Florida Medicaid Reform

Year 1
Final Annual Report
July 1, 2006 – June 30, 2007

1115 Research and Demonstration Waiver

Agency for Health Care Administration

Table of Contents

List of Charts

List of Tables

Letter from the Medicaid Director

Florida's 1115 Medicaid Reform Waiver is a comprehensive demonstration designed to improve the value of the Medicaid delivery system by coupling the increased use of managed care principles with innovative approaches like customized benefit packages, opt-out provisions, and health-related incentives or enhanced benefits for beneficiaries. The demonstration was implemented in Broward and Duval Counties on July 1, 2006 and will be expanded to Baker, Clay and Nassau Counties on July 1, 2007.

During the first year of operation, the demonstration created an environment that encouraged beneficiaries to more actively participate in the management of their health care and encouraged health plans to provide care that is more centered on a person's individual needs. Under Medicaid Reform, an increasing number of health plans participated and an increasing number of recipients voluntarily chose their health plans. Additionally, the aggregate value of the benefit packages offered to beneficiaries was greater than the value of the state plan in year one and this value increased for year two benefit packages.

Listed below are highlights from year one, including accomplishments and lessons learned. A more in depth review of these highlights including activities planned for year two are found in the body of the report.[1]

Accomplishments

- **Increased beneficiary's voluntary enrollment** rate.
- **Increased the number of health plans** from nine to sixteen from which beneficiaries can choose.
- **Increased the value of benefit packages** with the provision of services not previously covered by Medicaid (e.g. adult dental care and over-the-counter drug benefits).
- **Established the first specialty PSN** that serves children with chronic conditions in Broward and Duval Counties.
- **Established thirty-three plan performance measures** that will be collected over a three-year period to measure enrollee outcomes.
- **Developed business processes and implemented initial fiscal agent system changes for the Medicaid Encounter Data System** which will allow greater transparency of plan performance and increased payment accuracy.
- **Established health plans in the counties** of Baker, Clay and Nassau with enrollment scheduled to begin in September 2007.

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[1] Prepared by the Agency for Health Care Administration in accordance with Section 409.91213(1)(b), F.S., and Special Term and Condition #23 of Florida's 1115 Medicaid Reform Waiver. This report covers the first operational year of the waiver program beginning July 1, 2006 and lasting through June 30, 2007.

Lessons Learned

Health Plan Contracting

- **Additional training for PSN and PSN providers** was needed on claims processing.
- **A single complaints/issues database** was needed to better identify and track problems/issues raised by beneficiaries and/or providers.

Choice Counseling Program

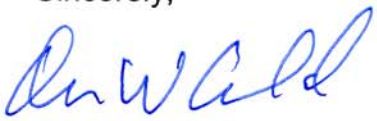
- **Re-structured public meetings** to keep the focus on one or two elements of the Choice Counseling Program thereby allowing for more in-depth discussion and strategies for improvement.
- **Developed a calendar of regular public meetings** to better facilitate and ensure continual feedback on the program.
- **Enhanced the field Choice Counselor's role** by having them assist the call center in finding beneficiaries who had not enrolled in a plan during the 30-day choice period.
- **Created the Special Needs Unit** to help educate medically complex beneficiaries and their families on how to access care.

Enhanced Benefit Program

- **Systems improvements** were made to process health plan files more efficiently, improve the user-interface, and improve production of the beneficiary monthly statement.
- **Streamlined the monthly statement** to provide only critical information to beneficiaries regarding credits earned and spent.
- **Determined increased outreach efforts** were needed to encourage beneficiaries participating in the program to use the credits earned, and to facilitate pharmacy participation.

The Agency gratefully acknowledges the Florida Legislature, beneficiaries, providers, and other key stakeholders for their assistance in making this demonstration a success. We expect there will be future opportunities for improvement as we gain more data and experience and we look forward to crossing these bridges together. The Florida Medicaid community is leading the way in improving care for all Florida citizens.

Sincerely,



Thomas W. Arnold
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 approved by the Centers for Medicare and Medicaid Services (CMS) on October 19, 2005. State authority to operate the program is located in Section 409.91211, Florida Statutes, which provides authorization for a statewide pilot program with implementation that began in Broward and Duval Counties on July 1, 2006. The program is in the process of expanding to Baker, Clay and Nassau Counties which is scheduled to begin July 1, 2007.

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of merging market-based approaches with a public entitlement program.

Key components of Medicaid Reform include:

- Comprehensive Choice Counseling;
- Customized Benefit Packages;
- Enhanced Benefits for participating in healthy behaviors;
- Risk Adjusted Premiums based on enrollee health status;
- Catastrophic Component of the premium (i.e., state reinsurance to encourage development of provider service networks and health maintenance organizations in rural and underserved areas of the State); and
- Low-Income Pool.

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Condition # 23 of the waiver. The State is required to submit an annual report for each operational year documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the 1115 Medicaid Reform Waiver. This report is for the first operational year beginning July 1, 2006 through June 30, 2007. For detailed information about the activities that occurred during the first four quarters of operation, refer to the quarterly 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

Initial health plan contracting activities began in February 2006 with the Agency's request for non-binding letters of intent to determine prospective plans' interests in participating in Reform in Broward or Duval County. The Agency received twenty-one responses from prospective plans. Of those, twelve indicated interest in participating as a Health Maintenance Organization (HMO) and nine indicated interest in participating as a Provider Service Network (PSN).

In February 2006, the Agency released the Reform Health Plan Application through an open application process to contract with any qualified plan that met all applicable requirements of state and federal regulations. All health plans, including current contractors wishing to participate as Reform health plans are required to complete an application. One application was developed for capitated and fee-for-service (FFS) PSN applicants. The application process focuses on four areas: organizational and administrative structure including fiscal sustainability; policies and procedures; on-site review; and contract routing process. In addition all plans are required to submit a Customized Benefit Plan for approval as part of the application process.

Under the open application process, there is no official due date for submission in order to participate as a plan. In Broward or Duval Counties, the Agency provided guidelines for application submission dates to ensure contracting by July 1, 2006. Prospective plans were encouraged to submit a complete application by April 17, 2006, in order to be considered for a July 1, 2006, effective date. The Agency received 18 applications of which seventeen sought to provide services to the TANF and SSI population; one application sought to render services as a specialty PSN.

Of these 18 applicants, all but two were approved as Reform health plans in Year One. The sixteen Reform health plans consist of ten HMOs and six PSNs. The two pending applications are expected to be completed and become operational by the end of 2007. Table 1 lists the 2006 Reform health plan applicants, date the application was received and date of approval.

Table 1 2006 Health Plan Applicants					
Plan Name	**Plan Type**	**Coverage Area**		**Receipt Date**	**Contract Date**
		Broward	**Duval**		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom	HMO	X		04/14/06	***Pending***
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista	HMO	X		04/14/06	06/29/06
Vista Health Plan SF	HMO	X		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	***Pending***

Table 2 lists the Medicaid Reform health plan contracts approved during 2006 by plan name, effective date of the contract, type of plan and coverage area. There have been no new Reform health plan contracts executed since December 2006. However, the Children's Medical Services PSN, the first approved specialty plan, was approved for expansion into Duval County on March 21, 2007, and the first enrollment began May 1, 2007, in that county.

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area**	
			Broward	**Duval**
AMERIGROUP Community Care	07/01/06	HMO	X	
Health Ease	07/01/06	HMO	X	X
Staywell	07/01/06	HMO	X	X
Preferred Medical Plan	07/0106	HMO	X	
United HealthCare	07/01/06	HMO	X	X

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area Broward**	**Duval**
Humana	07/01/06	HMO	X	
Phytrust dba Access Health Solutions	07/21/06	PSN	X	X
Total Health Choice	07/01/06	HMO	X	
South Florida Community Care Network	07/01/06	PSN	X	
Buena Vista	07/01/06	HMO	X	
Vista Health Plan SF	07/01/06	HMO	X	
Florida NetPASS	07/01/06	PSN	X	
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X
Pediatric Associates	08/11/06	PSN	X	
Children's Medical Services, Florida Department of Health	12/01/06	PSN	X	X
Universal Health Care	12/01/06	HMO	X	X

* Please note that the effective date listed in Table 2 represents the date when the plan is available as a choice but does not represent the date on which the plan receives enrollment.

Florida's pre-existing Medicaid HMOs provided the framework for Medicaid Reform. In Broward County, eight HMOs already participated in the Medicaid program. In Duval County, two HMOs participated prior to Reform. These HMOs had to submit Reform health plan applications but their infrastructure was already established and most had been providing Medicaid HMO services for five to ten years. As of June 30, 2007, ten HMOs were participating in Broward and Duval Counties.

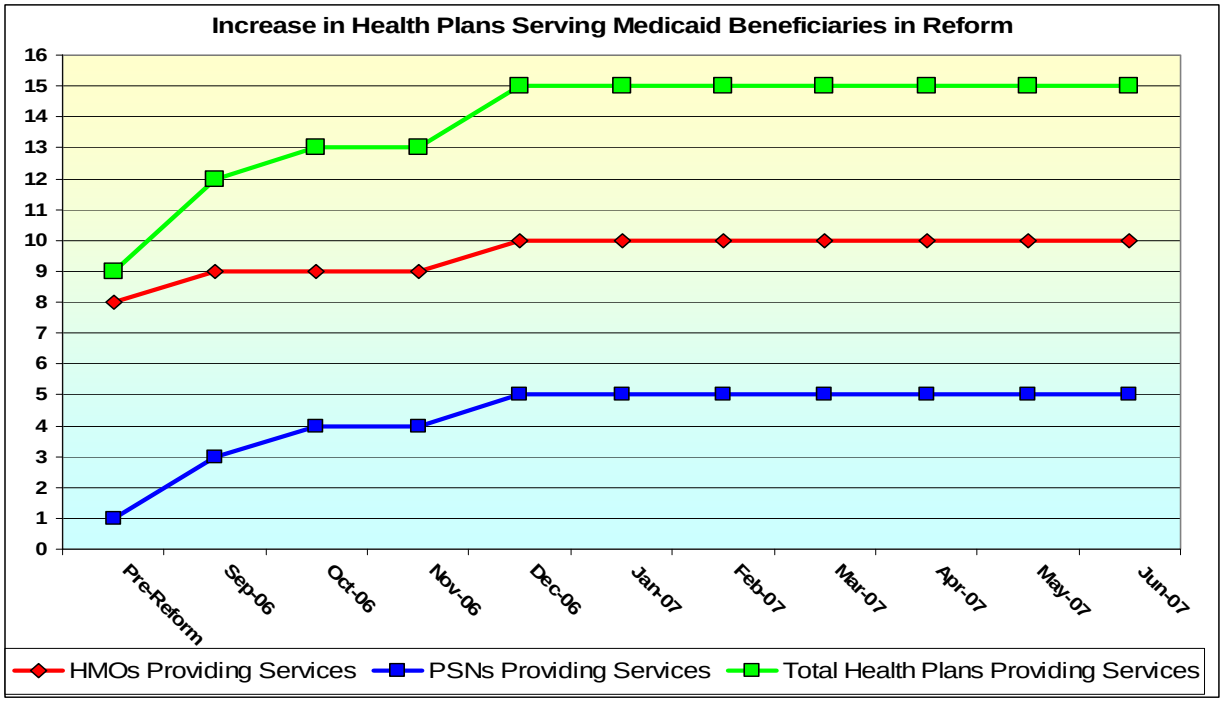
The Medicaid PSN program experienced the largest increase in participation by health plans. Prior to Medicaid Reform, there was only one Medicaid PSN that had been in existence. With the implementation of Reform, various physician and hospital groups sought to ensure they would continue to have a Medicaid patient base, and developed health plan networks and entered into subcontracts with third party administrators in order to submit applications to become Reform PSNs.

Two of the PSNs participating in Reform serve only children under age 21: the Florida Department of Health's Children's Medical Services (CMS) specialty plan for children with chronic conditions and Pediatric Associates, a PSN that had previously participated in Medicaid as a Pediatric Emergency Room Diversion provider. As of June 30, 2007, six PSNs were participating in Broward and Duval Counties.

At the end of the first year of operation, the Agency had established contracts with ten HMOs and five PSNs for a total of fifteen Reform health plans in Broward County; and four HMOs and three PSNs for at total of seven Reform health plans in Duval County. The number of health plans that beneficiaries can chose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform

Waiver. Chart A provides a graph of the increase in the number of health plans in Broward and Duval counties.

Chart A
Increased Number of Plans in Broward & Duval Counties



The Agency approved United HealthCare and Access Health Solutions applications for expansion to Baker, Clay and Nassau Counties and the resulting contract amendments were signed on June 29, 2007. These two entities will provide beneficiaries located in these expansion counties with a choice of enrolling in an HMO or a PSN, options that did not exist prior to Medicaid Reform.

In June 2007, the Agency also executed contract amendments for the majority of Reform health plans and anticipates all remaining plan contract amendments will be executed prior to September 1, 2007. The contract amendments for capitated plans included the draft capitation rates and the Agency approved customized benefit packages for the time period of September 1, 2007, through August 31, 2008. The contract amendments for FFS PSNs included the September 1, 2007, through August 31, 2008, draft capitation rates upon which each FFS PSN's contract reconciliation will be based, and the Agency approved expanded benefits for each FFS PSN. The Agency has submitted the contract amendments and the actuarial certification for the draft capitation rates to CMS as required.

Primary Care Provider (PCP) Participation in Reform

One question raised with the implementation of Medicaid Reform is what affects would there be on Florida Medicaid's primary care case management program, MediPass. Would MediPass PCPs continue to participate in Reform plans? Would MediPass

PCPs choose to join Reform health plans? In order for address the expressed concerns for continuity of care and the smooth transition of Medicaid beneficiaries into Reform health plans, the answers to these two questions are significant.

Based on the first year of operation, after reviewing data related to MediPass PCPs and the provider files submitted by the Reform health plans, the Agency found that over 93% of Broward County PCPs continued to participate in MediPass serving the voluntary populations after implementation of Medicaid Reform. Of those that left MediPass, only 2.3% voluntarily choose to leave. The rest of the PCPs that left MediPass were involuntarily discharged from MediPass due to non-compliance issues unrelated to Medicaid Reform (4.6%). Over 96% of MediPass PCPs joined at least one Broward Reform health plan (over 72% joined multiple Broward Reform health plans).

In Duval County, the Agency found that over 97% of PCPs continued to participate in MediPass post Medicaid Reform. Similar to Broward results, of those that left MediPass, only 2.8% voluntarily choose to leave. Over 91% of MediPass PCPs joined at least one Duval Reform health plan (over 77% joined multiple Duval Medicaid Reform health plans).

Charts B-1 through B-4 show the MediPass PCP participation from September 1, 2006 to June 30, 2007, in Broward and Duval Counties with the implementation of Medicaid Reform.

Chart B-1
Broward MediPass PCP Participation

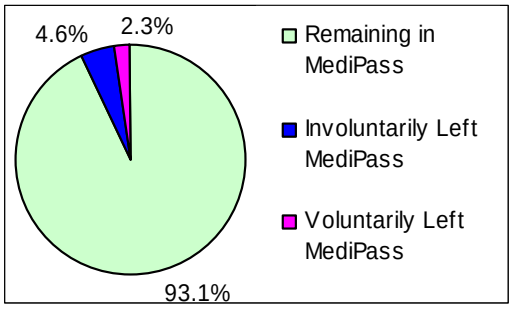


Chart B-2
Duval MediPass PCP Participation

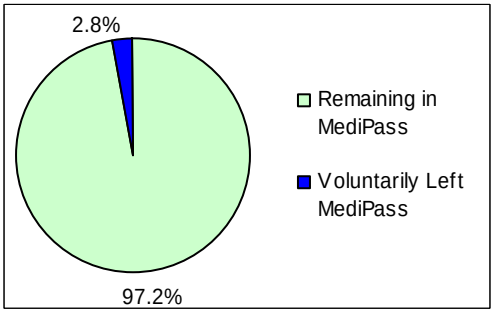


Chart B-3
Broward MediPass PCP Participation in Reform Plans

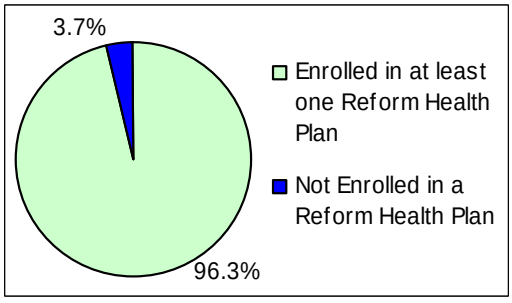
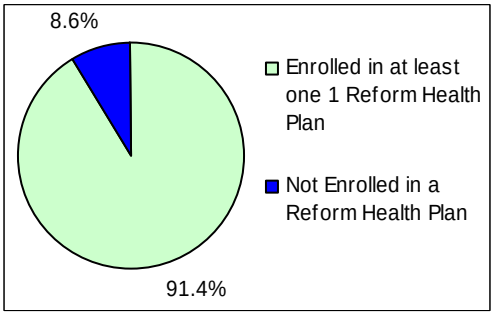


Chart B-4
Duval MediPass PCP Participation in Reform Plans



Charts C-1 and C-2 show the number of active MediPass PCPs enrolled in Reform health plans in Broward and Duval Counties from July 1, 2006 to June 30, 2007.

Chart C-1
Number of Active MediPass PCPs Enrolled in Broward Reform Plans

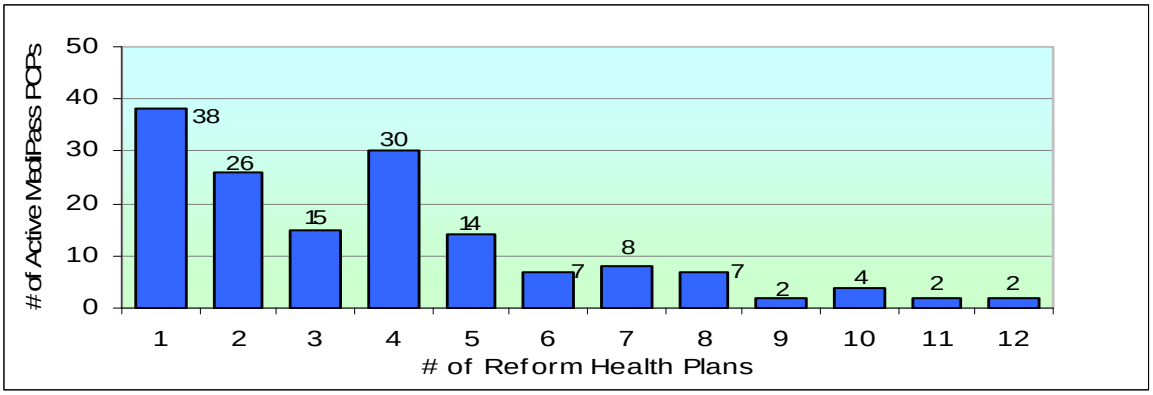
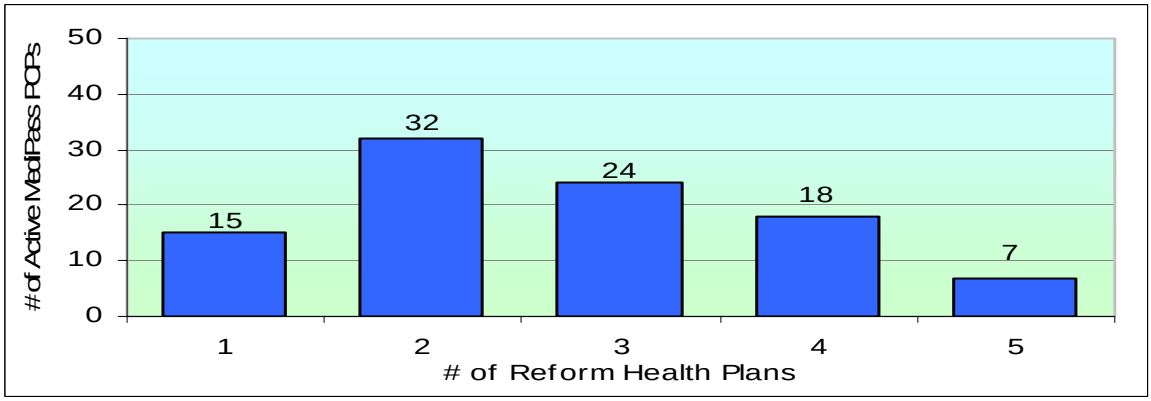


Chart C-2
Number of Active MediPass PCPs Enrolled in Duval Reform Plans



Year One at a Glance

A summary of the first year's accomplishments related to the health plan contracting process are provided below.

- Streamlined the health plan application process by developing one health plan application for both capitated applicants and fee-for-service (FFS) PSN applicants.
- Developed guidelines for the submission of health plan applications to ensure contracting by July 1, whenever possible.
- Approved a total of sixteen health plan applications by November 2006, with the majority of the approvals occurring before July 1, 2006. Ten of these are HMOs, six are PSNs.
- Continued technical assistance is provided for the two pending applicants who are expected to complete the contracting phase and become operational by the end of December 2007.

- Fifteen of the approved health plans operate in Broward County: ten HMOs and five PSNs.
- Seven of the approved health plans operate in Duval County: four HMOs and three PSNs.
- Of the six approved Reform FFS PSNs, one is the first specialty plan for children with chronic conditions that is operated by the Florida Department of Health Children's Medical Services.
- Approved two expansion applications submitted by current Reform health plans: one HMO and one PSN. These health plans were approved to expand to Baker, Clay and Nassau Counties beginning July 1, 2007.
- All HMOs have contracted to provide services at the comprehensive and catastrophic levels.

Lessons Learned

There were many lessons learned in the health plan contracting process during the first year of operation of Medicaid Reform. The Agency typically addressed these through contract amendments, policy transmittals, technical and operations conference calls, and systems implementation calls. Many of the lessons learned understandably occurred with the increased number of the PSNs, as these plans are mainly new entities operating as health plans in a FFS claims environment.

The following provides a list of the lessons learned and opportunities for improvement identified during the first year of operation in regards to the health plan contracting process. Additional information regarding lessons learned is provided under Section K., Policy and Administrative Issues.

- Florida Medicaid's current fiscal agent is at the end of its Medicaid contract and is not the vendor chosen to provide services under the new Medicaid fiscal agent contract which begins March 2008. With the current fiscal agent contract ending during the implementation of Medicaid Reform, several systems efficiencies could not be implemented until the new fiscal agent contract begins in March 2007. This delay has caused some administrative burden on Agency staff, PSN staff and providers as all work through claims process and enrollment file issues within the confines of the current fiscal agent system. A list of systems implementation issues have been provided to the new Medicaid fiscal agent in order to ensure systems enhancements are implemented in March 2008.

- PSNs contracted with third-party administrators (TPAs) for claims authorization and transmission to the Medicaid fiscal agent. While the PSNs contracted with TPAs with experience in claims processing, only two had direct experience with submission of such claims to the Medicaid fiscal agent in its required file formats. Lack of experience with Medicaid's fiscal agent procedures resulted in some claims processing delays until the PSNs and their TPAs became more familiar with the fiscal agent's formats and procedures.

- PSNs required more training on claims processing, particularly paper claims processing, and PSNs needed to provide more claims processing training to their providers, particularly to smaller providers that were unfamiliar with working with multiple payers within the fee-for-service Medicaid Program.

Look Ahead to Year Two

As health plans expand to Baker, Clay and Nassau Counties, the Agency remains committed to ensuring appropriate access to care. With the addition of two health plans in these counties, beneficiaries will have access to contracted providers and assurance of services within contracted time frames. The Agency will continue to monitor MediPass PCP participation during the second year of operation, both within Reform and in continuation of the MediPass program.

The Agency identified the need for specialized claims training for the PSN providers. The Agency required modifications to the PSNs training programs for their providers. Also modifications are being made to the Agency's monitoring process to ensure PSN training includes specialized training on provider/PSN file format requirements, file transmission processes, remittance voucher advice and how claims processing works compared to how it works under FFS Medicaid and the FFS PSN program.

Of significant importance is the requirement for FFS PSNs to become capitated by the beginning of their fourth contract year. Reform PSNs that began enrolling beneficiaries in September 2006, will be required to transition to the capitated reimbursement methodology by September 2009. To assist the PSNs with this process, the Agency will provide transition guidelines to the PSNs to facilitate the development of their transition plans for converting to a capitated health plan model. PSNs that began providing Reform services in 2006 are required to submit their transition plans to the Agency by December 2007. The Agency is developing transition guidelines which are scheduled to be released in the fall of 2007.

2. Benefit Package

Overview

Customization of benefit packages is one of the fundamental elements of Medicaid Reform. Medicaid beneficiaries are being offered choices in health plan benefit packages customized to provide services that better suit their needs. The health plans have become innovative by increasing the number and types of services that they offer in order to attract new enrollees. The standard state plan package may not be the perfect fit for every Medicaid beneficiary, and the beneficiaries are getting new opportunities to engage in decision-making responsibilities relating to their personal health care needs.

Year One at a Glance

The Agency, the health plans and the beneficiaries can see the value of customization. The Agency has seen an increase in the percentage of voluntary plan choices from an

average of 50.93% in non-reform to 67.74 % in Medicaid Reform. The Reform health plans have used the opportunity to offer additional, alternative and attractive services that were not available under the regular Florida Medicaid state plan. Evidence of this added potential value is reflected in both:

- The difference in actuarial value in any one year between Reform health plans and the state plan, and
- The difference in actuarial value over time between Reform plans and themselves.

Thus, early evidence suggests that reform plans are providing and will provide increasing value in terms of benefit packages to Medicaid beneficiaries. This is demonstrated by the summarized data in Table 3 and Chart D.

Table 3 summarizes the variation in benefits offered by the capitated plans providing services in the first year of Medicaid Reform (2006-2007) and those contracted to provide services for the second year (2007-2008). This shows the net effect on the enrollees as either an increase or decrease in the value of the service in the benefit package.

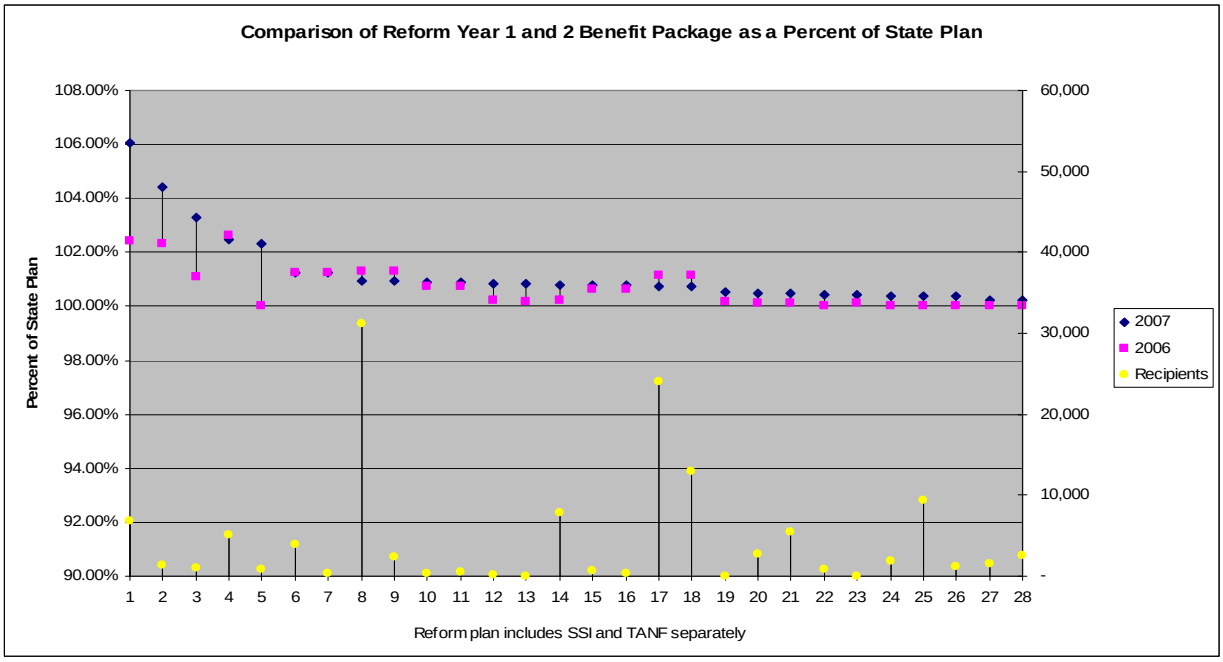
Table 3
Benefit Changes Summary

Benefit Description	# of Plans Increasing Service, Waiving or Reducing Co-Payments	# of Plans Reducing Service or Increasing or Adding Co-Payment
Behavioral Health Co-Payment	10	
Chiropractor Co-Payment	9	
Dental Services Co-Payment	3	1
Home Health Services Co-Payment	3	1
Hospital Outpatient NOS Co-Payment	5	
Hospital Outpatient Surgery Co-Payment	5	
Lab / X-ray Co-Payment	3	
Outpatient Mental Health Co-Payment	3	1
Physical Health Co-Payment	5	
Podiatrist Co-Payment	9	
Expanded Benefit	18	1

Benefit Description	# of Plans Increasing Service, Waiving or Reducing Co-Payments	# of Plans Reducing Service or Increasing or Adding Co-Payment
Chiropractor	4	
Hearing Services	1	
Podiatrist	4	
Vision Services	1	
Outpatient Pharmacy	8	6
Durable Medical Equipment	6	2
Hospital Outpatient Not Otherwise Specified (NOS)	15	

Chart D details the value of the benefit packages offered by plans in the first year of Medicaid Reform (2006-2007) and the benefit packages to be offered by plans in the second year (2007-2008) and the enrollment in the plan offering the benefit package.

