Florida Medicaid Reform

Quarterly Progress Report
July 1, 2010 – September 30, 2010

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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I. Waiver History

Background

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (federal CMS) on October 19, 2005. State authority to operate the program is located in Section 409.91211, Florida Statutes (F.S.), which provides authorization for a statewide pilot program with implementation that began in Broward and Duval Counties on July 1, 2006. The 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, F.S., 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, benefits, enrollment, grievances, and other operational issues. This report is the first quarterly report in Year Five of the demonstration for the period of July 1, 2010, through September 30, 2010. 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 approval as part of the application process. Customized Benefit Plans are described on Pages 6 through 10 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. If the demonstration extension is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, unless the PSN opts to convert to capitation earlier.

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

Current Activities

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. The initial on-site survey for Preferred Care Partners has been conducted, which is Phase III of the application review process.

During this quarter, the Agency also received a request from First Coast Advantage (PSN) to expand into Baker, Clay, and Nassau Counties. The request is currently under review by the Agency.

[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.

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

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
HealthEase***	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 d/b/a First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates**	PSN	X**		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	12/10/08
AHF MCO d/b/a Positive Health Care	HMO	X		01/28/08	02/18/10
Medica Health Plan of Florida	HMO	X		09/29/08	10/24/09
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		01/14/09	05/20/09
Preferred Care Partners, Inc.	HMO	X		01/21/10	***Pending***

*During Fall of 2008, the plan amended its contract to withdraw from this county.
**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 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****		
HealthEase***	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 d/b/a First Coast Advantage	07/01/06	PSN		X	
Pediatric Associates**	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO d/b/a Positive Health Care	05/01/10	HMO	X		

*During Fall of 2008, the plan amended its contract to withdraw from this county.
**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 these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.

Contract Amendments and Model Contracts

There were no general amendments completed during this quarter. Sunshine State Health Plan requested and received Agency approval to increase its maximum enrollment level in Clay County during the first quarter of Demonstration Five.

Contract Conversions/Terminations

There were no contract conversions or terminations during this quarter.

FFS PSN Conversion Process

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

While most FFS PSNs have submitted conversion workplans and applications to the Agency in order to comply with the previous 5-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications with the additional experience gained from the additional years of experience achieved.

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

Table 3 PSN Conversion to Capitation Timeline	
Deadline for the FFS PSN to submit its conversion workplan to the Agency.	09/01/2011
Deadline for the FFS PSN to submit its conversion application to the Agency.	09/01/2012
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2013.	06/30/2013

FFS PSN Reconciliations

By the end of this quarter, the Agency completed work on the first and second contract year reconciliations[2] (September 2006 through August 2007, and September 2007 through August 2008) for all, but two, FFS plans. The Agency continues to work with the FFS plans that have requested additional time for reconciliation data analysis.

Systems Enhancements

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

[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.

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 Research and Demonstration 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.

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 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 e-mailed 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 Demonstration Year Two, May 7, 2008, for Demonstration Year Three, and September 15, 2009, for Demonstration 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 value of each customized benefit package continues to exceed the Florida Medicaid State Plan benefit package in Year Five of the demonstration.

Current Activities

The benefit packages customized by the health plans for Demonstration Year Four became operational on January 1, 2010, and will remain valid until December 31, 2010, effectively overlapping Demonstration Year Four and Year Five. These benefit packages include 21 customized benefit packages for the HMOs and 13 benefit packages for the FFS PSNs. The plan will be required to submit a completed Plan Evaluation Tool during the second quarter of Demonstration Year Five with an effective date of January 1, 2011.

The eight 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 four FFS PSNs are Better Health, Children's Medical Services, First Coast Advantage, and the South Florida Community Care Network. On May 1, 2010, Positive Healthcare, the first demonstration HMO specialty plan for beneficiaries with HIV/AIDS, began accepting voluntary enrollment, and it also offers a customized benefit package.

During the previous quarter, Total Health Choice (HMO) was acquired by Simply Healthcare (HMO) and ceased operations on May 31, 2010. The Total Health Choice enrollees were transitioned into the Better Health Reform (PSN), of which Simply Healthcare is a minority owner, on June 1, 2010. Prior to approving the transition, the Agency compared provider networks, including behavioral health providers, to ensure continuity of care and the continued availability of current primary care providers. Total Health Choice members who were transitioned into Better Health were able to keep their expanded benefits originally offered by Total Health Choice. There was no change

in benefit package or provider network for beneficiaries who transitioned from Total Health Choice to Better Health.

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

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

During the first quarter of Demonstration Year Five, there were no changes to the number of Services requiring a co-payment.

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

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

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year. Year Four has now been separated into two sections, January 2010 and May 2010, to reflect the loss of the Total Health Choice benefit package as a choice. A 'Year Five' column has been added to Table 5 below. When compared with May of the fourth quarter in Year Four, it indicates no further changes occurred during the first quarter of Year Five.

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

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

Table 6 displays the number of Demonstration Year Four benefit packages not requiring co-payments by population and area, and has been split into two time periods to reflect the loss of the Total Health Choice benefit package as a choice. Table 6 shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments. A 'Year Five' column has been added to Table 6 below. When compared with the month of May in the fourth quarter of Year Four, it indicates no further changes occurred during the first quarter of Year Five.

Table 6
Number of Benefit Packages Requiring No Co-payments by Target Population & Area
Year Four 4th Quarter and Year Five 1st Quarter

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

In Year Five 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 Demonstration Years Two, Three and Four: the over-the-counter (OTC) drug benefits and the adult preventive dental benefits. The expanded services available to beneficiaries include:

- Over-the-counter drug benefit – $25 per household, per month;
- Adult Preventive Dental;
- Circumcisions for male newborns;
- Additional Adult Vision;
- Respite Care.

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

The PET submission procedure for Demonstration Year Five was similar to that of the four previous years. The updated version of the data book was released by the Agency during this quarter on September 30, 2010, and the new PET will be e-mailed to the health plans during the second quarter of Demonstration Year Five. The health plans' Year Five benefit packages will have an effective date of January 1, 2011. This extension was made in order to provide adequate notification to the beneficiaries of any changes 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 Five of the demonstration.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, and Medicaid Fair Hearing (MFH) system. In addition, plan contracts include timeframes for submission, plan response and resolution of beneficiary grievances. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the

health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel for enrollees in a FFS PSN (described below). This provides an additional level of appeal.

As defined in the health plan contracts:

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

Table 7
Grievances and Appeals
July 1, 2010 – September 30, 2010

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	46	22	63	110	270,159

*unduplicated enrollment count

During the first quarter of Demonstration Year Five, the number of grievances reported by PSNs dropped to its lowest number in the past year[3]. The number of HMO grievances increase from 56 in the fourth quarter of Demonstration Year Four to 63 in the first quarter of Demonstration Year Five. The number of appeals decreased for both PSNs (from 28 in the fourth quarter of Year Four to 22 in the first quarter of Year Five) and HMOs (from 135 in the fourth quarter of Year Four to 110 in the first quarter of Year Five).

Medicaid Fair Hearings (MFHs)

Table 8 provides the number of MFHs requested during the first quarter of Year Five. 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 11 MFH requests, six were related to denial of benefits/services, two were related to denial of prescription medication, one was related to difficulty or delay with an appointment, and two were related to the reduction/suspension/ termination of benefits/services. Six hearings were held, four of which were favorable to the HMO and two of which were pending a final decision/order at the end of the quarter. The members withdrew from two hearings and three hearings were pending at the end of the quarter.

Table 8
Medicaid Fair Hearing Requests
July 1, 2010 – September 30, 2010

PSN	3
HMO	8

[3] Table 8 in Demonstration Year Four Annual Report provides the PSN grievances reported by quarter.

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level, as only one grievance was submitted to the SAP and none were submitted to the BAP during this quarter.

Table 9 provides the number of requests to BAP and SAP for the first quarter of Demonstration Year Five. The one request to the SAP that was received was resolved in favor of the beneficiary.

Table 9 BAP and SAP Requests July 1, 2010 – September 30, 2010	
BAP	0
SAP	1

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 Florida 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 was previously accomplished through a consolidated automated database, implemented October 1, 2007, that was used by all Agency staff housed in the above locations to track and trend complaints/issues received. Beginning on October 1, 2009, Medicaid staff in the above locations started using the new Complaints/Issues Reporting and Tracking System (CIRTS), which allows real-time, secure access through the Agency's web portal for headquarters and Area Office staff.

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.

During this quarter, the Agency received 19 complaints/issues related to PSNs and received 37 complaints/issues related to HMOs, for a total of 56 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO) of this report. 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, the majority of the PSN complaints/issues were from members. Member issues included needing assistance in accessing providers and assistance in getting services authorized. The provider issues were regarding claims payment.

The majority of the HMO complaints/issues during this quarter were related to member issues, with the majority being related to members needing assistance with finding/seeing a provider, getting authorization for services, and getting assistance in obtaining medications. Other member issues included needing assistance related to balance-billing. 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.

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

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

5. On-Site Surveys & Desk Reviews

During this quarter, the Agency conducted on-site surveys of sixteen HMOs and four PSNs. The Agency survey staff consisted of health care analysts and registered nurses.

The reviews consisted of reviewing policies and procedures relating to care/case management coordination, grievance and appeals, utilization management and quality improvement, interviewing health plan staff, observing member services, and claims review. The Agency also reviewed medical records documenting case management activities.

Florida's Bureau of Medicaid Program Integrity conducted separate on-site fraud and abuse compliance reviews of one HMO and three PSNs. The reviews consisted of a

review of the policy and procedures and interviews with health plan staff regarding on-going health plan fraud and abuse activities.

The Agency continued to conduct desk-review of health plan provider networks for adequacy, review medical and behavioral health policies and procedures, review and approve performance improvement projects, quality improvement plans, disease management programs, member materials, and handbooks.

This quarter, the Agency's External Quality Review Organization vendor made minor refinements to the contract review tool based on testing the tool in the field.

Table 10 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 10 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

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 and access needed to make the most informed decisions about health plan choices.

During the fourth quarter of Year Four, Automated Health Systems (AHS) began rendering services for the Choice Counseling program. The implementation of the new Choice Counseling Vendor was successfully completed and AHS assumed full responsibility of all duties effective June 18, 2010.

The following are key events and efforts that occurred during the implementation of the new Choice Counseling Vendor and during this quarter:

- Installation of the new enrollment system, Health Track. Health Track is an intuitive system. The new system provides Choice Counselors with key information easier and quicker, allowing for a great focus on the beneficiary and less time spent on navigating the system. This system also integrates the Preferred Drug List (PDL) functionality into one system. Previously, the PDL function was a separate system from the enrollment system.
- Enhanced “Choice Selection Tools” in the Health Track enrollment system.
- Online Enrollment Application.
- Implementation and redesign of beneficiary letters, especially the New Eligible letter.

Current Activities

1. Choice Selection Tools

In October of 2008, the Agency implemented the Informed Health Navigator Solution (Navigator) as a PDL search system, under the previous Choice Counseling Vendor, Affiliated Computer Services (ACS). The Navigator function allowed the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets his or her prescribed drug needs. This information was provided to assist the beneficiary in making a health plan selection.

Beginning June 18, 2010, the new enrollment system, refered to as Health Track, includes the same PDL comparison function, as well as Primary Care Physician (PCP), Specialist and Hospital search comparison options. Collectively, these new functions are now known as, “Choice Selection Tools.”

A brief description of each Choice Selection Tool is outlined as follows:

- PDL Comparison: Each health plan’s PDL is compared against the beneficiary’s prescribed drug claims history, as well as any additional list of medications provided to the Choice Counselor by the beneficiary.

- PCP Comparison: Each health plan's provider network file is searched simultaneously, for the name of PCP's provided by the beneficiary.
- Specialist Comparison: Each health plan's provider network file is searched simultaneously, for the name of specialists provided by the beneficiary.
- Hospital Comparison: Each health plan's provider network file is searched simultaneously, for name of hospitals provided by the beneficiary.

PDL information is updated quarterly, prescription claims information is updated daily, and provider network files are updated monthly, at a minimum.

Upon entering the search criteria for each Choice Selection Tool, the system returns the results in an easy to read format, which sorts the health plans by those that meet the most of the beneficiaries' criteria to those that meet the least (see illustration below).

