Florida Medicaid Reform

Year 4
Annual Report
July 1, 2009 – June 30, 2010

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 four 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 Four. A more in-depth review of these highlights, including activities planned for Demonstration Year Five, are found in the body of the report.[1]

Highlights of Demonstration Year Four

- Approval of four health plan applications, including the specialty plan to serve beneficiaries living with HIV/AIDS in Broward County.
- Approval of one health plan expansion into Duval, Baker, Clay, and Nassau Counties.
- Approval of twelve health plan requests to increase maximum enrollment levels in various counties.
- Smooth transition of enrollees impacted by health plan acquisitions and terminations.
- Technical assistance provided to health plans located in the demonstration areas.
- In calendar year 2009, the demonstration plans improved in all but one performance measure compared to the previous calendar year. For most performance measures reported, the demonstration plans performed better than non-demonstration plans.
- Addition of incentives and sanctions related to performance measures.
- All written correspondence to beneficiaries were reviewed by the Agency which resulted in new, easier to understand beneficiary correspondence. The letters were also reviewed by beneficiaries, community partners and advocates to obtain public input through public meetings.

[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 fourth operational year of the waiver program, July 1, 2009 through June 30, 2010.

Letter from the Medicaid Director (Continued)

- As directed by the Centers for Medicare and Medicaid Services, procurement of a new Enrollment Broker Services vendor to render Choice Counseling services, with successful implementation of the new vendor, Automated Health Systems (AHS), in the final month of the third quarter of Demonstration Year Four.
- As directed by the Florida Legislature, the Agency successfully amended the requirements for Special Term and Condition # 105, regarding Demonstration Year Five LIP funding. The amended Special Term and Condition requires the completion of specified milestones by the State within certain timelines. The Agency met the Special Term and Condition #105 submission requirements for Demonstration Year Four, and is working towards fulfilling the submission requirements for Demonstration Year Five.

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,

Roberta K. Bradford
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 fourth operational year beginning July 1, 2009, through June 30, 2010. 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

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas[2]: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a customized benefit plan to the Agency for approval as part of the application process. Customized benefit plans are described on pages 13 through 18 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. If the three-year demonstration extension request is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, unless the PSN opts to convert to capitation earlier.

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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs), of which 22 applicants sought and received approval to provide services to the TANF and SSI population.

During Year Four of the demonstration, four new health plans became operational. Sunshine State Health Plan (HMO) began providing services in Broward County on July 1, 2009, and expanded into Baker, Clay, Duval, and Nassau Counties on August 1, 2009. Molina Health Plan (HMO) began providing services in Broward County on September 1, 2009. Medica Health Plan of Florida, Inc., (HMO) began providing services in Broward County on November 1, 2009. AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, doing business as Positive Health Care, a specialty plan

[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.

(HMO) for beneficiaries living with HIV/AIDS, began providing services in Broward County on May 1, 2010. This is the second specialty plan in the demonstration, the first being the specialty plan for children with chronic conditions that became operational in 2006.

The one health plan application still pending approval was submitted by Preferred Care Partners in January 2010. The initial on-site survey has been conducted and the Agency continues to provide guidance to Preferred Care Partners in their efforts to finalize policies and procedures.

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

Table 1
Health Plan Applicants

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

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

Table 2
Medicaid Reform Health Plan Contracts

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

*During Fall of 2008, the plan amended its contract to withdraw from this/these counties.
**During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.
***During Spring of 2009, the plan notified the Agency of its intent to withdraw from these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.

New Model Contract and Report Guide

All health plans signed the new consolidated model contract effective September 1, 2009. The consolidated model contract is a streamlined version of the previous separate model health plan contracts (non-demonstration and demonstration health plans including specialty plans). The Agency created one core contract that a health plan will sign with exhibits that detail any unique plan and population requirements of the particular plan (non-demonstration plans, demonstration plans, specialty population, age-group).

In addition, contract revisions included the removal of reporting templates and detailed reporting instructions from the contract and a first-time, plan-friendly, electronic, report guide companion to the contract. Report templates and detailed instructions are now conveniently provided to health plans through Report Guide postings on the Agency's website. This streamlined the Agency's ability for Agency staff to make changes to report formats and instructions, be responsive to their contractors, and keep up with technological advances without waiting for contract amendment development, negotiation, and execution prior to implementation. The Report Guide was positively received by the health plans and has been cited as a best practice. The design and implementation of this model contract and electronic report guide won the Agency a 2010 Davis Productivity Award, a major government improvement initiative which began in 1989.

Contract General Amendments

In Year Four of the demonstration, three general amendments to the health plan contracts were completed. The first implemented new benefit packages; the second fine-tuned language throughout the contract, primarily to correct citations and numbering issues; and the third added incentives and sanctions related to performance measures.

Expansion or Maximum Enrollment Increase Requests

One health plan, Sunshine State Health Plan (HMO), expanded to new demonstration counties in Demonstration Year Four. Sunshine started operations in Broward County, then expanded (after obtaining Agency approval) into Baker, Clay, Duval, and Nassau Counties.

In addition, the Agency received and approved twelve (12) requests from health plans to increase their maximum enrollment levels in various counties. During the fourth quarter of Demonstration Year Four, a Duval County PSN entered into discussions with the Agency regarding expansion into Baker, Clay and Nassau Counties.

Contract Conversions/Terminations

<u>Purchase Agreements/Acquisitions</u>

There were four purchase agreements/acquisitions in Demonstration Year Four. Based on a purchase agreement entered into between Molina Health Plan (HMO) and Florida NetPASS (FFS PSN), the NetPASS membership was transitioned to Molina this demonstration year. Similarly, based on a purchase agreement entered into between Sunshine State Health Plan (HMO) and Access Health Solutions (FFS PSN), the Access membership was transitioned to Sunshine the first quarter of Demonstration Year Four.

Also, Simply Healthcare (HMO) purchased Total Health Choice (HMO) and purchased a minority share of Better Health Plan (FFS PSN). Total Health Choice ceased operations May 31, 2010. As a result, the Total Health Choice membership was

transitioned to Better Health Plan during the fourth quarter of Demonstration Year Four. Prior to approving the transition, the Agency compared the plan's provider networks, including behavioral health providers, to ensure continuity of care and to ensure the continued availability of current primary care providers.

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

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

Terminations

Two HMOs (AMERIGROUP Community Care and Preferred Medical Plan) withdrew from the demonstration in Year Four. Each plan cited issues with hospital contract negotiations as the impetus for the withdrawal requests. Enrollees were transitioned into other health plans in Broward County effective January 1, 2010.

Health Plan Transition Process

The Agency's mission is to ensure quality care is provided to Florida's residents. Our primary goal when a Medicaid health plan leaves a demonstration county is to ensure continuity of care for all affected enrollees. The following is a summary of the processes and requirements established to enable us to reach this goal.

When a health plan decides to withdraw from a county, the health plan must provide written notice to the Agency at least 120 days prior to the anticipated effective date and must cease community outreach activities as specified in the contract (this 120-day advance notice was a new requirement specified in the 2009-2012 health plan contract; the previous contract had a 90-day advance notice requirement). The health plan is required to work with the Agency to ensure a smooth transition for enrollees. The model contract also allows the Agency to extend the termination date depending on the volume of health plan enrollees affected. Similarly, when a health plan is acquired, the health plan must give notice to the Agency at least 90 days prior to the anticipated effective date. In either situation, 60 days prior to the effective date, the Agency halts enrollment of new members into the health plan.

By contract, to ensure continuity of care, health plans are contractually required to honor prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first. Prearranged covered services could include provider appointments, surgeries, and prescriptions. For covered behavioral health services, this policy is extended for up to three months. Pregnant women may continue to see their OB/GYNs for the duration of the pregnancy regardless of whether or not the provider is a network provider in the new plan.

For each transition, enrollees are given written notification of the change and an opportunity to select another health plan. The health plan must send a letter to its members 60 days prior to the enrollment transition date. These member notices must include the date on which the health plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's Choice Counseling toll-free help line to obtain information on enrollment options and to request a change in health plans.

If the affected enrollee selects a new health plan 30 days prior to transition date, the Agency sends a letter confirming the effective date of enrollment into the new health plan.

If the affected enrollee does not select a new health plan 30 days prior to transition date, the Agency sends a letter to the enrollee with information on the new plan enrollment and how to contact the Agency's Choice Counseling toll free help line to request a change in health plans prior to the enrollment effective date.

All impacted beneficiaries are given 90 days after enrollment into the new health plan to select another health plan without cause.

In each scenario, the Agency carefully plans the transition of the affected enrollees into other health plans. To ensure continuity of care for affected enrollees as they enroll with new plans and to assist them through the choice process, the Agency follows a multi-layered approach:

- Assessing the capacity of the remaining plans and determining if those plans are able to ensure all impacted enrollees have access to quality care.
- Requiring the health plan to provide a listing of members' primary care providers (PCPs) to facilitate transition into a new health plan that also includes the PCP.
- Requiring the health plan to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new plan.
- Working with the plans and the Choice Counseling Vendor to create staggered withdrawal dates to ensure that the volume of beneficiaries being transitioned occurr in an organized manner.

- Working with the plans, the Agency's Choice Counseling Vendor, local area staff, and advocacy groups in ensuring appropriate and timely notice to enrollees, including developing and releasing flyers to locations and provider offices that are frequented by impacted enrollees to help ensure recipients understand the changes.
- Working with the plans to supply PCP and service information to ensure continuity of care and minimize disruption to the recipients, including reviewing the withdrawing plan's provider network to determine which PCPs are available in other health plans.
- Assisting PCPs unique to the withdrawing plan through the Medicaid provider enrollment process to facilitate their enrollment in other health plan networks.
- Identifying enrollees with high risk conditions or in active treatment and relaying this information on to specialist providers and PCPs in the new plan. Plans are required to continue the current treatment (as in high-risk OB, pregnant women will still see their current OB/GYNs until delivery regardless of whether the provider is in the new plan network).
- Conducting weekly calls with the Florida Medicaid Area Offices, Medicaid Contract Management, and the Agency's Choice Counseling Vendor to ensure all issues are resolved quickly.
- Periodically reviewing the complaints staff receive to ensure that any trends are appropriately discussed.

In addition, when the volume of impacted enrollees is high, the Agency works with its Choice Counseling Vendor to allow for additional counselors to properly manage the increased call volume and to station Field Choice Counselors in the Medicaid Area Offices to assist enrollees in their choice of a new plan.

FFS PSN Conversion Process

The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. If the three-year demonstration extension request is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

While most FFS PSNs have submitted conversion workplans and applications to the Agency in order to comply with the previous 5-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications with the additional experience gained from the additional years of operation. As FFS PSNs have become more experienced with managed care, the need for conversion workplans has decreased and the Agency has streamlined the conversion process to remove the submission of a conversion workplan in advance of the conversion application submission.

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

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

Systems Enhancements

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

Demonstration Year Four at a Glance

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

- Implementation of new health plan model contract and Report Guide.
- Approval of four health plan applications, including the specialty plan to serve beneficiaries living with HIV/AIDS in Broward County.
- Approval of one health plan expansion into Duval, Baker, Clay, and Nassau Counties.
- Approval of twelve health plan requests to increase maximum enrollment levels in various counties.
- Smooth transition of enrollees impacted by health plan purchases and terminations.
- Addition of incentives and sanctions related to performance measures.
- Technical assistance provided to health plans located in the demonstration areas.

Lessons Learned

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

- Staying up-to-date on new Medicaid Management Information System issues, conveying appropriate information to the health 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 plan transition and purchase was unique and required special programming.

Look Ahead to Demonstration Year Five

One key principle of the demonstration was that market competition would inspire innovation and create efficiencies in Medicaid coverage. Demonstration Year Five is anticipated as being another year of innovation, as the specialty plan for children with chronic conditions and the specialty plan for persons living with HIV/AIDS mature. These specialty plans will provide Florida Medicaid with more information on how to effectively provide care to specialized populations. It is expected that discussions with FFS PSNs will continue regarding expansion into the demonstration's rural counties.

Medicaid Management Information System training and technical assistance to the health plans will continue during Demonstration Year Five. 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 was 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.

The Agency will continue to work with the health plans to define new ways to encourage health plan performance. One such way recommended by the health plans is allowing a disproportionate share of enrollee assignments based on plan performance. The Agency will continue discussions with the health plans on how to develop such a program.

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 co-payments and offer additional services.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages 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. While plans may vary coverage for services in the last two categories, it should be noted that plans that choose to customize benefits must cover all categories of services under the State Plan.

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for all four years of the demonstration. Interested parties were notified that the data book would be e-mailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of the Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether 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 Demonstration Year Two, May 7, 2008, for Demonstration Year Three, and September 15, 2009, for Demonstration Year Four. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) are typically completed during the last quarter of each state fiscal year. The verification process 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 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 Four of the demonstration.

Demonstration Year Four at a Glance

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

There were ten (10) HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Four of the demonstration: Amerigroup, Freedom Health Plan, Humana, Medica, Molina Healthcare, Preferred Medical Plan, Sunshine State Health Plan, Total Health Choice, United Healthcare, and Universal Health Care. The six (6) FFS PSNs were Access Health Solutions, Better Health, Children's Medical Services, First Coast Advantage, NetPASS, and the South Florida Community Care Network. On May 1, 2010, Positive Healthcare, a new specialty HMO for the HIV/AIDS population, began accepting voluntary enrollment.

During the first quarter of Demonstration Year Four, Access Health Solutions was acquired by Sunshine State Health Plan and NetPASS was acquired by Molina. Subsequently, these PSNs ceased operations and their enrollees were transitioned into the acquiring health plans. During the second quarter of Demonstration Year Four, the HMOs Amerigroup and Preferred ceased operations in the demonstration. Beneficiaries enrolled in those plans were transitioned into the remaining health plans. During the last quarter of Demonstration Year Four, Total Health Choice (HMO) was acquired by Simply Healthcare (HMO) and ceased operations on May 31, 2010. The Total Health Choice Reform enrollees were transitioned into the Better Health Reform (PSN), of which Simply Healthcare is a minority owner, on June 1, 2010. Prior to approving the transition, the Agency compared provider networks, including behavioral health providers, to ensure continuity of care and the continued availability of current primary care providers. Total Health Choice members who were transitioned into Better Health were able to keep their expanded benefits originally offered by Total Health Choice. There was no change in benefit package or provider network for beneficiaries who transitioned from Total Health Choice to Better Health.

Table 4 lists the number of co-payments for each service type by each demonstration year. Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, Demonstration Year Three has been divided into three columns: July 1, 2008, through December 31, 2008; January 1, 2009, through November 30, 2009; and

December 2009. These different columns reflect the departure of health plans that ceased operations during Demonstration Year Three.

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

Table 4
Number of Co-payments by Type of Service by Demonstration Year

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

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

Table 5
Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year

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

Table 6 displays the number of Demonstration Year Four benefit packages not requiring co-payments by population and area, and has been split into two time periods to reflect the loss of the Total Health Choice benefit package. The table shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments.

Table 6
Number of Benefit Packages Requiring No Co-payments
by Target Population & Area
Demonstration Year Four

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

In Year Four of the demonstration, many health plans continue to provide services not currently covered by Medicaid in order to attract enrollees. In the health plan contract, these are referred to as expanded services. There are six different expanded services offered by the health plans during this contract year. The two most popular expanded services offered were the same as Demonstration Year Two and Three: the over-the-counter (OTC) drug benefits and the adult preventive dental benefits. The expanded services available to beneficiaries include:

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

Since the implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006, to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Demonstration Year Three to a monthly script limit only. In Demonstration Year One and Year Two, plans had the option of having a monthly script limit or a dollar limit on the pharmacy benefit. This change was made to standardize the mechanism used to limit the pharmacy benefit. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF of at least 98.5 percent.

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 was similar to that of the three previous years, but occurred at a later date because the benefit packages for Demonstration Year Three were extended until December 31, 2009. This extension was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Four of the demonstration. The updated version of the data book was released by the Agency on September 15, 2009, and the new PET was e-mailed to the health plans on September 17, 2009. The health plans' Demonstration Year Four benefit packages had an effective date of January 1, 2010.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, and Medicaid Fair Hearing (MFH) system. In addition, plan contracts include timeframes for submission, plan response and resolution of beneficiary grievances. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) as specified in Section 408.7056, F.S., for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel (BAP) for enrollees in a FFS PSN (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 forty-five (45) days from the date the Health Plan receives an Appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an Enrollee's request to exercise his or her rights to obtain services outside the network.

- Appeal means a request for review of an Action, pursuant to 42 CFR 438.400(b).
- Grievance means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Under the demonstration, the Legislature required that the Agency develop a process similar to the SAP for enrollees in a PSN as they 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.

Demonstration Year Four 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. Beginning with the second quarter of Year Four, the Agency's new health plan contract required the health plans to report the number of complaints that they received from members in their Grievance and Appeal reports. During Demonstration Year Four, Agency staff worked with the health plans to improve plan reporting on complaints. The Agency is reporting the number of complaints reported by the health plans for Demonstration Year Four in this report and will be reporting them on a quarterly basis beginning with the first quarterly report of Demonstration Year Five.

Plan-Reported Complaints

Table 7 provides the number of complaints reported by the PSNs and HMOs for the period October 1, 2009 – June 30, 2010. The health plan contract defines complaint as: Any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Health Plan employee, failure to respect the enrollee's rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan's Contract. A complaint is an informal component of the grievance system.

Table 7 Plan-Reported Complaints October 1, 2009 – June 30, 2010			
	PSN Complaints	**HMO Complaints**	**HMO & PSN Enrollment***
Oct – Dec 2009	114	858	272,449
Jan – March 2010	253	672	279,544
April – June 2010	311	865	287,453
Total	678	2,395	353,386

*unduplicated enrollment count

Grievances & Appeals

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 its 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.

Table 8 provides the number of grievances and appeals reported by the PSNs and HMOs for Demonstration Year Four.

Table 8 Grievances and Appeals July 1, 2009 – June 30, 2010					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
July – Sept 2009	127	15	80	39	259,173
Oct – Dec 2009	189	24	68	56	272,449
Jan – March 2010	91	19	38	85	279,544
April – June 2010	76	28	56	135	287,453
Total	**483**	**86**	**242**	**315**	353,386

*unduplicated enrollment count

The number of plan reported grievances and appeals fluctuated during Year Four of the demonstration. While PSNs had more grievances in Year Four (483) than in Year Three (165), this is due to spikes in Quarter One and Quarter Two as one PSN in particular had a large influx of new members and transitioned from one transportation provider to another. This PSN also mistakenly entered some complaints they received as grievances rather than complaints. The number of PSN Appeals varied from one quarter to the next. The number of HMO Grievances fluctuated as well, although the total number in Demonstration Year Four (242) is fewer than in Demonstration Year Three (693). The number of HMO Appeals increased during Demonstration Year Four, and the total number (315) is higher than Demonstration Year Three (295), although this

number is still relatively low given the total enrollment in the HMOs and PSNs, which grew over Demonstration Year Four.

Medicaid Fair Hearings (MFHs)

Table 9 provides the number of Medicaid Fair Hearings (MFHs) requested during Demonstration Year Four. MFHs are conducted through the Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members.

The Agency monitors the fair hearing process. Of the thirty (30) MFHs requests, eighteen (18) requests were related to denial of benefits/services, four (4) requests were related to denial of prescription medication, and eight (8) were related to the reduction of benefits. Eighteen (18) MFHs were held, although the beneficiary did not show or abandoned the hearing in six (6) of the cases. Out of the remaining twelve (12) hearings, nine (9) were decided in favor of the health plan, plan actions were confirmed as accurate and the plan having provided services appropriately. One (1) hearing had an outcome that was favorable to the beneficiary and the outcome was pending in two cases. Of the twelve (12) MFH requests that did not have hearings, seven (7) were resolved by the health plan and member, one (1) was rejected by the Department of Children and Families due to being improperly submitted, one (1) was withdrawn by the member, and three (3) were pending.

Table 9
Medicaid Fair Hearing Requests
July 1, 2009 – June 30, 2010

	PSN	HMO
July – Sept 2009	1	6
Oct – Dec 2009	1	1
Jan – March 2010	4	3
April – June 2010	2	12
Total	**8**	**22**

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances were submitted to the BAP and only four (4) were submitted to the SAP in Demonstration Year Four. Of the four (4) SAP grievance issues, one (1) was related to non-authorized services and three (3) were related to services not deemed medically necessary. One (1) issue was withdrawn, one (1) was found in the subscriber's favor, and two (2) were found in the HMO's favor.

The low number of MFHs and SAP and BAP requests indicate that the plans are resolving these issues internally as enrolled members are not requesting further review.

Table 10 provides the number requests to BAP and SAP for the period July 1, 2009, through June 30, 2010.

Table 10
BAP and SAP Requests
July 1, 2009 – June 30, 2010

	BAP	SAP
July – Sept 2008	0	3
Oct – Dec 2008	0	0
Jan – March 2009	0	1
April – June 2009	0	0
Total	**0**	**4**

Looking Ahead to Demonstration Year Five

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, MFHs, 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. The majority of 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 allowed 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 that was implemented October 1, 2007.

