Florida Medicaid Reform

Year 3
Annual Report
July 1, 2008 – June 30, 2009

1115 Research and Demonstration Waiver

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the 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 three 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. Listed below are highlights from demonstration Year Three. A more in depth review of these highlights, including activities planned for demonstration Year Four, are found in the body of the report.[1]

Highlights of Demonstration Year Three

- Implemented a new health plan contract management oversight process to ensure contract compliance and communication among all Agency staff.
- Implemented the Navigator Pharmacy Drug List system to enable beneficiaries to select a plan that best meets their prescribed drug needs.
- Approved three health plan applications and one health plan expansion into Duval, Baker, Clay, and Nassau Counties.
- Developed the Mental Health Unit and expanded the Special Needs Unit within the Choice Counseling Program.
- Created a more user friendly OTC products list for use by beneficiaries and the Enhanced Benefits counselors.
- Increased Enhanced Benefit Account purchases of health-related products from a total of $113,158.97 in Year Two to a total of $6,385,113.91 in Year Three.
- Increased enrollments by Field Choice Counselors at the local level by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These changes resulted in the certified Field Choice Counselors completing over 30 percent of the enrollments.

[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 third operational year of the waiver program, July 1, 2008 through June 30, 2009.

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. The Florida Medicaid community is leading the way in improving care for all Florida citizens.

Sincerely,

Phil E. Williams
Interim 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 (F.S.), 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 annual reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, F.S., 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 third operational year beginning July 1, 2008 through June 30, 2009. 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 22 health plan applications (15 health maintenance organizations and 7 provider service networks) of which 20 applicants sought to provide services to the TANF and SSI population. The two remaining applicants sought to render services as specialty health plans. Of the 22 health plan applications received, all but two were approved as health plans as of June 30, 2009.

The two pending applications were submitted by HMOs: AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application in January 2008, to serve beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of June 30, 2009, the specialty plan application was nearing completion of Phase III of the application process[2]. The other pending application is from Medica Health Plans of Florida, which is an HMO with a national base. As of June 30, 2009, this HMO application was in Phase II of the application process.

During Year Three of the demonstration, three health plan applicants completed the application process: Better Health Plan (a fee-for-service PSN), Molina Health Plan (HMO), and Sunshine State Health Plan (HMO).

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. Table 1 is located on the following page.

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

Table 1 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	09/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South FL Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista*	HMO	X*		04/14/06	06/29/06
Vista Health Plan SF*	HMO	X*		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates**	PSN	X**		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	12/10/08
Positive Health Care	HMO	X		01/28/08	***Pending***
Medica Health Plans of Florida	HMO	X		09/29/08	***Pending***
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		1/14/09	05/20/09

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

** During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.

*** During Spring of 2009, the plan notified the Agency of their intent to withdraw from this/these counties.

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan, and coverage area. Three new health plan contracts were executed during Year Three of the demonstration.

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 FL 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	10/01/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		

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

** During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.

*** During Spring of 2009, the plan notified the Agency of their intent to withdraw from this/these counties.

Contract Amendments

Three general amendments were executed during Year Three of the demonstration. Two amendments addressed capitation rates as required under Florida law (effective September 2008 and March 2009). One general amendment eliminated marketing and revised the encounter data provisions to provide health plans with timelines for submission and remediation of encounter data, as well as outlining corrective action measures and defining encounter data accuracy and completeness. In addition, many health plan-specific contract amendments were executed, including one health plan expansion into Duval, Baker, Clay, and Nassau Counties. Seven health plans requested and received Agency approval to increase their maximum enrollment levels in various counties. Two health plans requested a decrease in their maximum enrollment levels.

Contract Oversight

The Agency continued to refine it's health plan contract monitoring and oversight processes. New processes were fully implemented during Year Three, including monthly Oversight Team reviews of health plan monitoring activities, complaints, grievances, sanctions, and reporting to help ensure contract compliance and staff communication. A standard form was created to capture various elements of health plan contract compliance from the multiple bureaus responsible for monitoring and management. The forms are reviewed at the Oversight Team meetings, including additional action that may be necessary.

During the second and third quarters, the Agency reviewed and posted the results of the plan performance measures submitted by the health plans. In addition, the Agency Secretary and key Agency staff held face-to-face meetings with each plan's executive leadership to discuss individual plan performance and corrective action plans as needed. Agency staff continued work to develop minimum performance standard thresholds that will be incorporated into the September 2009 consolidated contract.

2009 Model Contract

During Year Three of the demonstration, Agency staff began working on contract revisions for the 2009 consolidated model health plan contract. The consolidated health plan model contract will be a streamlined version of the current separate model health plan contracts (FFS PSN, capitated PSN, HMO and specialty plan for children with chronic conditions, specialty plan for persons living with HIV/AIDS). The Agency is creating one core contract that a health plan will sign with exhibits that detail any unique plan and population requirements of the particular plan (FFS PSN, capitated PSN, HMO, specialty population, age group). In June 2009, the draft contract was shared with the health plans, Florida CHAIN, and Florida Legal Services (each of the later two are statewide advocacy groups). Feedback from these stakeholders is currently under review. The Agency intends to use this new model health plan contract for the contract period beginning September 1, 2009.

In addition, health plan contract revisions include the removal of reporting templates and detailed reporting instructions[3] from the contract and the creation of a plan-friendly electronic report guide companion to the contract. The report templates and detailed instructions will be provided to health plans through Report Guide postings on the Agency's website. This change will streamline the ability for the Agency staff to make changes to report formats and instructions and be responsive to health plan contractors. The Agency intends to workshop the Report Guide and template/instruction changes with health plan staff in July and August 2009.

The Agency is also sensitive to ensuring that access to specialty care is covered as much as possible within the health plan contract. To help accomplish this, during the last quarter of Year Three, the Agency requested its external quality review organization conduct a national review of health plan contract language and federal requirements regarding access to specialty care. The results of that review are expected early in demonstration Year Four.

Contract Conversions/Terminations

Purchase Agreements/Acquisitions

During demonstration Year Three, the Agency received notice of three health plan purchase agreements/acquisitions. Access Health Solutions (PSN) entered into a purchase agreement with Pediatric Associates (PSN) and transitioned beneficiaries in February 2009. Molina Health Plan (HMO) intends to enter into a purchase agreement with Florida NetPASS (PSN); and Sunshine State Health Plan (HMO) intends to enter into a purchase agreement with Access Health Solutions (PSN) with transition occurring in demonstration Year Four.

Prior to approving the acquisition, the Agency compared provider networks, including behavioral health providers to ensure continuity of care and to ensure the continued availability of current providers, with the purchasing plan. The Agency also compared behavioral health care provider networks to identify any enrollees in active behavioral health care in need of a written care coordination plan. Each purchasing plan also had to submit materials and implementation calendars to demonstrate to the Agency that network providers were properly educated about any changes to claims submissions and processing.

For each transition, enrollees were given written notification of the change and an opportunity to select another health plan. The health plan sent letters to its members 60 days prior to the enrollment-transition date and the Agency sent letters to the enrollees 30 days prior to the transition date. Beneficiaries impacted by the transition were given 90 days after the transition to disenroll without cause and select another plan. A detailed summary of the transitions are provided in demonstration Year Three quarterly reports.

[3] The removal of the reporting templates and detailed reporting instructions does not remove any of the health plan reporting requirements.

Terminations

Five HMOs notified the Agency of their intent to withdraw from demonstration counties during demonstration Year Three. United HealthCare withdrew from Broward County effective November 1, 2008; Vista South Florida and Buena Vista withdrew from Broward County effective December 1, 2008 and HealthEase and Staywell, both owned by parent company Wellcare, are withdrawing from Broward and Duval counties through a staggered transition process effective July 1, 2009. Wellcare's stated reasons for pulling out of these counties were not specific to the demonstration, but instead were related to the legislated March 1, 2009, capitation rate reduction.

In each scenario, the Agency carefully planned the transition of beneficiaries into other health plans. To mitigate disruption to affected enrollees as he or she enrolls with new plans and to assist beneficiaries through the health plan choice process, the Agency used the following multi-layered approach:

- Assessment of enrollment capacity in the remaining plans and determination of whether those plans were able to ensure all impacted beneficiaries had access to quality care.
- Worked closely with the plans and the Choice Counseling Program to create staggered withdrawal dates to ensure the volume of beneficiaries that were being transitioned occurred in an organized manner.
- Worked closely with the plans, the Choice Counseling Program, local Medicaid Area Office staff, and advocacy groups to ensure appropriate and timely notice to enrollees.
- Worked closely with the plans to supply primary care provider (PCP) and service information to ensure continuity of care and minimize disruption to the beneficiaries, including reviewing the withdrawing plan's provider network to determine which PCPs are available in other health plans.
- Assisted PCPs unique to the withdrawing plan through the Medicaid provider enrollment process to facilitate the provider's enrollment in other health plan provider networks.

In addition, the Agency amended the Choice Counseling vendor contract to allow for additional Choice Counselors to be hired to properly manage the increased call volume to the Call Center during the summer 2009 transition period. The Field Choice Counselors located in the Medicaid Area Offices in Broward and Duval counties assisted impacted enrollees in their choice of another plan. Monday through Friday, throughout the fourth quarter of this demonstration year, the Field Choice Counselors conducted special face-to-face Choice Counseling sessions specifically geared to transition enrollees. These face-to-face sessions will be continued through August 2009.

The Agency worked with the Choice Counseling vendor, the health plans and various advocacy groups to ensure the transition message being communicated would be easy to understand and available through many forums. The Agency developed and released flyers to advocacy groups, the Florida Department of Health, large Staywell

and HealthEase providers, shelters for the homeless, homeless meal locations, as well as the Florida Department of Children and Families to help ensure beneficiaries understood the changes that were occurring. In addition, Medicaid Area Office staff researched behavioral health service providers/case worker locations to include these organizations in the outreach activities.

The Agency continues to conduct weekly calls with the Medicaid Area Offices and the Choice Counseling vendor to ensure all issues are resolved quickly.

FFS PSN Conversion Process

Pursuant to the 2009 Legislation which revised section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the sixth year of operation (previously, the statute stated no later than the beginning of the fourth 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, 2011, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

Table 3 provides the list of 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	09/01/2011
Better Health	05/01/2014
Children's Medical Services Network, Florida Department of Health	12/01/2011
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2011
South Florida Community Care Network	09/01/2011

While most FFS PSNs have submitted conversion workplans and applications to the Agency in order to comply with the previous 3-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications to allow them to learn from the additional two years of experience. Table 4 provides the timeline for each step in this conversion process based on the current contract. However, the health plan contract that will go into effect on September 1, 2009, proposes to extend the FFS PSNs deadline for submission of the conversion work plan to 24 months after beginning operations and extends the deadline for submission of the conversion application to August 1 of the fourth year of operations.

Table 4
PSN Conversion to Capitation Timeline

Deadline for the FFS PSN to submit its conversion workplan to the Agency	01/31/2008
Deadline for the FFS PSN to submit its conversion application to the Agency	12/31/2008
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2011	06/30/2011

FFS PSN Reconciliations

During Year Three, the Agency continued work on two reconciliation[4] periods: one period for the first four months of the second contract year (September 2007 through December 2007) and the final reconciliation for the first contract year (September 2006 through August 2007). The Agency continues to provide technical assistance to PSNs that have requested additional time as they analyze their reconciliation data.

Year Three at a Glance

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

- Approval of three health plan applications.
- Approval of one health plan expansion into Duval, Baker, Clay, and Nassau counties.
- Smooth transition of enrollees impacted by health plan purchases and terminations.
- Elimination of direct marketing and inclusion of Medicaid encounter data submission requirements through a general contract amendment, with an effective date of March 1, 2009.
- Implementation of a new health plan contract management oversight process to ensure contract compliance and communication among all affected Agency staff.
- Posting of plan performance measures and additional emphasis on health plan improvement.
- 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.

Lessons Learned

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

- Staying up-to-date on new systems issues, as a result of the Fiscal Agent transition, communicating with the plans, and researching potential new issues was time intensive and required expert communication by all parties.
- From a Fiscal Agent and Medicaid Management Information System perspective, each health plan transition and purchase was unique and required special programming.

[4] 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 payment to them periodically according to contract requirements.

- Implementation of the new health plan contract management oversight process has improved communication among the Agency bureaus responsible for various aspects of contract compliance. The shared form and monthly meetings has fostered a stronger sense of teamwork.

Look Ahead to Year Four

One key principle of the demonstration was that market competition would inspire innovation and create efficiencies in Medicaid coverage. Demonstration Year Four is anticipated as being another year of innovation, 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. These specialty plans will provide Florida Medicaid with more information on how to effectively provide care to specialized populations. As FFS PSNs mature and strive toward the required conversion to capitation at the end of Year Five, 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 demonstration Year Four. As the new system priorities are refined, 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.

Health plans now have defined timelines for encounter data submission, as well as remediation of encounters failing compliance and/or adjudication. Demonstration Year Four will be the first year of full encounter data submission. The Agency will continue to work with the health plans to ensure accuracy and will determine how best to use the data. Additional contract requirements may occur in this area as the Agency's experience grows.

During the next year, the Agency will streamline various model health plan contracts into one model contract to eliminate duplicative review, reduce potential for inconsistent requirements across plan types (where appropriate), condense topics, design and implement a report guide companion to the contract, and help ensure that quality initiatives are applied consistently. Other expected contract initiatives include adding plan performance measure sanctions and incentives as well as researching additional ways to ensure appropriate access to specialty services.

In addition, the Agency is working to improve the application process and all related documents, develop a standardized workshop for potential applicants, and establish a timeline for application review and health plan implementation.

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 copayments and offer additional services.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages and verified that they were actuarially equivalent and that sufficient coverage was provided for all services. To develop the actuarial and sufficiency benchmarks, the Agency defined the target populations as Family and Children, Aged and Disabled, Children with Chronic Conditions, and Individuals with HIV/AIDS. The Agency then developed the sufficiency threshold for specified services. The Agency identified all services covered by the plans and classified them into three broad categories: covered at the State Plan limits, covered at the sufficiency threshold, and flexible. For services classified as "covered at the State Plan limit," the plan 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 in quickly identifying 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 a Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were released on May 23, 2007 for Year Two and May 7, 2008 for Year Three. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a

complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

The Agency, the health plans, and the beneficiaries can see the value of customization. The Agency has seen an increase in the percentage of voluntary plan choices. The health plans have used the opportunity to offer additional, alternative, and attractive services. In addition, the health plan enrollees are receiving additional services that were not available under the regular Florida Medicaid State Plan. The average value of the customized benefits package continued to exceed the Florida Medicaid State Plan benefit package during Year Three of the demonstration.

Year Three at a Glance

The benefit packages customized by the health plans for Year Three of the demonstration became operational on November 1, 2008 and were valid until August 31, 2009. These benefit packages include twenty-eight customized benefit packages for the HMOs and fourteen different expanded benefits for the FFS PSNs.

The twelve HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Three of the demonstration were Amerigroup, Buena Vista, Freedom Health Plan, HealthEase, Humana, Molina Healthcare, Preferred Medical Plan, StayWell, Total Health Choice, United Health Care, Universal Health Care, and Vista South Florida. The seven FFS PSNs were Access Health Solutions, Better Health, Children's Medical Services, First Coast Advantage, NetPass, Pediatric Associates, and the South Florida Community Care Network.

One significant change in the benefit packages for Year Three from Year Two is the increase in the total number of copayments from Demonstration Year Two. In total, there are eighty-five more copayments required during Year Three (104) than in Year Two (19). From Year Two to Year Three, there were increases in the number of copayments in all categories except dental. However, despite the increase in the number of copayments, twenty benefit packages (71%) have no copayments in all sixteen categories. It is important to note that copayments apply only to non-pregnant adults.

During the third quarter of demonstration Year Three, Buena Vista, Vista South Florida, and Pediatric Associates ceased operations within the demonstration counties. The beneficiaries who had been enrolled in these health plans were transitioned into the remaining plans. The departure of these plans, in particular the two Vista health plans, greatly changed the number of required copayments. The Vista health plans required copayments, one for every type of service, and as a result of their departure the total

number of copayments required decreased from 104 to 40. In addition, the percentage of benefit packages requiring no copayments increased to 83% (see Table 6 and 7).

Table 5 lists the number of copayments for each service type by each demonstration year. Year Three has been divided into two columns (July 1, 2008 to December 31, 2008 and January 1, 2009 to June 30, 2009) to reflect the plans which ceased operations during the third quarter.

Table 6 indicates the number and percentage of each benefit package which in total does not require any copayments, also shown by demonstration year. Table 7 shows that for each area and target population there were at least two benefit packages to choose from with no copayments.

Table 5
Number of Copayments by Type of Service by Demonstration Year

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

Table 6
Number & Percent of Total Benefit Packages Requiring No Copayments by Year

	Year One	Year Two	Year Three (July-Dec)	Year Three (Jan-June)
Total Number of Benefit Packages	**28**	**30**	**28**	**24**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**	**20**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**	**83%**

Table 7
Number of Benefit Packages Requiring No Copayments
by Target Population & Area
(Demonstration Year Three)

Target Population	List of Counties in Each Demonstration Area	Number of Benefit Packages Not Requiring Copayments
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	**4**
SSI (Aged and Disabled)	Broward	**8**
TANF (Children and Families)	Duval, Baker, Clay and Nassau	**2**
TANF (Children and Families)	Broward	**6**

In Year Three of the demonstration, many plans continued to provide services not currently covered by Medicaid to attract enrollees. In the health plan contract, these are referred to as "expanded services." There were eleven different expanded services offered by the health plans during Year Three. The two most popular expanded services offered were the same as Year Two: the over-the-counter (OTC) drug benefits and the adult preventive dental benefits. Thirteen of the customized benefit packages decreased their OTC value, while one added a $25 OTC benefit. The expanded services available to beneficiaries include:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventive 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;
- Respite care; and
- Nutrition Therapy.

Since implementation of the demonstration, no changes have been made to the sufficiency thresholds that were originally established for the first contract period of September 1, 2006 to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Year Three to a monthly prescription limit only. In Demonstration Year One and Year Two, plans had the option of having a monthly prescription limit or a dollar limit on the pharmacy benefit. This change will make it easier for beneficiaries to evaluate whether the health plan pharmacy benefit meets their needs and allow for enhanced oversight by the Agency. 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 Four

The Agency continues to review utilization 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. Examples of benefits that are more valued by beneficiaries are individualized alternative treatment and additional benefits that are not covered under state plan services.

The PET submission procedure for demonstration Year Four will be similar to that of previous years. The updated version of the data book will be released by the Agency on September 3, 2009, and the new PET will be made available to the health plans later in that month. Like in demonstration Year Three, the effective date of the Year Four benefit packages is scheduled to be November 1, 2009[5]. This will ensure that there is adequate notification to the beneficiaries of any reduction in their current health plan's benefit package. The November 1, 2009 effective date also allows time for the printing and distribution of the revised choice materials, which will include the plan benefit packages for demonstration Year Four.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, and Medicaid Fair Hearing (MFH) system. In addition, plan contracts include timeframes for submission, plan response and resolution of beneficiary grievances. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) as specified in section 408.7056, F.S., for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel for enrollees in a FFS PSN (as described on the following page). This provides an additional level of appeal.

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Health Plan to act within ninety (90) days from the date the Health Plan receives a Grievance, or 45 days from the date the Health Plan receives an Appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an Enrollee's request to exercise his or her rights to obtain services outside the network.
- Appeal means a request for review of an Action, pursuant to 42 CFR 438.400(b).

[5] The effective date may be revised after the rates are released in August 2009.

- Grievance means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

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

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

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

Year Three 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 issues 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 by enrolled members or providers utilizing the plan's internal grievance and appeal process. The Agency also uses this information as a part of continuous improvement and quality oversight.

Grievances & Appeals

Table 8 provides the number of grievances and appeals reported by the PSNs and HMOs for the period July 1, 2008 - June 30, 2009.

