Florida Medicaid Reform

Quarterly Progress Report
July 1, 2008 – September 30, 2008

1115 Research and Demonstration Waiver

Agency for Health Care Administration

Table of Contents

List of Tables

List of Charts

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

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of allowing market-based approaches to assist the state in its service to Medicaid beneficiaries.

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 Conditions # 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 Three of the demonstration for the period of July 1, 2008 through September 30, 2008. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including 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 to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 8 through 12 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. By state law, Reform FFS PSNs are also required to become capitated within three years of operations (for most PSNs this is September 1, 2009).

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

Since the beginning of the demonstration, the Agency has received 19 health plan applications (12 HMOs and 7 PSNs) of which 17 applicants sought and received approval to provide services to the TANF and SSI population. Two of the approved were also approved for expansion into Baker, Clay and Nassau Counties: Access Health Solutions (a PSN) and United Health Care (an HMO). Of the 19 health plan applicants received, all but two have been approved as health plans as of September 30, 2008.

The two pending applications are Better Health Plan, a FFS provider service network (PSN); and AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS. Better Health Plan underwent organizational and ownership changes which prevented them from completing the application process during demonstration Year Two. By the end of September 2008, Better Health Plan entered Phase IV of the application process (Phase IV is the contracting phase, where the individual health plan contract is drafted and routed for review and execution).

AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its health plan application to serve beneficiaries living with HIV/AIDS in January 2008. This application is the second specialty plan application the Agency has received (the

first being a specialty plan for children with chronic conditions). As of September 30, 2008, this specialty plan application was nearing completion of Phase II of the application process.

Table 1 provides a list of all health plan applicants, the date each application was received, the date of application approval and each plan's county of operation, as well as the 2 pending applications.

Table 1
Health Plan Applicants

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

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area. There have been no new health plan contracts executed since September 2007 (Freedom Health Plan HMO).

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

Contract Amendments and Model Contracts

During this quarter, amendments were executed with the health plans that addressed capitation rates for Year Three of the demonstration and the individual health plan benefit packages. During the last quarter of Year Two, the Agency had prepared for the rate amendments for the third contract year (September 2008 through August 2009). The date for the provision of draft rates was extended to allow the state's contracted actuaries to review Agency and plan documentation in order to ensure that the rates were actuarially sound. Due to the extension of the draft rate provision and in order to allow proper notice to beneficiaries of the change in benefits, the new health plans' benefits will take effect on November 1, 2008.

Three health plans amended their contracts to withdraw from certain counties within the demonstration area: United Health Plan submitted a request to withdraw from Broward County and the Agency amended their contract to indicate a November 1, 2008, withdrawal effective date. Vista Health Plan d/b/a Buena Vista and Vista Health Plan of South Florida submitted requests to withdraw from Broward County and the Agency

amended those contracts to indicate a December 1, 2008, withdrawal effective date. Health plans stated reasons for pull out was not specific to the demonstration or to the September 1, 2008, capitation rates; rather the health plans stated their withdrawal was related to network provider contracting issues. The Agency worked with these health plans to ensure proper and timely notice to beneficiaries of the plans withdrawal.

This quarter, the Agency continued to draft an additional general amendment to the current health plan contracts that may include encounter data, marketing and possible administrative simplifications that could be implemented in Demonstration Year Three. As the Agency's experience with Medicaid encounter data has increased, including input from the health plans in regard to their encounter data experience, the Agency expects to provide revised encounter data requirements through this general amendment. With the success of the demonstration's Choice Counseling program, the Agency is reviewing the possibility of elimination of direct marketing by the health plans through the health plan general amendment. The Agency is also reviewing all contractual requirements in an effort to consolidate the contract and to create efficiencies and may make administrative simplification revisions while maintaining provisions for quality of care.

Additionally this quarter, the Agency began work, with the assistance of a consultant, to streamline the health plan contracts to create one core contract with plan type exhibits or riders depending on the unique requirements of the particular plan type (FFS PSN or capitated PSN or HMO). The Agency intends to use this new model contract with the contract renewal period beginning September 1, 2009.

FFS PSN Conversion Process

Pursuant to section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the 4th year of operation. This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2009, unless the PSN opts to convert to capitation earlier. The Agency continues the efforts initiated in Demonstration Year Two to provide technical assistance to the PSNs in any conversion areas in which the plans might be lacking or for which they request assistance. In addition, the Agency has begun an internal review process to ensure that conversion issues related to FFS claims processing are appropriately deliberated and handled.

Table 3 provides the list of required capitation go-live dates for the current FFS PSN contractors.

Table 3
PSN Conversion to Capitation Implementation Dates

FFS PSN Name	Scheduled Capitation Implementation Date
Access Health Solutions	09/01/2009
Children's Medical Services Network, Florida Department of Health	12/01/2009
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2009
Florida NetPASS	09/01/2009
Pediatric Associates	10/01/2009
South Florida Community Care Network	09/01/2009

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

Table 4
PSN Conversion to Capitation Timeline

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

FFS PSN Reconciliations

During this quarter, the Agency continued to work with two reconciliation[1] periods: one period for the first 6 months of operations (September 2006 through February 2007) and one period for the second 6 months of operation (March 2007 through August 2007). Several PSNs required substantial technical assistance in the reconciliation process as either the entities were new to the reconciliation process or had experienced staffing changes. The Agency continues to provide technical assistance regarding the first reconciliation to the three PSNs that have requested additional time or assistance as they analyze their reconciliation data. The FFS PSN contract requires an annual reconciliation that provides a twelve-month review of claims data (to allow for the lag-time that occurs with a twelve month FFS claims filing period). The Agency expects data for the first final annual reconciliation period (September 1, 2006 through August 31, 2007) to be available to the PSNs during the next reporting period.

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

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

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Year One, Year Two, and Year Three of the demonstration. Interested parties were notified that the data book would be emailed to requesting entities. This information assisted prospective plans 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 first data book on March 22, 2006. Subsequent updates to the data book were released on May 23, 2007 for Year Two and May 7, 2008 for Year Three. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency, sufficiency test standards and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards and catastrophic coverage level based upon the most recent historical FFS utilization data.

The health plans have become innovative about expanding services to attract new enrollees and to benefit enrollees by broadening the spectrum of services. The standard 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 since Year One of the demonstration.

Current Activities

The benefit packages customized by the health plans for Demonstration Year Three will become operational on November 1, 2008 and will remain valid until August 31, 2009. These benefit packages include 28 customized benefit packages for the HMOs and 14 different expanded benefits for the FFS PSNs.

The 11 HMOs offering customized benefit packages for TANF and SSI targeted populations are AMERIGROUP Florida, Freedom Health Plan, HealthEase Health Plan of Florida, Humana Medical Plan, Wellcare of Florida d/b/a Staywell Health Plan of Florida, Preferred Medical Plan, Vista Health Plan of South Florida, Vista Health Plan d/b/a Buena Vista Healthplan, Total Health Choice, Universal Health Care and United Healthcare of Florida. The 6 FFS PSNs are Access Health Solutions, Children's Medical Services, First Coast Advantage, Florida Netpass, Pediatric Associates, and the South Florida Community Care Network.

One of the significant changes in the benefit packages for Year Three is the increase in the total number of copayments from Demonstration Year Two. In total, there are 85 more copayments required during Year Three (104) than in Year Two (19). From Year Two to Year Three, there were increases in the number of copayments in all categories

except dental. However, despite the increase in the number of copayments, 20 benefit packages (71%) have no copayments in all 16 categories. Table 5 displays the number of copayments for each service type, and Table 6 displays the number of plans that do not require copayments available to each target population in the demonstration areas.

Table 5
Number of Benefit Packages Requiring Copayments
Demonstration Years One, Two, and Three

Type of Service	Year One	Year Two	Year Three
Chiropractic	10	0	8
Hospital Inpatient: Behavioral Health	11	1	8
Hospital Inpatient: Physical Health	7	1	8
Podiatrist	10	0	7
Hospital Outpatient Services (Non-Emergency)	7	1	7
Hospital Outpatient Surgery	7	1	8
Mental Health	7	3	6
Home Health	4	1	8
Lab/X-Ray	5	1	7
Dental	4	4	4
Vision	4	0	5
Primary Care Physician	0	0	5
Specialty Physician	1	1	6
ARNP / Physician Assistant	0	0	5
Clinic (FQHC, RHC)	0	0	6
Transportation	5	5	6
Total	**82**	**19**	**104**
Total Number of Benefit Packages	**28**	**30**	**28**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**

Table 6
Number of HMOs Requiring No Copayments
By Target Population and Demonstration Counties

Target Population	Demonstration Counties	Number of HMOs Not Requiring Copayments
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	4
SSI (Aged and Disabled)	Broward	8
TANF (Children and Families)	Duval, Baker, Clay and Nassau	2
TANF (Children and Families)	Broward	6

In Year Three of the demonstration, many plans continue to provide services not currently covered by Medicaid to attract enrollees. In the health plan contract, these are referred to as expanded services. There are 11 different expanded services offered by the health plans during this contract year. The 2 most popular expanded services

offered were the same as Year Two: the over-the-counter (OTC) drug benefits and the adult preventative dental benefits. Thirteen of the customized benefit packages decreased their OTC value, while one added a $25 OTC benefit. The expanded services available to beneficiaries include:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition Therapy.

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

The Agency continues to review utilization and other data to establish options for allowing more customization and more flexibility in both Medicaid covered services and expanded services in the next operational years. Since the health plans can manage enrollee health care through utilization management and case management expertise, plans are better able to offer resources to provide care that is better suited to individual members. Examples of benefits that are more valued by beneficiaries are individualized alternative treatment and additional benefits that are not covered under state plan services.

The PET submission procedure for Demonstration Year Three was similar to that of the two previous years. The updated version of the data book was released by the Agency on May 7, 2008, and the new PET was made available to the health plans on May 23, 2008. However, the deadline for the health plans to submit their updated PETs was extended to August 13, 2008 due to the release of the draft rates on August 8, 2008. This extension required the effective date of the Year Three benefit packages to be revised to November 1, 2008. This revision was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice

materials, which included the plan benefit packages for Year Three of the demonstration.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, and Medicaid fair hearing system. In addition, plan contracts include timeframes for submission, plan response and resolution of beneficiary grievances. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. In addition, the Medicaid Reform health plan contracts include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations. This provides an additional level of appeal.

As defined in the health plan contracts:

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

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

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

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

Current Activities

In an effort to improve the demonstration, the Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. In an attempt to better understand the issues beneficiaries face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in our quarterly reports. The Agency also uses this information internally, as part of the Agency's continuous improvement efforts.

Grievances & Appeals

Table 7 provides the number of grievances and appeals by health plan type for the previous quarter ending June 30, 2008. The health plan grievance and appeals reporting cycle coincides with the due date for this quarterly report. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report will lag one quarter in each quarterly report and will be updated in the annual report to reflect the full year of data.

Table 7
Grievances and Appeals
April 1, 2008 - June 30, 2008

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	48	15	265	138	224,052

*unduplicated enrollment count

Summary of grievances and appeals.

Medicaid Fair Hearings

Medicaid Fair Hearings

Table 8 provides the number of Medicaid Fair Hearings (MFH) requested during the quarter ending September 30, 2008. Medicaid fair hearings are conducted through the Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members.

The Agency monitors the fair hearing process. Of the 23 MFH requests, 21 were related to denial of benefits/services, with one request for a plan change to MediPass and one request to change providers within a plan. Only 8 MFHs were actually held (all HMO related) and the outcome in four was favorable to the beneficiary, in one was favorable to the HMO and three await DCF's decision. Six hearing requests are pending at this time The other 9 MFH requests were resolved by the health plan prior to the hearing date.

Table 8 Medicaid Fair Hearing Requests *July 1, 2008 – September 30, 2008*	
PSN	3
HMO	20

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as 1 grievance has been submitted to the BAP, and none to the SAP for this quarter. The single BAP grievance issue, was related to speech therapy benefits and was resolved in favor of the health plan (HMO).

