,660,712	$308,373,454	$987.06
August 2011	311,787	$394,898,931	$68,931,416	$463,830,347	$1,487.65
September 2011	309,458	$242,573,135	$47,908,459	$290,481,594	$938.68
Q21 Total	**933,661**	**$897,184,808**	**$165,500,587**	**$1,062,685,395**	**$1,138.19**
October 2011	307,662	$185,681,455	$37,250,558	$222,932,013	$724.60
November 2011	305,786	$405,816,970	$77,239,455	$483,056,425	$1,579.72
December 2011	303,265	$189,314,012	$35,438,146	$224,752,158	$741.11
Q22 Total	**916,713**	**$780,812,437**	**$149,928,159**	**$930,740,596**	**$1,015.30**
January 2012	290,381	$239,317,133	$49,116,158	$288,433,291	$993.29
February 2012	290,339	$389,776,652	$76,272,631	$466,049,284	$1,605.19
March 2012	290,330	$177,634,805	$35,812,556	$213,447,361	$735.19
Q23 Total	**871,050**	**$806,728,589**	**$161,201,346**	**$967,929,935**	**$1,111.22**
April 2012	312,916	$275,686,028	$54,220,241	$329,906,270	$1,054.30
May 2012	311,290	$416,163,778	$78,399,857	$494,563,284	$1,588.76
June 2012	308,237	$186,297,339	$35,989,898	$222,287,237	$721.16
Q24 Total	**932,443**	**$878,147,146**	**$168,609,996**	**$1,046,757,142**	**$1,122.60**
MEG 1 Total	**19,772,892**	**$16,887,091,097**	**$3,577,088,018**	**$19,832,378,125**	**$1,003.01**

*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 39 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	1,343,704	$116,070,700	$122,430	$116,193,130	$86.47
August 2006	1,292,330	$272,615,188	$1,255,306	$273,870,494	$211.92
September 2006	1,308,403	$96,367,809	$345,759	$96,713,568	$73.92
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
October 2006	1,293,922	$183,471,982	$4,267,815	$187,739,798	$145.09
November 2006	1,277,102	$287,043,912	$13,069,579	$300,113,491	$235.00
December 2006	1,266,148	$110,714,051	$2,883,053	$113,597,104	$89.72
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
January 2007	1,252,859	$266,181,366	$23,259,122	$289,440,488	$231.02
February 2007	1,240,860	$176,632,680	$13,010,558	$189,643,238	$152.83
March 2007	1,234,344	$104,987,331	$8,197,611	$113,184,942	$91.70
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
April 2007	1,230,451	$170,285,018	$17,657,956	$187,942,974	$152.74
May 2007	1,218,171	$252,644,634	$32,885,813	$285,530,447	$234.39
June 2007	1,204,525	$93,978,970	$6,350,716	$100,329,686	$83.29
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
July 2007	1,198,205	$153,588,331	$17,975,233	$171,563,564	$143.18
August 2007	1,195,369	$257,178,317	$34,274,917	$291,453,235	$243.82
September 2007	1,194,789	$97,198,750	$4,900,087	$102,098,837	$85.45
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
October 2007	1,211,534	$271,137,490	$36,924,018	$308,061,507	$254.27
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$273,615,263	$39,329,414	$312,944,677	$254.19
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,569,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$164.78**
July 2008	1,343,457	$167,028,012	$23,597,521	$190,625,534	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**

Table 39 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
January 2009	1,425,771	$119,386,179	$8,007,586	$127,393,766	$89.35
February 2009	1,440,339	$228,220,385	$24,038,667	$252,259,052	$175.14
March 2009	1,432,269	$361,013,917	$41,788,973	$402,802,890	$281.23
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
July 2009	1,581,454	$333,483,694	$34,533,935	$368,017,629	$232.71
August 2009	1,583,503	$119,609,810	$13,057,173	$132,666,984	$83.78
September 2009	1,538,571	$370,920,307	$51,046,606	$421,966,913	$274.26
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
October 2009	1,634,683	$134,315,902	$10,464,027	$144,779,929	$88.57
November 2009	1,657,122	$250,553,059	$29,249,216	$279,802,275	$168.85
December 2009	1,667,649	$383,516,409	$50,010,230	$433,526,639	$259.96
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
January 2010	1,682,493	$116,073,248	$9,104,061	$125,177,309	$74.40
February 2010	1,700,550	$248,374,376	$29,806,739	$278,181,115	$163.58
March 2010	1,715,338	$409,161,539	$54,737,055	$463,898,594	$270.44
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**
July 2010	1,760,314	$119,876,307	$11,136,093	$131,012,400	$74.43
August 2010	1,785,641	$242,522,154	$29,130,986	$271,653,141	$152.13
September 2010	1,810,787	$404,205,540	$51,277,639	$455,483,179	$251.54
Q17 Total	**5,356,742**	**$766,604,001**	**$91,544,719**	**$858,148,719**	**$160.20**
October 2010	1,821,814	$136,151,894	$13,264,711	$149,416,605	$82.02
November 2010	1,823,878	$269,927,226	$32,202,089	$302,129,316	$165.65
December 2010	1,824,704	$442,615,707	$53,974,674	$496,590,381	$272.15
Q18 Total	**5,470,396**	**$848,694,828**	**$99,937,769**	**$948,632,597**	**$173.41**
January 2011	1,765,702	$136,138,730	$11,522,305	$147,661,035	$83.63
February 2011	1,741,315	$257,027,907	$30,781,930	$287,809,837	$165.28
March 2011	1,740,373	$394,755,478	$49,334,529	$444,090,007	$255.17
Q19 Total	**5,247,390**	**$787,922,115**	**$91,638,763**	**$879,560,878**	**$167.62**
April 2011	1,873,928	$126,334,678	$916,832,954	$143,167,632	$76.40