Table 8
Grievances and Appeals
July 1, 2008 – June 30, 2009

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
July-Sept 2008	40	15	187	41	224,830
Oct-Dec 2008	9	6	213	110	226,654
Jan-March 2009	54	9	170	85	236,375
April-June 2009	62	17	123	59	247,264
Total	**165**	**47**	**693**	**295**	311,563

*unduplicated enrollment count

While the number of plan reported grievances and appeals appears to increase during Year Three 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 9 provides the number of Medicaid Fair Hearings requested for the demonstration period July 1, 2008- June 30, 2009. 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 18 Medicaid Fair Hearings requests, 16 requests were related to denial of benefits/services, one request was related to substandard medical care, and one was unknown and pending more information from the Department of Children and Families, specifically related to pharmacy issues. Only two Medicaid Fair Hearings were actually held and the outcome resulted in the plan actions being confirmed as accurate and the plan having provided services appropriately. Seven Medicaid Fair Hearings were pending and the other nine requests were resolved by the health plan and member prior to the hearing date.

Table 9
Medicaid Fair Hearing Requests
July 1, 2008- June 30, 2009

	PSN	HMO
July-Sept 2008	3	2
Oct-Dec 2008	3	2
Jan-March 2009	1	1
April-June 2009	3	3
Total	**10**	**8**

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only one grievance was submitted to the BAP and three to the SAP in demonstration Year Three. The one BAP grievance issue was related to skilled private duty nursing and was resolved in favor of the health plan (PSN). Of the three SAP grievance issues, one was related to prescription medications and one was related to cancer treatment. Both of these issues were withdrawn, while the third issue was pending additional information.

Table 10 provides the number requests to BAP and SAP for the period July 1, 2008 through June 30, 2009.

Table 10
BAP and SAP Requests
July 1, 2008- June 30, 2009

	BAP	SAP
July-Sept 2008	1	0
Oct-Dec 2008	0	0
Jan-March 2009	0	0
April-June 2009	0	3
Total	**1**	**3**

Looking Ahead to Year Four

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 Medicaid 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 Medicaid 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

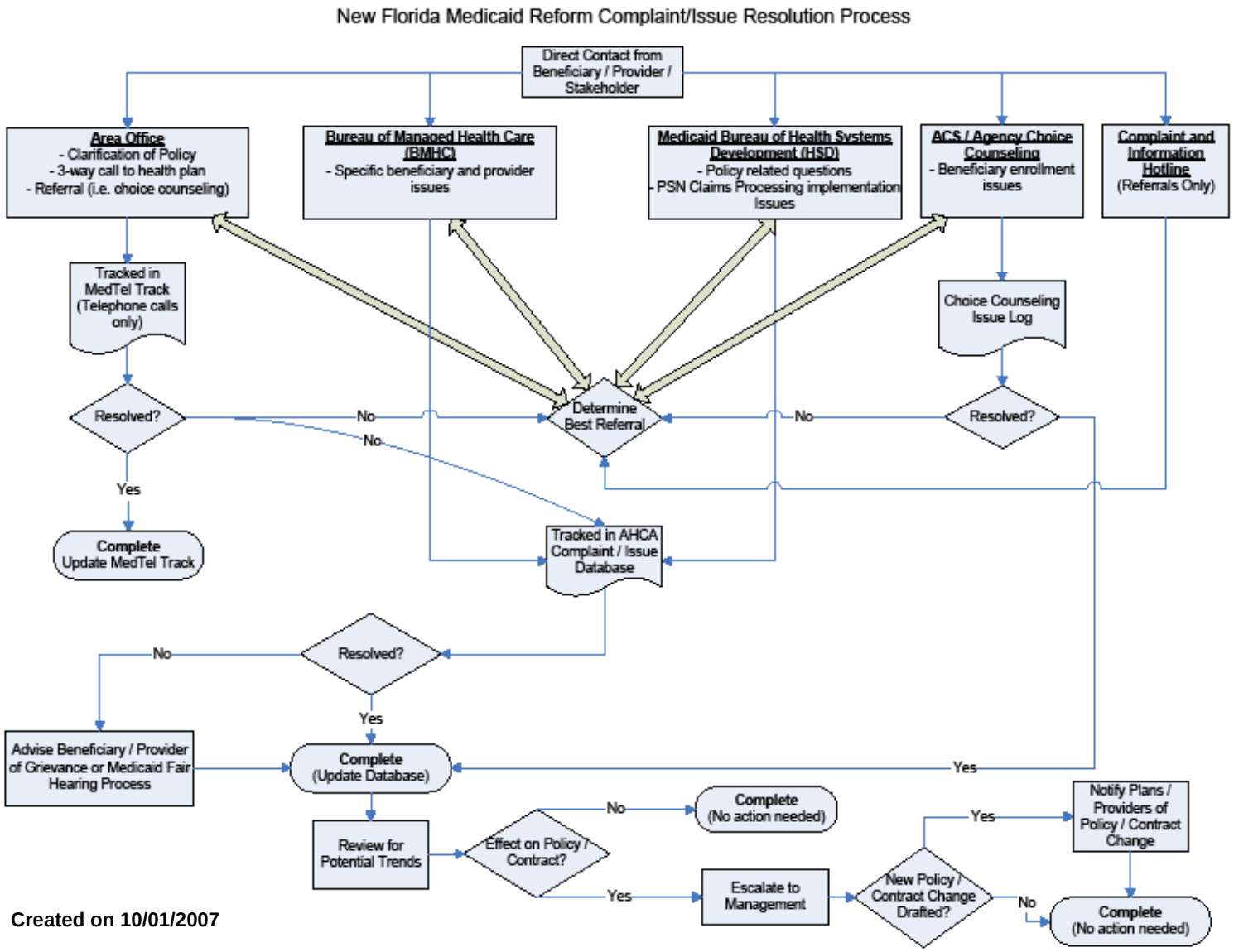
policy clarification were needed. Chart A provides an overview of the new process used for tracking complaints beginning October 1, 2007.

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.

In the first quarter of demonstration Year Three, a new Complaint System Development team was formed. Although the consolidated automated database that has been used since October 2007 is a significant improvement over the manual processes used to handle complaints previously, the Agency determined that having a centralized, real-time system would be best. The Complaint System Development Team that began meeting in July 2008 was tasked with compiling the specifications for a new system and working with the Agency's Information Technology staff to find out if they could create the system in-house. In the first three quarters of Year Three, the team met and worked on specifications for a new complaint and issues tracking system. In the third and fourth quarters of Year Three, the team met with Information Technology staff, who began developing a mock-up of a new system.

The complaints/issues received by the Agency regarding health plans are listed in the quarterly reports. In general, the complaints/issues received during Year Three were related to managed care in general and not specific to the demonstration.

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



Created on 10/01/2007

Year Three 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).

The Agency received a total of 267 complaints/issues regarding health plans in Year Three. The volume of complaints is low relative to the number of beneficiaries enrolled. Table 11 provides a summary of the complaints/issues received compared to enrollment during demonstration Year One and Table 12 provides a summary of demonstration Year Two. The complaints/issues received compared to enrollment during demonstration Year Three are provided in Table 13.

Table 11
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 12
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.*

Table 13
Year Three 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 Three Total	Complaints per 10,000
PSN	7	1.12	3	0.41	5	0.59	6	0.48	21	1.48
HMO	46	2.83	67	4.34	74	4.89	59	4.82	246	14.5
TOTAL	53	2.36	70	3.09	79	3.34	65	2.63	267	8.57
Enrollment*										
PSN		62,276		72,374		85,003		124,773		141,679
HMO		162,554		154,280		151,372		122,491		169,884
TOTAL		224,830		226,654		236,375		247,264		311,563

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

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 in 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 demonstration Year Three, the major reasons for complaints/issues were related to services (e.g., referral to a specialty provider and authorization of services) and claims processing (including payment delays). Charts B and C provide the total HMO and PSN complaints by complaint types (claims, customer service, services, and other).

Complaint type descriptions are as follows:

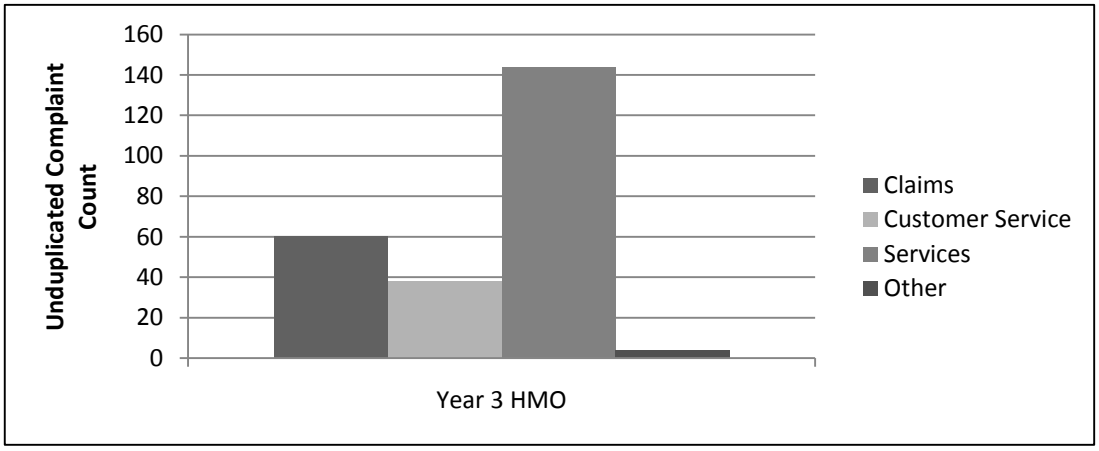
Claims	Claims complaints include, but are not limited to, timely provider payment, eligibility denial (claim denied because service was not eligible for payment or recipient was not eligible at the time of service), and issues regarding inpatient provider payment.
Customer Service	Customer Service complaints 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. There were no complaints related to dental services in Year Three.
Marketing[6]	Marketing complaints include, but are not limited to, aggressive marketing, cold calling, unauthorized marketing event and non-approved marketing materials. There were no marketing complaints in Year Three.
Prescribed Drugs	Prescribed Drug complaints include, but are not limited to, problems with service authorization denial or timeliness. There were no complaints categorized as Prescribed Drug complaints during Year Three.
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

[6] The Agency amended the health plan contracts to eliminate marketing in March 2009.

eligible to participate in the unborn activation process. The unborn activation process allows health plans to facilitate enrollment of newborns identified prior to birth. There were no complaints related to unborn activation in Year Three.

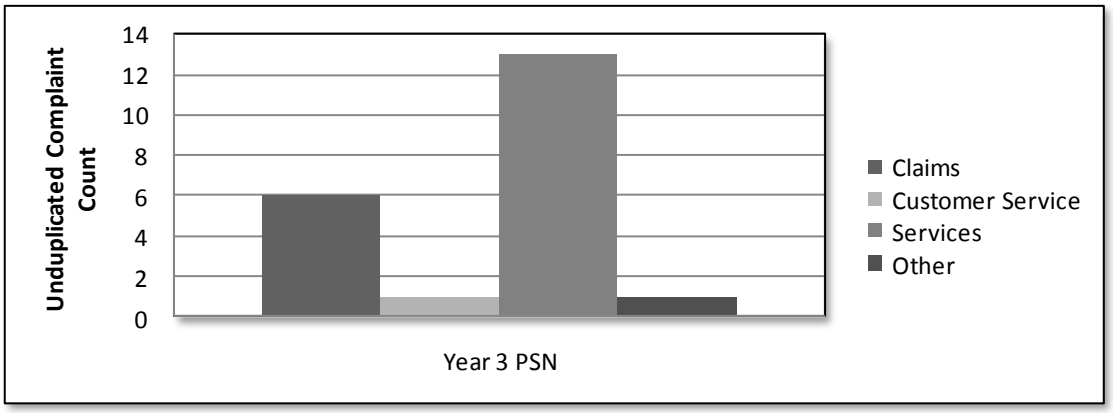
Other — Other complaints include those that don't fall into other general categories: for example, a provider called to ask for assistance in negotiating a payment rate with a health plan. The Agency maintains a neutral position regarding plan-provider negotiations.

Chart B. HMO Complaints by Type



Note: There were no unborn activation, dental, prescription drug, or marketing complaints in Year Three.

Chart C. PSN Complaints by Type

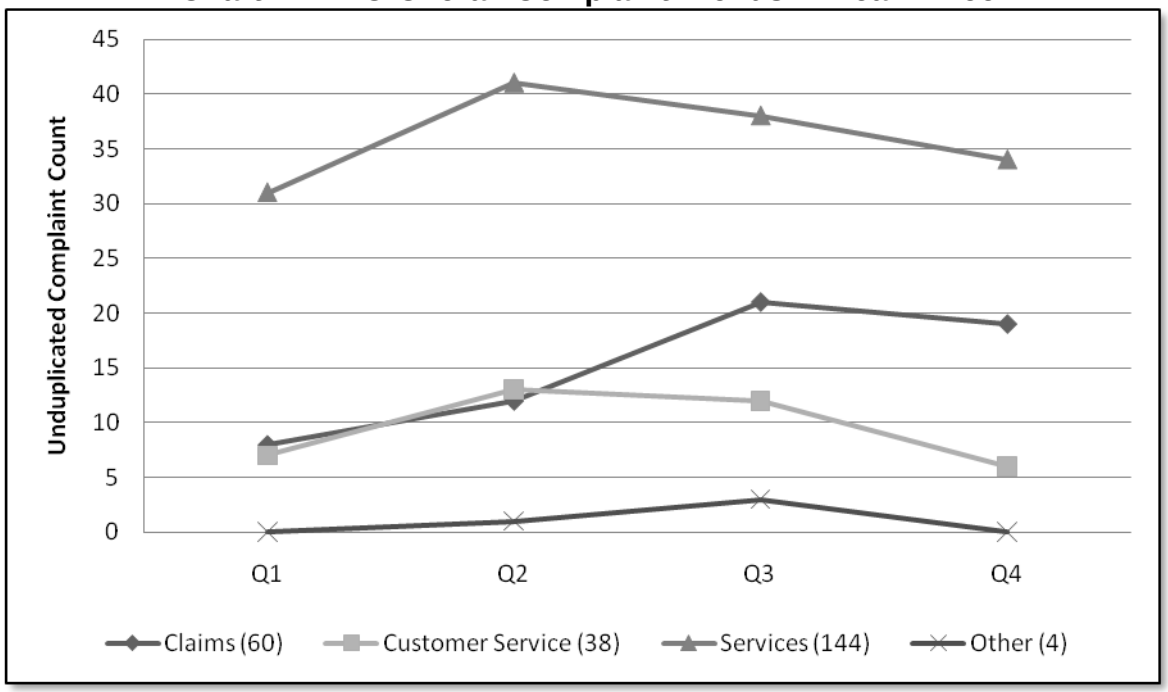


Note: There were no unborn activation, marketing, dental, or prescribed drug complaints in Year Three.

Trending reports on HMO and PSN complaints in Year Three are provided in Charts D and E. In Year Three, there were no marketing, dental, prescribed drug or unborn activation processing complaints reported through the complaint database for either HMO or PSN populations. While the volume of complaints and issues is small, there were more in Year Three than in Year Two, although on average there were still fewer than nine issues/complaints reported per 10,000 beneficiaries. With several plans transitioning in and out of particular counties in the fourth quarter of Year Three, the

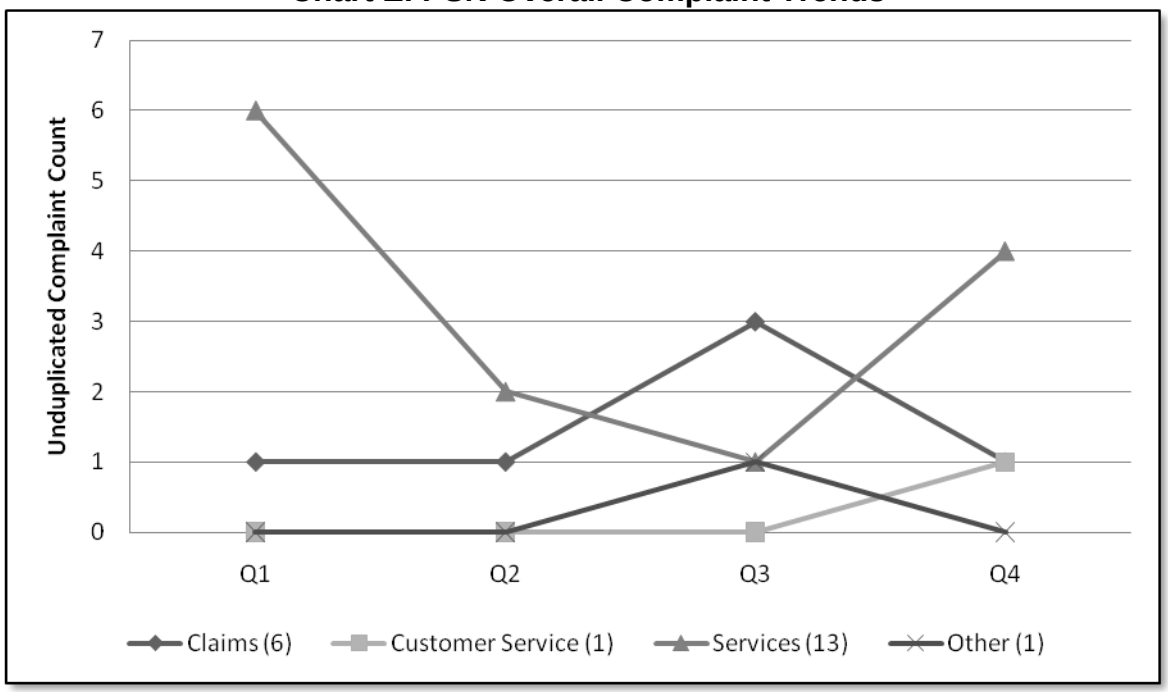
Agency reviewed complaints on a monthly basis to see whether these transitions were resulting in additional issues. Agency staff found that there were fewer complaints in the fourth quarter than there had been in the previous two quarters, and there were no complaints specific to the plan transitions.

Chart D. HMO Overall Complaint Trends in Year Three



Note: There were no unborn activation, dental, prescribed drugs, or marketing complaints in Year Three.

Chart E. PSN Overall Complaint Trends



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

Looking Ahead to Year Four

The Agency will continue to work with Information Technology staff on a new complaints and issues tracking system. The system will capture data in real-time and be accessible to staff at headquarters and in the Medicaid Area Offices. The test site for the new system will be available in the first quarter of Year Four, so that analysts may enter test cases and provide feedback on the new system. A training manual and/or video will be developed for the new system. The Complaint System Development Team intends to have the new system available for use at the beginning of the second quarter of Year Four.

Additionally, Agency staff will continue to produce trend reports on complaints and issues on a quarterly basis, so that they may be reviewed in contract management oversight meetings. Complaints and issues will be reviewed to identify any areas in need of special attention or that may indicate a need for policy clarification with the health plans.

5. On-Site Surveys

Year Three at a Glance

During demonstration Year Three, the Agency completed both desk reviews and on-site surveys of 16 HMOs and 7 PSNs. On-site surveys consisted of medical, disease management and care management record reviews for PSNs and review of utilization management processes for the HMOs. Initial on-site surveys also included a comprehensive network capacity review.

Initial On-Site Survey

During Year Three, three health plan applicants completed the application process: Better Health Plan (FFS PSN), Molina Health Plan (HMO), and Sunshine State Health Plan (HMO). These health plans received an initial on-site survey along with a comprehensive network capacity review.

Desktop Reviews

The desktop reviews focused on new and revised health plan policies and procedures, including medical and behavioral health. Provider network surveys were performed upon the health plan's request for expansion of the service areas and/or increases in enrollment in existing service areas. In addition, the desk reviews consisted of reviewing member material submitted by the health plans and a review of complaints received concerning the health plans and/or providers.

On-Site Surveys

The Agency worked to refine and strengthen the health plan survey process and monitoring tools with the assistance of Florida's External Quality Review Organization, Health Services Advisory Group, Inc. (HSAG). HSAG assisted the Agency in the development of scoring mechanisms to be utilized in desk reviews of health plans and

on-site surveys. In addition, HSAG worked with the Agency to refine questions to be used during the on-site visit. All monitoring functions are compliant with state and federal regulations.

Each of the health plans received an on-site survey during this demonstration year. The on-site surveys consisted of medical, disease management and care management record reviews for PSNs and review of utilization management processes for the HMOs.