Enrollment

Choice Tools : PCP | Preferred Drug List | Specialist | Hospital

Select a plan :

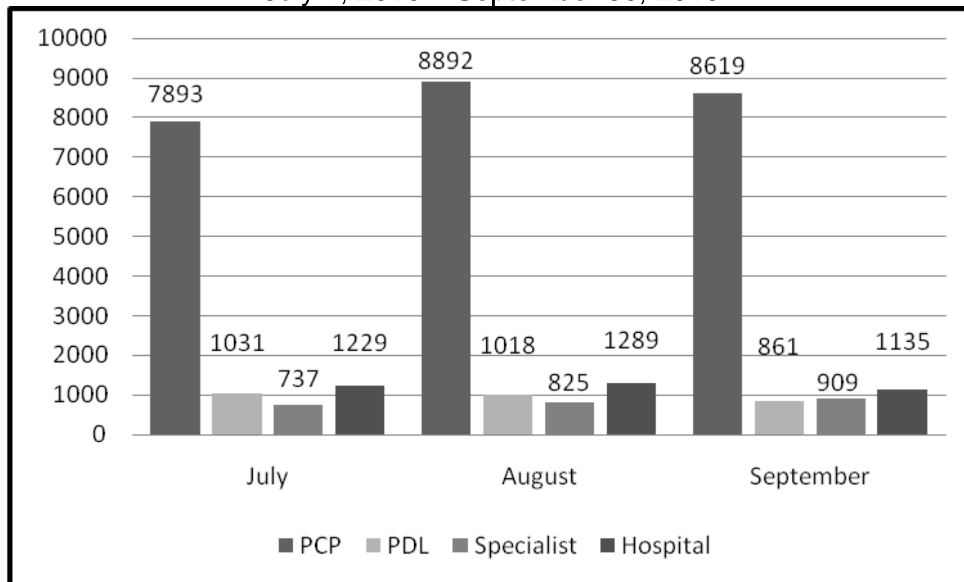
		Reset	Reset	Reset	Reset	Health Plan Name	Type
C						Better Health, LLC	PSN
						South Florida Community Care Network (MHS)	PSN
						Medica Health Plans	HMO
						Universal Health Care	HMO
P						Molina Healthcare	HMO
						Sunshine State Health	HMO
						South Florida Community Care Network (NBH...	PSN
						Freedom Health	HMO
						Positive Healthcare Florida	HMO

Effective Date: 11/01/2010
Members:

Change Reason: No Reason Given

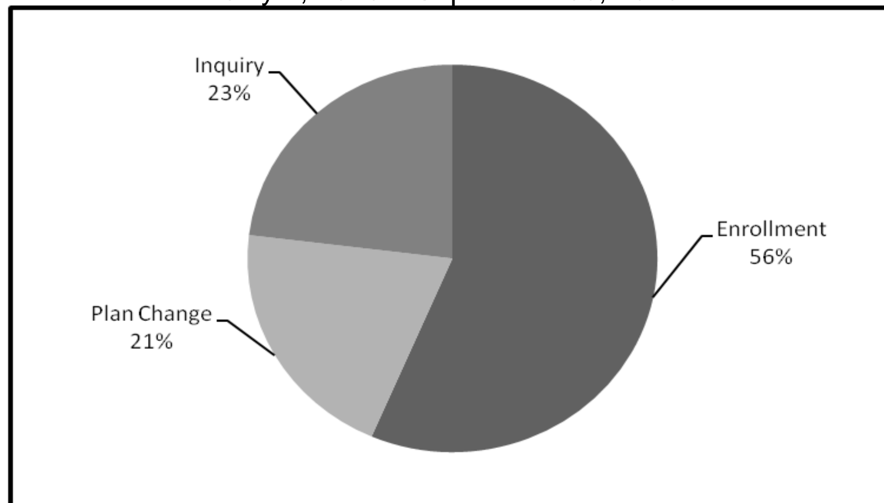
Chart A represents the number of times each Choice Selection Tool was utilized during the enrollment or plan change process for this quarter. The results are broken out by choice tool type.

Chart A
Choice Tool Use by Type
July 1, 2010 – September 30, 2010



Choice Counseling captures data to indicate whether a person is using the Choice Tools 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 during this quarter.

Chart B
Navigator Use by Call Type
July 1, 2010 – September 30, 2010



Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The 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. During this quarter, a total of 1,268 beneficiaries completed the automated survey.

The Customer Survey ratings consider 100% to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. 100% or 9 reflects a truly satisfied caller. The 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 he or she left a low score. The caller also has the ability to request a supervisor call back so the beneficiary can provide even more feedback on his or her experience.

Table 11 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) during this quarter. Survey results were not taken during the month of July as a result of other vendor transition efforts. The number of beneficiaries participating in the Survey this quarter was as follows: July - n/a, August - 678, and September - 590 (totaling 1,268).

The top three survey categories for this quarter were: “Being treated respectfully,” “Overall service provided by counselor” and “Quickly understood reason.” The three lowest scoring survey categories were: “Ease of understanding information,” “Amount of time you waited” and “How helpful do you find this counseling to be.”

Table 11 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
*July**	*August*	*September*
How helpful do you find this counseling to be		
n/a	86.1%	88.6%
Amount of time you waited		
n/a	86%	83.1%
Ease of understanding information		
n/a	77%	78.3%
Likelihood to recommend		
n/a	93.5%	93.6%
Overall service provided by Counselor		
n/a	95.7%	97.6%
Quickly understood reason		
n/a	95.4%	97.5%
Ability to help choose plan		
n/a	94.5%	95.8%
Ability to explain clearly		
n/a	95.4%	97.3%
Confidence in the information		
n/a	94.3%	96.1%
Being treated respectfully		
n/a	98.4%	98.1%

* Statistics are not available for July 2010 due to AHS vendor transition related to the beneficiary survey.

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 8:00a.m. – 8:00p.m., Friday 8:00a.m. – 7:00p.m., and Saturday 9:00a.m. – 1:00p.m. During this quarter, 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 57,403 calls during this quarter. This represents approximately a 7% decrease in call volume from the previous quarter. The decrease in call volume is mainly contributed to system coding changes made during the AHS implementation, which reduced duplicate calls and recent changes to beneficiary communications.

Table 12 compares the call volume of incoming and outgoing calls during the first quarter of Demonstration Year Four and Year Five.

Table 12 Comparison of Call Volume for First Quarter (Demonstration Year Four & Year Five)								
Type of Calls	**Jul. 2009**	**Jul. 2010**	**Aug. 2009**	**Aug. 2010**	**Sep. 2009**	**Sep. 2010**	**Year 4 1st Quarter Totals**	**Year 5 1st Quarter Totals**
Incoming Calls	27,345	17,348	26,137	20,634	26,302	19,421	**79,784**	**57,403**
Outgoing Calls	3,318	3,127	3,213	3,547	2,372	2,085	**8,903**	**8,759**
Totals	30,663	24,055	29,350	32,254	28,674	27,057	**88,687**	**66,162**

3. Mail

Outbound Mail

During this quarter, the Choice Counseling Vendor mailroom mailed the following:

- New-Eligible Packets (mandatory and voluntary) 21,759
- Confirmation Letters 23,262
- Open Enrollment Packets 45,942
- Transition Packets (mandatory and voluntary) 34
- Plan Transfer Letters (mandatory and voluntary) 0

The amount of returned mail for this quarter, 5.5%, is slightly above the estimated 3-5% contract standard. When return mail is received, the Choice Counseling staff accesses the Choice Counseling Vendor's enrollment system and the Florida Medicaid Management Information System to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team also assists in efforts to contact the beneficiary. The Choice Counseling staff re-addresses the packets or letters when possible, with the newly eligible mailings taking top priority. The implementation of the National Change of Address database should assist with decreasing the volume of return mail.

As part of an Agency effort to improve beneficiary communication, the Agency no longer sends a separate mandatory health plan assignment letter. The pending health plan mandatory assignment information is now included within each New-Eligible letter. A reminder notice is sent out to those who have not made a choice (self-selected a health plan) within the first 30 days of receiving their initial letter. If a choice is not made within the 30 day period following the reminder notice, the beneficiary is mandatorily enrolled into the assigned health plan on the first of the following month. However, beneficiaries still have 90 days to change, without cause, after the plan effective date.

Inbound Mail

During this quarter, the Choice Counseling Vendor processed the following:

- Plan Enrollments 799
- Plan Changes 14

The percentage of enrollments processed through the mail-in enrollment forms decreased to 1.4%, which is slightly below the historical trend of 2-5%. This new trend is expected to continue with the recent implementation of online enrollment access.

The Online Enrollment Application was implemented on September 1, 2010. Since implementation, 71 enrollments and 18 plan changes have been processed through the Online Enrollment Application. The Agency is working to increase beneficiary awareness of online access and expects the number of enrollments to increase. The Agency is also reviewing the enrollment form to evaluate whether the mail-in enrollment option is viable.

4. Face-to-Face/Outreach and Education

The Field Choice Counseling Outreach Team enhanced the group session conducted this quarter by making additional Field Choice Counselors available after the session to assist beneficiaries in plan choices and, if needed, providing the option for a beneficiary to meet with a Choice Counselor one-on-one at the beneficiary' convenience.

Table 13 provides the Choice Counseling Field activities during this quarter:

Table 13
Choice Counseling Outreach Activities

Field Activities	1st Quarter – Year 5
Group Sessions	265
Private Sessions	41
Home Visits & One-On-One Sessions	35
No Phone List	0
Outbound Phone List	10,933
Enrollments	5,710
Plan Changes	303

The Agency and the Choice Counseling Vendor are revising the survey instrument used to monitor the Field Choice Counselors' performance (specifically beneficiary satisfaction with assistance provided). Therefore, the survey statistics are not included in this quarter's report.

The Field Choice Counselors continued their efforts to reach the special needs population. These population groups tend to 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 health plan 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

The Outreach/Field team created the Mental Health Unit to provide more direct support to beneficiaries who access mental health services. Those beneficiaries in the special needs community remain a high priority within the unit. The efforts to build relationships with the organizations who serve these individuals are yielding positive results. The Mental Health Unit continues to expand its efforts by promoting community partnerships and taking the lead on event planning.

The Mental Health Unit completed 31 Private Sessions for a total of 88 attendees. The Unit also completed 7 staff presentations. The Choice Counseling Field staff participated in 2 health fairs that resulted in a total of 72 contacts.

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

- 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 provide mental health and substance abuse services and have been very receptive to working with the Field Choice 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, and a Licensed Practical Nurse that have both earned their Choice Counseling certification.

Summary of cases taken by the Special Needs Unit

A ‘case referral’ is when a Choice Counselor refers a case to the Special Needs Unit through the Choice Counseling Vendor, enrollment system (Health Track) 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 documented and reported on the verbal reviews and referrals as noted in Table 14.

Table 14
Number of Referrals and Case Reviews Completed
July 1, 2010 – September 30, 2010

	July	August	September
Case Referrals	26	13	8
Case Reviews	23	21	28

The Special Needs Unit staff scope of work includes:

- 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 completed during this quarter.

6. New Eligible Self Selection Data[4]

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 Fiscal Agent (HP Enterprise Services, LLC (HP)) and the Choice Counseling Vendor. The Agency and HP have identified and created Customer Service Requests (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with FMMIS and the Choice Counseling Vendor's enrollment system (Health Track). HP continues to work through the program changes. With the implementation of the new Choice Counseling Vendor in June 2010, some of the file transfer issues have been resolved. When the program changes are complete, and the month-end information comes through consistently, it will allow the Choice Counseling Vendor to determine the new eligible's and ensure the enrollment will be more successful. Prior to

[4] 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.

the Fiscal Agent transition, the Choice Counseling Vendor exceeded the self-selection standard. The Agency fully expects that when all corrections are in place, the Choice Counseling Vendor will not only meet, but exceed the 80% minimum standard set (in the Agency's Service Level Agreement) for the Self Selection Rate for Demonstration Year Five.

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the Choice Counseling Call Center, Medicaid headquarters or the Medicaid Area Office. In August of 2007, the Agency and the Choice Counseling Vendor implemented an automated beneficiary survey where complaints against the Choice Counseling Program can be filed and voice comments can be recorded to describe what occurred on the call. There were no complaints received related to the Choice Counseling Program during the first quarter of Demonstration Year Five.

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 the Choice Counseling Vendor 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' satisfaction, with the overall service provided by the Choice Counselors, indicate that more than 97% are satisfied with the Choice Counseling experience during this quarter. Survey results also indicate that 96% are satisfied with the Choice Counselor's ability to clearly explain health plan choices and 98% felt they were treated respectfully. The Choice Counseling Vendor continues to focus on improving communication between the Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

Survey scores and beneficiary comments are 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 that may require coaching or training.

The Agency Headquarters staff, the Medicaid Area Office staff, and the Choice Counseling Vendor's staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between the Medicaid Area Office staff and the Choice Counseling Vendor's Field staff.

The Choice Counseling Vendor's enrollment system has e-mail boxes , which enable the Agency staff and the Choice Counseling Vendor's staff to share information directly to resolve difficult cases, and hold regularly scheduled conference calls. The Choice Counseling Vendor has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the Call Center and Field Office have

been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

9. Summary

The Agency, the Choice Counseling Vendor and the Fiscal Agent remain committed to prioritizing and resolving identified data transfer issues.

The Choice Counseling Vendor continues to work hard to provide excellent customer service and to play a key role in identifying and resolving issues. The new Choice Counseling Vendor, AHS, demonstrated consistent performance this quarter, meeting or exceeding all Service Level Agreements.

The Agency will continue to partner with the new Choice Counseling Vendor to conduct periodic training on the new web enrollment application. The Agency continues to seek public input on the operation of the Choice Counseling Program by hosting periodic meetings.

The Agency has been 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.

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 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 Health Maintenance Organizations (HMOs), MediPass, Pediatric Emergency Room Diversion, Provider Service Networks (PSNs), and Minority Physician Networks (MPNs).

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

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

During the first quarter of the Demonstration Year One, 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 (Demonstration 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 the 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:

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

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

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

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, 2010, and ending September 30, 2010. This section contains the following enrollment reports:

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

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 12 Medicaid Reform health plans – eight (8) HMOs and four (4) fee-for-service PSNs. In the previous quarter, Total Health Choice was acquired by Simply Healthcare, and its Reform HMO in Broward County ceased operations on June 1, 2010. Total Health Choice Reform enrollees were transitioned into the Better Health Medicaid Reform PSN, of which Simply Healthcare is a minority owner. In addition, a new specialty plan for Medicaid Reform enrollees with HIV/AIDS, Positive Healthcare, began accepting voluntary enrollments on May 1, 2010.

