Florida Medicaid Reform

Quarterly Progress Report
October 1, 2007 – December 31, 2007

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Condition # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the second quarterly report in Year Two of the demonstration for the period of October 1, 2007 through December 31, 2007. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly reports and the annual report which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including current contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on page 5 and are an integral part of the demonstration.

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

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

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

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06

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

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

Current Activities

Table 1 indicates one pending contract from the initial set of health plan applicants; Better Health Plan, a FFS PSN. Better Health Plan has experienced a major change in network design and, at this time, the Agency anticipates its Phase III site survey may occur in the Spring of 2008. An expected date of application approval is unknown; however, the Agency continues to provide technical assistance to Better Health Plan. Additionally, the Agency continues to receive inquiries from other interested health providers on the prospects of submitting an application to become a Reform PSN or HMO but no additional applications have been received to date.

As of December 31, 2007, the Agency has contracted with 17 health plans; 11 of these are HMOs and 6 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note

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

Table 2
Medicaid Reform Health Plan Contracts

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

Transition – Baker, Clay and Nassau Counties

In December 2007, the Agency completed the transition of current recipients into the two Reform health plans approved for the three expansion counties (Baker, Clay and Nassau). These two health plans provide a choice of enrolling in an HMO or a PSN, options that did not exist for beneficiaries prior to the demonstration.

By the end of December 2007, the Agency executed contract amendments for the majority of Reform health plans relative to requirements in the following quality areas:

- The receipt and use of Medicaid redetermination date information;
- The structure, content, effectiveness of their Quality Improvement Programs, including performance improvement plans;

- Disease management programs;
- Cultural competency plan;
- Deficit Reduction Act of 2005 (related to compliance with the requirements of Section 6032, Employee Education About False Claims Recovery);
- Marketing
- PSN claims processing and reporting;
- PSN encounter data; and
- PSN conversion application requirements.

FFS PSN Conversion Process

In November 2007, the Agency provided the PSNs with guidelines for transitioning from FFS PSN contracts to capitated contracts via a Conversion WorkPlan and Conversion Application. These documents were also posted on the Agency's Reform website. Pursuant to s. 409.91211(3)(e), F.S., Reform FFS PSNs must convert to capitation by no later than the beginning of the fourth year of operation. This will require current PSNs to enter into a capitated health plan contract with a service date of September 1, 2009, unless the PSN opts to convert to capitation earlier. Prerequisite to executing a capitated contract, existing Reform FFS PSNs must submit a comprehensive conversion workplan, complete and submit the Medicaid Reform FFS PSN Conversion Application, and successfully pass all phases of the conversion application review process.

The conversion workplan will describe in detail how the PSN intends to meet the requirements in the conversion application. The conversion workplan must include goals and action steps for each submission requirement listed in the Conversion Application. The Agency provided a sample workplan format to the PSNs. The due date for the conversion workplans was January 31, 2008. Once the Agency receives the workplans it will review them and offer technical assistance in areas in which the plans are lacking.

Below is the timeline for each step in this conversion process:

PSN CONVERSION TO CAPITION TIMELINE	
01/31/2008	Deadline for the FFS PSN to submit its conversion workplan to AHCA
12/31/2008	Deadline for the FFS PSN to submit its Conversion Application to AHCA
06/30/2009	AHCA and successful conversion applicants execute capitated contracts for service begin date of 09/01/2009
08/31/2009	Current Reform FFS PSN contracts expire

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Reform Year One, and again, for Reform Year Two of the demonstration. Interested parties were notified that the data book would be mailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the updated data book on May 23, 2007, to assure that the plans were familiar with the required coverage thresholds for the September 1, 2007 through August 31, 2008 period. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous year. The annual process of verifying the actuarial equivalency, sufficiency test standards and the tool (PET) is completed

during the last quarter of each year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

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

Current Activities

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

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

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

- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Home-delivered meals for a period of time after surgery, providing nutrition essential for proper recovery for elderly and disabled;
- Respite care;
- Nutrition Therapy;
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined); and
- Adult Hospital Outpatient – Additional $3,500/year for hospital outpatient services at Shands Jacksonville only (maximum $5,000/year combined).

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

The Agency's goal is to make the most of this expertise by providing a variety of options and increasing variation in the options over the five year period of the demonstration project. During this quarter, the Agency's Continuous Improvement Team held forums to discuss benefits, among other topics, with beneficiaries and providers (see page 69 of this report for more details). In combination with beneficiary choice data, the Agency is using the information gathered during these sessions and the plan customized benefit packages to gauge the needs and preferences of beneficiaries. This experience and knowledge will ultimately benefit the beneficiaries by establishing a health care system with better opportunities for participating in health care choices and increasing personal engagement.

3. Grievance Process

Overview

The grievance and appeals process specified in the Reform health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, Medicaid fair hearing system, and timeframes for submission, plan response and resolution. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. In addition, the Medicaid Reform health plan contracts include a provision for the submission of unresolved grievances,

upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations. This provides an additional level of appeal.

As defined in the Medicaid Reform health plan contracts:

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

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

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

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

Current Activities

Since the implementation of the demonstration on July 1, 2006, no grievances or appeals have been reported to the Agency through its SAP or BAP. While the Agency is pleased that grievances and appeals have not reach the SAP or BAP, to improve the demonstration, the Agency recognizes the need to understand the nature of all issues,

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

Table 3 provides the number of grievances, appeals, and fair hearings by health plan type for this quarter. In addition, BAP and SAP requests are also included.

Table 3
Grievances and Appeals; Fair Hearings; BAP and SAP
October 1, 2007 – December 31, 2007

	PSN	HMO
Grievances	26	99
Appeals	15	22
Fair Hearings	0	0
BAP or SAP, as applicable by plan type	0	0

Grievances

For this quarter, there were a total of 125 grievances reported by the health plans, with six health plans having no grievances reported (four HMOs, two PSNs). This equates to a total of 125 grievances for approximately 192,900 enrolled members (based on December 2007 enrollment) in the 17 health plans. Health plans appear to be successfully resolving these grievances and appeals at the plan level as no grievances have been submitted to the SAP or BAP, and the number of fair hearings continues to be low.

Appeals

Health plans reported a total of 37 appeals this quarter. Eleven health plans did not report appeals (8 HMOs; 3 PSNs).

Medicaid Fair Hearing

Medicaid fair hearings are conducted through the Department of Children and Families (DCF) and as a result, health plans are not required to report the number of fair hearings requested by enrolled members. The Agency does monitor the fair hearing process. No fair hearings were held related to health plans this quarter.

The Agency continues to work with the health plans to ensure that quality of care and adequate service provision is provided to enrolled Medicaid recipients.

4. Complaint/Issue Resolution Process

Effective October 1, 2007, the Agency implemented a single database for reporting on health plan complaints/issues. The consolidated complaint database includes an

automatic referral process so that if complaints need to be referred from an area office to headquarters or to a different headquarters office, an email will automatically go to the unit with the referral.

The consolidated complaint database was developed utilizing the expertise of Agency staff. The staff worked diligently to define database fields and processes for capturing data. In addition, a subgroup continues to work on creating quality control reports as well as trend reports. This subgroup includes technical systems personnel, Bureau Chiefs, and administrators who use this data when trending over time to determine the volume of compliance issues and whether to recommend operational and policy changes. For this quarter, we will be reporting using the data collected via the complaints/issues database. Therefore, a change in formatting will be apparent.

During the next quarter, the Agency intends to conduct feedback meeting(s) with headquarters and area staff on the ease of using the database and to facilitate discussion on whether other training or changes are needed. In addition, the Agency will continue honing its trend and quality control reports. The Agency is tracking complaints by plan and will continue to review particular complaint data with the individual plans as trends become apparent.

This quarter, the Agency received 15 complaints/issues related to FFS PSNs and received 47 complaints/issues related to HMOs, for a total of 62 complaints. The complaints/issues received during this quarter are provided in Attachments I and II, sorted by PSN or HMO. Attachment I provides the details on the complaints/issues related to FFS PSNs and outlines the action(s) taken by the Agency or the Agency's Fiscal Agent, ACS, to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency to address those issues raised.

This quarter, the majority of PSN complaints/issues continued to be provider claims issues, with the remaining six being associated with member issues. Member issues included dental, medications, and specialty referrals. Provider issues included payment delays. This quarter, many delays were due to a backlog of paper claims at the Medicaid fiscal agent, unrelated to PSN processing but affecting PSN providers nonetheless. All but four provider issues have been closed and resolved. The Agency continues to facilitate conference calls between the providers, including some county health departments, and the PSNs to ensure providers are appropriately informed regarding claims processing requirements and health plans are processing claims appropriately.

During the quarter, the majority of the HMO complaints/issues were related to member issues, with only 16 complaints/issues being related to provider issues. Member issues included dental, medications and specialty referrals. Provider issues included payment delays/denials and eligibility confirmation. All issues except one provider issue have been closed and resolved.

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

Outreach Activities

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

B. Choice Counseling Program

Overview

Medicaid Reform is six months into Year Two of demonstration. The goals established for the Choice Counseling program prior to implementation continue to be realized and in many cases, the original goals have already been surpassed. With these successes, the Choice Counseling program continues to evaluate and improve the program.

In Medicaid Reform, beneficiaries are making their own decisions about health plan choices at the highest rate in the history of Florida's Medicaid managed care programs as they evaluate the benefit packages determining what the best coverage is for themselves and their families. Beneficiaries are also for the first time being asked for their feedback through the Customer Service Survey, and they are responding positively.

By choosing a plan that meets their needs, beneficiaries have access to the services they need, which is a fundamental goal of Medicaid Reform. A beneficiary voluntarily choosing his or her own health plan supports another key element of Medicaid Reform, which is a marketplace decision. As beneficiaries choose, they drive the competitive marketplace.

Another goal of Medicaid Reform is to increase patient responsibility and empowerment. Choice Counselors support this goal by reaching out to beneficiaries to ensure that over 65 percent of them will make their own health plan choice. During the second quarter, over 80 percent of the beneficiaries made their own health plan choice. This active decision increases patient satisfaction and provides the necessary foundation for the beneficiary to understand how to access care in a managed care setting.

As the Agency continues to work to improve the Choice Counseling program, the expertise of other states and input from Medicaid beneficiaries, advocates, providers, plans and other interested parties continue to play an integral role. The input provided by these key stakeholders continues to improve on the results achieved in Year Two of demonstration. The following highlights some of the major achievements of the Choice Counseling program:

- The highest voluntary enrollment rate in the history of Florida Medicaid managed care.
- Certified Choice Counselors ensuring each counselor has the knowledge and interpersonal skills necessary to serve Florida's most vulnerable population. This certification program is the first in the nation.
- Special Needs Unit to serve the medically complex and their families which allows beneficiaries enrolling in managed care for the first time to receive the additional assistance their health status requires.

- Intensive outreach campaign prior to implementation of the demonstration, to educate the community and beneficiaries on Medicaid Reform and the timeframes for plan choice and enrollment.
- Field Choice Counselor efforts to find and reach beneficiaries that are not responding to mailings, by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These changes resulted in over 38 percent of the enrollments being done at the local level. This enrollment level is significantly higher than the 10 percent estimated for field enrollment prior to implementation.

Details on these and other components of the Choice Counseling Program are described in detail in this section.

Current Activities

1. Public Meetings and Beneficiary Feedback

The Agency continues to conduct beneficiary focus groups and public meetings in the Reform counties to solicit input on the Choice Counseling Program. As a result of the feedback from public meetings held in previous quarters and two held during this quarter, more changes are coming to the Choice Counseling Program. These changes include the implementation of a preferred drug search functionality and additional changes to Choice Counseling materials.

During Year One of the demonstration, concerns about beneficiaries not being able to easily access information on prescribed medication coverage prior to enrollment was stressed at numerous meetings and in other communication with interested parties. The Agency and the Choice Counseling vendor, Affiliated Computer Services (ACS) researched the options available to address this concern. The outcome of the feedback and research was the development of the Navigator solution.

Navigator is a Preferred Drug List (PDL) search system. The Navigator system will contain each Medicaid Reform health plan's PDL and prescribed drug claims data. For those beneficiaries that have prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator would be able to pull their medication data and then provide detailed information on how each plan meets their current prescribed drug needs. Utilizing claims data would allow the information to be detailed down to dosage levels, number of times the medication is taken in a year and more. All this detail allows the system to provide more information to the beneficiary and does not require that they remember their current medications.

The Navigator system also has the capability to allow a Choice Counselor to input prescribed drugs for beneficiaries that do not have prior claims history. This process would permit the counselors to provide basic information to the beneficiaries on how each plan meets their current prescribed drug needs. The Choice Counselor's role would *not be* counseling beneficiaries on the medications themselves, but stating the results based on their search in the PDL of which health plans covered their medication.

This process would allow the beneficiary to select a plan more easily, and give them more criteria for selection.

The Agency brought a demonstration of the new Navigator PDL (Preferred Drug List) to a Public Meeting in December 2007 in Broward County, which was well received by the participants. The public comments and questions that were expressed are being considered as the system continues to be developed. We hope to bring the Navigator PDL demonstration into Duval County in the early part of 2008 for their feedback and comments, and implement the Navigator system within the first half of 2008.

