Florida Medicaid Reform

Quarterly Progress Report
July 1, 2007 – September 30, 2007

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Condition # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the first quarterly report in Year Two of the demonstration for the period of July 1, 2007 through September 30, 2007. For detailed information about the activities that occurred during Year One of the demonstration, refer to the previous quarterly reports and the annual report 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 current contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform 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: 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 for approval as part of the application process.

Under the open application process, there is no official due date for submission in order to participate as a health plan in Broward or Duval County. Instead, the Agency provides guidelines for application submission dates in order to ensure contracting by July 1 of each year. Prospective plans are informed that they have to submit a completed application by a date specified by the Agency, in order to be considered for a July 1 effective date.

As of June 30, 2007, the Agency has received 18 health plan applications. Seventeen of the 18 applicants sought to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population; one application sought to render services as a specialty PSN, the Department of Health's Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in both Duval and Broward Counties.

Table 1 lists the Reform health plan applicants, the date the application was received and date of approval.

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

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

In January 2007, the Agency posted the Reform Health Plan Expansion Application for current contractors wishing to expand into the Reform expansion counties (Baker, Clay and Nassau) on the Agency's Medicaid Reform Website with no submission deadline. The Agency also provided guidelines for application submission dates to ensure contracting by July 1, 2007. All prospective plans were informed that they had to submit a completed Reform expansion application (current contractors) or a completed Reform Health Plan Application (new applicants) by April 2, 2007, in order to be considered for an effective date of July 1, 2007, for Baker, Clay and Nassau counties. Two health plans were approved for Reform expansion, Access Health Solutions (a PSN) and United Health Care (an HMO).

Current Activities

The Agency executed a Reform health plan contract with Freedom Health Plan on September 25, 2007, with enrollment slated to begin in Broward County on November 1, 2007. Table 1 indicates one pending contract from the initial set of health plan applicants; Better Health Plan, a PSN. Better Health Plan, a FFS PSN applicant, has experienced a major change in network design and an expected date of application approval is unknown at this time. The Agency continues to provide technical assistance to Better Health Plan and continues to receive inquiries from other interested health providers on the prospects of submitting an application to become a Reform PSN or HMO.

As of September 30, 2007, the Agency has contracted with 17 health plans; 11 of these are HMOs and 6 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note

that the effective date listed in Table 2 represents the date when the plan became available as a choice but does not represent the date on which the plan received enrollment. There have been no new Reform health plan contracts executed since September 2007.

Table 2
Medicaid Reform Health Plan Contracts

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

In July 2007, the Agency began accepting enrollments into the two Reform health plans approved for the three expansion counties. These two health plans provide beneficiaries located in Baker, Clay and Nassau counties with a choice of enrolling in an HMO or a PSN, options that did not exist for them prior to Reform.

By the end of June 2007, the Agency executed contract amendments for the majority of Reform health plans and all remaining plan contract amendments, except for the Children's Medical Services PSN specialty plan, which were executed prior to September 1, 2007. The contract amendments for capitated plans included the draft capitation rates and the Agency approved customized benefit packages for the time period of September 1, 2007, through August 31, 2008. The contract amendments for FFS PSNs included the September 1, 2007, through August 31, 2008, draft capitation rates upon which each FFS PSN's contract reconciliation will be based, and the Agency

approved expanded benefits for each FFS PSN. The Children's Medical Services PSN is still under review relative to the contract transportation capitation rates.

During the quarter, the Agency continued to work on a general contract amendment to bring the current health plan contracts in accord with the consolidated contracts posted on the Agency's website in January 2007. This general amendment also incorporates several quality provisions relative to performance improvement plans, performance measures, quality improvement programs, disease management programs and claims processing. This amendment is expected to be released to the health plans and executed during the second quarter of demonstration Year Two, beginning October 1, 2007 and ending December 31, 2007.

2. Benefit Package

Overview

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Reform Year One, and again, for Reform Year Two of the demonstration. Interested parties were notified that the data book

would be 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 a Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the updated data book on May 23, 2007 to assure that the plans were familiar with the required coverage thresholds for the September 1, 2007 through August 31, 2008 period. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous year. The annual process of verifying of the actuarial equivalency, sufficiency test standards and the tool (PET) was completed during the last quarter of each 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 state plan package is no longer considered the perfect fit for every Medicaid beneficiary, and the beneficiaries are getting new opportunities to engage in decision-making responsibilities relating to their personal health care.

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

Current Activities

The health plan customized benefit packages for September 1, 2007 through August 31, 2008, became operational during this quarter; 30 customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The new benefit packages include the addition of 1 HMO and 1 FFS PSN for Reform expansion counties: Baker, Clay and Nassau. The 11 HMOs offering customized benefit packages for TANF and SSI targeted populations are AMERIGROUP Florida, HealthEase Health Plan of Florida, Humana Medical Plan, Wellcare of Florida d/b/a Staywell Health Plan of Florida, Preferred Medical Plan, Vista Health Plan of South Florida, Vista Health Plan d/b/a Buena Vista Healthplan, Total Health Choice, Universal United Healthcare of Florida and Freedom Health plan. The 6 FFS PSNs are First Coast Advantage, Access, Pediatric Associates, Children's Medical Services, Florida Net Pass and South Florida Community Care Network.

One of the significant changes in this year's benefit packages is the reduction in cost sharing. Many plans choose to distinguish themselves with the addition of services not currently covered by Medicaid. In the contract, these are referred to as expanded services. There are 11 different expanded benefits offered by Reform health plans this contract year. The two most popular expanded services offered were the same as last year's, the over-the-counter (OTC) drug benefits and adult preventative dental benefits. Four of the customized benefit packages expanded their OTC value from $10 to $25, while another 4 added a $25 OTC benefit. The expanded services available to beneficiaries include:

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for 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).

The Agency is in the process of reviewing utilization and other data to establish options for allowing more customization and more flexibility in the next operational years. Since the Reform health plans can manage health care of their enrollees through utilization management and case management expertise, plans can use 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 by under state plan services.

The Agency's goal is to make the most of this expertise by providing a variety of options and increasing variation in the options over the five year period of the demonstration project. During this quarter, Agency staff planned and scheduled focus groups to discuss benefits with beneficiaries and providers. In combination with beneficiary choice data, the Agency will use the information we learn in these sessions and the plan customized benefit packages to gauge the needs and preferences of beneficiaries. This experience and knowledge will ultimately benefit the beneficiaries by establishing a

health care system with better opportunities for participating in health care choices and increasing personal engagement.

3. Grievance Process

Overview

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

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

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

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

Current Activities

During the quarter, there were no formal grievances reported by HMOs. There were 5 total grievances reported by 1 PSN. Enrollees filed 4 of the grievances and a provider filed 1 grievance. Of the 5 grievances, 3 involved access issues in which all 3 resulted in appointments with primary care physicians being made. Of the additional 2 grievances; 1 involved billing in which the bill was paid by the plan and 1 involved requested services not covered by the plan. The grievances reported this quarter were resolved on average in 14 days, with the shortest time to resolution in 4 days and the longest 37 days.

During the quarter there were 4 total appeals reported by 1 PSN. All 4 appeals were filed by enrollees, with all 4 related to services requested not covered by the plan. Three of the appeals confirmed the plan's original decision, and 1 did not and was resolved in favor the enrollee. Of the appeals, the average time to resolution was 8 days, with the shortest 5 days and the longest 13 days to resolution.

During the quarter, health plan enrollees located in Broward County requested 4 Medicaid Fair Hearings: 1 PSN and 3 HMO. Two of the requests related to HMOs were withdrawn and the other is pending a hearing date. The hearing related to the PSN affirmed the Agency's action. Health plan enrollees located in Duval, Baker, Clay or Nassau Counties requested no Fair Hearings during this quarter.

The Agency's Medicaid Area Office staff worked diligently to resolve beneficiary and provider complaints/issues related to Medicaid Reform health plans. The Medicaid Area Office staff was able to identify and resolve plan related complaints/issues timely and with positive outcomes for enrollees. Additionally, the different Agency bureaus that are responsible for the implementation of the demonstration waiver have worked closely with Medicaid Area Office staff, health plans and providers to resolve complaints and issues prior to the issues moving to the formal grievance process. Greater detail of the Agency's efforts regarding complaint/issue resolution process is provided below. The Agency continues to monitor the appeal and grievance process and reporting.

4. Complaint/Issue Resolution Process

During the quarter, the Agency finalized the implementation of the single database for reporting on health plan complaints/issues. Cross training was completed with the area offices and Agency headquarters staff. The consolidated complaint database with the new automatic referral process began October 1, 2007. The consolidated complaint database will allow the Agency to create reports for trending and analysis.

This quarter, the Agency received 8 complaints/issues related to FFS PSNs and 12 complaints/issues received related to HMOs, for a total of 20 complaints (though one of the PSN complaints was determined to be not related to a health plan or to the demonstration). The complaints/issues received during this quarter are provided below in Table 3 and 4, sorted by PSN or HMO. Table 3 provides the details on the complaints/issues related to FFS PSNs and outlines the action that was taken by the Agency or the Agency's Fiscal Agent, ACS, to address the issues raised. Table 4 provides the details on complaints/issues related to the HMOs and outlines the action taken by the Agency to address those issues raised. This quarter is the last quarter under the old, separate, complaint systems. Beginning October 1, 2007, all health plan complaints will be housed under the consolidated complaint database.

Table 3 PSN Complaints/Issues	
PSN Informal Issue	**Action Taken**
1. Provider issue regarding multiple PSNs' lack of timely claims payment (031)	The Agency's HQ staff contacted each PSN and followed up with provider. The Agency's HQ staff and PSNs educated provider on how to properly reconcile payments received and fully complete claim forms. Another PSN found an isolated key-stroke error and corrected the claim.
2. Provider issue regarding PSN lack of timely claims payment (032)	The Agency's HQ staff contacted PSN and followed up with provider. Issue with PSN's Third Party Administrator (TPA) being correctly linked in the Florida Medicaid system. Customer service request to establish the link was installed incorrectly twice. Additionally, the TPA submitted faulty electronic files. PSN cut provider a check to pay for the claims while they sorted out their electronic filing capabilities.
3. Provider issue regarding PSN lack of timely claims payment (033)	The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Contract Management staff. PSN was submitting TPA claims incorrectly, but corrected their process. Provider educated on claims processing timelines.
4. Provider issue regarding PSN lack of timely claims payment (034)	The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Initially, provider educated on how to properly complete claim forms. Subsequently, there is an issue with PSN's TPA being correctly linked in the Florida Medicaid system. Customer service request to establish the link was installed incorrectly twice. Additionally, the TPA submitted faulty electronic files. PSN cut provider a check to pay for the claims while they sorted out the electronic filing capabilities.
5. Provider issue regarding Medicaid policy related to durable medical equipment (035)	Determined not to be a Medicaid Reform demonstration issue nor a health plan issue. This was an issue between a Medicaid fee-for-service provider and receiving payment on a matter unrelated to the demonstration.
6. Provider issue regarding PSN claim errors (036)	The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider educated on how to properly complete claim forms.
7. Provider issue regarding PSN lack of timely claims payment (037)	The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider educated on how to properly complete claim forms.
8. Provider issue regarding PSN electronic file composition (038)	The Agency's HQ staff facilitated review with PSN and followed up with provider. Not a Reform issue. Provider requesting enhancement to the PSN's claims system. The PSN agreed to consider the provider's request.

This quarter, PSN complaints/issues were mostly isolated provider claims issues. The Agency is tracking complaints by plan and is reviewing particular complaint data with the individual plans as trends become apparent. During this quarter, 2 PSNs were sanctioned for claims processing issues. The Agency continued to facilitate conference calls between the providers and the PSNs to ensure providers were appropriately informed regarding claims processing requirements and health plans were processing claims appropriately. No PSN beneficiary complaints were received at the Agency.

Table 4 provides the details on the complaints/issues related to HMOs and outlines the action that was taken by the Agency to address the complaints/issues raised.

Table 4 HMO Complaints/Issues	
Medicaid Informal Issue	Action Taken
1. Claim was denied because child was not added in FMMIS. (7183-03)	Child was added to and claims forwarded for reprocessing.
2. Member being denied 2nd chemo treatment and medications. (7184-03)	Member's chemotherapy was authorized and the member has been informed. Also, contacted Dr.'s office to obtain a Drug Evaluation Review form to expedite approval.
3. Member is having difficulty obtaining medication. Plan would only authorize up to nine prescriptions and she has fourteen. (7199-02)	The plan placed an over-ride in the system so that the member could obtain the fourteen prescriptions. The member has not been denied the medication unless she tries to refill them too soon. Member was sent a member handbook and instructions on the appeals and fair hearing process.
4. Capitation fee was paid on 2/28/2007 for member, but was not showing coverage for March 2007 in the system. (7207-03)	Eligibility has been updated and claims were adjusted to pay.
5. Member having trouble obtaining DME supplies. (7211-01)	Site Manager Nurse contacted member's physician and received the auth specifics, an authorization has been granted to that vendor, as provider refused to use plan approved vendor. The authorization is effective 07-30-07 thru 08-01-08.
6. Dispute between plan and provider regarding services provided. Member coverage was active during date in question. (7212-02)	Claims adjusted to pay on 08/08/07. The Agency's Medicaid Area 4 Office was informed that claims were approved for payment.
7. Claims dispute between provider and plan during Month of February 2007, recipient was covered at time of service. (7212-04)	Claims adjusted to pay. Provider notified by customer service.
8. Member was denied medications after receiving prior authorization from PCP. (7226-06)	Member filled prescription needed on 7/31/2007.
9. Member needs assistance with cost of dental procedures. (7241-01)	Reviewed Dental Benefits to find that member was eligible to receive assistance. Member was contacted with information.
10. Member in need of transportation services. (7250-01)	Member was contacted and advised to contact Choice Counseling to make another choice of HMO carrier for his Medicaid Reform since he can't have coverage with Vista for both his Medicaid and Medicare coverage. Member was also given the contact information for the approved Transportation provider to make arrangements.

Table 4 HMO Complaints/Issues	
Medicaid Informal Issue	Action Taken
11. Member having trouble obtaining DME supplies. (7211-01)	Site Manager Nurse contacted member's physician and received the auth specifics, an authorization has been granted to that vendor, as provider refused to use plan approved vendor. The authorization is effective 07-30-07 thru 08-01-08.
12. Dispute between plan and provider regarding services provided. Member coverage was active during date in question. (7212-02)	Claims adjusted to pay on 08/08/07. The Agency's Medicaid Area 4 Office was informed that claims were approved for payment.
13. Claims dispute between provider and plan during Month of February 2007, recipient was covered at time of service. (7212-04)	Claims adjusted to pay. Provider notified by customer service.
14. Member was denied medications after receiving prior authorization from PCP. (7226-06)	Member filled prescription needed on 7/31/2007.
15. Member needs assistance with cost of dental procedures. (7241-01)	Reviewed Dental Benefits to find that member was eligible to receive assistance. Member was contacted with information.
16. Member in need of transportation services. (7250-01)	Member was contacted and advised to contact Choice Counseling to make another choice of HMO carrier for his Medicaid Reform since he can't have coverage with Vista for both his Medicaid and Medicare coverage. Member was also given Logisicare Transportation to make arrangements.
17. Member has been trying to get a dentist for her children for the past year and her phone calls are not being returned. (7253-02)	Member was contacted with a dentist for her four children. The dentist's office has been contacted to confirm availability of appointments for all four children.
18. Medicaid provider is not being paid. (7267-01)	Pharmacy called the vendor and confirmed that the claims had been paid. One claim was not processed due to previous paid claims. Provider was contacted with explanation.

During the quarter, the majority of the HMO complaints/issues were related to provider payment issues. Other issues included dental, medications, durable medical equipment, eligibility confirmation and transportation. All issues except one have been closed and resolved to the beneficiary or provider's satisfaction.

The Agency's staff worked directly with the members and with the HMOs to resolve issues. Education was provided to members and to providers to assist them in obtaining the requested information/service and for future use. The HMOs were informed of all the member issues, and in most cases, the HMOs were instrumental in

obtaining the information or service. The Agency staff continues to monitor the HMOs for contractual compliance and plan performance.

Outreach Activities

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

B. Choice Counseling Program

Overview

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

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

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

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

over the course of the first year. These changes resulted in over 30 percent of the enrollments being done at the local level.

