Florida Medicaid Reform

Quarterly Progress Report
July 1, 2009 – September 30, 2009

1115 Research and Demonstration Waiver

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

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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 Terms 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 Four of the demonstration for the period of July 1, 2009, through September 30, 2009. 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 contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas[1]: 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 Health Care Administration (the Agency) for approval as part of the application process. Customized Benefit Plans are described on pages 7 through 11 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. Under current state law (as adopted during the 2009 Florida Legislative Session), the FFS PSNs are also required to become capitated after five years of operations (for most PSNs, this is September 1, 2011).

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.

Current Activities

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 20 applicants sought and received approval to provide services to the TANF and SSI population. The two health plan applications still pending were submitted by HMOs: AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, a specialty plan (HMO) for beneficiaries living with HIV/AIDS, and Medica Health Plans of Florida. AHF MCO of Florida doing business as Positive Health Care, submitted its specialty plan application in January 2008. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of September 30, 2009, this specialty plan application was nearing completion of Phase III of the application process. Medica Health Plans of Florida is an

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

HMO with a national base. As of September 30, 2009, this HMO application was nearing completion of Phase IV.

This quarter Sunshine State Health Plan (HMO) began providing services in Broward County on July 1, and expanded into Baker, Clay, Duval, and Nassau Counties on August 1. Molina Health Plan (HMO) began providing services in Broward County on September 1.

Table 1 provides a list of all health plan applicants, the date each application was received, the date of application approval or if the application is still pending, and each plan's county of operation.

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease***	HMO	X	X	04/14/06	06/29/06
Staywell***	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare *	HMO	X *	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista*	HMO	X *		04/14/06	06/29/06
Vista Health Plan SF*	HMO	X *		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates**	PSN	X **		05/09/06	08/11/06
Better Health Plan	PSN	X	X	05/23/06	12/10/08
Positive Health Care	HMO	X		01/28/08	***Pending***
Medica Health Plans of Florida	HMO	X		09/29/08	***Pending***
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		1/14/09	05/20/09

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

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

Table 2
Medicaid Reform Health Plan Contracts

Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care****	07/01/06	HMO	X****		
Health Ease***	07/01/06	HMO	X***	X***	
Staywell***	07/01/06	HMO	X***	X***	
Preferred Medical Plan****	07/0106	HMO	X****		
United HealthCare*	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista*	07/01/06	HMO	X*		
Vista Health Plan SF*	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X	
Pediatric Associates**	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	4/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		

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

Contract Amendments and Model Contracts

There were no general amendments during this quarter. Three health plans requested and received Agency approval during this quarter to increase their maximum enrollment levels in various counties.

All health plans signed the new consolidated model contract effective September 1, 2009. The consolidated model contract is a streamlined version of the previous separate model health plan contracts (non-Reform, Reform, FFS PSN, capitated PSN, HMO and specialty plan for children with chronic conditions, and specialty plan for persons living with HIV/AIDS). The Agency created one core contract

that a health plan will sign with exhibits that detail any unique plan and population requirements of the particular plan (FFS PSN, capitated PSN, HMO, Reform or non-Reform, specialty population, age-group).

In addition, contract revisions include the removal of reporting templates and detailed reporting instructions from the contract and the drafting of a first-time, plan-friendly, electronic, report guide companion to the contract. Report templates and detailed instructions will be conveniently provided to health plans through Report Guide postings on the Agency's website. This will streamline the ability for Agency staff to make changes to report formats and instructions, be responsive to their contractors, and keep up with technological advances without waiting for contract amendment development, negotiation, and execution prior to implementation. The Report Guide has received numerous compliments from the health plans and has been cited as a best practice.

The Agency is also sensitive to ensuring that access to specialty care is covered as much as possible within the health plan contract context. To help accomplish this, during the last quarter of Year Three, the Agency requested its external quality review organization conduct a national review of health plan contract language and federal requirements regarding access to specialty care. In addition, the Agency is communicating with other model states regarding the issue of ensuring access to specialty care.

Contract Conversions/Terminations

Based on a purchase agreement entered into between Molina Health Plan (HMO) and Florida NetPASS (FFS PSN), the NetPASS membership was transitioned to Molina this quarter. Similarly, based on a purchase agreement entered into between Sunshine State Health Plan (HMO) and Access Health Solutions (FFS PSN), the Access membership was transitioned to Sunshine this quarter.

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

For each transition, enrollees were given written notification of the change and an opportunity to select another health plan. The health plan sent letters to its members 60 days prior to the enrollment transition date and the Agency sent letters to the enrollees 30 days prior to the enrollment transition date. Beneficiaries impacted by the transition have 90 days after the transition to change plans without cause.

Throughout each transition process, the Agency also conducted weekly calls with the Florida Medicaid Area Offices and the Choice Counseling vendor to ensure all issues were resolved quickly.

This quarter the Agency received notice from two HMOs (AMERIGROUP Community Care and Preferred Medical Plan) of their intent to withdraw from the demonstration effective December 31, 2009. Each plan cites issues with hospital contract negotiations as the impetus for the withdrawal requests.

FFS PSN Conversion Process

Pursuant to a 2009 legislated revision to section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the 6th year of operation. Previous Legislation required conversion at the beginning of the fourth year of operation. This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2011, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

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

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

Table 4
PSN Conversion to Capitation Timeline

Deadline for the FFS PSN to submit its conversion workplan to the Agency.	01/31/2010
Deadline for the FFS PSN to submit its conversion application to the Agency.	12/31/2010
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2011.	06/30/2011

FFS PSN Reconciliations

During this quarter, the Agency continued work on two reconciliation[2] periods: one period for the first four months of the second contract year (September 2007 through December 2007) and the final reconciliation for the first contract year (September 2006 through August 2007). The Agency continues to provide technical assistance to PSNs that have requested additional time as they analyze their reconciliation data.

Systems Enhancements

With the conversion to the new Medicaid Fiscal Agent, new systems changes continue to occur and technical assistance is being provided for HMOs and PSNs (see Section K of this report under the heading: FFS PSN Systems Monthly Conference Calls). As the new system becomes fully operational, the Agency will continue to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These systems 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. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package, but could eliminate or reduce the co-payments and offer additional services not covered by Medicaid under the state plan.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages to ensure 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

[2] 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.

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 all four years 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. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were then released on May 23, 2007, for Year Two, May 7, 2008, for Year Three, and September 15, 2009, for Year Four.

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, and updated versions of the PET were released annually, shortly after the release of the latest data book. 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 design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

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

Current Activities

The benefit packages customized by the health plans for Demonstration Year Four become operational on January 1, 2010, and will remain valid until August 31, 2010. These benefit packages include 20 customized benefit packages for the HMOs and 12 benefit packages for the FFS PSNs.

The 8 HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Four of the demonstration are Freedom Health Plan, Humana, Medica Healthcare, Molina Healthcare, Total Health Choice, Sunshine State Healthplan, United Health Care and Universal Health Care. The 4 FFS PSNs are Better Health, Children's Medical Services, First Coast Advantage, and the South Florida Community Care Network.

Table 5 lists the number of copayments for each service type by each demonstration year. Year Three has been divided into 2 columns (July 1, 2008 to December 31, 2008 and January 1, 2009, to June 30, 2009) to reflect the departure of health plans that ceased operations during the third quarter of the year.

During the first quarter of Year Four, the total number of copays required by all health plans in the demonstration areas decreased from the second half of Year Three (January 2009 – June 2009) from 40 to 33. Copayments for Primary Care Physician, Specialty Physician, ARNP / Physician Assistant and Clinic (FQHC, RHC) were dropped in all plans in all areas for both SSI and TANF. The number of copayments for Chiropractic, Hospital Outpatient Services (Non-Emergency), Hospital Outpatient Surgery, Home Health, Lab/X-Ray, Primary Care Physician, Specialty Physician, ARNP / Physician Assistant and Clinic (FQHC, RHC) were all reduced, while the number of copayments for Mental Health, Dental and Vision increased.

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

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

Table 6 shows the number and percentage of benefit packages that do not require any copayments, separated by demonstration year. Table 7 displays the number of benefit packages not requiring copayments by population and area and shows that for each area and target population, there is at least one benefit package to choose from that does not require copayments.

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

	Year One	Year Two	Year Three (July-Dec)	Year Three (Jan-June)	Year Four
Total Number of Benefit Packages	**28**	**30**	**28**	**24**	**20**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**	**20**	**16**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**	**83%**	**80%**

Table 7
Number of Benefit Packages Requiring No Copayments
By Target Population & Area
1st Quarter of Demonstration Year Four

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

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

- Over-the-counter drug benefit $25 per household, per month,
- Adult Preventative Dental,
- Circumcisions for male newborns,
- Additional Adult Vision, and
- Nutrition Therapy.

Since the implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006, to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Year Three to a monthly script limit only. In Demonstration Year One and Year Two, plans had the option of having a monthly script limit or a dollar limit on the pharmacy benefit. This change was made to standardize the mechanism used to limit the pharmacy benefit. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF 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 Four was similar to that of the three previous years. The updated version of the data book was released by the Agency on September 15, 2009, and the new PET was emailed to the health plans on September 17, 2009. The health plans' Year Four benefit packages will have an effective date of January 1, 2010. This extension was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Four of the demonstration.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the managed care contractual process that was in place for the non-demonstration counties, 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 process is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel for enrollees in a FFS PSN (as described on the following page). The Assistance Panels provide an additional level of appeal for enrollees.

As defined in the health plan contracts:

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

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

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

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

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 its quarterly reports. The Agency also uses this information internally, as part of the Agency's continuous improvement efforts.

Grievances & Appeals

Table 8 provides the number of grievances and appeals by health plan type for the previous quarter ending June 30, 2009. 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. Please note that the April – June 2009 quarter was also reported in the Year Three Annual Report. The numbers that were reported in the Year Three Annual Report for the quarter are different from the numbers reported in this quarterly report due to identifying duplicate counts and unduplicating them.

Table 8
Grievances and Appeals
April 1, 2009- June 30, 2009

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	62	17	112	55	247,264

*unduplicated enrollment count

Medicaid Fair Hearings

Table 9 provides the number of Medicaid Fair Hearing requests during the quarter ending September 30, 2009. Medicaid Fair Hearings are conducted through the Florida 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. However, the Agency monitors the Medicaid Fair Hearing process. Of the 7 Medicaid Fair Hearing requests, six were related to denial of benefits/services and one was related to the reduction/suspension/termination of benefits/services. Two outcomes were favorable to the health plan, three hearings were withdrawn or abandoned and therefore favorable to the beneficiary, the beneficiary failed to show for one hearing, and one hearing was pending.

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

PSN	1
HMO	6

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only 3 grievances have been submitted to the SAP and none to the BAP for this quarter. Of the three SAP requests, one was found in favor of the HMO and two are pending.

Table 10 provides the number of requests to BAP and SAP for the quarter ending September 30, 2009.

Table 10 BAP and SAP Requests *July 1, 2009 – September 30, 2009*	
BAP	0
SAP	3

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 to the Florida Medicaid headquarters offices specified above for resolution.

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 12 complaints/issues related to PSNs and received 80 complaints/issues related to HMOs, for a total of 92 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO). Attachment I provides the details on the complaints/issues related to 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 the issues raised.

During this quarter, eight of the PSN complaints/issues were from members and four were from providers. Member issues included needing assistance in accessing

providers and assistance with ending balance billing. The provider issues were regarding claims payment and processing.

The majority of the HMO complaints/issues this quarter were related to member issues, with the majority being related to members needing assistance with finding/seeing a provider and getting authorization for services. Other member issues included needing assistance in getting enhanced benefit credits and members being mistakenly billed or balance-billed. Provider issues included payment delays/denials. The Agency continues to monitor enrollment complaint issues related to enrollment data provided to the health plans by the Fiscal Agent.

Agency staff worked directly with the members and with the HMOs and PSNs 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.

In the second quarter of Year Four, Agency staff will begin using the new Complaints/Issues Reporting and Tracking System, which will allow real-time, secure access through the Agency's web portal for headquarters and Area Office staff.