ACS implemented an automated beneficiary survey function in the Choice Counseling Call Center in August 2007. Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. During this quarter, over 1,967 beneficiaries completed the automated survey.

The survey questions are broken down into 5 main categories:

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

The Customer Survey ratings consider 100% to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. One hundred percent (100%) or 9 reflects a truly delighted caller. The scores translate into percentages as follows:

1= 00.00%,

2= 12.50%,

3= 25.00%,

4= 37.50%,

5=50.00%,

6=62.50%,

7= 75.00%, and

8= 87.50% 9=100%

The graph on the following page shows how beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from October through December of 2007:

Florida Choice Counseling

Percentage of Delighted Callers for Each Question

How helpful do you find this counseling to be		
Oct	Nov	Dec
89.10%	90.60%	89.40%

Satisfaction with the amount of time you waited to speak with a counselor		
Oct	Nov	Dec
80%	83.40%	80.90%

How easy it was to understand the information		
Oct	Nov	Dec
78.10%	79.50%	80.00%

How likely are you to recommend Choice Counseling helpline to friend or relative		
Oct	Nov	Dec
94.50%	95.80%	93.90%

Overall service provided by the Counselor		
Oct	Nov	Dec
96.90%	97.20%	97.40%

How quickly the Counselor understood why you called today		
Oct	Nov	Dec
95.90%	96.70%	95.30%

The Counselor's ability to help you choose your health plan		
Oct	Nov	Dec
92.40%	93.40%	93.60%

The Counselor's ability to explain things clearly		
Oct	Nov	Dec
96%	95.60%	96.20%

The confidence you have in the information given to you by the counselor		
Oct	Nov	Dec
95%	95.20%	94.80%

Satisfaction with being treated respectfully		
Oct	Nov	Dec
98%	96.50%	97.90%

Even though the initial feedback provided by beneficiaries has been very positive, the Agency and ACS are evaluating the responses on the materials. The overall ranking of the materials is high (over 78-80% and a ranking of 8 or 9) but a further analysis revealed more fluctuation in the response range for these questions compared to other questions. As a result, the Agency and ACS are reviewing the materials and working on possible revisions. Any considered changes will be vetted in public meetings and beneficiary focus groups as done previously.

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

2. Call Center

During this quarter, the Choice Counseling Call Center, located in Tallahassee, Florida, operated a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation were adjusted during this quarter to better align the call center hours with beneficiary demand. In October, call center hours were 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday. The call center was staffed with over 30 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole. The Agency and ACS made adjustments to staff schedules and prepared to pilot the new call center hours in November 2007.

Beginning November 1, 2007, the new Choice Counseling Call Center hours were implemented. The call center stayed open one additional hour during the evening on Monday and Thursday and the Saturday hours were adjusted to 9:00 a.m. – 11:00 a.m. The pilot plan was operational during November and December, and based on the continued low number of calls on Saturdays (both inbound and outbound), it was decided to continue the pilot into the next quarter with more adjustments in the call center hours. The Agency and ACS will continue to closely monitor call volume (both inbound and outbound) to maximize access for beneficiaries.

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 health plan choice and have not yet contacted Choice Counseling.

Attachment IV details the Choice Counseling Call Center activity for this quarter. The following is a highlight of the call volume during the quarter and ACS's performance on key contract standards:

Inbound Calls:	39,963
Outbound Calls:	12,437
Calls Abandoned:	
(The contract standard is <5% *monthly)*	2.28%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call Answered in <15 seconds:	76.73%
Calls Answered in <60 seconds:	80.26%
Calls Answered in <180 Seconds:	94.52%

The contract standard for calls answered in less then 180 seconds is 96%. With the implementation of a new script (which increased the counselors talk time by over three minutes per call) the Agency and ACS have been watching this very carefully. In October and November, the Choice Counselors were trained on the new script and demonstrated an overall percentage drop to 93.54% of all calls answered within 180 seconds. By December, the percentage was back up to 96.48%, as the Choice Counselors became more familiar with the script and the talk time returned to the nine minute range. The 15 and 60 second call rates do not have a contract standard but are monitored as well because they are indications of customer service provided by the call center.

3. Mail

Starting in October 2007, the volume of activity in the mailroom has decreased after the transition of beneficiaries located in Baker, Clay and Nassau counties was completed.

Outbound Mail

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

New-Eligible Packets	22,437
Auto-Assignment Letters	12,224
Confirmation Letters	8,685
Open Enrollment Packets	12,719
Transition Packets	10,067

During the quarter, the percentage of mail that was returned averaged 4.3% for the quarter. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary.

Inbound Mail:

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

Plan Enrollments	1,005
Plan Changes	391

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

4. Face-to-Face/Outreach and Education

The Field Choice Counselors continue to complete a significant number of enrollments and during the quarter the numbers of field enrollments increased. The numbers demonstrate that the adjustments made in the Field Choice Counseling activities, during the first year of operation, continues to allow ACS to service “hard to reach” populations.

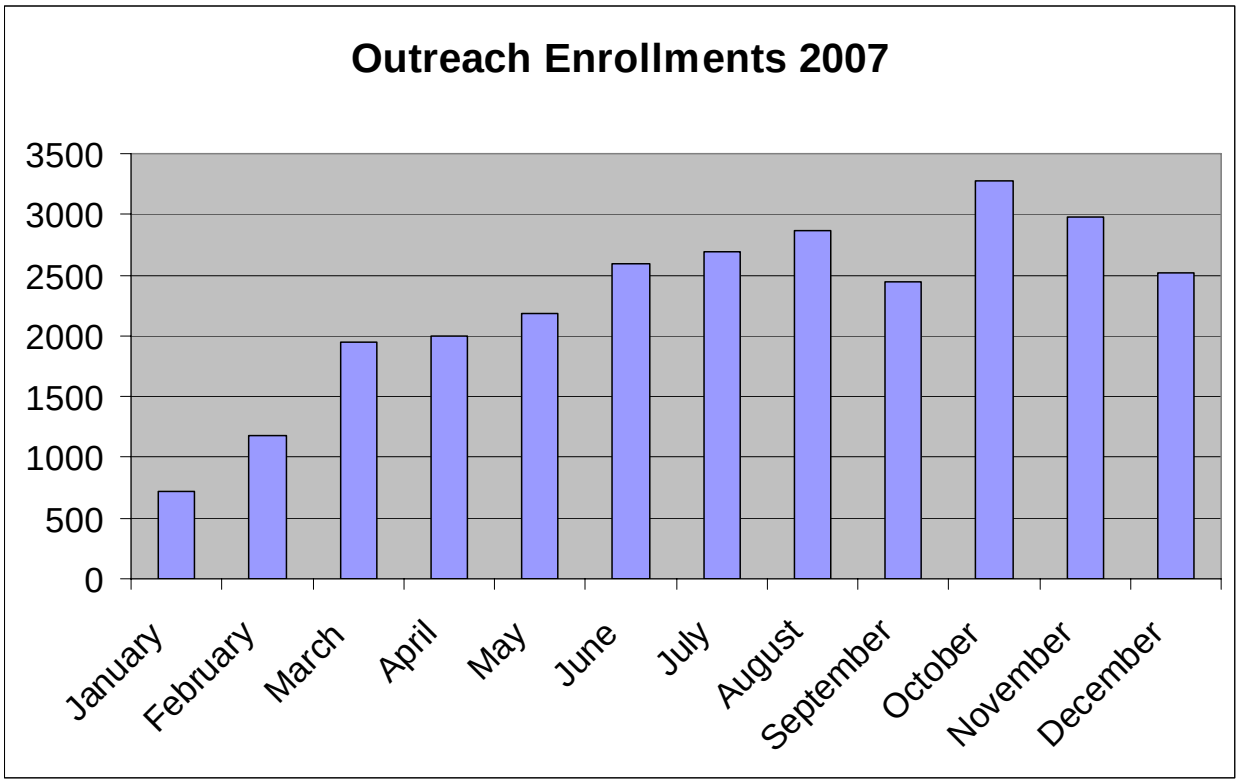
The major change in the Field Choice Counseling activities in this quarter was the implementation of a beneficiary call back monitoring system. During Year One of the demonstration, the Field Choice Counseling supervisors handled most of the Field monitoring done by ACS. In September of 2007, the quality monitoring staff, located in Tallahassee, began calling random beneficiaries who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 4 shows the beneficiaries’ responses (in percentages) from 161 beneficiaries randomly called that participated in the survey (from October through December 2007). The same percentage range used in the call center is used in the field, with 100% being a perfect score.

Table 4
Overall Choice Counseling Field Results

Able to complete enrollment/plan change at the session	93.8%
Felt the information provided by the Choice Counselor helped them make an informed decision	95.7%
The information was explained in a way that made it easy to understand	98.1%
The Choice Counselor was friendly/courteous	99.4%

At the end of the quarter, the enrollment activities processed by Field Choice Counselors were 8,882 enrollment activities. This is the highest quarterly enrollment effort in the Field. The highest Field Choice Counseling enrollment month so far was October 2007 with 3,363 Field enrollments. Table 5 demonstrates the dramatic increases in the Field Choice Counseling effort from implementation through the end of this quarter on December 31, 2007.

Table 5
Choice Counseling Enrollments for 2007



Another focus of the Field Choice Counselors was continuing to better reach the special needs and hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups has included: providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities and other types of community based organizations that serve these population groups. In October 2007, the Field Choice Counselors also focused their outbound calls on pending auto assignments, which is a list of recipients that have not made a choice of health plans and are within two weeks of being assigned to a health plan by the state. Contacting the beneficiaries on this list greatly helped increased the Field Choice Counseling enrollments and increased our customer service to beneficiaries.

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

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

Group Sessions	741
Private Sessions	105
Home Visits & One-On-One Sessions	144
"No Phone List"	1,403
Outbound Phone List	8,916
Enrollments	8,882
Plan Changes	254

5. Health Literacy

In December 2007, the new registered nurse supervisor was hired and began her duties in the Special Needs Unit with ACS. The Special Needs Unit has primary responsibility for the health literacy function in the Choice Counseling Program. Based on experience gained during Year One of the demonstration, the departure of the previous nurse provided an opportunity to evaluate the functions of this unit to ensure the goals of increasing health literacy and serving the needs of the medically and physically complex were being met. The evaluation was completed in the September 2007, and the Special Needs Unit when fully staffed will include: one registered nurse supervisor, two licensed practical nurses and one social worker. Additional nurses in the field will be added after this initial group has been hired and trained. The new nurse supervisor has completed her Choice Counseling certification and has begun the hiring process for an additional nurse for the unit.

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

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

6. Voluntary Selection Data

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

During this quarter, the voluntary enrollment rate was 80.70%. ACS was above the contract standard of 65% for the quarter. The Agency is especially pleased that the voluntary enrollment rate for each month of the quarter remained significantly above the 65% required by the contract. In fact, in all three months of the quarter, the voluntary enrollment rate was above 80%. A breakdown of the new-eligible enrollment figures for this quarter is provided in Table 6.

Table 6
New Eligible Voluntary Enrollment Rate
2nd Quarter in Year 2

Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Baker, Broward, Clay, Duval and Nassau Counties	
Voluntary Choice Total	19,592
Assigned Total	4,690
October Voluntary	6,781
November Voluntary	6,384
December Voluntary	6,427
Voluntary Enrollment Rate:	
Baker, Broward, Clay, Duval, Nassau Combined	80.70%

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. During the previous quarter, the Agency and ACS implemented an automated beneficiary survey where complaints against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call. The Agency is working with ACS on an avenue to account for the complaint recordings left via the automated survey so those comments can be added to this report.

During this quarter, there were 8 complaints filed related to the Choice Counseling Program. Attachment III provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves public meetings, beneficiary focus groups and the new automated survey previously mentioned in this report. The focus groups allow the Agency to hear from beneficiaries on the successes, complaints, as well as ideas for improvements. Another

important aspect is feedback received during the public meetings from the advocates, providers, plans and others who work with and represent beneficiaries.

The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries by striving for excellence in all areas. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results indicate that in October, 96.90% of beneficiaries were extremely satisfied with the Counselor's ability to explain things clearly. In November 2007, the percentage of satisfied beneficiaries rose to 97.20%, and in December 2007 it increased to 97.40%.

While focusing on explaining health plan information more clearly, the beneficiary's confidence in the information given to them by the Choice Counselor has also increased. As shown in Table 7, on average the Counselors earned a rating of 8.751 in October 2007, 8.757 (on a scale of 1 to 10) in November, and 8.767 in December of 2007, with an overall average of 8.754 for the quarter.

ACS distributes individual report cards to each counselor on his or her performance. Survey scores and beneficiary comments are also provided to the supervisors and counselors. The positive comments encourage the counselor to keep up the good work and negative comments help to point out weaknesses requiring coaching or training.

Table 7
Confidence in Information Provided by Counselors

CONFIDENCE	
October Average	8.751
November Average	8.757
December Average	8.767
3 Month Average	8.754
Point Change	0.0057
Percent Increase	0.07%

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

The Agency Headquarters, Medicaid Area Office, and ACS Choice Counseling staff members continue to utilize the internal feedback loop. This feedback loop involves: (1) face-to-face meetings between Medicaid Area Office staff and ACS Field staff, (2) e-mail boxes on ACS's enrollment system to enable the Agency and ACS staff to share information directly to resolve difficult cases, and (3) regularly scheduled weekly conference calls.