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

Current Activities

1. Public Meetings and Beneficiary Feedback

Prior to the implementation of Medicaid Reform and during the first year of operations, the Agency conducted several beneficiary focus groups and held public meetings in Broward and Duval counties to solicit input on the choice counseling program. As a result of the feedback from beneficiary focus groups and public meetings, several changes were instituted in the choice counseling program, including a re-write of the choice counseling script, re-design of the comparison charts, creation of a special needs unit and more.

While the focus groups and the public meetings provided excellent feedback, the Agency was concerned that the number of beneficiaries reached through these efforts was very low. The highest attendance at any one focus group was 10 beneficiaries and only a total of slightly over 50 beneficiaries were reached through all focus group opportunities. In addition, the number of beneficiaries attending other meetings attended by the Agency also was low. This low number does not allow the information shared by the beneficiaries to be generalized across the reform population and may not allow for identification of areas of beneficiary concern.

To address this issue, in August 2007, Affiliated Computer Services (ACS), the Agency's choice counseling vendor, implemented an automated beneficiary survey function in the call center. Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The survey questions are broken down into 5 main categories:

- Satisfaction or concerns with the Medicaid program as a whole;
- How helpful the choice counseling program is in assisting with making a health plan choice;
- Rating of the amount of time the beneficiary must hold before talking with an counselor;
- How easy the information is to understand; and
- Rating of the customer service provided by the counselor, including confidence in the information provided.

Attachment I provides the survey questions and the survey results for each question for August and September 2007.

During the months of August and September 2007, over 1,185 beneficiaries completed the automated survey. Initial feedback from the survey has been very positive. The questions in the survey that relate to Choice Counselor performance are rolled-up into 6 categories. The following highlights how beneficiaries scored Choice Counselors in these six areas. The scoring range is 1 to 9 with 1 being the lowest score and 9 being the highest.

Counselor Satisfaction:	8.791
Quickly Understood:	8.771
Choose Plan:	8.682
Explain Clearly:	8.745
Confidence:	8.702
Respect:	8.865

Even though the initial feedback has been very positive by the beneficiaries, the Agency and ACS are evaluating the responses on the materials. The overall ranking of the materials is high (over 77% gave a ranking of 8 or 9) but a further analysis revealed more fluctuation in the response range for these questions compared to other questions. As a result, the Agency and ACS are reviewing the materials and working on possible revisions. Any considered changes will be vetted in public meetings and beneficiary focus groups as done previously.

2. Call Center

During the first quarter, the Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida, operate 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. While the hours of operation for the call center remained 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with over 30 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls, the Agency and ACS began preparing for implementing a change to the call center hours.

At the end of the first year of operations for the call center, the volume of inbound calls during the Saturday hours of operation remained very low. Over the first 12 months, the highest call volume day for a Saturday was 132 calls compared to a high during the traditional business week of 1,544 calls. The average number of calls on Saturday was 48 over the first year. In addition, the number of successful outbound calls completed during the Saturday hours also was very low prompting the Agency and ACS to consider if having the call center open for additional hours during the traditional work week may better serve the needs of beneficiaries.

An analysis of call volumes during the last hour of operation during the Monday – Friday hours was completed and ACS is preparing to adjust the hours beginning November 1, 2007, to one additional hour during the evening on Monday and Thursday and adjusting

the Saturday hours to 9:00 a.m. – 11:00 a.m. This pilot will operate for one month. The outcome will be evaluated before any permanent change is made to call center hours.

The Choice Counseling call center also began assisting beneficiaries in Baker, Clay and Nassau counties with enrolling in Medicaid Reform health plans. In July 2007, the first set of letters were sent to current beneficiaries who need to transition to a Reform health plan. The transition continued through this quarter.

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 Reform health plan choice and have not yet contacted Choice Counseling.

Attachment II details the call center activity for this quarter. The following is a highlight of the call volume during the quarter and ACS's performance on key contract standards:

Inbound Calls:	41,930
Outbound Calls:	11,431
Calls Abandoned: *(The contract standard is* <5% *monthly)*	2%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call Answered in <15 seconds:	77.04%
Calls Answered in <60 seconds:	86.61%
Calls Answered in <180 Seconds:	96.37%

3. Mail

The volume of activity in the mailroom increased during this quarter due to the transition packets for Baker, Clay and Nassau counties and the beginning of open enrollment mailings to beneficiaries who are now in their once a year timeframe to change plans.

Outbound Mail

At the end of the quarter, the ACS mailroom had mailed the following:

New-Eligible Packets	20,177
Auto-Assignment Letters	12,172
Confirmation Letters	10,411
Open Enrollment Packets	31,788
Transition Packets	5,734

During the quarter, the percentage of mail that is returned averaged 4 percent per month. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary.

Inbound Mail:

At the end of the quarter, ACS had processed the following through inbound mail:

Plan Enrollments	971
Plan Changes	477

The percentage of enrollments processed through the mail-in enrollment forms has consistently remained around 5% of enrollments during the first year. This quarter did not see any significant change in the percentage of mail-in enrollments. The Agency and ACS are exploring options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program to better serve beneficiaries if this option was discontinued.

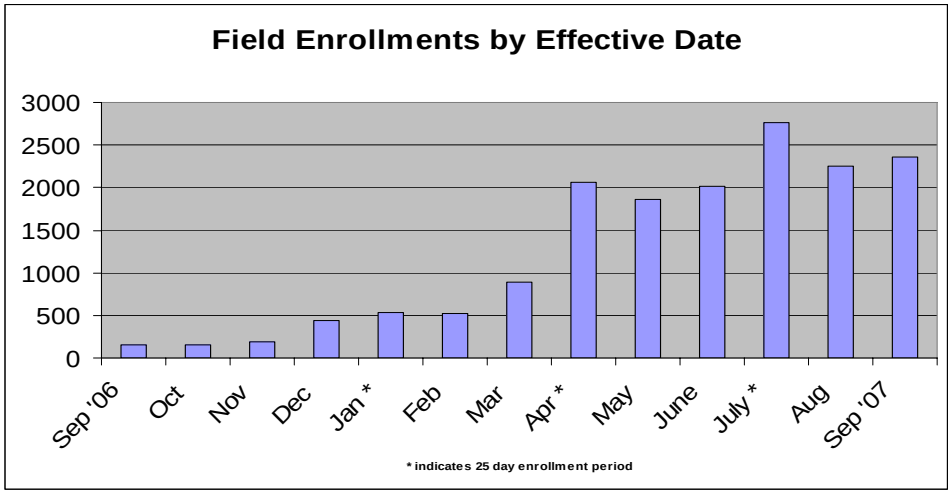
4. Face-to-Face/Outreach and Education

During the first year of operations, the field saw a significant increase in the number of enrollments completed by field Choice Counselors. During this quarter, the numbers for the field enrollments continue to increase. The numbers continue to demonstrate that the adjustments made in the field Choice Counseling activities during the first year continue to allow ACS to service “hard to reach” populations.

In addition to adding field activities for the expansion counties of Baker, Clay and Nassau, the other major change in the field Choice Counseling activities was the implementation of a beneficiary call back monitoring system. During the first year, the field Choice Counseling supervisors handled most of the field monitoring done by ACS. In September of 2007, the quality monitoring staff, located in Tallahassee, began calling at random beneficiaries who were served by field Choice Counselors. The monitors asked five questions to rate the customer service and accuracy of information provided by the field Choice Counselors.

At the end of the quarter, the enrollment activities processed by field Choice Counselors were 8,082 enrollment activities. This compares to the highest quarterly enrollment effort in the field during the first year of Medicaid Reform of 6,921. The Table 5 demonstrates the dramatic increases in the field Choice Counseling effort during the first year of Reform and this first quarter of Year Two:

Table 5
Total Field Enrollments by Month



Another focus of the field Choice Counselors was continuing to better reach the special needs and hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups has included providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities and other types of community based organizations that serve these population groups.

As the quarter was ending, ACS developed relationships with many community based organizations and providers in the expansion counties of Baker, Clay and Nassau. Due to the rural nature of especially Baker and Clay Counties, the Agency and ACS will closely monitor field efforts during the first few months of expansion to identify issues and change strategies if necessary to meet the needs of rural communities.

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

Group Sessions	851
Private Sessions	64
Home Visits & One-On-One Sessions	202
"No Phone List"	908
Outbound Phone List	11,274
Enrollments	8,082
Plan Changes	379

5. Health Literacy

During the quarter, the registered nurse in the Special Needs Unit resigned her position with ACS. The Special Needs Unit has primary responsibility for the health literacy function. ACS quickly identified other nurses within their company to handle the functions of the unit during the transitional time. Based on experience in year one of operations, the departure of the nurse provided an opportunity to evaluate the functions of the unit to ensure the goals of increasing health literacy and serving the needs of the medically and physically complex were being met. The evaluation was completed in the September 2007 and the Special Needs Unit will be staffed with one registered nurse supervisor, two licensed practical nurses and one social worker. Additional nurses in the field will be hired after this initial group has been hired and trained.

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

- Developing additional training for the Choice Counselors on working with and serving the medically, mentally or physically complex;
- Enhancing the scripts to educate beneficiaries on how to access care in a managed care environment;
- Designing tools that can be provided to beneficiaries on how to access care and other important facts in being a part of a managed care plan; and
- Developing reference guides to increase the choice counselors knowledge of Medicaid services.

The new script for the Special Needs Unit, implemented in the fourth quarter of Year One, continues to be evaluated to ensure it is meeting the following objectives:

- Increasing the expertise of the Choice Counselors in educating beneficiaries on how to pick a health plan.
- Assisting Medicaid beneficiaries in understanding what it means to be part of a managed care plan.
- Explaining what populations may enroll in a reform plan but are not required to enroll.
- Promoting the Enhanced Benefits Account Program to encourage both healthy behaviors and the beneficiaries spending the credits they earn.

6. Voluntary Selection Data

To ensure the effectiveness of the Choice Counseling Program, the Agency requires that a minimum of 65 percent of the new Medicaid eligibles make a voluntary Medicaid Reform health plan choice. At the end of Year Two of operation, this requirement increases to 80 percent.

During this quarter, the voluntary enrollment rate for Duval and Broward counties was 78.56 percent of all new eligibles. For Duval County, the rate was 73 percent and for Broward County the rate was 82 percent. The rate for Baker, Clay and Nassau counties

is not available as the first auto-assignment for the expansion counties will not occur until October 1, 2007.

ACS was above the contract standard of 65 percent for the quarter, but the Agency is especially pleased that the voluntary enrollment rate for each month of the quarter remained significantly above the 65 percent required by the contract and in fact, in two of the three months of the quarter, the voluntary enrollment rate was above 80 percent. A breakdown of the new-eligible enrollment figures for this quarter is provided in Table 6.

Table 6 New Eligible Voluntary Enrollment Rate **1st Quarter in Year 2**	
Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Broward County	
Voluntary Choice	10,041
Auto-Assigned	2,190
Duval County	
Voluntary Choice	5,691
Auto-Assigned	2,104
Voluntary Enrollment Rate:	
Broward and Duval Combined	78.56%
Broward only	82.09%
Duval only	73.00%

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. During this quarter, the Agency and ACS implemented an automated beneficiary survey where complaints against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call.

In this quarter, there were 16 complaints filed related to the Choice Counseling Program. Table 7 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 7 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	Action Taken
1. Beneficiary called to complain that a Choice Counselor provided the wrong open enrollment dates and her plan change needed to be processed due to medical needs.	➲ The counselor who took the original call that provided the open enrollment dates is no longer a Choice Counselor employee and the notes were incomplete. Due to the inability to verify the information, the beneficiary was allowed a good cause plan change due to the potential counselor error and also due to medical necessity.
2. Mother called to complain that her child has to enroll in a Medicaid Reform plan.	➲ Supervisor contacted the mother and discussed her concerns and also contacted the plan the child was enrolled in to provide extra assistance to the mother during the transition to a Reform plan.
3. Beneficiary complained that her pharmacy and primary care physician do not accept Reform plans.	➲ Choice Counselor worked with the Medicaid area office to determine what Reform health plans her pharmacy and primary care provider are affiliated with. Then a field Choice Counselor visited the beneficiary to complete an enrollment into the Reform plan that best met her needs.
4. Beneficiary was concerned that Medicaid Reform will change the benefits she receives. Also concerned that pharmacy and mental health providers do not participate in a Reform plan.	➲ Choice Counselor worked with the Medicaid area office to determine what Reform health plans her pharmacy and primary care provider are affiliated with. Then a field Choice Counselor visited the beneficiary to complete an enrollment into the plan that best met her needs.
5. Beneficiary complained that she can not keep her current health plan.	➲ Beneficiary can continue with her current health plan as her current plan is a Reform plan in her county of residence. A field Choice Counselor will contact the beneficiary to assist in her plan selection.
6. Provider submitted a concern on behalf of the beneficiary about her plan enrollment choices since the beneficiary is temporarily residing out of the county.	➲ Area Medicaid office and Choice Counselor worked together to exempt this beneficiary temporarily from enrolling in a Reform plan until she returns to a Reform county to reside.
7. Advocate expressed concern over the use of “Other” as a disenrollment reason by Choice Counselors.	➲ During the transition of beneficiaries, there was an oversight and a disenrollment reason for transition was not created. This resulted in all transition plan changes being coded as “Other.” An additional reason will be added if new transitions occur. ➲ To further address the issue, a policy is being developed by the Choice Counseling vendor that will require notes to be typed when a counselor selects the reason of “Other” to ensure appropriate use.

Table 7 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	Action Taken
8. Consumer organization complained that the plan's preferred drug list was not available through Choice Counseling.	➲ In the past several months, the Agency has intensified researching how the preferred drug list and additional valuable plan information can be made available through the Choice Counseling process. ➲ Over the next couple of months, the Agency's Choice Counseling unit will be holding public meetings in Broward and Duval counties on this issue. Proposals developed to address the concerns about the preferred drug lists and other benefits as part of the Choice Counseling process will be shared at these meetings.
9. Consumer organization inquired as to whether the services of the Special Needs unit were available to beneficiaries before they enrolled or selected a health plan.	➲ Confirmed that the Special Needs Unit was available to beneficiaries prior to plan selection or enrollment.
10. Complaint that a Choice Counselor completed a good cause plan change using the reason "plan leaving the county" which was not correct.	➲ Counselor was coached and put on increased monitoring as the wrong good cause reason was selected for the beneficiary. The plan was not leaving the county. Beneficiary was contacted and provided the correct information.
11. Complaint that a good cause plan change was processed incorrectly for a beneficiary. The reason selected was GC 18 which is a reduction in benefits.	➲ The plan the beneficiary was enrolled in did not have a decrease in benefits. The beneficiary was contacted and provided the correct information and the Choice Counselor was coached and put on increased monitoring.
12. Consumer group complained that Choice Counselors are ending the call when a special needs beneficiary can not pass the verification process and for not providing additional assistance.	➲ Two Choice Counselors involved were coached and put in refresher training. A new caller verification process was developed to better assist call center counselors in these situations. In addition, the call center staff was refreshed on utilizing field counselors and the special needs unit when difficult situations arise on the phone as these staff provide additional support that is often necessary for these groups.
13. Complaint that a Choice Counselor referred a beneficiary incorrectly to the area office.	➲ Choice Counselor did incorrectly refer a beneficiary with a provider change request to the area office instead of to the plan. Counselor was coached.
14. Consumer group complained that voluntary populations were erroneously being enrolled in reform plans.	➲ The Choice Counseling script was modified, per the group's request to include questions related to developmental disabilities. The script also specifically mentions foster care children, dual eligibles and pregnant women to assist the Choice Counselor in identifying the few individuals who may be coded incorrectly in the system and handle their enrollment and disenrollment requests appropriately. ➲ The few people inadvertently included in mandatory assignment were disenrolled as soon as they contacted Choice Counseling.

Table 7 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	Action Taken
15. Consumer group indicated that there were no policies or procedures for the good cause change process or to identify beneficiaries exempt/excluded Reform enrollment.	➲ Provided samples of policies and procedures and the call center script that specifically apply to these population groups and explained the process for these types of activities.
16. Consumer group complained about the lack of plan performance data available to beneficiaries making a plan choice.	➲ The Agency is in the process of collecting plan performance data. This data will be reported by the plans and by other independent evaluators in the second year of Reform operations and will be made available to beneficiaries and other stakeholders as the information is finalized

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves public meetings, beneficiary focus groups and the new automated survey previously mentioned in this report. The focus groups allow the Agency to hear from beneficiaries on the successes, complaints, as well as ideas for improvement of the Choice Counseling Program. Another important aspect is feedback that is received during the public meetings from the advocates, providers, plans and others who work with and represent beneficiaries.

