Florida Medicaid Reform

Year 2
Annual Report
July 1, 2007 – June 30, 2008

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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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 was expanded to Baker, Clay and Nassau Counties on July 1, 2007.

During the two years 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 the demonstration, 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 demonstration Year One and this value increased for Year Two benefit packages.

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

Accomplishments

- **Increased beneficiary's self-selection** rate in Year Two to an average of 81% (with the highest monthly average of 88% in April 2008).
- **Increased the number of plans** from 9 to 17 from which beneficiaries can choose since implementation of the demonstration.
- **Increased the value of benefit packages** for Year Two with the provision of services not previously covered by Medicaid (e.g., adult dental care and over-the-counter drug benefits).
- **Initiated the application process for the first specialty HMO** that serves people with HIV/AIDS in Broward County with enrollment scheduled to begin in Year Three**.**
- **Successful implementation in Baker, Clay and Nassau Counties**, the rural counties that adjoin Duval County, with 2 health plans: one HMO and one PSN. These health plans began providing services in the rural counties on September 1, 2007.

[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 second operational year of the waiver program, July 1, 2007 through June 30, 2008.

Lessons Learned

Choice Counseling Program

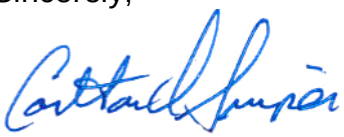
- **Created the Navigator Pharmacy Drug List system** through feedback from the public to enable beneficiaries to select a plan based on whether a plan can cover their medications.
- I**mplemented a customer service survey** that has helped keep a pulse on what the beneficiary thinks of the Choice Counseling process.
- **Increased Choice Counseling script effectiveness** by monitoring calls, receiving feedback from counselors and trainers on what works and what can be improved.
- **Special Needs Unit expanded** to better serve the medically complex and their families, allowing beneficiaries enrolling in managed care to receive the additional assistance their health status requires.
- **Field Choice Counselor efforts increased enrollments** at the local level by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These change resulted in the certified Field Choice Counselors completing over 30 percent of the enrollments.

Enhanced Benefit Program

- **Strengthened call center effectiveness** by rewriting the call center script and creating the ten most common EBAP questions/answers reference sheet.
- **Created a more user friendly OTC products list** for use by the counselors and beneficiaries.
- **Developed a provider network of pharmacies** which includes pharmacies that have been successful in processing Enhanced Benefits products.

The Agency gratefully acknowledges the Florida Legislature, beneficiaries, providers, and other key stakeholders for their assistance in making this demonstration a success. We continue to search for future opportunities for improvement as we gain more data and experience 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,



Carlton D. Snipes
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 demonstration program expanded to Baker, Clay and Nassau Counties on July 1, 2007.

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of 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 second operational year beginning July 1, 2007 through June 30, 2008. For detailed information about the activities that occurred during the previous 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

Since the beginning of the demonstration, the Agency has received 19 health plan applications (12 health maintenance organizations and 7 provider service networks) of which 17 applicants sought to provide services to the TANF and SSI population. The 2 remaining applicants sought to render services as specialty health plans. Of the 19 health plan applicants received, all but 2 have been approved as health plans by June 30, 2008.

The 2 pending applications are Better Health Plan, a fee-for-service (FFS) provider service network (PSN); and AIDS Healthcare Foundation, Inc., a specialty plan (health maintenance organization) for beneficiaries living with HIV/AIDS. Better Health Plan underwent organizational and ownership changes which prevented them from completing the application process during demonstration Year Two. By the end of June 2008, Better Health Plan is near completion of Phase II of the application process[2] (Phase II focuses on review of the applicant's provider network, reporting and policies and procedures).

AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its health plan application to serve beneficiaries living with HIV/AIDS in January 2008. This application is the second specialty plan application the Agency has received (the first being a specialty plan for children with chronic conditions). As of June 30, 2008, this specialty plan application was nearing completion of Phase II of the application process.

During Year Two of the demonstration, one health plan applicant (Freedom Health Plan) completed the application process. The contract with Freedom Health Plan, an HMO, was executed on September 25, 2007, and services began in Broward County in December 2007.

Table 1 provides a list of all health plan applicants, the date each application was received, the date of application approval and each plan's county of operation, as well as the 2 pending applications. Table 1 can be found on the following page of this report.

[2] The health plan application process includes the following four phases: (I) organizational and administrative structure; (II) policies and procedures; (III) on-site review; and (IV) contract routing process.

Table 1 Health Plan Applicants					
Plan Name	**Plan Type**	**Coverage Area**		**Receipt Date**	**Contract Date**
		Broward	**Duval**		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista	HMO	X		04/14/06	06/29/06
Vista Health Plan SF	HMO	X		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	***Pending***
Positive Health Care	HMO	X		01/28/08	***Pending***

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area. There have been no new health plan contracts executed since September 2007 (Freedom Health Plan). However, the Children's Medical Services PSN, the first approved specialty plan, that initially began providing services in Broward County in December 2006, was approved for expansion into Duval County on March 21, 2007, with the first enrollment beginning May 1, 2007, in that county. Table 2 can be found on the following page of this report.

Table 2 Medicaid Reform Health Plan Contracts					
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area**		
			Broward	**Duval**	**Baker, Clay, Nassau**
AMERIGROUP Community Care	07/01/06	HMO	X		
Health Ease	07/01/06	HMO	X	X	
Staywell	07/01/06	HMO	X	X	
Preferred Medical Plan	07/0106	HMO	X		
United HealthCare	07/01/06	HMO	X	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista	07/01/06	HMO	X		
Vista Health Plan SF	07/01/06	HMO	X		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X	
Pediatric Associates	08/11/06	PSN	X		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	9/25/07	HMO	X		

Transition – Baker, Clay and Nassau Counties

Health plan services began for beneficiaries located in the rural expansion counties of Baker, Clay and Nassau in September 2007. The Agency completed the transition of beneficiaries into the 2 health plans approved for the expansion counties in December 2007. These 2 health plans provide beneficiaries a choice of enrolling in an HMO (United HealthCare) or a PSN (Access Health Solutions), options that did not exist prior to the demonstration.

Rate Amendments, Model Contracts and Contract Oversight

Year Two of the demonstration included several general amendments: 1 amendment addressed health plan quality and 2 amendments addressed capitation rates as required under Florida law (occurring effective September 2007 and January 2008, respectively).

In response to stakeholder comments (received through the Agency's Continuous Improvement Team forums), review of complaint data, and recommendations by the Agency's Quality Team and external quality review organization, the Agency drafted a quality amendment that was reviewed with health plans in the fall of 2007. The quality

amendment which became effective January 1, 2008, included the following key components:

- Strengthened quality improvement program by: (a) adding the requirement for an annual submission of a Quality Improvement Plan, (b) clarifying requirements for the required Quality Improvement Committee, and (c) updating the performance measure collection and reporting requirements.
- Clarified the performance improvement plan requirements.
- Required health plans to follow the NCQA disease management guidelines.
- Added a requirement for an annual review of the cultural competency plan.
- Clarified reporting and training requirements related to fraud and abuse in accordance with the Deficit Reduction Act of 2005.
- Strengthened marketing requirements by: (a) revising the Agency's review process for requests to market, and (b) adding criteria for the use of Requests for Benefit Information (RBI). The health plans may leave blank RBIs in provider offices or other locations. Beneficiaries interested in learning more about a particular plan may submit an RBI to the health plan indicating his or her desire for a visit from that plan's marketer. The RBI information collected was limited through this amendment including the plan only being allowed to use the information one-time.
- Revised PSN claims processing requirements by adding performance metrics, claims authorization timeframes and reporting templates.
- Strengthened the PSN encounter data requirements.
- Added requirements related to FFS PSNs converting to capitation as required by Florida Statutes.
- Established criteria for the optional receipt and use of Medicaid redetermination date information for the purpose of notifying members that their Medicaid eligibility is about to expire.

During the last quarter of Year Two, the Agency prepared for the rate amendments for the third contract year in the demonstration (September 2008 through August 2009). Draft capitation rates are scheduled to be provided to the health plans in August and the health plans will be required to submit their new benefit packages for approval. The date for provision of draft rates was extended to allow the state's contracted actuaries to review Agency and plan documentation in order to ensure that the rates are actuarially sound. Due to the lateness of the draft rate provision and in order to allow proper notice to beneficiaries of the change in benefits, the new health plans' benefits will take effect on November 1, 2008. The Agency also posted its model Prepaid Health Plan and FFS PSN contracts which incorporated the general amendments executed in December 2007 and January 2008.

In addition, the Agency reviewed its health plan contract monitoring and oversight processes. New processes were developed and piloted in the last quarter of Year Two.

These new processes included: monthly review of health plan monitoring activities, complaints, grievances, sanctions, and reporting to help ensure contract compliance.

FFS PSN Conversion Process

Pursuant to s. 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the 4th year of operation. This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2009, unless the PSN opts to convert to capitation earlier. To facilitate this conversion, in November 2007, the Agency provided the PSNs with guidelines for transitioning from FFS PSN contracts to capitated contracts via a Conversion Workplan and Conversion Application. These documents were also posted on the Agency's Reform website. Prior to executing a capitated contract, the existing FFS PSNs are required to submit comprehensive conversion workplans, submit a completed FFS PSN Conversion Application, and successfully pass all phases of the conversion application review process.

Conversion workplans were due to the Agency by January 31, 2008, and all but 2 contractors submitted such workplans. The 2 contractors that did not submit work plans were health plans that were undergoing operational changes: one health plan is in acquisition process and the other, the Agency's specialty plan for children with chronic conditions, is in the process of submitting a workplan based on its unique position of being operated under the authority of the State of Florida Department of Health. In demonstration Year Two and continuing in the beginning of Year Three, the Agency is providing technical assistance conference calls with the PSNs in any areas in which the plans might be lacking or request assistance. Table 3 provides the list of required capitation go-live dates for the current FFS PSN contractors.

Table 3
PSN Conversion to Capitation Implementation Dates

FFS PSN NAME	SCHEDULED CAPITATION IMPLEMENTATION DATE
Access Health Solutions	9/01/2009
Children's Medical Services Network, Florida Department of Health	12/01/2009
Shands Jacksonville Medical Center dba First Coast Advantage	9/01/2009
Florida NetPASS	9/01/2009
Pediatric Associates	10/01/2009
South Florida Community Care Network	9/01/2009

Table 4 provides the timeline for each step in this conversion process:

Table 4
PSN Conversion to Capitation Timeline

01/31/2008	Deadline for the FFS PSN to submit its conversion workplan to the Agency
12/31/2008	Deadline for the FFS PSN to submit its conversion application to the Agency
06/30/2009	Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2009
08/31/2009	Current Reform FFS PSN contracts expire

FFS PSN Reconciliations

During demonstration Year Two, the Agency began two reconciliation[3] periods: one period for the first 6 months of operations (September 2006 through February 2007) and one period for the second 6 months of operation (March 2007 through August 2007). Several PSNs required substantial technical assistance in the reconciliation process as either the entities were new to the reconciliation process or had experienced staffing changes. The Agency continues to provide technical assistance to those PSNs that have requested additional assistance as they analyze their reconciliation data. The Agency expects data for the first final annual reconciliation period (September 1, 2006 through August 31, 2007) to be available to the PSNs during the first quarter of demonstration Year Three.

Year Two at a Glance

A summary of the Year Two accomplishments related to the health plan contracting process are provided below.

- Smooth implementation in Baker, Clay and Nassau Counties, the rural counties that adjoin Duval County, with 2 health plans: one HMO and one PSN. These health plans began providing services in the rural counties on September 1, 2007.
- Expansion of health plan quality contract provisions through a general amendment in the fall of 2007, with an amendment effective date of January 1, 2008.
- Approval of 1 health plan application (HMO) for Broward County.
- Technical assistance provided to health plans located in the demonstration areas.
- Review of a specialty plan application to serve beneficiaries living with HIV/AIDS in Broward County.
- Piloted a new health plan contract management oversight process to ensure contract compliance and communication among all affect Agency staff.
- Development and dissemination of guidelines for the conversion of FFS PSNs to capitation.

Lessons Learned

The following provides a list of the lessons learned and opportunities for improvement identified during demonstration Year Two regarding the health plan contracting process. Additional information regarding lessons learned is provided under Section K., Policy and Administrative Issues.

- Transitioning to a new Medicaid fiscal agent's systems requires intense testing and communications with the health plans. The Medicaid fiscal agent and Medicaid management information system changed during June 2008 with a go-live date of July 1, 2008. A list of systems implementation issues that were not implemented during a systems freeze that occurred in September 2007 are on hold until the new

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

Medicaid management information system is stabilized. These are changes necessary to allow for a smooth process for the authorization of services covered by the PSN as well as to ensure appropriate communication back to the PSN from the Medicaid fiscal agent in regards to claims paid, denied and pended.

- FFS PSNs pay many of their providers through the Medicaid fiscal agent system. The transition to the new fiscal agent system has posed some issues that the Agency and the PSNs are working through with providers. In addition, systems changes to address billing issues with the PSNs and their providers are on hold until the new Medicaid Management Information System is stabilized.
- FFS PSNs began their workplans for conversion to capitation with some challenges as claims data was not always readily available through new Medicaid Management Information Systems reports.
- Implementation in rural counties was accomplished with relative ease as 2 health plans built on the resources of the neighboring urban county along with a strong outreach and Choice Counseling program. This demonstrates the ability of the program to serve rural counties.

Look Ahead to Year Three

One core principle of the demonstration was that market competition would inspire innovation and create efficiencies in Medicaid coverage. As the specialty plan for children with chronic conditions matures and the specialty plan application for persons living with HIV/AIDS progresses for final approval, Year Three of the demonstration is anticipated as being a year of change and innovation. As FFS PSNs mature and strive toward the required conversion to capitation at the end of Year Three, many of the upcoming activities will focus on reviewing conversion workplans and readiness for their move to capitation.

With the conversion to the new Medicaid fiscal agent, new training and continued technical assistance will be needed for HMOs and PSNs and new systems changes will occur during Year Three. As the new system becomes stabilized, the Agency intends to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to be more innovative in their health care delivery and achieve efficiencies not currently available.

As our experience with Medicaid encounter data has increased and with input of health plans in regard to their encounter data experience, the Agency expects to enumerate new encounter data requirements through a general amendment. Through this amendment health plans will be required to adhere to defined timelines for encounter submission as well as remediation of encounters failing compliance and/or adjudication. The amendment will require the plans to implement review procedures for validation of encounter data submitted by providers. The amendment will also define the Agency's requirements on completeness and accuracy of encounter data submitted by the health plans.

With Florida's budget shortfall demanding efficiencies and the success of the demonstration's Choice Counseling program, the Agency is evaluating the elimination of many forms of marketing through a general amendment to health plan contractors and to eliminate contract requirements that are unnecessary for the provision of quality health plan services. In addition, during the upcoming year the Agency intends to streamline its various model health plan contracts into one model contract to eliminate duplicative review, reduce potential for inconsistent requirements across plan types (where appropriate), condensation of topics and help ensure that quality initiatives are applied consistently.

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Year One, Year Two, and Year Three of the demonstration. Interested parties were notified that the data book would be emailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of the Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the updated data book on May 23, 2007, to assure that the plans were familiar with the required coverage thresholds for the September 1, 2007 through August 31, 2008 period. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous year. The annual process of verifying the actuarial equivalency, sufficiency test standards and the PET is typically completed during the last quarter of each state fiscal year. The verification process includes a complete review of the actuarial equivalency and sufficiency test standards and catastrophic coverage level based upon the most recent historical FFS utilization data.

The health plans have become innovative about expanding services to attract new enrollees and to benefit current enrollees by broadening the spectrum of services. The standard state plan package is no longer considered the perfect fit for every Medicaid beneficiary, and with customized benefit packages the beneficiaries are getting new opportunities to engage in decision-making responsibilities relating to their personal health care.

The Agency, the health plans and the beneficiaries can see the value of customization – the Agency has seen an increase in the percentage of voluntary plan choices. The health plans have used the opportunity to offer additional, alternative and attractive services. In addition, the Reform health plan enrollees are receiving additional services that were not available under the regular Florida Medicaid state plan. An added bonus is that the average value of the customized benefit packages, as compared to the value of the Medicaid state plan benefit package, has increased from Year One to Year Two of the demonstration.

Year Two at a Glance

The benefit packages customized by the health plans for Year Two of the demonstration became operational on September 1, 2007 and were valid until August 31, 2008. These benefit packages included 30 customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The new set of benefit packages included the addition of 1 HMO and 1 FFS PSN for Reform expansion counties: Baker, Clay and Nassau. The 11 HMOs offering customized benefit packages for TANF and SSI targeted populations are AMERIGROUP Florida, HealthEase Health Plan of Florida, Humana Medical Plan, Wellcare of Florida d/b/a Staywell Health Plan of Florida, Preferred Medical Plan, Vista Health Plan of South Florida, Vista Health Plan d/b/a Buena Vista Healthplan, Total Health Choice, Universal Health Care, United Healthcare of Florida, and Freedom Health Plan. The 6 FFS PSNs are Access Health Solutions, Children's Medical Services, First Coast Advantage, Florida Netpass, Pediatric Associates, and the South Florida Community Care Network.

One of the significant changes in the Year Two benefit packages was the reduction of copayments. In total, there were 63 fewer copayments required during Year Two (9) than in Year One (72). Copayment reductions were made in nine types of services: chiropractic, hospital inpatient, podiatrist, hospital outpatient (non-emergency), hospital outpatient surgery, mental health, home health, lab/x-ray, and vision. Table 5 lists the number of plans requiring copayments for demonstration Year One and Year Two.

Table 5
Number of Plans Requiring Copayments

Type of Service	Year 1	Year 2	Difference
Chiropractic	10	0	-10
Hospital Inpatient	18	2	-16
Podiatrist	10	0	-10
Hospital Outpatient Services (Non-Emergency)	7	1	-6
Hospital Outpatient Surgery	7	1	-6
Mental Health	7	3	-4
Home Health	4	1	-3
Lab/X-Ray	5	1	-4
Vision	4	0	-4
Total	**72**	**9**	**-63**

In demonstration Year Two, many plans continued to provide services not currently covered by Medicaid to attract enrollees. In the standard contract language, these are referred to as expanded services. There are 11 different expanded services offered by Reform health plans during this contract year. The two most popular expanded services offered were: the over-the-counter (OTC) drug benefits and the 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 include:

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- 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;
- Respite care;
- Nutrition Therapy;
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined); and

- Adult Hospital Outpatient – Additional $3,500/year for hospital outpatient services at Shands Jacksonville only (maximum $5,000/year combined).

Since implementation of the demonstration, no changes have been made to sufficiency thresholds that were established for the first contract period of September 1, 2006 to August 31, 2007. In demonstration Years One and Two, the plans could limit the pharmacy benefit through 3 mechanisms: (a) establishing an annual dollar limit on the benefit; (b) establishing an annual script limit; or (c) establishing a monthly script limit. After reviewing the available data (including data related to the plans' pharmacy benefit limits) and reviewing concerns related to beneficiary's ability to understand an annual dollar limit, the Agency decided to limit the pharmacy benefit to a monthly script limit only. This change was made to standardize the mechanism used to limit the pharmacy benefit. This change will be effective in Year Three of the demonstration – November 1, 2008 to August 31, 2009. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF at 98.5 percent.

Looking Ahead to Year Three

The Agency continues to review utilization, service limits, and other data to establish options for allowing more customization and more flexibility in both Medicaid covered services and expanded services in the next operational years. Since the health plans can manage enrollee health care through utilization management and case management expertise, plans are better able to offer resources to provide care that is better suited to individual members.

The PET submission procedure for Year Three of the demonstration is similar to that of the two previous years; however, the deadline for submission by the health plans was extended due to the release of draft rates on August 8, 2008. An updated version of the data book was released on May 7, 2008, and the new PET was emailed to all of the health plans and placed on the Agency's website on May 23, 2008. All health plans in Baker, Broward, Clay, Duval, and Nassau counties were required to complete the PET and submit their proposed benefit packages (including any requested expanded benefits) to the Agency by August 13, 2008. The benefit package effective dates were revised to November 1, 2008 – August 31, 2009. Since the draft rates were not released until August, the change to the benefit package effective dates was made to provide adequate notice to the beneficiaries of any reduction in the plan benefit package and to allow time for printing and distribution of the revised choice materials that include the plan benefit packages for Year Three of the demonstration.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, Medicaid fair hearing system, and timeframes for submission, plan response and resolution. This is compliant with Federal grievance

system requirements located in Subpart F of 42 CFR 438. In addition, the Medicaid Reform health plan contracts include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations. This provides an additional level of appeal.

As defined in the Medicaid Reform health plan contracts:

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

Under 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 (same timeframes as SAP):

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

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

Year Two at a Glance

In an effort to improve the demonstration, the Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. In an attempt to better understand the issues beneficiaries face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in our quarterly reports and in this annual report. The information included in this section is plan reported grievance and appeals. These are grievances and appeals filed internally utilizing the plan's grievance and appeal process by enrolled

members or providers. The Agency will also use this information as a part of continuous improvement and quality oversight.

Grievances & Appeals

Table 6 provides the number of grievances and appeals reported by the PSNs and HMOs for the period July 1, 2007 - June 30, 2008.

Table 6
Grievances and Appeals
July 1, 2007 – June 30, 2008

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
July-Sept 2007	5	4	0	0	197,440
Oct-Dec 2007	26	15	99	22	212,195
Jan-March 2008	38	3	75	61	217,099
April-June 2008	43	13	260	177	224,052
Total	**112**	**35**	**434**	**260**	**287,015**

*unduplicated enrollment count

While the number of plan reported grievances and appeals appears to increase during Year Two of the demonstration, the low number of Medicaid Fair Hearings, SAP and BAP requests indicate that the plans are resolving these issues internally and enrolled members are not requesting further review.

Medicaid Fair Hearings

Table 7 provides the number of Medicaid Fair Hearings (MFH) requested for the demonstration period July 1, 2007- June 30, 2008. Medicaid fair hearings are conducted through the Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members.

The Agency monitors the fair hearing process. Of the 6 MFH requests, all requests were related to denial of benefits/services, with 2 requests specifically related to pharmacy issues. Only 2 MFHs were actually held and the outcome resulted in the plan actions being confirmed as accurate and the plan having provided services appropriately. The other 4 requests were resolved by the health plan prior to the hearing date.

Table 7
Medicaid Fair Hearing Requests
July 1, 2007- June 30, 2008

	PSN	HMO
July-Sept 2007	1	3
Oct-Dec 2007	0	0
Jan-March 2008	1	2
April-June 2008	2	1
Total	**4**	**6**

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only 3 grievances have been submitted to the BAP, and none to the SAP. Of the 3 BAP grievance issues, 1 was related to medically necessity of pharmacy and was resolved in favor of the health plan (PSN); the 2nd issue was deemed out of jurisdiction (OJJ) because the issue was submitted to the BAP prior to the plan internal grievance process being complete; and in the 3rd issue the release form was not submitted to the Agency to allow the BAP process to be completed.

Table 8 provides the number requests to BAP and SAP for the period July 1, 2007 through June 30, 2008.

Table 8
BAP and SAP Requests
July 1, 2007- June 30, 2008

	BAP	SAP
July-Sept 2007	0	0
Oct-Dec 2007	0	0
Jan-March 2008	1	0
April-June 2008	2	0
Total	**3**	**0**

Looking Ahead to Year Three

The Agency continues to work with the health plans to ensure that quality of care and adequate service provision are provided to enrolled Medicaid recipients. The Agency will continue to report all grievances and appeals, Medicaid Fair Hearings, and BAP and SAP requests in our quarterly reports and in the annual reports.

