Florida Medicaid Reform

Quarterly Progress Report
October 1, 2006 – December 31, 2006

1115 Research and Demonstration Waiver

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I. Waiver History

Background

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

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

Key components of Medicaid Reform include the following:

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

Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the second quarterly report for the period of October 1, 2006 through December 31, 2006. In addition to outlining the events that occurred during the second quarter of operation, the report provides a high level summary of pre-implementation and first quarter activities to ensure that there is a full accounting of activities.

II. Status Update of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Background

All health plans, including current contractors wishing to participate as Medicaid Reform health plans, were required to complete the Medicaid Reform Health Plan Application. One application was developed for both capitated applicants and fee-for-service (FFS) PSN applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition all plans were required to submit a Customized Benefit Plan for approval as part of the application process.

Under the open application process, there was no official due date for submission in order to participate as a plan in Broward or Duval County. Instead the Agency provided guidelines for submission dates in order to ensure contracting by July 1, 2006. Prospective plans were informed that they had to submit a completed application by April 17, 2006, in order to be considered for a July 1, 2006, effective date. The Agency received 14 applications by April 17, 2006, and another four after that date for a total of 18 applications. Seventeen of the 18 applicants sought to provide services to the TANF and SSI population; one application sought to render services as a specialty PSN. The Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in both Duval and Broward Counties.

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

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/17/06	06/29/06
Universal Health Care	HMO	X	X	04/17006	**11/28/06**
Humana	HMO	X		04/14/06	06/29/06
Phytrust dba Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom	HMO	X		04/14/06	***Pending***
Total Health Choice	HMO	X		04/14/06	06/07/06

Table 1 (Continued) Health Plan Applicants					
Plan Name	**Plan Type**	**Coverage Area** **Broward**	**Duval**	**Receipt Date**	**Contract Date**
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	06/29/26
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children Medical Services Network, Florida Department of Health	PSN	X	X	04/21/06	**11/02/06**
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	***Pending***

Current Activities

As of October 1, 2006, the beginning of the second quarter of operation, the Agency contracted with 14 health plans of which 9 are HMOs and 5 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date listed in Table 2 represents the date when the plan is available as a choice but does not represent the date on which the plan receives enrollment. Since October 1, 2006, the State entered into 2 additional contracts with 1 PSN, Children's Medical Services Network and 1 HMO, Universal Health Care. The Children's Medical Services Network is the first approved specialty plan to serve children with chronic conditions. As of December 31, 2006, the Agency has a total of 16 Reform health plans under contract. Two applications are still under review. Table 1 indicates the pending contracts. The Agency anticipates 1 additional HMO and PSN will be approved in the next quarter.

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area** **Broward**	**Duval**
AMERIGROUP Community Care	07/01/06	HMO	X	
Health Ease	07/01/06	HMO	X	X
Staywell	07/01/06	HMO	X	X
Preferred Medical Plan	07/0106	HMO	X	
United HealthCare	07/01/06	HMO	X	**X**
Humana	07/01/06	HMO	X	
Phytrust dba Access Health Solutions	07/21/06	PSN	X	**X**
Total Health Choice	07/01/06	HMO	**X**	

Table 2 (Continued) Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area** **Broward**	 **Duval**
South Florida Community Care Network	07/01/06	PSN	X	
Buena Vista	07/01/06	HMO	X	
Vista Health Plan SF	07/01/06	HMO	X	
Florida NetPASS	07/01/06	PSN	X	
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X
Pediatric Associates	08/11/06	PSN	X	
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	
Universal Health Care	12/01/06	HMO	X	X

2. Benefit Package

Background

A key aspect of Reform is a plan's ability to create a customized benefit package targeted to a specific population. Specifically, under Reform capitated plans were provided the opportunity to create a customized benefit package by varying the amount, duration and scope of services for non-pregnant adults. Capitated plans can also vary the copayments and provide coverage of additional services to customize the benefit packages. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package but could eliminate or reduce the copayments and offer additional services.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the customized benefit packages to ensure that they were actuarially equivalent and sufficient coverage was provided for all services. To develop the evaluation, the Agency defined the target populations as Family and Children, Aged and Disabled, Children with Chronic Conditions, and Individuals with HIV/AIDS. The Agency then developed the sufficiency threshold for specified services. The Agency identified all services covered by the plans and classified them into three broad categories as follows: covered at the State Plan limits; covered at the sufficiency threshold, and flexible. For those 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 made available a data book on April 10, 2006, to ensure the plans were familiar with the required coverage thresholds. The data book provided historic FFS

utilization data for all of the target populations. This information assisted prospective plans in quickly identifying the specific coverage limits required to meet a specified threshold. Table 3 provides a summary of services categorized as sufficiency tested services. The table provides the threshold of historical utilization required for each population and the respective coverage limit in order to be approved.

Table 3
Sufficiency Tested Services

Sufficiency Tested Services	Threshold Percentage	Unit (TANF)	Unit (SSI)	Dollars (TANF	Dollars (SSI)
Hospital Outpatient Services (Not Otherwise Specified)	98.5%			$ 146	$ 843
Home Health Services	99.85%	2	36	$ 82	$ 1,338
Durable Medical Equipment	98.5%			$ 57	$ 3,674
Pharmacy	98.5%	9 per month/ 56 per year	16 per month / 160 per year	$ 5,312	$ 24,473

A Plan Evaluation Tool (PET) was developed by the Agency for use in evaluating plan benefit packages. In addition, the Agency released an online version of the PET. The tool allowed a plan to obtain a preliminary determination as to whether it would meet the Agency's actuarial equivalency and sufficiency tests before submitting the benefit package. The PET was revised on May 26, 2006, to reflect the Legislature's decision to restore adult vision and adult hearing services and the addition of an adult partial dentures program to the standard Medicaid benefit.

Current Activities

During the second quarter, Universal Health Care was the only capitated health plan approved and authorized to offer a customized benefit. Universal Health Care was approved to operate in Broward and Duval Counties for the SSI and TANF populations. The plan elected to vary the amount of its services specific to the populations. The plan also chose to waive or decrease the copayment amounts required for some select services. The expanded benefit the plan offered was the over-the-counter drug benefit of $10 per household, per month.

The Agency also approved the Children's Medical Services Network to operate in Broward County, which is the State's first specialty plan to serve children with serious medical, developmental, behavioral or emotional conditions. The Children's Medical Services Network chose the FFS reimbursement payment methodology and could not develop a customized benefit package. The plan's cost sharing is consistent with the FFS limits for children.

The health plans are able to change their benefit packages on an annual basis only. Therefore, as new plans are approved, the plan may create a benefit package that differs from the plan's previous approach. New beneficiaries, who have not made a

choice or who are still in their open enrollment period, may select a new plan with a different benefit package. However, previously approved benefit packages will remain unchanged until the next contract year, starting September 1, 2007.

3. Grievance Process

Background

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

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

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

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

Current Activities

During the second quarter, no formal grievances have been filed with the Agency for HMO or FFS PSNs. The second quarterly report on enrollee (or provider) grievances and appeals is due to the Agency February 15, 2006. The Agency will provide a summary of results in the next quarterly report.

4. Other Operational Issues

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

During this quarter, the Agency refined several of the mechanisms instituted to facilitate the communication and resolution of Reform issues which included:

- Restructuring the Project Management Teams by modifying the team membership and adding new teams such as the County Readiness team and the Systems team. The County Readiness Team was created to provide recommendations regarding Reform roll-out to additional counties; and the Systems team was created to ensure that any on-going systems issues are addressed under the new Medicaid fiscal agent system being implemented in March 2008.

- Continuously updating the Medicaid Reform website to ensure the public, including beneficiaries and interested providers, have a place to obtain the most recent information available. Such information includes the Reform outreach meeting schedules for both Duval and Broward Counties, plan evaluation tool link, and Reform application frequently asked question documents.

The Reform issues that were brought forward for resolution this quarter included:

- Amending the health plan contracts to address rate changes and clarifications to enhanced benefit program requirements.

- Refining the health plan application process for Baker, Clay and Nassau Counties to ensure that plans would be available to the affected beneficiaries.

- Modifying the transition process for children with chronic conditions, who are currently enrolled in a non-reform health plan or MediPass, in order to ensure a smooth transition for this vulnerable population, while also ensuring that the Choice Counseling system and help line would not be impacted beyond contract capacity.

- Designing systems changes as overlap and inconsistencies were identified to ensure each operational area was addressed.

- Providing additional technical assistance through regularly scheduled conference calls with the Reform plans to provide additional information on particular implementation topics such as: provider file transmission, encounter data submission, enhanced benefit design, performance measures and claims file submissions.

- Conducting public workshops with the health plans and all interested stakeholders to obtain input on proposed Reform health plan performance measures including Agency-defined disease management measures.

- Refining the transition process for the current health plan population and MediPass population located in Baker, Clay and Nassau Counties into Reform plans, allowing appropriate time frames for choice and ensuring the Choice Counseling system and help line would not be impacted beyond contract capacity.

- Editing the call center and field scripts and re-designing the Choice Counseling enrollment packet as a result of feedback from the focus groups with beneficiaries.

Outreach Activities for Baker, Clay, & Nassau Counties

Communication with the community stakeholders in Baker, Clay, and Nassau Counties is critical to the successful expansion of Medicaid Reform into these rural communities. In October 2006, the Agency began hosting meetings for stakeholders in Baker, Clay, and Nassau Counties and will continue to conduct various outreach activities in these counties during the next several quarters. The Agency's headquarters staff in conjunction with our Medicaid Area Office staff conducted these outreach meetings.