The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries by striving to perfect all areas. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results indicate that in August 2007 92 percent of beneficiaries were delighted with the Counselor's ability to explain things clearly. In September 2007, the percentage of delighted callers increased to 96 percent. ACS continues to focus on improving communication between Counselors and beneficiaries and expects the score to increase.

While focusing on explaining things more clearly, the beneficiary's confidence in the information given to them by the Choice Counselor will also increase. As you can see in Table 8 below, on average Counselors earned a rating of 8.628 in August 2007. In September 2007, the score improved by 1.7% to 8.776.

ACS distributes individual report cards to each Choice Counselor. Survey scores and beneficiary comments are provided to Supervisors and Counselors. The positive comments encourage Choice Counselor to keep up the good work and the negative comments help to point out possible weaknesses requiring coaching or training.

Table 8
Confidence in Information Provided by Counselors

CONFIDENCE	
AUG AVERAGE	8.628
SEPT AVERAGE	8.776
AUG-SEPT AVERAGE	8.702
POINTCHANGE	0.1487
PERCENT INCREASE	1.72%

In addition to external feedback, ACS has implemented an employee feedback email system that allows call center Choice Counselors and field Choice Counselors to provide immediate comments on issues or barriers that they encounter as part of their daily work. It may be hard at the end of a shift to remember the issues they encountered and this anonymous email box allows them to send information that is reviewed by management and shared with the Agency.

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

C. Enrollment Data

Overview

During Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population in the demonstration areas of Broward and Duval Counties into Reform health plans over a period of seven months. The transition period for Broward and Duval Counties started in September of 2006 and ended in April of 2007. The transition plan staggered the enrollment of beneficiaries enrolled in various managed care programs operated under Florida's 1915(b) Managed Care Waiver into a Reform health plan. The types of managed care programs that these beneficiaries transitioned from include Health Maintenance Organizations (HMOs), MediPass, Pediatric Emergency Room Diversion Program, 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. Specifically, the Agency followed the transition schedule outlined below:

- **Non-committed MediPass:** Phased in over 7 months (1/2 in Month 1, then 1/6th 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 and half of the MediPass population who were required to transition to a Reform health plan. Beneficiaries were given 30 days to select a plan. If the beneficiary did not choose a plan the Choice Counselor assigned them to a plan. 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 beneficiaries were transitioned into the demonstration.

Current Activities

Transition Plan for Baker, Clay and Nassau Counties

The Agency also developed a transition plan for the enrollment of the existing Medicaid managed care population located in the demonstration areas of Baker, Clay, and Nassau Counties into Medicaid Reform health plans. Due to smaller population located in these counties, the transition plan will occur over a four month period which began September of 2007 and is scheduled to end January of 2008. This process was implemented to stagger the enrollment of beneficiaries enrolled in various managed care programs operated under Florida's 1915(b) Managed Care Waiver into a Medicaid

Reform health plan including HMOs, MediPass, and MPNs. The transition schedule for this demonstration area is as follows:

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

October 2007: Remaining beneficiaries located in Baker and Nassau Counties.

November 2007: Remaining beneficiaries located in Clay County.

December 2007: Clean up period to transition any remaining beneficiaries located in Baker, Clay, and Nassau Counties.

During this quarter, enrollment in Medicaid Reform health plans located in Baker, Clay, and Nassau counties was based on this transitional process. Specifically, the September 2007 transition focused on enrollment of all non-committed MediPass beneficiaries into a Reform health plan. Beneficiaries are given 30 days to select a plan. If the beneficiary does not choose a plan, then the Choice Counselor will assign them to a plan. The earliest date of enrollment in a Baker, Clay, or Nassau county Reform health plan was September 1, 2007. The next phases of the transition plan for beneficiaries located in these counties will take place during the next quarter of operation beginning October 1, 2007 and ending December 31, 2007.

Monthly Enrollment Reports

The Agency provides a monthly enrollment report for all Medicaid Reform health plans. This monthly enrollment data is available on the Agency's website at the following URL:

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

Below is a summary of the monthly enrollment in Medicaid Reform for this quarter beginning July 1, 2007 and ending September 30, 2007. This section contains the following Medicaid Reform enrollment reports:

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

All Medicaid Reform health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 16 Medicaid Reform health plans – ten HMOs and six FFS PSNs. There are two categories of Medicaid beneficiaries who are enrolled in Reform 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 this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

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

Table 9
Medicaid Reform 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)
# 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 addition 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 Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 10 on the following page for the State Fiscal Year 2007-08, 1st Quarter – Year Two Medicaid Reform Enrollment Report.

Table 10
Medicaid Reform Enrollment Report
(July 1, 2007 through September 30, 2007)

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	10,645	1,366	3	103	**12,117**	**6.14%**	11,365	6.62%
Buena Vista	HMO	6,216	692	1	51	**6,960**	**3.53%**	6,883	1.12%
HealthEase	HMO	49,837	5,667	3	465	**55,972**	**28.35%**	56,302	-0.59%
Humana	HMO	8,828	2,009	3	176	**11,016**	**5.58%**	11,221	-1.83%
Preferred Medical Plan	HMO	1,626	485	0	36	**2,147**	**1.09%**	2,254	-4.75%
StayWell	HMO	30,006	2,936	1	279	**33,222**	**16.83%**	31,194	6.50%
Total Health Choice	HMO	1,240	278	0	28	**1,546**	**0.78%**	1,536	0.65%
United Health Care	HMO	14,600	2,116	4	272	**16,992**	**8.61%**	15,016	13.16%
Universal Health Care	HMO	221	30	0	1	**252**	**0.13%**	355	-29.01%
Vista South Florida	HMO	3,143	360	3	46	**3,552**	**1.80%**	3,282	8.23%
HMO Total		**126,362**	**15,939**	**18**	**1,457**	**143,776**	**72.82%**	**139,408**	**3.13%**
Access Health Solutions	PSN	9,151	2,181	3	101	**11,436**	**5.79%**	12,121	-5.65%
CMS	PSN	1,449	2,023	0	10	**3,482**	**1.76%**	3,311	5.16%
First Coast Advantage	PSN	12,734	3,542	3	200	**16,479**	**8.35%**	16,416	0.38%
NetPass	PSN	3,238	1,505	0	98	**4,841**	**2.45%**	5,352	-9.55%
Pediatric Associates	PSN	9,703	572	0	1	**10,276**	**5.20%**	11,233	-8.52%
SFCCN	PSN	4,768	2,248	1	133	**7,150**	**3.62%**	7,761	-7.87%
PSN Total		**41,043**	**12,071**	**7**	**543**	**53,664**	**27.18%**	**56,194**	**-4.50%**
Reform Enrollment Totals		**167,405**	**28,010**	**25**	**2,000**	**197,440**	**100.00%**	**195,602**	**0.94%**

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 this quarter reflect those beneficiaries who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 197,440 beneficiaries enrolled in Medicaid Reform during this quarter. There were 16 Reform plans with market shares ranging from 0.13 percent to 28.35 percent.

2. Medicaid Reform Enrollment by County Report

Medicaid Reform is currently operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of Reform HMOs and Reform PSNs in each county is listed in Table 11 on the following page.

Table 11
Number of Reform Health Plans in Demonstration Counties

County Name	# of Reform HMOs	# of Reform PSNs
Baker	**1**	**1**
Broward	**10***	**6***
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

Note: There are two CMS Reform PSNs in Broward County – CMS (North Broward) and CMS (South Broward). Freedom Health Plan was approved for Broward County but is not counted as enrollment did not occur during this quarter.

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Medicaid Reform counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, Reform HMOs are listed first, followed by Reform PSNs. Table 12 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 12
Medicaid Reform Enrollment by County Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# 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 Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 13 and located on the following page.

Table 13
Medicaid Reform Enrollment by County Report
(July 1, 2007 through September 30, 2007)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
United Health Care	HMO	Baker	69	13	0	2	**84**	**55.63%**	0	N/A
Access Health Solutions	PSN	Baker	53	14	0	0	**67**	**44.37%**	0	N/A
Total Reform Enrollment for Baker			**122**	**27**	**0**	**2**	**151**	**100.00%**	**0**	**N/A**
Amerigroup	HMO	Broward	10,645	1,366	3	103	**12,117**	**10.18%**	11,365	6.62%
Buena Vista	HMO	Broward	6,216	692	1	51	**6,960**	**5.85%**	6,883	1.12%
HealthEase	HMO	Broward	14,560	1,540	3	127	**16,230**	**13.63%**	15,789	2.79%
Humana	HMO	Broward	8,828	2,009	3	176	**11,016**	**9.25%**	11,221	-1.83%
Preferred Medical Plan	HMO	Broward	1,626	485	0	36	**2,147**	**1.80%**	2,254	-4.75%
StayWell	HMO	Broward	27,251	2,604	1	228	**30,084**	**25.27%**	28,451	5.74%
Total Health Choice	HMO	Broward	1,240	278	0	28	**1,546**	**1.30%**	1,536	0.65%
United Health Care	HMO	Broward	5,889	1,015	3	149	**7,056**	**5.93%**	6,348	11.15%
Universal Health Care	HMO	Broward	91	20	0	0	**111**	**0.09%**	159	-30.19%
Vista South Florida	HMO	Broward	3,143	360	3	46	**3,552**	**2.98%**	3,282	8.23%
Access Health Solutions	PSN	Broward	2,822	961	2	45	**3,830**	**3.22%**	4,455	-14.03%
CMS North Broward	PSN	Broward	592	993	0	6	**1,591**	**1.34%**	1,560	1.99%
CMS South Broward	PSN	Broward	206	324	0	2	**532**	**0.45%**	524	1.53%
Netpass	PSN	Broward	3,238	1,505	0	98	**4,841**	**4.07%**	5,352	-9.55%
Pediatric Associates	PSN	Broward	9,703	572	0	1	**10,276**	**8.63%**	11,233	-8.52%
SFCCN	PSN	Broward	4,768	2,248	1	133	**7,150**	**6.01%**	7,761	-7.87%
Total Reform Enrollment for Broward			**100,818**	**16,972**	**20**	**1,229**	**119,039**	**100.00%**	**118,173**	**0.73%**
United Health Care	HMO	Clay	449	58	0	3	**510**	**57.11%**	0	N/A
Access Health Solutions	PSN	Clay	323	60	0	0	**383**	**42.89%**	0	N/A
Total Reform Enrollment for Clay			**772**	**118**	**0**	**3**	**893**	**100.00%**	**0**	**N/A**
HealthEase	HMO	Duval	35,277	4,127	0	338	**39,742**	**51.58%**	40,513	-1.90%
StayWell	HMO	Duval	2,755	332	0	51	**3,138**	**4.07%**	2,743	14.40%
United Health Care	HMO	Duval	8,078	992	1	114	**9,185**	**11.92%**	8,668	5.96%
Universal Health Care	HMO	Duval	130	10	0	1	**141**	**0.18%**	196	-28.06%
Access Health Solutions	PSN	Duval	5,817	1,125	1	56	**6,999**	**9.08%**	7,666	-8.70%
CMS	PSN	Duval	651	706	0	2	**1,359**	**1.76%**	1,227	N/A
First Coast Advantage	PSN	Duval	12,734	3,542	3	200	**16,479**	**21.39%**	16,416	0.38%
Total Reform Enrollment for Duval			**65,442**	**10,834**	**5**	**762**	**77,043**	**100.00%**	**77,429**	**-0.50%**
United Health Care	HMO	Nassau	115	38	0	4	**157**	**50.00%**	0	N/A
Access Health Solutions	PSN	Nassau	136	21	0	0	**157**	**50.00%**	0	N/A
Total Reform Enrollment for Nassau			**251**	**59**	**0**	**4**	**314**	**100.00%**	**0**	**N/A**
Reform Enrollment Totals			**167,405**	**28,010**	**25**	**2,000**	**197,440**		**195,602**	**0.94%**

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 the primary care provider. The unique beneficiary counts are separated by the counties the plans operate in.

During this quarter, there was an enrollment of 151 beneficiaries in Baker County, 119,039 beneficiaries in Broward County, 893 beneficiaries in Clay County, 77,043 beneficiaries in Duval County, and 314 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 44.37 percent to 55.63 percent, 16 Broward County Reform plans with market shares ranging from 0.09 percent to 25.27 percent, two Clay County Reform plans with market shares ranging from 42.89 percent to 57.11 percent, seven Duval County Reform plans with market shares ranging from 0.18 percent to 51.58 percent, and two Nassau County Reform plans with market shares of 50.00 percent each.

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

The Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either voluntarily or mandatorily) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 14 provides a description of each column in this report.

Table 14
Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data Descripitons

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)
# Voluntary Enrolled	The number of unique beneficiaries who voluntarily enrolled with the plan during the current reporting quarter
# Mandatory Enrolled	The number of unique beneficiaries who were mandatorily enrolled with the plan during the current reporting quarter
Total # Enrolled	The total number of unique beneficiaries enrolled with the plan during the current reporting quarter; voluntary and mandatory combined
% Enrolled Voluntary	The percentage of the total number of beneficiaries enrolled with the plan during the current reporting quarter who were enrolled voluntarily
# Disenrolled	The number of unique beneficiaries who disenrolled from the plan during the current reporting quarter

There are two primary classes of Medicaid beneficiaries reported: those who have enrolled in Medicaid Reform and those who have disenrolled from the program during the current reporting quarter.

A. Medicaid Reform Enrollees

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

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the current reporting quarter but then left the program. The count is performed by comparing two beneficiary lists: one for the current reporting quarter and one for the first month after the current reporting quarter. If a beneficiary appears on the current reporting quarter enrollment list but not on the enrollment list for the first month following the current reporting quarter, the beneficiary is counted as disenrolled. For example, disenrollments for the first quarter of state fiscal year 2007-08 are those beneficiaries who appear on the enrollment list for July 2007 to September 2007, but not on the enrollment list for October 2007.

The unique beneficiary counts in the Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report are divided by plan type in Table 15. Plans are listed by plan type (Reform HMO first, then Reform PSN) and in alphabetical order. Total counts for the quarter are also provided for HMOs and PSNs as well as the entire Medicaid Reform demonstration.

Table 15
Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data
(State Fiscal Year 2007-08, 1st Quarter – Demonstration Year 2)

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	11,125	992	**12,117**	**91.81%**	1,783
Buena Vista	HMO	Broward	6,454	506	**6,960**	**92.73%**	1,146
HealthEase	HMO	Broward	15,183	1,047	**16,230**	**93.55%**	2,251
HealthEase	HMO	Duval	38,233	1,509	**39,742**	**96.20%**	6,582
Humana	HMO	Broward	10,207	809	**11,016**	**92.66%**	1,649
Preferred Medical Plan	HMO	Broward	1,551	596	**2,147**	**72.24%**	395
StayWell	HMO	Broward	28,610	1,474	**30,084**	**95.10%**	4,019
StayWell	HMO	Duval	2,285	853	**3,138**	**72.82%**	624
Total Health Choice	HMO	Broward	909	637	**1,546**	**58.80%**	320
United Health Care	HMO	Baker	84	0	**84**	**100.00%**	5
United Health Care	HMO	Clay	6,320	736	**7,056**	**89.57%**	1,222
United Health Care	HMO	Broward	510	0	**510**	**100.00%**	39
United Health Care	HMO	Duval	8,074	1,111	**9,185**	**87.90%**	1,796
United Health Care	HMO	Nassau	157	0	**157**	**100.00%**	5
Universal Health Care	HMO	Broward	62	49	**111**	**55.86%**	27
Universal Health Care	HMO	Duval	25	116	**141**	**17.73%**	35
Vista South Florida	HMO	Broward	3,162	390	**3,552**	**89.02%**	507
HMO Total			**132,951**	**10,825**	**143,776**	**92.47%**	**22,405**
Access Health Solutions	PSN	Baker	67	0	**67**	**100.00%**	0
Access Health Solutions	PSN	Clay	3,302	528	**3,830**	**86.21%**	616
Access Health Solutions	PSN	Broward	383	0	**383**	**100.00%**	23
Access Health Solutions	PSN	Duval	5,534	1,465	**6,999**	**79.07%**	1,283
Access Health Solutions	PSN	Nassau	157	0	**157**	**100.00%**	6
CMS North Broward	PSN	Broward	1,359	0	**1,359**	**100.00%**	122
CMS South Broward	PSN	Broward	1,590	1	**1,591**	**99.94%**	114
CMS	PSN	Duval	532	0	**532**	**100.00%**	46
First Coast Advantage	PSN	Duval	14,795	1,684	**16,479**	**89.78%**	2,235
Netpass	PSN	Broward	4,254	587	**4,841**	**87.87%**	715
Pediatric Associates	PSN	Broward	9,810	466	**10,276**	**95.47%**	1,671
SFCCN	PSN	Broward	6,042	1,108	**7,150**	**84.50%**	1,052
PSN Total			**47,825**	**5,839**	**53,664**	**89.12%**	**7,883**
Reform Enrollment Totals			**180,776**	**16,664**	**197,440**	**91.56%**	**30,288**

For this quarter, there were 180,776 voluntary enrollments (91.56 percent) in Medicaid Reform. Of those, 132,951 beneficiaries were enrolled in an HMO and 47,825 were enrolled in a PSN.