4. Complaints/Issues Resolution Process

Overview

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on what is working and not working in managed care under the demonstration. Complaints/issues come to the Agency from beneficiaries, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received are: local Area Offices, headquarters Bureau of Managed Health Care, and headquarters Bureau of Health Systems Development being the primary Agency locations. 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 and the Agency tracks these to ensure resolution. During demonstration Year One, the Agency determined several of the manual processes used by the Agency to handle complaints did not lend themselves to easy tracking or

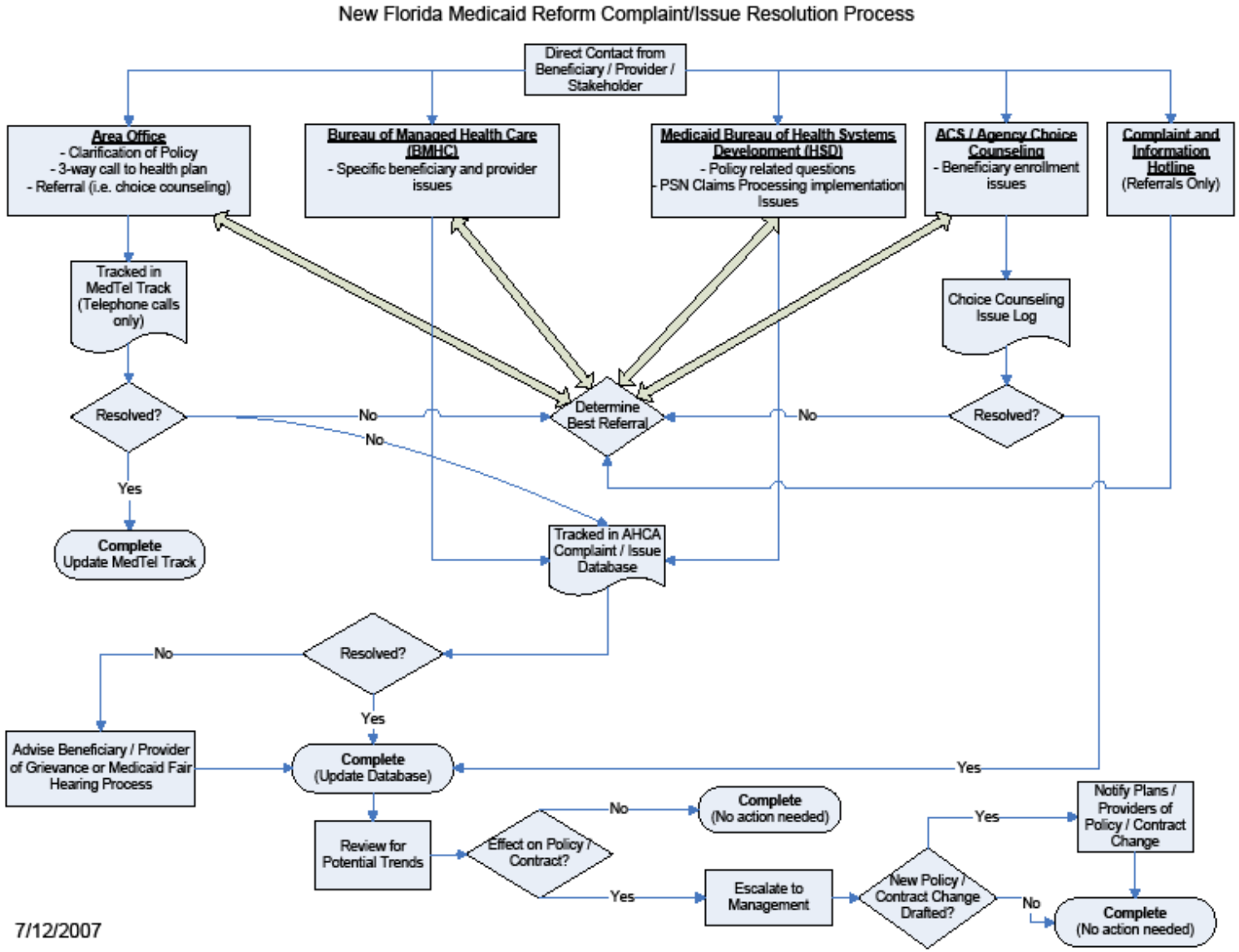
trending. An internal Agency workgroup was created to develop a consolidated automated database that could be used by all staff housed in the above locations to track and trend complaints/issues received.

During the first quarter of demonstration Year Two, the Agency trained staff on the new consolidated automated database and on October 1, 2007, this database was implemented. The database allows the Agency to not only track complaints but to automatically refer complaints to the appropriate Agency office for resolution. During demonstration Year Two, Agency staff refined the complaint database and processing procedures based on staff feedback in March 2008. In addition, Agency staff began working on trend reports to determine whether changes in contractual language or policy clarification were needed. Chart A provides an overview of the new process used for tracking complaints beginning October 1, 2007.

The complaints/issues received by the Agency regarding health plans are listed in the quarterly reports. In general, the complaints/issues received during Year Two were related to managed care in general and specific to the demonstration.

In addition, in Year Two, the Agency developed a contract management oversight process that ensured that the number and types of complaints received were being reviewed by health plan analysts responsible for plan oversight as well as bureau management. In addition to the trend reports developed for management review, in May 2008, the Agency began to pilot monthly plan oversight meetings which include the review of complaints received regarding specific health plans.

Chart A. Complaint/Issue Resolution Process – Effective October 1, 2007



Year Two at a Glance

The Agency's complaints/issues resolution process addresses beneficiaries and provider complaints/issues, and the review of complaint data has led to several revisions in health plan contracts (general amendment effective January 1, 2008) and sanctions against health plan contractors.

The Agency received a total of 229 complaints/issues regarding health plans in Year Two. The volume of complaints is low relative to the number of beneficiaries enrolled. Table 9 provides a summary of the complaints/issues received compared to enrollment during demonstration Year One. Table 10 provides a summary of the complaints/issues received compared to enrollment during demonstration Year Two.

Table 9
Year One 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	0.19	18	3.28	10	1.78	29	4.28
HMO	0	0.00	6	0.99	18	1.41	37	2.65	61	3.87
TOTAL	0	0.00	7	0.62	36	1.97	47	2.40	90	3.99
Enrollment*										
PSN		488		52,620		54,925		56,194		67,836
HMO		7,116		60,701		127,606		139,408		157,745
TOTAL		7,604		113,321		182,531		195,602		225,581

**Enrollment is enrollment at last month of quarter and year end. Complaint tracking system not available; numbers provided from manual process.*

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

**Enrollment is enrollment at last month of quarter and year end. Complaint tracking system implemented second quarter of Year Two resulting in more accurate reporting.*

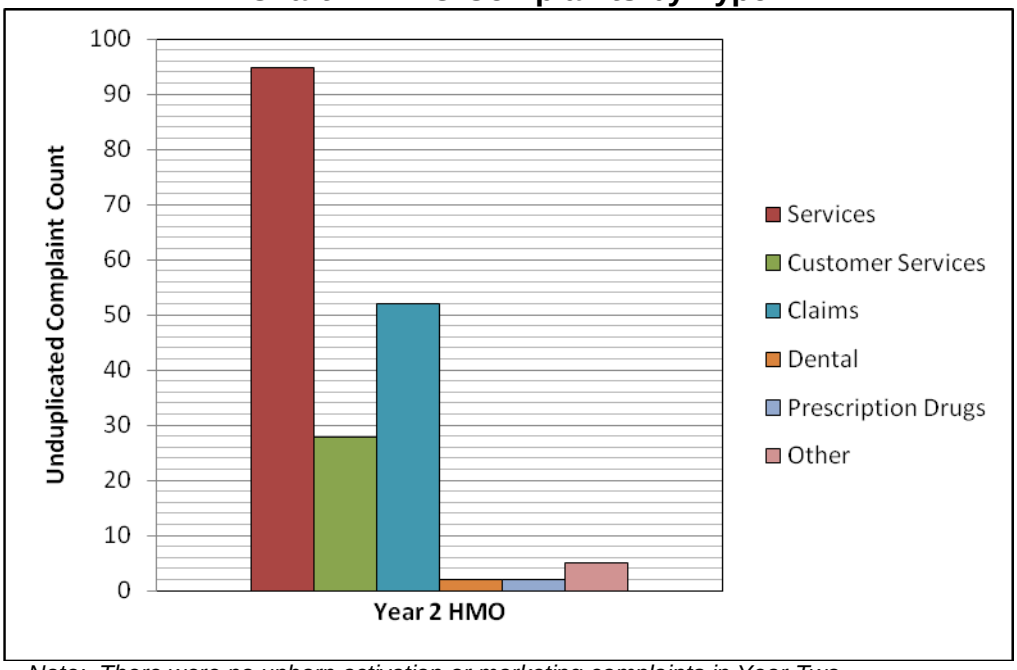
All complaints/issues were worked and addressed with the health plans and providers, some resulting in sanctions. Issues requiring policy with the health plans were discussed on biweekly technical and operations calls, policy transmittals, and by email. As noted earlier the majority of complaints/issues are related to managed care in general and not specific to the demonstration. Agency staff will continue to resolve complaints in a timely manner and to monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

In Year Two, the major reasons for complaints/issues were related to services (referral to a specialty provider and authorization of services) and claims processing (including payment delays). Charts B and C provide the total HMO and PSN complaints by complaint types (claims, customer service, dental, marketing, prescribed drugs, services, unborn and other).

Complaint type descriptions are as follows:

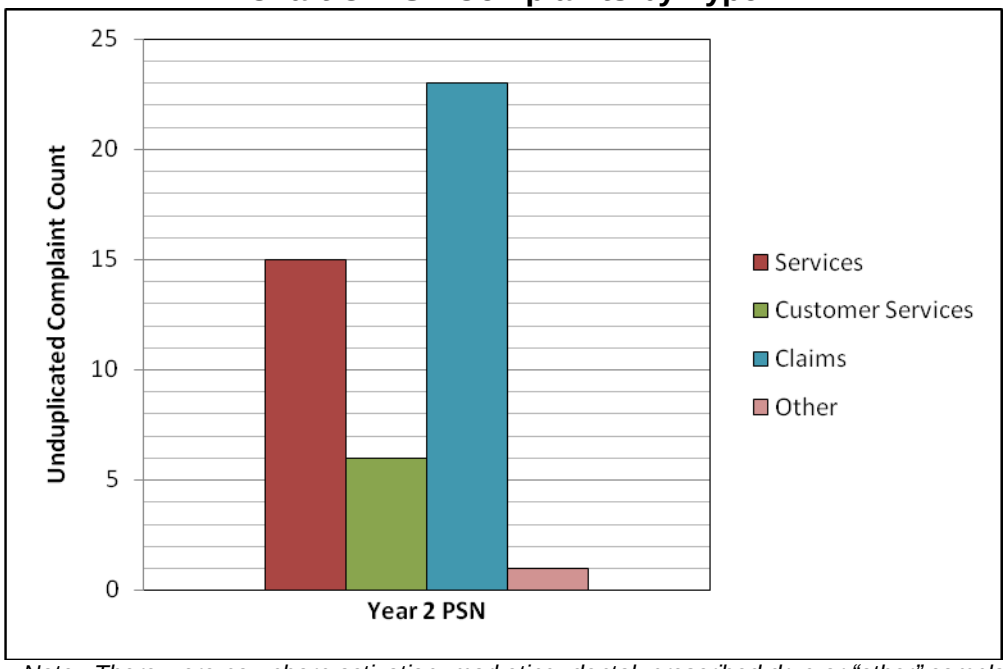
Claims	Claims complaints include, but are not limited to, timely provider payment, eligibility denial (claim denied because service was not eligible for payment or recipient was not eligible at the time of service), and issues regarding inpatient provider payment.
Customer Service	Customer Service complaints include, but are not limited to, issues regarding enrollment, disenrollment, member verification, provision of incorrect information by a customer service representative, and inability to obtain member materials.
Dental	Dental service complaints include, but are not limited to, problems locating a dental provider and service authorization denial or timeliness.
Marketing	Marketing complaints include, but are not limited to, aggressive marketing, cold calling, unauthorized marketing event and non-approved marketing materials.
Prescribed Drugs	Prescribed Drugs complaints include, but are not limited to, problems with service authorization denial or timeliness.
Services	Service complaints include, but are not limited to, complaints received from providers and beneficiaries regarding timely service authorization requests, participating provider availability and authorization denials.
Unborn	Unborn complaints include, but are not limited to, complaints received regarding issues related to the appropriate enrollment of newborns who were identified by the plan prior to birth as being eligible to participate in the unborn activation process. The unborn activation process allows health plans to facilitate enrollment of newborns identified prior to birth.
Other	Other complaints include those that don't fall into other general categories: for example, a provider called to ask for assistance in negotiating a payment rate with a health plan. The Agency does not get involved with provider negotiations.

Chart B. HMO Complaints by Type



Note: There were no unborn activation or marketing complaints in Year Two

Chart C. PSN Complaints by Type

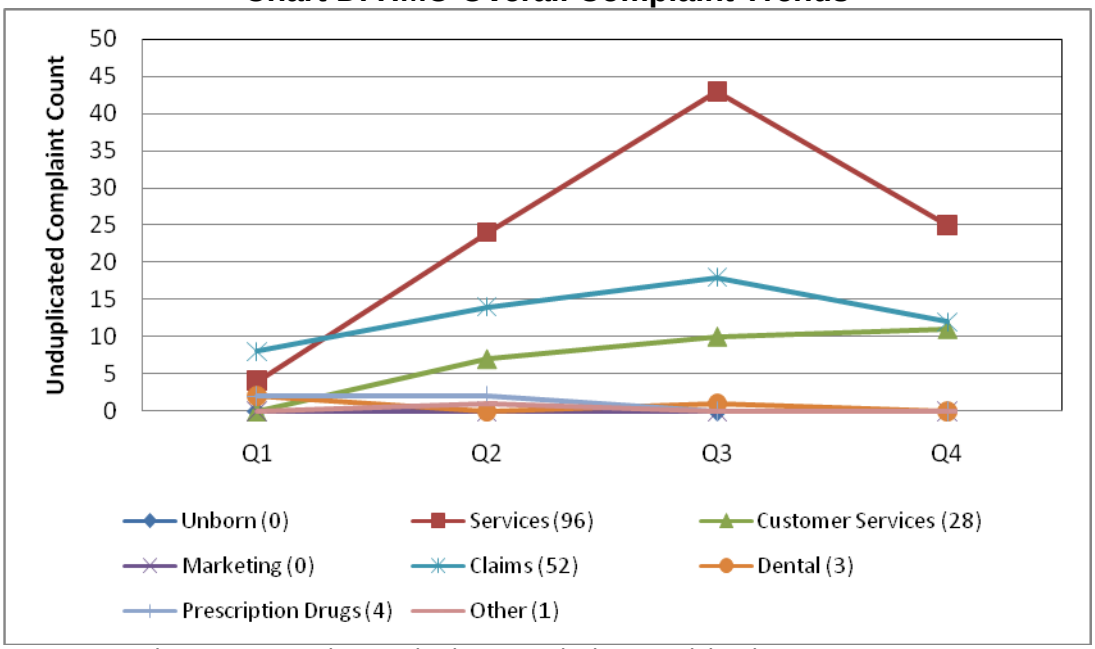


Note: There were no unborn activation, marketing, dental, prescribed drug or "other" complaints in Year Two

Trending reports on HMO and PSN complaints are provided in Charts D and E. In Year Two, there were no marketing complaints or unborn activation processing complaints reported through the complaint database for either HMO or PSN populations, and no dental or prescription drug complaints for the PSN population. In addition, while the

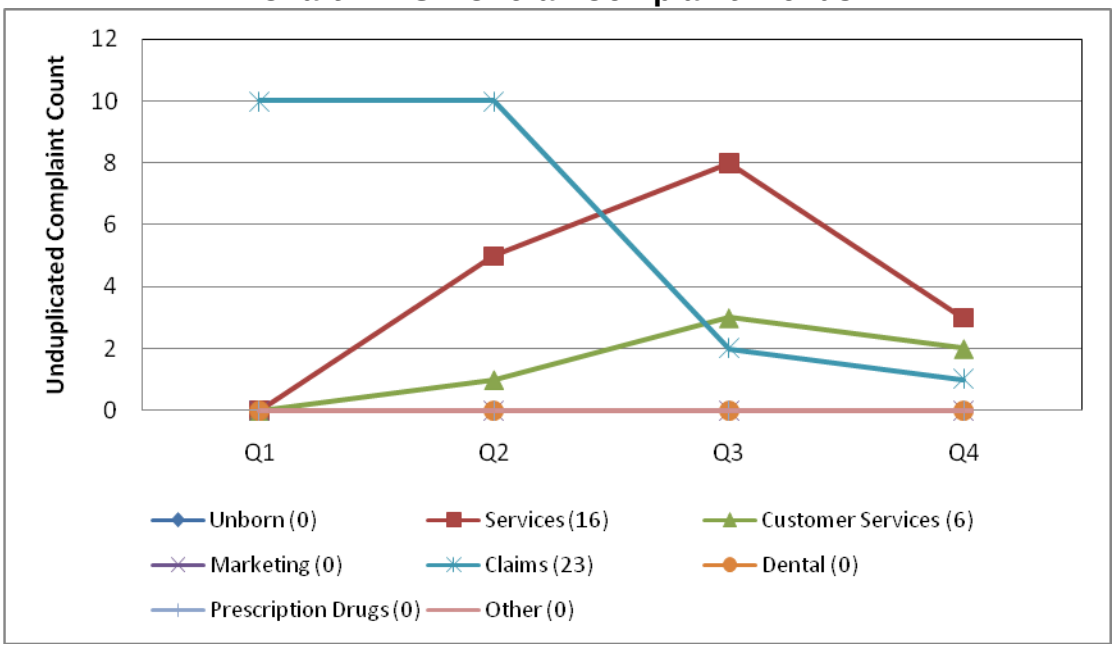
volume of complaints is small, there was a significant drop in the volume of PSN claims processing complaints in Year Two, after implementation of the January 1, 2008 contract amendment that included electronic and paper claims processing time frames and reporting.

Chart D. HMO Overall Complaint Trends



Note: There were no unborn activation or marketing complaints in Year Two

Chart E. PSN Overall Complaint Trends



Note: There were no unborn activation, marketing, dental, prescribed drug or other complaints in Year Two

Lessons Learned and Looking Ahead to Year Three

Year Two saw the creation of the consolidated database that was identified as a Year One lesson learned. The following list outlines the Year Two lessons learned and improvements made to the complaint/issues resolution process along with the next steps for Year Three.

- **Complaint Resolution Updates Shared with Originating Agency Office.** During the feedback sessions held in March 2008, Agency staff requested notification that referred complaints were being worked.

  Action Taken: Database staff revised the system to automatically update the file when an analyst begins the review of the referred complaint. In addition, the Agency is reviewing how it can more quickly update the area offices with the master database information.

- **Real-Time Data Base Needed to Track Complaints/Issues**. The March 2008 feedback meetings with current complaint database users confirmed the need for a database that would allow viewing complaints in real-time. The current database is updated weekly, thus providing a lag time in viewing updates and new actions.

  Action Taken: As part of the Agency's continuous quality improvement efforts, a new team was created and charged with identifying a long-term solution for all managed care complaints and is scheduled to begin in July 2008. The primary focus of the team is to determine the database requirements that will allow for real-time viewing and entry of data, statewide, and that will have appropriate quality controls and reporting.

- **Trend Reports Need Further Analysis.** While the initial trend reports were produced during demonstration Year Two, additional work and resources are needed going forward to ensure that quality controls are applied and the trend reports and data are continually gleaned for their intrinsic value.

  Action Taken: The report functions for the database were consolidated, thus creating a quality controls function in terms of data reported and entered. The Agency has instituted monthly and quarterly review meetings where trend reports can be discussed and reviewed.

- **Improvement Needed in PSN Claims Processing**. Through continued review of complaint/issue data, the Agency determined that PSN providers continue to express concerns with payment delays.

  Action Taken: The Agency amended its current PSN contracts to ensure that claims were authorized and processed within appropriate time frames and that acknowledgement of claims receipt would be provided by the PSN to PSN providers.

- **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: With the ending of the incumbent fiscal agent's contract and resulting transition to a new fiscal agent system effective July 1, 2008, major systems changes had to be held until the new fiscal agent system is stabilized. However, the Agency conducted several meetings to discuss possible FFS PSN claims processing changes in preparation of the new system implementation. The Agency will continue to work towards implementation of needed systems changes.

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

  Action Taken: The Agency amended its health plan contracts to contractually require that health plan formulary information be available on each health plan's website. In addition, the Agency began working with its Choice Counseling vendor to develop a prescribed drug navigation system that would make health plan drug information easily available to the Choice Counselors.

- **Service Authorization, Referrals and Primary Care Provider Availability**. Through the review of complaint/issue data, the Agency determined that service authorization and referrals continued to be issues with some health plan members and providers. Some health plan member service staff lacked clear understanding of the health plan's processes for authorization and referrals, and some health plan members were unclear as to how to contact the health plan for referrals and primary care provider selection and needed assistance in locating health plan providers. In addition, as the transition between Medicaid fiscal agents became closer, the outgoing fiscal agent had some issues with timely enrollment files, thus affecting health plans being able to accurately reflect new members at the start of a month.

  Action Taken: The Agency continued to work 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. In addition, the Agency began a pilot process to monitor plan provider network submissions and access to those providers in November 2007, and instituted that monitoring as an operational function in the spring of 2008. The Agency also continued to work with the outgoing fiscal agent to ensure that timely enrollment files were provided and to work with the health plans to ensure care was timely authorized and that primary care providers were appropriately identified. As the Medicaid system transition is completed, the Agency will continue to work with health plans, beneficiaries and providers to mitigate any transition issues that may occur.

5. On-Site Surveys

Year Two at a Glance and Looking Ahead to Year Three

In the spring and summer of 2007, the Agency performed on-site surveys of all 17 health plans. These surveys gauged compliance with standards set forth in each plan's contract with the Agency and included a review of policies and procedures and information technology systems including claims payments and provider networks. The results of these surveys were all health plans are currently in good standing with the State and there were no sanctions.

The Agency has begun surveying the health plans for 2008. These reviews will focused more on operational issues, and plan employee interviews. Examples of operational issues include: the reviewing of claims payments, listening in on the plan's member services calls, and reviewing of grievance files. These surveys will be completed by the end of calendar year 2008.

B. Choice Counseling Program

Overview

Year Two of the demonstration has shown that Choice Counseling is empowering beneficiaries to actively participate in their health care. Beneficiaries are making decisions about their health plan choices at the highest rate in Florida's history. By selecting the plan that best meets their needs, beneficiaries have greater access to the services they need, which is a fundamental goal of the demonstration.

The Choice Counseling team is the front line for the beneficiary both in the Field and at the Call Center, and Choice Counselors have embraced their role in helping beneficiaries evaluate benefit packages and understand the plan selection process.

A beneficiary voluntarily choosing his or her own health plan also supports another key element of the demonstration, which is a marketplace decision. As beneficiaries choose, the beneficiaries themselves drive the competitive marketplace and as a result, plans are offering more competitive benefit packages to achieve enrollment of Medicaid beneficiaries.