Table 39 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
May 2011	1,877,042	$255,956,821	$33,906,598	$289,863,419	$154.43
June 2011	1,860,701	$291,409,133	$39,973,326	$331,382,459	$178.10
Q20 Total	**5,611,671**	**$673,700,632**	**$90,712,877**	**$764,413,510**	**$136.22**
July 2011	1,894,919	$259,656,357	$32,638,562	$292,294,919	$154.25
August 2011	1,908,952	$435,988,483	$55,271,229	$491,259,713	$257.35
September 2011	1,891,285	$269,817,069	$33,364,459	$303,181,528	$160.30
Q21 Total	**5,695,156**	**$965,461,910**	**$121,274,250**	**$1,086,736,159**	**$190.82**
October 2011	1,927,438	$152,385,612	$17,583,568	$169,969,180	$88.18
November 2011	1,928,774	$468,337,497	$66,128,240	$534,465,738	$277.10
December 2011	1,916,808	$157,910,141	$16,091,075	$174,001,216	$90.78
Q22 Total	**5,773,020**	**$778,633,250**	**$99,802,883**	**$878,436,134**	**$152.16**
January 2012	1,822,959	$252,551,795	$33,783,082	$286,334,877	$157.07
February 2012	1,811,968	$457,595,125	$63,262,036	$520,857,161	$287.45
March 2012	1,806,127	$150,429,478	$18,286,764	$168,716,242	$93.41
Q23 Total	**5,441,054**	**$860,576,398**	**$115,331,882**	**$975,908,280**	**$179.36**
April 2012	1,966,756	$292,598,685	$38,771,593	$331,370,279	$168.49
May 2012	1,970,680	$481,066,431	$66,493,796	$547,560,228	$277.85
June 2012	1,957,829	$149,314,866	$17,030,689	$166,345,554	$84.96
Q24 Total	**5,895,265**	**$922,979,983**	**$122,296,078**	**$1,045,276,061**	**$177.31**
MEG 2 Total	**111,763,888**	**$16,674,367,065**	**$1,868,308,512**	**$18,542,675,577**	**$165.91**

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

Table 40 MEG 1 and 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	3,357,141	$3,066,429,103	$550,235,443	$3,616,664,546	$1,077.30
WOW DY4 Total	3,357,141			$4,012,454,923	$1,195.20
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY05 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY05 Total	3,499,758	$3,246,260,637	$589,957,628	$3,836,218,264	$1,096.14
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(681,339,357)	
% of WOW PCCM MEG 1					84.92%
DY05 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY05 Total	21,686,199	$3,223,679,142	$397,656,848	$3,621,335,990	$166.99
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,264,081,557)	
% of WOW PCCM MEG 2					61.53%
DY06 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY06 Total	3,653,867	$3,130,122,885	$595,842,852	$3,725,965,737	$1,019.73
WOW DY5 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(1,231,052,929)	
% of WOW PCCM MEG 1					75.17%
DY06 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY06 Total	22,956,197	$3,338,478,916	$436,385,262	$3,774,864,178	$164.44
WOW DY5 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,785,328,239)	
% of WOW PCCM MEG 2					57.54%

Table 41 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,469,939,779	$987,614,476	$7,457,554,254	$296.10
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,945,420,914)	
% Of WOW					71.69%
DY 6	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,468,601,801	$1,032,228,114	$7,500,829,915	$281.88
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(4,016,381,167)	
% Of WOW					65.13%

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 40), compared to WOW of $948.79 (Table 37), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 40), compared to WOW of $199.48 (Table 37), 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 40), compared to WOW of $1,024.69 (Table 37), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 40), compared to WOW of $215.44 (Table 37), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.86 (Table 40), compared to WOW of $1,106.67 (Table 37), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 40), compared to WOW of $232.68 (Table 37), which is 71.76% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,077.30 (Table 40), compared to WOW of $1,195.20 (Table 37), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 40), compared to WOW of $251.29 (Table 37), which is 66.42% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,096.14 (Table 40), compared to WOW of $1,290.82 (Table 37), which is 84.92% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.99 (Table 40), compared to WOW of $271.39 (Table 37), which is 61.53% of the target PCCM for MEG 2.

For Demonstration Year Six, MEG 1 has a PCCM of $1,019.73 (Table 40), compared to WOW of $1,356.65 (Table 37), which is 75.17% of the target PCCM for MEG 1. MEG 2 has a PCCM of $164.44 (Table 40), compared to WOW of $285.77 (Table 37), which is 57.54% of the target PCCM for MEG 2.

Tables 40 and 41 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 41) 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 41 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 41) 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 41 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 41) 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 41 is $309.25. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 41) is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 41 is $297.57. Comparing the calculated weighted averages, the actual PCCM is 76.94% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 41) is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 41 is $296.10. Comparing the calculated weighted averages, the actual PCCM is 71.69% of the target PCCM.

For Demonstration Year Six, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 41) is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 41 is $281.88. Comparing the calculated weighted averages, the actual PCCM is 65.13% of the target PCCM.

Table 42
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,736
Q5	$114,252,478
Q6	$191,429,386
Q7	$319,005,892
Q8	$329,734,446
Q9	$165,186,640
Q10	$226,555,016
Q11	$248,152,977
Q12	$178,992,988
Q13	$209,118,811
Q14	$172,524,655
Q15	$171,822,511
Q16	$455,671,026
Q17	$324,573,642
Q18	$387,535,118
Q19	$180,732,289
Q20	$353,499,776
Q21	$57,414,775
Q22	$346,827,872
Q23	$175,598,167
Q24	$227,391,753
Total Paid	$5,802,981,757

Table 43 shows that the expenditures for the first 24 quarters for MEG 3, the Low Income Pool (LIP), were $5,802,981,757 (72.54% of the $8 billion cap).