C. Enrollment Data

Overview

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

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

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

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

Current Activities

Transition Plan for Baker, Clay and Nassau Counties

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

Waiver) into a Medicaid Reform health plan. The population was transitioned from HMOs, MediPass, and MPNs. The transition schedule for Baker, Clay and Nassau counties is as follows:

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

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

November 2007 Enrollment: Remaining beneficiaries located in Clay County.

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

During this quarter, enrollment in Medicaid Reform health plans located in Baker, Clay, and Nassau counties was primarily based on this transitional process. Specifically, the October, November, and December 2007 transition focused on enrollment of all remaining beneficiaries located in these counties into a Reform health plan, as well as a small number of newly eligible beneficiaries. Beneficiaries were given 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 Baker, Clay, or Nassau county Reform health plan was September 1, 2007.

Monthly Enrollment Reports

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

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

Below is a summary of the monthly enrollment in Medicaid Reform for this quarter, beginning October 1, 2007 and ending December 31, 2007. This section contains the following Medicaid Reform enrollment reports:

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

All Medicaid Reform health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 17 Medicaid Reform health plans – eleven HMOs and six fee-for-service PSNs. There are two categories of Medicaid beneficiaries who are enrolled in Reform health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 8 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 8
Medicaid Reform Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 9 on the following page for the Fiscal Year 2007-08, 2nd Quarter – Year Two Medicaid Reform Enrollment Report.

Table 9
Medicaid Reform Enrollment Report
(Fiscal Year 2007-08, 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	11,623	1,483	0	136	**13,242**	**6.24%**	12,117	9.28%
Buena Vista	HMO	6,171	703	2	53	**6,929**	**3.27%**	6,960	-0.45%
Freedom Health Plan	HMO	35	8	0	1	**44**	**0.02%**	0	N/A
HealthEase	HMO	49,301	5,570	3	508	**55,382**	**26.10%**	55,972	-1.05%
Humana	HMO	8,659	1,958	3	205	**10,825**	**5.10%**	11,016	-1.73%
Preferred Medical Plan	HMO	1,524	466	0	44	**2,034**	**0.96%**	2,147	-5.26%
StayWell	HMO	31,070	3,034	1	291	**34,396**	**16.21%**	33,222	3.53%
Total Health Choice	HMO	1,315	288	0	39	**1,642**	**0.77%**	1,546	6.21%
United Health Care	HMO	19,209	2,550	6	364	**22,129**	**10.43%**	16,992	30.23%
Universal Health Care	HMO	155	27	0	0	**182**	**0.09%**	252	-27.78%
Vista South Florida	HMO	4,003	418	2	54	**4,477**	**2.11%**	3,552	26.04%
HMO Total		**133,065**	**16,505**	**17**	**1,695**	**151,282**	**71.29%**	**143,776**	**5.22%**
Access Health Solutions	PSN	15,831	3,169	2	141	**19,143**	**9.02%**	11,436	67.39%
CMS	PSN	1,620	2,097	0	15	**3,732**	**1.76%**	3,482	7.18%
First Coast Advantage	PSN	12,661	3,507	3	237	**16,408**	**7.73%**	16,479	-0.43%
NetPass	PSN	3,052	1,499	1	120	**4,672**	**2.20%**	4,841	-3.49%
Pediatric Associates	PSN	9,623	555	0	1	**10,179**	**4.80%**	10,276	-0.94%
SFCCN	PSN	4,417	2,206	0	156	**6,779**	**3.19%**	7,150	-5.19%
PSN Total		**47,204**	**13,033**	**6**	**670**	**60,913**	**28.71%**	**53,664**	**13.51%**
Reform Enrollment Totals		**180,269**	**29,538**	**23**	**2,365**	**212,195**	**100.00%**	**197,440**	**7.47%**

The Reform market share percentage for each plan is calculated once all beneficiaries have been counted and the total number of beneficiaries enrolled is known.

The enrollment figures for this quarter reflect those beneficiaries who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 212,195 beneficiaries enrolled in Medicaid Reform during this quarter. There were 17 Reform plans with market shares ranging from 0.02 percent to 26.10 percent.

2. Medicaid Reform Enrollment by County Report

Medicaid Reform is currently operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of Reform HMOs and Reform PSNs in each county is listed in Table 10 on the following page.

Table 10
Number of Reform Health Plans in Demonstration Counties

County Name	# of Reform HMOs	# of Reform PSNs
Baker	**1**	**1**
Broward	**11**	**6***
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

*Note: There are two CMS Reform PSNs in Broward County – CMS (North Broward) and CMS (South Broward).

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Medicaid Reform counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, Reform HMOs are listed first, followed by Reform PSNs. Table 11 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 11
Medicaid Reform Enrollment by County Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 12 and located on the following page.

Table 12
Medicaid Reform Enrollment by County Report
(Fiscal Year 2007-08, 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				
United Health Care	HMO	Baker	424	80	0	8	**512**	**23.25%**	84	509.52%
Access Health Solutions	PSN	Baker	1,502	182	0	6	**1,690**	**76.75%**	67	2422.39%
Total Reform Enrollment for Baker			**1,926**	**262**	**0**	**14**	**2,202**	**100.00%**	**151**	**1358.28%**
Amerigroup	HMO	Broward	11,623	1,483	0	136	**13,242**	**10.87%**	12,117	9.28%
Buena Vista	HMO	Broward	6,171	703	2	53	**6,929**	**5.69%**	6,960	-0.45%
Freedom Health Plan	HMO	Broward	35	8	0	1	**44**	**0.04%**	0	N/A
HealthEase	HMO	Broward	14,684	1,463	2	134	**16,383**	**13.45%**	16,230	0.94%
Humana	HMO	Broward	8,659	1,958	3	205	**10,825**	**8.89%**	11,016	-1.73%
Preferred Medical Plan	HMO	Broward	1,524	466	0	44	**2,034**	**1.67%**	2,147	-5.26%
StayWell	HMO	Broward	28,041	2,678	1	234	**30,954**	**25.42%**	30,084	2.89%
Total Health Choice	HMO	Broward	1,315	288	0	39	**1,642**	**1.35%**	1,546	6.21%
United Health Care	HMO	Broward	6,655	1,075	4	186	**7,920**	**6.50%**	7,056	12.24%
Universal Health Care	HMO	Broward	60	19	0	0	**79**	**0.06%**	111	-28.83%
Vista South Florida	HMO	Broward	4,003	418	2	54	**4,477**	**3.68%**	3,552	26.04%
Access Health Solutions	PSN	Broward	2,438	892	0	47	**3,377**	**2.77%**	3,830	-11.83%
CMS North Broward	PSN	Broward	632	1,008	0	8	**1,648**	**1.35%**	1,591	3.58%
CMS South Broward	PSN	Broward	244	347	0	4	**595**	**0.49%**	532	11.84%
Netpass	PSN	Broward	3,052	1,499	1	120	**4,672**	**3.84%**	4,841	-3.49%
Pediatric Associates	PSN	Broward	9,623	555	0	1	**10,179**	**8.36%**	10,276	-0.94%
SFCCN	PSN	Broward	4,417	2,206	0	156	**6,779**	**5,57%**	7,150	-5.19%
Total Reform Enrollment for Broward			**103,176**	**17,166**	**15**	**1,422**	**121,779**	**100.00%**	**119,039**	**2.30%**
United Health Care	HMO	Clay	2,123	195	0	16	**2,334**	**30.87%**	510	357.65%
Access Health Solutions	PSN	Clay	4,511	694	0	22	**5,227**	**69.13%**	383	1264.75%
Total Reform Enrollment for Clay			**6,634**	**889**	**0**	**38**	**7,561**	**100.00%**	**893**	**746.70%**
HealthEase	HMO	Duval	34,617	4,007	1	374	**38,999**	**50.36%**	39,742	-1.87%
StayWell	HMO	Duval	3,029	356	0	57	**3,442**	**4.44%**	3,138	9.69%
United Health Care	HMO	Duval	9,274	1,076	2	148	**10,500**	**13.56%**	9,185	14.32%
Universal Health Care	HMO	Duval	95	8	0	0	**103**	**0.13%**	141	-26.95%
Access Health Solutions	PSN	Duval	5,323	1,116	2	65	**6,506**	**8.40%**	6,999	-7.04%
CMS	PSN	Duval	744	742	0	3	**1,489**	**1.92%**	1,359	9.57%
First Coast Advantage	PSN	Duval	12,661	3,507	3	237	**16,408**	**21.19%**	16,479	-0.43
Total Reform Enrollment for Duval			**65,743**	**10,812**	**8**	**884**	**77,447**	**100.00%**	**77,043**	**0.52%**
United Health Care	HMO	Nassau	733	124	0	6	**863**	**26.92%**	157	449.68%
Access Health Solutions	PSN	Nassau	2,057	285	0	1	**2,343**	**73.08%**	157	1392.36%
Total Reform Enrollment for Nassau			**2,790**	**409**	**0**	**7**	**3,206**	**100.00%**	**314**	**921.02%**
Reform Enrollment Totals			**180,269**	**29.538**	**23**	**2,365**	**212,195**		**197,440**	**7.47%**

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

During this quarter, there was an enrollment of 2,202 beneficiaries in Baker County; 121,779 beneficiaries in Broward County; 7,561 beneficiaries in Clay County; 77,447 beneficiaries in Duval County; and 3,206 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 23.25 percent to 76.75 percent; 17 Broward County Reform plans with market shares ranging from 0.04 percent to 25.42 percent; two Clay County Reform plans with market shares ranging from 30.87 percent to 69.13 percent; seven Duval County Reform plans with market shares ranging from 0.13 percent to 50.36 percent; and two Nassau County Reform plans with market shares ranging from 26.92 percent to 73.08 percent.

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

The Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either voluntarily or mandatorily) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 13 provides a description of each column in this report.

Table 13
Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# Voluntary Enrolled	The number of unique beneficiaries who voluntarily enrolled with the plan during the current reporting quarter
# Mandatory Enrolled	The number of unique beneficiaries who were mandatorily enrolled with the plan during the current reporting quarter
Total # Enrolled	The total number of unique beneficiaries enrolled with the plan during the current reporting quarter; voluntary and mandatory combined
% Enrolled Voluntary	The percentage of the total number of beneficiaries enrolled with the plan during the current reporting quarter who were enrolled voluntarily
# Disenrolled	The number of unique beneficiaries who disenrolled from the plan during the current reporting quarter

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

A. Medicaid Reform Enrollees

There are two ways a beneficiary can enroll in a Medicaid Reform health plan: voluntarily and mandatorily. Voluntary enrollments include newly-eligible beneficiaries who made a voluntary choice of which plan or program to enroll in. In addition, beneficiaries who were already enrolled in a managed care plan (including MediPass) and then were transitioned into a plan when Medicaid Reform began are included in the voluntary enrollment counts. Mandatory enrollments include newly-eligible beneficiaries who have not made a choice and assigned to a health 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 state fiscal year 2007-08 are those beneficiaries who appear on the enrollment list for October 2007 to December 2007, but not on the enrollment list for January 2008.

The unique beneficiary counts in the Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data report are divided by plan type in Table 14. Plans are listed by plan type (Reform HMO first, then Reform PSN) and in alphabetical order. Total counts for the quarter are also provided for HMOs and PSNs as well as the entire Medicaid Reform demonstration.