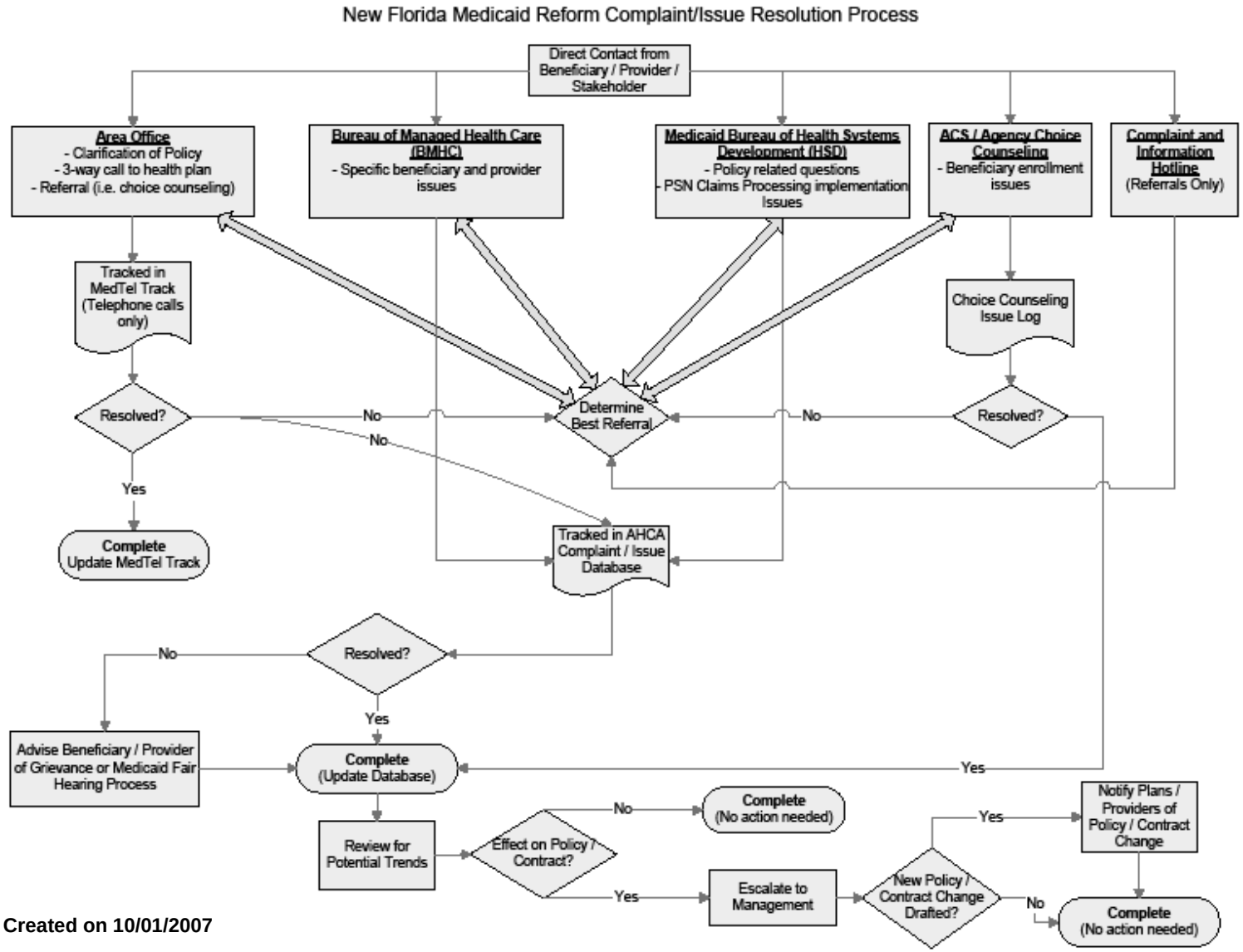
In addition, in Demonstration Year Two, the Agency developed a contract management oversight process that ensured that the number and types of complaints received were being reviewed by health plan analysts responsible for plan oversight as well as bureau management. In addition to the trend reports 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 Demonstration Year Three, the team met and worked on specifications for a new complaint and issues tracking system. In the third and fourth quarters of Demonstration Year Three, the team met with Information Technology staff, who began developing a mock-up of a new system.

In the first quarter of Demonstration Year Four, Information Technology staff made the new system available for testing by the Complaint System Development team and staff who regularly handle complaints/issues. Staff tested the new system and provided feedback to Information Technology staff. The new Complaints/Issues Reporting and Tracking System (CIRTS) went live on October 1, 2009. Initially, the new system was used solely by those staff who had used the previous system, but training was provided to additional staff during Demonstration Year Four, and other Area Office staff began using the system in the spring of 2010. Users have responded positively to the new system, noting that it is much easier to use than the previous system.

The complaints/issues received by the Agency regarding health plans are listed in the quarterly reports. In general, the complaints/issues received during Demonstration Year Four 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

Demonstration Year Four 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 287 complaints/issues regarding health plans in Demonstration 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.

Table 12 provides a summary of Demonstration Year Two, and Table 13 summarizes Demonstration Year Three. The complaints/issues received compared to enrollment during Demonstration Year Four are provided in Table 14.

Table 11
Year One Health Plan Complaints/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 Complaints/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 Demonstration Year Two resulting in more accurate reporting.*

Table 13 Year Three Health Plan Complaints/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.*

Table 14 Year Four Health Plan Complaints/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 Four Total	Complaints per 10,000
PSN	11	1.1	8	0.8	15	1.6	7	0.6	41	2.7
HMO	81	5.0	60	3.4	57	3.1	46	2.8	244	12.0
TOTAL	92	3.5	68	2.5	72	2.6	52	1.8	285	8.1
Enrollment*										
PSN		96,526		94,240		96,277		125,911		150,437
HMO		162,647		178,209		183,267		161,542		202,949
TOTAL		259,173		272,449		279,544		287,453		353,386

**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 regarding policy were discussed with the health plans in biweekly technical and operations calls, policy transmittals, and by e-mail. As noted earlier, the majority of complaints/issues are related to managed care in general and not specific to the demonstration. Agency staff will continue to resolve complaints in a timely manner and monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

In Demonstration Year Four, 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) for Demonstration Year Four.

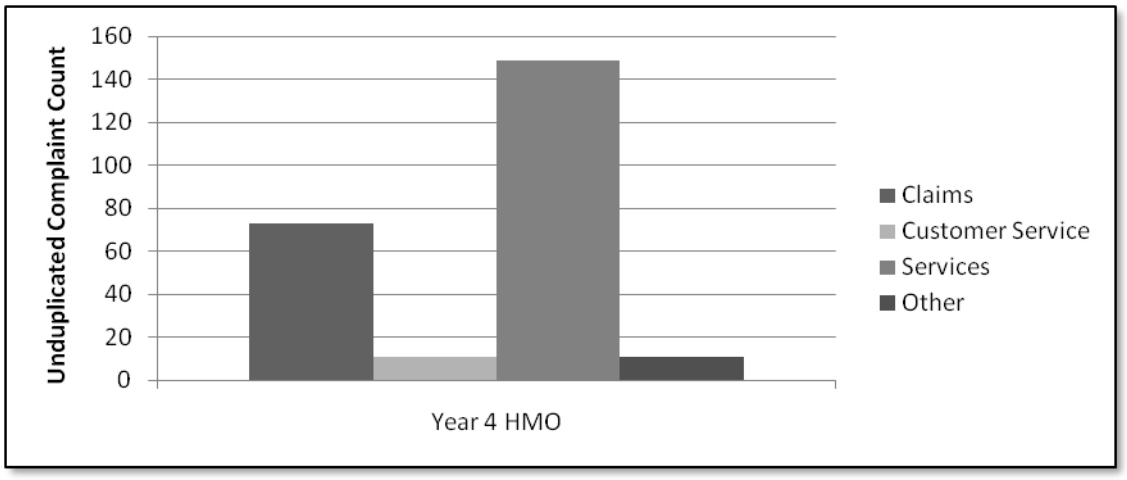
Complaint type descriptions are as follows:

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 Demonstration Year Four.
Marketing[3]	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 Demonstration Year Four.
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 Demonstration Year Four.
Services	Service complaints include, but are not limited to, complaints received from providers and beneficiaries regarding timely service authorization requests, participating provider availability and authorization denials.
Unborn	Unborn complaints include, but are not limited to, complaints received regarding issues related to the appropriate enrollment of newborns who were identified by the plan prior to birth as being eligible to participate in the unborn activation process. The unborn activation process allows health plans to facilitate enrollment of newborns identified prior to birth. There were no complaints related to unborn activation in Demonstration Year Four.
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.

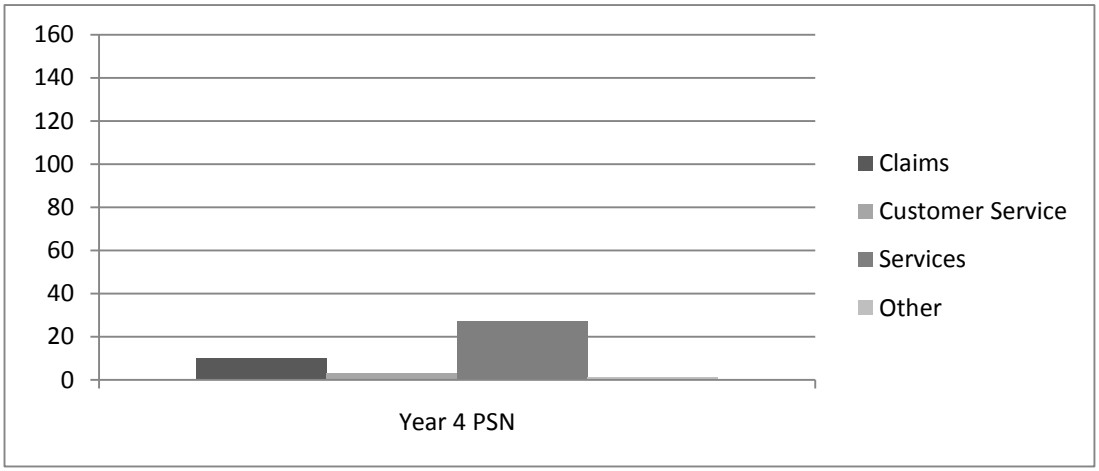
[3] The Agency amended the health plan contracts to eliminate marketing in March 2009.

Chart B. HMO Complaints by Type
Demonstration Year Four



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

Chart C. PSN Complaints by Type
Demonstration Year Four

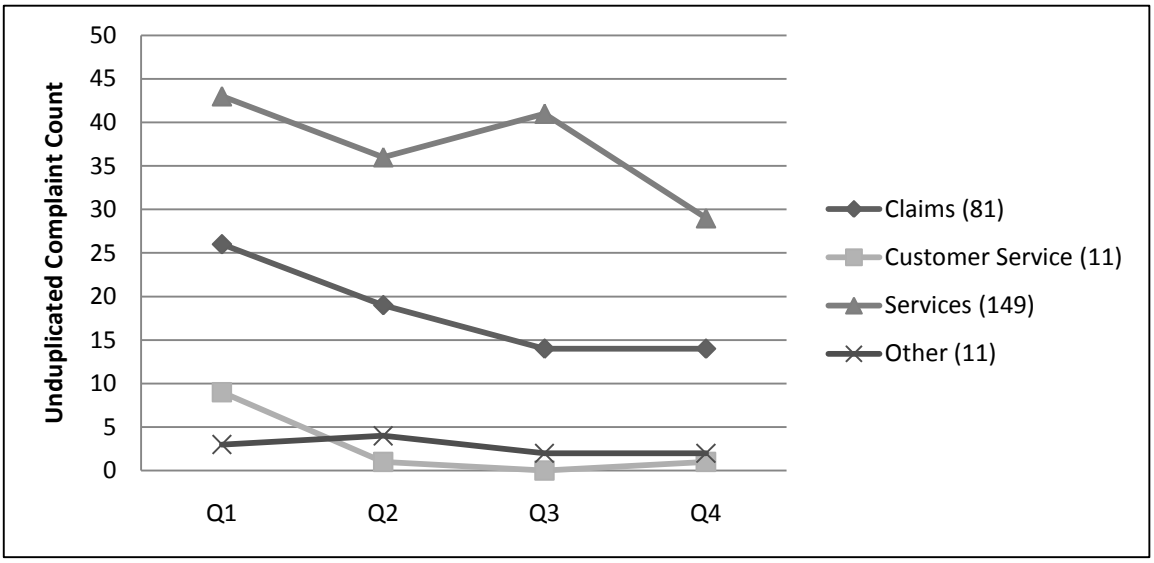


Note: There were no unborn activation, dental, prescription drug, or marketing complaints in Year Four.

Trending reports on HMO and PSN complaints in Demonstration Year Four are provided in Charts D and E. In Demonstration Year Four, 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 complaints received in Demonstration Year Four than in Year Three. Due to the increase in the number of beneficiaries, however, the average rate of issues reported dropped from Year Three (8.57 per 10,000 beneficiaries) to Year Four (8.1 per 10,000 beneficiaries). With several plans transitioning in and out of particular counties in the fourth quarter of Demonstration Year Three, the Agency reviewed complaints on a monthly basis to see whether these transitions resulted 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

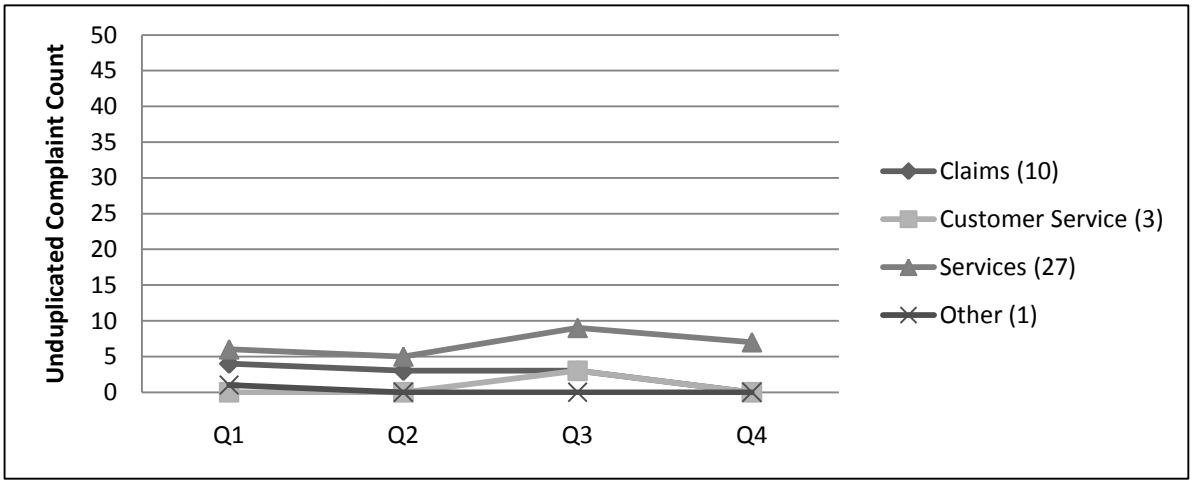
there were no complaints specific to the plan transitions. In Demonstration Year Four, the Agency continued to review complaints on a monthly basis.

Chart D. HMO Overall Complaint Trends
Demonstration Year Four



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

Chart E. PSN Overall Complaint Trends
Demonstration Year Four



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

Looking Ahead to Demonstration Year Five

The Agency will continue to review complaints on a monthly basis and 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

Demonstration Year Four at a Glance

During Demonstration Year Four, the Agency completed both desk reviews and on-site surveys of all Reform HMOs and PSNs. On-site surveys consisted of medical, disease management and care management record reviews, and review of selected parts of the health plan contract. Initial on-site surveys also included a comprehensive network capacity review.

Initial On-Site Survey

During Demonstration Year Four, three (3) health plan applicants received an initial on-site survey along with a comprehensive network capacity review. One (1) health plan applicant received an initial on-site survey along with a comprehensive network capacity review; however, as of the end of Demonstration Year Four, the contract is under review and has not been executed.

Desk Reviews

The desk reviews focused on new and revised policies and procedures, including medical, fraud and abuse, and behavioral health. Provider network reviews were performed upon the health plan's request for expansion of the service areas and/or increases in enrollment in existing service areas. In addition, the desk reviews consisted of reviewing member materials and a review of complaints received concerning the beneficiaries 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 desktop reviews and on-site surveys. In addition, HSAG worked with the Agency to refine questions to be used during the on-site visit. The monitoring tools have been utilized and all monitoring functions are compliant with state and federal regulations. A member of HSAG staff accompanied agency staff on a review per contract requirement.

Table 15 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 15
On-site Survey Categories

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

Each of the health plans received an on-site survey during this demonstration year. The on-site surveys consisted of medical, behavioral health, disease management and care management record reviews, and review of grievance and appeals, administration and management, care/care management, fraud and abuse and quality improvement and utilization management processes.

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

B. Choice Counseling Program

Overview

Year Four of the demonstration continued to equip beneficiaries with additional tools to manage their health care choices. The goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health by providing them with the information they need to make the most informed decisions about health plan choices.

The Preferred Drug List (PDL) search functionality, called the Informed Health Navigator Solution (Navigator), enables beneficiaries to select a health plan based upon their 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.

There were several changes during Demonstration Year Four, some of which impacted the operational components of the Choice Counseling program:

- Procurement for a new Enrollment Broker Services vendor to render Choice Counseling to resolve a conflict of interest concern with the previous vendor, Affiliated Computer Services (ACS).
- The Access Health Solutions (FFS PSN) to Sunshine State Health Plan (HMO) transition impacted the Choice Counseling Call Center during the first quarter.
- The withdrawal of two health plans from Broward County increased the Choice Counseling Call Center call volume during the first two quarters of Year Four.
- The HIV/AIDS Specialty Plan became available to beneficiaries as a choice during the third quarter.
- Continued work to resolve file transfer issues between the Fiscal Agent, HP Enterprise Services, LLC (HP), and Choice Counseling Vendor.
- Implementation of the new Choice Counseling Vendor, Automated Health Systems (AHS), began in the final month of the third quarter.

As the various changes referenced above occurred, the Agency worked with the vendors to minimize impact on the beneficiaries where possible. The following actions have been taken during the course of Demonstration Year Four:

- Requesting the Field Choice Counselors to reach out to community partners to help communicate with beneficiaries;
- Requiring the Field Choice Counselors to address Choice Counselor Call Center call-backs (from messages taken), and handling an increased amount of plan changes and enrollments;
- Implementing a Mental Health Unit with certain Field Choice Counselors addressing questions specific to mental health;

- Using Special Needs Unit nurses to reach out and help those who have complex health needs; and
- Adding additional staffing to handle an increase in the call volume.

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

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

The input provided by these key stakeholders resulted in a comprehensive, innovative Choice Counseling Program that was able to achieve the following results in Year Four of the demonstration:

- Expansion of Mental Health Unit efforts to include community relations and event planning.
- During Demonstration Year Four all written correspondence to beneficiaries was evaluated for clarity and effectiveness. This review resulted in the implementation of new, easier to understand communication for the beneficiaries. The letters were reviewed by beneficiaries, community partners and advocates for feedback prior to finalization, during public meetings held in the demonstration counties.
- Implementation of a new enrollment system, Health Track, to improve Choice Counseling service provided to beneficiaries.

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

1. Response to Beneficiary Feedback

Demonstration Year Four at a Glance

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

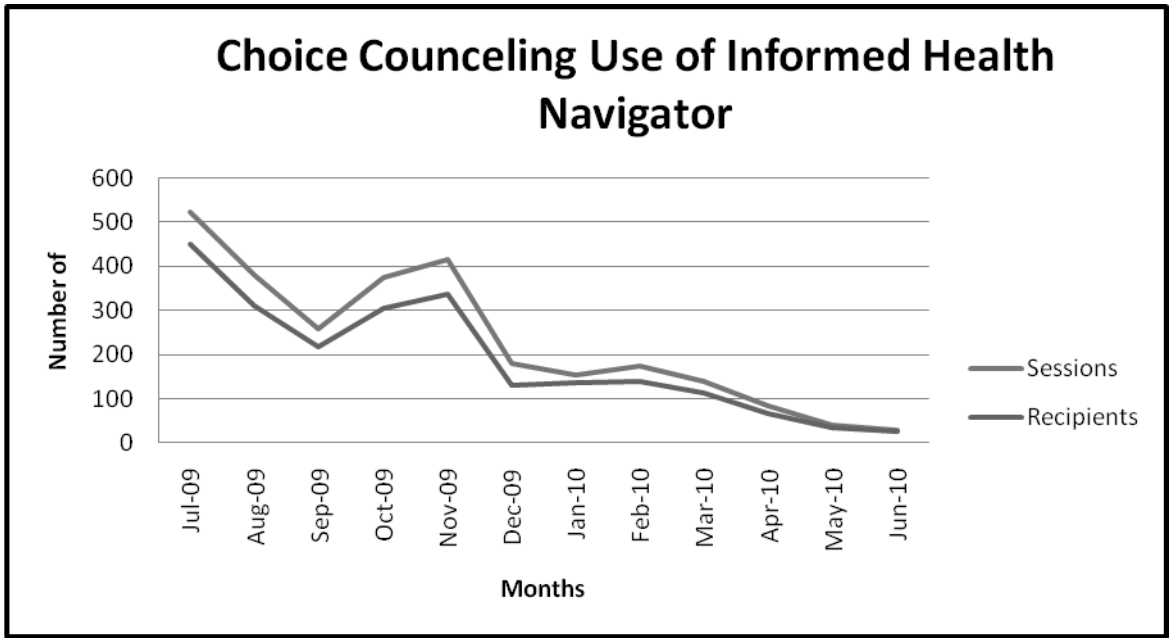
The search for a product/system that would allow the beneficiary to determine drug coverage as a choice driver resulted in a system called the Informed Health Navigator Solution (Navigator). Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator 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), the Navigator

pulls the medication data and provides detailed information on how each plan meets the beneficiary's current prescribed drug needs. The Navigator also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries who do not have prior claims history or have not yet received a new prescription in their 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.

Chart F provides the Navigator statistics for Demonstration Year Four. "Sessions" represents the number of times the Navigator program was utilized, and "Recipients" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate session and recipient.

Since the "Go Live" date of October 27, 2008, through June 30, 2010, for the Navigator, there have been a total of 7,419 Sessions, and 5,853 Recipients that have utilized the system. Usage of Navigator declined during Demonstration Year Four, with primary usage occurring during plan transitions and withdrawals.

Chart F. Navigator Use by Session & Unique Recipient
Demonstration Year Four



Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The survey went live in August of 2007 and since implementation 16,296 surveys have been completed. During Demonstration Year Four, 4,623 beneficiaries completed the automated survey.

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

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

Table 16 contains the average score by month for each question asked in the Beneficiary Customer Survey for Demonstration Year Four. The lower ratings for June are related to the Choice Counseling Vendor transition (ACS to AHS).

Table 16
Beneficiary Customer Survey for Demonstration Year Four
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											
88.40%	89.40%	88.70%	88.70%	88.70%	90.20%	84.6%	86.3%	81.60%	83.70%	84.90%	79.40%
Satisfaction with the amount of time you waited to speak with a counselor											
51.20%	45.90%	33.70%	33.70%	27.50%	17.60%	60.50%	73.80%	75.40%	79.50%	82.50%	48.50%
How easy it was to understand the information											
79.80%	76.90%	77.00%	77.00%	79.60%	76.40%	75.90%	76.60%	76.50%	75.70%	80.30%	57.40%
How likely are you to recommend Choice Counseling helpline to friend or relative											
92.30%	89.40%	90.10%	90.10%	87.70%	83.50%	91.40%	92.90%	89.50%	91.40%	94.40%	83.80%
Overall service provided by Counselor											
96.60%	96.50%	98.30%	98.30%	95.80%	96.10%	96.50%	95.50%	94.70%	94.70%	94.20%	85.30%
How quickly the Counselor understood why you called today											
97.10%	95.70%	96.90%	96.90%	95.30%	95.00%	95.80%	95%	93.30%	95.60%	96.00%	86.80%
The Counselor's ability to help you choose your health plan											
95.20%	93.90%	95.40%	95.40%	94.30%	94.10%	93.50%	93.60%	91.10%	91.40%	91.00%	80.90%
The Counselor's ability to explain things clearly											
96.90%	94.60%	97.60%	97.60%	95.30%	95.50%	94.40%	94.10%	92.60%	93.50%	95.20%	88.20%
The confidence you have in the information given to you by the counselor											
96.40%	94.10%	94.90%	94.90%	94.30%	95.30%	94.60%	94.30%	91.90%	90.50%	92.30%	85.30%
Satisfaction with being treated respectfully											
98.30%	97.60%	98.10%	98.10%	96.30%	97.20%	97.20%	97.20%	95.70%	95.80%	96.60%	89.70%

2. Call Center

Demonstration Year Four 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 Demonstration Year Two in an effort to better align the Call Center hours with beneficiary demand. The Call Center hours were adjusted to Monday through Thursday, 8:00a.m. – 8:00p.m. and Friday, 8:00a.m. – 7:00p.m., thus providing no Saturday hours. The Agency and Choice Counseling Vendor have continued to closely monitor call volume (both inbound and outbound) and the number of voicemail 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 Year Four of the demonstration.

