Florida Medicaid Reform

Quarterly Progress Report
October 1, 2008 – December 31, 2008

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 Conditions # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the second quarterly report in Year Three of the demonstration for the period of October 1, 2008 through December 31, 2008. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 8 through 11 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. By state law, Reform FFS PSNs are also required to become capitated after three years of operations (for most PSNs, this is September 1, 2009).

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

Since the beginning of the demonstration, the Agency has received 21 health plan applications (14 HMOs and 7 PSNs) of which 18 applicants sought and received approval to provide services to the TANF and SSI population. Two of the approved applicant's were also approved for expansion into Baker, Clay and Nassau Counties: Access Health Solutions (a PSN) and United Health Care (an HMO). The most recent health plan application was approved in December 2008: Better Health Plan, a FFS provider service network (PSN). It is anticipated that Better Health Plan will have its first enrollment in May 2009. Of the 21 health plan applications received, all but three have been approved as health plans as of December 31, 2008.

The three pending applications were all submitted by HMOs in 2008: AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS, Medica Health Plans of Florida, and Molina Health Plan. AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application to serve beneficiaries living with HIV/AIDS in January 2008. This application is the second specialty plan application the Agency has received (the first being a specialty plan for children with chronic conditions). As of December 31, 2008, this specialty plan application was nearing completion of Phase III of the application process.

Medica Health Plans of Florida and Molina Health Plan are both HMOs with a national base. Molina Health Plan (HMO) has entered into an agreement with NetPass Health Plan (FFS PSN) and the NetPass membership is scheduled to be transitioned over a period of several months to Molina prior to July 1, 2009. During the staggered transition process, the NetPass enrollees will be given written notification of this change and an opportunity to select another health plan.

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

Table 1
Health Plan Applicants

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

* During Fall of 2008, the health plan amended their contracts to withdrawal from this/these counties.
**During Fall of 2008, the health plan terminated their contract for this county.

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area. There have been no new health plan contracts executed since December 2008 (Better Health Plan FFS PSN).

Table 2
Medicaid Reform Health Plan Contracts

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

* During Fall of 2008, the health plan amended their contracts to withdrawal from this/these counties.
**During Fall of 2008, the health plan terminated their contract for this county.

Contract Amendments and Model Contracts

During this quarter, amendments that addressed capitation rates for Demonstration Year Three and the individual health plan benefit packages were executed with most of the remaining health plans. In the previous quarter, three health plans had amended their contracts to withdraw from certain counties within the demonstration area:

- United Health Plan submitted a request to withdraw from Broward County and the Agency amended their contract to indicate a November 1, 2008, withdrawal effective date.

- Vista Health Plan d/b/a Buena Vista and Vista Health Plan of South Florida submitted requests to withdraw from Broward County and the Agency amended those contracts to indicate a December 1, 2008, withdrawal effective date.

The health plans stated reasons for pulling out of these counties was not specific to the demonstration or to the September 1, 2008, capitation rates; rather the plans stated their withdrawal was related to network provider contracting issues. The Agency worked with these health plans to ensure proper and timely notice to beneficiaries of the plans withdrawal. During this quarter, the Agency worked with its choice counseling vendor and the health plans to ensure that appropriate notice was provided to both providers and enrollees and that beneficiaries were given the opportunity to select a health plan before being assigned to a plan. All affected beneficiaries were appropriately transitioned by December 1, 2008.

In addition, the Agency worked this quarter to facilitate the upcoming transition of Pediatric Associates Health Plan (FFS PSN) membership, to Access Health Solutions, slated to take effect February 1, 2009. During the transition process, the Pediatric Associates enrollees will be given written notification of this change and an opportunity to select another health plan.

During this quarter, the Agency also finalized a general health plan contract amendment that included encounter data and marketing changes to be implemented in early 2009. As the Agency's experience with Medicaid encounter data has increased, including input from the health plans, the Agency determined the need for a general contract amendment to provide health plans with timelines for submission and remediation of encounter data as well as outlining corrective action measures and defining encounter data accuracy and completeness. With the success of the demonstration's Choice Counseling Program, the Agency is reviewing the possibility of elimination of direct marketing by the health plans through the health plan general contract amendment process.