Chart D
Values of Benefit Packages Year 1 to Year 2 and Enrollment



The ten Reform health plans that were approved during the first year of Reform included HMOs authorized to create customized benefit packages. Five plans elected to vary the amount of their services specific to the population. Six HMOs and one PSN chose to waive cost sharing. Three HMOs imposed cost sharing for select services, and three PSNs charged cost sharing consistent with the FFS limit. Finally, many plans chose to add services that are not currently covered by Medicaid. The expanded services include the following:

- OTC drug benefits from $10-$25 per household per month
- Adult Preventive Dental Services
- Elective Circumcisions
- Acupuncture
- Therapeutic Massage
- Respite Care
- Additional Adult Vision Services – up to $125 per year for upgrades such as scratch-resistant lenses
- Additional Hearing Services – up to $500 per year for Hearing Aid upgrades
- Home-delivered meals following surgery

In June 2007, the Agency received and reviewed 28 proposed customized benefit packages from the capitated plans and 13 different expanded benefits proposals from the fee for service plans. The proposals from ten HMOs and six fee for service PSNs included proposals for Reform expansion counties, Baker, Clay and Nassau. The approved customized benefit packages are for September 1, 2007 to August 31, 2008.

The two most popular expanded services offered are the same as last year's; OTC drug benefits and adult preventive dental benefits. Four of the customized benefit packages increased the OTC value from $10 to $25, while another 4 added a $25 OTC benefit. Many of the expanded services available in September 2007 are the same as those offered in September 2006.

For the second year of Medicaid Reform, the 2007-2008 customized benefit packages added the following expanded benefits.

- Nutrition Therapy
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined)
- Adult Hospital Outpatient – Additional $3,500/year for hospital outpatient services at Shands Jacksonville only (maximum $5,000/year combined)

While the one benefit not offered for the upcoming contract 2007-2008 year is Therapeutic Massage.

Look Ahead to Year Two

The Agency will continue to examine the possibilities of allowing more customization by periodically reevaluating the percentages that can be shifted and the services that can be varied. Since Reform health plans can manage health care of their enrollees through utilization management and case management expertise, the plans can shift costs and allow for the provision of added services and alternative treatment. The Agency's goal is to make the most of this expertise by providing a variety of options and increasing variation in the options over the five year period of the demonstration project. Focus groups are scheduled to discuss benefits with beneficiaries and providers. In combination with beneficiary choice data, the Agency will use the information that we learn in these sessions and the Reform health plan proposals submitted in the customized benefit packages to gauge the needs and preferences of the Medicaid Reform beneficiaries. This experience and knowledge will ultimately benefit the beneficiaries by establishing a health care system with better opportunities for participating in health care choices and increasing personal engagement.

3. Grievance Process

Overview

The Grievance and appeals processes are specified in the in the Reform health plan contract and were modeled after the existing managed care contractually required processes. The grievance and appeals processes include a grievance process, appeal process, Medicaid Fair Hearing system, and timeframes for submission, plan response and resolution. This is consistent with the Federal Grievance System Requirements located at 42 CFR 400. In addition, the Medicaid Reform health plan contracts include a provision for the submission of unresolved grievances, upon completion of the health plans internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOS, prepaid health clinics and exclusive provider organizations. This provides an additional level of appeal.

Under Reform, the Legislature required that the Agency develop a process similar to the SAP as enrollees in a FFS PSN do not have access to the SAP. In accordance with Section 409. 91211(3)(q), F.S., the Agency developed the Beneficiary Assistance Panel (BAP) which is similar in structure and process to the SAP. The BAP will review grievances within the following timeframes:

1. General grievances will be reviewed by the state panel within 120 days.

2. Grievances that the state determines pose an immediate and serious threat to an enrollee's health will be reviewed by the state panel within 45 days.

3. Grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee will be reviewed by the state panel within 24 hours.

Enrollees in a Reform Health Plan can file a request for a Medicaid Fair Hearing at any time and are not required to exhaust the plan's internal appeal process prior to seeking a Fair Hearing.

Year One at a Glance

During the first year of operation, July 1, 2006 through June 30, 2007 there were no formal grievances filed with the Agency for Reform HMOs or FFS PSNs.

With a more established managed care system in Broward, many beneficiaries were already familiar with health plan service provision, and the existing health plans were experienced with service provision and provider reimbursement, which appears to have reduced the necessity of filing formal grievances to resolve issues. Additionally, the Area Office staff worked diligently to resolve beneficiary and provider complaints/issues related to Reform health plans. The Area Office staff was able to identify and resolve plan related complaints/issues timely and with positive outcomes for beneficiaries. Additionally, the different Agency bureaus that are responsible for the implementation of the Medicaid Reform Waiver have worked closely with Area Office staff, Reform health plans and providers to resolve complaints and issues prior to the issues moving to the formal grievance process.

Look Ahead to Year Two

The Agency continues to monitor the Reform health plan grievance and appeals process and outcomes.

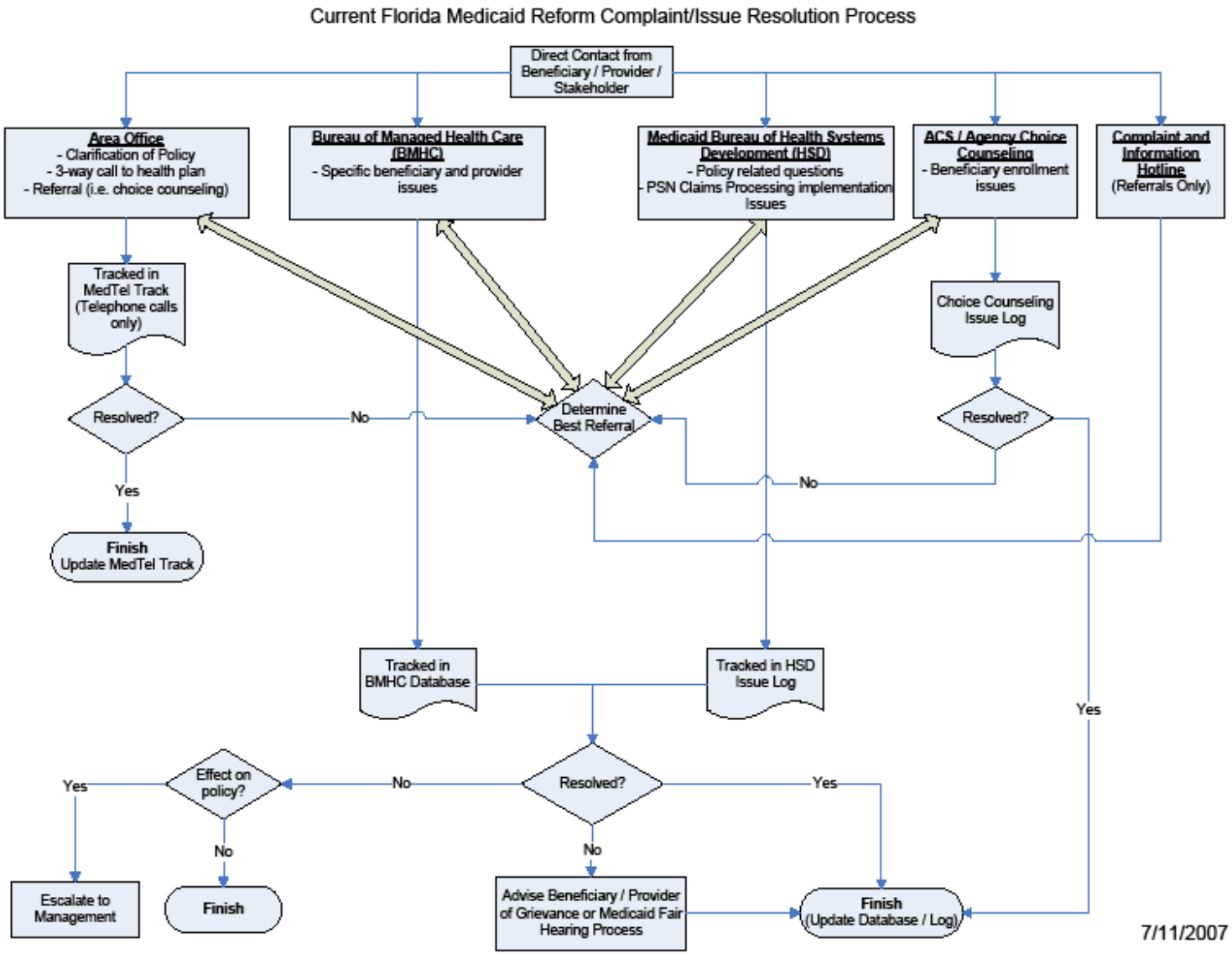
4. Complaints/Issues Resolution Process

Overview

Complaints/issues received by the Agency regarding the Reform health plans provide the Agency with feedback regarding what is working and not working in managed care under Medicaid Reform. Complaints/issues come to the Agency from beneficiaries, advocates, providers and other stakeholders. The complaints/issues are worked by Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution. Chart E-1 provides an overview of the current process used for tracking complaints during the first year of Medicaid Reform.

During the first year of operation, the complaints/issues received by the Agency regarding health plans are listed in Attachments I and II. In general, the complaints/issues received are related to managed care but some have unique significance relative to implementation of the 1115 Medicaid Reform Waiver.

Chart E-1. Current Medicaid Reform Complaint/Issue Resolution Process



Year One at a Glance

The Agency's complaints/issues resolution process effectively addresses beneficiaries and provider complaints/issues.

The Agency received a total of 90 complaints/issues regarding health plans. None of these complaints/issues have escalated to a formal grievance. The major reasons for complaints/issues were claims processing (particularly PSNs), service provision (dental and pharmacy), and primary care physician availability. Modifications were made to formalize the tracking and trending with the creation of a single data base. All complaints/issues were worked and addressed with the health plans and providers, some resulting in sanctions. Issues requiring policy with the health plans were discussed on biweekly technical and operations calls, policy transmittals, and by email. Table 4 provides a summary of the complaints/issues received during the first year of operation.

Table 4
Health Plan Complaint/Issues

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	0.08	18	0.61	10	0.27	29	0.79
HMO	0	0.00	6	0.57	18	1.20	37	2.50	61	4.12
TOTAL	0	0.00	7	0.30	36	0.81	47	0.91	90	1.74
Enrollment*										
PSN		7,116		128,837		293,691		367,707		367,707
HMO		488		105,280		149,847		148,175		148,175
TOTAL		7,604		234,117		443,538		515,882		515,882

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

It is important to note that the majority of complaints/issues are related to managed care in general and reflect operational issues rather than Reform implementation issues. Agency staff will continue to resolve complaints in a timely manner and to monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

Lessons Learned

There were lessons learned and improvements made to the Agency's complaint/issues resolution process. The primary lesson learned was the need to develop a single data base to track and trend complaints/issues from beneficiaries or health plans allowing for faster problem identification and resolution. The issues identified and actions taken during the year are outlined below.

- **Single Data Base Needed to Track Complaints/Issues**. With the implementation of Medicaid Reform, the Agency began receiving requests for reports of complaint data and, with no single tracking system for complaints/issues the Agency was unable to easily provide this information.

Action Taken: As part of the Agency's continual focus on quality improvements, a Reform team created a workgroup that was charged with the development of a single database for housing and reporting on all complaints and issues. Data base proposals were reviewed with the primary focus on a deliverable that would allow for easy tracking and trending of the complaint/issue data.

Tracking complaints/issues in a single database will provide the Agency with the ability to more easily identify trends in problem areas. While this has been done informally in the past, a more formal process is being implemented to ensure that this information is tapped for all of its intrinsic value. Staff are currently working on training and process documents necessary for the anticipated September 2007 go-live date.

- **Definition for Complaint/Issue Needed.** The workgroup proposed a definition for complaint/issue to ensure that all offices would report such information consistently. The definition proposed was based on the definition the Agency uses for its primary case management program, MediPass.

  Action Taken: This definition was adopted through the project management process that has facilitated the implementation of the 1115 Medicaid Reform Waiver.

  The Agency definition of managed care complaint/issue is as follows: an expression of dissatisfaction, including dissatisfaction with the administration, claims, practices or provisions of services, which relates to the quality of care provided through health plan contracts; is submitted to the Agency; and cannot be resolved by speaking to the complainant. Managed care complaints/issues are not requests for customer service; however, if Agency staff judges such requests as requiring special treatment due to the caller's demeanor or point of reference, then that would be considered a complaint/issue.

  Please see Chart E-2 which provides the new Reform managed care complaint processing process slated for implementation in September 2007.

- **Improvement Needed in PSN Claims Processing**. Through the review of complaint/issue data, the Agency determined that additional training was needed for both providers (particularly therapy, home health, community mental health and prescribed pediatric extended care (PPEC) service providers) and PSNs.

  Action Taken: The Agency provided PSNs additional training and policy clarifications. Providers were assisted through the claims process changes by both the PSNs and Agency staff at both Headquarters and Area Offices. In addition, revisions were made in the review of PSN provider training material in the expansion counties to ensure 'hot topics' were presented and could be addressed up front.

- **System's Changes Needed to Process PSN Claims.** Through the review of complaint/issue data, the Agency determined that Medicaid fiscal agent systems

changes were needed for both the PSNs and providers to properly classify claims paid and denied as belonging to a particular PSN.

Action Taken: Changes easily made to the Medicaid Management Information System were processed; however, due to the ending of the incumbent fiscal agent's contract and resulting transition to a new fiscal agent system, some changes had to be held until the new fiscal agent.

- **HMO Prescription Drug Formularies Needed for Beneficiaries.** Through the review of complaint/issue data, the Agency determined that plan prescribed-drug formulary information are an area of concern for HMO members in Reform.

  Action Taken: The Agency worked with the HMOs to ensure this information was available on each health plan's website and that their member services staff were able to access this information and talk informatively about their restrictions with potential and current members. This important topic, and the reiteration that health plan materials should always be up-to-date, addressed on several biweekly Technical and Operations calls with the Reform health plans throughout the first year in Reform.

- **Service Authorization and Referrals**. Through the review of complaint/issue data, the Agency determined that service authorization and referrals were issues with health plan members and providers, including new providers entering into the managed care arena. Some health plan member service staff lacked clear understanding of the new processes in place for authorization and referrals related to the plan's customized benefit packages. This issue came up particularly with dental and prescribed drug services.

  This issue was exacerbated early in Reform as some health plan member service staff did not have updated provider directory identifiable for their Reform plans and there was confusion between Reform plan and non-Reform plan directory information. In addition, while the Medicaid system could identify a beneficiary enrolled in a Reform plan versus a non-Reform plan, the vendor systems that provide this information to the provider community at-large did not have this information identified.

  Action Taken: The Agency worked with the health plans to ensure the service authorization and referral information was provided to plan members and providers. The plans were also required to ensure their member service staff understood and could relate the new processes in place for authorization and referrals related to the plan's customized benefit packages. The Florida Medicaid fiscal agent's system issue, ability to identify a beneficiary enrolled in Reform plan versus a non-reform plan, was corrected in December 2006.

- **Prescribed Pediatric Extended Care (PPEC) Concerns.** Through the review of complaint/issue data, the Agency determined PPECs had concerns regarding the

coordination of transportation services and therapy services. While PPEC services are not covered through the Reform health plans with the exception of the CMS specialty plan, there are coordination requirements for all of the health plans.

All health plans in Reform (PSNs, HMOs and specialty plans) are contractually required to provide transportation services. Children continue to receive the required transportation; however, it is being provided by the health plans' contracted transportation providers. In some cases, the health plans' transportation providers are not the same providers that were providing transportation services prior to Reform. This results in PPECs having to coordinate with various different transportation providers.

Therapy services have always been required health plan services. Under Reform, however, therapy services are flexible benefits and may be adjusted according to the health plan's customized benefit plan. Some PPECs are also therapy providers. For such PPECs, providing therapy services to patients at their facilities alleviates the need for coordination with other therapy providers.

Action Taken: To assist the PPECs with these concerns, the Agency included PPEC representatives as well as Agency PPEC experts on a technical and operations conference call with all Reform health plans. The health plans were provided a good overview of PPEC services and the coordination issues involved for their members. It is the Agency's hope that this discussion and the materials provided will help facilitate the dialogue between PPECs and the health plans.

- **Primary Care Provider Availability.** Primary care provider availability was a small but familiar issue in managed care.

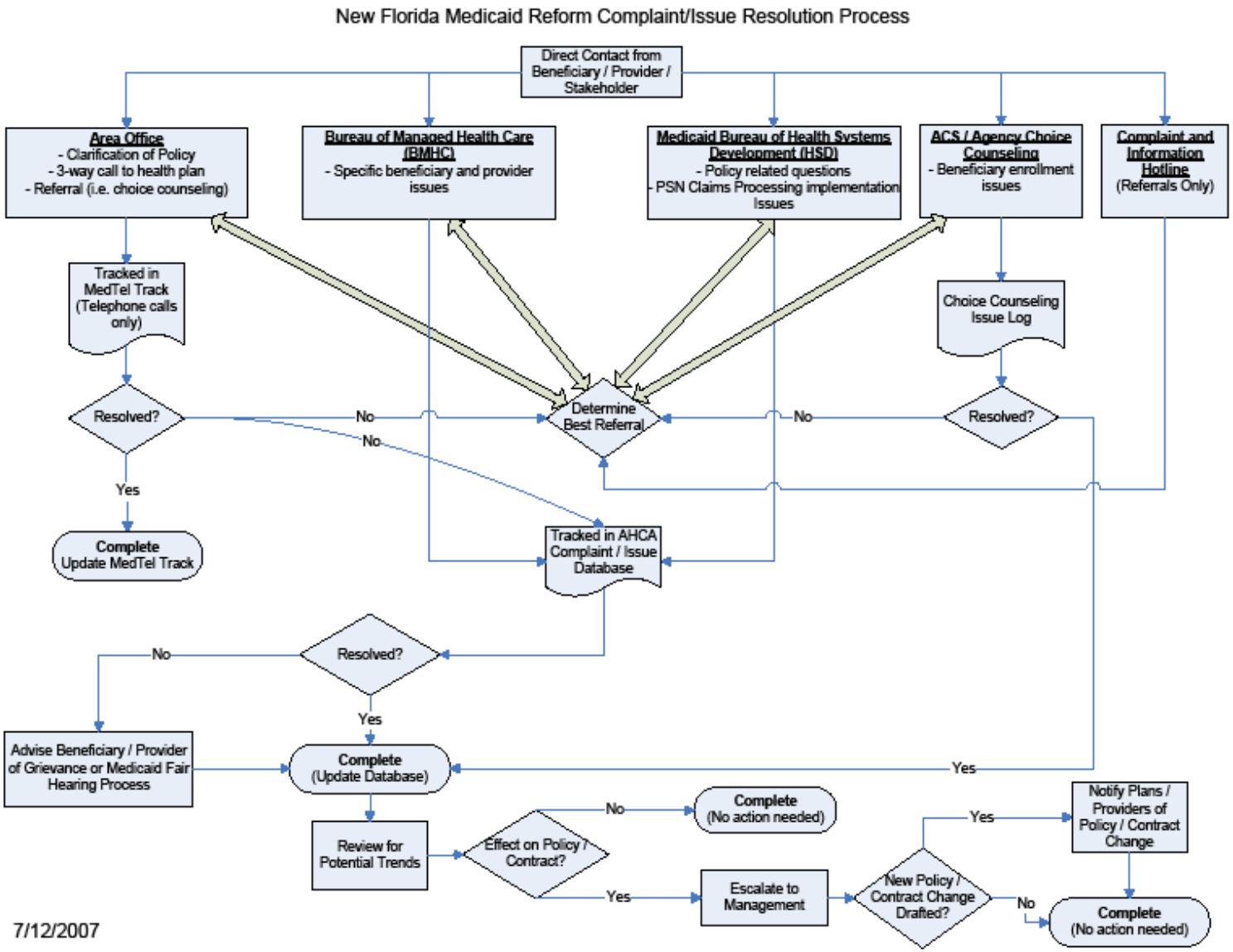
  Action Taken: The Agency worked with the health plans to ensure their provider file information was up-to-date and accurate.

Look Ahead to Year Two

The Agency expects that the implementation of our consolidated complaint/issue database will facilitate the tracking and reporting of complaints. Chart E-2 provides the new Reform managed care complaint/issue resolution process slated for implementation in September 2007. Trends will be easier to identify and will facilitate quicker remediation. During the second year of operation, the Agency will be able to gather additional information necessary to determine whether its short-term solution is workable over the full waiver implementation time period or whether a more robust complaint/issue tracking system is needed.

In addition, relative to PSN claims processing, the Agency is considering adding additional claims processing language in the PSN's contracts. Amendment language is currently being routed in the Agency for review.

Chart E-2. New Medicaid Reform Complaint/Issue Resolution Process



5. Outreach Activities

Overview

Prior to Reform implementation, the Agency instituted several mechanisms to facilitate Medicaid Reform Outreach efforts. One such mechanism was the establishment of the Outreach Team. The objective of the team was to develop an outreach strategy, coordinate outreach events, and develop other methods for distributing Reform information to beneficiaries, advocates, potential health plans, providers, and all other interested parties.

In September 2005, the Agency began attending or hosting monthly meetings in both Broward and Duval Counties. As the need for more localized meetings became apparent, the outreach strategy evolved. As implementation neared, the Agency increased its outreach efforts extensively. Increased efforts included not only the continuation of the monthly outreach meetings, but multiple meetings or training sessions geared toward providers and beneficiaries held at the local area offices. The focus of these meetings was to provide specific information to each of these groups on how Medicaid Reform would affect them.

In May 2006, the Agency published a brochure written for Medicaid beneficiaries that provided an introduction to Medicaid Reform. In June 2006, the Agency contracted with two minority public relations firms in Broward and Duval Counties to assist in increasing awareness of Medicaid Reform implementation in the local community. The “Check It Out” theme evolved into the development of a brightly colored blue and green “Check It Out” envelope which escalated the outreach efforts or campaign to a higher level. The purpose of the campaign was to create a branding around Medicaid Reform so that enrollment materials would be anticipated and recognizable. The envelope became the focal point of all presentations, outreach activities, and was promoted through local radio spots. The goal was to make Medicaid beneficiaries and the organizations that served them aware of the envelope they would receive in the mail and what action had to be taken when it arrived.

In addition, the Agency mailed the Medicaid Reform Brochure and training flyer to all Medicaid beneficiaries in Broward and Duval Counties who would be required to enroll in a Medicaid Reform Plan. Information about Reform was also posted to the Medicaid Reform website which was developed as an outreach tool. The site provided general information about Reform, training information for providers, plans, and beneficiaries, as well as plan related Medicaid Reform information. The website also allowed users to sign up for the workshop sessions on-line.

Year One at a Glance

In July 2006, the primary outreach and education efforts moved from the Agency to the Choice Counseling vendor. The Choice Counseling vendor continued outreach efforts through a continued relationship with the minority public relations firms that had been established with the agency. As a result, more radio spots were played on a variety of

stations in Broward and Duval Counties. Posters for doctors' offices, health departments, eligibility offices, and other locations; billboards; and bus transit materials were developed for use in areas with a high density of Medicaid beneficiaries.

In order to assess the current success and concerns regarding Reform from plans, beneficiaries, and advocates, the agency conducted follow-up workshops in November 2006 for Medicaid Reform participants in Broward and Duval Counties. The purpose of these meetings was to give an update about Reform and to provide a platform for open communication between the Agency and stakeholders where comments and concerns regarding Medicaid Reform could be expressed.

Shortly following the implementation of Medicaid Reform in Broward and Duval Counties, outreach efforts began in Baker, Clay, and Nassau Counties. Communication with the community stakeholders in Baker, Clay, and Nassau Counties was critical to the successful expansion of Medicaid Reform into these communities. Again, the outreach strategy was re-evaluated and new outreach approaches were developed. The new strategies resulting in workshop/trainings being held for plans, providers, and beneficiaries at local establishments throughout Baker, Clay, and Nassau Counties; letters being mailed to every Medicaid provider in these counties; multiple mailings of the Medicaid Reform Brochure and training schedule to beneficiaries; one-on-one meetings with MediPass providers who were unable to attend group workshop sessions; the development of comprehensive outreach presentations which allowed for a very direct and targeting outreach approach; and the continual updating of information on the Medicaid Reform website.

In October 2006, the Agency began hosting meetings for stakeholders in Baker, Clay, and Nassau Counties. The following topics were covered during the plan workshops:

- General Overview of Medicaid Reform
- Choice Counseling
- Rural Provider Service Network Start-Up Funds
- Unique Needs in Rural Areas
- Rate Setting
- Risk Adjusting
- Data Book
- Demonstration of the Plan Design Evaluation Tool
- FFS PSN Reconciliation Process
- Technical Assistance for Filling out the Application
- Choice Counseling and Plan Responsibilities
- Marketing of Plans Under Reform

In February 2007, outreach to providers in the expansion areas began. Training flyers announcing the workshop opportunities were developed, mailed to every Medicaid enrolled provider in the expansion area, and posted to the Medicaid Reform website. A banner message (sent by fax and e-mailed) was also posted to remind all Medicaid providers in these counties of the expansion of Reform effective July 1, 2007, and to

encourage them to attend one of the Medicaid Reform Workshops. The list of topics covered during the outreach meetings is provided below.

- General Overview of Medicaid Reform
- Customized Benefit Packages
- Provider Enrollment
- Beneficiary Enrollment Process/Timelines
- Opt-Out Options
- Enhanced Benefits
- Choice Counseling
- Authorization Process
- Agency Monitoring of Plans
- Resources/Local Contacts

In addition to the outreach methods outlined above, a series of banner messages and publications in the Medicaid Provider Bulletin were also utilized as a means to communicate Reform information to providers in Medicaid Reform counties.

In March 2007, outreach to beneficiaries in Baker, Clay, and Nassau Counties began with the mailing of the Medicaid Reform Brochure and training schedule to all beneficiaries residing in the expansion counties who were required to participate in Reform. Information regarding Medicaid Reform and training sessions was also made available to beneficiaries on the Medicaid Reform website. The beneficiaries had the ability to sign-up for the session on-line. To further promote attendance at the outreach meetings, the Medicaid Reform Brochure and training schedule was mailed a second time in May 2007 to all beneficiaries residing in Baker, Clay, and Nassau Counties who were required to participate in Reform.

The list of topics covered during the outreach meeting is provided below.

- General Overview of Medicaid Reform
- Choice Counseling
- Enrollment Process
- Preparation Process
- Participating Eligibility Categories
- Enhanced Benefits
- Opt-Out Option
- Customized Benefit Packages

Lessons Learned

A total of 56 outreach workshops have been held with 815 beneficiaries, plans, and advocates attending the workshops. Attachment III shows a detailed list of the outreach meetings, the target audience, the meeting location, and the number of attendees participating which occurred during the first year.

During initial outreach efforts, a global strategy was used to provide Medicaid Reform information to beneficiaries, providers, and plans. This strategy consisted of conducting meetings at university centers and large auditoriums on a monthly basis. Shortly, following the initiation of the outreach efforts, it became evident that the global approach was not an effective means for outreach to beneficiaries. As a result, a local strategy was initiated. Local area office staff conducted outreach meetings to beneficiaries at a variety of community locations on multiple days/times.

An important consideration in scheduling meetings for beneficiaries is their ability and interest in attending such meetings. Transportation difficulties were identified as key challenges for Medicaid beneficiaries wishing to attend meetings. Taking this challenge into consideration, the outreach strategy was further expanded to include the mailing of Medicaid Reform information to all beneficiaries in the event the beneficiary was unable to attend an outreach meeting. A Medicaid Reform website was also established to provide an addition means for beneficiaries to obtain Medicaid Reform information.

The attendance of providers at the local outreach meetings was not as high as the Agency would like to have seen. The assumption was that it is difficult for a provider to leave his/her practice to attend a meeting. Evening meetings for providers were then offered but not well attended. As a result, information regarding Medicaid Reform was disseminated via letters mailed to all Medicaid providers, banner messages, and informational sessions held at the provider's office and telephonically.

Look Ahead to Year Two

Outreach efforts continue to take place in Duval, Broward, Baker, Clay, and Nassau Counties through the activities conducted by the Choice Counseling vendor (see Choice Counseling section of this report for further details). Agency staff will continue to assist providers, beneficiaries, and advocates via the Agency call centers and in conjunction with Choice Counseling outreach events.