The Agency primarily targeted the outreach meetings to beneficiaries and providers. The list of topics covered during the outreach meetings is below. Attachment 1 shows a detailed list of this quarter's outreach meetings, the target audience, the meeting location, and the number of attendees. For the list of outreach meetings provided to beneficiaries and providers located in Broward and Duval Counties, refer to the first Medicaid Reform quarterly report.

~ General Overview of Medicaid Reform
~ Choice Counseling
~ Rural Provider Service Network Start-Up Funds
~ Unique Needs in Rural Areas
~ Rate Setting
~ Risk Adjusting
~ Data Book
~ Demonstration of the Plan Design Evaluation Tool
~ FFS PSN Reconciliation Process
~ Technical Assistance for Filling out the Application
~ Choice Counseling and Plan Responsibilities
~ Marketing of Plans Under Reform

B. Choice Counseling Program

Current Activities

Focus Groups

At the beginning of the second quarter of operation, the Agency and the Agency's Choice Counseling vendor, Affiliated Computer Services (ACS), began the process of collecting the first feedback on the Choice Counseling process in Broward and Duval Counties. The first step in the process was to conduct focus groups with beneficiaries who had engaged in the Choice Counseling process in Broward and Duval Counties.

The meetings were facilitated by representatives from the Agency's consulting group, Alicia Smith & Associates. The Agency felt that a non-Medicaid facilitator might encourage attendees to participate fully in the meeting and not feel that the information shared could somehow have a negative impact. The focus group questions concentrated on the beneficiaries' experience with the Choice Counseling Program, beginning with the first mailing of materials through enrollment or auto-assignment to a plan. Extensive notes and an audio tape from each meeting were reviewed and discussed by the Agency and ACS. As the second quarter came to a close, the Agency and ACS were in process of editing the call center and field scripts and re-designing the Choice Counseling enrollment packet as a result of feedback from the focus groups.

Transition

During the second quarter, the transition of current non-reform health plan or MediPass beneficiaries into Reform plans continued. At the end of the first quarter, 7,604 Medicaid beneficiaries were enrolled in Reform health plans. During the first quarter, the transition primarily consisted of the transition of MediPass and Provider Service Network enrollees. As the second quarter began the transition of the Provider Service Network enrollees was completed and an increase in the transition of the non-reform HMO members into Reform health plans began. In addition, in November 2006, the first Medicaid Reform specialty plan, Children's Medical Services Network PSN, became operational in Broward County. The transition process was expanded to include 100 percent of the specialty plan's non-reform enrollees.

As the second quarter ended, over 106,000 Medicaid beneficiaries were enrolled into Reform health plans. The following numbers show the number of transition packets sent during the second quarter:

- October 2006: 16,034 Mandatory Packets and 774 Voluntary Packets
- November 2006: 17,032 Mandatory Packets and 0 Voluntary Packets
- December 2006: 13,275 Mandatory Packets and 1,481 Voluntary Packets

Call Center

During the second quarter, the Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida continued to operate both a toll-free number, as well as a number for the hearing impaired callers and a language line to assist with calls in over 100 languages. The hours of operation remained 8:00 a.m. – 7:00 p.m., Monday – Friday and 9:00 a.m. – 1:00 p.m. on Saturday with 43 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

The biggest change for the call center during the second quarter was the creation of a special needs unit. The special needs unit was instituted in November 2006 and is currently staffed by one Registered Nurse. The primary purpose of the special needs unit is to assist beneficiaries with complex medical needs in selecting a Medicaid reform health plan that best fits their needs. When a beneficiary is identified by a Choice Counselor as having complex or special medical needs, the special needs unit will take over the choice counseling function. Through three-way calls with the health plans to discuss benefit packages, limitations and prescription drug formularies and provider searches, the nurse will provide expertise and knowledge of medical conditions to better help the beneficiary understand the choices available.

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

While the call volume in the second quarter remained high, ACS continued to meet and exceed the contract standards as required by the Agency. Attachment II details the call center activity for the entire second quarter. The following is a highlight of the call volume during the quarter and ACS's performance on key contract standards:

Inbound Calls: 50,869
Outbound Calls: 11,738

Calls Abandoned: 1%
(The contract standard is <5% monthly)

Calls Answered within 4 rings: 100%

Call Answer Rate:

- Call Answered in <15 seconds: 87.66%
- Calls Answered in <60 seconds: 91.58%
- Calls Answered in <180 Seconds: 98.88%

Mail

As the overall volume of activity in the Choice Counseling Program increased during the second quarter, so did the volume of activity in the mailroom. Both the outbound mail and inbound mail numbers saw dramatic increases in the second quarter.

<u>Outbound Mail</u>

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

New-Eligible Packets	18,815
Transition Packets	48,596
Auto-Assignment Letters	14,601
Confirmation Letters	26,241

To date, the percentage of mail that is returned is averaging about 6 percent per month. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary.

<u>Inbound Mail:</u>

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

Plan Enrollments	1,175
Plan Changes	2,379

Face-to-Face/Outreach and Education

During the second quarter, the face-to-face portion of the Choice Counseling Program began a major shift away from public or group sessions to one-on-one sessions and follow-up visits to the homes of beneficiaries who have no phone and have not responded to the mailings. These visits are referred to as "No Phone List" visits. The primary focus of these visits is to remind beneficiaries they only have 30 days to make a plan choice and to inform them of the final date to make a voluntary choice. If the beneficiary is willing, the Choice Counselor can provide counseling or simply leave information. The result of these efforts has been an almost 50 percent increase in the number of voluntary enrollments and plan changes processed by the field Choice Counselors.

Another primary focus of the field Choice Counselors during the second quarter was continuing to better reach the special needs and hard to reach populations. These

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

Mass media efforts continue in these areas and include billboards, radio spots, taxi toppers, posters in public transit and posters and brochures in state agencies and community-based organizations. In addition, the second quarter saw a dramatic increase in the number of health fairs attended by the field Choice Counselors. These venues provide opportunities to raise awareness of the Choice Counseling Program among community organizations and the provider community as well as provide opportunities to enroll Medicaid beneficiaries.

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

Group Sessions	640
Private & One-on-One Sessions	274
Home Visits & "No Phone" List	1,113
Enrollments	1,181
Plan Changes	431

Health Literacy

During the second quarter, the Agency and ACS continued to further develop the health literacy and health disparity function of the Choice Counseling Program. The registered nurse hired to serve in the special needs unit will be the lead for ACS on further defining this component of the program. As the registered nurse begins work on defining the program, ACS continued their previous effort in the health literacy areas. These efforts included helping Medicaid beneficiaries understand what it means to be part of a managed care plan. The call center and field scripts include language that describes the role of a primary care doctor, how that doctor coordinates all other necessary care, how the beneficiary will use a network of doctors, and more. In addition, when a beneficiary enrolls, the follow-up confirmation letter encourages the beneficiary to make an appointment with their doctor and again provides a statement of understanding regarding what it means to be enrolled in managed care.

In addition to explaining managed care, the Choice Counseling staff also provides information and education on the enhanced benefits program. As part of the enhanced benefits description, the counselor also talks about how engaging in the healthy behaviors will help overall health outcomes in addition to earning credits toward the purchase of health-related items. The Agency and ACS also continue to obtain copies of health-related brochures, especially those related to appropriate screenings, such as immunizations, mammograms, prostate screenings, pre-natal care, and more. These brochures are provided at no cost to the beneficiary during the face-to-face meeting with the field Choice Counselor. In addition, when the field Choice Counselors attend health fairs and other public events, they will have these brochures available for attendees to take home.

Voluntary Selection Data

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

During the second quarter, the first calculation of the voluntary enrollment rate contained three months of beneficiary enrollment into Medicaid Reform plans. For monitoring purposes, the voluntary selection rate is based on new enrollees only and does not include current beneficiaries who are transitioning to a Reform plan. The voluntary enrollment rate for both Reform counties was 60 percent of all new eligibles. For Duval County, the rate was 55.3 percent and for Broward County the rate was 64.9 percent. While ACS was slightly below the contract standard of 65 percent, the Agency remains pleased with the enrollment numbers due to the fact that ACS is serving approximately 30,000 transition beneficiaries each month in addition to the new eligibles. A breakdown of the new-eligible enrollment figures for the second quarter is provided in Table 4.