To continually evaluate the effectiveness of the Choice Counseling Program, a Customer Service Survey was implemented in August of 2007. The survey allows the beneficiary to give honest feedback about their experience with the Choice Counseling process. The beneficiaries are utilizing the survey and their responses continue to be very positive. The results from the Customer Service Survey have been an important part in evaluating and improving the Choice Counseling program.

As the Agency continues to improve the Choice Counseling Program, the input from Medicaid beneficiaries, and other interested parties continues to play an important role. 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 Two of the demonstration:

- The highest new eligible self-selection rate (previously referred to as "voluntary enrollment rate") in the history of Florida Medicaid managed care.
- Certified Choice Counselors, ensuring that 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 expanded to serve the medically complex and their families allowing beneficiaries enrolling in managed care to receive the additional assistance their health status requires.
- Successful expansion into Baker, Clay and Nassau Counties by the end of 2007.
- Customer Service Survey, capturing the beneficiaries' feedback about their experiences with Choice Counseling.

- Field Choice Counselor efforts to find and reach beneficiaries that are not responding to mailings, by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These changes resulted in over 30 percent of the enrollments being done at the local level. This enrollment level is significantly higher than the 10 percent estimated for field enrollment prior to implementation.
- A preferred drug search functionality as an option in selecting a health plan (in response to feedback from stakeholders). That research resulted in the development of the ACS Navigator solution (to be implemented in the fall of 2008).

Details on these and other components of the Choice counseling Program are described below.

1. Public Meetings and Beneficiary Feedback

Year Two at a Glance

One of the primary goals of the demonstration is to increase the active participation of Medicaid beneficiaries in their health care. 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. The Agency has held public meetings in the demonstration counties to solicit input on the Choice Counseling Program. As a result of the feedback from previous public meetings, the implementation of a preferred drug search functionality called the Navigator solution is planned for the Choice Counseling Program in the fall of 2008.

Navigator is a Preferred Drug List (PDL) search system. The Navigator system will contain each health plan's PDL and prescribed drug claims data. For those beneficiaries that have prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator will pull their medication data and then provide detailed information on how each plan meets the beneficiaries' current prescribed drug needs. This detail allows the system to provide more information to the beneficiary and does not require that the individual remember their current medications.

The Navigator system also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries that do not have prior claims history. This function will allow the Choice Counselor to provide basic information to the beneficiaries on how each plan could meet their current prescribed drug needs. The Choice Counselor's role will not be counseling beneficiaries on the medications themselves, but stating the results based on their search in the PDL of which health plans covered their medication. This information will allow the beneficiary to be able to select his or her plan more easily, as it will provide more information for selection.

The Agency along with ACS/Navigator team held a public meeting in December 2007 and in January 2008 and presented the system to the health plans. The comments and

questions that were expressed in these forums resulted in the Agency and ACS analyzing how to better display generic drugs in the Navigator system. There were follow up meetings held in Broward in May and in Duval in June of 2008 to demonstrate the system with the updated Navigator panels and counselor talking points (set as a mock call environment). The demonstration was very well received and additional suggestions were made to add important information that can be displayed in the system. The comments from those meetings are posted on the AHCA Agency website: (http://ahca.myflorida.com/Medicaid/medicaid_reform/medrefmeetings.shtml)
The Agency is working with ACS to finalize the panels and the Choice Counselor script in preparation for implementation of Navigator in late September or October 2008.

Beneficiary Customer Survey

Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The survey went live in August of 2007. Between August 2007 through June of 2008, over 6,191 beneficiaries completed the automated survey.

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

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

As stated above, the survey provides for a caller to rank his or her experience in all areas of the call on a scale from 1 through 9. If a recipient scores a category between 1 and 3, the caller has the ability to leave a comment about why they left a low score. The caller also can request a supervisor call back so the beneficiary can provide even more feedback on his or her experience.

Year Two Overview (August 2007- June 2008)

Table 11 contains the average score by month for each question asked in the survey for Year Two of the demonstration.

Table 11 Choice Counseling
Percentage of Delighted Callers for Each Question

How helpful do you find this counseling to be										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
86.4%	91.5%	89.1%	90.6%	89.4%	90.8%	90.8%	88.9%	87.6%	89.8%	88.5%

Satisfaction with the amount of time you waited to speak with a counselor										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
82.2%	85.0%	80.1%	83.4%	80.9%	77.9%	81.8%	82.1%	83.1%	81.6%	80.7%

How easy it was to understand the information										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
64.0%	64.7%	64.8%	67.2%	64.2%	77.0%	81.1%	80.1%	80.5%	77.3%	78.9%

How likely are you to recommend Choice Counseling helpline to friend or relative										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
90.0%	96.1%	94.5%	95.8%	93.9%	94.4%	95.6%	94.1%	94.4%	93.2%	94.7%

Overall service provided by Counselor										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
94.4%	97.9%	96.9%	97.2%	97.4%	96.8%	97.9%	96.0%	96.9%	95.5%	97.1%

How quickly the Counselor understood why you called today										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
94.9%	96.8%	95.9%	96.7%	95.3%	95.9%	97.7%	95.5%	95.4%	95.2%	97.3%

The Counselor's ability to help you choose your health plan										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
91.5%	95.6%	92.4%	93.4%	93.6%	95.0%	97.0%	93.4%	94.2%	92.5%	96.1%

The Counselor's ability to explain things clearly										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
92.9%	96.6%	96.0%	95.6%	96.2%	95.5%	97.7%	95.5%	95.4%	94.5%	96.5%

The confidence you have in the information given to you by the counselor										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
92.5%	95.9%	95.0%	95.2%	94.8%	95.7%	96.8%	95.5%	95.4%	94.6%	94.0%

Satisfaction with being treated respectfully										
Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
96.8%	98.3%	98.0%	96.5%	97.9%	97.9%	99.1%	97.4%	97.2%	97.3%	97.5%

2. Call Center

Year Two at a Glance

The Choice Counseling call center, located in Tallahassee, Florida, operates a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation were adjusted during the second quarter of year two to better align the call center hours with beneficiary demand. The call center hours were adjusted to Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. - 7:00 p.m., thus providing no Saturday hours. The Agency and ACS have continued to closely monitor call volume (both inbound and outbound) and the number of voice mail messages left over the weekends, to maximize access for beneficiaries. The amount of calls and number of voice mails left over weekends over the last 6+ months (reported by ACS) indicates that the current weekday hours of operation are maximizing access for the beneficiaries. The call center has over 32 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

The primary function of the Choice Counseling call center is to handle inbound calls from Medicaid beneficiaries and assist them in the enrollment process. The secondary function is to place calls to beneficiaries in their 30-day choice window, who need to make a health plan choice and have not yet contacted Choice Counseling.

The following are highlights of call center statistics from July 1, 2007 – June 30, 2008:

Total Inbound Calls:	168,078
Average Speed of Answer:	29 sec
Total Abandoned Calls:	3,948
Abandonment Rate:	
(The contract standard is <5% monthly)	2.35%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call answered in < 15 seconds:	73.56%
Call answered in < 60 seconds:	83.29%
Call answered in < 180 seconds:	95.80%
Total Outbound Calls:	51,141

Calls answered in less than 180 seconds have a contract standard of 96%. The 15 and 60 second call rates do not have a contract standard, but are monitored as well because they are indications of customer service provided by the call center. The call center made some improvements in their workforce management during the third quarter of Year Two. Incoming call history was analyzed and high volume call patterns in the call center were tracked. In reviewing that history, the call center was able to implement a call pattern work schedule which allows more FTEs to be answering calls during peak time periods, thus handling more calls with less abandonment, and quicker response times during those key hours of operation.

3. Mail

Year Two at a Glance

In Year Two, the largest volume of mailings compared to Year One came from the new eligible and open enrollment packets. In the summer of 2007, the transition of beneficiaries located in Baker, Clay and Nassau Counties began with the mailing of the required transition materials. The transition of beneficiaries into the expansion counties was completed in December 2007. The following highlights the volume for the largest mailings completed by the mailroom during demonstration Years One and Two. Mailings are grouped by family or case. This means if there are 2 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.

Mail Room Statistics	Year 1	Year 2
New Eligible Packets	66,832	84,696
Transition Mailings	119,002	17,730
Auto-Assignment Letters	49,390	48,147
Confirmation Letters	49,029	57,537
Open Enrollment Packets	2,641	74,412

During Year Two, enrollments completed through the mail consistently remained at 5% (or less) each month. Mail-in enrollments remain significantly lower than the enrollments completed through the call center or by the field counselors.

ACS mailed 28,319 Annual Reminder Notices to those who are exempt from Open Enrollment in two mailings; November 2007 and April/ May 2008, informing beneficiaries (who are exempt from Open Enrollment) that they may change their health plan at any time.

4. Face-to-Face/Outreach and Education

Year Two at a Glance

Looking back over the results of the outreach effort through Year Two brings to light three important points that should be considered:

- Community Partners
- Self Selection Rate
- Minimal Complaints

During the first two years of the demonstration, the Choice Counseling Program has made dedicated efforts to make contact with every community based organization serving Medicaid beneficiaries. This was done in an effort to establish a partnership and a line of communication between the local community and the field staff. Private sessions with mental health and assisted living facilities allowed the Field Choice Counselors to work closely with case managers or family members to help these individuals transition as smoothly as possible.

During Year Two, the self-selection rate increased to an average of 81% (with the highest monthly average of 88% in April 2008). This increase is a direct reflection of the outreach efforts used by the Field Choice Counselors. When the demand for face to face counseling was not as high as expected, Field Counselors began an outbound effort that included both calling and visiting homes of beneficiaries. This resulted in a tremendous increase in enrollments being generated in the field which in turn caused the increase in the self-selection rate. For the first time in Florida, Medicaid beneficiaries who didn't understand his or her enrollment packet enough to make the call to Choice Counseling had someone in their local community reaching out to them personally to help them to make an educated plan choice.

Another innovation utilized by outreach that affected the self-selection rate was the development of a flyer entitled *"You've Applied for Medicaid - What's Next"*. The flyer is targeted to Medicaid applicants and is distributed by the Florida Department of Children and Families and Social Security as well as various community organizations that provide eligibility determination assistance. This flyer has a colored picture of the enrollment envelope and informs the beneficiary that if determined eligible for Medicaid, he or she will be receiving the Choice Counseling materials in the mail and is required to make a plan choice within 30 days. This notification has caused a higher initial response rate, which has in turn increased the self-selection rate.

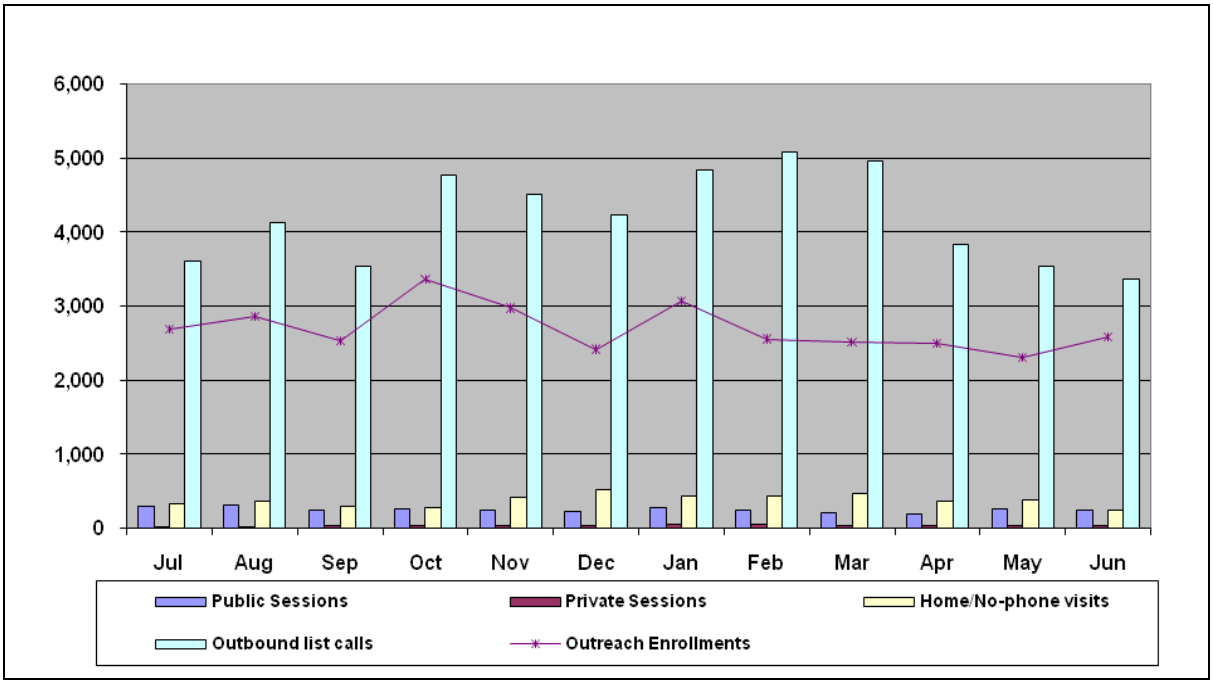
The minimal number of complaints received has been the result of several factors. ACS and AHCA's commitment to resolving issues in a timely fashion made the greatest impact. The efforts of the program to provide choice counseling and enrollment broker services have expanded within the demonstration counties to include education and support to various organizations and community groups and the beneficiaries they serve. The Field Choice Counselors have developed a reputation as being knowledgeable, compassionate and dedicated among the partners that have been established.

Table 12 lists the type and volume of Field Choice Counselor activities during Year Two of the demonstration.

Table 12
Choice Counseling Outreach Activity
July 2007 – June 2008

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Public Sessions	288	314	249	265	249	227	277	244	216	184	253	235	**3,001**
Private Sessions	14	21	29	39	40	26	52	48	38	31	35	27	**400**
Home/No-phone visits	333	357	290	285	409	523	427	432	466	366	373	250	**4,511**
Outbound list calls	3,613	4,124	3,535	4,769	4,516	4,230	4,830	5,078	4,954	3,826	3,531	3,369	**50,375**
Outreach Enrollments	2,693	2,863	2,534	3,363	2,977	2,425	3,072	2,563	2,518	2,506	2,314	2,582	**32,410**

Chart F. Choice Counseling Outreach Activities
July 2007 – June 2008



5. Health Literacy

Year Two at a Glance

The Choice Counseling Program provides information and education on what it means to be in a managed care plan, and how to decide what plan is best for individual families. The staff also provides information on the Enhanced Benefits Program. As the Choice Counseling Program staff describe enhanced benefits to the beneficiary, the counselor discusses how engaging in healthy behaviors will improve overall health and earn credits which can be used to purchase specific over the counter items that help his or her families.

The Choice Counseling Program's Special Needs Unit continues to address health disparities and health literacy. This unit has primary responsibility for the health literacy function and continues to be a very important part of the Choice Counseling Program. In December 2007, a new registered nurse (RN) supervisor was hired, earned her certification in the Choice Counseling process, and began her duties in the Special Needs Unit with ACS. The RN supervisor was able to build on lessons learned from the first nurse employed by the Special Needs Unit to improve assistance provided to beneficiaries as well as strengthening training provided to the Choice Counselors. The RN supervisor developed and implemented training for the Choice Counselors which outlines how the Special Needs Unit works and how (and when) to refer beneficiaries to the unit for help. In March 2008, a licensed practical nurse (LPN) was hired to work in

the Special Needs Unit. The LPN completed her Choice Counseling certification course in April 2008, and is an active part of the Special Needs Unit.

The staffing goal of the unit, after a previous evaluation (performed in 2007), is to staff the Special Needs Unit with one RN supervisor, two LPNs and one social worker, with additional nurses being hired for the field in the near future.

In addition to restructuring of the Special Needs Unit, the scope of work for the unit was expanded to include:

- Development of additional training for the Choice Counselors' on working with and serving the medically, mentally or physically complex;
- Enhancement of the scripts to educate beneficiaries on how to access care in a managed care environment;
- Development of reference guides to increase the Choice Counselors knowledge of Medicaid services, and information about diseases; and
- Participation in the development of the Navigator PDL section of the Choice Counseling script.

6. New Eligible Self-Selection Data

Year Two at a Glance

During demonstration Year Two, the Agency revised the terminology used for describing voluntary enrollment data to improve clarity and understanding of how the demonstration is working. In the Medicaid Reform program, the term "voluntary" has been used to refer to both beneficiaries who can voluntarily participate in the demonstration and also to beneficiaries who voluntarily chose his or her own health plan. To avoid multiple uses of a single term, the Agency changed the terminology used when referring to beneficiaries who are making their own plan selection. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate",* it is now referred to as *"New Eligible Self-Selection Rate"*. The term *"self-selection"* is used to refer to beneficiaries who choose their own plan and the term *"assigned"* will be used for beneficiaries who do not choose their own plan.

The Choice Counseling Program is effectively empowering beneficiaries as demonstrated by the new eligible self-selection rate (previously referred to as voluntary enrollment rate). The Agency requires that a minimum of 65% of the new eligibles make a voluntary health plan choice. Beginning in demonstration Year Three, this requirement increases to 80%.

In Year Two, the lowest self-selection rate average was 74% and the highest was 88%. ACS did consistently achieve self-selection rates above the 65% contract standard.

7. Complaints/Issues

Year Two 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 Year Two, 27 complaints were received regarding the Choice Counseling Program. The majority of complaints received by the Choice Counseling Program related to beneficiaries not having access to the plans preferred drug list information. As stated earlier, the Agency researched the possibilities to add a PDL search functionality to the Choice Counseling process and is preparing to implement the Navigator PDL search system in October 2008. The complaints and actions taken to resolve the complaints were summarized in the quarterly reports.

8. Quality Improvement

Year Two at a Glance

A key component of the Choice Counseling Program is a continuous quality improvement effort. Quality improvement ideas currently come from several sources: the customer service survey (listening to beneficiary comments), quality monitoring of the phone and Field Choice Counselors, feedback from public meetings, beneficiary focus groups and choice counselor focus groups. These forums allow the Agency to hear from beneficiaries and counselors on the successes and complaints, as well as receive ideas for improvement for the Choice Counseling Program.

The major change in the Field Choice Counseling activities was the implementation of Quality Assurance Monitoring of the Field Choice Counselors. During demonstration Year One, the Field Choice Counseling supervisors conducted most of the Field monitoring done by ACS. In late September of 2007, the quality monitoring staff, located in Tallahassee, began calling at random beneficiaries who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 13 shows the beneficiaries' responses (in percentages) from 420 beneficiaries randomly called who participated in the survey (from October 1, 2007 through June, 30 2008). The same percentage range used in the call center is used in the field, with 100% being a perfect score.

Table 13
Field Choice Counseling – Monitoring Results
(October 2007 – June 2008)

Able to complete enrollment/plan change at the session	96.35%
Felt the information provided by the Choice Counselor helped them make an informed decision	93.88%
The information was explained in a way that made it easy to understand	97.81%
The Choice Counselor was friendly/courteous	98.44%

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 as part of their daily work. An anonymous email box allows Choice Counselors to immediately send information that is reviewed by management.

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 and meetings.

Lessons Learned and Looking Ahead to Year Three

During Year Two, the Choice Counseling Program identified the following areas for improvement. A description of the lessons learned and steps to be taken in the upcoming year are provided below.

- Navigator PDL Implementation
- Customer Service Survey
- Script Enhancement
- Special Needs Unit
- Mail-in Enrollments

Navigator: The ability of a beneficiary to select a health plan based on whether a plan can cover his or her medications was a big need brought to the Agency's attention by interested parties. The Agency and ACS held public meetings to obtain feedback and to find an effective solution. As a result of the feedback, the Agency began researching the Navigator PDL system and presented the system to the public for feedback. Modifications to the system were made based on input from the public. During Year Three of the demonstration, the Navigator PDL system will be finalized (both script and panels), and then after implementation, the Agency will hold additional public meetings for further comments and suggestions.

Customer Service Survey: The received feedback from the beneficiary remained a big issue in Year Two. The implementation of the customer service survey has helped keep a pulse on what the beneficiary thinks of the Choice Counseling process both at the call center and in the field. The goal for demonstration Year Three is to revisit the questions on the survey and target some additional areas in which to get beneficiary feedback such as: possible materials changes, incorporating the Field Choice Counselors in the automated survey for the beneficiaries, and possible script enhancements as needed.

Script effectiveness: The Choice Counselors phone script is another area that continues to be improved. This is an ongoing work in progress as the Agency and ACS

monitor calls, and receive feedback from counselors and trainers on what language works and what can be improved to make the beneficiaries' experience and understanding better. The component that includes the Navigator PDL choice piece will be added and tested and ACS and the Agency will continue to monitor and evaluate the effectiveness of the script (in part and as a whole), making changes as needed.

Special Needs Unit: Another area that was discussed during Year Two for inclusion in Year Three activities, 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 health information would be a big step in reducing health disparities. This strategy will be explored and developed during Year Three of the demonstration as the Special Needs Unit continues to be defined and developed.

Mail-In Enrollment: The Agency and ACS are discussing 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. In Year Three, as these options are reviewed, there will be opportunity to present these ideas to the public for their input as decisions are made regarding whether this remains a viable option for enrollment.

C. Enrollment Data

Overview

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

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

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

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

Prior to the start of demonstration Year Two, the Agency developed another transition plan for the 3 expansion counties: Baker, Clay and Nassau. This plan was designed to enroll the existing Medicaid managed care population located in the 3 expansion counties into Reform health plans. Due to the smaller Medicaid populations located in these counties, the transition plan was implemented over a 4 month period with transitions beginning in September 2007 and ending in December 2007. As in Year One of the demonstration, this process was implemented to stagger the enrollment of beneficiaries into the demonstration. As before, the beneficiaries were transitioned from

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

HMOs, MediPass, and MPNs. The transition schedule for Baker, Clay and Nassau Counties was as follows:

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

Table 14 contains the quarterly enrollment for each health plan during Year Two of the demonstration, and shows how enrollment in the demonstration increased over this time period. The quarterly enrollment for each of the HMOs is displayed in Chart G, and Chart H shows the quarterly enrollment for each of the PSNs.