B. Choice Counseling Program

Overview

With the implementation of Medicaid Reform, beneficiaries for the first time have been given the opportunity to choose between health plans offering different benefit packages. A major component of beneficiaries successfully accessing care in Medicaid Reform is their ability to evaluate the benefit packages available and choose a plan that best meets their individual health care needs. By choosing a plan that meets their needs, beneficiaries will have access to the services they need, which is a fundamental goal of Medicaid Reform. When a beneficiary voluntarily chooses their own health plan, it also supports another key element of Medicaid Reform, which is marketplace decisions. As beneficiaries choose, the beneficiaries themselves will be driving the competitive marketplace and plans will need to offer competitive benefit packages to achieve enrollment of Medicaid beneficiaries.

Another goal of Medicaid Reform is to increase patient responsibility and empowerment. Choice Counselors support this goal by reaching out to beneficiaries to ensure that over 65 % of them will make their own health plan choice. This active decision increases patient satisfaction and provides the necessary foundation for the beneficiary to understand how to access care in a managed care setting.

To ensure the Choice Counseling Program effectively serves beneficiaries, the Agency included the expertise of other states and input from Medicaid beneficiaries, advocates, providers, plans and other interested parties in the development to the Choice Counseling Program. The input provided by these key stakeholders resulted in a comprehensive, innovative Choice Counseling Program that was able to achieve the following results in year one of Medicaid Reform:

- The highest voluntary enrollment rate in the history of Florida Medicaid managed care.
- Certified Choice Counselors ensuring each counselor has the knowledge and interpersonal skills necessary to serve Florida's most vulnerable population. This certification program is the first in the nation.
- Special Needs Unit to serve the medically complex and their families which allows beneficiaries enrolling in managed care for the first time to receive the additional assistance their health status requires.
- Branding (format, style and color) of the enrollment packet and envelope allowing both beneficiaries and providers an easy way to identify these critical enrollment materials.
- Intensive outreach campaign prior to implementation of Reform to educate the community and beneficiaries on Medicaid reform and the timeframes for plan choice and enrollment.

- Implementation of field Choice Counselors to serve the hard to reach populations. The field Choice Counselor's effort significantly changed over the course of the first year to better serve this population. These changes resulted in over 30 percent of the enrollments being done at the local level.

Details on these and other components of the choice counseling program are described below.

1. Public Meetings and Focus Groups

Year One at a Glance

One of the primary goals of Medicaid Reform is to increase the active participation of Medicaid beneficiaries in their health care. Choice Counseling is the first step in actively engaging beneficiaries empowering them to be able to make their own choice of health plans. When Choice Counseling was implemented, the Agency and the Agency's Choice Counseling vendor, Affiliated Computer Services (ACS) recognized that feedback from beneficiaries and other interested stakeholders would be critical to creating a Choice Counseling Program that would serve Florida's most vulnerable citizens and empower beneficiaries to make informed choices.

To this end, the Agency and ACS conducted two rounds of focus groups with beneficiaries in year one of Medicaid Reform. The focus group questions concentrated on the beneficiaries' experience with Choice Counseling beginning with the first mailing of materials through enrollment or auto-assignment to a plan. Extensive notes and an audio tape from each meeting were reviewed and discussed by the Agency and ACS.

As the first year came to a close, the Agency and ACS had made the following changes to the Choice Counseling Program based on feedback received at beneficiary focus groups and public meetings: 1) a special needs unit staffed by registered nurses was created in November 2006; 2) completed a re-design of the Choice Counseling enrollment packets in June 2007; 3) completed a rewrite of the call center script and 4) changed strategies in the field to more effectively reach beneficiaries in November 2006

Lessons Learned

One of the major challenges facing the Agency and ACS is obtaining enough feedback from beneficiaries to be able to make generalizations across the Medicaid Reform population on the effectiveness of the Choice Counseling Program. Attendance at focus groups remained small but the groups provided good feedback and some changes to the Choice Counseling Program were implemented as a result including more strategies to reach larger groups of beneficiaries are needed.

The Choice Counseling Program involves many facets. The first year demonstrated that holding public meetings focused on one or two elements of the program allow for more in-depth discussion and strategies for improving the program. Prior to implementation, general public meetings were held and the discussion was not centered

on any particular topic long enough to garner specific ideas or strategies for improvement. The public meetings held on the Choice Counseling materials resulted in detailed discussions centered on materials and plan benefits. The meetings resulted in not only changes to the materials, but also changes to the call center script to address topics discussed.

Another key lesson learned was the need to develop a calendar for public meetings. The public meetings have provided an excellent interactive forum but during the first year they were not held on a regular basis. This did not allow interested parties to have a comfort level that consistent opportunities for input in the Choice process would be available.

Interviewing Choice Counselors about the operation of the program was an element that was overlooked until the fourth quarter of the first year. Since Choice Counselors interact daily with beneficiaries they were able to provide detailed feedback on areas of the program that are working well and areas that need changes or improvement.

Look Ahead to Year Two

One of the first strategies to reach more beneficiaries is an automated survey that will be a part of the Choice Counseling call center. The survey will primarily be an avenue to evaluate the quality of the customer service provided by call center staff, but it will have capacity for questions to be added on “hot topics”. These questions will allow the Agency to collect feedback from beneficiaries and make changes to Choice Counseling or other aspects of the Reform initiative based on beneficiary survey results.

The Agency and ACS will develop a public meeting calendar that can be posted on the Agency’s Medicaid Reform website. The schedule will have proposed meeting dates and discussion topics. The Agency will also allow interested parties to suggest topics for future meetings.

2. Call Center

Year One at a Glance

On July 1, 2006 the Medicaid Reform Choice Counseling call center, operated by ACS, began accepting calls from beneficiaries. The call center, located in Tallahassee, Florida operates a toll-free number as well as a toll-free number for the hearing impaired callers, and uses a language line to assist with calls in over 100 languages. The hours of operation for the call center are 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with more than 30 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole are employed to answer calls and assist beneficiaries in understanding their health plan choices.

During the first three weeks of operation, the call center supported the outreach efforts of the Agency and the ACS field staff by answering questions on Medicaid Reform, providing timeframes for when individuals would need to transition to a Reform plan and

more. The following are key statistics on the call center's performance during the first three weeks of implementation:

Inbound Calls:	1,271
Outbound Calls:	719
Number of Calls Abandoned:	1
Calls Answered within 4 rings:	100.00%

The call center fielded informational calls until July 24 when full Choice Counseling services began for Medicaid beneficiaries in Broward and Duval counties. The call volume increased from a high call volume day of 108 calls prior to July 24 to handling a high volume day of over 1,400 calls. Even with the dramatic increase in calls, the call center was still able to provide quality customer service and maintain contract compliance. As transition ended during the third quarter, the call volume decreased. Since March the call center, on average, has received 4,000 less calls a month than during the seven-month transition period. The following statistics highlights call center statistics from July 24, 2006 – June 30, 2007:

Inbound Calls:	169,310
Outbound Calls:	40,231
Number of Calls Abandoned:	1,779
% age of Calls Abandoned: *(The contract standard is <5% monthly)*	1.05%
Calls Answered within 4 rings:	100.00%

Table 5 provides the Choice Counseling Call Answer Rate for the first year of Medicaid Reform.

Table 5
Choice Counseling Call Answer Rates – Year 1

	Average Speed to Answer (seconds)	% Answered Calls	% of calls answered in less than 15 seconds	% of calls answered less than 60 seconds	% of calls answered less than 180 seconds
August	18	96.73%	87.43%	90.70%	98.05%
September	37	93.87%	74.16%	79.69%	95.27%
October	7	99.11%	92.69%	95.44%	99.86%
November	20	96.75%	85.47%	88.73%	97.44%
December	15	97.72%	84.84%	90.58%	99.34%
January	21	97.17%	82.23%	91.33%	99.96%
February	5	99.25%	94.14%	97.33%	99.11%
March	6	99.15%	92.77%	96.12%	98.89%
April	3	99.72%	94.27%	98.49%	99.78%
May	4	99.60%	91.65%	97.89%	99.63%
June	9	99.26%	81.78%	95.60%	99.33%

Lessons Learned

When Medicaid Reform was implemented, the Agency had no prior experience with transitioning large volumes of beneficiaries into new health plans. As a result, the Agency and ACS had to estimate call volume in order to appropriately staff the call center to meet the needs of beneficiaries. While the estimates were accurate and allowed beneficiaries to receive the assistance they needed, the Agency and ACS was able to collect information on the types of calls received, issues/barriers beneficiaries were experiencing in making the transition, and specific information beneficiaries needed during a transitional phase. All of the lessons learned during the initial transition will be applied to future transitions and will be reflected through additional choice counseling components designed to enhance beneficiary education to allow for more informed health care choices.

Medicaid Reform also allowed the health plan's to vary or customize benefit packages for some services. This was the first time in Florida that this type of flexibility was available to the plans and the first time beneficiaries had to make a choice between different benefit packages. Again, with no prior experience in educating beneficiaries on how to choose between different benefit packages, an initial script for use by the Choice Counselors was developed and implemented. Within three months of implementation, the Agency and ACS were evaluating the effectiveness of the script by conducting focus groups, attending community forums on Medicaid Reform and monitoring calls. As a result of this feedback the script was modified. The major changes in the script were in the following areas: the opt-out portion, how to choose a plan, enhanced benefits and caller verification.

Look Ahead to Year Two

One area of the script that continues to be refined is the explanation of managed care. The first year demonstrated that the transition into a managed care environment can cause confusion for some beneficiaries on how to access services, transitional coverage, and more. While the script contains language to provide information on accessing services in a health plan, the Agency and ACS continue to evaluate new language or other avenues in which more assistance can be provided to beneficiaries. In year two, the script will continue to be refined to include additional elements relating to managed care.

With the related revisions of the new script, the Agency will continue to monitor and evaluate the effectiveness of the script. The Agency will monitor calls with beneficiaries, and conduct additional focus group meetings with beneficiaries and Choice Counselors. Feedback from these various strategies will be reviewed and changes will be made to the script as needed.

Another area of consideration for year two is changing the call center hours. Over the first year of Medicaid Reform, the volume of calls received in the call center during the Saturday hours has remained consistently low. The highest call volume for a Saturday was 132 calls compared to a high one day volume of over 1,400 calls during normal

business hours. The Agency and ACS are exploring the option of eliminating Saturday hours and instead have the call center open for an additional hour during normal business days.

3. Mail

Year One at a Glance

The first year of Medicaid Reform brought many changes to the mailroom. When Medicaid Reform was implemented in July 2006, the mandatory and voluntary transition letters were the largest volume mailing. As the third quarter began, the transition mailings dropped off significantly as the transition timeline neared completion, but preparations for new mailings began. The fourth quarter saw the addition of reinstatement letters and annual open enrollment letters added to the mailroom activities. The following highlights the volume for the largest mailings completed by the mailroom in year one. Mailings are grouped by family or case. This means if there are two children in one case, there would only be one mailing sent to the household instead of two. Therefore, the number of individuals is higher than the number of mailings:

New-Eligible Packets	66,832
Transition Mailings	119,002
Auto-Assignment Letters	49,390
Confirmation Letters	49,029
Open Enrollment Packets	2,641

Over the first year of Medicaid Reform, enrollments completed through the mail consistently remained at 5 % each month. Mail-in enrollments remain significantly lower than the enrollment completed through the call center or by the field counselors.

Lessons Learned

Initially, the transition packets and new eligible packets for beneficiaries required to enroll in a Reform plan contained both the Children and Families plan comparison charts and the Aged and/or Disabled plan comparison charts. Feedback from public meetings and beneficiary focus groups was that this combination caused confusion for some beneficiaries who were not sure which chart they should be reviewing for plan benefits.

When the materials were redesigned, one of the changes required the mailroom to separate the transition mailings and new eligible packets into two separate mailings per county. For example, each day there are two sets of letters for Broward County new eligibles. One set of letters are for those beneficiaries in the Children and Families eligibility groups and one set of letters are for those in the Aged and Disabled eligibility groups.

Another lesson from year one in the mailroom is that many of the enrollment forms that are mailed in by beneficiaries contain errors that prevent the enrollment from being

processed. These errors require staff to contact the beneficiary via phone to clarify information or to obtain additional information. In the third quarter, some changes were made to the enrollment form to try and make it easier for beneficiaries to understand. The enrollment forms will be monitored closely over the next few months to determine if the changes have improved the mail enrollment option or if other solutions need to be considered.

Look Ahead to Year Two

The Agency and ACS are monitoring changes to the enrollment form and also exploring additional options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. One consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program if this option was discontinued to better serve beneficiaries.

4. Face-to-Face/Outreach and Education

Year One at a Glance

At the beginning of Medicaid Reform, the field staff was developing relationships with community-based organizations and provider offices. Since these relationships were in their infancy, most of the face-to-face sessions with Medicaid beneficiaries had to be conducted in eligibility offices and local work force offices. Over the first few months key relationships were developed and most of the face-to-face sessions were being held at community-based organizations, mental health or other assisted living facilities, homeless shelters, low-income housing complexes and other targeted locations.

Over the first year, the development of local level relationships has focused on organizations that work with special needs or hard to reach populations. These populations may be less inclined to enroll over the phone due to physical, mental or other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process.

By the end of the second quarter, the face-to-face portion of the Choice Counseling Program began a major shift away from public or group sessions to one-on-one sessions, supporting the call center in conducting outbound calls and follow-up visits to the homes of beneficiaries who have no phone and have not responded to the mailings. This change in focus continued in the third and fourth quarters and the change continues to produce outstanding results.

By the end of the first year, the field Choice Counselors had completed the following activities:

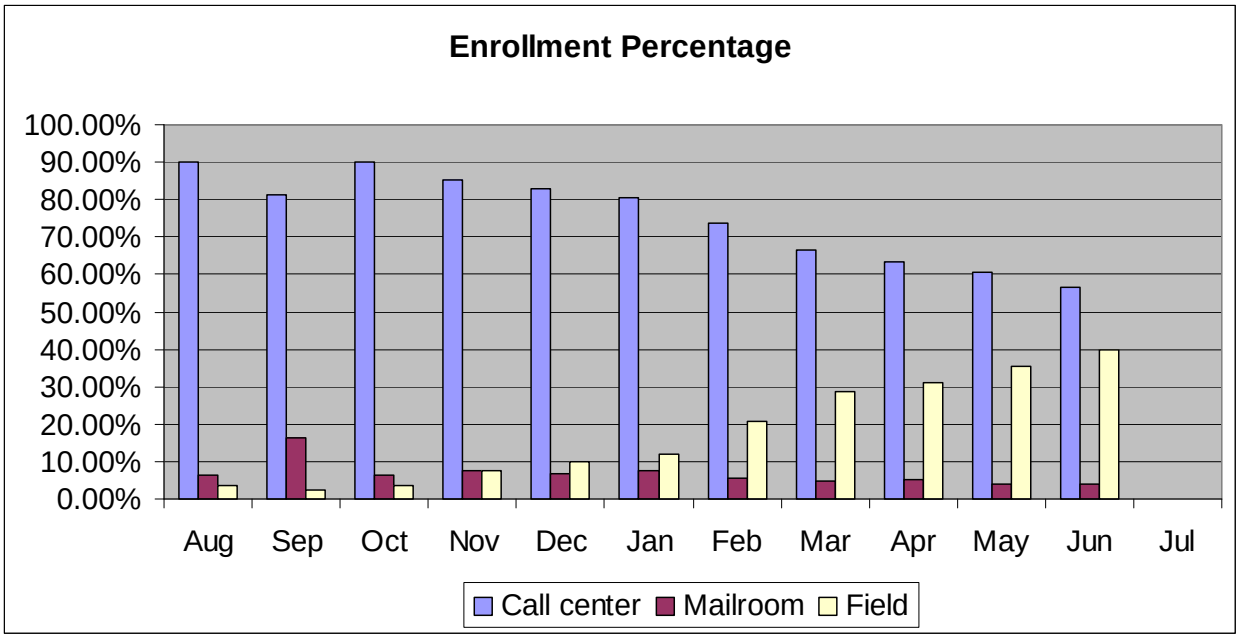
	Jul & Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Public Seminars	527	289	230	187	223	252	232	247	253	261	320
Private Seminars	75	130	103	73	98	132	67	55	55	45	27
Home/No-phone visits	0	0	0	501	625	774	454	316	264	366	308
Outbound list	0	0	0	0	0	0	976	2969	2691	2617	3165

Lessons Learned

One of the major lessons learned in the field over the first year was the importance of having community partners to assist in reaching the Medicaid beneficiaries. Two other major factors in the success the field achieved over the last six months are a result of making outbound calls to support the call center efforts and trying to find beneficiaries who have not enrolled and have no phone number on file. All of these efforts have resulted in dramatic increases in the field enrollments. Table 6 and Chart F highlight the dramatic increases realized in the field Choice Counseling efforts over the first year of Medicaid Reform:

Table 6 Field Choice Counseling Enrollments by Month	
August	208
September	148
October	203
November	421
December	517
January	723
February	1182
March	1951
April	2004
May	2186
June	2595

Chart F. Choice Counseling Enrollment Percentage



Look Ahead to Year Two

With the success the field Choice Counselors achieved through the new strategies, year two at this time does not include major shifts in the focus of the field efforts. Field staff will continue to pursue additional community partners to continue to increase the number of "hard to reach" populations served by the field staff. In addition, the Agency and ACS will closely monitor field efforts during the first few months of expansion in Baker, Clay and Nassau Counties to identify issues and change strategies, if necessary, to meet the needs of these communities.

In the development of the Choice Counseling Program, the Agency and ACS had initially planned to have some staff of community-based organizations certified as Choice Counselors to provide broader reach of the Choice Counseling efforts. The implementation of this effort was delayed due to the following concerns: 1) how to monitor community based staff to ensure compliance with ACS policies and procedures; 2) development of criteria to identify community-based organizations and staff that would be good candidates for the certification; and 3) additional dollars it may take to train community-based organizations and have them provide Choice Counseling services. In year two, the Agency and ACS will continue to explore this avenue and make a final determination on the feasibility of incorporating this strategy into the Choice Counseling Program.

5. Health Literacy

Year One at a Glance

One of the more challenging aspects of the first year has been the creation of a health literacy and health disparities program. The primary health literacy function that the Choice Counseling staff engages in is helping Medicaid beneficiaries understand what it means to be part of a managed care plan. The Agency felt this was a primary function since it is through the Choice Counseling process that a beneficiary will become associated with a managed care organization and knowing how to access care through the plan is critical for the beneficiary. The call center and field scripts include language about the role of a primary care doctor, how that doctor coordinates all other necessary care, how the beneficiary will use a network of doctors, and more. In addition, when a beneficiary enrolls, the confirmation letter that is mailed to them encourages them to make an appointment with their doctor and again provides a statement of understanding regarding what it means to be enrolled in managed care.

In addition to understanding managed care, the Choice Counseling staff also provides information and education on the Enhanced Benefits Program. As the Choice Counseling staff describe enhanced benefits to the beneficiary, the counselor will also talk about how engaging in healthy behaviors will improve their overall health and while they earn credits which can be used to purchase specific items.

The creation of the Special Needs Unit in November 2006 was one of the biggest areas where Choice Counseling is addressing health disparities and health literacy. The

registered nurse in this unit personally assists beneficiaries with complex needs so they understand how to make a health plan choice and how to access care. The nurse conducts three-way calls with the beneficiary and the health plan to assist the beneficiary in making a plan choice. The nurse participates in the conversation to ensure the beneficiary understands the information being provided by the plan and knows how to access care once they are enrolled. ACS is now in the process of hiring a second registered nurse to serve complex beneficiaries.

Lessons Learned

Overall feedback from the first year indicates that beneficiaries transitioning from MediPass or the fee-for-service environment encountered the most anxiety during the transition to Medicaid Reform. The creation of the Special Needs Unit did help to reduce the anxiety and educating the complex beneficiaries on how to access care in a managed care environment. Additional efforts need to be made in assisting these beneficiaries in not only understanding how to make a health plan choice, but also educating them on accessing care once they are enrolled in a managed care plan.

Look Ahead to Year Two

As Medicaid Reform moves forward into year two of operation, the Agency and ACS will continue to develop additional strategies to assist beneficiaries transitioning from a fee-for-service or MediPass environment into a managed care setting. As part of this effort, the scripts and materials will be evaluated to see if enhancements can be made. In addition, this topic will be considered for upcoming focus groups and public meetings to solicit feedback on how to best meet the needs of this population of beneficiaries.

Another area under consideration for year two is how to incorporate disease management education or other appropriate health outcome discussions into the Special Needs Unit. Since the beneficiaries handled by this unit have complex needs, the ability of the registered nurses to educate beneficiaries on disease management or other type health information would be a big step in reducing health disparities. This strategy will be explored and developed during year two of Medicaid Reform.

6. Voluntary Selection Data

Year One at a Glance

The Choice Counseling Program is effectively empowering beneficiaries. The Agency requires that a minimum of 65% of the new Medicaid eligibles make a voluntary Reform health plan choice. At the end of two years, this requirement increases to 80%.

During the first year of Medicaid Reform, the voluntary enrollment rate was calculated only for three quarters of the year. This was due to the fact that the first auto-assignment into a Reform plan occurred during the 2nd quarter of the fiscal year. The three-quarter calculation of the voluntary enrollment rate for both Reform counties was 67.74% of all new eligibles. For Duval County, the rate was 64.61% and for Broward County the rate was 69.80%. ACS was above the contract standard of 65%. In the first

year of operations, the lowest voluntary enrollment rate was 57 % and the high was 81%. ACS did consistently achieve voluntary enrollment rates above the contract standard for year one, but the Agency is seeking to achieve a consistent voluntary enrollment rate in the upper 70s for year two. A breakdown of the new-eligible enrollment figures for the first year is provided in Table 7.

Table 7 New Eligible Voluntary Enrollment Rate October 1, 2006 – June 1, 2007	
Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
2nd quarter	
Voluntary Enrollment Rate	62%
3rd quarter	
Voluntary Enrollment Rate	66%
4th quarter	
Voluntary Enrollment Rate	74.63%
Average Annual	67.74%

Lessons Learned

The past year has demonstrated some trends in new eligibles. The average number of new eligibles was slightly over 7,600 a month for the two counties combined. This is above the estimated average the Agency developed prior to implementation. The Agency has estimated, based on 2006 caseload, that the average monthly new eligible population would be around 6,600. The number of new eligibles had the highest spike of over 9,400 for April 1 enrollment and a low of just over 6,100 for March 1 enrollment. These trends have been documented and will be used in year two to better predict volumes which will assist Choice Counseling in effectively reaching the beneficiaries and consistently achieving a voluntary enrollment rate in the mid-70th percentile.

Look Ahead to Year Two

With the new strategies that were implemented during year one in the field and call center, changes to the materials and a year's worth of data related to new eligibles, ACS is in a good position to consistently move towards achieving voluntary enrollment rates near the 80th percentile. In addition, with the experience gained in year one, ACS has much better tracking reports to allow earlier response to increased numbers of new eligibles, lower incoming call volumes, or other factors that would impact the voluntary enrollment rate.

7. Complaints/Issues

Year One at a Glance

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. During the first year

of Reform, 52 complaints were received regarding Choice Counseling. These issues were documented in the quarterly reports and the outcome of the complaints summarized. The complaints demonstrated a pattern that many beneficiary issues were being raised through advocates and other interested parties. Many of these issues centered around confusion on being assigned to a plan or other enrollment errors. Another consistent theme raised by advocacy groups was lack of access to each plan's preferred drug list by the Choice Counselors.

Lessons Learned

In the early months of Medicaid Reform the entire enrollment and auto-assignment process seemed to cause confusion for many beneficiaries and advocates. The Agency and ACS will explore these processes with beneficiaries in upcoming focus groups and also will be a "hot topic" that will be explored through the automated beneficiary survey that will be included in the Choice Counseling call center. Feedback received will be evaluated and any necessary modifications to scripts and materials will be made.

Look Ahead to Year Two

Over the first year, Florida State University was evaluating the Choice Counseling Program. Early results from this survey indicate positive feedback from beneficiaries on the Choice Counseling Program. These positive indicators include: 1) over 68 % indicated it was not a problem to choose a health plan, 79% indicated they would not change plans at the end of the enrollment year; 3) and 71% indicated it was not a problem to find a doctor or nurse they are happy with. While these initial results on some key indicators are positive, the sample size of only 275 beneficiaries is too low to generalize the information across the Medicaid Reform population. The Agency and ACS will continue to monitor additional responses and seek other avenues to validate this initial response.

The Agency and ACS will also look at strategies to improve beneficiary and advocate understanding of the enrollment time frame and processes and continue to work on additional plan benefit information that can be added to the Choice Counseling Program.

8. Quality Improvement

Year One 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 public meetings, beneficiary focus groups and choice counselor focus groups previously mentioned in this report. These forums allow the Agency to hear from beneficiaries and counselors on the successes and complaints, as well as ideas for improvement of the Choice Counseling Program. Another important aspect is feedback from the advocates, providers, plans and others who work with and represent beneficiaries.

In addition to external feedback, ACS has implemented an employee feedback email system that allows call center choice counselors and field choice counselors to provide immediate comments on issues or barriers that they encounter as part of their daily work. An anonymous email box allows Choice Counselors to immediately send information that is reviewed by management and shared with the Agency.

The Agency's headquarter staff, Medicaid Area Office staff, and ACS Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between Area Medicaid staff and ACS field staff, e-mail boxes on ACS' enrollment system so Agency staff and ACS can share information directly from the system to work difficult cases, and regularly scheduled weekly conference calls.

Lessons Learned

The feedback received in these various forums has resulted in issues being raised that have not been validated by beneficiaries. For example, many express concerns over the lack of pharmacy information being available through Choice Counseling. The beneficiary focus groups have not supported this concern, but the number of beneficiaries that can be reached through focus groups is not representative of the Medicaid Reform population.

Focus groups with choice counselors were not conducted until the fourth quarter of year one of Medicaid Reform. These focus groups provided a lot of information on beneficiary experience with the Choice Counseling Program. The Choice Counselors were able to provide information on successes, challenges, barrier to beneficiaries and much more as a result of their daily interaction with beneficiaries. These focus groups will be added as part of the continual evaluation of the program.

Look Ahead to Year Two

As a result of the issues raised in the first year of Medicaid Reform, the Agency and ACS began developing an automated survey that became a part of the Choice Counseling call center during the fourth quarter of operations. Beneficiaries who call the toll-free Choice Counseling helpline will be given the opportunity to participate in an automated survey at the end of the call. The survey will have questions relating to the quality of customer service provided by the Choice Counselors but will also contain questions on "hot topics" or areas of interest. Issues that have been raised that have not been able to be validated will be included in the survey questions after implementation. This will allow the Agency to hear from hundreds of beneficiaries on particular issues and be able to make appropriate changes in the program and also provide valuable feedback to interested parties.

C. Enrollment Data

Year One at a Glance

Prior to the start of the state fiscal year, the Agency developed a transition plan for the purpose of enrolling existing non-reform Medicaid beneficiaries in demonstration counties (Broward and Duval) into Medicaid Reform health plans. The beneficiaries were enrolled into Medicaid Reform over a period of seven months, starting in September of 2006 and ending in April of 2007. The plan was designed to stagger the enrollment of beneficiaries into the two Medicaid Reform health plan types: Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs). The types of managed care programs that the beneficiaries were transitioned from included HMOs, PSNs, MediPass, Pediatric Emergency Room Diversion Program, 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 proposed the following transition schedule:

- **Non-Committed MediPass:** 1/2 in month 1, then 1/6 in each following month.
- **HMO Population:** 1/12 in months 2, 3, and 4. Then 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 operation of the Medicaid Reform program, enrollment in the demonstration counties was comprised of half of the non-committed MediPass population, as well as newly eligible beneficiaries. Beneficiaries had 30 days to select a plan. If the beneficiary did not choose a plan during the 30-day choice period, then the beneficiary was assigned to a plan. The earliest date of enrollment in a Reform health plan was September 1, 2006. During the remaining quarters of state fiscal year 2006-07, enrollment in Medicaid Reform increased greatly as more beneficiaries were transitioned in from the HMO, PSN, and MediPass Non-Reform populations.

Table 8 contains the quarterly enrollment for each Medicaid Reform health plan, and shows how enrollment in the Medicaid Reform program increased over the 2006-07 state fiscal year. The quarterly enrollment for each Medicaid Reform HMO is displayed in Chart G, and Chart H shows the quarterly enrollment for each of the Medicaid Reform PSNs.