Table 43
MEG 3 Total Expenditures: Low Income Pool

DY*	Total Paid	DY Limit	Percent of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$807,232,567	$1,000,000,000	80.72%
DY07		$1,000,000,000	
DY08		$1,000,000,000	
Total MEG 3	$5,802,981,757	$8,000,000,000	72.54%

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

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

G. Encounter and Utilization Data

Overview

The Agency is required to capture medical service 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. Additionally, section 409.91211(3)(p), F.S., 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, beginning in 2006, using the Medicaid Rx (MedRx) model. Initially, there were three phases to the collection, processing and validation of encounter data. The first phase was an interim phase to meet the objectives of risk-adjusted rates that consisted of the statewide collection of pharmacy encounter data from all health plans capitated for these services. The two remaining phases involved the statewide collection of encounter data within the FLMMIS from health plans for all Medicaid covered services. The second phase occurred with the prior Medicaid fiscal agent, ACS, and the third phase occurred with the current Medicaid fiscal agent, HP. The two phases for collection were necessary due to Florida's transition to a new Medicaid fiscal agent and its implementation of a new FLMMIS.

Demonstration health plans began the process of submitting HIPAA compliant X12 and National Council for Prescription Drug Program (NCPDP) encounter data in Demonstration Year One. NCPDP pharmacy encounter claims are now used as the total basis for the monthly risk scores they generate. The transition from the limited proprietary quarterly Rx data used previously was deemed prudent after parallel testing and comparison of the results showed a discrepancy of less than 1% between the two data sources. Risk adjustment factors are calculated monthly for 13 health plans now operating in the five demonstration counties.

Demonstration Year Six at a Glance

During Demonstration Year Six, the Agency continued analytic data validation of encounter data through operational processes including analysis of: encounter volumetric by plan and claim type; analysis of services provided per enrollee; analysis of key data elements within the encounter claims to identify correlation and trends; examination of encounter claim content validating the existence of critical fields; and expanded reporting to include timeliness (period between encounter file creation and processing) as well as accuracy (reporting encounters with defects through validation reporting).

A report titled, Exploratory Analysis of Medicaid Claims and Encounter Data, was presented to the Florida Legislature in October 2011. The report documents analyses of encounter and fee-for-service data measuring Emergency Department Utilization, Preventable Hospitalizations, and overall Managed Care Organization (MCO) performance (History and Physical 180 Day Utilization). The report compared Reform Pilot counties to similarly sized counties in the rest of the state. The report can be accessed at the following link:
http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/Exploratory_Analysis_of_Medicaid_Claims_and_Encounte_%20Data_for_House_120711.pdf

The Agency has utilized pharmacy encounter claims for the rate setting process since Demonstration Year Four. As a second step in the rate setting process, the Agency began testing inpatient extract data sets in 2010. After a round of testing, collection of production-ready data was concluded in April 2011. During Demonstration Year Six, Agency staff incorporated a refined inpatient encounter data set encounter data into the rate setting process for capitated payments to the demonstration health plans.

The Medicaid Program Oversight unit is comprised of internal subject matter experts and external consultants with experience in the risk adjustment and medical encounter data collection processes. The unit supported the implementation and operational activities of the collection of Medicaid encounters for capitated health plans and, in Demonstration Year Six, transitioned to a more analytical and reporting role. The unit designed health plan encounter dashboards and technical report cards for the purpose of communicating to plans performance related to contract compliance such as timeliness, accuracy and completeness of encounter data. For example, volumetric dashboards that portray individual plan encounter submission volumes compared to statewide volumetrics for the same period are reported.

Technical assistance related to the standard transactions is now being provided by the Medicaid fiscal agent. Regarding encounter data processing, the Agency implemented changes to allow for distribution of the health care claim payment remittance advice 835 transactions and easier claims remediation. A more robust set of front end encounter edits has also been implemented. Additionally, the Agency developed an automated attestation and balancing process for the volume of claims files from front end to back end.

The Agency created a provider mass registration process to require plans to register any provider that is not already registered or enrolled in FLMMIS and from which there may be an encounter. The requirement for mass registration allows for encounter claims to adjudicate properly where the billing provider or rendering provider would not otherwise be recognized by the Medicaid system. The Agency is enhancing a provider linking/delinking process report to aid in ensuring their all network providers are appropriately linked to their health plan.

Looking Ahead to Demonstration Year Seven

In Demonstration Year Seven, the Agency will focus on additional ways to analyze and utilize encounter data from demonstration health plans. The Agency will incorporate outpatient encounter data into the rate setting process. As noted above, pharmacy and inpatient encounter data are currently being utilized for rate setting purposes. The Agency will also be developing plans for transitioning to a diagnosis-based risk-adjustment model such as the Chronic Illness and Disability Payment System.

The Agency will also continue to develop analyses of access, quality and cost metrics that can be derived from encounter data. The Agency has developed a model to analyze Ambulatory Care Sensitive Conditions that it will continue to refine. The Agency developed baseline analysis to assess access to specialty care for orthopedics, neurology and dermatology in Demonstration Year Six. Additional analyses are expected during Demonstration Year Seven. The Agency is also performing an analysis of medical service and pharmacological treatments using statistical analysis (using discriminant classification) for monitoring the association between medical and pharmacological treatments within clinical practice guidelines, which follows the Health Effectiveness Data and Information Set (HEDIS) measures.

H. Demonstration Goals

Overview

The demonstration is designed to fundamentally change the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of demonstration, and will continue to use the evaluation as a means to inform policy decisions in both the short and long term. As lessons are learned on an incremental basis, these data will be used to shape the expansion of the demonstration, as well as evaluate the impact of the three year extension of the demonstration. There are six (6) key design elements of the demonstration tracked by the Agency in order to evaluate progress towards achieving its goals. Information about each key evaluation objective is below.