5. On-Site Surveys

During the quarter, the Agency conducted focused reviews at three HMOs and four PSNs. Each of the HMOs had a utilization management review of its prior authorization system, including a review of its policies and procedures and interviews with plan staff. The PSNs had medical record, disease management and case management record reviews, which included a review of policies and procedures and interviews with plan staff. Also reviewed were behavioral health policies and procedures in the services, utilization management, quality of care, medical records, claim processing and grievance and appeal categories. Interviews with plan staff were also conducted. Additional reviews will be conducted by the Agency next quarter.

The Agency continued to work with the EQRO vendor, HSAG, on refining the survey instrument. HSAG has also reviewed one plan's quality improvement process, which showed the plan was in compliance; however, some changes and additions to the plan's quality improvement process were needed. The report will be included in the HSAG's year-end report to the Agency.

Table 11 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 11 On-Site Survey Categories
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Grievances & Appeals
➲ Financials

B. Choice Counseling Program

Overview

The demonstration has completed the first quarter of Year Four. A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health care by providing them with the information they need to make the most informed decisions about health plan choices.

The following are key events and efforts that have occurred during this quarter:

- Contract Procurement Process: The nature of the contract procurement process and vendor preparation for transition became apparent during this quarter. Staff retention and efficiency were areas of primary concern.
- Access [MPN/PSN] transition to Sunshine State Health Plan, effective September 1, 2009: This transition occurred a few months after the Healthease and Staywell withdrawal that occurred in the fourth quarter of Year Three.
- Amerigroup and Preferred health plan withdrawals from Broward County: The pending plan withdrawals began to impact the Call Center in late August of 2009.
- Expansion of Mental Health Unit efforts: This quarter the Mental Health Unit took on a community relations role, including event planning.
- Fiscal Agent Implementation Challenges & Resolutions: The Agency, ACS and EDS continue to work on efforts to correct system conflicts and errors.

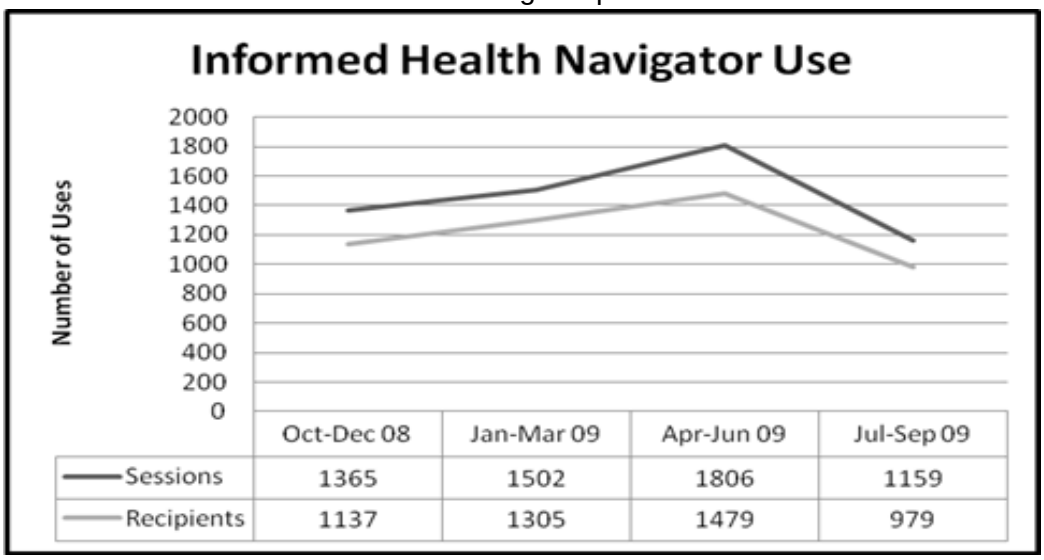
Current Activities

1. Informed Health Navigator Solution (Navigator)

Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets beneficiary prescribed drug needs. This additional information is provided to assist the beneficiary in making a plan selection. The Navigator system contains each health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator pulls the prescription data and provides detailed information on how each plan meets the beneficiary's current prescribed drug needs. This detail allows the Choice Counselor to provide more information to the beneficiary and does not require that the individual remember his or her 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 or have received a new prescription not yet in their records. The Choice Counselor's role is to share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications.

During the quarter, there was a decline in Navigator usage with no discernable reason. Chart A provides the Navigator statistics for period October 2008 through September 2009. The decline in usage represents a significant decrease compared to previous quarters as noted in Chart A. This quarter, the totals for the Navigator were 1,159 sessions and 979 unique recipients utilized the system.

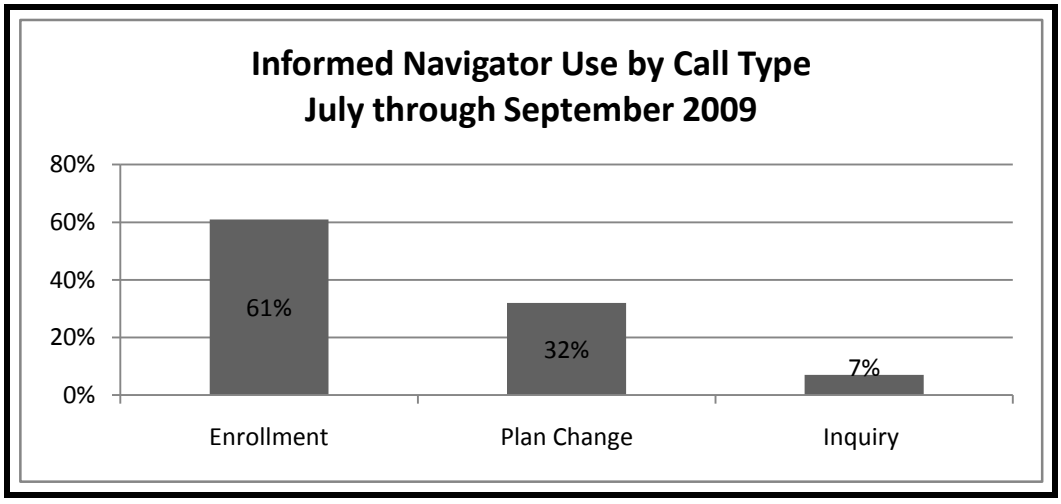
Chart A
Navigator Use by Session & Unique Recipient
October 2008 through September 2009



	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09	Jul-Sep 09
Sessions	1365	1502	1806	1159
Recipients	1137	1305	1479	979

Beginning the previous quarter, Choice Counseling started capturing data to indicate whether a person was using the Navigator for an enrollment, plan change, or an inquiry. Chart B shows (by percentages) what types of calls were received using this program as a choice driver over the quarter.

Chart B
Navigator Use by Call Type
July 2009 through September 2009



Beneficiary Customer Survey

Each beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The Call Center does have a set day of the week when the Choice Counselors offer the survey to callers. This helps to reach the goal of at least 400 completed surveys each month. A total of 1,252 beneficiaries completed the automated survey from July 1, 2009 to September 30, 2009.

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

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

If a beneficiary scores a category between 1 and 3, the caller has the ability to leave a comment about why they left a low score. The caller also has the ability to request a supervisor call them back so the caller can provide more feedback on his or her experience.

The scores for the amount of time the beneficiary had to "wait on hold" continued to decline. The reduction in the score for the hold time began in August 2008, and correlates with the increased number of incoming calls to the Call Center due to issues with the new Fiscal Agent. Other factors, as outlined in the overview at the beginning of this section, also contributed to the increased call volume for this quarter.

ACS continues to utilize various mitigation efforts, as reported in the Call Center section of the report, to offset the caller's wait time.

The table 12 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from July through September of 2009. The number of beneficiaries participating in the Survey this quarter was as follows: July - 414, August - 423, and September - 415 (totaling 1,252).

The top three survey categories for the quarter were: "Being treated respectfully," "Overall service provided by counselor" and "Quickly understood reason". The three lowest scoring survey categories were: "Amount of time waiting to speak with a Choice Counselor", "How easy was it to understand information received" and "How helpful do you find this counseling to be."

Table 12 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
July	**August**	**September**
How helpful do you find this counseling to be		
88.4%	89.4%	88.7%
Amount of time you waited		
51.2%	45.9%	33.7%
Ease of understanding info		
79.8%	76.9%	77.0%
Likelihood to recommend		
92.3%	89.4%	90.1%
Overall service provided by Counselor		
96.6%	96.5%	98.3%
Quickly understood reason		
97.1%	95.7%	96.9%
Ability to help choose plan		
95.2%	93.9%	95.4%
Ability to explain clearly		
96.9%	94.6%	97.6%
Confidence in the information		
96.4%	94.1%	94.9%
Being treated respectfully		
98.3%	97.6%	98.1%

2. Call Center

The Choice Counseling Call Center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The Call Center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday, 8:00 a.m. – 8:00 p.m. and Friday, 8:00 a.m. – 7:00 p.m., providing no Saturday hours. The Call Center had an average of 39 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls.

The Choice Counseling Call Center received 79,784 calls in this quarter. This represents approximately a 3% decrease in call volume from the last quarter of Year Three. However, compared to the first quarter of Year Three, there was a 31% increase. Several factors have contributed to the continued increase of call volume for the quarter and are outlined in the overview at the start of this section.

The Agency and ACS have been in continual communication about the call volume and ACS has worked very diligently to handle this increase in volume. Various mitigation efforts continue to be utilized and will remain in place for the duration of the contract.

- The Call Back Manager gives the beneficiaries an alternative to physically waiting on the line. This feature allows beneficiaries to reserve their place in the call queue, without having to actually remain on the phone. The beneficiary receives an automatic return call when they are next in "line". The beneficiary may also designate a future date and time to receive a return call. When the specified date and time arrive, the system dials them and places them with the next available counselor. This feature is offered to the beneficiaries 20 seconds after making their initial options selection and approximately every 45 seconds thereafter.

- A modified phone script is used to allow agents to identify caller needs more quickly, separating normal calls from specialized needs due to other issues.

- Field staff is made available Monday through Friday at the Medicaid Area Offices to help handle walk-ins and callers who need assistance with plan changes or have questions.

In addition, the Agency continues to work closely with ACS to ensure the Call Center is sufficiently staffed, as well as to identify other methods to address the increased call volume.

Table 13 compares the call volume of incoming and outgoing calls during the first quarter of Demonstration Year Three and Year Four.

Table 13
Comparison of Call Volume for First Quarter
(Year Three & Year Four)

Type of Calls	July 2008	July 2009	August 2008	August 2009	Sept 2008	Sept 2009	Year 3 1st Quarter Totals	Year 4 1st Quarter Totals
Incoming Calls	14,853	27,345	20,068	26,137	26,030	26,302	**60,951**	**79,784**
Outgoing Calls	4,015	3,318	4,165	3,213	4,257	2,372	**12,437**	**8,903**
Totals	18,868	30,663	24,233	29,350	30,287	28,674	**73,388**	**88,687**

3. Mail

Outbound Mail

During this quarter, the ACS mailroom mailed the following:

- New-Eligible Packets (mandatory and voluntary) 23,378
- Auto-Assignment Letters 28,893
- Confirmation Letters 23,881
- Open Enrollment Packets 40,909
- Transition Packets 681
- Plan Transfer Letters (mandatory and voluntary) 43,845

During this quarter, a new letter for health plan transfers was mailed to those beneficiaries who were in Access health plan in each of the demonstration counties. There were two different letters sent depending on whether the beneficiary is mandatory or voluntary for managed care. The number of letters above reflect both the mandatory and voluntary letters together.

The amount of returned mail has increased this quarter. The increase is attributed to the increased mailing associated with Access health plan transition, but is still within 3-5% range estimated for return mail. When returned mail is received, the Choice Counseling staff access 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. The Outreach Team is instrumental in this effort in contacting beneficiaries. The Choice Counseling staff work to re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail:

During the quarter, ACS processed the following:

- Plan Enrollments 1,549
- Plan Changes 196

The percentage of enrollments processed through the mail-in enrollment forms has remained between 2 and 5% of total enrollments.

4. Face-to-Face/Outreach and Education

During the quarter, the Field Choice Counseling Outreach Team continued to be available in the Area Offices to assist those beneficiaries that are having trouble reaching the Call Center or have additional questions. Table 14 provides a comparison of the Field activities for the fourth quarter of Year Three and the first quarter of Year Four.