Table 8
Quarterly Medicaid Reform Enrollment by Plan – Year 1
State Fiscal Year 2006-07

Plan Name	Plan Type	Number of Enrollees by Quarter			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Amerigroup	HMO	624	4,756	10,365	11,365
Buena Vista	HMO	210	2,844	6,825	6,883
HealthEase	HMO	2,857	24,907	53,302	56,302
Humana	HMO	323	4,507	11,194	11,221
Preferred Medical Plan	HMO	55	1,139	2,302	2,254
StayWell	HMO	1,801	12,665	27,136	31,194
Total Health Choice	HMO	33	738	1,298	1,536
United Health Care	HMO	1,029	7,643	12,696	15,016
Universal Health Care	HMO	0	0	14	355
Vista South Florida	HMO	184	1,502	2,474	3,282
HMO Totals		**7,116**	**60,701**	**127,606**	**139,408**
Access Health Solutions	PSN	23	12,889	12,263	12,121
CMS	PSN	0	141	2,087	3,311
First Coast Advantage	PSN	215	14,678	15,482	16,416
Netpass	PSN	129	5,727	5,658	5,352
Pediatric Associates	PSN	0	11,749	11,423	11,233
South FL Community Care Network	PSN	121	7,436	8,012	7,761
PSN Totals		**488**	**52,620**	**54,925**	**56,194**
Medicaid Reform Totals		**7,604**	**113,321**	**182,531**	**195,602**

Chart G
Quarterly Medicaid Reform Enrollment for HMOs – Year 1
State Fiscal Year 2006-07

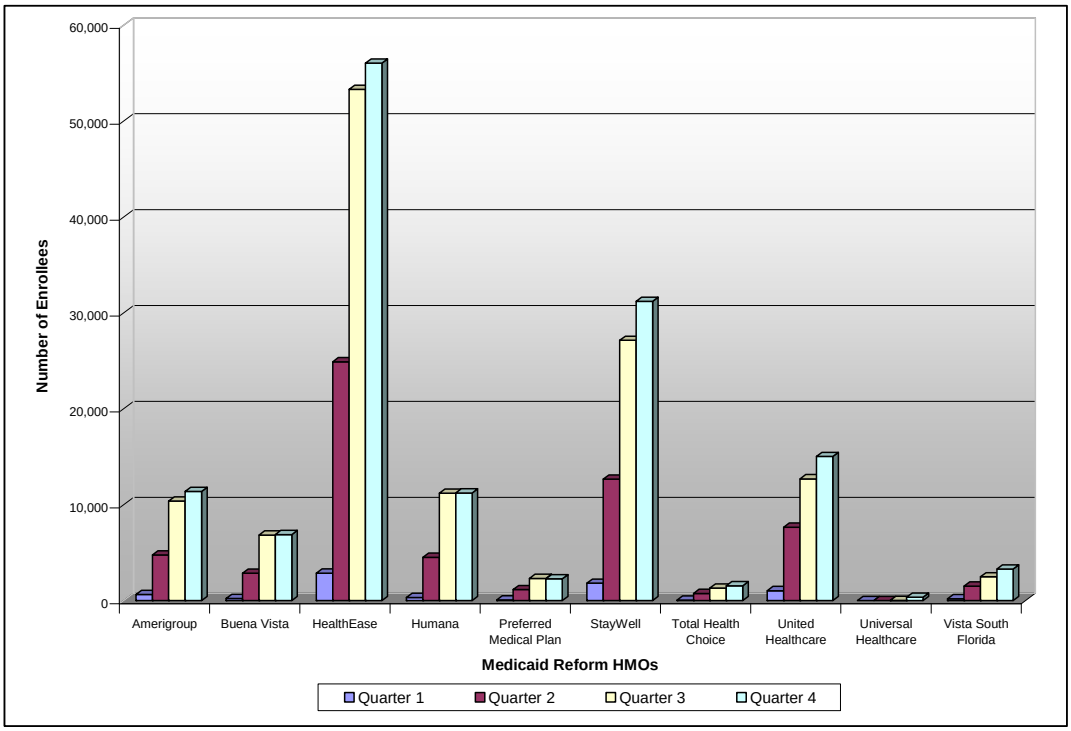
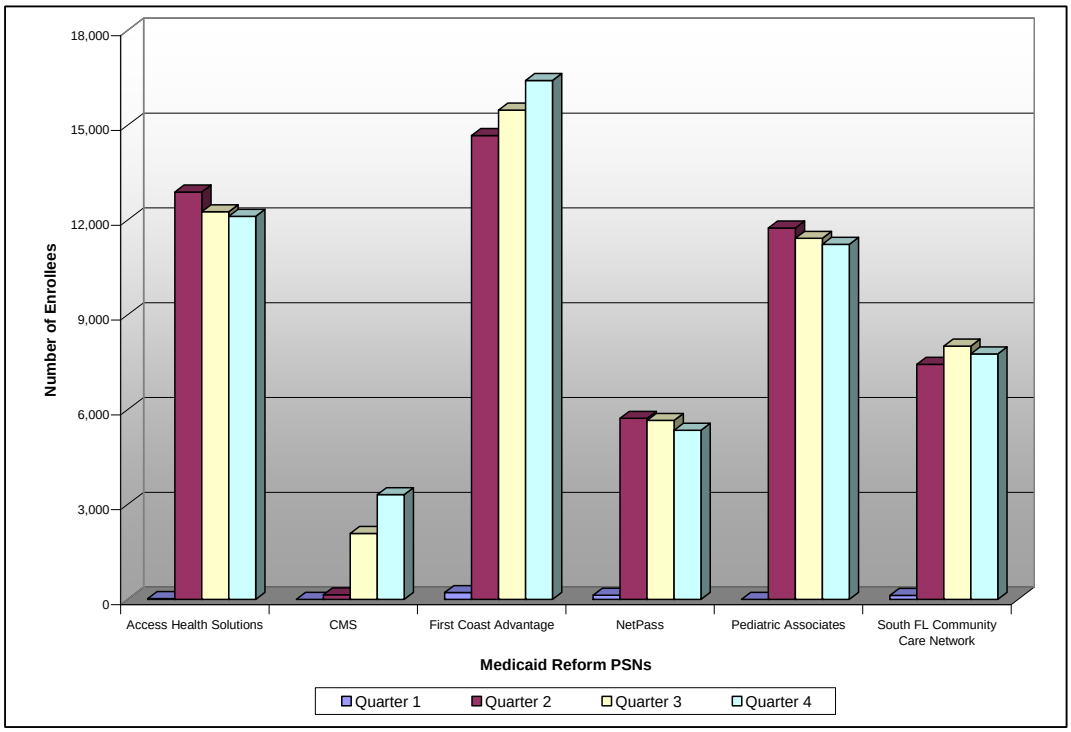


Chart H
Quarterly Medicaid Reform Enrollment for PSNs – Year 1
State Fiscal Year 2006-07



Year in Review

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 URL: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml

This section of the Medicaid Reform annual report contains summaries of the monthly enrollment reports from the first year of the Medicaid Reform program – September 1, 2006 through June 30, 2007. The following annual enrollment reports are included:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data

All Medicaid Reform health plans located in the two demonstration counties are included in each of the enrollment reports. During the first year of operation, there were a total of16 Medicaid Reform health plans - ten HMOs and six fee-for-service PSNs. There were two categories of Medicaid beneficiaries who were enrolled in Reform health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). In the reports, the SSI beneficiary category is broken down based on the beneficiary's eligibility for Medicare.

1. Medicaid Reform Enrollment Report

The annual Medicaid Reform Enrollment Report is a complete look at the entire enrollment for Medicaid Reform for the state fiscal year being reported. Table 9 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 9
Medicaid Reform Enrollment Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform health plan
Plan Type	The plan's type (HMO or PSN)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled – Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled – Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan; TANF and SSI combined
Market Share For Reform	The percentage of the total Medicaid Reform population that the plan's beneficiary pool accounts for
Enrolled in Previous Year	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan during the previous reported fiscal year
% Change From Prev. Year	The change in percentage of the plan's enrollment from the previous reported fiscal year to the current reported fiscal year

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the 2006-07 state fiscal year. Please refer to Table 10 for the annual Medicaid Reform Enrollment report for state fiscal year 2006-07.

Table 10
Medicaid Reform Enrollment Report – Year 1
State Fiscal Year 2006-07 – September 1, 2006 through June 30, 2007

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Previous Year	% Increase From Prev. Year
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	11,301	1,404	3	101	**12,809**	**5.68%**	0	N/A
Buena Vista	HMO	7,150	719	1	46	**7,916**	**3.51%**	0	N/A
HealthEase	HMO	56,991	6,061	2	462	**63,516**	**28.16%**	0	N/A
Humana	HMO	10,520	2,211	7	201	**12,939**	**5.74%**	0	N/A
Preferred Medical Plan	HMO	2,088	540	0	43	**2,671**	**1.18%**	0	N/A
StayWell	HMO	31,478	2,967	7	259	**34,711**	**15.39%**	0	N/A
Total Health Choice	HMO	1,458	303	0	27	**1,788**	**0.79%**	0	N/A
United Health Care	HMO	15,055	2,058	4	260	**17,377**	**7.70%**	0	N/A
Universal Health Care	HMO	311	44	0	1	**356**	**0.16%**	0	N/A
Vista South Florida	HMO	3,236	376	1	49	**3,662**	**1.62%**	0	N/A
HMO Totals		139,588	16,683	25	1,449	**157,745**	**69.93%**	0	N/A

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Previous Year	% Increase From Prev. Year
			No Medicare	Medicare Part B	Medicare Parts A & B				
Access Health Solutions	PSN	12,523	2,478	1	99	**15,101**	**6.69%**	0	N/A
CMS	PSN	1,479	1,998	0	13	**3,490**	**1.55%**	0	N/A
First Coast Advantage	PSN	14,742	3,827	2	204	**18,775**	**8.32%**	0	N/A
NetPass	PSN	4,857	1,689	1	113	**6,660**	**2.95%**	0	N/A
Pediatric Associates	PSN	13,695	625	0	0	**14,320**	**6.35%**	0	N/A
South FL Community Care Network	PSN	6,777	2,576	1	136	**9,490**	**4.21%**	0	N/A
PSN Totals		54,073	13,193	5	565	**67,836**	**30.07%**	0	N/A
Reform Enrollment Totals		**193,661**	**29,876**	**30**	**2,014**	**225,581**	**100.00%**	**0**	**N/A**

The market share percentage is calculated once enrolled beneficiaries have been counted from each plan and the total number enrolled in Medicaid Reform throughout the state fiscal year is known.

The Medicaid Reform enrollment figures for state fiscal year 2006-07 reflect those individuals who voluntarily selected a health plan as well as those who were mandatorily assigned to one. Many Medicaid Reform beneficiaries were transitioned from Non-Reform health plans to Reform health plans. There were a total of 225,581 beneficiaries enrolled in Medicaid Reform during state fiscal year 2006-07. There were 16 Medicaid Reform health plans with market shares ranging from 0.16 percent to 28.16 percent.

2. Medicaid Reform Enrollment Report by County

During state fiscal year 2006-07, Medicaid Reform was operational in two counties: Broward and Duval. There were ten HMOs and five PSNs operating in Broward County, and there were four HMOs and three PSNs serving Duval County. The Medicaid Reform Enrollment by County Report portion of this annual report is similar to the Medicaid Reform Enrollment Report; however, enrollment has been separated by county. Broward County plans are listed first, followed by Duval. Table 11 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 11
Medicaid Enrollment by County Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform health plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage

Column Name	Column Description
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in previous Year	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reported state fiscal year
% Change From Previous Year	The change in percentage of the plan's enrollment from the previous reported state fiscal year to the current reported year (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 12 and located on the following page.

Table 12
Medicaid Reform Enrollment by County Report – Year 1
State Fiscal Year 2006-07 – September 2006 through June 2007

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Previous Year	% Increase from Prev. Year
				No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	Broward	11,301	1,404	3	101	**12,809**	**9.36%**	0	N/A
Buena Vista	HMO	Broward	7,150	719	1	46	**7,916**	**5.79%**	0	N/A
HealthEase	HMO	Broward	16,040	1,587	1	114	**17,742**	**12.97%**	0	N/A
Humana	HMO	Broward	10,520	2,211	7	201	**12,939**	**9.46%**	0	N/A
Preferred Medical Plan	HMO	Broward	2,088	540	0	43	**2,671**	**1.95%**	0	N/A
StayWell	HMO	Broward	28,709	2,659	7	222	**31,597**	**23.09%**	0	N/A
Total Health Choice	HMO	Broward	1,458	303	0	27	**1,788**	**1.31%**	0	N/A
United Health Care	HMO	Broward	5,982	1,065	1	162	**7,210**	**5.27%**	0	N/A
Universal Health Care	HMO	Broward	130	29	0	0	**159**	**0.12%**	0	N/A
Vista South Florida	HMO	Broward	3,236	376	1	49	**3,662**	**2.68%**	0	N/A
Access Health Solutions	PSN	Broward	4,399	1,154	0	42	**5,595**	**4.09%**	0	N/A
CMS	PSN	Broward	913	1,339	0	11	**2,263**	**1.65%**	0	N/A
Netpass	PSN	Broward	4,857	1,689	1	113	**6,660**	**4.87%**	0	N/A
Pediatric Associates	PSN	Broward	13,695	625	0	0	**14,320**	**10.47%**	0	N/A
South FL Community Care Network	PSN	Broward	6,777	2,576	1	136	**9,490**	**6.94%**	0	N/A
Total Reform Enrollment for Broward			**117,255**	**18,276**	**23**	**1,267**	**136,821**	**100.00%**	**0**	N/A
HealthEase	HMO	Duval	40,951	4,474	1	348	**45,774**	**51.57%**	0	N/A
StayWell	HMO	Duval	2,769	308	0	37	**3,114**	**3.51%**	0	N/A
United Health Care	HMO	Duval	9,073	993	3	98	**10,167**	**11.45%**	0	N/A
Universal Health Care	HMO	Duval	181	15	0	1	**197**	**0.22%**	0	N/A
Access Health Solutions	PSN	Duval	8,124	1,324	1	57	**9,506**	**10.71%**	0	N/A
CMS	PSN	Duval	566	659	0	2	**1,227**	**1.38%**	0	N/A
First Coast Advantage	PSN	Duval	14,742	3,827	2	204	**18,775**	**21.15%**	0	N/A
Total Reform Enrollment for Duval			**76,406**	**11,600**	**7**	**747**	**88,760**	**100.00%**	**0**	N/A
Reform Enrollment Totals			**193,661**	**29,876**	**30**	**2,014**	**225,581**		**0**	N/A

As with the Medicaid Reform Enrollment Report, beneficiaries are extracted from the monthly Medicaid eligibility file and are then counted uniquely based on what plan is listed as their primary care provider. The unique beneficiary counts are separated by the counties the plans operate in.

During the first year of operation, there was an enrollment of 136,821 beneficiaries in Broward County and 88,760 beneficiaries in Duval County. Of the fifteen Reform plans with enrollees in Broward County, market shares ranged from 0.12 percent to 23.09 percent. In Duval County, there were seven Reform plans with market shares ranging from 0.22 percent to 51.57 percent.

3. Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data

The Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either voluntarily or mandatorily) with a plan at some point during the first state fiscal year of operation, as well as those who were disenrolled during the same time period. Table 13 provides a description of each column in the Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report.

Table 13
Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform health plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# Voluntary Enrolled	The number of unique beneficiaries who voluntarily enrolled with the plan during the reported state fiscal year
# Mandatory Enrolled	The number of unique beneficiaries who were mandatorily enrolled with the plan during the reported state fiscal year
Total # Enrolled	The total number of unique beneficiaries enrolled with the plan during the reported state fiscal year; voluntary and mandatory combined
% Enrolled Voluntary	The percentage of the total number of beneficiaries enrolled with the plan during the reported state fiscal year who were enrolled voluntarily
# Disenrolled	The number of unique beneficiaries who disenrolled from the plan during the reported state fiscal year

There are two primary categories of Medicaid beneficiaries analyzed in this report: those who have enrolled in Medicaid Reform and those who have disenrolled from the program during the reported state fiscal year.

A. Medicaid Reform Enrollees

There are two ways a beneficiary can enroll in a Medicaid Reform program: voluntarily or mandatorily. Voluntary enrollments include newly-eligible beneficiaries who made a voluntary choice of which plan or program to enroll in. In addition, beneficiaries who were already enrolled in a managed care plan (including MediPass) and then were transitioned into a plan when Medicaid Reform began are included in the voluntary enrollment counts. The calculation of the mandatory enrollment percentage includes only newly-eligible beneficiaries who have not made a choice and who were assigned to a plan.

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the reported state fiscal year but then left the program. The count was performed by comparing two beneficiary lists: one for state fiscal year 2006-07 and one for the first month after, July 2007. If a beneficiary appeared on the state fiscal year 2006-07 enrollment list not on the enrollment list for July 2007, the beneficiary was counted as disenrolled.

The unique beneficiary counts in the Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report are divided by plan type in Table 14. Total counts for the state fiscal year are provided for HMOs, PSNs, and the entire Medicaid Reform program.

Table 14
Voluntary & Mandatory Selection Rates & Disenrollment Data – Year 1
State Fiscal Year 2006-07 – September 2006 through June 2007

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	11,772	1,037	**12,809**	**92%**	2,976
Buena Vista	HMO	Broward	7,383	533	**7,916**	**93%**	2,198
HealthEase	HMO	Broward	16,629	1,113	**17,742**	**94%**	4,111
HealthEase	HMO	Duval	44,508	1,266	**45,774**	**97%**	11,430
Humana	HMO	Broward	12,031	908	**12,939**	**93%**	3,449
Preferred Medical Plan	HMO	Broward	2,000	671	**2,671**	**75%**	853
StayWell	HMO	Broward	30,122	1,475	**31,597**	**95%**	6,916
StayWell	HMO	Duval	2,448	666	**3,114**	**79%**	758
Total Health Choice	HMO	Broward	1,079	709	**1,788**	**60%**	529
United Health Care	HMO	Broward	6,378	832	**7,210**	**88%**	1,773
United Health Care	HMO	Duval	9,157	1,010	**10,167**	**90%**	3,066
Universal Health Care	HMO	Broward	90	69	**159**	**57%**	47
Universal Health Care	HMO	Duval	36	161	**197**	**18%**	41
Vista South Florida	HMO	Broward	3,229	433	**3,662**	**88%**	750
HMO Total			**146,862**	**10,883**	**157,745**	**93%**	**38,897**
Access Health Solutions	PSN	Broward	7,877	1,629	**9,506**	**83%**	3,296
Access Health Solutions	PSN	Duval	4,975	620	**5,595**	**89%**	1,941
CMS	PSN	Broward	2,263	0	**2,263**	**100%**	380
CMS	PSN	Duval	1,227	0	**1,227**	**100%**	77
First Coast Advantage	PSN	Duval	16,923	1,852	**18,775**	**90%**	4,216
Netpass	PSN	Broward	5,932	728	**6,660**	**89%**	2,133
Pediatric Associates	PSN	Broward	13,814	506	**14,320**	**96%**	5,160
South FL Community Care Network	PSN	Broward	8,184	1,306	**9,490**	**86%**	2,868
PSN Total			**61,195**	**6,641**	**67,836**	**90%**	**20,071**
Reform Enrollment Totals			**208,057**	**17,524**	**225,581**	**92%**	**58,968**

During state fiscal year 2006-07, there were 208,057 voluntary enrollments (92 percent) in Medicaid Reform. Of those, 146,862 beneficiaries were enrolled in an HMO and 61,195 were enrolled in a PSN.

D. Opt Out Program

Overview

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

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

Description of Opt Out Process

Medicaid beneficiaries interested in the Opt Out Program are referred to HMS by the Choice Counseling Program and/or the Medicaid beneficiary contacts HMS directly. The beneficiary is provided the toll-free number for the Opt Out Program so he or she may follow-up directly with HMS if preferred. HMS sends a New Referral Letter to the beneficiary requesting employer information and requests a signed release by the beneficiary in order for HMS to contact the beneficiary's employer. The New Referral Letter also advises that the beneficiary will be responsible for cost sharing requirements (deductibles, co-insurance and co-payments).

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

After HMS receives the required information from the employer, HMS follows up with the beneficiary to discuss the insurance that is available through the beneficiary's employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the employer. After enrollment into Opt Out Program, the beneficiary is sent an Enrollment Letter that confirms the beneficiary is enrolled in the Opt Out Program. HMS then begins to process the premiums according to the required frequency. If the beneficiary

is unable to enroll in the Opt Out Program (e.g., not open enrollment), the beneficiary is sent an Opt Out denial letter. The HMS system is flagged to contact the beneficiary when *s/he* is eligible for the Opt Out Program.

The HMS system has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The system tracks enrollee characteristics (eligibility category, type of employer-sponsored insurance and type of coverage). The system will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. To date no enrollee has chosen to disenroll from Opt Out into a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Year One at a Glance

During the first year of operation, the Agency regularly held meetings with HMS to ensure the Opt Out process continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified this year that required the Agency to make any changes to the process.

Opt Out Program Statistics

A total of 36 calls have been received at the Opt Out toll-free call center since September 1, 2006, when the program began accepting enrollment.

- Sixteen of the callers were determined not to have ESI available or did not want to pay out-of-pocket expenses.
- Fifteen of the callers requested and received information regarding the Opt Out Program (e.g. New Referral Letter and Release to contact employer) but have not followed through with enrollment into the program to date.
- Five of the calls resulted in enrollment into the Opt Out Program as described below. The five callers are in the Children and Family eligibility category.

    1. The caller was enrolled in the Opt Out Program during the second quarter with a coverage effective date of October 1, 2006. This caller lost her job during the third quarter and was subsequently disenrolled from the Opt Out Program on February 28, 2007. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.
    2. The caller began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter.

       The father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The five children's Medicaid eligibility

ended February 28, 2007, and they were subsequently disenrolled from the Opt Out Program.

3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter. The effective date for enrollment was during the third quarter on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his four children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter. The effective date for enrollment was during the fourth quarter on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter. The effective date for enrollment was during the fourth quarter on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

By the end of the year, eight individuals were enrolled in the Opt Out Program. The enrollees have chosen to be reimbursed for their premiums. Table 15 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2007.

Table 15
Opt Out Statistics
September 1, 2006 – June 30, 2007

Eligibility Category	Effective Date of Enrollment	Type of Employer Sponsored Plan	Type of Coverage	Number of Beneficiaries Enrolled	Effective Date of Disenrollment	Reason for Disenrollment
Children & Family	10/01/06	Large Employer	Single	1	2/28/07	Loss of Employment
Children & Family	01/01/07	Large Employer	Family	5	2/28/07	Loss of Medicaid Eligibility
Children & Family	02/01/07	Large Employer	Family	4	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A

Table 16 provides a comparison to the premium reimbursed to the Opt Out enrollees compared to the premium available to them under Medicaid Reform.

Table 16
Opt Out Statistics
September 1, 2006 – June 30, 2007

Enrollees	Monthly Opt Out Rate	Monthly Employee Premium	Difference
Enrollee -1	$180.96	$161.50	$19.46
Total	**$180.96**	**$161.50**	**$19.46**
Enrollee -2	$105.51	$53.46	$52.05
Enrollee -3	$93.20	$53.46	$39.74
Enrollee -4	$105.51	$53.46	$52.05
Enrollee -5	$105.51	$53.46	$52.05
Enrollee -6	$93.20	$53.46	$39.74
Total*	**$502.93**	**$267.30**	**$235.63**
Enrollee -7	$91.78	$86.12	$5.66
Enrollee -8	$109.63	$86.12	$23.51
Enrollee -9	$109.63	$86.12	$23.51
Enrollee -10	$109.63	$86.12	$23.51
Total*	**$420.67**	**$344.48**	**$76.19**
Enrollee - 11	$93.20	$98.18	**($4.98)**
Enrollee - 12	$91.06	$98.18	**($7.12)**
Total*	**$184.26**	**$196.36**	**($12.10)**
Enrollee - 13	$93.20	$74.44	$18.76
Enrollee - 14	$105.51	$74.44	$31.07
Total*	**$198.71**	**$148.88**	**$49.83**
GRAND TOTAL	**$1,487.53**	**$1,118.52**	**$369.01**

*Enrollees are in the same family.

E. Enhanced Benefits Program

Overview

The Enhanced Benefits Account Program (EBAP) component of Medicaid Reform is an innovative program designed as an incentive to promote and reward beneficiaries for participating in healthy behaviors. Florida Medicaid had no previous experience in implementing this type of program. In addition, health plans, pharmacies and beneficiaries also had no history with using and accessing this type of program. This innovative program presented many challenges during implementation that were handled through an internal agency team, the creation of an Enhanced Benefits Advisory Panel, and input from health plans and other interested parties in the two reform counties.

One of the major goals of Medicaid Reform is to increase access to care and to improve health outcomes for Medicaid beneficiaries. The EBAP accomplishes both of those goals by offering credits to beneficiaries who engage in healthy behaviors such as well-baby check-ups and immunizations; age-appropriate health screenings, participation in disease management programs and more. When a beneficiary makes the healthy decision to receive these necessary services they earn credits which can be used to purchase over-the-counter health related items such as vitamins, cold medicine, first-aid supplies, and more. These products also can assist beneficiaries in maintaining a healthy lifestyle and improving overall health outcomes. All Medicaid beneficiaries who enroll in a Medicaid Reform Health Plan are eligible for the program. No separate application or process is required prior to participation.

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 worth of credit each state fiscal year. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. The credit dollars earned may be carried forward each fiscal year so the beneficiary does not lose unused credits at the end of the fiscal year.

1. Current Call Center Activities

Year One at a Glance

The EBAP call center, located in Tallahassee, Florida, began taking calls on November 1, 2006. The call center is operated by the Choice Counseling vendor, ACS, and offers a toll-free number as well as a toll-free number for the hearing impaired callers, and uses a language line to assist with calls in over 100 languages. The hours of operation for the call center are 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with employees who speak English, Spanish and Haitian-Creole to answer calls.

The first few months experience in the call center was very different from the last six months. In the first two months, most beneficiaries had not yet earned enhanced benefits credits and as a result the call volume was low. The first month of call center operations, the call center only received 379 calls compared to 2,500 calls in May 2007.

The primary function of the call center is to handle inbound calls from Medicaid beneficiaries and answer questions on the Enhanced Benefit program and provide information on credits earned and spent by beneficiaries. The following is a highlight of the call volume during the first year:

Inbound Calls:	13,865
Calls Abandoned:	255 or 1.8%
Average Talk Time	4.74 minutes

Lessons Learned

Since the EBAP was an entirely new concept for Florida Medicaid, there was no experience the Agency and ACS could utilize when developing scripts and other tools. Over the past two months, many changes have be made in the call center to adapt to operational experience and additional call center enhancements will be put in place.

Look Ahead to Year Two

The Agency and ACS have experienced a significant call volume and have enough months of experience to begin evaluating additional changes for the EBAP. In year two, the Enhanced Benefits call center script will be revised and new tools to allow call center staff to better assist beneficiaries will be developed. Primary changes will focus on creating a pharmacy network so the call center can assist beneficiaries in locating a Medicaid pharmacy that is processing Enhanced Benefits credits. The Agency is also creating a more user-friendly Enhanced Benefits product list specifically for the call center. This will allow the call center to more easily help beneficiaries find products to purchase.

2. System Activities

Year One at a Glance

With the creation of the EBAP, the Agency had to develop a system to process earned credits and also a systematic way for beneficiaries to purchase items with their credits. The Enhanced Benefits Information System (EBIS) was implemented in November 2006. This system receives and processes reports from each Reform Health Plan containing the healthy behaviors beneficiaries have completed. The system will display eligibility and plan enrollment information on the individual beneficiary as well as information on the behaviors they have completed and credits earned. The EBIS system also receives information on the purchases that beneficiaries have made and this information is also displayed. In addition, the EBIS system generates account balances and creates monthly beneficiary statements. This system is accessed by the call center staff to assist beneficiaries with account questions.

To allow beneficiaries to use their credits to purchase health related products, the Agency utilizes the Florida Medicaid's fiscal agent's pharmacy point of sale system known as Prescription Drug Claims System (PDCS).

Lessons Learned

The EBIS has undergone a series of modifications as the Agency gained operational experience during this first year. These changes included programming new edits to process the monthly health plan files more efficiently, changing some aspects of the user interface of EBIS to better serve the users, and improving the production of the beneficiary monthly statement. In addition to system functionality changes, the monthly statement was streamlined to provide only critical information for a beneficiary to see credits earned and spent. The statement changes were made because the statements had become cumbersome and confusing to beneficiaries.

The PDCS system provided a portal for the Enhanced Benefits Program to become operational and provided a system to pharmacies that was familiar. The first year has revealed some limitations in the system. Since PDCS was originally designed to be a prescription drug system, some functionality does not lend itself to the Enhanced Benefits Program. Some limitations have been corrected by changes to PDCS and other limitations were addressed by modifications to processes.

Look Ahead to Year Two

The Agency continues to seek ways to improve the Enhanced Benefits Program. Two avenues being explored are the implementation of a debit-card type system or a mail-order program to replace the current systems used in the program. The other option under consideration is improvements to the current system to allow for additional flexibilities needed for the program.

3. Outreach and Education for Beneficiaries

Year One at a Glance

As EBAP was implemented, the Agency created three main venues for beneficiaries to receive information on the program. Every beneficiary enrolled in a health plan has access to EBAP. The first was through the Choice Counseling script. When a beneficiary is going through the Choice Counseling process, the EBAP is explained and promoted to the beneficiary. Once a beneficiary is enrolled in a plan, the beneficiary receives an EBAP welcome packet. As a beneficiary earns credits or purchases items, monthly statements are mailed to keep the beneficiary up-to-date with their account balance. Promotion of the EBAP program was approached as a separate and distinct outreach effort, in an attempt to avoid overwhelming beneficiaries with information about Medicaid Reform and to allow them to focus on each component enrollment process.