The survey process was consistent across health plan types (HMO and PSN). The survey team consisted of a team leader and at least two team members and lasted an average of three days. Health Plan policies and procedures were reviewed prior to the on-site visit. The results of these surveys were all health plans are currently in good standing with the State and there were no sanctions administered. Table 14 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 14
On-Site Survey Categories

➲ Services	➲ Provider Coverage
➲ Marketing	➲ Provider Records
➲ Utilization Management	➲ Claims Process
➲ Quality of Care	➲ Grievances & Appeals
➲ Provider Selection	➲ Financials

Purchase Agreements/Acquisitions

As noted earlier in this report, the Agency received notice from three health plans that they are entering into purchase agreements during Year Three. The health plans are: Access Health Solutions (PSN) who entered into a purchase agreement with Pediatric Associates (PSN) and transitioned beneficiaries in February 2009; Molina Health Plan (HMO) entered into a purchase agreement with Florida NetPASS (PSN); and Sunshine State Health Plan (HMO) intends to enter into a purchase agreement with Access Health Solutions (PSN) with transition occurring in demonstration Year Four.

Prior to approving the acquisition, the Agency compared provider networks, including behavioral health providers to ensure continuity of care and to ensure the continued availability of current providers, with the acquiring plan. The Agency also compared behavioral health care provider networks to identify any enrollees in active behavioral health care in need of a written care coordination plan. Each acquiring plan also had to submit materials and implementation calendars to demonstrate to the Agency that network providers were properly educated about any changes to claims submissions and processing.

During Year Three, five HMOs notified the Agency of their intent to withdraw from demonstration counties during Year Three. United HealthCare withdrew from Broward

County effective November 1, 2008; Vista South Florida and Buena Vista withdrew from Broward County effective December 1, 2008; and HealthEase and Staywell, both owned by parent company Wellcare, withdrew from Broward and Duval counties through a staggered transition process effective July 1, 2009. The withdrawals required comprehensive network capacity reviews to assess the capacity of the remaining plans in the area to ensure all impacted beneficiaries have access to quality care.

Contract Oversight/Monitoring Process

The Agency continued to refine the health plan contract monitoring and oversight processes. New processes were fully implemented during Year Three, including monthly team reviews of health plan monitoring activities, complaints, grievances, sanctions, and reporting to help ensure contract compliance and staff communication. A standard form was created to capture various elements of contract compliance from the multiple bureaus responsible for monitoring and management.

Looking Ahead to Year Four

In looking forward to Year Four, the Agency will continue to refine and strengthen the health plan survey process and monitoring tools with the assistance of Florida's External Quality Review Organization, HSAG. HSAG assisted the Agency in the development of scoring mechanisms to be utilized in desk reviews of health plans and on-site surveys. The Agency will implement the new survey process and monitoring tools in January, 2010.

B. Choice Counseling Program

Overview

During Year Three of the demonstration, beneficiaries continued to empower with additional tools to manage their health care choices. A continual goal of the demonstration is to encourage beneficiaries to take control and responsibility for their health by providing information they need to make informed decisions about their health plan choices. The implementation of a Preferred Drug List (PDL) search functionality called the Informed Health Navigator Solution (Navigator) in October 2008, further enabled beneficiaries to select a plan based upon their individual medication and health plan coverage needs. 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.

In July 2008, the Florida Medicaid Program moved to a new system developed and implemented by the new Fiscal Agent, EDS (Electronic Data Systems). The implementation of this system has been a massive undertaking as it impacts over 2,000,000 beneficiaries and over 80,000 providers throughout the State of Florida. The transition to the new Fiscal Agent has impacted the exchange of enrollment and eligibility information with the demonstration's Choice Counseling System. The Agency has worked closely with the Choice Counseling vendor, Affiliated Computer Services (ACS) and new fiscal agent, EDS, to ensure beneficiary's needs are addressed in a timely manner. The following actions have been taken during the course of demonstration Year Three:

- Allowing good cause plan changes when a beneficiary has had any difficulty accessing Choice Counseling services or when the information in the Choice Counseling System has been incomplete;
- Requesting the Field Choice Counselors reach out to community partners to help communicate with beneficiaries;
- Requiring the Field Choice Counselors to assist the Choice Counselor Call Center with call backs (from messages taken), and handle an increased number of plan changes and enrollments;
- Implementing a Mental Health Unit that included identified seasoned Field Choice Counselors who were familiar with the Choice Counseling process to address questions specific to mental health;
- Using the nurses in the Special Needs Unit to reach out and help callers who have complex health needs; and
- Adding Choice Counseling staff to handle additional call volume.

The Choice Counseling Program is the front line for the beneficiary both in the Field and at the Call Center. 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 marketplace decision. As they choose, the beneficiaries themselves drive the competitive marketplace. As a result, plans are offering competitive benefit packages to attract enrollment of beneficiaries.

As the Agency continues to improve the Choice Counseling Program, the input from beneficiaries, and other interested parties continues to play an important role. Feedback provided by key stakeholders has resulted in a comprehensive, innovative Choice Counseling Program that achieved the following results in Year Three of the demonstration:

- Certified Choice Counselors which ensures 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.
- Successful implementation of a Preferred Drug List search functionality as an option in selecting a health plan, known as the Informed Health Navigator Solution.
- Creation of the Mental Health Unit (MHU) to provide more direct support to beneficiaries who access mental health services.

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

Year Three at a Glance

1. Public Meetings and Beneficiary Feedback

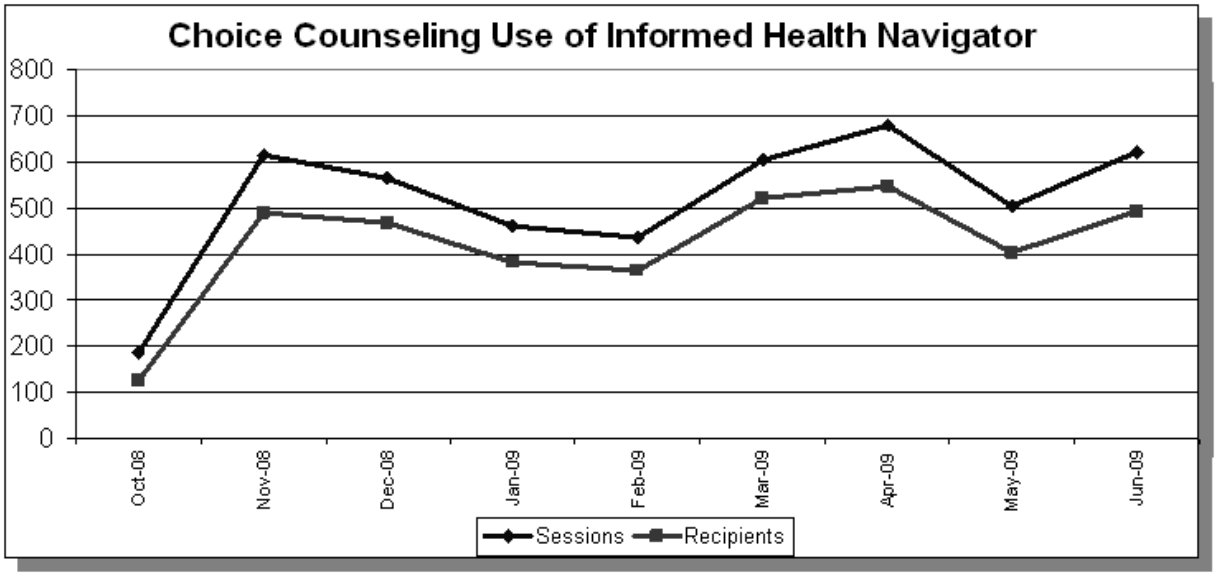
One of the primary goals of the demonstration is to increase the active participation of beneficiaries in their health care. The Agency and the Agency's Choice Counseling vendor recognize that feedback from beneficiaries and other interested stakeholders is critical. Based on the feedback received, availability of prescribed drug information is important and the ability to search health plans' drug lists for that information is significant as a health plan choice driver (for a segment of the population).

The outcome of the search for a product/system that would allow the beneficiary to determine drug coverage before making a health plan choice, resulted in the development of a system called The Informed Health Navigator Solution (or Navigator). Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator system contains each health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator pulls the medication data and provides detailed information on how each plan meets the beneficiary's current prescribed drug needs. The Navigator system also has the capability to allow a Choice Counselor to input prescribed drugs for beneficiaries who do not have prior claims history or have received a new prescription not yet in his or her records. This function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets their prescribed drug needs. The Choice

Counselor's role is to share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications.

The graph below provides the Navigator statistics from October 27, 2008, through June 30, 2009. "Sessions" represents the number of times the Navigator program was utilized, and "Beneficiaries" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for his or her child (different ID number), that would be considered a separate session and recipient.

Since the "Go Live" date of October 27, 2008 through June 30, 2009, for the Navigator, there have been a total of 4,668 sessions, and 3,583 unique beneficiaries who have utilized the system. On average the Navigator is used between 100-150 times per week.



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, and since implementation 11,672 surveys have been completed. For demonstration Year Three, July 2008 through June of 2009, over 5,725 beneficiaries completed the automated survey.

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

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

Year Three Overview (July 2008 – June 2009)

Table 15 contains the average score by month for each question asked in the Beneficiary Customer Survey for demonstration Year Three.

Table 15
Beneficiary Customer Survey
Percentage of Delighted Callers for Each Question

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
How helpful do you find this counseling to be											
87.20%	90.10%	87.60%	86.60%	87.30%	85.30%	88.50%	87.50%	86.30%	86.60%	83.60%	88.60%
Satisfaction with the amount of time you waited to speak with a counselor											
82.30%	68.10%	52.70%	40.50%	38.30%	32.80%	41.40%	64.60%	46.50%	29.30%	23.10%	39.40%
How easy it was to understand the information											
77.10%	78.40%	80.30%	77.10%	74.10%	76.50%	78.30%	75.30%	76.00%	79.60%	72.20%	76.50%
How likely are you to recommend Choice Counseling helpline to friend or relative											
91.30%	90.90%	90.90%	91.30%	89.80%	88.20%	92.50%	90.70%	91.90%	87.10%	84.80%	91.90%
Overall service provided by Counselor											
95.30%	95.00%	95.50%	96.20%	95%	95.90%	95.80%	95.50%	96.30%	94.70%	94%	96.80%
How quickly the Counselor understood why you called today											
93.20%	95.70%	95.00%	95.50%	94.80%	94.90%	94.00%	94.70%	96.00%	95.20%	93.90%	96.20%
The Counselor's ability to help you choose your health plan											
93.20%	93.60%	92.60%	93.80%	92.30%	92.70%	93.00%	94.70%	95.80%	94.20%	93.50%	95.60%
The Counselor's ability to explain things clearly											
94.20%	94.80%	95.20%	94.90%	94.50%	94.00%	94.00%	95.50%	96.20%	94.00%	95.10%	96.60%
The confidence you have in the information given to you by the counselor											
93.20%	94.20%	94.40%	93.10%	94.00%	92.20%	93.00%	93%	94.60%	91.20%	92.80%	95.30%
Satisfaction with being treated respectfully											
96.00%	96.90%	97.20%	96.40%	97.00%	97.10%	96.80%	97%	97.30%	97.50%	96.20%	98.50%

2. Call Center

Year Three 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 call center had an average of 36.5 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls during demonstration Year Three.

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

Find below the Call Center Statistics for demonstration Years Two and Three.

	Year Two	**Year Three:**
Total Inbound Calls:	168,078	298,673
Average Speed of Answer:	29 sec	533 sec
Total Abandoned Calls:	3,948	75,494
Abandonment Rate: *(The contract standard is <5% monthly)*	2.35%	25.28%
Calls Answered within 4 rings:	**100.00%**	**100.00%**
Call Answer Rate: Call answered in < 180 seconds:	95.80%	38.23%[7]
Total Outbound Calls:	**51,141**	**61,957**

Below is a list of factors, which affected the call volume for demonstration Year Three:

- New Fiscal Agent transition: Affiliated Computer Services (ACS) receives all files from the new system. Issues with the accuracy of the information have impacted performance.
- Health plan transitions: Various health plan transitions have occurred in the demonstration counties.
- Medicaid enrollment: In demonstration Year Three, Florida Medicaid enrollment has increased.

[7] The significant increase in call volume has increased the beneficiary wait time.

3. Mail

Year Three at a Glance

In Year Three, the largest volume of mailings came from open enrollment packets. This would be typical progression once all of the transition is complete and beneficiaries go through their normal process for years One and Two. Auto-Assignment and Confirmation letters have also shown a significant increase as our Medicaid population increases.

The following highlights the volume for the largest mailings completed by the mailroom during the demonstration years. Mailings are grouped by family or case. This means if there are 2 children in one case, only one mailing is 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	Year 3
New Eligible Packets	66,832	84,696	95,178
Transition Mailings	119,002	17,730	3,221
Auto-Assignment Letters	49,390	48,147	129,456
Confirmation Letters	49,029	57,537	106,634
Open Enrollment Packets	2,641	74,412	166,227

During Year Three, 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 Choice Counselors.

The Agency's Choice Counseling vendor mailed 19,405 Annual Reminder Notices to those beneficiaries who are exempt from Open Enrollment. The reminders are to inform beneficiaries who are exempt from Open Enrollment that they may change their health plan at any time. The reminders were sent in two mailings; October 2008 and April 2009.

4. Face-to-Face/Outreach and Education

Year Three at a Glance

The Choice Counseling Program has made dedicated efforts to work with local community based organizations serving Medicaid beneficiaries since the beginning of the demonstration. This was done in an effort to establish a partnership and a line of communication between the local community and the Field Choice Counseling staff. In the second quarter of Year Three, the Outreach/Field Team created the Mental Health Unit (consisting of three Field Choice Counselors) to provide more direct support to beneficiaries who access mental health services. The Mental Health Unit placed a high priority on responding to the needs of beneficiaries in this special needs community. The efforts made by the Choice Counseling Program to build relationships with the organizations who serve these beneficiaries continue to yield positive results.

Since implementation of the Mental Health Unit, the unit has held 99 Private Sessions with 355 attendees, all of whom receive services from community partners that work with individuals who access mental health services. The Mental Health Unit received 244 referrals from community partners for beneficiaries needing Choice Counseling services that were unable to attend scheduled face-to-face Choice Counseling sessions or were not able to complete their plan selection via the Call Center due to his or her special needs. Thirty-five staff presentations were completed continuing the initiative to provide education and information to the case managers and workers serving Medicaid beneficiaries. The Mental Health Unit played a key role this year, along with the rest of the Outreach/Field Team and community partners, in informing beneficiaries about their health plan choices.

To date over 120 organizations have been identified and a contact attempt has been made by a Field Choice Counselor. As a result, the Outreach/Field Team has established several key relationships and developed strong working partnerships. Some of the large organizations include:

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

These groups provide mental health and substance abuse services and have been very receptive to working with the Field Choice Counselors. 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. The Field Choice Counselors have developed a reputation, among the community partners, as being knowledgeable, compassionate and dedicated.

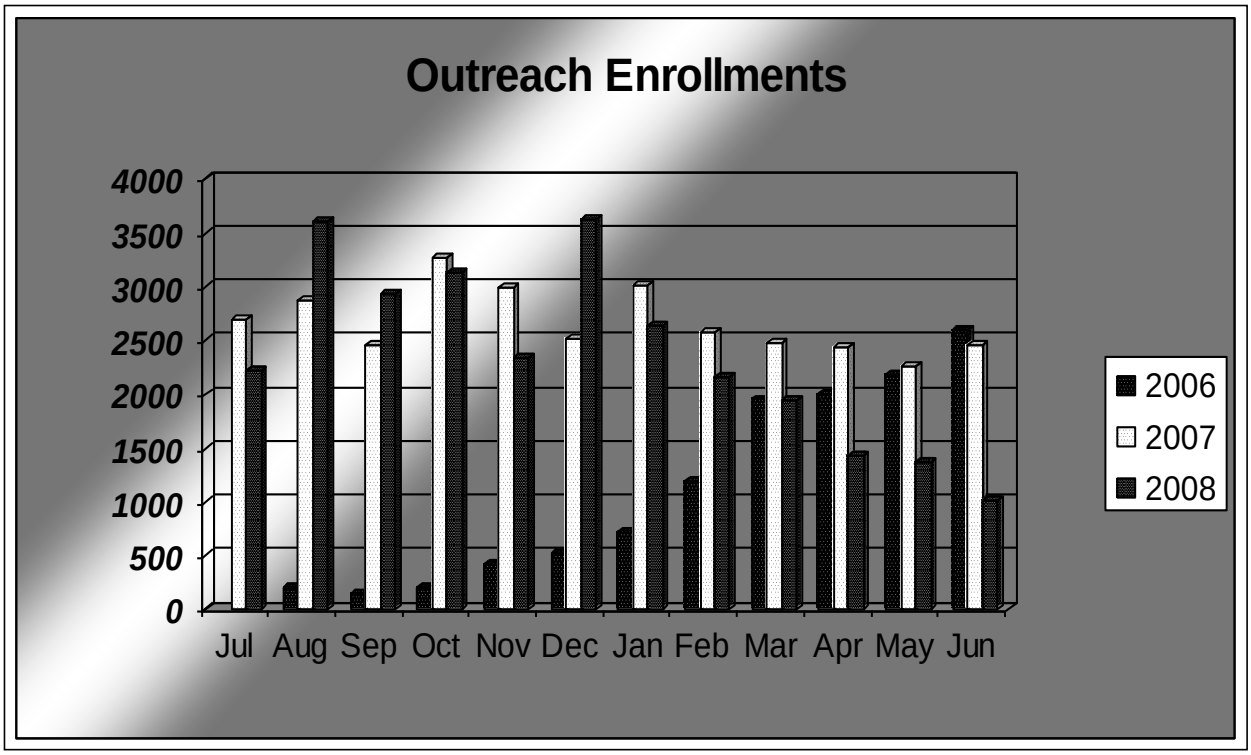
Table 16 lists the type and volume of Outreach/Field Choice Counselor activities during Year Three of the demonstration.

Table 16
Choice Counseling Outreach Activity
July 2008 – June 2009

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	**Total**
Public Sessions	248	214	276	240	186	192	197	188	218	229	176	173	**2,537**
Private Sessions	49	31	31	34	18	36	35	33	50	52	31	15	**415**
Home/No-phone visits	462	264	211	189	174	112	224	45	40	3	3	13	**1,740**
Outbound list calls	4407	4021	4484	4554	3668	4009	3912	2089	1082	352	104	657	**33,339**
Outreach Enrollments	2600	3694	2841	2585	2023	3327	2631	2151	1933	1427	1364	1007	**27,583**

Table 17 shows the number of enrollments during the first three years of the demonstration.

Table 17
Choice Counseling Outreach Enrollments
August 2006 – June 2009



5. Health Literacy

Year Three at a Glance

The Choice Counseling Program's Special Needs Unit addresses health disparities and health literacy. The Special Needs Unit continues to be a very important part of the Choice Counseling Program. The Special Needs Unit has a Registered Nurse (RN) supervisor, and a Licensed Practical Nurse (LPN) who have both earned their Choice Counseling certification.

The RN supervisor developed and implemented training for the Choice Counselors in the Call Center and in the Field Offices which outlines how the Special Needs Unit works and how (and when) to refer beneficiaries to the unit for help.

Other duties of the Special Needs Unit 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;
- Participation in the development of the Navigator PDL section of the Choice Counseling script; and
- Development of a tracking log to capture the number and type of counselor's verbal inquiries, case referrals, and reviews.

Summary of Cases Referred to Special Needs Unit:

During Year Three of the demonstration, case referrals the Special Needs Unit received each month were captured beginning in September of 2008. From September 2008 through June 2009, there were 191 new case referrals and 41 case reviews received and processed by the Special Needs Unit. The terms "case referrals" and "case reviews" are defined below. During the last quarter of Year Three, the Special Needs Unit started documenting and reporting on the verbal reviews. The 41 case reviews are from April 2009 through June 2009.

A case referral is when a Choice Counselor refers a case to the Special Needs Unit through the Choice Counseling Vendor's enrollment system for follow up. The Special Needs Unit completes the research, follow-ups with the beneficiary, and handles/resolves the referral as needed.