Table 14
Quarterly Medicaid Reform Enrollment by Plan
July 2007 – June 2008

Plan Name	Plan Type	Number of Enrollees by Quarter – Year 2			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Amerigroup	HMO	12,117	13,242	14,142	14,915
Buena Vista	HMO	6,960	6,929	6,802	6,816
Freedom	HMO	0	44	172	255
HealthEase	HMO	55,972	55,382	54,923	55,553
Humana	HMO	11,016	10,825	10,654	10,745
Preferred Medical Plan	HMO	2,147	2,034	1,938	1,876
StayWell	HMO	33,222	34,396	34,904	36,108
Total Health Choice	HMO	1,546	1,642	1,858	2,031
United Healthcare	HMO	16,992	22,129	25,492	28,736
Universal Healthcare	HMO	252	182	559	837
Vista South Florida	HMO	3,552	4,477	5,139	6,089
HMO Totals		**143,776**	**151,282**	**156,583**	**163,961**
Access Health Solutions	PSN	11,436	19,143	18,928	18,609
CMS	PSN	3,482	3,732	3,931	4,191
First Coast Advantage	PSN	16,479	16,408	16,389	16,525
Netpass	PSN	4,841	4,672	4,501	4,255
Pediatric Associates	PSN	10,276	10,179	10,342	10,239
South FL Community Care Network	PSN	7,150	6,779	6,425	6,272
PSN Totals		**53,664**	**60,913**	**60,516**	**60,091**
Medicaid Reform Totals		**197,440**	**212,195**	**217,099**	**224,052**

Chart G.
Quarterly Medicaid Reform Enrollment for HMOs
July 2007 – June 2008

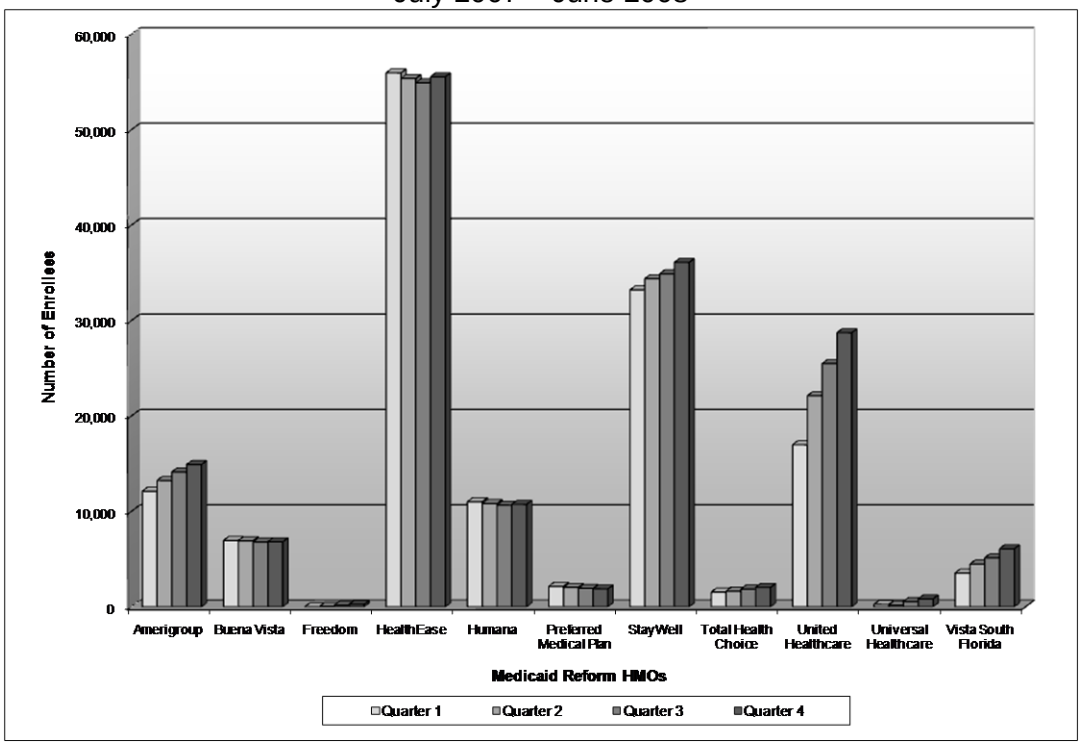
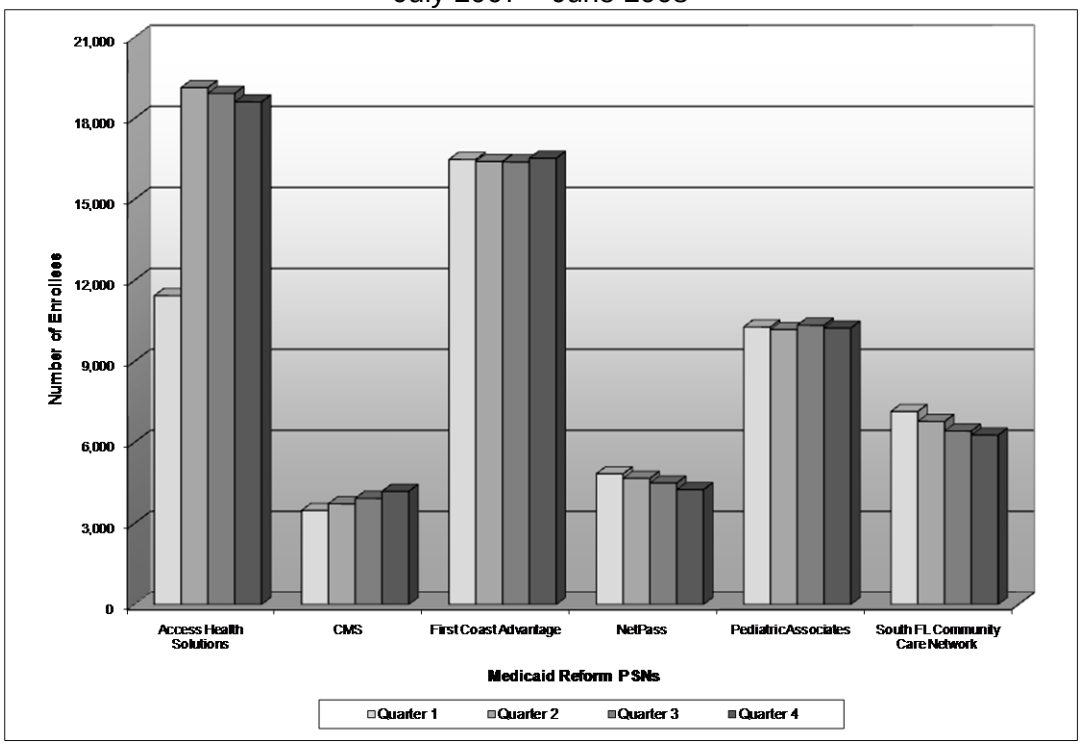


Chart H.
Quarterly Medicaid Reform Enrollment for PSNs
July 2007 – June 2008



Year Two at a Glance

Monthly Enrollment Reports – Year Two

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

Below is a summary of the annual enrollment in the demonstration for Year Two, July 1, 2007 - June 30, 2008. This section contains the following enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- Medicaid Reform Voluntary Population Enrollment Report
- Summary of Self-Selections, Assignments, and Disenrollment Data

All health plans located in the 5 demonstration counties are included in each of the reports. During Year Two, there were a total of 17 health plans – 11 HMOs and 6 FFS PSNs. There are 2 categories of Medicaid beneficiaries who are enrolled in health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment report for demonstration Year Two and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The annual Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the demonstration for the waiver being reported. Table 15 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 15
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 health plan at any time beginning July 1, 2007 and ending June 30, 2008. Please refer to Table 16 for the annual Medicaid Reform Enrollment report for Year Two of the demonstration (July 1, 2007 – June 30, 2008).

Table 16
Medicaid Reform Enrollment Report
July 1, 2007 through June 30, 2008

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	16,711	1,882	4	239	**18,836**	**6.56%**	12,809	47.05%
Buena Vista	HMO	8,138	795	5	92	**9030**	**3.15%**	7916	14.07%
Freedom Health Plan	HMO	234	44	0	6	**284**	**0.10%**	0	N/A
HealthEase	HMO	64,364	6,306	11	793	**71,474**	**24.90%**	63,516	12.53%
Humana	HMO	11,454	2,242	11	350	**14,057**	**4.90%**	12,939	8.64%
Preferred Medical Plan	HMO	2,100	548	1	70	**2,719**	**0.95%**	2,671	1.80%
StayWell	HMO	41,725	3,679	12	473	**45,889**	**15.99%**	34,453	33.19%
Total Health Choice	HMO	2,318	441	4	58	**2,821**	**0.98%**	1,788	57.77%
United Health Care	HMO	32,082	3,695	11	664	**36,452**	**12.70%**	17,635	106.70%
Universal Health Care	HMO	851	134	1	13	**999**	**0.35%**	356	180.62%
Vista South Florida	HMO	6780	586	8	102	**7,476**	**2.60%**	3,662	104.15%
HMO Totals		186,757	20,352	68	2,860	**210,037**	**73.18%**	157,745	33.15%
Access Health Solutions	PSN	20,347	3,478	7	231	**24,063**	**8.38%**	15,101	59.35%
CMS	PSN	2,355	2,475	0	21	**4,851**	**1.69%**	3,490	39.00%
First Coast Advantage	PSN	16,380	3,911	6	358	**20,655**	**7.20%**	18,775	10.01%
NetPass	PSN	3,855	1,652	2	187	**5,696**	**1.98%**	6,660	-14.47%
Pediatric Associates	PSN	12,763	640	0	2	**13,405**	**4.67%**	14,320	-6.39%
South FL Community Care Network	PSN	5,691	2,373	3	241	**8,308**	**2.89%**	9,490	-12.46%
PSN Totals		61,391	14,529	18	1,040	**76,978**	**26.82%**	67,836	13.48%
Reform Enrollment Totals		**248,148**	**34,881**	**86**	**3,900**	**287,015**	**100.00%**	**225,581**	**27.23%**

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

The enrollment figures for demonstration Year Two reflect those beneficiaries who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from Non-Reform health plans to Reform health plans. There were a total of 287,015 beneficiaries enrolled in the demonstration during Year Two. There were 17 health plans with market shares ranging from 0.10 percent to 24.90 percent.

2. Medicaid Reform Enrollment by County Report

During demonstration Year Two, Medicaid Reform was operational in 5 counties: Baker, Broward, Clay, Duval and Nassau. The number of HMOs and PSNs operating in each county is listed in Table 17.

Table 17
Number of Reform Health Plans in Demonstration Counties

County Name	Number of Reform HMOs	Number of Reform PSNs
Baker	**1**	**1**
Broward	**11**	**5**
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down further by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 18 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 18
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
# 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 in Table 19 and located on the following page.

Table 19
Medicaid Reform Enrollment by County Report
July 2007 through June 2008

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Year	% Increase from Prev. Year
				No Medicare	Medicare Part B	Medicare Parts A & B				
United Healthcare	HMO	Baker	757	103	0	9	**869**	**29.47%**	0	N/A
Access Health Solutions	PSN	Baker	1,869	199	0	12	**2,080**	**70.53%**	0	N/A
Total Reform Enrollment for Baker			**2,626**	**302**	**0**	**21**	**2,949**	**100.00%**	**0**	**N/A**
Amerigroup	HMO	Broward	16,711	1,882	4	239	**18,836**	**11.49%**	12,809	47.05%
Freedom Health Plan	HMO	Broward	234	44	0	6	**284**	**5.51%**	0	N/A
Buena Vista	HMO	Broward	8,138	795	5	92	**9,030**	**0.17%**	7,916	14.07%
HealthEase	HMO	Broward	19,011	1,863	10	219	**21,103**	**12.87%**	17,742	18.94%
Humana	HMO	Broward	11,454	2,242	11	350	**14,057**	**8.57%**	12,939	8.64%
Preferred Medical Plan	HMO	Broward	2,100	548	1	70	**2,719**	**1.66%**	2,671	1.80%
StayWell	HMO	Broward	37,583	3,190	12	387	**41,172**	**25.10%**	31,597	30.30%
Total Health Choice	HMO	Broward	2,318	441	4	58	**2,821**	**1.72%**	1,788	57.77%
United Health Care	HMO	Broward	10,210	1,456	8	310	**11,984**	**7.31%**	7,468	60.47%
Universal Health Care	HMO	Broward	238	57	1	5	**301**	**0.18%**	159	89.31%
Vista South Florida	HMO	Broward	6,780	586	8	102	**7,476**	**4.56%**	3,662	104.15%
Access Health Solutions	PSN	Broward	2,927	960	4	75	**3,966**	**2.42%**	5,595	-29.12%
CMS North Broward	PSN	Broward	906	1,166	0	12	**2,084**	**1.27%**	1,666	25.09%
CMS South Broward	PSN	Broward	361	397	0	5	**763**	**0.47%**	597	27.81%
Netpass	PSN	Broward	3,855	1,652	2	187	**5,696**	**3.47%**	6,660	-14.47%
Pediatric Associates	PSN	Broward	12,763	640	0	2	**13,405**	**8.17%**	14,320	-6.39%
South FL Community Care Network	PSN	Broward	5,691	2,373	3	241	**8,308**	**5.07%**	9,490	-12.46%
Total Reform Enrollment for Broward			**141,280**	**20,292**	**73**	**2,360**	**164,005**	**100.00%**	**137,079**	**19.64%**
United Healthcare	HMO	Clay	3,839	301	1	40	**4,181**	**38.35%**	0	N/A
Access Health Solutions	PSN	Clay	5,903	777	0	42	**6,722**	**61.65%**	0	N/A
Total Reform Enrollment for Clay			**9,742**	**1,078**	**1**	**82**	**10,903**	**100.00%**	**0**	**N/A**
HealthEase	HMO	Duval	45,353	4,443	1	574	**50,371**	**48.12%**	45,774	10.04%
StayWell	HMO	Duval	4,142	489	0	86	**4,717**	**4.51%**	2,856	65.16%
United Health Care	HMO	Duval	15,920	1,637	2	280	**17,839**	**17.04%**	10,167	75.46%
Universal Health Care	HMO	Duval	613	77	0	8	**698**	**0.67%**	197	254.31%
Access Health Solutions	PSN	Duval	7,047	1,251	2	95	**8,395**	**8.02%**	9,506	-11.69%
CMS	PSN	Duval	1,088	912	0	4	**2,004**	**1.91%**	1,227	63.33%
First Coast Advantage	PSN	Duval	16,380	3,911	6	358	**20,655**	**19.73%**	18,772	10.01%
Total Reform Enrollment for Duval			**90,543**	**12,720**	**11**	**1,405**	**104,679**	**100.00%**	**88,502**	**18.28%**
United Healthcare	HMO	Nassau	1,356	198	0	25	**1,579**	**35.25%**	0	N/A
Access Health Solutions	PSN	Nassau	2,601	291	1	7	**2,900**	**64.75%**	0	N/A
Total Reform Enrollment for Nassau			**3,957**	**489**	**1**	**32**	**4,479**	**100.00%**	**0**	**N/A**
Reform Enrollment Totals			**248,148**	**34,881**	**86**	**3,900**	**287,015**		**225,581**	**27.23%**

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 in which he plans operate.

During Year Two of the demonstration, there was an enrollment of 2,949 beneficiaries in Baker County, 164,005 beneficiaries in Broward County, 10,903 beneficiaries in Clay County, 104,679 beneficiaries in Duval County, and 4,479 beneficiaries in Nassau

County. There were two Baker County Reform plans with market shares ranging from 29.47 % to 70.53 %, 17 Broward County Reform plans with market shares ranging from 0.17 % to 25.10 %, two Clay County Reform plans with market shares ranging from 38.35 % to 61.65 %, seven Duval County Reform plans with market shares ranging from 0.67 % to 48.12 %, and two Nassau County Reform plans with market shares ranging from 35.25 % to 64.75 %.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 20 and 21 may choose to enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who 1chose to enroll in a health plan during Year Two of the demonstration. Table 20 provides a description of each column in this report.

Table 20
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 21 on the following page lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 21
Medicaid Reform Voluntary Population Report
July 2007 through June 2008

Plan Name	Plan Type	Plan County	Reform Voluntary Populations – Year 2								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	2	109	0	26	16	227	380	1.77%	18,836
Buena Vista	HMO	Broward	1	40	0	9	7	90	147	1.09%	9,030
Freedom Health Plan	HMO	Broward	0	1	0	0	0	6	7	1.62%	284
Healthease	HMO	Broward	3	176	0	33	16	213	441	1.67%	21,103
Healthease	HMO	Duval	6	668	0	63	28	547	1,312	2.33%	50,371
Humana	HMO	Broward	3	91	0	29	22	339	484	2.66%	14,057
Preferred Medical Plan	HMO	Broward	0	21	0	6	5	66	98	2.85%	2,719
Staywell	HMO	Broward	6	286	0	61	21	378	752	1.40%	41,172
Staywell	HMO	Duval	1	58	0	6	6	80	151	2.80%	4,717
Total Health Choice	HMO	Broward	1	14	0	3	2	60	80	2.55%	2,821
United Healthcare	HMO	Baker	0	14	0	0	0	9	23	1.68%	869
United Healthcare	HMO	Broward	3	96	1	33	22	296	451	3.08%	11,984
United Healthcare	HMO	Clay	0	35	0	7	9	32	83	1.33%	4,181
United Healthcare	HMO	Duval	7	226	0	29	24	258	544	2.80%	17,839
United Healthcare	HMO	Nassau	2	17	0	1	4	21	45	2.65%	1,579
Universal	HMO	Broward	0	1	0	0	0	6	7	0.48%	301
Universal	HMO	Duval	1	8	0	0	1	7	17	1.56%	698
Vista South Florida	HMO	Broward	0	65	0	21	5	105	196	2.18%	7,476
HMO Total	**HMO**		**36**	**1,926**	**1**	**327**	**188**	**2,740**	**5,218**	**2.48%**	**210,037**
Access Health Solutions	PSN	Baker	0	7	0	1	2	10	20	0.45%	2,080
Access Health Solutions	PSN	Broward	0	23	0	13	3	76	115	2.41%	3,966
Access Health Solutions	PSN	Clay	2	32	2	9	4	38	87	0.78%	6,722
Access Health Solutions	PSN	Duval	3	82	1	14	5	92	197	2.05%	8,395
Access Health Solutions	PSN	Nassau	0	19	0	1	0	8	28	0.43%	2,900
CMS	PSN	Broward	1	36	0	152	0	17	226	7.94%	2,847
CMS	PSN	Duval	1	43	1	47	0	4	96	4.88%	2,004
First Coast Advantage	PSN	Duval	3	171	0	76	19	345	614	2.65%	20,655
NetPass	PSN	Broward	1	36	1	31	4	185	258	3.78%	5,696
Pediatric Associates	PSN	Broward	2	105	0	21	0	2	130	0.87%	13,405
SFCCN	PSN	Broward	1	135	1	38	13	231	419	4.67%	8,308
PSN Total	**PSN**		**14**	**689**	**6**	**403**	**50**	**1,008**	**2,170**	**2.82%**	**76,978**
Reform Enrollment Totals			**50**	**2,615**	**7**	**730**	**238**	**3,748**	**7,388**	**2.57%**	**287,015**
				2,665		**737**		**3,986**			

4. Summary of Self-Selections, Assignments, and Disenrollment Data

The Summary of Self-Selections, Assignments, and Disenrollment Data report lists the number of beneficiaries who were enrolled (either by self-selection or by assignment) with a plan at some point during Year Two of the demonstration, as well as those who were disenrolled during the same time period. Table 22 provides a description of each column in this report.

Table 22
Summary of Self-Selections, Assignments, and Disenrollment Data Report
Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# Self-Selections	The number of unique beneficiaries who chose to enroll with the plan during the current reporting quarter
# Assigned	The number of unique beneficiaries who were assigned to the plan during the current reporting quarter
Total # Enrolled	The total number of unique beneficiaries who were enrolled with the plan during the current reporting quarter: self-selection and assigned to a plan combined
% Self-Selections	The percentage of the total number of beneficiaries who chose to enroll with the plan during the current reporting quarter
# Disenrolled	The number of unique beneficiaries who disenrolled from the plan during the current reporting quarter

There are two primary classes of Medicaid beneficiaries reported: those who have enrolled in Medicaid Reform and those who disenrolled from the program during Year Two of the demonstration.

A. Medicaid Reform Enrollees

There are two ways a beneficiary can enroll in a health plan: by choosing the plan themselves or by being assigned to a plan. Self-selections include newly-eligible beneficiaries who chose 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 the demonstration began are included in the self-selection counts. Assigned enrollments include newly-eligible beneficiaries who have not made a choice and were assigned to a health plan.

B. Medicaid Reform Disenrollees

A Medicaid Reform disenrollee is defined as a beneficiary who was enrolled in the demonstration at some point during the current reporting year but then left the demonstration program. The count is performed by comparing 2 beneficiary lists: 1 for the current reporting year and 1 for the first month after the current reporting year. If a beneficiary appears on the current reporting year enrollment list, but not on the enrollment list for the first month following the current reporting year, the beneficiary is counted as disenrolled. Disenrollments for Year Two of the demonstration are those beneficiaries who appear on the enrollment list for July 2007 to June 2008, but not on the enrollment list for July 2008.

The unique beneficiary counts in the Summary of Self-Selections, Assignments, and Disenrollment Data report are shown in Table 23. Plans are listed by plan type (HMO

first, then PSN) and in alphabetical order by county. Total counts for the year are also provided for HMOs and PSNs as well as the entire demonstration program.

Table 23
Summary Self-Selections*, Assignments, and Disenrollment Data
July 2007 through June 2008

Plan Name	Plan Type	Plan County	# Self-Selections	# Assigned	Total # Enrolled	% Self-Selections	# Disenrolled
Amerigroup	HMO	Broward	17,410	1,426	**18,836**	**92%**	7,577
Buena Vista	HMO	Broward	8,294	736	**9,030**	**92%**	2,877
Freedom Health Plan	HMO	Broward	98	186	**284**	**35%**	267
HealthEase	HMO	Broward	19,432	1,671	**21,103**	**92%**	6,762
HealthEase	HMO	Duval	47,306	3,065	**50,371**	**94%**	15,081
Humana	HMO	Broward	12,864	1,193	**14,057**	**92%**	4,185
Preferred Medical Plan	HMO	Broward	1,951	768	**2,719**	**72%**	976
StayWell	HMO	Broward	38,871	2,301	**41,172**	**94%**	14,351
StayWell	HMO	Duval	3,002	1,715	**4,717**	**64%**	2,283
Total Health Choice	HMO	Broward	1,989	832	**2,821**	**71%**	1,564
United Health Care	HMO	Baker	675	194	**869**	**78%**	852
United Health Care	HMO	Broward	10,901	1,083	**11,984**	**91%**	5,677
United Health Care	HMO	Clay	3,750	431	**4,181**	**90%**	4,035
United Health Care	HMO	Duval	15,519	2,320	**17,839**	**87%**	9,404
United Health Care	HMO	Nassau	1,445	134	**1,579**	**92%**	1,532
Universal Health Care	HMO	Broward	138	163	**301**	**46%**	208
Universal Health Care	HMO	Duval	149	549	**698**	**21%**	539
Vista South Florida	HMO	Broward	6,882	594	**7,476**	**92%**	4,130
HMO Total			**190,676**	**19,361**	**210,037**	**91%**	**82,300**
Access Health Solutions	PSN	Baker	1,933	147	**2,080**	**93%**	2,055
Access Health Solutions	PSN	Broward	3,289	677	**3,966**	**83%**	732
Access Health Solutions	PSN	Clay	6,080	642	**6,722**	**90%**	6,655
Access Health Solutions	PSN	Duval	6,354	2,041	**8,395**	**76%**	2,378
Access Health Solutions	PSN	Nassau	2,633	267	**2,900**	**91%**	2,875
CMS	PSN	Broward	2,847	0	**2,847**	**100%**	731
CMS	PSN	Duval	2,004	0	**2,004**	**100%**	627
First Coast Advantage	PSN	Duval	18,305	2,350	**20,655**	**89%**	5,638
Netpass	PSN	Broward	4,946	750	**5,696**	**87%**	1,354
Pediatric Associates	PSN	Broward	12,831	574	**13,405**	**96%**	4,143
South FL Community Care Network	PSN	Broward	6,842	1,466	**8,308**	**82%**	2,115
PSN Total			**68,064**	**8,914**	**76,978**	**88%**	**29,303**
Reform Enrollment Totals			**258,740**	**28,275**	**287,015**	**90%**	**111,603**

* Self-selection totals include newly-eligible beneficiaries who chose which plan to enroll in, as well as beneficiaries who chose to stay in the health plan they were transitioned into.