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

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

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

Since the beginning of the demonstration, the Agency has received 28 health plan applications (20 HMOs and eight PSNs) of which 23 applicants sought and received approval to provide services to the TANF and SSI population. The following applications remain under review:

- Simply Healthcare HMO (Broward County)
- Healthease HMO (all five demonstration counties)
- Magellan Complete Care (Broward County)
- Simply Healthcare d/b/a Clear Health Alliance specialty plan for individuals living with HIV or AIDS (Broward County)

At the request of the applicant, review and implementation of Community Health Plan of South Florida FFS PSN (Broward County) is on hold.

Patient satisfaction 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

In Demonstration Year Five, the Agency approved 22 benefit packages for the HMOs and 10 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits

were effective for the contract period of January 1, 2011 to December 31, 2011 for nine HMOs and four PSNs.

In Demonstration Year Six, the Agency approved 21 benefit packages for the HMOs and 10 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2012 to December 31, 2012 for nine HMOs and four PSNs. The following is a list of the expanded benefits offered by the capitated plans of which the over-the-counter drug benefits and adult preventive dental benefits were the most frequently offered.

- Over-the-counter drug benefit – $25 per household, per month,
- Adult preventive dental,
- Circumcisions for male newborns,
- Adult vision services,
- Wellness and nutrition therapy, and
- Respite care.

Improving Access to Specialists

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

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

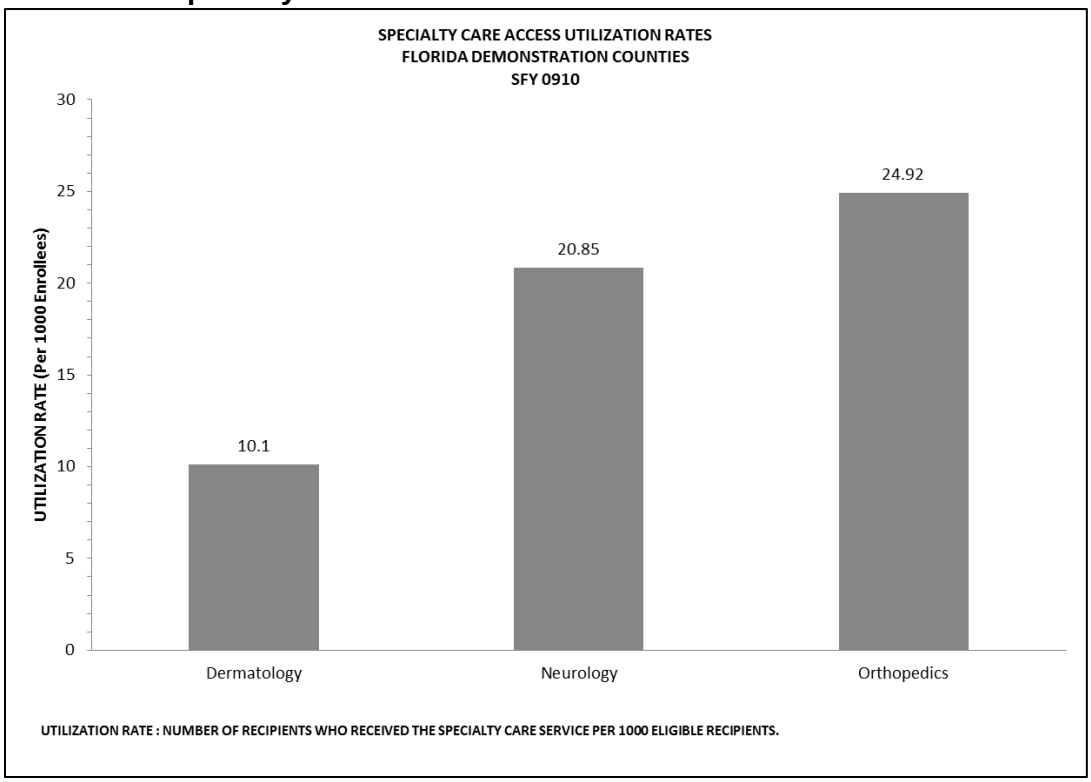
During the second quarter of Demonstration Year Two, the Agency began additional provider network analysis of the Medicaid health plans, including each demonstration health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories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

Specialties identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care were subject to focused reviews of provider network files and provider surveys in Demonstration Year Two through Year Five. Results of these reviews and surveys are provided in earlier quarterly and annual reports.

In Demonstration Year Six, the Agency began developing additional ways to analyze health plan encounter data to assess health care access. The most recent analyses focus on three types of specialty care: orthopedics, neurology, and dermatology. The analyses used encounter data to