Table 14
Quarterly Summary of Voluntary* & Mandatory Selection Rates & Disenrollment Data
(Fiscal Year 2007-08, 2nd Quarter)

Plan Name	Plan Type	Plan County	# Voluntary Enrolled*	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary*	# Disenrolled
Amerigroup	HMO	Broward	12,269	973	**13,242**	**93%**	1,676
Buena Vista	HMO	Broward	6,443	486	**6,929**	**93%**	941
Freedom Health Plan	HMO	Broward	13	31	**44**	**30%**	0
HealthEase	HMO	Broward	15,290	1,093	**16,383**	**93%**	2,163
HealthEase	HMO	Duval	37,243	1,756	**38,999**	**95%**	5,428
Humana	HMO	Broward	10,014	811	**10,825**	**93%**	1,442
Preferred Medical Plan	HMO	Broward	1,471	563	**2,034**	**72%**	324
StayWell	HMO	Broward	29,458	1,496	**30,954**	**95%**	3,777
StayWell	HMO	Duval	2,333	1,109	**3,442**	**68%**	615
Total Health Choice	HMO	Broward	1,058	584	**1,642**	**64%**	323
United Health Care	HMO	Baker	7,209	711	**7,920**	**91%**	1,149
United Health Care	HMO	Clay	9,131	1,369	**10,500**	**87%**	1,561
United Health Care	HMO	Broward	446	66	**512**	**87%**	60
United Health Care	HMO	Duval	2,141	193	**2,334**	**92%**	309
United Health Care	HMO	Nassau	781	82	**863**	**90%**	99
Universal Health Care	HMO	Broward	47	32	**79**	**59%**	16
Universal Health Care	HMO	Duval	14	89	**103**	**14%**	0
Vista South Florida	HMO	Broward	4,081	396	**4,477**	**91%**	637
HMO Total			**139,442**	**11,480**	**151,282**	**92%**	**20,520**
Access Health Solutions	PSN	Baker	1,630	60	**1,690**	**96%**	135
Access Health Solutions	PSN	Clay	2,883	494	**3,377**	**85%**	448
Access Health Solutions	PSN	Broward	5,009	218	**5,227**	**96%**	606
Access Health Solutions	PSN	Duval	5,092	1,414	**6,506**	**78%**	992
Access Health Solutions	PSN	Nassau	2,266	77	**2,343**	**97%**	253
CMS North Broward	PSN	Broward	1,489	0	**1,489**	**100.00%**	131
CMS South Broward	PSN	Broward	1,648	0	**1,648**	**100.00%**	112
CMS	PSN	Duval	595	0	**595**	**100.00%**	44
First Coast Advantage	PSN	Duval	14,745	1,663	**16,408**	**90%**	1,932
Netpass	PSN	Broward	4,135	537	**4,672**	**89%**	0
Pediatric Associates	PSN	Broward	9,765	414	**10,179**	**96%**	1,367
SFCCN	PSN	Broward	5,722	1,057	**6,779**	**84%**	877
PSN Total			**54,979**	**5,934**	**60,913**	**90%**	**6,897**
Reform Enrollment Totals			**194,421**	**17,774**	**212,195**	**92%**	**27,417**

* Voluntary enrollments include newly-eligible beneficiaries who made a voluntary choice of which plan to enroll in, as well as beneficiaries who voluntarily chose to stay in the health plan they were transitioned into.

For this quarter, there were 194,421 voluntary enrollments (92% percent) in Medicaid Reform. Of those, 139,442 beneficiaries were enrolled in an HMO and 54,979 were enrolled in a PSN.

D. Opt Out Program

Overview

In January 2006, the Agency developed 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 contracted with Health Management Systems, Inc. (HMS), the current third party liability contractor, to administer the Opt Out Program. HMS submitted its proposal on March 31, 2006. The proposal provided a complete description of the Opt Out Program work flow which included the process for contacting beneficiaries, contacting employers, establishing the premium payment process and maintaining the Opt Out Program database. The Agency entered into a contract with HMS to conduct the Opt Out Program on July 1, 2006.

In April 2006, the Agency developed a plan for the outreach activities for employers in the pilot counties. A letter to employers and summary of the Opt Out process was mailed to major employers in the pilot counties beginning in June 2006, notifying them of the Opt Out Program and provided them a summary of the Opt Out process. During Year One of the demonstration, the Agency conducted nine conference calls with several large employers to answer questions and request they accept premiums on behalf of Opt Out enrollees.

Description of Opt Out Process

Medicaid beneficiaries interested in the Opt Out Program are referred to HMS by Medicaid Reform Choice Counselors. The beneficiary my also call HMS's toll-free number for the Opt Out Program directly. After initial contact with the beneficiary, 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 following: the insurance that is available through the beneficiary's employer; how much the premium will be; and how payment of the premium will be processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact his or her employer directly to receive detailed information on the benefits available. After enrollment into Opt Out Program, the beneficiary is sent an enrollment letter that confirms the beneficiary is enrolled in the Opt Out Program. HMS then begins to process the premiums according to the required frequency. If the beneficiary is

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

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

Current Activities

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

Opt Out Program Statistics

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

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

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

    2. A father, who had health insurance through his employer, began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter of Year One.

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

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

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

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

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

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

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

By the end of this quarter, a total of ten individuals were enrolled in the Opt Out Program. Table 15 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending December 31, 2007.

Table 15 Opt Out Statistics September 1, 2006 – December 31, 2007						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
Children & Family	10/01/06	Large Employer	Single	1	2/28/07	Loss of Employment
Children & Family	01/01/07	Large Employer	Family	5	2/28/07	Loss of Medicaid Eligibility
Children & Family	02/01/07	Large Employer	Family	4	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	08/01/07	Large Employer	Family	1	Still Enrolled	N/A
Children & Family	09/01/07	Small Employer	Family	1	Still Enrolled	N/A

E. Enhanced Benefits Program

Overview

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

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

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

Current Activities

1. Call Center Activities

During this quarter, the Medicaid Reform Enhanced Benefits call center, located in Tallahassee, Florida, continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers. In addition, a language line is used to assist with calls in over 100 languages. The hours of operation for the call center remained 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with employees who speak English, Spanish and Haitian-Creole to answer calls. The Saturday hours changed to 9:00 am – 11:00 am beginning in November 2007.

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

Inbound Calls:	**6,120**
Calls Abandoned:	**122**
Average Talk Time	**6.0**

2. System Activities

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

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

3. Outreach and Education for Beneficiaries

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

Now that the EBAP is a year old, the Agency has data and other information on the successes and challenges to this new and innovative program. The number of beneficiaries earning credits is well within the estimates the Agency had developed prior to implementation. The number of credits being spent by beneficiaries in comparison to the amount earned remains low but is increasing each month.

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

- The EBAP call center script is rewritten and is in use by the call center.
- A user friendly product purchase list has been separated by product category and is in final review stages.

- Provider network of pharmacies successfully processing Enhanced Benefit purchases is available for beneficiaries seeking a pharmacy to use.
- A statement insert highlighting smaller groups of products was finalized and was inserted in December statements. Purchases increase significantly with the use of the statement.

The Agency held two public meetings in Duval and Broward counties to provide an open forum to receive suggestions on how to improve the EBAP. The meeting in Duval County occurred on November 5th and the meeting in Broward County occurred on December 5th. During both public meetings, beneficiary participation was low; however, there was representation from Medicaid advocates and Reform Health Plans. Some of the changes mentioned during the meetings included: making revisions to the welcome packet; changing the name of the program; creating flyers for providers, pharmacies, other social service agencies; and moving to a debit card system. Many ideas were presented to improve the program and will be presented to the Agency's Enhanced Benefits Advisory Panel and Enhanced Benefits Quality Improvement Team to review and to decide which items are feasible to implement. Comments from the meetings are available on the Agency's Medicaid Reform website under Enhanced benefits.

4. Outreach and Education for Pharmacies

The Agency continues to provide EBAP outreach and education to pharmacies regarding the design and billing process for the program. The Agency's Medicaid Area Office Pharmacists continue 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. As was noted last quarter, the Agency's EBAP outreach and education activities have reduced the number of billing questions the Agency receives during the quarter.

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

A system change request to the Agency's pharmacy system was implemented in the month of December 2007, and there has been some confusion as to how to bill EB claims. The EB call center has been instrumental in getting up-to-date information to local pharmacies or relaying problems to the Agency to address. This change has allowed the Enhanced Benefits purchases to be identified by a two-digit identifying code. The system change has also eliminated some of the edits and other processing features of the pharmacy system that are not needed in the Enhanced Benefits environment. Although EBAP outreach and education to the pharmacies was done, getting the word out to all the pharmacies regarding the new billing procedure has been a grassroots effort in which we have contacted corporate and local pharmacies regarding the changes.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel meeting was held on October 5, 2007. The primary focus of the meeting was to discuss the welcome packet materials, health plan utilization of the healthy behavior credits, and recipient usage of credits. Analysis has indicated that for the first year of the EBAP (September 1, 2006 through June 2007) showed the forty-nine percent of the dollars earned were for regular office visits or for non-preventive type services. During this meeting, the panel discussed scheduling the public meetings that were then held in November and December of 2007.

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

6. Enhanced Benefits Statistics

Table 16 provides the Enhanced Benefit Account Program statistics beginning October 1, 2007 and ending December 31, 2007.

Table 16
Enhanced Benefit Account Program Statistics

2nd Quarter Activity – Year 2		October 07	November 07	December 07
I.	Number of plans submitting reports by month	30 of 31	30 of 31	30 of 31
II.	Number of enrollees who received credit for healthy behaviors by month	42,591	33,744	34,376
III.	Total dollar amount credited to accounts by each month	$1,215,667.50	$895,305.00	$901,687.50
IV.	Total cumulative dollar amount credited through the end each month	$8,048,298.66	$8,943,603.66	$9,845,291.16
V.	Total dollar amount of credits used each month by date of service	$80,162.45	$50,134.92	$96,551.65
VI.	Total cumulative dollar amount of credits used through the month by date of service	$370,962.43	$421,097.35	$517,649.00
VII.	Total cumulative number of enrollees who used credits through the end of each month	11,242	12,257	14,043

7. Complaints

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

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

During this quarter, out of 5,549 beneficiaries who purchased one or more products with their Enhanced Benefits credits, 59 complaints were recorded through the call center, the Enhanced Benefits mailbox, or sent directly to the Agency related to the EBAP. Table 17 provides a summary of the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 17
Enhanced Benefit Beneficiary Complaints

Beneficiary Complaint	Action Taken
1. Forty beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program.	➲ The Agency continues to provide technical assistance to pharmacies regarding Enhanced Benefit Account Program.
2. Three beneficiaries complained about the processing fee that is currently associated with EB.	➲ Once the customer service request (CSR) is in production, this fee will be disabled.
3. Sixteen beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching at the pharmacy.	➲ The Agency has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list. Enhanced Benefits Quality Team is working on a solution.

F. Low Income Pool

Overview

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

- On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. On March 16, 2006, CMS requested additional information of these sources and the Agency submitted a revised source of non-Federal share funding to be used to access the LIP funding to CMS on April 7, 2006.

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

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

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

Current Activities

The second quarter of State Fiscal Year (SFY) 2007-2008, the Low Income Pool (LIP) Council held three (3) meetings.

On November 6, 2007, the LIP Council held its first meeting of the quarter via a conference call. The members discussed many issues including Property Tax Reform proposals and the need for local governments and taxing districts to keep the Agency

informed of the potential effect that the taxing referendums may have on their ability to provide IGTs during SFY 2008-09.

The largest discussion of this meeting reviewed the effects of the $81 million loss of non-recurring General Revenue for SFY 2008-09. A model was provided showing what the different effects of the removal of $81 million in General Revenue (GR) Funds would have on the various components of the LIP program. The model adhered to three concepts:

a. How the LIP program would function with the removal of the $81 in non-recurring GR;
b. The decrease in the Federal Medical Assistance Percentage (FMAP) rate and the consequential increase in the non-federal match; and
c. The unknown increase or decrease in the cost of exemptions to celings.

A few of the LIP council members offered to produce other methods of funding and to provide them at the next council meeting.

During the LIP Council meetings held, November 28, 2007 at the Tampa International Airport and December 13, 2007 via conference call, the Agency provided updates to the LIP Council members on the status of the Letters of Agreements which were sent to local governments and taxing districts during the first quarter. The LIP Council also reviewed and discussed eleven models for SFY 2008-09. In addition, the LIP Council heard the following updates from Provider Access Systems that are participating in LIP for SFY 2007-08. LIP Council members stated they would continue the funding distribution model discussion at the next LIP Council meetings.

Provider Access System Updates

- ***Florida Association of Community Health Centers****:* There are 40 Federally Qualified Health Centers (FQHCs) operating in Florida providing quality health care in more than 220 service locations. With the $15.3 million received in LIP funds, these community health centers were able to see: an additional 57,000 patients with nearly 50% being uninsured; increase in the number of providers by 8%; expansion of the locations of centers by 36; increase the total number of sites to 219 to serve the additional patients; increase of nearly 18% in the most critical shortage of providers - dental.

- ***Department Of Health – Sarasota Health Care Access*****:** The Sarasota Health Care Access (SHCA) is a county wide, integrated system of care for the uninsured and medically undeserved populations in Sarasota County. The objectives of this program are to reduce unnecessary utilization of hospital inpatient and emergency room services while improving access to primary care, specialty care and oral health services. With these objectives, the SHCA hopes to strengthen linkages and communication among area safety net providers and capitalize and build on existing health care system capacity. There are 12 SHCA partners.

- ***Department Of Health – Duval County Health Department*:** The primary goal of the Duval County Health Department (DCHD) is to address the issues of limited health access for uninsured, especially adults and hospital-focused indigent/uninsured primary care. To work towards this goal, the DCHD strives to: assume a leadership role in improving primary care access in Duval County; improve collaboration among safety net stakeholders in increasing primary care capacity and connecting uninsured and underserved without regular sources of primary care to medical homes; reduce reliance on emergency rooms (ERs) for treatment and management of Ambulatory Care Sensitive conditions; and apply the LIP's leveraging potential to expand primary care health access for the uninsured and medically underserved. DCHD's achievements with previous/current LIP funds have allowed DCHD to leverage additional local, state and federal funding to expand primary care options for uninsured and low income persons of all ages. Lastly, LIP-financed expansions leveraged a doubling of federal Health Resource and Services Administration investment in uninsured primary care, expanding availability of medical homes.