During demonstration Year Two, there were 258,740 self-selections (90 percent). Of those, 190,676 beneficiaries were enrolled in an HMO and 68,064 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 the 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 he or she 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 Two at a Glance

During Year Two of the demonstration, the Agency contacted HMS on a regular basis 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.

An Invitation to Negotiate was released during the third quarter of Year Two on January 22, 2008 for Third Party Liability Recovery Services that included the Opt Out Program. The current Opt Out contract with HMS will expire on October 31, 2008. The Agency plans to contract with one Vendor for Third Party Liability Recovery Services and the Opt Out Program beginning November 1, 2008.

Opt Out Program Statistics

- 42 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 19 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.

A description of the Opt Out enrollees is provided below.

1. The caller was enrolled in the Opt Out Program during the second quarter of Year One with a coverage effective date of October 1, 2006. The individual lost her job during the third quarter of Year One 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 of Year One. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter of Year One.

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 of Year One. The effective date for enrollment was during the third quarter of Year One 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. The four children's Medicaid eligibility ended and they were subsequently disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One 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. The mother disenrolled from her employer's health insurance plan. Therefore, the two children were disenrolled from the Opt Out Program. The mother has subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Year Two on January 1, 2008 (Item Number 11).
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One 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. One of the children's Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program.
6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's

Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

8. The caller began the process to enroll her three children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her three children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
9. The caller began the process to enroll her two children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 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.
10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 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.
11. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. 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. Both children's Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.
12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. 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. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child remained Medicaid eligible and is still enrolled in the Opt Out Program. The disenrolled child became Medicaid eligible again during the fourth quarter of Year Two and subsequently re-enrolled in the Opt Out Program effective May 1, 2008 (Item Number 26).
13. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

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

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

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

17. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

18. The caller began the process to enroll his two children during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

19. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

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

22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

23. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

25. The caller began the process to enroll during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job during the fourth quarter of Year Two. As a result, the individual has been disenrolled from the Opt Out Program.

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

Table 24 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2008. Current Opt Out enrollment, as of June 30, 2008, is 23.

Table 24 Opt Out Statistics September 1, 2006 –June 30, 2008						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Single	1	02/28/07	Loss of Employment
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	3	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	Still Enrolled 02/29/08	N/A Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	N/A	N/A
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	2	N/A	N/A
C & F	04/01/08	Large Employer	Single	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	05/01/08	Large Employer	Family	1	05/31/08	Loss of Employment
C & F	05/01/08	Large Employer	Family	1	N/A	N/A

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

E. Enhanced Benefits Program

Overview

The Enhanced Benefits Account Program (EBAP) component of the demonstration 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 demonstration counties.

One of the major goals of the demonstration is to increase access to care and to improve health outcomes for Medicaid beneficiaries. The EBAP attempts to accomplish 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 Reform health plan are eligible for this program. No separate application or process is required prior to participation.

Beneficiaries enrolled in a 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 state fiscal year so the beneficiary does not lose unused credits at the end of the state fiscal year.

Year Two accomplishments for the Enhanced Benefit Program include:

- Public meetings dedicated to raising awareness and usage of Enhanced Benefits by making the following improvements:
    - More user friendly OTC products list.
    - New monthly insert which advertises healthy behavior themes and OTC products related to the theme.

  Several improvements were identified in Year Two to be implemented in Year Three including:
    - New statement with a coupon.
    - New program name (Enhanced Benefit Reward$ Program).
    - Creation of new Welcome Packet about EBA.
    - Streamlined FAQ for the EB Call Center.

- Increased purchases of health-related products from a total of $113,172.35 in Year One to a total of $2,545,961.16 in Year Two.
- Successful implementation of administrative components of EBA with the new fiscal agent EDS and PDCS vendor First Health.
- Identified changes to the healthy behaviors that beneficiaries could engage in to earn credits to better align the healthy behaviors with the goal of the enhanced benefits program.

Administration of the Enhanced Benefits Accounts

The Enhanced Benefits Accounts Program is administered through 2 separate systems, the Enhanced Benefits Information System (EBIS) and the Pharmacy Point of Sale System. The EBIS acts as a data repository that houses healthy behavior activity information of beneficiaries (as reported by their reform plans), Enhanced Benefit Account (EBA) purchases (as recorded in the Agency's Pharmacy Point of Sale System), and EBA balances. The Enhanced Benefits Information System (EBIS) also is a means for the Enhanced Benefit Call Center as well as internal Agency resources to view the Enhanced Benefit Account information of beneficiaries in a central location via the Internet. EBIS was created and is contracted with an outside vendor, ISC, which performs administrative duties which include monthly statement generation, transaction testing, application recovery plan, participation project status meetings, database/website monitoring/maintenance, system backups, and AHCA phone support. ISC also provides all users of the EBIS with customer support, secure hosting services/support, provides all equipment, maintains office space/work stations, and provides needed enhancements to the system, all in a secure environment.

The Agency's Pharmacy Point of Sale System is the system where beneficiaries can access their credits through their Medicaid Gold Card at any Medicaid participating pharmacy. The Pharmacy System also is the true system which receives the credits from EBIS and where all the debit transactions are recorded and transmitted to EBIS on a weekly basis.

Participation Rates and Assessment of Expenditures

Table 25 provides the participation rates and expenditures by comparing credits earned each month, by date of service of the earned credit and expenditures each month by date of service. When comparing the date in which the beneficiary went to the doctor (date of service) by the dates the beneficiary spent a credit, the Active Participation Rate is calculated in the last column of Table 25 located on the following page.

The active participation rates (see Table 25) have steadily increased each month with a dramatic increase in late December 2007 and January 2008 when the first insert was mailed and reached the beneficiaries. Creation of the insert was very successful in increasing the call volume and the spending of the earned credits at the pharmacy, from $404,044.95 in the first half of Year Two to $ 2,028,726.79 in the second half of Year Two.

Table 25 Enhanced Benefits Information System Summary					
Month of Claims	**Number Credited**	**Dollar Amount**	**Earned by Date of Service***	**Purchases by Date of Service**	**Active Participation Rates**
Demonstration Year 1					
Sep-06	452	$9,260.00	$40,202.50		
Oct-06	2,702	$74,845.00	$249,542.50		
Nov-06	8,502	$249,027.50	$366,097.50	$203.87	0.06%
Dec-06	11997	$331,822.50	$487,102.50	$840.55	0.17%
Jan-07	18,245	$515,720.00	$631,890.00	$3,424.90	0.54%
Feb-07	19,159	$524,172.50	$621,636.16	$8,716.25	1.40%
Mar-07	23,232	$634,003.66	$722,477.50	$17,574.09	2.43%
Apr-07	23,184	$619,397.50	$647,160.00	$13,992.22	2.16%
May-07	27,934	$787,382.50	$653,342.50	$28,306.64	4.33%
Jun-07	22,326	$572,367.50	$585,930.00	$40,113.83	6.85%
Year 1 Totals	**91,564**	**$4,317,998.66**	**$5,005,381.16**	**$113,172.35**	**0.022%**
Demonstration Year 2					
Jul-07	28,589	$791,520.00	$943,790.00	$44,384.70	4.70%
Aug-07	32,671	$887,682.50	$982,095.00	$70,911.44	7.22%
Sep-07	30,926	$835,430.00	$872,717.50	$62,306.52	7.14%
Oct-07	42,591	$1,215,667.50	$1,101,032.50	$80,152.87	7.28%
Nov-07	33,744	$895,305.00	$885,127.50	$50,090.15	5.66%
Dec-07	34,376	$901,687.50	$819,125.00	$96,199.27	11.74%
Jan-08	32,927	$853,935.00	$973,635.00	$192,651.11	19.79%
Feb-08	35,280	$893,972.50	$896,935.00	$201,522.48	22.47%
Mar-08	36,397	$925,917.50	$851,337.50	$309,345.83	36.34%
Apr-08	35,540	$850,887.50	$786,625.00	$353,031.31	44.88%
May-08	30,227	711,277.50	$616,312.50	$471,499.13	76.50%
Jun-08	35,485	$974,177.50	$321,345.00	$500,694.00	155.81%
Year 2 Totals	**178,494**	**$10,737,460.00**	**$10,050,077.50**	**$2,432,788.81**	**24%**
	Total # Credited Unduplicated	**Total Amount Earned**	**Total Amount Earned**	**Purchase Total**	**Overall Rate**
Cumulative Total	**204,243**	**$15,055,458.66**	**$15,055,458.66**	**$2,545,961.16**	**16.91%**

*** Health Plans may submit healthy behaviors up to one year after the date of service.**

Potential cost savings

The University of Florida (UF) Medicaid Reform Evaluation Team will evaluate the administrative costs associated with the program including how much plans have contributed and how much of those funds have been distributed to enrollees. UF will also examine the effect of Enhanced Benefits participation on reducing total expenditures. This analysis will be completed towards the end of Year Five when UF expects to have encounter data as well as several years of Enhanced Benefit data. Presently, UF is conducting the general fiscal analysis of the demonstration but will be able to look at the associated cost savings on expenditures for PSNs only. The analysis of Enhanced Benefits on the HMO side will take place when encounter data are available.

1. Call Center Activities

Year Two 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. with employees who speak English, Spanish and Haitian-Creole; the call center is no longer open on Saturday.

The second year of operation of the call center was very different from the first year. In demonstration Year One, there were only 13,865 calls in comparison to Year Two where there were 53,155 calls. The increase in calls was due to beneficiaries becoming more knowledgeable about the program and the monthly statement insert.

The primary function of the call center is to handle inbound calls from beneficiaries about the Enhanced Benefit program, provide information on credits earned and spent by beneficiaries and assist beneficiaries at the pharmacy. The following is a highlight of the call volume during Year Two:

Inbound Calls:	53,155*****
Calls Abandoned:	2,795 or .05%
Average Talk Time	5.65 minutes

Lessons Learned

In Year Two, based on more experience with the EBAP, the Agency rewrote the call center script and created the ten most common EBAP questions/answers reference sheet. We also created a more user friendly over-the-counter (OTC) products list for use by the counselors and beneficiaries, which grouped similar categories of products together in both Excel and PDF format. A provider network of pharmacies was also created which includes pharmacies that have been successful in processing Enhanced Benefits products as a referral tool for the counselors.

Look Ahead to Year Three

The Agency and ACS have experienced a significant increase in call volume due to the success of the inserts with the monthly statements. The Agency and ACS will continue to evaluate call center activities to bring additional improvements for the EBAP.

2. System Activities

Year Two 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 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 displays 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 regarding purchases the beneficiaries have made and this information is also displayed. In addition, the EBIS system generates account balances and creates monthly beneficiary statements for beneficiaries who have had activity in the previous month and implemented in Year Two, quarterly statements are generated for beneficiaries who have not had recent activity.

This system is accessed by the call center staff to assist beneficiaries with account questions. Some enhancements to the system are the fiscal years are separated per each fiscal year which allows easier views for the counselors. Another enhancement to the system is the statements are accessible via the web and can be printed to mail second statements to beneficiaries who want another copy of their statement. 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). One change to the PDCS was to disallow the dispensing fee of $4.23 for OTC products. This change had a new billing method; outreach was completed to the pharmacies before the change was implemented. Many pharmacies were still unaware of this change and the call center was instrumental in assisting pharmacies and beneficiaries with the new information, by faxing the instructions to pharmacies. The statements mailed to the beneficiary also had the new pharmacy instructions.

Lessons Learned

The EBIS did not undergo many modifications in Year Two but instead focused on making sure the processes within the system were operating as efficiently as possible. The vendor of EBIS along with the Agency also worked on the transition to a new prescription drug claims system within the new fiscal agent operations so that credits and debits within the EBAP would transition without issues.

Look Ahead to Year Three

The Agency continues to seek ways to improve the Enhanced Benefits Program. One change that will be implemented with the new PDCS will be to change the pricing of the OTC products that is both fair and reasonable to both the beneficiary and pharmacy. The idea of implementation of a debit-card type system is still an option the Agency will consider if the demonstration expands to additional counties.

3. Outreach and Education for Beneficiaries

Year Two at a Glance

There are still 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 or quarterly statements are mailed to keep the beneficiary up-to-date with their account balance. The introduction of an insert with the statement was implemented during the December 2007 statement which reached the beneficiaries in January 2008. The inserts promote specific products beneficiaries can purchase in a themed manner to correlate with a healthy activity or event such as Heart Health in February or back to school in August. The call center call volume increased from 6,120 in the 2nd quarter (Year Two) to 17,067 in the 3rd quarter (Year Two) with the introduction of the insert.

Lessons Learned

Creation of the insert was very successful in increasing the call volume and the expenditures of the earned credits at the pharmacy, from $404,044.95 in the first half of Year Two to $ 2,028,726.79 in the second half of Year Two. By the end of Year Two, beneficiaries have (by date of service) cumulatively earned $15,055,458.66 million in credits and had used approximately $2,545,944.09. The outreach efforts to focus on using the credits have been a success.

Look Ahead to Year Three

To further increase beneficiaries' usage of their credits, the Agency will continue to enhance and modify material mailed to the beneficiary. One major change will be branding the name of the program from the Enhanced Benefits Account Program to the **Enhanced Benefits Reward$ Program** on any marketing materials that will go to the beneficiary. Another change includes revamping the monthly statement to look more like a coupon. The coupon will clearly give the amount of credits available along with simple instructions for the pharmacy to redeem the coupon. We will also produce marketing materials for providers about the Program to ensure their participation in assisting the beneficiaries to make healthy choices regarding their health.

4. Outreach and Education for Pharmacies

Year Two at a Glance

The Agency continues to provide outreach and education to pharmacies regarding the design and billing process for the program. Once again the Agency's Medicaid Area Office Pharmacists have proven to be a key element in providing on-site training in Broward and Duval Counties with some of the billing changes related to the program. Although the number of billing questions the Agency received during Year Two was steady, the call center was also instrumental in assisting the pharmacy and beneficiary with how to process the OTC products. The Agency has also met with management of some of the larger chain pharmacies in Florida to discuss the program outreach and billing issues.

Lessons Learned

Some 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 with the program and the need to train new staff at the pharmacy. 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 Three

The Agency is committed to continually streamline the process for pharmacies when processing an Enhanced Benefits purchase. Agency staff are working with the vendor within the new fiscal agent to implement changes that will allow pricing of Enhanced Benefit purchases that will be fair and equitable for both the pharmacy and the beneficiary. The Agency would also like to reduce the vast number of the same products available for purchase so the list of products can be more manageable for both the pharmacy and beneficiary to use.

5. Enhanced Benefits Advisory Panel

Year Two at a Glance

The Enhanced Benefits Advisory Panel is a 7-member, Agency-appointed panel. During Year Two, the Panel was responsible for the adoption of and EBAP policy change to reduce the general office visit from 2 occurrences to 1 and the credit amount from $15/$25 to $7.50. This change was made to align the behaviors that earn credits with the goal of the Enhanced Benefits program which is to incentivize beneficiaries to make healthy choices. The general office visits are non-preventive care. The Agency wants to continue to offer some general office visits to encourage appropriate use of primary care providers when a beneficiary is ill, but Year One and Year Two credits earned demonstrated that almost 50% of the credits earned were for non-preventive office visits (see Table 26). This change will emphasize the behaviors that are preventive.

The Panel also approved the changes to the program name, welcome packet and monthly statements. The Enhanced Benefits Advisory Panel continues to be a sound resource to review and discuss the EBAP outreach efforts and documentation.

Looking Ahead to Year Three

During Year Three, the Panel will be evaluating the impact of the change made to the general office visits. Once the impact is known, the Panel will work on identifying other services or healthy behaviors that can be added to the list. Examples of the types of behaviors that will be considered are pre-natal care and diabetic blood tests. The Panel will also look at outreach efforts to increase the amount of credits used by beneficiaries.

The outreach efforts the Panel will consider are materials that providers can use to promote the Enhanced Benefits program with beneficiaries they serve and opportunities for pharmacies to promote the program within their store locations.

Enhanced Benefits Statistics

Table 26 provides a count of healthy behaviors and the sum of granted credit amounts for Year Two of the demonstration.

Table 26
Healthy Behaviors Counts and $
(July 2007- June 2008 by date of service)

Procedure	Count of Procedure Code	Sum of Granted Credit Amount
Office Visit-Adult/Child	676,583	$7,417,067.50
Childhood Preventive Care	207,851	$4,975,560.00
Maintenance Drug	118,143	$878,150.00
Dental	43,557	$669,250.00
EYE Adult/Child	26,414	$357,805.00
Pap Smear	20,692	$420,590.00
Preventive Care Child & Adult	11,259	$200,245.00
Preventive Care Adult	3,554	$49,765.00
Mammogram	1,596	$23,607.50
Colorectal Screening	1,392	$23,757.50
Hypertension Disease Management Program	1,189	$10,215.00
Diabetes Disease Management Program	1,077	$13,250.00
Asthma Disease Management Program	683	$11,007.50
HIV/AIDS Disease Management Program	241	$2,672.50
Congestive Heart Failure Disease Management Prog	138	$2,210.00
Administrative Credit	10	$151.16
Adult Dental Cleaning (preventative services)	5	$30.00
Other Disease Management Program	4	$75.00
Flu Shot	2	$50.00

From program inception to June 30, 2008, a total of 204,243 beneficiaries have earned $15,055,458.66 in Enhanced Benefit credits. As of June 30, 2008, 47,379 beneficiaries have spent $2,545,944.09 in credits.

Table 27 compares credits earned by credits expended (by date of service) since implementation of the program in September 2006. No expenditures were made during the first two months of operation, September and October of 2006.

Table 27 Earned Credits by Month by Date Of Service		
Month & Year	**Sum of Granted Credit Amount**	**Sum of Expenditures**
Sept 2006	$40,202.50	
Oct 2006	$249,542.50	
Nov 2006	$366,097.50	$203.87
Dec 2006	$487,102.50	$840.55
Jan 2007	$631,890.00	$3,424.90
Feb 2007	$621,636.16	$8,716.25
March 2007	$722,477.50	$17,574.09
April 2007	$647,160.00	$13,992.22
May 2007	$653,342.50	$28,306.64
June 2007	$585,930.00	$40,113.83
Year 1 Totals	**$5,005,381.16**	**$113,172.35**
July 2007	$943,790.00	$44,384.70
Aug 2007	$982,095.00	$70,911.44
Sept 2007	$872,717.50	$62,306.52
Oct 2007	$1,101,032.50	$80,152.87
Nov 2007	$885,127.50	$50,090.15
Dec 2007	$819,125.00	$96,199.27
Jan 2008	$973,635.00	$192,651.11
Feb 2008	$896,935.00	$201,522.48
March 2008	$851,337.50	$309,345.83
April 2008	$786,625.00	$353,028.35
May 2008	$616,312.50	$471,495.51
June 2008	$321,345.00	$500,683.51
Year 2 Totals	**$10,050,077.50**	**$2,432,771.74**
Cumulative Totals	**$15,055,458.66**	**$2,545,944.09**

Table 28 highlights the amount of credits submitted by each health plan for beneficiaries as of June 30, 2008 (date of service):

Table 28 Credits Submitted By Health Plan	
Plan Name	**Sum of Granted Credit Amount**
Access Health Solutions-Baker	$60,665.00
Access Health Solutions-Broward	$252,560.00
Access Health Solutions-Clay	$168,895.00
Access Health Solutions-Duval	$473,075.00
Access Health Solutions-Nassau	$59,565.00
Amerigroup -Broward	$1,099,490.00
Buena Vista-Broward	$627,495.00
CMS Duval/Ped-I-Care	$89,822.50
CMS North	$167,432.50
CMS South	$57,842.50
First Coast Advantage-Shands Jax-Duval	$1,345,812.50
Netpass - Broward	$469,072.50
Freedom Health Plan	$1,305.00
Healthease-Broward	$1,023,227.50
Healthease-Duval	$2,434,320.00
Humana -Broward	$858,892.50
SFCCN – Memorial Healthcare System-Broward	$259,215.00
SFCCN – N. Broward Hosp Dist-Broward	$296,278.66
Pediatric Associates	$989,517.50
Preferred Medical Plan-Broward	$72,692.50
Staywell-Broward	$1,922,047.50
Staywell-Duval	$198,397.50
Total Health Choice-Broward	$94,377.50
United Healthcare FL-Baker	$28,005.00
United Healthcare FL-Broward	$632,655.00
United Healthcare FL-Clay	$124,430.00
United Healthcare FL-Duval	$771,647.50
United Healthcare FL-Nassau	$42,215.00
Universal Health Care Broward	$3,250.00
Universal Health Care Duval	$8,392.50
Vista Healthplan S FL-Broward	$422,865.00

Table 29 provides the top fifteen purchases made by beneficiaries from July 1, 2007 through June 30, 2008.

Table 29
Most Common Purchase
(July 2007 – June 2008)

Description	Count Of Description*
HUGGIES BABY WIPES NAT CARE	33,259
LISTERINE ANTISEPTIC	10,162
JOHNSON'S BABY SHAMPOO	8,815
HUGGIES ULTRATRIM STEP 4	8,416
JOHNSON'S BABY LOTION	5,033
CHILDREN'S MOTRIN 100 MG/5	5,027
PAMPERS BABY-DRY SIZE 4	5,024
JOHNSON'S BABY POWDER	4,874
HUGGIES ULTRATRIM STEP 3	4,795
HUGGIES ULTRATRIM STEP 5	4,451
AQUAFRESH TOOTHPASTE	4,254
CHILDS TYLENOL PLUS COLD SU	4,143
PAMPERS BABY-DRY SIZE 5	4,097
COMFORT-STRETCH DIAPERS SIZ	4,029
HUGGIES PULL-UPS 3T-4T BOYS	3,997

*****includes purchase/return combinations

Table 30 provides the Enhanced Benefit Account Program statistics for demonstration Year Two.

Table 30
Enhanced Benefit Account Program Statistics

Year Two Activities		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
I.	Number of plans submitting reports by quarter.	27 of 31	30 of 31	30 of 31	31 of 31
II.	Number of enrollees who received credit for healthy behaviors by Quarter (Not unduplicated).	92,186	110,711	104,604	101,252
III.	Total dollar amount credited to accounts by each quarter.	$2,514,632.50	$3,012,660.00	$2,673,825.00	$2,536,342.50
IV.	Total cumulative dollar amount credited through each quarter.	$6,832,631.16	$9,845,291.16	$12,519,116.16	$15,055,458.66
V.	Total dollar amount of credits used each quarter by date of service.	$177,602.66	$226,849.02	$704,489.96	$1,325,188.00
VI.	Total cumulative dollar amount of credits used through the quarter by date of service.	$290,775.01	$517,649.00	$1,221,121.51	$2,545,924.72
VII.	Total cumulative number of enrollees who used credits through the quarter.	9,402	14,043	27,140	47,379

6. Complaints

Year Two 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. While no formal evaluation of this has been conducted, the Agency feels confident that the health plans are submitting healthy behaviors to the Agency on a very timely basis so that beneficiaries can earn credit dollars.

During Year Two, the Agency did receive a total of 381 complaints related to pharmacy issues which included rudeness of pharmacy staff, pharmacy not aware of the program, pharmacy not allowing the purchase, or difficulty getting the item purchased. Other complaints were related to the pricing of the OTC products such as the dispensing fee or pricing difference from shelf price versus the price charged at the pharmacy counter. The final group of complaints was regarding the difficulty with utilizing the on-line OTC products list and the interaction with the list at the pharmacy.