A case review is when the Special Needs Unit helps with questions from a Choice Counselor as the counselor is on a call with a beneficiary. Most reviews can be handled verbally and quickly. Some reviews may end up as a referral to the Special Needs Unit if there is more research and follow up required.

6. New Eligible Self-Selection Data

Year Three at a Glance

During demonstration Year Two, the Agency revised the terminology originally used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate",* 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 new eligible numbers for self-selection have not been reported since June 2008, due to issues with daily file and month end processing transfers between EDS, the new Fiscal Agent and the Agency's Choice Counseling vendor. The Agency, the Choice Counseling vendor and EDS have identified and created Customer Service Request's (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes, between the Medicaid system (FMMIS) and the ACS

enrollment system (BESST). An Advance Planning Document (APD) was submitted and approved by the Centers for Medicare and Medicaid Services, to support the effort of completing the related CSR's. This effort should be complete within 6 months. There have been improvements made to the daily and monthly files that transfer from EDS to the Choice Counseling vendor and some issues have been resolved. When the corrections to the system are complete, and the month end and daily file information come through consistently and correctly, it will allow the Choice Counseling vendor to determine the new eligibles and ensure improved enrollment success. Prior to the Fiscal Agent transition, the Choice Counseling vendor exceeded the self-selection standard. The Agency fully expects when the corrections are in place, the Choice Counseling vendor will not only meet but exceed the 80% minimum standard set in the Self Selection Rate for demonstration Year Four.

7. Complaints/Issues

Year Three 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 Three, 8 complaints were received regarding the Choice Counseling Program. The complaints received by the Choice Counseling Program this demonstration year were not consistently related to one type of issue. The complaints related to beneficiaries not getting enrolled into a plan that they selected, receiving incorrect information from a Choice Counselor or not being able to disenroll from a health plan. Find below the total number of Choice Counseling Program complaints by demonstration year. The specific complaints and the actions taken to resolve them are summarized in the quarterly reports.

Demonstration Year	Total Number of Complaints Received
Year One	52
Year Two	27
Year Three	8

8. Quality Improvement

Year Three at a Glance

A key component of the Choice Counseling Program is a continuous quality improvement effort. Quality improvement suggestions come from the Beneficiary Customer Survey (listening to beneficiary comments), quality monitoring of the Call Center and Field Choice Counselors, and feedback from public meetings. These forums allow the Agency to hear from beneficiaries and Choice Counselors on successes and complaints, and receive ideas for improvement for the Choice Counseling Program.

One of the primary elements of the quality improvement involves the automated Beneficiary Customer Survey previously mentioned in this report. The survey results

and comments help the Agency's Choice Counseling Vendor and the Agency improve customer service to Medicaid beneficiaries. The Beneficiary Customer Survey results reporting the beneficiaries' confidence in the Counselor's ability to explain health plan choices indicate that more than 95% are satisfied with the Choice Counseling experience (both Field and Call Center) for Year Three. The Agency's Choice Counseling vendor continues to focus on improving communication between Counselors and beneficiaries and evaluating comments left by beneficiaries to improve customer service.

The Choice Counseling vendor distributes individual report cards to each Choice Counselor on his or her performance. Survey scores and beneficiary comments are also provided to Supervisors. The positive comments encourage the Choice Counselor to keep up the good work and the negative comments help to point out possible weaknesses that require coaching or training.

Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality assurance monitoring staff randomly calls 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 18 shows the responses of 633 beneficiaries, in percentages, who were randomly called to participate in the survey (from July 1, 2008 through June 30, 2009). The same percentage range used in the Call Center is used in the Field Offices, with 100% being a perfect score.

Table 18
Field Choice Counseling – Monitoring Results
(July 2008- June 2009)

Able to complete enrollment/plan change at the session	98.60%
Felt the information provided by the Choice Counselor helped them make an informed decision	97.19%
The information was explained in a way that made it easy to understand	98.67%
The Choice Counselor was friendly/courteous	99.71%

In addition to external feedback, the Choice Counseling vendor has implemented an anonymous employee feedback email system that allows Call Center and Field Choice Counselors to provide immediate comments on issues as part of their daily work. This information is reviewed by management and addressed as needed.

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

Lessons Learned and Looking Ahead to Year Four

During Year Three, 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.

- Mental Health Unit
- Navigator PDL Usage
- Public Feedback

Mental Health Unit: The Mental Health Unit was created to ensure that beneficiaries with mental health needs are provided with more direct support. The Mental Health Unit placed a high priority on responding to the needs of beneficiaries in this special needs community. The increased communication with community partners has improved the ability to reach this special needs population and enhanced their ability to participate in health choices, and to be informed of changes in the health plans located in his or her county. In the coming year, continued efforts will be made to further establish this vital link with community partners.

Navigator: The ability of a beneficiary to select a health plan based on whether a plan can cover his or her medications was a significant need brought to the Agency's attention by interested parties. Being sensitive to this need and hearing the feedback of the beneficiaries, the Agency and the Choice Counseling vendor completed the implementation of the Navigator PDL system. The Choice Counselors conducted an average of 519 sessions per month since implementation. Going forward, the Choice Counseling Program will hold public meetings to gain further feedback from beneficiaries regarding the Navigator PDL system.

Public Feedback: Feedback received during Year Three of the demonstration reinforced the importance of public outreach. For demonstration Year Four, the Agency will renew its focus on increasing public interaction and feedback, for the continued improvement of the Choice Counseling Program. Public feedback and interaction is vital for the success of the program.

C. Enrollment Data

Overview

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

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

- **Non-committed MediPass[8]:** Phased in over 7 months (1/2 in Month 1, then 1/6 in each following month)
- **HMO Population:** 1/12 in Months 2, 3, and 4 and 1/4 in Months 5, 6, 7
- **PSN Population:** 1/3 in each of Months 2, 3, and 4.

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

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

- **September 2007 Enrollment:** Non-committed MediPass located in Baker, Clay, and Nassau Counties.

[8] 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.

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

The demonstration was not expanded in Year Three, and continues to operate in the counties of Baker, Broward, Clay, Duval, and Nassau. Table 19 contains the quarterly enrollment for each health plan during Year Three 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 F, and Chart G shows the quarterly enrollment for each of the PSNs.

Table 19
Quarterly Medicaid Reform Enrollment by Plan
Year Three: July 2008 – June 2009

Plan Name	Plan Type	Number of Enrollees by Quarter – Year 3			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Amerigroup	HMO	15,052	16,572	17,663	24,876
Buena Vista	HMO	6,725	4,777	0	0
Freedom	HMO	485	1,124	1,648	1,219
HealthEase	HMO	54,963	52,448	50,165	27,220
Humana	HMO	10,781	13,225	17,912	17,096
Molina Healthcare	HMO	0	0	0	5,182
Preferred Medical Plan	HMO	1,967	2,755	3,892	3,160
StayWell	HMO	35,087	33,756	32,049	3,350
Total Health Choice	HMO	2,369	4,022	7,963	20,201
United Healthcare	HMO	26,551	16,864	13,687	12,318
Universal Health Care	HMO	1,876	3,665	6,393	7,869
Vista South Florida	HMO	6,698	5,072	0	0
HMO Totals		**162,554**	**154,280**	**151,372**	**122,491**
Access Health Solutions	PSN	19,987	23,101	37,547	55,638
Better Health, LLC	PSN	0	0	0	4,518
CMS	PSN	4,334	4,708	5,080	5,751
First Coast Advantage	PSN	17,430	20,030	23,377	30,902
Netpass	PSN	4,051	5,475	7,467	8,826
Pediatric Associates	PSN	9,673	10,234	515	0
South FL Community Care Network	PSN	6,801	8,826	11,017	19,138
PSN Totals		**62,276**	**72,374**	**85,003**	**124,773**
Medicaid Reform Totals		**224,830**	**226,654**	**236,375**	**247,264**

Chart F
Quarterly Medicaid Reform Enrollment for HMOs
Year Three: July 2008 – June 2009

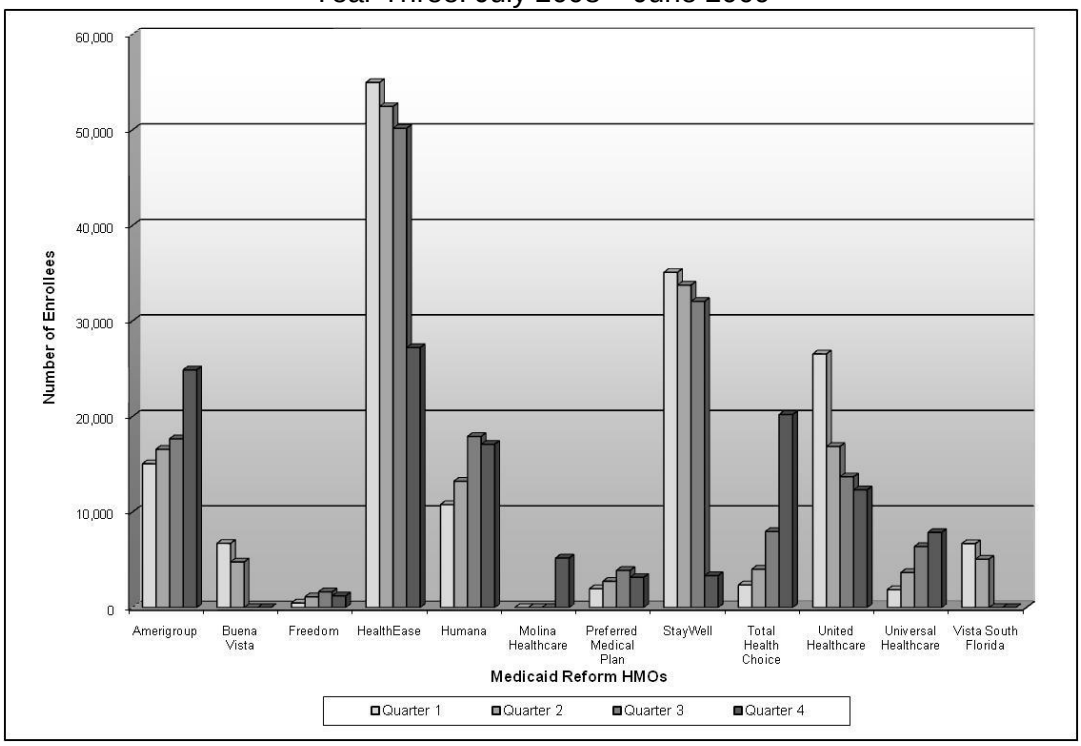
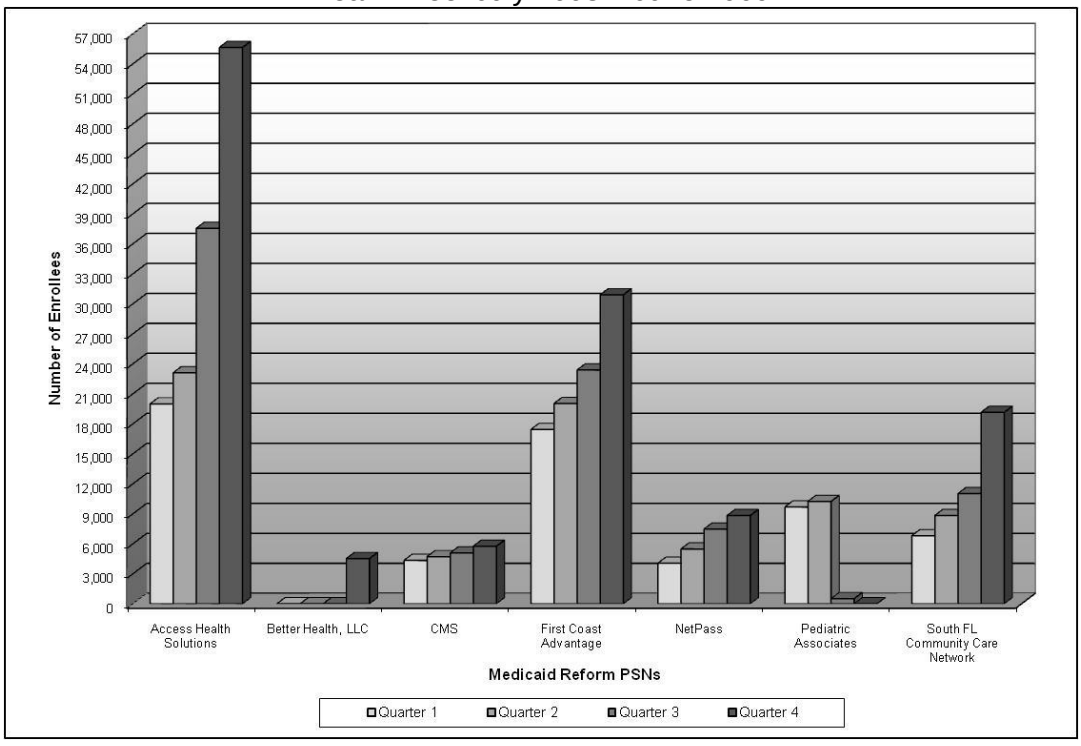


Chart G
Quarterly Medicaid Reform Enrollment for PSNs
Year Three: July 2008 – June 2009



Year Three at a Glance

Monthly Enrollment Reports – Year Three

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 Three, July 1, 2008 – June 30, 2009. This section contains the following enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- Medicaid Reform Voluntary Population Enrollment Report

All health plans located in the 5 demonstration counties are included in each of the reports. During Year Three, there were a total of 19 health plans – 12 HMOs and 7 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 Three 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 year being reported. Table 20 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 20
Medicaid Reform Enrollment Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform 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, 2008 and ending June 30, 2009. Please refer to Table 21 for the annual Medicaid Reform Enrollment report for Year Three of the demonstration.

Table 21
Medicaid Reform Enrollment Report
Year Three: July 1, 2008 through June 30, 2009

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	26,555	2,872	13	678	**30,118**	**9.67%**	18,836	59.90%
Buena Vista	HMO	1,216	93	2	126	**1,437**	**0.46%**	9,030	-84.09%
Freedom Health Plan	HMO	1,403	259	2	46	**1,710**	**0.55%**	284	502.11%
HealthEase	HMO	35,549	3,623	6	1,147	**40,325**	**12.94%**	71,474	-43.58%
Humana	HMO	17,572	3,015	15	724	**21,326**	**6.84%**	14,057	51.71%
Molina Healthcare	HMO	4,581	571	1	29	**5,182**	**1.66%**	0	N/A
Preferred Medical Plan	HMO	3,373	705	4	161	**4,243**	**1.36%**	2,719	56.05%
StayWell	HMO	11,823	708	5	573	**13,109**	**4.21%**	45,889	-71.43%
Total Health Choice	HMO	19,015	2,432	9	393	**21,849**	**7.01%**	2,821	674.51%
United Healthcare	HMO	17,235	1,677	6	697	**19,615**	**6.30%**	36,452	-46.19%
Universal Health Care	HMO	7,907	1,143	0	257	**9,307**	**2.99%**	999	831.63%
Vista South Florida	HMO	1,451	94	4	114	**1,663**	**0.53%**	7,476	-77.76%
HMO Total	**HMO**	**147,680**	**17,192**	**67**	**4,945**	**169,884**	**54.53%**	**210,037**	**-19.12%**
Access Health Solutions	PSN	54,935	6,252	7	981	**62,175**	**19.96%**	24,063	158.38%
Better Health, LLC	PSN	4,020	476	0	22	**4,518**	**1.45%**	0	N/A
CMS	PSN	3,445	2,901	0	69	**6,415**	**2.06%**	4,851	32.24%
First Coast Advantage	PSN	28,782	5,068	0	863	**34,713**	**11.14%**	20,655	68.06%
NetPass	PSN	7,834	2,011	4	393	**10,242**	**3.29%**	5,696	79.81%
Pediatric Associates	PSN	2,084	46	0	63	**2,193**	**0.70%**	13,405	-83.64%
SFCCN	PSN	17,538	3,311	3	571	**21,423**	**6.88%**	8,308	157.86%
PSN Total	**PSN**	**118,638**	**20,065**	**14**	**2,962**	**141,679**	**45.47%**	**76,978**	**84.05%**
Reform Enrollment Totals		**266,318**	**37,257**	**81**	**7,907**	**311,563**	**100.00%**	**287,015**	**8.55%**

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 Three reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from Non-Reform health plans to Reform health plans. There were a total of 311,563 unique beneficiaries enrolled in the demonstration during Year Three. There were 19 health plans with market shares ranging from 0.46 percent to 19.96 percent.

2. Medicaid Reform Enrollment by County Report

During Year Three of the demonstration, Medicaid Reform was operational in five counties: Baker, Broward, Clay, Duval and Nassau. The number of HMOs and PSNs operating in each county is listed in Table 22.

Table 22
Number of Reform Health Plans in Demonstration Counties

County Name	Number of Reform HMOs	Number of Reform PSNs
Baker	**1**	**1**
Broward	**12**	**6**
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 23 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 23
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 24 on the following page.

Table 24
Medicaid Reform Enrollment by County Report
Year Three: July 2008 through June 2009

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	825	114	0	22	**961**	25.78%	869	10.59%
Access Health Solutions	PSN	Baker	2,485	241	0	41	**2,767**	74.22%	2,080	33.03%
Total Reform Enrollment for Baker			**3,310**	**355**	**0**	**63**	**3,728**	**100.00%**	**2,949**	**26.42%**
Amerigroup	HMO	Broward	26,555	2,872	13	678	**30,118**	17.27%	18,836	59.90%
Buena Vista	HMO	Broward	1,216	93	2	126	**1,437**	0.82%	9,030	-84.09%
Freedom Health Plan	HMO	Broward	1,403	259	2	46	**1,710**	0.98%	284	502.11%
HealthEase	HMO	Broward	4,401	301	5	258	**4,965**	2.85%	21,103	-76.47%
Humana	HMO	Broward	17,572	3,015	15	724	**21,326**	12.23%	14,057	51.71%
Molina Healthcare	HMO	Broward	4,581	571	1	29	**5,182**	2.97%	0	N/A
Preferred Medical Plan	HMO	Broward	3,373	705	4	161	**4,243**	2.43%	2,719	56.05%
StayWell	HMO	Broward	10,691	601	5	498	**11,795**	6.76%	41,172	-71.35%
Total Health Choice	HMO	Broward	19,015	2,432	9	393	**21,849**	12.53%	2,821	674.51%
United Healthcare	HMO	Broward	1,315	132	3	233	**1,683**	0.97%	11,984	-85.96%
Universal Health Care	HMO	Broward	3,782	613	0	129	**4,524**	2.59%	301	1402.99%
Vista South Florida	HMO	Broward	1,451	94	4	114	**1,663**	0.95%	7,476	-77.76%
Access Health Solutions	PSN	Broward	19,088	2,212	4	318	**21,622**	12.40%	3,966	445.18%
Better Health, LLC	PSN	Broward	4,020	476	0	22	**4,518**	2.59%	0	N/A
CMS	PSN	Broward	1,974	1,846	0	45	**3,865**	2.22%	2,847	35.76%
NetPass	PSN	Broward	7,834	2,011	4	393	**10,242**	5.87%	5,696	79.81%
Pediatric Associates	PSN	Broward	2,084	46	0	63	**2,193**	1.26%	13,405	-83.64%
SFCCN	PSN	Broward	17,538	3,311	3	571	**21,423**	12.29%	8,308	157.86%
Total Reform Enrollment for Broward			**147,893**	**21,590**	**74**	**4,801**	**174,358**	**100.00%**	**164,005**	**6.31%**
United Healthcare	HMO	Clay	4,595	325	1	82	**5,003**	34.41%	4,181	19.66%
Access Health Solutions	PSN	Clay	8,509	864	0	164	**9,537**	65.59%	6,722	41.88%
Total Reform Enrollment for Clay			**13,104**	**1,189**	**1**	**246**	**14,540**	**100.00%**	**10,903**	**33.36%**
Healthease	HMO	Duval	31,148	3,322	1	889	**35,360**	31.33%	50,371	-29.80%
Staywell	HMO	Duval	1,132	107	0	75	**1,314**	1.16%	4,717	-72.14%
United Healthcare	HMO	Duval	9,097	927	1	327	**10,352**	9.17%	17,839	-41.97%
Universal Health Care	HMO	Duval	4,125	530	0	128	**4,783**	4.24%	698	585.24%
Access Health Solutions	PSN	Duval	20,868	2,536	0	382	**23,786**	21.08%	8,395	183.34%
CMS	PSN	Duval	1,471	1,055	0	24	**2,550**	2.26%	2,004	27.25%
First Coast Advantage	PSN	Duval	28,782	5,068	0	863	**34,713**	30.76%	20,655	68.06%
Total Reform Enrollment for Duval			**96,623**	**13,545**	**2**	**2,688**	**112,858**	**100.00%**	**104,679**	**7.81%**
United Healthcare	HMO	Nassau	1,403	179	1	33	**1,616**	26.58%	1,579	2.34%
Access Health Solutions	PSN	Nassau	3,985	399	3	76	**4,463**	73.42%	2,900	53.90%
Total Reform Enrollment for Nassau			**5,388**	**578**	**4**	**109**	**6,079**	**100.00%**	**4,479**	**35.72%**
Reform Enrollment Totals			**266,318**	**37,257**	**81**	**7,907**	**311,563**		**287,015**	**8.55%**

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 the plans operate.