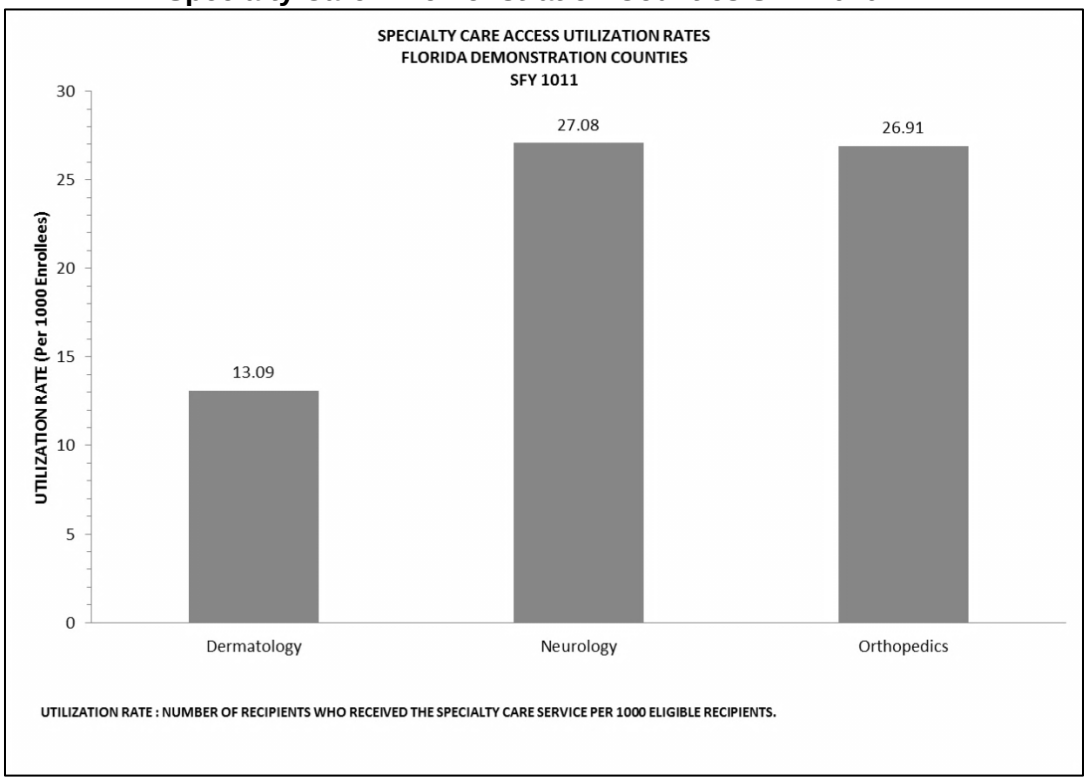
target the number of recipients receiving these specialty services in demonstration counties. This measure applies the recipient utilization[8] per 1,000 eligible recipients. The data in Charts J and K on depict the total number of distinct recipients that were either provided a service by a specialist, or were provided services within a specialty procedure code range. The analyses are intended to serve as a baseline measurement for future analytics of access to care, as well as a basis for identifying opportunities for encounter data improvements over the next several quarters. Certain encounter data improvements intended to benefit such analyses, such as improving submitted provider information, are already underway.

Chart J
Specialty Care – Demonstration Counties SFY 2009-10



[8] The total recipients receiving specialty services in the demonstration counties over the total eligible recipient population across the demonstration counties.

Chart K
Specialty Care – Demonstration Counties SFY 2010-11



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

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

During the first quarter of Demonstration Year Six, the Agency received the fourth year of performance measure submissions from the health plans. In most cases, the statewide average results for the demonstration plans continued in a steady upward trend, although there were some exceptions. It is important to note, when reviewing this year's results, that the measurement year for submissions was 2010. A number of health plans left the demonstration in late 2009 and early 2010; therefore, they were present in the statewide calculations last year, but not this year. Additionally, this year's submission included several health plans reporting complete data for the first year, which is a time when data issues may negatively impact rates. Nevertheless, the overall trends were generally positive. The 2011 Managed Care Performance Measures results can be viewed in Attachment II of this report.

Highlights in the performance measure results reported in 2011:

- Performance of the health plans was above the national mean on several components of the of the Comprehensive Diabetes Care measure and on Well-Child Visits in the 3rd-6th years of life, along with several other HEDIS measure. The health plans had a weighted mean that was above the National Mean [as published by National Committee for Quality Assurance (NCQA) for the Medicaid product line] for 11 of the Healthcare Effectiveness Data and Information Set (HEDIS) measures reported in 2011.

- Significantly increased select health plans HEDIS measure performance over time: Childhood Immunization Status increased 9% for Combo 2 and 11.9% for Combo 3, between 2009 and 2011 reporting. Adult BMI assessment increased 10.8% from 2010 to 2011 reporting. Annual Dental Visits increased 18.8% between 2008 and 2011.

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

During Demonstration Years Five and Six, the Agency worked toward the development of an incentive program to reward higher performing health plans with enhanced auto-assignments. The Agency finalized a draft methodology for assigning recipients who fail to actively choose a health plan during the enrollment period. The methodology includes both HEDIS performance measures and other reporting metrics. In October 2011, the Agency had a conference call with the health plans to review this methodology. The health plans then submitted some additional questions and comments to the Agency regarding the process, which the Agency reviewed during the second and third quarters of Demonstration Year Six. The lessons learned from the process of developing an incentive program methodology will be taken into account as the Agency develops the standards against which health plans will be measured to earn a one percent incentive related to the Achieved Savings Rebates under the Statewide Medicaid Managed Care program to be implemented in 2014, after obtaining approval from Federal CMS.

Performance measure reports for calendar year 2011 are due to the Agency during the first quarter of Demonstration Year Seven. Results will be provided in the first quarterly report.

(3)(b) Reduction in ambulatory sensitive hospitalizations

During Demonstration Year Six, the Agency has developed a model to analyze the utilization of Ambulatory Care Sensitive Conditions (ACSC) using the Agency for Healthcare Research and Quality (AHRQ) quality indicators (QI) to analyze the prevalence of ACSC that lead to preventable hospitalizations. The model has been developed to aggregate utilization data across multiple FFS and managed care delivery systems. The reports include morbidity scoring utilizing MedRx, utilization by per member per month normalized to report per/1000 recipients, and a distribution by category of the QI's for statewide (FFS & Managed Care), reform, non-reform, and per-MCO basis. The preliminary results are under review; the final results should be available during Demonstration Year Seven.

Reports are being regenerated for designated Florida counties possessing similar Standard Metropolitan Statistical Areas (SMSA) characteristics, which are classified by small rural, medium rural, medium urban, and large urban, using SFY 2009-10 encounter data. The earlier versions of these reports were presented to the Florida Legislature during the second quarter of Demonstration Year Six and have provided the foundation for follow-up analysis.

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

During Demonstration Year Six, the Agency has developed a model to analyze the utilization of emergency departments (ED) based on the New York University ED algorithm. The model is set up to process data generating comparable results across the FFS recipients and managed care enrollees. The reports include a volumetric with morbidity scoring utilizing MedRx, utilization per member per month per/1000, and distribution by reporting ED utilization category

on a statewide (FFS & Managed Care), reform, non-reform and per plan basis. The preliminary results are under review for modification if necessary. The final results will be available during Demonstration Year Seven.