This quarter work continued on contract revisions for the 2009 consolidated health plan contract. This will be a streamlined version of the current separate model health plan contracts; the Agency will create one core contract that a health plan will sign with plan type exhibits or riders depending on the unique requirements of the particular plan type (FFS PSN or capitated PSN or HMO). The Agency intends to use this new model contract with the contract renewal period beginning September 1, 2009. Additionally, the Agency began work this quarter to review the results of the performance measures submitted by the health plans and to develop minimum thresholds that will be incorporated into the consolidated contract.

FFS PSN Conversion Process

Pursuant to section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the 4th year of operation. This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2009, unless the PSN opts to convert to capitation earlier. The Agency

continues efforts initiated in Demonstration Year Two to provide technical assistance to the PSNs in any conversion areas in which the plans might be lacking or for which they request assistance. In addition, the Agency has begun an internal review process to ensure that conversion issues related to FFS claims processing are appropriately discussed and resolved.

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

Table 3
PSN Conversion to Capitation Implementation Dates

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

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

Table 4
PSN Conversion to Capitation Timeline

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

FFS PSN Reconciliations

During this quarter, the Agency continued to work with two reconciliation[1] periods: one period for the first 6 months of the second year of operations (September 2007 through February 2008) and the final reconciliation for the first year of operations (September 2006 through August 2007). Two PSNs continued to require substantial technical assistance in the reconciliation process as either the entities were new to the reconciliation process or had experienced staffing changes. The Agency continues to

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

provide technical assistance to PSNs that have requested additional time or assistance as they analyze their reconciliation data.

Systems Enhancements

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

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Year One, Year Two, and Year Three of the demonstration. Interested parties were notified that the data book would be emailed

to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were released on May 23, 2007 for Year Two and May 7, 2008 for Year Three. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

The health plans have become innovative about expanding services to attract new enrollees and to benefit enrollees by broadening the spectrum of services. The standard 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. The average value of the customized benefits package continues to exceed the Medicaid State Plan benefit package in Year Three of the demonstration.

Current Activities

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

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

One of the significant changes in the benefit packages for Year Three is the increase in the total number of copayments from Demonstration Year Two. In total, there are 85 more copayments required during Year Three (104) than in Year Two (19). From Year Two to Year Three, there were increases in the number of copayments in all categories except dental. However, despite the increase in the number of copayments, 20 benefit packages (71%) have no copayments in all 16 categories. Please note that copayments only apply to non-pregnant adults. Table 5 displays the number of copayments for each service type, and Table 6 displays the number of plans that do not require copayments available to each target population in the demonstration areas.

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

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

Table 6
Number of Benefit Packages Requiring No Copayments
By Target Population & Demonstration Counties

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

In Year Three of the demonstration, many plans continue to provide services not currently covered by Medicaid to attract enrollees. In the health plan contract, these are referred to as expanded services. There are 11 different expanded services offered by the health plans during this contract year. The 2 most popular expanded services offered were the same as Year Two: the over-the-counter (OTC) drug benefits and the adult preventative dental benefits. Thirteen of the customized benefit packages decreased their OTC value, while one added a $25 OTC benefit. The expanded services available to beneficiaries include:

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

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

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

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

package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Three of the demonstration.

3. Grievance Process

Overview

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

As defined in the health plan contracts:

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

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

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

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

Current Activities

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

Grievances & Appeals

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

Table 7
Grievances and Appeals
July 1, 2008 – September 30, 2008

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	40	15	187	41	224,830

*unduplicated enrollment count

Medicaid Fair Hearings

Table 8 provides the number of MFH requested during the quarter ending December 31, 2008. Medicaid fair hearings are conducted through the Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members.