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

Listed below are Choice Counseling Call Center statistics for Demonstration Year Four.

Call Center Statistics - Demonstration Year 5					
Metrics	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**SFY 2009-10**
Inbound Calls Received	79,784	62,601	58,440	61,686	262,511
Average Speed of Answer	791	1,454	132	147	631
Abandoned Calls	27,961	28,499	5,461	4,505	66,426
Abandonment Rate[4]	35.0%	45.5%	9.3%	7.3%	25.3%
Calls Answered	51,823	34,102	52,979	57,181	196,085
Calls Answered in <180 seconds	29.6%	20.4%	73.4%	75.8%	49.8%
Outbound Calls	8,903	6,203	8,168	6,813	30,087

Below is a list of factors, which affected the call statistics for Demonstration Year Four:

- New Fiscal Agent transition: Affiliated Computer Services (ACS) receives all files from the new system.
- Health Plan Transitions: Various health plan transitions have occurred in the demonstration counties.

The Agency placed ACS under a Corrective Action Plan regarding performance improvement. With the transition to the new Choice Counseling Vendor, the Agency has noted significant improvement in the call center statistics. The call abandonment rate is expected to be at or below the contract standard of 5% percent in Demonstration Year Five.

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

3. Mail

Demonstration Year Four at a Glance

In Demonstration Year Four, there was a decline in all mailings compared to Demonstration Year Three. However, the volume in Demonstration Year Four is higher than Years One and Two. The higher volume in Demonstration Year Three is primarily contributed to multiple plan transitions and withdrawals, which required additional mailings.

Table 17 highlights the volume for the largest mailings completed by the mailroom during the demonstration. Mailings are grouped by family or case. This means if there are 2 children in one case, only one mailing will be sent to the household instead of two. Therefore, the number of individuals is higher than the number of mailings.

Table 17
Mail Room Statistics Per Demonstration Year

Type	Year 1	Year 2	Year 3	Year 4
New Eligible Packets	66,832	84,696	95,178	87,702
Transition Mailings	119,002	17,730	3,221	2,045
Auto-Assignment Letters	49,390	48,147	129,456	84,384
Confirmation Letters	49,029	57,537	106,634	84,489
Open Enrollment Packets	2,641	74,412	166,227	137,648

During Demonstration Year Four, 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 Choice Counseling Call Center or by the Field Choice Counselors.

In October 2009, the Choice Counseling Vendor mailed 10,160 Annual Reminder Notices to those 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.

4. Face-to-Face/Outreach and Education

Demonstration Year Four at a Glance

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

- Expansion of the Mental Health Unit's duties
- Proactive outreach efforts provided valuable assistance to beneficiaries during plan transitions

During the first three years of the demonstration, the Choice Counseling Program made dedicated efforts to contact community based organizations serving Medicaid beneficiaries. This was done in an effort to establish a partnership and a line of

communication between the local community and the field staff. During the second quarter of Demonstration 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. Those beneficiaries in the special needs community who are the highest risk for adverse effects caused by continuity of care related issues have been a high priority within the Mental Health Unit. The efforts made earlier to build relationships with the organizations and people who serve them are yielding good results.

During Demonstration Year Four, the role of the Mental Health Unit was expanded to include community relations and event planning, in order to continue the efforts of improving community interaction. The Mental Health Unit has had 82 Private Sessions with 304 attendees, all of whom received services from community partners working with the special needs community. The Mental Health Unit also received 136 referrals from community partners for beneficiaries needing Choice Counseling that were not able to attend scheduled sessions. Fifty-three (53) staff presentations were completed as well, continuing the initiative to provide education and information to the case managers and workers serving beneficiaries with special needs. The Mental Health Unit played a key role along with the rest of the Outreach/ Field team and community partners to help ease the transition for Healthease and Staywell members in both Broward and Duval Counties.

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

These groups all 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 as being knowledgeable, compassionate and dedicated among the partners that have been established.

Minimum complaints from beneficiaries regarding either the Choice Counseling Call Center or the Outreach/Field team are another area that has great significance. The Choice Counseling Vendor and the Agency's commitment to resolving issues in a timely manner made a positive impact. In the Call Center and in the field, if a beneficiary has

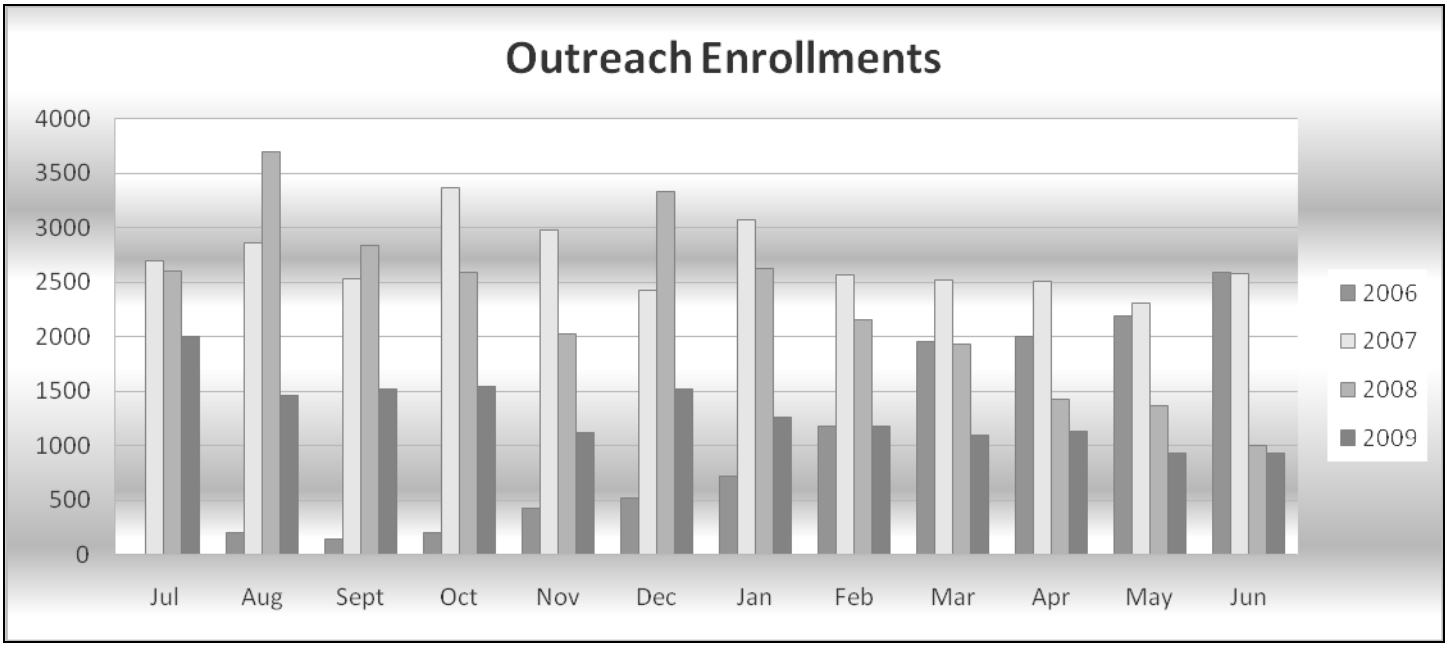
a problem, then the problem is handled with expediency and care. The Choice Counselors have resources available such as the Special Needs Unit, Choice Counselors available in the field to meet someone face to face if needed, and supervisors (both in the field and the Call Center) who give guidance and assistance. The availability of these services alleviates most complaints, because the issues are resolved quickly. The efforts of the program to provide Choice Counseling services to beneficiaries has taken away many of the concerns beneficiaries have and empowered them with the information they need to select the best health plans for themselves and their families.

Table 18 lists the type and volume of Outreach/Field Choice Counselor activities during Demonstration Year Four, and Chart G shows the number of enrollments over the four years of the demonstration.

Table 18
Choice Counseling Outreach Activity
Demonstration Year Four

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Public Sessions	203	260	275	302	243	279	240	275	252	212	187	153	2,881
Private Sessions	14	33	49	42	41	41	31	34	41	31	23	15	395
Home/No-Phone Visits	124	314	521	305	139	292	240	199	287	233	177	167	2,998
Outbound List Calls	2,083	1,197	877	756	673	1,316	1,264	1,263	1,098	1,225	843	950	13,545
Outreach Enrollments	2,006	1,466	1,517	1,546	1,117	1,519	1,267	1,178	1,102	1,131	928	933	15,710

Chart G. Choice Counseling Outreach Enrollments
Demonstration Years One – Four



5. Health Literacy

Demonstration Year Four 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) that 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 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 Counselor's 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 Choice Counselor's verbal inquiries, case referrals, and reviews.

<u>Summary of Cases Taken by the Special Needs Unit:</u>

During Year Four of the demonstration, case referrals the Special Needs Unit took for each month were captured beginning in September of 2008. From September 2008 through June 2010 there were 303 new case referrals and 113 case reviews received and processed by the Special Needs Unit. During the fourth quarter of Demonstration Year Three, the Special Needs Unit started documenting and reporting on the verbal reviews as indicated in their scope of work.

A case referral is when a Choice Counselor refers a case to the Special Needs Unit through the ACS enrollment system (BESST) for follow-up. The Special Needs Unit will do the research, follow-up with the beneficiary, and handle/resolve the referral.

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

6. New Eligible Self-Selection Data

Demonstration Year Four at a Glance

During Demonstration Year Two, the Agency revised the terminology used for describing voluntary enrollment data to improve clarity and understanding of how the demonstration is working. 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 July 2008 due to issues with daily-file and month-end processing transfers between the new Fiscal Agent and Choice Counseling Vendor. The Agency, Choice Counseling Vendor and Fiscal Agent 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 federal CMS, to support the effort of completing the related CSR's. This effort is ongoing as new issues are identified. There have been improvements made to the daily and monthly files that transfer from the Fiscal Agent to the Choice Counseling Vendor and some issues have been resolved. When the improvements are complete, and the month-end and daily-file information processes consistently, it will allow the Choice Counseling Vendor to determine the new eligible's and ensure improved enrollment success.

7. Choice Counseling Complaints/Issues

Demonstration Year Four at a Glance

A beneficiary can file a complaint about the Choice Counseling Program either through the Choice Counseling Call Center, Agency headquarters or the Medicaid Area Office. During Demonstration Year Four, one complaint was received regarding the Choice Counseling Program.

8. Quality Improvement

Demonstration Year Four at a Glance

A key component of the Choice Counseling Program is a continuous quality improvement effort. Quality improvement ideas currently come from the customer service survey (listening to beneficiary comments), quality monitoring of the phone 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 survey previously mentioned in this report. The survey results and comments help the Choice Counseling Vendor and the Agency improve customer service to Medicaid beneficiaries. The survey results reporting the beneficiaries'

confidence in the Choice Counselor's ability to explain health plan choices indicate that more than 97% are satisfied with the Choice Counseling experience (both Field and Call Center) for Demonstration Year Four average. The Agency continues to focus on improving communication between Choice 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 their performance. Survey scores and beneficiary comments are also provided to Supervisors and Choice Counselors. The positive comments encourage the Choice Counselor to keep up the good work and the negative comments help to point out possible weaknesses requiring coaching or training.

Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee, Florida. The quality monitoring staff randomly call 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 19 shows the responses in percentages, of beneficiaries who were randomly called to participate in the survey during Demonstration Year Four. The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 19
Field Choice Counseling – Monitoring Results
Demonstration Year Four

Able to complete enrollment/plan change at the session	99.00%
Felt the information provided by the Choice Counselor helped them make an informed decision	99.25%
The information was explained in a way that made it easy to understand	99.92%
The Choice Counselor was friendly/courteous	100.00%

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

The Agency's headquarter staff, Medicaid Area Office staff, and Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between Area Medicaid staff and the Choice Counseling Vendor field staff, e-mail boxes on the Choice Counseling Vendor's enrollment system so Agency staff and the 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 Demonstration Year Five

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

- Beneficiary Written Correspondence Improvement
- Improved Tools for Access and Education
- Public Feedback

Beneficiary Written Correspondence Improvement

During Demonstration Year Four, the Agency evaluated all beneficiary communications for clarity and effectiveness, which resulted in significant changes to most beneficiary correspondence. The Agency hosted public meetings in the demonstration counties to receive feedback from beneficiaries, community partners and advocates regarding the changes. The changes were implemented during the fourth quarter of Demonstration Year Four. Correspondence will be reviewed annually. In Demonstration Year Five, the Agency will review the brochures and websites utilized by beneficiaries for improvements on clarity and usefulness.

Improved Tools for Access and Education

During Demonstration Year Four, the Agency selected and implemented Automated Health Systems (AHS) as the new Choice Counseling Vendor. AHS assumed operational responsibility on June 18, 2010. The new enrollment system, Health Track, provides improved functionality and additional tools for assisting beneficiaries. In addition to PDL search capabilities, Health Track also includes enhanced provider, specialist, and hospital search functionality. The results from these tools are uniquely displayed to always show the agent the health plan which best meets the needs of the beneficiary at the top. In the first quarter of Demonstration Year Five, the Agency will launch online enrollment capability for beneficiaries to make their health plan selections via the internet. The beneficiaries will then have access to all of the tools used by the agents to aid them in making their choice when it is convenient for them.

Public Input

In Demonstration Year Four, the Agency continued to increase public interaction to provide opportunities for feedback. In Demonstration Year Five, the Agency will continue this effort, which is vital for the success and continued development 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 that beneficiaries transitioned from included Health Maintenance Organizations (HMOs), MediPass, Pediatric Emergency Room Diversion, Provider Service Networks (PSNs), and Minority Physician Networks (MPNs).

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

- **Non-committed MediPass[5]:** 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:

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

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

The demonstration was not expanded in Year Three or Year Four, and continues to operate in the counties of Baker, Broward, Clay, Duval, and Nassau. Table 20 contains the quarterly enrollment for each health plan during Year Four 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 H, and Chart I shows the quarterly enrollment for each of the PSNs.

Table 20
Quarterly Medicaid Reform Enrollment by Plan
Demonstration Year Four

Plan Name	Plan Type	Number of Enrollees by Quarter – Year 4			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Amerigroup	HMO	21,534	2,240	0	0
Freedom	HMO	995	814	1,008	2,199
Humana	HMO	14,481	12,315	10,492	8,999
Medica	HMO	0	39	988	1,521
Molina Healthcare	HMO	13,547	19,101	20,300	21,986
Positive Healthcare	HMO	0	0	0	22
Preferred Medical Plan	HMO	2,550	325	0	0
Sunshine	HMO	61,755	84,406	89,908	96,582
Total Health Choice	HMO	27,265	32,079	33,637	3,211
United Healthcare	HMO	11,293	10,463	9,545	8,954
Universal Health Care	HMO	9,227	16,427	17,389	18,068
HMO Totals		**162,647**	**178,209**	**183,267**	**161,542**
Access Health Solutions	PSN	15,593	0	0	0
Better Health, LLC	PSN	4,853	8,377	8,092	35,634
CMS	PSN	6,317	6,645	6,884	7,014
First Coast Advantage	PSN	45,739	48,982	49,468	49,666
NetPASS	PSN	889	0	0	0
SFCCN	PSN	23,135	30,236	31,833	33,597
PSN Totals		**96,526**	**94,240**	**96,277**	**125,911**
Medicaid Reform Totals		**259,173**	**272,449**	**279,544**	**287,453**

Chart H.
Quarterly Medicaid Reform Enrollment for HMOs

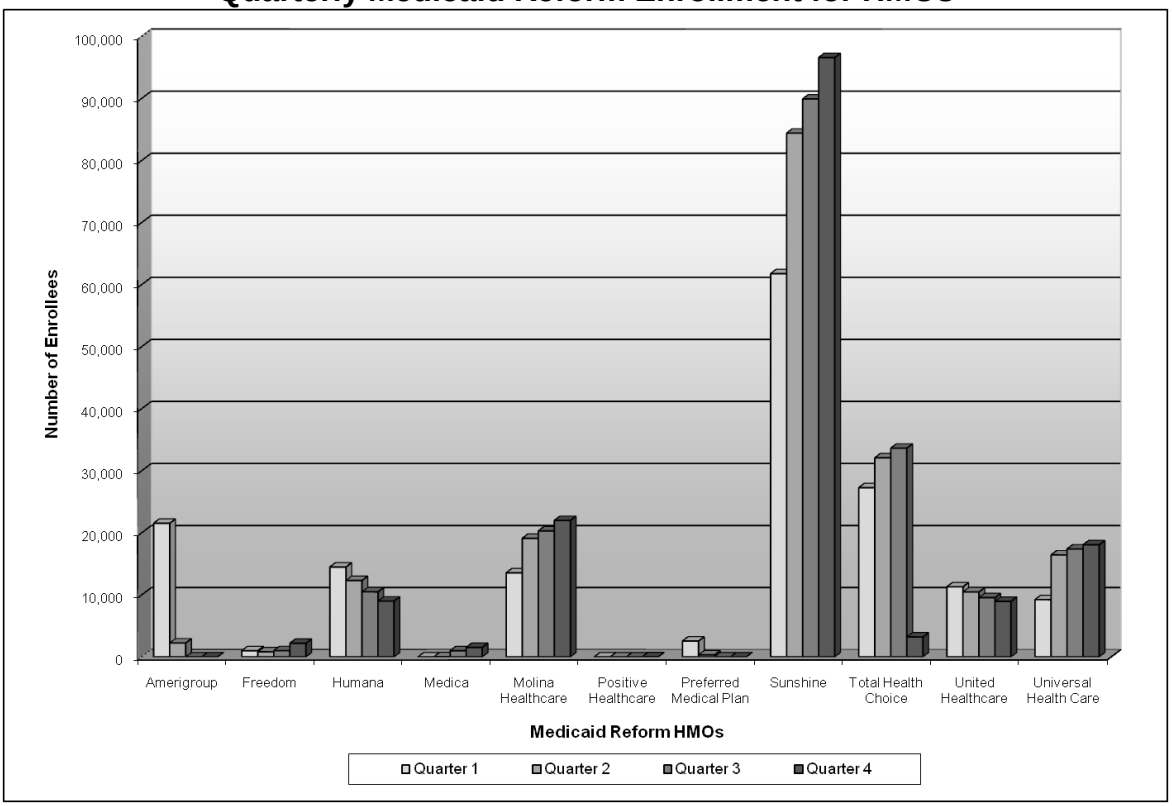
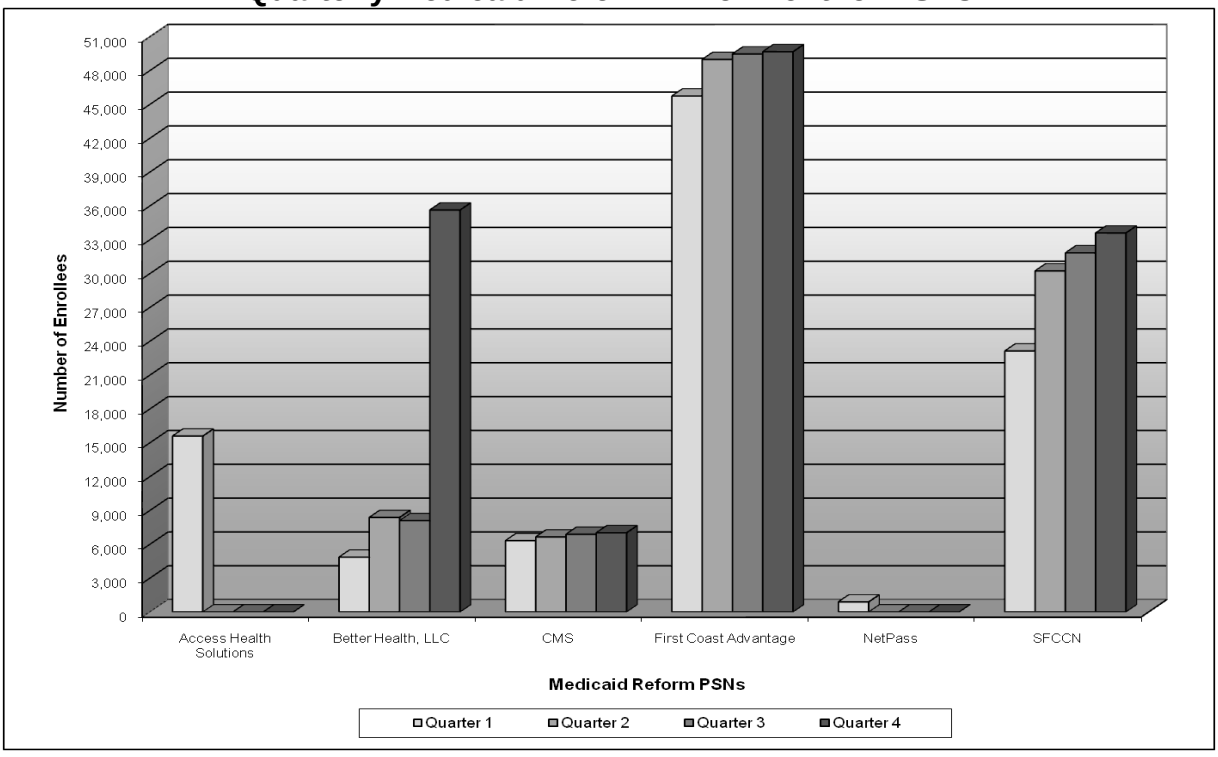


Chart I.
Quarterly Medicaid Reform Enrollment for PSNs



Demonstration Year Four at a Glance

Monthly Enrollment Reports – Year Four

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 for Demonstration Year Four. 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 Four, there were a total of 17 health plans – 11 HMOs and 6 FFS PSNs. There are 2 categories of Medicaid beneficiaries who are enrolled in health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment report for demonstration Year Four 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 21 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 21
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, 2009 and ending June 30, 2010. In order to obtain a unique count, only the recipients' most recent month of enrollment in the program is used. Please refer to Table 22 for the annual Medicaid Reform Enrollment report for Year Four of the demonstration.