There are two categories of Medicaid beneficiaries who are enrolled in the demonstration health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 15 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 15
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 additional Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's beneficiary pool accounts for
Enrolled in 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 16 on the following page for State Fiscal Year 2010-11, First Quarter Medicaid Reform Enrollment Report.

Table 16 **Medicaid Reform Enrollment** (Fiscal Year 2010-11, 1st Quarter)										
			# SSI Enrolled							
Plan Name	Plan Type	# TANF Enrolled	No Medicare	Medicare Part B	Medicare Parts A & B	Total # Enrolled	Market Share for Reform	Enrolled in Previous Quarter	% Increase from Prev. Qtr.
Freedom Health Plan	HMO	2,737	420	0	64	**3,221**	**1.19%**	2,199	46.48%
Humana	HMO	5,417	1,707	1	162	**7,287**	**2.70%**	8,999	-19.02%
Medica	HMO	1,835	319	0	50	**2,204**	**0.82%**	1,521	44.90%
Molina Healthcare	HMO	18,760	3,274	8	349	**22,391**	**8.29%**	21,986	1.84%
Positive Healthcare	HMO	6	52	0	4	**62**	**0.02%**	22	N/A
Sunshine	HMO	83,733	8,713	8	672	**93,126**	**34.47%**	96,582	-3.58%
United Healthcare	HMO	6,604	884	0	49	**7,537**	**2.79%**	8,954	-15.83%
Universal Health Care	HMO	14,903	2,030	2	277	**17,212**	**6.37%**	18,068	-4.74%
HMO Total	**HMO**	**133,995**	**17,399**	**19**	**1,627**	**153,040**	**56.65%**	**158,331**	**-3.34%**
Better Health, LLC	PSN	27,680	3,987	5	516	**32,188**	**11.91%**	35,634	-9.67%
CMS	PSN	3,638	3,158	0	15	**6,811**	**2.52%**	7,014	-2.89%
First Coast Advantage	PSN	39,060	6,230	4	832	**46,126**	**17.07%**	49,666	-7.13%
SFCCN	PSN	27,730	3,772	2	490	**31,994**	**11.84%**	33,597	-4.77%
PSN Total	**PSN**	**98,108**	**17,147**	**11**	**1,853**	**117,119**	**43.35%**	**125,911**	**-6.98%**
Reform Enrollment Totals		**232,103**	**34,546**	**30**	**3,480**	**270,159**	**100.00%**	**284,242**	**-4.95%**

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-demonstration health plans to demonstration health plans. There were a total of 270,159 beneficiaries enrolled in the demonstration during this quarter. There were twelve (12) demonstration health plans with market shares ranging from 0.02 percent to 34.47 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 17 on the following page.

Table 17 Number of Reform Health Plans in Demonstration Counties (Fiscal Year 2010-11, 1st Quarter)		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**0**
Broward	**7**	**3**
Clay	**2**	**0**
Duval	**3**	**2**
Nassau	**2**	**0**

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 18 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 18 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 additional Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as in Table 19 and located on the following page.

Table 19
Medicaid Reform Enrollment by County Report
(Fiscal Year 2010-11, 1st Quarter)

				# SSI Enrolled						
Plan Name	**Plan Type**	**Plan County**	**# TANF Enrolled**	**No Medicare**	**Medicare Part B**	**Medicare Parts A & B**	**Total # Enrolled**	**Market Share For Reform by County**	**Enrolled in Prev. Qtr.**	**% Increase From Prev. Qtr**
Sunshine	HMO	Baker	2,477	228	0	11	**2,716**	**84.90%**	2,853	-4.80%
United Healthcare	HMO	Baker	403	74	0	6	**483**	**15.10%**	567	-14.81%
Total Reform Enrollment for Baker			**2,880**	**302**	**0**	**17**	**3,199**	**100.00%**	**3,420**	**-6.46%**
Freedom Health Plan	HMO	Broward	2,737	420	0	64	**3,221**	**2.19%**	2,199	46.48%
Humana	HMO	Broward	5,417	1,707	1	162	**7,287**	**4.96%**	8,999	-19.02%
Medica	HMO	Broward	1,835	319	0	50	**2,204**	**1.50%**	1,521	44.90%
Molina Healthcare	HMO	Broward	18,760	3,274	8	349	**22,391**	**15.23%**	21,986	1.84%
Positive Healthcare	HMO	Broward	6	52	0	4	**62**	**0.04%**	22	181.82%
Sunshine	HMO	Broward	29,826	2,662	3	181	**32,672**	**22.22%**	33,315	-1.93%
Universal Health Care	HMO	Broward	9,049	1,423	1	195	**10,668**	**7.26%**	11,251	-5.18%
Better Health, LLC	PSN	Broward	27,680	3,987	5	516	**32,188**	**21.89%**	35,634	-9.67%
CMS	PSN	Broward	2,254	2,076	0	11	**4,341**	**2.95%**	4,425	-1.90%
SFCCN	PSN	Broward	27,730	3,772	2	490	**31,994**	**21.76%**	33,597	-4.77%
Total Reform Enrollment for Broward			**125,294**	**19,692**	**20**	**2,022**	**147,028**	**100.00%**	**152,949**	**-3.87%**
Sunshine	HMO	Clay	8,669	829	0	49	**9,547**	**75.21%**	10,314	-7.44%
United Healthcare	HMO	Clay	2,925	210	0	12	**3,147**	**24.79%**	3,731	-15.65%
Total Reform Enrollment for Clay			**11,594**	**1,039**	**0**	**61**	**12,694**	**100.00%**	**14,045**	**-9.62%**
Sunshine	HMO	Duval	38,712	4,570	4	398	**43,684**	**42.92%**	45,225	-3.41%
United Healthcare	HMO	Duval	2,424	503	0	21	**2,948**	**2.90%**	3,567	-17.35%
Universal Health Care	HMO	Duval	5,854	607	1	82	**6,544**	**6.43%**	6,817	-4.00%
CMS	PSN	Duval	1,384	1,082	0	4	**2,470**	**2.43%**	2,589	-4.60%
First Coast Advantage	PSN	Duval	39,060	6,230	4	832	**46,126**	**45.32%**	49,666	**-7.13%**
Total Reform Enrollment for Duval			**87,434**	**12,992**	**9**	**1,337**	**101,772**	**100.00%**	**107,864**	**-5.65%**
Sunshine	HMO	Nassau	4,049	424	1	33	**4,507**	**82.46%**	4,875	-7.55%
United Healthcare	HMO	Nassau	852	97	0	10	**959**	**17.54%**	1,089	-11.94%
Total Reform Enrollment for Nassau			**4,901**	**521**	**1**	**43**	**5,466**	**100.00%**	**5,964**	**-8.35%**
Reform Enrollment Totals			**232,103**	**34,546**	**30**	**3,480**	**270,159**		**284,242**	**-4.95%**

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

During this quarter, there was an enrollment of 3,199 beneficiaries in Baker County, 147,028 beneficiaries in Broward County, 12,694 beneficiaries in Clay County, 101,772 beneficiaries in Duval County, and 5,466 beneficiaries in Nassau County. There were two (2) Baker County health plans with market shares ranging from 15.1 percent to 84.9 percent, ten (10) Broward County health plans with market shares ranging from 0.04 percent to 22.22 percent, two (2) Clay County health plans with market shares ranging from 24.79 percent to 75.21 percent, five (5) Duval County health plans with market shares ranging from 2.43 percent to 45.32 percent, and two (2) Nassau County health plans with market shares ranging from 17.54 percent to 82.46 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 20 and 21 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. "New" enrollees are defined as those beneficiaries who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 20 provides a description of each column in this report.

Table 20
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 21 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 21
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2010-11, 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	
Freedom Health Plan	HMO	Broward	1	20	2	3	9	55	**69**	**2.14%**	**3,221**
Humana	HMO	Broward	2	41	-	30	9	154	**319**	**4.38%**	**7,287**
Medica	HMO	Broward	4	7	1	5	7	43	**54**	**2.45%**	**2,204**
Molina Healthcare	HMO	Broward	14	127	4	42	31	325	**522**	**2.33%**	**22,391**
Positive Healthcare	HMO	Broward	-	-	-	-	-	4	**-**	**0.00%**	**62**
Sunshine	HMO	Baker	3	32	-	2	-	11	**50**	**1.84%**	**2,716**
Sunshine	HMO	Broward	13	130	3	21	21	163	**353**	**1.08%**	**32,672**
Sunshine	HMO	Clay	5	69	1	5	4	45	**144**	**1.51%**	**9,547**
Sunshine	HMO	Duval	34	479	2	65	39	363	**957**	**2.19%**	**43,684**
Sunshine	HMO	Nassau	2	42	1	5	4	30	**82**	**1.82%**	**4,507**
United Healthcare	HMO	Baker	1	3	-	1	1	5	**12**	**2.48%**	**483**
United Healthcare	HMO	Clay	-	28	1	3	1	11	**49**	**1.56%**	**3,147**
United Healthcare	HMO	Duval	2	76	-	12	-	21	**133**	**4.51%**	**2,948**
United Healthcare	HMO	Nassau	-	8	-	6	-	10	**24**	**2.50%**	**959**
Universal Health Care	HMO	Broward	6	66	-	10	16	179	**290**	**2.72%**	**10,668**
Universal Health Care	HMO	Duval	11	55	-	2	11	71	**164**	**2.51%**	**6,544**
HMO Total	HMO		98	1,183	15	212	153	1,490	**3,222**	**2.11%**	**153,040**
Better Health, LLC	PSN	Broward	23	206	1	56	24	496	**806**	**2.50%**	**32,188**
CMS	PSN	Broward	1	51	7	177	-	11	**247**	**5.69%**	**4,341**
CMS	PSN	Duval	-	64	4	88	-	4	**155**	**6.28%**	**2,470**
First Coast Advantage	PSN	Duval	29	597	1	139	27	808	**1,703**	**3.69%**	**46,126**
SFCCN	PSN	Broward	15	429	-	69	19	473	**1,038**	**3.24%**	**31,994**
PSN Total	**PSN**		**68**	**1,347**	**13**	**529**	**70**	**1,792**	**3,949**	**3.37%**	**117,119**
Reform Enrollment Totals			**166**	**2,530**	**28**	**741**	**223**	**3,282**	**7,171**	**2.65%**	**270,159**

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

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

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

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

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

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

The Opt Out database has been designed to comply with the Special Terms and Conditions of the waiver. The database tracks enrollee characteristics such as eligibility category, type of employer-sponsored insurance and type of coverage. The database will also track the reason for an individual disenrolling in an ESI Program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. 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 that they continually meet the established eligibility requirements.

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

Opt Out Program Statistics

- 80 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 62 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 Demonstration Year Five, there are currently 18 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees are provided in Attachment III of this report.

Table 22 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending September 30, 2010.

Table 22 Opt Out Statistics September 1, 2006 – September 30, 2010						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
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	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/2010	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	02/28/10	Loss of Medicaid Eligibility
C & F	12/01/08	Large Employer	Family	5	1/19/10	Disenrolled from Commercial Insurance
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	2 1	06/30/09 01/27/10	Loss of Medicaid Eligibility Disenrolled from Commercial Insurance
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	05/31/10	Loss of Medicaid Eligibility
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Small Employer	Family	1	08/31/10	Loss of Medicaid Eligibility
C & F	09/01/09	Large Employer	Family	3	12/31/09	Loss of Medicaid Eligibility
SSI	01/01/10	Large Employer	Family	1	Still Enrolled	N/A
C & F	04/01/10	Large Employer	Family	3	Still Enrolled	N/A
C & F	05/01/10	Large Employer	Family	2	Still Enrolled	N/A
C & F	06/01/10	Large Employer	Family	1	06/01/10	Never enrolled child in Commercial Insurance
C & F	07/01/10	Large Employer	Family	2	Still Enrolled	N/A
SSI	09/01/10	Large Employer	Family	1	Still Enrolled	N/A

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

E. Enhanced Benefits Account Program

Overview

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

Beneficiaries enrolled in a demonstration health plan may earn up to $125.00 of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (HP Enterprise Services, LLC (HP)) Pharmacy Point of Sale System, currently maintained and managed by the HP subcontractor, Magellan (formally 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 government issued photo 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 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 HP subcontractor, Magellan, to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

During this quarter, the Enhanced Benefits Call Center, managed by the new Choice Counseling Vendor (Automated Health Systems (AHS)), 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 8:00a.m. – 8:00p.m., Monday – Thursday, 8:00a.m. – 7:00p.m. on Friday, and 9:00a.m. – 1:00p.m on Saturday.

The primary function of the Call Center is to answer all inbound calls relating to program questions, provide Enhanced Benefits Account updates on credits earned/used, and assist beneficiaries with utilizing the web based over-the-counter product list. As mentioned in the previous quarter, the Choice Counseling Vendor, AHS, implemented the Automated Voice Response System (AVRS) on June 18, 2010, for beneficiaries who need balance only information. The new AVRS is a success; since last quarter, inbound calls have decreased by about 1,000 calls and reduced the abandonment rate.