Table 14 Choice Counseling Outreach Activities		
Field Activities	**Year 3 4th Quarter**	**Year 4 1st Quarter**
Group Sessions	578	738
Private Sessions	98	96
Home Visits & One-On-One Sessions	107	141
No Phone List	3	818
Outbound Phone List	1,113	4,157
Enrollments	3,999	4,989
Plan Changes	4,683	480

Beginning in July 2009, the Outreach Program began a concerted effort to refocus the face-to-face counseling to contact the "hard to reach" beneficiaries by increasing the number of Public and Private Sessions. This resulted in 25% of the total number of enrollments being completed by Field Counselors.

The outbound efforts were responsible for the other 75% of Outreach enrollments. The Field Counselors returned to making the No-phone list the top priority, with 818 beneficiary contact attempts made this quarter, resulting in 486 completed enrollments. Field Counselors also made 4,157 outbound list calls during the quarter, which resulted in 2,705 completed enrollments.

Since September of 2007, the Field Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff randomly call beneficiaries who were served by Field Choice Counselors. The beneficiaries are asked four survey questions in order to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 15 shows the responses in percentages from 148 beneficiaries who participated in the surveys (from July-September 2009). The same percentage range used by the Call Center (see page 19 of this report) is used in the field, with 100% being a perfect score.

Table 15 Overall Field Choice Counseling Results July 2009 – September 2009	
Able to complete enrollment/plan change at the session	98.00%
Felt the information provided by the Choice Counselor helped them make an informed decision	98.00%
The information was explained in a way that made it easy to understand	100.00%
The Choice Counselor was friendly/courteous	100.00%

ACS continues to evaluate the monitoring telephone survey results and has made updates to the Field Counselors tools which are used for outbound calls and face-to-face sessions to better serve beneficiaries.

The Field Counselors continued their efforts to better reach the special needs and other hard to reach populations. These 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.

The Mental Health Unit:

During the second quarter of Year Three, the Mental Health Unit was created to provide more direct support to beneficiaries who access mental health services. The Mental Health Unit is comprised of three highly experienced Field Counselors who have been with the program since July of 2006. Two of the Field Counselor's are located in Broward County and one is located in Duval County. A primary goal of the Mental Health Unit is to establish and maintain partnerships with case managers and other local service providers who work directly with this special needs group.

The Mental Health Unit was very active during this quarter completing 50 private Sessions for 180 attendees and followed up on 139 referrals from community partners. The Unit also conducted 39 different presentations to caseworkers and support staff.

To date over 120 organizations have been identified and a beneficiary contact attempt was made by a Field Counselor. As a result, the Mental Health Unit has established several key relationships and developed strong working partnerships. Some of the large organizations include:

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

These groups all provide mental health and substance abuse services and have been very receptive to working with the Field Counselors.

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse supervisor, and a Licensed Practical Nurse who have both earned their Choice Counseling certification.

Summary of Cases Taken by the Special Needs Unit:

Forty-eight new case referrals and thirty-seven case review requests/inquiries were received and processed by the Special Needs Unit during this quarter.

A 'case referral' is when a counselor refers a case to the Special Needs Unit through the ACS enrollment system (BESST) or verbally via phone transfer, for follow up. The Special Needs Unit conducts the research and resolves the referral.

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

This quarter, the Special Needs Unit began documenting and reporting on the verbal reviews and referrals as outlined in Table 16 below.

Table 16
Number of Referrals and Case Reviews Completed
1st Quarter, Year 4

	July 09	August 09	September 09
Case Referrals	21	17	10
Case Reviews	20	10	7

The Special Needs Unit staff scope of work has 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;
- Development of health related reference guides to increase the Choice Counselors knowledge of Medicaid services (which is ongoing);
- Participation in the development of the Navigator Choice Counseling script; and
- Development and implementation of a tracking log to capture the number and type of counselor's verbal inquiries, which was done during the first portion of the quarter.

6. New Eligible Self Selection Data[3]

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 Florida Medicaid's

[3] 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.

Fiscal Agent (EDS) and ACS Choice Counseling. The Agency, ACS and EDS have identified and created customer service requests (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with the Medicaid system (FMMIS) and the ACS enrollment system (BESST). EDS will work through the program changes and should have the work complete within the next 6 months. Some improvements have been made to the daily and monthly files that transfer from EDS to ACS and some issues have been resolved. When the program changes are complete, and the month end information comes through consistently and correctly, it will allow ACS to determine the new eligible's and ensure the enrollment will be more successful. Prior to the Fiscal Agent transition, ACS exceeded the self-selection standard. The Agency fully expects when the corrections are in place, ACS will not only meet but exceed the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

The new eligible enrollments in this report are taken from ACS records and are preliminary. There were 40,073 total enrollments for this quarter. Of those enrollments, those that self selected a plan were 21,247 (broken down by month: 6,572 for July; 8,301 for August; and 6,374 for September 2009). There were a total of 18,826 beneficiaries assigned to a plan for the quarter.

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 about Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call.

During the quarter, there were no complaints filed related to the Choice Counseling Program.

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 the automated survey previously mentioned in this report. The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Choice Counselor's ability to explain health plan choices indicate that more than 98% are satisfied with the Choice Counseling experience (both Field and Call Center). ACS continues to focus on improving communication between Counselors and beneficiaries and evaluating comments left by beneficiaries to improve customer service.

Included in this report are comments from beneficiaries who expressed their appreciation to either a Call Center or Field Supervisor for the Choice Counselors who helped them. The individual counselors that received this positive feedback have gone

the extra mile and have offered a “helping hand” to those who they spoke with in person or on the phone. 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 40 reported compliments to supervisors about counselors offering exceptional 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.

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 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 in learning and working in a new system. The Agency, ACS and EDS remain committed to identifying, prioritizing and resolving these challenges. Recently, additional staffing resources were added to the EDS systems team, with the sole purpose of correcting identified issues and continuing a root cause analysis, as it relates to the demonstration.

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 the organization. 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 (including Good Cause plan changes).

The pending transition of the Choice Counseling Program is a primary focus for all parties involved at this time. The continued effort currently being given by all will play a significant role in assuring that the transition is a success.

The Agency is planning a series of public meetings to occur over the course of the next couple of quarters. The Agency looks to communicate with the community regarding the current and future state of the Choice Counseling program.

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

The Agency believes that the Choice Counseling Program will resume its exceptional performance standards once the daily and month end files are working properly.

C. Enrollment Data

Overview

In anticipation of Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population into the health plans located in the demonstration counties of Broward and Duval. The transition period for Broward and Duval lasted seven months, beginning in September of 2006 and ending in April of 2007. The transition plan staggered the enrollment of beneficiaries who were enrolled in various managed care programs (operated under Florida's 1915(b) Managed Care Waiver) into demonstration health plans. The types of managed care programs that beneficiaries transitioned from included HMOs, MediPass, Pediatric Emergency Room Diversion, 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[4]:** Phased in over 7 months (1/2 in Month 1, then 1/6 in each following month)
- **HMO Population:** 1/12 in Months 2, 3, and 4, and 1/4 in Months 5, 6, and 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 demonstration health plan was September 1, 2006. During the second, third, and fourth quarters of operation of Year One, enrollment in the demonstration increased greatly as more existing Medicaid beneficiaries were transitioned into health plans.

The Agency also developed a transition plan for Year Two of the demonstration, which expanded the 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 demonstration health plan. The beneficiaries were transitioned from HMOs, MediPass, and MPNs. The transition schedule for Baker, Clay and Nassau counties was as follows:

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

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

- **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 during Year Four.

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, 2009, and ending September 30, 2009. 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 health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 17 health plans (ten HMOs and six fee-for-service PSNs). Two HMOs, HealthEase and StayWell, which have been included in previous quarterly and annual reports, ceased operations during the fourth quarter of Year Three and their enrollees were transitioned into the remaining demonstration health plans. As such, only their previous quarterly enrollments are included in this quarter's report. Additionally, Access Health Solutions and Netpass were acquired by Sunshine State Health Plan and Molina Healthcare, respectively. Their enrollees are currently in the process of being transitioned to their new demonstration health plans.

There are two categories of Medicaid beneficiaries who are enrolled in the 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 on the following pages.

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 17 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 17
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 18 for Year Four, first quarter Medicaid Reform Enrollment Report.

Table 18
Medicaid Reform Enrollment Report
(Fiscal Year 2009-10, 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	19,031	2,372	2	129	**21,534**	**8.31%**	24,876	-13.43%
Freedom Health Plan	HMO	818	163	0	14	**995**	**0.38%**	1,219	-18.38%
HealthEase	HMO	0	0	0	0	**0**	**0.00%**	27,220	-100.00%
Humana	HMO	11,898	2,397	2	184	**14,481**	**5.59%**	17,096	-15.30%
Molina Healthcare	HMO	11,104	2,315	2	126	**13,547**	**5.23%**	5,182	161.42%
Preferred Medical Plan	HMO	2,003	510	0	37	**2,550**	**0.98%**	3,160	-19.30%
StayWell	HMO	0	0	0	0	**0**	**0.00%**	3,350	-100.00%
Sunshine	HMO	55,009	6,653	0	93	**61,755**	**23.83%**	0	N/A
Total Health Choice	HMO	24,137	2,833	1	294	**27,265**	**10.52%**	20,201	34.97%
United Healthcare	HMO	10,080	1,166	0	47	**11,293**	**4.36%**	12,318	-8.32%
Universal Health Care	HMO	8,066	1,033	1	127	**9,227**	**3.56%**	7,869	17.26%
HMO Total	**HMO**	**142,146**	**19,442**	**8**	**1,051**	**162,647**	**62.76%**	**122,491**	**32.78%**
Access Health Solutions	PSN	14,121	965	3	504	**15,593**	**6.02%**	55,638	-71.97%
Better Health, LLC	PSN	4,281	521	1	50	**4,853**	**1.87%**	4,518	7.41%
CMS	PSN	3,412	2,892	0	13	**6,317**	**2.44%**	5,751	9.84%
First Coast Advantage	PSN	38,991	6,069	0	679	**45,739**	**17.65%**	30,902	48.01%
NetPass	PSN	568	104	0	217	**889**	**0.34%**	8,826	-89.93%
SFCCN	PSN	19,550	3,197	3	385	**23,135**	**8.93%**	19,138	20.89%
PSN Total		**80,923**	**13,748**	**7**	**1,848**	**96,526**	**37.24%**	**124,773**	**-22.64%**
Reform Enrollment Totals		**223,069**	**33,190**	**15**	**2,899**	**259,173**	**100.00%**	**247,264**	**4.82%**

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 259,173 beneficiaries enrolled in the demonstration during this quarter. There were 17 demonstration health plans with market shares ranging from 0.34 percent to 23.83 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter the demonstration remained operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 19 on the following page.

Table 19 Number of Reform Health Plans in Demonstration Counties		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**1**
Broward	**10**	**6**
Clay	**2**	**1**
Duval	**5**	**3**
Nassau	**2**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 20 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 20 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 in Table 21 and located on the following page.