Table 22
Medicaid Reform Enrollment Report
Demonstration Year Four: July 1, 2009 through June 30, 2010

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	2,429	173	1	111	**2,714**	**0.77%**	30,118	-90.99%
Buena Vista	HMO	0	0	0	0	**0**	**0.00%**	1,437	-100.00%
Freedom Health Plan	HMO	2,156	336	2	58	**2,552**	**0.72%**	1,710	49.24%
HealthEase	HMO	0	0	0	0	**0**	**0.00%**	40,325	-100.00%
Humana	HMO	9,999	2,150	7	279	**12,435**	**3.52%**	21,326	-41.69%
Medica	HMO	1,376	221	0	48	**1,645**	**0.47%**	0	N/A
Molina Healthcare	HMO	22,242	3,548	17	428	**26,235**	**7.42%**	5,182	406.27%
Positive Healthcare	HMO	1	21	0	0	**22**	**0.01%**	0	N/A
Preferred Medical Plan	HMO	407	62	0	27	**496**	**0.14%**	4,243	-88.31%
StayWell	HMO	0	0	0	0	**0**	**0.00%**	13,109	-100.00%
Sunshine	HMO	101,243	9,811	10	810	**111,874**	**31.66%**	0	N/A
Total Health Choice	HMO	10,473	692	4	207	**11,376**	**3.22%**	21,849	-47.93%
United Healthcare	HMO	10,295	1,175	1	78	**11,549**	**3.27%**	19,615	-41.12%
Universal Health Care	HMO	19,228	2,435	9	379	**22,051**	**6.24%**	9,307	136.93%
Vista South Florida	HMO	0	0	0	0	**0**	**0.00%**	1,663	-100.00%
HMO Total	**HMO**	**179,849**	**20,624**	**51**	**2,425**	**202,949**	**57.43%**	**169,884**	**19.46%**
Access Health Solutions	PSN	4,160	378	1	464	**5,003**	**1.42%**	62,175	-91.95%
Better Health, LLC	PSN	32,341	4,564	11	582	**37,498**	**10.61%**	4,518	729.97%
CMS	PSN	4,543	3,487	0	19	**8,049**	**2.28%**	6,415	25.47%
First Coast Advantage	PSN	50,977	7,355	5	1,048	**59,385**	**16.80%**	34,713	71.07%
Netpass	PSN	245	61	0	212	**518**	**0.15%**	10,242	-94.94%
Pediatric Associates	PSN	0	0	0	0	**0**	**0.00%**	2,193	-100.00%
SFCCN	PSN	34,953	4,401	9	621	**39,984**	**11.31%**	21,423	86.64%
PSN Total	**PSN**	**127,219**	**20,246**	**26**	**2,946**	**150,437**	**42.57%**	**141,679**	**6.18%**
Reform Enrollment Totals		**307,068**	**40,870**	**77**	**5,371**	**353,386**	**100.00%**	**311,563**	**13.42%**

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 Four reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-demonstration health plans to the demonstration health plans. There were a total of 353,386 unique beneficiaries enrolled in the demonstration during Year Four. There were 17 health plans with market shares ranging from 0.01 percent to 31.66 percent.

2. Medicaid Reform Enrollment by County Report

During Year Four of the demonstration, the demonstration 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 23.

Table 23 Number of Reform Health Plans in Demonstration Counties		
County Name	**Number of Reform HMOs**	**Number of Reform PSNs**
Baker	**2**	**1**
Broward	**10**	**5**
Clay	**2**	**1**
Duval	**3**	**3**
Nassau	**2**	**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 (See Table 25). 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 24 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 24 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, Duval, Baker, Clay or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in 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.

Table 25
Medicaid Reform Enrollment by County Report
Demonstration Year Four: July 2009 through June 2010

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				
Sunshine	HMO	Baker	3,046	269	0	17	**3,332**	**78.22%**	0	N/A
United Healthcare	HMO	Baker	665	96	0	9	**770**	**18.08%**	961	-19.88%
Access Health Solutions	PSN	Baker	129	16	0	13	**158**	**3.71%**	2,767	-94.29%
Total Reform Enrollment for Baker			**3,840**	**381**	**0**	**39**	**4,260**	**100.00%**	**3,728**	**14.27%**
Amerigroup	HMO	Broward	2,429	173	1	111	**2,714**	**1.40%**	30,118	-90.99%
Buena Vista	HMO	Broward	0	0	0	0	**0**	**0.00%**	1,437	-100.00%
Freedom Health Plan	HMO	Broward	2,156	336	2	58	**2,552**	**1.32%**	1,710	49.24%
HealthEase	HMO	Broward	0	0	0	0	**0**	**0.00%**	4,965	-100.00%
Humana	HMO	Broward	9,999	2,150	7	279	**12,435**	**6.41%**	21,326	-41.69%
Medica	HMO	Broward	1,376	221	0	48	**1,645**	**0.85%**	0	N/A
Molina Healthcare	HMO	Broward	22,242	3,548	17	428	**26,235**	**13.52%**	5,182	406.27%
Positive Healthcare	HMO	Broward	1	21	0	0	**22**	**0.01%**	0	N/A
Preferred Medical Plan	HMO	Broward	407	62	0	27	**496**	**0.26%**	4,243	-88.31%
StayWell	HMO	Broward	0	0	0	0	**0**	**0.00%**	11,795	-100.00%
Sunshine	HMO	Broward	35,047	2,958	5	213	**38,223**	**19.70%**	0	N/A
Total Health Choice	HMO	Broward	10,473	692	4	207	**11,376**	**5.86%**	21,849	-47.93%
United Healthcare	HMO	Broward	0	0	0	0	**0**	**0.00%**	1,683	-100.00%
Universal Health Care	HMO	Broward	11,798	1,724	5	265	**13,792**	**7.11%**	4,524	204.86%
Vista South Florida	HMO	Broward	0	0	0	0	**0**	**0.00%**	1,663	-100.00%
Access Health Solutions	PSN	Broward	1,248	73	0	144	**1,465**	**0.76%**	21,622	-93.22%
Better Health, LLC	PSN	Broward	32,341	4,564	11	582	**37,498**	**19.33%**	4,518	729.97%
CMS	PSN	Broward	2,779	2,262	0	14	**5,055**	**2.61%**	3,865	30.79%
Netpass	PSN	Broward	245	61	0	212	**518**	**0.27%**	10,242	-94.94%
Pediatric Associates	PSN	Broward	0	0	0	0	**0**	**0.00%**	2,193	-100.00%
SFCCN	PSN	Broward	34,953	4,401	9	621	**39,984**	**20.61%**	21,423	86.64%
Total Reform Enrollment for Broward			**167,494**	**23,246**	**61**	**3,209**	**194,010**	**100.00%**	**174,358**	**11.27%**
Sunshine	HMO	Clay	11,234	1,001	0	81	**12,316**	**68.92%**	0	N/A
United Healthcare	HMO	Clay	4,464	304	1	21	**4,790**	**26.80%**	5,003	-4.26%
Access Health Solutions	PSN	Clay	618	82	0	65	**765**	**4.28%**	9,537	-91.98%
Total Reform Enrollment for Clay			**16,316**	**1,387**	**1**	**167**	**17,871**	**100.00%**	**14,540**	**22.91%**
HealthEase	HMO	Duval	0	0	0	0	**0**	**0.00%**	35,360	-100.00%
StayWell	HMO	Duval	0	0	0	0	**0**	**0.00%**	1,314	-100.00%
Sunshine	HMO	Duval	46,687	5,099	5	457	**52,248**	**40.27%**	0	N/A
United Healthcare	HMO	Duval	3,924	635	0	35	**4,594**	**3.54%**	10,352	-55.62%
Universal Health Care	HMO	Duval	7,430	711	4	114	**8,259**	**6.37%**	4,783	72.67%
Access Health Solutions	PSN	Duval	1,880	180	1	213	**2,274**	**1.75%**	23,786	-90.44%
CMS	PSN	Duval	1,764	1,225	0	5	**2,994**	**2.31%**	2,550	17.41%
First Coast Advantage	PSN	Duval	50,977	7,355	5	1,048	**59,385**	**45.77%**	34,713	71.07%
Total Reform Enrollment for Duval			**112,662**	**15,205**	**15**	**1,872**	**129,754**	**100.00%**	**112,858**	**14.97%**
Sunshine	HMO	Nassau	5,229	484	0	42	**5,755**	**76.83%**	0	N/A
United Healthcare	HMO	Nassau	1,242	140	0	13	**1,395**	**18.62%**	1,616	-13.68%
Access Health Solutions	PSN	Nassau	285	27	0	29	**341**	**4.55%**	4,463	-92.36%
Total Reform Enrollment for Nassau			**6,756**	**651**	**0**	**84**	**7,491**	**100.00%**	**6,079**	**23.23%**
Reform Enrollment Totals			**307,068**	**40,870**	**77**	**5,371**	**353,386**		**311,563**	**13.42%**

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 Four of the demonstration, there were 353,386 recipients enrolled in the program; 4,260 beneficiaries in Baker County, 194,010 beneficiaries in Broward County, 17,871 beneficiaries in Clay County, 129,754 beneficiaries in Duval County, and 7,491 beneficiaries in Nassau County. There were three Baker County plans with market shares ranging from 3.71 percent to 78.22 percent, 15 Broward County plans with market shares ranging from 0.01 percent to 20.61 percent, three Clay County plans with market shares ranging from 4.28 percent to 68.92 percent, six Duval County plans with market shares ranging from 1.75 percent to 45.77 percent, and three Nassau County plans with market shares ranging from 4.55 percent to 76.83 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 26 and 27 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 Four of the demonstration. Table 26 provides a description of each column in this report.

Table 26
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 27 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 27
Medicaid Reform Voluntary Population Report
Year Four: July 2009 through June 2010

Plan Name	Plan Type	Plan County	Reform Voluntary Populations – Year 4								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	0	59	0	24	0	112	**195**	**7.18%**	**2,714**
Freedom Health Plan	HMO	Broward	10	10	1	4	34	26	**85**	**3.33%**	**2,552**
Humana	HMO	Broward	0	92	0	32	0	286	**410**	**3.30%**	**12,435**
Medica	HMO	Broward	7	2	2	3	41	7	**62**	**3.77%**	**1,645**
Molina Healthcare	HMO	Broward	73	116	27	26	244	201	**687**	**2.62%**	**26,235**
Positive Healthcare	HMO	Broward	0	0	0	0	0	0	**0**	**0.00%**	**22**
Preferred Medical Plan	HMO	Broward	0	10	0	6	0	27	**43**	**8.67%**	**496**
Sunshine	HMO	Baker	10	30	1	1	12	5	**59**	**1.77%**	**3,332**
Sunshine	HMO	Broward	83	108	6	15	142	76	**430**	**1.12%**	**38,223**
Sunshine	HMO	Clay	41	56	0	4	32	49	**182**	**1.48%**	**12,316**
Sunshine	HMO	Duval	190	378	34	35	261	201	**1,099**	**2.10%**	**52,248**
Sunshine	HMO	Nassau	21	25	1	3	27	15	**92**	**1.60%**	**5,755**
Total Health Choice	HMO	Broward	51	112	6	2	112	99	**382**	**3.36%**	**11,376**
United Healthcare	HMO	Baker	0	8	0	1	3	6	**18**	**2.34%**	**770**
United Healthcare	HMO	Clay	9	33	0	10	8	14	**74**	**1.54%**	**4,790**
United Healthcare	HMO	Duval	0	123	0	16	0	35	**174**	**3.79%**	**4,594**
United Healthcare	HMO	Nassau	0	10	3	6	4	9	**32**	**2.29%**	**1,395**
Universal Health Care	HMO	Broward	34	62	5	7	155	115	**378**	**2.74%**	**13,792**
Universal Health Care	HMO	Duval	40	65	2	5	64	54	**230**	**2.78%**	**8,259**
HMO Total	**HMO**		**569**	**1,299**	**88**	**200**	**1,139**	**1,337**	**4,632**	**2.28%**	**202,949**
Access Health Solutions	PSN	Baker	0	10	0	2	2	11	**25**	**15.82%**	**158**
Access Health Solutions	PSN	Broward	1	93	1	26	13	131	**265**	**18.09%**	**1,465**
Access Health Solutions	PSN	Clay	1	48	0	15	3	62	**129**	**16.86%**	**765**
Access Health Solutions	PSN	Duval	17	159	7	33	45	169	**430**	**18.91%**	**2,274**
Access Health Solutions	PSN	Nassau	1	29	0	2	2	27	**61**	**17.89%**	**341**
Better Health, LLC	PSN	Broward	94	152	24	40	267	326	**903**	**2.41%**	**37,498**
CMS	PSN	Broward	5	58	36	172	0	14	**285**	**5.64%**	**5,055**
CMS	PSN	Duval	10	57	12	88	0	5	**172**	**5.74%**	**2,994**
First Coast Advantage	PSN	Duval	183	703	25	130	281	772	**2,094**	**3.53%**	**59,385**
Netpass	PSN	Broward	0	32	0	23	0	212	**267**	**51.54%**	**518**
SFCCN	PSN	Broward	113	433	20	61	170	460	**1,257**	**3.14%**	**39,984**
PSN Total	**PSN**		**425**	**1,774**	**125**	**592**	**783**	**2,189**	**5,888**	**3.91%**	**150,437**
Reform Enrollment Totals			**994**	**3,073**	**213**	**792**	**1,922**	**3,526**	**10,520**	**2.98%**	**353,386**

D. Opt Out Program

Overview

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

In April 2006, the Agency began planning outreach activities for employers located in Broward and Duval Counties. The Agency mailed letters to major employers in the demonstration 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 (9) conference calls with several large employers to answer questions and request that they accept premiums on behalf of Opt Out enrollees.

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

<u>Description of Opt Out Process</u>

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? What is the insurance company? What is the premium amount and frequency? When is the open enrollment period?

After the required information from the employer is received, the Opt Out specialist follows-up with the beneficiary to discuss the insurance that is available through 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 re-enroll in a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Demonstration Year Four at a Glance

During Year Four of the demonstration, the vendor has continued to monitor program participants, ensuring that they continually meet the established eligibility requirements.

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

Opt Out Program Statistics

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

A description of the Opt Out enrollees is provided in Attachment I of this report.

Table 28 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2010. Current Opt Out enrollment, as of June 30, 2010, is 14.

Table 28
Opt Out Statistics
September 1, 2006 – June 30, 2010

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

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

E. Enhanced Benefits Account Program

Overview

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

- Successful transition of Enhanced Benefit Call Center to the new Choice Counseling vendor, Automated Health Systems
    - Automated Voice Response System (AVRS) for beneficiaries who want their balance only through AHS
- A leveling off for purchases of health-related products from a total of $113,158.97 in Year One to a total of $2,431,838.97 in Year Two to a total of $6,385,113.91 in Year Three, and finally a total of $6,132,260.10 in Year Four.

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

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 HP's vendor formerly First Health, now Magellan. The EBIS acts

as a data repository that houses healthy behavior activity information of beneficiaries (as reported by their health plans), Enhanced Benefit Account (EBA) purchases (as recorded in the Agency's Pharmacy Point of Sale System), and EBA balances. The Enhanced Benefits Information System (EBIS) also is a means for the Enhanced Benefit Call Center as well as internal Agency resources to view the Enhanced Benefit Account information of beneficiaries in a central location via the Internet. EBIS was created and is contracted with an outside vendor, Image Software Inc., 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. Image Software Inc., also provides all users of the EBIS with customer support, secure hosting services/support, provides all equipment, maintains office space/work stations, and provides needed enhancements to the system, all in a secure environment.

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

Participation Rates and Assessment of Expenditures

Table 29 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 29 located on the following page.

The active participation rates (see Table 29) have continued to increase each year because beneficiaries are purchasing at a higher rate than they are earning credits. This was not the case for Demonstration Years One and Two, where the active participate rate for those years was .02% and 23%, respectively. Demonstration Year Four active participating rate is 77.7%. The active participation rate is calculated by comparing by date of service for purchases and by participation in a healthy behavior for that month. 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 29 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 4					
Jul-09	35,410	$740,827.50	$920,607.50	-$440,659.99	47.9%
Aug-09	47,021	$868,735.00	$939,730.00	-$382,324.35	40.7%
Sep-09	53,641	$1,188,342.50	$701,290.00	-$574,232.19	81.9%
Oct-09	40,118	$718,847.50	$676,160.00	-$708,614.80	104.8%
Nov-09	33,135	$630,752.50	$569,882.50	-$652,294.50	114.5%
Dec-09	34,323	$675,107.50	$539,140.00	-$617,923.56	114.6%
Jan-10	26,171	$529,807.50	$534,142.50	-$484,716.30	90.7%
Feb-10	26,214	$531,817.50	$500,142.50	-$344,630.76	68.9%
Mar-10	31,208	$653,792.50	$697,487.50	-$460,163.80	66.0%
Apr-10	37,055	$720,220.00	$664,120.00	-$537,416.40	80.9%
May-10	31,563	$644,857.50	$576,855.00	-$474,355.31	82.2%
Jun-10	34,512	$746,787.50	$568,600.00	-$454,519.20	79.9%
Year 4 Totals	**213,742**	**$8,649,895.00**	**$7,888,157.50**	**$6,131,851.16**	**77.7%**

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

Potential Cost Savings

The University of Florida (UF) Medicaid Reform Evaluation Team will evaluate the administrative costs associated with the program including how much plans have contributed and how much of those funds have been distributed to enrollees. UF will also examine the effect of Enhanced Benefits participation on reducing total expenditures. This analysis will be completed towards the end of 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 but 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 validated encounter data is available.

1. Call Center Activities

Demonstration Year Four at a Glance

The Enhanced Benefits Account Program Call Center, located in Tallahassee, Florida, began taking calls on November 1, 2006. The Call Center was operated by the Choice Counseling vendor, ACS, 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. Automated Health System is now the current Choice Counseling and EB call center vendor.

During Demonstration Year Four, the number of inbound calls to the Call Center decreased to 76,825 calls, compared to the reported 94,035 inbound calls in Demonstration Year Three. Out of the 76,825 inbound calls received during Year Four, 72,810 calls were answered, of which 75% percent were related to beneficiaries calling inquiring about their credit balance (or balance only calls). The primary reasons for the decrease in inbound calls and the reduced call abandonment rate for Year Four are:

- Increased outreach efforts
- New brochure to beneficiaries to educate them about the Enhanced Benefits Accounts Program.

Additional detail regarding these improvements can be found in the remainder of this section.

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 Demonstration Year Four:

Inbound Calls:	**76,825**
Calls Abandoned:	**5.2%**
Average Talk Time	**4.3 minutes**

Lessons Learned

In Demonstration Year Four, the call center has primarily handled calls related to beneficiary EBA balances. The current Choice Counseling Call Center Vendor, AHS, has implemented and is operating an automated voice response system to handle the balance-only calls. Statistical information will be provided in the Demonstration Year Five quarterly reports.

Looking Ahead to Demonstration Year Five

The Agency has chosen Automated Health Systems as the new Choice Counseling/EB Call Center Vendor. They have successfully implemented an automated solution for the balance only calls through AVRS. The new call center is also performing outbound calls to beneficiaries who have never used their EBA balances. The Agency will continue to evaluate call center activities to bring additional improvements for the EBAP.

2. System Activities

Demonstration Year Four at a Glance

With the creation of the Enhanced Benefits Account Program, the Agency had to develop a system to process earned credits and also a systematic way for beneficiaries

to purchase items with their credits. The EBIS was implemented in November 2006. This system receives and processes reports from each Reform Health Plan containing the healthy behaviors beneficiaries have completed. The system displays eligibility and plan enrollment information on the individual beneficiary as well as information on the behaviors they have completed and credits earned. The EBIS system also receives information regarding purchases the beneficiaries have made and this information is also displayed. In addition, the EBIS system generates account balances and creates monthly beneficiary statements for beneficiaries who have had activity in the previous month and, implemented in Year Two, quarterly statements are generated for beneficiaries who have not had recent activity. Year Three included a coupon statement which encouraged beneficiaries to use credits earned. In Demonstration Year Four, there was continuation of mailing statements and flyers.

To allow beneficiaries to use their credits to purchase health related products, the Agency utilizes the Florida Medicaid's fiscal agent's pharmacy point of sale system. Although there were no major system enhancements in Demonstration Year Four, there was the creation of the file for AHS. The file is for the AVRS which gives the balance only of beneficiaries with an EBA balance. ISC created the file which is generated and sent to AHS via secure FTP of the balance only for the AVRS system. Transition to the new vendor, AHS, was successful; the new call center was trained in EBIS and scripts were updated.

Lessons Learned and Looking Ahead to Demonstration Year Five

Demonstration Year Five will include moving the functionality of EBIS into the Choice Counseling Vendor. ISC will continue to continue the daily monitoring and maintenance of the production website which the EB Call Center accesses to assist beneficiaries regarding earned credits and purchases. There were no system issues in Demonstration Year Four.

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 is considering.

3. Outreach and Education for Beneficiaries

Demonstration Year Four at a Glance

There are still three main occurrences when beneficiaries receive information about the program. Every beneficiary enrolled in a health plan has access to EBAP. 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, which 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 the account balance; this is the third and reoccurring instance. A change during Demonstration 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. The Demonstration Year Four monthly flyer insert continued to focus on healthy behaviors that are more proactive on behalf of the beneficiary. There were also five new behaviors added for credit: blood test for diabetes maintenance (HbA1c), the prostate specific antigen, Healthy Start screening during the first trimester, and a CPT code was found for smoking cessation (rather than using the Agency EB code for smoking cessation).

Lessons Learned

The outreach efforts to focus on using the credits continue to be a success. Purchases have steadily increased and stabilized. Continuation of grass roots efforts, through mail out and partnerships with health agencies, continue to spread the word about this program.

Look Ahead to Demonstration Year Five

Since the focus to increase beneficiary's purchases is a success, the Agency will continue to focus on beneficiaries participating in the underutilized healthy behaviors by modifying the insert to advertise and educate on certain healthy behaviors. The call center will also do outbound calls to beneficiaries who have never spent their EBA credits. Education will be provided to those beneficiaries about the program.

4. Outreach and Education for Pharmacies

Demonstration Year Four 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 has significantly decreased as more and more pharmacies are familiar with the program. We have also continued use of a "Network Pharmacy List" which lists pharmacies that are actively participating in the EBA based on monthly sales. The call center refers beneficiaries to these pharmacies if they call and complain about a pharmacy. The Product list is updated at least on a quarterly basis. The Agency has continued to work with these pharmacies on a one-on-one basis to address the issues they are encountering and to make changes to the system and program as necessary.

Look Ahead to Demonstration Year Five

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 point of sale vendor to assist pharmacies as needed.

5. Enhanced Benefits Advisory Panel

Demonstration Year Four at a Glance

The Enhanced Benefits Advisory Panel is a 7-member, Agency-appointed panel. During Demonstration Year Four, the Enhanced Benefits Advisory Panel was responsible for adding additional healthy behaviors mentioned earlier, for credit earnings by the beneficiaries. The panel met four times during Demonstration Year Four.