Table 4
New Eligible Voluntary Enrollment Rate
Second Quarter

Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Broward County	
Voluntary Choice	8,474
Auto-Assigned	4,783
Duval County	
Voluntary Choice	5,065
Auto-Assigned	4,097
Voluntary Enrollment Rate:	
Broward and Duval Combined	60%
Broward only	64.9%
Duval only	55.3%

Complaints/Issues

A beneficiary can file a complaint about Choice Counseling Program either through the call center, Agency headquarters or the area Medicaid Office. In the second quarter, there were 14 complaints filed related to the Choice Counseling Program. Table 5 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 5
Beneficiary Complaints & Action Taken

Beneficiary Complaint	Action Taken
1. Beneficiary called regarding incorrect information provided by a Choice Counselor regarding plan choice.	➲ The beneficiary provided the name of the individual that provided the incorrect information and this individual was a representative from a Reform plan. The information regarding this incident was provided to the Agency's Bureau of Managed Health Care for investigation.
2. Beneficiary called stating their plan change activity for October was cancelled by the Choice Counselor.	➲ The case was accessed in enrollment system and the plan change activity was recorded. The activity did not show a cancellation. The Choice Counselor was coached on explaining activities to beneficiaries to avoid confusion.
3. Individual's child got assigned to a Reform plan in Duval County when the family lives in St. John's County.	➲ Zip codes and county codes for some beneficiaries are not correct, i.e. system shows them living in Duval County, but they live in neighboring county. This is also an issue in non-reform counties. Medicaid Reform Choice Counseling Program and the Agency will use the same process used in the non-reform counties.
4. Beneficiary angry that eligibility was ending the end of the month and felt that Medicaid Reform was the reason eligibility was ending.	➲ Referred to Department of Children and Families to work with beneficiary on eligibility issues.
5. Beneficiary stated that the Choice Counselor asked her if someone was in her home threatening to kill her when she called to enroll.	➲ The Choice Counselor was counseled on working with beneficiaries who speak different languages and the need to use the language line and put on increased monitoring. Counselor tried to communicate and the beneficiary did not understand the duress language from the script. A Creole speaking counselor called the beneficiary to follow-up and ensured all the information the counselor provided was understood.
6. Complaint from a grandfather that the enrollment for grandson did not process.	➲ After the enrollment activity did not correctly process in the Florida MMIS during month-end processing; the Choice Counselor explained options for access to services to the grandfather and answered his questions. Then, the Choice Counselor processed the grandfather's enrollment choice for the grandson for next effective date for enrollment. The Agency continues to work on system issues that have caused a small number of transactions to not process correctly in the Florida MMIS system.

Table 5 Beneficiary Complaints & Action Taken	
Beneficiary Complaint	**Action Taken**
7. Foster Care child living in Dade County was enrolled in a Broward County Reform plan.	➲ The address of the foster care child in the Medicaid system was Broward County. ACS and the area office worked together to get the child into a plan in Dade County. This issue also occurs in Medicaid Options and ACS will use the same procedures in Reform counties.
8. Beneficiary provided with incorrect information regarding a plan's behavioral health providers.	➲ The provider file was searched and the plan was not coding their behavioral health providers with the correct code and the two providers were not located in the plan's network file. The Choice Counselor notified the plan and requested they make the correction to the coding of their behavioral health provider files. The Choice Counselor also notified the Agency contract manager to ensure the plan corrects the coding errors related to behavioral health provider files.
9. Choice Counselor didn't ask what doctors the beneficiary used and didn't seem to know anything about the plans. Beneficiary was referred to the plan that in turn referred the beneficiary back to the Choice Counseling Program.	➲ This complaint was also overheard when the Agency was monitoring the call center. The counselor who took the complaint call was able to assist the beneficiary and make an enrollment. The Agency requested the Choice Counselor who did not assist the beneficiary be put on increased monitoring and be provided follow-up training on customer service skills. Agency will also follow-up with increased monitoring of this counselor.
10. Beneficiary has multiple medical conditions and multiple doctors. None of her three main doctors take the same Reform plan and the beneficiary is concerned about changing any of these three doctors.	➲ The Agency and ACS are working together to find a Reform plan that will authorize services from all providers. In the meantime, the beneficiary will stay in current plan to continue to receive treatment.
11. Beneficiary called to enroll a child in a Reform plan on October 12. Beneficiary was confused that child was still in the old plan the next day.	➲ The enrollment into the Reform plan will not be effective until November 1st. All counselors will be reminded of the importance of stressing the enrollment effective dates for beneficiaries who are trying to enroll.
12. Beneficiary stated that her children could not see their current doctor under Medicaid Reform and that there were no doctors near her home in Reform.	➲ Beneficiary only provided a phone number and no other information to locate information in the enrollment system. Choice Counseling Program supervisor called multiple times to reach the beneficiary and left a voice mail for the beneficiary to call her.
13. Beneficiary enrolled in a Reform plan and her physician does not accept the plan. The beneficiary is going to deliver her baby very soon.	➲ Agency contacted the health plan and they authorized the beneficiary to continue to see her doctor.
14. Various general complaints about the Choice Counseling Program have been received from advocacy groups that are located in Broward County.	➲ The Agency has requested specific information from the advocacy groups to allow the Agency to properly investigate and resolve any identified problems. To date, the Agency has yet to receive specific information from the advocacy groups that would allow us to investigate,

Table 5 Beneficiary Complaints & Action Taken	
Beneficiary Complaint	**Action Taken**
	address any possible problems, and provide feedback to the groups on the outcome of the investigation.

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 beneficiary focus groups previously mentioned in this report. The focus groups allow the Agency to hear from beneficiaries the successes, complaints, as well as ideas for improvement of the Choice Counseling Program. Another important aspect is feedback from the advocates, providers, plans and others who work with and represent beneficiaries. In November, the Agency hosted the first meeting to provide a forum for these groups to discuss Medicaid Reform, with a primary focus on the Choice Counseling Program. The Agency will continue to hold these general forums as well as forums focused on issues relating to a particular choice counseling subject, such as material redesign.

In addition to external feedback, the Agency headquarters staff, the Agency area office staff, and ACS Choice Counseling staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between area Medicaid staff and ACS field staff, e-mail boxes on ACS' enrollment system so Agency staff and ACS can share information directly from the system to work difficult cases, and regularly scheduled conference calls.

C. Enrollment Data

Background

The Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population in the demonstration areas into Medicaid Reform health plans over a period of seven months starting in September 2006 and ending in April of 2007. The transition plan was designed to stagger the enrollment of beneficiaries enrolled in various managed care programs operated under Florida's 1915(b) Managed Care Waiver into a Medicaid Reform health plan. The types of managed care programs the beneficiaries transition from include HMOs, MediPass, Pediatric Emergency Room Diversion Program, Provider Service Network (PSN), and Minority Physician Networks.

During the development of the transition plan, consideration was given to the volume of calls the Choice Counseling Program would be able to handle each month. Specifically, the Agency proposed the following transition schedule:

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

During the first quarter of operation of the Medicaid Reform Program, enrollment in Reform health plans was based on a transitional process. Specifically, the July transition focused on enrollment of newly eligible beneficiaries and half of the MediPass population who were required to transition to a Reform health plan. Beneficiaries had 30 days to select a plan. If the beneficiary did not choose a plan, then the Choice Counselor assigned them to a plan. The earliest date of enrollment in a Reform health plan was September 1.

This section below provides enrollment figures as well as voluntary and mandatory rates for the second quarter of operation (October 1, 2006 through December 31, 2006).

Current Activities

The Agency provides a monthly enrollment report for Medicaid Reform health plans. This monthly enrollment data is available on the Agency's website at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml
Below is a summary of the monthly enrollment reports for the second quarter. The second quarter report includes enrollment figures from October 1, 2006, through December 31, 2006. This report contains the following enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment Report by County

- Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data

All Medicaid Reform health plans located in the two demonstration areas are included in each of the reports. During the second quarter, Medicaid Reform included a total of 16 HMOs and FFS PSNs. One HMO, Universal Healthcare, was effective on December 1, 2006, but did not begin enrollment until January 1, 2007. Therefore, this HMO had no enrollees during the second quarter of Fiscal Year 2006-07 and is not reported in the tables and charts that follow. There are two categories of Medicaid beneficiaries who are enrolled in Reform health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiary's 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 6 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 6
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 recipients enrolled with the plan
# SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled-Medicare Part B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled-Medicare Parts A & B	The number of SSI recipients who are enrolled with the plan and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of recipients enrolled with the plan; TANF and SSI combined
Market Share For Reform	The percentage of the total Medicaid Reform population that the plan's recipient pool accounts for
Enrolled in Prev. Qtr.	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Change 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 7 for the Fiscal Year 2006-07 Quarter 2 Reform Enrollment Report.

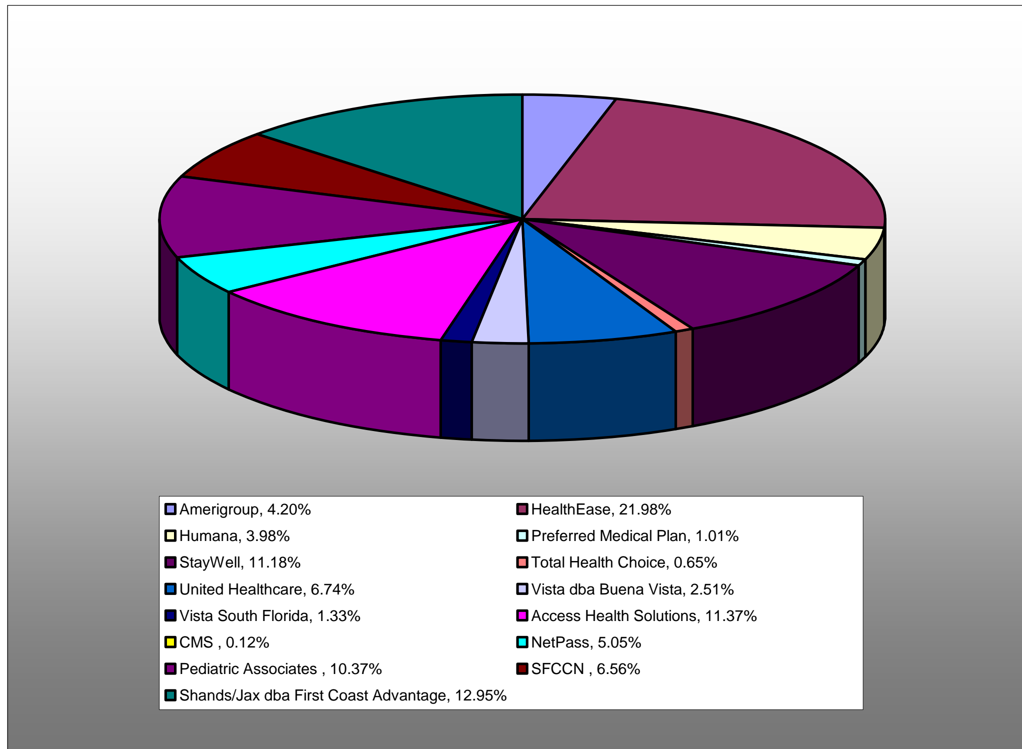
Table 7
Medicaid Reform Enrollment Report (Fiscal Year 2006-07, 2nd Quarter)*