Table 9 provides the number requests to BAP and SAP for the quarter ending June 30, 2008.

Table 9 BAP and SAP Requests *July 1, 2008 – September 30, 2008*	
BAP	**1**
SAP	**0**

4. Complaint/Issue Resolution Process

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on what is working and not working in managed care under the demonstration. Complaints/issues come to the Agency from beneficiaries, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received by the Agency are as follows:

- Medicaid Local Area Offices,
- Medicaid Headquarters Bureau of Managed Health Care,
- Medicaid Headquarters Bureau of Health Systems Development, and
- Medicaid Choice Counseling Helpline. Health plan complaints received by the Choice Counseling Helpline are referred for resolution to the Florida Medicaid headquarter offices specified above.

The complaints/issues are worked by Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. This tracking is accomplished through a consolidated automated database, implemented October 1, 2007, that is used by all Agency staff housed in the above locations to track and trend complaints/issues received.

The Agency tracks complaints by plan and plan type (PSN and HMO) and continues to review particular complaint data on individual plans on a monthly basis and reviews complaint trends on a quarterly basis at the management level.

This quarter, the Agency received 7 complaints/issues related to FFS PSNs and received 44 complaints/issues related to HMOs, for a total of 51 complaints. The complaints/issues received during this quarter are provided in Attachments I and II, respectively by PSN or HMO. Attachment I provides the details on the complaints/issues related to FFS PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address those issues raised.

This quarter, the majority of PSN complaints/issues were access related, with only one being a claim related issue. Member issues included access to specialists and specialty referrals, authorization of out-of-network services and prescribed drug authorizations. The one provider issue was regarding timely claims payment.

During the quarter, the majority of the HMO complaints/issues were related to member issues, with the majority being related to access and authorization issues and the second largest number being related to problems resulting from incorrect enrollment information. Other member issues included dental, prescribed drugs, and enhanced benefits. Provider issues included payment delays/denials; however, some of the enrollment issues also affected timely provider payment. With the change in fiscal agents taking effect at the start of this quarter, the Agency is monitoring the enrollment complaint issues to determine whether this issue is related to enrollment data provided to the health plans by the fiscal agent or related to the timeliness and accuracy of the health plans updating their member information.

The Agency's staff worked directly with the members and with the HMOs to resolve issues. For both PSN and HMO issues, education was provided to members and to providers to assist them in obtaining the requested information/service and for future use. The HMOs and PSNs were informed of all the member issues, and in most cases, the HMOs and PSNs were instrumental in obtaining the information or service needed by the member or provider.

Agency staff will continue to resolve complaints in a timely manner and to monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

5. On-Site Surveys

In the spring and summer of 2007, the Agency performed on-site surveys of all 17 Reform health plans. These surveys gauged compliance with standards set forth in each plan's contract with the Agency and included a review of policies and procedures and information technology systems including claims payments and provider networks.

The results of these surveys were all health plans are currently in good standing with the State and there were no sanctions.

The State has begun surveying all Reform health plans for 2008. These reviews will be focused more on operational issues, and plan employee interviews. The surveys will be completed by the end of 2008.

B. Choice Counseling Program

Overview

The demonstration is in its first quarter of Year Three. A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health by providing them with the information they need to make the most informed decisions about health plan choices. The implementation of a Preferred Drug List (PDL) search functionality called the Informed Health Navigator Solution (Navigator) further enables beneficiaries to select a health plan based upon their medication and health plan coverage needs. During this quarter, the Navigator script was finalized, the health plan's PDLs were tested and loaded, training materials were prepared, and implementation is planned for the end of October 2008.

In July 2008, the Florida Medicaid Program moved to a new system developed and implemented by the new fiscal agent, EDS (Electronic Data Systems). This new system incorporates both the fiscal agent support and the managed care non-Reform enrollment broker functions under one system. The implementation of this system has been a massive undertaking as it impacts over 2,000,000 recipients and over 80,000 providers throughout the state. The transition to the new fiscal agent also impacted the exchange of enrollment and eligibility information with the Medicaid Reform Choice Counseling System, HMOs, PSNs and the state's primary case management program operated under Florida's 1915(b) Managed Care Waiver. It receives data from other agencies such as the Florida Department of Children and Families and Social Security Administration, and handles claims exchanges. There are more than 10 large files that transfer information on a daily, weekly or monthly basis.

The transition to a new system has impacted the Choice Counseling program operating under the demonstration. The Reform Choice Counselor, Affiliated Computer Services (ACS), receives its newly eligible information, enrollment and all data from the new fiscal agent, EDS. The information that has been conveyed has been incomplete, leaving the Medicaid Reform Choice Counseling System with either less data than would be expected (for new eligible's) or a larger than expected amount of data. Resolving this issue has been a top priority with the Agency, ACS and EDS. Receiving correct data is key for ACS to be able to meet contract standards for enrollment, call statistics, and mailroom standards, etc. ACS, EDS and the Agency have worked diligently to rectify the issues as they have been identified, so that the information exchange is processed and handled as efficiently as possible. ACS and EDS have demonstrated the ability to problem solve and have made great efforts to work together along with the Agency to resolve these issues.

The Agency and ACS have a great commitment to serving the beneficiary. During the transition, the Agency and ACS have worked together to ensure beneficiaries needs are addressed in a timely manner with actions such as:

- Authorizing the Choice Counseling Call Center and Field Choice Counselors to allow Good Cause plan changes when a beneficiary has had any difficulty accessing

choice counseling services or the information in the Medicaid Reform Choice Counseling System has been incomplete;

- The Field Choice Counselors working to reach out to community partners to help communicate with beneficiaries;
- The Field Choice Counselors helping handle more Choice Counselor Call Center call backs (from messages taken), and handling an increased amount of plan changes and enrollments; and
- Special Needs Unit Nurses reaching out to help those that have complex health needs, and helping with beneficiary messages and call backs.

These efforts along with others mentioned in this section are helping beneficiaries remain satisfied with their overall Choice Counseling experience.

Satisfaction levels are monitored through the Customer Service Survey which continues to be utilized by the beneficiary. The Agency and ACS are closely monitoring their responses. The beneficiary's experience and feedback is very important especially during this transition time, and their responses continue to be very positive. The positive Customer Service Survey responses received speak very highly about the efforts being made by the Choice Counselors, and beneficiaries are able to connect and receive what they need to make plan changes and enrollments.

Current Activities

1. Public Meetings and Beneficiary Feedback

The Agency has held beneficiary focus groups and public meetings in the demonstration counties to solicit input on the Choice Counseling program. As a result of the feedback from previous public meetings, the implementation of a preferred drug search functionality called the Informed Health Navigator Solution (Navigator) is scheduled to go live in the Choice Counseling program October, 2008.

Navigator is a Preferred Drug List (PDL) search system. The Navigator system will contain each Medicaid Reform health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator will pull the medication data and then provide detailed information on how each plan meets the beneficiary's current prescribed drug needs. This detail allows the system to provide more information to the beneficiary and does not require that the individual remember their current medications. The Navigator system also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries who do not have prior claims history. This function would allow the Choice Counselor to provide basic information to the beneficiaries on how each plan could meet their current prescribed drug needs.

The Choice Counselor's role would not be counseling a beneficiary on the medications themselves, but stating the results based on their search in the PDL of which health

plans covered the beneficiary's medication. This information would allow the beneficiary to be able to select his or her plan more easily, as it will provide more information for selection.

In previous quarters, the Agency conducted public meetings to receive input on Navigator and in this quarter, the Agency solicited comments at a Technical Advisory Panel Meeting (TAP) and recommendations were made to add language to the Navigator script. The Agency and ACS took those suggestions and have finalized the script in preparation for the training and "go live" date at the end of October, 2008. The demonstration was well received and the comments from the attendees were very positive.

Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. During the months of July through September of 2008, over 1,507 beneficiaries completed the automated survey. The survey seeks input regarding:

- 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 a counselor;
- How easy the information is to understand;
- Rating the customer service provided by the counselor, including confidence in the information provided; and
- Rating the likeliness of recommending the Choice Counseling helpline to someone else.

The Customer Survey ratings consider 100% to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. 100% or 9 reflect a truly satisfied caller. The scoring range translates into the following percentages:

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

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

During the first quarter of Demonstration Year Three, the overall beneficiary survey scores remain high although the scores for the amount of time the beneficiary has to "wait on hold" have declined. This reduction in score for the hold time, began in August, which correlates with the increase in incoming call volume to the ACS Choice Counseling Call Center (which began in August). The increase in call volume is related to issues with the transition to the new fiscal agent and an increase in the number of new eligibles. ACS notified the Agency immediately of the increase in call volume and beneficiary wait time. To creatively and quickly handle the increase in calls, the call center created the "red alert" messaging system as an immediate response to offset the caller's wait time. This allows a beneficiary on hold (for 5 minutes) to leave a message with a live person and receive a call back within 24 hours. This action has helped beneficiaries get the responses they need in a shorter amount of time, and we expect that the hold time score are expected to improve within the next quarter. In addition, ACS is hiring more choice counselors to handle the temporary increased call volume related to transition issues.

The other areas reflected in the survey are continuing to show high scores. The one area that has consistently showed a medium score since the introduction of the customer service survey is the "ease of understanding the information". The materials that illustrate the benefit plans are an area that the Agency and Choice Counseling continue to look at for ways to convey the message in an easier format. This will be reviewed again during Year Three as we strive to improve the program.

Chart A on the following page shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from July through September of 2008.

Chart A Choice Counseling
Percentage of Satisfaction of Callers for Each Question

How helpful is this counseling		
July	***August***	***September***
87.2%	**90.1%**	**87.6%**

Satisfaction with the amount of time you waited		
July	***August***	***September***
82.3%	**68.1%**	**52.7%**

How easy was it to understand the information		
July	***August***	***September***
77.1%	**78.4%**	**80.3%**

How likely are you to recommend Choice Counseling helpline to a friend or relative		
July	***August***	***September***
91.3%	**90.9%**	**90.9%**

Satisfaction with overall service of Choice Counselor		
July	***August***	***September***
95.3%	**95.0%**	**95.5%**

How quickly the Choice Counselor understood your reason for calling		
July	***August***	***September***
93.2%	**95.7%**	**95.0%**

The Choice Counselor's ability to help you choose a plan		
July	***August***	***September***
93.2%	**93.6%**	**92.6%**

The Choice Counselor's ability to explain the information clearly		
July	***August***	***September***
94.2%	**94.8%**	**95.2%**

Confidence in the information received		
July	***August***	***September***
93.2%	**94.2%**	**94.4%**

Satisfaction with being treated respectfully		
July	***August***	***September***
96.0%	**96.9%**	**97.2%**

The number of beneficiaries participating in the Survey was as follows: July - 485, August - 483, and September – 539 (totaling 1,507).

2. Call Center

Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida, operates a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation were adjusted during the second quarter of Year Two to better align the call center hours with beneficiary demand. Beginning January 2008, the call center hours were adjusted to Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., thus providing no Saturday hours. The call center has over 32 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls. (An additional 7 more full time FTEs and 3 part time employees will be joining the Choice Counseling team in October.)

ACS call center has been reporting a continually growing volume of incoming calls (particularly in August and September). According to ACS, there were a large number of incoming calls related to the non-reform managed care programs which operate under authority of Florida's 1915(b) Managed Care Waiver, and health plans leaving a particular county, or changes in their benefits. The Agency and ACS have been in constant communication about the call volume since this spike began in August, and ACS has done an outstanding job to handle this increase in volume with both short and long term solutions.

The following actions were implemented to cover the continued increase of call volume:

1. A "red alert" messaging system was implemented to give beneficiaries the opportunity to leave a message after 5 minutes of hold time. Call backs to these beneficiaries happen within 24 hours (from 5-7pm daily). (This is a short term solution that will be phased out).

2. 10 new staff (7 full time and 3 part time employees) have been hired and are currently in training with an implementation of November 2008.

This increase in calls, along with an increase in the Medicaid eligible population, has made it clear that an increase in Call Center staff is the correct action to cover the volume. The messaging and call back option is being used as an intermediate solution until the new counselors are trained and on the phones (or until the wait time to reach a counselor is back under the set standards).