Looking Ahead to Demonstration Year Five

The Enhanced Benefits Advisory Panel will discuss adding smoking cessation products to the list of OTC product list. The Agency will also look to the panel for guidance in possible expansion of use of credits for office visits – for those beneficiaries who have lost Medicaid eligibility.

<u>Enhanced Benefits Statistics</u>

Table 30 provides a cumulative count of healthy behaviors and the sum of granted credit amounts for the demonstration.

From program inception to June 30, 2010, a total of 350,824 beneficiaries have earned $30,454,108.66 in Enhanced Benefit credits. As of June 30, 2009, 272,424 beneficiaries have spent $8,930,398.42 in credits.

Table 30 Healthy Behavior Counts and $ (September 2006 - June 2010 by date of service)		
Healthy Behavior	**Count of Procedure Code**	**Sum of Granted Credit Amount**
Office Visit-Adult/Child	665716	$10,089,307.50
Childhood Preventive Care	524892	$13,093,757.50
Compliance with prescribed maintenance drugs	274084	$2,049,375.00
Dental Preventive Services-Adult/Child	94873	$2,360,982.50
Vision Exam-Adult/Child	49381	$1,230,067.50
Pap Smear	44323	$1,105,037.50
Child & Adult Preventive Care	31967	$582,350.00
Adult Preventive Care	9321	$139,155.00
HbA1c-Diabetes Maintenance	3991	$59,542.50
Mammography	3958	$97,670.00
Colorectal Screening	2683	$66,350.00
Hypertension Disease Management Program	1238	$30,270.00
Prostate Specific Antigen PSA	1195	$17,852.50
Diabetes Disease Management Program	946	$23,035.00
Healthy Start Screen - 1st Trimester	866	$12,990.00
Asthma Disease Management Program	683	$16,895.00
HIV/AIDS Disease Management Program	310	$7,697.50
Congestive Heart Failure Disease Management Program	123	$2,977.50
Other Disease Management Program	57	$1,382.50
Dental Preventive Services-Adult/Child	11	$162.50
Administrative Credit	10	$151.16
Flu Shot	7	$175.00
Exercise Program	2	$50.00
Exercise Program 6 Months Success	2	$30.00
Smoking Cessation Program	1	$25.00
Smoking Cessation 6 months Success	1	$15.00

Table 31 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 31 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	0
Oct-06	$249,542.50	0
Nov-06	$366,097.50	$203.87
Dec-06	$487,102.50	$840.55
Jan-07	$631,890.00	$3,424.90
Feb-07	$621,636.16	$8,716.25
Mar-07	$722,477.50	$17,574.09
Apr-07	$647,160.00	$13,992.22
May-07	$653,342.50	$28,306.64
Jun-07	$585,930.00	$40,113.83
Year 1 Totals	**$5,005,381.16**	**$113,172.35**
Demonstration Year 2		
Jul-07	$943,790.00	$44,384.70
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	$388,174.48
Aug-08	$691,197.50	$550,109.57
Sep-08	$649,355.00	$399,778.90
Oct-08	$610,170.00	$447,146.30
Nov-08	$510,127.50	$621,714.31
Dec-08	$497,597.50	$687,201.89

Table 31 Comparison of Credits Earned by Credits Expended		
Month of Claims	**Earned by Date of Service***	**Purchases by Date of Service**
Jan-09	$575,282.50	$756,522.24
Feb-09	$369,185.00	$537,540.62
Mar-09	$621,027.50	$490,833.88
Apr-09	$616,705.00	$496,236.27
May-09	$572,660.00	$517,902.37
Jun-09	$630,025.00	$491,310.10
Year 3 Totals	**$7,179,602.50**	**$6,384,470.93**
Demonstration Year 4		
Jul-09	$920,607.50	$440,659.99
Aug-09	$939,730.00	$382,324.35
Sep-09	$701,290.00	$574,232.19
Oct-09	$676,160.00	$708,614.80
Nov-09	$569,882.50	$652,294.50
Dec-09	$539,140.00	$617,923.56
Jan-10	$534,142.50	$484,716.30
Feb-10	$500,142.50	$344,630.76
Mar-10	$697,487.50	$460,163.80
Apr-10	$664,120.00	$537,416.40
May-10	$576,855.00	$474,355.31
Jun-10	$568,600.00	$454,519.20
Demonstration Year 4	**$7,888,157.50***	**$6,584,451.34**
Cumulative Total*	**$31,194,606.16***	**$15,062,223.60**

*Includes date of service data from the August 10, 2010, healthy behavior report from the health plans.

Table 32 highlights the amount of credits submitted by each health plan for beneficiaries as of June 30, 2010 (date of service):

Table 32
Amount of Credits Submitted by Health Plan
Demonstration Year Four

County	Health Plan Company Name	Granted Credit Amount
Baker	Sunshine State Health Plan, Inc.-Baker	$39,637.50
Baker	Access Health Solutions	$21,690.00
Baker	United Healthcare of Florida, Inc.	$18,660.00
Broward	Molina	$430,310.00
Broward	Sunshine State Health Plan, Inc.-Broward	$479,517.50
Broward	Medica Health Plans of Florida, Inc.	$12,430.00
Broward	Preferred Medical Plan, Inc.	$23,222.50
Broward	Access Health Solutions	$165,717.50
Broward	Total Health Choice, Inc	$737,900.00
Broward	Freedom Health Plan	$19,660.00
Broward	CMS Network Broward North	$145,397.50
Broward	CMS Network Broward South	$48,555.00
Broward	Humana Inc.	$383,460.00
Broward	AMERIGROUP Florida, Inc.	$254,695.00
Broward	South Florida Community Care Network	$587,227.50
Broward	South Florida Community Care Network	$629,332.50
Broward	Universal Health Care Broward	$269,420.00
Broward	Better Health	$194,942.50
Broward	Positive Healthcare Florida	$200.00
Broward	Florida NetPass, LLC	$30,772.50
Clay	Sunshine State Health Plan, Inc. - Clay	$118,347.50
Clay	Access Health Solutions	$54,847.50
Clay	United Healthcare of Florida, Inc.	$124,352.50
Duval	Sunshine State Health Plan, Inc. -Duval	$603,640.00
Duval	Access Health Solutions	$225,577.50
Duval	SHANDS JAX D/B/A First Coast Advantage	$2,037,180.00
Duval	CMS Duval/Ped-I-Care	$87,032.50
Duval	United Healthcare of Florida, Inc.	$109,735.00
Duval	Universal Health Care Duval	$121,970.00
Nassau	Sunshine State Health Plan, Inc.-Nassau	$61,462.50
Nassau	Access Health Solutions	$13,207.50
Nassau	United Healthcare of Florida, Inc.	$33,342.50

Table 33 provides the top twenty-five purchases in terms of dollar amount, made by beneficiaries from July 1, 2009, through June 30, 2010

Table 33
Top 25 Beneficiary Purchases*
Demonstration Year Four: July 1, 2009 – June 30, 2010

	Description	Count	Sum	Average
1	COMFORT-STRETCH	48023	-$354,641.14	-$7.38
2	HUGGIES BABY WIPES	46740	-$166,227.56	-$3.56
3	BABY WIPES	33100	-$96,098.16	-$2.90
4	LISTERINE ANTISEPTIC	31705	-$135,187.63	-$4.26
5	HUGGIES PULL-UPS	31358	-$313,275.63	-$9.99
6	COMFORT-SMOOTH	29026	-$116,990.15	-$4.03
7	HUGGIES ULTRATRIM	28468	-$264,550.92	-$9.29
8	SUPREME DIAPERS	25561	-$196,152.13	-$7.67
9	KOTEX	23082	-$101,447.01	-$4.40
10	HUGGIES SUPREME	22415	-$212,832.39	-$9.50
11	BABY SHAMPOO	20547	-$69,839.96	-$3.40
12	PAMPERS BABY-DRY	19741	-$171,142.51	-$8.67
13	BABY LOTION	14815	-$51,225.62	-$3.46
14	BABY POWDER	12792	-$37,559.69	-$2.94
15	AQUAFRESH	12542	-$30,290.39	-$2.42
16	ISOPROPYL ALCOHOL	12126	-$27,218.85	-$2.24
17	CHILDREN'S MOTRIN	11320	-$66,243.66	-$5.85
18	CETAPHIL	10654	-$61,129.34	-$5.74
19	CHILDREN'S IBUPROFEN	10103	-$46,686.55	-$4.62
20	IBUPROFEN	9982	-$46,629.19	-$4.67
21	BABY OIL	9462	-$30,676.07	-$3.24
22	BAND-AID	9060	-$29,665.49	-$3.27
23	HYDROGEN PEROXIDE	9042	-$12,847.79	-$1.42
24	SENSODYNE	8817	-$38,533.58	-$4.37
25	AVEENO	8669	-$59,364.6	-$6.85

*Includes purchase/return combinations

Table 34 provides the Enhanced Benefit Account Program statistics for Demonstration Year Four.

Table 34
Enhanced Benefit Account Program Statistics

Year Four Activities		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
I.	Number of plans [6]submitting reports by quarter.	29 of 30	35 of 35	35 of 35	35 of 35
II.	Number of enrollees who received credit for healthy behaviors by Quarter (Not unduplicated).	136,072	107,576	83,593	103,130
III.	Total dollar amount credited to accounts by each quarter.	$2,797,905.00	$1,393,955.00	$1,715,417.50	$2,111,857.50
IV.	Total cumulative dollar amount credited through each quarter.	$24,602,118.50	$26,626,826.16	$28,342,243.66	$30,454,101.16
V.	Total dollar amount of credits used each quarter by date of service.	$1,397,398.20	$1,958,923.88	$1,289,579.45	$1,466,359.18
VI.	Total cumulative dollar amount of credits used through the quarter by date of service.	$10,327,744.39	$12,286,445.35	$13,596,001.28	$15,062,291.87
VII.	Total cumulative number of enrollees who used credits through the quarter (not unduplicated).	58,893	79,293	55,873	60,409

6. Complaints

Demonstration Year Four 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 Four, the Agency did receive a total of 259 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

[6] Health plans that have withdrawn from the demonstration are required to continue to report beneficiary healthy behaviors that occurred while the plan was operational in the demonstration. Healthy behaviors can be submitted up to one year from the date of service.

complaints were regarding the difficulty with utilizing the on-line over-the-counter (OTC) products list and the interaction with the list at the pharmacy. The final group of complaints related to beneficiaries inquiring about not having healthy behaviors reported by the health plan.

Lessons Learned and Look Ahead to Demonstration Year Five

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.

Table 35 lists the dollar amount and count of beneficiaries who have lost EBA eligibility and credits because they have not been Medicaid eligible for three years.

Table 35
Count of Beneficiaries Who Lost EBA Eligibility and Credits

Month	Beneficiary Count	Total Dollar Amount
Oct-09	102	$2,831.73
Nov-09	187	$5,955.77
Dec-09	333	$11,336.22
Jan-10	534	$17,999.77
Feb-10	660	$22,834.99
Mar-10	822	$31,685.68
Apr-10	957	$37,048.05
May-10	1091	$44,578.67
Jun-10	1193	$49,160.88
Jul-10	1378	$63,194.90
Total	7257	$286,626.66

F. Low Income Pool

Overview

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

On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to 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.

On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP, and entities eligible to receive reimbursement. Federal CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006. After a total of nine updates to the Reimbursement and Funding Methodology document, the Agency received approval from federal CMS on December 2, 2009, of the June 26, 2009, submission of the document.

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

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

Demonstration Year Four at a Glance

<u>LIP Council Changes</u>

The Florida Legislature amended the statutory provisions specific to the LIP Council during the 2009 Legislative session. These provisions increased the number of members to be appointed to the Council as well as specified criteria for the seats. The

Council's purpose is to advise the Agency and legislature on the financing and distributions of the LIP. The following is the language authorized in s. 409.911(10), Florida Statues:

> "The Agency for Health Care Administration shall create a Medicaid Low-Income Pool Council by July 1, 2006. The Low-Income Pool Council shall consist of 24 members, including 2 members appointed by the President of the Senate, 2 members appointed by the Speaker of the House of Representatives, 3 representatives of statutory teaching hospitals, 3 representatives of public hospitals, 3 representatives of nonprofit hospitals, 3 representatives of for-profit hospitals, 2 representatives of rural hospitals, 2 representatives of units of local government which contribute funding, 1 representative of family practice teaching hospitals, 1 representative of federally qualified health centers, 1 representative from the Department of Health, and 1 nonvoting representative of the Agency for Health Care Administration who shall serve as chair of the council. Except for a full-time employee of a public entity, an individual who qualifies as a lobbyist under s. 11.045 or s. 112.3215 may not serve as a member of the council. Of the members appointed by the Senate President, only one shall be a physician. Of the members appointed by the Speaker of the House of Representatives, only one shall be a physician. The physician member appointed by the Senate President and the physician member appointed by the Speaker of the House of Representatives must be physicians who routinely take calls in a trauma center, as defined in s. 395.4001, or a hospital emergency department. The council shall:
>
> - Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.
> - Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
> - Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
> - Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year."

<u>LIP Council Meetings</u>

The LIP Council held five meetings between the first, second, and third quarters of Demonstration Year Four to prepare recommendations for Demonstration Year Five on the following dates:

- October 29, 2009
- December 2, 2009
- December 17, 2009
- January 8, 2010
- January 22, 2010

Also during the third quarter of Demonstration Year Four, the Agency sent to the Governor, Speaker and President the LIP Council recommendations, as directed in Florida Statute, on February 1, 2010. A copy of the LIP Council recommendations can be found on the Agency's Low Income Pool webpage at:

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

The LIP Council also met during the fourth quarter of Demonstration Year Four, on May 24, 2010, to discuss the waiver renewal process, compliance with Special Term and Condition #105 and State Fiscal Year 2011-12 LIP on the following date:

In November 2009, the Agency requested that federal CMS to amend STC #105 of the Florida Medicaid Reform Waiver. This amendment allowed for the release of an additional $300 million in LIP funds to the State that may have otherwise been retained by the federal government. The Agency received confirmation of the approval of amended STC #105, January 29, 2010.

In the amended STC #105, federal CMS modified the way cost limits must be calculated for State Fiscal Years 2009-10 and SFY 2010-11 and requested additional reporting. The following is the Agency's compliance with the amended STC #105 during Demonstration Year Four:

- April 30, 2010, the Agency submitted a Draft reconciliation review tool and instructions per STC #105 (1)(a).
- May 31, 2010, the Agency submitted a report to federal CMS detailing the alternative delivery systems provided by LIP hospitals per STC #105 (2)(a).
- June 29, 2010, the Agency submitted a schedule for the completion of provider reconciliation for Demonstration Years One, Two, Three, and Four, per STC #105 (1)(b).
- June 29, 2010, the Agency submitted a letter detailing by LIP category the LIP allocations for SFY 2010-11, as approved by the Florida Legislature per #105 105 (2)(b).

Copies of each of the STC #105 deliverables as submitted to federal CMS can on found on the Agency's Low Income Pool webpage at:

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

Premium Assistance Project

Palm Beach County LIP Premium Assistance Program 2009-10 Annual Review

The following is an update from the Health Care District of Palm Beach (HCDPB) Premium Assistance project that received funding through LIP in Demonstration Year Four. This premium assistance program received $15 million in LIP Funding to provide service to district residents who would otherwise be uninsured.

Palm Beach County, Florida has experienced a very successful year for the Low Income Pool Premium Assistance Program. The program, part of Florida's Medicaid Reform Waiver, is a demonstration program targeted at reducing the number of uninsured residents in Palm Beach County and providing a medical home and greater access to health care services.

Under the premium assistance program, $13,367,014 of local property tax revenue was provided to the State of Florida as an inter-governmental transfer (IGT) under the Low Income Pool program. The matching funds received from the federal government were used by the State of Florida to fund Low Income Pool Special Medicaid Payments including this premium assistance demonstration program.

A special Medicaid payment in the amount of $15,867,014 was provided to support the premium assistance program. The special Medicaid payments were directed to a government operated, non-profit insurance company known as Healthy Palm Beaches, Inc. This insurance company exclusively administers health benefit programs to low-income individuals and Medicaid populations.

Healthy Palm Beaches is owned and operated by the Health Care District of Palm Beach County. The Health Care District is an independent taxing district charged with the responsibility of advancing access to health care services for Palm Beach County residents. All funds received under the demonstration program were used to fund two health coverage products (Vita Health and Coordinated Care) that have been designed to reduce the number of uninsured residents in Palm Beach County. Approximately $10 million was utilized by Healthy Palm Beaches to fund Vita Health and the remaining $5 million was utilized to fund Coordinated Care. Each of these programs and the successes from 2009-10 are discussed below.

Vita Health

Vita Health is a health coverage plan offered by Healthy Palm Beaches, a government operated, non-profit insurance company. Vita Health is filed with the Agency under the statutory authority of a Health Flex product, s. 408.909, Florida Statutes. Vita Health is designed exclusively for working individuals and families in Palm Beach County, providing affordable health coverage for uninsured single parents, families and individuals whose employers do not offer health benefits for full and part-time employees and individuals who are self employed. Vita Health is a health coverage program that includes a provider network of 11 hospital providers and over 330 primary and specialty care providers. Vita Health covers a range of basic medical needs including emergency and inpatient hospital services, as well as preventive care, prescriptions, laboratory and radiology services.

Vita Health provides subsidized, low-cost health coverage to uninsured residents who do not qualify for Medicaid, Medicare, KidCare, or other public assistance. Monthly premiums range from $30 to $125 per individual with the balance funded by the special Medicaid payment and local government funds. The chart below provides the member share of the monthly premium and the total monthly premium by member type.

Member Type	Age Limitation	Member Monthly Premium	Total Monthly Premium*
Child	1 – 20 years	$30.00	$88.92 – $98.07
Adult	21 – 54 years	$65.00	$225.17 – $248.34
Adult	55 – 64 years	$125.00	$416.68 – $459.56

* Premium assistance is greater for individuals below 150% of the Federal Poverty Level.

To be eligible for Vita Health, an applicant must meet certain criteria. They cannot be eligible for other programs such as Medicaid, Medicare, or the VA. They must have been uninsured for the last six months unless the applicant lost eligibility in Medicaid or KidCare within 90 days prior to applying. They must provide proof of Palm Beach County residency and be between the ages of 1 and 65. All Vita Health applicants must also meet qualifying income requirements with incomes up to 300% of Federal Poverty Level Guidelines (FPLG) (up to $32,490 per year for individual, up to $66,150 per year for family of four).

Coordinated Care

The Coordinated Care Program is a health coverage program provided at no cost to qualifying residents of Palm Beach County, Florida who live near or below poverty. This program is closely coordinated with other State and Federal programs to ensure that no duplicate funding occurs. Applicants qualifying for Medicaid, Medicare, or any other entitlement program do not qualify for Coordinated Care. Coordinated Care is a health coverage program that includes a provider network of 13 hospital providers and over 1,100 primary and specialty care providers, including federally qualified health centers and community hospitals. Residents enrolled in the Coordinated Care Program receive medical benefits to cover the cost of primary care, specialty care, hospitalization, emergency care, radiology and laboratory services, and prescription drugs.

To be eligible for Coordinated Care, an applicant must meet certain criteria. They cannot be eligible for other programs such as Medicaid, Medicare, or the VA. They must provide proof of Palm Beach County residency and have assets no higher than $5,000 for an individual, $6,000 for a married couple, or $10,000 if they are self-employed. All Coordinated Care applicants must also meet qualifying income requirements with incomes up to 150% of FPLG (less than $33,075 per year for family of four or $16,245 for an individual) and up to 200% of FPLG for pregnant women (individuals with income up to $21,660 per year).

Summary of Services Provided by Vita Health and Coordinated Care

During SFY 2009-10, the LIP Premium Assistance Demonstration Program provided many important services to the Vita Health and Coordinated Care members. The following is a summary of services provided.

Period: July 1, 2009 - June 30, 2010	Total
Unduplicated Members	25,423
Primary Care Encounters	91,565
OB/GYN Encounters	10,274
Prescriptions Filled	342,384
Laboratory Service Encounters	72,459
Radiology Service Encounters	63,954
Specialty Physician Encounters	155,472
Inpatient Discharges	2,440
Inpatient Days	10,154
Hospital Outpatient Encounters	35,818
Emergency Room Visits	32,017
Outpatient Ambulatory Surgery Encounters	9,169

See Attachment II for examples of Low Income Pool Success Stories, for a variety of public health projects operating in multiple locations across the state during Demonstration Year Four.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting

The 1115 Medicaid Reform Waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to

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

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

I. Eligibles and enrollee member months are identified;
II. Claims data for included services are identified using the list created through 'I' above;
III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:
    a. MEG #1 SSI-Related
    b. MEG #2 Children and Families
    c. Reform – Managed Care Waiver SSI – no Medicare
    d. Reform – Managed Care Waiver TANF
    e. Reform – Managed Care Waiver SOBRA and Foster Children
    f. Reform – Managed Care Waiver Age 65 and Older
IV. Using the paid claims data extracted, the expenditures are identified by service type within each of the groupings in 'III' above and inserted on the appropriate line on the CMS 64 waiver templates;
V. Expenditures that are also identified as Home and Community Based (HCBS) Waiver services are identified and the corresponding HCBS waiver template expenditures are adjusted to reflect the hierarchy of the 1115 waiver reporting.