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	4,198	535	3	20	**4,756**	**4.20%**	624	662.18%
HealthEase	HMO	22,415	2,344	3	145	**24,907**	**21.98%**	2,857	771.79%
Humana	HMO	3,679	772	2	54	**4,507**	**3.98%**	323	1,295.36%
Preferred Medical Plan	HMO	895	234	0	10	**1,139**	**1.01%**	55	1,970.91%
StayWell	HMO	11,420	1,180	9	56	**12,665**	**11.18%**	1,801	603.22%
Total Health Choice	HMO	606	125	0	7	**738**	**0.65%**	33	2,136.36%
United Healthcare	HMO	6,459	1,101	3	80	**7,643**	**6.74%**	1,029	642.76%
Vista dba Buena Vista	HMO	2,569	264	1	10	**2,844**	**2.51%**	210	1,254.29%
Vista South Florida	HMO	1,303	184	0	15	**1,502**	**1.33%**	184	716.30%
Access Health Solutions	PSN	10,515	2,353	0	21	**12,889**	**11.37%**	23	55,939.13%
CMS	PSN	80	57	0	4	**141**	**0.12%**	0	N/A
NetPass	PSN	4,118	1,575	4	30	**5,727**	**5.05%**	129	4,339.53%
Pediatric Associates	PSN	11,186	563	0	0	**11,749**	**10.37%**	0	N/A
SFCCN	PSN	5,173	2,225	4	34	**7,436**	**6.56%**	121	6,045.45%
Shands/Jax dba First Coast Advantage	PSN	11,203	3,413	1	61	**14,678**	**12.95%**	215	6,726.98%
Reform Enrollment Totals		**95,819**	**16,925**	**30**	**547**	**113,321**	**100.00%**	**7,604**	**1,390.28%**

**** This table does not include Reform plans that have not yet received enrollment.***

The total market share percentage is calculated once beneficiaries have been counted from each plan and the total number enrolled is known. The total market share percentage by plan with enrollees is displayed graphically in Chart A.

Chart A Market Share for Medicaid Reform



The enrollment figures for the second quarter of Fiscal Year 2006-07, reflects those individuals who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, many Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 113,321 recipients enrolled in Medicaid Reform during the second quarter of Fiscal Year 2006-07. There were 15 Reform plans with market shares ranging from 0.12 percent to 21.98 percent.

2. Medicaid Reform Enrollment Report by County

Medicaid Reform is operational in two counties: Broward and Duval. There are 10 HMOs and 5 PSNs operating in Broward County, and there are 4 HMOs and 2 PSNs serving Duval County. The Medicaid Reform Enrollment Report by County section of this Quarterly Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Broward County plans are listed first, followed by Duval. Table 8 describes the columns of information that each Reform health plan provides to the Agency for this report.

Table 8 Medicaid Reform Enrollment Report by County Description	
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 (Broward or Duval)
# TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI recipients 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 recipients 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 recipients who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of recipients 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 recipient pool accounts for
Enrolled in previous Qtr.	The total number of recipients (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Change From Previous Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 9.

Table 9
Medicaid Reform Enrollment Report by County
(Fiscal Year 2006-07, 2nd Quarter)*

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	Broward	4,198	535	3	20	**4,756**	**7.06%**	624	562.18%
HealthEase	HMO	Broward	6,677	700	1	44	**7,422**	**11.01%**	1,107	470.46%
Humana	HMO	Broward	3,679	772	2	54	**4,507**	**6.69%**	323	1,295.36%
Preferred Medical Plan	HMO	Broward	895	234	0	10	**1,139**	**1.69%**	55	1,970.91%
StayWell	HMO	Broward	10,212	1,041	9	44	**11,306**	**16.77%**	1,751	545.69%
Total Health Choice	HMO	Broward	606	125	0	7	**738**	**1.09%**	33	2,136.36%
United Healthcare	HMO	Broward	2,423	550	3	50	**3,026**	**4.49%**	590	412.88%
Vista dba Buena Vista	HMO	Broward	2,569	264	1	10	**2,844**	**4.22%**	210	1,254.29%
Vista South Florida	HMO	Broward	1,303	184	0	15	**1,502**	**2.23%**	184	716.30%
Access Health Solutions	PSN	Broward	3,954	1,145	0	11	**5,110**	**7.58%**	13	39,207.69%

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
CMS	PSN	Broward	80	57	0	4	**141**	**0.21%**	0	N/A
Netpass	PSN	Broward	4,118	1,575	4	30	**5,727**	**8.50%**	129	4,339.53%
Pediatric Associates	PSN	Broward	11,186	563	0	0	**11,749**	**17.43%**	0	N/A
SFCCN	PSN	Broward	5,173	2,225	4	34	**7,436**	**11.03%**	121	6,045.45%
Total Reform Enrollment for Broward			**57,073**	**9,970**	**27**	**333**	**67,403**	**100.00%**	**5,140**	**1,211.34%**
HealthEase	HMO	Duval	15,738	1,644	2	101	**17,485**	**38.08%**	1,750	899.14%
StayWell	HMO	Duval	1,208	139	0	12	**1,359**	**2.96%**	50	2,618.00%
United Healthcare	HMO	Duval	4,036	551	0	30	**4,617**	**10.05%**	439	951.71%
Access Health Solutions	PSN	Duval	6,561	1,208	0	10	**7,779**	**16.94%**	10	77,690.00%
Shands/Jax dba First Coast Advantage	PSN	Duval	11,203	3,413	1	61	**14,678**	**31.97%**	215	6,726.98%
Total Reform Enrollment for Duval			**38,746**	**6,955**	**3**	**214**	**45,918**	**100.00%**	**2,464**	**1,763.56%**
Reform Enrollment Totals			**95,819**	**16,925**	**30**	**547**	**113,321**		**7,604**	**1,390.28%**

**** This table does not include Reform plans that have not yet received enrollment.***

As with the Medicaid Reform Enrollment Report, recipients are extracted from the monthly Medicaid eligibility file and are then counted uniquely based on what plan is listed as the primary care provider. The unique recipient counts are separated by the counties the plans operate in. The percentage of the Medicaid Reform market share for each plan in each county is represented in Charts B and C.

Chart B
Market Share for Medicaid Reform in Broward County

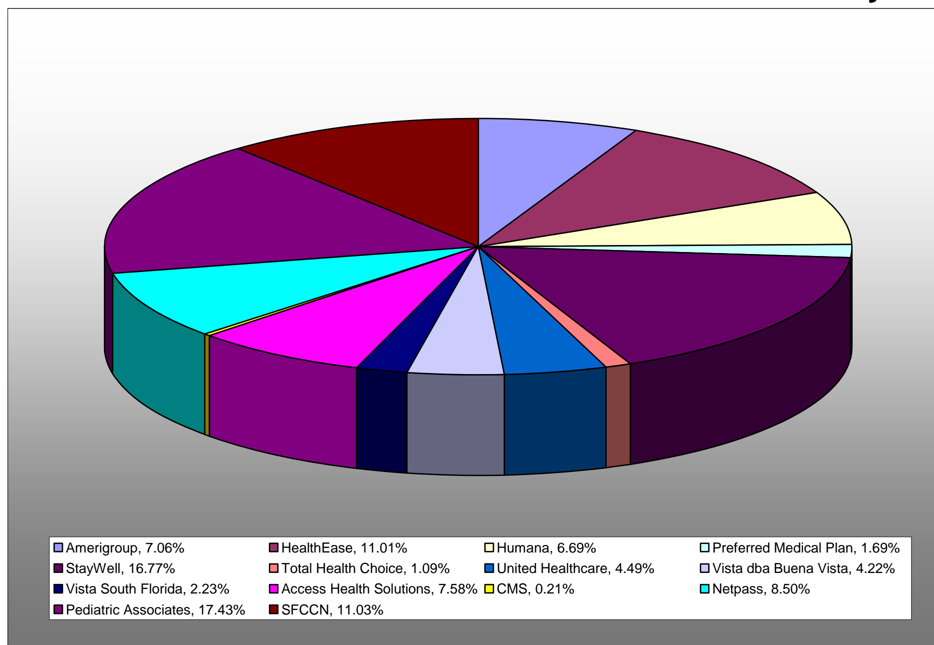
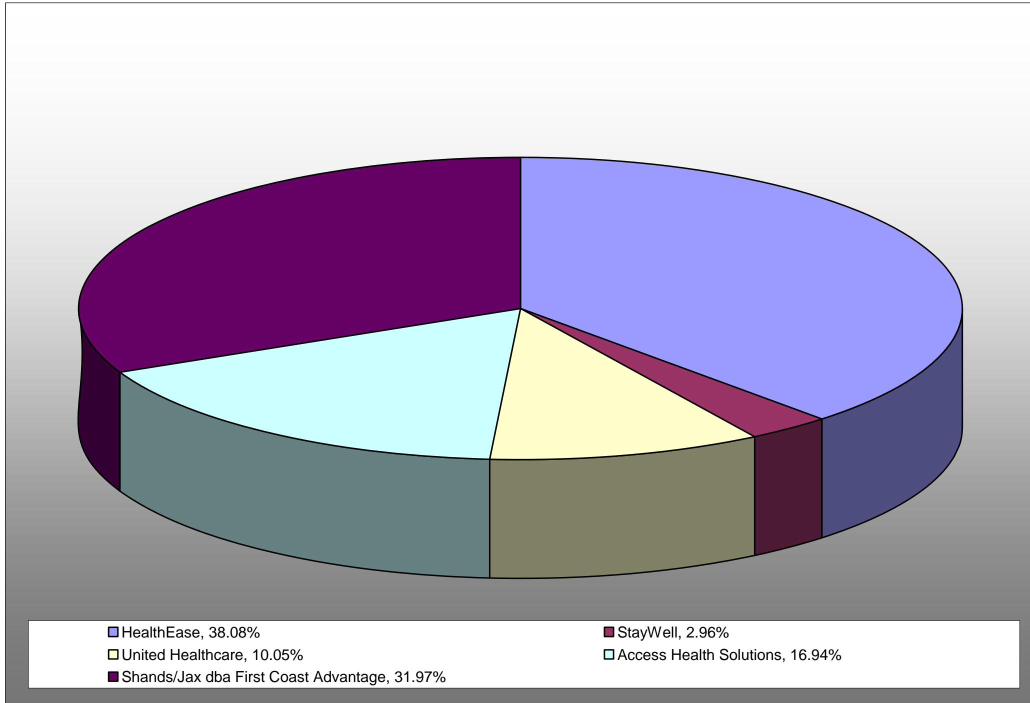