Table 21
Medicaid Reform Enrollment by County Report
(Fiscal Year 2009-10, 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				
Sunshine	HMO	Baker	1,822	177	0	0	**1,999**	**63.02%**	0	N/A
United Health Care	HMO	Baker	592	84	0	4	**680**	**21.44%**	727	-6.46%
Access Health Solutions	PSN	Baker	440	40	0	13	**493**	**15.54%**	2,397	-79.43%
Total Reform Enrollment for Baker			**2,854**	**301**	**0**	**17**	**3,172**	**100.00%**	**3,124**	**1.54%**
Amerigroup	HMO	Broward	19,031	2,372	2	129	**21,534**	**15.05%**	24,876	-13.43%
Freedom Health Plan	HMO	Broward	818	163	0	14	**995**	**0.70%**	1,219	-18.38%
HealthEase	HMO	Broward	0	0	0	0	**0**	**0.00%**	782	-100.00%
Humana	HMO	Broward	11,898	2,397	2	184	**14,481**	**10.12%**	17,096	-15.30%
Molina Healthcare	HMO	Broward	11,104	2,315	2	126	**13,547**	**9.47%**	5,182	161.42%
Preferred Medical Plan	HMO	Broward	2,003	510	0	37	**2,550**	**1.78%**	3,160	-19.30%
StayWell	HMO	Broward	0	0	0	0	**0**	**0.00%**	3,154	-100.00%
Sunshine	HMO	Broward	17,796	1,977	0	28	**19,801**	**13.84%**	0	N/A
Total Health Choice	HMO	Broward	24,137	2,833	1	294	**27,265**	**19.05%**	20,201	34.97%
Universal Health Care	HMO	Broward	5,393	712	1	84	**6,190**	**4.32%**	3,974	55.76%
Access Health Solutions	PSN	Broward	3,720	181	0	144	**4,045**	**2.83%**	20,118	-79.89%
Better Health, LLC	PSN	Broward	4,281	521	1	50	**4,853**	**3.39%**	4,518	7.41%
CMS	PSN	Broward	1,976	1,852	0	9	**3,837**	**2.68%**	3,471	10.54%
Netpass	PSN	Broward	568	104	0	217	**889**	**0.62%**	8,826	-89.93%
SFCCN	PSN	Broward	19,550	3,197	3	385	**23,135**	**16.16%**	19,138	20.89%
Total Reform Enrollment for Broward			**122,275**	**19,134**	**12**	**1,701**	**143,122**	**100.00%**	**135,715**	**5.46%**
Sunshine	HMO	Clay	5,532	612	0	7	**6,151**	**50.86%**	0	N/A
United Health Care	HMO	Clay	3,597	260	0	14	**3,871**	**32.00%**	3,706	4.45%
Access Health Solutions	PSN	Clay	1,835	171	0	67	**2,073**	**17.14%**	7,626	-72.82%
Total Reform Enrollment for Clay			**10,964**	**1,043**	**0**	**88**	**12,095**	**100.00%**	**11,332**	**6.73%**
HealthEase	HMO	Duval	0	0	0	0	**0**	**0.00%**	26,438	-100.00%
StayWell	HMO	Duval	0	0	0	0	**0**	**0.00%**	196	-100.00%
Sunshine	HMO	Duval	27,181	3,574	0	53	**30,808**	**32.22%**	0	N/A
United Health Care	HMO	Duval	4,857	682	0	23	**5,562**	**5.82%**	6,697	-16.95%
Universal Health Care	HMO	Duval	2,673	321	0	43	**3,037**	**3.18%**	3,895	-22.03%
Access Health Solutions	PSN	Duval	7,231	512	3	251	**7,997**	**8.36%**	21,790	-63.30%
CMS	PSN	Duval	1,436	1,040	0	4	**2,480**	**2.59%**	2,280	8.77%
First Coast Advantage	PSN	Duval	38,991	6,069	0	679	**45,739**	**47.83%**	30,902	48.01%
Total Reform Enrollment for Duval			**82,369**	**12,198**	**3**	**1,053**	**95,623**	**100.00%**	**92,198**	**3.71%**
Sunshine	HMO	Nassau	2,678	313	0	5	**2,996**	**58.05%**	0	N/A
United Health Care	HMO	Nassau	1,034	140	0	6	**1,180**	**22.86%**	1,188	-0.67%
Access Health Solutions	PSN	Nassau	895	61	0	29	**985**	**19.09%**	3,707	-73.43%
Total Reform Enrollment for Nassau			**4,607**	**514**	**0**	**40**	**5,161**	**100.00%**	**4,895**	**5.43%**
Reform Enrollment Totals			**223,069**	**33,190**	**15**	**2,899**	**259,173**		**247,264**	**4.82%**

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

During this quarter, there was an enrollment of 3,172 beneficiaries in Baker County, 143,122 beneficiaries in Broward County, 12,095 beneficiaries in Clay County, 95,623 beneficiaries in Duval County, and 5,161 beneficiaries in Nassau County. There were three Baker County health plans with market shares ranging from 15.54 percent to 63.02 percent, 13 Broward County health plans with market shares ranging from 0.62 percent to 19.05 percent, three Clay County health plans with market shares ranging from 17.14 percent to 50.86 percent, six Duval County health plans with market shares ranging from 2.59 percent to 47.83 percent, and three Nassau County health plans with market shares ranging from 19.09 percent to 58.05 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 22 and 23 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 22 provides a description of each column in this report.

Table 22
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 23 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 23
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2009-10, 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	0	115	0	42	0	131	**288**	**1.34%**	21,534
Freedom Health Plan	HMO	Broward	0	8	0	4	0	14	**26**	**2.61%**	995
Humana	HMO	Broward	0	99	0	40	0	186	**325**	**2.24%**	14,481
Molina Healthcare	HMO	Broward	3	54	1	20	21	107	**206**	**1.52%**	13,547
Preferred Medical Plan	HMO	Broward	0	22	0	8	0	37	**67**	**2.63%**	2,550
Sunshine	HMO	Baker	0	11	0	0	0	0	**11**	**0.55%**	1,999
Sunshine	HMO	Broward	5	30	1	3	14	14	**67**	**0.34%**	19,801
Sunshine	HMO	Clay	0	24	0	0	1	6	**31**	**0.50%**	6,151
Sunshine	HMO	Duval	3	93	0	10	7	46	**159**	**0.52%**	30,808
Sunshine	HMO	Nassau	0	11	0	0	0	5	**16**	**0.53%**	2,996
Total Health Choice	HMO	Broward	9	145	3	33	44	251	**485**	**1.78%**	27,265
United Healthcare	HMO	Baker	0	8	0	1	0	4	**13**	**1.91%**	680
United Healthcare	HMO	Clay	1	34	0	10	2	12	**59**	**1.52%**	3,871
United Healthcare	HMO	Duval	0	121	0	16	0	23	**160**	**2.88%**	5,562
United Healthcare	HMO	Nassau	0	11	0	4	0	6	**21**	**1.78%**	1,180
Universal	HMO	Broward	5	36	0	7	10	75	**133**	**2.15%**	6,190
Universal	HMO	Duval	0	38	0	5	0	43	**86**	**2.83%**	3,037
HMO Total	**HMO**		**26**	**860**	**5**	**203**	**99**	**960**	**2,153**	**1.32%**	**162,647**
Access Health Solutions	PSN	Baker	0	19	0	3	2	11	**35**	**7.10%**	493
Access Health Solutions	PSN	Broward	0	131	2	29	2	142	**306**	**7.56%**	4,045
Access Health Solutions	PSN	Clay	2	69	0	17	3	64	**155**	**7.48%**	2,073
Access Health Solutions	PSN	Duval	10	337	1	72	18	236	**674**	**8.43%**	7,997
Access Health Solutions	PSN	Nassau	1	51	0	4	2	27	**85**	**8.63%**	985
Better Health, LLC	PSN	Broward	3	21	0	4	11	40	**79**	**1.63%**	4,853
CMS	PSN	Broward	1	43	4	177	0	9	**234**	**6.10%**	3,837
CMS	PSN	Duval	0	52	2	80	0	4	**138**	**5.56%**	2,480
First Coast Advantage	PSN	Duval	0	48	0	28	0	217	**293**	**32.96%**	889
NetPass	PSN	Broward	10	356	0	57	14	374	**811**	**3.51%**	23,135
SFCCN	PSN	Broward	9	598	2	122	39	640	**1,410**	**3.08%**	45,739
PSN Total	**PSN**		**36**	**1,725**	**11**	**593**	**91**	**1,764**	**4,220**	**4.37%**	**96,526**
Reform Enrollment Totals			**62**	**2,585**	**16**	**796**	**190**	**2,724**	**6,373**	**2.46%**	**259,173**

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

D. Opt Out Program

Overview

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

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

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

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

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

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

After the required information from the employer is received, the Opt Out specialist follows up with the beneficiary to discuss the insurance that is available through the employer, how much the premium will be and how payment of the premium will be

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

The Opt Out database has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The database tracks enrollee characteristics such as eligibility category, type of ESI and type of coverage. The database will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. To date no enrollee has chosen to disenroll from the Opt Out Program 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

During this quarter, the vendor has continued to monitor program participants, ensuring they continually meet the established eligibility requirements.

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

Opt Out Program Statistics

- 71 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 42 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the first quarter of Year Four, there are currently 29 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

1. The caller was enrolled in the Opt Out Program during the second quarter of Year One with a coverage effective date of October 1, 2006. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost their job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.

2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment was during the third quarter of Year One on January 1, 2007. The father of the children 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 children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.

3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of 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 children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.

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

5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of 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. The mother started the process to re-enroll the second child in the Opt Out Program. As a result, both children are now enrolled in the Opt Out Program (Item Number 36).

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

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

7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out program.

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

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

10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out program.

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

12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's

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

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

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

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out program.

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

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

18. The caller began the process to enroll his two children during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his two children's

Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The father lost his job effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

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

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

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

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

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

31. The caller began the process to enroll her child in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during

the second quarter of Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child is still enrolled in the Opt Out Program.

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

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

34. The caller began the process to enroll in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her family coverage. The individual is still enrolled in the Opt Out Program.

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

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

37. The caller began the process to enroll in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on July 1, 2009. The individual has health insurance

available through her employer. The individual works for a small employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual is still enrolled in the Opt Out Program.

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

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

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

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

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

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

Table 24 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending September 30, 2009. Current Opt Out enrollment, as of September 30, 2009, is 29.

Table 24
Opt Out Statistics
September 1, 2006 – September 30, 2009

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

Table 24 Opt Out Statistics September 1, 2006 – September 30, 2009						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	10/01/08	Large Employer	Individual	1	Still Enrolled	N/A
C & F	12/01/08	Large Employer	Family	5	Still Enrolled	N/A
C & F	12/01/08	COBRA	Family	1	Still Enrolled	N/A
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	1 2	Still Enrolled 06/30/09	N/A Loss of Medicaid Eligibility
C & F	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	Still Enrolled	N/A
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	3	Still Enrolled	N/A

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

E. Enhanced Benefits Account Program

Overview

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

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 in credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (EDS) pharmacy point of sale system currently maintained and managed by the EDS subcontractor First Health. 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 database referred to as the 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. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the EDS subcontractor First Health to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

During this quarter, the 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 answer all inbound calls relating to program questions, provide EBA account updates on credits earned/used, and assist beneficiaries with utilizing the web based OTC product list. The majority of the calls are related to beneficiaries requesting information regarding their account balances. A total of 16,275 calls or 74% of all answered calls were related to account balances.

The following is a highlight of the call center activities during the quarter:

Inbound Calls:	**23,586**
Calls Abandoned:	**1499**
Average Talk Time:	**4.21 minutes**

Average Abandonment Rate:	**6.1%**
Enhanced Benefits Reward$	
Welcome Letters:	**92,438**

2. System Activities

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

Other system activities are related to preparing both the pharmacy benefits manager system and EBIS to report beneficiaries who have been without Medicaid eligibility for three consecutive years. The first time a beneficiary may reach the three consecutive year is November 1, 2009.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during the quarter. There were 289,568 beneficiary coupon/quarterly statements mailed to beneficiaries during the quarter. The calls received this quarter were primarily related to beneficiaries seeking current balance information. The counselors are able to provide up to date information to each beneficiary, covering the latest weekly balances. The Agency is designing new flyers which focus on preventative behaviors for the next quarter.

4. Outreach and Education for Pharmacies

The Agency did not conduct any outreach and education activities with the pharmacies this quarter. On an ongoing basis, the pharmacy benefits manager (First Health) does provide technical assistance to pharmacy's regarding all billing aspects of the EBAP.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel met on August 11 and September 10 of 2009. The primary focus of the meetings was adding new healthy behaviors which would result in credits for participation in more preventive behaviors. The panel voted to add the HbA1c blood test, the PSA blood test, and the healthy start screening during the 1st trimester of pregnancy. All of these behaviors can receive a once per year credit of $15.00. The panel also voted to add an additional CPT code for smoking cessation. The plan is working to add new healthy behaviors which are in line with the plan performance measures.

6. Enhanced Benefits Statistics

Table 25 provides the Enhanced Benefit Account Program statistics beginning July 1, 2009 and ending September 30, 2009.