Table 23 highlights the Enhanced Benefits Call Center activities during this quarter:

Table 23
Highlights of the Enhanced Benefits Call Center Activities
July 1, 2010 – September 30, 2010

Enhanced Benefits Call Center Activity	July	August	September
Calls Received	5,681	6,182	6,898
Calls Answered	5,527	5,945	6,668
Abandonment Rate	2.71%	3.82%	3.33%
Average Talk Time (minutes)	4.6	4.5	4.6
Calls Handled by the AVRS	5,089	7,043	8,950
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	11,220	10,621	10,511

2. System Activities

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day of each month. The 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 separate statement, sent at least once per year for beneficiaries who have a balance with no new activity.

The vendor of EBIS, Image Software Inc., continues to provide Enhanced Benefits Account balance data to the Choice Counseling Vendor's AVRS three times each week for each beneficiary who has an Enhanced Benefits Account credit balance. Since the implementation of the new AVRS option, it has been utilized by more beneficiaries and continues to be successful.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during this quarter. There were 163,595 coupon statements mailed to beneficiaries during this quarter. Along with the beneficiary coupon statements, a flyer focused on the new ARVS service and a healthy behavior theme was also included in the mail out. The Choice Counselors continue to provide up-to-date information for beneficiaries regarding their Enhanced Benefits Account balances and the opportunity to earn healthy behavior credits. During this quarter, the Choice Counseling Vendor also began calling beneficiaries' who have never utilized their Enhanced Benefits Account balance. The number of outbound calls made during the quarter are listed below. A script was created to perform the outbound call. The number of outbound calls made during the quarter are listed below.

	July	August	September	1st Quarter Total
Outbound Calls	760	594	673	2,027

4. Outreach and Education for Pharmacies

The pharmacy benefits manager, Magellan, provides ongoing technical assistance to pharmacies as needed related to all billing aspects of the EBAP.

5. Enhanced Benefits Advisory Panel

There was no Enhanced Benefits Advisory Panel meeting this quarter. The August 30, 2010, meeting was cancelled due to turnover in the membership. New members were identified this quarter. The next meeting will be scheduled when the new members appointments are final.

6. Enhanced Benefits Statistics

As of end of this quarter, 9,728 beneficiaries lost EBA eligibility for a total of $412,189.38 and they no longer have access to those credits.

Table 24 provides the Enhanced Benefits Account Program statistics for this quarter.

Table 24
Enhanced Benefits Account Program Statistics

First Quarter Activities – Year Four		July 2010	August 2010	September 2010
I.	Number of plans submitting reports by month in each county[6]	33 of 23	27 of 23	29 of 23
II.	Number of enrollees who received credit for healthy behaviors by month	50,726	50,794	48,247
III.	Total dollar amount credited to accounts by each month	$976,692.50	$1,002,365.00	$941,822.50
IV.	Total cumulative dollar amount credited through the end each month	$31,430,801.16	$32,433,166.16	$33,374,988.66
V.	Total dollar amount of credits used each month by date of service	$451,968.91	$550,053.12	$590,376.04
VI.	Total cumulative dollar amount of credits used through the month by date of service	$15,514,075.00	$16,064,128.10	$16,654,504.10
VII.	Total unduplicated number of enrollees who used credits each month	18,743	21,344	21,945

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.

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

During this quarter, over 24,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 20 (less than .0008%) complaints were recorded through the Call Center related to the EBAP. The decrease in complaints is attributed to improved staff training. Table 25 provides a summary of the complaints received during this quarter and outlines the actions taken by the Enhanced Benefits Call Center, the Agency, or HP (through Magellan) to address the issues raised.

Table 25
Enhanced Benefits Beneficiary Complaints
July 1, 2010 – September 30, 2010

Beneficiary Complaint	Action Taken
1. Ten (10) beneficiaries called to complain the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program. The call center also refers beneficiaries to an actively participating pharmacy in their area.
2. Four (4) beneficiaries complained about healthy behaviors not submitted by the health plan on behalf of the beneficiary.	➲ The Agency researches with each health plan regarding healthy behaviors not submitted. In most cases, the health plan submitted the behaviors in the next report submission. In a few cases, some beneficiaries had already reached occurrence limits on some of the behaviors; therefore, credit would not have been credited to the beneficiary account.
3. Six (6) beneficiaries complained about the balance in their account, either regarding pricing of products or duplicate pricing of one item.	➲ The Agency researched along with the pharmacy vendor regarding these complaints. The vendor was able to resolve issue with the pharmacy.

F. Low Income Pool

Overview

In accordance with the Special Term and Condition (STC) #100 of the Florida Medicaid 1115 Research and 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 federal CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. On March 16, 2006, federal 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 federal CMS on April 7, 2006.

On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement. Federal CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006.

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

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

Current Activities

July 21, 2010, Low Income Pool Council Meeting

On July 21, 2010, a LIP Council meeting was conducted via conference call by Agency staff located in Tallahassee, Florida.

At the meeting, the Agency provided a brief update to the LIP Council on the progress of the 1115 waiver extension request and the Letters of Agreement (LOAs) for the SFY 2010-11.

The Agency provided an update to the LIP Council on STC 105 submissions as follows:

- STC 105 (1)(a) was submitted to federal CMS on April 30, 2010, and resubmitted to make a grammatical correction on June 14, 2010. The purpose of Amended STC 105 (1)(a) is to provide a review tool and instructions to be used for the reconciliation of the LIP expenditures to allowable provider costs. This milestone was set with a deadline submission of April 30, 2010. The purpose of this document is to meet Milestone (1)(a) requirements of the terms of the amendment by providing a review tool and instructions to be used for the reconciliation of the LIP payments to provider costs limits.
- STC 105 (1)(b) was submitted to federal CMS on June 30, 2010. This amended STC was to provide CMS a schedule for the completion of provider reconciliations statewide for Demonstration Years One, Two, Three, and Four by June 30, 2010.
- STC 105 (2)(a) was submitted to federal CMS on May 31, 2010. The purpose of this document is to meet Milestone (2)(a) requirement of the amended STC by providing a baseline report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for SFY 2009-10 to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings. This report provided a baseline assessment of current administrative capabilities Also, Milestone (2)(a) developed a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventive care settings.
- STC 105 (2)(b) was submitted to federal CMS on June 30, 2010. This document is to provide an update with SFY 2010-11 projections for LIP dollars allocated to participating providers by June 30, 2010. This update includes descriptions of increases to allocations and changes to current allocations.

All submissions can be found on the Agency's Low Income Pool (LIP) website at:

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

Discussion was also held regarding the highlights of the General Appropriations Act (GAA) 2010-11 Model. A model of distribution for SFY 2010-11 was assembled for the LIP Council to review. A copy of the GAA 2010-11 model can be found on the Agency's LIP website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/2010-07-21/lip_sfy_10-11_gaa.pdf

August 18, 2010, Low Income Pool Council Meeting

On August 18, 2010, the LIP Council meeting was conducted via conference call by Agency staff located in Tallahassee, Florida.

The Agency provided an update on the LOAs and noted that most of the LOAs were completed and sent to the providers, and that the remainder of the LOAs will be sent out by the end of the week.

A more in depth discussion took place on the Federal Medical Assistance Percentage (FMAP). It was noted that Congress acted and the President approved a step-down extension of the enhanced FMAP. From this point through December 2010, the current enhanced FMAP under the original terms of the American Recovery and Reinvestment Act is 67.64%. With the new step-down approach, the FMAP will change to 64.81% for the period of January through March 2011. For the period of April through June 2011, the FMAP is set to be 62.93%. By taking the three FMAP federal levels collectively, this would create a blended FMAP for SFY 2010-11 of 64.83%. The Agency advised the Council that models would be created which included the new percentages.

The meeting was concluded with an update on the 1115 wavier extension request. The LIP Council was informed that on August 17, 2010, federal CMS advised the Agency that they would review and process the State's request to renew the demonstration waiver under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the State.

September 15, 2010, Low Income Pool Council Meeting

On September 15, 2010, the LIP Council meeting was conducted via conference call by Agency staff located in Tallahassee, Florida. The LIP Council discussed the definition of Safety Net, status of the 1115 waiver extension request, reporting deadlines, and the Legislative Budget Commission.

The LIP Council was informed of several key points noted at the latest Legislative Budget Committee meeting. One key point was updating the Agency's budget to reflect the changes in the Federal Medical Assistance Percentage (FMAP) and realigning the State share versus Federal share of funding. A copy of the updated SFY 2010-11 LIP distribution model based on the LBC approval was distributed to the LIP Council and can be found on the Agency's LIP website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/2010-09-15/sfy_2010-11_lbc_model.pdf

Upcoming LIP Council meetings are scheduled for the following dates:
October 20, 2010; November 17, 2010; December 15, 2010; and January 19, 2011.

The LIP Council report including the recommendations for funding and distributions of Low Income Pool, Disproportionate Share Hospital program, exemptions to ceilings, and buybacks for SFY 2011-12 is due to the Governor and Legislature on February 1, 2011.

G. Monitoring Budget Neutrality

Overview

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

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

To determine if a person is eligible for the 1115 Medicaid Reform Waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted Medicaid eligibility is assigned an eligibility category by the Florida Department of Children and Families. Specific categories are identified for each MEG under the 1115

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

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

I. Eligibles and enrollee member months are identified;

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

III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:

a. MEG #1 SSI–Related
b. MEG #2 Children and Families
c. Reform – Managed Care Waiver SSI–no Medicare
d. Reform – Managed Care Waiver TANF
e. Reform – Managed Care Waiver SOBRA and Foster Children
f. Reform – Managed Care Waiver Age 65 and Older;

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

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

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

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

Definitions:

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

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. 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.

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, 2010. Case months provided in 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**	**$111,968,931**	**$763,459,242**	**$1,007.18**
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
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**
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
Q15 Total	**847,324**	**$781,783,604**	**$141,815,963**	**$923,599,567**	**$1,090.02**
Q16 Total	**852,445**	**$811,240,631**	**$142,745,339**	**$953,985,969**	**$1,119.12**
July 2010	289,450	$166,097,229	$32,548,825	$198,646,054	$686.29
August 2010	288,959	$257,400,660	$50,362,126	$307,762,786	$1,065.07
September 2010	290,464	$378,046,090	$67,416,195	$445,462,285	$1,533.62
Q17 Total	**868,873**	**$801,543,979**	**$150,327,146**	**$951,871,125**	**$1,095.52**
MEG 1 Total	**13,483,694**	**$11,956,899,014**	**$1,878,717,749**	**$13,835,616,764**	**$1,026.10**

* 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**
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
Q15 Total	**5,098,381**	**$773,609,163**	**$93,647,855**	**$867,257,018**	**$170.10**
Q16 Total	**5,203,143**	**$793,529,141**	**$90,471,922**	**$884,001,063**	**$169.90**
July 2010	1,760,314	$119,876,307	$11,136,093	$131,012,400	$74.43
August 2010	1,785,641	$242,522,154	$29,130,986	$271,653,141	$152.13
September 2010	1,810,787	$404,205,540	$51,277,639	$455,483,179	$251.54
Q17 Total	**5,356,742**	**$766,604,001**	**$91,544,719**	**$858,148,719**	**$160.20**
MEG 2 Total	**72,408,898**	**$10,836,397,949**	**$1,127,314,009**	**$11,963,711,958**	**$165.22**

* 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 29), 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 $1,022.14 (Table 29), compared to WOW of $1,024.69 (Table 26), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 29), compared to WOW of $215.44 (Table 26), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.10 (Table 29), compared to WOW of $1,106.67 (Table 26), which is 95.52% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.83 (Table 29), compared to WOW of $232.68 (Table 26), which is 71.70% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,061.81 (Table 29), compared to WOW of $1,195.20 (Table 26), which is 88.84% of the target PCCM for MEG 1. MEG 2 has a PCCM of $165.44 (Table 29), compared to WOW of $251.29 (Table 26), which is 65.84% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $971.18 (Table 29), compared to WOW of $1,290.82 (Table 26), which is 75.24% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.64 (Table 29), compared to WOW of $271.39 (Table 26), which is 59.19% of the target PCCM for MEG 2.

Tables 29 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 $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the 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 $309.04. Comparing the calculated weighted averages, the actual PCCM is 83.01% 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 $387.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 30 is $294.32. Comparing the calculated weighted averages, the actual PCCM is 76.05% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 30) is $413.67. 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 $273.76. Comparing the calculated weighted averages, the actual PCCM is 66.18% 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	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,935,870,094	$499,430,086	$3,435,300,180	$1,057.10
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(161,091,799)	
% of WOW PCCM MEG 1					95.52%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,570,301,225	$281,642,115	$2,851,943,340	$166.83
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,125,684,031)	
% of WOW PCCM MEG 2					71.70%

Table 29 Continued MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	3,352,695	$3,018,364,058	$541,546,650	$3,559,910,708	$1,061.81
WOW DY4 Total	3,352,695			$4,007,141,064	$1,195.20
Difference				$(447,230,356)	
% of WOW PCCM MEG 1					88.84%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	19,964,506	$2,955,399,051	$347,489,239	$3,302,888,290	$165.44
WOW DY4 Total	19,964,506			$5,016,880,713	$251.29
Difference				$(1,713,992,423)	
% of WOW PCCM MEG 2					65.84%
DY05 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY05 Total	868,873	$715,917,850	$127,918,169	$843,836,019	$971.18
WOW DY5 Total	868,873			$1,121,558,646	$1,290.82
Difference				$(277,722,627)	
% of WOW PCCM MEG 1					75.24%
DY05 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY05 Total	5,356,742	$762,970,333	$97,531,480	$860,501,813	$160.64
WOW DY5 Total	5,356,742			$1,453,766,211	$271.39
Difference				$(593,264,398)	
% of WOW PCCM MEG 2					59.19%

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	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,506,171,319	$781,072,201	$6,287,243,520	$309.04
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,288,775,831)	
% Of WOW					83.01%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,317,201	$5,973,763,109	$889,035,888	$6,862,798,998	$294.32
WOW	23,317,201			$9,024,021,777	$387.01
Difference				$(2,161,222,779)	
% Of WOW					76.05%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	6.225,615	$1,478,888,183	$225,449,649	$1,704,337,832	$273.76
WOW	6,225,615			$2,575,324,857	$413.67
Difference				$(870,987,026)	
% Of WOW					66.18%

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	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Total Paid	**$4,073,982,007**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$75,927,158	$1,000,000,000	7.59%
Total MEG 3	$4,073,982,007	$5,000,000,000	81.48%

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

The expenditures for the first seventeen quarters for MEG 3, the Low Income Pool (LIP), were $4,073,982,007 (81.48% of the $5 billion cap).