Chart C
Market Share for Medicaid Reform in Duval County



During the second quarter of operation, there was an enrollment of 67,403 recipients in Broward County and 45,918 recipients in Broward County. There were 14 Reform plans with enrollees in Broward County, with market shares ranging from 0.07 percent to 17.43 percent. In Duval County, there were five Reform plans with market shares ranging from 2.96 percent to 38.08 percent.

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

The Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report lists the number of Medicaid Reform recipients who were enrolled (either voluntarily or mandatorily) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 10 describes the information that each Reform health plan provides to the Agency for this report.

Table 10 Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data	
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 (Broward or Duval)
# Voluntary Enrolled	The number of unique recipients who voluntarily enrolled with the plan during the current reporting quarter
# Mandatory Enrolled	The number of unique recipients who were mandatorily enrolled with the plan during the current reporting quarter
Total # Enrolled	The total number of unique recipients enrolled with the plan during the current reporting quarter; voluntary and mandatory combined
% Enrolled Voluntary	The percentage of the total number of recipients enrolled with the plan during the current reporting quarter who were enrolled voluntarily
# Disenrolled	The number of unique recipients who disenrolled from the plan during the current reporting quarter

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

A. Medicaid Reform Enrollees

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

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the current reporting quarter but then left the program. The count is performed by comparing two beneficiary lists: one for the current reporting quarter and one for the first month after the current reporting quarter. If a beneficiary appears on the current reporting quarter enrollment list but not on the enrollment list for the first month following the current reporting quarter, the beneficiary is counted as disenrolled. For example, disenrollments for the second quarter of Fiscal Year 2006-07 are those beneficiaries who appear on the enrollment list for October 2006 to December 2006 but not on the enrollment list for January 2007.

The unique beneficiary counts in the Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report are divided by plan type in Table 11. Total counts for the quarter are also provided for both HMOs and PSNs, as well as the entire Medicaid Reform program.

Table 11
Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data (Fiscal Year 2006-07, 2nd Quarter)*

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	4,379	377	4,756	92%	494
HealthEase	HMO	Broward	6,996	426	7,422	94%	689
HealthEase	HMO	Duval	16,817	668	17,485	96%	1,763
Humana	HMO	Broward	4,181	326	4,507	93%	505
Preferred Medical Plan	HMO	Broward	814	325	1,139	71%	129
StayWell	HMO	Broward	10,877	429	11,306	96%	1,140
StayWell	HMO	Duval	871	488	1,359	64%	155
Total Health Choice	HMO	Broward	406	332	738	55%	97
United Healthcare	HMO	Broward	2,679	347	3,026	89%	384
United Healthcare	HMO	Duval	3,677	940	4,617	80%	525
Vista dba Buena Vista	HMO	Broward	2,658	186	2,844	93%	313
Vista South Florida	HMO	Broward	1,328	174	1,502	88%	194
HMO Total			55,683	5,018	60,701	92%	6,388
Access Health Solutions	PSN	Broward	6,866	913	7,779	88%	903
Access Health Solutions	PSN	Duval	4,811	299	5,110	94%	576
CMS	PSN	Broward	141	0	141	100%	9
Netpass	PSN	Broward	5,370	357	5,727	94%	667
Pediatric Associates	PSN	Broward	11,496	253	11,749	98%	1,567
SFCCN	PSN	Broward	6,818	618	7,436	92%	800
Shands/Jax dba First Coast Advantage	PSN	Duval	13,712	966	14,678	93%	1,309
PSN Total			49,214	3,406	52,620	94%	5,831
Reform Enrollment Totals			104,897	8,424	113,321	93%	12,219

This table does not include Reform plans that have not yet received enrollment.

For the second quarter of Fiscal Year 2006-07, there were 104,897 voluntary enrollments (93 percent) in Medicaid Reform. Of those, 55,683 beneficiaries were enrolled in an HMO and 49,214 were enrolled in a PSN.

D. Opt Out Program

Background

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

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

Description of Opt Out Process

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

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

After HMS receives the required information from the employer, HMS follows-up with the beneficiary to discuss the insurance that is available through their employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether or not he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the employer. After

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

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

Current Activities

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

Opt Out Program Statistics

During this quarter, 15 calls were received at the Opt Out toll-free call center and a total of 6 persons enrolled in the Opt Out Program.

- Four of the callers were determined not to have ESI available.
- Five of the callers had ESI available but decided they were not interested in the program.
- Four of the callers requested and received information regarding the Opt Out program (e.g. New Referral Letter and Release to contact employer) but have not followed through with enrollment into the program to date.
- Two of the calls resulted in enrollment into Opt Out. Both callers are in the Children and Family eligibility category.

  One caller enrolled in Opt Out effective October 1, 2006. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

  The other caller began the process to enroll his five Medicaid eligible children in the Opt Out Program with an effective date of January 1, 2007. The father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

By the end of the second quarter, a total of seven individuals were enrolled in the Opt Out Program, which includes the person who enrolled in the program during the first quarter.

E. Enhanced Benefit Program

Background

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

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

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

Current Activities

At the beginning of the quarter, the Agency received the first monthly healthy behavior reports from the plans as scheduled on October 10, 2006. In addition, the Agency implemented the new Enhanced Benefits Information System (EBIS) and the Enhanced Benefits Call Center effective November 1, 2006.

Outreach and Education for Beneficiaries

The welcome packets continue to be mailed to new Reform enrollees every month, which provides detailed information regarding their eligibility for the program and the benefits provided through the program. The package contains an Enhanced Benefits Account Program brochure and a letter to the enrollee regarding the program.

In December, the Agency mailed the first detailed monthly statement to all active Enhanced Benefits Account Program members. This statement provided an itemized listing of the activity on his or her account since enrollment into the program. The next statement is scheduled to be mailed out the first week of February, 2007. The February statement and all future statements will only reflect account activity since the previous statement.

Outreach and Education for Pharmacies

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

The Enhanced Benefits Advisory Panel met in October and November 2006. The primary focus of the meetings has been to finalize recommendations related to the outreach documents, such as the monthly statement, and providing advice for relevant policy, such as defining the term "structured program." The panel did not meet in December.

Enhanced Benefit Account Program Statistics:

Second Quarter Activity		October	November	December
I.	**Number of plans submitting reports by month**	**18 of 19**	**19 of 19**	**19 of 19**
II.	**Number of enrollees who received credit for healthy behaviors by month**	**452**	**2,702**	**8,502**
III.	**Percentage of Reform enrollees who receive credits each month**	**0.97%**	**3.43%**	**8.06%**
IV.	**Number of enrollees who received credit and used credits by month**	**N/A**	**5**	**53**
V.	**Total dollar amount credited to accounts by month**	**$9,260.00**	**$74,845.00**	**$249,027.50**
VI.	**Total dollar amount of credits used by month**	**N/A**	**$67.04**	**$660.14**

F. Low Income Pool

Background

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

- On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP to CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. 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 to CMS on April 7, 2006.

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

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

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

Current Activities

The Agency submitted to CMS the final Reimbursement and Funding Methodology document, November 22, 2006. During the December 28, 2006, conference call with CMS, CMS confirmed that the Agency was in compliance with STC #101 through the submission of the final Reimbursement and Funding Document. CMS further stated that additional questions for clarification from CMS will be forthcoming.

At the beginning of the quarter, the LIP Council members met to discuss the following issues: (a) the State Fiscal Year 2007-2008 anticipated distribution and funding (of non-federal share) of the LIP, (b) Disproportionate Share Hospital (DSH) program, and (c) hospital reimbursement program. The Council meeting dates for this quarter were: September 27, 2006, October 20, 2006, November 29, 2006, and December 11, 2006.