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

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

Definitions:

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

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. The quarterly totals match the expenditures reported on the CMS 64 report, which is the amount that will be used in the monitoring process by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

Table 36 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 36
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 37 through 41 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2010. Case months provided in the tables 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 37 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$109,209,309	$909,045	$110,118,354	$446.18
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$204,666,715	$9,068,294	$213,735,009	$864.97
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$279,485,810	$29,362,800	$308,848,610	$1,245.10
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$198,742,236	$31,793,702	$230,535,938	$919.18
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$188,079,271	$31,056,750	$219,136,021	$871.08
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$298,437,791	$47,839,499	$346,277,290	$1,372.13
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$287,896,155	$50,059,242	$337,955,397	$1,338.26
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$111,968,931**	**$763,459,242**	**$1,007.18**
April 2008	254,500	$302,204,899	$52,469,635	$354,674,534	$1,393.61
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
July 2008	277,846	$192,176,160	$32,392,732	$224,568,891	$808.25
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**
October 2008	266,157	$232,318,022	$41,009,801	$273,327,823	$1,026.94
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**

Table 37 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
July 2009	277,093	$319,718,390	$52,941,079	$372,659,469	$1,344.89
August 2009	274,819	$168,336,551	$33,437,914	$201,774,466	$734.21
September 2009	270,484	$358,692,409	$67,384,681	$426,077,090	$1,575.24
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
October 2009	275,733	$169,233,974	$30,153,422	$199,387,395	$723.12
November 2009	277,577	$252,330,497	$45,182,664	$297,513,161	$1,071.82
December 2009	277,220	$348,404,305	$61,931,546	$410,335,851	$1,480.18
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
January 2010	282,575	$159,062,482	$29,470,651	$188,533,134	$667.20
February 2010	283,235	$249,307,944	$44,581,877	$293,889,821	$1,037.62
March 2010	281,514	$373,413,178	$67,763,434	$441,176,612	$1,567.16
Q15 Total	**847,324**	**$781,783,604**	**$141,815,963**	**$923,599,567**	**$1,090.02**
April 2010	280,909	$253,666,997	$48,259,799	$301,926,796	$1,074.82
May 2010	283,942	$174,652,397	$31,571,736	$206,224,133	$726.29
June 2010	287,594	$303,907,266	$49,657,712	$353,564,978	$1,229.39
Q16 Total	**852,445**	**$732,226,661**	**$129,489,247**	**$861,715,907**	**$1,010.88**
MEG 1 Total	**12,614,821**	**$11,076,341,065**	**$1,715,134,511**	**$12,791,475,577**	**$1,014.00**

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

Table 38 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	1,343,704	$116,070,700	$122,430	$116,193,130	$86.47
August 2006	1,292,330	$272,615,188	$1,255,306	$273,870,494	$211.92
September 2006	1,308,403	$96,367,809	$345,759	$96,713,568	$73.92
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
October 2006	1,293,922	$183,471,982	$4,267,815	$187,739,798	$145.09
November 2006	1,277,102	$287,043,912	$13,069,579	$300,113,491	$235.00
December 2006	1,266,148	$110,714,051	$2,883,053	$113,597,104	$89.72
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
January 2007	1,252,859	$266,181,366	$23,259,122	$289,440,488	$231.02
February 2007	1,240,860	$176,632,680	$13,010,558	$189,643,238	$152.83
March 2007	1,234,344	$104,987,331	$8,197,611	$113,184,942	$91.70
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
April 2007	1,230,451	$170,285,018	$17,657,956	$187,942,974	$152.74
May 2007	1,218,171	$252,644,634	$32,885,813	$285,530,447	$234.39
June 2007	1,204,525	$93,978,970	$6,350,716	$100,329,686	$83.29
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
July 2007	1,198,205	$153,588,331	$17,975,233	$171,563,564	$143.18
August 2007	1,195,369	$257,178,317	$34,274,917	$291,453,235	$243.82
September 2007	1,194,789	$97,198,750	$4,900,087	$102,098,837	$85.45
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
October 2007	1,211,534	$271,137,490	$36,924,018	$308,061,507	$254.27
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$273,615,263	$39,329,414	$312,944,677	$254.19
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,569,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$164.78**
July 2008	1,343,457	$167,028,012	$23,597,521	$190,625,534	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
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**

Table 38 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
July 2009	1,581,454	$333,483,694	$34,533,935	$368,017,629	$232.71
August 2009	1,583,503	$119,609,810	$13,057,173	$132,666,984	$83.78
September 2009	1,538,571	$370,920,307	$51,046,606	$421,966,913	$274.26
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
October 2009	1,634,683	$134,315,902	$10,464,027	$144,779,929	$88.57
November 2009	1,657,122	$250,553,059	$29,249,216	$279,802,275	$168.85
December 2009	1,667,649	$383,516,409	$50,010,230	$433,526,639	$259.96
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
January 2010	1,682,493	$116,073,248	$9,104,061	$125,177,309	$74.40
February 2010	1,700,550	$248,374,376	$29,806,739	$278,181,115	$163.58
March 2010	1,715,338	$409,161,539	$54,737,055	$463,898,594	$270.44
Q15 Total	**5,098,381**	**$773,609,163**	**$93,647,855**	**$867,257,018**	**$170.10**
April 2010	1,720,938	$253,484,728	$30,906,075	$284,390,803	$165.25
May 2010	1,737,239	$137,689,965	$11,390,819	$149,080,785	$85.81
June 2010	1,744,966	$285,875,642	$31,065,785	$316,941,426	$181.63
Q16 Total	**5,203,143**	**$677,050,335**	**$73,362,678**	**$750,413,013**	**$144.22**
MEG 2 Total	**67,052,156**	**$9,953,315,142**	**$1,018,660,047**	**$10,971,975,189**	**$163.63**

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

Table 39 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**	**$2,655,180,625**	**$445,971,300**	**$3,101,151,925**	**$1,022.14**
WOW DY2 Total	**3,033,969**			**$3,108,877,695**	**$1,024.69**
Difference				**$(7,725,769)**	
% of WOW PCCM MEG 1					**99.75%**
DY02 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	**14,829,991**	**$2,254,071,149**	**$264,786,465**	**$2,518,857,614**	**$169.85**
WOW DY2 Total	**14,829,991**			**$3,194,973,261**	**$215.44**
Difference				**$(676,115,647)**	
% of WOW PCCM MEG 2					**78.84%**
DY03 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY03 Total	**3,249,742**	**$2,929,166,025**	**$498,754,183**	**$3,427,920,209**	**$1,054.83**
WOW DY3 Total	**3,249,742**			**$3,596,391,979**	**$1,106.67**
Difference				**$(168,471,771)**	
% of WOW PCCM MEG 1					**95.32%**
DY03 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY03 Total	**17,094,840**	**$2,567,544,536**	**$281,489,731**	**$2,849,034,267**	**$166.66**
WOW DY3 Total	**17,094,840**			**$3,977,627,371**	**$232.68**
Difference				**$(1,128,593,104)**	
% of WOW PCCM MEG 2					**71.63%**

Table 39 MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY04 Total	**3,352,695**	**$2,860,428,027**	**$506,557,483**	**$3,366,985,511**	**$1,004.26**
WOW DY4 Total	**3,352,695**			**$4,007,141,064**	**$1,195.20**
Difference				**$(640,155,553)**	
% of WOW PCCM MEG 1					**84.02%**
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 Total	**19,964,506**	**$2,838,043,266**	**$336,519,140**	**$3,174,562,407**	**$159.01**
WOW DY4 Total	**19,964,506**			**$5,016,880,713**	**$251.29**
Difference				**$(1,842,318,306)**	
% of WOW PCCM MEG 2					**63.28%**

Table 40 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**	**$4,909,251,774**	**$710,757,766**	**$5,620,009,540**	**$314.60**
WOW	**17,863,960**			**$6,303,850,956**	**$352.88**
Difference				**$(683,841,416)**	
% Of WOW					**89.15%**
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	**20,344,582**	**$5,496,710,561**	**$780,243,914**	**$6,276,954,476**	**$308.53**
WOW	**20,344,582**			**$7,574,019,350**	**$372.29**
Difference				**$(1,297,064,875)**	
% Of WOW					**82.87%**
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	**23,317,201**	**$5,698,471,293**	**$843,076,624**	**$6,541,547,917**	**$280.55**
WOW	**23,317.201**			**$9,024,021,777**	**$387.01**
Difference				**$(2,482,473,860)**	
% Of WOW					**72.49%**

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 39), compared to WOW of $948.79 (Table 36), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 39), compared to WOW of $199.48 (Table 36), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 (Table 39), compared to WOW of $1,024.69 (Table 36), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 39), compared to WOW of $215.44 (Table 36), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,054.83 (Table 39), compared to WOW of $1,106.67 (Table 36), which is 95.32% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.66 (Table 39), compared to WOW of $232.68 (Table 36), which is 71.63% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,004.26 (Table 39), compared to WOW of $1,195.20 (Table 36), which is 84.02% of the target PCCM for MEG 1. MEG 2 has a PCCM of $159.01 (Table 39), compared to WOW of $251.29 (Table 36), which is 63.28% of the target PCCM for MEG 2.

Tables 39 and 40 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 40) 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 40 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 40) 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 40 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 40) 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 40 is $308.53. Comparing the calculated weighted averages, the actual PCCM is 82.87% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 40) is $387.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 40 is $280.55. Comparing the calculated weighted averages, the actual PCCM is 72.49% of the target PCCM.

Table 41
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Total Paid	**$3,749,408,365**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$873,476,332	$1,000,000,000	87.35%
Total MEG 3	$3,749,408,365	$5,000,000,000	74.99%

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

As shown in Table 41, the expenditures for the first sixteen quarters for MEG 3, the Low Income Pool (LIP), were $3,749,408,365 (74.99% of the $5 billion cap).

During Demonstration Year Three, the Florida Legislature directed the Agency to carry forward approximately $123 million dollars from the Demonstration Year Three LIP appropriation until an amendment of the STC #105 could be negotiated. Upon approval of the amendment, approximately $123 million dollars in carry forward funding was provided to the Agency through appropriations for Demonstration Year Four. The appropriations for Demonstration Year Four totaled $1,001,250,000 plus the

$123,577,163 of carry forward LIP funds for a grand total of $1,124,827,163. Due to the payment process and the reporting period, payments made after June 30, 2010, are not captured in the fourth quarter's report or the Year Four annual report. However, payments for each demonstration year are allowed to be processed for payment through September 30. The first quarter of Demonstration Year Five report will provide the final payment totals for Demonstration Year Four.

H. Encounter and Utilization Data

Overview

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

The Medicaid Encounter/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 Team continues to support the implementation and operational activities of the collection of Medicaid encounters for capitated health plans within the FLMMIS.

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

Demonstration Year Four at a Glance

The Agency accomplished the following encounter data activities during Demonstration Year Four:

- Continued to refine the risk-adjusted methodology for Year Four capitation payments to health plans, according to Florida Statutes.
- Implemented statewide collection of medical services encounter data from all capitated health plans. Submissions included encounter data for the historical periods described below:
  - Capitated health plans – January 1, 2007 to June 30, 2009.
- Implemented National Council for Prescription Drug Programs, Inc., (NCPDP) 5.1 Telecommunications Standard for pharmacy encounter data statewide.
- Implemented statewide collection of pharmacy services encounter data from all capitated health plans. Submissions included encounter data for the historical period described below:
  - Capitated health plans for July 1, 2009 – June 30, 2010.

- Continued to collect and process ongoing medical services and pharmacy services encounter data beginning with July 1, 2009, dates of service.
- Reconciled plan submissions to data certifications provided by the plans.
- Notified plans where remediation was needed through exception reporting and other analyses.
- Started analytic data validation of encounter data through a variety of methods:
  - Internal procedures including analysis of submission volume by plan and claim type; analysis of services provided per enrollee; and analysis of key data elements within the encounter claims to identify correlation and trends.
  - External data validation procedures by three vendors:
    - Mercer began performing encounter data validation as part of a larger defined project of validation.
    - Actuarial validation by both Mercer and Milliman, Inc., as part of the rate setting process for SFY 2010-11 managed care capitation rates.
    - Began discussing opportunities with the Agency's External Quality Review Organization, Health Services Advisory Group, for additional encounter validation activities.
- Included encounter data as part of base data for use in developing managed care capitation rates for SFY 2010-11.
- Continued to update the MEDS website to include fiscal agent and Agency information related to the Encounter Data submission.
- 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 HP environment.
- Provided outreach and technical assistance with health plans to discuss submission specifics and address their potential issues and concerns. Also participated in technical and operations calls with the health plans to respond to questions and technical issues.
- Continued meeting with the Agency Encounter Data Utilization Team to identify uses for the managed care encounter data.
- Began transition of operational aspects of encounter data collection to the fiscal agent.
- Initiated planning of provider mass enrollment effort for managed care provider not participating in Medicaid fee-for-service.

Pharmacy Encounter Data Collection and Processing Activities (First Phase)

The demonstration 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 comply with these requirements beginning 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 the demonstration waiver.

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 by the fiscal agent in the MMIS, 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 on-site meetings by the MEDS team at health plan locations was provided;

- Testing and validation of the HP MMIS encounter data collection and processing systems continued throughout the year;
- Continuous analysis of quality review findings to ensure improvements in the quality of encounter data submissions from health plans; 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. Phase 3 collection and processing activities are operational. The Agency's data quality improvement efforts continue through validation activities.

Look Ahead to Demonstration Year Five

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

- Joint Agency and health plan analysis of medical services and pharmacy services 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 possible health plan under-reporting of encounter claims;
- Adding functionality for new Medicaid programs as directed by Agency management;
- Transitioning to the use of NCPDP data (from MMIS) in the Medicaid Rx Model for risk adjusted rates; and
- Analyzing the medical services data to determine when data quality and completeness support the transition to a diagnosis-based model.

I. Demonstration Goals

Overview

The demonstration is designed to fundamentally change the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of demonstration, and 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, two Minority Physician Networks (MPNs), for a total of twelve managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of the demonstration operated as prepaid ambulatory health plans offering enhanced medical management services to beneficiaries enrolled in MediPass, Florida's primary care case management program.

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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010.

During Year Four of the demonstration, four new health plans became operational. Sunshine State Health Plan (HMO) began providing services in Broward County on July 1, 2009, and expanded into Baker, Clay, Duval, and Nassau Counties on August 1, 2009. Molina Health Plan (HMO) began providing services in Broward County on September 1, 2009. Medica Health Plan of Florida, Inc. (HMO) began providing services in Broward County on November 1, 2009. AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS, began providing services in Broward County on May 1, 2010. This is the second specialty plan in the demonstration, the first

being the specialty plan for children with chronic conditions that became operational in 2006.

The one health plan application still pending approval was submitted by Preferred Care Partners in January 2010. The initial on-site survey has been conducted and the Agency continues to provide guidance to Preferred Care Partners in their efforts to finalize policies and procedures. In addition, the Agency has entered into discussions with a PSN for expansion into Baker, Clay and Nassau Counties.

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

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

Access to Services Not Previously Covered

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

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

By the end of the first quarter of Demonstration Year Two, the Agency had approved thirty (30) customized benefit packages for the HMOs and thirteen (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 one (1) HMO and one (1) FFS PSN for the expansion counties of Baker, Clay and Nassau.

One of the most significant changes in benefits from Demonstration 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 Demonstration Year Two were the same as those offered in Year One: the 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 Demonstration Year Two included each of the services that were first available in Demonstration Year One (see the list above). Only one benefit, Complimentary/Alternative Medicine, was dropped in Demonstration Year Two.

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

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult 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 the OTC drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Demonstration Year Three included:

- 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 28 customized benefit packages for the HMOs and 14 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 11 HMOs and 6 PSNs. In the third quarter of Year Three of the demonstration 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 24 customized benefit packages approved for 9 HMOs and 12 for the remaining 5 PSNs at the beginning of the fourth quarter of Demonstration Year Three. Throughout this reporting quarter, recipients enrolled in the demonstration plans, HealthEase and StayWell, were transitioning to other plans due to the withdrawal of WellCare from the demonstration. This transition was completed at the beginning of the first quarter of Year Four of the demonstration.

In Demonstration Year Four, 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 Demonstration Year Four, the most popular expanded benefits offered by the capitated plans were OTC drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Demonstration Year Four include:

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

In Demonstration Year Four, the Agency approved 21 benefit packages for the HMOs and 13 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010, to August 31, 2010, for eight HMOs and four PSNs. During the first quarter of Demonstration Year Four, Access Health Solutions was acquired by Sunshine State Health Plan and NetPASS was acquired by Molina. Subsequently, these PSNs ceased operations and their enrollees were transitioned into the acquiring Reform health plans. During the second quarter of Demonstration Year Four, the HMOs, Amerigroup and Preferred, ceased operations in the demonstration. Beneficiaries enrolled in those plans were transitioned into the remaining Medicaid Reform plans. During the last quarter of Demonstration Year Four, Total Health Choice (HMO) was acquired by Simply Healthcare (HMO) and ceased operations on May 31, 2010. The Total Health Choice Reform enrollees were transitioned into the Better Health Reform (PSN), of which Simply Healthcare is a minority owner, on June 1, 2010. Prior to approving the transition, the Agency compared provider networks, including behavioral health providers, to ensure continuity of care and the continued availability of current primary care providers. Total Health Choice members who were transitioned into Better Health were able to keep their expanded benefits originally offered by Total Health Choice. There was no change in benefit package or provider network for beneficiaries who transitioned from Total Health Choice to Better Health.

Positive Healthcare, the first HMO specialty plan for beneficiaries with HIV/AIDS, began accepting enrollment on May 1, 2010.

Improving Access to Specialists

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

1. Identifying the number of unduplicated providers that participate in Reform;
2. Identifying providers that were not 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 Demonstration 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 one 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 42 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 42 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 moved 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 focused on statewide samples rather than the Medicaid Area-focused samples.

During Demonstration Year Four, Agency staff conducted quarterly provider network surveys for July and October 2009 and January and May 2010. The analysis and follow-up for the July and October surveys was completed in Year Four. In July 2009, a total of 651 providers were sampled from the health plan provider network files. The survey results and follow-up by Agency staff indicated that 95% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. For the October 2009 quarterly survey, a total of 630 providers were sampled from the provider network files, and 98.4% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. Most of the follow-up on the third quarterly surveys, which were conducted from January through March 2010, was completed during Demonstration Year Four, but the remainder of the follow-up will be completed in the first quarter of Demonstration Year Five.

During the first quarter of Demonstration Year Five, Agency staff will complete the follow-up and analysis for the January-March quarterly survey and the May-July 2010 quarterly survey. Results for these surveys will be included in the first quarterly report for Demonstration Year Five. The surveys will be conducted on a semi-annual basis beginning in October 2010.

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

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

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

Year Four of the demonstration continued to be active in the area of performance measurement and quality. The second annual submission of performance measure data was due to the Agency on July 1, 2009. Two (2) plans were granted extensions due to unforeseen issues with their data systems. All data was submitted to the Agency by July 28, 2009.

Compared to the performance measures submitted to the Agency for the first year of the demonstration waiver, statewide average performance showed improvement in all measures with the exception of one. Of particular note are gains achieved in the Annual Dental Visit, Controlling Blood Pressure, and the Follow-Up after Hospitalization for Mental Illness 30-day measures. It should be noted that these improvements occurred prior to the implementation of the Agency's performance measure improvement strategy. Table 43 lists the statewide average results for each measure that was submitted in both Demonstration Year One and Year Two.

Table 43 Statewide Average Performance Measure Results 2008 – 2009 Comparison			
Measure	**2008 Statewide Average**	**2009 Statewide Average**	**Difference**
Annual Dental Visit	15.2%	28.5%	13.3%
Adolescent Wellcare	44.2%	46.5%	2.3%
Controlling Blood Pressure	46.3%	55.9%	9.6%
Cervical Cancer Screening	48.2%	52.2%	4.0%
Diabetes – HbA1c Testing	78.9%	80.1%	1.2%
Diabetes - HbA1c Poor Control INVERSE	48.3%	46.8%	-1.5%
Diabetes - Eye Exam	35.7%	44.0%	8.3%
Diabetes - LDL Screening	80.0%	80.2%	0.2%
Diabetes - LDL Control	29.3%	35.9%	6.6%
Diabetes – Nephropathy	79.2%	80.3%	1.1%
Follow-Up after Mental Health Hospital – 7 day	20.6%	29.3%	8.7%
Follow-Up after Mental Health Hospital – 30 day	35.5%	46.6%	11.1%
Prenatal Care	66.6%	67.4%	0.8%
Postpartum Care	53.0%	51.5%	-1.5%
Well-Child First 15 Months – Zero Visits INVERSE	4.9%	1.6%	-3.3%
Well-Child First 15 Months – Six Visits	44.4%	49.3%	4.9%
Well-Child 3-6 years	71.3%	75.7%	4.4%

Seven (7) additional performance measures (eleven with sub-measures counted separately) were submitted by health plans in 2009 as planned in the Agency's three-year phase-in schedule. Of those new measures, most have statewide averages near or above the national mean (See Table 44).

Table 44 Second Year Measures		
Measure	**National Mean**	**2009 Statewide Average**
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 20-44 years	76.8%	71.8%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 45-64 years	82.4%	84.7%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 65 years and older	78.8%	83.6%
Antidepressant Medication Management (AMM) Acute	42.8%	52.0%
Antidepressant Medication Management (AMM) Continuation	27.4%	29.8%
Use of Appropriate Medications for People with Asthma (ASM)	86.9%	83.6%
Breast Cancer Screening (BCS)	50.0%	51.4%
Childhood Immunization Status (CIS) Combo 2	72.3%	63.6%
Childhood Immunization Status (CIS) Combo 3	65.6%	53.8%
Frequency of Prenatal Care (FPC)	59.3%	52.6%
Lead Screening in Children (LCS)	61.5%	54.8%

Health plans were also required to submit performance measure data for their populations outside of the demonstration project. Again using statewide average data, Reform outperformed Non-Reform in 20 of 27 measures (See Table 45).

Table 45
2009 Reform versus Non-Reform Comparison

Measure	2009 Non-Reform	2009 Reform	Difference
Adolescent Well-Care	46.0%	46.5%	0.5%
Controlling Blood Pressure	51.6%	55.9%	4.3%
Cervical Cancer Screening	53.8%	52.2%	*
Diabetes – HbA1c Testing	75.1%	80.1%	5.0%
Diabetes - HbA1c Poor Control INVERSE	51.7%	46.8%	-4.9%
Diabetes - Eye Exam	41.9%	44.0%	2.1%
Diabetes - LDL Screening	76.3%	80.2%	3.9%
Diabetes - LDL Control	29.4%	35.9%	6.5%
Diabetes – Nephropathy	76.1%	80.3%	4.2%
Follow-Up after Mental Health Hospital – 7 day	37.2%	29.3%	*
Follow-Up after Mental Health Hospital – 30 day	51.7%	46.6%	*
Prenatal Care	69.1%	67.4%	*
Postpartum Care	50.1%	51.5%	1.4%
Well-Child First 15 Months – Zero Visits INVERSE	3.0%	1.6%	-1.4%
Well-Child First 15 Months – Six Visits	51.0%	49.3%	*
Well-Child 3-6 years	72.5%	75.7%	3.2%
Adults' Access to Preventive Care – 20-44 Years	69.3%	71.8%	2.5%
Adults' Access to Preventive Care – 45-64 Years	82.2%	84.7%	2.5%
Adults' Access to Preventive Care – 65+ Years	74.7%	83.6%	8.9%
Antidepressant Medication Mgmt – Acute	45.6%	52.0%	6.4%
Antidepressant Medication Mgmt -- Continuation	31.2%	29.8%	*
Appropriate Medications for Asthma	87.0%	83.6%	*
Breast Cancer Screening	47.5%	51.4%	3.9%
Childhood Immunization Combo 2	61.8%	63.6%	1.8%
Childhood Immunization Combo 3	52.0%	53.8%	1.8%
Frequency of Prenatal Care	51.6%	52.6%	1.0%
Lead Screening	46.0%	54.8%	8.8%

*A difference is shown only for measures where Reform outperformed non-Reform.