During Demonstration Year Three, the Florida Legislature directed the Agency to carry forward approximately $123 million dollars from the Demonstration Year Three LIP appropriation until an amendment of the STC #105 could be negotiated. Upon approval of the amendment, approximately $123 million dollars in carry forward funding was provided to the Agency through appropriations for Demonstration Year Four. The appropriations for Demonstration Year Four totaled $1,001,250,000 plus the $123,577,163 of carry forward LIP funds for a grand total of $1,124,827,163. Due to the payment process and the reporting period, payments made after June 30, 2010, were not captured in the Fourth Quarter report or Draft Annual Report of Demonstration Year Four. This report for the first quarter of Demonstration Year Five includes the final payment totals for Demonstration Year Four.

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 the demonstration health plans. Risk adjustment was phased in over a period of three years, using the Medicaid Rx (MedRx) model. The Agency plans to transition to a diagnosis-based model such as the Chronic Illness and Disability Payment System.

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

Current Activities

Encounter data collection in Florida Medicaid Management Information System (FMMIS) is operational and plans are making regular monthly submissions. Current day encounter claims are routinely processing in the claims systems and move to claims history (Decision Support System/DSS) as they are processed. The Agency continues to reconcile monthly data submissions to the encounter data certifications provided by the plans. Encounter records reflect the reported level of services provided to beneficiaries in Medicaid capitated managed care plans.

At present there are two concurrent encounter data collection efforts:

- The collection of medical and pharmacy encounter data for all Medicaid-covered services within FMMIS. (Planned uses for these data include, but are not limited to, health plan capitation rate setting, services and utilization analysis, supporting health plan quality and performance metrics, and supporting managed care fraud and abuse prevention and detection.)
- The collection of quarterly pharmacy encounter data in a proprietary format for risk-adjusting demonstration health plans' capitation rates. The July 2010 submissions of this data were the last. The Agency will begin using the National Council for Prescription Drug Programs (NCPDP) pharmacy data from claims history. Because NCPDP pharmacy claims are included in plan encounter data submissions, there is no longer a need for plans to submit this separate extra data set.

<u>Data Validation</u>

Analytic validation continues for all encounter data received to date and for all future submissions by plan by month. A feedback loop allows the Agency to communicate results to the health plans using a series of standard reports, including a dashboard.

Data validation efforts during the first quarter of Demonstration Year Five included the following:

- The first package of encounter data dashboards was sent to all capitated plans in August 2010. Dashboard results are based on each plan's submitted encounter data. All demonstration plans received a statewide dashboard as well as individual dashboard(s) for their own plan, one for the demonstration counties and one for the other counties in which they operate, if applicable.
- Each dashboard contained four charts along with the detailed counts used to create the charts. Dashboard charts included:
    - The total number of services for SFY 2008-09, by month and claim type (Inpatient, Outpatient, Medical, Dental, and Pharmacy).
    - The SFY 2008-09 percentage of each claim type submitted by the plan.
    - A comparison of the plan's per member per month services to the statewide average per member per month services.
    - The plan's total services by month.
- Several plans were required to respond to questions from the Agency regarding the service volume reported in encounter data. As a result, subsequent data submissions will be forthcoming.
- Three external vendors, Mercer, Milliman, Inc., and Health Services Advisory Group (HSAG), are assisting the Agency with encounter data processing and validation. Mercer and Milliman are the Agency's contracted actuaries and HSAG is the Agency's External Quality Review Organization (EQRO).
    - Mercer and Milliman performed validation procedures and determined the pharmacy encounter data completeness and accuracy meant that they would be used as part of the base data for setting the health plan capitation rates.
    - The Agency is currently awaiting an encounter data validation proposal from HSAG.
    - As part of a larger project, Mercer has developed data intake processes and sets of general validation reports that summarize the quality and completeness of the various data sources. The final report from Mercer is expected in the next quarter.

The following are the highlights for this quarter:

- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans (i.e., MEDS and NCPDP Companion Guides, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions).
- Provided outreach and technical assistance with health plans 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.

- Held weekly update meetings for Medicaid management to discuss the progress of encounter data submission and receipt and any system issues that may impact processing and reporting.
- Continued meeting with the Agency Encounter Data Utilization Team and identified uses for the managed care encounter data.
- Continued performing the encounter data analytic validation procedures.
- Worked with external vendors to determine the status of their validation activities.
- Worked with EQRO vendor to develop validation activities.
- Continued transition of operational aspects of encounter data validation to the fiscal agent.
- Continued planning of provider mass enrollment effort.
- Completed transition to new risk adjustment vendor.
- Conducted comparison and parallel testing using NCPDP and proprietary data in the MedRx model.

Quarterly Pharmacy Encounter Data Collection For Risk Adjustment

To comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed to calculate individual risk scores for both the Medicaid fee-for-service and managed care populations. Using the MedRx 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 were applied to capitated premium rates for Medicaid-enrolled populations in the demonstration counties monthly from October 2006 through June 2008. As mentioned in previous quarterly reports, Legislation required that capitation premiums be fully risk-adjusted and health plan corridor factors were no longer to be applied effective in Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting demonstration capitation rates was January 1, 2009, through December 31, 2009, paid through March 31, 2010. 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 the first quarter of Demonstraiton Year Five regarding the collection, validation, and utilization of quarterly pharmacy encounter data for risk-adjustment purposes:

- Continued to collect and process pharmacy encounter data and in proprietary format 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.

- Provided MEDS NCPDP-format pharmacy data for SFY 2008-09 to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use. Continued parallel testing and comparison between the two data sources.
- Provided MEDS diagnosis-based encounter data for SFY 2008-09 to the risk adjustment vendor on June 30, 2010, for use in a dry run comparison of the CDPS model risk score results to the MedRx risk score results based on pharmacy encounter data.
- For this period, risk adjustment plan factors were calculated for the following health plans:

Better Health Plan	Medica Healthcare Plan	Positive Health Care
Children's Medical Services, Florida Department of Health	SFCCN – Memorial Healthcare System	United Healthcare
Freedom Health Plan	SFCCN – North Broward Hospital Districts	Universal Health Care
Humana	Shands Jacksonville Medical Center d/b/a First Coast Advantage	
Molina Health Plan	Sunshine	

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1-year-old' population, or specialty plans/populations such as HIV/AIDS and Childrens Medical Services (CMS). Plans such as Positive Health Care, an HIV/AIDS specialty plan, and CMS are included here only because they have additional enrollment outside the HIV/AIDS population (Positive Health Care) and outside the under 1-year-old (CMS – kids) population.
- Enrollment in the demonstration counties this quarter for the month of September 2010 for risk adjustment purposes totaled 238,013 and was distributed as follows:

September 2010	Broward	Duval, Baker, Clay, and Nassau
Children & Families	110,954	97,483
SSI	16,451	13,125
Totals	**127,405**	**110,608**

- Pharmacy data to support risk adjustment capitation rate premium calculations were collected and processed through MedRx during this quarter. The Agency expects to transition to NCPDP pharmacy data using the MedRx model by the third quarter of Demonstration Year Five. It is the longer-term goal to transition from a pharmacy-based model to a diagnostic risk-adjustment model such as CDPS or use a combination of pharmacy and diagnostic data in a model such as CDPS – Rx.

The process of providing plan risk factors for the demonstration rate setting and budget neutrality will continue into the next quarter. Another dry run of the CDPS model using diagnosis-based encounter data will occur next quarter and the results will be analyzed. The Agency will continue to test and compare results between CDPS and MedRx until the quality and completeness of the diagnosis-based encounter data support transitioning to a diagnostic risk-adjustment model, such as CDPS.

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

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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. The initial on-site survey for Preferred Care Partners has been conducted, which is in Phase III of the application review process. The Agency also received a request from First Coast Advantage (PSN) to expand into Baker, Clay, and Nassau Counties. The request is under review.

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 Five 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 Demonstration Year Five include:

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

For Demonstration Year Five, the Agency approved 21 benefit packages for the HMOs and 13 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010, to August 31, 2010, for eight HMOs and four PSNs. Positive Healthcare, the first Reform HMO specialty plan for beneficiaries with HIV/AIDS, began accepting enrollment on May 1, 2010. In addition, Total Health Choice was acquired by Simply Healthcare and ceased operations on May 31, 2010. The Total Health Choice Reform enrollees were transitioned to the Better Health Reform PSN, of which Simply Healthcare is a minority owner, on June 1, 2010.

Improving Access to Specialists

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

1. Identifying the number of unduplicated providers that participate in Reform;
2. Identifying providers that were not 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 Demonstration 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 beneficiary 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 divided among 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 Demonstration Year Two and in Demonstration Year Three (March 2008 through March 2009), the Agency conducted 11 monthly surveys. These surveys included both a sample of 300 providers across the state, 15 from each health plan, and a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist). 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. The results of these surveys are provided in Table 33.

Table 33 Results of Provider Network Validation Surveys March 2008 through March 2009			
Survey Month/Year	**Statewide Accuracy Rate**	**Geographic Medicaid Area**	**Medicaid Area Accuracy Rate**
March 2008	88%*	10	95%*
April 2008	88%*	4	84%*
May 2008	97%	11	99%
June 2008	96%	9	97%
August 2008	97%	6	100%
September 2008	99%	3	99%
October 2008	100%	5	100%
November 2008	100%	8	100%
January 2009	99%	7	100%
February 2009	99%	2	100%
March 2009	99%	1	100%

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

As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area had 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 quarter. The quarterly survey results that have been analyzed to date are in Table 34.

Table 34 Results of Provider Network Validation Surveys July 2009 through January 2010	
Survey Month/Year	**Statewide Accuracy Rate**
July 2009	95%
October 2009	98.4%
January 2010	96.6%

During this quarter, Agency staff finished the January survey follow-up and analysis. A total of 652 providers were sampled from the provider network files and 96.6% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. Agency staff began following-up with providers that were surveyed as part of the May quarterly survey.

Agency staff will prepare for the next survey during the second quarter of Demonstration Year Five, which will be fielded in October 2010. The May survey follow-up and analysis will be completed as well. The surveys will be conducted on a semi-annual basis moving forward, with the next survey taking place in April 2011.

The Agency is also working on the National Provider Identification and provider matching initiatives. When completed, these two initiatives will result in the provider

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

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

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

During this quarter, the Agency continued work developing an enhanced auto-assignment methodology to reward higher performing health plans. During the previous two quarters, the health plans offered suggestions for measures to be included in an assignment methodology. The Agency examined the non-HEDIS metrics suggested by the health plans for reliability, standardization, and fairness among all participating health plans. This was important to ensure that no measure disproportionately favored small or large plans, PSNs or HMOs, or new or established plans. The Agency also examined the options for timely systems change in the FMMIS system. The Agency will hold a workshop with interested health plans during the next quarter to finalize the methodology and timeline for implementation.

On July 1, 2010, the Agency began collection of its third year of performance measures from the health plans. The list of performance measures selected at the outset of the demonstration was phased in over a three year implementation schedule. This year was the first year that the full list of intended measures were collected and reported. The data represents care delivered during calendar year 2009.

Most health plans submitted performance measure data timely and accurately, allowing a complete analysis to be completed during this quarter. The analysis showed many successes, a few areas for monitoring, and stable performance overall. The complete result set can be viewed in Attachment IV of this report.

Annual Dental Visit, a measure that is particularly challenging for most health plans, achieved an 18.2% increase over the course of the demonstration with a 4.9% increase over the past year. Childhood Immunization Status saw a one-year increase of 6.4% in Combo 2 and 8.9% in Combo 3. (The referenced Combo 2 and Combo 3 indicators represent measures of different required immunizations that a child should have according to the periodicity schedule recommended by the Centers for Disease Control and Prevention. Combo 3 is inclusive of Combo 2.) Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.

Well-Child Visits in the First 15-Months of Life saw a decline this year. The state is investigating possible systemic issues that may have resulted in an artificial decline in

the rate, particularly when compared to the strong performance of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.

The measures submitted this year are subject to new contract terms that require formal interventions for all measures scoring below the 50th national percentile. An October 1, 2010, deadline was provided to health plans for submission of the Performance Measure Action Plans, which will outline the selected interventions and timeline for each measure. If the interventions fail to improve the measures, sanctions may be assessed in response to the 2011 performance measure submission.