Since the EBAP was a new program, allowing a few months to learn what type of outreach or information was needed was also imperative and a reason for the slower approach to outreach. By allowing the transition period to occur without much influx of information on Enhanced Benefits the Agency could garner information on what strategies were needed to encourage beneficiaries to participate in the EBAP.

Lessons Learned

During the first year, beneficiaries earned over $4 million in credits and had used approximately $140,000 of those credits. To increase beneficiary usage of earned credits, the Agency decided to change the focus of EBAP outreach efforts. The initial efforts focused on encouraging beneficiaries to participate in the program by earning credits. The new outreach efforts will need to focus on using the credits.

Look Ahead to Year Two

To increase beneficiaries' usage of their credits, the Agency developed a list of strategies that will be implemented in year two. Those initiatives include enhancements and modifications to the call center script; development of a user friendly product purchase list; pharmacy network lists that identify pharmacies successfully processing Enhanced Benefit purchases; an outreach program utilizing the expertise of the Choice Counseling field counselors; and a review of all enhanced benefits materials. To assist in these activities, the Agency has assembled a new internal team to provide the necessary support to this effort. In addition, the Enhanced Benefits Advisory Panel will provide support and expertise to the new initiatives.

4. Outreach and Education for Pharmacies

Year One at a Glance

The Agency continues to provide outreach and education to pharmacies regarding the design and billing process for the program. The Agency's Medicaid Area Office Pharmacists have proven to be a key element in providing on-site training in Broward and Duval Counties. The Agency's outreach and education activities have reduced the number of billing questions the Agency received during last quarter of the first year.

Lessons Learned

Pharmacies have had some challenges with processing the Enhanced Benefits credits for beneficiaries. Some of these challenges have been due to the lack of familiarity of the new program and the need to train staff. Other barriers are the extensive product list and the lack of time available to assist beneficiaries in finding a product that will process and system limitations that caused some transactions to error off. 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 changes to the system and program as necessary.

Look Ahead to Year Two

The Agency is committed to streamlining the process for pharmacies when processing an Enhanced Benefits purchase. A system change request to the Agency's pharmacy system was in development in the fourth quarter. This change will allow Enhanced Benefits purchases to be identified by a two-digit identifying code. The system will also be changed to eliminate some of the edits and other processing features of the pharmacy system that are not needed in the Enhanced Benefits environment. Once

these changes are in place, outreach and education to the pharmacies will be completed.

In addition, a single page reference sheet will be developed for the EBAP. Once approved, the Agency will provide copies to participating pharmacies and the call center. The reference sheet will contain billing procedures and categories with examples of items included in each category. The goal of this document is to reduce questions regarding types of products that may be purchased using the individual account credits.

5. Enhanced Benefits Advisory Panel

Year One at a Glance

The Enhanced Benefits Advisory Panel is a 7-member, Agency-appointed panel. Over the first year, the Panel was responsible for the adoption of the operating charter; approved list of approved healthy behaviors; and the list of approved items for purchase. The Enhanced Benefits Advisory Panel has also proven to be a sound resource to review and discuss the EBAP outreach efforts and documentation such as the welcome letters and brochures for the beneficiaries.

Enhanced Benefits Statistics

Table 17 provides a count of healthy behaviors and the sum of granted credit amounts.

Table 17
Healthy Behavior Counts & Dollars

Procedure	Count of Procedure Code	Sum of Granted Credit Amount
Office Visit-Adult/Child	165,614.00	$2,135,127.50
Childhood Preventive Care	55,676.00	$1,369,942.50
Maintenance Drug	36,592.00	$272,912.50
Dental	13,827.00	$216,945.00
EYE Adult/Child	6,706.00	$96,000.00
Pap Smear	6,254.00	$134,350.00
Preventive Care Child & Adult	2,652.00	$47,135.00
Preventive Care Adult	857.00	$12,147.50
Mammogram	448.00	$9,002.50
Asthma Disease Management Program	409.00	$7,700.00
Colorectal Screening	371.00	$6,925.00
Diabetes Disease Management Program	326.00	$7,320.00
Congestive Heart Failure Disease Management Program	53.00	$1,300.00
HIV/AIDS Disease Management Program	29.00	$692.50
Hypertension Disease Management Program	13.00	$292.50
Administrative Credit	10.00	$151.16
Adult Dental Cleaning (preventative services)	3.00	$30.00
Flu Shot	1.00	$25.00

As of June 30, 2007, a total of 91,564 beneficiaries have earned $4,317,998.66 in Enhanced Benefit credits. As of June 30, 2007, 5,681 beneficiaries have spent $148,752.20 in credits.

Table 18 provides the Enhanced Benefit Account Program statistics beginning April 1, 2007 and ending June 30, 2007.

Table 18
Enhanced Benefit Account Program Statistics

Fourth Quarter Activity		April	May	June
I.	Number of plans submitting reports by month	23 of 23	21 of 23	23 of 23
II.	Number of enrollees who received credit for healthy behaviors by month	23184	27934	22326
III.	Percentage of Reform enrollees who receive credits each month*	41.31%	47.97%	52.55%
IV.	Number of enrollees who received credit and used credits by month	2025	3103	4432
V.	Total dollar amount credited to accounts by month	$619,397.50	$787,382.50	$572,367.50
VI.	Total dollar amount of credits used by month	$44,649.98	$72,893.65	$109,757.81**

***** Represent total number of beneficiaries from Sept. 2006 thru end of month divided by total number of beneficiaries enrolled in a Reform Plan.

****** Number slightly lower because of return of a purchased item.

Table 19 provides the top ten purchases made by beneficiaries through June 30, 2007.

Table 19
Top 10 Purchases through June 30, 2007

Description	Count of Description *
CHILDREN'S MOTRIN 100 MG/5	540
PRILOSEC OTC 20 MG TABLET	422
CHILD'S TYLENOL SUSPENSION	417
HUGGIES BABY WIPES NAT CARE	362
CHILDS TYLENOL PLUS COLD SU	307
FLINTSTONES TABLET CHEWABLE	287
BENADRYL ALLERGY LIQUID	277
TYLENOL INFANTS + COLD/COUG	233
FLINTSTONES COMPLETE TABLET	228
CVS NON-ASPIRIN SUSPENSION	209

*****includes purchase/return combinations

6. Complaints

Year One at a Glance

As the EBAP 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 beneficiaries would have questions about their account balance. After eight months of operating the EBAP, the Agency has not seen many complaints related to credits being submitted by Reform health plans. While no formal evaluation of this has been conducted, the Agency feels confident that the Reform health plans are submitting healthy behaviors to the Agency on a very timely basis so that beneficiaries can earn credit dollars. Table 20 highlights the amount of credits submitted by each Reform health plan for beneficiaries as of June 30, 2007:

Table 20
Earned Through Health Plan

Plan Name	Sum Of Granted Credit Amount
First Coast Advantage-Shands Jax-Duval	$508,302.50
Pediatric Associates	$389,037.50
Healthease-Duval	$373,750.00
Staywell-Broward	$368,570.00
Amerigroup Comm Care-Broward	$355,152.50
Humana Medical Plan-Broward	$284,117.50
Healthease-Broward	$229,607.50
Healthease-Duval	$228,187.50
Buena Vista-Broward	$222,522.50
Florida Netpass - Broward	$194,690.00
United Healthcare FL-Broward	$193,837.50
Access Health-Duval	$162,640.00
United Healthcare FL-Duval	$123,162.50
South Florida Community Care Network Broward	$222,211.16
Access Health-Broward	$112,285.00
Vista Healthplan S FL-Broward	$106,305.00
United Healthcare FL-Duval	$88,920.00
Staywell-Duval	$32,640.00
Staywell-Duval	$24,902.50
Preferred Medical Plan-Broward	$23,390.00
Total Health Choice-Broward	$18,205.00
CMS Network Broward	$54,522.50
Universal Health Care Duval	$770.00
Universal Health Care Broward	$270.00

Note: Table 20 lists each Reform plan by county.

The Agency did not anticipate that eight months into the program the volume of complaints against pharmacies not being able to process credits would remain so high. During the last quarter of this first year, the Agency still had 29 complaints from beneficiaries related to pharmacies not being able to process their Enhanced Benefits purchases.

Lessons Learned

Pharmacies had more difficulty than anticipated with processing Enhanced Benefits credits. Also, while beneficiaries earned their Enhanced Benefits credits at the level estimated prior to implementation, the use of those credits was much lower than anticipated. This issue has required the Agency to reevaluate the entire EBAP to identify new strategies to increase the amount of credits used by Medicaid beneficiaries.

Look Ahead to Year Two

The newly created Enhanced Benefits team, with assistance from the Enhanced Benefits Panel and the Technical Advisory Panel, will conduct a review of all components of the EBAP. At the end of the review, recommendations will be developed and implementation of new strategies will begin. The first areas under review by the Enhanced Benefits team include:

1) Use of the PDCS system for processing purchases including exploring debit-card or mail-order systems for the program;
2) Products for purchase by beneficiaries and evaluating the effectiveness of the list;
3) Healthy behaviors list to ensure they meet the goal of improving health outcomes and if not, recommending changes to the behaviors and credits earned;
4) Rewrite of the Enhanced Benefit call center scripts, materials and statements; and
5) Outreach strategy to increase use of the credits earned.

F. Low Income Pool

Overview

The Low Income Pool (LIP) was created through the Special Terms and Conditions (STCs) of the Florida Medicaid 1115 Demonstration Waiver. The LIP provided for an annual allotment of $1 billion in distributions to Provider Access Systems for their continued services to Medicaid, the uninsured, and the underinsured populations. In accordance with STC # 100, the availability of funds for the LIP was contingent upon the Agency meeting a set of LIP pre-implementation milestones. The pre-implementation milestone conditions are described in the bullets below. The Agency satisfied all of the pre-implementation milestones by June 30, 2006. The first year of LIP distributions began July 1, 2006.

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

- Reimbursement and Funding Methodology document: On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP, and entities eligible to receive reimbursement. CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006. A subsequent revision of the document was provided on November 22, 2006 after conversations with CMS.

- Termination of the hospital inpatient Upper Payment Limit (UPL) program and limit inpatient Medicaid reimbursement to the Medicaid inpatient costs: On June 27, 2006, Florida submitted a State Plan Amendment (SPA) #06-006 to CMS to terminate the current inpatient supplemental payment program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. In the event of termination of the Florida Medicaid 1115 Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration. (On March 21, 2007, the SPA was approved by CMS.)

On June 30, 2006, the Agency received confirmation from CMS stating that "as of July 1, 2006, the State of Florida is permitted to make expenditures from the Low Income

Pool (LIP) in accordance with the Special Terms and Conditions (STCs) approved October 19, 2005."

Year One at a Glance

A LIP Council was appointed in accordance with HB 3-B and codified in s. 409.911(9), Florida Statutes, to advise the Agency and legislature on the financing and distributions of the LIP. More specifically;

> 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 17 members, including 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, and 1 representative of family practice teaching hospitals. The Council shall:

- Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.
- Advise the Agency for Health Care administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
- Advise the Agency of 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 the February 1 of each year."

The LIP Council held six meetings between the first and third quarters of the first year. The Council discussed the Reimbursement and Funding Methodology document, provider distributions and funding for year one, reviewed STCs #101 and #102 and heard presentations from Provider Access Systems interested in receiving funding during State Fiscal Year (SFY) 2007-08. The LIP Council spent a significant amount of time reviewing the impact of the increased costs on Provider Access Systems, deliberated on the impact of the increased costs and availability of local taxing funds in light of the increased state share requirement for matching federal funds, and, during the third quarter of year one, approved their legislative recommendations for State Fiscal Year (SFY) 2007-08.

During the first quarter of first year, the Agency worked with the local governments and health care taxing districts regarding the execution of Letters of Agreements with the Agency for LIP funding. In addition, the Agency worked with the local governments and health care taxing districts regarding CMS' request to provide copies of any provider agreements executed between the local governments and/or health care taxing districts

with the providers in their communities regarding the LIP funds. The Agency finalized the documentation of permissible LIP expenditures (referred to as the LIP Cost Limit) and required all LIP Provider Access Systems to complete a LIP Cost Limit. The LIP Cost Limit provides the assurance that no provider would receive a LIP distribution in excess of its cost for serving the Medicaid, uninsured, and underinsured populations. The first LIP distribution was made during the first quarter.

During the second quarter of first year, in response to STCs #101 and #102, the LIP Council assigned a workgroup to define the various data elements to be collected for the LIP Milestone reporting document. The Agency submitted the final Reimbursement and Funding Methodology document on November 22, 2006, which incorporated the requirements of STC #101, including the method for documenting the number of individuals and types of services provided with LIP funding. The data collection document is referred to as the LIP Milestone document. All Provider Access Systems are required to submit a LIP Milestone document to the Agency. During the December 28, 2006, conference call with CMS, CMS confirmed that the Agency was in compliance with Demonstration year one Milestone STC# 101.

On May 24, 2007, in an effort to increase access and accuracy of data, a LIP web-based reporting tool was made available for Provider Access Systems to input their LIP Cost Limit data and LIP Milestone data. The Agency established the reporting deadlines which was provided to all Provider Access Systems via mail and was posted on the internet as part of the LIP Reform web-page. All Provider Access Systems were required to submit “pre-LIP” milestone data, referred to as the base year data. This information was due on June 1, 2007. The milestone data representing year one of LIP is due August 15, 2007. The base year and year one LIP Milestone data will be provided to all Provider Access Systems and the University of Florida LIP evaluator. This information will be used as part of the cost-effectiveness study, in compliance with STC #102.

During the first year, the Agency received $ 398,568,739 as the state share of LIP funding from 33 local governments and health care taxing districts and distributed a total of $966,461,540 to LIP Provider Access Systems. It is important to note that due to the timing and receipt of funding from local governments/health care taxing districts for the state share funding for LIP, some of the LIP distributions for year one of the waiver will be finalized during the first quarter of second year of the wavier.

Table 21 provides the summary of LIP distributions for year one of the Medicaid Reform Waiver.

Table 21 Summary of LIP Distribution Year 1 Provider Access System	Distributions July 1, 2006 – June 30, 2007
Hospital	
SafetyNet	$106,098,400
Specialty Pediatric Hospitals	$2,000,000
Trauma Centers	$12,375,000
Primary Care Hospital	$11,906,617
Rural Hospitals	$8,383,500
Poison Control Hospitals	$3,172,979
Low Income Pool 1	$578,000,000
Low Income Pool 2	$180,000,000
Low Income Pool 3	$55,441,900
Hospital subtotal	**$957,378,396**
Non-Hospital	
County Primary Care Initiatives	$850,000
St. John's River Rural Health Network	$583,333
FQHCs	$8,149,811
Non-Hospital subtotal	**$9,583,144**
Grand Total	**$966,961,540**

Look Ahead to Year Two

The Agency will begin year two by working with the local governments and health care taxing districts to secure the state, non-federal, match portion of the LIP funding for SFY 2007-08. During the 2007 legislative session, funding for the total annual allotment of $1 billion LIP expenditures was appropriated to Provider Access Systems for SFY 2007-08. During year two of LIP, the Agency's focus will be primarily on STC #102, which includes a cost-effectiveness study of the LIP. The State has contracted with the University of Florida to conduct the evaluation of LIP, as part of the overall reform evaluation. The LIP evaluation will include the cost-effectiveness study. The cost-effectiveness study, anticipated to be completed by January 2008, will be shared with the Provider Access Systems. The Agency will then review the study with the federal Centers for Medicare and Medicaid Services (CMS) to "define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the low-income pool for demonstration year 3 through 5" (STC #102).

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

To determine if a person is eligible for the 1115 Medicaid Reform Waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

I. Eligibles and enrollee member months are identified;
II. Claims data for included services are identified using the list created through 'I' above;
III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report;

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

IV. Using the paid claims data extracted, the expenditures are identified by service type within each of the groupings in 'III' above and inserted on the appropriate line on the CMS 64 waiver templates;
V. Expenditures that are also identified as Home and Community Based (HCBS) Waiver services are identified and the corresponding HCBS waiver template expenditures are adjusted to reflect the hierarchy of the 1115 waiver reporting.

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

Statistics tables below show the current status of the program's Per Capita Cost per Month (PCCM) in comparison to the negotiated PCCM as detailed in the Special Terms and Conditions (STC # 116) of the Waiver.

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 do 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 the Centers for Medicare and Medicaid Services.

Year One at a Glance

For the first demonstration year, the 1115 Medicaid Reform Waiver is budget neutral as required by the Special Terms and Conditions of the Waiver. MEG 1 has a PCCM of $875.74 (Table 23), compared to WOW of $948.79 (Table 22), which is 92.30% of the target PCCM for MEG 1. MEG 2 has a PCCM of $158.80 (Table 24) compared to WOW of $199.48 (Table 22), which is 79.61% of the target PCCM for MEG 2.

Table 25 provides cumulative expenditures and case-months for the reporting period of July 1, 2006 to June 30, 2007. The combined PCCM targets are calculated by weighting MEGs 1 and 2 using the actual case-months. In addition, the PCCM targets as provided in the Special Terms and Conditions are also weighted using the actual case-months. The weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 22) is $328.24. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided on Tables 23 and 24 is $281.99. Comparing the calculated weighted averages, the actual PCCM is 85.91% of the target PCCM.

Table 22 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116.

Table 22
PCCM Targets

WOW PCCM	MEG 1	MEG 2
DY01	$ 948.79	$ 199.48
DY02	$ 1,024.69	$ 215.44
DY03	$ 1,106.67	$ 232.68
DY04	$ 1,195.20	$ 251.29
DY05	$ 1,290.82	$ 271.39

Tables 23 through 26 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2007. 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.

Other Issues

Due to an oversight in reporting the non-enrolled reform eligible expenditures, the State reported expenditures for non-enrolled dual eligibles on the CMS 64 for the first two quarters of Demonstration Year 01. These expenditures have been identified and the prior periods have been adjusted through the CMS 64 reporting process for the quarter ending June 30, 2007. The 3rd quarterly report included the correct amounts for the impacted months and therefore no changes are required.

The quarter total expenditures reported in the 3rd quarterly report (Tables 15 and 16) were net of rebates. Since the PCCM targets provided in the Special Terms and Conditions #116 of the Waiver were not calculated net of rebates, the PCCM targets reported in this report were revised to include the collection of rebates. No changes were made to the CMS 64 report, as the rebate amounts are provided on the CMS 64 templates for each MEG.

The LIP expenditures are contingent upon securing the state, non-federal, share through local governments and health care taxing districts. Since LIP is a new program to many local governments, the executing of Letters of Agreement for the state, non-federal, share took slightly longer than anticipated. The Agency did not release any LIP payments to Provider Access Systems until the appropriate documents were secured. By the end of the first year of operation, all Letters of Agreement were executed and Provider Access System distributions were made accordingly.

Table 23
MEG 1 Statistics: SSI Related

DY01		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Jul – 06	261,613	$109,390,027	$600,241	$109,990,268	$420.43
Aug – 06	260,641	$290,239,642	$2,569,296	$292,808,939	$1,123.42
Sep – 06	258,963	$151,632,644	$1,917,184	$153,549,828	$592.94
Q1 Total	**781,217**	**$557,259,673**	**$ 5,086,722**	**$562,346,395**	**$719.83**
Oct – 06	260,493	$218,143,288	$4,673,965	$222,817,252	$855.37
Nov – 06	259,752	$312,799,991	$13,335,318	$326,135,309	$1,255.56
Dec – 06	260,065	$168,324,557	$5,249,437	$173,573,994	$667.43
Q2 Total	**780,310**	**$706,715,609**	**$24,690,376**	**$731,405,985**	**$937.33**
Jan – 07	260,390	$301,700,335	$19,269,886	$320,970,221	$1,232.65
Feb – 07	261,186	$225,983,270	$10,729,527	$236,712,797	$906.30
Mar - 07	266,681	$162,942,196	$7,256,963	$170,199,159	$638.21
Q3 Total	**788,257**	**$700,393,754**	**$38,038,470**	**$738,432,224**	**$936.79**
Apr – 07	267,563	$206,811,966	$23,638,822	$230,450,788	$861.30
May – 07	268,130	$295,089,378	$34,658,736	$329,748,114	$1,229.81
Jun - 07	268,522	$149,052,964	$13,847,948	$162,900,912	$606.66
Q4 Total	**804,215**	**$657,121,159**	**$72,784,392**	**$729,905,551**	**$907.60**
DY01 Total	**3,153,999**	**$2,621,490,195**	**$140,599,960**	**$2,762,090,155**	**$875.74**
WOW DY1 Total				**$2,975,596,229**	**$948.79**
Difference				**$ (213,506,074)**	
% of WOW PCCM MEG1					**92.30%**

***** Quarterly expenditure totals do 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.

Table 24
MEG 2 Statistics: Children and Families

DY01		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Jul – 06	1,295,214	$116,458,910	$127,380	$116,586,290	$90.01
Aug – 06	1,286,292	$273,890,601	$1,278,032	$275,168,632	$213.92
Sep – 06	1,276,974	$101,678,854	$310,378	$101,989,233	$79.87
Q1 Total	**3,858,479**	**$498,189,408**	**$1,715,790**	**$499,905,198**	**$129.56**
Oct – 06	1,273,251	$191,457,471	$4,041,139	$195,498,611	$153.54
Nov – 06	1,252,855	$299,005,334	$13,001,406	$312,006,740	$249.04
Dec – 06	1,246,544	$123,282,253	$1,763,262	$125,045,515	$100.31
Q2 Total	**3,772,650**	**$623,448,816**	**$19,606,645**	**$643,055,462**	**$170.45**
Jan – 07	1,216,944	$284,440,302	$21,346,634	$305,786,936	$251.27
Feb – 07	1,219,671	$196,269,428	$9,240,222	$205,509,650	$168.50
Mar - 07	1,296,192	$119,706,461	$5,627,070	$125,333,531	$96.69
Q3 Total	**3,732,807**	**$612,194,137**	**$36,444,373**	**$648,638,510**	**$173.77**
Apr – 07	1,289,543	$182,303,461	$17,518,977	$199,822,438	$154.96
May - 07	1,277,379	$269,355,204	$33,253,849	$302,609,053	$236.90
Jun - 07	1,270,325	$105,916,963	$6,513,132	$112,430,095	$88.50
Q4 Total	**3,837,247**	**$564,828,924**	**$57,487,857**	**$622,316,780**	**$162.18**
DY01 Total	**15,201,183**	**$2,298,661,285**	**$115,254,665**	**$ 2,413,915,950**	**$158.80**
WOW DY1 Total				**$ 3,902,199,885**	**$199.48**
Difference				**$(1,488,283,935)**	
% of WOW PCCM MEG2					**79.61%**

*Quarterly expenditure totals do 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.

Table 25
MEG 1& 2 Cumulative Statistics

	Actual CM	MEG 1&2 Actual Spend		Total	PCCM
DY 1 Meg 1&2	18,355,182	$4,701,805,568	$264,694,849	$ 4,966,500,417	$281.99
WOW	18,355,182			$ 6,877,796,114	$328.24
Difference				$(1,911,295,697)	
% Of WOW					85.91%

Table 26
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount DY 01
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,737
Total Paid	$966,961,540
Limit	$1,000,000,000
% of Limit Used	96.70%

The expenditures during year 1 for MEG 3, the Low Income Pool (LIP), were $966,961,540.

H. Encounter and Utilization Data

Overview

The Agency is required to capture encounter data 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. The interim pharmacy data and future medical services encounter data will be used to support s. 409.91211(3)(p), Florida Statutes, requiring that a risk-adjusted methodology be a component of the rate setting process for capitated payments to Reform health plans. Risk adjustment is to be phased in over a period of three years beginning with the Medicaid Rx model and transitioning to a diagnostic based model such as the CDPS (Chronic Illness and Disability Payment System).

The Medicaid Encounter Data System (MEDS) / Risk Adjustment Team, including internal subject matter experts and external consultants with experience in the risk adjustment and encounter collection processes, continues to support the implementation and operational activities related to Medicaid encounter data.

The collection, validation, and processing of encounter data occurs in three phases. The first phase, an interim phase to meet the objectives of risk adjusted rates, consists of the statewide collection of pharmacy encounter data from all health plans capitated for these services. The second and third phases involve the statewide collection of encounter data from health plans for all Medicaid covered services. The second phase occurs with the incumbent fiscal agent and the third phase occurs with the new fiscal agent for Florida Medicaid.

Year One at a Glance

The Agency Medicaid Encounter Data System accomplished the following activities during the first year of operation:

- Defined a risk-adjusted methodology for capitation payments to Reform health plans;
- Created a webpage for all information related to the Medicaid Encounter Data System;
- Developed an encounter data submission guide (business/technical specifications for full encounter data) for managed-care organizations;
- Defined business processes and implemented system changes to collect and process encounter data from managed-care organizations;
- Defined business specifications for the edits on the Florida Medicaid Management Information System (FMMIS);
- Designed tables in the Medicaid Decision Support System to accept encounter data from FMMIS to be used in analyses and structured queries;
- Created an initial suite of reports to support utilization, quality, and trend analyses;

- Defined an interim solution for full encounter data validation;
- Achieved Council for Affordable Quality Health Care (CAQH) compliance with The Accredited Standards Committee (ASC) X12 transaction requirements;
- Ensured data met both ASC and Florida Medicaid requirements; and
- Established communication protocols, a key ingredient to the success of an encounter data system, to facilitate clear and constant interaction between the MEDS team and Medicaid Reform Health Plans.

Pharmacy Encounter Data Collection and Processing Activities (First Phase)

The Medicaid Reform Waiver requires a risk-adjusted methodology to be used as a component in the rate setting process for capitated payments to Reform Health Plans. To comply with these requirements in the first year of Reform, pharmacy encounter data was collected statewide from all capitated Medicaid Health Maintenance Organizations (HMOs). These data, combined with pharmacy fee-for-service claims, Medicaid eligibility, and enrollment information, are utilized in the risk-adjusted rate setting process for Medicaid Reform.

Using the Medicaid Rx risk-adjustment model developed by the University of California, San Diego (UCSD), the NDCs (National Drug Codes) reported on pharmacy encounters indicate certain chronic diseases, and a Medicaid enrollee is assigned a statistically derived risk score based on the drugs utilized. An individual's risk score is an indicator of future health care utilization, and is updated on a quarterly basis as new claims and encounter data are collected.

Reform health plans are assigned a plan risk factor based on the aggregate risk scores of their enrolled populations. As health plan enrollment changes monthly, the health plan risk factors are calculated and applied to the rate setting process. Health plan risk factors, budget neutral risk factors, and the derived risk corridor plan factor have been applied to capitated premium rates beginning in October 2006 and each subsequent month thereafter for Medicaid enrolled populations in Reform counties.

Pharmacy data and the Medicaid Rx risk adjustment model will continue to be used for the calculation of risk-adjusted rates in the Reform counties, until comprehensive encounters for all medical services are collected in the Medicaid Encounter Data System (MEDS) and are of sufficient quality and completeness to be used for this purpose.

Pharmacy Encounter Data Utilization (First Phase) for HMOs

The following figures and tables represent utilization and statistics from the collection of pharmacy encounter data from the capitated Reform Health Maintenance Organizations (HMOs) for a measurement period encompassing June 2006 (3 months prior to reform

enrollment) through March 2007. The statistics are limited since these encounter data are reported using a minimum data set specific to risk adjustment requirements. **Figures 1a, 1b, and 1c** show the HMO enrollment numbers, unduplicated encounters, and unduplicated users of services indicated by prescription medication usage, in thousands for Broward County HMOs. The source data for these figures is reported in Table 27. The charts show the transition, beginning in September 2006, of Medicaid beneficiaries from non-Reform HMOs to Reform HMOs.

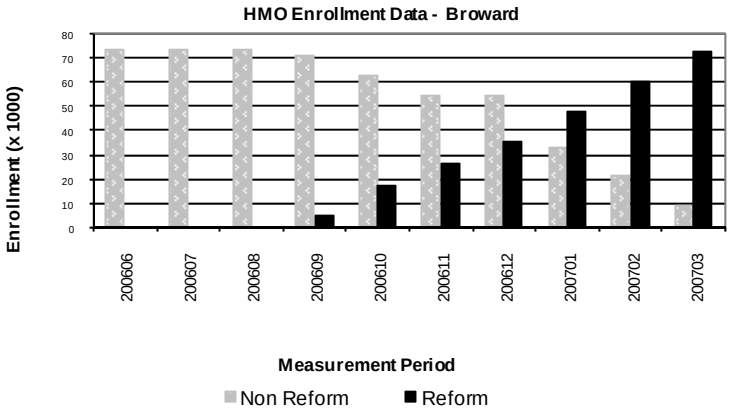


Fig. 1a

The Broward County HMO enrollment numbers in **Figure 1a** clearly show that Reform enrollment numbers climbed, through the measurement period, to non-Reform HMO enrollment levels seen at the start of the period. Combining the enrollment numbers for non-Reform and Reform HMOs, during any month, shows that enrollment levels have increased since September 2006. Factors contributing to the growth of HMO enrollment include new Medicaid beneficiaries joining the HMOs, shifting of enrollees from non-Reform HMOs to Reform HMOs, or the movement of fee-for-service (MediPass) beneficiaries into HMOs under Reform.