The state finalized the list of required performance measures for the (calendar year) 2010 submission and made changes to the specifications for the Agency-Defined measures in response to comments from health plans and HEDIS auditors. The amended list of measures is provided in Table 46 on the following page. Specifications for the Agency-defined measures may be viewed on the following Agency webpage: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Table 46 Medicaid Managed Care Performance Measures			
HEDIS		**Note**	**Benchmark Year**
1	Adolescent Well Care Visits – (AWC)		HEDIS 2007
2	Adults' Access to Preventive /Ambulatory Health Services – (AAP)		HEDIS 2008
3	Ambulatory Care – (AMB)		N/A
4	Annual Dental Visits – (ADV)		HEDIS 2007
5	Antidepressant Medication Management – (AMM)		HEDIS 2008
6	BMI Assessment – (ABA)		HEDIS 2009
7	Breast Cancer Screening – (BCS)		HEDIS 2008
8	Cervical Cancer Screening – (CCS)		HEDIS 2007
9	Childhood Immunization Status – (CIS) – Combo 2 and 3		HEDIS 2008
10	Comprehensive Diabetes Care – (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy		HEDIS 2007
11	Controlling High Blood Pressure – (CBP)		HEDIS 2007
12	Follow-up Care for Children Prescribed ADHD Medication – (ADD)		HEDIS 2009
13	Immunizations for Adolescents – (IMA)	new	HEDIS 2011
14	Lead Screening in Children – (LSC)		HEDIS 2008
15	Mental Health Utilization – Inpatient, Intermediate, & Ambulatory Services – (MPT)		N/A
16	Persistence of Beta-Blocker Treatment after a Heart Attack – (PBH)		HEDIS 2009
17	Prenatal and Postpartum Care – (PPC)		HEDIS 2007
18	Use of Appropriate Medications for People With Asthma – (ASM)		HEDIS 2008
19	Well-Child Visits in the First 15 Months of Life – (W15)		HEDIS 2007
20	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)		HEDIS 2007
Agency-Defined Measures			
21	Follow-Up after Hospitalization for Mental Illness – (FHM)		CY 2009
22	Mental Health Readmission Rate – (RER)		CY 2008
23	Lipid Profile Annually – (LPA)		CY 2009
24	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy – (ACE)		CY 2008
25	Prenatal Care Frequency (PCF)	new	CY 2009
26	Frequency of HIV Disease Monitoring Lab Tests – (CD4 and VL)		CY 2009
27	Highly Active Anti-Retroviral Treatment – (HAART)		CY 2009
28	HIV-Related Medical Visits – (HIVV)		CY 2009
29	Percentage of Enrollees Participating in Disease Management Program (DM)		N/A
30	Transportation Timeliness (TRT)	new	CY 2010
31	Transportation Availability (TRA)	new	CY 2010

During Demonstration Year Four, the Agency continued implementation of the performance measure improvement strategy. Health plans submitted quarterly reports detailing their activities since inception of the corrective action plans, referred to as Performance Measure Action Plans. Most health plans reported that they were on track with their chosen interventions and reinforced their commitment to dedicating resources toward improvements. A select few health plans, however, struggled with their own internal timelines due to personnel and technology resource deficits. Agency Quality staff scheduled teleconferences will all health plans to discuss their progress and begin to identify best practices that could be shared with all health plans.

As the final phase of the Performance Improvement Strategy, the Agency finalized incentive and sanctions language for the health plan contracts. Non-monetary incentives were created to acknowledge high performance. A quality designation system will be developed that highlights those health plans that have achieved the state standards for excellence. A quality award program will also be put in place that allows health plans to compete for the top rankings to foster continual improvement.

A sanctions strategy was developed to ensure that no health plan continues to operate below a floor threshold established by the state. Based on comparisons to HEDIS national benchmarks, the sanctions will be levied if a plan fails to improve after being given the opportunity to institute corrective action. The health plans were given opportunity for input prior to finalizing the language. A staggered implementation schedule was included in response to their comments. Because incentives with a fiscal impact are more effective than non-monetary incentives, the state has formed a Value-Based Purchasing/Pay-for-Performance workgroup to look at additional incentives for high performance. The first task of the workgroup is to recommend a new auto-assignment methodology for beneficiaries who do not select a health plan that disproportionately awards higher performing health plans with a greater portion of the available recipients. The existing system operates via a round-robin process that attempts to provide health plans with an equal number of recipients.

The second task of the workgroup will be to recommend a methodology and funding source to provide financial incentives to high performing health plans. Unlike the auto-assignment task that already has statutory authority for implementation, the financial incentive will result in a recommendation to the Florida Legislature for implementation.

In the fourth quarter of Demonstration Year Four, the Pay-for-Performance and Value-Based Purchasing Team held workshops with Medicaid health plans to obtain input on the methodology for enhanced auto-assignments. Two workshops were held. The first, on May 19, 2010, offered an opportunity for participating health plans to suggest data sources that should be included in the methodology and to raise issues that should be considered to ensure all plans are treated equitably. The health plans requested that metrics, in addition to the required performance measures, be included and suggested indicators such as claims processing and payment timeliness and Child Health Check-Up rates, among others. Participants raised concerns about how a methodology could

affect new plans, small plans, and plans who served a disproportionate number of enrollees with serious illnesses.

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

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

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

(3)(b) Reduction in ambulatory sensitive hospitalizations

The Agency has begun capturing encounter data from its managed care plans and is examining the possibility of assessing Ambulatory Sensitive Hospitalizations through the encounter data. The methodology used in a prior report that was applied to an alternate data source will now be applied to the encounter data. The Agency anticipates being able to report on Ambulatory Sensitive Hospitalizations during the first half of Demonstration Year Five.

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

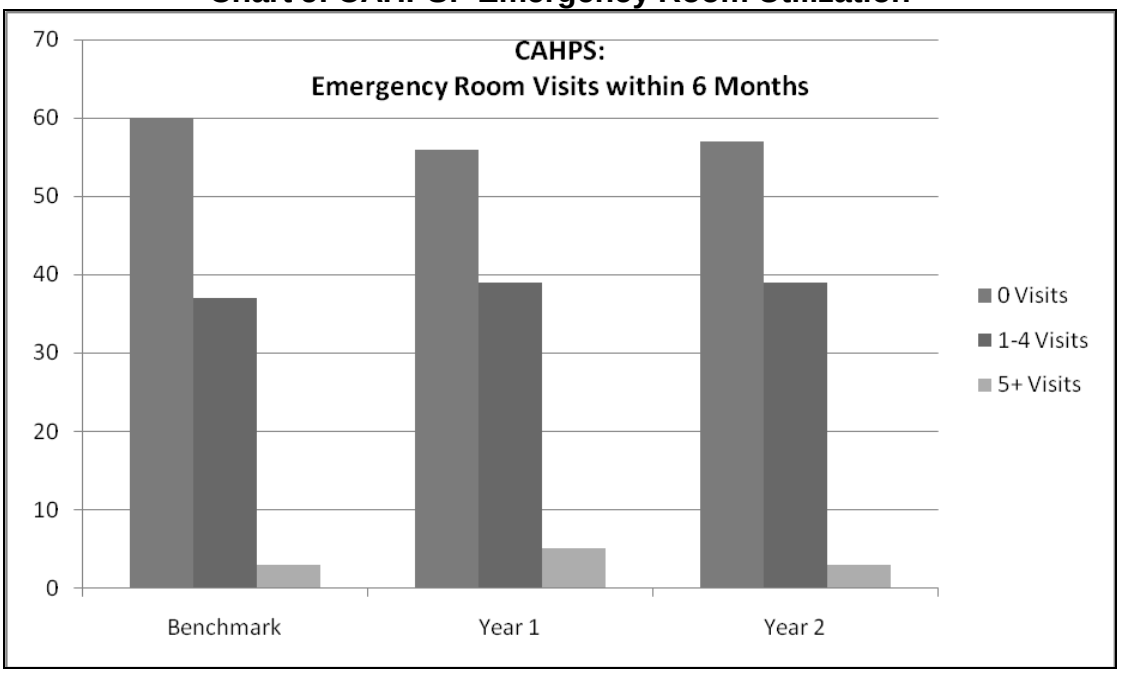
Within the array of performance measures health plans are required to report is a measure that targets emergency room utilization. This measure, Ambulatory Care, requires the health plans to report emergency room visits per 1000 member months. The state received data for this measure in 2008 and 2009. In the demonstration counties for 2009, the statewide aggregate rate per 1000 member months was 72.6. This rate was an increase from the reported rate in 2008 of 66.3. Table 47 compares the results of Reform and Non-Reform performance for 2008 and 2009.

Table 47
HEDIS – Ambulatory Care – Emergency Department Visits per Member Month

	2008	2009	Change
Reform	66.3	72.6	+6.3
Non-Reform	59.9	61.3	+1.4

The Agency has three-years of CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results for the demonstration waiver. One-year serves as the benchmark year and was administered to MediPass recipients prior to the transition into the managed care plans. Two (2) follow-up surveys were administered in Broward and Duval Counties and one follow-up survey was administered in the rural counties. Included in this survey are questions regarding emergency room utilization. When comparing emergency room utilization via CAHPS across the three-years, from county to county, and by plan type (HMO or PSN), there are no statistically significant differences (See Chart J).

Chart J. CAHPS: Emergency Room Utilization



Additional analysis will be needed to determine where opportunities for reduction of emergency room utilization exist. Early analysis of health plan encounter data yielded some issues with the data itself that limited the state's ability to do a full analysis of the issue. The state is working to establish interventions to target the reduction of emergency department use that will be informed from deeper analysis from the encounter data when ready. A number of health plans in the demonstration already operate Emergency Room Diversion programs. This will be encouraged for health plans that do not. The Agency is in discussion with its contracted External Quality Review Organization to establish a statewide collaborative project to reduce emergency room utilization.

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

For individuals who chose to opt-out of the demonstration, the Agency, through its vendor, established a database that captures the employer's health care premium

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

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

(1) Primary care physician was not enrolled with a Medicaid Reform health plan.
(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:

(1) were not employed;
(2) did not have access to employer sponsored insurance; or
(3) after hearing about opt out, decided to remain with their Medicaid Reform health plan where there were not co-pays and deductibles.

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

The Agency has contracted with the University of Florida (UF) to conduct patient satisfaction surveys throughout the five-year demonstration period.

Enrollee Satisfaction

The Agency has contracted with 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 Four, the Agency and UF agreed to apply two new approaches in the presentation of findings for the Year Two follow-up surveys. First, survey findings are to be presented in a “chartbook” format. The intent of the new format is to make survey findings understandable through a series of very clear data displays. Second, survey findings will be partitioned into three logical groups, each group presented in a separate volume. Volume 1 of this chartbook series will present survey results by county. Volume 2 will break out survey results by plan type, and Volume 3 will group responses by enrollee demographics.

Finalization of the *Enrollee Satisfaction: Volume 1 of the Year Two Follow-Up Survey* will be available on the Agency’s website in the first quarter of Year Five, with subsequent volumes expected shortly thereafter.

Survey fieldwork for Demonstration Year Three follow-up started on Wednesday, May 12, 2010, and telephone interviews were completed on Monday, July 12, 2010, with a yield of 7,014 completed interviews.

Mental Health Enrollee Satisfaction

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

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

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

Mental Health Analysis Objectives

Objective 1: The Experience of Care and Health Outcomes (ECHO) survey was conducted to assess the experiences and levels of satisfaction of enrollees who receive mental health services. Using a stratified random sample, a total of 1,319 interviews were administered by telephone to enrollees with severe mental illness (SMI) or severe emotional disturbance (SED).

The ECHO survey was fielded from May – July 2009 in the two urban demonstration counties (Broward and Duval) and a control county (Orange). A report related to survey outcomes is being finalized by the Agency and is expected sometime in the first quarter of Demonstration Year Five.

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

Objective 3: The report is being reviewed by the Agency. UF and the Agency are working through methodological issues. At this time, there is no anticipated date for this deliverable.

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

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

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

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

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

Special Term and Condition #102, Demonstration Year Two Milestones, states that, “the State will conduct a study to evaluate the cost effectiveness of various provider access systems.” This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost effectiveness study to the Agency by the third quarter of Demonstration Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the 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 (Demonstration Year One). It was determined that the reporting data would be based on the state fiscal periods, rather

than the various provider fiscal periods. PASs with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

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

The 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, Intergovernmental Transfers (IGTs), charge, cost, and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports were used for the cost-effectiveness study. The UF provided a "Plan for Evaluation of the Low Income Pool Program" to the Agency. The cost-effectiveness will be measured in the method described below.

> ”In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost / Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in ‘natural units’ (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome.” (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 federal CMS along with the LIP Program Highlights: Year 1 (SFY 2006-07) as prepared by UF. The LIP Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to federal CMS.

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

> “The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted to CMS.
>
> Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.
>
> Beginning with the annual report for demonstration year four, the State must include a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the demonstration.”

The Agency received the "*Evaluation of the Low-Income Pool Program Using Milestone Data: SFY 2008-09*" provided by the University of Florida. The report can be found on the Agency's Low Income Pool website at:

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

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

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

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

- The number of hospitals receiving LIP funding increased in comparison to those receiving funding from the SMP program: 87 hospitals received Special Medicaid Payments (SMP) funding in SFY 2005-06, with 163, 160, and 162 hospitals receiving LIP funding in SFY 2006-07, 2007-08, and 2008-09, respectively.
- Non-hospital providers began receiving funding under the LIP program: 43 and 44 non-hospital providers received LIP payments in SFY 2006-07 and SFY 2007-08, respectively, increasing to 59 non-hospital providers receiving LIP payments in SFY 2008-09.
- Total funding increased under the LIP program in comparison to the SMP program: total SMP payments were approximately $666.9 million in SFY 2005-06, with total LIP payments being approximately $998.7 million in SFY 2006-07, approximately $1.0 billion in SFY 2007-08, and approximately $876.3 million in SFY 2008-09.
- When adjusted for inflation (2005=100), total SMP payments were approximately $666.9 million, with total LIP payments being approximately $967.2 million in SFY 2006-07, approximately $941.7 million in SFY 2007-08, and approximately $807.8 million in SFY 2008-09.
- Hospitals receiving LIP payments served an estimated total of approximately 3.6 – 3.8 million Medicaid, uninsured, and underinsured individuals in each of the first three years of Medicaid Reform.

- Non-hospital providers receiving LIP payments served an estimated total of approximately 800,000 – 1 million Medicaid, uninsured, and underinsured individuals in the first three years of Medicaid reform.
- For hospitals, the average (SMP or) LIP payment received for each Medicaid, uninsured, and underinsured individual served declined during Medicaid Reform in comparison to the year prior to Medicaid Reform: in nominal terms, $ per individual was $267 in SFY 2005-06, $176 in SFY 2006-07, $166 in SFY 2007-08, and $167 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $267 in SFY 2005-06, $171 in SFY 2006-07, $156 in SFY 2007-08, and $154 in SFY 2008-09.
- For non-hospital providers, the average LIP payment for each Medicaid, uninsured, and uninsured individual served declined between SFY 2006-07 (first year in which non-hospital providers received funding) and SFY 2008-09: in nominal terms, $ per individual was $102 in SFY 2006-07, $91 in SFY 2007-08, and $73 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $98 in SFY 2006-07, $85 in SFY 2007-08, and $67 in SFY 2008-09.
- Results based on individuals served must be used with caution given that they are based only on data for hospitals and non-hospital providers that reported milestone data in a given year. The percentage of providers receiving payments that reported milestone data varied across years from 84 – 96% for hospitals and from 63 – 89% for non-hospital providers. Particularly in years with a low reporting percentage, results might demonstrate a different pattern if all providers had reported milestone data.

Looking Ahead to Demonstration Year Five

During Demonstration Year Five, the Agency will collect the SFY 2009-10 Milestone data for further research and evaluation. The Agency will also continue to provide quality success stories from providers receiving LIP dollars.

Low-Income Pool Program Success Stories

As provided in the previous quarterly reports, Attachment I of this report provides information of programs and services impacted by the LIP.

J. Evaluation of Medicaid Reform

Overview

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

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

Demonstration Year Four at a Glance

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

During this reporting period, there were two "external" reports on the demonstration submitted for publication:

- The article, "Successful Implementation in the Public Sector: Lessons Learned from Florida's Medicaid Reform Program" was submitted by UF to The Journal of Public Health Management and Practice.
- A report entitled, "Medicaid Reform: Broward County Physicians' Experiences" was commissioned by The Health Foundation of South Florida, performed by UF researchers, and released in the third quarter of Demonstration Year Four.[7]

3. Evaluations in Demonstration Year Four

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.

[7] This report was inadvertently omitted in the third quarterly report of Demonstration Year Four.

Enrollee Satisfaction Demonstration Year Two Follow-up Survey: Volumes 1 – 3

The Agency has contracted with 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.

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

Objective 3: The report is being reviewed by the Agency. UF and the Agency are working through methodological issues. At this time, there is no anticipated date for this deliverable.

Organizational Analysis

The organizational analysis component of the Medicaid Reform Evaluation describes the development of Medicaid Reform in Florida, as well as the specific demonstration projects in the demonstration counties of Duval, Broward, and the three expansion counties (Baker, Clay, and Nassau). The organizational analysis focuses on three main areas: the Reform implementation process, the Reform health plans (including HMOs and PSNs), and the choice counseling organization(s). Multiple Organizational Analyses reports are being finalized by UF and the Agency and will be available in the first quarter of Demonstration Year Five.

Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal) 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 federal CMS regarding the independent evaluation of this new analysis. A summary report of the qualitative survey can be found on the Agency’s website at:

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

Fiscal Analysis

In follow-up to the first (univariate) fiscal analysis, a preliminary draft of the multivariate analyses report was delivered to the Agency for review during the second quarterly reporting period of Demonstration Year Four. *Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analyses,* will provide an update to the univariate report findings, and also looks at demonstration data by various subgroups (gender, race, etc.) against specific controls. The preliminary draft of this report has been reviewed and several changes to the report are being made. It is anticipated that the Agency will have this report in the second quarterly reporting period of Demonstration Year Five.

Low-Income Pool (LIP)

In July 2006, the State of Florida introduced broad-ranging reform of the Florida Medicaid Program, with the establishment of the Low-Income Pool (LIP) Program being one of several components of the demonstration. The LIP consists of a capped annual allotment of $1 billion (the "pool"), with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.[8] The conditions of the LIP are discussed in the Special Terms and Conditions (STCs) of the waiver, as approved by the federal Centers for Medicare and Medicaid Services (CMS).[9]

The *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2006-2007 Florida Hospital Uniform Reporting System (FHURS) Data* is currently being finalized by the UF. The report evaluates the link between payments from the LIP-related programs and the provision of services to Medicaid, underinsured, and uninsured populations using data from FHURS. This evaluation measures services along four dimensions: adjusted days, gross revenue, net revenue, and operating expense, in order to gain a more complete picture of the amount of services obtained from a given amount of LIP-related payments. This report is one of a series of reports that will evaluate the Low-Income Pool Program throughout the demonstration period. All evaluation studies will use data on LIP-related payments as provided by the Agency, but two different data sets will be used to assess the amount of services provided: data from FHURS and data from the LIP Milestone Reporting Requirements for CMS. These studies will cover periods both before Reform was implemented and during implementation and operation for purposes of comparison. Evaluations of the LIP utilizing Milestone data (for SFYs 2007-08 and 2008-09) and FHURS data (SFY 2006-07) will be available in separate reports before the end of the first quarter of Demonstration Year Five.

Additional information regarding LIP activities during the Medicaid Reform Evaluation can be found in Section F of this report.

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

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

Progress Reports on Key Aspects of the Evaluation

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

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

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

Looking Ahead to Demonstration Year Five

While it may be a bit premature to draw conclusions regarding the overall impact of the demonstration, initial comparative information is available for the Years One, Two, and Three 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. In many ways, the evaluation of Medicaid Reform in Florida has been an iterative process. Lessons learned in the first years of evaluation activities have been applied and significant process improvements have been made in the reporting of information related to Medicaid Reform in Florida.

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. A complete list of FAC members is available on the Agency's website at:

http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/medicaid_reform_fac_mMembers_update_Jan_2010.pdf

FAC members represent key stakeholders with strong interests in the demonstration, such as representatives from the state's hospital and managed care industries, the Florida Medical Association, other health professional groups, advocacy organizations, legislative leadership, or other entities. The FAC provides input from key community stakeholders. There was no FAC meeting held during evaluation Demonstration Year Four, however, planning for a meeting in Demonstration Year Five is in the preliminary stages.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF, as a required activity in the federal 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 on the Agency's website at:

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 demonstration waiver. There was no TAC meeting held during evaluation Demonstration Year Four, however, planning for a meeting in Demonstration Year Five is in the preliminary stages.

K. Policy and Administrative Issues

Overview

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

- Technical Advisory Panel Meetings
- Policy Transmittals and Dear Provider Emails and Letters
- 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 Four of the demonstration. This section of the annual report provides the highlights of key issues addressed during Demonstration Year Four.

Demonstration Year Four at a Glance

Medicaid Reform Technical Advisory Panel

With the demonstration fully operational during Year Four, the Medicaid Reform Technical Advisory Panel (TAP) met periodically (once each quarter). 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. While Demonstration Year Three brought the Agency's performance measures initiative and health plan transitions as new agenda items, Year Four also brought three new agenda items:

- Discussion regarding projected increases in Medicaid caseload and possible legislative managed care expansions;
- Discussion of national health care reform and how Florida may be affected; and
- Update on the demonstration extension request.

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

Policy Transmittals

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

- Changes in Florida fraud and abuse policy and law, allowing rewards for reporting fraud and abuse and providing posters and brochures for printing and dissemination.
- Changes in Medicaid service provision policy in such areas as Vaccination procedures and processes for the 2009 H1N1 Swine Flu vaccine and disposable incontinency supplies.
- Guidelines and resources for FFS PSNs to develop their comprehensive plans for transitioning to capitated models.
- Third party liability reporting changes for HMOs and PSNs.
- Claims processing updates, including changes for FFS PSNs, revised claims adjustment reason codes and changes in physician and practitioner fee schedules.
- 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.
- Information regarding the consolidated health plan contract and electronic Report Guide quarterly changes for the September 1, 2009, through August 31, 2012, contract period.
- Updated Plan Evaluation Tool (PET) and/or benefit request submission deadlines for the September 1, 2009, through August 31, 2010, contract period and the September 1, 2010, through August 31, 2011, contract period.

Biweekly Technical and Operations Calls

The Agency conducted 24 biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants between July 1, 2009, and June 30, 2010. The purpose of the calls is to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through e-mail, telephone inquiries, and previous technical calls.

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

Approximately 20 participants attended in person and the popularity of these calls is shown by over 100 phone lines in active use on the calls. Items that have topics for almost all calls include updates and statuses on Medicaid encounter data submissions; EDS transition issues, including enrollment transmissions, claims processing, and the transmission of primary care provider choices; and updates on the 2009 – 2012 health plan contract, report guide and benefits amendments.