Table 10 shown on the following page compares the call volume during the first quarter of Year Two and Year Three.

Table 10 Call Volume 1st Quarter Year Two and Year Three		
	Year Two	**Year Three**
Inbound Calls:	41,930	60,951
Outbound Calls:	11,431	12,437
Calls Abandoned: (The contract standard is <5% monthly)	1.90%	12.86%
Calls Answered within 4 rings:	100%	100%
Call Answer Rate:		
Calls Answered in <15 Seconds:	77.04	41.31
Calls Answered in <60 Seconds:	86.61	49.87
Calls Answered in <180 Seconds:	96.38	67.85

Calls answered in less than 180 seconds have a contract standard of 96%. The 15 and 60 second call rates do not have a contract standard, but are monitored as well because they are indications of customer service provided by the Call Center. Choice Counseling has been meeting and exceeding contract standards in the Call Center for the last 2 years. The statistics above show that in the first quarter of Year Three, there were over 19,000 more calls taken than were reported in the first quarter of Demonstration Year Two. This increase affects not only the answer times, but all the set standards.

The answer rate of the incoming calls has been affected by the increase in incoming calls along with fiscal agent transition issues. The call answer rate dropped during the period August 2008 through September 2008. With an increase in the number of employees to answer the calls, the answer rate and other standards will continue to move back in the direction they had been in the last 24 months.

3. Mail

The mail room equipment and process has been evaluated by ACS and a plan for this area of the project will be proposed to the Agency in the next quarter.

<u>Outbound Mail</u>

During the quarter, the ACS mailroom mailed the following:

New-Eligible Packets	24,190
Auto-Assignment Letters	26,240
Confirmation Letters	20,508
Open Enrollment Packets	34,738
Transition Packets	996

During this quarter, the amount of returned mail exceeded the Year Two average of 2-3%. The amount of return mail has increased due to the system issues which increased the number of incorrect beneficiary addresses. When a request for a letter was received with additional characters (i.e.: an apartment number) the system would cut off the additional characters and the letter was sent out without proper address information causing a large number of letters to be returned.

The Agency and ACS have worked diligently to correct the address fields with the fiscal agent so the Medicaid Reform Choice Counseling System would accept and read the data correctly. 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. Also, the Choice Counseling staff worked to re-address the packets or letters that are missing digits in the street address field, with the newly eligible mailings taking top priority. The amount of returned mail processed this quarter was 11,980 pieces.

Inbound Mail:

During the quarter, ACS processed the following:

Plan Enrollments	800
Plan Changes	77

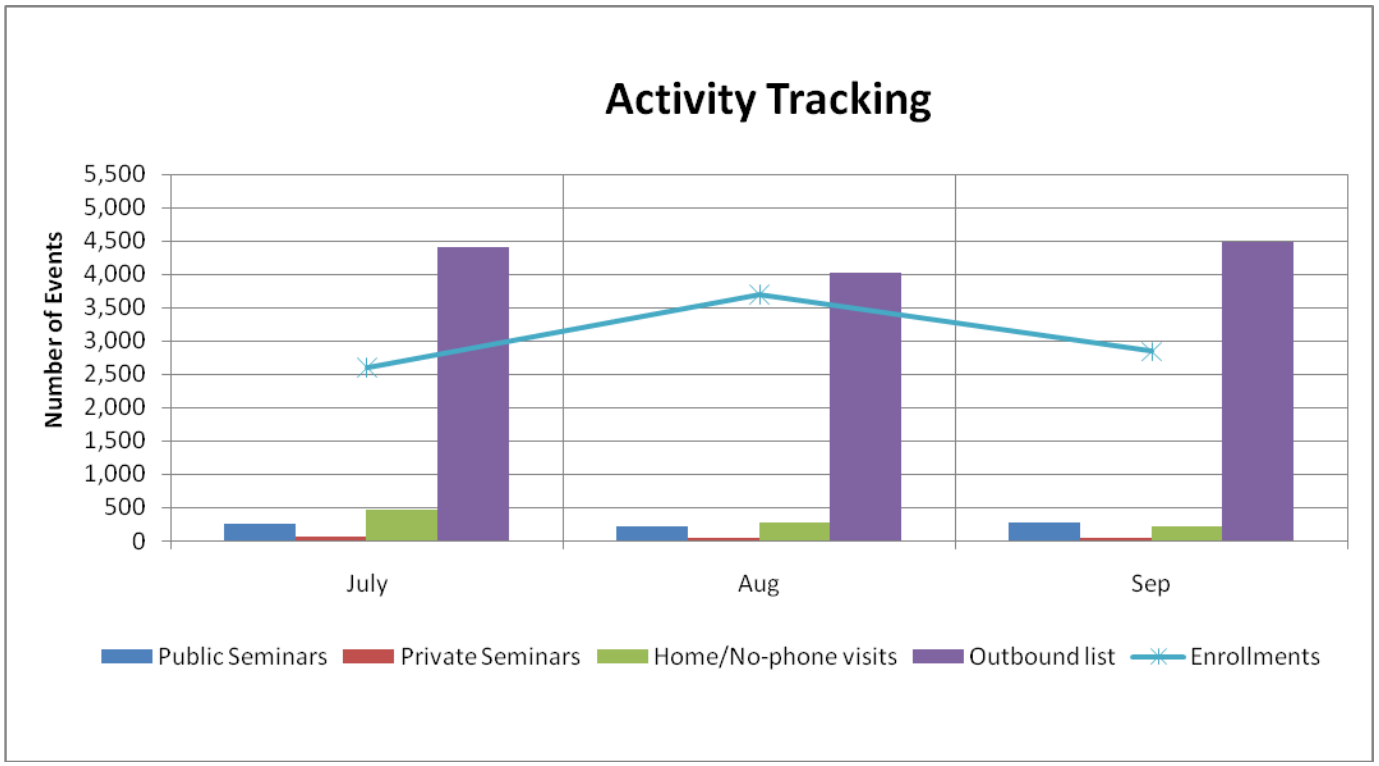
The percentage of enrollments processed through the mail-in enrollment forms has remained around 3.5% of enrollments. The Agency and ACS are exploring options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other 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 quarter, the Field Choice Counseling Outreach team has continued to focus its efforts to reach those beneficiaries with a pending assignment. The data exchange between the new fiscal agent and the Medicaid Reform Choice Counseling System has not always worked successfully but the team has made great efforts to help out in other areas such as return calls from the call center, and continued public and private seminars to reach beneficiaries. These efforts have resulted in a record setting month in August 2008, as the Field Choice Counselor’s enrolled 3,603 beneficiaries.

Chart B provides the type and volume of Field Choice Counselors activities from July 2008 – September 2008.

Chart B Choice Counseling Outreach Activities
July 2008 – September 2008



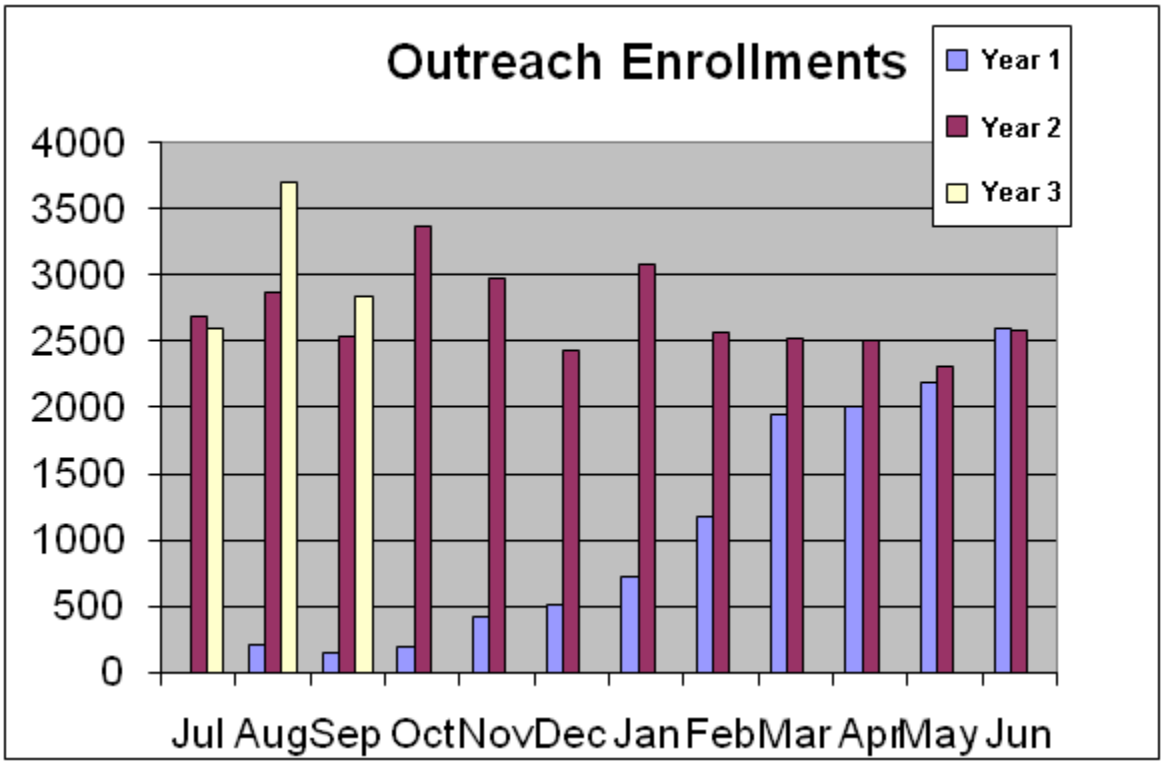
Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff has been calling beneficiaries at random who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 11 shows the beneficiaries' responses (in percentages) from 96 beneficiaries randomly called who participated in the survey (from July 2008 to August 2008). The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 11 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	98.50%
Felt the information provided by the Choice Counselor helped them make an informed decision	98.50%
The information was explained in a way that made it easy to understand	99.00%
The Choice Counselor was friendly/courteous	100.00%

ACS continues to evaluate the monitoring results and has made updates to tools the Field Counselors use for both outbound calls and face-to-face sessions to better serve beneficiaries.

At the end of the first quarter of Year Three, the enrollments processed by Field Choice Counselors were 9,135 enrollment activities. Chart C demonstrates the enrollment activity levels of the Field Choice Counselors during Years One, Two and Three of the demonstration.

Chart C
Field Choice Counseling Outreach Enrollments



Another focus of the Field Choice Counselors is 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 have 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. During this quarter, the Field Choice Counselors continued to focus outbound calls on the call backs provided from the Call Center and the pending auto assignments (which is a list of beneficiaries who have not made a choice of health plans and are within a few weeks of being assigned to a health plan by the state). ACS continues working on the development of relationships with

many community based organizations and providers in the expansion counties of Baker, Clay and Nassau.

During this quarter, the Field Choice Counselors completed the following activities:

Group Sessions	738
Private Sessions	111
Home Visits & One-On-One Sessions	178
"No Phone List"	926
Outbound Phone List	12,912
Enrollments	9,135
Plan Changes	490

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. In December 2007, a new registered nurse supervisor (RN) was hired, earned her certification in the Choice Counseling process, and began her duties in the Special Needs Unit with ACS. The RN supervisor has developed and implemented training for the Choice Counselors which outlines how the Special Needs Unit works and how to refer beneficiaries to the unit for help. In March 2008, a licensed practical nurse (LPN) was hired to work in the Special Needs Unit. The LPN completed her Choice Counseling certification course in April and is a valuable part of the Special Needs Unit.

The staffing goal of the unit, after an evaluation (performed in 2007), is to staff the Special Needs Unit with one RN supervisor, two LPNs 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:

- Development of additional training for the Choice Counselors working with and serving the medically, mentally or physically complex;
- Enhancements to the scripts to educate beneficiaries on how to access care in a managed care environment;
- Design and development of tools that can be provided to beneficiaries on how to access care and other important facts about managed care plans;
- Development of reference guides to increase the Choice Counselors knowledge of Medicaid services; and
- Participation in the development of the Navigator Choice Counseling script.