Table 25
Enhanced Benefit Account Program Statistics

1st Quarter Activities – Year Four		July 09	August 09	Sept 09
I.	Number of plans submitting reports by month in each county	29 of 30	29 of 30	29 of 30
II.	Number of enrollees who received credit for healthy behaviors by month	35,410	47,021	53,641
III.	Total dollar amount credited to accounts by each month	$740,827.50	$868,735.00	1,188342.50
IV.	Total cumulative dollar amount credited through the end each month	$22,545,041.16	$23,413,776.16	$24,602,118.50
V.	Total dollar amount of credits used each month by date of service	$440,642.29	$382,318.75	$574,437.16
VI.	Total cumulative dollar amount of credits used through the month by date of service	$9,370,988.48	$9,753,307.23	$10,327,744.39
VII.	Total unduplicated number of enrollees who used credits each month	18,751	17,076	23,066

Total count of beneficiaries who have used credits from the beginning of the program through 9/25/09 were 133,988.

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 this quarter are issues surrounding the health plans not submitting healthy behaviors to the Agency.

During this quarter, over 23,066 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 62 (less than 1%) complaints were recorded through the call center related to the EBAP.

F. Low Income Pool

Overview

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

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

2009 Legislation – Distribution of LIP Funds

The State of Florida's State Fiscal Year (SFY) 2009-2010 General Appropriations Act (GAA) and Senate Bill 2602, the Implementing Bill accompanying the GAA, included language that reduced the total budget authority of SFY 2008-2009 LIP distributions by $123,577,163. This change made the new total anticipated LIP distributions for SFY 2008-2009 $877,872,837. The 2009-2010 GAA provides that the sum of $123,577,163 in budget authority is provided to make payments to hospitals under the LIP Program. The distribution of the LIP funds for SFY 2009-2010 is contingent upon the Agency obtaining an amendment to the STCs of the Florida Medicaid Reform section 1115

demonstration that allows for the distribution of $1 billion in LIP distributions in the fifth year of the waiver (SFY 2010-2011). If the amendment to the demonstration is not approved by January 31, 2010, then the LIP funds shall be used in SFY 20010-2011 for the LIP Program as appropriated in the GAA for SFY 2010-2011.

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

At the request of federal CMS staff, the Agency submitted a letter on September 2, 2009 to CMS to formally request that the Agency have access to the full billion in Demonstration Year Five.

Current Activities

In the first quarter of Demonstration Year Four the Agency began its work with counties and taxing districts to contract for the Non-Federal Share of SFY 2009 - 2010 Low Income Pool (LIP). Upon receipt of non-federal share, the Agency made the final LIP Year Three distributions in the amount of $154,730,052 making Year Three total distributions $877,493,058. The total amount of Demonstration Year Four distributions released during the first quarter was $73,458,140.

New appointments to the LIP Council were made during the first quarter of Demonstration Year Four in accordance with amendment to Section 409.911 F.S., as specified in Chapter 2009-42, Laws of Florida, to increase the Council membership from 17 members to 24 members as follows:

- Two members appointed by the President of the Florida Senate,
- Two members appointed by the Speaker of the Florida House of Representatives,
- Three representatives of statutory teaching hospitals,
- Three representatives of public hospitals,
- Three representatives of nonprofit hospitals,
- Three representatives of for-profit hospitals,
- Two representatives of rural hospitals,
- Two representatives of units of local government which contribute funding,
- One representative of family practice teaching hospitals,
- One representative of federally qualified health centers,
- One representative from the Florida Department of Health, and
- One nonvoting representative of the Agency for Health Care Administration who serves as Chair of the LIP Council.

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

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

The first LIP Council meeting of SFY 2009-10 is scheduled for October 29, 2009.

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 CMS, 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 STC #116.

Definitions:

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

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

Current Activities

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

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

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

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

In the following tables (Tables 26 through 31), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

Table 26 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC #116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 26
PCCM Targets

WOW PCCM	MEG 1	MEG 2
DY01	$ 948.79	$ 199.48
DY02	$ 1,024.69	$ 215.44
DY03	$ 1,106.67	$ 232.68
DY04	$ 1,195.20	$ 251.29
DY05	$ 1,290.82	$ 271.39

Tables 27 through 31 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending September 30, 2009. Case months provided in the Tables 27 and 28 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 27
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
Q8 Total	**764,701**	**$661,690,100**	**$115,119,581**	**$776,809,682**	**$1,015.83**
Q9 Total	**818,560**	**$708,946,109**	**$116,915,711**	**$825,861,820**	**$1,008.92**
Q10 Total	**791,043**	**$738,232,869**	**$128,483,862**	**$866,716,731**	**$1,095.66**
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
July 2009	277,093	$319,718,390	$52,941,079	$372,659,469	$1,344.89
August 2009	274,819	$168,336,551	$33,437,914	$201,774,466	$734.21
September 2009	270,484	$358,692,409	$67,384,681	$426,077,090	$1,575.24
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
MEG 1 Total	**10,084,522**	**$8,792,362,024**	**$1,306,611,657**	**$10,098,973,681**	**$1,001.43**

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

Table 28
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$ 164.78**
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
July 2009	1,581,454	$333,483,694	$34,533,935	$368,017,629	$232.71
August 2009	1,583,503	$119,609,810	$13,057,173	$132,666,984	$83.78
September 2009	1,538,571	$370,920,307	$51,046,606	$421,966,913	$274.26
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
MEG 2 Total	**51,791,178**	**$7,734,270,275**	**$761,926,040**	**$8,496,196,315**	**$164.05**

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

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 29), compared to WOW of $948.79 (Table 26), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 329), compared to WOW of $199.48 (Table 26), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,017.03 (Table 29), compared to WOW of $1,024.69 (Table 26), which is 99.25% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.62 (Table 29), compared to WOW of $215.44 (Table 26), which is 78.73% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,022.05 (Table 29), compared to WOW of $1,106.67 (Table 26), which is 92.35% of the target PCCM for MEG 1. MEG 2 has a PCCM of $162.68 (Table 29), compared to WOW of $232.68 (Table 26), which is 69.92% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $968.52 (Table 29), compared to WOW of $1,195.20 (Table 26), which is 81.03% of the target PCCM for MEG 1. MEG 2

has a PCCM of $163.75 (Table 29), compared to WOW of $251.29 (Table 26), which is 65.17% of the target PCCM for MEG 2.

Tables 28 and 30 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 30) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 30 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 30) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 30 is $313.54. Comparing the calculated weighted averages, the actual PCCM is 88.85% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 30) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 30 is $299.95. Comparing the calculated weighted averages, the actual PCCM is 80.57% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 30) is $391.77. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 30 is $283.52. Comparing the calculated weighted averages, the actual PCCM is 72.37% of the target PCCM.

Table 29
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,642,260,593	$443,388,028	$3,085,648,621	$1,017.03
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(23,229,074)	
% of WOW PCCM MEG 1					99.25%
DY02 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY02 Total	14,829,991	$2,251,096,108	$264,299,192	$2,515,395,299	$169.62
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(679,577,962)	
% of WOW PCCM MEG 2					78.73%
DY03 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY03 Total	3,249,742	$2,837,189,404	$484,206,781	$3,321,396,185	$1,022.05
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(274,995,794)	
% of WOW PCCM MEG 1					92.35%
DY03 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY03 Total	17,094,840	$2,504,182,350	$276,879,038	$2,781,061,388	$162.68
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,196,565,983)	
% of WOW PCCM MEG 2					69.92%

Table 29 Continued
MEG 1 & 2 Annual Statistics

DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	822,396	$681,345,640	$115,165,303	$796,510,943	$968.52
WOW DY4 Total	822,396			$982,927,699	$1,195.20
Difference				$(186,416,756)	
% of WOW PCCM MEG 1					81.03%
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 Total	4,703,528	$685,335,627	$84,883,099	$770,218,727	$163.75
WOW DY4 Total	4,703,528			$1,181,949,551	$251.29
Difference				$(411,730,825)	
% of WOW PCCM MEG 2					65.17%

Table 30
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,863,960	$4,893,356,701	$707,687,219	$5,601,043,920	$313.54
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(702,807,035)	
% Of WOW					88.85%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	20,344,582	$5,341,371,753	$761,085,820	$6,102,457,573	$299.95
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,471,561,777)	
% Of WOW					80.57%
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	5,525,924	$1,366,681,267	$200,048,403	$1,566,729,670	$283.52
WOW	5,525,924			$2,164,877,250	$391.77
Difference				$(598,147,581)	
% Of WOW					72.37%

Table 31
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$228,188,192**
Total Paid	**$2,968,459,554**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$896,562,439	$1,000,000,000	89.66%
DY04	$73,458,140	$1,000,000,000	7.35%
Total MEG 3	$2,968,459,554	$5,000,000,000	59.37%

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

The expenditures for the first thirteen quarters for MEG 3, the Low Income Pool (LIP), were $2,968,459,554 (59.37% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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

Current Activities

During the quarter July 1, 2009, through September 30, 2009, the Agency continued collecting and verifying encounter data from all capitated health plans on a statewide basis for all Medicaid covered services. There are two collection efforts occurring concurrently: the collection of encounter data for all Medicaid covered services within the Florida Medicaid Management Information System (FMMIS), and the collection of quarterly pharmacy encounter data for risk adjustment purposes.

The Agency started processing production medical services and pharmacy encounter data statewide this quarter. As reported last quarter, HMOs remain in various states of readiness to submit encounter claims to the Agency. PSNs remain in various states of readiness to submit transportation encounter claims.

The following are the highlights for this quarter:

- Resumed collecting and processing HIPAA-compliant (X12) medical services encounter data through the Fiscal Agent (EDS) in the new FMMIS.
- Initiated collecting and processing HIPAA-compliant (NCPDP) pharmacy services encounter data through the Pharmacy Benefits Manager (First Health).
- Performed data assessment activities to support encounter data collection and processing in the FMMIS. These activities include pre-review of production MCO medical services and pharmacy files to verify the accuracy of the data submitted.
- Conducted an encounter data technical assistance workshop in Tallahassee in early September 2009 to address specific HMO submission issues.

- Notified the health plans that all historical encounter data are to be submitted to the Agency by October 31, 2009. Historical encounter data include all medical services encounter data for paid dates January 1, 2007, through June 30, 2009, and all pharmacy encounter data for paid dates July 1, 2008 through June 30, 2009.
- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans including MEDS and NCPDP Companion Guides, Data Submission Strategy Guidelines, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions.
- Participated in encounter data submission meetings with each health plan to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Developed a SQL Server environment to allow the team to begin analysis of the historical encounter data as quickly as possible. These encounter data will assist in determining if "under-reporting" is occurring and track encounter volume and PMPM by plan by service.
- Continued to test and refine reports and HIPAA-compliant EDI processes used to communicate various operational errors and invalid transaction content to health plans for remediation of identified encounters failing FMMIS edits.
- Worked with the Fiscal Agent to refine the Medicaid Decision Support System (DSS) to support data quality validation through analysis of the volume, accuracy, and completeness of encounter data submitted.
- Held weekly update meetings for Medicaid management specific to progress of the Agency and the health plans in the receipt and submission of encounter data.
- Conducted weekly MEDS Team meetings to discuss project progress, risks, and issues that needed to be addressed to keep the Agency on track.
- Initiated the Agency Encounter Data Utilization Team, to provide inter-bureau input to the MEDS Team by developing and prioritizing uses for the MEDS data after implementation.

During the quarter, to comply with the requirements of the demonstration waiver, health care pharmacy encounter data 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 populations. Using the Medicaid Rx model, the health plans were assigned plan risk factors for both 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 for each subsequent month thereafter for Medicaid-enrolled populations in Reform counties. As mentioned in previous reports, legislation required that capitation premiums be fully risk adjusted and

health plan corridor factors were no longer to be applied effective with Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting Reform capitation rates was January 1, 2008, through December 31, 2008, paid through March 31, 2009. This measurement period was used to generate risk adjustment factors for the health plans operating in the five demonstration counties.