- ***Department Of Health – Okaloosa County Health Department*:** LIP funds have allowed for follow-up medical exams/diagnostic tests, and treatment services for women with abnormal results for breast exams and pap smears. Tests and services include mammograms, liquid-based cervical cytology tests, HPV tests, colposcopy services, cryotherapy, etc; and the placement of an ARNP and a LPN three days a week at the Crossroads Medical Clinic, a free medical clinic for the uninsured. Activities associated with LIP funds have led to the establishment of a functioning network to serve the uninsured including Okaloosa CHD, Crossroads Medical Clinic, North Okaloosa Medical Center, Ft. Walton Beach Medical Center, and Sacred Heart Hospital.

- ***Department Of Health – Walton County Health Department*:** LIP funds have supported an additional part-time physician and part-time ARNP in the CHD primary care clinic in Defuniak Springs; two additional exam rooms; 873 additional visits for acute and episodic illnesses and injuries have been funded; and 1,089 additional OB/GYN visits have been funded.

- ***Department Of Health – Lee County Health Department*:** LIP funds have supported the expansion of women's health services, primarily OB/GYN, at Lehigh Clinic; screening for over 2,000 women for gynelogical cancers, diabetes, hypertension, and STDs; and treatment for urinary tract infections and pelvic infections which if not addressed would often result in an ER visit.

- ***Department Of Health – Charlotte County Health Department*:** LIP funds have provided an additional ARNP in the Primary Care Clinic who generates about 4,500 encounters annually; along with a Hepatitis C treatment clinic that provides pharmaceutical, medical exams and care coordination to Hepatitis C infected persons.

- ***St. Johns River Rural Health Network*:** With the support received from the LIP program, the St. Johns River Rural Health Network has been able to provide primary care services inclusive of CHD, annual and quarterly check-ups, urgent care, preventative services (i.e.: flu shots and other vaccines) and access to pharmacy assistance programs including prescription medications and supplies like glucose test strips. Along with specialty services offering ophthamology and podiatry, disease management has grown to include facilitation of participation in health care; enhanced patient-provider communication; assessment and care plan development; and ongoing monitoring and education and encouragement for self care (i.e.: medication, diet and exercise).

The Agency is continuing to work with local governments and taxing districts to complete all outstanding Letters of Agreement. A total of $191,429,386 in LIP distributions were made to Provider Access Systems during this quarter.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

Current Activities

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

Budget neutrality figures are not included in this report as the Agency is researching unexpected variances in the case months for the eligible but not enrolled population which are recipients who are a mandatory population but are located in non-reform counties. The Agency has been in contact with the Centers for Medicare and Medicaid Services (CMS) to discuss the variance and possible changes. It was determined by the Agency and CMS that it would be appropriate to hold the submission of these figures until the Agency has identified and corrected all issues pertaining to the variance. The Agency will continue to communicate with CMS as the issues are resolved. CMS has stated that submission of the budget neutrality status is not required prior to the submission of the next quarterly report.

H. Encounter and Utilization Data

Overview

The Agency is required to capture encounter data in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes. The interim pharmacy data and future medical services encounter data will be used to support: 409.91211(3)(p), Florida Statutes, requiring that a risk-adjusted methodology be a component of the rate setting process for capitated payments to Reform health plans. Additionally, 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, comprised of internal subject matter experts and external consultants with experience in the risk adjustment and encounter collection processes, continues to support the implementation and operational activities of Medicaid encounter data.

Current Activities

During this quarter, to comply with the requirements of the 1115 Medicaid Reform Waiver, health care pharmacy and Medicaid enrollee information were collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid population. 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.

This quarter's activities included:

- The collection and processing pharmacy encounter data continues on a quarterly basis. The recent 12-month measurement period used in the Medicaid Rx methodology for risk-adjusting Reform capitation rates was April 1, 2006 through March 31, 2007 paid through June 30, 2007. This measurement period was used in the generation of risk adjustment factors for seventeen (17) Reform plans in Broward, Duval, Baker, Nassau, and Clay counties servicing 172,482 Medicaid recipients in TANF and SSI populations.
- The Pharmaceutical data continue to be collected and processed through Medicaid Rx to support risk adjustment capitation rate premium calculations until encounter data for all services is of sufficient quality and completeness to transition to the CDPS (Chronic Illness and Disability Payment System) risk adjustment model.

In addition, the Agency continued to design and develop the MEDS to capture encounter data from all capitated health plans for all covered services. The following are the highlights for this quarter:

- Health plans are in various stages of production readiness to submit X12 encounter data. Six (6) HMOs have submitted test files and received certifications to submit X12 837 encounter claims. Additionally, encounter data for the period of September 2006 through December 2006 is being collected under the incumbent FA / FMMIS from five (5) HMOs. A total of 1,027,949 encounter claims for the period September 2006 – December 2006 has been received and processed. One HMO has not submitted X12 837 test files nor has it been certified for submission of encounter data.
- Two (2) PSNs have submitted test files demonstrating their capability to generate X12 HIPAA compliant 837P transportation claims. Of the two PSNs who have submitted test files, one PSN has submitted a total of 687 capitated transportation encounter claims for the period September 2006 through December 2007. Other PSNs continue to complete tasks associated with certification and submission of test files.
- The MEDS team continues to participate in the design and development of the new Florida MMIS.
- The MEDS team is continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the health plans.
- Participation of the MEDS team in “stand-alone” meetings with health plans and biweekly technical and operations meetings continued during this period.
- Reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content to capitated health plans is continuing to be validated and tested by the MEDS team and incumbent Fiscal Agent (FA).
- Design of the data structure and supporting processes to extract encounter claims to the Medicaid Decision Support System (DSS) is continuing.
- The MEDS team continues to work with health plans to resolve technical and X12 transaction format and content questions. The MEDS team held a technical workshop in December 2007, to discuss current encounter specific topics and the transition to the new fiscal agent. There were 67 participants representing 11 health plans, Agency bureaus, and several consulting organizations.

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, continued. The scheduled activities associated with the testing and subsequent implementation of MEDS is also 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

Medicaid Reform is fundamentally changing the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of Medicaid Reform, and anticipates using the evaluation as a means to inform policy decisions in both the short and long term. As lessons are learned on an incremental basis, these data will be used to shape further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation. There are six (6) key design elements of Medicaid Reform tracked by the Agency in order to evaluate progress towards achieving its goals. Information about each key evaluation objective is below.

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

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

As reported last quarter, the Agency has established contracts with 11 HMOs and 6 PSNs for a total of 17 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. One of the plans is a specialty PSN plan which serves children with chronic conditions in both Broward and Duval Counties. The number and types of health plans that beneficiaries can chose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform Waiver. Additionally, the Agency established contracts with 1 HMO and 1 PSN in Baker, Clay and Nassau counties and enrollment began in September 2007. None of these health plan options had a presence in these counties.

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

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

All of the capitated Reform health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year One of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter (OTC) drug benefits and adult preventive dental benefits. New expanded benefits available to beneficiaries during Year One of the demonstration included the following:

- Over-the-counter drug benefit from $10-$25 per household, per month.

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

By the end of the last quarter, the Agency had approved 30 health plan customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits are effective for the contract period September 1, 2007 to August 31, 2008. These included 1 HMO and 1 FFS PSN for the counties: Baker, Clay and Nassau. No new plan benefit packages were reviewed or approved this quarter.

As reported last quarter, one of the significant changes in benefits for this contract period, September 1, 2007 to August 31, 2008, was continued reduction in cost sharing. Many plans choose to offer expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. The two most popular expanded services offered were the same as last year's, the over-the-counter (OTC) drug benefits, and adult preventative dental benefits. Four of the customized benefit packages expanded their OTC value from $10 to $25, while another 4 added a $25 OTC benefit. The majority of the expanded services available to beneficiaries for Year Two of the demonstration, are the same as those offered during Year One (see list above).

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

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

The one expanded benefit that was dropped for the contract year, September 1, 2007 to August 31, 2008 was the Complimentary/Alternative Medicine benefit.

Improving Access to Specialists

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

will guarantee access to care for beneficiaries. As the first year of the demonstration ended, the Agency had begun the first intensive review of the Reform health plan provider network files to evaluate the effectiveness of Reform in improving access. The analysis includes the following steps.

1. Identifying the number of unduplicated providers that participate in Reform;

2. Identifying providers that were not fee-for-service providers, but now serve beneficiaries as a part of Reform;

3. Comparison of plan networks that were operational prior to Reform with the Reform health plan networks at the end of Year One of the waiver; and

4. Comparison of Reform provider networks to the active fee-for-service providers.

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

During this quarter, the Agency began additional provider network analysis of Medicaid managed care plans, including Medicaid Reform health plans. Beginning in October 2007, the Agency directed all Medicaid Managed Care Plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on recipient access to providers (e.g., the provider only accepts current patients, children, women). In November 2007, Agency staff began to improve the process of validating the accuracy of the health plans' provider network files. The Agency worked with contractors to create a survey tool aimed at measuring whether providers are indeed contracted with the health plans that report them as part of their networks, and if so, whether the providers' restrictions match those reported in the health plan files. Agency staff were trained to use this survey tool to call providers' offices and verify provider participation and restrictions in Medicaid managed care plans.

In December 2007, the Agency pulled a sample of 713 providers, 39 from each health plan's provider network file that was submitted to the Agency. This sample was split up between 21 Agency staff members, who conducted the surveys in mid-December. Of the 713 providers in the sample, 58.5% participated in the survey. Of those who participated, 84.4% of the providers confirmed participation in the health plans. These

results should be considered preliminary, as the Agency is currently following up with the health plans to see if they have a provider contract on file for those providers whose office managers did not confirm participation with a health plan. Thus, the accuracy rate of the provider network files may be higher than our preliminary results indicate.

In the third quarter of Year Two, the Agency will fully analyze the survey data and work to improve the survey and validation process. Once fully analyzed, these data will be used to re-run and complete the Agency's analysis of access to specialty care.

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

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

The Agency will monitor the Medicaid Reform health plan enrollees through the HEDIS performance measures and the plan's disease management enrollees through Agency-defined disease management measures. The Medicaid Reform health plan contract specifies the performance measures that will be collected starting January 1, 2007 through December 31, 2007, and reported to the Agency July 1, 2008.

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

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

During this quarter, the Agency became aware that the National Committee for Quality Assurance had retired two HEDIS measures that were included on the Agency's list of

33 performance measures required for Medicaid Reform. The Agency is in the process of modifying the measure selection in response. Both the health plans and Florida's contracted External Quality Review Organization will be asked to review and comment on the Agency's proposed replacement measures. Specifications for the Year Two disease management measures will also be provided to the plans for comment at that time.

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

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

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

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

The individuals who decided not to opt out were:

(a) not employed,

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

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

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

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

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

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

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

Additionally, a component of the Medicaid Reform evaluation is a longitudinal qualitative study designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall healthcare system, and their current experiences under Medicaid Reform. Continuing qualitative interviews and focus groups were conducted with enrollees between July 2007 and December 2007. A total of 45 enrollees participated in 14 in-depth telephone interviews and four focus groups in Broward, Duval, Baker, Clay, and Nassau Counties.

While these findings cannot be used to assess the success or failure of Reform at this time, they demonstrate some aspects of how Medicaid enrollees are responding to the program changes. Key findings from the longitudinal qualitative study are summarized in Section J Evaluation of last quarter's report.

The Agency also intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. For Broward and Duval Counties, the disease management patient satisfaction surveys will be conducted during 2008 to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for six months.

The Agency originally planned to conduct the disease management patient satisfaction surveys in the fall of 2007. In June and July 2007, the Reform plans submitted disease management enrollment data to the Agency with analysis being completed this quarter. These data showed variability in the plans' identification and enrollment of beneficiaries, making it difficult to compare the Reform plans' disease management programs. At this time, the Agency is determining how best to measure patient satisfaction with disease management under Reform, in order to have the most meaningful and useful results.

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

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

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

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

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

During the third quarter of Year One, the Agency continued its work with the University of Florida's Medicaid Reform Evaluation team. On January 30, 2007, the Agency received a request for pre-LIP information from the University of Florida's Medicaid Reform Evaluation team. On February 20, 2007, the Agency responded, via e-mail, with the electronic data requested. The data requested included information from the

hospital Upper Payment Limit (UPL) program, Disproportionate Share Hospital (DSH) program, and the hospital reimbursement exemption costs. In addition, data from the Florida Hospital Uniform Reporting System and hospital Medicaid audited DSH data was provided. A conference call was held on March 6, 2007, to review the data provided.

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

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

STC #102, Demonstration Year Two Milestones, specifies that, “the State will conduct a study to evaluate the cost effectiveness of various provider access systems.” This study will be done by the UF LIP Evaluation team. The UF LIP Evaluation Team will provide the cost effectiveness study to the Agency by the third quarter of Year Two. The cost effectiveness study will be based on the measurements of the LIP Milestone reports provided by the Provider Access Systems. A sample of the LIP Milestone report is provided in the Reimbursement and Funding Methodology document. It should be noted that the LIP Milestone reports represent a snapshot of a 12 month period of time.

The LIP Milestone data collected includes data for hospital Provider Access Systems and non-hospital Provider Access Systems. All Provider Access Systems completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. Provider Access Systems with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency’s request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

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

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

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

possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome." (pp 10-11)

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

During the second quarter of Year Two, the Agency received a preliminary first draft of "Evaluation of The Low-Income Pool Program Using Milestone Data: SFY 2005-06 and SFY 2006-07" from the University of Florida LIP Evaluation Team. The draft includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102). The draft was reviewed by the Agency staff, and comments of clarification were offered. The Agency will continue to work with the University of Florida LIP Evaluation Team on the study.