6. New Eligible Self Selection Data[2]

The new eligible numbers for self selection have not been reported since July 2008 due to issues with daily file and month end processing transfers from the fiscal agent and ACS Choice Counseling. Without the correct new eligible information, the new beneficiaries who need to select a plan cannot be identified and ACS Choice Counseling Call Center and field personnel cannot consistently have a target to reach. The July Self Selection Rate (which was the only Self Selection Rate calculated since implementation) was at 71%, which was down from the previous quarter due to information transfer challenges. The previous quarter had a rate of 83.32% (April - June 2008). New Eligible Enrollments for the quarter were as follows: 5,281 for July; 9,824 for August; and 9,800 for September 2008; totaling 24,905 enrollments.

The Agency has suspended the calculations of the Self Selection Rate until the system issues are addressed. There have been no sanctions imposed during this time since the issues impacting self selection are not ACS issues. This situation is being monitored on a continual basis.

The Agency, ACS and EDS are having daily conversations and corrective work is in process to rectify this very important issue. The daily file of information that transfers from EDS to ACS has made improvements and almost all of the issues are rectified. With the daily information coming through consistently and correctly, it will allow ACS to determine who the new eligibles are, and ACS can contact those who need to make a plan selection in a timely manor, thus meeting (and exceeding) the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

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. In August of 2007, 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. The Agency continues to work with ACS on an avenue to account for the complaint recordings left via the automated survey.

In this quarter, there were 3 complaints filed related to the Choice Counseling Program. Attachment III provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

[2] The Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate",* the data is referred to as *"New Eligible Self-Selection Rate"*. The term *"self-selection"* is now used to refer to beneficiaries who choose their own plan and the term *"assigned"* is now used for beneficiaries who do not choose their own plan.

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 reporting the beneficiaries' confidence in the Counselor's ability to explain health plan choices indicate that more than 95% are satisfied with the Choice Counseling experience. ACS continues to focus on improving communication between Counselors and beneficiaries and evaluating comments left by beneficiaries to improve customer service.

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

Included in this report are comments from beneficiaries who expressed their appreciation to one of our Call Center Supervisors for the Choice Counselors who helped them when they called the Choice Counseling Helpline. The individual counselors that received this positive feedback have gone the extra mile and have offered a "helping hand" to those who have called in. These beneficiaries have taken the initiative on their own to contact the supervisors to compliment the work that the counselors have done. During this quarter, there were 32 reported comments to supervisors about counselors going above and beyond the call to help beneficiaries. Table 12 provides examples of positive feedback about Choice Counselors.

Table 12 **Helping Hands** **Examples of Positive Feedback about Choice Counselors** **July 1, 2008 - September 30, 2008**
A beneficiary who called to compliment **Beverly Woodson** said, "Beverly was very good with talking to me. Actually, she was excellent. I asked a lot of questions; she was very patient. I really appreciated her service."
A beneficiary who called to say **April Hill** was very helpful and gave her all the information she needed said, "I have been on the phone all day and in just three minutes of speaking with April I got everything I needed. Thanks for having a pleasant person like April."

Table 12 Helping Hands Examples of Positive Feedback about Choice Counselors July 1, 2008 - September 30, 2008
"**Angela Reshard** really helped me today, she was able to get me the information that I needed and presented it in a very good way. I'm very happy and pleased with the service provided. Thank you."
"**Stephanie Hays** was very helpful to me, she answered all my questions. I appreciate all that she did for me; is nice that you have agents like her. She took her time to explain every little detail to me. I'm very happy now."
"Both **Felisha Bell and Martine Estime** provided world class service during an enrollment and a call back."
Two beneficiaries commended **Glenique Seabrooks** for her willingness to answer questions and provide them with information for contacting the appropriate agency during red alert message taking. Thank you, Glenique, for providing excellent customer service.
A beneficiary who called to say that **April Hill** was great said, "She really helped me and I appreciated her being patient. I had been calling everywhere and no one seemed to help but April. Thanks for having a wonderful person like April."

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 the Choice Counselors 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. ACS has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the call center and field have been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

9. Summary

Overall with a project as large as transitioning to a new Medicaid fiscal agent, there are bound to be challenges for everyone as we all learn and work in a new system. The issues that have developed are difficult but are not insurmountable. The problems have been identified, prioritized, and are being systematically worked through with the help of ACS, EDS and the Agency.

EDS has worked very hard to ensure that any fiscal agent activities that affect Choice Counseling are given a high priority, so that the beneficiary can receive the attention and care that is needed.

ACS continues to work hard to provide excellent customer service to the beneficiaries and has continued to play a key role in identifying and resolving issues as they come up in all areas of their organization. Even with these difficulties, the beneficiary is treated with the highest regard and given the opportunity to make plan selections and changes through whatever process is necessary to help them, especially during this time (including Good Cause).

Based on historical performance, the Agency believes that Reform Choice Counseling will resume their exceptional performance standards once the daily and month end files are working properly. The Agency is proposing that the Self Selection Rate calculation resume after one month timeframe of accurate file exchange is established. This will help ensure that the problems have been resolved and a level playing field will be established for ACS to perform. In the mean time, all parties continue to work to meet that goal in as short a time as possible.

The Agency has been in contact with CMS to discuss the Fiscal Agent transition changes as it relates to Choice Counseling Self-Selection rates. The Agency will continue to communicate with CMS as progress is made.

C. Enrollment Data

Overview

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

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

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

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

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

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

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

The demonstration was not expanded in Year Three, and continues to operate in the counties of Baker, Broward, Clay, Duval, and Nassau.

Current Activities

Monthly Enrollment Reports

The Agency provides a comprehensive monthly enrollment report, which includes the enrollment figures for all health plans in the demonstration. 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 the demonstration for this quarter, beginning July 1, 2008 and ending September 30, 2008. This section contains the following Medicaid Reform enrollment reports:

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

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 17 Medicaid Reform health plans – eleven HMOs and six fee-for-service 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 13 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 13 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 14 for the Fiscal Year 2008-09, First Quarter Medicaid Reform Enrollment Report.

Table 14
Medicaid Reform Enrollment Report
(Fiscal Year 2008-09, 1st Quarter)

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	13,018	1,661	3	370	**15,052**	**6.69%**	14,915	0.92%
Buena Vista	HMO	5,890	685	2	148	**6,725**	**2.99%**	6,816	-1.34%
Freedom Health Plan	HMO	374	91	1	19	**485**	**0.22%**	255	90.20%
HealthEase	HMO	48,450	5,499	5	1,009	**54,963**	**24.45%**	55,553	-1.06%
Humana	HMO	8,435	1,972	7	367	**10,781**	**4.80%**	10,745	0.34%
Preferred Medical Plan	HMO	1,437	445	3	82	**1,967**	**0.87%**	1,876	4.85%
StayWell	HMO	31,392	3,084	6	605	**35,087**	**15.61%**	36,108	-2.83%
Total Health Choice	HMO	1,900	399	0	70	**2,369**	**1.05%**	2,031	16.64%
United Health Care	HMO	22,940	2,874	7	730	**26,551**	**11.81%**	28,736	-7.60%
Universal Health Care	HMO	1,468	331	1	76	**1,876**	**0.83%**	837	124.13%
Vista South Florida	HMO	6,004	570	4	120	**6,698**	**2.98%**	6,089	10.00%
HMO Total		**141,308**	**17,611**	**39**	**3,596**	**162,554**	**72.30%**	**163,961**	**-0.86%**
Access Health Solutions	PSN	16,535	3,091	6	355	**19,987**	**8.89%**	18,609	7.41%
CMS	PSN	2,065	2,226	0	43	**4,334**	**1.93%**	4,191	3.41%
First Coast Advantage	PSN	13,414	3,556	2	458	**17,430**	**7.75%**	16,525	5.48%
NetPass	PSN	2,509	1,355	3	184	**4,051**	**1.80%**	4,255	-4.79%
Pediatric Associates	PSN	9,083	522	0	68	**9,673**	**4.30%**	10,239	-5.53%
SFCCN	PSN	4,472	2,058	2	269	**6,801**	**3.02%**	6,272	8.43%
PSN Total		**48,078**	**12,808**	**13**	**1,377**	**62,276**	**27.70%**	**60,091**	**3.64%**
Reform Enrollment Totals		**189,386**	**30,419**	**52**	**4,973**	**224,830**	**100.00%**	**224,052**	**0.35%**

The demonstration 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 self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 224,830 beneficiaries enrolled in the demonstration during this quarter. There were 17 Reform health plans with market shares ranging from 0.22 percent to 24.45 percent.

2. Medicaid Reform Enrollment by County Report

The demonstration 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 15 on the following page.

Table 15 Number of Reform Health Plans in Demonstration Counties		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**1**	**1**
Broward	**11**	**5**
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down 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 16 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 16 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 in Table 17 and located on the following page.

Table 17
Medicaid Reform Enrollment by County Report
(Fiscal Year 2008-09, 1st Quarter)

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	722	112	0	13	**847**	**31.37%**	756	12.04%
Access Health Solutions	PSN	Baker	1,650	181	0	22	**1,853**	**68.63%**	1,798	3.06%
Total Reform Enrollment for Baker			**2,372**	**293**	**0**	**35**	**2,700**	**100.00%**	**2,554**	**5.72%**
Amerigroup	HMO	Broward	13,018	1,661	3	370	**15,052**	**11.94%**	14,915	0.92%
Buena Vista	HMO	Broward	5,890	685	2	148	**6,725**	**5.34%**	6,816	-1.34%
Freedom Health Plan	HMO	Broward	374	91	1	19	**485**	**0.38%**	255	90.20%
HealthEase	HMO	Broward	14,090	1,574	3	293	**15,960**	**12.66%**	16,540	-3.51%
Humana	HMO	Broward	8,435	1,972	7	367	**10,781**	**8.55%**	10,745	0.34%
Preferred Medical Plan	HMO	Broward	1,437	445	3	82	**1,967**	**1.56%**	1,876	4.85%
StayWell	HMO	Broward	28,376	2,675	6	523	**31,580**	**25.05%**	32,736	-3.53%
Total Health Choice	HMO	Broward	1,900	399	0	70	**2,369**	**1.88%**	2,031	16.64%
United Health Care	HMO	Broward	6,804	1,074	7	299	**8,184**	**6.49%**	9,079	-9.86%
Universal Health Care	HMO	Broward	302	110	1	23	**436**	**0.35%**	238	83.19%
Vista South Florida	HMO	Broward	6,004	570	4	120	**6,698**	**5.31%**	6,089	10.00%
Access Health Solutions	PSN	Broward	1,892	773	2	84	**2,751**	**2.18%**	2,828	-2.72%
CMS	PSN	Broward	1,112	1,390	0	35	**2,537**	**2.01%**	2,474	2.55%
Netpass	PSN	Broward	2,509	1,355	3	184	**4,051**	**3.21%**	4,255	-4.79%
Pediatric Associates	PSN	Broward	9,083	522	0	68	**9,673**	**7.67%**	10,239	-5.53%
SFCCN	PSN	Broward	4,472	2,058	2	269	**6,801**	**5.40%**	6,272	8.43%
Total Reform Enrollment for Broward			**105,698**	**17,354**	**44**	**2,954**	**126,050**	**100.00%**	**127,388**	**-1.05%**
United Health Care	HMO	Clay	2,960	244	0	67	**3,271**	**35.01%**	3,534	-7.44%
Access Health Solutions	PSN	Clay	5,280	700	0	91	**6,071**	**64.99%**	5,499	10.40%
Total Reform Enrollment for Clay			**8,240**	**944**	**0**	**158**	**9,342**	**100.00%**	**9,033**	**3.42%**
HealthEase	HMO	Duval	34,360	3,925	2	716	**39,003**	**47.14%**	39,013	-0.03%
StayWell	HMO	Duval	3,016	409	0	82	**3,507**	**4.24%**	3,372	4.00%
United Health Care	HMO	Duval	11,380	1,275	0	324	**12,979**	**15.69%**	14,015	-7.39%
Universal Health Care	HMO	Duval	1,166	221	0	53	**1,440**	**1.74%**	599	140.40%
Access Health Solutions	PSN	Duval	5,316	1,141	0	124	**6,581**	**7.95%**	6,106	7.78%
CMS	PSN	Duval	953	836	0	8	**1,797**	**2.17%**	1,717	4.66%
First Coast Advantage	PSN	Duval	13,414	3,556	2	458	**17,430**	**21.07%**	16,525	5.48%
Total Reform Enrollment for Duval			**69,605**	**11,363**	**4**	**1,765**	**82,737**	**100.00%**	**81,347**	**1.71%**
United Health Care	HMO	Nassau	1,074	169	0	27	**1,270**	**31.74%**	1,352	-6.07%
Access Health Solutions	PSN	Nassau	2,397	296	4	34	**2,731**	**68.26%**	2,378	14.84%
Total Reform Enrollment for Nassau			**3,471**	**465**	**4**	**61**	**4,001**	**100.00%**	**3,730**	**7.27%**
Reform Enrollment Totals			**189,386**	**30,419**	**52**	**4,973**	**224,830**		**224,052**	**0.35%**

As with the Medicaid Reform Enrollment Report, the number of beneficiaries are extracted from the monthly Medicaid eligibility file and are then counted uniquely based on what plan the beneficiary is enrolled in. The unique beneficiary counts are separated by the counties the plans operate in.