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

- Continued to collect and process 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 plans for corrective action, if necessary.
- Implemented the updated Medicaid Rx Model that includes logic changes made by the developer and Florida-specific cost weights.
- For this period, risk adjustment plan factors were calculated for the following health plans:

Amerigroup Community Care	Molina Health Plan	Sunshine State Health Plan
Better Health Plan	SFCCN – Memorial Healthcare System	Total Health Choice
Children's Medical Services, Florida Department of Health	SFCCN – North Broward Hospital Districts	United HealthCare
Freedom Health Plan	Preferred Medical Plan	Universal Health Care
Humana	Shands Jacksonville Medical Center dba First Coast Advantage	

Note: Effective August 1, 2009, Molina (HMO) purchased NetPass (PSN).
Effective September 1, 2009, Sunshine State Health Plan (HMO) purchased Access Health Solutions (PSN).

- The demonstration enrollment that is 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 2009 totaled 203,727 and was distributed as follows:

September 2009	Broward	Duval, Baker, Clay, and Nassau
Children & Families	97,769	78,987
SSI	15,427	11,544
Totals	**113,196**	**90,531**

- Pharmaceutical data will continue to be collected and processed through Medicaid Rx to support risk adjustment of capitation rate premium calculations until encounter data for all services are collected in the FMMIS and are of sufficient quality and completeness for a transition to a diagnostic risk-adjustment model such as CDPS.

The process of providing plan risk factors for rate setting and budget neutrality will continue into the next quarter. The MEDS team continues to work on activities associated with the collection and processing of encounters. These activities include providing technical support to capitated health plans, reviewing end-to-end processing results, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection, validation and utilization of both historical and current encounter data.

I. Demonstration Goals

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

Prior to the implementation of the demonstration, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two 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 MPNs that operated in Broward and Duval Counties prior to implementation of the demonstration operated as prepaid ambulatory health plans offering enhanced medical management services to beneficiaries enrolled in MediPass, Florida's primary care case management program.

The Agency currently has contracts with 8 HMOs and 4 PSNs for a total of 12 Reform health plans in Broward County; and 3 HMOs and 3 PSNs for at total of 6 Reform health plans in Duval County.

As noted in Section A of this report, this quarter the Agency received notice from two HMOs of their intent to withdraw from the demonstration effective 12/01/2009. Each HMO cites issues with hospital contract negotiations as the impetus for the withdrawal requests.

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 20 applicants sought and received approval to provide services to the TANF and SSI population. Of the 22 applications received, all but two were approved as health plans as of September 30, 2009.

This quarter, Sunshine State Health Plan (HMO) began providing services in Broward County on July 1, 2009, and expanded into Baker, Clay, Duval, and Nassau Counties on August 1, 2009. Molina Health Plan (HMO) began providing services in Broward County on September 1, 2009.

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

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 Four 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 Four include:

- Over-the-counter drug benefit of $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Adult Vision Services;
- Nutrition Therapy.

In Year Four, the Agency approved 20 benefit packages for the HMOs and 12 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010 to August 31, 2010 for 8 HMOs and 4 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 beneficiary access to providers (e.g., if the provider only accepts current patients, or if they only treat children and women, etc.).

Also in October 2007, 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 32 shows the results of these analyses.

Table 32
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 beneficairy 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 2008 and from Area 4 (Duval, Baker, Clay, Nassau, St. Johns, Flagler, and Volusia counties) in April 2008.

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 2008 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.

Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. 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 2008, 116 (99%) had current contracts with the health plans from which they were sampled.

During the second quarter of Year Three, the Agency followed up on and analyzed the June 2008 survey results. As mentioned above, the Agency's follow-up now includes 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 June 2008 statewide survey, the combined results from the survey and the follow-up indicate that 288 (96%) 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 9 in June 2008, 114 (97%) had current contracts with the health plans from which they were sampled.

Surveys were conducted in August, September, October, and November 2008. During the third quarter of Year Three, the Agency followed up on and analyzed the August and September surveys. In the August 2008 statewide survey, the combined results from the survey and follow-up indicate that 291 (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 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk Counties) in August 2008, all 117 (100%) had current contracts with the health plans from which they were sampled. The September survey results were very similar, with 297 (99%) of the 300 providers in the statewide sample having current contracts with the health plan; and with 99 (99%) of the 100 providers in the Medicaid Area 3 sample having current contracts with the health plans for which they were surveyed. The Medicaid Area 3 (Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, and Sumter Counties) sample contained 100 provider records rather than 117 due to there being 22 provider records for dentists rather than 39.

During the fourth quarter of Year Three, the Agency followed up on and analyzed the October and November 2008 surveys and the January through March 2009 surveys. In the October 2008 survey, the combined survey results and follow-up by Agency staff indicate that 100% of the sampled providers had current contracts with the health plans for which they were surveyed, in both the statewide (300 providers) and Area 5 (115 providers from Pasco and Pinellas counties) samples. The November 2008 survey had the same results, with 100% of the statewide sample (283 providers) and 100% of the Area 8 sample (95 providers from Sarasota, DeSoto, Charlotte, Glades, Lee, Hendry, and Collier counties) confirmed as participating in the health plans from which they were sampled.

In January 2009, there was an increase in the number of health plans and thus, the number of providers that were sampled and surveyed statewide. In the January, February, and March surveys, the combined survey results and follow-up by Agency staff indicated that 99% of the providers sampled statewide had current contracts with the health plans for which they were surveyed, while 100% of the providers in the focused Medicaid Area samples had current contracts with the health plans. The focused areas in January, February, and March 2009 were Area 7, Area 2, and Area 1, respectively.

As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area has been sampled, the Agency has moved to quarterly provider network surveys, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) when possible. The survey focus is on statewide samples rather than the Medicaid Area-focused samples each month.

During the first quarter of Year Four, Florida Medicaid Area Office staff conducted the first quarterly provider network survey. Agency staff began following up on the survey results, which will be completed and analyzed in the second quarter of Year Four. The

second quarterly provider network survey will be conducted during the second quarter of Year Four as well.

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

For individuals who chose to opt out of the demonstration, the Agency established a database that captures the employer's health care premium information and whether the premium is for individual or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the 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 demonstration include:

1) elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance and
2) primary care physician was not enrolled with a Medicaid Reform health plan.

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 health plan where there were not co-pays and deductibles.

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

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

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

The latest report, *Medicaid Reform Enrollee Satisfaction: Year One Follow-Up Survey,* was released in March 2009, and can be viewed on our website at: http://ahca.myflorida.com/Medicaid/quality_management/pdf/cahps_report_final_03-12-09.pdf. Find below a summary of the Year One Follow-up Survey results.

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

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

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

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

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

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

Broward County:

- The percentage rating their overall health care at the highest level declined for the overall, SSI and non-SSI populations.
- For the overall population and among the non-SSI enrollees, the proportion giving their personal doctor the highest rating increased.
- For SSI enrollees, the percentage giving overall plan satisfaction the highest rating declined.

- There was no change in specialty care ratings.
- The percentage of PSN and HMO enrollees rating their personal doctor at the highest level increased.

Duval County:

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

Select Demographic Characteristics: Broward and Duval Counties:

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

Patient Satisfaction Survey Schedule

The projected timeline for the remaining follow-up surveys to be conducted in Broward and Duval Counties are outlined below. Data from the Year Two follow-up survey were collected between March and June 2009, and the report analysis is due to be submitted to the Agency by UF in winter 2009.

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

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

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

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

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

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

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

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from UF LIP Evaluation Team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to UF LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year 2005-

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

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

Special Term and Condition #102, Demonstration Year Two Milestones, states that, "the State will conduct a study to evaluate the cost effectiveness of various provider access systems." This study has been done by the UF LIP EvaluationTeam. 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 PAS entities. 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 and non-hospital PAS entities. All PAS entities 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. PAS entities with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

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

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

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

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

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

as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to CMS.

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

During the first quarter of Year Four, the Agency reviewed the SFY 2007-08 Milestone report from UF. The Agency will provide feedback to UF LIP evaluation team during the second quarter of Demonstration Year Four. At the beginning of the third quarter of Demonstration Year Four, the Agency looks forward to the final review. The Agency will share the Demonstration Year Three data with UF evaluation team to allow for the evaluation on Demonstration Year Three to begin.

J. Evaluation of Medicaid Reform

Overview

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

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

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) has conducted several reviews of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. Their ninth and final report on the Reform demonstration was issued in the fourth quarter of Year Three, and there are no anticipated updates to this report series. The purpose of the OPPAGA publications was to provide reports that focused on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. OPPAGA's final recommendation to the Legislature (June 2009), recommended that the state not expand the demonstration waiver to other areas until more information becomes available to evaluate the program's success.

The series of nine OPPAGA reports on the Medicaid Reform Demonstration can be found at the website link: http://www.oppaga.state.fl.us/summary.aspx?reportnum=09-29.

3. UF Independent Evaluation in State Fiscal Year 2009-2010

UF will continue to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency. Semi-annual study reports were submitted by the researcher during the first quarter of Year Four, and this information will be reported to CMS in the second and third quarter reports of Year Four.

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

In addition to the studies already initiated, the Agency is now evaluating the mental and behavioral health services provided in the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). This study is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF. UF is evaluating the impact of the demonstration on beneficiaries who are receiving mental health services, and results from the first progress report of the comprehensive mental health study plan will be submitted to CMS during the next quarterly reporting period.

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in the fourth quarter of Year Three. This report (two year pre- and post implementation), *An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*," addresses two year pre- and post demonstration, and can be found at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_viii_d_fisca_analysis_report_07-10-09.pdf.

A multivariate analysis report is scheduled to be submitted to the Agency in the second quarter of Year Four, and an interim progress report on Follow-Up Year Three of the Demonstration's Fiscal Analysis is scheduled to be submitted to the Agency for review in January 2010.

The first fiscal analysis provided an initial indication of the 1115 demonstration waiver costs in comparison to enrollee expenditures during the pre- and post-demonstration periods. The Agency continues to work with health plans to collect and process encounter data, and once those data are validated, it will be possible to determine precisely what services are purchased with expenditures on individual enrollees over time.

University of Florida - Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[5]) study designed to help understand demonstration enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. This has now been accomplished, and the independent evaluator will be replacing the qualitative study with an analysis from another area of the demonstration that needs to be assessed in order to further enhance the pilot program.

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 over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on the demonstration and the evaluation efforts. The next annual meeting will occur on December 14, 2009, at the Agency for Health Care Administration in Tallahassee, Florida.

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. A list of the TAC members and their expertise can be found here:
http://mre.phhp.ufl.edu/advisorycommittees/index.htm#tac

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

Demonstration Year Three annual TAC meeting took place on March 27, 2009, at the University of Florida in Gainesville. In addition to the TAC representatives, all project

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

areas of the evaluation were represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focused on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

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 five different processes:

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

In nearly all these forums, the transition of Florida Medicaid's Management Information System (FMMIS) from the legacy system to the new fiscal agent, Electronic Data Systems, Inc., computer system and the consolidated contract for 2009 – 2012 have continued to be a popular topics. 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.), there was only one TAP meeting that took place this quarter. The nine member TAP created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration, met in August 2009 to discuss the following topics:

- Health plan capitation rates development,
- Medicaid encounter data collection and processing, and
- An update from the University of Florida on its Medicaid Reform evaluation.

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

Policy Transmittals

During this quarter, there were no policy transmittals and no Dear Provider letters released to the health plans. However, there were several Dear Provider emails that provided updated information regarding the new health plan contract for the period

September 1, 2009, through August 31, 2012, the new electronic Health Plan Report Guide companion to the new contract, and dates for the health plans' submission of their completed Plan Evaluation Tools (PETs) relative to the September 1, 2009, through August 30, 2010, contract year and general information relative to implementation dates for new benefits effective date.

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, without regard to whether 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 over 100 phone lines in active use on the calls. With fewer implementation items or issues related to the transition to the new Medicaid fiscal agent and system, the attendance on these calls has decreased from the 200 plus phone lines in active use during implementation and transition to the new fiscal agent. Items that have made an appearance at almost all calls include updates and statuses on Medicaid encounter data submissions; EDS transition issues, including enrollment transmissions, claims processing, and the transmission of primary care provider choices; and updates on the 2009-2012 health plan contract, report guide and benefits amendments.