D. Opt Out Program

Overview

In January 2006, the Agency began developing a process to ensure all beneficiaries who have access to employer sponsored insurance (ESI) are provided the opportunity to opt out of Medicaid and select an ESI plan. The Agency decided to contract with Health Management Systems, Inc.(HMS), the current third party liability contractor, to administer the Opt Out program. HMS submitted its proposal on March 31, 2006. The proposal provided a complete description of the Opt Out Program work flow which included the 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 in the pilot counties. A letter to employers and summary of the Opt Out process was developed and finalized in June 2006. The Agency mailed letters to major employers in the pilot counties beginning in June 2006, notifying them of the Medicaid Reform Opt Out Program and providing them a summary of the Opt Out process. The Agency has conducted nine conference calls with several large employers to answer questions and request they accept premiums on behalf of Opt Out enrollees.

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

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

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

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

Letter that confirms the beneficiary is enrolled in the Opt Out Program. HMS then begins to process the premiums according to the required frequency. If the beneficiary is unable to enroll in the Opt Out Program (e.g., not open enrollment), the beneficiary is sent an Opt Out denial letter. The HMS system is flagged to contact the beneficiary when *s/he* is eligible for the Opt Out Program.

The HMS system has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The system tracks enrollee characteristics (eligibility category, type of employer-sponsored insurance and type of coverage). The system will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Current Activities

During this quarter, the Agency regularly held meetings (via conference call) with HMS to ensure the Opt Out process continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified during this quarter that required the Agency to make any changes to the process.

Opt Out Program Statistics

A total of 63 calls were received at the Opt Out toll-free call center since September 1, 2006, when the program began accepting enrollment.

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

    1. The caller was enrolled in the Opt Out Program during the second quarter of year one with an coverage effective date of October 1, 2006. This caller lost her job during the third quarter of year one and was subsequently disenrolled from the Opt Out Program on February 28, 2007. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

    2. The caller began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter of year one. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter of year one.

The father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The five children's Medicaid eligibility ended February 28, 2007, and they were subsequently disenrolled from the Opt Out Program.

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

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

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

6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of year two. The effective date for enrollment was during the first quarter of year two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of year two. The effective date for enrollment was during the first quarter of year two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

By the end of this quarter, a total of ten individuals were enrolled in the Opt Out Program. Table 16 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending September 30, 2007.

Table 16 Opt Out Statistics September 1, 2006 – September 30, 2007						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
Children & Family	10/01/06	Large Employer	Single	1	2/28/07	Loss of Employment
Children & Family	01/01/07	Large Employer	Family	5	2/28/07	Loss of Medicaid Eligibility
Children & Family	02/01/07	Large Employer	Family	4	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	08/01/07	Large Employer	Family	1	Still Enrolled	N/A
Children & Family	09/01/07	Small Employer	Family	1	Still Enrolled	N/A

E. Enhanced Benefits Program

Overview

The Enhanced Benefits Account Program (EBAP) component of Reform is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid beneficiaries who enroll in a Medicaid Reform Health Plan are eligible for the program. No separate application or process is required prior to participation.

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 worth of credit per state fiscal year. Credits are posted to individual accounts that are established and maintained within Florida's fiscal agent's pharmacy point of sale system known as Prescription Drug Claims System (PDCS). Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the beneficiary's Medicaid Gold Card or their Medicaid identification number and a picture ID.

The Agency approves credits for participation of approved healthy behaviors using date of service, eligibility, and approved behavior edits within a new database named Enhanced Benefits Information System (EBIS). All Medicaid Reform health plans are required to submit monthly reports for their Reform members who had paid claims for approved healthy behaviors within the prior month. These reports are uploaded into the EBIS database for processing and approval.

Current Activities

1. Call Center Activities

During the quarter, the Medicaid Reform Enhanced Benefits call center, located in Tallahassee, Florida continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers, and used a language line to assist with calls in over 100 languages. The hours of operation for the call center remained 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with employees who speak English, Spanish and Haitian-Creole to answer calls.

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

Inbound Calls:	**7091**
Calls Abandoned:	**264**
Average Talk Time	**6.2**

2. System Activities

At the beginning of the quarter, the new state fiscal year began. The transition to a new fiscal year required system changes to appropriately apply credits to the correct fiscal year and to restart the ability to earn additional credits in the new fiscal year. The changes in the system also provide a viewing capability so call center staff can differentiate between credits in the previous fiscal year and those earned in the current fiscal year.

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day each month. The Enhanced Benefits Information System (EBIS) continues to operate effectively with minor modifications to ensure efficient processing of enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each recipient who has activity for the month and a quarterly statement process for recipients who have a balance only with no new activity.

3. Outreach and Education for Beneficiaries

The welcome packets continue to be mailed to new Medicaid Reform enrollees every month, which provides detailed information regarding their eligibility for the program and the benefits provided through the program. The package contains an EBAP brochure and a letter to the enrollee regarding the program. Feedback from call center staff and review of enhanced benefits activities indicates that the packets may not be achieving the intended educational outcome. The Agency is reviewing the welcome packet, in conjunction with the Enhanced Benefits Panel, to evaluate if the packet is being used as originally intended and if modifications are necessary.

Now that the EPAP is a year old, the Agency has data and other information on the successes and challenges to this new and innovative program. The number of beneficiaries earning credits is well within the estimates the Agency had developed prior to implementation. Unfortunately, the number of credits being spent by beneficiaries remains low.

The Agency has taken several steps to increase the amount of credits that beneficiaries spend. Preliminary results from these efforts have some positive impact as the amount of credits spent by beneficiaries more than doubled compared to the 4th quarter of year one of reform. The initiatives outlined last quarter and their current status are highlighted below:

- The EPAP call center script is rewritten and is in use by the call center.
- A user friendly product purchase list has been separated by product category and is in final review stages.
- Provider network of pharmacies successfully processing Enhanced Benefit purchases is available for beneficiaries seeking a pharmacy to use.

- A statement insert highlighting smaller groups of products was finalized and is ready to be inserted in the October statements.

To support these efforts, the Agency began planning a public meeting in Broward and Duval counties to provide an open forum to receive suggestions on how to improve the Enhanced Benefits program. The meeting in Duval County will occur on November 5th and the meeting in Broward County is scheduled for December 5th. The public meetings will be supported by outbound calls to beneficiaries who have earned credits but have not used their credits. All the information will then be evaluated by the Enhanced Benefits Panel, the Agency's internal Enhanced Benefits Quality Improvement team and the call center and necessary changes to the program will be implemented.

4. Outreach and Education for Pharmacies

The Agency continues to provide EBAP outreach and education to pharmacies regarding the design and billing process for the program. The Agency's Medicaid Area Office Pharmacists have proven to be a key element in providing onsite training at scheduled meetings in Broward and Duval Counties. In addition to the training sessions, the Agency provides one-on-one training to pharmacists when requested. The Agency's EBAP outreach and education activities have reduced the number of billing questions the Agency received during this quarter.

While the EBAP outreach and education to pharmacies had resulted in a reduction in the number of billing questions, the Agency is committed to streamlining the process for pharmacies when processing an enhanced benefits purchase. This area continues to be one of the primary reasons for complaints about the EBAP.

A system change request to the Agency's pharmacy system was in testing with further modifications during this quarter. This change will allow the Enhanced Benefits purchases to be identified by a two-digit identifying code. The system will also be changed to eliminate some of the edits and other processing features of the pharmacy system that are not needed in the Enhanced Benefits environment. Once these changes are in place, EBAP outreach and education to the pharmacies will be completed. In addition, a single page EBAP reference sheet will be developed. Once approved, the Agency will have laminated copies provided to participating pharmacies and the call center. The EBAP reference sheet will contain billing procedures and categories with examples of items included in each category. The goal of this document is to reduce the questions regarding types of products that may be purchased using the individual account credits.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel meeting is scheduled for October 5, 2007. The primary focus of the meeting will be to discuss the welcome packet materials, health plan utilization of the healthy behavior credits, and recipient usage of credits. Initial analysis had indicated the beneficiaries may be earning credits by engaging in non-preventive type services. The Panel will be charged with evaluating the credits earned

to date and recommending changes in behaviors that earn credits, dollar amounts earned for behaviors and related issues, to better align credits earned with engaging in preventive care.

Upcoming Panel meetings will continue to focus on beneficiary strategies mentioned previously in the document. The Panel will provide technical assistance and guidance in the development and finalization of the strategies to increase beneficiary usage of their accounts.

6. Enhanced Benefits Statistics

Table 17 provides the Enhanced Benefit Account Program statistics beginning July 1, 2007 and ending September 30, 2007.

Table 17
Enhanced Benefit Account Program Statistics

1st Quarter Activity – Year 2		July	August	September
I.	Number of plans submitting reports by month	24 of 25	24 of 25	27 of 31
II.	Number of enrollees who received credit for healthy behaviors by month	28,589	32,671	30,926
III.	Percentage of Reform enrollees who receive credits each month*	57.82%	63.63%	67.87%
IV.	Number of enrollees who received credit and used credits by month	5,849	7,871	9,402
V.	Total dollar amount credited to accounts by month	$791,520.00	$887,682.50	$835,430.00
VI.	Total dollar amount of credits used to date	$154,272	$225,194	$287,554

***** Represents the total number of beneficiaries from 2006 thru end of month divided by total number of beneficiaries enrolled in a Reform health plan.

7. Complaints

A beneficiary can file a complaint about the EBAP through the call center and those complaints are documented in the system utilized by the call center and reported to the Agency on a weekly basis. The complaints are reviewed and worked by the Agency to resolve the issue the beneficiary is having in regards to the program. The primary reason for complaints remains pharmacies not processing enhanced benefits purchases for the beneficiary.

In April 2007, when the operation of the EBAP was transitioned to the Medicaid Choice Counseling unit, it was determined that a tracking system for Enhanced Benefits complaints was in place. The 4th quarter report contained the first reporting of Enhanced Benefits complaints that were identified without a central reporting structure.

This quarter's report contains the first complete reporting of Enhanced Benefits complaints.

During this quarter, out of the 4,970 beneficiaries that purchased one or more products with their Enhanced Benefits credits, 138 complaints were recorded through the call center related to the EBAP. Table 18 provides a summary of the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 18
Beneficiary Complaints

Beneficiary Complaint	Action Taken
1. One hundred twenty-one beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program.	➲ The Agency continues to provide technical assistance to pharmacies regarding Enhanced Benefit Account Program.
2. Six beneficiaries complained about the processing fee that is currently associated with EB.	➲ Once the CSR is in productions, this fee will be disabled.
3. Eleven beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching at the pharmacy.	➲ The Agency is developing a more user friendly OTC Products list on the Enhanced Benefits web site.

F. Low Income Pool

Overview

In accordance with the Special Terms and Conditions #100 of the Florida Medicaid 1115 Demonstration Waiver, the Agency has met all the specified pre-implementation milestones. The availability of funds for the Low Income Pool (LIP) in the amount of $1 billion 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. CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006.

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

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

Current Activities

At the beginning of the quarter, the LIP Council (Council) members, as appointed by the Agency, scheduled the first meeting for State Fiscal Year (SFY) 2007-08. The first meeting was a one hour telephone conference call initiated at the Agency, on September 11, 2007.

The Council reviewed the anticipated distribution amounts and payment schedule for SFY 2007-08. An update was provided by the Agency to the Council members on the status of the Letters of Agreement, a total of 51 which were sent to local governments and taxing districts during the first quarter with 16 having been executed during the first quarter of Year Two. The Council also received a status report from the University of Florida (UF) LIP Evaluation Team regarding the progress of the cost effectiveness study, prepared in accordance with STC #102. The cost effectiveness study is due from the UF LIP Evaluation Team by January 2008. After receipt of the study, the Agency will distribute the results to the Provider Access Systems and review the study with the federal Centers for Medicare and Medicaid Services (CMS), in accordance with STC #102, to define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured and underinsured.

During the Council conference call, the Council chairman also discussed that in SFY 2008-09, approximately $81 million in non-recurring state general revenue funds will automatically be deducted from the LIP and hospital program appropriations. This reduction in funding, in addition to the possible ramifications of the current state property taxes issues, may result in insufficient IGTs available for the SFY 2008-09 to fully fund the LIP program at the $1 billion level.

During the first quarter of SFY 2007-08, upon receipt of the final state, non-federal share matching portion of LIP funding, the Agency made the final LIP Year One distributions in the amount of $30,794,286. The total amount of LIP Year Two distributions made during the first quarter of SFY 2007-08 was $83,458,192.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

All queries and work papers related to the quarterly reporting of waiver expenditures on the CMS 64 report are maintained by the Agency. In addition, all identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated and provided to the Agency's Finance and Accounting unit which certifies

and submits the CMS 64 report. This check sum process allows the state to verify that no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

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

Definitions:

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

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

Current Activities

For the 1st quarter of Demonstration Year Two, 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.

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 is 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 is based on the date of service for the expenditure.

For Demonstration Year One; MEG 1 has a PCCM of $936.91 (Table 22), compared to WOW of $948.79 (Table 19), which is 98.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $168.28 (Table 22), compared to WOW of $199.48 (Table 19), which is 84.36% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $701.82 (Table 22), compared to WOW of $1,024.69 (Table 19), which is 68.49% of the target PCCM for MEG 1. MEG 2 has a PCCM of $119.11 (Table 22), compared to WOW of $215.44 (Table 19), which is 55.29% of the target PCCM for MEG 2.

Tables 22 and 23 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 23) is $328.24. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 23 is $300.36. Comparing the calculated weighted averages, the actual PCCM is 91.51% 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 23) is $353.22. The actual PCCM weighted for the reporting period

using the actual case-months and the MEG specific actual PCCM as provided in Table 23 is $218.32. Comparing the calculated weighted averages, the actual PCCM is 61.81% of the target PCCM.

Table 19 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 19
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 20 through 24 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending September 30, 2007. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 20
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**781,217**	**$557,259,673**	**$ 5,086,722**	**$562,346,395**	**$719.83**
Q2 Total	**780,310**	**$706,715,609**	**$24,690,376**	**$731,405,985**	**$937.33**
Q3 Total	**788,257**	**$700,393,754**	**$38,038,470**	**$738,432,224**	**$936.79**
Q4 Total	**804,215**	**$657,121,159**	**$72,784,392**	**$729,905,551**	**$907.60**
Jul – 07	273,568	$198,473,780	$33,297,408	$231,771,188	$847.22
Aug – 07	274,259	$305,037,127	$49,071,640	$354,108,767	$1,291.15
Sep - 07	273,741	$152,627,385	$23,912,004	$176,539,388	$644.91
Q5 Total	**821,568**	**$662,578,925**	**$106,931,500**	**$769,510,424**	**$936.64**
MEG 1 Total	**3,975,567**	**$3,284,069,120**	**$247,531,459**	**$3,531,600,579**	**$888.33**

***** Quarterly expenditure totals do not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions.

Table 21
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,858,479**	**$498,189,408**	**$1,715,790**	**$499,905,198**	**$129.56**
Q2 Total	**3,772,650**	**$623,448,816**	**$19,606,645**	**$643,055,462**	**$170.45**
Q3 Total	**3,732,807**	**$612,194,137**	**$36,444,373**	**$648,638,510**	**$173.77**
Q4 Total	**3,837,247**	**$564,828,924**	**$57,487,857**	**$622,316,780**	**$162.18**
Jul – 07	1,336,725	$167,001,756	$18,188,307	$185,190,063	$138.54
Aug - 07	1,334,212	$273,285,396	$34,951,297	$308,236,692	$231.03
Sep - 07	1,333,093	$110,181,450	$4,938,559	$115,120,009	$86.36
Q5 Total	**4,004,030**	**$562,819,446**	**$58,288,259**	**$621,107,705**	**$155.12**
MEG 2 Total	**19,205,213**	**$2,861,480,731**	**$173,542,924**	**$3,035,023,654**	**$158.03**

*Quarterly expenditure totals do not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions.