J. Evaluation of Medicaid Reform

Overview

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

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

A. Evaluations Affiliated with the Agency or its Contractors

Agency Internal Review

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

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

Some of the conclusions of this report are as follows:

- Enhancements are needed in ongoing, evaluative processes by which the Agency can gather timely access to care and quality indicators.
- Area offices, Choice Counselors, Bureau of Managed Health Care, and Bureau of Health Systems Development staff have been instrumental in making sure that individual transition and access issues are addressed and in facilitating communication with the health plans on behalf of beneficiaries.
- For most HMOs and PSNs, preferred drug lists and/or specific drug coverage information is not accessible online or through customer service phone numbers.
- The Enhanced Benefits Account Program, although generally viewed as a positive idea, has encountered serious implementation problems. Adaptive actions have

been taken, although it is unknown how effective those changes will be in encouraging pharmacy and beneficiary participation.

Highlights of recommendations from the report are listed below.

- Staff should be commended for their dedication and persistence in implementing the Medicaid Reform Pilot Project with few additional resources and within an extremely short timeframe.
- Develop a staffing plan for key headquarters divisions, bureaus and area offices and seek resources to ensure adequate staffing prior to further expansion.
- Continue efforts to adopt a consolidated, real-time complaint/issue tracking system with features needed to promote a coordinated response and analytical capabilities for producing trend reports. Include in the system a means to track indicators of inappropriate denial by health plans.
- Develop plans to validate and utilize all available encounter data in evaluating access to care trends.
- Pursue alternatives, such as a contract amendment, use of Choice Counselors and/or technological solutions to ensure beneficiaries have easy access to health plan preferred drug lists and pharmacy benefit information prior to choosing a health plan.
- Ensure the Choice Counseling Special Needs Unit is adequately staffed.

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

Urban Institute – Early Impact of Transitioning to Medicaid Reform

UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. A total of 1,850 interviews were completed. All data sets were delivered to the Urban Institute in May 2007, and a draft article was completed by Urban/Kaiser in November to be submitted to a peer-reviewed journal. Following the normal review procedures, reports will be disseminated through the accepting journal's website and the KFF website.

University of Oregon – Impact of Incentivizing Health Behaviors

UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid Reform beneficiaries. Data collection was by means of focus groups and telephone surveys. All data sets were delivered to the University of Oregon during 2007. The report compared the Enhanced Benefits Programs in Florida and Idaho, and is available at the University of Oregon website: http://pppm.uoregon.edu/index.cfm?mode=news&id=506.

Florida State University – Choice Counseling Program

Florida State University (FSU) evaluated the Choice Counseling Program's materials given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver. This evaluation is part of a contract with the Agency. The final report was received in July 2007. Following the regular Agency review process, the report was posted on AHCA's website at http://ahca.myflorida.com/Medicaid/quality_management/mrp/index.shtml. In general, respondents reported being satisfied with the Program. Choice counselors are pleased with the training materials offered, and recipients found choice counseling to be a helpful and informative service.

University of Florida – Low Income Pool Study

The Agency contracted with the University of Florida to conduct an evaluation of the Low Income Pool (LIP), including cost-effectiveness and the impact of LIP on increased access for uninsured individuals as required by STC#102 of the waiver. UF submitted a plan for this evaluation in July 2007, which is posted on the Agency's website at http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/plan_for_evaluating_lip_final_02-2007.pdf .

B. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

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

General Accounting Office

The General Accounting Office conducted a review of Florida's 1115 Medicaid Reform Waiver and the Vermont 1115 Demonstration Waiver. The report entitled "Medicaid Demonstration Waivers: Lack of Opportunity for Public Input During Federal Approval Process Still a Concern (GAO-07-694R)" was released in July 2007 and available on the GAO website: http://www.gao.gov/decisions/appro/309734.pdf.

Current Activities

Highlights of this quarter's activities include presentations by UF at various meetings and data collection for future analysis and reporting. A summary of the evaluation activities conducted during this quarter include:

1. Florida Advisory Committee Meeting

On December 12, 2007, the Agency and UF jointly sponsored the second annual Florida Advisory Committee (FAC) meeting in Tallahassee. The FAC consists of

experts from Florida who can advise the evaluation on matters having to do with the uninsured, Medicaid issues, and other concerns with Medicaid Reform.

2. Technical Advisory Panel Presentation

On October 29, 2007, principal investigator Paul Duncan presented on the status of the evaluations of Florida's Medicaid Reform at the Agency's Technical Advisory Panel meeting in Tallahassee. The Technical Advisory Panel is a group of experts in different fields who meet to advise the overall Medicaid Reform Waiver (rather than just the evaluation).

3. Data Collection

UF conducted another round of key informant interviews with Reform plans and Agency employees in key positions. This round of interviews will be compared to the ones performed in 2006 and early 2007, and will be used to measure changing opinions concerning Reform over the period of the evaluation. In addition, four focus groups were held (one each in Baker, Nassau, Clay, and Duval Counties) to gather information for the longitudinal study, an in-depth study following certain recipients throughout the Reform time period.

Information on the Enhanced Benefits Program was also collected. These data will be used to analyze the program to determine how much the program is used, reasons why the program is not used, and compare program participants to non-participants.

Finally, during fall 2007, the UF Survey Research Center in the Bureau of Economic and Business Research collected data for the patient satisfaction survey. This is an ongoing satisfaction survey based on the CAHPS (Consumer Assessment of Health Providers and Systems) Survey. The data collected will be compared to the baseline (pre-Reform) data to yield preliminary comparative data.

K. Policy and Administrative Issues

Current Activities

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

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

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

These forums continue to provide excellent discussion and feedback on proposed processes, and providing finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums the Agency continues its initiatives on process and program improvement that were also addressed in the Inspector General's program review of the Medicaid Reform pilot.

In addition to these forums, the Agency also conducted two meetings with the PSNs and HMOs to discuss drafts of the Agency's general amendment on quality issues. Feedback from the health plans was very helpful in navigating the changes that were being made relative to the claims processing, performance measures, disease management and reporting.

Medicaid Reform Technical Advisory Panel (TAP)

The Medicaid Reform Technical Advisory Panel (TAP) in the second quarter of Year Two focused on risk-adjusted rates for the health plans due to a special legislative session that reduced rates and services, some retroactive, during the current contract year. In addition, discussion included choice counseling, enhanced benefit and Medicaid encounter data collection updates as well as a summary the continuous improvement forums held by the Agency in November in Duval and Broward counties (see also Continuous Improvement Team subsection). Also discussed was the Agency's decision to not propose Reform expansion at this time.

Policy Transmittals and Dear Provider Letters

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

- Clarification to Reform PSNs on how to submit requests to the Florida Department of Financial Services for marketing representative appointments.
- Clarification to health plans regarding payment rates appropriate to county health departments.
- Advisement to health plans regarding the reduction of performance improvement projects and clarification on those required performance improvement projects.
- Reminder to the health plans regarding an initial health care assessment required for children taken into protective custody, emergency shelter or the foster program operated by the Florida Department of Children and Families.
- Clarification to Reform PSNs regarding how to submit claims for inpatient services that were not paying correctly in the Florida Medicaid Management and Information System (FMMIS).
- Guidelines to Reform FFS PSNs on how the process to convert from a FFS PSN to a capitated health plan, and timeframes for submission of applicable documents.
- Clarification to county health departments regarding prior authorization and reimbursement policies included in health plan contracts.
- Clarification to Reform health plans regarding reporting requirements for performance measure data.

Biweekly Technical and Operations Calls

The Agency conducted six (6) biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants during this quarter. The Technical and Operation Issues Conference Calls provide an avenue for direct communication between the health plans' operations and technical experts and the Agency's experts in the respective subject matter. Though some of the same issues are addressed at a higher level in the Technical Advisory Panel meetings, the Agency has the opportunity through this forum to respond to detailed questions posed through email, telephone inquiries, and previous technical calls.

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

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

- Update information on Choice Counseling Program activities
- Health plan network provider registration processes
- National Provider Identification (NPI) registration technical assistance;
- Medicaid Enhanced Benefit Account Program updates;
- Performance measures reporting updates and technical assistance;
- Revisions in the process for submitting involuntary disenrollment requests;
- Compliance issues, such as, reminding plans to submit accurate and up-to-date provider network files and updating the provider lists on their respective websites;
- Discussion on Medicaid fiscal agent transition issues;
- Medicaid Encounter Data Systems updates and formal questions and answers;
- Contract amendment progress and Reform Year Two updates, including the process and timeline for provision of Medicaid redetermination date information to health plans; and
- External Quality Review Organization Contract Updates and Notification of Webinars and other meeting opportunities.

Fee-for-Service PSN Systems Implementation Issues Calls

The PSN Policy and Contracting Unit continued with its monthly PSN systems implementation calls; however, the content of these calls has transitioned from the majority being in regard to the current Medicaid fiscal agent system to being about transition to the new Medicaid fiscal agent system. Items that continue to be addressed include the following:

- National Provider Identification requirements;
- How to minimize the paper claims processing backlog with the current fiscal agent; and
- Crosswalk of files received under the current Medicaid fiscal agent system to files that will be received under the new Medicaid fiscal agent system.

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

Continuous Improvement Team

The Continuous Improvement Team created at the end of Reform Year One provides operational staff with feedback from enrollees, providers, plans and advocates on the specific tenants of the Agency's 1115 Medicaid Reform Waiver, including Reform implementation. The role of the continuous improvement team is to provide an independently moderated forum for discussion of Reform processes at the local level.

The first Agency forums were held in November 2007 in Broward and Duval counties and public notice for the meetings were included in the Florida Administrative Weekly and the Agency's website and notices were sent to our Reform interested parties list. The forums included topics such as outreach, plan customer service, benefits, and plan provider services. In Duval County, approximately 60 providers and interested stakeholders attended the provider session and approximately 25 recipients and interested stakeholders attended the recipient session. In Broward County, approximately 150 providers and interested stakeholders attended the provider session and approximately 60 recipients and interested stakeholders attended the recipient session.

Agency staff is in the process of compiling the data from the forums and providing responses back to issues raised. The forums gave providers and recipients an opportunity to provide input and for the Agency staff to hear their concerns. Staff received some useful information regarding the topics addressed, and it was clear that many who came to the meetings wanted an opportunity to provide their comments to policy makers. Many issues raised were not related to the particular topics that were being addressed and most were related to managed care in general rather than true Reform implementation issues. However, what was clear was that stakeholders want to be heard and that more communication is better than less. Particular findings include the following:

- Depending on the topic to be discussed in a forum and depending on the audience, multi-prong approaches need to be used when providing meeting notice.
- Greater advance notice of meetings was preferred.
- Clearly defined agenda and meeting structure will increase clear feedback on Forum topics.
- Format of community forum may need to be tailored depending on Forum topic to allow for increased efficiency of meeting time.
- Stakeholder input is valuable; community forums are an important tool for soliciting stakeholder feedback.
- Stakeholders want to hear about how their feedback is used.

A summary of November's forum will be posted on the Agency's website and provided to the Legislature and attendees. Agency responses to particular issues raised and resolution/progress on those issues will also be provided to attendees.

These forums will occur throughout Year Two of the demonstration. Some forums will be held in both Duval and Broward Counties. Some will be held in Tallahassee. The next community forums are scheduled for providers in Duval and Broward Counties for March 2008. Topics to be covered during next quarter's meetings are related to service authorizations and claims processing, particularly:

- Lessons learned from the first year of implementation;
- Types of information that would be useful in plan-sponsored and/or AHCA-sponsored trainings; and

- Recommendations for development of a handbook on authorization processes and claims payment.

Attachment I
PSN Complaints/Issues

PSN Complaints/Issues October 1, 2007 – December 31, 2007	
PSN Informal Issue	**Action Taken**
1. Grandmother called because grandchildren cannot get an appointment with a PSN dental provider.	➲ PSN contacted grandmother of beneficiary and found dental provider willing to work with beneficiary. Appointment provided and issue resolved.
2. Enrollee needs to have tooth extracted and is concerned about other health issues and getting an appointment.	➲ PSN contacted and enrollee will be seen by dental provider tomorrow.
3. Member needs out-of-network authorization for specialist appointment she had scheduled when she was FFS prior to plan assignment.	➲ PSN contacted and the appointment will be rescheduled.
4. Beneficiary has script for item that PSN says is not covered by the PSN, and referred the beneficiary to the Area Office for confirmation.	➲ Area Office staff provided beneficiary with the appropriate code for this item so the plan could identify it was a covered service.
5. Enrollee having problems with getting dentures fixed and has complicated case.	➲ PSN contacted and customer service requested to assist enrollee.
6. Beneficiary having difficulty obtaining scripts for pain medications.	➲ PSN worked with recipient to schedule appropriate appointments. PSN followed up to ensure recipient kept appointments and was able to fill prescriptions.
7. Provider states that reform PSNs delay processing claims.	➲ Area Office provider specialists worked with the plans and were able to resolve the claims payment issues.
8. Provider issue regarding PSN lack of timely claims payment.	➲ Resolution in Progress.
9. PSN provider issue regarding timely claims payment from the PSN.	➲ The PSN has accounted for the outstanding claims and will continue to work the provider to be sure claims are tracked and paid in a timely manner.
10. Provider issue regarding multiple PSNs lack of timely claims payment.	➲ Resolution in Progress.
11. Provider issue regarding PSN lack of timely claims payment.	➲ Resolution in Progress.