Lessons Learned and Look Ahead to Year Three

Some pharmacies continue to report problems or issues with the EBAP. These issues include: problems with credits processing through the PDCS system and high pharmacy staff turnover that results in constant retraining efforts and pricing of the OTC products. While purchases have significantly increased from Year One to Year Two, utilization is not at the same rate as earning of the credits. The problems surrounding the pharmacy issues will require the Agency to work with the new fiscal agent to take advantage of the enhanced features available in the new system. In addition, outreach/training efforts for pharmacy personnel will continue and the Agency will continue to evaluate implementing a debit card type technology.

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 Two 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 than February 1 of each year."

Continuing its previous work, the LIP Council held six meetings between the first and third quarters of Year Two. There were no LIP Council meetings during the fourth quarter.

During the first quarter of Year Two, the Council reviewed anticipated distribution amounts and payment schedule for SFY 2007-08. The Council also received a status report from the University of Florida (UF) LIP Evaluation Team regarding the process of the cost effectiveness study, prepared in accordance with STC #102, to define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured and underinsured.

During the second quarter of Year Two, the Council discussed many issues including Property Tax Reform proposals and the potential effect that the taxing referendums may have on local governments' ability to provide Intergovernmental Transfers (IGTs) during SFY 2008-09.

The LIP Council heard updates from Provider Access Systems that are participating in LIP for Year Two of the demonstration.

During the third quarter of Year Two, the Low Income Pool (LIP) Council held two meetings. The first meeting consisted of the LIP Council members listening to

presentation from six counties where monies were requested for various health care initiatives, and discussing the exemption costs, funding distribution models and LIP alternatives. During the second meeting, Council members discussed LIP funding distribution models that had been requested at the previous meeting. After much discussion, the LIP council members voted selecting Model 21B as the model to be sent to the Governor and Florida Legislature. This model was not selected unanimously, as three council members opposed this recommendation.

The LIP Council Chair sent the Low Income Pool Council recommendations for State Fiscal Year 2008-09 with a letter to the Secretary of the Florida Agency for Health Care Administration on February 4, 2008, to forward to the Governor and Legislature on behalf of the Council. On February 25, 2008, the LIP Council Chair sent a detailed report regarding the LIP Council recommendations to the Secretary of the Florida Agency for Health Care Administration.

During the last quarter of Year Two, the Agency continued to work with CMS regarding the Reimbursement and Funding Methodology document. CMS conducted an on-site visit to the Agency to review LIP distribution calculations and interview staff. On June 18, 2008, the Agency was informed via e-mail that CMS would be performing audits on 6 of the LIP hospitals to review documentation in support of uncompensated care.

During the first quarter of Year Two, the Agency distributed $83,458,192 to LIP Provider Access Systems. The second quarter distributions were $190,379,162; third quarter distributions were $319,005,892; and fourth quarter distributions were $329,734,446 making the total distribution for the second year of the waiver $922,577,692. 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 demonstration Year Two will be finalized during the first quarter of demonstration Year Three.

Look Ahead to Year Three

The Agency will begin demonstration Year Three 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 2008-09 (demonstration Year Three). During the 2008 legislative session, funding for the total annual allotment of $1 billion LIP expenditures was appropriated to Provider Access Systems for SFY 2008-09. During demonstration Year Three of LIP, the Agency's focus will be continued documentation of LIP Milestones to evaluate the cost-effectiveness of various Provider Access Systems (hospital and non-hospital providers). The Agency will also continue to work with CMS to finalize the Reimbursement and Funding Methodology document.

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 are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five year trend for each MEG. This trend is then applied to the most recent year (5^{th} year), which is known as the base year, and projected forward through the waiver period. Additional negotiations were involved in the final Budget Neutrality calculations set forth in the approved waiver packet.

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

The 1115 Medicaid Reform Waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to capture the expenditures by service type paid during the quarter that are subject to the monitoring of the Budget Neutrality. There are three MEGs within the 1115 Medicaid

Reform Waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, an additional five templates (one for each of the 1915(b) Managed Care Waiver MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

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

Definitions:

- **PCCM** - Calculated per capita cost per month which is the total spend divided by the case months.
- **WOW PCCM** - Is the without waiver PCCM. This is the target that the state cannot exceed in order to maintain Budget Neutrality.
- **Case months** - The months of eligibility for the populations subject to the waiver as defined as included populations in the waiver. In addition, months of eligibility for voluntary enrollees during the period of enrollment within a Medicaid Reform health plan are also included in the case month count.
- **MCW Reform Spend -** Expenditures subject to the Reform Budget Neutrality for those not enrolled in a Reform Health Plan but subject to the Reform Waiver (currently all non dual eligibles receiving services through the 1915(b) Managed Care Waiver).
- **Reform Enrolled & Non-MCW Spend** - Expenditures for those enrolled in a Reform Health Plan.
- **Total Spend** - Total of MCW Reform Spend and Reform Enrolled Spend.

The quarterly totals 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.

Years One and Two at a Glance

The 1115 Medicaid Reform Waiver is budget neutral as required by the Special Terms and Conditions of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

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

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by Special Term and Condition # 108 is monitored using data based on date of service. The PMPM and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The Special Terms and Conditions specify that the state will

track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year.

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

Table 31 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 31
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 32 through 36 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2008. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 32
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$109,209,309	$909,045	$110,118,354	$446.18
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$204,666,715	$9,068,294	$213,735,009	$864.97
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$279,485,810	$29,362,800	$308,848,610	$1,245.10
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$198,742,236	$31,793,702	$230,535,938	$919.18
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$188,079,271	$31,056,750	$219,136,021	$871.08
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$298,437,791	$47,839,499	$346,277,290	$1,372.13
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$287,896,155	$47,839,499	$335,735,655	$1,329.47
February 2008	252,261	$208,197,150	$33,089,608	$241,286,757	$956.50
March 2008	253,219	$146,744,275	$24,856,235	$171,600,510	$677.68
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
April 2008	254,500	$302,204,899	$52,469,635	$354,674,534	$1,393.61
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$197,361,740	$35,312,356	$232,674,096	$912.58
Q8 Total	**764,701**	**$655,801,882**	**$114,515,897**	**$770,317,779**	**$1,007.35**
MEG 1 Total	**6,012,384**	**$5,033,119,781**	**$660,104,205**	**$5,693,223,987**	**$946.92**

* 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 without adjustment of rebates.

Table 33
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	1,343,704	$116,070,700	$122,430	$116,193,130	$86.47
August 2006	1,292,330	$272,615,188	$1,255,306	$273,870,494	$211.92
September 2006	1,308,403	$96,367,809	$345,759	$96,713,568	$73.92
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
October 2006	1,293,922	$183,471,982	$4,267,815	$187,739,798	$145.09
November 2006	1,277,102	$287,043,912	$13,069,579	$300,113,491	$235.00
December 2006	1,266,148	$110,714,051	$2,883,053	$113,597,104	$89.72
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
January 2007	1,252,859	$266,181,366	$23,259,122	$289,440,488	$231.02
February 2007	1,240,860	$176,632,680	$13,010,558	$189,643,238	$152.83
March 2007	1,234,344	$104,987,331	$8,197,611	$113,184,942	$91.70
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
April 2007	1,230,451	$170,285,018	$17,657,956	$187,942,974	$152.74
May 2007	1,218,171	$252,644,634	$32,885,813	$285,530,447	$234.39
June 2007	1,204,525	$93,978,970	$6,350,716	$100,329,686	$83.29
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
July 2007	1,198,205	$153,588,331	$17,975,233	$171,563,564	$143.18
August 2007	1,195,369	$257,178,317	$34,274,917	$291,453,235	$243.82
September 2007	1,194,789	$97,198,750	$4,900,087	$102,098,837	$85.45
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
October 2007	1,211,534	$271,137,490	$36,924,018	$308,061,507	$254.27
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$273,615,263	$39,329,414	$312,944,677	$254.19
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$162,745,780	$22,261,241	$185,007,021	$143.82
Q8 Total	**3,856,584**	**$560,208,722**	**$70,729,589**	**$630,938,310**	**$163.60**
MEG 2 Total	**29,992,810**	**$4,370,655,707**	**$386,492,267**	**$4,757,147,974**	**$158.61**

* 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 without adjustment of rebates.

For Demonstration Year One, MEG 1 has a PCCM of $969.52 (Table 34), compared to WOW of $948.79 (Table 31), which is 102.19% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.08 (Table 34), compared to WOW of $199.48 (Table 31), which is 80.25% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $924.72 (Table 34), compared to WOW of $1,024.69 (Table 31), which is 90.24% of the target PCCM for MEG 1. MEG 2 has a PCCM of $157.11 (Table 34), compared to WOW of $215.44 (Table 31), which is 72.93% of the target PCCM for MEG 2.

Tables 34 and 35 provide cumulative expenditures and case-months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case-months. In addition, the PCCM targets as provided in the Special Terms and Conditions are also weighted using the actual case-months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 35) is $322.50. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 35 is $292.97. Comparing the calculated weighted averages, the actual PCCM is 90.84% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 35) is $352.88. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 35 is $287.48. Comparing the calculated weighted averages, the actual PCCM is 81.47% of the target PCCM.

Table 34
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,625,165,889	$262,476,239	$2,887,642,128	$969.52
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$61,751,761	
% of WOW PCCM MEG 1					102.19%
DY01 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162.819	$2,291,520,276	$135,672,077	$2,427,192,353	$160.08
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				($597,486,781)	
% of WOW PCCM MEG 2					80.25%
DY02 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,407,953,892	$397,627,966	$2,805,581,858	$924.72
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				($303,295,837)	
% of WOW PCCM MEG 1					90.24%
DY02 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	18,686,575	$2,079,135,431	$250,820,190	$2,329,955,621	$157.11
WOW DY2 Total	18,686,575			$3,194,973,261	$215.44
Difference				($865,017,640)	
% of WOW PCCM MEG 2					72.93%

Table 35
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
Meg 1 & 2	18,141,234	$4,916,686,165	$398,148,316	$5,314,834,482	$292.97
WOW	18,141,234			$5,850,569,502	$322.50
Difference				($535,735,020)	
% Of WOW					90.84%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	21,720,544	$4,487,089,323	$648,448,156	$5,135,537,479	$287.48
WOW	21,720,544			$6,303,850,956	$352.88
Difference				($1,168,313,476)	
% Of WOW					81.47%

Table 36
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Total Paid	**$1,921,383,741**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$922,577,692	$1,000,000,000	92.26%
Total MEG 3	$1,921,383,741	$5,000,000,000	38.43%

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

The expenditures for the first eight quarters for MEG 3, the Low Income Pool (LIP), were $1,921,383,741 (38.43% of the $5 billion cap).

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. Two additional phases, involving the statewide collection of encounter data within the Medicaid Management Information System (MMIS) from health plans for all Medicaid covered services, were necessary to account for the collection of data during Florida's transition of fiscal agents. The second phase occurred with the prior fiscal agent (ACS) and the third phase occurs with the current fiscal agent (EDS) for Florida Medicaid.

Year Two at a Glance

The Agency Medicaid Encounter Data System accomplished the following activities during demonstration Year Two:

- Continued to refine the risk-adjusted methodology for Year Two capitation payments to Reform health plans, according to law;
- Enhanced the MEDS website to include new Fiscal Agent (EDS) information related to the Medicaid Encounter Data System;
- Updated the encounter data submission guide (business/technical specifications for full encounter data) for managed-care organizations to support the new Fiscal Agent data collection and processing requirements;
- Updated business specifications for the new Fiscal Agent (EDS) system edits on the Florida Medicaid Management Information System (FMMIS);

- Defined updates supporting the new Fiscal Agent's Medicaid Decision Support System to accept encounter data from FMMIS used in analyses and structured queries;
- Updated and enhanced reports used to support utilization, quality, and trend analyses;
- Collected and processed 5,272,922 encounter claims from 15 MCOs through June 2008 using the prior Fiscal Agent (ACS) MMIS;
- Prepared for testing and the "dry runs" for CDPS (Chronic Illness and Disability Payment System) to support diagnostic base risk adjustment.

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 continue to comply with these requirements in the second 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, were 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 risk adjustment using a diagnostic model.

Pharmacy Encounter Data Utilization (First Phase) for HMOs and PSNs

The following figures and tables represent utilization and statistics from the collection of pharmacy encounter data from the capitated Reform Health Maintenance Organizations (HMOs) and pharmacy fee-for-service claim data from the Reform Provider Service

Networks (PSNs) for a measurement period encompassing April 2007 through March 2008. The statistics are limited since the encounter data are reported using a minimum data set specific to risk adjustment requirements.

Figures 1a, 1b, and 1c show the HMO and PSN enrollment numbers, unduplicated encounters, and unduplicated users of services indicated by prescription medication usage, in thousands, for Broward County HMOs and PSNs. The source data for these figures is reported in Table 37. The charts show the monthly distributions of Medicaid beneficiaries enrolled in non-Reform and Reform HMOs and PSNs spanning from April 2007 to March 2008.

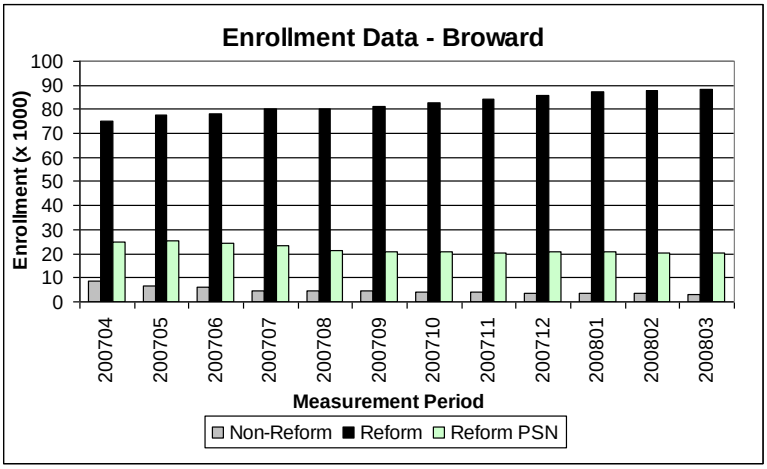


Fig. 1a

The Broward County HMO enrollment numbers in **Figure 1a** show that non-Reform enrollment numbers have declined during this time period, while the Reform enrollment numbers have continued to increase. PSN numbers declined from April 2007 through August 2007, and have subsequently remained relatively consistent through the reporting period. Overall, the total enrollment has increased slightly throughout this time period. The primary factor contributing to the growth of enrollment is due to new Medicaid beneficiaries entering the Medicaid program.

Figure 1b shows the unduplicated number of HMO and PSN pharmacy encounters during the measurement period for Broward County. The chart shows that the number of pharmacy encounters under Reform have grown slightly during the measurement period while pharmacy encounters for Non-Reform HMOs continue to steadily decline. Also, as would be expected with growing membership, the chart reflects a net overall growth of unduplicated pharmacy encounters.

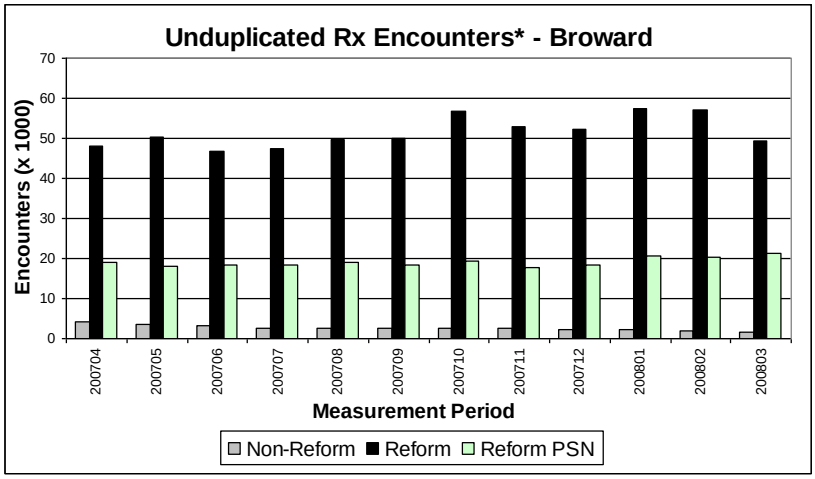


Fig. 1b

**PSN values represent actual claims*

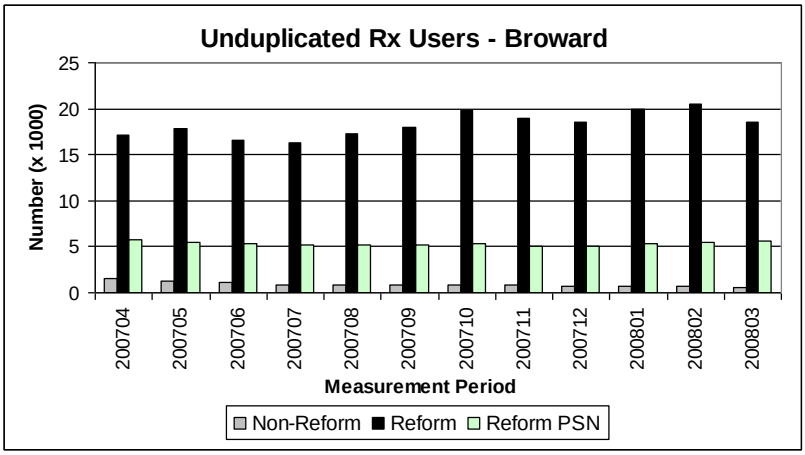


Fig. 1c

Figure 1c depicts the growth in unduplicated Reform HMO users of pharmacy services and the decrease in users of pharmacy services for non-Reform HMOs. This pattern is consistent with what is observed in the HMO unduplicated pharmacy encounters. Also, while the numbers of unduplicated Reform HMO users of pharmacy services has shown some growth, the number of unduplicated users of the same services for Reform PSNs has been relatively stable across the measurement period.

Figures 2a and 2b are indicators of HMO and PSN utilization of pharmacy services, and juxtapose measures from non-Reform and Reform HMOs and PSNs for Broward County to allow comparison.

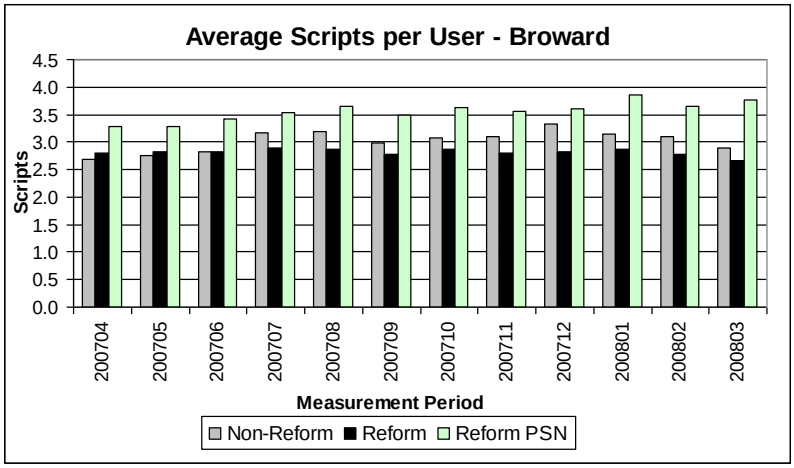


Fig. 2a

Figure 2a shows the average number of prescription medications (scripts) per user for non-Reform and Reform HMOs, as well as PSNs over the measurement period. It is interesting to note that utilization under non-Reform HMOs is lower during the first two months of the measurement period, but is consistently higher than the Reform HMOs for each following month. The greater per recipient utilization in non-Reform HMOs may be attributed to the remaining voluntary population which tends to be sicker. It is also interesting to note that the average scripts per user within the PSNs is consistently higher, for any period, than the HMOs. Additional analysis with comprehensive data is required to identify any differences and its sources, to accurately measure utilization of services under Reform.

Figure 2b shows a comparison of users per 100 enrollees for the non-Reform and Reform HMOs, and PSNs in Broward County. The chart shows that under Reform, this measure compares favorably 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 and PSNs. Once again, additional analysis with comprehensive data is required to identify any differences and its sources, to accurately measure access to services under Reform.

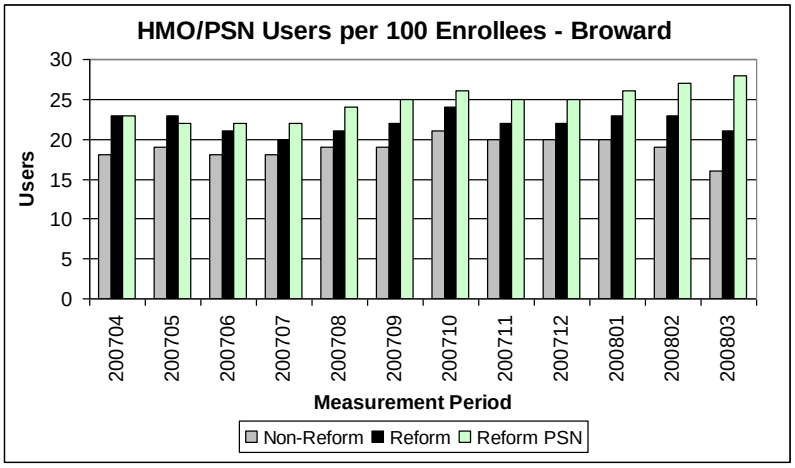


Fig. 2b

Figures 3a, 3b, and 3c show HMO and PSN enrollment numbers, unduplicated encounters, and unduplicated users of services based on prescriptions, in thousands, for Duval County HMOs and PSNs. Duval County also includes the additional expansion of reform counties of Baker, Clay, and Nassau added in September 2007. The source data for these figures is reported in Table 39. The charts show the monthly distributions of Medicaid beneficiaries enrolled in non-Reform and Reform HMOs and PSNs spanning April 2007 through March 2008.

HMO and PSN enrollment numbers, **Figure 3a,** for Duval County and expansion counties, also show that Medicaid beneficiary enrollment in Reform HMOs and PSNs continues to increase when compared to enrollment in non-Reform HMOs. Overall, the total number of enrollees has seemingly increased steadily during this time period. The primary factor contributing to the growth of enrollment is due to new Medicaid beneficiaries entering the Medicaid program.

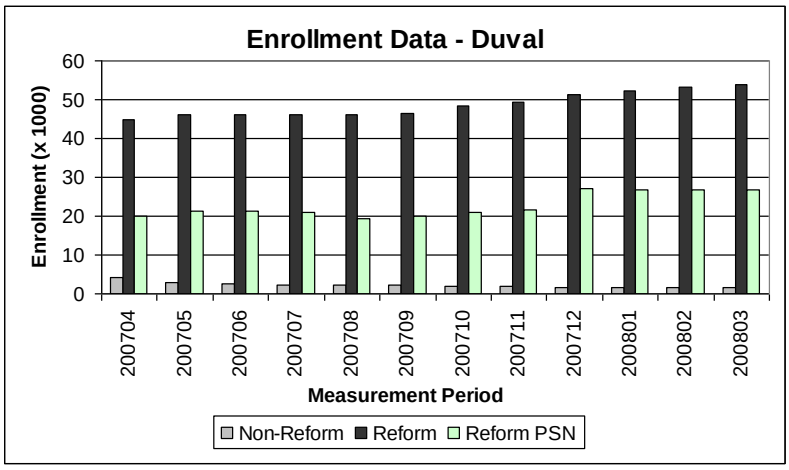


Fig. 3a

Figure 3b shows the unduplicated number of HMO and PSN pharmacy encounters under non-Reform and Reform during the measurement period for Duval County and expansion counties. This chart shows an upward trend in the total number of encounters through the measurement period, with the Reform encounters increasing and the non-Reform encounters decreasing over time or remaining relatively stable. The growth is consistent with the enrollment growth that is due to new Medicaid beneficiaries entering the Medicaid program.