During Year Three of the demonstration, there were 311,563 recipients enrolled in the program; 3,728 beneficiaries in Baker County, 174,358 beneficiaries in Broward County,

14,540 beneficiaries in Clay County, 112,858 beneficiaries in Duval County, and 6,079 beneficiaries in Nassau County. There were two Baker County health plans with market shares ranging from 25.78 percent to 74.22 percent, 18 Broward County health plans with market shares ranging from 0.82 percent to 17.27 percent, two Clay County health plans with market shares ranging from 34.41 percent to 65.59 percent, seven Duval County health plans with market shares ranging from 1.16 percent to 31.33 percent, and two Nassau County health plans with market shares ranging from 26.58 percent to 73.42 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 25 and 26 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 chose to enroll in a health plan during Year Three of the demonstration. Table 25 provides a description of each column in this report.

Table 25
Medicaid Reform Voluntary Population Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan 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 26 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 26
Medicaid Reform Voluntary Population Report
Year Three: July 2008 through June 2009

Plan Name	Plan Type	Plan County	Reform Voluntary Populations – Year 3								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	50	53	0	3	257	17	380	1.26%	30,118
Buena Vista	HMO	Broward	33	1	1	0	89	0	124	8.63%	1,437
Freedom Health Plan	HMO	Broward	3	0	0	1	20	0	24	1.40%	1,710
HealthEase	HMO	Broward	76	54	2	5	166	1	304	6.12%	4,965
HealthEase	HMO	Duval	249	279	3	15	480	18	1,044	2.95%	35,360
Humana	HMO	Broward	37	45	0	5	357	16	460	2.16%	21,326
Molina Healthcare	HMO	Broward	4	0	0	0	20	1	25	0.48%	5,182
Preferred Medical Plan	HMO	Broward	12	8	0	0	74	3	97	2.29%	4,243
StayWell	HMO	Broward	124	93	2	11	302	17	549	4.65%	11,795
StayWell	HMO	Duval	24	8	1	0	57	7	97	7.38%	1,314
Total Health Choice	HMO	Broward	37	9	1	0	183	8	238	1.09%	21,849
United Healthcare	HMO	Baker	4	1	0	0	7	1	13	1.35%	961
United Healthcare	HMO	Broward	52	0	3	0	222	0	277	16.46%	1,683
United Healthcare	HMO	Clay	22	15	1	4	37	2	81	1.62%	5,003
United Healthcare	HMO	Duval	65	106	5	6	202	5	389	3.76%	10,352
United Healthcare	HMO	Nassau	5	3	1	0	24	1	34	2.10%	1,616
Universal Health Care	HMO	Broward	6	0	0	0	60	1	67	1.48%	4,524
Universal Health Care	HMO	Duval	33	3	0	0	56	4	96	2.01%	4,783
Vista South Florida	HMO	Broward	49	2	2	0	77	1	131	7.88%	1,663
HMO Total	**HMO**		**885**	**680**	**22**	**50**	**2,690**	**103**	**4,430**	**2.61%**	**169,884**
Access Health Solutions	PSN	Baker	4	2	0	0	11	6	23	0.83%	2,767
Access Health Solutions	PSN	Broward	7	18	1	0	83	50	159	0.74%	21,622
Access Health Solutions	PSN	Clay	25	26	2	0	41	24	118	1.24%	9,537
Access Health Solutions	PSN	Duval	53	73	4	5	143	76	354	1.49%	23,786
Access Health Solutions	PSN	Nassau	18	17	0	0	29	7	71	1.59%	4,463
Better Health, LLC	PSN	Broward	2	0	0	0	16	0	18	0.40%	4,518
CMS	PSN	Broward	6	36	5	14	1	9	71	1.83%	3,865
CMS	PSN	Duval	18	29	4	10	1	3	65	2.55%	2,550
First Coast Advantage	PSN	Duval	111	130	2	17	231	303	794	2.29%	34,713
NetPass	PSN	Broward	12	23	1	0	114	124	274	2.68%	10,242
Pediatric Associates	PSN	Broward	15	99	1	4	1	2	122	5.56%	2,193
SFCCN	PSN	Broward	48	134	3	3	162	160	510	2.38%	21,423
PSN Total	**PSN**		**319**	**587**	**23**	**53**	**833**	**764**	**2,579**	**1.82%**	**141,679**
Reform Enrollment Totals			**1,204**	**1,267**	**45**	**103**	**3,523**	**867**	**7,009**	**2.25%**	**311,563**

Previous annual and quarterly reports have included an additional report that displays a summary of Self-Selection, Assignment Rates, and Disenrollment data. In July of 2008, the Agency transitioned to a new Fiscal Agent and subsequently, the entire Medicaid data system was overhauled. At this time, the data necessary to calculate the values of this report as previously captured are not available. However, future annual and quarterly reports will include this report as soon as the data is available.

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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 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.

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. ACS State Healthcare, LLC (ACS) was awarded the contract and took over administration of the Opt Out Program effective November 1, 2008. The contract with the former vendor, HMS, expired on October 31, 2008.

Description of Opt Out Process

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

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

After the required information from the employer is received, the Opt Out specialist follows up with the beneficiary to discuss the insurance that is available through the employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether he or she wants to opt out of

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

The Opt Out database has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The database tracks enrollee characteristics such as eligibility category, type of employer-sponsored insurance and type of coverage. The database will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. 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 Three at a Glance

During Year Three of the demonstration, the Agency contracted with ACS to conduct the Opt Out Program. In conjunction with ACS, the Agency ensured that the vendor transition was smooth and seamless for all program participants. No major problems were identified this year that required the Agency to make any changes to the process.

Opt Out Program Statistics

- 61 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 40 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the fourth quarter of Year Three, there are currently 21 individuals enrolled in the Opt Out Program.

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 December 31, 2007 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 effective December 31, 2007. 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. The children's Medicaid eligibility ended March 31, 2008 and they were subsequently disenrolled from the Opt Out Program (Item Number 11).

5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of 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. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out program.
8. The caller began the process to enroll her three children 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 premiums to pay the employee portion for their family coverage. All three children are still enrolled in the Opt Out Program.
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 premiums to pay the employee portion for their family coverage. Both children are still enrolled in the Opt Out Program.
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 premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan during the third quarter of Year Two effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out program.
11. The caller began the process to enroll her two children 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 premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's

Medicaid eligibility ended March 31, 2009 and as a result has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the fourth quarter of Year Two and subsequently re-enrolled in the Opt Out Program effective May 1, 2008. The child's Medicaid eligibility ended March 31, 2009, and as a result, has been disenrolled from the Opt Out Program (Item Number 26).

13. The caller began the process to enroll 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. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of 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. The child is still enrolled in the Opt Out Program.

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of 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. The mother disenrolled from her employer's health insurance plan during the third quarter of Year Three effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out program.

16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of 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. The father lost his job during the first quarter of Year Three effective September 26, 2008. As a result, the child has been disenrolled from the Opt Out Program.

17. The caller began the process to enroll 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. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

18. The caller began the process to enroll his two children 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 premiums to pay the employee portion for their family coverage. The father lost his job during the first quarter of Year Three effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

19. The caller began the process to enroll 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. The individual's Medicaid eligibility ended September 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of 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. The child's Medicaid eligibility ended May 31, 2008. The child has subsequently been disenrolled from the Opt Out Program.

21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of 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. The child is still enrolled in the Opt Out Program.

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

23. The caller began the process to enroll 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. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

25. The caller began the process to enroll 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 effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of 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. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the first quarter of Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2009. As a result, all four children have been disenrolled from the Opt Out Program.

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

29. The caller began the process to enroll in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on October 1, 2008. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The child is still enrolled in the Opt Out Program.

30. The caller began the process to enroll her five children in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on December 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. All five children are still enrolled in the Opt Out Program.

31. The caller began the process to enroll her child in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child is still enrolled in the Opt Out Program.
32. The caller began the process to enroll her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. Both children are still enrolled in the Opt Out Program.
33. The caller began the process to enroll herself and her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended during the fourth quarter of Year Three on June 30, 2009. As a result, they have both been disenrolled from the Opt Out program. The other child remained Medicaid eligible and is still enrolled in the Opt Out program.
34. The caller began the process to enroll in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her family coverage. The individual is still enrolled in the Opt Out Program.
35. The caller began the process to enroll her child in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

Table 26 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2009. Current Opt Out enrollment, as of June 30, 2009, is 21.

Table 26 Opt Out Statistics September 1, 2006 – June 30, 2009						
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 Job
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 N/A	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	N/A	N/A
C & F	10/01/07	Large Employer	Family	2	N/A	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Single	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	N/A	N/A
C & F	10/01/08	Large Employer	Single	1	N/A	N/A
C & F	12/01/08	Large Employer	Family	5	N/A	N/A
C & F	12/01/08	ERISA	Family	1	N/A	N/A
C & F	01/01/09	Large Employer	Family	2	N/A	N/A
SSI C & F	01/01/09	Large Employer	Family	2 1	06/30/09 N/A	Loss of Medicaid Eligibility N/A
C & F	03/01/09	Large Employer	Family	1	N/A	N/A
SSI	03/01/09	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 of 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 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.

Demonstration Year Three accomplishments for the Enhanced Benefit Program include:

- Successful transition of existing Enhanced Benefit credits to the new Fiscal Agent (EDS).
    - Automation of Credit and Debit files between the Enhanced Benefits Information System (EDS) and First Health.
    - Automation of monthly statement/coupon between EBIS and EDS.
- Increased purchases of health-related products from a total of $113,158.97 in demonstration Year Two to a total of $6,385,113.91 in demonstration Year Three.

Administration of the Enhanced Benefits Accounts

The Enhanced Benefits Accounts Program is administered through two separate systems, the Enhanced Benefits Information System (EBIS) and the Pharmacy Point of

Sale System through EDS's vendor First Health. 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. 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 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 27 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 27 located on the following page.

The active participation rates (see Table 27) have continued to increase each month with beneficiaries purchasing and using earned credits when compared to the date of service for both activities. The highest month of purchases was January 2009 with a monthly record of $756,497.53 with an active participation rate of 147%. Mailing of the monthly insert, which focuses each month on health related products, has continued to be very successful in increasing the call volume and the spending of the earned credits at the pharmacy.

Table 27
Enhanced Benefits Information System Summary

Month of Claims	Number Credited	Earned by Date Created	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**	**0.02%**
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	$1,113,220.00	$80,152.87	7.20%
Nov-07	33,744	$895,305.00	$897,445.00	$50,090.15	5.58%
Dec-07	34,376	$901,687.50	$834,907.50	$96,201.45	11.52%
Jan-08	32,927	$853,935.00	$996,050.00	$192,651.11	19.34%
Feb-08	35,280	$893,972.50	$922,135.00	$201,522.48	21.85%
Mar-08	36,397	$925,917.50	$892,452.50	$309,345.83	34.66%
Apr-08	35,540	$850,887.50	$850,625.00	$353,031.31	41.50%
May-08	30,227	711,277.50	$721,262.50	$471,499.13	65.37%
Jun-08	35,485	$974,177.50	$692,177.50	$500,632.17	72.33%
Year 2 Totals	**178,494**	**$10,737,460.00**	**$10,718,877.50**	**$2,432,729.16**	**23%**
Demonstration Year 3					
Jul-08	39,238	$756,660.00	$836,270.00	$388,182.39	**46%**
Aug-08	36,264	$677,492.50	$688,407.50	$550,111.42	**80%**
Sep-08	38,188	$694,390.00	$636,655.00	$399,778.90	**63%**
Oct-08	34,743	$698,770.00	$577,890.00	$447,088.09	**77%**
Nov-08	27,707	$517,755.00	$464,472.50	$621,721.58	**134%**
Dec-08	26,826	$527,315.00	$449,002.50	$687,201.89	**153%**
Jan-09	22,665	$427,037.50	$513,337.50	$756,497.53	**147%**
Feb-09	12,422	$250,290.00	$301,652.50	$537,540.62	**178%**
Mar-09	28,949	$614,042.50	$533,230.00	$490,865.46	**92%**
Apr-09	27,369	$579,320.00	$471,405.00	$496,206.27	**105%**
May-09	25,261	$516,962.50	$423,507.50	$517,911.90	**122%**
Jun-09	23,239	$488,720.00	$184,125.00	$491,390.86	**267%**
Year 3 Totals	**272,424**	**$6,748,755.00**	**$6,079,955.00**	**$6,384,496.91**	**105%**
	Total # Credited Unduplicated	**Total Amount Earned**	**Total Amount Earned**	**Purchase Total**	**Overall Rate**
Cumulative Total	**204,243**	**$21,804,213.66**	**$21,804,213.66**	**$8,930,398.42**	**40.96%**

* 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 in demonstration 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 and will be able to look at the associated cost savings on expenditures for PSNs only. The analysis of Enhanced Benefits for the HMOs will take place when full encounter data is available.

1. Call Center Activities

Year Three 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 and offers a toll-free number for the regular population of callers, as well as a toll-free number for hearing impaired callers. The call center also 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, with employees who speak English, Spanish and Haitian-Creole; the call center is no longer open on Saturday.

The third year of call center operation was very different from the first year. In demonstration Year One, there were 13,865 calls; Year Two, 53,155 calls; and Year Three, 94,035 calls. Beneficiary credit balance inquires is the primary reason for the increase in calls during Year Three. Although monthly coupon statements are mailed when there is recent activity on the account, beneficiaries still want more recent balance information. Out of the 84,890 calls answered, 65,080 were balance only calls.

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 Three:

Inbound Calls:	94,035
Calls Abandoned:	9,145 or 10%
Average Talk Time	4.8 minutes

Lessons Learned

In Year Three, the call center has primarily handled calls related to beneficiary EBA balances. A request has been made to both the Choice Counseling vendor and the Fiscal Agent (EDS through First Health) to submit cost proposals to offer an automated solution to handle the balance only calls. First Health offering this solution appears to be an excellent choice as their system has the most up-to-date balances. The Choice

Counseling vendor has preliminarily indicated that automating the balance only calls will greatly reduce the number of call center agents needed for the Enhanced Benefit Call Center.

Look Ahead to Year Four

The Agency will review both proposals from First Health and the Choice Counseling vendor regarding automation of the balance only calls and implement an automated solution for the balance only calls. The Agency and the Choice Counseling vendor will continue to evaluate call center activities to bring additional improvements for the EBAP.

2. System Activities

Year Three at a Glance

During demonstration Year Three, a coupon was added with a statement which encouraged beneficiaries to use credits earned. The coupon successfully increased beneficiary utilization of credits and provided beneficiaries with current balance information.

The Agency continues to utilize the Florida Medicaid Fiscal Agent's pharmacy point of sale system which allows beneficiaries to use their credits to purchase health related products. Although no system enhancements were made during demonstration Year Three, the transition to the new vendor, First Health, was successful completed. Automation of both the credit and debit file between EBIS and First Health was also accomplished in Year Three.

Lessons Learned and Look Ahead

The EBIS did not undergo many modifications in demonstration Year Three; instead focus was on increased system performance and easier scalability. The vendors of EBIS main duties are to monitor and perform periodic maintenance of the system. They also monitor and maintain the production web site which the EB call center accesses to assist beneficiaries regarding earned credits and purchases. There were no system issues in demonstration Year Three.

The Agency continues to seek ways to improve the Enhanced Benefits Program. 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 Three at a Glance

Every beneficiary enrolled in a health plan has access to EBAP. There are still three main occurrences when beneficiaries receive information about the program. The first instance is 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 then receives an EBAP welcome letter which is the second instance. In demonstration Year Two a welcome packet was mailed; the welcome packet included a letter along with a color brochure which explained in detail the Enhanced Benefit program.

In Demonstration Year Three, the existing letter was modified to include all the information the brochure contained but in a two page letter. 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; this is the third and reoccurring instance. A change that occurred during Year Three was the introduction of a monthly coupon statement which focused on a beneficiary's current balance along with the insert. The inserts promote specific products beneficiaries may purchase in a themed manner to correlate with a healthy activity or event.

Lessons Learned

During Year Three, the outreach efforts continued to focus on helping beneficiaries use credits earned. The outreach efforts have been very successful as beneficiary purchases have steadily increased and stabilized, since the beginning of demonstration Year Three. The beneficiary purchases have not gone below $300,000 a month in Year Three, with a monthly high of over $700,000 purchases in January 2009. When comparing the last two years of purchases, beneficiaries purchased $3.9 million more in Year Three than in Year Two. There was an average monthly increase of 397% for each month when comparing demonstration Year Two to Year Three purchases.

Look Ahead to Year Four

Since the focus to increase beneficiary's purchases is now a success, the program will focus on beneficiaries participating in the underutilized healthy behaviors by modifying the insert to advertise and educate on certain healthy behaviors. Another proposed change is to add additional healthy behaviors that are more preventive and the inserts will be used to introduce those new behaviors. The new inserts will also educate the benefits of the healthy behavior as well as inform about the credit amount that can be earned.

Demonstration Year Four will be the year in which beneficiaries will lose any earned Enhanced Benefits credits if he or she has been without Medicaid eligibility continuously for three years. November 2009, will be the first time that this can occur, since November 2006, is when credits were first earned. The Agency will begin reporting the number of such beneficiaries in the second quarter of Year Four.

4. Outreach and Education for Pharmacies

Year Three at a Glance

The Agency continues to provide outreach and education to pharmacies regarding the design and billing process for the program as needed.

Lessons Learned

Although there are still complaints from beneficiaries regarding some product availability or treatment at some pharmacies, this type of a complaint has significantly decreased as more and more pharmacies are familiar with the program. During Year Three, the extensive product list of over-the-counter products that can be purchased was modified to also list pharmacy chain brands that are available for purchase. 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 Four

The Agency is committed to continually streamline the process for pharmacies when processing an Enhanced Benefits purchase. Agency staff continues to work with the pharmacy vendor to assist pharmacies as needed.

5. Enhanced Benefits Advisory Panel

Year Three 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.

During Year Three, the program aligned the healthy behaviors that earn credits with the goal of incentivizing beneficiary healthy choices. General office visits which now total $8,678,465.00 earned, is second in amount earned to the preventable office visits which has a total of $8,796,447.50 in overall dollars earned.

Looking Ahead to Year Four

During Year Four, the Panel will decide which new healthy behaviors will be added. The Panel would like to include healthy behaviors that are the same as the Agency defined performance measures the health plans are responsible for reporting. Examples of the types of behaviors that will be considered are pre-natal care during the first trimester, diabetic monitoring blood tests, prostate tests and others.

Enhanced Benefits Statistics

Table 28 provides a cumulative count of healthy behaviors and the sum of granted credit amounts for each since the implementation of the demonstration.