PSN Complaints/Issues October 1, 2007 – December 31, 2007	
PSN Informal Issue	**Action Taken**
12. Provider issue regarding PSN lack of timely claims payment.	➲ The provider issues with the PSN were the result of provider staff issues/inexperience. PSN and AHCA HQ provided technical assistance to the provider.
13. Provider issue with large amounts of claim denials in their ERVs and issues with timely PSN claims payment.	➲ AHCA headquarters staff facilitated review with the PSN and the provider. PSN identified the issue within the claims file (the referring physician information was inadvertently removed from the 837 process) and re-submitted all claims to fiscal agent for processing. PSN has developed processes to ensure this issue does not occur again.
14. PSN provider having problems with timely claims payment from PSN.	➲ Resolution in Progress.
15. PSN providers are having difficulty obtaining payment.	➲ The PSN was contacted. Claims were processed by the fiscal agent, and the providers were paid.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
1. Enrollee lives in St. Johns County but is enrolled in Duval County Reform. She needs transportation, but the provider will not serve her because she doesn't live in Duval.	➲ This is a border county/zip code issue. While her address is being fixed by DCF, the HMO provider has agreed to provide the transportation needed. Enrollee has been referred to Choice Counseling to change plans once address correction has been made.
2. Enrollee wants 30-day inpatient substance abuse rehab and hasn't heard from the HMO if this is a covered service. The facility she wants to go to does accept the HMO members.	➲ Advised enrollee that the only inpatient substance abuse services that are covered by Medicaid health plans are 28-day day inpatient substance abuse treatment for pregnant enrollees, and detox. Other than that, recipients seeking substance abuse types of services must seek those through fee-for-service Medicaid, not health plans.
3. Enrollee needed to have her wisdom teeth removed and said she was told by the HMO representative that they didn't provide that service and to call local area office.	➲ Enrollee's mom was contacted by HMO dental provider representative and member benefits were discussed. Enrollee ‘s mom took down provider information and was asked if she needed assistance in making an appointment. She said no because she had to get with the enrollee to find out his schedule first. No further assistance was needed.
4. HMO member is having difficulty obtaining authorization for medications from the HMO.	➲ HMO contacted member-and she received her medications. Issue resolved
5. Enrollee’s mom is having trouble with getting bills paid.	➲ HMO was contacted about the issue. HMO, in turn, contacted the member and the issue was resolved.
6. Enrollee is having problems getting one of three scripts filled by HMO. She wants to know status so she can make one pharmacy trip. She called HMO and they will not discuss status with her.	➲ Area staff contacted HMO and medication was called in by primary care physician and has been approved for one year. Enrollee delighted.
7. Enrollee is pregnant and cannot find a provider that will see her.	➲ HMO contacted enrollee to provide OB provider list and set up an appointment for her.

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
8. Enrollee has severe injury and is scheduled for surgery next Monday. She needs scripts for two non-covered drugs that are to maintain status until surgery can be performed. Enrollee is concerned with getting prior authorization for medicines and that the clinic where she is having the surgery does not participate with the HMO.	➲ HMO staff quickly researched her issues and a plan representative had been trying for some time to reach her to obtain more information. A plan representative was finally able to reach her and then the prescribing physician and now has the appropriate forms and instructions for the drugs.
9. Enrollee called with complaint concerning letter received from the plan cancelling her case management.	➲ Member contacted by HMO and case management services are now resumed.
10. Enrollee's established OB does not participate and needs assistance obtaining out of network authorization for treatment and for referral to high-risk OB group until enrollee can disenroll.	➲ HMO has authorized care by the nonparticipating OBs and has assigned a case manager. Member called and expressed appreciation.
11. Enrollee was not satisfied with services provided by the plan.	➲ HMO contacted and has authorized new service after second opinion/evaluation.
12. Provider was unable to verify beneficiary eligibility with Reform HMO. FMMIS indicated beneficiary was enrolled with Reform HMO.	➲ HMO representative verified the beneficiary's enrollment and stated that she would notify the provider.
13. Provider representative called stating they are at an impasse in contract negotiations with HMO and may terminate their contract with the HMO.	➲ Advised provider representative that AHCA does not intervene in contract disputes. Advised that they issue, by letter, their intent to terminate their contract with the HMO.
14. Provider states HMO erroneously denied beneficiary for a date of service.	➲ Plan was contacted and verified eligibility.
15. Reform provider denied beneficiary eligibility for a date of service.	➲ Reform provider subsequently verified the patient's eligibility.
16. HMO member wants reimbursement for fee paid for medical services.	➲ AHCA contacted HMO and HMO reimbursed the member.
17. Beneficiary states HMO's dental subcontractor has not reimbursed him for the payment he made, incorrectly.	➲ HMO contacted subcontractor and overpayment identified refunded to beneficiary.

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
18. Beneficiary has concerns regarding bills she received from different providers.	➲ Reviewed information submitted by beneficiary. Several of the bills she received from providers appear to also have been billed to Medicaid and were probably sent to her in error. Agency staff was sent copy of the material and requested permission to contact providers to resolve.
19. Beneficiary believed she was denied access to surgical procedure recommended by non-participating provider.	➲ HMO was contacted and enrollee was seen by a participating provider and re-evaluated.
20. Provider had problems obtaining an authorization from HMO dental subcontractor.	➲ Patient does not meet medical necessity standards. Dental subcontractor may provide courtesy authorization.
21. Provider having difficulty obtaining authorization from HMO dental subcontractor.	➲ Authorization denied for lack of medical necessity.
22. Provider having difficulty obtaining authorization from HMO dental subcontractor.	➲ Authorization approved.
23. Provider having difficulty obtaining authorization from HMO dental subcontractor.	➲ Authorization denied for lack of medical necessity.
24. Mother of enrollee stated that the HMO had denied son's surgery to repair injury caused during birth.	➲ AHCA headquarters contacted HMO regarding this issue. HMO stated that the authorization request from provider was denied because the provider is not a participating provider in their network. HMO found another specialist in-network that could perform the surgery. Mother was informed.
25. Recipient was frustrated in attempting to utilize earned Enhanced Benefits credits.	➲ Recipient was referred to two other pharmacies within his zip code where Enhanced Benefits credits have been successfully processed.
26. The provider reported the HMO is having a payment reversed due to the member not being covered during the dates of service.	➲ HMO was contacted and has updated their system to reflect the member's coverage during the dates of service. Claims have been resubmitted by the provider to have the claims re-processed.

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
27. The HMO member needs a prescription filled. A prior authorization was sent. The prescription has not been authorized.	➲ The medication was approved. The member picked the medications up and appreciated the follow-up call from the HMO.
28. Provider called regarding incorrect payment received from the HMO.	➲ The HMO is scheduling a meeting with the provider to advise how the payment was allocated.
29. County Health Department called that an HMO is having trouble contracting Orthodontists. They appear to have only one at the time that will sometimes see Medicaid patients.	➲ Resolution in Progress. The HMO is in the process of contracting with a facility..
30. The HMO member, who had a high-risk pregnancy, was being denied services at a hospital.	➲ No contact had been made with the HMO member due to her phone being disconnected. A letter was mailed to the member to find out if she is being seen for post-partum care. She failed to make contact with the HMO. On a follow-up, the member was contacted and reported giving birth to her child. She stated she was okay and requested the HMO call her back later. The nurse case manager of the HMO also reviewed the member's file after member gave birth to her child. The notes indicated the child was fine.
31. The HMO member is experiencing a high-risk pregnancy, and the hospital is refusing to see her. She would like assistance in finding an OB/ GYN.	➲ The HMO was contacted and the member is currently receiving care at a facility's case management (CM) program and the HMO's OB CM program.
32. The HMO member is having problems finding an OB/GYN and getting tests.	➲ Staff contacted the HMO. An Obstetric Consultants facility agreed to perform the necessary tests. The member now has an appointment scheduled with the group.
33. Father of HMO beneficiaries called due to daughter's medication getting denied when he went to get the prescription filled.	➲ The HMO was contacted and, after verification from the PCP, agreed to reimburse for the medication. Father was advised to save his receipt when he picked up the medication.

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
34. HMO member denied ever receiving a status on her grievance filed with her HMO. The member filed the grievance because she was not getting any assistance from her current PCP.	➲ The HMO was contacted and the member was assigned a new PCP.
35. HMO member was told by the health care facility that they do not accept the member's HMO; however, member was told prior to enrolling with the HMO that the facility was within their network. Member would like for her son to continue to receive services there.	➲ The HMO was contacted and the plan faxed an authorization to the health care facility for four sessions. Member was informed of this by the HMO.
36. Capitation was not paid by the HMO to the provider.	➲ The HMO updated eligibility and nine claims were sent back for reprocessing.
37. HMO member would like to disenroll from the current HMO.	➲ Member was advised to contact the HMO to file a grievance.
38. HMO member called and stated the HMO is telling her a drug is not covered by Medicaid; however, it is on the PDL.	➲ The HMO authorized the medication.
39. Health care facility is alleging that the HMO owes them a large amount for unpaid claims.	➲ The HMO reports they have made every effort to have a signed contract with the health care facility, but the facility has not followed through with the steps needed to complete the process. Therefore, any services other than emergency services are non-covered, out-of-network services. The HMO denies having received any claims from the facility and, therefore, owes no money to them.
40. Claim was denied by the HMO for dental.	➲ The bill should have been submitted to Medicaid.
41. HMO provider called regarding non-payment of HMO claims. The provider has approximately three beneficiaries for which they have not received payment. Provider received billing errors stating they were past the HMO claims.	➲ Provider Relations has reached out to the provider's office. It was stated that they were not aware that the members were in a Medicaid HMO. They will be sending over their documentation for review and approval.

HMO Complaints/Issues October 1, 2007 – December 31, 2007	
HMO Informal Issue	**Action Taken**
42. The HMO member was informed by the pharmacist that the plan doesn't cover his prescriptions. Member would like to find out if there is a generic form of the prescriptions.	➲ The HMO confirmed with the pharmacy that the pharmacy did not have the member's id number. This information was provided to the pharmacy and the prescriptions were then run. The member was then told to bring the receipt back to get reimbursed.
43. HMO member needs assistance with obtaining a specialist.	➲ The member was switched to another HMO, but stated she will contact Medicaid Options to get back with her former HMO. The requested specialist accepts only Medicare, and was mistakenly listed as a participating provider with her former HMO.
44. Mother of HMO members is unable to fill kids' prescriptions due to the HMO stating they are not in their system.	➲ The issue was closed-out by the Agency due to the member's failure to respond to the Agency as well as to the HMO.
45. Claim denied based on the type of procedure.	➲ HMO was contacted and the issue is resolved.
46. Claim denied because plan claimed beneficiary was not a member of the HMO.	➲ HMO was contacted and the issue is resolved.
47. Claim denied because HMO member is not showing as listed as a member.	➲ HMO was contacted and the issue is resolved.

Attachment III
Choice Counseling Beneficiary Complaints

Beneficiary Complaints October 1, 2007 – December 31, 2007	
Beneficiary Complaint	Action Taken
1. Complaint that Choice Counseling was giving erroneous information about a specific provider not participating with a certain PSN.	➲ Provider files were checked to see if doctor was participating in Broward County. The doctor was not listed in the plan's Broward County Reform provider file. The plan was provided information on how to correctly submit the doctor on their Reform provider file.
2. Advocate group concerned that Choice Counseling is not notifying beneficiaries of their right to change plans for cause.	➲ The Agency delegates this requirement to the health plan. Choice Counseling did agree to change a few letters based on suggestions from the group.
3. Advocate expressed concern about the accuracy of the provider network files.	➲ Information was shared with the Agency's health plan contract compliance units to verify the accuracy of the health plan files.
4. Consumer Organization contacted the Agency on behalf of a beneficiary regarding his new address and information on Reform health plans. The payee and beneficiary address were in a non-reform area.	➲ Choice Counseling provided information to the consumer organization on how to update address and other information so the beneficiary can be correctly enrolled in a health plan in their county of residence.
5. Provider submitted a complaint on behalf of a beneficiary who had called Choice Counseling for a Plan change for her newborn.	➲ The mother was not listed on the child's case and the address information was incorrect. The mother was referred to DCF to update the child's (payee) information. A Choice Counselor Supervisor followed up with the mother to ensure the issues were taken care of and the plan change could be processed.
6. Complaint from a beneficiary regarding a call to Choice Counseling in which the caller was treated rudely by one of the Counselors.	➲ The Choice Counselor was coached on customer service and put on increased monitoring. There was an apology letter sent to the beneficiary.
7. Complaint from a beneficiary after calling Choice Counseling and being treated rudely when the beneficiary was transferred from a Plan's phone line.	➲ The Choice Counselor is unable to complete a call when a beneficiary is forwarded from a Health Plan's phone line. The Counselor was coached on customer service and put on increased monitoring.
8. Beneficiary complained that when she spoke with a Choice Counselor she was treated rudely by the Counselor.	➲ The Counselor was coached on customer service and put on increased monitoring. The beneficiary was sent an apology letter.