The Agency provided an update to the LIP Council members on: (a) the status of the Letters of Agreement, which were sent to local governments/taxing districts during the first quarter, and (b) the requirement that the local governments/taxing districts shall submit, to the Agency, copies of any provider agreements executed regarding the LIP funds. During the LIP Council meetings held in November and December, the Council reviewed various models regarding the State Fiscal Year 2007-2008 distribution of funds. During the review of the models, the LIP Council discussed the decrease in federal match and how to address the additional state share requirement. In addition, the LIP Council heard presentations from different Provider Access Systems requesting participation in the LIP for State Fiscal Year 2007-2008.

At the end of the quarter, the Agency is continuing to work with the local governments/taxing districts regarding the execution of Letters of Agreement. The LIP Council assigned a workgroup to define the various data elements to be collected for the LIP Milestone reporting document.

During the second quarter of SFY 06-07, the Agency provided CMS with a total of 12 Local Agreements and upon receipt of local matching funds, made a total of $299,648,658 in LIP distributions to Provider Access Systems.

G. Monitoring Budget Neutrality

Background

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

Current

During the reporting quarter, CMS added an additional template to the CMS 64 report to capture the Low-Income Pool (LIP) expenditures subject to the waiver. These expenditures were not reported separately last quarter; however, the Agency is reporting the LIP second quarter expenditures separately and will also submit a prior period adjustment to reflect the LIP first quarter expenditures.

The Agency has submitted expenditures for the first and second quarter of the demonstration waiver via the CMS 64 report. However, through communication with CMS, those CMS 64 reports will need to be revised. Once the revisions are made and both parties are confident of the accuracy of the CMS 64 report, the budget neutrality statistics will be completed. The Agency will work with CMS to ensure the accuracy of the reporting and will submit the budget neutrality statistics listed below in the next quarterly report for the first three quarters of the demonstration waiver.

Statistics:

1) Enrollment - By Medicaid Eligibility Group (MEG), by Month

2) Growth of Enrollment - Eligibles and Enrollees by MEG, by Month

3) Monthly Expenditures - By MEG, by Month

4) Average Cost Per Member Per Month (PMPM) - By MEG, by Month and for waiver as a whole

5) Average Cost Per Enrollee Per Month - By MEG, by Month and for waiver as a whole

6) Average PMPM compared to Budget Neutrality Projected PMPM

7) Total Cost Compared to the Projected Total Cost

H. Encounter and Utilization Data

Background

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

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

Current Activities

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

Also during this quarter, the Agency continued designing and developing MEDS to capture encounter data from all capitated health plans for all covered services. Activities included:

- Enhancement of Florida's incumbent Medicaid Management Information System (MMIS) system to support the capture, validation, and adjudication of encounter claims received from Managed Care Organizations (MCOs).

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

- Participation of the MEDS team in "stand-alone" technical and Medicaid policy meetings with MCOs as well as Medicaid Reform technical & operations conference calls.

- Design of a questionnaire that was sent from the Agency in early November 2006 assessing MCO readiness for testing and subsequent submission of encounter claim data.

- The MEDS team continued to respond to MCO ad-hoc operational and technical questions or issues through the MEDS email account established in September 2006.

- Reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content to capitated health plans is being validated and tested by the MEDS team and incumbent Fiscal Agent (FA).

- System edits and quality assurance processes to review and analyze encounter claim data received from capitated health plans were finalized and communicated to MCOs and the incumbent FA.

- Design of the data structure and supporting processes to extract encounter claims to the Medicaid Decision Support System (DSS) was completed.

- Participation in the design and development from MEDS in the new Florida MMIS.

At the end of the quarter, the processes providing plan risk factors for Medicaid Reform rate setting, encompassing the generation of risk factors accounting for budget neutrality and the risk corridor, will continue. The scheduled activities associated with the testing and subsequent implementation of MEDS is continuing. This encompasses technical support with capitated health plans, deployment of enhancements within the Florida MMIS system, and the creation and dissemination of operational documentation to support MEDS testing, production readiness and ongoing collection of encounter data.

I. Demonstration Goals

Current Program

As outlined in the approved 1115 Medicaid Reform Demonstration Waiver, the key design elements of Florida's Medicaid Reform provide the state and CMS with an opportunity to implement and evaluate innovative and market-driven approaches to modernizing Medicaid. During the first quarter, the Agency's progress towards achieving the six evaluation objectives outlined in the approved 1115 Medicaid Reform Demonstration Waiver is described below.

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

   Prior to the implementation of Medicaid Reform, the Agency contracted with various managed care programs including: 8 HMOs, 1 PSN, 1 Pediatric Emergency Room Diversion Program, 2 Minority Physician Networks (MPNs) for a total of 12 managed care programs in Broward County; and 2 HMOs and 1 MPN for a total of 3 managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of Medicaid Reform operated as prepaid ambulatory health plans offering enhanced medical management services to beneficiaries enrolled in MediPass, Florida's primary care case management program.

   By the end of the second quarter, the Agency established contracts with 10 HMOs and 5 PSNs for a total of 15 Reform health plans in Broward County; and 4 HMOs and 2 PSNs for a total of 6 Reform health plans in Duval County. This is a considerable increase in the number of health plans that beneficiaries can chose. The Agency is currently reviewing two additional health plan applications, 1 HMO and 1 PSN. In addition, the Agency believes that individuals were provided more choice as Reform health plans offered benefit packages that included services not previously covered by Medicaid.

   The PSN contract established during the second quarter with the Children's Medical Services Network will serve children with chronic conditions. This PSN contract is the first specialty plan approved to operate under Reform. This plan is limited to children with serious medical, developmental, behavioral or emotional conditions and will provide health care services that meet the child's unique needs. With the addition of this specialty plan, the Agency increased the choice of different types of health plans being offered in Reform as compared to the first quarter of operation.

   As reported last quarter, it is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The Agency intends to provide the survey results to the beneficiaries in the

form of Choice Counseling materials so that they will have comparable information relative to how satisfied enrollees are with their Reform health plan. The health plans will also use the survey results for their quality improvement programs to improve health outcomes of their beneficiaries.

In addition to the CAHPS surveys, the Agency intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. The Reform plans will not begin conducting the disease management patient satisfaction surveys until September 2007, to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for 6 months.

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

All of the capitated Reform health plans offered expanded or additional benefits which were not previously covered by the State under the State Plan. The most popular expanded benefits offered by the capitated plans were an over-the-counter (OTC) drug benefits and adult preventive dental benefits. New expanded benefits available to beneficiaries include the following:

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

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

The Agency will monitor the Medicaid Reform health plan enrollees through the HEDIS performance measures and the plan's disease management enrollees through Agency-defined disease management measures. The Medicaid Reform health plan contract specifies the performance measures that will be collected starting January 1, 2007 through December 31, 2007, and reported to the Agency

October 1, 2008, including the ones identified above. The contract language provides that the Agency may add or remove requirements with 30 days' advance notice.

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

After a full review, the Agency identified a total of 34 proposed performance measures of which 21 Agency-defined measures would be applicable to the disease management enrollees that are not currently listed in the contract. These measures will be collected over a three-year period. During the first year, the Agency will collect 13 performance measures. The Agency finalized these changes during the second quarter by conducting public meetings to obtain input from the Reform health plans and all interested parties on the proposed performance measures and the timeline for implementation of the measures. The Agency presented the changes to the performance measures currently listed in the contract including the additional disease management measures and the timeline for implementation of the measures to health plans during a public workshop held on October 26, 2006. The Agency then provided the Reform plans with the formal written notification on December 8, 2006.

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

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

In the first quarter, one person chose to opt out because her primary care physician was not enrolled with a Medicaid Reform health plan. At the end of the second quarter, an additional six individuals chose to opt out because they elected to use the Medicaid Opt Out medical premium to pay the family members employee portion of their employer sponsored insurance. The individuals who decided not to opt out were: (a) not employed, (b) did not have access to ESI, or (c) after hearing about opt

out decided to remain with their Medicaid Reform plan where there were not co-pays and deductibles.

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

   Please refer to the response to objective #1.

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

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

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

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

   As required under STC # 102 in demonstration year 2, the State is conducting a study of the cost-effectiveness of the various PAS (hospital and non-hospital providers). The State has contracted with the University of Florida to conduct the evaluation of LIP including cost-effectiveness and the impact of LIP on increased access for uninsured individuals. During the second quarter, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for the study required in year 2 of the demonstration.

J. Evaluation of Medicaid Reform

Background

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

In addition, to the contract with UF, several other evaluations are being conducted. During the first quarter, UF developed a subcontract with the Urban Institute (with funding from the Kaiser Family Foundation) to study the early impact of transition for Medicaid Reform enrollees.

Additional Pre-Implementation Activities and Accomplishments[2]:

- The MRE Team applied for and obtained IRB (Institutional Review Board) approval for the evaluation, allowing human subjects (Medicaid recipients) to be part of the research for the evaluation.
- The MRE Team submitted a detailed work plan providing a step-by-step map of the tasks they will take to complete the evaluation over year one (a contract deliverable).
- UF submitted a summary report on the Medicaid Reform Section 1115 Waiver Process.
- UF submitted a report describing managed care organizations and other Reform Health Plans in the two Reform counties, Broward and Duval.
- The MRE team began baseline (pre-implementation) key informant interviews with various groups (Agency management, Reform plans, Choice Counselors, etc.).
- Local liaisons were hired in Broward and Duval Counties to coordinate activities in those areas and to report on items that happened between visits by UF.

[1] Note: Contract deliverables are routinely submitted to the Agency in draft form; the Agency returns comments; UF submits a final version; an Agency Technical Assistance Group formally reviews and approves the deliverable; and an invoice for it is submitted and paid. Unless specified otherwise, any deliverable mentioned as submitted means the final version.
[2] For more information and detail, see the first quarterly report (July through September 2006) submitted by AHCA to CMS.