Figure 1b shows the unduplicated number of HMO pharmacy encounters during the measurement period for Broward County. The chart shows a similar pattern of growth for encounters under Reform as it does for growth in enrollment under Reform, for enrollees. Again, the pattern reflects a net overall growth of unduplicated pharmacy encounters.

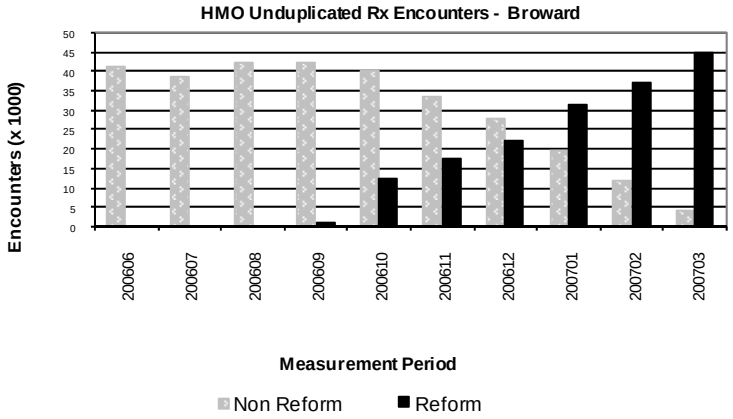


Fig. 1b

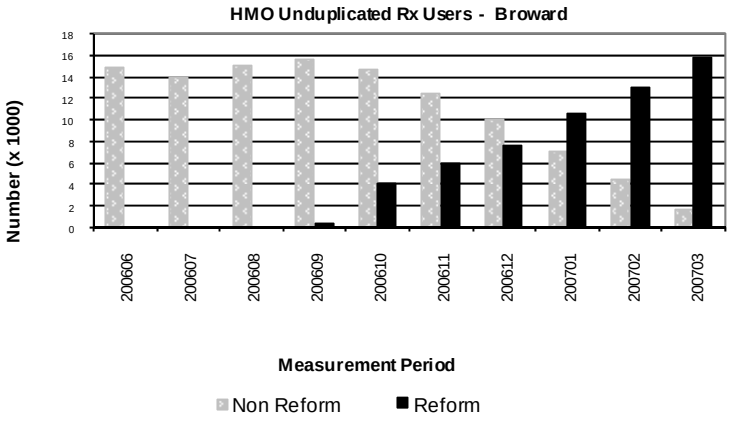


Fig. 1c

Figure 1c depicts the growth in unduplicated HMO users of pharmacy services as the transition from non-Reform HMOs to Reform HMOs progresses across the measurement period. The overall numbers of unduplicated users has increased, and during any given month during Reform, the level of users is well above that of the non-Reform periods.

Figures 2a and 2b are indicators of HMO utilization of pharmacy services, and juxtapose measures from non-Reform and Reform HMOs for Broward County to allow comparison. It should be noted that since the first three months of the measurement period are prior to Reform enrollment, they do not have any data for Reform (see Table 28), and the summary measures are calculated using available data only.

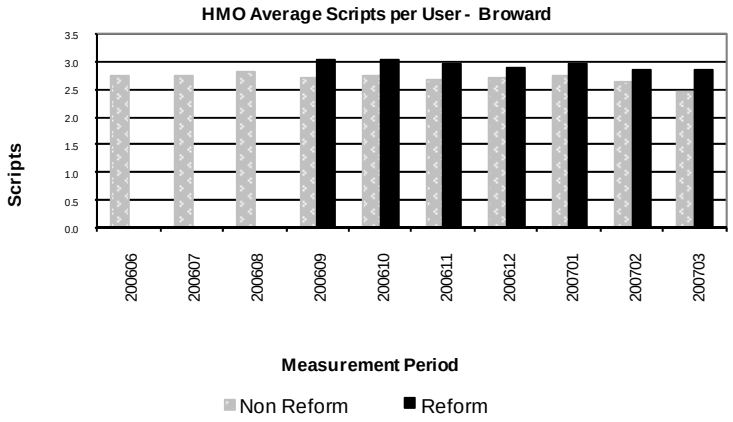


Fig. 2a

Figure 2a shows the average number of prescription medications (scripts) per user for non-Reform and Reform HMOs over the measurement period. It is interesting to note that from its inception, utilization under Reform HMOs appears to be consistently higher than for non-Reform HMOs. The greater utilization in Reform HMOs could be attributed

to coverage of former fee-for-service beneficiaries with greater utilization patterns and higher burdens of illness, or increased access to pharmacy services under Reform. **Figure 2b** shows a comparison of users per 100 enrollees for the non-Reform and Reform HMOs in Broward County. The chart shows that, generally, under Reform, this measure compares favorably, if not better, than under non-Reform. Again, this could be attributed to increased access to pharmacy services, or greater utilization of services by former fee-for-service beneficiaries now enrolled in Reform HMOs. Additional analysis with comprehensive data is required to identify any differences and its sources, to accurately measure access to services under Reform.

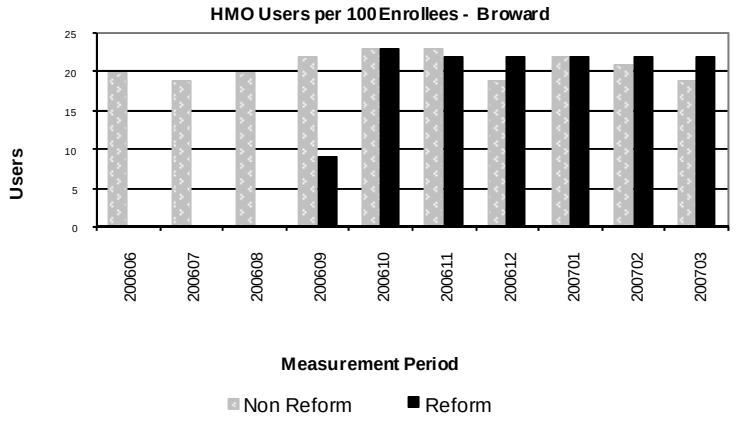


Fig. 2b

Figures 3a, 3b, and 3c show HMO enrollment numbers, unduplicated encounters, and unduplicated users of services based on prescriptions, in thousands, for Duval County HMOs. The source data for these figures is reported in Table 29. The charts show the transition, beginning in September 2006, of Medicaid beneficiaries from non-reform HMOs to Reform HMOs.

HMO enrollment numbers, **Figure 3a,** for Duval County, also show increased Medicaid beneficiary enrollment in HMOs corresponding with Reform enrollment in Duval County beginning September 2006, and continuing through the measurement period, although the numbers are not as high as in Broward County.

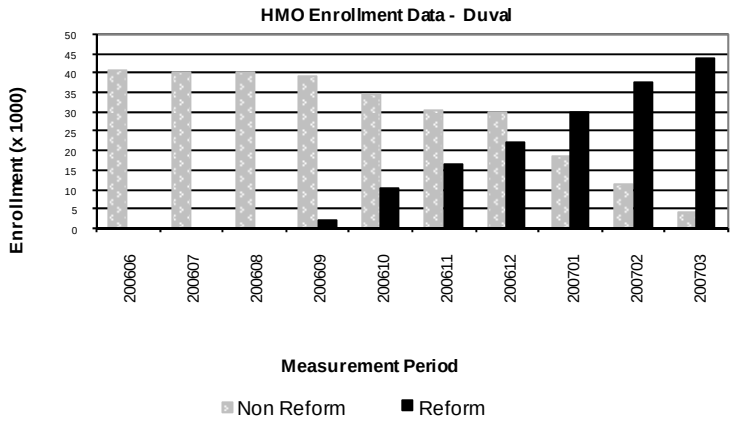


Fig. 3a

Figure 3b shows the unduplicated number of HMO pharmacy encounters under non-reform and Reform during the measurement period for Duval County. The chart shows a similar pattern of growth for encounters under Reform as it does for growth in enrollment under Reform, for enrollees. Also, as in the case of Broward County, the data show a net overall growth in HMO unduplicated encounters, although the actual numbers are lower than they are in Broward County. The growth may be attributable to transitioning beneficiaries from fee-for-service system to Reform HMOs, new Medicaid beneficiaries entering the plan, or by existing enrollees moving from non-reform to Reform HMOs.

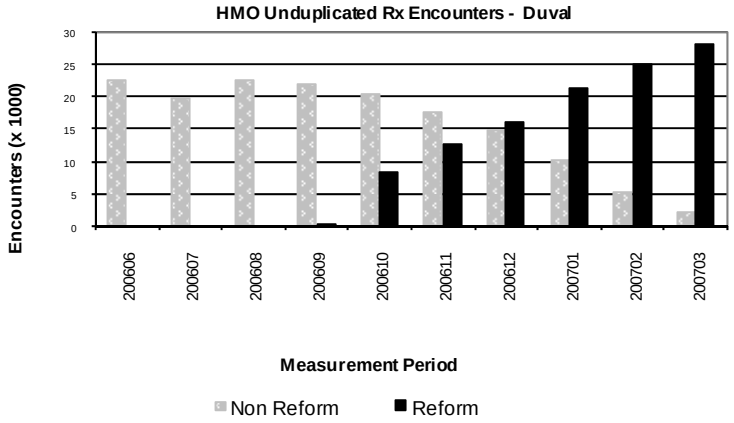


Fig. 3b

Figure 3c shows the unduplicated HMO number of users of pharmacy services as the transition from non-reform HMOs to Reform HMOs progresses across the measurement period. The overall numbers of unduplicated users has increased, as in the previous two charts, following reform implementation. As can be expected, the level of users is well above that of the non-reform periods, reflecting the movement of fee-for-service beneficiaries with greater utilization of services into HMOs, as well as due to new Medicaid enrollees in the Reform County, and shifts of beneficiaries from non-Reform HMOs to HMOs under Reform.

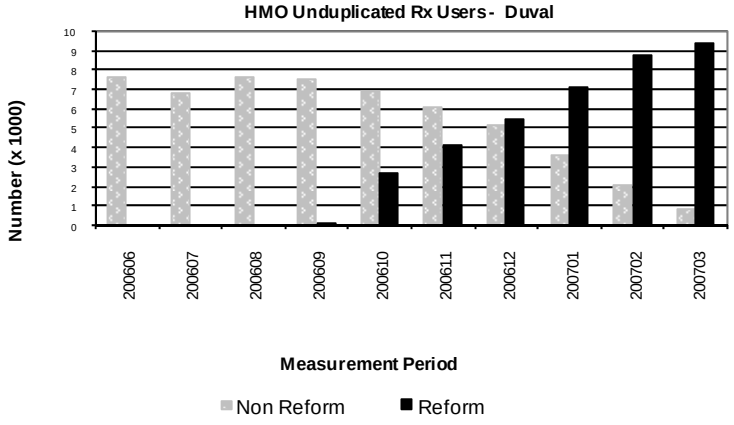


Fig. 3c

Figures 4a and 4b are indicators of HMO utilization of pharmacy services, and as in the previous charts, utilize pharmacy data submitted by HMOs. Also, as in the charts for Broward County, to allow comparison of Medicaid enrollee utilization patterns, data for non-Reform HMOs and Reform HMOs have been used to derive summary measures and charted.

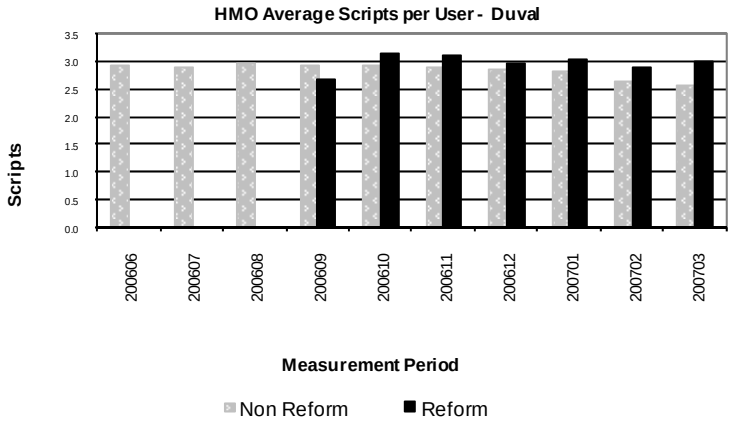


Fig 4a

Figure 4a shows the average number of prescription medications (scripts) per user in Duval County for Medicaid enrollees in non-Reform and Reform HMOs. As is the case for Broward County, the average is slightly higher among enrollees in Reform HMOs, at about 3 scripts per user. The overall average scripts per user, however, remained very close to the pre-implementation, non-Reform HMO utilization level.

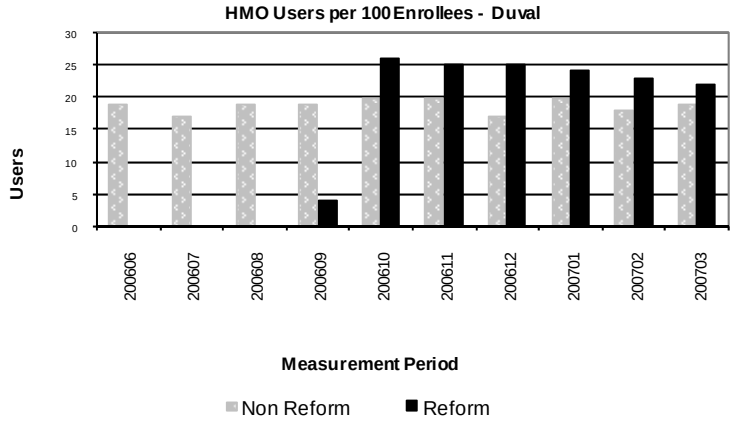


Fig. 4b

Figure 4b shows the number of users of pharmacy services among all Medicaid enrollees for both non-Reform HMOs and Reform HMOs in Duval County. The overall trend for users in non-Reform HMOs appears to be relatively stable compared to the pre-enrollment Reform period (June 2006 through August 2006), while users in Reform

HMOs spike to about 25 per 100 enrollees after the first month of enrollment, then stabilizes at around 23 per 100 enrollees, and at a higher level than for non-Reform HMOs.
The four following tables (Tables 27 through 30) illustrate the number of Medicaid HMO beneficiaries within each of the two Reform areas (Duval and Broward) and the corresponding numbers of HMO pharmacy encounter claims used to calculate individual risk factors.

Table 27 presents HMO pharmacy encounters in relation to total pharmacy users and total Medicaid enrollees by month and year in Broward HMOs. It also reveals the transition of Medicaid beneficiaries from non-Reform to Reform HMOs. These data are depicted in Figures 1a, 1b, and 1c.

Table 27
Broward HMO Pharmacy Encounters by Month for Year 1

Service Month	BROWARD					
	NON-REFORM			REFORM		
	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Encounters	Total Users	Total Enrollees
2006/Jun	41,534	14,982	73,888	0	0	0
2006/Jul	38,650	14,025	73,515	0	0	0
2006/Aug	42,709	15,104	74,084	0	0	0
2006/Sep	42,719	15,614	71,222	1,286	424	4,854
2006/Oct	40,410	14,671	62,663	12,431	4,096	17,442
2006/Nov	33,878	12,577	54,821	17,708	5,986	26,635
2006/Dec	27,839	10,167	54,579	21,939	7,555	35,060
2007/Jan	19,921	7,188	33,418	31,375	10,545	47,998
2007/Feb	11,908	4,501	21,440	37,326	13,082	60,266
2007/Mar	4,373	1,782	9,560	45,091	15,826	72,396
Total	**303,941**	**110,611**	**529,190**	**167,156**	**57,514**	**264,651**

Data Source: AHCA; Mercer Consulting, Inc.

Table 28 lists the statistical measures for HMOs in Broward County, with average prescription medications (scripts) per user, and users of services as a percent of all Medicaid enrollees, computed for reform and non-reform to allow comparisons. These measures are depicted in Figures 2a and 2b.

Table 28
Statistical Measures for HMOs in Broward County for Year 1

Service Month	BROWARD			
	NON-REFORM		REFORM	
	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)
2006/Jun	2.77	20	0.00	0
2006/Jul	2.76	19	0.00	0
2006/Aug	2.83	20	0.00	0
2006/Sep	2.74	22	3.03	9
2006/Oct	2.75	23	3.03	23
2006/Nov	2.69	23	2.96	22
2006/Dec	2.74	19	2.90	22
2007/Jan	2.77	22	2.98	22
2007/Feb	2.65	21	2.85	22
2007/Mar	2.45	19	2.85	22
Average	**2.71**	**21**	**2.94**	**20.2**

Table 29 presents HMO pharmacy encounters in relation to total pharmacy users and total Medicaid enrollees by month and year in Duval HMOs. It also reveals the transition of Medicaid beneficiaries from non-Reform to Reform HMOs. These data are depicted in Figures 3a, 3b, and 3c.

Table 29
Duval HMO Pharmacy Encounters by Month for Year 1

Service Month	DUVAL					
	NON-REFORM			REFORM		
	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Encounters	Total Users	Total Enrollees
2006/Jun	22,710	7,688	40,721	0	0	0
2006/Jul	19,930	6,858	40,498	0	0	0
2006/Aug	22,857	7,661	40,423	0	0	0
2006/Sep	22,115	7,555	39,541	239	89	2,225
2006/Oct	20,602	6,969	34,858	8,328	2,648	10,288
2006/Nov	17,768	6,122	30,474	12,572	4,074	16,559
2006/Dec	15,006	5,216	30,319	15,951	5,424	22,010
2007/Jan	10,425	3,683	18,712	21,412	7,083	29,949
2007/Feb	5,497	2,085	11,480	25,182	8,735	37,665
2007/Mar	2,112	824	4,277	28,047	9,418	43,561
Total	**159,022**	**54,661**	**291,303**	**111,731**	**37,471**	**162,257**

Data source: AHCA; Mercer Consulting, Inc.

Table 30 lists the statistical measures for Duval County HMOs, with average prescription medications (scripts) per user, and users of services as a percent of all Medicaid enrollees, computed for reform and non-reform to allow comparisons. These measures are depicted in Figures 4a and 4b.

Table 30
Statistical Measures for HMOs in Duval County for Year 1

Service Month	DUVAL			
	NON-REFORM		REFORM	
	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)
2006/Jun	2.95	19	0	0
2006/Jul	2.91	17	0	0
2006/Aug	2.98	19	0	0
2006/Sep	2.93	19	2.69	4
2006/Oct	2.96	20	3.15	26
2006/Nov	2.90	20	3.09	25
2006/Dec	2.88	17	2.94	25
2007/Jan	2.83	20	3.02	24
2007/Feb	2.64	18	2.88	23
2007/Mar	2.56	19	2.98	22
Average	**2.85**	**18.0**	**2.96**	**21.2**

Comprehensive Medicaid Encounter Data Collection and Processing Activities (Second and Third phases of MEDS)

Notable strides to achieving statewide encounter claims for all Medicaid covered services have been made during the first year of reform. Many of the business processes and communications protocols established during the pharmacy collection of encounters from Medicaid HMOs have been incorporated into the collection and processing activities for comprehensive encounter data. When these data have been validated and are of sufficient quality and completeness, there will be a transition of the Medicaid beneficiary risk management from the pharmacy based Medicaid Rx to the diagnosis based CDPS (Chronic Illness and Disease Payment System).

As presented in Table 31, Medicaid Reform Health Plans have successfully achieved goals of producing X12 HIPAA compliant transactions that meet Council for Affordable Quality Health Care (CAQH) compliance requirements. Additionally, a number of the health plans have provided test files to the Agency for review of Florida specific X12 transaction content, and received an endorsement that would allow them to submit X12 HIPAA compliant encounter claims following prescribed activities within the Medicaid Encounter Data System (MEDS) project plan. As of this reporting period in the reform

counties, there are a total of 10 Medicaid Health Maintenance Organizations (HMOs) and 5 Provider Service Networks (PSNs) required to submit HIPAA compliant encounter claims.

The Medicaid Reform Health Plan achievements, encompassing both HMOs and PSNs, associated with the collection and processing of HIPAA compliant encounter claims are depicted in Table 31.

Table 31
Medicaid Reform Health Plan Achievements
Year 1 (July 1, 2006 – June 30, 2007)

Objective	Number of HMOs Achieving Objective	Number of PSNs Achieving Objective
Received CAQH compliance of ASC X12 transactions	10	2
Submitted test files to AHCA for review of Florida specific X12 transaction content and received an endorsement to begin submitting "production status" encounter claims	6	2
Submit "production status" ASC X12 encounter claims for adjudication within the Florida Medicaid Management Information System	2	0

Note: In Reform areas, there are a total of 10 Medicaid Health Maintenance Organizations (HMOs) and 5 Provider Service Networks (PSNs) – not all PSNs are capitated for transportation at this time.

In addition to the accomplishments of the Medicaid Reform Health Plans, the Agency has successfully enhanced the incumbent Fiscal Agent's Florida Medicaid Management Information System to collect and perform X12 compliance validation, to validate encounter claim content ensuring data meets both ASC and Florida Medicaid requirements, to complete processes typically identified with adjudication of encounter claims, and to perform pricing at service line and claim levels. ASC X12 communications are provided to health plans in the form of the following: TA1 (Interchange Acknowledgment); X12 997 (Functional Acknowledgement); X12 277U (Unsolicited Claim Status); with the X12 835 (Payment Remittance Advice) forthcoming.

Future activities incorporated into the Medicaid Encounter Data System project plan include a "learning period" where X12 compliant encounter claims submitted by Medicaid Reform Health Plans will be jointly analyzed by the Agency and the health plans during the initial four months of processed encounter claims.

Following the successful conclusion of the "learning period," the Medicaid Reform Health Plans will begin the submission of aged encounter claims with payment dates beginning January 2007. During these scheduled activities, encounter data will be continually analyzed with consultation provided to the Medicaid Reform Health Plans on

quality review findings. Once Medicaid Reform Health Plans have individually achieved the submission of aged encounter claims, they will begin “current date” submissions.

Look Ahead to Year Two

The Agency’s Medicaid Encounter Data System activities for the second year of operation include:

- On-going collection of encounter data from Medicaid Reform Health Plans;
- Joint Agency/Health Plan analyses of X12 compliant encounters;
- Continuous analysis of quality review findings to ensure improvements in the quality of encounter data submissions from reform health plans;
- Define business processes and business specifications for edits in the new FMMIS effective March 1, 2008;
- Create a complete suite of reports to support feedback to health plans and efforts for improvements in health care access, quality and cost-effectiveness; and
- Integrate existing encounter data collection systems into the MEDS environment.

I. Demonstration Goals

Medicaid Reform is fundamentally changing the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of Medicaid Reform, and anticipates using 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 further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation. There are six key design elements of Medicaid Reform 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 Medicaid Reform, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two Minority Physician Networks (MPNs) for a total of twelve managed care programs in Broward County; and two HMOs and one MPN for a total of three managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of Medicaid Reform operated as prepaid ambulatory health plans offering enhanced medical management services to beneficiaries enrolled in MediPass, Florida's primary care case management program.

At the end of the first year of operation, the Agency established contracts with ten HMOs and five PSNs for a total of fifteen Reform health plans in Broward County; and four HMOs and three PSNs for at total of seven Reform health plans in Duval County. One of the plans is a specialty PSN plan which serves children with chronic conditions in both Broward and Duval Counties. The number and types of health plans that beneficiaries can chose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform Waiver. Additionally, the Agency approved the expansion of one HMO and one PSN into Baker, Clay and Nassau counties during the last quarter of the first year with enrollment scheduled to begin in September 2007.

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

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

Services Not Previously Covered

All of the capitated Reform health plans offered expanded or additional benefits which were not previously covered by the State under the State Plan. During the first year, the most popular expanded benefits offered by the capitated plans were an over-the-

counter (OTC) drug benefits and adult preventive dental benefits. New expanded benefits available to beneficiaries during the first year of Reform included the following:

- Over-the-counter drug benefit from $10-$25 per household, per month
- Adult Preventative Dental
- Circumcisions for male newborns
- Acupuncture/Medicinal Massage
- Additional Adult Vision – up to $125 per year for upgrades such as scratch resistant lenses
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid
- Home-delivered meals for a period of time after surgery, providing nutrition essential for proper recovery for elderly and disabled.

By the end of the first year of operation, the Agency had reviewed 28 health plan proposed customized benefit packages from the HMOs and 13 different expanded benefits proposals from the FFS PSNs. The proposed customized benefit packages and expanded benefits were submitted for the upcoming contract period September 1, 2007 to August 31, 2008. These submissions also included 1 HMO and 1 FFS PSN for the Reform expansion counties: Baker, Clay and Nassau.

One of the significant changes in benefits for the upcoming contract period was continued reduction in cost sharing. Many plans choose to offer expanded or additional benefits which were not previously covered by the State under the State Plan. The two most popular expanded services offered were the same as last year's, the over-the-counter (OTC) drug benefits, and adult preventative dental benefits. Four of the customized benefit packages expanded their OTC value from $10 to $25, while another 4 added a $25 OTC benefit. The expanded services available to beneficiaries for year two of Medicaid Reform starting in September 2007 are the same as those offered during the first year of Reform as listed above.

The following expanded benefits that were added for year two of Medicaid Reform include:

- Respite care
- Nutrition Therapy
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined)
- Adult Hospital Outpatient – Additional $3,500/year for hospital outpatient services at Shands Jacksonville only (maximum $5,000/year combined)

The one expanded benefit that was dropped for the upcoming contract year was the Complimentary/Alternative Medicine benefit.

Improving Access to Specialists

The 1115 Medicaid Reform Waiver is designed to improve access to specialty care for beneficiaries. Through the contracting process, each Reform health plan is required to provide documentation to the Agency of a network of providers including specialist that will guarantee access to care for their enrolled members. The Agency continues to monitor access by evaluating the provider networks for each of the Reform health plans. As the first year of Reform ended, the Agency had begun the first intensive review of the Reform health plan provider network files to evaluate the effectiveness of Reform in improving access. The analysis includes the following steps:

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

The provider network analysis mentioned above will provide good indicators of how effective Medicaid Reform has been during the first year in achieving the objective of improving access to specialists. The data will not however be a complete look at the access to care picture. Since the Agency currently does not have full encounter data for the Reform health plans, the Agency is limited in its ability to take additional steps in analyzing this objective. The next step would be to compare the providers contained in the Reform plan's network to encounter data to ensure that all the listed providers were actively seeing Reform enrollees. This analysis can be completed for the fee-for-service Provider Service Networks as their providers are enrolled Medicaid providers but at this time the Agency can not do this analysis for the capitated plans.

Furthermore, the capitated Reform plan provider files currently do not contain a unique identifier, such as a Medicaid provider number, for each provider. The lack of this portion of the provider data results in the Agency conducting a manual process to try and unduplicate those providers.

Upon completion of the provider file analysis, the Agency will have the first set of data to evaluate the effectiveness of Medicaid Reform in improving access to specialty care in year one. These data will allow the Agency to evaluate contractual requirements for the Reform plans and make any adjustments that may be necessary. It will also allow the Agency to work with the plans to implement any new standards, or to partner with the plans to implement new approaches or ideas to not only achieve, but to exceed, the objective of improving access to specialists.

The Agency is also working on the National Provider Identification and provider matching initiatives. When completed, these two initiatives will result in the provider files containing unique identifiers for each provider. This information will shorten the timeframes to collect this necessary data and improve the accuracy of the information.

As the encounter data system is fully implemented, this unique identifier will allow the Agency to take additional steps in identifying active providers.

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.*

The Agency will monitor the Medicaid Reform health plan enrollees through the HEDIS performance measures and the plan's disease management enrollees through Agency-defined disease management measures. The Medicaid Reform health plan contract specifies the performance measures that will be collected starting January 1, 2007 through December 31, 2007, and reported to the Agency July 1, 2008, including the ones identified above.

Prior to implementation and during the first quarter of operation, the Agency reviewed the HEDIS measures and Agency-defined performance measures specified in the Reform health plan contracts to ensure the measures were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable. The Agency also reviewed the disease management performance measures used by health plans and disease management programs nationally and in Florida to determine which of those measures the plans would be required to collect and report to the Agency.

After a full review of the measures along with public input obtained through public meetings, the Agency identified a total of 33 proposed performance measures of which 21 Agency-defined measures would be applicable to the disease management enrollees that are not currently listed in the contract. These measures will be collected over a three-year period. During the first year of Reform, the Agency will collect 13 performance measures. The first set of performance measures will be reported to the Agency on July 1, 2008, for the measurement year beginning January 1, 2007 and ending December 31, 2007.