(3)(b) Reduction in ambulatory sensitive hospitalizations.

As noted in the previous report, the Ambulatory Sensitive Hospitalization analysis will be updated when hospital data is available.

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

The HEDIS measure Ambulatory Care includes an indicator that measures the use of emergency rooms per 1,000 member months. For the 2009 reporting year (measurement year 2008), the aggregate rate for all Reform plans was 72.6. In 2010 (measurement year 2009), the rate fell slightly to 72.1, indicating the use of the emergency room has been fairly stable over the past two years. The Agency is working with the External Quality Review Organization, Health Services Advisory Group, to develop a collaborative intervention to target emergency room utilization in Reform counties.

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

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

The reasons individuals have chosen to opt out of 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:

(1) were not employed,
(2) did not have access to employer sponsored insurance, or

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

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

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

Enrollee Satisfaction: Year Two Follow-Up Survey Report - Volumes 1, 2, and 3 (2009), are to be submitted to the Agency in a staged delivery. During this quarter, Volume 1 was finalized by the Agency. This volume presents survey results by county. Volume 2, which addresses enrollee satisfaction differences by plan type, has been submitted to the Agency and is currently under review. It is anticipated that this volume will be finalized during the next quarter. Volume 3 will assess enrollee satisfaction differences by enrollee subgroup (race/ethnicity demographics), and will be submitted to the Agency during the next quarter.

UF began fieldwork for the next iteration of this survey on Wednesday, May 12, 2010, and telephone interviews were terminated on Monday, July 12, 2010, with a yield of 7,014 completed interviews. UF is currently in the process of reviewing the results of these survey activities.

The results of past surveys can be viewed on the Agency's website at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

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 the non-hospital PAS entities allows for increased access to services for the Medicaid, underinsured, and uninsured populations.

During the Year One of the LIP, the following PASs received State appropriations for LIP distributions: Hospitals, County Health Departments (CHDs), the St. John's River Rural Health Network (SJRRHN), and Federally Qualified Health Centers (FQHCs). 7

During the first two quarters of Demonstration Year One, the State approved a PAS distribution methodology and worked with these PAS entities establishing Letters of Agreement with the local governments or health care taxing districts.

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

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

During the third quarter of Demonstration 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 Demonstration 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 (SFY 2005-06) by July 31, 2007. The LIP Milestone data for Year One of LIP (SFY 2006-07) 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 Demonstration 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 Evaluation team. The UF LIP Evaluation Team provided the cost-effectiveness study to the Agency by the third quarter of Demonstration Year Two (January 2008). The cost-effectiveness study is based on the measurements of the LIP Milestone reports provided by the 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 PASs 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 (Demonstration Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PASs with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency’s request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

- Primary Care Clinic Encounters
- Obstetric/GYN Encounters
- Disease Management Encounters
- Mental Health/Substance Abuse Encounters
- Dental Service Encounters
- Prescription Drug Encounters

- Laboratory Service Encounters
- Radiology Services
- Specialty Encounters
- Care Coordination Encounters

The PAS entities input the data for the pre-LIP and Demonstration 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 University of Florida 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 final 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 Demonstration Waiver, the Agency submitted a letter to federal CMS along with the LIP Program Highlights: Demonstration Year 1 (SFY 2006-07) as prepared by UF. The LIP Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to federal CMS.

In the fourth quarter of Demonstration 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 SFY 2007-08 Milestone in report from UF 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 Demonstration Year Four, the Agency reviewed the SFY 2007-08 Milestone report from UF. The Agency provided additional feedback to the UF LIP evaluation team during this quarter. The Agency looks forward to the final review the first quarter of Demonstration Year Five. The Agency will share the Demonstration Year Three data with the UF evaluation team to allow for the evaluation on Demonstration Year Three to begin.

Current Activities

The final SFY 2008-09 Milestone report from the University of Florida was received this quarter and can be accessed on the Agency's website by clicking on the link below:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

This report provides a detailed examination of LIP and LIP-related payments and services provided to Medicaid, uninsured, and underinsured individuals during Demonstration Year Three, SFY 2008-09. The report also compares summary measures for a four-year period : SFY 2005-06 (year immediately preceding the demonstration) and SFYs 2006-07, 2007-08, and 2008-09 (first three years of the demonstration).

Key Findings for SFY 2008-09:

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

J. Evaluation of Medicaid Reform

Overview

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

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

1. Evaluations Affiliated with the Agency or its Contractors

During this quarter, there were no "external" reports on the demonstration.

2. Evaluations Commissioned by Governmental Agencies

During this quarter, there were no new studies released commissioned by the governmental agencies.

3. Independent Evaluation by the University of Florida

UF continues 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 MRE contract between UF and the Agency.

During this quarter, the following areas of UF's independent evaluation conducted and/or produced reports.

University of Florida – Progress Reports on Key Aspects of the Evaluation

These semi-annual administrative reports provide summary and status information about the MRE. Progress is reported for all associated tasks identified in the work plan categorized by major evaluation subprojects. During this quarter, one progress report (July – December 2009) was finalized. This progress report has been submitted to federal CMS and is available on the Agency's website at:

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

The remaining progress report (January – June 2010) is under review with the Agency and will be submitted to federal CMS once the Agency has approved it.

University of Florida – Mental Health Analysis

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

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

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

Objective 1: A second draft for the Objective 1 report was submitted to the Agency by the researcher during the current quarterly reporting period. An approved report should be submitted to federal CMS for review towards the end of the second quarterly reporting period of Year Five.

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

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

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. This report, *An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*, addresses two years pre- and two years post implementation, and can be found on the Agency's website at:

http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_viii_d_fisca_analysis_report_07-10-09.pdf.

In follow-up to the first fiscal analyses, a preliminary draft of the multivariate analyses report: *Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analyses,* was reviewed by the Agency and sent back to UF with suggested changes. This report provides an update to the univariate report findings, and also looks at demonstration data by various subgroups (gender, race, etc.) against specific controls. During that review, some methodological problems were identified and addressed. It is anticipated that the Agency will have this report in its final stages by the end of the second quarter of Demonstration Year Five.

University of Florida – Low Income Pool (LIP)

In July 2006, the State of Florida introduced broad-ranging reform of the Florida Medicaid Program, with the establishment of the Low Income Pool (LIP) Program being one of several components of the demonstration. The LIP consists of a capped annual allotment of $1 billion (the "pool"), with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.[7] The conditions of the LIP are discussed in the Special Terms and Conditions of the waiver, as approved by the federal Centers for Medicare and Medicaid Services (CMS).[8]

In an ongoing process, UF is producing a series of reports that evaluate the LIP Program throughout the demonstration period. All evaluation studies use data on LIP-related payments as provided by the Agency, but two different data sets are used to assess the amount of services provided—data from FHURS and data from the LIP Milestone Reporting Requirements for federal CMS.

During this quarter, an *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2006-2007 Florida Hospital Uniform Reporting System (FHURS) Data* was finalized and approved by the Agency. This evaluation measures services along four dimensions—adjusted days, gross revenue, net revenue, and operating expense, in order to gain a more complete picture of the amount of services obtained from a given amount of LIP-related payments.

The report *Medicaid Reform Evaluation of the Low-Income Pool Using Milestone Data: SFY 2008-2009* was also approved during this quarter.

University of Florida – Organizational Analyses

The University of Florida is producing an ongoing series of reports that summarize organizational aspects of Florida's Medicaid Reform Pilot. Through a combination of qualitative and quantitative study designs, these reports address a broad range of structural and policy issues raised by the demonstration process. Data are collected from Agency sources and from informant interviews.

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[7] State of Florida, Agency for Health Care Administration (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml, accessed September 12, 2009).
[8] *Federal CMS Special Terms & Conditions* (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf, accessed October 26, 2007).

During this quarter, UF submitted the report, *Medicaid Reform Organizational Analyses: April 2009 – March 2010.* The Agency is currently reviewing this report. It is anticipated that a final version of the report will be available during the second quarter of Demonstration Year Five.

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. A list of the FAC members and their demographic information can be on the Agency's website at:

http://fdhcdev/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

There was no FAC meeting held during this quarter: however, a meeting will be scheduled during Demonstration Year 5.

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 on the Agency's website at:

http://mre.phhp.ufl.edu/advisorycommittees/index.htm#tac

The purpose of this committee is to, over the five-year demonstration period, provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The UF research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary or requested. The TAC meets annually over the five years of the demonstration. There was no TAC meeting held during this quarter, however, a meeting will be during Demonstration Year 5.

In addition to the TAC representatives, all project areas of the evaluation are 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 focuses 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 capitated 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 Letters and E-mails;
- Health Plan Technical and Operations Conference Calls;
- PSN Systems Implementation Monthly Conference Calls; and
- General Amendment/Contract Overview Calls.

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. In conference call forums, the focus during this quarter has been on operational updates and information exchange.

Medicaid Reform Technical Advisory Panel

There was only one Technical Advisory Panel (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 and discussed the following topics:

- Choice counseling vendor transition, including notice that the online web enrollment would go live August 30, 2010, reports on call center statistics, and a demonstration of the new system;
- Medicaid encounter data collection and risk adjustment, including the focus on the use of proprietary pharmacy data versus the National Council for Prescription Drug Programs (NCPDP) pharmacy data in the Medicaid Rx model. Discussion also included Chronic Illness and Disability Payment System (CDPS) model testing, and the Agency's intent to use a new risk adjustment contractor and transition efforts that were underway; and
- Health plan capitation rate setting and draft September 2010 rates, including discussion on data sources used, retroactive claims, budgetary inflation factors and notice that the Agency was continuing to accept comments regarding rate setting.

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

Policy Transmittals and Dear Provider Letters

During this quarter, there were no policy transmittals and three Dear Provider letters released to the health plans. The dear provider letters covered the new annual fraud, abuse and overpayment reporting required by the 2010 Legislature's addition of Section 409.91212, F.S.; clarification on vaccine administration for children in MediKids, a component of Florida's child health insurance program; and clarification regarding encounter claim submission for obstetrical kick payment services.

In addition, there were several Dear Provider e-mails providing updated information relative to the Medicaid program during this quarter. Issues addressed included:

- Changes in Medicaid physician and practitioner fee schedules;
- Extensions for the submission of benefit change requests for the 2010-11 health plan contract year; and
- Notice to PSNs that due to new statutory language in Chapter 2010-144, Laws of Florida, current Reform FFS PSNs were being provided additional time to convert to a capitated model, and that the conversion application previously due in August 2010 did not need to be submitted.

Technical and Operational Issues Conference Calls

During this quarter, the Agency conducted three monthly 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 TAP meetings and to respond to plan questions posed through e-mail, telephone inquiries, and previous technical calls. Previously these calls occurred biweekly, but with Reform being fully operational, the need for biweekly calls had significantly lessened. As discussed with the health plans in June, a decision was made to change to monthly calls beginning in July 2010. Unless a particular need arises for calls to occur more often, the technical and operations calls are now monthly.

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

Approximately 20 participants attended in person and the popularity of these calls continues to be shown by over 100 phone lines in active use on the calls. The agenda items discussed on the calls this quarter have been varied. These included:

- Several data update issues:
  - Update on outstanding fiscal agent systems change requests,
  - Third party recoupment initiatives,
  - Reminder on National Provider Identifier registration requirements, and
  - Discussion on the National Correct Coding Initiative;
- Upcoming health plan survey on electronic health records survey to identify existing electronic record initiatives that health plans and providers may already be conducting and, also, update on the Electronic Health Record Incentives grant (distrubted on ARRA) and incentives that will be implemented to assist providers in implementing electronic health record initiatives;
- Update on encounter data submissions and implementation of dashboard reports regarding health plan compliance on the Agency's website; and
- Update on Medicaid Program Integrity fraud and abuse desk reviews, surveys and reporting changes.

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 purpose of these calls is to provide a forum to discuss claims processes and enrollment file issues that are unique to the FFS PSN model. The PSNs are 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, Bureau of Contract Management, Area Office staff, and Bureau of Managed Health Care staff responsible for monitoring the health plans. PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs' contracted TPAs. During this quarter, the PSN Association requested an additional forum for unresolved issues and the Agency responded by scheduling an additional call with association members. Unresolved issues include those that are in the systems change queue for implementation and anecdotal issues pending examples to be submitted from PSNs for Agency research.

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

- Medicaid fiscal agent transition issues relative to PSN enrollees, claims remittance advice, and enrollment file formats;
- Revisions requested by the PSNs in terms of the electronic remittance advice that they receive, and

- Claims systems changes in the queue until their priority status for systems change reaches a higher priority level, including items related to Medicare crossover claims and chiropractic claims, and manual workarounds until such changes are made.

In addition to these calls, the Agency continued to coordinate technical assistance 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 couple of repeat providers. Modification of the current claims process (to streamline the claims processing function) for FFS PSNs remains under consideration.

General Amendment/Contract Overview Calls

During this quarter, amendment and contract overview discussions were handled during the regularly scheduled technical and operational issues conference calls. There were separate calls held with the plans regarding capitation rate development for the 2010-11 capitation rates.