During this quarter there was an enrollment of 2,700 beneficiaries in Baker County, 126,050 beneficiaries in Broward County, 9,342 beneficiaries in Clay County, 82,737 beneficiaries in Duval County, and 4,001 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 31.37 percent to 68.63 percent, 16 Broward County Reform plans with market shares ranging from 0.35 percent to 25.05 percent, two Clay County Reform plans with market shares ranging from 35.01 percent to 64.99 percent, seven Duval County Reform plans with market shares ranging from 1.74 percent to 47.14 percent, and two Nassau County Reform plans with market shares ranging from 31.74 percent to 68.26 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 18 and 19 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. Table 18 provides a description of each column in this report.

Table 18
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 19 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 19
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2008-09, 1st Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	5	79	0	21	31	172	**308**	**2.05%**	**15,052**
Buena Vista	HMO	Broward	1	29	2	10	13	64	**119**	**1.77%**	**6,725**
Freedom Health Plan	HMO	Broward	0	0	1	1	14	1	**17**	**3.51%**	**485**
Healthease	HMO	Broward	4	115	1	26	21	135	**302**	**1.89%**	**15,960**
Healthease	HMO	Duval	18	438	5	62	29	400	**952**	**2.44%**	**39,003**
Humana	HMO	Broward	2	56	2	25	39	224	**348**	**3.23%**	**10,781**
Preferred Medical Plan	HMO	Broward	1	13	0	6	12	45	**77**	**3.91%**	**1,967**
Staywell	HMO	Broward	5	188	0	60	16	260	**529**	**1.68%**	**31,580**
Staywell	HMO	Duval	5	24	0	6	8	48	**91**	**2.59%**	**3,507**
Total Health Choice	HMO	Broward	1	9	0	2	15	36	**63**	**2.66%**	**2,369**
United Healthcare	HMO	Baker	1	4	0	0	1	4	**10**	**1.18%**	**847**
United Healthcare	HMO	Broward	3	47	1	27	14	188	**280**	**3.42%**	**8,184**
United Healthcare	HMO	Clay	0	25	0	11	6	24	**66**	**2.02%**	**3,271**
United Healthcare	HMO	Duval	2	153	1	32	18	175	**381**	**2.94%**	**12,979**
United Healthcare	HMO	Nassau	0	5	0	2	1	17	**25**	**1.97%**	**1,270**
Universal	HMO	Broward	1	0	0	0	15	4	**20**	**4.59%**	**436**
Universal	HMO	Duval	8	8	1	0	31	5	**53**	**3.68%**	**1,440**
Vista South Florida	HMO	Broward	3	44	0	19	10	57	**133**	**1.99%**	**6,698**
HMO Total	**HMO**		**60**	**1,237**	**14**	**310**	**294**	**1,859**	**3,774**	**2.32%**	**162,554**
Access Health Solutions	PSN	Baker	1	3	0	3	3	9	**19**	**1.03%**	**1,853**
Access Health Solutions	PSN	Broward	0	16	1	11	15	54	**97**	**3.53%**	**2,751**
Access Health Solutions	PSN	Clay	1	28	1	12	14	23	**79**	**1.30%**	**6,071**
Access Health Solutions	PSN	Duval	6	63	2	15	21	64	**171**	**2.60%**	**6,581**
Access Health Solutions	PSN	Nassau	3	21	2	2	8	9	**45**	**1.65%**	**2,731**
CMS	PSN	Broward	0	32	8	130	0	9	**179**	**7.06%**	**2,537**
CMS	PSN	Duval	0	36	1	50	0	4	**95**	**5.29%**	**1,797**
First Coast Advantage	PSN	Duval	13	138	4	79	50	284	**568**	**3.26%**	**17,430**
NetPass	PSN	Broward	1	28	1	26	19	128	**203**	**5.01%**	**4,051**
Pediatric Associates	PSN	Broward	2	104	2	20	0	1	**129**	**1.33%**	**9,673**
SFCCN	PSN	Broward	3	118	1	36	32	159	**349**	**5.13%**	**6,801**
PSN Total	**PSN**		**34**	**587**	**23**	**384**	**162**	**744**	**1,934**	**3.11%**	**62,276**
Reform Enrollment Totals			**94**	**1,824**	**37**	**694**	**456**	**2,603**	**5,708**	**2.54%**	**224,830**

Previous Medicaid Reform quarterly reports have included an additional report that displays a summary of Self-Selection, Assignment Rates, and Disenrollment data. In July of 2008, the Agency underwent a fiscal agent change and subsequently, the entire Medicaid data system was overhauled. At this time, the data necessary to calculate the values of this report are not available. However, future quarterly reports will include this report.

D. Opt Out Program

Overview

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

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

Description of Opt Out Process

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

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

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

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

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

Current Activities

An Invitation to Negotiate was released during the third quarter of Year Two on January 22, 2008 for Third Party Liability Recovery Services that included the Opt Out Program. The current Opt Out contract with HMS will expire on October 30, 2008. The Agency plans to contract with one Vendor (ACS State Healthcare, LLC) for Third Party Liability Recovery Services and the Opt Out Program beginning November 1, 2008. During the first quarter of Year Three, the Agency has been working with ACS in order to transition the Opt Out Program from HMS to ACS.

Opt Out Program Statistics

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

A description of the Opt Out enrollees is provided below.

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

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

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

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

available through her employer. The mother elected to use her three children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

9. The caller began the process to enroll her two children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

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

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

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

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

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

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
17. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.
18. The caller began the process to enroll his two children during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
19. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.
20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
23. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
25. The caller began the process to enroll during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job during the fourth quarter of Year Two. As a result, the individual has been disenrolled from the Opt Out Program.
26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.
27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the first quarter of Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

Table 20 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending September 30, 2008. Current Opt Out enrollment, as of September 30, 2008, is 25.

Table 20 Opt Out Statistics September 1, 2006 –September 30, 2008						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Single	1	02/28/07	Loss of Employment
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	3	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	Still Enrolled 02/29/08	N/A Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	N/A	N/A
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	2	N/A	N/A
C & F	04/01/08	Large Employer	Single	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	05/01/08	Large Employer	Family	1	05/31/08	Loss of Employment
C & F	05/01/08	Large Employer	Family	1	N/A	N/A
C & F	07/01/08	Large Employer	Family	4	N/A	N/A

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

E. Enhanced Benefits Program

Overview

The Enhanced Benefits Account Program (EBAP) 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 credits 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 the Prescription Drug Claims System (PDCS) with ACS, (previous) Fiscal Agent, and First Health, the PBM operator under EDS, (new) Fiscal Agent. 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 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 this 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. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The operation hours are 8:00 a.m. - 8:00 p.m., Monday – Thursday, and 8:00 a.m. - 7:00 p.m. on Friday.

The primary function of the call center is to handle inbound calls from Medicaid beneficiaries and answer questions on the Enhanced Benefit program and provide information on credits earned and used by beneficiaries. Due to fiscal agent transition issues impacting Enhanced Benefits, the majority of the calls during the quarter related to beneficiaries requesting information regarding their account balances.

The following is a highlight of the call volume during the quarter:

Inbound Calls:	**23,905**
Calls Abandoned:	**2,150**
Average Talk Time	**5.19 min**

2. System Activities

Much of the system activities revolved around the transition to the new fiscal agent. EBIS sends monthly credit files and receives weekly debit files from the PDCS system, and this set of file transfers was automated successfully with the new vendor.

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day each month. Each month, an eligibility file is scheduled to be uploaded into the Enhanced Benefits Information System (EBIS); however because of fiscal agent transition issues the file was delayed in its creation and consequently delayed in uploading into EBIS. The health plans' files for the months of August and September were not processed this quarter. The fiscal agent transition also resulted in some conversion issues and consequently there were delays in generating the statement to each recipient who had either earned an enhanced benefits credit or made a purchase in the month. Enhanced Benefits statements were mailed in July, but were not mailed in August and September. To assist beneficiaries with balance information, the Call Center printed and mailed Enhanced Benefits account balance information to beneficiaries as requested during this period.

The Agency has been in contact with CMS to discuss the Fiscal Agent transition changes as it relates to Enhanced Benefit statement generation delays. The Agency has a target date of mid December for this issue to be resolved and will continue to communicate with CMS as progress is made.

3. Outreach and Education for Beneficiaries

The Enhanced Benefits Quality Team and the Enhanced Benefits Panel reviewed and evaluated the success of the welcome packet. Based on the recommendations from the Panel, the EB Quality team created a double sided one page document which encompasses much of the information in the original brochure. This change was implemented successfully beginning July 1, 2008. In addition, on July 1 the name of the Enhanced Benefits program changed to the Enhanced Benefits Reward$ Program and all outreach and marketing materials have been transitioned to the new name.

The amount of purchases did not drop below $70,000; with an average purchase amount of $102,000 weekly. The weekly amount of purchases still remained above the purchase amounts beneficiaries spent prior to the implementation of new outreach activities in February 2008 even without statement mailings.

4. Outreach and Education for Pharmacies

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

Since many corporate pharmacies complained about the system change to disallow the dispensing fee, which has OTC products now paying at below shelf price, Agency staff is working with the new fiscal agent to reimburse pharmacies the "shelf price" of an

OTC item instead of the Medicaid pricing. This process requires a managerial over-ride or some other intervention to submit a usual and customary price for an OTC item to Florida Medicaid that matches the posted shelf price for that item. The Agency hopes to implement this change with the new Fiscal Agent during the second quarter of this fiscal year. Outreach to pharmacies about this change will be coordinated prior to implementation.

While the EBAP outreach to and education of 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.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel held a meeting on September 9, 2008. The primary focus of the meetings was to discuss the changes in the Program that were implemented this quarter. There were also pharmacy representatives who discussed their desire to have the EB pricing logic adjusted to shelf pricing.

6. Enhanced Benefits Statistics

Table 21 provides the Enhanced Benefit Account Program statistics beginning July 1, 2008 and ending September 30, 2008.

Table 21
Enhanced Benefit Account Program Statistics

1st Quarter Activity – Year Three		July 2008	August 2008	September 2008
I.	**Total number of plans by county by month**	31 of 31	31 of 31	31 of 31
II.	**Number of enrollees who received credit for healthy behaviors by month**	39,238	36,264	38,188
III.	**Total dollar amount credited to accounts by each month**	$756,660.00	$677,492.50	$694,390.00
IV.	**Total cumulative dollar amount credited through the end each month**	$15,812,118.66	$16,489,611.16	$17,184,001.16
V.	**Total dollar amount of credits used each month by date of service**	$388,248.48	$550,124.73	$399,962.49
VI.	**Total cumulative dollar amount of credits used through the month by date of service**	$2,934,177.62	$3,484,302.35	$3,884,264.84
VII.	**Total cumulative number of enrollees who used credits through the end of each month**	51,875	60,087	65,463

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 regarding the program. The primary reason for complaints remains issues surrounding the pharmacies processing enhanced benefits claims.