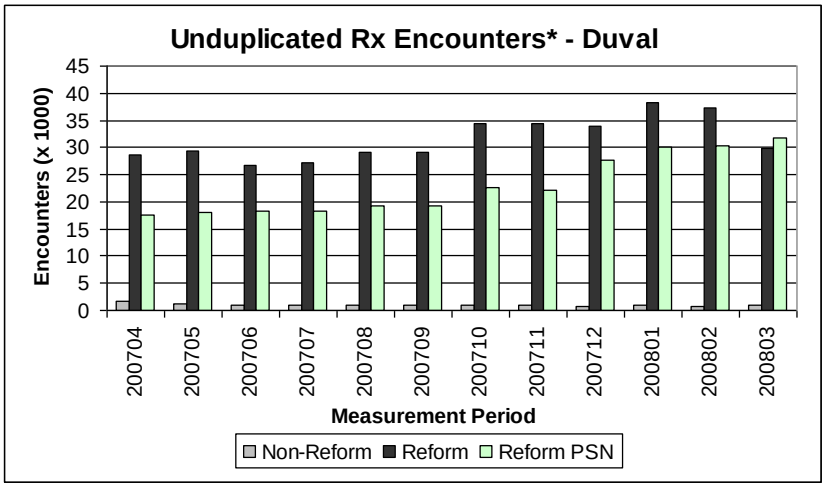


Fig. 3b

**PSN values represent actual claims*

Figure 3c shows the unduplicated HMO and PSN number of users of pharmacy services for both Reform and non-Reform HMOs and Reform PSNs across the measurement period. The overall number of unduplicated users is increasing during this period, as can be expected with increasing enrollment.

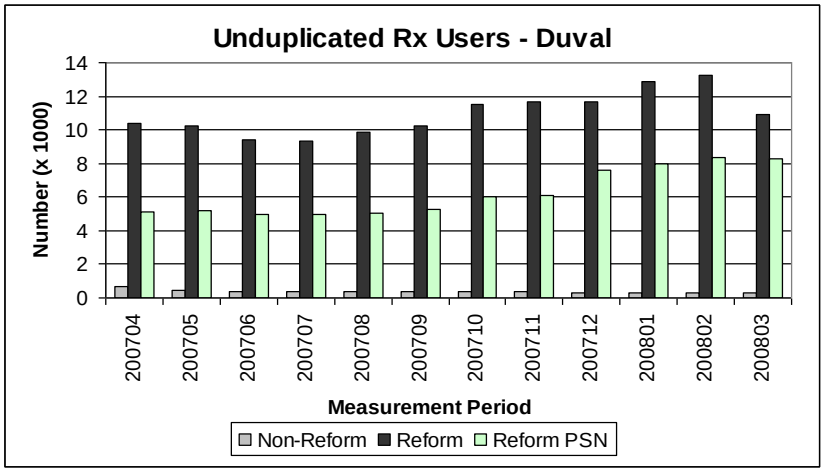


Fig. 3c

Figures 4a and 4b are indicators of HMO and PSN utilization of pharmacy services, and as in the previous charts, utilize pharmacy data submitted by HMOs and fee-for-service pharmacy claims. 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; and while there is no comparable non-Reform PSN data, the available data for PSN utilization of pharmacy services is included as before in previous charts.

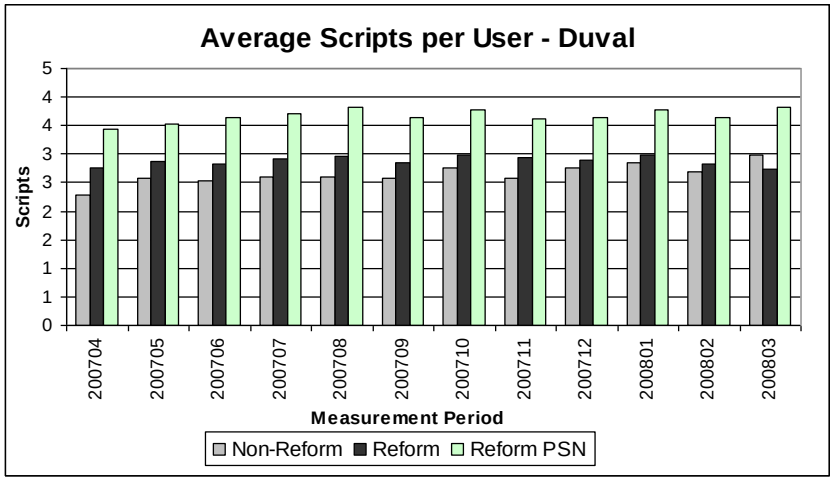


Fig 4a

Figure 4a shows the average number of prescription medications (scripts) per user in Duval County and expansion counties for Medicaid enrollees in non-Reform and Reform HMOs and Reform PSNs. Unlike Broward County, the average is slightly higher among enrollees in Reform HMOs than enrollees in non-Reform HMOs in every month, excluding March 2008. It is also interesting to note that the average scripts per user within the PSNs is consistently higher, for any period, than the Reform HMOs. Additional analysis with comprehensive data is required to identify any differences and its sources, to accurately measure utilization of services under Reform.

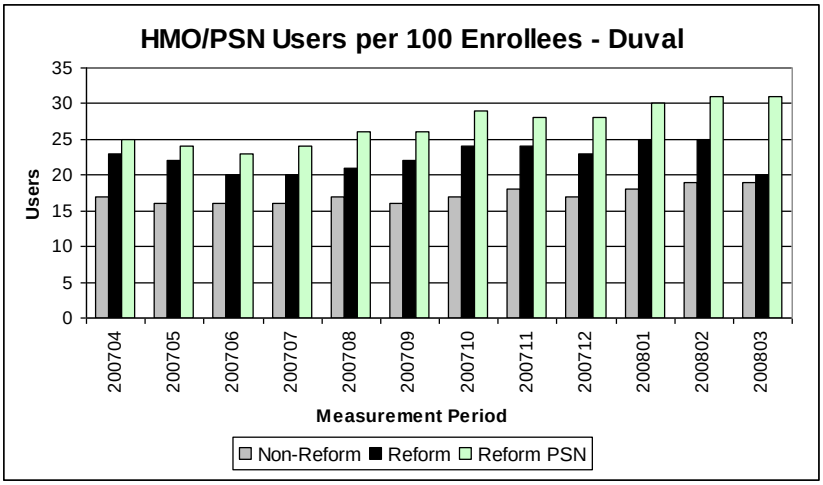


Fig. 4b

Figure 4b shows the number of users of pharmacy services among all Medicaid enrollees for both non-Reform HMOs and Reform HMOs and PSNs in Duval County and expansion counties. The overall trend for users in non-Reform HMOs appears to be relatively stable for the first 9 months and then slightly increases during the rest of the measurement period. The trend for users in Reform HMOs fluctuated between 20

to 25 users per 100 enrollees, and is consistently higher than non-Reform HMOs throughout the entire measurement period. The trend for users in Reform PSNs fluctuated between 23 to 31 users per 100 enrollees, and is consistently higher than Reform HMOs throughout the entire measurement period.

The four following tables (Tables 37 through 40) illustrate the number of Medicaid HMO and PSN beneficiaries within each of the five Reform counties (Duval and expansion counties, and Broward) and the corresponding numbers of HMO pharmacy encounter claims and PSN fee-for-service claims used to calculate individual risk factors.

Table 37 presents HMO pharmacy encounters and PSN fee-for-service claims in relation to total pharmacy users and total Medicaid enrollees by month and year in Broward HMOs and PSNs. It also demonstrates the differences of Medicaid beneficiaries from non-Reform and Reform HMOs and Reform PSNs. These data are depicted in Figures 1a, 1b, and 1c.

Table 37
Broward HMO Pharmacy Encounters and PSN claims by Month
(April 2007 through March 2008)

Service Month	BROWARD								
	NON-REFORM			REFORM			REFORM PSNs		
	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Claims	Total Users	Total Enrollees
April 07	4,190	1,558	8,656	47,936	17,183	74,938	19,004	5,775	24,861
May 07	3,507	1,269	6,646	50,339	17,802	77,615	18,124	5,505	25,248
June 07	3,270	1,157	6,336	46,801	16,538	78,047	18,461	5,377	24,441
July 07	2,705	852	4,710	47,259	16,283	80,158	18,381	5,206	23,525
Aug 07	2,675	837	4,523	49,706	17,240	80,443	19,022	5,200	21,462
Sept 07	2,542	852	4,382	50,147	18,030	81,112	18,250	5,237	20,999
Oct 07	2,736	889	4,205	56,933	19,840	82,955	19,445	5,356	20,638
Nov 07	2,499	809	4,024	53,041	18,920	84,447	17,863	5,031	20,297
Dec 07	2,320	694	3,547	52,409	18,570	85,907	18,374	5,097	20,603
Jan 08	2,150	684	3,467	57,272	19,923	87,315	20,755	5,388	20,589
Feb 08	2,038	660	3,390	57,107	20,571	87,892	20,184	5,538	20,498
March 08	1,522	525	3,297	49,414	18,554	88,368	21,358	5,680	20,233
Total*	**32,154**	**10,786**	**57,183**	**618,364**	**219,454**	**989,197**	**229,221**	**64,390**	**263,394**

**Total for users and enrollees represents case months, not unduplicated counts*
Data Source: AHCA; Mercer Consulting, Inc.

Table 38 lists the statistical measures for HMOs and PSNs 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 38
Statistical Measures for HMOs and PSNs in Broward County
(April 2007 through March 2008)

Service Month	BROWARD					
	NON-REFORM		REFORM		REFORM PSNs	
	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)
April 07	2.69	18	2.79	23	3.29	23
May 07	2.76	19	2.83	23	3.29	22
June 07	2.83	18	2.83	21	3.43	22
July 07	3.17	18	2.9	20	3.53	22
Aug 07	3.2	19	2.88	21	3.66	24
Sept 07	2.98	19	2.78	22	3.48	25
Oct 07	3.08	21	2.87	24	3.63	26
Nov 07	3.09	20	2.8	22	3.55	25
Dec 07	3.34	20	2.82	22	3.6	25
Jan 08	3.14	20	2.87	23	3.85	26
Feb 08	3.09	19	2.78	23	3.64	27
March 08	2.9	16	2.66	21	3.76	28
Average	**2.98**	**18.86**	**2.82**	**22.19**	**3.56**	**24.45**

Table 39 presents HMO pharmacy encounters and PSN claims in relation to total pharmacy users and total Medicaid enrollees by month and year in HMOs and PSNs in Duval and expansion counties. It also shows the differences of Medicaid beneficiaries from non-Reform and Reform HMOs and Reform PSNs. These data are depicted in Figures 3a, 3b, and 3c.

Table 39
HMO Pharmacy Encounters & PSN Claims for
Duval & Expansion Counties by Month
(April 2007 through March 2008)

	DUVAL								
	NON-REFORM			REFORM			REFORM PSNs		
	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Encounters	Total Users	Total Enrollees	Total Pharmacy Claims	Total Users	Total Enrollees
April 07	1,595	699	4,141	28,746	10,383	44,949	17,508	5,111	20,119
May 07	1,141	444	2,787	29,373	10,211	46,168	18,132	5,158	21,413
June 07	1,046	413	2,658	26,693	9,420	46,187	18,175	4,980	21,242
July 07	995	382	2,354	27,182	9,325	46,277	18,278	4,941	21,015
Aug 07	997	385	2,244	29,178	9,871	46,246	19,305	5,036	19,458
Sept 07	892	347	2,148	29,183	10,207	46,329	19,230	5,268	19,909
Oct 07	1,004	362	2,070	34,447	11,520	48,303	22,693	6,022	21,053
Nov 07	945	368	2,026	34,338	11,688	49,487	22,089	6,123	21,592
Dec 07	789	286	1,708	33,843	11,688	51,145	27,748	7,611	27,203
Jan 08	864	303	1,651	38,283	12,838	52,195	30,152	7,986	26,786
Feb 08	819	304	1,617	37,366	13,211	53,365	30,257	8,337	26,899
March 08	876	293	1,579	29,930	10,931	53,946	31,821	8,313	26,723
Total*	**11,963**	**4,586**	**26,983**	**378,562**	**131,293**	**584,597**	**275,388**	**74,886**	**273,412**

**Total for users and enrollees represents casemonths, not unduplicated counts*
Data source: AHCA; Mercer Consulting, Inc.

Table 40 lists the statistical measures for Duval County and expansion county HMOs and PSNs, 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 40
Statistical Measures for HMOs & PSNs in Duval & Expansion Counties
(April 2007 through March 2008)

	DUVAL					
	NON-REFORM		REFORM		REFORM PSNs	
	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)	Average Scripts per User	Users (% of Enrollees)
April 07	2.28	17	2.77	23	3.43	25
May 07	2.57	16	2.88	22	3.52	24
June 07	2.53	16	2.83	20	3.65	23
July 07	2.6	16	2.91	20	3.7	24
Aug 07	2.59	17	2.96	21	3.83	26
Sept 07	2.57	16	2.86	22	3.65	26
Oct 07	2.77	17	2.99	24	3.77	29
Nov 07	2.57	18	2.94	24	3.61	28
Dec 07	2.76	17	2.9	23	3.65	28
Jan 08	2.85	18	2.98	25	3.78	30
Feb 08	2.69	19	2.83	25	3.63	31
March08	2.99	19	2.74	20	3.83	31
Average	**2.61**	**17.00**	**2.88**	**22.46**	**3.68**	**27.39**

Comprehensive Medicaid Encounter Data Collection and Processing Activities (Second and Third phases of MEDS – Statewide data from capitated health plans)

Notable strides to achieving statewide encounter claims collection and processing for all Medicaid covered services have been made during the period. The business processes and communications protocols established to support “phase 2” of the MEDS project plan supporting the prior Fiscal Agent (ACS) were successfully implemented. These activities included, but were not limited to:

- Development and distribution of MEDS documentation supporting the incumbent Fiscal Agent (ACS) specific to X12 837 P,I,D Florida specifications;
- HIPAA transmission protocols supporting the collection of encounter EDI transactions and the distribution of processing results;
- Encounter analysis reporting supporting encounter submission accuracy, quality, and trend analysis;

- Extensive communications with MCOs regarding X12 transaction deficiencies through Agency sponsored workgroup conferences, individual MCO telephone conservations, and onsite meetings by the MEDS team at MCO locations;
- The collection and processing of 5,272,922 encounter claims from 15 MCOs through June 2008;
- The update and distribution of MEDS documentation supporting the new Fiscal Agent (EDS) specific to X12 837 P,I,D and NCPDP Florida specifications;
- Testing and validation of new Fiscal Agent (EDS) MMIS encounter data collection and processing systems prior to implementation in July 2008;
- Preparation for the dry runs for CDPS (Chronic Illness and Disability Payment System) to support diagnostic base risk adjustment; and
- The continuous review and enhancement of 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.

During this period pharmacy encounter data using NCPDP transaction formats, encounter data from waiver programs, or data from other prepaid health plans besides HMOs were not collected. Additionally, only capitated transportation encounter data were collected from PSNs who sub-capitated the service. The following figures and tables represent utilization and statistics from the collection of X12 encounter data from capitated MCOs for the period through June 2008.

During this period MCOs remain in various states of production readiness. As illustrated in the MCO Encounter Data Submission Readiness table, one (1) PSN and fourteen (14) HMOs submitted encounter data to the Agency, while four (4) PSNs and four (4) HMOs continue to experience encounter data X12 formatting and completeness challenges. The MEDS team continues to work with these MCOs to address outstanding issues.

MCO Encounter Data Submission Readiness

MCO Encounter Data Submission	PSNs	HMOs
Have not submitted test files	3	1
Attempting to submit test files	1	3
Submitted X12 EDI transactions for all or part of the period Sept 2006 through June 2008	1	14

Through this period 5,272,922 encounter claims have been submitted, with 807,078 failed and/or rejected prior to encounter claims adjudication. The following table depicts the distribution of the 4,465,844 encounter claims accepted and adjudicated within MMIS.

Encounter Claims Passing Adjudication Edits

Encounter Claim Passing Adjudication by Category	Encounter Claims	Recipients	Providers
Inpatient	41,591	19,700	323
Outpatient	347,501	106,401	431
Medical	3,999,854	530,751	18,785
Dental	18,546	2,560	99
Transportation	58,352	21,204	94

As previously mentioned, a total of 807,078 Encounter Claims was reported with one or more exceptions posted during pre-processing or adjudication; distribution by exception code category is:

Encounter Claims Exceptions by Category

CATEGORY	PERCENT
Duplicates & Other	0.84
Diagnosis	2.85
Recipient	1.01
Services	20.02
Provider*	75.28

**The most significant number of exceptions during this period were provider related, due to the relatively new requirement for registration of health plan providers in MMIS.*

The encounter data collected through the previous period continues to be validated for sufficient quality and completeness, to proceed with testing and "dry runs" supporting the diagnosis based CDPS during first half of demonstration Year Three.

Many of the business processes and communications protocols established during the previous period supporting the collection and processing of encounters from Medicaid HMOs have been incorporated into the processing activities supporting the new Fiscal Agent. Additionally, MEDS team "lessons learned" as well as findings from research obtained from other States, CMS, and accrediting agencies continued to be monitored and used to update MEDS business processes and communications protocols.

Look Ahead to Year Three

Future activities incorporated into the Medicaid Encounter Data System (MEDS) project plan include the following:

- Bringing "all" MCOs current with their submission of X12 compliant encounter data;
- Validating encounter claims converted from the previous Fiscal Agent MMIS environment;

- Joint Agency/Health Plan analysis of X12 compliant encounter data focusing on reducing encounter claim defects;
- Extending internal reviews and reporting of encounter data with a focus on accuracy, completeness, and timeliness of MCO submissions;
- Identifying and examining causes of MCO under-reporting of encounter claims;
- Implementing NCPDP following 5.1 Telecommunications Standard for pharmacy encounter data collection;
- Integrating other data collection from waiver programs or other than HMO prepaid plans into the MEDS environment, for example Nursing Home Diversion and Prepaid Mental Health Plans;
- Add functionality for new Medicaid programs as directed by Agency management;
- Undertaking activities associated with the migration of “risk adjusted rates” from the current Medicaid/RX model to CDPS;
- Initiating activities associated with the transition to ASC X12 5010 and the NCPDP 6.0 Telecommunications Standard, when available, for encounter claim processing; and
- Continuous analysis of quality review findings to ensure improvements in the quality of encounter data submissions from MCOs.

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 (6) 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 the demonstration, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two Minority Physician Networks (MPNs) for a total of twelve managed care programs in Broward County; and two HMOs and one MPN for a total of three managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of 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.

As reported previously, the Agency has established contracts with 11 HMOs and 5 PSNs for a total of 17 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 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 choose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform Waiver. Additionally, the Agency established contracts with 1 HMO and 1 PSN in Baker, Clay and Nassau counties and enrollment began in September 2007. None of these health plan options previously had a presence in these three counties.

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

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

Access to Services Not Previously Covered

All of the capitated health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year One of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter (OTC) drug benefits and adult preventive dental benefits. New

expanded benefits available to beneficiaries during Year One of the demonstration included the following:

- Over-the-counter drug benefit from $10-$25 per household, per month,
- Adult Preventative Dental,
- Circumcisions for male newborns,
- Acupuncture,
- 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, and
- 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 quarter of Year Two, the Agency had approved 30 customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of September 1, 2007 to August 31, 2008 and included 1 HMO and 1 FFS PSN for the expansion counties of Baker, Clay and Nassau.

One of the most significant changes in benefits from Year One to Year Two was the continued reduction in cost sharing. Many plans chose to offer expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. The two most popular expanded services offered in Year Two were the same as those offered in Year One: the over-the-counter (OTC) drug benefits and the adult preventative dental benefits. Four of the health plans expanded their OTC drug value from $10 to $25, while another four added a $25 OTC drug benefit. The expanded services offered to beneficiaries by the health plans in Year Two included each of the services that were first available in Year One (see the list above). Only one benefit, Complimentary/Alternative Medicine, was dropped in Year 2.

The following expanded benefits were offered by the health plans for Year Two of the demonstration:

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- 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;
- Respite care;
- Nutrition Therapy;

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

Improving Access to Specialists

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

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

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

That same month the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 41 on the following page shows the results of these analyses.

Table 41
Results of Analyses of Access to Specialty Care
in Duval County (Pre- and Post-Reform)

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

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

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

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

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

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

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

The Agency continues to perform this random sampling analysis each month, and is currently analyzing the May 2008 and June 2008 survey results.

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

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

(a) The first set of performance measure is due July 1, 2008, for the measurement period January 1 2007 to December 31, 2008. These data will allow the state to develop a baseline that will be used to measure improvement in the overall health status of enrollees. As the end of the year approached, the state answered questions about specifications and submission procedures from health plans preparing their data submissions. Although a few health plans requested short extensions on the due date as a result of unforeseen problems, the majority of health plans are prepared to submit data on July 1, 2008. Seven health plans submitted data files prior to the deadline.

Although the original list of required performance measures was disseminated to health plans in December 2006, the several changes were made to the list of performance measures in response to modifications to the Healthcare Effectiveness Data and Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA). Two measures that had been selected by the state were retired by NCQA: Mental Health Utilization: Inpatient Discharges and Average Length of Stay; and Adolescent Immunization Status, although NCQA stated its intent to return Adolescent Immunization Status in 2009 with revisions. In response to these changes, the state created a new Agency-defined measure, Mental Health Readmission Rate, which tracks the rate at which persons who are hospitalized for a mental illness are re-hospitalized within 30 days. The state also added 2 new HEDIS measures: Follow-up Care for Children Prescribed ADHD Medication and Lead Screening in Children. Since NCQA stated its intent to return the Adolescent Immunization Status measure, the state postponed submission of this data until Year Three, which represents calendar year 2009. The full revised list of the required measures and their phase-in schedule can be found on the following page in Table 42.

During demonstration Year Two, the state provided specifications to the health plans on the Agency-defined measures for measurement year two, which represents calendar year 2008. These measures include Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy for enrollees participating in the disease management program for Congestive Heart Failure, Lipid Profile Annually for enrollees in the Hypertension disease management program, and the aforementioned Mental Health Readmission Rate. Although the state had expressed intent in the December 2006 list of measures to create two additional Agency-defined measures for the Asthma disease management program (Use of Rescue Medication and Use of Controller Medication), it was decided that a HEDIS measure, Use of Appropriate Medications for People with Asthma, was suitable for this purpose and more efficiently collected by the health plans.

Once all performance measure data are compiled after July 1, 2008, the state will begin a process of analyzing the data for comparison against national benchmarks and within-state, plan-to-plan comparisons.