- The MRE team gathered baseline information on the various aspects of Medicaid Reform, including customized benefit packages, Opt-Out, funding methodology of the Low Income Pool, development and implementation of pilot programs, etc.
- UF and the Agency jointly developed the initial enrollee satisfaction survey instrument, based on the CAHPS (Consumer Assessment of Healthcare Providers and Systems). This information will serve as a baseline against which to compare future surveys throughout the demonstration period.

First Quarter Activities & Accomplishments

- A Technical Advisory Council, a team of national experts in evaluation and Medicaid issues, was appointed and held its initial meeting via conference call. Members include Dr. Robert Hurley (Medical College of Virginia), Dr. Marsha Gold (Mathematica Policy Research, Inc.), and Dr. Bryan Dowd (University of Minnesota).
- The Agency appointed the Florida Advisory Committee, a group of statewide experts in health care and Medicaid.
- The MRE Team began development of a data matrix that shows measures, data elements to be collected, in what data system(s) the elements reside, and who at the Agency is the main contact for that data system. This data matrix will continue to be updated and used throughout the evaluation.
- The MRE Team began organizational data collection on each of the health plans that applied to participate in Medicaid Reform.
- The MRE Team began fieldwork for the CAHPS-based enrollee satisfaction survey, including determining the sample size and beginning to survey recipients.

Current Activities

At the beginning of the second quarter, the Medicaid Reform Evaluation (MRE) Team met with various stakeholders to determine data sources and extraction protocols; collect data where they exist; and establish benchmarks against which to compare the data for the remainder of the demonstration period. Data collection and analysis will continue throughout the five-year contract period. Designing and completing this data needs matrix is a key activity of this quarter.

Throughout this quarter, the MRE Team continued key informant interviews with Agency management, Reform plans, Choice Counselors, community stakeholders, Medicaid recipients, and other stakeholders impacted by Reform. While the initial interviews contained questions regarding the respondents' thoughts about how implementation might be achieved and other pre-implementation issues, this quarter's interviews (round two) asked respondents about implementation and how Medicaid Reform is working in its early stages. Focus groups were held in Duval and Broward County as part of this effort.

On December 13, 2006, the Florida Advisory Committee held its first meeting at the Agency's headquarters office. The committee was presented with background information about Medicaid Reform and the University evaluation, and committee members were invited to give input. This committee will meet on a yearly basis throughout the five year evaluation period, and additional member input will be sought (via email or conference call) when needed.

The Agency directed the MRE Team to coordinate the other evaluations that are being conducted on various aspects of Reform, including:

- The Kaiser Family Foundation/Urban Institute evaluation; and
- The University of Oregon's Centers for Health System Change and the Robert Wood Johnson Foundation evaluation.

The Agency also directed the MRE Team to coordinate their efforts with Office of Program Policy Analysis and Government Accountability (OPPAGA) evaluation that is being conducted pursuant to Chapter 2005-133, Laws of Florida.

Additional key activities being conducted by UF this quarter include:

- Dr. Niccie McKay of the MRE Team completed a detailed Low Income Pool Evaluation Plan, including definition of key concepts, specific data to be collected, and description of evaluation analyses.
- The MRE Team is testing the feasibility of conducting its community stakeholder survey via the Web, using Survey Monkey. If approved, this study will be conducted in late January.
- The MRE Team conducted focus groups in Broward and Duval Counties. In each county, three types of groups were interviewed: beneficiaries, AHCA field staff, and ACS field staff. (ACS is the Agency's Choice Counseling vendor.) One purpose of the focus group with beneficiaries is to help identify members for the longitudinal study panel (the group of recipients to be followed over the entire five-year evaluation period).
- The data matrix continues to be updated and refined. Members of the MRE team met with the Agency Systems Team to gather information and input.
- To facilitate data sharing, UF has designated a space on its secure drive for the Agency's appointed staff to place data files.
- On a regular basis, MRE Team members attend conferences, meetings, and conference calls concerning Medicaid Reform, in order to gather data where possible and share information about the Evaluation.
- Fieldwork for the baseline enrollee satisfaction survey was finished, and analysis begun. Results of these analyses will provide comparison information for use throughout the rest of the evaluation.

K. Policy and Administrative Issues

Current Activities

During the second quarter, the Agency released several policy transmittals to the Reform health plans to:

- Notify the health plans which of the quality performance measures will be added or removed from the current list of performance measures specified in the Reform health plan contracts. This policy transmittal was developed after the Agency held workshops in October of 2006 with the health plans and all interested stakeholders to obtain input on the quality performance measures.

- Provide additional information about the steps the plans must follow when submitting their encounter data.

- Clarify the process for newborn enrollments into a PSN.

- Provide supplementary information about the process the PSNs must follow when submitting involuntary disenrollments.

Additional policy transmittals are expected to be released in the third quarter. The Agency intends to release policy transmittals to PSNs that clarify: (a) the process to follow when reporting third party coverage and (b) the services for which paper claims are required and those that require additional pricing documentation.

The Agency continues to conduct Technical and Operational Issues Conference Calls on a biweekly basis. During this quarter, there were a total 7 calls with at least 70 participants. These calls were initiated to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to questions posed through email and telephone inquiries. All health plans are invited to participate, whether or not they are currently operating in Reform counties. The Agency staffs these calls with administrative experts in all areas, 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. Topics and agenda items have included various file formatting and submission requirements, Choice Counseling activities, network provider registration processes, Medicaid Enhanced Benefits documents and data systems, Medicaid Encounter Data Systems, provider and member information, accessing data exchange and secured file transmission servers, reports, enrollment rosters, reimbursement, performance measures reporting requirements, best practices in HIV/AIDS disease management programs, claims payment and kick payment processing. Feedback indicates that the calls are well received and a good forum for discussion of the technical and operational issues.

Attachment I Medicaid Reform Outreach Meetings October 1, 2006 – December 31, 2006					
Date	**Location**	**Target Audience**	**Type of Meeting**	**Subject**	**Approximate Number of Attendees**
10/16/06	Clay County	Providers - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Rural Provider Service Network Start-Up Funds • Unique Needs in Rural Areas	44
10/16/06	Clay County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	22
11/01/06	Baker County	Providers - Baker, Clay and Nassau	Informative	• Rate Setting • Risk Adjusting • Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	13
11/01/06	Baker County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	23
12/11/06	Nassau County	Providers - Baker, Clay and Nassau	Technical Assistance	• Technical Assistance for Filling out the Application • Choice Counseling and Plan Responsibilities • Rural Health Plan Start-Up Funds Application • Marketing of Plans Under Reform	35
12/11/06	Nassau County	Beneficiaries - Baker, Clay and Nassau	Informative	• General Reform • Choice Counseling • Unique Needs in Rural Areas	31

Attachment II

Florida Medicaid Reform Choice Counseling
Call Center Activity Report

ACS

Month: October-06

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						<5% Monthly	100%	180 seconds			<=1% monthly
				36,653							
MON	10/2/2006	1,282	1,279	37,932	3	0.2%	100%	707.00	6.22	239	0.0%
TUE	10/3/2006	1,127	1,120	39,052	7	0.6%	100%	338.00	6.68	231	0.0%
WED	10/4/2006	1,176	1,167	40,219	9	0.8%	100%	299.00	6.22	205	0.0%
THU	10/5/2006	1,364	1,325	41,544	39	2.9%	100%	1288.00	6.68	178	0.0%
FRI	10/6/2006	1,046	1,035	42,579	11	1.1%	100%	427.00	6.33	167	0.0%
SAT	10/7/2006	61	60	42,639	1	1.6%	100%	132.00	7.96	107	0.0%
	Week Ending	6,056	5,986		70	1.2%	100%		6.4	1127	0%
MON	10/9/2006	1,137	1,132	43,771	5	0.4%	100%	539.00	6.60	208	0.0%
TUE	10/10/2006	1,117	1,091	44,862	26	2.3%	100%	606.00	7.03	171	0.0%
WED	10/11/2006	938	936	45,798	2	0.2%	100%	87.00	6.55	193	0.0%
THU	10/12/2006	979	976	46,774	3	0.3%	100%	361.00	6.45	224	0.0%
FRI	10/13/2006	823	821	47,595	2	0.2%	100%	170.00	6.36	120	0.0%
SAT	10/14/2006	64	64	47,659	0	0.0%	100%	150.00	6.07	98	0.0%

Attachment II

Florida Medicaid Reform Choice Counseling
Call Center Activity Report

ACS

Month: **October-06**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				36,653							
	Week Ending	5,058	5,020		38	0.8%	100%		6.6	1014	0%
MON	10/16/2006	1,102	1,100	48,759	2	0.2%	100%	337.00	6.57	269	0.0%
TUE	10/17/2006	1,012	1,008	49,767	4	0.4%	100%	212.00	6.72	172	0.0%
WED	10/18/2006	930	930	50,697	0	0.0%	100%	165.00	6.35	340	0.0%
THU	10/19/2006	906	904	51,601	2	0.2%	100%	774.00	6.42	323	0.0%
FRI	10/20/2006	664	664	52,265	0	0.0%	100%	218.00	6.10	186	0.0%
SAT	10/21/2006	37	37	52,302	0	0.0%	100%	52.00	7.27	70	0.0%
	Week Ending	4,651	4,643		8	0.2%	100%		6.5	1360	0%
MON	10/23/2006	926	926	53,228	0	0.0%	100%	12.00	6.15	206	0.0%
TUE	10/24/2006	772	772	54,000	0	0.0%	100%	82.00	6.02	191	0.0%
WED	10/25/2006	765	765	54,765	0	0.0%	100%	50.00	6.42	198	0.0%
THU	10/26/2006	653	653	55,418	0	0.0%	100%	157.00	6.15	297	0.0%
FRI	10/27/2006	576	576	55,994	0	0.0%	100%	125.00	6.93	285	0.0%
SAT	10/28/2006	35	35	56,029	0	0.0%	100%	109.00	7.56	126	0.0%