During this quarter, over 13,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 82 complaints were recorded through the call center related to the EBAP. Table 22 provides a summary of the complaints and outlines the actions taken by either the Agency or EDS to address the issues raised.

Table 22
Enhanced Benefit Beneficiary Complaints

Beneficiary Complaint	Action Taken
1. Forty 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, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefit Account Program.
2. Twenty-five 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 has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list not in the particular pharmacy of choice.
4. Seventeen beneficiaries complained about not having a recent credit statement.	➲ Call center provided current credit balance.

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. In addition to the termination of UPL, the SPA also 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

During the first quarter of State Fiscal Year (SFY) 2008-2009, there were two Low Income Pool (LIP) Council meetings.

July 28, 2008 Meeting
On July 28, 2008, the LIP Council held their first meeting of SFY 2008-09 at Memorial Regional Hospital in Hollywood, Florida from 10:00 am to 4 pm. Agency for Health Care Administration Secretary Holly Benson jointed the meeting via conference call and encouraged the LIP Council members to continue exploring options and alternatives during these difficult financial times in the State of Florida.

The Council members were informed that the Agency has not received final approval from CMS on the Reimbursement and Funding Methodology and that they (the Agency) continues to work with CMS in an effort to move this process along.

The LIP Chair discussed Legislature's decision as to the distribution of LIP funds for SFY 2008-09.

A Department of Health representative provided an update on the Non-Hospital LIP programs supporting primary care and emergency room diversion. Legislature appropriated $6.5 million to DOH to oversee these programs.

The remainder of the meeting entailed discussion of Florida's financial outlook for SFY 2009-2010 and overall funding priorities for LIP.

September 19, 2008
The September 19, 2008 LIP Council meeting was held from 10:00 am to 3:00 pm in the Tampa International Airport. This was the second LIP Council meeting in the first quarter of SFY 2008-09.

The meeting discussed exemptions for SFY 2008-09, based on July rates, a presentation of the Florida Hospital Uniform Reporting System (FHURS) and a presentation of SFY 2009-2010 LIP models with updated FFP. An update of the status of letter of agreements and activities with CMS staff was provided by the Agency.

In addition to the Lip council meeting, CMS visited Tallahassee September 25, 2008 to audit the local Federally Qualified Health Center (FQHC) and to meet with Agency staff.

The Agency began its work with local governments and taxing districts on all Letters of Agreement (LOAs) for SFY 2008-09. Payments to Provider Access Systems will begin as LOAs are executed and IGTs received.

This report does not provide an update of expenditures. The reporting of these expenditures is related to the system impacts as stated in the budget neutrality section.

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

As noted earlier in the report, Florida Medicaid transitioned to a new fiscal agent on July 1, 2008. This transition has brought a new system base as well as other changes. In addition to providers and users of the new system having to familiarize themselves with the system and new processes, the Florida Bureau of Medicaid Program Analysis is modifying the Systems Support data base to receive downloads from the new system. This process of modifying the Systems Support data base is taking more time than expected. Due to these delays, the reports that are typically generated to provide the status of budget neutrality are not available for this reporting period. Modifications are expected to be complete prior to the submission of the Quarterly Report for the quarter ending December 31, 2008.

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 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. Moreover, 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, comprising of internal subject matter experts and external consultants with experience in the risk adjustment and encounter collection processes, continues to support the implementation and operational activities of Medicaid encounter data.

Current Activities

During this quarter, to comply with the requirements of the Medicaid Reform Waiver, the Agency continued moving forward with its efforts to collect and verify encounter data from all capitated health plans on a statewide basis for all Medicaid covered services. There are two collection efforts occurring concurrently as part of MEDS, namely the collection of all encounter data for all covered services within our Florida Medicaid Management Information System (FMMIS), and the collection of quarterly pharmacy encounter data for risk adjustment purposes.

The following are the highlights for this quarter in regard to the collection and validation of encounter data within FMMIS:

- Continued support of testing activities associated with FMMIS under EDS to support encounter data collection and processing.
- Conversion of historical encounters collected under the prior fiscal agent (ACS) continues to be refined in the new fiscal agent (EDS).
- The MEDS team continues to work with health plans and the Agency's PBM (First Health under EDS) to coordinate the collection of pharmacy encounters within FMMIS using the NCPDP format. Throughout this period, seven (7) HMOs have submitted test files for certification; four (4) HMOs are in various states of testing preparation.
- The MEDS team is continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the health plans.

- Participation of the MEDS team in “stand-alone” meetings with health plans and biweekly technical and operations meetings continued during this period in order to resolve technical and X12 transaction format and content questions.

- The MEDS team continues to analyze encounter data, in aggregate and at the MCO level, collected during the period of September 2007 through June 2008. The purpose is to identify trends, statistically significant defects, and anomalies. The outcomes of this research will result in corrective action recommendations to be discussed within the Agency and MCO management.

- Continued testing and refinement of reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content to health plans for remediation of any encounters failing FMMIS edits.

- The Medicaid Decision Support System (DSS) is being used to support validation, accuracy, and completeness of encounter data. The Agency is refining processes and measures to validate the quality and volume of the data received from health plans.

- As reported in the 4th quarterly report for Year Two, HMOs remain in various states of readiness in terms of submitting encounter data through June 2008. With the numerous transition activities and tasks associated with the new fiscal agent operations, no encounters for this reporting period have been processed through EDS MMIS.

- PSNs also remain in various states of readiness for submission of transportation encounter claims. Again, no transportation encounters have been processed for this reporting period for the same reason mentioned previously.

During this quarter, to comply with the requirements of the Medicaid Reform Waiver, health care pharmacy and Medicaid enrollee information were collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid population. Using the Medicaid Rx model, the health plans were assigned plan risk factors, for TANF and SSI, based on the aggregate risk scores of their enrolled populations in those categories under the demonstration. 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 the demonstration.

The following are the highlights for this quarter in regard to the collection, validation, and utilization of quarterly pharmacy encounter data for risk adjustment purposes:

- Beginning the third year of Reform, as per legislation, capitation premiums were fully risk adjusted and health plan corridor factors were no longer applied to the capitated

premium rates. As such, the budget neutral plan factors are now being utilized to calculate the capitation rates.

- Medicaid continues collecting and processing pharmacy encounter data on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated and any significant changes from the previous quarter's submission are reported to the health plan for corrective action if necessary.

- The most recent 12-month measurement period used in the Medicaid Rx methodology for risk-adjusting Reform capitation rates for this reported quarter was January 1, 2007 through December 31, 2007 paid through March 31, 2008. This measurement period was used to generate risk adjustment factors for the health plans operating in the five demonstration counties.

- Pharmaceutical data will continue to be collected and processed through Medicaid Rx to support risk adjustment capitation rate premium calculations until encounter data for all services is collected in the FMMIS and is of sufficient quality and completeness to transition to the CDPS (Chronic Illness and Disability Payment System) diagnostic risk adjustment model.

- For this quarterly period, risk adjustment plan factors were calculated for the following health plans:

Access Health Solutions	Amerigroup	Buena Vista
Freedom Health Plan	United Health Care	Universal Health Care
HealthEase	Humana	Preferred Medical Plan
StayWell	NetPass	Pediatric Associates
Vista South Florida	Total Health Choice	SFCCN - North Broward Hospital District
SFCCN - Memorial Healthcare	CMS	

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty plans/populations such as HIV/AIDS and CMS. Enrollment for risk adjustment purposes in the demonstration counties for the month of September 2008 totaled 180,450 and was distributed as follows:

September 2008	Broward	Duval, Baker, Clay, and Nassau
Children & Families	86,249	68,095
SSI	14,541	11,565
Totals	**100,790**	**79,660**

At the end of the quarter, the process of providing plan risk factors for rate setting in the demonstration, encompassing the generation of risk factors accounting for budget

neutrality, will continue. Scheduled activities as defined within the MEDS project plan associated with the collection and validation of encounters are continuing. This encompasses technical support with capitated health plans, reviewing end-to-end testing results, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection, validation and utilization 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 (6) key design elements of Medicaid Reform tracked by the Agency in order to evaluate progress towards achieving its goals. Information about each key evaluation objective is below.

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

Prior to the implementation of 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.

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

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

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

Access to Services Not Previously Covered

All of the capitated health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year Three of the demonstration, the most popular expanded benefits offered by the capitated plans were

over-the-counter (OTC) drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Year Three include:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition Therapy.

In Year Three, the Agency approved 28 customized benefit packages for the HMOs and 14 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits are effective for the contract period of November 1, 2008 to August 31, 2009 for 11 HMOs and 6 PSNs.

Improving Access to Specialists

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

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

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

That same month the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 23 shows the results of these analyses.

Table 23
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

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

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

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

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

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

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

During the first quarter of Demonstration Year Three, the Agency analyzed the May 2008 survey results and has been following up on the June 2008 survey results. Starting with the May survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the May 2008 statewide survey, the combined results from the survey and the follow-up indicate that 292 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 11 in May, 116 (99%) had current contracts with the health plans from which they were sampled.

The Agency is continuing to follow up and analyze the June survey results. Surveys were conducted in August and September, and findings from these surveys should be available for the Year Three second quarter report.

The Agency is also working on the National Provider Identification and provider matching initiatives. When completed, these two initiatives will result in the provider files containing unique identifiers for each provider. This information will shorten the

timeframes to collect these necessary data and improve the accuracy of the information. As the encounter data system is fully implemented, this unique identifier will allow the Agency to take additional steps in identifying active providers, as well as determining how many unduplicated providers are participating in the demonstration

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

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

Although the original list of required performance measures was disseminated to health plans in December 2006, several changes were made to the list of performance measures in response to modifications to the Healthcare Effectiveness Data and Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA). Two measures that had been selected by the state were retired by NCQA: Mental Health Utilization: Inpatient Discharges and Average Length of Stay; and Adolescent Immunization Status. NCQA has stated its intent to return Adolescent Immunization Status in 2009 with revisions. In response to these changes, the state created a new Agency-defined measure, Mental Health Readmission Rate, which tracks the rate at which persons who are hospitalized for a mental illness are re-hospitalized within 30 days. The state also added 2 new HEDIS measures: Follow-up Care for Children Prescribed ADHD Medication and Lead Screening in Children. Since NCQA stated its intent to return the Adolescent Immunization Status measure, the state postponed submission of this data until Year Three, which represents calendar year 2009. The full revised list of the required measures and their phase-in schedule can be found in Table 24.

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

HEDIS measure, Use of Appropriate Medications for People with Asthma, was suitable for this purpose and more efficiently collected by the health plans.

In the first quarter of Demonstration Year Three, the health plans submitted their performance measure data for Year One (calendar year 2007) and the Agency began reviewing and analyzing these data. Analyses of these data are being conducted and will be reported in the second quarter report for Year Three.

Table 24
Performance Measures

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

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

(c) Delays in encounter data collection have also affected the state's ability to analyze the demonstration project's impact on emergency room utilization. On July 1, 2008, health plans submitted data for the Ambulatory Care HEDIS measure. A component of this measure is emergency department utilization per 1,000 member months. These data will be submitted to the state annually and will allow the state to trend the impact the demonstration project has had on emergency room use. Because the state wishes to examine this goal on a more frequent basis, we are exploring options for other sources of data that will allow comparisons to be made until full encounter data is available.

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

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

The reasons individuals have chosen to opt out of Medicaid Reform include:

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

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

The individuals who decided not to opt out:

(a) were not employed,

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

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

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

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

Future surveys will yield more information regarding patient satisfaction, and a description of these follow up surveys is provided below.