Table 22
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	MEG 1&2 Actual Spend		Total	PCCM
MEG 1 - DY01 Total	3,153,999	$2,783,2238,246	$171,771,111	$2,955,009,357	$936.91
WOW DY1 Total	3,153,999			$2,992,482,896	$948.79
Difference				($37,473,540)	
% of WOW PCCM MEG 1					98.75%
DY01 – MEG 2	**Actual CM**	**MEG 1&2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,201,183	$2,435,440,796	$122,659,837	$2,558,100,633	$168.28
WOW DY1 Total	15,201,183			$3,032,332,020	$199.48
Difference				($474,231,388)	
% of WOW PCCM MEG 2					84.36%
DY02 – MEG 1	**Actual CM**	**MEG 1&2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY02 Total	821,568	$500,830,874	$75,760,349	$576,591,222	$701.82
WOW DY2 Total	821,568			$841,852,514	$1,024.69
Difference				($265,261,292)	
% of WOW PCCM MEG 1					68.49%
DY02 – MEG 2	**Actual CM**	**MEG 1&2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	4,004,030	$426,039,934	$50,883,087	$476,923,022	$119.11
WOW DY2 Total	4,004,030			$862,628,223	$215.44
Difference				($385,705,201)	
% of WOW PCCM MEG 2					55.29%

Table 23
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1&2 Actual Spend		Total	PCCM
Meg 1 & 2	18,355,182	$5,218,679,042	$294,430,947	$5,513,109,990	$300.36
WOW	18,355,182			$6,024,814,917	$328.24
Difference				($511,704,927)	
% Of WOW					91.51%
DY 02	**Actual CM**	**MEG 1&2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	4,825,598	$926,870,808	$126,643,436	$1,053,514,244	$218.32
WOW	4,825,598			$1,704,480,737	$353.22
Difference				($650,966,493)	
% Of WOW					61.81%

Table 24
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,737**
Q5	**$114,252,478**
Total Paid	**$1,081,214,018**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$997,755,826	$1,000,000,000	99.78%
DY02	$83,458,192	$1,000,000,000	8.35%
Total MEG 3	$1,081,214,018	$5,000,000,000	21.62%

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

The expenditures for the first five quarters for MEG 3, the Low Income Pool (LIP), were $1,081,214,018 (21.62% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

The Agency is required to capture encounter data in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes. The interim pharmacy data and future medical services encounter data will be used to support s. 409.91211(3)(p), Florida Statutes, requiring that a risk-adjusted methodology be a component of the rate setting process for capitated payments to Reform health plans. Risk adjustment is to be phased in over a period of three years beginning with the Medicaid Rx model and transitioning to a diagnostic based model such as the CDPS (Chronic Illness and Disability Payment System).

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

Current Activities

During the quarter, to comply with the requirements of the Medicaid Reform Waiver, health care pharmacy and Medicaid enrollee information is collected and aggregated by health plans and submitted for processing of risk scores. This data is submitted to the Agency within 30 days of the close of this quarter for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid population. The Reform health plans were assigned a plan risk factor based on the aggregate risk scores of their enrolled populations under Medicaid Reform. Health plan factors, budget neutrality and the derived risk corridor plan factor have been applied to capitated premium rates beginning in October 2006 and each subsequent month thereafter for Medicaid enrolled populations in Reform counties.

During this quarter, the Agency also began to capture encounter data from all capitated health plans for all covered services. Activities included:

- Florida's Medicaid Management Information System (FMMIS) is being used to support the capture, validation, and adjudication of encounter claims received from Managed Care Organizations (MCOs).

- The MEDS team is continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the MCOs.

- Participation of the MEDS team in "stand-alone" and biweekly technical and operations meetings with MCOs continued during this period.

- Reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content is being disseminated to plans.

- The Medicaid Decision Support System (DSS) is being used to support the validation and completeness of encounter data.

- Nine (9) of twelve (12) HMOs have submitted encounter claim files for one or more months for the period of September – December 2006. Preparations are now being made to accelerate the collection of encounter claims bringing plans to current month encounter claim submission status.

- The MEDS team is continuing to work with HMOs to resolve technical and X12 transaction format and content questions.

- Provider Service Networks (PSNs) have been contacted and a strategy to submit encounter claim data for capitated transportation services (emergency and non-emergency) have been communicated. To that end, the MEDS team focused on one PSN to submit encounter claims for the period of September 2006 – September 2007, and that PSN is now submitting encounter claims for current period. The MEDS team continues to work with the other PSNs in various states of readiness, to achieve similar results.

- The MEDS team continues to participate in the design and development of the new Florida MMIS, to ensure the ongoing capture, validation, and adjudication of encounter claims when the new fiscal agent becomes operational in March 2008.

At the end of the quarter, the processes providing plan risk factors for Medicaid Reform rate setting, encompassing the generation of risk factors accounting for budget neutrality and the risk corridor continues. The scheduled activities as defined within the MEDS project plan associated with the collection and validation of encounter claims is continuing. This encompasses technical support with capitated health plans, reporting on encounter claims submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection of encounter data.

I. Demonstration Goals

Medicaid Reform is fundamentally changing the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of Medicaid Reform, and anticipates using the evaluation as a means to inform policy decisions in both the short and long term. As lessons are learned on an incremental basis, these data will be used to shape further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation. There are six key design elements of Medicaid Reform tracked by the Agency in order to evaluate progress towards achieving its goals. Information about each key evaluation objective is below.

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

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

At the end of this quarter, the Agency established contracts with 11 HMOs and 6 PSNs for a total of 16 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. One of the plans is a specialty PSN plan which serves children with chronic conditions in both Broward and Duval Counties. The number and types of health plans that beneficiaries can chose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform Waiver. Additionally, the Agency established contracts with 1 HMO and 1 PSN in Baker, Clay and Nassau counties and enrollment began in September 2007.

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.*

All of the capitated Reform health plans offered expanded or additional benefits which were not previously covered by the State under the 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/Medicinal Massage
- Additional Adult Vision – up to $125 per year for upgrades such as scratch resistant lenses
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid
- Home-delivered meals for a period of time after surgery, providing nutrition essential for proper recovery for elderly and disabled.

By the end of this quarter, the Agency had approved 30 health plan customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits are effective for the contract period September 1, 2007 to August 31, 2008. These included 1 HMO and 1 FFS PSN for the counties: Baker, Clay and Nassau.

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

The following expanded benefits were added for Year Two of the demonstration including:

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

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

Improving Access to Specialists

The 1115 Medicaid Reform Waiver is designed to improve access to specialty care for beneficiaries. Through the contracting process, each Reform health plan is required to provide documentation to the Agency of a network of providers including specialist that will guarantee access to care for their enrolled members. The Agency continues to

monitor access by evaluating the provider networks for each of the Reform health plans. As the first year of Reform ended, the Agency had begun the first intensive review of the Reform health plan provider network files to evaluate the effectiveness of Reform in improving access. The analysis includes the following steps:

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

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

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

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

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

The Agency will monitor the Medicaid Reform health plan enrollees through the HEDIS performance measures and the plan's disease management enrollees through Agency-defined disease management measures. The Medicaid Reform health plan contract

specifies the performance measures that will be collected starting January 1, 2007 through December 31, 2007, and reported to the Agency July 1, 2008.

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

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

When the Agency has sufficient encounter data stored in the Medicaid Encounter Data System to analyze (see Section H for progress in this area), then these performance measures data will be used to evaluate the demonstration's success toward reducing ambulatory-sensitive hospitalizations and use of emergency room care.

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

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

Based on the information gathered during this quarter, the reason individuals have chosen to opt out of Medicaid Reform is to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.

The individuals who decided not to opt out were:

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

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

It is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida (UF) to conduct yearly Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. When CAHPS comparison survey data are collected during 2009, some inferences can begin to be made regarding patient satisfaction. The CAHPS health plan survey is one of a family of standardized survey instruments used widely in the healthcare industry to assess enrollees' experiences and satisfaction with their health care.

"Benchmark" pre-Reform survey data were collected during the fall 2006. The purpose of these data is to serve as a baseline for the consumer survey data to be collected and compared throughout the course of the five-year Medicaid Reform evaluation. A draft report was released by UF to the Agency in July 2007 that describes the methodology used to collect the data and presents weighted and unweighted frequency distributions by county. The beneficiaries surveyed were enrolled in MediPass, Florida's primary care case management program, and non-Reform Medicaid HMOs in Broward and Duval counties. This survey is designed to measure the level of patient satisfaction present prior to the implementation of the Medicaid Reform Waiver. Key findings from the benchmark survey are summarized in Section J Evaluation of this report.

The timeline for conducting the CAHPS health plan survey is provided below.

Patient Satisfaction Survey Projected Timeline	
Fall 2006	Benchmark data collected on beneficiaries prior to enrollment in a Reform health plan.
Summer 2007	Analysis of benchmark data completed.
Fall 2007	Initial survey conducted of beneficiaries enrolled in Reform health plans.
Fall 2008	Comparison survey conducted of beneficiaries enrolled in Reform health plans.
Summer 2009	Analysis of Year 1 comparison data completed.

Additionally, a component of the Medicaid Reform evaluation is a longitudinal qualitative study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall healthcare system, and their current experiences under Medicaid Reform. Baseline qualitative interviews and focus groups were conducted with enrollees between October 2006 and May 2007. A total of 37 enrollees were interviewed from both Broward and Duval Counties. All participants are early enrollees to Medicaid Reform or were about to be enrolled in Medicaid Reform plans.

Since all longitudinal qualitative study participants did not have long-term experiences with Medicaid Reform, these baseline findings cannot be used to assess the success or failure of Reform at this time, but can be used to demonstrate how Medicaid enrollees

may respond to the program changes. Key findings from the longitudinal qualitative study are summarized in Section J Evaluation of this report.

The Agency also intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. For Broward and Duval Counties, the disease management patient satisfaction surveys will be conducted, during the fall of 2007, to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for six months.

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

Prior to the implementation of the Medicaid Reform Waiver, Florida's State Plan included a hospital 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 of Year One, the State approved a PAS distribution methodology and has worked with these PAS entities establishing agreements with the local governments or health care taxing districts.

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

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

During the third quarter of Year One, the Agency continued its work with the University of Florida's Medicaid Reform Evaluation team. On January 30, 2007, the Agency received a request for pre-LIP information from the University of Florida's Medicaid

Reform Evaluation team. On February 20, 2007, the Agency responded, via e-mail, with the electronic data requested. The data requested included information from the hospital Upper Payment Limit (UPL) program, Disproportionate Share Hospital (DSH) program, and the hospital reimbursement exemption costs. In addition, data from the Florida Hospital Uniform Reporting System and hospital Medicaid audited DSH data was provided. A conference call was held on March 6, 2007, to review the data provided.

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the University of Florida LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to the University of Florida LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year 2005-2006) by July 31, 2007. The LIP Milestone data for Year One of LIP (State Fiscal Year 2006-2007) was due to the Agency from all Providers Access Systems no later than August 15, 2007. This information has been shared with the University of Florida LIP Evaluation team in September 2007. The University of Florida and the Agency will utilize the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

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

STC #102, Demonstration Year Two Milestones, states that, “the State will conduct a study to evaluate the cost effectiveness of various provider access systems.” This study will be done by the UF LIP Evaluation team. The UF LIP Evaluation Team will provide the cost effectiveness study to the Agency by the third quarter of Year Two (January 2008). The cost effectiveness study will be based on the measurements of the LIP Milestone reports provided by the Provider Access Systems. 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 Provider Access Systems and non-hospital Provider Access Systems. All Provider Access Systems completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. Provider Access Systems 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 Provider Access System 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 Provider Access Systems input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the UF LIP Evaluation team. The UF LIP Evaluation team will use the data (along with data previously submitted such as pre-LIP payments, IGTs, charge, cost, and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports will be 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 study 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)

Upon receipt of the study from the UF LIP Evaluation team, the Agency will distribute the study to the Provider Access Systems (in accordance with STC #102). In addition, the Agency will discuss the study and "define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured" with CMS in accordance with STC #102.

J. Evaluation of Medicaid Reform

Overview

Prior to implementation of demonstration, many evaluation tasks were undertaken; some were completed, many are ongoing. In November 2005, the Agency contracted for the required 1115 Medicaid Reform Waiver evaluation with an independent entity, the University of Florida (UF).[1] The evaluation was designed to incorporate criteria in the waiver, plus those in the special terms and conditions. The Agency designed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to CMS on February 15, 2006. The Agency incorporated comments from the CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to CMS on May 24, 2006, receiving approval on June 13, 2006.

The Medicaid Reform Evaluation (MRE) is, as it was intended to be, a five-year, over-arching study that will present its major findings in 2010. Many people were interested in seeing findings much sooner, so the Agency and several other entities chose to do shorter-term evaluations to look at specific issues. Descriptions are below.

A. Evaluations Affiliated with the Agency or its Contractors

Agency Internal Review

As requested by the Agency's Secretary, the Office of the Inspector General is conducted a review of Medicaid Reform implementation. The objectives of this review are as follows:

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

The final report was published on September 28, 2007, and can be viewed at http://ahca.myflorida.com/Executive/Inspector_General/IG_Report_Page.shtml.

Urban Institute – Early Impact of Transitioning to Medicaid Reform

UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. A total of 1,850 interviews were

[1] Note: Contract deliverables are routinely submitted to the Agency in draft form; the Agency returns comments; UF submits a final version; an Agency Technical Assistance Group formally reviews and approves the deliverable; and an invoice for it is submitted and paid. Unless specified otherwise, any deliverable mentioned as submitted means the final version.

completed. All data sets were delivered to the Urban Institute in May 2007. Following the normal review procedures, reports will be disseminated through KFF website.

University of Oregon – Impact of Incentivizing Health Behaviors

UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid Reform beneficiaries. Data collection was by means of focus groups and telephone surveys. All data sets were delivered to the University of Oregon earlier this year. Following normal review procedures, reports will be disseminated through the University of Oregon website:
http://pppm.uoregon.edu/index.cfm?mode=news&id=506

Florida State University – Choice Counseling Program

Florida State University (FSU) evaluated the Choice Counseling Programs materials given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver. This evaluation is part of a contract with the Agency. The final report was received in July 2007. A summary of the key findings is provided under Current Activities of this section.

University of Florida – Low Income Pool Study

The Agency has contracted with the University of Florida to conduct an evaluation of the Low Income Pool (LIP), including cost-effectiveness and the impact of LIP on increased access for uninsured individuals as required by STC#102 of the waiver. Please see Section I Demonstration Goals of this report for more information.

B. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

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

General Accounting Office

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

Current Activities

Highlights of this quarter activities include completion of baseline reports in the Client Satisfaction area and on the Low Income Pool (LIP) Program. A summary of the evaluation activities conducted during this quarter include:

1. Florida State University – Choice Counseling Program

The evaluation of the Choice Counseling Programs materials was two-pronged. The first involves the surveying of choice counselors for their feedback on the Choice Counseling education and testing/certification materials that were developed. The second, and perhaps more significant portion, is a survey of Medicaid Reform beneficiaries concerning their feedback on the Choice Counseling materials, such as the beneficiary grid, the website, and the Choice Counseling received prior to plan selection. Questions included how each participant chose his/her plan, why they chose it, whether they had any problems, and overall rating of the counseling process.

Training Materials and Content

Choice Counselors reported being satisfied with the materials, content, and procedures covered during the training program. In general, the counselors reported that the training program prepared them not only for answering beneficiaries' questions about Medicaid Reform and health plans, but also for the many non-reform questions raised by beneficiaries.