Attachment IV
Choice Counseling Call Center Activity Report
ACS Florida Medicaid Reform Choice Counseling
Month: October-07

CALL CENTER ACTIVITY REPORT

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON	10/1/2007	997	961	42,078	36	3.6%	100%	6.9%	620.00	360.00	357.00	8:26	501	0.0%
TUE	10/2/2007	844	820	42,898	24	2.8%	100%	3.9%	281.00	394.00	502.00	8:02	218	0.0%
WED	10/3/2007	791	783	43,681	8	1.0%	100%	0.1%	183.00	136.00	190.00	8:19	202	0.0%
THU	10/4/2007	711	697	44,378	14	2.0%	100%	0.7%	182.00	196.00	137.00	8:53	360	0.0%
FRI	10/5/2007	537	535	44,913	2	0.4%	100%	0.0%	171.00	180.00	1.00	8:23	136	0.0%
SAT	10/6/2007	45	44	44,957	1	2.2%	100%	0.0%	152.00	0.00	0.00	7:34	7	0.0%
	Week Ending	3,925	3,840		85	2.2%	100%					8:23	1424	0%
MON	10/8/2007	708	699	45,656	9	1.3%	100%	0.8%	232.00	187.00	192.00	8:48	397	0.0%
TUE	10/9/2007	680	680	46,336	0	0.0%	100%	0.1%	162.00	106.00	183.00	8:43	148	0.0%
WED	10/10/2007	659	659	46,995	0	0.0%	100%	0.0%	140.00	139.00	0.00	8:16	138	0.0%
THU	10/11/2007	629	621	47,616	8	1.3%	100%	0.3%	219.00	77.00	222.00	9:10	353	0.0%
FRI	10/12/2007	509	505	48,121	4	0.8%	100%	0.6%	186.00	239.00	74.00	9:09	84	0.0%
SAT	10/13/2007	46	44	48,165	2	4.3%	100%	2.2%	201.00	116.00	41.00	10:41	14	0.0%
	Week Ending	3,231	3,208		23	0.7%	100%					8:49	1134	0%
MON	10/15/2007	759	748	48,913	11	1.4%	100%	1.1%	287.00	179.00	181.00	9:08	434	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
TUE	10/16/2007	664	662	49,575	2	0.3%	100%	0.2%	206.00	151.00	0.00	9:12	143	0.0%
WED	10/17/2007	656	654	50,229	2	0.3%	100%	0.3%	184.00	198.00	41.00	8:08	155	0.0%
THU	10/18/2007	765	747	50,976	18	2.4%	100%	5.6%	911.00	475.00	406.00	9:15	308	0.0%
FRI	10/19/2007	504	502	51,478	2	0.4%	100%	0.4%	234.00	192.00	11.00	8:34	112	0.0%
SAT	10/20/2007	41	41	51,519	0	0.0%	100%	0.0%	54.00	0.00	0.00	7:41	0	0.0%
	Week Ending	3,389	3,354		35	1.0%	100%					8:52	1152	0%
MON	10/22/2007	784	760	52,279	24	3.1%	100%	3.7%	321.00	223.00	538.00	9:11	324	0.0%
TUE	10/23/2007	638	632	52,911	6	0.9%	100%	1.6%	465.00	218.00	161.00	8:39	123	0.0%
WED	10/24/2007	627	623	53,534	4	0.6%	100%	0.2%	184.00	159.00	135.00	8:37	141	0.0%
THU	10/25/2007	595	595	54,129	0	0.0%	100%	0.0%	156.00	141.00	131.00	9:04	263	0.0%
FRI	10/26/2007	489	485	54,614	4	0.8%	100%	0.2%	198.00	116.00	0.00	8:53	160	0.0%
SAT	10/27/2007	62	62	54,676	0	0.0%	100%	1.6%	189.00	137.00	0.00	8:18	6	0.0%
	Week Ending	3,195	3,157		38	1.2%	100%					8:52	1017	0%
MON	10/29/2007	977	863	55,539	114	11.7%	100%	44.6%	759.00	996.00	685.00	10:18	398	0.0%
TUE	10/30/2007	792	765	56,304	27	3.4%	100%	8.9%	368.00	471.00	221.00	9:48	178	0.0%
WED	10/31/2007	656	651	56,955	5	0.8%	100%	1.7%	255.00	220.00	0.00	9:40	176	0.0%
THU		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
	Week Ending	2,425	2,279		146	6.0%	100%					9:57	752	0%
MON		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
THU		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0		0		100%					0:00	0	0%
	Month End	**16,165**	**15,838**		**327**	**2.0%**	**100%**					**8:54**	**5479**	**0.0%**

ACS Florida Medicaid Reform Choice Counseling

Month: **November 2008** **CALL CENTER ACTIVITY REPORT**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	56,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU	11/1/2007	756	737	57,692	19	2.5%	100%	5.7%	444.00	782.00	265.00	8:35	154	0.0%
FRI	11/2/2007	658	638	58,330	20	3.0%	100%	2.9%	427.00	724.00	178.00	8:31	286	0.0%
SAT	11/3/2007	32	32	58,362	0	0.0%	100%	0.0%	162.00	130.00	0.00	8:59	5	0.0%
	Week Ending	1,446	1,407		39	2.7%	100%					8:33	445	0%
MON	11/5/2007	849	772	59,134	77	9.1%	100%	28.0%	610.00	521.00	598.00	9:48	218	0.0%
TUE	11/6/2007	712	697	59,831	15	2.1%	100%	3.8%	266.00	314.00	204.00	8:58	139	0.0%
WED	11/7/2007	685	671	60,502	14	2.0%	100%	3.9%	326.00	344.00	193.00	9:01	284	0.0%
THU	11/8/2007	667	648	61,150	19	2.8%	100%	1.9%	568.00	354.00	176.00	9:34	196	0.0%
FRI	11/9/2007	547	538	61,688	9	1.6%	100%	2.2%	266.00	527.00	210.00	9:31	145	0.0%
SAT	11/10/2007	27	27	61,807	0	0.0%	100%	11.1%	399.00	458.00	0.00	13:42	10	0.0%
	Week Ending	3,487	3,353		134	3.8%	100%					9:24	992	0%
MON	11/12/2007	0	0	61,807	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE	11/13/2007	955	878	62,685	77	8.1%	100%	24.6%	458.00	883.00	548.00	9:28	202	0.0%
WED	11/14/2007	838	804	63,489	34	4.1%	100%	10.1%	405.00	439.00	308.00	10:06	187	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU	11/15/2007	830	813	64,302	17	2.0%	100%	3.9%	249.00	264.00	315.00	9:54	415	0.0%
FRI	11/16/2007	469	466	64,768	3	0.6%	100%	3.0%	269.00	206.00	187.00	11:01	138	0.0%
SAT	11/17/2007	16	16	64,797	0	0.0%	100%	0.0%	0.00	0.00	0.00	10:13	19	0.0%
	Week Ending	3,108	2,977		131	4.2%	100%					10:00	961	0%
MON	11/19/2007	680	669	65,466	11	1.6%	100%	6.0%	424.00	754.00	539.00	9:31	201	0.0%
TUE	11/20/2007	515	508	65,974	7	1.4%	100%	1.7%	260.00	123.00	211.00	10:48	197	0.0%
WED	11/21/2007	400	400	66,374	0	0.0%	100%	0.0%	76.00	0.00	0.30	8:52	57	0.0%
THU	11/22/2007	0	0	66,374	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI	11/23/2007	0	0	66,374	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT	11/24/2007	0	0	66,410	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	1,595	1,577		18	1.1%	100%					9:45	455	0%
MON	11/26/2007	937	866	67,276	71	7.6%	100%	19.5%	727.00	971.00	720.00	9:30	318	0.0%
TUE	11/27/2007	610	591	67,867	19	3.1%	100%	3.4%	401.00	737.00	146.00	9:54	136	0.0%
WED	11/28/2007	688	670	68,537	18	2.6%	100%	4.5%	330.00	271.00	222.00	9:34	116	0.0%
THU	11/29/2007	739	716	69,253	23	3.1%	100%	9.7%	380.00	430.00	235.00	9:29	197	0.0%
FRI	11/30/2007	514	508	69,761	6	1.2%	100%	2.5%	342.00	193.00	111.00	8:54	104	0.0%
SAT		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,488	3,351		137	3.9%	100%					9:29	871	0%
MON		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
TUE		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
THU		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0		0		100%					0:00	0	0%
	Month End	**13,124**	**12,665**		**459**	**3.5%**	**100%**					**9:31**	**3724**	**0.0%**

ACS

Florida Medicaid Reform Choice Counseling

Month: **December 2007**

CALL CENTER ACTIVITY REPORT

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI		0	0	69,761	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT	12/1/2007	27	27	69,789	0	0.0%	100%	0.0%	170.00	151.00	0.00	11:30	4	0.0%
	Week Ending	27	27		0	0.0%	100%	0.0%				11:30	4	0%
MON	12/3/2007	694	666	70,455	28	4.0%	100%	10.4%	418.00	511.00	228.00	9:32	294	0.0%
TUE	12/4/2007	557	548	71,003	9	1.6%	100%	1.4%	219.00	159.00	210.00	9:38	168	0.0%
WED	12/5/2007	620	611	71,614	9	1.5%	100%	1.1%	206.00	227.00	218.00	10:03	157	0.0%
THU	12/6/2007	579	567	72,181	12	2.1%	100%	5.0%	373.00	302.00	210.00	10:23	144	0.0%
FRI	12/7/2007	450	448	72,629	2	0.4%	100%	0.2%	190.00	77.00	70.00	9:44	97	0.0%
SAT	12/8/2007	17	17	72,650	0	0.0%	100%	5.9%	250.00	178.00	0.00	17:33	4	0.0%
	Week Ending	2,917	2,409		60	2.1%	100%	0.0%				11:45	864	0%
MON	12/10/2007	713	656	73,306	57	8.0%	100%	14.6%	510.00	611.00	512.00	10:35	158	0.0%
TUE	12/11/2007	527	522	73,828	5	0.9%	100%	4.4%	368.00	357.00	0.00	11:57	261	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
WED	12/12/2007	571	570	74,398	1	0.2%	100%	0.0%	123.00	166.00	0.00	10:50	119	0.0%
THU	12/13/2007	540	539	74,937	1	0.2%	100%	0.9%	199.00	188.00	169.00	11:01	125	0.0%
FRI	12/14/2007	481	481	75,418	0	0.0%	100%	0.0%	114.00	131.00	144.00	11:09	84	0.0%
SAT	12/15/2007	22	22	75,444	0	0.0%	100%	4.5%	301.00	131.00	0.00	10:30	3	0.0%
	Week Ending	2,854	2,790		64	2.2%	100%	0.0%				11:04	750	0%
MON	12/17/2007	719	698	76,142	21	2.9%	100%	7.4%	359.00	791.00	132.00	12:02	146	0.0%
TUE	12/18/2007	530	530	76,672	0	0.0%	100%	0.2%	174.00	183.00	147.00	11:32	136	0.0%
WED	12/19/2007	559	556	77,228	3	0.5%	100%	0.0%	160.00	155.00	121.00	13:03	100	0.0%
THU	12/20/2007	712	680	77,908	32	4.5%	100%	6.0%	348.00	1131.00	227.00	12:15	449	0.0%
FRI	12/21/2007	431	430	78,338	1	0.2%	100%	0.5%	230.00	241.00	160.00	11:38	99	0.0%
SAT	12/22/2007	0	0	78,343	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,951	2,894		0	1.9%	100%	0.0%				12:07	930	0%
MON	12/24/2007	169	169	78,512	0	0.0%	100%	0.0%	89.00	0.00	0.00	10:31	29	0.0%
TUE	12/25/2007	0	0	78,512	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED	12/26/2007	466	461	78,973	5	1.1%	100%	2.1%	183.00	478.00	225.00	11:20	198	0.0%
THU	12/27/2007	499	482	79,455	17	3.4%	100%	2.2%	249.00	184.00	250.00	11:31	131	0.0%
FRI	12/28/2007	431	430	79,885	1	0.2%	100%	0.2%	212.00	170.00	16.00	11:49	163	0.0%
SAT	12/29/2007	0	0	79,890	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	1,565	1,542		0	1.5%	100%	0.0%				11:26	521	0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard						**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON	12/31/2007	360	360	80,250	0	0.0%	100%	0.0%	180.00	0.37	0.00	11:47	165	0.0%
TUE		0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0
WED		0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0
THU		0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0
FRI		0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0
SAT		0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0
	Week Ending	360	360		0	0.0%	100%	0.0%	0.00	0.00	0.00	11:47	165	0%
	Month End	**10,674**	**10,022**		**124**	**1.2%**	**100%**	0.0%	0.00	0.00	0.00	**11:37**	**3234**	**0.0%**