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

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

During Demonstration Year Seven, collaborative groups will continue interventions targeted to the particular issues of each patient stream and will strengthen community partnerships and infrastructure to reduce unnecessary utilization. The patient streams are in the process of being finalized.

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

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

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

During the fourth quarter of Demonstration Year Five, the Agency received the report, *Medicaid Reform Enrollee Satisfaction Year 3 Follow-Up Survey*. This report includes descriptions of enrollee satisfaction ratings for their health care, health plan, personal doctor, and specialists. The Agency will be reviewing this report and feedback will be given to UF during the first quarter of Demonstration Year Seven so that this report may be finalized and posted. Findings from this report were included in the Final Evaluation Report, which the Agency submitted to Federal CMS on December 15, 2011.

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

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

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

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

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

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

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

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

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges

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

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

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

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

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

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

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

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

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

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

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

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

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

- LIP payments supported a variety of Florida Department of Health Emergency Room Alternative projects.

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

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

Demonstration Year Six at a Glance

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

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

Throughout Demonstration Year Five (DY5), the Agency collected information from hospitals related to budgeted uninsured and medical items outside of inpatient care. During the third quarter of Demonstration Year Five, the Agency provided the SFY 2009-10 Milestone data for further research and evaluation with the LIP evaluation team at the University of Florida. The Agency has received and reviewed the results from UF during SFY 2011-12, and continues to work with UF on completion of the report.

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

I. Evaluation of Medicaid Reform

Overview

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

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

Demonstration Year Six at a Glance

During the fourth quarter of Demonstration Year Six, the Agency submitted a draft evaluation design to Federal CMS on April 12, 2012, as specified in STC #80. The draft evaluation design included a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the demonstration. In June 2012, the Agency discussed the draft evaluation design with Federal CMS and received written comments on June 12, 2012. In addition, the Agency worked with two public state universities on research designs for the various components of the evaluation, and drafted one of the two contracts for this evaluation work.

Looking Ahead to Demonstration Year Seven

In the first quarter of Demonstration Year Seven, the Agency will revise the draft evaluation design to address the comments received from Federal CMS and will submit the final evaluation design to Federal CMS by August 10, 2012, as required by STC #81. The evaluation contracts will be finalized and executed, and the Agency will provide the universities with data needed for evaluation activities.

J. Policy and Administrative Issues

Overview

During Demonstration Year Six, the Agency continued to address policy, administrative and operational issues with health plans through the following main processes:

- Technical Advisory Panel regular meetings,
- Policy Transmittals and Dear Provider letters and e-mails,
- Health Plan Technical and Operational conference calls,
- PSN systems implementation regular conference calls
- General amendment and contract overview calls and meetings, and
- Fraud and abuse regular meetings.

Overall, these forums provided excellent opportunity for discussion and collecting feedback on proposed processes, implementation issues, and communicating finalized policy in documented products. The quarterly progress reports provide detail of issues covered during Demonstration Year Six. This section of the annual report provides the highlights of key issues addressed during Demonstration Year Six.

Demonstration Year Six at a Glance

Medicaid Reform Technical Advisory Panel

During Demonstration Year Six, the Medicaid Reform Technical Advisory Panel (TAP) held three meetings on the following dates:

- October 3, 2011
- December 9, 2011
- March 19, 2012

The nine-member TAP was 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. Areas in which advice from TAP is particularly sought includes risk-adjusted rate setting, benefit design, the Choice Counseling program, including implementation of the pharmacy Navigator system in October 2008, the Enhanced Benefits Account program, health plan capitation rates development, Medicaid encounter data collection and processing, and updates on the Florida Medicaid Reform evaluations. Each demonstration year has brought new agenda items, and Demonstration Year Six was no exception. A new topic that was included for discussion this year was an update on the MMA program enacted into law by the 2011 Florida Legislature (including update on waiver amendment requests).

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

Policy Transmittals and "Dear Provider" Letters

During Demonstration Year Six, the Agency released four policy transmittals and several "Dear Provider" letters/emails to the health plans. The policy transmittals were operational in nature as processes have become stabilized in the demonstration counties. The major issues

addressed in the various policy transmittals and "Dear Provider" letters/emails are summarized below:

- Clarification that the Agency is responsible for payment for multi-visceral/intestinal transplants and this clarification will be made in the next general health plan amendment.
- Notice to FFS PSNs regarding additional timeframe for converting to capitated payment model.
- Provision of performance measures due to the Agency, specifications for such measures and HEDIS national means and percentiles that will be used as the performance benchmark for each measure.
- Health Plan Report Guide quarterly changes for the September 1, 2011 through August 31, 2012 contract year, including required quarterly and annual medical loss ratio reporting.
- Updated Plan Evaluation Tool (PET) and/or benefit request submission deadlines/extensions for the September 1, 2011 through August 31, 2012 contract period and the September 1, 2012 through August 31, 2013 contract period, respectively.
- General information regarding the 5010 X12 companion guide postings, provider mass registration and encounter data updates.
- Notices regarding the last 2009-2012 Medicaid Health Plan Contract general amendment and the draft 2012-2015 Medicaid Health Plan Model Contract.

Technical and Operational Issues Conference Calls

The Agency conducted 10 Technical and Operational Issues Conference Calls with health plans and health plan applicants between July 1, 2010 and June 30, 2011. The purpose of the calls is to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through e-mail, telephone inquiries, and previous technical calls. While in previous demonstration years, these calls were held biweekly, in July 2010, in agreement with the health plans, these calls became monthly as the need for more frequent calls lessened. In addition, other calls were held by the Agency to discuss encounter data requirements and rate setting methodology.