- Information provided was very thorough and prepared the counselors for communicating with and assisting beneficiaries in learning about their health plan choices. Some of the information provided during the training program was not used every day, but useful to know, and helpful to answer Reform and non-reform questions.
- Choice counselors staffing the call center felt that some training information was oriented toward face-to-face counselors, and face-to-face counselors felt some information was oriented to the call center counselors.
- Some focus group participants (counselors) would have liked the materials to have been written in an easier-to-understand style.
- There was some dissatisfaction with the organization of the training manual's content.
- Face-to-face (Field) Choice Counselors reported using the training manual as a field reference. Consequently, the counselors recommended the manual be adapted as a field reference tool with an index for quicker reference.

Beneficiary Response to Choice Counseling

From the beneficiaries' perspectives, Choice Counseling was reported to be a helpful and informative service during their transition from non-reform managed care settings into Medicaid Reform health plans. Based on the survey results, Choice Counselors are meeting the needs or expectations of a large majority of beneficiaries. The results of the Beneficiary Enrollment Surveys are as follows:

- The majority of beneficiaries usually or always felt respected (89 percent) and listened to (87 percent) while speaking with Choice Counselors. Approximately 11 percent of the beneficiaries never or only sometimes felt respected, while about 13 percent felt that someone never or only sometimes listened to them.
- Similarly, 88 percent of the beneficiaries felt the Choice Counselor usually or always explained things to them, and 87 percent thought counselors usually or always spent enough time with them.
- Eighty-three percent (83 percent) felt the Choice Counselor usually or always seemed knowledgeable about the beneficiaries' choices.
- Eighty-five percent (85 percent) of the survey respondents reported they would recommend Choice Counseling to family or friends, and 84 percent reported they would use Choice Counseling again.
- On a scale of 0 to 10, the beneficiaries who encountered Choice Counselors rated them an overall 8.3. While these finding suggest Choice Counselors are meeting the needs of beneficiaries in general, there is room for improvement. For example, 17 percent of the survey respondents thought their Choice Counselor was never or only sometimes knowledgeable about their choices, indicating a need for improved Choice Counselor training.

In general, most beneficiaries appear to have a relatively easy time choosing their health plan. There are subgroups, however, that have a more difficult time. These issues should be further explored to simplify the process for these populations.

- Approximately 90 percent of beneficiary respondents reported it was "Not a problem" or "A small problem" to choose a health plan, while about 10 percent said it was "A big problem." There are, however, some important demographic differences to consider:
    - Older beneficiaries report having a more difficult time picking their plan.
    - Similarly, respondents who report poorer health status also have a harder time picking their plan.

The two-most common reasons cited for choosing a particular health plan were: "Because of the benefits," and "My doctor was in the plan."

- Among respondents who are new to Medicaid, benefits was the most common reason for choosing a health plan.
- Among respondents who are changing to a Medicaid Reform health plan from MediPass, their doctor's plan was the most common reason.

The survey results regarding beneficiary materials are as follows:

- Almost all the respondents (96 percent) reported that it was "Not a problem" (72 percent) or "A small problem" (24 percent) understanding the information in the Benefits Comparison Chart.

- On the other hand, 19 percent reported it was “A big problem” understanding the information on the website and in the DVD/Video.
- It is also worth noting that only 73 respondents (13 percent of the sample) reported viewing the website, and only 37 respondents (six percent of the sample) reported viewing the DVD/Video. This data suggests that the information on the website and DVD/Video could be simplified. Additionally, the low numbers of respondents who reported viewing the DVD/Video suggest that this tool is not visible to the Medicaid community in general.

2. University of Florida – Organizational Analysis

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

The organizational aspects of Medicaid Reform, covering the time period of approximately July 2006 to March 2007 (Reform development, implementation, and early operations) were evaluated. Data were collected from the Agency’s Medicaid website, other Agency sources, informant interviews, and a stakeholder survey.

Beginning July 1, 2006, Florida implemented Medicaid Reform in Broward and Duval Counties, enrolling beneficiaries in Medicaid Reform plans beginning September 1, 2006. As of March 31, 2007, approximately 165,674 beneficiaries were enrolled in Medicaid Reform health plans in these two counties.

In total, 16 health plans were participating in Medicaid Reform as of March 2007. Six of the participating plans are Provider Service Networks (PSNs). Two of these PSNs are operated by safety net hospitals (First Coast Advantage and South Florida Community Care Network), and the others are physician networks. The remaining 10 plans are health maintenance organizations (HMOs). Of the participating plans, 13 began enrolling patients at the beginning of Medicaid Reform, while the others began participating at a later time. In both Broward and Duval counties, there are now more health plans available to Medicaid beneficiaries in each of the Reform counties than before implementation of Medicaid Reform.

By definition, Medicaid Reform increased the number of participants in Medicaid managed care in both Broward and Duval counties. Enrollment under Medicaid Reform varies based on plan organizational characteristics. After the first six months, the majority of Medicaid Reform beneficiaries belonged to HMOs (70 percent) rather than PSNs. New participating organizations in the Medicaid Reform markets are, for the most part, Provider Service Networks (PSNs). So far, Medicaid Reform has not drawn

any new commercial players to the Medicaid market or drawn Medicaid plans from other states to Florida.

Overarching Themes and Observations

The organizational analysis found several overarching themes derived from over 107 interviews with key informants involved with Medicaid Reform, including leaders and staff members of the Agency, participating health plans, and other stakeholders, such as community members and advocates.

Themes from the Agency's Perspective

Several themes were identified based on the Agency's perspective. First, Medicaid Reform was implemented very quickly, and the Agency was committed to meeting its legislated timeline. Second, the implementation of a disciplined, specific Project Management approach was critical to the successful implementation of Medicaid Reform. From the very beginning, the Agency organized key participants into teams that included staff from various bureaus within Medicaid, content experts, and trained, experienced project managers. Third, strong leadership at all levels played an integral role in the development and implementation of Reform. Next, effective internal communication and external communication were critical success factors in the development and implementation of Medicaid Reform. However, maintaining effective communication among all stakeholders was a challenge for the Agency. Finally, the state's dedication of significant resources to Medicaid Reform development and implementation was critical to the initiative's success. Resources including funding, vendors, human resources, information, and time were all valuable in the process.

Themes from the Health Plans' Perspective

Several overarching themes were identified based on the Medicaid Reform health plans' views. First, plans indicated that the major reason for participating in Medicaid Reform was to remain in the Medicaid business. Most plans were participating in Medicaid prior to Medicaid Reform, and they wanted to maintain their patient bases. Second, although plans were given some latitude in benefit design, most reported only minimal changes to their benefit structure from pre-reform plans. Additionally, plans made few changes to provider networks, and problems with contracting that existed pre-reform remained.

Plans indicated that the most positive aspect of the Medicaid Reform process was the communication occurring with the Agency. Medicaid Reform implementation went more smoothly than anticipated. However, some aspects of implementation did not go smoothly. Technical difficulties were cited with regard to implementation; in particular, problems involving the fiscal intermediary. Plans commented that Medicaid Reform greatly increased administrative burden, specifically citing increased reporting requirements. The perceived higher level of competition among Medicaid health plans in Broward County was mentioned as another negative aspect of operating at the beginning of Medicaid Reform.

With regard to the new programs included in Medicaid Reform, plans had differing viewpoints. Overall, plans were supportive of the Choice Counseling concept. Prior to implementation and in the early stages of Medicaid Reform, however, some participants expressed concern about member access to Choice Counselors and the accuracy of information provided. While Medicaid Reform plans expressed support for the idea of the enhanced benefits accounts program (EBAP), most felt the program would be difficult to meaningfully operationalize. The consensus among health plans is that the concepts of disease management and outcomes tracking are good things; however, the methods of choosing and tracking programs were questioned by some plans. For the most part, HMOs and PSNs are both supportive of the concept of risk-adjusted premiums, but some organizations had questions about the proposed methodologies used in calculating the rates.

The final theme identified from the health plan interviews relates to the new competitive relationships emerging from Medicaid Reform. Many plans felt that HMOs and PSNs are not "on a level playing field" in the marketplace. HMOs indicated that provider-affiliated PSNs have an advantage with regard to contracting. A key issue concerned the ability of hospitals to demand "above-market payment rates" from health plans that they now compete with as PSNs. Some PSNs, however, suggested that HMOs have a market advantage with regard to flexibility in benefit design and mechanisms used to pay providers.

Themes from Stakeholders' Perspectives

Themes were derived from the stakeholder survey and key informant interviews. For the most part, most stakeholders indicated that it is still too soon to tell how well Medicaid Reform is working. However, when stakeholders did issue opinions about Medicaid Reform, those opinions were overwhelmingly negative. A specific stakeholder concern regarded the difficulties certain populations (e.g., mentally ill and disabled) have with Medicaid Reform.

Many questions remain unanswered with regard to the success of Florida's Medicaid Reform initiative. The evaluation will continue to monitor learning in the marketplace from various perspectives.

In addition, the evaluation will continue to track Medicaid Reform's ability to succeed in the rural expansion areas. As more data become available regarding the attitudes and behaviors of Medicaid Reform beneficiaries, the evaluators will begin to explore the implications of beneficiary health plan choices and other important aspects of Medicaid Reform. However, the evaluators want to caution all stakeholders about jumping to conclusions about the success or failure of Medicaid Reform before more time has passed and meaningful data are available.

3. University of Florida – Patient Satisfaction Survey

One component of the MRE is a yearly survey that tracks Medicaid enrollee experiences and levels of satisfaction. "Benchmark" pre-Reform survey data were

collected during fall 2006. The purpose of these data is to serve as a baseline for the consumer survey data to be collected and compared throughout the course of the Medicaid Reform evaluation. A draft report was released by UF to the Agency in July 2007 that describes the methodology used to collect the data and presents weighted and unweighted frequency distributions by county. Information from that report is summarized here. This report when finalized will be made available on the Agency's website http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

The majority of items for the benchmark survey were drawn from the Consumer Assessment of Health Providers and Systems (CAHPS), health plan survey version 3.0. The CAHPS health plan survey is one of a family of standardized survey instruments used widely in the healthcare industry to assess enrollees' experiences and satisfaction with their health care.

The initial universe was composed of Medicaid enrollees living in the two pilot counties prior to the implementation of Reform. Respondents had to meet certain criteria to be included as potential respondents:

- Beneficiaries had to have at least six months of continuous participation in one of the eligible plans, Fee-for-Service (FFS) or MediPass, and be deemed eligible to be enrolled in Reform; and
- They had to live in a household with a valid phone number as determined by GENESYS, a contracted commercial service. A household was identified as a unique phone number, and persons sharing this phone number were presumed to reside in the same household.

During fall 2006, the UF Survey Research Center in the Bureau of Economic and Business Research (BEBR) administered the benchmarking survey questionnaire in four versions: Adult MediPass; Adult non-MediPass, Child MediPass, and Child non-MediPass. In the latter two survey versions, a parent, guardian, or other family member responded on behalf of their underage child.

A total of 5,767 surveys were completed. Survey data were weighted to reflect managed care program share in each county and survey non-response. Frequency distributions by county were calculated for various survey items.

Overall, satisfaction levels were high. For example, on a scale of 0 (the worst possible health care) to 10 (the best possible health care), roughly 70 percent of individuals scored their **health plan** an 8, 9, or 10; and 80 percent scored their **overall care** an 8, 9, or 10.

However, there are a few areas of concern that should be closely tracked during the evaluation period. Specifically, many beneficiaries had some difficulty getting help from Medicaid's or a health plan's customer service. Gaining access to specialty care was

also problematic. In addition, about 50 percent experienced delays while they waited for approval from Medicaid or their health plan. Although these are not specifically Reform issues, it is still important to track these issues during implementation to see whether they improve.

This year's data will serve as a benchmark or baseline against which to compare the data collected during the rest of the Medicaid Reform Evaluation. Lessons will begin to be learned next year, when we can compare what happened during the implementation of Reform to what was happening prior. Those comparisons will yield important information, as will each year remaining in the demonstration period.

4. University of Florida – Longitudinal Survey

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

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

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

The following key issues, however, are worth noting and following throughout the evaluation period.

- **Control of health is influenced by individual belief, money and resources, and faith.** Respondents noted that maintaining health is related to an individual's belief in their own ability to influence their health. Other factors, notably money and resources, and faith in God, are also key to maintaining or regaining health. Consequently, the lack of resources (e.g., money for healthy food or to sign up for an exercise program) may deter initial participation and program completion in the Enhanced Benefit Account Program. Thus, although consumers may appreciate being rewarded for healthy behaviors, this may not provide sufficient incentive to get them involved in healthy behaviors, especially those behaviors that are not paid for by the Medicaid program.

- **Relationships with physicians are important to consumers.** Medicaid consumers cherish their relationships with their physician providers. Health plan choice is almost always dictated by advice from the physician or physician office staff and a desire to remain with that physician.

- **Medicaid consumers actively pursue health and health care information.** Although physicians are major sources of health information, consumers also look to a variety of other resources (e.g., the Internet, library) for information on their health and health care. Notably, social networks are vital to gaining information on providers and health plans. Among the consumers interviewed, the Choice Counseling Program had not yet emerged as a major source of health information, but instead is used as a mechanism to select a health plan.

- **Experiences with Medicaid and the health care system are not always positive.** Respondents spoke of non-reform-related issues such as re-enrollment, restricted prescription drug coverage, perceived restrictiveness of MediPass relative to the traditional fee-for-service arrangement, and difficulty finding specialty providers and dentists who will take Medicaid. Medicaid Reform does not specifically address these issues. It is important to consider these barriers, and measure the extent to which they may impact the stated goals of Medicaid Reform.

- **Consumer knowledge of Medicaid Reform is uneven.** General consumer understanding of the concept of "Medicaid Reform" is limited. When asked, individuals may have heard of specific aspects, but the terminology such as Choice Counselors or Enhanced Benefits were unfamiliar to many respondents. Several consumers had heard of the Enhanced Benefit Account Program, but none had participated in the program. None were aware of the Opt-out program.

  An additional 10 individuals from Broward and Duval Counties and 15 individuals from the expansion counties of Baker, Clay, and Nassau will participate in a first round of interviews in the Summer and Fall of 2007. The 37 focus group and in-depth interview respondents will be contacted for a second round of in-depth interviews in late Fall of 2007. This second round of interviews will focus on beneficiary experiences since the last interview with obtaining health care under Medicaid Reform.

K. Policy and Administrative Issues

Current Activities

The Agency continues to identify and resolve various operational issues for both prepaid health plans and FFS PSNs. The Agency's internal and external communication processes continue to play a key role in managing and resolving issues effectively and efficiently during the fourth quarter of operation.

This quarter, policy, administrative and operational issues are addressed by five different processes:

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

Overall, these forums have provided excellent discussion and feedback on proposed processes, working through issues as they occur, and providing finalized policy in documented products. In addition, the Agency's Inspector General's program review of the Medicaid Reform pilot provided an informative analysis, highlighting many items and processes that had become Medicaid initiatives for process and program improvement. This information will help the Agency fulfill its commitment to improve the value of the Medicaid program through Reform by coupling the increased use of managed care principles with the innovative approaches in Reform (customized benefit packages, comprehensive choice counseling, risk-adjusted premiums and enhanced benefits for health behaviors.

While team processes played a large role in the implementation of Medicaid Reform, as processes became operational, most year two changes are being handled through operational roles; however, the Continuous Improvement Team is providing an avenue for operational staff to hear directly from enrollees and providers on how Reform is working.

Medicaid Reform Technical Advisory Panel (TAP)

The Medicaid Reform Technical Advisory Panel (TAP) in the fourth quarter focused on risk-adjusted rates for the contract year beginning September 1, 2007, flexible benefits offered by plans for the new contract year, kick payment processing, Medicaid encounter data collection progress, choice counseling, enhanced benefits design, and transition to the new Medicaid fiscal agent beginning March 1, 2008. Due to the transition to the new Medicaid fiscal agent, customer service requests (systems change requests) in the current fiscal agent system have stopped effective October 1, 2007.

Policy Transmittals

During the quarter, the Agency released several policy transmittals and Dear Provider letters/emails to the Reform health plans. These are summarized below:

- Clarification of the fee-for-service Reform PSN paper claims processing requirements under the current fiscal agent system.

- Clarification to Reform health plans regarding county health department services and payment rates associated with those services.

- Notification to health plans of the revision in the number of performance improvement plans required for the contract year beginning September 1, 2007, based on the recommendation of the Agency's external quality review organization (EQRO). This reduction was made to allow plans to allocate more dedicated resources to the management of the PIPs.