Follow-Up Surveys (Broward and Duval Counties)

The year one follow-up survey was designed to assess enrollees' experiences and satisfaction with their health care after enrollment in a Reform health plan. It is anticipated that the finalized Year One follow-up Survey findings will be included in the next quarterly report. The beneficiaries who participated in the year one follow-up survey were enrolled in a Reform health plan located in Broward and Duval Counties, and this final survey report will contain the first comparison of pre- and post-Reform survey data.

The chart below shows the projected timeline for the future follow-up surveys to be conducted in Broward and Duval Counties for the duration of the demonstration.

Patient Satisfaction Surveys – Broward and Duval (Projected Timeline)		
Survey	**Description**	**Timeline**
Year Two Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Two.	Fall 2008
Year Three Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Three.	Fall 2009
Year Four Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Four.	Fall 2010

Patient Satisfaction Surveys in Baker, Clay & Nassau Counties

The benchmark satisfaction survey data of beneficiaries located in Baker, Clay and Nassau Counties were collected during the fall of 2007 and winter of 2008. The beneficiaries surveyed were enrolled in MediPass, which is Florida's primary care case management program in these expansion counties. The benchmark satisfaction report data will be included in the next quarterly report. A Year One follow-up survey will then be conducted sometime in the fall of 2008 and winter 2009. This survey is designed to capture an assessment of enrollees' experiences with their health care after enrollment in a Reform health plan.

Qualitative Study

In addition to the patient satisfaction surveys, the Agency contracted with UF to conduct a qualitative study that is designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

Due to the significantly decreasing sample size of study participants, these findings could not be used to assess program satisfaction from the beneficiary perspective (due to unanticipated eligibility loss). However, the Agency is currently working with UF on a

replacement strategy that will accurately reflect patient satisfaction information from the beneficiary standpoint.

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

were provided. A conference call was held on March 6, 2007, to review the data provided.

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the 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 was shared with the University of Florida LIP Evaluation team in September 2007. The University of Florida and the Agency is using the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

During the first quarter of Year Two, the Agency and the 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 has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost effectiveness study to the Agency by the third quarter of Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the 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 were used for the cost effectiveness study. The UF provided a “Plan for Evaluation of the Low Income Pool Program” to the Agency. The cost effectiveness will be measured in the method described below.

> ”In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost / Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in ‘natural units’ (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure.

In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome." (pp 10-11)

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

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

During the first quarter of Year Three, the Agency sent a letter to all Provider Access Systems (PAS) that received LIP funds during SFY 2007-08, asking them to complete the SFY 2007-08 Milestone document online. This information will be shared with the University of Florida LIP Evaluation team during the second quarter. The University of Florida and the Agency will utilize the SFY 2007-08 LIP Milestone data to continue the evaluation LIP and its impact on increased access to services for Medicaid, uninsured and underinsured populations. The Agency anticipates the first draft of the Evaluation of the Low Income Pool Program during the third quarter.

J. Evaluation of Medicaid Reform

Overview

The evaluation of the demonstration is an ongoing process, scheduled to be completed in June 2010. In November 2005, the Agency contracted for this required 1115 Medicaid Reform Waiver evaluation with an independent entity, the University of Florida (UF). 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 is, as it was intended to be, a five-year, over-arching study that will present its major findings in 2010. Many people are interested in seeing findings much sooner, so the Agency, as well as several other external entities conduct short term evaluations to look at specific Medicaid Reform issues throughout the year. Descriptions of the evaluation reports which occurred during the first quarter of Year Three are provided below.

1. Evaluations Affiliated with the Agency or its Contractors

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. This study was subsequently published by Health Affairs on October 14, 2008, and can be viewed at http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w523.

In follow up, the Kaiser Commission on Medicaid and the Uninsured issued Policy Brief #7823 entitled, Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status. This policy brief can be found at, http://www.kff.org/medicaid/upload/7823.pdf.

UF and the Urban Institute established an additional subcontract during SFY 2007-2008, and UF has conducted the fieldwork for a cross-sectional study being done by the Institute. A projected date on report findings has not yet been released.

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) has conducted several reviews of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. This Chapter provides that

reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. OPPAGA released the following reports during the first quarter of Year Three of the demonstration:

- "Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Portion," Report Number 08-45, July 2008. http://www.oppaga.state.fl.us/reports/pdf//0845rpt.pdf.
- "Medicaid Reform: Choice Counseling Goals Met, But Some Beneficiaries Experience Difficulties Selecting a Health Plan that Suits Them," Report Number 08-46, July 2008. http://www.oppaga.state.fl.us/reports/pdf/0846rpt.pdf.
- "Medicaid Reform: Risk-Adjusted Rates Used to Pay Medicaid Reform Health Plans Could Be Used to Pay All Capitated Rates," Report Number 0854, July 2008. http://www.oppaga.state.fl.us/reports/pdf/0854rpt.pdf.
- "Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved: Information Difficult for Beneficiaries to Locate and Compare," Report Number 08-55, September 2008. http://www.oppaga.state.fl.us/reports/pdf/0855rpt.pdf

3. UF Independent Evaluations in FY08-09

UF will continue to coordinate all evaluation activities pertaining to the 1115 Medicaid Reform Waiver.

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

In addition to the studies already initiated, the Agency is evaluating the mental and behavioral aspects of care provided in the five demonstration counties (Broward, Duval, Baker, Clay, and Nassau). This study is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF.

University of Florida - Qualitative Survey

One of the components of the evaluation is a qualitative (previously called longitudinal[4]) study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

Due to the significantly decreasing sample size of study participants, these findings could not be used to assess program satisfaction from the beneficiary perspective (due to unanticipated eligibility loss). However, the Agency is currently working with UF on a replacement strategy for producing a project deliverable that will accurately reflect patient satisfaction information from the beneficiary standpoint.

[4] This study was originally intended to be longitudinal; that is, it would follow the same recipients over time from before implementation through the end of the study period. However, it proved difficult to locate the same recipients and convince them to participate numerous times.

University of Florida – Organizational Analysis

The organizational analysis component of the evaluation describes the development of demonstration in Florida, as well as the specific projects in the demonstration counties—Duval, Broward, Baker, Clay, and Nassau. The organizational analysis focuses on three main areas: (1) the implementation process; (2) the health plans (including health maintenance organizations and provider service networks); and (3) the choice counseling organization(s). Comparative findings are in the process of analysis and review within the Agency, and are expected to be reported in the next quarterly report.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state's hospital and managed care industries, the medical association, other health professional groups, advocacy organizations, legislative leadership, or other entities. The FAC meets annually (usually in December or January), over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on Medicaid Reform and the evaluation. The third annual meeting is tentatively scheduled for January 30, 2009.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. The purpose of this committee is to provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary. The next TAC meeting is scheduled to occur in March of 2009.

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. During this quarter, the Agency's internal and external communication processes continue to play a key role in managing and resolving issues effectively and efficiently.

Policy, administrative and operational issues are generally addressed by four different processes:

- Technical Advisory Panel regular meetings;
- Policy Transmittals and Dear Provider Emails;
- Bi-weekly Reform Health Plan Technical and Operations Conference Calls; and
- PSN Systems Implementation Monthly Conference Calls.

In nearly all these forums, the transition of Florida Medicaid's Management Information System from the legacy system to the new fiscal agent, Electronic Data Systems, Inc., computer system has been foremost in time and preparation. These forums continue to provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums the Agency continues its initiatives on process and program improvement.

Medicaid Reform Technical Advisory Panel

With the delay in posting the health plan capitation rates effective September 1, 2009 (discussed in Section A.), no Technical Advisory Panel (TAP) meetings were held during this quarter.

Policy Transmittals

During this quarter, there was only one policy transmittal and no Dear Provider letters released to the health plans. The policy transmittal released was one to the PSNs which provided written confirmation of contract policy regarding their default identification numbers that were no longer acceptable on their Medicaid provider network files and that PSNs now were required to include national provider identification numbers in fields on their network files. There were several Dear Provider emails, however, that provided updated submission dates for the health plans' completed Plan Evaluation Tool (PET) relative to the September 1, 2008 through August 30, 2009 contract period.

Biweekly Technical and Operations Calls

This quarter, the Agency conducted six biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants. The purpose of these calls is to communicate the Agency's response to issues addressed at a higher level in

the Technical Advisory Panel meetings and to respond to plan questions posed through email, telephone inquiries, and previous technical calls.

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

Approximately 20 to 30 participants attended in person and the popularity of these calls is shown by the 200 phone lines in active use on the calls. Again, as there were fewer implementation items, the transition to the new Medicaid fiscal agent and system, and the mandatory implementation of the NPI became the number one and two agenda items. Fiscal agent transition issues, including enrollment transmissions, claims processing, the transmission of primary care provider choices and eligibility verification were routine topics.

Other typical agenda items included:

- Choice Counseling Program updates, including the upcoming drug finder program that will allow choice counselors to view beneficiary drug information and what health plans provide;
- Discussion of a change in FFS Medicaid policy regarding additional provider types that can now provide fluoride varnish applications;
- Discontinuation of the health plan disenrollment file under the new Medicaid fiscal agent;
- Medicaid Encounter Data Systems updates, including notice of schedules for submission and changes in file formats; and
- General Amendment updates, including September 2008 rate and benefit amendment timelines.

Feedback from call participants indicates that the calls are well received, a good forum for discussion of technical and operational issues, and an avenue for quick discussion and feedback on identified operational issues.

Fee-for-Service PSN Systems Implementation Issues Calls

The original purpose of these calls was to provide a forum to discuss claims processes and enrollment file issues that were unique to the FFS PSN model. The PSNs were encouraged to submit questions and/or issues in advance in order for systems research to occur internally at the Agency (or between the Agency and the Agency's Medicaid fiscal agent). Agency participants included management and key technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Contract Management Bureau, Area Office staff and Bureau of Managed Health Care staff responsible for monitoring

the health plans. PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs contracted TPAs.

During this quarter, with the transition to the new Florida Medicaid fiscal agent system, the Agency responded to PSN requests and increased the monthly systems implementation issues calls to biweekly in order to provide rapid feedback to the PSNs regarding resolutions to claims processing issues resulting from transition.

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

- Medicaid fiscal agent transition issues relative to PSN enrollees, claims vouchers, and enrollment file formats;
- National Provider Number identification and Medicaid provider identification matching issues;
- Paper claims backlog issues as the new fiscal agent accepted the legacy Medicaid fiscal agent's claims that were not processed at the start of the transition;
- Transportation capitation payments (now completed through the Medicaid fiscal agent rather than a manual process resulting in gross adjustment payments); and
- Issues relative to the systems freeze due to the transition of the Florida Medicaid Management Information System (FMMIS).