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				36,653							
	Week Ending	3,727	3,727		0	0.0%	100%		6.3	1303	0%
MON	10/30/2006	862	862	56,891	0	0.0%	100%	1.00	6.27	180	0.0%
TUE	10/31/2006	712	712	57,603	0	0.0%	100%	26.00	6.17	118	0.0%
WED		0		57,603	0	0.0%	100%				0.0%
THU		0		57,603	0	0.0%	100%				0.0%
FRI		0		57,603	0	0.0%	100%				0.0%
SAT		0		57,603	0	0.0%	100%				0.0%
	Week Ending	1,574	1,574		0	0.0%	100%		6.2	298	0%
MON		0		57,603		0.0%					
TUE		0		57,603		0.0%					
WED		0		57,603		0.0%					
THU		0		57,603		0.0%					
FRI		0		57,603		0.0%					
SAT		0		57,603		0.0%					

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				36,653							
	Week Ending	0	0		0		0%		0.0	0	0%
	Month End	**21,066**	**20,950**		**116**	**0.6%**	**100%**		**6.4**	**5102**	**0.0%**

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				57,603							
MON		0		57,603	0	0.0%	100%				0.0%
TUE		0		57,603	0	0.0%	100%				0.0%
WED	11/1/2006	922	920	58,523	2	0.2%	100%	195.00	5.90	208	0.0%
THU	11/2/2006	941	937	59,460	4	0.4%	100%	165.00	5.91	203	0.0%
FRI	11/3/2006	799	797	60,257	2	0.3%	100%	138.00	6.03	157	0.0%
SAT	11/4/2006	112	109	60,366	3	2.7%	100%	174.00	6.53	4	0.0%
	Week Ending	2,774	2,763		11	0.4%	100%		6.0	572	0%
MON	11/6/2006	1,544	1,397	61,763	147	9.5%	100%	2583.00	6.12	157	0.0%
TUE	11/7/2006	1,088	1,078	62,841	10	0.9%	100%	501.00	6.00	484	0.0%
WED	11/8/2006	956	948	63,789	8	0.8%	100%	638.00	6.28	234	0.0%
THU	11/9/2006	859	839	64,628	20	2.3%	100%	364.00	6.47	159	0.0%
FRI	11/10/2006	0		64,628	0	0.0%	100%	0.00			0.0%

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Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				57,603							
SAT	11/11/2006	0		64,628	0	0.0%	100%	0.00			0.0%
	Week Ending	4,447	4,262		185	4.2%	100%		6.2	1034	0%
MON	11/13/2006	1,154	1,140	65,768	14	1.2%	100%	873.00	6.37	291	0.0%
TUE	11/14/2006	961	958	66,726	3	0.3%	100%	392.00	6.27	252	0.0%
WED	11/15/2006	908	877	67,603	31	3.4%	100%	1137.00	6.73	231	0.0%
THU	11/16/2006	808	808	68,411	0	0.0%	100%	190.00	6.65	318	0.0%
FRI	11/17/2006	614	614	69,025	0	0.0%	100%	226.00	6.38	222	0.0%
SAT	11/18/2006	55	54	69,079	1	1.8%	100%	363.00	6.75	12	0.0%
	Week Ending	4,500	4,451		49	1.1%	100%		6.5	1326	0%
MON	11/20/2006	780	779	69,858	1	0.1%	100%	159.00	6.63	213	0.0%
TUE	11/21/2006	581	580	70,438	1	0.2%	100%	411.00	6.20	266	0.0%
WED	11/22/2006	468	467	70,905	1	0.2%	100%	127.00	5.62	215	0.0%
THU	11/23/2006	0		70,905	0	0.0%	100%	0.00			0.0%
FRI	11/24/2006	0		70,905	0	0.0%	100%	0.00			0.0%

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				57,603							
SAT	11/25/2006	0		70,905	0	0.0%	100%	0.00			0.0%
	Week Ending	1,829	1,826		3	0.2%	100%		6.2	694	0%
MON	11/27/2006	935	930	71,835	5	0.5%	100%	215.00	6.37	167	0.0%
TUE	11/28/2006	786	785	72,620	1	0.1%	100%	140.00	6.58	98	0.0%
WED	11/29/2006	684	681	73,301	3	0.4%	100%	368.00	6.43	177	0.0%
THU	11/30/2006	816	814	74,115	2	0.2%	100%	111.00	6.25	178	0.0%
FRI		0		74,115	0	0.0%	100%	0.00			0.0%
SAT		0		74,115	0	0.0%	100%	0.00			0.0%
	Week Ending	3,221	3,210		11	0.3%	100%		6.4	620	0%
MON		0		74,115		0.0%					
TUE		0		74,115		0.0%					
WED		0		74,115		0.0%					
THU		0		74,115		0.0%					
FRI		0		74,115		0.0%					

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				57,603							
SAT		0		74,115		0.0%					
	Week Ending	0	0		0		0%		0.0	0	0%
	Month End	**16,771**	**16,512**		**259**	**1.5%**	**100%**		**6.3**	**4246**	**0.0%**

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				74,115							
MON		0		74,115	0	0.0%	100%				0.0%
TUE		0		74,115	0	0.0%	100%				0.0%
WED		0		74,115	0	0.0%	100%				0.0%
THU		0		74,115	0	0.0%	100%				0.0%
FRI	12/1/2006	627	627	74,742	0	0.0%	100%	338.00	6.03	141	0.0%
SAT	12/2/2006	69	69	74,811	0	0.0%	100%	56.00	5.50	47	0.0%
	Week Ending	696	696		0	0.0%	100%		6.0	188	0%
MON	12/4/2006	1,251	1,184	75,926	67	5.4%	100%	1269.00	6.02	131	0.0%
TUE	12/5/2006	1,129	1,106	77,032	23	2.0%	100%	588.00	6.38	127	0.0%
WED	12/6/2006	857	848	77,880	9	1.1%	100%	319.00	6.02	120	0.0%
THU	12/7/2006	725	722	78,602	3	0.4%	100%	271.00	6.47	101	0.0%
FRI	12/8/2006	570	568	79,170	2	0.4%	100%	231.00	6.87	75	0.0%

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Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				74,115							
SAT	12/9/2006	51	51	79,221	0	0.0%	100%	3.00	6.30	2	0.0%
	Week Ending	4,583	4,479		104	2.3%	100%		6.3	556	0%
MON	12/11/2006	934	927	80,148	7	0.7%	100%	456.00	6.25	170	0.0%
TUE	12/12/2006	805	797	80,945	8	1.0%	100%	332.00	5.83	77	0.0%
WED	12/13/2006	655	652	81,597	3	0.5%	100%	248.00	6.33	96	0.0%
THU	12/14/2006	618	617	82,214	1	0.2%	100%	258.00	6.28	62	0.0%
FRI	12/15/2006	503	480	82,694	23	4.6%	100%	926.00	6.20	145	0.0%
SAT	12/16/2006	31	31	82,725	0	0.0%	100%	0.00	7.05	114	0.0%
	Week Ending	3,546	3,504		42	1.2%	100%		6.2	664	0%
MON	12/18/2006	801	796	83,521	5	0.6%	100%	416.00	6.02	329	0.0%
TUE	12/19/2006	598	597	84,118	1	0.2%	100%	181.00	6.67	164	0.0%
WED	12/20/2006	616	613	84,731	3	0.5%	100%	138.00	6.07	97	0.0%
THU	12/21/2006	635	634	85,365	1	0.2%	100%	241.00	5.93	91	0.0%
FRI	12/22/2006	323	323	85,688	0	0.0%	100%	100.00	5.72	62	0.0%

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Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				74,115							
SAT	12/23/2006	0		85,688	0	0.0%	100%	0.00			0.0%
	Week Ending	2,973	2,963		10	0.3%	100%		6.1	743	0%
MON	12/25/2006	0		85,688	0	0.0%	100%				0.0%
TUE	12/26/2006	473	472	86,160	1	0.2%	100%	278.00	5.95	70	0.0%
WED	12/27/2006	525	522	86,682	3	0.6%	100%	241.00	5.73	143	0.0%
THU	12/28/2006	591	590	87,272	1	0.2%	100%	343.00	5.98	136	0.0%
FRI	12/29/2006	461	459	87,731	2	0.4%	100%	494.00	6.90	68	0.0%
SAT	12/30/2006	0		87,731	0	0.0%	100%				0.0%
	Week Ending	2,050	2,043		7	0.3%	100%		6.1	417	0%
MON		0		87,731		0.0%					
TUE		0		87,731		0.0%					
WED		0		87,731		0.0%					
THU		0		87,731		0.0%					
FRI		0		87,731		0.0%					

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Standard						**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
				74,115							
SAT		0		87,731		0.0%					
	Week Ending	0	0		0		0%		0.0	0	0%
	Month End	**13,848**	**13,685**		**163**	**1.2%**	**100%**		**6.2**	**2568**	**0.0%**