- Clarification to Reform HMOs regarding medical screenings for children taken into protective custody, emergency shelter or Florida's foster care program.

Biweekly Technical and Operations Calls

The Agency conducted six biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants during this quarter. The Technical and Operation Issues Conference Calls provide an avenue for direct communication between the health plans' operations and technical experts and the Agency's experts in the respective subject matter. Though some of the same issues are addressed at a higher level in the Technical Advisory Panel meetings, the Agency has the opportunity through this forum to respond to detailed questions posed through email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether or not they are currently operating in the Medicaid Reform counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. A broad spectrum of stakeholders attends and requests the weekly agendas. This includes health plan chief executive staff, government relations and compliance managers, health plan information systems managers, health plan subcontractors, and potential health plan applicants.

This quarter there was a wide variance in attendance, possibly due to summer vacation months. In person, 20 to 30 people attended while approximately 70 to 150 people participate by phone, depending on the agenda. Typical agenda items included:

- Electronic file formatting, submission requirements, and accessing data exchange and secured file transmission servers
- Update information on Choice Counseling Program activities

- Health plan network provider registration processes
- National Provider Identification (NPI) registration technical assistance, including a review of formal questions and answers;
- New Medicaid Management Information System (MMIS) processes;
- Medicaid Enhanced Benefit Account Program updates;
- Medicaid Encounter Data Systems updates and formal questions and answers;
- Performance measures reporting updates and technical assistance;
- Obstetric labor and delivery kick payment processing;
- Revisions in the process for submitting involuntary disenrollment requests;
- Compliance issues, such as, reminding plans to submit accurate and up-to-date prescribed drug lists and updating the lists on their respective websites;
- Instruction for navigating reports on the fiscal agent's data exchange;
- Contract amendment progress and Reform year two updates, such as,changes necessary with Mercer's certification of the HMO capitation rates which are also used to benchmark the PSNs;
- Policy Clarification regarding plan payments to county health departments; and
- External Quality Review Organization Contract Updates and Notification of Webinars and other meeting opportunities.

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

The PSN Policy and Contracting Unit continued with its monthly PSN systems implementation calls; however, the number of new items have dwindled on these calls to a few operational issues. The new topics this quarter were relative to the National Provider Number, paper claims processing backlog with the current fiscal agent, some clarification of transmission issues and concern regarding the changes in fiscal agents. In addition, the Agency notified PSNs through this call that the current Medicaid fiscal agent was unable to install a systems change that would cause claims submitted by certain provider types to deny unless authorization was provided by the fee-for-service PSN. Unfortunately, this change as well as others will have to wait until the new fiscal agent, EDS, begins March 1. The PSNs have, however, all certified that they were ready and able to accept this systems change.

In addition to these calls, the Agency has coordinated to conduct technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed.

Continuous Improvement Team

At the end of Year One of the demonstration, the Continuous Improvement Team was created to provide operational staff with feedback from enrollees, providers and health plans on what is working in Reform and what may need modification. The role of the continuous improvement team is to provide an independently moderated forum for discussion of Reform processes at the local level. This information will then be provided back to the operational areas working with the respective topic, as well as to Medicaid leadership, in order to ensure that the Agency keeps a continuous improvement process flowing throughout the implementation of the demonstration. The areas the team will provide feedback on are as follows:

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

These forums will occur throughout Year Two of the demonstration. Some forums will be held in both Duval and Broward Counties, some will be held in Tallahassee. The first will occur in November 2007 and cover outreach, customer service, plan benefits, and provider services. The forums are currently slated to be complete in May 2008. During this quarter, the team spent time honing the formats for the forums and processes for collecting feedback as well as finalizing the presentations for the first forum.

Attachment I
Choice Counseling Beneficiary Survey

Automated Beneficiary Survey Questions

Please use a 1 to 9 scale, where ONE is always the lowest rating score and NINE is always the highest rating. You may also use any number on the scale between one and nine for your rating.

1. **Q1 - MEDICAID SATISFACTION** Thinking about your experiences with Florida Medicaid, what is your overall satisfaction with the Medicaid program?
2. **Q2 - HELPFUL** Choice Counseling is here to help you select the right health plan. How helpful do you find this counseling to be? One means not at all helpful and nine means very helpful or you can use any number between one and nine.
3. **Q3 - WAIT TIME** Rate your satisfaction with the amount of time you waited to speak with a counselor today.
4. How did you hear about the Choice Counseling number you called today? Press 1 if it was from a mailing, 2 if it was a radio ad, 3 for Department of Children and Families, 4 if it was from a doctor's office, 5 from a friend or family member, or 6 from some other place.
5. Did you receive information about choosing your Medicaid health plan? Press 1 if you received information. Press 2 if you did not.
6. **Q4 - EASILY UNDERSTAND** Please rate how easy it was to understand the information. One means that it was not easy at all; nine means that it was very easy or you can use any number between one and nine.
7. Were you calling today to resolve a problem or to ask a question or choose a plan? Press 1 if your call today was about a problem or 2 if it was to choose a plan or to ask a question.
8. Please enter the number of times you have called about this same question or to enroll, including this call. So, if your call today was the only call, answer with a 1 or if it was the second call about this specific issue, enter the number 2.
9. Press 1 if the last counselor you talked to has taken care of your problem. Press 2 if you feel your problem has not been taken care of.
10. Press 1 if the last counselor you talked to has taken care of your question or completed your enrollment. Press 2 if you feel your question or enrollment has not been taken care of.
11. **Q5- RECOMMEND** Based on all of your experience with us today, how likely are you recommend the Choice Counseling helpline to a friend or someone in your family? One is not at all likely, nine is very likely or you can use any number between one and nine to rate how likely you are to recommend Choice Counseling.
12. **Q6 - COUNSELOR SATISFACTION** Please rate the overall service provided by the Counselor you just spoke to.
13. **Q7 - QUICKLY UNDERSTOOD** Your satisfaction with how quickly the Counselor understood why you called today.
14. **Q8 - CHOOSE PLAN** The Counselor's ability to help you choose your health plan
15. **Q9 - EXPLAIN CLEARLY** The Counselor's ability to explain things clearly
16. **Q10 - CONFIDENCE** The confidence you have in the information given to you by the counselor
17. **Q11 - RESPECT** Your satisfaction with being treated respectfully

Attachment I Choice Counseling Beneficiary Survey

Beneficiary Survey Results per Question — August – September 2007

August-07				
Question #	Rate 1-3	Rate 4-7	Rate 8-9	Total Count
Q1	20	106	285	411
	4.87%	25.79%	69.34%	
Q2	9	47	355	411
	2.19%	11.44%	86.37%	
Q3	17	56	338	411
	4.14%	13.63%	82.24%	
Q4	16	61	263	340
	4.71%	17.94%	77.35%	
Q5	8	33	370	411
	1.95%	8.03%	90.02%	
Q6	3	20	388	411
	0.73%	4.87%	94.40%	
Q7	4	17	390	411
	0.97%	4.14%	94.89%	
Q8	5	30	376	411
	1.22%	7.30%	91.48%	
Q9	6	23	382	411
	1.46%	5.60%	92.94%	
Q10	7	24	380	411
	1.70%	5.84%	92.46%	
Q11	2	11	398	411
	0.49%	2.68%	96.84%	

September-07				
Question #	Rate 1-3	Rate 4-7	Rate 8-9	Total Count
Q1	27	188	559	774
	3.49%	24.29%	72.22%	
Q2	3	63	708	774
	0.39%	8.14%	91.47%	
Q3	27	89	658	774
	3.49%	11.50%	85.01%	
Q4	23	96	501	620
	3.71%	15.48%	80.81%	
Q5	3	27	744	774
	0.39%	3.49%	96.12%	
Q6	0	16	758	774
	0.00%	2.07%	97.93%	
Q7	4	21	749	774
	0.52%	2.71%	96.77%	
Q8	6	28	740	774
	0.78%	3.62%	95.61%	
Q9	2	24	748	774
	0.26%	3.10%	96.64%	
Q10	5	27	742	774
	0.65%	3.49%	95.87%	
Q11	2	11	761	774
	0.26%	1.42%	98.32%	

Number of surveys completed for August 411
Number of comments 197
Number of positive comments 179
Number of negative comments 18

Number of surveys completed for September 774
Number of comments 356
Number of positive comments 327
Number of negative comments 29

Attachment I Choice Counseling Beneficiary Survey

August 2007 - *Positive Comments*

- This representative was great. Have him teach the other representatives that are totally unhelpful.
- This counselor was very courteous, professional, and respectful. He also was very helpful in explaining everything in detail, so that I didn't have to ask him any questions, because he explained everything. He's done a really well job.
- The gentleman was very informative, direct, and to the point. He made it easy for me to understand and gave me all the information I needed. I was quite satisfied with his performance.
- The counselor was very well spoken. She took her time and explained everything to me. She asked if I had any questions and made sure I understood everything. I had no problems. Everything went smoothly. I'm very satisfied with her performance today.
- The counselor was very attentive, she explained the product very well, and she understood what I was saying. She was very helpful and very efficient.
- Stephanie was very responsive, very kind, considerate, and asked all the right questions. I got all the information. She answered asked a couple of times to see if I needed anything. She knows her job, and knows how to do it. That's very unusual for Medicaid.
- She was extremely helpful. I have been calling around for several days trying to figure out how I need to switch my insurance companies. I explained to her what happened and she was very helpful and within minutes she told me what I needed to do and how to do it. She took care of my problem and I feel so much better about it.

August 2007 - *Negative Comments*

1. Betty was very helpful. She listened to what I was talking about. She explained everything. The prior representatives didn't know anything.
2. I think that the reps should be more prepared for all the questions that they could be asked. I need to figure out which pediatrician is good or not and I need to have their addresses, and they don't know what to tell you.
3. They are not ready for you to be able to pick a good pediatrician and they don't recommend you any or give you any options to pick from various different names. The girl said that Humana will not be able to give me a listing to see if I will get a good one or not.
4. I am not saying that my enrollment was not taken care of, I am just not sure if it was correctly. I was put on hold quite a few times and she asked me the same questions over and over, so I am not sure of her level of competency. I hope someone else will come behind her and look over it.
5. I need a plan so that I can stay with my present doctor. I'm presently enrolled in Stay Well. I need a plan that will take my ophthalmologist. He doesn't take the Stay Well plan. I don't know what I'm going to do because I'm going to lose my eye doctor.
6. They are not ready for you to be able to pick a good pediatrician and they don't recommend you any or give you any options to pick from various different names. The girl said that Humana will not be able to give me a listing to see if I will get a good one or not

Attachment I Choice Counseling Beneficiary Survey

September 2007 - *Positive Comments*

- "Jessica was just helpful, so friendly, and so confident that this plan would go through for my grandson who has special needs. Normally I would never take the time to respond to any type of questionnaire, but I felt compelled to do so today because she was so helpful. I was dreading this phone call."
- "The counselor that worked with me today was very pleasant, had a good customer service attitude, was very knowledgeable about the different health plans that Medicaid had to offer, and, overall, was extremely helpful in helping me to choose a plan. I would recommend her and I think she is doing an awesome job. Thank you."
- "The counselor was very knowledgeable in the areas I needed help in. She was very patient, and didn't rush me off the phone. That's very important in customer service. She went above and beyond to assist me today. Thank you very much."
- "I was very pleased with the customer service I received during this phone call. You guys are doing a good job. The changes you've made, the improvements, are great. It makes me feel reassured."
- "When I first called this number today I was very confused. I didn't know what to do, or where to go. This counselor, April, was so very helpful and understanding. She talked me through it so I completely understood everything she said. I feel good about my choices and the doctor I picked. I'm totally happy."
- "April was very helpful. She was very thorough. She didn't let me make any choices without hearing the options. We went through a lot of doctors to find a doctor. She was very patient. She was very knowledgeable and confident about her knowledge. I enjoyed speaking with her today."
- "Jessica was extremely helpful to me. She helped resolve the problem that I had, and choosing a plan that was most effective for my child. I thoroughly appreciate that. I'm not too familiar with the insurance. She helped explain to me the difference between the two insurances and what would better suit my child. I'd definitely highly recommend her as a Choice counselor. She did an awesome job. I hope she continues doing that awesome job. She's helped me and I know she'll help many others. Thank you very much."
- "The counselor was very helpful and she had a clear understanding of how the program worked and was very helpful in helping me understand that I had other choices to make as far as a health care provider. Thank you."
- "She was very helpful, understanding, gave me enough information, was a great counselor, had patience, and I would recommend for her to be my choice if I had to call again."
- "The person I spoke to this morning was very helpful, knowledgeable, and understood all of my needs. I think she satisfied me with this plan and I would recommend to anyone to call and speak with her. Thank you very much."

Attachment I Choice Counseling Beneficiary Survey

September 2007 - *Positive Comments*

- "My counselor was very diligent. She knew what she was trying to help me with. I really didn't know what I was supposed to do. This is my first time with my daughter in this situation and she was very helpful. She made me feel like I was important, that this call was important. She gave me credit for who I was. She was a person who made me feel like she was doing her job, but at the same time, she cared about me. I really think that she is a very good person."
- "The counselor that I spoke to today was most helpful. She was very thorough and efficient. I had questions about different health plans. She helped me make the best choice for my child, as far as the doctor that I was choosing to be her primary care physician, and the hospitals that I wanted to be able to attend, if there were an emergency. This counselor did an excellent job and I do appreciate it."
- "The counselor that I spoke to was very efficient. She helped me out a lot to understand my plans. She didn't force me into anything, she let me make my own decision, and I thought she was very good at what she was doing."
- "This counselor had helped me more than any other person I have dealt with on the Medicaid system. I was completely satisfied. She answered all of my questions and helped me completely with the problem, and solved it. She was excellent in everything. Very courteous and respectful. I had called four hours to other agencies and got no help. She completely helped me with my problem and solved everything. She's excellent at her job."
- "The counselor was very helpful, polite, and understanding of our difficult situation, which was nothing compared to the terrible experiences we had a year ago at the Medicaid offices where even the manager was extremely rude and talked down to us like we were trash. The counselor today was very professional, polite, and did everything she could to answer every question."
- "I worked with Gloria. She had more information than I have been able to get with any other calls, either from Choice counseling, DCF, or from the actual HMO plans themselves. She needs to be recognized for the work that she's doing. She did an excellent job."

September 2007 – *Negative Comments*

1. Betty was very sweet and very helpful. It is not her that I had a problem with; it is the system. She was very helpful, polite, and I apologized to her several times for being out of it. She was very understanding and a very nice lady. She does her job very well.
2. I had called several times earlier today. I talked to a girl named Stephanie. I was given no help at all. I called a few minutes ago and was helped immediately, to direct me to wherever I needed to go. She needs to really be commended. Thank you.

Attachment I Choice Counseling Beneficiary Survey

September 2007 - *Negative Comments*

3. I'm very happy with the service I received. My only concern is the limitations of the number of doctors that are available for pediatric services for children in our area. It totally eliminates any of the doctors in Baker County. They can no longer serve the children in Baker County and that's a disappointment to me.
4. She knew everything. She was very knowledgeable, and helped me with everything I needed to know. The first counselor did not, but this one did. I really appreciate it.
5. I would like to say that Demethra was very helpful. Although, I have to do some other things, she was very respectful and kind in her mannerisms, which is something that you don't get throughout the department. I would like to commend her for her helpfulness. Thank you very much.
6. Dominique was very helpful. I've dealt with several people who acted like they didn't have the time of day. She took the time to listen to what I needed to find out. She was very explicit in her comments, and very helpful. Thank you. She makes things a lot easier.
7. I have not received my gold card, which I was supposed to receive over a month ago. I cannot really get any information about Medicaid, how it works. That is the only reason. Thank you.
8. I had to call several numbers to try to get something satisfied, figured out today, and it's still not satisfied. I had to call Aetna. They have canceled my plan with no changes two different times. I have had to call and spend several hours trying to figure it out. I'm not notified when anything happens. Apparently, my plans have been cancelled because I had previous insurance, which I don't and never did since I have been approved. They didn't notify me. I go to get a prescription for my baby and I can't get it. It's been a week and I still don't have prescription, so this is just ridiculous.
9. You guys are eliminating your entire dental. You can't get the fillings, crowns, and deep cleanings. You're getting rid of everything. Dental is a part of your good health.
10. My son has United Health Care. I shouldn't have to be going through all this just to go see a dentist. Medicaid shouldn't allow insurance companies to just shrug us off.
11. Finding the specialist is very difficult in your living area and transportation is bad. That is one of the main problems. The medication from the drug store, the allotment per month, they never have anything you need in stock. That is it. Thank you.
12. My mom is on Medicaid and I have no luck with getting doctors through the Medicaid plan. She is with Access Health Solutions. We can't find any doctors for her, and can't get a home help aid for her, can't get a nurse to come see her. She is very sick and I just am not getting anywhere with Medicaid.
13. I have a 2 year old who is on Medicaid. There was a Medicaid reform in Jacksonville, Florida that I was not made aware of and now my son, who is sick, I had no idea where to take him for medical attention.