Other agenda items included:

- Home health services provision and authorization requirements;
- Blood lead screening information;
- Provider fee schedule posting;
- Medicaid Program Integrity quarterly fraud and abuse reporting secure transmission site information;
- Health plan transition updates; and
- External quality review webinars regarding performance improvement plans.

Feedback from call participants continues to indicate 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.

By the end of Year Three, only five issues remained unresolved at the start of this quarter. Those unresolved are either waiting for systems changes to occur or for concrete examples to be received from PSNs in order to research whether provider education or a systems changes is needed. With only five issues remaining, the Agency is reviewing the need for continuing these monthly calls. In fact, with the PSN industry's consent, no call was held during September of 2009.

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;
- Claims issues in the queue, but still unaddressed as they work their way through systems change priorities; and
- Reporting issues.

In addition, the Agency continues to intend to work with the PSNs and key stakeholders to modify the current claims process for FFS PSNs in order to streamline the claims processing function.

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

General Amendment/Contract Overview Calls

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

This quarter, calls occurred regarding the following:

- The 2009-2012 health plan contract to review changes made to the released drafts based on comments received from the health plans, industry and advocates, and prompt additional feedback.
- The new companion Health Plan Report Guide to review format and content, prompt feedback, and provide updates on changes made relative to industry comments received.

Additional information regarding the new contract is located in Section A.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues July 1, 2009 – September 30, 2009	
PSN Informal Issue	**Action Taken**
1. A PSN member contacted the Agency and reported wanting services from the PSN but having reached the maximum allowable benefit.	➲ The PSN attempted to assist the member with this issue but the member was uncooperative and was asked to leave the provider's office. The PSN helped the member with several other issues and the member withdrew the original complaint.
2. A provider reported to the Agency that the PSN would not authorize urgently needed items for a PSN member.	➲ The PSN had previously authorized the items, but the member and provider had not checked to see that they were already authorized. The PSN worked with the provider to clarify the process.
3. A PSN member reported needing ongoing treatment by specialty providers who are not part of her new plan network.	➲ The PSN provided the requested authorization.
4. A PSN member switched to a new plan and her usual providers are not participating in the new plan's network. The PSN member's parent requested authorizations for the child to see those providers until the plan change is effective.	➲ The PSN authorized the member to see the non-participating providers.
5. A provider contacted the Agency and reported that the PSN has not paid their claims.	➲ Agency staff requested that the provider work with the PSN, and asked the PSN to work with the provider and to keep Agency staff informed.
6. A provider reported to the Agency that the PSN was not paying some of their claims.	➲ Agency staff determined that the provider submits all claims via paper, which the provider is finding to be a slow and inefficient process. The PSN is working closely with the provider to ensure that outstanding claims are resolved.
7. A PSN member who is disabled reported transportation issues and dignity issues with provider office staff. The member requested to go back to straight Medicaid.	➲ Agency disenrolled the member for the PSN.
8. A PSN member's father reported to the Agency that the PSN reduced home health hours for a ventilator-dependent infant.	➲ Agency staff spoke with the member's father who was following up with the PSN to get a doctor's letter stating that the child's home health hours should not be reduced. He is working with the PSN and is satisfied with the outcome.
9. A provider reported to the Agency that the PSN has not paid their claims.	➲ The PSN paid all of the outstanding claims and contacted the provider to confirm this.

PSN Complaints/ Issues July 1, 2009 – September 30, 2009	
PSN Informal Issue	**Action Taken**
10. A PSN member reported being assigned to a new plan which is unable to arrange continuing care with the member's current non-participating providers.	➲ The PSN's case managers worked with the member and non-participating providers to develop a plan of care. All parties are satisfied.
11. A PSN member reported to the Agency that the PSN gave her referrals to specialists who no longer accept the plan.	➲ The PSN's case manager worked with the member to set her up with the requested referrals.
12. A PSN member reported to the Agency that a provider is suing the member's family for the balance due on their account.	➲ The PSN reported to the Agency that an agreement had been negotiated with the provider. The provider dropped all legal action against the member's family and submitted claims to the PSN for payment. The member's family is satisfied.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
1. An HMO member's parent reported to the Agency that the child was disenrolled from the HMO without the parent requesting it. The member and sibling need health care services.	➲ HMO staff and Agency staff confirmed the disenrollments, but could find no reason why it happened. The HMO's panel is now at capacity, so Agency staff advised the parent to choose a new plan in which the member's primary care provider also participates. The member's parent is satisfied.
2. An HMO member's mother reported to the Agency that a provider will not see the member until all charges are paid and the HMO will not pay the claims.	➲ Agency staff research found that the provider does not participate with the HMO. The provider informed the member's parent in advance that they were not a participating provider and that the parent would have to pay all the charges if she wanted to continue receiving services at that office, which the parent agreed to in writing. The issue is closed.
3. An HMO member reported that the HMO refuses to replace necessary equipment which is urgently needed.	➲ The HMO reported to the Agency that it had received only one request for replacement equipment in all the years the member was in the HMO. The HMO approved the request after proper supporting documentation was received. The member was notified of this outcome.
4. A provider reported to the Agency that the HMO is denying claims.	➲ The HMO researched this and reported to the Agency that one claim for this provider was paid and the second had never been submitted. The provider is now submitting the second claim and is satisfied.
5. A former HMO member reported being disenrolled from the HMO for unknown reasons. The former member would like to be enrolled in the HMO again, but it is currently at its capacity limit.	➲ Due to the capacity limit on the HMO, the beneficiary's request could not be accommodated. Agency Area Office and Choice Counseling staff assisted the beneficiary in choosing another plan.
6. A former HMO member's mother is being balance billed by a provider because the HMO denied claims based on eligibility.	➲ The HMO reported to the Agency that it advised the provider not to balance bill the former member's mother. The HMO worked with the provider to resolve the claims dispute.
7. An HMO member's parent reported being balance billed by a provider because the HMO will not pay the out-of-network claim.	➲ Agency staff research found that the parent insisted that the provider see the member after being advised that the provider did not participate in the HMO. The provider had the parent sign a financial responsibility form in advance. The HMO will not pay the claim or reimburse the parent. The issue is closed.

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
8. An HMO member's mother reported to the Agency that the HMO is denying provider claims for the member because of an alleged Third Party Liability.	➲ The HMO reported to the Agency that it corrected the member database and processed the claims for payment. The HMO notified the member's mother.
9. A former HMO member reported to the Agency that the HMO denied provider claims, stating she was not active in the HMO on the date of service. Agency staff confirmed in the Florida Medicaid Management Information System (FMMIS) that the beneficiary was enrolled in the HMO on that date.	➲ The HMO reported to the Agency that it corrected its member database, but that the provider never billed the HMO for services to the former member and did not attempt to balance bill the beneficiary.
10. An HMO member reported to the Agency that she needs a new specialist, but stated that the HMO is unwilling to assist in getting her a specialist who handles high-risk patients.	➲ The HMO reported to the Agency that it helped the member find an appropriate specialist.
11. A provider contacted the Agency and reported being unable to obtain authorization for services from the HMO.	➲ The HMO reported to the Agency that it approved the services for eligible members.
12. An HMO member reported to the Agency being unable to obtain a prescription and dental services.	➲ The HMO reported to the Agency that the member was seen by a pain management specialist and a dentist. A new prescription was filled by the member.
13. A provider reported to the Agency that the HMO has not paid the provider's claims.	➲ Agency staff notified the HMO of the complaint and the HMO had the provider fax copies of the claims to HMO staff who worked with the provider to resolve the issue.
14. An HMO member reported to the Agency that the HMO denied the member's prescriptions.	➲ The HMO reported to the Agency that it has authorized the medication. Agency staff confirmed with the member that he currently has a supply of the medications. The HMO has arranged for a refill of the drug to be available to the member on or before the last day of his current supply.
15. An HMO member reported to the Agency that the HMO denied the member's prescription.	➲ The HMO reported that it sent a fax to the member's physician advising that the medication in question was not on the formulary as well as a listing of alternative medications.
16. An HMO member reported to the Agency that the HMO denied the member's prescription and that the member has not been able to obtain expanded benefits.	➲ The HMO reported to the Agency that neither the member nor the physician had contacted the HMO regarding the medication. The HMO has not received a prior authorization request from the physician. The HMO tried to get through to the physician's office. The HMO processed the Over-the-Counter benefit.
17. A pharmacy reported to the Agency that the	➲ The HMO reported to the Agency that it

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
HMO has not approved a prior authorization for a prescription for a member.	approved the prescription and that the pharmacy had been notified.
18. An HMO member reported difficulties obtaining medication.	➲ Per the member's request, the HMO reported to the Agency that they will be having the medication sent to the member's home.
19. An HMO member reported to the Agency that the HMO denied authorization for a motorized wheelchair.	➲ The HMO reported to the Agency that it authorized repair of the motorized wheelchair that the patient currently owns.
20. An HMO member reported to the Agency that the HMO denied a prescription medication.	➲ The HMO reported to the Agency that the physician was contacted and advised that the member could receive the generic medication.
21. An HMO member reported to the Agency that they have not received the Medicaid Reform Over-the-Counter benefit of up to $25 per month per household.	➲ The HMO reported that the member is referring to Enhanced Benefits credits. The HMO was aware of this issue and worked with Agency staff to correct it.
22. An HMO member contacted the Agency complaining of the inability to find a provider under her HMO.	➲ Agency staff contacted the HMO who reached out to the member and provided assistance in finding a provider.
23. An HMO member contacted the Agency and reported that the HMO denied a prescription.	➲ The HMO reported to the Agency that the medication has been authorized for another month.
24. A provider reported to the Agency that the HMO has not paid her claims.	➲ The HMO reported that the provider was sent a check. The provider told Agency staff that she will reconcile the payment with her claims and contact the Agency if there are any remaining unpaid claims.
25. An HMO member reported residency change to a new county and needs the HMO in the old county to assist during the transition of care. The member needs a prescription for his current condition.	➲ Agency staff contacted the HMO and they helped fill prescriptions in the new county while the member gets enrolled in a new plan. The member will be fee-for-service until the new plan takes effect.
26. A provider contacted the Agency and reported that the HMO is denying claims on the basis that the member was not active with the HMO on the dates of service. Agency staff research in FMMIS indicated that the member was enrolled in the HMO for the dates in question.	➲ The HMO reported to the Agency that the claim has been adjusted and will be sent out on the next remittance.
27. An HMO member's mother reported to the Agency that she is unable to find an orthopedic surgeon for her son.	➲ The HMO reported to the Agency that it authorized 6 visits to an out-of-network provider.
28. An HMO member's mother reported to the Agency that the HMO did not give enhanced benefit credits to the member.	➲ The HMO reported to the Agency that the member's claims were entered into the system and will be pulled on the next monthly file sent to the Agency. The HMO will double-check to make sure that the member's enhanced benefit credits show up in the next run.

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
29. An HMO member's mother contacted the Agency needing specialized dental assistance for her child.	➲ Agency staff worked with the HMO to locate a dentist that could assist the member's child.
30. A provider contacted the Agency and reported having difficulty getting paid for a claim. The provider stated that the HMO is not responding to any attempts to contact their office.	➲ The HMO contacted the provider to address billing issues. There were errors in the provider's claims as they were submitted, so HMO staff coached the provider in how to properly submit claims.
31. A provider contacted the Agency and reported not being paid for immunization claims.	➲ The HMO's Provider Relations Manager contacted the provider and is working on her concerns. The HMO Provider Relations staff reviewed proper billing practices with the provider and provided education regarding the uses of the HMO's claims status look-up.
32. An HMO member's mother reported to the Agency that she never received enhanced benefit credits for her two children.	➲ The HMO requested an update of the Enhanced Benefit Account credits.
33. An HMO member contacted the Agency and reported receiving a bill from the hospital.	➲ The HMO reported to the Agency that it is working with the member because the HMO has already paid the hospital bill.
34. A provider reported to the Agency that the HMO paid them incorrectly.	➲ The HMO reported to the Agency that the provider billed incorrectly. HMO staff advised the provider of this, the provider will begin complying with the correct billing guidelines.
35. An HMO member's mother reported to the Agency that the member has not received enhanced benefit credits.	➲ The HMO reported to the Agency that it has fixed the Enhanced Benefits Report and submitted it to the fiscal agent.
36. An HMO member changed plans and reported that the member's psychiatrist is not in the new plan's network. The member is running out of prescription medication.	➲ The HMO contacted the member and resolved the provider and medication issues.
37. An HMO member contacted the Agency and reported needing medication and a doctor's appointment.	➲ The HMO reported to the Agency that the member's information has been updated and the member has been notified and assisted.
38. A provider contacted the Agency and reported not being included in the transition from a PSN to an HMO in the county. The provider wants to continue servicing Medicaid members and be a provider with the new HMO plan.	➲ Agency staff contacted HMO management to request that the former PSN provider be allowed to become a provider for the HMO to serve Medicaid members. The HMO worked out details with the provider.
39. An HMO member reported needing authorization to see a doctor who does not accept the HMO.	➲ Choice counseling staff worked with the beneficiary to select a new health plan.
40. An HMO member's mother contacted the Agency to report that the HMO is not recognizing the child as a member.	➲ The HMO worked with the member's mother and resolved the issues.