Table 42 Performance Measures						
Medicaid Reform Performance Measures			Yr 1	Yr 2	Yr 3	Comments
Plan Population Measures	***Existing Contract Measures***					
	1.	Breast Cancer Screening – (BCS)		✓		
	2.	Cervical Cancer Screening – (CCS)	✓			
	3.	Childhood Immunization Status – (CIS)		✓		
	4.	Adolescent Immunization Status – (AIS)			✓	
	5.	Well-Child Visits in the First 15 Months of Life – (W15)	✓			
	6.	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life– (W34)	✓			
	7.	Adolescent Well Care Visits – (AWC)	✓			
	8.	Number of Enrollees Admitted to the State Mental Hospital	✓			Agency-Defined Measure
	New Performance Measures & Contract Replacement Measures					
	9.	Follow-Up after Hospitalization for Mental Illness – (FUH)	✓			Contract Replacement Measure
	10.	Antidepressant Medication Management – (AMM)		✓		
	11.	Use of Appropriate Medications for People with Asthma – (ASM)		✓		Allows trending for effectiveness of Disease Management Program
	12.	Controlling High Blood Pressure – (CBP)	✓			Same As Above
	13.	Comprehensive Diabetes Care – (CDC) – *Without Blood Pressure Measure*	✓			Same As Above
	14.	Adults Access to Preventive /Ambulatory Health Services – (AAP)		✓		
	15.	Annual Dental Visits – (ADV)	✓			Contract Replacement Measure
	16.	Prenatal and Postpartum Care – (PPC)	✓			Partial Prior Year Data Needed
	17.	Frequency of Ongoing Prenatal Care – (FPC)		✓		Partial Prior Year Data Needed
	18.	Ambulatory Care – (AMB)	✓			
	19.	Mental Health Readmission Rate		✓		
	20.	Mental Health Utilization – Inpatient, Intermediate, & Ambulatory Services – (MPT)			✓	
	21.	Follow-up Care for Children Prescribed ADHD Medication (ADD)			✓	
	22.	Lead Screening in Children (LSC)		✓		

(b) Without robust, valid encounter data, the state has experienced delays in its ability to examine reductions in ambulatory sensitive hospitalizations (refer to Section H for an update on the Encounter Data project). In response to this delay, the state is examining options for other sources of data that will allow an analysis of this issue.

(c) Delays in encounter data collection have also affected the state's ability to analyze the demonstration project's impact on emergency room utilization. On July 1, 2008, health plans will submit data for the Ambulatory Care HEDIS measure. A component of this measure is emergency department utilization per 1000 member months. These data will be submitted to the state annually and will allow the state to trend the impact the demonstration project has had on emergency room use. Because the state wishes to examine this goal on a more frequent basis, we are

exploring options for other sources of data that will allow comparisons to be made until full encounter data is available.

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 second 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 entered into a contractual arrangement with the University of Florida (UF), to conduct yearly Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. When CAHPS comparison survey data are collected during 2009, inferences can begin to be made with regard to patient satisfaction. The CAHPS health plan survey is one of a family of standardized survey instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care.

In order to provide an indication of "benchmark" or "pre-reform" findings, survey data was collected from Broward and Duval Counties during fall 2006. These findings will serve as a baseline for the consumer survey data which will be collected and compared throughout the course of the five-year Medicaid Reform evaluation. In July 2007, UF released a draft report to the Agency, which describes the methodology used to collect that data. It is available at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_ivd_medicaid_reform_annual_report_2006_final.pdf.

The Agency will conduct the CAHPS survey of beneficiaries enrolled in Medicaid Reform health plans on an annual basis. The first "comparative" CAHPS was collected during winter 2007; a draft report with these findings will be released by UF in approximately February 2009.

Additionally, the Agency intends to provide survey results from fall 2007, to the beneficiaries through Choice Counseling materials. These materials will contain comparative information regarding the satisfaction of enrollees in their new Reform health plan. The health plans will also use the survey results for their quality improvement programs to further advance health outcomes of their beneficiaries.

UF also conducted a benchmark CAHPS survey of beneficiaries located in Baker, Clay, and Nassau counties. These benchmark data will be compared to future survey results, to measure the level of patient satisfaction in these three counties prior to and after the implementation of the demonstration waiver.

Another component of the Medicaid Reform evaluation is a qualitative study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health, their previous experiences with Medicaid, and their experiences and understanding of the health care system under Medicaid Reform. Continuing qualitative interviews and focus groups were conducted with enrollees between July 2007 and December 2007, in Broward, Duval, Baker, Clay, and Nassau Counties.

While these findings cannot be used to assess the success or failure of Reform at this time, they demonstrate some aspects of how Medicaid enrollees are responding to the new program changes. Preliminary findings from the qualitative study are summarized in Section J of this report.

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 later in this fiscal year, to ensure that the transition of enrollees to the plans is complete, and beneficiaries have been enrolled in the plan for six months.

The Agency originally planned to conduct the disease management patient satisfaction surveys in the fall of 2007. In June and July 2007, the Reform plans submitted disease management enrollment figures to the Agency. These data showed variability in the plans' identification and enrollment of beneficiaries, making it difficult to compare the Reform plans' disease management programs. The number of enrollees varied greatly across Reform plans, thus preventing statistically valid comparisons between the enrollees' rates of satisfaction by plan. At this time, the Agency is determining how best to measure patient experiences with care for their chronic conditions under Reform, in order to have the most meaningful and useful results.

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

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

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

Additional Services realized in demonstration Year One through LIP funding to non hospital providers such as CHDs, FQHCs and SJRRHN were continued in demonstration Year Two.

Federally Qualified Health Centers (FQHCs)

There are 40 FQHCs operating in Florida providing quality health care in more than 220 service locations. With the $15.3 received in LIP funds, these community health centers were able to see an additional 57,000 patients with nearly 50% being uninsured; the number of providers was increased by 8%; locations of centers were expanded by 36, bring the total number of sites to 219 to serve the additional patients; with the most critical shortage of providers, dental staff was expanded by nearly 18%.

Department Of Health (DOH) – Sarasota Health Care Access

The Sarasota Health Care Access (SHCA) is a county wide, integrated system of care for the uninsured and medically underserved populations in Sarasota County. The objectives of this program are to reduce unnecessary utilization of hospital inpatient and emergency room services while improving access to primary care, specialty care and oral health services. With these objectives, the SHCA hopes to strengthen linkages and communication among area safety net providers and

capitalize and build on existing health care system capacity. There are 12 SHCA partners.

DOH – Duval County Health Department

The main goal of the Duval County Health Department (DCHD) is to address the issues of limited health access for uninsured, especially adults and hospital-focused indigent/uninsured primary care. To work towards this goal, the DCHD strives to assume a leadership role in improving primary care access in Duval County; improve collaboration among safety net stakeholders; increase primary care capacity and connect uninsured and underserved without regular sources of primary care to medical homes; reduce reliance on ERs for treatment and management of Ambulatory Care Sensitive conditions; and apply the LIP's leveraging potential to expand primary care health access for the uninsured and medically underserved. DCHD's achievements with previous/current LIP funds have allowed DCHD to leverage additional local, state and federal funding to expand primary care options for uninsured and low income persons of all ages. Lastly, LIP-financed expansions leveraged a doubling of federal HRTSA investment in uninsured primary care, expanding availability of medical homes.

DOH – Okaloosa County Health Department

Received LIP funds have allowed for follow-up medical exams/ diagnostic tests, and treatment services for women with abnormal results for breast exams and pap smears; tests and services including mammograms, liquid-based cervical cytology tests, HPV tests, colposcopy services, cryotherapy, etc; and the placement of an ARNP and a LPN three days a week at the Crossroads Medical Clinic, a free medical clinic for the uninsured. Activities associated with LIP funds have led to the establishment of a functioning network to serve the uninsured including Okaloosa CHD, Crossroads Medical Clinic, North Okaloosa Medical Center, Ft. Walton Beach Medical Center, and Sacred Heart Hospital.

DOH – Walton County Health Department

LIP funds have supported an additional part-time physician and part-time ARNP in the CHD primary care clinic in Defuniak Springs; two additional exam rooms; 873 additional visits for acute and episodic illnesses and injuries have been funded; and 1,089 additional OB/GYN visits have been funded.

DOH – Lee County Health Department

LIP funds have supported the expansion of women's health services, primarily OB/GYN, at Lehigh Clinic; screening for over 2,000 women for gynecological cancers, diabetes, hypertension, and STDs; and treatment for urinary tract infections and pelvic infections which if not addressed would often result in an ER visit.

DOH – Charlotte County Health Department

LIP funds have provided an additional ARNP in the Primary Care Clinic who generates about 4,500 encounters annually; along with a Hepatitis C treatment clinic

that provides pharmaceutical, medical exams and care coordination to Hepatitis C infected persons.

St. Johns River Rural Health Network

With the support received from the LIP program, the St. Johns River Rural Health Network has been able to provide Primary care services inclusive of CHD, annual and quarterly check-ups, urgent care, preventative services (i.e.: flu shots and other vaccines) and access to pharmacy assistance programs including prescription medications and supplies like glucose test strips. Along with specialty services offering Ophthalmology and Podiatry, Disease Management has grown to include facilitation of participation in health care; enhanced patient-provider communication; assessment and care plan development; and ongoing monitoring and education and encouragement for self care (i.e., medication, diet and exercise).

In demonstration Year Two, as required under STC # 102, the State conducted a study to evaluate the cost-effectiveness of the various Provider Access Systems (hospital and non-hospital providers). The State of Florida contracted with the University of Florida to complete this study and to determine the impact of LIP on increased access for uninsured individuals.

The University of Florida Evaluation team provided the Agency with a written report in April of 2008. In accordance with STC 102 of Florida's 1115 Medicaid Reform Waiver, the results of this study were shared with Federal CMS on April 21, 2008. On June 30, 2008, the Agency submitted a letter to CMS along with the Low Income Pool Program Highlights: Year 1 (SFY 2006-07) document as prepared by the University of Florida. The Low Income Pool Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida Low Income Pool program. During demonstration Year Three, using the results of the study as a guideline, the State and CMS will define the scale of the provider access system 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 Three through Five. During demonstration Year Three, the state will develop a plan for the statewide implementation of the demonstration by the end of Year Five.

J. Evaluation of Medicaid Reform

Overview

The evaluation of Medicaid Reform is an ongoing process, and is scheduled to be completed in June 2010. In November 2005, the Agency contracted for this required 1115 Medicaid Reform Waiver evaluation with an independent entity, the University of Florida (UF). The evaluation was designed to incorporate specific criteria from the waiver, in addition to items contained in the Special Terms and Conditions. The Agency designed and submitted the draft evaluation design of the waiver to CMS on February 15, 2006. The Agency incorporated comments from the CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design for the 1115 Medicaid Reform Evaluation (MRE) to CMS on May 24, 2006. Approval was received from CMS on June 13, 2006.

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

The MRE is 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, therefore, the Agency, along with several other entities have conducted shorter-term evaluations which look at specific issues. Descriptions of reports released during demonstration Year Two are listed below.

Year Two at a Glance

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 conducted a review of the implementation of the1115 Medicaid Reform Wavier. The review objectives were as follows:

- Document the current status of Medicaid Reform impact from the perspectives of stakeholders, coupled with available performance data.
- Provide recommendations 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 report was released in September 2007. The Medicaid Program has examined the findings of the report, and is working toward achieving the necessary goals through its Continuous Improvement program.

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 demonstration. 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.

UF and the Urban Institute established an additional subcontract during Year Two. UF will repeat the fieldwork for a cross-sectional study being conducted by the Institute.

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 by UF. Following normal review procedures, reports are being disseminated by the University of Oregon. Two issue briefs and a resource paper were released in July 2007, and are available here: http://pppm.uoregon.edu/index.cfm?mode=news&id=506.

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) has conducted several reviews of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. This Chapter provides that reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. OPPAGA released the following reports during demonstration Year Two:

- Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program, Report Number 08-37, June 2008;
- Medicaid Reform: More Managed Care Options Available; Differences Limited by Federal and State Requirements, Report Number 08-38, June 2008; and
- Medicaid Reform: Two-Thirds of the Initial Pilot Counties Beneficiaries Are Enrolled in Reform Plans, Report Number 08-40, June 2008.

General Accounting Office

The General Accounting Office (GAO) conducted 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)" was released July 24, 2007, and

published on the GAO website: http://www.gao.gov/new.items/d07694r.pdf. A second letter, also released July 24, 2007, was titled "Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act." It is available on the GAO website at http://www.gao.gov/decisions/other/309734.pdf.

The GAO conducted an additional review of Florida's 1115 Medicaid Waiver. The report, titled "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns (GAO-08-87)" was released in January 2008 and is available on the GAO website: http://www.gao.gov/new.items/d0887.pdf.

3. Evaluations in Demonstration Year Two

UF will continue to coordinate all evaluation activities pertaining to the demonstration, which will be conducted by various entities.

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

In addition to the studies already initiated, the Agency will fund a study of the mental and behavioral aspects of Medicaid in the Reform and expansion counties (Broward, Duval, Baker, Clay, and Nassau). This study will be conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF.

University of Florida - Qualitative Survey

One of the components of the MRE is a qualitative (previously called longitudinal[5]) study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health care, their previous experiences with Medicaid, and the overall healthcare system. Additionally, this study looks at current enrollee health care 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 were early enrollees to the demonstration, or were about to be enrolled in Medicaid Reform plans. This group is not intended to be representative of all demonstration participants due to its small size, and possible differences from the rest of Reform.

Due to the small number of participants involved, this study cannot be generalized to other Medicaid recipients. It can only be used to demonstrate how this group of Medicaid enrollees respond to program changes. The baseline findings were reported in July 2007; the initial comparative information is scheduled for release in July 2008.

[5] This study was originally intended to be longitudinal; that is, it would follow the same recipients over time from before implementation through the end of the study period. However, it proved difficult to locate the same recipients and convince them to participate numerous times. Therefore, the study will replace dropped-out recipients with others, leading to a "qualitative" but not "longitudinal" study.

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 first findings were reported in July 2007, with comparative information expected in July 2008.

Year Three of Reform

It is too early to determine the impact of Florida's Medicaid Reform initiative. However, comparative information is beginning to be available. These data will be used to track the demonstration's progress towards the evaluation objectives. As more data are gathered 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 the demonstration. However, it is important to caution against jumping to conclusions about the success or failure of the demonstration before more time has passed, and meaningful information is 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 Secretary. FAC members represent key stakeholders with strong interests in the demonstration, 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 the demonstration 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—CHAIN), 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, 2006 at Agency headquarters. The purpose of this meeting was to provide an overview of the demonstration and evaluation processes, while also enabling committee members the opportunity to provide input.

The December 12, 2007, annual meeting of the FAC was also held at Agency headquarters. The purpose of this meeting was to give FAC members an update on status of the evaluation. The members were updated on evaluation activities that had occurred during the previous year, and to allow an opportunity for the members to ask questions or provide input with regard to the evaluation process.

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 allow a formal setting for the TAC members to provide the MRE Team with methodological expertise, contacts, advice, and insights.

The second annual TAC meeting was held in Gainesville, Florida, on March 7, 2008. This meeting's purpose was for UF team members to meet with TAC members to discuss the projects and reports being conducted, and to provide input and advice as appropriate.

K. Policy and Administrative Issues

Overview

In general, policy, administrative and operational issues were addressed through processes identified and implemented during demonstration Year One, with the addition of one new venue, the Continuous Improvement Team. The Continuous Improvement Team was created at the end of Year One to provide the Agency's operational staff with feedback from all stakeholders including enrollees, providers, plans and advocates on specific tenants of the demonstration. Such feedback was provided through public forums, independently moderated and locally held to ensure beneficiary and provider participation. The main processes used to collect and address administrative and operational issues during demonstration Year Two were:

- Technical Advisory Panel Meetings
- Policy Transmittals and Dear Provider Emails
- Bi-weekly Reform Health Plan Technical & Operational Conference Calls
- PSN Systems Implementation Monthly Conference Calls
- Continuous Improvement Team

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

Year Two at a Glance

Medicaid Reform Technical Advisory Panel

With the majority of implementation issues being resolved during Year One, the Medicaid Reform Technical Advisory Panel (TAP) met periodically (five times) during Year Two of the demonstration. The 9 member TAP was created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration. Areas in which advice from TAP is particularly sought includes risk-adjusted rate setting, benefit design, the Choice Counseling and Enhanced Benefits programs and Medicaid encounter data collection and processing. Two new key items on the agenda during demonstration Year Two were: the implementation of Choice Counseling's Navigator Program and the transition to a new Medicaid fiscal agent that was originally to take effect March 1, 2008, and was extended to July 1, 2008. The TAP continued to be helpful through their provider and plan insight – ensuring Agency processes and procedures were well thought out and properly vetted.

Policy Transmittals

During Year Two, the Agency released many policy transmittals and Dear Provider letters/emails to the health plans. These policy transmittals were more operational in nature as processes have become stabilized in the demonstration counties. The issues addressed in the various policy transmittals are summarized below:

- Clarification on the submission of obstetrical kick payments and the provision of an extension of the claim submission deadline.
- Medicaid redetermination date notice requirements – for health plans participating in the provision of notices to enrollees whose Medicaid redetermination dates were upcoming.
- Notice to health plans that their default identification numbers were no longer acceptable on their Medicaid provider network files and that health plans now were required to include national provider identification numbers in fields on their network files.
- Modifications in behavioral health record reviews and staff reporting (with input from providers as well as health plans).
- Modification to performance measures relative to the Agency-defined performance measures as well as certain Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Reduction in the number of performance improvement plans that health plans had to conduct based on feedback from the Agency's external quality review organization.
- Clarification on the payment requirements for certain county health department services.
- Reiteration of the importance of accurate provider network files and notice to health plans of the Agency's sanctioning authority in regards to inaccurate files.
- Reiteration of the importance of ensuring the health plan's provision of physical screenings of children taken into protective custody, emergency shelter or foster care.
- Notice of availability of Child Health Check-Up outreach materials for distribution.
- Provision of a PSN Provider Medicaid Fiscal Agent File Layout Guide.
- Notice of availability of NPI provider crosswalks to allow PSNs to see how their plan network providers had registered their NPI with Florida Medicaid.
- Notice regarding the implementation of the Agency's Comprehensive Hemophilia Disease Management program and how PSN recipients can take advantage of the program.
- Updated Plan Evaluation Tool (PET) and submission deadlines for the September 1, 2008 through August 30, 2009 contract period.

Biweekly Technical and Operations Calls

The Agency conducted 27 biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants between July 1, 2007 and June 30, 2008. The purpose of the calls is to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether or not they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of the demonstration, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers and health plan subcontractors.

Approximately 20 to 30 participants attended in person and the popularity of these calls is shown by the 200 phone lines in active use on the calls. Again, as there were fewer implementation items, the transition to the new Medicaid fiscal agent and system, and the mandatory implementation of the NPI became the number one and two agenda items by the beginning of 2008. Fiscal agent transition issues, including file transfer testing was a key routine topic. NPI provider identification and crosswalks of files to assist plans in ensuring they had correctly registered NPIs for their providers were key NPI concerns with the May 2008 NPI implementation date.

Other typical agenda items included:

- Medicaid fiscal agent processing of HIPAA compliant transactions and reports;
- Network and prescribed drug list compliance reminders and issues;
- Enrollment issues, including identification and resolution of transmission issues;
- Choice Counseling Program updates, including the upcoming drug finder program that will allow choice counselors to view beneficiary drug information and what health plans provide;
- Discontinuation of the health plan disenrollment file under the new Medicaid fiscal agent;
- Medicaid Enhanced Benefit Account Program updates;
- Medicaid Encounter Data Systems updates, including notice of schedules for submission and changes in file formats;
- Review of proposed and new performance measures reporting requirements;
- Review of the new hemophilia disease management program;
- Claims payment issues;
- Kick payment processing;
- Behavioral health medical records audits and staff reporting;

- External Quality Review Organization updates and notification of Webinars and other meeting opportunities; and
- General Amendment updates, including September 2008 rate and benefit amendment timelines.

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.

Fee-for-Service PSN Systems Implementation Issues Calls

With the Reform implementation timeline in conjunction with the transition to the new 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 continue assisting the PSNs with systems issues. 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 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.

During demonstration Year One, over 60 issues were opened and addressed through the Systems Implementation Issues Calls, and approximately 55 of those were resolved, with a few of the remaining issues being left unresolved until the systems freeze is lifted in the new Medicaid fiscal agent system. During demonstration Year Two, approximately 40 issues were opened and approximately 55 were resolved (including remaining items from Year One), with four issues carrying over into demonstration Year Three. Approximately 50% of the issues received during Year Two regarded the Medicaid fiscal agent systems conversion and 25% were related to the mandatory requirement for NPI submission effective May 2008. The statistics show that only about 10 issues reported were related to ongoing fiscal agent operations, indicating relative stability in PSN claims and report issues.

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

- Medicaid fiscal agent transition and testing issues relative to PSN enrollees, claims vouchers, and enrollment file formats.
- National Provider Number identification and Medicaid provider identification matching issues.
- Paper claims backlog issues as the legacy Medicaid fiscal agent staff found other employment toward the end of their contract and less trained staff took over the paper claims processing activities.
- Revisions to the PSNs' electronic remittance voucher to ensure it included final claims adjustments when inpatient per diem rates were changed retroactively.
- Issues relative to the systems freeze due to the transition of the Florida Medicaid Management Information System (FMMIS).

In addition, once the new FMMIS is stabilized, the Agency will continue to work with the new Florida Medicaid fiscal agent to install a systems change that will cause claims submitted by the following provider types to be denied unless authorization is provided by the FFS PSN:

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

Due to problems the home health, community mental health and targeted case management providers experienced in Year One, 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.

In addition as noted elsewhere in this report, the Agency intends to work with the PSNs and key stakeholders to modify the current claims process for FFS PSNs in order to streamline the claims processing function by removing the claims processing step that includes the providers submitting claims to the FFS PSNs and the FFS PSNs having to accept and transmit the authorized claims to the Medicaid fiscal agent and instead allow providers to submit claims directly to the Medicaid fiscal agent and have the FFS PSNs authorize the claims through the Medicaid fiscal agent for payment.

In addition to these calls, the Agency continued to coordinate technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, it has been needed only with a few providers.

Continuous Improvement Team Forums

The Continuous Improvement Team was created to provide operational staff with feedback from enrollees, providers and health plans on what is working in the demonstration and what may need modification. The team was made up of Agency staff from many bureaus as well as an independent team member from Mercer, Inc., who conducted the forums and provided key technical support on agendas, handouts, and feedback collection. The feedback received was collected through independently moderated public forums held by the Team on certain processes. While information received was put to immediate use by Agency staff, the Agency intends to release a summary report that reflects the Continuous Improvement Team Forums and resulting activities. The areas for which the team collected feedback are as follows:

- Outreach
- Plan Customer Service
- Plan Benefits and Services
- Plan Provider Services
- Service Authorization
- Claims Processing
- PSN Lessons Learned
- Expansion into rural counties (Baker, Clay and Nassau Counties)
- Medicaid Encounter Data System implementation

These forums were held throughout Year Two of the demonstration. Some were held locally, in both Duval and Broward counties, in order to be accessible to providers, stakeholders and affected beneficiaries, and some involving health plans were held in Tallahassee. Key feedback included the following:

- Stakeholder input is valuable.
- The need for improved communication on the Agency's activities as many providers and beneficiaries were unaware that corrections had been implemented to address many of the issues.
- The need for multiple venues (meetings, written notices, etc.).
- Greater advance notice of forums was needed so that more stakeholders could attend.
- Claims processing delays and managed care service authorization processes were frustrating to providers.
- Providers were appreciative of both Agency Area Office and Headquarters staff assistance in navigating the implementation of the demonstration.
- Health plans were impeded by the rapid implementation of the demonstration and the timing of the transition to a new Medicaid fiscal agents (which reduced the Agency's ability to perform systems changes timely).
- Health plans applauded the Agency's biweekly technical and operations calls, PSN systems implementation and technical assistance plan-specific calls, and Area Office technical assistance throughout implementation, Year One, and Year Two.