Attachment I Choice Counseling Beneficiary Survey

September 2007 - *Negative Comments*

14. I'm not happy. They don't give you what you need, or what the doctor has ordered. They deny and deny you without giving you service. You put in a complaint and they still do nothing about it.
15. The preferred prescription plan. Everyone has special needs and needs to be on special medications. There should never be a problem with that. The plan also needs more good doctors.
16. I have many problems. People keep changing my plan. I'm not very happy.
17. It took 5 separate phone calls to get any type of answer. I never get the same answers.
18. I'm Lucy Grier. I just moved down from Boston. I've tried for 4 weeks to request a Medicaid gold card. I'm bipolar, and I must have my medicine. I was told they'd mail me out a gold card, but I never got it.
19. My name is Lucy Grier. I chose a doctor and they were supposed to send me a gold card through the mail. I never received it. I need my medication.
20. I'm not happy because I had Medicaid, then I was switched to MediPass without knowledge of it, and I am trying to get to the doctor today and they are telling me that I no longer have MediPass, I have been switched over to access health solutions. I have no paper work on any of this, and I have spent the past 2 to 3 hours on the phone trying to figure out a way to get to the doctor.
21. I was calling to find out who accepts Medicaid for the glucose testing strips. The lady was very helpful, but unfortunately didn't have answers for me.
22. Trying to find out if my health plan covers mental health counseling.
23. She took care of all my basic questions. I needed more information, so she is mailing me out a packet of status review. Then I will be selecting another plan.
24. I started out belonging with Memorial Health Care Services. My doctors were involved through them. My problem is that neither of my 2 major doctors could be found through Memorial Health Care Services.
25. I didn't complete the question over the options because it doesn't show up in the program that I chose, the doctor that I have selected. So I have to talk to the doctor and see in which of the two plans he is in and I have to call again to the representative of options so that I can receive the application.
26. My problem was not taken care of. My son has a toothache. I still have to call United Health Care. It's up to them if they'll want to send my son to the dentist. He's in pain. What is he supposed to do?
27. I need the provider switched. I asked her what I needed to do, to change the provider, because I was given a provider versus being assigned to the same provider. She told me that I needed to call this number to have that done.

28. I called wondering why prescription did not go through. I was told that Aetna had said that I had insurance with them, which I have never had the whole time I have been on Medicaid. My account was cancelled without notifying me. I have been waiting. It's been over a week since my baby has been able to get medication, and I still can't get it. I was never notified of any change, which is absolutely ridiculous.
29. It is just ridiculous that things got canceled before notifying the applicant, or the case person, so I have no idea. I go to get the prescription for the baby. I can't get it because it's been canceled, because supposedly I had Aetna, which I have never had since I have applied with you. Why wasn't I notified? Here I go to get a prescription. I can't get it and the baby is without medicine for over a week, and I still haven't gotten it. I still need information about medication, dental, and I haven't received any of that.

Attachment II
Choice Counseling Call Center Activity Report

Month: July-07

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON	7/2/2007	901	893	893	8	0.9%	100%	0.0%	126.00	84.00	84.00	6.75	174	0.0%
TUE	7/3/2007	574	572	1,465	2	0.3%	100%	0.0%	89.00	71.00	0.00	7.42	220	0.0%
WED	7/4/2007	0	0	1,465	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
THU	7/5/2007	622	621	2,086	1	0.2%	100%	0.0%	99.00	93.00	49.00	7.40	206	0.0%
FRI	7/6/2007	463	462	2,548	1	0.2%	100%	0.0%	104.00	56.00	0.00	7.18	209	0.0%
SAT	7/7/2007	36	35	2,583	1	2.8%	100%	0.0%	70.00	101.00	0.00	8.90	1	0.0%
	Week Ending	2,596	2,583		13	0.5%	100%					7.2	810	0%
MON	7/9/2007	701	693	3,276	8	1.1%	100%	0.4%	172.00	205.00	87.00	7.67	201	0.0%
TUE	7/10/2007	515	513	3,789	2	0.4%	100%	0.0%	157.00	160.00	0.00	7.83	144	0.0%
WED	7/11/2007	566	565	4,354	1	0.2%	100%	0.0%	143.00	35.00	0.00	6.45	133	0.0%
THU	7/12/2007	585	583	4,937	2	0.3%	100%	0.0%	135.00	73.00	0.00	7.02	158	0.0%
FRI	7/13/2007	459	458	5,395	1	0.2%	100%	0.0%	88.00	123.00	1.00	7.57	258	0.0%
SAT	7/14/2007	41	40	5,435	1	2.4%	100%	0.0%	128.00	91.00	99.00	8.47	4	0.0%
	Week Ending	2,867	2,852		15	0.5%	100%					7.3	898	0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON	7/16/2007	705	679	6,114	26	3.7%	100%	1.1%	256.00	216.00	338.00	7.93	162	0.0%
TUE	7/17/2007	592	583	6,697	9	1.5%	100%	0.2%	139.00	334.00	127.00	7.83	184	0.0%
WED	7/18/2007	516	513	7,210	3	0.6%	100%	0.0%	121.00	104.00	116.00	7.90	209	0.0%
THU	7/19/2007	570	561	7,771	9	1.6%	100%	1.4%	428.00	609.00	59.00	8.25	187	0.0%
FRI	7/20/2007	422	421	8,192	1	0.2%	100%	0.0%	108.00	66.00	98.00	7.20	202	0.0%
SAT	7/21/2007	42	41	8,233	1	2.4%	100%	0.0%	136.00	330.00	0.00	8.43	10	0.0%
	Week Ending	2,847	2,798		49	1.7%	100%					7.9	954	0%
MON	7/23/2007	833	813	9,046	20	2.4%	100%	0.7%	188.00	264.00	292.00	8.22	162	0.0%
TUE	7/24/2007	620	616	9,662	4	0.6%	100%	0.0%	100.00	74.00	99.00	7.42	182	0.0%
WED	7/25/2007	694	682	10,344	12	1.7%	100%	0.6%	220.00	166.00	104.00	7.28	160	0.0%
THU	7/26/2007	631	620	10,964	11	1.7%	100%	1.0%	230.00	283.00	101.00	8.00	169	0.0%
FRI	7/27/2007	526	519	11,483	7	1.3%	100%	0.0%	138.00	95.00	37.00	8.42	153	0.0%
SAT	7/28/2007	38	37	11,520	1	2.6%	100%	0.0%	39.00	67.00	0.00	8.73	8	0.0%
	Week Ending	3,342	3,287		55	1.6%	100%					7.9	834	0%
MON	7/30/2007	953	861	12,381	92	9.7%	100%	23.1%	717.00	368.00	410.00	8.48	77	0.0%
TUE	7/31/2007	744	661	13,042	83	11.2%	100%	34.0%	726.00	846.00	838.00	8.22	110	0.0%
WED		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
THU		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
FRI		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
SAT		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending	1,697	1,522		175	10.3%	100%					8.4	187	0%
MON		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
TUE		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
WED		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
THU		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
FRI		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
SAT		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
	Week Ending	0	0		0		100%					0.0	0	0%
	Month End	**13,349**	**13,042**		**307**	**2.3%**	**100%**					**7.7**	**3683**	**0.0%**

Attachment II
Choice Counseling Call Center Activity Report

Month: August-07

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
TUE		0	0	13,042	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
WED	8/1/2007	745	718	13,760	27	3.6%	100%	5.1%	293.00	292.00	219.00	7.95	147	0.0%
THU	8/2/2007	632	617	14,377	15	2.4%	100%	4.1%	358.00	200.00	159.00	8.32	128	0.0%
FRI	8/3/2007	563	558	14,935	5	0.9%	100%	0.4%	220.00	133.00	76.00	8.12	308	0.0%
SAT	8/4/2007	55	55	14,990	0	0.0%	100%	1.8%	262.00	64.00	0.00	8.82	35	0.0%
	Week Ending	1,995	1,948		47	2.4%	100%					8.1	618	0%
MON	8/6/2007	783	758	15,748	25	3.2%	100%	1.3%	277.00	183.00	30.00	7.90	113	0.0%
TUE	8/7/2007	665	660	16,408	5	0.8%	100%	0.0%	129.00	132.00	47.00	7.73	158	0.0%
WED	8/8/2007	608	593	17,001	15	2.5%	100%	1.5%	245.00	233.00	293.00	8.80	186	0.0%
THU	8/9/2007	616	607	17,608	9	1.5%	100%	0.6%	259.00	207.00	123.00	7.60	110	0.0%
FRI	8/10/2007	527	523	18,131	4	0.8%	100%	0.4%	258.00	160.00	25.00	8.23	95	0.0%
SAT	8/11/2007	67	65	18,196	2	3.0%	100%	4.5%	240.00	0.00	0.00	1.93	5	0.0%
	Week Ending	3,266	3,206		60	1.8%	100%					7.9	667	0%
MON	8/13/2007	789	732	18,928	57	7.2%	100%	14.1%	481.00	291.00	435.00	8.45	224	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
TUE	8/14/2007	719	697	19,625	22	3.1%	100%	4.2%	298.00	581.00	143.00	8.25	117	0.0%
WED	8/15/2007	748	728	20,353	20	2.7%	100%	3.7%	496.00	283.00	396.00	7.42	123	0.0%
THU	8/16/2007	658	621	20,974	37	5.6%	100%	19.6%	1008.00	594.00	1630.00	7.95	119	0.0%
FRI	8/17/2007	518	504	21,478	14	2.7%	100%	5.0%	332.00	421.00	84.00	8.12	76	0.0%
SAT	8/18/2007	45	45	21,523	0	0.0%	100%	0.0%	111.00	255.00	0.00	9.70	6	0.0%
	Week Ending	3,477	3,327		150	4.3%	100%					8.1	665	0%
MON	8/20/2007	773	750	22,273	23	3.0%	100%	1.4%	299.00	284.00	199.00	8.08	148	0.0%
TUE	8/21/2007	665	660	22,933	5	0.8%	100%	0.0%	147.00	141.00	99.00	8.48	147	0.0%
WED	8/22/2007	712	708	23,641	4	0.6%	100%	0.3%	284.00	149.00	31.00	9.03	160	0.0%
THU	8/23/2007	643	635	24,276	8	1.2%	100%	1.2%	324.00	175.00	253.00	8.72	271	0.0%
FRI	8/24/2007	539	538	24,814	1	0.2%	100%	0.0%	83.00	83.00	51.00	8.20	96	0.0%
SAT	8/25/2007	60	60	24,874	0	0.0%	100%	0.0%	101.00	101.00	0.00	9.07	15	0.0%
	Week Ending	3,392	3,351		41	1.2%	100%					8.5	837	0%
MON	8/27/2007	970	954	25,828	16	1.6%	100%	1.6%	266.00	190.00	245.00	8.72	160	0.0%
TUE	8/28/2007	739	712	26,540	27	3.7%	100%	9.1%	591.00	842.00	249.00	8.08	173	0.0%
WED	8/29/2007	691	687	27,227	4	0.6%	100%	0.0%	158.00	158.00	168.00	8.57	218	0.0%
THU	8/30/2007	653	648	27,875	5	0.8%	100%	0.5%	235.00	200.00	384.00	8.87	167	0.0%
FRI	8/31/2007	511	502	28,377	9	1.8%	100%	0.6%	251.00	287.00	0.00	9.05	137	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
SAT		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending	3,564	3,503		61	1.7%	100%					8.6	855	0%
MON		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
TUE		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
WED		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
THU		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
FRI		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
SAT		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
	Week Ending	0	0		0		100%					0.0	0	0%
	Month End	**15,694**	**15,335**		**359**	**2.3%**	**100%**					**8.3**	**3642**	**0.0%**

Attachment II
Choice Counseling Call Center Activity Report

Month: September-07

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
TUE		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
WED		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
THU		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
FRI		0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
SAT	9/1/2007	0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending	0	0		0		100%					0.0	0	0%
MON	9/3/2007	0	0	28,377	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	0.0%
TUE	9/4/2007	880	864	29,241	16	1.8%	100%	1.5%	292.00	207.00	223.00	8.48	169	0.0%
WED	9/5/2007	683	664	29,905	19	2.8%	100%	2.1%	242.00	532.00	279.00	8.82	159	0.0%
THU	9/6/2007	663	657	30,562	6	0.9%	100%	0.0%	216.00	237.00	58.00	8.28	222	0.0%
FRI	9/7/2007	523	523	31,085	0	0.0%	100%	0.0%	144.00	0.00	105.00	8.27	157	0.0%
SAT	9/8/2007	39	39	31,124	0	0.0%	100%	0.0%	106.00	0.00	0.00	8.42	17	0.0%
	Week Ending	2,788	2,747		41	1.5%	100%					8.5	724	0%
MON	9/10/2007	829	821	31,945	8	1.0%	100%	0.1%	208.00	164.00	0.36	8.57	202	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
TUE	9/11/2007	651	649	32,594	2	0.3%	100%	0.0%	121.00	205.00	97.00	8.67	209	0.0%
WED	9/12/2007	623	619	33,213	4	0.6%	100%	0.0%	147.00	172.00	0.24	8.40	192	0.0%
THU	9/13/2007	630	627	33,840	3	0.5%	100%	0.0%	149.00	178.00	0.00	8.62	192	0.0%
FRI	9/14/2007	588	581	34,421	7	1.2%	100%	0.7%	196.00	92.00	391.00	8.25	142	0.0%
SAT	9/15/2007	49	49	34,470	0	0.0%	100%	2.0%	207.00	68.00	0.00	9.05	118	0.0%
	Week Ending	3,370	3,346		24	0.7%	100%					8.5	1055	0%
MON	9/17/2007	850	815	35,285	35	4.1%	100%	1.1%	335.00	205.00	328.00	8.55	285	0.0%
TUE	9/18/2007	726	716	36,001	10	1.4%	100%	0.3%	211.00	170.00	135.00	8.68	211	0.0%
WED	9/19/2007	675	674	36,675	1	0.1%	100%	0.6%	206.00	106.00	139.00	8.90	228	0.0%
THU	9/20/2007	725	713	37,388	12	1.7%	100%	1.9%	339.00	307.00	117.00	8.83	247	0.0%
FRI	9/21/2007	505	503	37,891	2	0.4%	100%	0.0%	140.00	0.01	0.00	8.13	155	0.0%
SAT	9/22/2007	44	43	37,934	1	2.3%	100%	0.0%	193.00	137.00	98.00	10.26	15	0.0%
	Week Ending	3,525	3,464		61	1.7%	100%					8.7	1141	0%
MON	9/24/2007	761	757	38,691	4	0.5%	100%	0.1%	199.00	164.00	93.00	9.00	218	0.0%
TUE	9/25/2007	705	697	39,388	8	1.1%	100%	0.7%	184.00	344.00	137.00	8.56	231	0.0%
WED	9/26/2007	634	633	40,021	1	0.2%	100%	0.0%	139.00	108.00	158.00	8.81	283	0.0%
THU	9/27/2007	579	579	40,600	0	0.0%	100%	0.0%	129.00	51.00	103.00	9.38	199	0.0%
FRI	9/28/2007	489	481	41,081	8	1.6%	100%	0.0%	164.00	193.00	133.00	9.56	183	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
SAT	9/29/2007	36	36	41,117	0	0.0%	100%	0.0%	133.00	134.00	0.00	10.01	72	0.0%
	Week Ending	3,204	3,183		21	0.7%	100%					9.0	1186	0%
MON		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
TUE		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
WED		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
THU		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
FRI		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
SAT		0	0	41,117	0	0.0%	100%	0.0%	0.00	0.00	0.00	0.00	0	
	Week Ending	0	0		0		100%					0.0	0	0%
	Month End	**12,887**	**12,740**		**147**	**1.1%**	**100%**					**8.7**	**4106**	**0.0%**