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
41. An HMO member's mother contacted the Agency to report that the member's medication is no longer being covered by the HMO.	➲ The HMO contacted the member's mother to discuss changes that were made to its preferred drug list.
42. A provider reported that the HMO is not reimbursing properly for claims.	➲ The HMO reported to the Agency that it is working with the provider to get the claims properly reimbursed.
43. An HMO member contacted the Agency to report having difficulty obtaining durable medical equipment and a denial letter.	➲ The HMO was given the member's physical address to mail out the denial letter.
44. An HMO member was switched from a PSN to the HMO without the member's consent. The HMO member's parent reported that the child needs to be seen by a primary care provider as she's ill. The member's parent is unable to reach the new HMO to coordinate care and needs primary care provider access as soon as possible.	➲ The HMO reported to the Agency that it contacted the doctor and worked with him to agree to see the children that day. The member's parent was able to take the children and they received care.
45. An HMO member's plan was changed. The member's mother reported being unable to get in touch with the new plan to take the member to a primary care provider, and the child needs to be seen immediately.	➲ The HMO contacted the doctor and the doctor agreed to see the child that day. The parent was able to take the member to receive care.
46. An HMO member's plan was changed and the member's mother reported being unable to reach the new plan to get a new primary care provider and treatment for the member.	➲ The HMO contacted the doctor and the doctor agreed to see that child that afternoon. The parent was able to take the member to receive care.
47. An HMO member reported needing to obtain prior authorization to see a pain management specialist.	➲ The HMO approved the prior authorization.
48. An HMO member reported being previously enrolled in a PSN. The member would like to get prescriptions from the primary care provider but the provider is not with the new plan.	➲ The HMO contacted the member and suggested a provider so that the member could be seen and have access to needed medication.
49. An HMO member reported being unable to get his prescription.	➲ Agency staff research found that the HMO member attempted to get a prescription drug prescribed by a non-participating provider. The member has not yet contacted the HMO or gotten a prescription from a participating provider.
50. A provider reported a claim payment issue to the Agency.	➲ The HMO resubmitted the claim for payment.
51. A provider contacted the Agency and reported a claim payment issue.	➲ The HMO reprocessed the claim.
52. A provider contacted the Agency and reported that HMO members residing in his assisted	➲ HMO management met with the provider, Agency counseling area representative,

HMO Complaints/Issues July 1, 2009 – September 30, 2009	
HMO Informal Issue	**Action Taken**
living facility do not have adequate access to transportation or mental health services.	pharmacy provider, and other personnel to resolve issues. The HMO resolved transportation concerns by clarifying the process for assisted living facility members. A local transportation provider may contract with the HMO. The HMO also resolved concerns about mental health services; it is working on contracts with two mental health providers. The HMO will continue to work closely with the provider to further improve communication and transparency in the service delivery process.
53. An HMO member reported having difficulty receiving his over-the-counter drug benefit from the HMO.	➲ The HMO reported to the Agency that it resolved the issue with the Pharmacy.
54. An HMO member's parent reported needing to change her children's primary care providers. One child (18 mos.) was assigned to a provider who does not accept babies, and the child is sick and needs to see a doctor.	➲ The HMO resolved the issue. The primary care provider changes are effective immediately and new ID cards were sent. The HMO advised the member's mother that if she has any issues before receiving the cards to have the provider call the HMO for verification.
55. A behavioral health provider reported concerns to the Agency regarding member transition between plans and how this would affect members' services.	➲ The HMO contacted the provider and resolved the concerns.
56. An HMO member reported needing services to the Agency, but the member claims the HMO is not showing up as a member.	➲ Agency Area Office staff provided information to the HMO and HMO staff updated their database and scheduled appointments for the member with the requested specialist. The member is satisfied.
57. A provider contacted the Agency to report that the HMO denied claims because a member was not active on the dates of service.	➲ Agency staff verified that the member was active on the dates of service. Staff from the provider's office reported to the Agency that the claims were paid after errors on the claims were corrected. The provider is satisfied.
58. An HMO member called the HMO to obtain services but the HMO stated she was not in its member database.	➲ The HMO reported to the Agency that it updated its member database and immediately reached out to assist the member with her request.
59. An HMO member called the Agency to report that although she chose the HMO voluntarily, she now wants to be exempted from managed care.	➲ The HMO and Agency staff contacted the member and explained to her that she cannot be exempted from managed care assignments.
60. An HMO member reported to the Agency that she needs emergency services, but that the HMO stated the services are not emergency and are therefore not covered.	➲ The HMO reported to the Agency that its subcontractor had no record of the member calling to request services. Agency staff received information from the member stating that she and her provider considered the

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	requested services to be emergency services. The HMO reported to the Agency that the provider stated that the member had never actually been to the office and had only called to describe the issue. The HMO contacted the member and told her to meet with the provider as it had arranged an appointment for her.
61. An HMO member's parent reported receiving no enrollment information from the HMO and needing to access services for the member.	➲ The HMO reported to Agency staff that they had contacted the mother. The family had moved without giving the plan their new address, so the enrollment packet had not been received. The HMO mailed a new packet to the family and the member's parent is satisfied.
62. An HMO member reported being balance billed by providers for services.	➲ The HMO reported to the Agency that the HMO had already paid all the providers the Medicaid rates. The HMO advised the providers that they cannot balance bill the member.
63. An HMO member reported to the Agency that she wants a referral to a specialist, but that the HMO is unable to provide the referral.	➲ The HMO reported to the Agency that the case manager had contacted the member and provided multiple referrals to specialists, but the member rejected all except one and had some objections to that provider as well. The HMO reported that the member had agreed to see another specialist and was evaluated. The member has not responded to further follow-up calls from the HMO.
64. An HMO member reported to the Agency that she wishes to continue seeing a non-participating provider, but has not discussed this request with the HMO. The member called again soon after to report she was in labor.	➲ The HMO reported to the Agency that they advised the member to see an in-network provider and advised the member to go directly to a participating hospital close to her home. The HMO made arrangements for her to be received and deliver the baby. The HMO reported to the Agency that the member disregarded directions and went to a non-participating hospital in another county that is out of the plan coverage area to deliver. The member has not contacted the HMO or Area Office since then.
65. An HMO member reported needing services immediately but the member's mother said the HMO does not show the member in its system and told the mother that the HMO does not provide the requested services.	➲ The HMO reported to the Agency that the member was seen by a specialist and the immediate health need was addressed. The member's mother was not satisfied with the provider, so the HMO has arranged for visits with another provider. The member's mother is now satisfied.
66. An HMO member's grandmother states the HMO will not approve a name brand	➲ The HMO reported to the Agency that HMO staff spoke to the member's primary care

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medication for the member.	provider and the pharmacy. The primary care provider stated that the generic medication works fine and had written the prescription for the generic. Pharmacy staff confirmed that the member had been using the generic medication while with a previous plan. The HMO stands by its decision to provide the generic equivalent of the medication.
67. An HMO member contacted the Agency and reported that the HMO has not given her referrals to specialists and that she needs to treat urgent health needs.	➲ The HMO reported that they had no record of requests from the member for specialist referrals and that the member's primary care provider reported never having seen the member. The HMO advised the member to make an appointment with her primary care provider so that it may be determined if specialty referrals are needed.
68. An HMO member contacted the Agency and reported that her ongoing therapy treatments are in jeopardy because the provider does not participate in her new HMO.	➲ The HMO reported that it recently signed a network agreement with the provider. The HMO worked with the providers involved to ensure that the member got an appointment for her regular therapy.
69. An HMO member reported that she would like to switch to a primary care provider closer to her home.	➲ The HMO reported to the Agency that a case manager assisted the member in finding a primary care provider close to her home. The member is satisfied.
70. An HMO member contacted the Agency to report that his providers for ongoing therapy are not participating in his new health plan, so he may have to terminate his ongoing therapy.	➲ The HMO reported to the Agency that it worked with the member's providers to secure necessary documentation to issue authorization for continued care. After the information was received, the HMO issued an authorization for ongoing therapy treatments. The member was cleared for continued therapy.
71. An HMO member reported to the Agency that he is handicapped and unable to access services through the primary care provider assigned by the HMO.	➲ The HMO reported to the Agency that they identified another primary care provider in the network who was fully equipped to meet the member's needs and happy to have him as a patient. The HMO contacted the member and his mother and both were pleased with this solution.
72. An HMO member reported to the Agency that she was mistakenly assigned to a managed care plan. She requested assistance to ensure that necessary services will continue until she can go back to her previous status.	➲ The HMO reported to the Agency that it worked with the member, her primary care provider, and the pharmacy to make sure that the member's medications were approved for the month.
73. An HMO member contacted the Agency to report that he was mistakenly assigned to the HMO. The assignment has been corrected but	➲ The HMO reported to the Agency that the member's current primary care provider would not accept an authorization request from the

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will not go into effect until the beginning of the next month and the member needed to see his non-participating primary care provider immediately.	HMO. The HMO advised the mother to take the member to an urgent care clinic or emergency room if necessary until the new health plan enrollment takes effect. The parent agreed to this solution.
74. An HMO member reported to the Agency that he wishes to continue seeing a non-participating specialist for follow-up services.	➲ The HMO reported to the Agency that they advised the member that he will be in the share of cost eligibility group as of the next month. The HMO approved any office visits for the member in the current month.
75. The parent of HMO members reported to the Agency that the HMO subcontractor approved a visit to a non-participating provider, but that the parent had to pay for services out-of-pocket.	➲ The HMO reported to the Agency that the parent will be reimbursed for out of pocket payments. The HMO subcontractor was advised not to schedule appointments with non-participating providers in the future.
76. A former HMO member's parent reported to the Agency that a provider told her the HMO was not paying claims for services to the member.	➲ The HMO reported that its records show two claims had been paid for services to the member on the stated dates of service. The HMO attempted to contact the former member's parent to see if any other claims are outstanding. If the HMO is not able to reach the parent, then a certified letter will be sent.
77. A provider reported that the HMO is denying claims submitted for services rendered to member.	➲ The HMO reported that the former member was in the HomeSafeNet program so claims must be submitted directly to the fiscal agent. The HMO advised the provider of this and the provider submitted the claims to the fiscal agent.
78. A provider contacted the Agency to report that the HMO is denying a claim because of Third Party Liability coverage.	➲ Agency staff found no Third Party Liability in place for the member on the date of service. HMO staff reported to the Agency that they found no Third Party Liability in place either. The HMO reprocessed the claim for payment.
79. An HMO member reported that the HMO has not provided referrals to a physician to treat the member's health care complaints.	➲ The HMO reported to the Agency that they had arranged three office visits with a provider for the member and notified him. The member has the HMO contact's direct line number if he needs further assistance.
80. An HMO member's grandparent took the member to a non-participating provider and the HMO denied the claims. The grandparent is being balance billed by the provider.	➲ The HMO reported to the Agency that they agreed to pay the provider for out-of-network services. The HMO has advised the member's grandmother to ask for change of address so the member can be reassigned to a plan in her current county of residence.

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