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

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

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues July 1, 2008 – September 30, 2008	
PSN Informal Issue	**Action Taken**
1. A PSN member contacted Agency staff requesting assistance in finding a specialist	➲ A PSN representative spoke with the member and provided him with an additional listing of specialty providers, discussed the member's plan of care set forth by his primary care physician and confirmed the member has an appointment soon.
2. A PSN member's mother contacted the Agency in regards to not being able to obtain a specialist for her son.	➲ The PSN contacted the member's mother to inform her they are willing to authorize services out-of-network and is discussing referrals with an appropriate Case Manager.
3. Agency staff received a call from PSN member. The member needs surgery and was referred to a hospital from her primary care physician (PCP).	➲ The PSN contacted the PCP who advised that the member was referred to a hospital in April and the authorization needed was provided. The PCP office staff will re-fax authorization to the hospital. The PSN member was contacted and advised of what was done.
4. A PSN member contacted Agency staff to inquire if reimbursement was possible for a Medicaid covered prescription even though it was not provided through a Medicaid participating provider.	➲ The PSN contacted the member to advise she would not be reimbursed for prescriptions since she did not use a participating provider. PSN member agreed to contact her primary care provider for further treatment and the issue resolved.
5. A PSN member contacted Agency staff concerning his prior authorization for his medication.	➲ The PSN case manager investigated and discovered that the member's primary care provider faxed the incorrect authorization form. When all errors were corrected authorization was provided.
6. The PSN is not authorizing a procedure for a member because the provider is out-of-network	➲ The PSN resolved the issue of using an out-of-network facility for the procedure and reaffirmed authorization approval for the procedure. The family is satisfied with this outcome.
7. The Area Office received a provider issue regarding lack of timely claims payment	➲ Agency staff facilitated a review with PSN and the provider to determine whether the issues are with the provider, the PSN or with the Medicaid fiscal agent and continues to provide technical assistance to the provider.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
1. An HMO member was unable to get medications.	➲ The HMO was contacted and it was determined that the pharmacy was billing incorrectly. The pharmacy was provided correct information and the issue was resolved.
2. An HMO member was enrolled with an HMO until 8/1 and wishes to continue receiving chemotherapy at a non-participating hospital while still enrolled in the health plan.	➲ The HMO has provided authorization to the non-participating hospital for services. A representative at the non-participating hospital has been notified of the authorization.
3. An HMO member contacted Agency staff concerning his need to find a local primary care provider.	➲ AHCA staff contacted the HMO and the representative contacted the member to select a provider and assisted the member in scheduling and confirming the first appointment.
4. An HMO member contacted Agency staff due to the inability to pick up prescriptions. The pharmacy advised the member that there would be a wait period because the amount of medication prescribed exceeded the amount allowed per month per the HMO.	➲ The HMO representative advised the member that, per the member handbook, there is a limit on the number of medications allowed per month, excluding birth control, chemotherapy and/or AIDS/HIV medications. The HMO representative agreed to review the member's prescriptions to determine if an exception was needed.
5. Providers appear to be balance billing member's family after HMO denied claim because providers were not in plan network.	➲ The HMO paid all claims and notified member's parent that they were not responsible for any charges.
6. An HMO member states that the HMO incorrectly denied request for necessary services.	➲ HMO worked with member and the provider to submit a prior authorization request to Medicaid. The prior authorization was approved and member took delivery of the equipment.
7. An HMO member's specialty provider will not continue to see her because the HMO will not pay claims.	➲ The HMO agreed to pay outstanding provider claims even though the provider is out-of-network. The HMO is working with the member to identify a new specialty provider within the network. The member is satisfied with this outcome.

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
8. An HMO member states he is unable to get approval from the HMO for necessary specialty services and states his health has been adversely affected.	➲ The HMO agreed to provide required authorizations so member can obtain necessary specialty care. The member has been contacted and is satisfied with this resolution.
9. An HMO member states he wants the HMO to pay for August visits to an out-of-network specialist because the HMO erroneously listed specialist as being a member of their provider network.	➲ The HMO agreed their provider network list contained an error and agreed to pay for the two out-of-network office visits scheduled for August 2008. The member was notified of this resolution.
10. An HMO member has not yet received credit for healthy behavior event in April 2008.	➲ The HMO verified credit is due and will submit this information to the Agency. Credit will post to account shortly thereafter.
11. An HMO denied service for a member because prior authorization was required. The member states that the primary care physician had already furnished the required information.	➲ The HMO was contacted and it approved the prior authorization request and the service was arranged immediately. The plan notified the member's family that the service was available.
12. An HMO denied service for child because she is not enrolled in the HMO. The child requires this service immediately.	➲ The HMO added the child effective 8/1/08. The parent was advised that the plan will pay for any services rendered during August 2008.
13. An HMO member wants the health plan to reinstate discontinued services.	➲ The HMO worked with member to explain why he isn't eligible for the requested services. The HMO will assist the member with follow-through on referrals to community agencies that provide the requested services. The member is satisfied.
14. An HMO discontinued certain services for the member and the member's parent wants services restored.	➲ The member's parent appealed the decision to end services and appeal was denied by the HMO. The HMO has ordered a full evaluation of member's health status and will re-evaluate its decision on services after the evaluation results are reviewed.
15. An HMO member mistakenly disenrolled from the old HMO and enrolled in the current HMO. This HMO did not show him as member and therefore the member has been unable to get services.	➲ The new HMO has corrected its member database and has authorized needed services. The member has received the services.
16. An HMO member saw an out-of-network physician without HMO authorization and the HMO will not pay claim. The member is being billed by provider.	➲ The HMO will not pay claim because specialist did not check Medicaid eligibility. The HMO advised the specialist not to bill the member. The plan also worked with member to explain the process on how to get a referral. The member is satisfied.

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
17. An HMO member states that her HMO will not authorize her to use a non-approved treatment even though her primary care physician (PCP) has sent documented prior authorization requests several times.	➲ The HMO issued a one time authorization for the requested item and worked with the PCP to clarify what needs to be included in the prior authorization request. The PCP will resubmit. The member is satisfied.
18. An HMO did not reassign a member to the previous PCP when member re-enrolled after brief break. The mother continued to take the member to the previous PCP and the HMO refused to pay claims. Family is now being balanced billed.	➲ The HMO switched the member back to the desired PCP and advised the provider to submit claims for payment. The family was advised that the issue was resolved and they are satisfied.
19. A provider's office states that an HMO denies that a beneficiary is a member.	➲ The HMO acknowledged that the member is in the HMO. The HMO advised the provider to see member and submit claims for payment.
20. An HMO states a beneficiary is not a member but a provider eligibility check shows beneficiary is a member.	➲ The HMO verified that the member is enrolled and advised the provider to request the necessary service authorizations.
21. A member stated that an HMO refused to authorize necessary service.	➲ The HMO authorized the requested service and the member's family was notified.
22. A member's parent states that an HMO is unwilling to authorize necessary emergency care.	➲ The HMO attempted to contact member's mother but calls were not returned. The HMO also sent a letter as a follow-up. The member's mother has not contacted Area Office again. Issue is being closed as no contact is available.
23. A member states that an HMO sub-contractor referred him to a provider to receive services but then refused to authorize completion of the procedure.	➲ The HMO worked with the member to obtain records needed so the prior authorization request could be completed. The plan has received, reviewed and approved the prior authorization request and the procedure will be completed immediately.
24. An HMO denied service on the grounds that the beneficiary is not a member of the plan.	➲ The beneficiary is no longer eligible for managed care and was supposed to have been disenrolled from the HMO. The beneficiary has been successfully disenrolled and the provider was notified they can provide the service and submit claims directly to the Medicaid fiscal agent.
25. An HMO denied a provider claim because the member was not enrolled in the plan on dates of service, but eligibility checks indicate that the member was enrolled in the plan on those dates.	➲ The HMO researched the claim, determined that member eligibility was not the issue and then asked for additional detail from the provider. The HMO subsequently paid the claim.

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
26. An HMO requested recoupment of claims payment from a provider because the beneficiary was never a plan member. The provider states they verified the beneficiary was a plan member on the dates of service.	➲ The HMO researched the issue and stated that the member's eligibility was not the problem - the problem was member was erroneously listed as having third party insurance. This indicator has been removed and the HMO has advised provider to ignore the recoupment request.
27. An HMO denied a provider's claims for three beneficiaries because they were not members on the dates of service. The provider states eligibility and plan membership was verified on each beneficiary.	➲ The HMO did not question members' eligibility, but had erroneously added third party insurance indicators to their enrollment files. The HMO had paid the provider's claims and was asking for recoupment. The HMO has corrected the members' files and has advised the provider to disregard the recoupment request.
28. An HMO denied service authorization to a provider on the grounds that the beneficiary is not a current plan member.	➲ The HMO acknowledged that the beneficiary is a member but stated the member had requested an item not covered by the plan. The plan has authorized the provider to issue the member a covered item that will meet the immediate need and has educated the member and the provider on how to submit a prior authorization request.
29. An HMO will not authorize service for beneficiary because he is not shown in their member database. The beneficiary's caseworker states beneficiary is showing in FMMIS as being a plan member.	➲ The HMO confirmed the beneficiary was a plan member and authorized the requested services.
30. An HMO stated to a beneficiary's parent that the beneficiary is not a member. A check of Medicaid eligibility shows the beneficiary is a plan member.	➲ The HMO verified that the beneficiary is a current plan member and notified the member's parent of this finding. No services were denied, the parent was only checking eligibility.
31. An HMO will not authorize necessary services because the beneficiary is not listed in its member database.	➲ The HMO verified the member's status, updated its member database and provided the necessary services.
32. An HMO member's grandmother states the plan is not paying the balance of an inpatient claim and, therefore, the member is being balanced billed by the service provider.	➲ The HMO worked with the subcontractor and the provider to ascertain why the provider had not submitted any of the member's claims to the HMO. The provider will submit claims to plan subcontractor. The provider and the member have been advised by the plan that the member cannot be balanced billed.

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
33. An HMO member's parent states that the plan is limiting services required by the member.	➲ The HMO evaluated the member's needs and agreed to provide a higher level of care. The member will be moving to a new HMO effective 10/1/08 but current HMO agrees to cover all services used during September 2008.
34. An HMO member needs a procedure from an out-of-network provider. The member's advocate is requesting emergency disenrollment from the plan.	➲ The HMO agreed, per contract, to cover all of the member's claims during the period of enrollment. No emergency disenrollment was required. The member was already enrolled in new HMO effective 10/1/08.
35. An HMO member could not get prescription drugs filled.	➲ The HMO recipient received authorization for the needed prescription.
36. An HMO member needs authorization for dental services.	➲ The HMO determined the recipient's requested dental services are not medically necessary.
37. An HMO member is in need of a referral to a participating provider within the HMO for treatment outside of the recipient's county of residence.	➲ A Letter of Agreement has been established between a provider and the HMO to provide such services. An appointment was made on the HMO member's behalf with the provider.
38. An HMO member in need of covered service was unable to find an oral surgeon.	➲ The member was contacted and scheduled an appointment. The member was given the direct number should she have any additional problems.
39. An HMO member is in need of a vaccination, stating the plan is not covering it.	➲ The current HMO denied the authorization. The recipient is still in the 90 day open enrollment period and will do a plan change.
40. An HMO member called and is in desperate need of home health services.	➲ The HMO provided the required services to the recipient.
41. An HMO reversed payment to a provider for services rendered.	➲ Members to which the services were provided have been verified as being in the HMO at the time services were provided. The HMO reviewed the situation and resolved the complaint.
42. An HMO provider disputed recipient claim adjudication.	➲ The HMO reprocessed the claim. The provider will be receiving payment for this claim.
43. An HMO member is having difficulty getting authorization for surgery.	➲ The recipient was verified to be the HMO's member. The authorization request was received, processed and will be approved pending the surgery center sending the medical records for review to substantiate the medical necessity for the procedure.

HMO Complaints/Issues July 1, 2008 – September 30, 2008	
HMO Informal Issue	**Action Taken**
44. An HMO member has moved and is having problems obtaining an authorization until the new enrollment plan takes effect.	➲ The HMO has approved the authorizations for the member. The member has been contacted by the HMO and the issue is resolved.

Attachment III
Choice Counseling Beneficiary Complaints

Beneficiary Complaints and Action Taken July 1, 2008- September 30, 2008	
Beneficiary Complaint	**Action Taken**
1. Beneficiary spoke with a Choice Counselor to inquire about her child's enrollment and was unable to provide ID verification for herself as being the payee for the child. The Counselor was not able to give her the information requested.	➲ ACS Choice Counseling apologized for the inconvenience and told the payee what was needed for them to be able to verify her and to provide her the information. She stated that there was a man from the Choice Counseling number that had given her the information previously without identity verification. When asked if the beneficiary could provide the name of the counselor, she could not. It was not indicated in the case information that anyone had spoken with her.
2. Beneficiary called to check on her dis-enrollment from a health plan (due to pregnancy) and was told that she was not dis-enrolled. The beneficiary complained about not being able to dis-enroll.	➲ ACS Choice Counseling did process the dis-enrollment correctly and it appears that there was a system issue that caused her to reinstate. The Agency took care of the system issue and she was dis-enrolled properly.
3. Beneficiary was given incorrect information from two Choice Counselors. She was not listed on the child's case but needed to be referred to the proper source for that to be taken care of.	➲ A Choice Counseling supervisor did speak to the beneficiary, was able to pull up the case information and directed her properly. The two counselors were coached on making proper referrals.