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

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

Based on the information gathered during the first year of operation, the reasons individuals have chosen to opt out of Medicaid Reform include:

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

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

The individuals who decided not to opt out were:

(a) not employed,

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

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

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

It is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The beneficiaries surveyed were enrolled in MediPass, Florida's primary care case management program, and non-reform Medicaid HMOs in Broward and Duval counties to measure the level of patient satisfaction present prior to the implementation of the Medicaid Reform Waiver. The results of the survey will serve as a baseline against which to compare future surveys throughout the demonstration period. Preliminary results of the CAHPS survey conducted in 2006 were submitted to the Agency during the fourth quarter with a full analytical report due from the University of Florida in the fall of 2007.

The Agency will conduct the CAHPS survey of beneficiaries enrolled in Medicaid Reform health plans on an annual basis. The Agency intends to provide the survey results obtained in the fall of 2007 to the beneficiaries in the form of Choice Counseling materials so that they will have comparable information relative to how satisfied enrollees are with their Reform health plan. The health plans will also use the survey results for their quality improvement programs to improve health outcomes of their beneficiaries.

In addition to surveying beneficiaries in Duval and Broward, the Agency plans to conduct a benchmark CAHPS survey of beneficiaries located in Baker, Clay, and Nassau counties. The Agency plans to establish benchmark data for those beneficiaries located in these three rural counties to measure the level of patient satisfaction present prior to the implementation of the Medicaid Reform Waiver. The results of this survey will serve as a baseline against which to compare future surveys in rural counties throughout the demonstration period.

The Agency also intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension.

For Broward and Duval Counties, the disease management patient satisfaction surveys will be conducted in September 2007, to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for six months.

Objective 6: *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 inpatient Upper Payment Limit (UPL) program that allowed for Special Medicaid Payments to hospitals for their services to the Medicaid population. The Medicaid Reform Waiver eliminated Florida's UPL program and created the Low Income Pool (LIP) program that provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The 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 submitted and met Special Term and Condition (STC) #101, Year 1 Milestone, which included an updated LIP Reimbursement and Funding Methodology document that described the distributions to the approved Provider Access Systems and the permissible expenditures for the PAS entities receiving LIP funds. The Agency for Health Care Administration (the Agency) worked with over twenty (20) local governments and or health care taxing districts that provided 41.24%, the state, non-federal share, of the $1 billion LIP funds.

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

As required under STC # 102 for demonstration year 2, the State is conducting a study of the cost-effectiveness of the various Provider Access Systems. The State has contracted with the University of Florida to conduct the evaluation of LIP, including cost-effectiveness and the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations. During the second quarter of year 1, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for this study.

During the third quarter of year 1, the Agency continued its work with the University of Florida's Medicaid Reform Evaluation team. On January 30, 2007, the Agency received a request for pre-LIP information from the University of Florida's Medicaid Reform Evaluation team. On February 20, 2007, the Agency responded, via e-mail, with the electronic data requested. The data requested included information from the hospital

inpatient Upper Payment Limit (UPL) program, Disproportionate Share Hospital (DSH) program, and the hospital exemption to reimbursement ceilings and targets. In addition, data from the Florida Hospital Uniform Reporting System (FHURS) and hospital Medicaid audited DSH data was provided. A conference call was held on March 6, 2007 to review the data provided.

By the fourth quarter of year 1 the Agency submitted additional information, such as intergovernmental transfer (IGT) data for pre-LIP years, to the University of Florida LIP Evaluation team and confirmed the timeline to release the pre-LIP Milestone data (based on State Fiscal Year 2005-2006 activities). The LIP Milestone data includes data for Medicaid, uninsured, and underinsured beneficiaries for services provided by the individual Provider Access Systems. The data required include encounters, patient days, patient discharges, and patient case-mix.

In an effort to receive the information most efficiently, the Agency created a web-based reporting tool. The web-based reporting tool was created during the third and fourth quarters of year 1. The Agency worked with the Provider Access Systems in creating and testing the web-based reporting tool to ensure the smoothest (and quickest) transition for providers entering the data. The entry of the data on the web-based reporting tool allows for the Agency to have immediate access of the information, which allows for a quicker review and analysis. In addition, the Agency is able to extract the data in various formats for internal review and for the University of Florida LIP Evaluation team.

The LIP Milestone data for year 1 of LIP (State Fiscal Year 2006-2007) was due to the Agency from all Providers Access Systems on August 15, 2007. This information will be shared with the University of Florida LIP Evaluation team by September 2007. The University of Florida and the Agency will utilize the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102). This evaluation is anticipated to be completed by January 2008.

After sharing the results of the study with the Provider Access Systems, the Agency will then review the results of the cost-effectiveness study with the federal Centers for Medicare and Medicaid Services to “define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the low-income pool for demonstration year 3 through 5” (STC #102). By the end of demonstration year 2, June 30, 2008, the state will “develop a plan for the statewide implementation of the demonstration by the end of waiver year 5” (STC #102).

J. Evaluation of Medicaid Reform

Overview

The Agency contracted with the University of Florida (UF) to complete the five-year evaluation of the approved 1115 Medicaid Reform Waiver. The evaluation includes the six evaluation objectives specified in approved 1115 Medicaid Reform Waiver, from a baseline in the year prior to implementation on July 1, 2006, through the demonstration period ending June 30, 2010. This evaluation is known as the Medicaid Reform Evaluation, or the MRE.

The MRE Team consists of UF professors and staff in charge of the contract and various aspects of the evaluation. The Team consists of the following people: Paul Duncan (Principal Investigator); Lilly Bell (Project Manager); Christy Lemak and Amy Yarbrough (Investigators, Organizational Analyses); Allyson Hall (Investigator, Quality of Care, Outcomes, and Enrollee Experience Analyses); Jeffrey Harman (Investigator, Fiscal Analyses); and Niccie McKay (Investigator, Low-Income Pool Analyses).

The Medicaid Reform Evaluation is, as it was intended to be, a five-year, over-arching study that will present its major findings in 2010. Many individuals and organizations including the Florida Legislature were interested in reviewing findings much sooner, so the Agency and several other entities have conducted with shorter-term evaluations to look at specific issues. Descriptions are below.

1. Evaluations Affiliated with the Agency or its Contractors

Agency Internal Review

As requested by the Secretary of the Agency for Health Care Administration, the Office of the Inspector General is conducting a review of the implementation of the1115 Medicaid Reform Wavier. The review objectives are as follows:

- Document the current status of Medicaid Reform impact from the perspectives of stakeholders, coupled with available performance data.
- Provide recommendations, as indicated, that will assist executive leadership in decision-making regarding expansion of 1115 Medicaid Reform Waiver.
- Provide recommendations regarding self-evaluative activities for new projects.

The final report is due in September 2007.

Urban Institute – Early Impact of Transitioning to Medicaid Reform

UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. A total of 1,850 interviews were completed. All data sets were delivered to the Urban Institute in May 2007. Following the normal review procedures, reports will be disseminated by the KFF.

University of Oregon – Impact of Incentivizing Health Behaviors

UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid beneficiaries. Data collection was done by means of focus groups and telephone surveys. All data sets were delivered to the University of Oregon earlier this year. Following normal review procedures, reports will be disseminated by the University of Oregon.

Florida State University – Choice Counseling Program

Florida State University (FSU) evaluated the Choice Counseling Programs materials given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver. This evaluation is part of a contract with the Agency. The final report will be received in July 2007.

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) is conducting an evaluation of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. This Chapter provides that the report focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion, and asks that the evaluation be submitted by June 30, 2008.

General Accounting Office

The General Accounting Office is conducting a review of Florida's 1115 Medicaid Reform Waiver and the Vermont 1115 Demonstration Waiver. The report entitled "Medicaid Demonstration Waivers: lack of Opportunity for Public Input during Federal Approval Process Still a Concern (GAO-07-694R)" is to be released in July 2007 and will be published on the GAO website: http://www.gao.gov/index.html.

3. Evaluations Year Two

UF will continue to coordinate all evaluation activities pertaining to the 1115 Medicaid Reform Waiver. In addition to the studies already initiated, the Agency expects to be funding a study to evaluate the mental and behavioral health aspects of Medicaid Reform as described below. UF will make available the results of the CAHPS "benchmark" survey data in September of 2007.

Louis de la Parte Florida Mental Health Institute at the University of South Florida

In addition to the studies already initiated, the Agency expects to be funding a study by the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF) (through a subcontract between UF and USF). This study will evaluate the

mental and behavioral health aspects of Medicaid Reform in the Reform counties (Broward, Duval, and the expansion counties of Baker, Clay, and Nassau).

University of Florida - Longitudinal Survey

One of the components of the MRE is a longitudinal qualitative study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall healthcare system, and their current experiences under Medicaid Reform.

Baseline qualitative interviews and focus groups were conducted with enrollees between October 2006 and May 2007. A total of 37 enrollees were interviewed from both Broward and Duval Counties. All participants are early enrollees to Medicaid Reform or were about to be enrolled in Medicaid Reform plans.

Since all study participants did not have long-term experiences with Medicaid Reform, these baseline findings cannot be used to assess the success or failure of Medicaid Reform at this time, but can be used to demonstrate how Medicaid enrollees may respond to the program changes. The preliminary findings are expected in July 2007.

University of Florida – Organizational Analysis

The organizational analysis component of the MRE describes the development of Medicaid Reform in Florida, as well as the specific demonstration projects in the Reform Counties—Duval, Broward, and the three initial expansion counties (Baker, Clay, and Nassau). The organizational analysis focuses on three main areas: the Reform implementation process, the Reform health plans (including health maintenance organizations and provider service networks), and the choice counseling organization(s). The findings are expected in July 2007.

Year Two of Medicaid Reform

It is too early to determine the impact of Florida's Medicaid Reform initiative. During the second year of operation, the evaluation will continue to track Medicaid Reform's ability to make progress towards the evaluation objectives. As more data becomes available regarding the attitudes and behaviors of Medicaid Reform beneficiaries, the evaluators will begin to explore the implications of beneficiary health plan choices and other important aspects of Reform. However, it is important to caution against jumping to conclusions about the success or failure of Medicaid Reform before more time has passed and meaningful data are available.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state's hospital and managed care industries, the medical association, other health

professional groups, advocacy organizations, legislative leadership, or other entities. The FAC meets annually over the five years of the evaluation project. The meetings will provide an opportunity for advisory committee members to obtain current information on Medicaid Reform and the evaluation, and to provide their input regarding the latter.

The FAC members include Randy Kammer (Blue Cross and Blue Shield of Florida), Andy Behrman (Florida Association of Community Health Centers), Bob Wychulis (Florida Association of Health Plans, Inc.), Lisa Margulis (Florida Community Health Action Information Network), Bonita Sorensen (Florida Department of Health), Ralph Gladfelter (Florida Hospital Association), Coy Irvin (Florida Medical Association), Bob Brooks (Florida State University), Steven Marcus (Health Foundation of South Florida), and Steve Burgess (Office of Insurance Regulation).

The first annual FAC meeting was held in Tallahassee, Florida on December 13, 2007 at Agency headquarters. The purpose of the meeting was to provide an overview of the Reform and the evaluation processes and enable the committee members to provide input.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. The purpose of this committee is to provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC will review and provide input on the detailed analysis plan for each project. The research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions as necessary. The TAC meets annually over the five years of the project.

The TAC includes Dr. Robert Hurley (Medical College of Virginia), Dr. Marsha Gold (Mathematica Policy Research, Inc.), Dr. Jennifer Kenney (The Urban Institute), and Dr. Bryan Dowd (University of Minnesota).

The first annual TAC meeting was held in Orlando, Florida on March 9, 2007. The purpose of the meeting was to provide a formal setting for the TAC members to provide the MRE Team with methodological expertise, contacts, advice, and insights.

K. Policy and Administrative Issues

Overview

With the implementation of any new project, there are always policy, administrative and operational issues that arise that require resolution. Medicaid Reform implementation was not different in this regard. In general, policy, administrative and operational issues were addressed by five different processes:

- Technical Advisory Panel Monthly Meetings
- Policy Transmittals and Dear Provider Emails
- Bi-weekly Reform Health Plan Technical and Operations Conference Calls
- Project Management Decision Points
- PSN Systems Implementation Monthly Conference Calls

Overall, these forums have provided excellent opportunity for collecting feedback on proposed processes, working through implementation issues as they occurred, and providing finalized policy in documented products.

Year One at a Glance

Medicaid Reform Technical Advisory Panel

The Medicaid Reform Technical Advisory Panel (TAP) met monthly during the first year of Medicaid Reform through March 2007, discontinued during the regular Florida Legislative Session, and resumed meetings on June 1, 2007. The nine member TAP was created by the 2005 Legislature, appointed by the Agency, and advises the Agency on various implementation issues relative to Medicaid Reform. Areas in which advice from TAP is particularly sought includes risk-adjusted rate setting, benefit design and Choice Counseling Program. The TAP was particularly helpful during implementation of Medicaid Reform including the initial transition of Medicaid beneficiaries into Medicaid Reform health plans. Their provider and plan insight and comments relative to the processes being used by Florida Medicaid assisted in smoothing the transition of beneficiaries to Medicaid Reform and helped ensure that the products in Medicaid Reform – Choice Counseling, Enhanced Benefits Account design, risk-adjusted rate setting, plan evaluation tool (to ensure the health plan's customized benefit package met the Agency's standards), Medicaid encounter data collection and processing – were well thought out and properly vetted.

Policy Transmittals

During the first year of the wavier, the Agency released many policy transmittals and Dear Provider letters/emails to the Reform health plans. These are summarized below:

- Clarification of state 2006 Legislative changes adding additional adult services for dental, hearing and vision services. Dental, hearing and vision services are benefits that the health plans may customize (flexible benefits), with the one exception being that adult hearing aid services must be provided at the State Plan level of coverage.

- Notification to health plans that they could now include, in their list of network providers, providers located in adjacent counties provided that the providers had signed contracts allowing them to provide services for plan members county of residence and that the plan would continue to comply with all transportation requirements, including transportation to these out-of-county providers. This notice allowed Reform health plans with the opportunity to not only use providers that had traditionally provided services to Medicaid beneficiaries based on natural referral patterns that exist in the FFS domain but to include them in the materials used by choice counselors to assist Medicaid beneficiaries in the health plan selection process.

- Advisement to the health plans that all plan providers not enrolled as Medicaid providers in the Medicaid's Florida Management Information System (FMMIS) must be registered with FMMIS in order for the Agency to process encounter data and to provide a systems check to ensure these providers have not been terminated from the Medicaid FFS program and are eligible to participate in the health plans' networks.

- Advisement to the health plans of revisions in the contracted quality performance measures required of the health plans during the three-year contract period. After a series of workshops with health plans and receipt of requested input from interested parties (health plans, advocacy and provider groups) regarding the performance measures, the Agency selected thirty-three performance measures for the plans to report. Twenty of the measures must be reported on for all plan members, thirteen additional measures must be provided for members participating in the Reform health plans' disease management programs. These measures will be phase-in over the next three contract years and is cumulative, meaning that by the third year of the waiver, all thirty-three measures must be reported.

- Clarification to the PSNs regarding the process for newborn enrollments.

- Provision of supplementary information to the PSNs regarding the process to be followed for the submission of involuntary disenrollments.

- Clarification to the PSNs on how to notice the Agency when enrollees had other creditable coverage.

- Advisement to the health plans that the Agency would conduct the Disease Management Patient Satisfaction Survey and the Disease Management

Provider Satisfaction Surveys for the first survey year, rather than having the health plans conduct these surveys for their members.

- Notification to health plans of replacement of the UB-92 claim form by the UB-04 claim form and instructions regarding the completion of the new claim form.

- Announcement that the Agency was now allowing health plans to have access the Enhanced Benefit Information System in order for health plans to provide customer service for their members regarding the members participation in the Agency's Enhanced Benefits program.

Biweekly Technical and Operations Calls

The Agency conducted 24 biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants over Year One of Reform. The purpose of the Technical and Operation Issues Conference 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 email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether or not they are currently operating in the Medicaid Reform counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of Reform, 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 the participants on the call increasing from an estimated 70 participants to an estimated 150 participants in the fourth quarter of Year One. Typical agenda items included:

- Discussion of Electronic file formatting and submission requirements, including accessing data exchange and secured file transmission servers,
- Fiscal agent processing of HIPAA compliant transactions and reports,
- Discussion of enrollment issues, including identification and resolution of transmission issues;
- Update information on Choice Counseling Program activities, as well as information on changes in file format and transmission procedures;
- Health plan network provider registration processes;
- National Provider Identification (NPI) implementation updates;
- New Medicaid Management Information System (MMIS) implementation updates;

- Medicaid Enhanced Benefit Account Program updates;
- Medicaid Encounter Data Systems updates, including notice of schedules for submission and changes in file formats;
- Review of performance measures reporting requirements;
- Review of disease management and coordination activities relative to members living with HIV and AIDS.
- Claims payment issues;
- Kick payment processing;
- Overview of Prescribed Pediatric Extended Care (PPEC) services and the coordination aspects of those services. This overview was provided by representatives of the PPEC industry and Agency's Medicaid Services staff.

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.

Project Management Decision Points

The Project Management Teams for Medicaid Reform met weekly during the first year of Reform, ensuring that implementation and operational issues that came up through operations, team members, and TAP were discussed and researched appropriately. As issues were thought out and resolutions recommended, the Agency used a decision point process to ensure that Agency's Medicaid Reform Steering Members were comfortable and agreed with the team member recommendations.

Over the first year of the waiver, thirty-five decision points were discussed through the Project Management process used to implement Medicaid Reform. Decisions made were noticed to the appropriate interested parties through various methods: contract amendment, policy transmittals, Dear Provider letters and emails, technical and operations conference calls, and in operational processes. Major decisions made included the following:

- Institution of a grievance process for the Enhanced Benefit Account Program
- Institution of a Reform expansion process for existing Reform plans, allowing an expansion application process for existing Reform health plans
- Expansion application deadlines
- List of Enhanced Benefit allowable purchases
- Enrollment process for children eligible to participate in the specialty plan for children with chronic conditions and their siblings
- Process for transitioning members in the three expansion counties into Reform plans

- Allowance for the HMOs to have an additional 90 days to submit OB kick payment claims in HIPAA-compliant format.
- Requirement for health plans to offer the same benefit package to the full service area, not vary it county by county.

Fee-for-Service PSN Systems Implementation Issues Calls

With the fast implementation of Reform into the current Florida Medicaid fiscal agent system as well as 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 to work through the systems issues relative to the start up of Reform. The result of this was the implementation of biweekly conference calls beginning in October between the Agency and the PSNs strictly to discuss and, as appropriate, resolve claims processing and enrollment file transmittal questions and issues. While these calls were scheduled biweekly at the start of the first year, and, as many implementation issues were resolved, these calls transitioned to a monthly schedule beginning in January 2007.

The purpose of these targeted calls was to provide a forum to discuss claims processes and enrollment file issues that were unique to the FFS PSN model. 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 key technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Contract Management Bureau, 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.

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

- Enrollment File formats and modifications needed to file formats to ensure that PSNs could appropriately identify new members.
- Electronic Remittance Voucher file layouts and values and inclusion of pharmacy claims data on PSN members.
- Assistance with working the Medicaid reimbursement handbooks and HIPAA X12 File transmission processes to ensure the PSNs were appropriately transmitting electronic claims as well as paper claims.
- Inclusion of a required pharmacy field in the PSNs' electronic remittance voucher (ERV) so that PSNs could comply with Enhanced Benefits data requirements;
- Resolution of systems issues that resulted in a delay of administrative allocation payments
- Resolution of problems related providers submitting incorrect tax identification information to the PSNs which was resulting in claims denials.

- NPI implementation and implementation of the new UB-04 and CMS-1500 claims forms. Since the FFS PSNs' claims processing system has to operate in concert between the provider and the Medicaid fiscal agent, much time was and continues to be dedicated on the provision of technical assistance in these areas.

In addition, the Agency continues to work with the current Florida Medicaid fiscal agent to install a systems change that will cause claims submitted by the following provider types to deny unless authorization is provided by the fee-for-service PSN:

- Home Health,
- Independent laboratory,
- Dental,
- Community Mental Health, and
- Targeted Case Management.

Due to problems these providers have incurred in home health, community mental health and targeted case management, the Agency formally requested that each FFS PSN submit a claims processing certification prior to implementing that systems change. The certification requires that FFS PSNs attest that their claims authorization and processing system were ready to accept and process these claims and that they had trained all such providers. Once the Agency receives this certification, the Agency will enter the implementation process for this systems change. Based on feedback received from all FFS PSNs, the Agency agreed to remove independent laboratory services from the change request. Since independent laboratory services are mostly connected to other services requiring authorization, the FFS PSNs felt more comfortable allowing those claims to pay without holding them up in a possibly duplicative authorization process.

In addition to these calls, the Agency has also coordinated technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed. The Agency has also conducted claims processing training with the PSNs in both Duval and Broward counties.

Fraud and Abuse Activities

The Agency has conducted two meetings with the Reform health plans relative to fraud and abuse activities. The first was in December 2006 and provided the health plans with technical assistance regarding the new Medicaid Reform contract fraud and abuse requirements. In June 2007, the Agency conducted a Fraud and Abuse Summit and invited all health plans to attend. The summit provided an opportunity for the Agency to share with the plans the results of its review of the health plans' fraud and abuse efforts and provided the health plans with an informal environment in which to exchange ideas.

External Quality Review Organization Quarterly Meetings with Reform Health Plans

Florida Medicaid's external quality review organization (EQRO), Health Services Advisory Group (HSAG) and the Agency's staff conducted quarterly technical assistance meetings with managed care organizations and prepaid inpatient health plans including the Medicaid Reform health plans. The topics typically included:

- The health plans' Performance Improvement Plans.
- The EQRO's process for review of the Performance Improvement Plans and other required quality assessment and improvement activities.
- 'One on one' health plan technical assistance sessions with HSAG staff on performance improvement plans and other required quality assessment and improvement activities.
- Round table discussion of upcoming contract issues relative to the Agency's quality initiatives.

Look Ahead to Year Two

The Agency will continue its current Technical and Operations calls, PSN Systems Implementation calls, project management decision process, and TAP as methods of identifying and resolving operational and policy issues. Specific issues identified for the second year of Medicaid Reform include the following.

Transition to New Medicaid Management Information System (MMIS)

The Agency continues the critical work with Florida Medicaid's fiscal agent transition team relative to how Florida's MMIS will operate for the Reform health plans. As the new MMIS programming is near completion, Medicaid staff continues to provide the fiscal agent transition team with policy clarification and systems change orders which cannot be fixed in the current MMIS and were not included in the initial design phase of the new MMIS. So far, only systems enhancements have been identified and the new MMIS is slated to handle those change orders once the new system is fully implemented.

The new Florida Medicaid fiscal agent system is expected to go live on March 1, 2008. In order to reduce the risk of unsuccessfully implementing the new MMIS, change requests (also known as change orders) for the current MMIS were limited this quarter and notification was provided that only file maintenance changes would be processed through the end of September 2007.

The Agency expects that implementation of the new Medicaid Management Information System will be a key factor in operations in the coming year, and testing with the health plans will be a critical facet to success.

National Provider Identification (NPI)

NPI implementation, while not a component of Reform, is of great interest to our health plans as their provider networks, enrollment file transmissions, claims processes, etc., will all be revised to include the NPI. The Agency will continue to work with the Reform health plans through targeted calls and the regularly scheduled Technical and Operations calls to address health plan concerns.

Medicaid Reform Waiver Implementation/Expansion

Special Term and Condition (STC) # 27 of the 1115 Medicaid Reform Waiver provides that near or full geographic implementation of Medicaid Reform is expected by June 2010; and STC # 31 acknowledges that expansion of the waiver will occur only as authorized by the Florida State Legislature. Section 409.91211(1)(b), Florida Statutes, the Florida Legislature specified that upon completion of the evaluation provided for in Section 3, Chapter 2005-133, Laws of Florida, the Agency may request statewide expansion of the demonstration project. Statewide phase-in to additional counties would be contingent upon review and approval by the Florida Legislature.

In keeping with the approved Medicaid Reform Waiver and the Special Terms and Conditions of the waiver, the Agency, through its Project Management processes, has drafted guiding principles for consideration during any expansion of waiver implementation counties. The guiding principles are listed below and the Agency will use these principles in making expansion recommendations to the Governor and the Florida legislature.

Medicaid Reform Waiver Implementation - Guiding Principles

1. Review current service referral and delivery patterns that cross counties, including PCP selection. Implement the waiver in a manner that acknowledges and addresses those patterns, even if those counties cross Agency areas.
2. Target Reform waiver implementation in counties with managed care experience (at least one HMO).
3. Include counties with larger Medicaid mandatory populations sooner rather than later to ensure waiver budget neutrality.
4. Consider beneficiary access to the Choice Counseling help-line and the potential impact of waiver implementation on the choice counseling contract.
5. Consider other Agency initiatives affecting either beneficiaries or providers in potential waiver implementation counties (such as Florida Senior Care counties, behavioral health contract implementation, and hospitalist program counties).
6. Minimize the risk of implementing the new Medicaid fiscal agent system (from ACS to EDS) by reviewing the Reform Waiver implementation counties against the EDS implementation timeline (slated to occur March 2008). A change from one Medicaid Management Information System to another has not occurred in over 10 years, and many file maintenance and other systems changes are required

to implement the Medicaid Reform waiver in a new county. Implementing Reform in a new county during the transition period could negatively impact the new MMIS implementation and Reform.

7. Review the total number of Medicaid beneficiaries available in a county, or group of counties, to ensure the population is sufficient to make plans financially viable. Other expansion areas for consideration could include counties with smaller numbers of potential enrollees that are geographically close to an established Reform area and have patterns of medical care referral that make them a logical extension to the established Reform area.

8. Consider and incorporate lessons learned from prior Reform county implementations.

Attachment I
PSN Complaints/Issues for Year One

PSN Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**PSN Informal Issue**	**Action Taken**
1st Quarter	None	N/A
2nd Quarter	1. Provider issue regarding multiple PSNs' lack of timely claims payment (001)	HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. One PSN updated its trading partner information to ensure rapid processing by the Medicaid fiscal agent. Another PSN corrected a system mapping error and resubmitted claims that had previously denied. Both PSNs also educated provider on how to properly and fully complete claim forms.
3rd Quarter	1. Provider issue regarding multiple PSNs' lack of timely claims payment (002)	HQ staff facilitated review with each PSN. One PSN found no evidence that provider had submitted claims. Another PSN educated the provider on how to properly and fully complete claim forms and service authorization requests.
	2. Provider issue regarding multiple PSNs' lack of timely claims payment (003)	HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff and Medicaid Contract Management staff. Area Office staff attended meetings between provider and PSNs. Two PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms. One PSN found no evidence that provider had submitted claims.
	3. Provider issue regarding multiple PSNs' lack of timely claims payment (004)	HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Based on research, provider educated on how to properly and fully complete claim forms. Medicaid fiscal agent resolved issue related to claim submitter IDs.
	4. Provider issue regarding PSN lack of timely claims payment (005)	HQ staff facilitated review with PSN and provider. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms.
	5. Provider issue regarding multiple PSNs' lack of timely claims payment (006)	HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. Medicaid fiscal agent resolved issue related to claim submitter IDs. Provider educated on how to properly and fully complete claim forms and hot to request service authorization.
	6. Provider issue regarding PSN lack of timely claims payment (007)	HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. Medicaid fiscal agent resolved issue related to claim submitter IDs. Provider educated on how to properly and fully complete claim forms.

PSN Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**PSN Informal Issue**	**Action Taken**
3rd Quarter (continued)	7. Provider issue regarding multiple PSNs' lack of timely claims payment (008)	HQ staff facilitated review with PSN and provider. Medicaid fiscal agent resolved issue related to claim submitter IDs. Provider educated on how to properly and fully complete claim forms.
	8. Provider issue regarding multiple PSNs' lack of timely claims payment (009)	HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. Medicaid fiscal agent resolved issue related to claim submitter IDs. One PSN corrected a system mapping error and resubmitted claims that had previously denied. Provider educated on how to properly and fully complete claim forms.
	9. Provider issue regarding multiple PSNs' lack of timely claims payment (010)	HQ staff facilitated review with each PSN, provider, and Medicaid Contract Management staff systems staff. HQ staff hosted multiple conference calls. PSN assisted provider in updating her billing system. Provider educated on how to properly and fully complete claim forms.
	10. Provider issue regarding PSN timely authorizations and payments (011)	HQ staff facilitated review with PSN and provider. Based on research, provider was educated on how to properly and fully complete claim forms and service authorization requests.
	11. Provider issue regarding PSN lack of timely claims payment (012)	HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Area Office staff, PSN, and local fiscal agent representative met with provider. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms. Medicaid fiscal agent reprocessed some claims that should have paid as submitted.
	12. Provider issue regarding PSN timely payments (013)	HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Meeting between PSNs' TPA and provider attended by Area Office staff. PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms.
	13. Provider issue regarding PSN lack of timely claims payment (014)	HQ staff facilitated review with PSN and provider. Provider educated on how to properly and fully complete claim forms.
	14. Provider issue regarding multiple PSNs' lack of timely claims payment (015)	HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Provider meetings with PSNs attended by Area Office staff. PSNs added staff to process claims. Provider educated on how to properly and fully complete claim forms.