All health plans are invited to participate, whether or not they are currently operating in the demonstration counties. Additionally, the Technical and Operational Issues Conference 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 140 phone lines in active use on the calls during the last quarter of Demonstration Year Six. Agenda topics that have appeared on most calls include updates and statuses on Medicaid encounter data submissions, choice counseling, fraud and abuse, and Medicaid fiscal agent system changes.

Other agenda items included:

- Update on the Medicaid electronic health record incentive program;
- Update on the 5010 implementation and testing timeline;

- External Quality Review Organization updates and webinar reminders;
- Encounter data updates, due dates and processing clarifications;
- Review of policy transmittals (see policy transmittals above);
- State legislative updates; and
- General Amendment and contract updates, including September 2011 and 2012 rate and benefit amendment timelines, databook, fine-tuning amendment timelines, the upcoming contract period model contract beginning September 1, 2012, and quarterly updates in the Health Plan Report Guide.

Feedback from call participants indicates 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.

FFS PSN Systems Implementation Issues Conference Calls

As a result of the newness of the PSNs and their third party administrators in processing claims through the Medicaid fiscal agent claims process, the Agency determined that additional resources were needed to assist the PSNs with systems issues, and implemented special, biweekly, technical assistance calls for the PSNs. While these calls started out as biweekly in Demonstration Year One, they became monthly in Demonstration Year Two and continued to occur in several months in Demonstration Year Six. The purpose of these calls was to provide a forum to discuss claims processes and enrollment file issues that were unique to the FFS PSN model.

During these conference calls, the Agency and the PSNs discussed and, as appropriate, resolved claims processing and enrollment file transmittal questions and issues. The PSNs were 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 technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Contract Management Bureau, Medicaid 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 as well as key staff at the PSNs-contracted TPAs.

Of over 150 issues brought up through these system issues calls, during Demonstration Year Six, there were few new issues opened. By the end of Demonstration Year Six, only five issues remained as unresolved. Those unresolved are waiting for prioritization in order for those systems changes to occur. With only five issues remaining, the Agency has modified these monthly calls with the PSNs so that if there is no update to discuss, the monthly call is cancelled. Where available, manual workarounds have been implemented to address these issues.

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

- Correct processing of certain Medicare crossover claims.
- Correcting missing enrollments from monthly PSN enrollment files.
- Revisions to the PSNs' electronic remittance voucher to ensure inclusion of final claims adjustments and additional supplemental files provided until voucher changes can be made.
- Correct reporting HIV/AIDS capitation rates and categories not being reported correctly on PSN enrollment and payment files.

In addition to these calls, the Agency continued to coordinate technical assistance calls 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 providers.

General Amendment/Contract Overview/Training Calls and Meetings

During Demonstration Year Six, several conference calls/meetings were held with health plans regarding the following:

- A general amendment for the health plan contract that included the following major contract changes:
  - Requiring quarterly and annual medical loss ratio reporting beginning with the July 1, 2012, quarter.
  - Clarifying requirements for plans requesting assignment, transfer, withdrawal or termination to ensure the Agency receives the data needed to ensure adequate transition planning and maintenance of existing case/care coordination and facilitate continuity of care.
  - Requiring health plans to review preferred drug list changes with its pharmacy and therapeutics committee.
  - Requiring the health plan's assistance in dispute resolution between the Agency and the drug manufacturer regarding federal drug rebates.
  - Revising encounter data reporting requirements for pharmacy services.
  - Revising accreditation requirements for subcontracted managed behavioral health organizations.
  - Providing health plans with the option of providing certain dental and behavioral health services through telemedicine.
  - Implementing Florida statutory revisions in the FFS PSN reconciliation process and in the conversion to capitation requirements.

These calls provided the Agency with an opportunity to provide overviews of upcoming amendments, contract changes and current processes and provided forums for health plans to provide feedback on the topics being discussed.

Fraud and Abuse Meetings

The Agency held quarterly meetings on fraud and abuse initiatives; these were attended by over 40 health plan representatives. To help ensure health plan attendance, the meetings were held either in Tallahassee or at south/central Florida locations. The fraud and abuse meetings included the following:

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

K. 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 Medicaid Reform 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 Medicaid Reform 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 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 Presentation Meeting Video
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. The waiver extension request document can be viewed by visiting the Agency's 1115 Medicaid Reform webpage at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Request for Additional Information

On December 16, 2010, the Agency received a letter from Federal CMS requesting additional information on Florida's 1115 waiver extension request. This letter can be viewed by visiting the Agency's 1115 Medicaid Reform webpage at the following link:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

On January 11, 2011, the Agency responded to Federal CMS's request for additional information on Florida's 1115 waiver extension request. The Agency's response and attachments can be viewed by visiting the Agency's 1115 Medicaid Reform webpage at the following link:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Request for Temporary Extensions of the Waiver

During Demonstration Year Six, the waiver expiration date was temporarily extended by Federal CMS to December 15, 2011. The temporary extensions ensured continued service delivery to Medicaid recipients and provided additional time to finalize the waiver authorities, expenditure authority and the Special Terms and Conditions of the waiver. The letters are posted on the Agency's Medicaid Reform webpage at the following link:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Federal Approval of the Waiver Extension Request

On December 15, 2011, Federal CMS approved the three-year waiver extension request the Agency submitted on June 30, 2010. The waiver extension period is December 16, 2011 through June 30, 2014. The federal approval documents for the three-year waiver extension request can be found on the Agency's 1115 Medicaid Reform webpage at the following link:
http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Public Comments

Public comments related to the 1115 Medicaid Reform Waiver 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

Attachment I
Report on the One Problem Clinic at the Okaloosa County Health Department

The One Problem Clinic at the Okaloosa County Health Department is a clinic designed to provide individuals with primary medical care for any one health problem they may have. The One Problem Clinic's goal is to provide affordable health care and provide a service that will divert non-emergency care away from hospital emergency rooms for patients of all ages. After being open for approximately nine months, the One Problem Clinic staff set out to answer questions about the clinic and those who sought care in the clinic: Who are the clients that access care from the One Problem clinic and why are they coming to the clinic (Demographics and Diagnosis)? Why do they use the One Problem Clinic rather than another source of medical care? Where would they go for care if the One Problem Clinic was not available?