L. Waiver Extension Request

Legislative Direction

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

Development of Waiver Extension Request

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

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

Schedule of Public Meetings				
Location	**Date**	**Time**	**FAW Notice**	**Agenda/Presentation**
Tallahassee 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL	5/21/10	1:00p.m. – 3:30p.m.	Notice	Final Agenda Final Presentation Meeting Video
Duval County The Arc Jacksonville 1050 North Davis Street Jacksonville, FL 32209	6/8/10	1:00p.m. – 3:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Broward County Broward County Health Department Main Auditorium 780 SW 24 Street Fort Lauderdale, FL 33315	6/9/10	10:00a.m. – 12:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Nassau County Nassau County Children and Family Education Center 86207 (479) Felmor Road Yulee, FL 32097	6/10/10	2:00p.m. - 4:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Clay County Clay County Agricultural Center 2463 SR 16 W	6/11/10	10:00a.m. - 12:00p.m.	Notice	Final Agenda Final Presenation Meeting Video

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

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

Submission of the Waiver Extension Request

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

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

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

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

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

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues July 1, 2010 – September 30, 2010	
PSN Informal Issue	**Action Taken**
1. A PSN member's parent reported needing follow-up care for the member but that the provider does not participate with the member's new health plan.	➲ The PSN contact reported to the Agency that they reached the member's parent and the parent selected a new provider who participates with the PSN. The PSN explained to the parent the process to obtain authorization for follow-up care and the parent will follow through. PSN staff will continue to work with the parent to ensure the care is authorized and provided. The member's parent is satisfied.
2. A PSN member reported to the Agency that a PCP would not see him because he is Muslim.	➲ Agency staff contacted the PSN member who was very verbally abusive to staff. Agency staff contacted the PCP's office to verify the member's story and was told that the member had gone to the office without an appointment and became verbally abusive and threatening to office staff. The PCP offered to see the member after seeing those with appointments, but the member left after making threats to office staff and the PCP said he is no longer willing to see the member. PSN staff identified a new PCP for the member and scheduled an appointment for him. They attempted to contact the member and left multiple messages with information about the new PCP and appointment. The member did not show up for the appointment. Agency staff successfully contacted the member the next morning, who confirmed that he received the information but did not want to see that PCP. The member refused to call the PSN to get another PCP and instead called a Department of Health (DOH) office demanding assistance. DOH staff referred the issue back to the Agency, and Agency staff conducted a three-way call with the member and the PSN. The member was referred to another PCP, an appointment was made, and transportation was arranged.
3. A PSN member's parent reported to the Agency that the PSN was unresponsive to requests for assistance to arrange for necessary health care.	➲ The PSN contact reported that the member's parent was contacted by a PSN case manager, who helped coordinate care for the member. The member's mother is satisfied with the PSN's response.

PSN Complaints/ Issues July 1, 2010 – September 30, 2010	
PSN Informal Issue	**Action Taken**
4. A PSN member reported that the PSN is not providing necessary home health services.	➲ The PSN contact reported to the Agency that the member is receiving services from a waiver program. The PSN has coordinated a plan of care with the waiver agency and a full schedule of necessary services is now in place. The PSN contact reported that the member's parent has been released from the hospital and will again provide a portion of the member's care. The member and her family are satisfied.
5. A PSN member's parent reported to the Agency that the member needs a specialist but that the parent was unaware that the member was assigned to a new health plan.	➲ The PSN contact reported to the Agency that a case manager worked with the family and an authorization was issued so that the member could see the specialist they had previously selected. The member's parent is very pleased.
6. A provider reported to the Agency that the PSN's dental subcontractor did not pay claims for services and that the subcontractor claimed the members were not covered by the PSN on the date of service.	➲ Agency staff found that the members were covered by the PSN at the time of service. The PSN and its dental subcontractor reported to the Agency that the dental provider is not in the network but that they will research it further. The PSN reached out to the member to ensure that the member has an in-network dentist.
7. A PSN member reported that she was unable to see a provider because the PSN denied the provider's previous claims.	➲ Agency staff checked the Medicaid Management Information System, which showed that the member had Medicare coverage, although the member stated she does not. A DCF contact reported to the Agency that Medicare coverage was erroneously added to the member's file and would be removed. Agency staff notified the PSN and the provider that this error was being corrected. The PSN contact reported that the provider's claims were resubmitted for payment and the provider was notified.
8. A PSN member's parent reported that she cannot obtain a timely appointment with a PSN network specialist.	➲ The PSN contact reported to the Agency numerous attempts to reach the member's parent have failed because the call always goes to voicemail and the mailbox is full. The PSN issued authorization for the member to see the specialist she needs but was unable to get through to the parent with the information. PSN staff located another phone number for the parent and contacted her with the authorization information. The member's parent is satisfied.
9. A PSN member reported to the Agency that she was erroneously assigned to the PSN and the PSN has been unable to arrange for care that she needs.	➲ The PSN contact reported to the Agency that care was authorized for the member. The member disenrolled from the PSN the next month and is now back in fee-for-service Medicaid.

PSN Complaints/ Issues July 1, 2010 – September 30, 2010	
PSN Informal Issue	**Action Taken**
10. A PSN member's parent reported to the Agency that the member was unable to obtain needed medications from the PCP in the PSN.	➲ The PSN contact reported to the Agency that the PCP was unable to prescribe medications due to member's condition, and, instead provided an alternative medication, referred the member to a pain management provider and other specialists to assist the member.
11. A PSN member reported being balance billed by providers she had been seeing before the plan converted from an HMO to a PSN.	➲ The PSN contact reported to the Agency that further research showed the member is dual eligible and has Medicare coverage. Therefore, crossover claims were denied. The PSN advised the providers not to balance bill the member because the amount paid by Medicare exceeded the Medicaid allowable rate. The member is satisfied.
12. A provider contacted the Agency with questions regarding billing and claims being denied by the PSN.	➲ The PSN contact reported to the Agency that its Claims Director has communicated with the provider regarding denials and the claims will be reprocessed. Agency staff confirmed this with the provider.
13. A PSN member's parent reported to the Agency that the member was erroneously disenrolled from her previous plan and auto-assigned to another PSN. The member has appointments for evaluation and treatment with providers who do not participate with the member's current PSN.	➲ Agency staff contacted both PSNs (the previous and current) and decided the quickest way to remedy the situation was to ask for a segment update in the Medicaid Management Information System to get the member into the previous PSN immediately. The segment update was done immediately and the member's parent was notified that she could take the member to the scheduled appointments.
14. A PSN member's parent reported being unable to obtain information on network providers and said that PSN staff treated him rudely.	➲ The PSN contact reported to the Agency that their staff member said the member's parent had been rude to her. The PSN had already mailed the provider directory to the member and an appointment was made for the member with a network dermatologist. PSN staff notified the parent and the parent thanked them for responding so quickly.
15. A PSN member's parent reported needing a specialist but not being able to get a good referral from the PSN.	➲ The PSN contact reported that a case manager had been in touch with the member's parent and a specialist and arranged an appointment. The parent stated that the appointment time was inconvenient for her so the PSN rescheduled the appointment. The parent is satisfied.
16. A PSN member contacted the Agency because he needs a wheelchair and did not understand that he needs to go through the PSN to get one.	➲ The PSN contact reported that a case manager contacted the member and has been working with him. An evaluation was in progress to determine the type of custom wheelchair the member needs and he will also be evaluated for possible physical therapy needs.

PSN Complaints/ Issues July 1, 2010 – September 30, 2010	
PSN Informal Issue	**Action Taken**
17. A PSN member's parent reported to the Agency that the member needs surgery but the specialist does not participate with the PSN.	➲ The PSN contact reported that a case manager has been working with the specialist provider. The specialist accepted an out-of-network agreement with the PSN. The PSN reviewed the clinical notes and approved the procedure and notified the member's parent.
18. A PSN member's sister reported to the Agency that surgery scheduled for the member may not be authorized by the PSN.	➲ The PSN contact reported that authorization was given for the surgery 10 days prior to the member's sister calling the Agency. Agency staff and PSN staff contacted the member's family to notify them that the surgery was approved and should proceed on schedule. The PSN also confirmed that all recommended follow-up care will be authorized by the plan.
19. A PSN member's parent reported to the Agency that the member needs to see a specialist who is not in the PSN's network. The parent said the member was supposed to move to a new plan so he could see the specialist but the new enrollment was cancelled due to a problem in the system.	➲ The PSN contact reported to the Agency that after talking to the member's parent, it was ascertained that the specialist requested is actually in the PSN network. PSN staff advised the parent to obtain authorization from the member's PCP so that the member may see the specialist. The member's parent still would like to change plans for the member, so Agency staff is working on this. The parent is satisfied.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
1. An HMO provider reported to the Agency that claims for urgent care services are being denied incorrectly.	➲ Agency staff contacted HMO staff to look into the reason for the claims denial. The HMO's claims department pulled and checked the claims underpayments. The HMO repaid the amount requested by the provider.
2. An HMO member's parent reported to the Agency that the HMO is not paying the member's claims for hospital services and services from a non-network provider.	➲ The HMO contact reported to the Agency that they were in contact with the member's parent and gathering information on the unpaid claims. The member's parent selected a network provider as the member's new primary care provider (PCP). HMO staff determined that all the unpaid claims are for the provider, there were no hospital claims. The provider had not submitted any claims to the HMO, so the plan requested that the provider do so for review and determination. The HMO paid the provider's claims for the time that the member was in the hospital. HMO staff notified the provider and the member's parent that subsequent office visit claims were denied because the provider knew that the beneficiary was a member of an HMO with which the provider does not participate.
3. An HMO member reported being unable to obtain a benefits packet and ID card because the HMO has the wrong home address on file.	➲ The HMO contact reported to the Agency that the member's address has been corrected and a benefits packet and ID card have been sent to the member. The HMO notified the member.
4. An HMO member reported being unable to fill a prescription at a pharmacy.	➲ Agency staff contacted the HMO staff, who called the pharmacy to complete the refill from the member's specialist.
5. An HMO member reported to the Agency that she has heart and kidney problems and is having problems accessing services. When she tried getting services at Shands Jacksonville she was told to go to Gainesville.	➲ Agency staff contacted the HMO to have them research why the member was unable to receive proper care. HMO staff found that the member was unknowingly switched to another health plan. The member called the counseling line and the HMO worked to get her medical needs met.
6. An HMO member complained that her PCP's referral to an endocrinologist was done in April but the provider facility informed her that no appointments are available until January 2011.	➲ Agency staff contacted the HMO to find an earlier appointment for the member. The HMO contacted several providers and was able to set up a specialist appointment for the member at the end of August. The member is satisfied.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
7. An HMO member reported to the Agency that she was erroneously assigned to the HMO and could no longer access services from her regular PCP.	➲ The HMO contact reported that they contacted the member's provider, who agreed to accept out-of-network authorization and payment. The member was able to make an appointment with the provider and the member is satisfied.
8. An HMO member reported to the Agency that he is having problems getting prescriptions filled every month.	➲ The HMO's subcontracted behavioral health organization worked with the member and reported to the Agency that the member was able to fill his prescription and was referred for case management services.
9. An HMO member's parent reported being denied transportation services by the HMO's subcontractor.	➲ The HMO contact worked with the member's parent and made an immediate transportation appointment for the member. The member's parent is satisfied and grateful for the quick resolution.
10. An HMO member reported being unable to obtain authorization for medications from the HMO.	➲ The HMO contact reported to the Agency the full case summary for the member. The prior authorization documentation from the prescribing physician did not support the continued use of narcotic pain medications, and the member's PCP (who was not the prescribing physician) did not support the request for the medication and had been unaware that another physician had prescribed them for the member. Based on this information, the HMO denied authorization for the medications. HMO staff have attempted to reach the member to explain the reasons for the denial but have been unable to reach the member.
11. An HMO member reported being unable to obtain services because the HMO records show that she is no longer active in the HMO.	➲ The HMO contact reported to the Agency that its files were corrected and the member is now active. HMO staff notified the member that she could begin obtaining services immediately.
12. An HMO member's parent reported to the Agency that she wants the member exempted from managed care due to issues involving obtaining necessary services.	➲ The HMO contact reported to the Agency that a case manager contacted the member's parent and determined that the real issue is that the member needs oral surgery. The HMO worked with an oral surgeon and provided authorization for the surgery. The provider and the member's parent arranged an appointment and the parent is satisfied.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
13. An HMO member reported to the Agency that he was unable to obtain necessary medications through the HMO.	➲ The HMO contact reported to the Agency that the member has been provided with several drugs but that others are not on the formulary and require generic alternatives or approved prior authorization requests. HMO staff explained this to the member in the past and continue to work with the member's providers to obtain necessary information. After receiving the necessary information, the HMO approved the medications. The member obtained the medications and is satisfied.
14. An HMO member's brother and legal representative contacted the Agency and reported that the member is being sued for unpaid claims but is not competent to deal with the issue.	➲ The HMO contact reported to the Agency that its claims unit researched the unpaid claims and contacted the hospital to resubmit the primary claim, which the HMO then paid. The hospital ordered the collections agency and law firm to drop collection efforts. HMO staff notified the member's brother that the claims issue is resolved and that collection efforts will cease. The member's brother was told to contact the HMO directly if additional issues with this situation arise.
15. An HMO member who is dual eligible reported being billed by a provider for the balance on crossover claims.	➲ The HMO contact reported to the Agency that after multiple calls to the provider, the balance on the member's statement was adjusted to zero. The HMO notified the member of this.
16. A provider reported to the Agency that her claims were denied for services for a former member of the HMO.	➲ The HMO contact reported to the Agency that their claims unit reviewed the claims and determined that the original denials were valid. Therefore, the claims will continue to be denied. HMO staff informed the provider of this.
17. An HMO member's adoptive parent reported not being allowed to choose a provider for the member because the HMO subcontractor claims she is not the legal guardian.	➲ The HMO contact reported to the Agency that the subcontractor contacted the member's parent and updated their file. The HMO helped the parent select a dental provider for the member and the parent is now satisfied.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
18. An HMO member's parent reported to the Agency that the HMO has no specialist that can treat the member and wanted to change plans.	➲ The HMO contact reported to the Agency that the member's parent has not returned messages from the plan. The member's PCP's office staff reported that they were able to reach the member's parent and referred the member to a specialist. The specialist referred the member's parent back to the PCP's office with information on a surgeon, so that staff could assist the parent in making arrangements for treatment. The parent tried to make an appointment with the surgeon independently and was turned away. HMO staff worked with the parent, who now understands the process and will work through the PCP's office to make arrangements. The parent is satisfied.
19. An HMO member's legal guardian reported being unable to select a provider because her name does not appear as the payee in the HMO's member file.	➲ The HMO contact reported to the Agency that the HMO confirmed the legal guardian's name with the dental subcontractor. The HMO worked with the member's guardian to select a dental provider.
20. An HMO member reported to the Agency that she could not obtain a referral to a specialist through the HMO.	➲ The HMO contact reported to the Agency that they worked with the member and a specialist she had seen when she had different insurance. An out-of-network agreement was made with the specialist and the member received the referral. The member is satisfied.
21. An HMO member reported being advised by the HMO that necessary services were not covered.	➲ The HMO contact reported to the Agency that a case manager contacted the member immediately and made arrangements for home health services and equipment the member needed.
22. An HMO member's mother reported to the Agency that the member's specialists and hospital are not in the HMO network, and that his scheduled surgery is thus in jeopardy.	➲ The HMO contact reported to the Agency that they reviewed the member's medical records to assess his health situation. After conferring with the member's mother, HMO staff determined that the providers are in the HMO network. An HMO case manager coordinated care planning and arranged for home health services for the member. The member and parent are satisfied.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
23. An HMO member's PCP reported to the Agency that the member needs a transplant procedure but that the facility to which he was referred does not participate with the HMO.	➲ The HMO contact reported that a case manager spoke with the member and the PCP and determined that the member is not scheduled for a transplant. The member is actually scheduled to be assessed by a specialist. Several different courses of treatment will be considered and more will be known after the specialist's assessment. The member, PCP, and specialist will be working with the HMO case manager to ensure proper follow through.
24. An HMO member's niece (the payee) reported that she could not get the member's medication filled at the pharmacy due to the lack of a "prescription drug card." She stated that the HMO did not provide her with help initially and that the member had to go for several days without her medication. The member now has the medication but still does not have the card or know how to get it, and the niece is worried about getting future medications without it.	➲ The HMO contact reported to the Agency that the member's prescription drug plan with them terminated at the end of May and that she has a new plan. A new card had been sent to the member but to a different address. HMO staff reached out to the member to provide the number to call to change her address and have the card mailed to her. The member was given the card number to use until the actual card arrives.
25. An HMO member reported to the Agency that the HMO changed his medications without his consent and refused to replace a broken piece of equipment.	➲ The HMO contact reported that HMO staff previously advised the member that it is Medicaid policy to provide generic alternatives unless the member's physician submits a prior authorization request showing medical necessity for a brand name drug. The member's physician did not submit any prior authorizations for the member. HMO staff also reported that the member's glucose monitor was not actually broken—the member wanted a brand sold in a chain pharmacy instead of the one provided to him by the HMO's DME provider. The HMO stands by the services provided to the member and thoroughly explained this to the member.
26. A provider reported to the Agency that he has been having trouble getting claims paid by the HMO in a timely manner since last year.	➲ The PSN contact reported to the Agency that they are working with the provider to resolve this issue. The Agency will continue to monitor this issue until it is resolved.
27. Provider office staff reported to the Agency that a claim was denied by the HMO because the provider was out of network.	➲ The HMO contact reported to the Agency that an out-of-network agreement was reached with the provider and the claim will be resubmitted for payment. HMO staff advised the provider of this and contacted the member's parent so that she understood that the member was now assigned to a network provider for future care.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
28. A provider reported to the Agency that claims for services to a member were denied because the HMO files showed that the member was not active on the date of service.	➲ The HMO contact reported to the Agency that they are working with Agency headquarters staff to get information to correct their member files so that the claims can be resubmitted for payment. HMO staff will contact the provider when the system is ready to process the claims correctly.
29. An HMO member's parent reported that the member's Medicaid claims are denying because the HMO says he has third party liability (TPL). The parent says the member does not have TPL.	➲ The HMO contact reported that the member shows up as having TPL in their system. The Agency's TPL unit did not find any TPL for the member and determined that the HMO confused the member with another individual with the same name. HMO staff reported that the member's file was corrected and that the provider's claims are being paid.
30. Provider office staff reported to the Agency that the HMO stated that members seeking services are not in the HMO.	➲ The HMO reported to the Agency that its coordinator attempted to contact the dental office that afternoon to confirm that the members were eligible but the office was closed. The HMO coordinator will continue to reach out to the provider's office.
31. An HMO member reported to the Agency that the HMO is not providing her with a specialist she needs to see after having been in the hospital and that the HMO is requiring that she redo all of the tests that she had done in the hospital.	➲ The HMO contact reported to the Agency that its case manager began outreach to the member a week before the member called the Agency. The case manager contacted the member's non-participating provider, who treated the member in the hospital, and found that the provider's notes do not indicate that a specialist was suggested for the member or that any repeat testing was required. The case manager gave the provider her contact information so that she could be of assistance in the future. The HMO's Provider Services unit reached an out-of-network agreement with the provider until the member can be transitioned to her in-network PCP. The case manager notified the member of this information and encouraged the member to call her if she needs assistance with coordinating visits with specialists.
32. An HMO member reported to the Agency that the HMO was unable to provide him with a referral to a specialist.	➲ The HMO contact reported to the Agency that an appropriate specialist referral was obtained. HMO staff notified the member and the member's PCP so that an appointment could be scheduled.