PSN Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**PSN Informal Issue**	**Action Taken**
3rd Quarter (continued)	15. Provider issue regarding PSN timely authorizations and payments (016)	HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider educated on how to properly and fully complete claim forms and service authorization requests. Medicaid fiscal agent reprocessed some claims that should have paid as submitted.
	16. Provider issue regarding PSN delays in authorizing services (017)	HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. One PSN gave the provider the correct phone number for requesting authorizations and resubmitted claims that had denied due to a PSN keying error. Another PSN found no evidence that provider had ever requested service authorization.
	17. Provider issue regarding PSN delays in authorizing services and payments (018)	HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms and service authorization requests. PSN providing weekly progress reports to HQ until all outstanding claims are paid.
	18. Provider issue regarding multiple PSNs' authorizations and lack of timely claims payment (019)	HQ staff facilitated review with each PSN, provider, and Medicaid Area Office staff. Based on research, provider reminded to check recipient eligibility before providing services and educated on how to properly and fully complete claim forms and service authorization requests. Two PSNs found no evidence that provider had submitted claims. Each PSN worked with provider to expedite processing of claims. One PSN updated its trading partner information to ensure rapid processing by the Medicaid fiscal agent.
4th Quarter	1. PSN provider issue regarding PSN lack of timely claims payment (020)	At the PSN's request, the Agency's Headquarters (HQ) staff submitted a customer service request (CSR) to allow provider to submit claims directly to Florida Medicaid's Fiscal Agent. The provider was advised to correct tax ID information on his Florida Medicaid provider file. HQ staff periodically checked with Medicaid Contract Management staff until CSR was implemented. Then, notified PSN and Area Office staff, who notified provider.
	2. PSN provider issue regarding multiple PSNs' lack of timely claims payment (021)	The Agency's HQ staff facilitated review with each PSN and provider. The Agency's HQ and PSNs educated provider on how to properly reconcile payments received. Both PSNs educated the provider on how to properly and fully complete claim forms. The Agency's HQ staff provided information on how to order new CMS-1500 claim forms.

PSN Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**PSN Informal Issue**	**Action Taken**
4th Quarter (Continued)	3. PSN provider issue regarding PSN lack of timely claims payment (022)	The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider was educated regarding timelines by which the PSN submits claims to Florida Medicaid's Fiscal Agent. Provider revised its billing process accordingly.
	4. PSN provider issue regarding PSN lack of timely claims payment (023)	The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms.
	5. PSN provider issue regarding multiple PSNs' lack of timely claims payment (024)	The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms. PSNs submitted corrective action plan to ensure proper education and processing by their subcontracted claims managing entities.
	6. PSN provider issue regarding multiple PSNs' lack of timely claims payment (025)	The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Florida Medicaid's Fiscal Agent reprocessed claims impacted by a recent system issue. PSNs identified keying errors and resubmitted impacted claims.
	7. PSN provider issue regarding PSN lack of timely claims payment (026)	The Agency's HQ staff facilitated review with PSN and provider. Provider educated on how to properly reconcile payments received. PSN identified keying errors and resubmitted impacted claims.
	8. PSN provider issue regarding PSN lack of timely claims payment (027)	The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Area Office staff processed backlog of paper claims. The PSN submitted corrective action plan to ensure proper education and processing by their subcontracted claims managing entities.
	9. PSN provider issue regarding PSN lack of timely claims payment (*028)	At the PSN's request, the Agency's Headquarters (HQ) staff submitted a customer service request (CSR) to allow provider to submit claims directly to Florida Medicaid's Fiscal Agent. The provider was advised to correct tax ID information on his Florida Medicaid provider file. HQ staff periodically checked with Medicaid Contract Management staff until CSR was implemented. Then, notified PSN and Area Office staff, who notified provider.

PSN Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**PSN Informal Issue**	**Action Taken**
4th Quarter (Continued)	10. Member complained about her PCP. (*029)	Member referred to Area 10 office for assistance.
	11. Member general complaint about lack of providers for authorizations.(*030)	Referred to PSN for reference and network review.

***** Please note: this report has been updated to include three additional complaints/issues (9, 10, & 11 above) that were inadvertently left out of 4th quarter report submitted to CMS on August 29, 2007.

Attachment II
HMO Complaints/Issues for Year One

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
1st Quarter	**None**	**N/A**
2nd Quarter	1. Member needs vision referral (6347-02)	Area office was contacted to get demographic on client and confirm with the Plan to respond on the outcome. Member was seen at provider. Arrangements for service and reimbursement were made.
	2. Member cannot find pediatric dentist that sees children under the age of five (6350-04)	Sent an email to member requesting identifying information. Also, requested that the plan check into this issue with dental provider and locate pediatric dental providers. The plan has non-par pedodontists that sees children under the age of five. They are working on contracting with these providers.
	3. Authorization for drugs denied and requesting to see specialist (6354-01)	The plan was contacted by phone and email and agreed to provide the member with the requested medication and referral to an orthopedic specialist. Client has been encouraged to contact PCP. The plan customer service representative contacted member. Member no longer wanted the medication. Member contacted her PCP and scheduled an appointment for 12/28/06. Drug Evaluation forms were faxed to the PCP for approval. Member was also given the name, address and number of an orthopedic doctor.
	4. Problem obtaining authorization for drugs, and problems with current plan PCP (6361-01)	After plan was contacted, case manager provided member with list of alternative PCP's to select from. Case manager spoke with client on several occasions to resolve issue. After a few denials of different drugs, PCP prescribed Diltia XT. Member had paid out of pocket for 30 day supply, but was reimbursed.
	5. Member was transferred from MediPass to an HMO plan and is now being denied for the same drug she has used for many years (6311-01)	Member filed appeal with plan on 11/1/06 and denial was upheld. AHCA was informed by the plan that the PCP did not provided necessary clinical documentation to support the medical necessity for Buprenex. Member was sent the denial letter advising her of her rights to a Medicaid Fair Hearing.
	6. Problems finding dental service in local area (6361-03)	Plan was contacted. A Dental Provider Relations representative spoke with the member's mother to discuss her issues. Member's mother indicated that this was no longer an issue and that she already had made an appointment with the same dentist her child had seen before.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
3rd Quarter	1. Member is having problems obtaining authorization to see Psychiatrist (7072-02)	Member was enrolled in Medipass, but was transferred to a Reform PSN plan. His current Psychiatrist was offered a contract with the plan, but did not accept. Member has not been able to see a Psychiatrist or get medication since 11/06. The Director of Client Relations for the plan was contacted. He immediately approved a six month authorization for the member to see his Psychiatrist. Appointment was made for 3/21/07.
	2. Problem obtaining authorization for circumcision (7078-04)	The Plan was contacted to make arrangements with the member for medical services. The child was over one years of age and the plan only covers circumcisions for babies up to one years of age. The plans medical director reviewed the provider's authorization request and denied it for lack of medical necessity. An elective circumcision after one years of age is not a covered benefit.
	3. Neurologist and Ophthalmologist do not except member's current health plan (7002-01)	Plan was contacted. Operations Specialist spoke to member to inform her that her Neurologist is not in the plan's network. Plan authorized, for continuity of care purposes, to continue treatment from 1-12-07 through 2-2-07. Member has agreed to subsequently transfer to a provider within the network. Member was informed that Ophthalmologist accepts the member's plan.
	4. Member requested information on dental care (7025-04)	Dental provider is the responsible plan. Dental provider indicated that they did not have member in their system. Confirmation letter was faxed to dental provider so member could make appointment.
	5. Dental Provider alleged that claims for patients under 21 are being denied by Reform plan (7050-02)	Plan was contacted and subsequently requested provider to fax all denied claims for reconsideration.
	6. Member was confused about enrollment requirements into Nursing Home Diversion Program (7057-02)	Member was contacted and provided with the necessary information. Member was enrolled into the program effective 4/1/07.
	7. Provider alleged that the plan denied payment of claims for immunizations (7067-02)	After plan was contacted, the plan agreed to pay for all outstanding immunization claims.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
3rd Quarter (Continued)	8. Member has pending application for different plan. Member is currently in regular HMO plan and has been unable to receive home health care. Overall, member was confused about the enrollment process (7068-03)	Member was informed that he has to be disenrolled from regular HMO plan before being enrolled into the new plan. Member was segmented out of HMO plan to facilitate immediate enrollment into the new plan. This should provide the member with the necessary care.
	9. Father of beneficiary indicated that authorizations for mental health drugs necessary to keep son out of hospital were frequently denied by plan; that assigned PCP refuses to see member; and also requested plan change (7068-04)	Plan was contacted. AHCA staff requested that member receives intensive case management as well as evaluation for day treatment. The plan agreed to reevaluate the beneficiary and reconsider the denial for various prescription drugs. In the meantime, beneficiary has been changed to another plan effective 4/1/07 based on the father's request.
	10. Provider alleged that the dental provider did not provide Fee Schedule to Dental office (7025-05)	Dental office was contacted by a Provider Relations Supervisor with the dental provider. A copy of the Fee schedule was faxed to the provider's office.
	11. Problems accessing dental services (7038-03)	Member was contacted and given the phone number for the dental provider to schedule an appointment.
	12. Diabetic test strips are being denied by pharmacy (7043-03)	The plan was contacted. The plan contacted the pharmacy to resolve issue. Apparently the Pharmacy did not process the diabetic supplies correctly. However, they are now processed correctly, and member was able to receive requested test strips.
	13. Beneficiary requested assistance with Enhanced Benefits Account (7043-04)	The plan was contacted by the Agency to send appropriate information to member. Plan sent member the requested information.
	14. Member was sent letter to enroll in HMO Reform plan although member was enrolled in another plan (7043-08)	Member was inadvertently sent a letter to pick a Reform plan and was changed to a regular HMO Reform plan. Member was reenrolled in the original plan.
	15. Provider indicated that payment for transplant services were denied by plan (7061-04)	Provider was called and was informed of the reimbursement process for transplant services by the plan. The plan was advised to educate providers on the documentation needed to receive payment.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
3rd Quarter (Continued)	16. Member was Auto-assigned to wrong plan (7062-02)	Member was contacted and reassigned to plan of his choice.
	17. Member requested plan change because assigned PCP was too far away (7074-06)	Member was assisted in changing health care plan.
	18. Provider having problems getting payment from the plan (7075-02)	The plan was contacted and agreed to pay the provider.
4th Quarter	1. HMO member's mother wants to enroll her child into another plan because her PCP does not accept her current plan (7093-03)	HMO member's current HMO was contacted and has authorized two visits with member's PCP and agreed to give more if needed. Child will be enrolled into mother's plan of choice effective 5/1/07.
	2. HMO member has been waiting enrollment into plan since January, 2007 (7093-04)	HMO member was enrolled in the plan effective 4/1/07.
	3. HMO member is having issues receiving a referral to see a specialist. Member also wants to file a grievance with the plan (7095-04)	The HMO contacted member to assist in finding a specialist. An out of network provider was offered, but member did not want to travel that far. A grievance with the health plan was never filed.
	4. HMO member is unable to finish ongoing treatment to his teeth because provider stopped accepting Medicaid (7096-03)	The HMO was contacted and they instructed the member to file a grievance with the dental network. The dental network was contacted and stated they did receive the grievance and are working on the issue.
	5. HMO member needs authorization to go to Texas Children's Hospital for heart/lung transplant (7096-05)	The HMO was contacted and agreed to cover case management and transportation.
	6. Hospital is having issues getting an authorization on a HMO member; member is not showing on the HMO's enrollment system (7101-02)	The HMO was contacted and stated that the member was in their system and the issue was human failure. Authorization for services has been approved.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
4th Quarter (Continued)	7. HMO claim is being denied. (7101-03)	The HMO was contacted and stated the member was not enrolled with them. Our records indicate the member is enrolled in the plan and they were asked to update the member's file. The plan has updated their records and the claim was paid.
	8. HMO member is in need of a liver transplant (7106-01)	The HMO was contacted and the member has been approved for a transplant and is currently the first on the transplant list.
	9. HMO member is in need of a liver transplant (7106-02)	The HMO was contacted and confirmed that the member has been authorized and is in case management.
	10. HMO member was mistreated by their HMO and had questions about over the counter drugs and reimbursement (7107-02)	A representative of the HMO contacted the member and assisted her with ordering her over the counter items and provided information about reimbursement.
	11. HMO member was denied drugs (7109-01)	The HMO was contacted and agreed to provide enough medication to get the member through until his appointment. The doctor will then write a full prescription.
	12. Complaint against transportation provider's phone line (7109-03)	A wrong number was being dialed in order to get in touch with transportation provider. The HMO member was sent the correct number and was able to get through.
	13. HMO member is in need of a liver transplant (7110-01)	The HMO was contacted and confirmed that the member has been authorized and is in case management.
	14. HMO member mother needs dental care for her children and is being denied by their current HMO because of county change (7116-03)	The HMO member's mother called Choice Counseling for a plan change but they were unable to process the request. We emailed Choice Counseling to look into this issue because the current plan is not covered in the member's new county. Member was contacted by Medicaid Options and a plan change has been made so they will be able to receive the dental care.
	15. HMO member is having problems receiving drugs from their plan (7123-02)	The HMO was contacted and provided limited authorization for the medication with instruction for member to receive further evaluation. A representative from the plan contacted the guardian of the member about the concerns with the medication prescribed.
	16. HMO member having issues getting authorization for dental needs (7124-01)	The HMO was contacted and sent a copy of the dental contract.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
4th Quarter (Continued)	17. HMO member is not showing as being enrolled with the HMO (7124-04)	The HMO was contacted and has corrected their system to show member as enrolled.
	18. HMO member has high risk pregnancy and the hospital does not accept her plan (7128-01)	The HMO member has changed her plan.
	19. HMO member needs to see a specialist and none are available in area (7135-01)	The HMO member does not want to travel out of area to see a specialist. The HMO was contacted and has found a specialist within the area for the member to see.
	20. HMO member wants to enroll into plan but is being declined (7137-01)	The HMO member was enrolled into desired plan effective June 1, 2007.
	21. HMO member is being billed for services that should be covered by plan (7138-01)	The HMO was contacted and corrected eligibility, reprocessed the claims and contacted the member mom for closure.
	22. HMO member is having problems receiving drugs (7142-02)	The prescribing physician did not obtain the prior authorization for the increase in the medication. The HMO was contacted and stated that the authorization is good for a year. The HMO contacted member's mother to inform her that the medication was ready for pick up at the pharmacy.
	23. HMO member wants to change plans (7144-02)	The HMO was contacted and will be going to member's home to assist in the application process.
	24. HMO member was removed from transplant list due to change in plan (7145-01)	The new HMO is case managing the member and is awaiting reactivation on the waiting list. At this point, no further action is required.
	25. HMO member wants to change plans (7145-05)	The HMO member has been enrolled into a new plan effective June 1, 2007
	26. HMO member is having problems continuing their care from a specialist (7145-06)	The HMO spoke with the specialist and he has agreed to continue treating patients that he was seeing prior to implementation of Medicaid Reform.
	27. HMO provider's claims are being denied (7149-01)	HMO claims were adjusted by plan and paid.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
4th Quarter (Continued)	28. HMO member was in the process of dental care when provider was banned from participation in Medicaid (7152-01)	The HMO member was unable to get in contact with the dental provider in the middle of his dental care. The dentist has been banned from participation in Medicaid or Medicare per Emergency Suspension Order on August 13, 2002. Member filed for a Medicaid Fair Hearing, but withdrew his request. The HMO member stated that he has gone through the grievance process with the plan, but the plan ended the process and retained counsel. The HMO member is considering a medical malpractice suit, but really just wants appropriate dental care. The dental network has referred this case to Medicaid Fraud.
	29. HMO member wants clear fillings from dental provider (7152-04)	The HMO was contacted and explained that clear fillings are not covered. The dental network then contacted the member to explain what types of fillings are covered.
	30. HMO member is having issues getting dental network to fund his procedures (7152-06)	The HMO was contacted and per dental network, the services the HMO member is seeking are not covered under the HMO. Member is no longer concerned with his dental issues and will be switching back to his previous plan.
	31. HMO member needs ID card (7152-07)	The HMO contacted the member and verified address to send another ID card. The HMO also faxed member's eligibility verification to their PCP.
	32. HMO member is having issues finding an Ob/Gyn that specializes in cancer treatment (7162-05)	The HMO member has filed a grievance with the HMO. The HMO contacted the member to refer her to an Ob/Gyn, but they do not specialize in her condition. The HMO found another Ob/Gyn that the member will be seeing.
	33. HMO member is seeking a good cause plan change because current plan can not provide a specialist (7166-07)	The HMO contacted member via letter and informed her that there is no authorization on file and to contact her PCP. The HMO also contacted the member by phone and explained to her that they need an authorization request from her PCP. Information was forwarded to Choice Counseling to make final determination.
	34. HMO member needs ID card and a member handbook (7169-06)	The HMO contacted the member and left several messages. The HMO has sent member a new ID card and member materials.
	35. HMO member has reached his prescription cap and is in need of more medication (7170-22)	The pharmacy has re-run all of the claims and has contacted the member. For the entire month of May 2007, the member received case management and had his/her prescriptions filled. The recipient changed plans with an effective date of June 1, 2007.

HMO Complaints/Issues July 1, 2006 - June 30, 2007		
Time Period	**HMO Informal Issue**	**Action Taken**
4th Quarter (Continued)	36. HMO member needs to see a doctor and wants to file a grievance with her plan (7180-01)	The HMO contacted the member and informed her that she does not have a PCP (even though there is a name on her ID card) and to go to the emergency room. The member asked to speak to a supervisor to complain and was told no one was there and they would not let her speak to someone to file a grievance. The Agency HQ staff contacted the HMO and they stated the issue has been handled and resolved and the member reported she was satisfied.
	37. HMO member is having issues getting drugs authorized (7190-01)	The HMO member's mother stated that she has submitted all necessary paperwork to the HMO in order for her son to receive this medication. E-mail was sent to the HMO requesting that they honor a 30 day prescription until further evaluation can be conducted. The HMO did honor the 30 day prescription and the authorization will be good for one year unless the doctor changes the dosage. Mother is satisfied with ending results.

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings	10/05/05	Duval County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • Choice Counseling	45
	11/22/05	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • Choice Counseling	60
	12/12/05	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	45
	12/13/05	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	50
	01/31/06	Duval County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	95
	02/01/06	Broward County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	110

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	02/28/06	Duval County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • What will Reform plans look like? • Enrollment Introduction (high level)	110
	02/28/06	Duval County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	45
	03/01/06	Broward County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	60
	03/01/06	Broward County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	85
	03/01/06	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview (basic) • What will Reform plans look like? • Enrollment Introduction (high level)	110
	03/15/06	Duval County	Advocates Health Advisory Council – Baker County	Area Office Outreach	• Materials were provided, and followed up with discussion.	20

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	03/16/06	Duval County	Advocates Health Advisory Council – Clay County	Area Office Outreach	• Materials were provided, and followed-up with discussion.	15
	03/20/06	Broward County	One Community Partnership / Governance Board Meeting	Area Office Outreach	• Medicaid Reform Overview	75
	03/21/06	Duval County	Advocates Diabetic Services and Supplies	Area Office Outreach	• Medicaid Reform	1
	03/23/06	Duval County	Potential Plans	Technical Assistance	• Data Book • Demonstration of Plan Design Evaluation Tool • FFS PSN Reconciliation Process	42
	03/24/06	Broward County	Potential Plans	Technical Assistance	• Data Book • Demonstration of Plan Design Evaluation Tool • FFS PSN Reconciliation	44
	03/28/06	Duval County	Advocates Robert F. Kennedy Community Center	Area Office Outreach	• Materials were provided on Medicaid Reform	1
	03/29/06	Duval County	Advocates Ronald MacDonald House	Area Office Outreach	• Medicaid Reform Materials provided.	1

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	03/29/06	Duval County	Medicaid Beneficiaries Mary Singleton Center	Area Office Outreach	• Exhibitor only	100
	03/30/06	Duval County	Advocates Riverside Presbyterian Apartments/Residences	Area Office Outreach	• Medicaid Reform	2
	04/04/06	Duval County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	50
	04/05/06	Duval County	Advocates Patient Educators	Area Office Outreach	• Materials provided on Medicaid with Reform discussion. • Reform and its general effects.	15
	04/06/06	Duval County	Medicaid Beneficiaries Campus Towers	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	15
	04/06/06	Duval County	Advocates ARC Parent Forum	Area Office Outreach	• No presentation given. • Materials provided on Medicaid Reform. • Discussion in response to the materials.	10
	04/10/06	St. John's County	St. John's Civic Roundtable	AHCA Invited	• Medicaid Reform Overview	30

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	04/10/06	Duval County	Advocates Florida Christian Apartments / Sundale Manor	Area Office Outreach	• Medicaid Reform Overview	2
	04/11/06	Duval County	Advocates KIDS Council	Area Office Outreach	• Medicaid Reform Overview	15
	04/11/06	Broward County	Home Health Provider	Area Office Outreach	• Medicaid Reform Overview	18
	04/13/06	Broward County	MediPass Providers	Area Office Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	60
	04/18/06	Broward County	MediPass Providers	Area Office Outreach	• Reform Overview • Provider Enrollment • Patient Enrollment	55
	04/20/06	Broward County	Sister Agencies	Area Office Outreach	• Medicaid Reform Overview	65
	04/20/06	Duval County	Advocates SAGES Coalition	Area Office Outreach	• Medicaid Reform Overview	14
	04/25/06	Broward County	Therapy Providers	Area Office Outreach	• Medicaid Reform Overview	74
	04/25/06	Duval County	Beneficiaries Riverside Presbyterian Apartments	Area Office Outreach	• Medicaid Reform Overview	35

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	05/01/06	Duval County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	13
	05/03/06	Duval County	Specialty Hospital / Health Educators	Area Office Outreach	• Medicaid Reform Overview	20
	05/04/06	Duval County	Advocates	Area Office Outreach	• Reform Overview	10
	05/04/06	Broward County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	40
	05/08/06	Duval County	Neighborhood Partnership for the Protection of Children (Beaches)	Area Office Outreach	• Medicaid Reform Overview	Cancelled
	05/08/06	Nassau County	Advocates and Providers and Potential Plans	AHCA Invited	• Medicaid Reform, roll out to rural counties • Development of PSNs	50
	05/12/06	Broward County	SFHHA/Healthcare Summit	Area Office Outreach	• Choice Counseling	20
	05/12/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 40 total
	05/15/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	35

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	05/16/06	Duval County	Behavioral Health Industry and Providers	AHCA Invited	• Medicaid Reform, effects on the behavioral health industry	40
	05/16/06	Duval County	Potential Plans	General Outreach	• Choice Counseling • Marketing	120
	05/17/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
	05/17/06	Broward County	Potential Plans	General Outreach	• Choice Counseling • Marketing	194
	05/18/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	8
	05/18/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
	05/24/06	Broward County	Providers	Area Office Outreach	• Medicaid Reform Overview	12
	05/25/06	Duval County	DCF Call Center	Area Office Outreach	• Medicaid Reform Overview	54
	05/30/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 70 total
	06/01/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	06/02/06	Duval County	Medicaid Providers	Area Office Outreach	• Medicaid Reform Overview	20
	06/05/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
	06/05/06	Duval County	Independent Living Resource Center	Area Office Outreach	• Medicaid Reform Overview	15
	06/06/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
	06/06/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
	06/09/06	Duval County	Jacksonville Area Service Coordinators	Area Office Outreach	• Medicaid Reform Overview	15
	06/12/06	Duval County	Jacksonville Townhouse Apartments	Area Office Outreach	• Medicaid Reform Overview	25
	06/12/06	Duval County	Integrated Services Team Meeting	Area Office Outreach	• Medicaid Reform Overview	35
	06/13/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	6
	06/14/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
	06/15/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	06/15/06	Duval County	Neighborhood Partnership for the Protection of Children (Jacksonville)	Area Office Outreach	• Medicaid Reform Overview	Cancelled
	06/15/06	Duval County	DCF Caseworkers	Area Office Outreach	• Medicaid Reform Overview	30
	06/16/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	20
	06/20/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
	06/21/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	42
	06/21/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	35
	06/21/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
	06/21/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
	06/22/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
	06/23/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	45
	06/23/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	30

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
Pre-implementation Outreach Meetings (continued)	06/23/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	18
	06/23/06	Broward County	Children's Diagnostic and Treatment Center (CDTC)	Area Office Outreach	• Medicaid Reform Overview	75
	06/26/06	Duval County	Professionals	Area Office Outreach	• Medicaid Reform Overview	45
	06/27/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9
	06/27/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
	06/27/06	Duval County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	62
	06/27/06	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	64
	06/27/06	Duval County	Beneficiaries	General Outreach	• Choice Counseling	55
	06/28/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
	06/28/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
	06/28/06	Broward County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	36
	06/28/06	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	55
	06/28/06	Broward County	Beneficiaries	General Outreach	• Choice Counseling	79
	06/30/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
1st Quarter Outreach Meetings	07/05/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	6
	07/06/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	14
	07/07/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	13
	07/07/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	16

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
1st Quarter Outreach Meetings (continued)	07/11/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
	07/11/06 PM	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	16
	07/12/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
	07/12/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	8
	07/13/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
	07/17/06 PM	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
	07/17/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	13
	07/17/06	Broward County	Medicaid Providers	Area Office Outreach	• Medicaid Reform Overview	80
	07/19/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	14
	07/20/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
	07/21/06	Broward County	PAC Case Managers	Area Office Outreach	• Medicaid Reform Overview	23

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
1st Quarter Outreach Meetings (continued)	07/21/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	48
	07/27/06	Broward County	Behavioral Health Providers	Area Office Outreach with Representatives from Headquarters	• Behavioral Health in Medicaid Reform	
	08/05/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview • Health Fair @ Shands	800
	8/17/06	DCF – District 4	Access Health Solutions	Area Office Outreach	• Medicaid Reform Overview	
	8/18/06	Published 8/18		Article	”Verifying Medicaid Eligibility under Reform"	
	8/18/06	Broward County	Cleveland Clinic (MediPass PCP Staff)	Area Office Out Reach	• Medicaid Reform Overview	
	8/24/06	DCF – District 4	United Healthcare	Area Office Outreach	• Medicaid Reform Overview	16
	08/26/06	Duval County	VOICE Conference	Area Office Outreach	• Medicaid Reform Overview	
	8/30/06	HealthEase Conference Room	HealthEase and Staywell	Area Office Outreach	• Medicaid Reform Overview	
	8/30/06	DCF – District 4	First Coast Advantage-Shands	Area Office Outreach	• Medicaid Reform Overview	

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
	09/13/06	Duval County	VOICE Community Meeting	Area Office Outreach	• Medicaid Reform Overview	
2nd Quarter Outreach Meetings	10/16/06	Clay County	Providers - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Rural Provider Service Network Start-Up Funds • Unique Needs in Rural Areas	44
	10/16/06	Clay County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	22
	11/01/06	Baker County	Providers - Baker, Clay and Nassau	Informative	• Rate Setting • Risk Adjusting • Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	13
	11/01/06	Baker County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	23

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
2nd Quarter Outreach Meetings (continued)	12/11/06	Nassau County	Providers - Baker, Clay and Nassau	Technical Assistance	• Technical Assistance for Filling out the Application • Choice Counseling and Plan Responsibilities • Rural Health Plan Start-Up Funds Application • Marketing of Plans Under Reform	35
	12/11/06	Nassau County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	31
3rd Quarter Outreach Meetings	01/03/07	Twin Lakes Medical	Senator Evelyn Lynn, Healthy Start Coalition and several Local Doctors	Informative	• General Reform	15
	02/15/07 AM	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	10

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
3rd Quarter Outreach Meetings (continued)	02/15/07 PM	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	7
	02/20/07	Nassau County Council on Aging	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	5
	02/28/07	Baker County Health Department	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	6
	03/05/07 AM	Orange Park Town Hall	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	14
	03/05/07 PM	Orange Park Town Hall	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	17
	03/14/07	Baker County Health Department	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	9
	03/19/07	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	7

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
	03/20/07	Nassau County Council on Aging	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	8
4th Quarter Outreach Meetings	04/10/07	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	11 total, from 3 sessions
	04/16/07	Clay County Administrative Offices (Board of County Commissioners)	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	16 total, from 3 sessions
	04/24/07	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	7 total, from 3 sessions
	04/30/07	Nassau County Children and Family Education Center	Providers – Baker, Clay and Nassau Counties	Informative	• General Reform	4 total, from 2 sessions
	05/08/07	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	2 total, from 2 sessions
	05/09/07	Clay County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	20 total, from 3 sessions
	05/16/07	Westside Senior Center – Hilliard, FL	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	5 total, from 2 sessions

Attachment III
Medicaid Reform Outreach Meetings
October 2005 – June 2007

	Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
4th Quarter Outreach Meetings (continued)	05/23/07	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	3 total, from 3 sessions
	06/05/07	Clay County Administrative Offices (Board of County Commissioners)	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	13 total, 3 sessions
	06/13/07	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	11 total, from 3 sessions
	06/19/07	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform	30 total, from 3 sessions