Who are the clients that access care through the One Problem Clinic and what is their One Problem?

In order to obtain demographic data from February 2011 to November 2011, the health department database was used to obtain a "crystal report" which contains information on patient's race, gender, age, and diagnosis code. In addition to the database, a survey was developed and given to patients as they checked in at the One Problem Clinic. The survey was given to patients for two weeks in January 2012, and 48 surveys were completed. A section of the survey included boxes for the patient's gender and age group. Of the 45 patients who responded with their gender, 40% were male and 60% were female. Patients were also asked on the survey their age group in which 47 patients responded and the distribution is displayed on the chart below. From the crystal reports, ages of 1,257 patients were obtained and are displayed below. Gender was obtained on 1,262 patients from the database showing 77.9% female and 22.1% male.

Age Range Distribution from Database (2/28/2011 to 11/17/2011)		**Age Distribution from Survey**	
Age Range	**Percentage**	**Age Range**	**Percentage**
0-18	23%	0-18	7%
19-29	32%	19-29	38%
30-39	17%	30-39	32%
40-49	13%	40-49	4%
50+	15%	50+	19%

Diagnosis codes for patients were obtained from the crystal reports and the top ten diagnoses are shown below, a total of 1888 diagnoses were shown in the crystal report.
Of the patients seen from February 28, 2011 to November 17, 2011, 62.7% did not pay for services (due to coverage or determined low income) and 12.5% paid in full for services.

- Upper Respiratory Infection
- Urinary Tract Infection
- Strep/Sore Throat
- Benign Hypertension

- Dermatitis
- Lumbago/Back Ache
- Sinusitis
- Cellulitis
- Ear Infection
- Unspecific Abdominal Pain

Why do patients use the One Problem Clinic?

To answer this question, responses of 48 patients were used from the survey. The results of the responses are shown in the chart below. Patients responding with "other" stated they either had no insurance, had no doctor, just moved here, or they were living in a shelter house. The response with the highest percentage was the cost of service, and second was the ability to get a same day appointment.

Reasons for Patients using the Clinic	
Reasons	**Percentage**
Cost	45%
Location	16%
No Other Physician Available	6%
Same Day Appointment	23%
Other	10%

Where would patients go if the One Problem Clinic was not available?

Since the One Problem Clinic was created to provide ER diversion for patients seeking quality care at lower cost and in non-emergency situations, the question was asked on the survey about where patients would go if the service provided by the One Problem Clinic was not offered. The results of this survey are displayed below. The response with the highest percentage was that patients would seek care in their nearest hospital emergency room. No patients answered that they would go to a free clinic such as the Hope Clinic or Crossroads. Patients responding with "other" answered they would go to the Opportunity Health Clinic, they would go nowhere or stay home, they don't know what they would do, or they would go to a doctor who accepted Medicaid.

As an additional question, patients were asked how they heard about the One Problem Clinic; the distribution of responses is displayed below. Patients who responded with other stated that they heard from an "OH client" (Opportunity Health), the Waterfront Rescue Mission, Access FL, or a Counselor at a shelter (patient who came from shelter house).

Other Options for Clinical Care	
Options	**Percentage**
Hospital Emergency Room	48%
Health Center (Freeport or Crestview)	0%
Urgent Care	14%
Free Clinic	19%
Private Doctor's Office	4%

How Clients Heard about One Problem Clinic	
Source	**Percentage**
Friend or Family	50%
ER sent them	2%
Sign in Health Department	6%
Website	10%
HD Staff Member	19%
Other	14%

Summary

According to survey and crystal reports obtained from the health department database, patients are utilizing the One Problem Clinic for a variety of ailments. Also, according to survey, most patients would in fact be going to a hospital emergency room for their non-emergency care. In addition, the above results reveal that the One Problem Clinic is being used by a majority of persons under 40 years of age, with awareness of the clinic arising from a variety of sources. The above is to serve as an informative report on the One Problem Clinic, which is successfully serving the Fort Walton Beach area.

Attachment II
2011 Managed Care Performance Measures

Bold = Better than the national mean

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

	Non-Reform*					Reform*					
Measure	2008	2009	2010	2011	Trend	2008	2009	2010	2011	Trend	National Mean**
Appropriate Medications for Asthma	n/a	87.0%	87.0%	86.6%	-	n/a	83.6%	87.6%	86.0%	-	88.6%
Breast Cancer Screening	n/a	47.5%	50.1%	50.9%	+	n/a	51.4%	56.9%	**59.2%**	+	52.4%
Childhood Immunization Combo 2	n/a	61.8%	71.4%	73.8%	+	n/a	63.6%	70.0%	72.6%	+	74.3%
Childhood Immunization Combo 3	n/a	52.0%	63.7%	67.9%	+	n/a	53.8%	62.7%	65.7%	+	69.4%
Frequency of Prenatal Care	n/a	51.6%	54.3%	**60.6%**	+	n/a	52.6%	46.9%	44.0%	-	61.6%
Lead Screening	n/a	46.0%	53.1%	53.5%	+	n/a	54.8%	52.0%	54.1%	+	66.4%
Adult BMI Assessment	n/a	n/a	31.2%	**48.3%**	+	n/a	n/a	41.9%	**52.7%**	+	34.6%
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	n/a	n/a	37.8%	**37.1%**	-	n/a	n/a	43.6%	**44.5%**	+	36.6%
Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance	n/a	n/a	46.6%	**46.7%**	+	n/a	n/a	n/a	n/a	n/a	41.7 %

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

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