Table 28
Healthy Behaviors Counts and $
(September 2006- June 2009 by date of service)

Procedure	Count of Procedure Code	Sum of Granted Credit Amount
Office Visit-Adult/Child	477,571	$8,678,465.00
Childhood/Adult Preventive Care	360,018	$8,796,447.50
Maintenance Drug	185,978	$1,393,587.50
Dental	52,878	$1,314,635.00
EYE Adult/Child	28,427	$708,167.50
Pap Smear	29,000	$723,067.50
Mammogram	2986	$73,630.00
Colorectal Screening	126	$42,692.50
Hypertension Disease Management Program	1034	25,312.50
Diabetes Disease Management Program	744	$21,622.50
Asthma Disease Management Program	628	$15,530.00
HIV/AIDS Disease Management Program	299	$7,422.50
Congestive Heart Failure Disease Management Prog	117	$2,857.50
Administrative Credit	10	$151.16
Adult Dental Cleaning (preventive services)	3	$45.00
Other Disease Management Program	21	$515.00
Flu Shot	2	$50.00
Smoking Cessation 6 months Success	1	$15.00

Since the program was implemented on June 30, 2009, a total of 272,272 beneficiaries have earned $21,804,213.66.66 in Enhanced Benefit credits. As of June 30, 2009, 272,424 beneficiaries have spent $8,930,398.42 in credits.

Table 29 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 29 Comparison of Credits Earned by Credits Expended		
Month of Claims	**Earned by Date of Service***	**Purchases by Date of Service**
Demonstration Year 1		
Sep-06	$40,202.50	
Oct-06	$249,542.50	
Nov-06	$366,097.50	$203.87
Dec-06	$487,102.50	$840.55
Jan-07	$631,890.00	$3,424.90
Feb-07	$621,636.16	$8,716.25
Mar-07	$722,477.50	$17,574.09
Apr-07	$647,160.00	$13,992.22
May-07	$653,342.50	$28,306.64
Jun-07	$585,930.00	$40,113.83
Year 1 Totals	**$5,005,381.16**	**$113,172.35**
Demonstration Year 2		
Jul-07	$943,790.00	$44,384.70
Aug-07	$982,095.00	$70,911.44
Sep-07	$872,717.50	$62,306.52
Oct-07	$1,113,220.00	$80,152.87
Nov-07	$897,445.00	$50,090.15
Dec-07	$834,907.50	$96,201.45
Jan-08	$996,050.00	$192,651.11
Feb-08	$922,135.00	$201,522.48
Mar-08	$892,452.50	$309,345.83
Apr-08	$850,625.00	$353,031.31
May-08	$721,262.50	$471,499.13
Jun-08	$692,177.50	$500,632.17
Year 2 Totals	**$10,718,877.50**	**$2,432,729.16**
Demonstration Year 3		
Jul-08	$836,270.00	$388,182.39
Aug-08	$688,407.50	$550,111.42
Sep-08	$636,655.00	$399,778.90
Oct-08	$577,890.00	$447,088.09
Nov-08	$464,472.50	$621,721.58
Dec-08	$449,002.50	$687,201.89
Jan-09	$513,337.50	$756,497.53
Feb-09	$301,652.50	$537,540.62
Mar-09	$533,230.00	$490,865.46
Apr-09	$471,405.00	$496,206.27
May-09	$423,507.50	$517,911.90
Jun-09	$184,125.00	$491,390.86
Year 3 Totals	**$6,079,955.00**	**$6,384,496.91**
	Total Amount Earned	**Purchase Total**
Cumulative Total	**$21,804,213.66**	**$8,930,398.42**

Table 30 highlights the amount of credits submitted by each health plan for beneficiaries as of June 30, 2009 (date of service).

Table 30
Amount of Credits Submitted by Health Plan

County	Health Plan Company Name	Granted Credit Amount
Baker	Access Health Solutions	$131,615.00
Baker	United Healthcare of Florida, Inc.	$52,372.50
Broward	Molina	$4,057.50
Broward	Preferred Medical Plan, Inc.	$127,150.00
Broward	Access Health Solutions	$436,652.50
Broward	Total Health Choice, Inc	$257,657.50
Broward	Staywell	$2,936,870.00
Broward	HealthEase	$1,465,260.00
Broward	Vista Healthplan, Inc. (Buena Vista)	$752,742.50
Broward	Vista Healthplan of South Florida, Inc.	$575,045.00
Broward	Freedom Health Plan	$10,977.50
Broward	CMS Network Broward North	$261,550.00
Broward	CMS Network Broward South	$90,757.50
Broward	Humana Inc.	$1,247,855.00
Broward	United Healthcare of Florida, Inc.	$752,682.50
Broward	AMERIGROUP Florida, Inc.	$1,310,805.00
Broward	South Florida Community Care Network	$471,008.66
Broward	South Florida Community Care Network	$422,687.50
Broward	Pediatric Associates PSN, LLC	$1,068,720.00
Broward	Universal Health Care Broward	$25,940.00
Broward	Better Health	$850.00
Broward	Florida NetPass, LLC	$706,985.00
Clay	Access Health Solutions	$333,405.00
Clay	United Healthcare of Florida, Inc.	$239,800.00
Duval	Access Health Solutions	$752,962.50
Duval	Staywell	$259,082.50
Duval	HealthEase	$3,388,200.00
Duval	SHANDS JAX D/B/A First Coast Advantage	$2,254,565.00
Duval	CMS Duval/Ped-I-Care	$173,520.00
Duval	United Healthcare of Florida, Inc.	$1,040,697.50
Duval	Universal Health Care Duval	$59,730.00
Nassau	Access Health Solutions	$113,630.00
Nassau	United Healthcare of Florida, Inc.	$78,380.00

Table 31 provides the top twenty-five purchases in terms of dollar amount, made by beneficiaries from July 1, 2008 through June 30, 2009.

Table 31
Top 25 Beneficiary Purchases*

#	Description	Count	Sum	Average
1	HUGGIES ULTRATRIM	93143	-$931,141.98	-$10.00
2	PAMPERS BABY-DRY	61238	-$611,121.04	-$9.98
3	HUGGIES PULL-UPS	57270	-$556,854.25	-$9.72
4	HUGGIES BABY WIPES	105166	-$412,393.2	-$3.92
5	LISTERINE ANTISEPTIC	41825	-$171,192.2	-$4.09
6	HUGGIES BABY WIPES NAT CARE	33240	-$143,175.41	-$4.31
7	HUGGIES ULTRATRIM STEP 4	8413	-$102,762.26	-$12.21
8	HUGGIES SUPREME	9669	-$92,453.08	-$9.56
9	BLOOD PRESSURE MONITOR	4425	-$89,033.39	-$20.12
10	COMFORT-STRETCH	12519	-$87,317.63	-$6.97
11	KOTEX	18812	-$76,977.43	-$4.09
12	SUPREME DIAPERS	10734	-$67,627.19	-$6.30
13	JOHNSON'S BABY SHAMPOO	24286	-$67,249.15	-$2.77
14	AVEENO	10074	-$66,234.87	-$6.57
15	MOTRIN	13069	-$65,072.21	-$4.98
16	TYLENOL EXTRA STRENGTH	9565	-$61,921.25	-$6.47
17	CETAPHIL	10486	-$60,891.94	-$5.81
18	KIDPANT	8607	-$58,924.26	-$6.85
19	PAMPERS BABY-DRY SIZE 4	5023	-$55,669.33	-$11.08
20	HUGGIES ULTRATRIM STEP 3	4795	-$55,486.16	-$11.57
21	LUBRIDERM	8878	-$53,887.55	-$6.07
22	HUGGIES ULTRATRIM STEP 5	4451	-$52,025.37	-$11.69
23	PAMPERS BABY-DRY SIZE 5	4092	-$47,652.5	-$11.65
24	HUGGIES PULL-UPS 3T-4T BOYS	3996	-$46,643.98	-$11.67
25	CHILDREN'S TYLENOL	9014	-$46,323.91	-$5.14

*****includes purchase/return combinations

Table 32 provides the Enhanced Benefit Account Program statistics for demonstration Year Three.

Table 32
Enhanced Benefit Account Program Statistics

Year Three Activities		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
I.	Number of plans submitting reports by quarter.	31 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).	113,690	89,276	64,036	75,869
III.	Total dollar amount credited to accounts by each quarter.	$2,128,542.50	$1,743,840.00	$1,291,370.00	$1,585,002.50
IV.	Total cumulative dollar amount credited through each quarter.	$17,184,001.16	$18,927,841.16	$20,219,211.16	$21,804,213.66
V.	Total dollar amount of credits used each quarter by date of service.	$1,338,072.71	$1,756,011.56	$1,784,903.61	$1,451,014.00
VI.	Total cumulative dollar amount of credits used through the quarter by date of service.	$3,884,264.84	$5,640,934.85	$7,425,146.50	$8,930,408.65
VII.	Total cumulative number of enrollees who used credits through the quarter.	65,463	87,873	103,596	120,935

6. Complaints

Year Three 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 Three, the Agency did receive a total of 238 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 related to difficulty with utilizing the on-line OTC products list and the interaction with the list at the pharmacy. The final group of complaints was beneficiaries inquiring about not having healthy behaviors reported by the health plan.

Lessons Learned and Look Ahead to Year Four

Further refinement of the OTC product list will occur with frequent updates of the list posted onto the EB website. 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 (PASs) 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 pre-implementation milestones by June 30, 2006. The first year of LIP distributions began July1, 2006.

- **Sources of Non- Federal Share of LIP funds:** On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to CMS for approval. 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.

- **Termination of the hospital inpatient Upper Payment Limit (UPL) program and limit to inpatient Medicaid reimbursement to the Medicaid inpatient cost:** On June 27, 2006, Florida submitted a State Plan Amendment (SPA) # 06-006 to CMS to terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid 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 has agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

On June 30, 2006, the Agency received confirmation from 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 Three at a Glance

The LIP Council was appointed in accordance with House Bill 3-B and Codified in s. 409.911(9), F.S., 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 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 the 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."

LIP Council Membership

During the first three years of the demonstration, the LIP Council consisted of 17 members. Beginning July 1, 2009, the LIP Council members will increase from 17 members to 24 members. Section 409.911, F.S., was amended during the 2009 Legislative session to specify the following changes in the LIP Council Membership. The 24 member LIP Council will include:

- Two members appointed by the President of the Florida Senate,
- Two members appointed by the Speaker of the Florida House of Representatives,
- Three representatives of statutory teaching hospitals,
- Three representatives of public hospitals,
- Three representatives of nonprofit hospitals,
- Three representatives of for-profit hospitals,
- Two representatives of rural hospitals,
- Two representatives of units of local government which contribute funding,
- One representative of family practice teaching hospitals,
- One representative of federally qualified health centers,

- One representative from the Florida Department of Health, and
- One nonvoting representative of the Agency for Health Care Administration who serves as Chair of the LIP Council.

Additional changes to the LIP Council membership specified in Florida Statutes include:

- Except for a full-time employee of a public entity, an individual who qualifies as a lobbyist under section 11.045 or s. 112.3215, F.S, may not serve as a member of the council.
- Of the LIP Council members appointed by the Senate President, only one shall be a physician.
- Of the LIP Council members appointed by the Speaker of the House of Representatives, only one shall be a physician.
- The physician member appointed by the Senate President and the physician member appointed by the Speaker of the House of Representatives must be physicians who routinely take calls in a trauma center, as defined in section 395.4001, F.S., or a hospital emergency department.

The LIP Council's mission and responsibilities as originally specified in section 409.911, F.S., were not amended during the 2009 Legislative Session.

LIP Council Meetings

The LIP Council held six meetings in the first three quarters of demonstration Year Three. There were no LIP Council meetings held during the fourth quarter. The agendas for the LIP Council meetings are posted on the Agency's website and can be viewed at this link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/upcoming_meetings.shtml .

LIP Council Recommendations – State Fiscal Year 2009-2010

On February 3, 2009, LIP Council Chair sent the Agency the LIP Council's recommendation for SFY 2009-2010 funding and distribution to be forwarded to the Governor and Legislature. On February 16, 2009, LIP Council Chair followed up the LIP Council's SFY 2009-2010 LIP funding and distribution recommendations with a detailed report provided to the Agency, Governor, and Legislature. The SFY 2009-2010 LIP recommendations and the detail report are posted on the Agency's website at http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml, toward the bottom of the page under the heading "LIP Council Recommendations to Governor and Legislature for SFY 2009-10".

The SFY 2009-10 LIP Council recommendations continued the trend of increasing LIP funding for LIP projects outside of the Provider Access Systems (PAS) hospital providers as outlined in the chart below.

State Fiscal Year	Total UPL/ LIP to Hospitals	Total UPL/ LIP to Non Hospital
2004-2005	$631,919,923	$0
2005-2006	$666,856,525	$0
2006-2007	$979,352,587	$19,305,630
2007-2008	$978,550,936	$21,449,060
2008-2009	$975,250,000	$26,200,000
2009-2010	$948,932,985	$51,317,014

Reimbursement and Funding Methodology Document

On June 24, 2009, the Agency submitted to CMS an updated Reimbursement and Funding Methodology document that includes updated LIP expenditures and the definition of expenditures eligible for federal matching funds under the LIP. This document was submitted as the final version of the Reimbursement and Funding Methodology document in accordance with STCs # 93, # 98 and #101a.

> **93. Reimbursement and Funding Methodology Document.**
> In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low Income Pool."
>
> **98. Low Income Pool Permissible Non-Hospital Based Expenditures.**
> To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.
>
> **101a. Demonstration Year 1 Milestones.**
> The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91).

2009 Legislation – Distribution of LIP Funds

The State of Florida's State Fiscal Year (SFY) 2009-2010 General Appropriations Act (GAA) and Senate Bill 2602, the Implementing Bill accompanying the GAA, included language that reduced the total budget authority of SFY 2008-2009 LIP distributions by

$123,577,163. This change made the new total anticipated LIP distributions for SFY 2008-2009 $877,872,837. The 2009-2010 GAA provides that the sum of $123,577,163 in budget authority is provided to make payments to hospitals under the LIP Program. The distribution of the LIP funds for SFY 2009-2010 is contingent upon the Agency obtaining an amendment to the STCs of the Florida Medicaid Reform section 1115 demonstration that allows for the distribution of $1 billion in LIP distributions in the fifth year of the waiver (SFY 2010-2011). If the amendment to the demonstration is not approved by January 31, 2010, then the LIP funds shall be used in SFY 2010-2011 for the LIP Program as appropriated in the GAA for SFY 2010-2011.

The Agency has scheduled a conference call for July 15, 2009, with CMS-Central and Regional Offices to discuss the 2009 Legislation in GAA for SFY 2009-2010, related to the distribution of LIP funds (as described in the paragraph above). The Agency has sent an electronic copy of the 2009 session provisions to CMS staff in preparation for the call.

SFY 2008-2009 Low Income Pool Projects

An overview of the activities undertaken by the Department of Health affiliated PAS entities with funding provided from the LIP program during SFY 2008-2009 can be found in Attachment IV of the third quarter report, Year Three. These PAS entities include the County Health Departments (listed below) and the St. Johns River Rural Health Network (see Attachment IV of third quarter report, Year Three).

- Citrus County Health Department
- Dixie County Health Department (Dixie and Gilchrist Counties)
- Duval County Health Department
- Jefferson & Madison County Health Departments (Jefferson & Madison Counties)
- Lake County Health Department
- Okaloosa County Health Department (Focus on the service area of the Fort Walton Beach Medical Center)
- Orange County Health Department
- Pinellas County Health Department (PinCHD)
- Polk County Health Department
- Sarasota County Health Department

Successes in Florida FQHCs

The LIP funding has been instrumental in Florida's Federally Qualified Health Centers' (FQHCs) efforts to successfully expand services working with hospitals, county health departments, and other local organizations to serve Florida's uninsured and underinsured populations. Currently, there are 44 FQHCs operating in Florida that provide quality health care in more than 230 service locations. The service locations include eight County Health Departments who also operate an FQHC. The LIP funds have assisted in an increase of nearly 22% in new FQHC service locations beginning in SFY 2006-2007. Allowing for a dramatic rise in the number of homeless patients being

serviced (12%), the LIP funds have also allowed for a continued growth in the number of clinical providers in FQHCs throughout Florida. Twenty FQHCs are developing or have established ER Diversion Programs with partner hospitals throughout Florida. The ER Diversion Programs are instrumental in elevating the overutilization of hospital emergency departments and delivering cost efficient primary health care.

A brief overview of the activities undertaken by Florida's FQHCs with funding provided from the LIP Program during SFY 2008-2009 can be found in Section F LIP of the fourth quarter report, Year Three.

Looking Ahead to Year Four

During demonstration Year Four, the LIP funds will be expanding in new areas. The LIP Council recommended and the Governor and Legislature approved LIP funding for two Premium Assistance Programs, one in Miami-Dade County and another in Palm Beach County. For the first time, LIP funding includes a category that is to fund hospital based primary care initiatives. Currently, the Agency is working with Florida Department of Health on the application process to determine who will qualify. In SFY 2009-10 FQHCs will receive $18.2 million dollars in LIP funding, a $3 million dollar increase of SFY 2008-09.

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 (MEGs) established through the Budget Neutrality of the 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 (Individuals Over Age 65)
- Family Planning Eligibles
- Women with breast or cervical cancer
- MediKids

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

Excluded Services:

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

Expenditure Reporting:

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

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

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

I. Eligibles and enrollee member months are identified;

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

III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:
   a. MEG #1 SSI-Related
   b. MEG #2 Children and Families
   c. Reform – Managed Care Waiver SSI – no Medicare
   d. Reform – Managed Care Waiver TANF
   e. Reform – Managed Care Waiver SOBRA and Foster Children
   f. Reform – Managed Care Waiver Age 65 and Older

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

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

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

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

Definitions:

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

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

Years One, Two and Three 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.

The expenditures in the following tables do not match the expenditures reported on the CMS 64 report for the quarter ending June 30, 2009. The CMS 64 report included an expenditure run with a date of payment of July 1, 2009, for services with dates of payment beginning July 1, 2009, which is the beginning of Demonstration Year 4. The total reported on the June 30, 2009, CMS 64 report is $194,690,585 for Demonstration Year Four. This amount includes $83,120,812 for MEG 1 and $111,569,773 for MEG 2. These amounts will be included on the next Quarterly Report.