Other agenda items included:

- Fraud and abuse initiatives and reminders, including required reporting, report attestations, and upcoming changes in report formats;
- Medicaid Services policy updates and reminders, including lead screening, swine flu vaccines, county health department services and ADA accommodations;
- External Quality Review Organization updates and webinar reminders;
- Choice Counseling Program update, including new vendor information with AHS becoming the Agency's new Choice Counseling Vendor in June 2010;
- My Florida Health eBook and eBaby Book Announcement;
- Review of proposed and new performance measures reporting requirements;
- Plan withdrawals and transitions;
- Review of policy transmittals (see policy transmittals above);
- State legislative updates; and
- General Amendment and contract updates, including September 2009 rate amendments and benefit amendment timelines, fine-tuning amendments (see A of this report), the upcoming contract period beginning September 1, 2010, and the 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 Reform implementation timeline in conjunction with the transition to the new Florida Medicaid fiscal agent system as well as the newness of the PSNs and their third party administrators in processing claims through the Medicaid fiscal agent claims process, the Agency determined that additional resources were needed to assist the PSNs with systems issues, and implemented special, biweekly, technical assistance calls for the PSNs. While these calls started out as biweekly in Demonstration Year One, they became monthly in Demonstration Year Two and continued to occur monthly through Demonstration Year Four. 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.

Of over 150 issues brought up through these System Implementation Issues calls, during Demonstration Year Four, only 5 new issues were opened. By the end of Demonstration Year Four, only 11 issues remained as unresolved. Those unresolved are waiting for prioritization in order for those systems changes to occur. With only 11 issues remaining, and only one of those submitted during the last quarter, the Agency is reviewing the need for continuing these monthly calls with the PSNs. Where available, manual workarounds have been implemented to address these issues.

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

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

In addition, the Agency continues its intent 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 Demonstration Year Four, several conference calls were held with health plans regarding upcoming general amendments and contract changes. 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 occurring regard the following:

- Modifications in encounter data reporting;
- Inclusion of performance measure sanctions and proposed performance measure incentives; and
- Modifications in reporting requirements.

L. Waiver Extension Request

Legislative Direction

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

Development of Waiver Extension Request

In preparing the waiver extension request document, the Agency held a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver as authorized by the Florida Legislature. The agenda items for the public meetings included: description of the legislation passed during the 2010 Florida Legislative Session which impacts the waiver, an overview of the existing waiver, and a description of the draft extension request. There was an opportunity for public comment during the meetings.

The location, date and time of the public meetings that were held are provided below. In addition, the Agency accepted written comments on the waiver extension request via mail or e-mail. A complete summary of the public notice and public process used in the development of the wavier extension request is included in the final waiver extension request and posted on the Agency's website.

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

Schedule of Public Meetings				
Location	**Date**	**Time**	**FAW Notice**	**Agenda/Presentation**
Clay County Clay County Agricultural Center 2463 SR 16 W Green Cove Springs, FL 32043	6/11/10	10:00a.m. - 12:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Baker County Baker County Health Department 480 W. Lowder Street Macclenny, FL 32063	6/11/10	2:00p.m. - 4:00p.m.	Notice	Final Agenda Final Presentation Meeting Video

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

Submission of the Waiver Extension Request

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

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

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

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

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

Attachment I
Description of Opt Out Enrollees

The following is a description of the Opt Out enrollees.

1. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the second quarter of Demonstration Year One on October 1, 2006. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.
2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on January 1, 2007. The father has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.
3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer’s health insurance plan effective December 31, 2007. As a result, the children were disenrolled from the Opt Out Program. The mother subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Demonstration Year Two on January 1, 2008. The children’s Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program (Item Number 11).
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical

premium to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program. The mother re-enrolled the child in the Opt Out Program during the fourth quarter of Demonstration Year Three on May 1, 2009 (Item Number 36).

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

11. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.
12. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's Medicaid eligibility ended March 31, 2009, and as a result has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the fourth quarter of Demonstration Year Two and subsequently re-enrolled in the Opt Out Program effective May 1, 2008. The child's Medicaid eligibility ended March 31, 2009, and as a result, has been disenrolled from the Opt Out Program (Item Number 26).
13. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on February 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on February 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the third quarter of Demonstration Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out Program.
16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was

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

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

18. The caller began the process to enroll his two children in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The father lost his job effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended May 31, 2008. As a result, the child has been disenrolled from the Opt Out Program.

21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2010. As a result, the child has been disenrolled from the Opt Out Program.

22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother

of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended November 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

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

24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

25. The caller began the process to enroll in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

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

28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The

mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.

29. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on October 1, 2008. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual's Medicaid eligibility ended February 28, 2010. As a result, the individual has been disenrolled from the Opt Out Program.

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

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

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

33. The caller began the process to enroll herself and her two children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended effective June 30, 2009. As a result, the mother and child were disenrolled from the Opt Out Program. The other child

remained eligible and enrolled in the Opt Out Program. The mother has now discontinued her employer's health insurance plan due to high cost and now she is looking into private insurance. As a result, the other child has also been disenrolled from the Opt Out Program effective January 27, 2010.

34. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended December 31, 2009. As a result, the individual has been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

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

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

44. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the third quarter of Demonstration Year Four on January 1, 2010. The father has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

45. The caller began the process to enroll her three children in the Opt Out Program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the fourth quarter of Demonstration Year Four on April 1, 2010. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.

Attachment II
Low Income Pool Success Stories

Alachua County Low Income Pool Project

Expanded Primary Care Services: The Alachua LIP project offers extended hours for medical services and accepts walk-ins for primary and urgent care. In the first six months, the program has provided an estimated 5000 walk-in visits. Results of patient surveys indicate: 27% would have gone to the emergency room (ER) if they could not have come to the Alachua County Health Department (ACHD), and 59.6% were uninsured. Applying survey results to all walk-in visits suggests that in six months, access to outpatient services through the LIP program averted 1350 visits to the ER, of which 805 would have been uninsured.

Emergency Room Referrals: The Alachua LIP program accepts referrals from Shands hospital for patients who used ER services and have no primary care physician (PCP). The clients meet with a medical home coordinator (MHC) who facilitates access to needed medical care, including short term follow up of therapies begun in the hospital. The MHC also assists them to enroll in a medical home and, if uninsured, screens and helps them to apply for possible financial assistance.

In the first three months of the program, 42 referrals were received for patients who had been hospitalized. The majority have one or more chronic conditions such as diabetes or hypertension. The average age was 48 years old, 26% were homeless and 50% were uninsured. In addition to preventing further unnecessary use of ER services through enrollment in a medical home, the program reduces length of hospital stays by accepting patients who cannot be discharged without a physician willing to accept responsibility for managing immediate medical needs, such as anticoagulant therapy. In the first three months, 19% of clients needed this type of follow-up care.

Disease Management: In the first two months, the program provided disease management education to 24 adult clients with diabetes. Clients are recruited from the Health Department clinic, and from the emergency room referrals. Most of the patients are uninsured and unable to purchase the supplies needed to effectively home monitor blood glucose levels. They receive supplies and self management education on a monthly basis.

Case History: A 47 year old man who was homeless and uninsured. He was admitted to the hospital because he was vomiting blood due to an unmanaged GI disorder. Because of the LIP program he: received medical care at ACHD to stabilize his condition; and was able to enroll in Medicaid, which will be retroactive to include the hospital stay. He has selected an internal medicine practice as his permanent PCP, reduced his tobacco use and is permanently living with a family member.

Hospital Perspective: The hospital case managers were asked for feedback on the LIP program ER referral service. This is a quote from one of them, “GREAT! They took a chronic physical therapy and managed to somewhat (sic) avoid ER return and assist pt with finally getting his Medicaid! They also assisted in follow up for pain management clinic and are trying to get pt into a drug rehab program! They are responsive and helpful and wonderful!”

Citrus County Health Department (CCHD) LIP Project

The Citrus County Health Department (CCHD) project is designed to improve access to and ensure appropriate utilization of health care. Through three distinct program initiatives, the CCHD LIP Project has proven to be very successful.

Diabetes Disease/Case Management Program: Program data for the past year indicates that over eighty percent (81.4%) of the new diabetics seen have made the Citrus County Health Department their medical home. Additionally, patient outcome measures indicate that clients enrolled in the program have improved diabetes management. This past month, the CCHD Diabetes Management Program has instituted group care which will provide additional support and management tools for these clients.

Emergency Room Diversion Clinics: CCHD now provides ER Diversion/Urgent Care Services at 3 sites Citrus County. These clinics provide an invaluable service for Citrus County. Data indicates that over 38% of the clients seen would either go without care or would utilize the ER for care. Over the past year, the CCHD ER diversion clinics have saved an average of $500,000.00 in ER cost. Additionally, over 72% of ER diversion clients have made the CCHD their medical home. These clients are provided with primary care and chronic disease prevention services and have access to all CCHD services including, dental care, mental health, and pharmacy services. During the previous year, CCHD provided over 2 million dollars of prescription medications through the Drug Manufacturers' Indigent Drug Program.

Department of Children and Family (DCF) Benefits Access: CCHD works collaboratively with DCF to provide on-site eligibility assistance at all CCHD clinical sites. There are 4 out-posted DCF workers and ACCESS Computers available to assist residents so they can apply for Medicaid, Food Stamps, and temporary cash assistance. This partnership enables community members to get face-to-face assistance to access coverage.

The following stories show how important the LIP funding is to the Citrus County Health Department:

- A CCHD client in her 40’s had a diagnosis of cervical cancer. She had no idea that coverage was available to her until nursing staff talked to her about Medicaid. She had a teenager at home and qualified for care. After DCF workers processed her application, the patient was referred to Moffitt Cancer Center for treatment.

- A CCHD client in her 40's, with a teenager at home, needed a hysterectomy because of concerns about ovarian cancer. She had no idea she might qualify for medical coverage. With quick attention, we were able to help her get on Medicaid, and she is now at Shands receiving the medical care she needs.
- A 63 year old man had worked for the past 48 years as an electrician, until he recently became unemployed and uninsured. After going without care for some time, he became a patient at CCHD. This man suffers from high blood pressure, chronic heart failure, and pulmonary disease. CCHD is now his medical home, where he is provided with primary care and is able to obtain the many prescription medications that he needs.

Jefferson and Madison County Health Departments LIP Project

Utilizing Low Income Pool funds, Jefferson and Madison County Health Departments have increased access to care for the uninsured through a variety of approaches, the most notable being the establishment of new primary care access points within the County Health Department (CHD). Both CHDs have enhanced their capacity to provide care through the hiring of Advanced Registered Nurse Practitioners to provide primary care, family planning and OB services. In addition, both CHDs have expanded primary care clinic hours as well as offering an *After Hours* clinic. Both sites have increased "open access" through changes to scheduling procedures to provide services to walk-ins.

Both CHDs employ full-time Eligibility Specialists who conduct the following activities:

- Screen patients for eligibility for public health insurance and assist them in applying if they are potentially eligible. Public health insurances include Medicaid, Cover Florida, KidCare, and Social Security Disability.
- Refer patients who are uninsured to free or low-cost primary care,
- Coordinate medical appointments, and
- Promote the assignment of a medical home.

Through a partnership with Tallahassee Memorial Healthcare (TMH), the LIP project utilizes a Patient Navigator located at the Bixler Emergency Department to:

- Identify Jefferson and Madison County patients who utilize TMH ER for non-emergent conditions,
- Coordinate community health care resources to support care, and
- Promote the assignment of a medical home.

The coordination of community health care resources includes education, referral, follow-up, and case management services to identified patients.

Each project site provides Pharmacy Assistance Program services that serve CHD providers and community providers to ensure uninsured patients receive needed

medications. The LIP project employs one full-time Prescription Assistance Specialist to provide these services.

Lastly, specialty coordination for chronic medical conditions is funded through the project. MCHD and JCHD share a Senior LPN who provides disease management services to those patients who have been identified as having diabetes or hypertension. Disease management services include the monitoring of compliance with standards of care, case management, facilitation of support groups, and coordination of care.

Project Data

- Increased access to health care for the uninsured and underinsured in Jefferson and Madison Counties through the expansion of County Health Department primary care capacity (January 2009 through March 2010 the project provided services to 945 new patients). Diverted 79 from the emergency room, estimated saving of $132,720.00 in ER charges (January 1, 2009 – March 31, 2010).
- After Hours Clinic in Madison County served: 758 total patients seen, diverted 110 from the ER, an estimated saving of $184,800.00 in ER charges (May 6, 2009 – March 31, 2010).
- LIP funding provided the means to continue Jefferson and Madison County's prescription assistance program. July 2008 through December 2009 the project provided assistance to 331 uninsured individuals with 1,069 prescriptions with a value of $406,633.00.

Lake County Health Department (LCHD) LIP Project

According to the 2010 Florida County Health Ranking, 27% of Lake County Adults (roughly 62,500) are uninsured and 27% of Lake County's population (78,417) does not have a primary care home.

Lake Primary Care Project (Lake PCP)

- Increased access to care including one evening a week
- Increased provider access by allowing all LCHD providers to see Lake PCP clients for sick visits
- Has enrolled 466 clients into a primary care home since starting in 2009. There are 425 active clients
- Disease management care coordination including creating a care plan account for over 3,760 services and currently managing 72 high severity clients with weekly follow-up. Low severity clients receive monthly follow-up
- Increased access to alternate geographical locations through partnerships with 2 local hospital indigent clinics; has enrolled 116 clients into a primary care home since starting in March 1, 2010. There are 116 active clients

- Partnership with a Mental Health Provider to see clients on-site has decreased referral time from 2 months to 1 week (45 clients have been referred)
- Prescription Assistance Program has assisted 148 clients in receiving 1851 prescriptions
- Compassionate Care Program assisted 67 clients in receiving 117 prescriptions at no cost
- Mammogram and cervical cancer screening is available as needed
- Value of in-kind services to Lake PCP clients: $70,564.17

Community Partnerships

- Assisted clients with lodging needs, helping them get back on their feet
- Provided assistance to all clients needing food/meal assistance
- Access to specialty services for Lake PCP clients through referrals
- Eye exams and glasses from local charitable organizations

Case Example:

- A client presented with a persistent cough was sent for a chest x-ray indicating abnormalities. Client was immediately referred to a pulmonologist and diagnosed with stage IV lung cancer. Oncologist immediately began treatment.

Impact on Local Hospitals

- Hospital referrals account for 23% of enrollment into the Lake PCP Program
- Successful Emergency Room diversion program through Lake PCP Program

Program	ER Diversion	Average Cost	Total ER Savings
Lake County Health Department	867	$ 2,293.03	$ 1,985,430.00
Partnership with Indigent Clinics	86	$ 2,293.03	$ 197,200.58

Pinellas County Health Department LIP Project

The Pinellas County LIP project provides disease management and outreach services and two primary care clinics for uninsured clients. Clients receiving services provided through the LIP are very appreciative of the staff and services that would otherwise be inaccessible to them. Projects has received many positive comments from clients for staff going above and beyond in providing client care.

Diabetes disease management is provided by two RN diabetes disease managers who focus on monitoring clients' care plans and conducting weekly self management education classes for a target population of 752 diabetics. The diabetes disease managers collaborate closely with the primary care team including nutritionists and

disease managers for COPD, asthma, hypertension, and obesity. Quarterly, the diabetes disease managers provide 600 services, including more than 90 new care plans and 435 care coordination services. Additionally, the disease managers teach weekly diabetes self management education classes in collaboration with the nutritionists at the medical homes. A cardiovascular disease manager began in March 2010 as part of the LIP grant project to serve 200 identified clients with cardiovascular disease.

The outreach team includes an RN and Eligibility Specialist who provide nursing assessments and eligibility screenings at five sites within the County and attends various community events. The outreach team receives regular referrals of uninsured discharged patients from local hospitals (inpatient and emergency room) who they assist in establishing a medical home. The team also works to establish a medical home for individuals who receive a 30-day prescription card when discharged from St. Anthony's Hospital through a pilot program with Pinellas County Health and Human Services. Quarterly, this team processes an average of 670 emergency room referrals, 100 hospital inpatient referrals, 375 eligibility field assessments and 300 nursing field screening assessments.

Primary care clinics include a Saturday clinic at Pinellas CHD, St. Petersburg, from 8:00a.m. – 3:00p.m. and a Thursday clinic at Pinellas CHD, Pinellas Park, from 2:30p.m. – 6:00p.m. These clinics provide a primary care medical home option for clients without insurance who would otherwise utilize emergency rooms as their method of receiving care. Currently, there are 347 unduplicated clients participating in these LIP clinics. On average, 85 medical encounters are provided monthly to these clients. Because of their association with the LIP Clinics, these clients have access to the specialty care network of the Pinellas County Health Department Volunteer Program. These clients have access to continued specialty care by referral from the LIP clinic examiners to the following clinics: Acupuncture Clinic, Cardiologist (in private office), Dermatologist (in private office), Diabetic Dental Clinic, Gastroenterology Clinic, General Surgery Clinic, Gynecology and Annual Exam Clinic, Ophthalmology Clinic, Nephrology and Hypertension Clinic, Osteo Manipulation Therapy Clinic, Physical Therapy Rehabilitation Clinic, Podiatry Clinic and Urology Clinic.

The LIP team focuses on primary, secondary and tertiary prevention with physicians and mid-level providers managing the entire continuum of care. Unnecessary emergency room usage is being impacted for the LIP clients by identifying the low income and uninsured Pinellas County residents through the outreach team, by offering alternative medical care through the LIP Clinics, and by providing education and disease management through the Disease Managers.

Sarasota Healthcare Access (a LIP Funded Program) – Success Stories

During a typical week, Sarasota Healthcare Access (SHCA), a LIP funded program, receives between 40 and 50 referrals from seven area emergency rooms and hospital in-patient units in Sarasota County. During calendar year 2009, SHCA received 2,148 new referrals and 548 repeat referrals. Of these, SHCA staff were able to contact and

provide services to 1,444 patients. During this same time period, there were 5,979 unduplicated patients who received primary care at one of the Sarasota County Health Department sites and who originally entered care through SHCA. During March 2010, SCHD saw the highest number of patients at their four sites, logging in 8,392 clinical encounters. Of these, 1,054 were unduplicated patients who entered care through SHCA.

The following case studies provide a sample of the services SHCA provides:

- A Caucasian woman in her mid-forties was admitted to SMH with nausea and vomiting. She was diagnosed with diabetes, having a blood sugar in the 800s. A Social Worker from the hospital made a referral to SHCA. The SHCA nurse case manager contacted this patient and helped her set up an appointment with Sarasota CHD Adult Health. This lady was unaware of the existence of the Health Department and the availability of primary care. The nurse case manager taught her how to inject herself with insulin and contacted the patient at least weekly regarding diet, exercise and diabetic care. She also helped her straighten out her chaotic work schedule. This lady eventually lost 50-60 pounds, and through proper nutrition, was able to eliminate her need for insulin. Her diabetes is now controlled through diet and oral medication and her blood sugar is under control.

- A 51 year-old male Caucasian was referred to Sarasota Healthcare Access (SHCA) from Sarasota Memorial Hospital, where he was inpatient. He was discharged after having had multiple strokes. The patient was unemployed, had no income, transportation or medical coverage. The SHCA Social Worker/Case Manager initiated eligibility for him to access primary care through the Sarasota County Health Department (SCHD). A follow-up appointment was scheduled for him at Adult Health at the Venice site. He was brought to his primary care visit by an aunt who was the only family member he had as support. After his initial visit he was provided with information on how to apply for SSD. He was also referred to our RN Chronic Disease case manager so that she could provide him with one-to-one health education and counseling. Several months later, the patient returned for a re-check and notified staff that he had been approved for SSD. The patient is compliant, friendly and stated, “he appreciates all the support and help he receives from the nice ladies who helped set him up with primary care services.”

- A tearful and depressed uninsured black gentleman in his late thirties came to the health department after being seen at the Sarasota Memorial ER. The Sarasota Healthcare Access RN case manager helped him through the clinic eligibility process and he was given an appointment for our adult primary care clinic. By working with his physician, he was given appropriate medications and referrals to help him with his depression. He routinely takes his medication and has been able to secure a job and maintain a place to live.

- A 44 year old patient was referred to SCHD subsequent to hospitalization at SMH and having stents placed. He was head of a household and had been providing for

family with 2 children. He lost his job and was on the way to losing his home. SCHD was able to secure this gentleman a clinic card and establish him with a primary care provider. This family was extremely appreciative, stating that they have never had to use our resources. The patient's mandatory Plavix prescription was obtained through the needymeds.org resource. This patient is part of the SHCA's Chronic Disease Case Management program and this has become self sufficient with the resources we have provided.

SHCA access case managers receive numerous daily calls from people who have lost their jobs and health insurance and have no idea how to navigate the complex system of health care access. Many have chronic conditions and do not know how to they will continue to obtain their medications. If they have children, project case mangers lead them to Medicaid web-site on their computer. These individuals are educated on the eligibility process including the documents they need, who to contact and how to make appointments. Many have chronic conditions and do not know how they will continue to obtain their medications.

Through the pharmacy case manager, SHCA is able to secure high cost medications not on the Health Department formulary, which the patient needs. An example is Plavix, which is prescribed to prevent blood clots from forming after a patient with a cardiac blockage has been stinted. Other medications provided under medication assistance include those for seizures, asthma and diabetes. The pharmacy case manager works with the patient to complete the application, obtains the physician's signature and contacts the drug provider. This process allows the patient to receive the necessary medications which they could not otherwise afford and keeps their condition under control. An example of cost savings for two patients is outlined below. Both of these middle aged patients had been working for many years. When they lost their jobs and health insurance, they stopped taking their medications and landed in the ER. They entered primary care through the SHCA program and are supported in obtaining their medications, some of which are on the Health Department formulary and others need to be accessed through our Medication Program. This support had resulted in significant cost savings to these patients.

- Patient A, a diabetic, was established with Sarasota Healthcare Access in August of 2009. She was prescribed 11 formulary monthly maintenance medications and along with 4 medications that are accessed through our Medication Assistance Program. Total medication costs for the patient for her first month of treatment would have been $2,536.16 for the following drugs:

  - Januvia $495.39
  - Lamictal $1,111.42
  - Actos $512.77
  - Advair Diskus $416.58

Low Income Pool Success Stories

Patient B, diagnosed with congestive heart failure, was established with Sarasota Healthcare Access in July of 2007. He is prescribed 14 monthly maintenance formulary medications along with 5 non-formulary medications. The cost of his non-formulary medications for one month of treatment would have been $1,595.04, had he not received Medication Assistance support.

- Coreg $268.20
- Bidil $324.09
- Altace $170.73
- Welchol $452.76
- Nexium $379.26

Because of their chronic conditions, both patients now receive chronic disease case management.

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