HMO Complaints/Issues July 1, 2010 – September 30, 2010	
HMO Informal Issue	**Action Taken**
33. An HMO member's parent reported that the HMO was unable to provide a good specialist referral and that the member needs surgery.	➲ The HMO contact reported to the Agency that the HMO scheduled an appointment for the member with the surgeon identified by the member's mother, but that she has not returned their calls. HMO staff reached the mother and informed her of the scheduled appointment. The mother is very satisfied.
34. An HMO member reported to the Agency that she wants to be exempted from managed care assignment because she needs a procedure and her physician is not a Medicaid provider.	➲ The HMO contact reported that HMO staff spoke to both the member and the provider and the provider agreed to accept the Medicaid rate for doing the procedure. The HMO case manager advised the member that the HMO will work with her to get the procedure done with the provider she wants. HMO staff have told the member that they will work with her to obtain the services she needs.
35. A provider's office reported to the Agency that the HMO denied a necessary medication for a member.	➲ The HMO contact reported to the Agency that its lead pharmacy technician said they reversed the medication because their system did not show that the HMO had approved the medication. The HMO's medical director worked with the member's provider and determined that the medication is necessary and it was approved. HMO staff notified the provider and the member's mother that the medication was approved and could be picked up at the pharmacy.
36. An HMO member reported to the Agency that she is unable to obtain medications because the HMO does not show her in their member database.	➲ The HMO contact reported to the Agency that their member database was updated. HMO staff contacted both the member and the pharmacy to authorize release of the medications. The member was very pleased with the quick resolution.
37. An HMO member reported to the Agency that he was unable to obtain medications because the HMO does not show him as being an active member.	➲ The HMO contact reported to the Agency that its member database has been updated. HMO staff contacted the member and advised him that his member materials are in the mail and he could obtain his medications now. The member was very pleased.

Attachment III
Description of Opt Out Enrollees

A description of the Opt Out enrollees is provided below.

1. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the second quarter of Demonstration Year One on October 1, 2006. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.

2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on January 1, 2007. The father has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.

3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.

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

5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her

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

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

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

8. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended on September 30, 2009. As a result, the children were disenrolled from the Opt Out Program. The mother re-enrolled her children in the Opt Out Program during the fourth quarter of Demonstration Year Four on April 1, 2010 (Item Number 45).

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

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

disenrolled from her employer's health insurance plan effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.

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

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

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

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

33. The caller began the process to enroll herself and her two children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to

pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended effective June 30, 2009. As a result, the mother and child were disenrolled from the Opt Out Program. The other child remained eligible and enrolled in the Opt Out Program. The mother has now discontinued her employer's health insurance plan due to high cost and now she is looking into private insurance. As a result, the other child has also been disenrolled from the Opt Out Program effective January 27, 2010.

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

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

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

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

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

39. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on August 1, 2009. The mother has health insurance available through her employer. The mother elected to use her

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

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

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

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

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

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

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

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

47. The caller began the process to enroll her child in the Opt Out program during the fourth quarter of Demonstration Year Four. The effective date for enrollment was during the fourth quarter of Demonstration Year Four on June 1, 2010. The mother of the child did not enroll her child in her employer's insurance. As a result, the child has been disenrolled from the Opt Out Program.

48. The caller began the process to enroll his two children in the Opt Out program during the fourth quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Five on July 1, 2010. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.

49. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Five. The effective date of enrollment was during the first quarter of Demonstration Year Five on September 1, 2010. 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.

Attachment IV
2010 Managed Care Performance Measures

Bold = Better than the national mean

	Non-Reform*			Reform*		
Measure	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**
Annual Dental Visit	n/a	n/a	25.5%	15.2%	28.5%	33.4%
Adolescent Well-Care	41.9%	**46.0%**	**45.7%**	**44.2%**	**46.5%**	**46.3%**
Controlling Blood Pressure	52.7%	51.6%	**53.0%**	46.3%	**55.9%**	**53.4%**
Cervical Cancer Screening	56.6%	53.8%	55.3%	48.2%	52.2%	50.8%
Diabetes – HbA1c Testing	74.7%	75.1%	76.4%	**78.9%**	**80.1%**	**82.8%**
Diabetes - HbA1c Poor Control INVERSE	48.5%	51.7%	46.4%	**48.3%**	46.8%	44.9%
Diabetes - Eye Exam	36.3%	41.9%	48.3%	35.7%	44.0%	45.4%
Diabetes - LDL Screening	**75.6%**	**76.3%**	**77.9%**	**80.0%**	**80.2%**	**83.5%**
Diabetes - LDL Control	29.5%	29.4%	**33.8%**	29.3%	**35.9%**	**36.1%**
Diabetes – Nephropathy	**77.1%**	**76.1%**	**77.1%**	**79.2%**	**80.3%**	**81.9%**
Follow-Up after Mental Health Hospital – 7 day	30.5%	37.2%	24.2%	20.6%	29.3%	25.4%
Follow-Up after Mental Health Hospital – 30 day	47.0%	51.7%	41.4%	35.5%	46.6%	41.3%
Prenatal Care	71.7%	69.1%	69.5%	66.6%	67.4%	75.2%
Postpartum Care	58.5%	50.1%	52.7%	53.0%	51.5%	52.1%
Well-Child First 15 Months – Zero Visits INVERSE	**2.8%**	**3.0%**	4.2%	4.9%	**1.6%**	6.0%
Well-Child First 15 Months – Six Visits	44.0%	51.0%	46.1%	44.4%	49.3%	35.4%
Well-Child 3-6 years	**71.1%**	**72.5%**	**74.9%**	**71.3%**	**75.7%**	72.7%
Adults' Access to Preventive Care – 20-44 Years	n/a	69.3%	67.9%	n/a	71.8%	71.2%
Adults' Access to Preventive Care – 45-64 Years	n/a	82.2%	81.2%	n/a	**84.7%**	**84.9%**
Adults' Access to Preventive Care – 65+ Years	n/a	**74.7%**	66.9%	n/a	**83.6%**	**83.7%**
Antidepressant Medication Mgmt – Acute	n/a	**45.6%**	**46.8%**	n/a	**52.0%**	**56.3%**
Antidepressant Medication Mgmt -- Continuation	n/a	**31.2%**	**29.2%**	n/a	**29.8%**	**43.8%**
Appropriate Medications for Asthma	n/a	**87.0%**	**87.0%**	n/a	83.6%	**87.6%**
Breast Cancer Screening	n/a	47.5%	**50.1%**	n/a	**51.4%**	**56.9%**
Childhood Immunization Combo 2	n/a	61.8%	71.4%	n/a	63.6%	70.0%
Childhood Immunization Combo 3	n/a	52.0%	63.7%	n/a	53.8%	62.7%
Frequency of Prenatal Care	n/a	51.6%	54.3%	n/a	52.6%	46.9%
Lead Screening	n/a	46.0%	53.1%	n/a	54.8%	52.0%
Adult BMI Assessment	n/a	n/a	**31.2%**	n/a	n/a	**41.9%**
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	n/a	n/a	**37.8%**	n/a	n/a	**43.6%**
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance	n/a	n/a	**46.6%**	n/a	n/a	n/a

* Data are submitted to the Agency by HMOs and PSNs and are audited by NCQA-Certified HEDIS auditors. Data does not include Medicaid FFS or MediPass.

** National Mean as published by NCQA, Medicaid product line.

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