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 33 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 33
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 34 through 38 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2009. 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 34 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$109,209,309	$909,045	$110,118,354	$446.18
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$204,666,715	$9,068,294	$213,735,009	$864.97
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$279,485,810	$29,362,800	$308,848,610	$1,245.10
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$198,742,236	$31,793,702	$230,535,938	$919.18
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$188,079,271	$31,056,750	$219,136,021	$871.08
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$298,437,791	$47,839,499	$346,277,290	$1,372.13
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$287,896,155	$50,059,242	$337,955,397	$1,338.26
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$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	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,119,581**	**$776,809,682**	**$1,015.83**
July 2008	277,846	$192,176,160	$32,392,732	$224,568,891	$808.25
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,915,711**	**$825,861,820**	**$1,008.92**
October 2008	266,157	$232,318,022	$41,009,801	$273,327,823	$1,026.94
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58

Table 34 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q10 Total	**791,043**	**$738,232,869**	**$128,483,862**	**$866,716,731**	**$1,095.66**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
MEG 1 Total	**9,262,126**	**$7,945,614,674**	**$1,152,847,983**	**$9,098,462,656**	**$982.33**

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

Table 35 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**

Table 35 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
October 2007	1,211,534	$271,137,490	$36,924,018	$308,061,507	$254.27
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$273,615,263	$39,329,414	$312,944,677	$254.19
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,469,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$164.78**
July 2008	1,343,457	$167,028,012	$23,597,521	$190,625,534	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
January 2009	1,425,771	$119,386,179	$8,007,586	$127,393,766	$89.35
February 2009	1,440,339	$228,220,385	$24,038,667	$252,259,052	$175.14
March 2009	1,432,269	$361,013,917	$41,788,973	$402,802,890	$281.23
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
MEG 2 Total	**47,087,650**	**$6,910,256,464**	**$663,288,326**	**$7,573,544,790**	**$160.84**

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

Table 36 MEG 1 & 2 Annual Statistics					
DY01 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY01 Total	**2,978,415**	**$2,631,566,388**	**$263,851,544**	**$2,895,417,932**	**$972.13**
WOW DY1 Total	**2,978,415**			**$2,825,890,368**	**$948.79**
Difference				**$69,527,564**	
% of WOW PCCM MEG 1					**102.46%**
DY01 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY01 Total	**15,162,819**	**$2,293,656,191**	**$135,864,711**	**$2,429,520,901**	**$160.23**
WOW DY1 Total	**15,162,819**			**$3,024,679,134**	**$199.48**
Difference				**$(595,158,233)**	
% of WOW PCCM MEG 2					**80.32%**
DY02 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY02 Total	**3,033,969**	**$2,632,920,981**	**$441,425,660**	**$3,074,346,641**	**$1,013.31**
WOW DY2 Total	**3,033,969**			**$3,108,877,695**	**$1,024.69**
Difference				**$(34,531,053)**	
% of WOW PCCM MEG 1					**98.89%**
DY02 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	**14,829,991**	**$2,246,768,250**	**$264,010,165**	**$2,510,778,415**	**$169.30**
WOW DY2 Total	**14,829,991**			**$3,194,973,261**	**$215.44**
Difference				**$(684,194,846)**	
% of WOW PCCM MEG 2					**78.59%**
DY03 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY03 Total	**3,249,742**	**$2,681,127,304**	**$447,570,779**	**$3,128,698,083**	**$962.75**
WOW DY3 Total	**3,249,742**			**$3,596,391,979**	**$1,106.67**
Difference				**$(467,693,896)**	
% of WOW PCCM MEG 1					**87.00%**
DY03 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY03 Total	**17,094,840**	**$2,369,832,024**	**$263,413,450**	**$2,633,245,474**	**$154.04**
WOW DY3 Total	**17,094,840**			**$3,977,627,371**	**$232.68**
Difference				**$(1,344,381,897)**	
% of WOW PCCM MEG 2					**66.20%**

Table 37 MEG 1 & 2 Cumulative Statistics					
DY 01	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	**18,141,234**	**$4,925,222,579**	**$399,716,255**	**$5,324,938,833**	**$293.53**
WOW	**18,141,234**			**$5,850,569,502**	**$322.50**
Difference				**$(525,630,669)**	
% Of WOW					**91.02%**
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	**17,863,960**	**$4,879,689,231**	**$705,435,825**	**$5,585,125,056**	**$312.65**
WOW	**17,863,960**			**$6,303,850,956**	**$352.88**
Difference				**$(718,725,900)**	
% Of WOW					**88.60%**
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	**20,344,582**	**$5,050,959,328**	**$710,984,229**	**$5,761,943,557**	**$283.22**
WOW	**20,344,582**			**$7,574,019,350**	**$372.29**
Difference				**$(1,812,075,794)**	
% Of WOW					**76.08%**

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 36), compared to WOW of $948.79 (Table 33), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 36), compared to WOW of $199.48 (Table 33), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,013.31 (Table 36), compared to WOW of $1,024.69 (Table 33), which is 98.89% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.30 (Table 36), compared to WOW of $215.44 (Table 33), which is 78.59% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $962.75 (Table 36), compared to WOW of $1,106.67 (Table 33), which is 87.00% of the target PCCM for MEG 1. MEG 2 has a PCCM of $154.04 (Table 36), compared to WOW of $232.68 (Table 33), which is 66.20% of the target PCCM for MEG 2.

Tables 36 and 37 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 37) 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 37 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 37) 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 37 is $312.65. Comparing the calculated weighted averages, the actual PCCM is 88.60% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 37) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 37 is $283.22. Comparing the calculated weighted averages, the actual PCCM is 76.08% of the target PCCM.

Table 38
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Total Paid	**$2,740,271,362**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$741,832,387	$1,000,000,000	74.18%
Total MEG 3	$2,740,271,362	$5,000,000,000	54.81%

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

The expenditures for the first twelve quarters for MEG 3, the Low Income Pool (LIP), were $2,740,271,362 (54.81% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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

There are three phases to the collection, validation, and processing of encounter data. 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 involve the statewide collection of encounter data within the Medicaid Management Information System (MMIS) from health plans for all Medicaid covered services. The additional phases were necessary due to Florida's transition to a new Fiscal Agent and its implementation of a new MMIS. The second phase occurred with the prior Medicaid Fiscal Agent (ACS) and the third phase occurs with the current Fiscal Agent (EDS).

Year Three at a Glance

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

- Continued to refine the risk-adjusted methodology for Year Three capitation payments to Reform health plans, according to law;
- Continued to update the MEDS website to include Fiscal Agent (EDS) information related to the Medicaid Encounter Data System;
- Updated the encounter data submission guides to include technical specifications for data collection and processing related to capitated, non-emergency transportation; medical; institutional; dental; and pharmacy encounter claims in the EDS environment;
- Updated system edits within the Florida Medicaid Management Information System (FMMIS) to support encounter data validation;
- Defined updates to the Medicaid Decision Support System for encounter data analyses and structured queries ; and
- Provided specifications for reports used to demonstrate utilization, quality, and trend analyses.

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 the demonstration health plans. To continue to comply with these requirements in Year Two of the demonstration, pharmacy encounter data were 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 prescription and over-the-counter (OTC) 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.

The demonstration 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 the demonstration counties.

Pharmacy data and the Medicaid Rx risk adjustment model will continue to be used for the calculation of risk-adjusted rates in the demonstration 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 within the framework of a diagnostic model.

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

The second phase of MEDS was successfully completed with the transition to a new Fiscal Agent in July 2008. During MEDS phase 2, the Agency made great progress toward statewide encounter claims collection and processing for all Medicaid covered services by implementing business processes and communications protocols with health plans, and by defining Florida-specific encounter content requirements. These activities were successfully implemented in phase 2 and carried into phase 3.

The MEDS Team continued to refine structures and processes implemented in phase 2, and to work with health plans by reviewing and testing encounter data files. Other phase 3 activities include, but are not limited to:

- MEDS Florida-specific documentation supporting the Fiscal Agent (EDS) for X12 837 Professional, Institutional and Dental were completed and updated/distributed as necessary;

- HIPAA transmission protocols incorporating addenda information necessary to support the collection of encounter EDI transactions were updated and distributed;
- Extensive communication with health plans regarding X12 transaction deficiencies identified in phase 2 through Agency-sponsored workgroup conferences, individual health plan telephone conservations, and onsite meetings by the MEDS team at health plan locations was provided;
- Testing and validation of the EDS MMIS encounter data collection and processing systems continued throughout the year; and
- Continuous review and enhancement of communication protocols, a key ingredient to the success of an encounter data system, was undertaken to facilitate clear and constant interaction between the MEDS team and the health plans.

In addition to the activities above, the MEDS team has used its lessons learned during phase 2 as well research findings from other States, CMS, and/or accrediting agencies to update MEDS business processes and communications protocols.

Look Ahead to Year Four

Future activities incorporated into the MEDS project plan include the following:

- Bringing Florida Medicaid health plans current with their submission of HIPAA-compliant encounter data (medical services and pharmacy);
- Joint Agency and 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 health plan submissions;
- Identifying and examining causes of health plan under-reporting of encounter claims;
- Implementing National Council for Prescription Drug Programs, Inc., (NCPDP) following 5.1 Telecommunications Standard for pharmacy encounter data collection;
- Adding 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 diagnosis-based model such as the CDPS; and
- Continuous analysis of quality review findings to ensure improvements in the quality of encounter data submissions from health plans.

I. Demonstration Goals

The demonstration is designed to fundamentally change the current Florida Medicaid program. For this reason, the state is very interested in evaluate the impact of demonstration, 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 the demonstration tracked by the Agency in order to evaluate progress towards achieving its goals. Information about each key evaluation objective is below.

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

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

The Agency currently has contracts with nine HMOs and five PSNs for a total of fourteen health plans in Broward County; and four HMOs and three PSNs for at total of seven health plans in Duval County. As noted in Section A of this report, United Health Plan, Vista, and Vista Health Plan of South Florida ceased operations in Broward County during the second quarter of Year Three. The health plans' stated reasons for pulling out of these counties were not specific to the demonstration or to the September 1, 2008, capitation rates; rather the plans stated their withdrawal was related to network provider contracting issues. In the third quarter of Year Three, two HMOs, Staywell and HealthEase notified the Agency of their intent to cease operations in the demonstration area effective July 1, 2009. Both health plans are owned by parent company, Wellcare. Wellcare's stated reasons for pulling out of these counties were not specific to the demonstration but instead were related to the legislated March 1, 2009, capitation rate reduction. See Section A of the fourth quarter report of demonstration Year Three for detailed information about the HealthEase and Staywell transition process.

Since the beginning of the demonstration, the Agency has received twenty-two health plan applications (fifteen HMOs and seven PSNs) of which twenty applicants sought and received approval to provide services to the TANF and SSI population. Of the twenty-two health plan applications received, all but two were approved as health plans as of June 30, 2009.

The most recent application was received January 14, 2009, from Sunshine State Health Plan, an HMO. Sunshine State Health Plan was approved in May 2009, with its first enrollment scheduled for July 2009. In addition, Sunshine State Health Plan has requested to expand into Baker, Clay and Nassau Counties.

The two health plan applications still pending were submitted by HMOs: AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS, and Medica Health Plans of Florida. AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application in January 2008 to serve beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of June 30, 2009, this specialty plan application was nearing completion of Phase III of the application process. Medica Health Plans of Florida is an HMO with a national base. As of June 30, 2009, this HMO application was in Phase II of the application process.

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 included the following:

- Over-the-counter drug benefit from $10-$25 per household, per month,
- Adult Preventive 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 thirty 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 preventive 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:

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult Preventive 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).

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

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventive 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;
- Respite care; and
- Nutrition Therapy.

In demonstration Year Three, the Agency approved twenty-eight customized benefit packages for the HMOs and fourteen different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of November 1, 2008 to August 31, 2009 for eleven HMOs and six PSNs. In the third quarter of Year Three, two HMOs, Buena Vista and Vista South Florida, as well as one PSN, Pediatric Associates, ceased operations in the demonstration areas. As a result there were twenty-four customized benefit packages approved for nine HMOs and twelve for the remaining five PSNs at the beginning of the fourth quarter of Year Three. Throughout the fourth quarter of Year Three, beneficiaries enrolled in HealthEase and StayWell were transitioned to other health plans. The transition process was completed July 1, 2009.

Demonstration Year Two to Year Three initially saw an increase in the total number of copayments, but in the third quarter of Year Three, Buena Vista, Vista South Florida, and Pediatric Associates ceased operations within the demonstration counties. As a result, the number of copayments dropped substantially in total. In addition the effect of the plans which withdrew created a higher percentage of plans with no copayments on any service. Many plans continued 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 Three were the same as those offered in the previous years, the over-the-counter (OTC) drug benefit and the adult preventive dental benefit. Of all of the plans that offered an OTC drug benefit, 14 offered a $25 OTC drug value and 1 offered a $20 benefit. The expanded services offered to beneficiaries by the health plans in Year Three included each of the services that were first available in Year Two except meals-on-wheels, which was dropped in Year Three.

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 Medicaid 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 Medicaid 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.).

Additionally, during the second quarter of Year Two, 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 35 in the fourth quarter report for Year Three shows the results of these analyses. 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 the demonstration 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.

From March 2008 through March 2009, the Agency administered and conducted eleven monthly provider network validation surveys. In each of the eleven months, Agency staff pulled a sample of providers across the state, fifteen from each health plan, to be surveyed. Additionally, a geographic sample of one hundred-seventeen providers, thirty-nine of each provider type (PCP, Individual Practitioner, and Dentist) was pulled from each Medicaid Area, one area per month. The statewide sample became larger in January 2009 as more health plans began providing services. The geographic samples ended up with fewer than hundred-seventeen providers in Medicaid Areas with fewer

health plans, as they had fewer than thirty-nine dentists to sample from, in which case the population of dentists was surveyed rather than a sample.

Table 39 shows, by survey month, the percentage of sampled providers who were confirmed as having contracts with the health plans from which they were sampled. The table includes the figure for both the statewide and the Medicaid Area geographic surveys each month. It should be noted that the March and April 2008 surveys have a lower accuracy rate than the nine later months due to a change in the follow up process that Agency staff conducted to confirm provider contracts with the health plans. In March and April 2008, Agency headquarters staff followed up with health plans for those providers who were surveyed and failed to confirm participation with a health plan. Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan.

Table 39
Results of Provider Network Validation Surveys
March 2008 through March 2009

Survey Month/Year	Statewide Accuracy Rate	Geographic Medicaid Area	Medicaid Area Accuracy Rate
March 2008	88%*	10	95%*
April 2008	88%*	4	84%*
May 2008	97%	11	99%
June 2008	96%	9	97%
August 2008	97%	6	100%
September 2008	99%	3	99%
October 2008	100%	5	100%
November 2008	100%	8	100%
January 2009	99%	7	100%
February 2009	99%	2	100%
March 2009	99%	1	100%

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

As of the March 2009 survey, each of the eleven Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area has been sampled, and the surveys are consistently finding that those providers included in the provider network files are in fact contracted with the plans, the Agency will move to quarterly provider network surveys in Year Four, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) where able. The survey will focus on statewide samples rather than the Medicaid Area-focused samples each month. During the first quarter of Year Four, the Agency will conduct the first quarterly provider network survey and will begin analyzing the 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) In Year Three, the first set of performance measure data was submitted to the Agency. This performance measure data was for the reporting period January 1, 2007 to December 31, 2007. Although these submissions were due to the Agency on July 1, 2008, several health plans were granted extensions due to unforeseen issues with data systems and HEDIS vendors. The final set of data was submitted to the Agency on October 1, 2008.

The health plan data was compiled for review and analysis. Table 35 in the second quarter report for Year Three provides the list of the performance measures and the corresponding rates by health plan. The data can also be viewed on our website at the following link: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

With the submission of the first year data for review, the Agency was able to discuss performance goals and strategies for improvement with greater specificity. The state worked with Alicia Smith and Associates, Inc., to assist with the development of a performance improvement strategy for the health plan performance measures. This strategy outlines the Agency's goals for performance measures and a timeline during which health plans are expected to achieve the goals, see Attachment III of the third quarter report for Year Three. For HEDIS measures, the Agency expects health plans to perform at the 75th percentile as specified in the HEDIS National Means and Percentiles, published by the National Committee for Quality Assurance. The Agency has not adopted a goal for Agency-defined measures and intends to develop benchmarks for those measures after the second year data submission.

To achieve the goal established by the Agency, the health plans were required to complete corrective action plans for all performance measures that fall below the 50th percentile. The corrective action plans must be designed to achieve performance at the 75th percentile in two years for measures falling below the 25th percentile and three years for measures above the 25th percentile but below the 50th percentile. It should be noted that this improvement strategy applies to both Reform and Non-Reform health plans as the Agency has committed to improving quality throughout our managed care system.

To impart to the health plans the importance of the performance measures and the Agency's commitment to improvement, the Secretary for the Agency for Health Care Administration met with health plans individually to discuss their performance. The

Agency's quality staff also held workshops with each health plan to discuss and improve their corrective action plans, culminating in the submission of final corrective action plans in late March and early April 2009. Health plans will be required to report quarterly on the progress they have made toward the goals in their corrective action plans. The Agency developed and distributed a quarterly reporting template, and the first report submission is due to the Agency on August 17, 2009.

Also in Year Three, the Agency updated the list of performance measures and completed the specifications for the final group of Agency-defined measures. In November 2008, the Agency disseminated draft specifications for the Year 3 Agency–Defined Measures to the health plans for review and comment. Comments from health plans, the EQRO, and HEDIS auditors were reviewed and incorporated, and a final policy transmittal was distributed to the health plans on May 26, 2009. The revised list removed separate reporting of measures for the disease management population. This was done in response to differing methodologies within the health plans for identifying and enrolling recipients into the programs and in response to a desire to reduce reporting burdens on the health plans. Instead, health plans will report measures for the disease states targeted by the disease management programs, but the measures will be applied to the entire health plan population. To capture disease management information, the health plans will now report a measure that asks for the percentage of enrollees participating in each of the disease management programs. This will allow the state to identify any relationships between high performance and high disease management participation.

The second annual submission of performance measures was due to the Agency on July 1, 2009. Preliminary analyses suggest that some improvement has been noted in the performance of the demonstration health plans. Year Four of the demonstration will focus on interventions to improve performance by each of the health plans. Quarterly reports will be a valuable tool in this process, as will the initiation of regular conference calls with health plan quality staff to identify best practices and foster collaboration.

(b) Due to delays in encounter data collection, the Agency constructed an alternative data resource to examine the effect the demonstration project had on Ambulatory Sensitive Hospitalizations (ASH). This alternative source can provide a precursor tool for measuring ASH criteria until the primary encounter data system becomes fully operational and is generating reliable information. This alternative data is constructed from merging two separate databases within the Agency. The first data source comes from the Hospital Inpatient Discharge Data from the Florida Center for Health Information and Policy Analysis (FCHIPA). FCHIPA is a division within the Agency that collects, validates and analyses an information repository covering all inpatient care provided in Florida. As required by Florida Statute, all hospitals in the state are required to routinely provide FCHIPA with an electronic data set for all their inpatient stays regardless of payer. The second data source is Medicaid claim

history covering HMO capitation payments and Fee-For-Service (FFS) inpatient paid claims.

The Medicaid capitation claims identify HMO recipients by Social Security Number (SSN) and their enrollment dates. This data set is matched against the Hospital Discharge Data which contains the patient's SSN and date of admission. The successful matches (based on SSN+Date) identify those occasions of an inpatient stay that occurred in the same month that Medicaid made a capitation payment to a specific HMO to cover that recipient's care. Thus, this matched data is considered a viable precursor method for identifying HMO covered inpatient care.

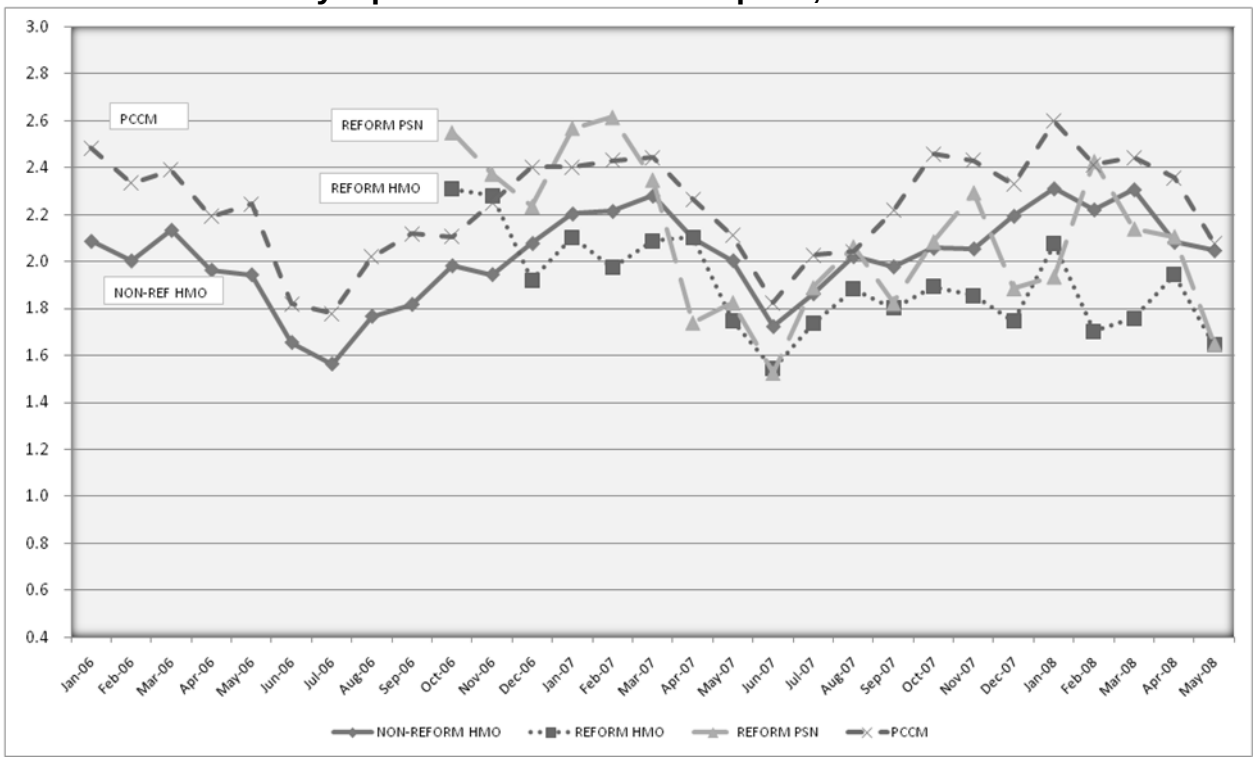
A calculation was applied to this HMO matched data to compensate for missing SSN's that exist in both data resources. Approximately 2% of Medicaid capitation claims data did not have an SSN identified. Approximately 13% of the FCHIPA Hospital Discharge data lacked a valid SSN. In order to measure the rate of success for matching SSN's, an "SSN Comparison Group" was constructed from FFS inpatient claims. The premise is all Medicaid paid inpatient admissions are contained in the Hospital Discharge data. The same SSN+Date matching exercise was performed on this SSN Comparison Group. The level of matching success achieved in this exercise was then applied to the matched HMO inpatient data in order to extrapolate the total volume of HMO inpatient admissions. This FFS comparative matching exercise was performed on 5 years of inpatient data. The average successful matching rate for this Comparison Group was 81.7%. Thus, the matched HMO inpatient data is also defined as representing 81.7% of the total inpatient care provided by the Medicaid HMO's.

The ASH indicators were then applied to this precursor HMO inpatient encounter data. A total of 24 of these indicators were individually calculated and aggregated. The ASH rates of admission were compiled monthly covering January 2006 through June 2008. The ASH rates were prepared for the Reform HMOs, Non Reform HMOs and Reform PSNs. Primary Care Case Management (PCCM) was included to provide comparative reference. For this exercise, the Children's Medical Services Reform PSNs were excluded in order to facilitate a more uniform comparison.

Charts H and I present the findings from this exercise. These charts demonstrate a measurably lower ASH admission rate for the Reform health plan enrollees.

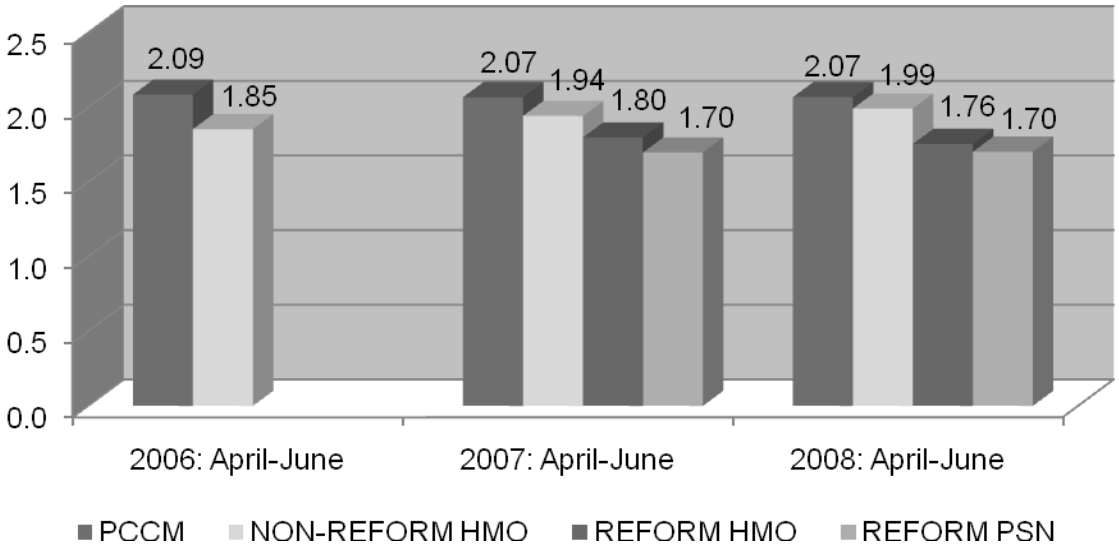
(c) Delays in encounter data collection have affected the Agency's ability to analyze the demonstration project's impact on emergency room utilization. On July 1, 2008, health plans submitted data for the Ambulatory Care HEDIS measure. A component of this measure is emergency department utilization per 1,000 member months. These data will be submitted to the Agency annually and will allow the Agency to trend the impact the demonstration project has had on emergency room use. The second annual submission is due to the Agency on July 1, 2009.

Chart H Ambulatory Care Sensitive Conditions
Monthly Inpatient Admission Rate per 1,000 Enrollees*



* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

Chart I Ambulatory Sensitive Hospitalizations
Comparison of Average Inpatient Admission Rates per 1,000 Enrollee*



* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

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.*

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

During demonstration Year Three, the Agency finalized the *Medicaid Reform Enrollee Satisfaction: Year One Follow-Up Survey Report*, which can be viewed on our website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml. The *Enrollee Satisfaction: Year Two Follow-Up Survey* is scheduled to be finalized and reported during the second quarter of Year Four of the demonstration.

Summary Information – Enrollee Experience & Satisfaction (Broward & Duval)

The goal of the *Medicaid Reform Enrollee Satisfaction: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey* is to measure health care experiences and satisfaction levels prior to and throughout the implementation of the demonstration.

Summary Findings: Year One Follow-Up in Broward & Duval Counties:

- For the majority of all comparisons, statistically significant differences are not observed between Broward and Duval Counties.
- Almost half (46%) reported it was always easy to get an appointment with a specialist.
- About 81% of enrollees in Broward County, and 76% in Duval County reported choosing their health plan.
- About 58% of enrollees in Broward County, and 63% in Duval County reported awareness of the Enhanced Benefits Rewards (EBR) Program.
- Over 60% reported awareness of the Choice Counseling Program.
- Approximately 60% rated their overall satisfaction with care at the highest level (level 9 or 10).
- Non-SSI enrollees tended to provide higher ratings of their health care than SSI enrollees.

Summary Findings: Comparison of the Benchmark Survey Results and Year One Follow-Up Survey Results in Broward & Duval Counties:

- Demographics and health characteristics did not differ in any way except for age.
- The percentage rating their overall satisfaction with care at the highest level decreased (66.54% to 59.63%).
- The percentage rating their satisfaction with their personal doctor at the highest level increased (70.19% to 73.41%).

Broward County:

- The percentage rating their overall health care at the highest level declined for the overall, SSI and non-SSI populations.
- For the overall population and among the non-SSI enrollees, the proportion giving their personal doctor the highest rating increased.
- For SSI enrollees, the percentage giving overall plan satisfaction the highest rating declined.
- There was no change in specialty care ratings.
- The percentage of PSN and HMO enrollees rating their personal doctor at the highest level increased.

Duval County:

- With a few exceptions, ratings did not change between 2006 and 2008.
- The percentage rating their overall health care at the highest level declined for the overall population and for non-SSI individuals.
- The percentage of HMO enrollees rating their overall care at the highest level declined.

Select Demographic Characteristics: Broward and Duval Counties:

	Benchmark Survey	Year 1 Follow-Up Survey
Excellent or very good health (For overall health assessment, enrollee responded as "excellent" or "very good")	60.56	59.83
Female (Enrollee Gender)	53.90	54.25
Hispanic/Latino (Enrollee Ethnicity)	20.28	20.35
Black/African-American (Enrollee Ethnicity)	55.50	55.57
SSI (Categorical Eligibility)	19.23	18.91
Mean Age (Of Enrollee)	16.56	15.43

The following tables contain the percentage of program enrollees that reported the "Highest Level of Satisfaction," or a "9 or 10" on a Rating Scale of "1 to 10."

Select Satisfaction Measures: Broward and Duval Counties		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.10	57.37
Overall Satisfaction with Care	66.54	59.63
Personal Doctor Rating	70.19	73.41
Specialist Rating	60.39	63.32

Select Satisfaction Measures: SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	53.39	45.76
Overall Satisfaction with Care	56.41	48.68
Personal Doctor Rating	67.09	67.01
Specialist Rating	64.56	64.35

Select Satisfaction Measures: Non-SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	59.88	60.10
Overall Satisfaction with Care	68.98	62.53
Personal Doctor Rating	70.97	76.64
Specialist Rating	60.29	62.58

Select Satisfaction Measures: SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.91	53.12
Overall Satisfaction with Care	59.19	55.38
Personal Doctor Rating	69.41	68.82
Specialist Rating	63.80	58.65

Select Satisfaction Measures: Non-SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.57	58.74
Overall Satisfaction with Care	68.40	60.87
Personal Doctor Rating	70.29	71.88
Specialist Rating	55.0	65.88

Select Satisfaction Measures: PSN (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.96	56.11
Overall Satisfaction with Care	63.67	60.82
Personal Doctor Rating	70.56	76.19
Specialist Rating	61.93	62.72

Select Satisfaction Measures: HMO (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: PSN (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: HMO (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.33	56.72
Overall Satisfaction with Care	64.01	59.54
Personal Doctor Rating	66.98	69.67
Specialist Rating	49.11	62.07

Follow-Up Surveys (Broward & Duval Counties)

The projected timeline for the follow-up surveys to be conducted in Broward and Duval Counties are outlined below. Data from the Year Two follow-up survey were collected between March and June 2009. Analyses are currently underway and are projected to be reported in the fall of 2009.

Patient Satisfaction Surveys – Broward & Duval Counties Projected Timeline		
Survey	**Description of Survey Activity**	**Timeline**
Year Two "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Three.	Winter 2009
Year Three "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Four.	Winter 2010

Follow-Up Surveys (Baker, Clay, and Nassau Counties)

During demonstration Year Three, UF also conducted a benchmark CAHPS survey of beneficiaries located in Baker, Clay, and Nassau counties. These benchmark data were shared in the March 2009 Year One follow-up survey report, as a baseline for the three rural demonstration counties. In the fall of 2009, follow up enrollee satisfaction data will be shared as part of the *Medicaid Reform Enrollee Satisfaction: Year Two Follow-Up Survey.* This report will measure the level of patient satisfaction in these three counties prior to and after the implementation of the demonstration waiver.

Find below the projected timeline for the follow-up surveys to be conducted in Baker, Clay, and Nassau Counties

Patient Satisfaction Surveys – Baker, Clay, and Nassau Counties Projected Timeline		
Survey	**Description of Survey Activity**	**Report**
Year One "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Three.	Fall 2009
Year Two "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Four.	June 2010

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

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

During the first year of the LIP, the following PASs received State appropriations for LIP distributions: Hospitals, County Health Departments (CHDs), the St. John's River Rural Health Network (SJRRHN), and Federally Qualified Health Centers (FQHCS). During the first two quarters of Year One, 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.

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

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

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the UF LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to the UF LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year

2005-2006) by July 31, 2007. The LIP Milestone data for Year One of LIP (State Fiscal Year 2006-2007) was due to the Agency from all PASs no later than August 15, 2007. This information was shared with the UF LIP Evaluation team in September 2007. The UF and the Agency is using the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

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

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

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

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

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

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

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

> "In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost/Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in 'natural units' (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments/LIP Program Outcome." (pp 10-11)

The UF LIP Evaluation was received from UF on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the PASs. This document includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

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

In the fourth quarter of Year Three, the Agency has submitted the SFY 2007-08 Milestone data to UF. The Milestone data will be used in accordance with STC #102 of the waiver. The Agency looks forward to receiving SFY 2007-08 Milestone in report form from the UF in September 2009. This document will include an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

Looking Ahead to Year Four

Once the Agency receives approval from the Centers for Medicare and Medicaid Services of the final Reimbursement and Funding Methodology Document (RFMD) dated June 26, 2009, all providers that have received LIP funding will be notified and educated regarding the new LIP cost limit methodology. LIP providers have been made aware that they will be required to revise their cost limit reported information.

J. Evaluation of Medicaid Reform

Overview

The evaluation of Medicaid Reform is an ongoing process, 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). This evaluation was designed to incorporate criteria in the waiver, plus those in the Special Terms and Conditions. The Agency developed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to CMS on February 15, 2006. The Agency incorporated comments from the CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to CMS on May 24, 2006. CMS approval was received on June 13, 2006.

The Medicaid Reform Evaluation is a five-year "over-arching" study that will present its major findings in 2010. However, due to the increasing interest in observing preliminary findings much sooner, the Agency, as well as several other external entities, has continued to conduct short term studies to look at specifically identified Medicaid Reform issues. These "interim" assessments will likely continue to occur throughout the five-year evaluation period. Descriptions of reports released during demonstration Year Three are listed below.

Year Two at a Glance

1. Evaluations Affiliated with the Agency or its Contractors

During this quarter of the reporting period, there were no reports on the demonstration associated with the Agency or its contractors.

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 law 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 Three:

- Report No. 08-64 Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers, published in November 2008.
- Report No. 08-55 Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved; Information Difficult for Beneficiaries to Locate and Compare, published in September 2008.

- Report No. 08-54 Medicaid Reform: Risk-Adjusted Rates Used to Pay Medicaid Reform Health Plans Could Be Used to Pay All Medicaid Capitated Plans, published in September 2008.
- Report No. 08-46 Medicaid Reform: Choice Counseling Goal Met, But Some Beneficiaries Experience Difficulties Selecting a Health Plan That Best Meets Their Needs, published in July 2008.
- Report No. 08-45 Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion, published in July 2008

3. Evaluations in Demonstration Year Three

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

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

In addition to the studies already initiated, the Agency is evaluating the mental and behavioral services provided in the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). This study is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF. A comparison or "control" group in Orange County has been included in this study, which is intended to provide a typical "picture" of mental health service provision in a non-demonstration county. This will allow UF to evaluate the impact of the demonstration on beneficiaries who are receiving mental health services. The first interim/progress report of the comprehensive mental health study plan has been submitted to the Agency for review, and results will be made available during the first quarter of demonstration Year Four.

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. The report, "*An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*," can be found at:
http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml.

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 to be provided to CMS in September 2009.

University of Florida - Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[9]) study designed to help understand demonstration enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration. The primary purpose of this study was to inform the development of further research on demonstrated outcomes. This has now been accomplished, and the independent evaluator will be replacing the qualitative study with an analysis from another area of the demonstration that needs to be assessed in order to further enhance the pilot program. The Agency will be initiating communications with CMS regarding the independent evaluation of this new analysis.

Looking Forward to Year Four

It is too early to draw conclusions regarding the overall impact of the demonstration. However, initial comparative information is available for the Years One and Two of the demonstration. As more data are gathered, the evaluators will begin to explore the implications of beneficiary health plan choices and other important aspects of the demonstration.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was identified during the first year of the demonstration 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 provides input from key community stakeholders. The FAC members include Randy Kammer (Blue Cross and Blue Shield of Florida), Andy Behrman (Florida Association of Community Health Centers), Greg Mellowe (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).

There was no FAC meeting held during evaluation Year Three, however, a meeting is scheduled for December 14, 2009, at the Agency headquarters in Tallahassee. The

[9] 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.

purpose of this meeting will be to provide an update on evaluation activities and receive input from the FAC on the process of the evaluation.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF, as a required activity in the CMS approved evaluation plan. 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 separate evaluation studies. A list of the TAC members and their expertise can be found here: http://mre.phhp.ufl.edu/advisorycommittees/index.htm#tac.

The purpose of this committee is to, over the five-year demonstration period, provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The UF research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary or requested. The TAC meets annually over the five years of the project.

This year's annual TAC meeting took place on March 27, 2009, at the University of Florida in Gainesville. In addition to the TAC representatives, all project areas of the evaluation were represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focused on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations in Florida's demonstration.

K. Policy and Administrative Issues

Overview

In general, during demonstration Year Three, policy, administrative and operational issues were addressed with health plans through the following main processes:

- Technical Advisory Panel Meetings
- Policy Transmittals and Dear Provider Emails and Letters
- Bi-weekly Reform Health Plan Technical & Operational Conference Calls
- PSN Systems Implementation Monthly Conference Calls
- General Amendment/Contract Overview Calls

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 Three of the demonstration. This section of the annual report provides the highlights of key issues addressed during demonstration Year Three.

Year Three at a Glance

Medicaid Reform Technical Advisory Panel

With the demonstration fully operational during Year Three, the Medicaid Reform Technical Advisory Panel (TAP) met periodically (four times) this year. The nine member TAP was created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration. Areas in which advice from TAP is particularly sought includes risk-adjusted rate setting, benefit design, the Choice Counseling program, including implementation of the pharmacy Navigator system in October 2008, the Enhanced Benefits program, health plan capitation rates development and Medicaid encounter data collection and processing. Two new key discussion items on the agenda during demonstration Year Three were:

- Agency's performance measures initiative (setting first-ever performance benchmarks and performance measure action plans) and
- Transition of Staywell and HealthEase members to other Reform health plans and the Agency's strategic plan for notice, choice and assignment.

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

- Provision of written confirmation of contract policy regarding default identification numbers no longer being accepted in Medicaid provider network files and that PSNs now were required to include national provider identification numbers in certain fields in the network files.
- Provision of new procedures for the activation of Medicaid identification numbers for newborns enrolled in Medicaid through the unborn activation process. These new procedures were required due to administrative simplifications made by the Department of Children and Families relative to the unborn activation process.
- Provision of performance measures due to the Agency, specifications for such measures and HEDIS national means and percentiles that will be used as the performance benchmark for each measure.
- 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.
- Updated Plan Evaluation Tool (PET) and submission deadlines for the September 1, 2008 through August 30, 2009 contract period.
- Information regarding the consolidated health plan contract and electronic Report Guide for the new September 1, 2009 through August 31, 2012 contract period.

Biweekly Technical and Operations Calls

The Agency conducted 25 biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants between July 1, 2008 and June 30, 2009. 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 participants attended in person and the popularity of these calls is shown by an average of 160 phone lines in active use on the calls. Consistent agenda items continued to include the following: the new Florida fiscal agent enrollment file and claims processing; Medicaid Encounter Data collection, including transmission schedules and changes to file formats; and external quality review organization updates.

Other typical agenda items included:

- Choice Counseling Program updates, including the Pharmacy Navigator program that was implemented in October 2008 that allows choice counselors to view beneficiary drug information and what prescribed drugs each health plan provides;
- Discontinuation of the health plan disenrollment file under the new Medicaid fiscal agent;
- Medicaid Enhanced Benefit Account Program updates;
- Review of proposed and new performance measures reporting requirements;
- Process for submission of plan-indentified HIV/AIDS enrollees to the Agency;
- Plan withdrawals and transitions;
- Review of policy transmittals (see policy transmittals above);
- State legislative updates; and
- General Amendment and contract updates, including September 2008 rate amendments and benefit amendment timelines, marketing and encounter data amendments (see A.), March 2009 rate reduction amendment, and the upcoming contract period beginning September 1, 2009, and the new electronic Report Guide companion to that contract.

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 demonstration 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 assist the PSNs with systems issues. While these calls started out as biweekly in demonstration Year One, they became monthly in demonstration Year Two and continued to occur monthly during demonstration Year Three. The purpose of these calls was to provide a forum to discuss claims processes and enrollment file issues that were unique to the FFS PSN model.

During these monthly conference calls, the Agency and the PSNs discussed and, as appropriate, resolved claims processing and enrollment file transmittal questions and issues. The PSNs were encouraged to submit questions and/or issues in advance in

order for systems research to occur internally at the Agency (or between the Agency and the Agency's Medicaid fiscal agent). Agency participants included management and 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 Three, over 50 issues were opened and addressed through the Systems Implementation Issues Calls (including six carried over from Year Two), and approximately 22 of these were issues were received during the first two months of new Florida Medicaid Management Information System (FMMIS) implementation. By the end of the Year Three, only five issues remained unresolved. Those unresolved are either waiting for systems changes to occur or for concrete examples to be received from PSNs in order to research whether provider education or a systems changes is needed.

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, the Agency continues to intend 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.

General Amendment/Contract Overview Calls

During Year Three, several conference calls were held with health plans regarding upcoming general amendments and contract changes for the new three-year contract period beginning September 1, 2009. These calls provided the Agency with an opportunity to provide an overview of upcoming amendments and contract changes and a forum for health plans to provide feedback. Calls occurred regarding the following:

- Marketing and encounter data amendment effective March 1, 2009, including elimination of direct and indirect marketing, inclusion of community outreach provisions and inclusion of Medicaid encounter data submission and compliance standards.
- Contract consolidation under the new contract period September 1, 2009 through August 31, 2012, including review of format changes, deletion of requirements and new requirements for the new three-year contract period.

Additional information regarding these amendments/contract changes is located in Section A.