The Agency monitors the fair hearing process. Of the 5 MFH requests, 4 were related to denial of benefits/services with one request for an unknown reason. Information is pending on this case. Of the 5 MFH requests, one is complete with the outcome favorable to the beneficiary while 4 are still open and pending.

Table 8
Medicaid Fair Hearing Requests
October 1, 2008 – December 31, 2008

PSN	3
HMO	2

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as 8 grievances have been submitted to the SAP and none to the BAP for this quarter. Three out of the 8 grievances were resolved in favor of the beneficiary, while the other 5 are still pending.

Table 9 provides the number requests to BAP and SAP for the quarter ending December 31, 2008.

Table 9 **BAP and SAP Requests** *October 1, 2008 – December 31, 2008*	
BAP	0
SAP	8

4. Complaint/Issue Resolution Process

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

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

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

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

This quarter, the Agency received three complaints/issues related to FFS PSNs and received 64 complaints/issues related to HMOs, for a total of 67 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO). Attachment I provides the details on the complaints/issues related to FFS

PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

This quarter, two of the PSN complaints/issues were from members and only one was from a provider. Member issues included access to specialists and receiving Enhanced Benefit credits for healthy behaviors. The one provider issue was regarding denial of claims payment.

During the quarter, the majority of the HMO complaints/issues were related to member issues, with the majority being related to problems resulting from incorrect enrollment information. Other member issues included access to and authorization of services (including obtaining prescribed drugs and specialty referrals), enhanced benefits, and members being mistakenly billed or balance-billed. Provider issues included payment delays/denials; however, some of the enrollment issues also affected timely provider payment. With the transition to the Fiscal Agent still in process during this quarter, the Agency continues to monitor the enrollment complaint issues related to enrollment data provided to the health plans by the Fiscal Agent.

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

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

5. On-Site Surveys

In the spring and summer of 2007, the Agency performed on-site surveys of all 17 Reform health plans. These surveys gauged compliance with standards set forth in each plan's contract with the Agency and included a review of policies and procedures and information technology systems including claims payments and provider networks. The results of these surveys were all health plans are currently in good standing with the State and there were no sanctions.

During calendar year 2008, the State performed on-site reviews of 11 HMOs and 3 PSNs. The on-site review of Pediatric Associates that was scheduled to be completed was canceled since its membership will be transitioned to Access Health Solutions effective February 1, 2009, unless recipients choose another plan. The on-site review of Children's Medical Services and South Florida Community Care Network are scheduled to be performed during the next quarter.

The survey process was consistent across health plan types (HMO and PSN). The State's survey team consisted of a team leader and at least two team members and lasted an average of three days. Health plan policies and procedures were reviewed prior to the onsite visit. The results of the surveys indicate that the health plans surveyed are in compliance with all state and federal regulations and there were no sanctions administered. Table 10 provides the list of on-site survey categories.

Table 10 On-Site Survey Categories
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Grievances & Appeals
➲ Financials

In 2008, the State worked to refine and strengthen the health plan survey process and monitoring tools with the assistance of Florida's External Quality Review Organization, Health Services Advisory Group, Inc. (HSAG). HSAG assisted the State in the development of scoring mechanisms to be utilized in desk reviews of health plan policies and procedures and on-site reviews. In addition, HSAG worked with the State to refine questions to be used during the on-site visit. All monitoring functions are compliant with state and federal regulations.

B. Choice Counseling Program

Overview

The demonstration is in its second quarter of Year Three. A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health by providing them with the information they need to make the most informed decisions about health plan choices. Choice Counseling continues to look at ways to offer choices and reach the beneficiary. During this quarter, the Preferred Drug List (PDL) search functionality called the Informed Health Navigator Solution (Navigator) went live, and continues to grow in use as a way to choose a health plan. Another innovation this quarter (identified as an ongoing need) has been to reach out and provide support to beneficiaries that access mental health services. The Outreach/Field has developed a Mental Health Unit (MHU) in an effort to provide direct support to those beneficiaries. The MHU was started with the help of Community Based Organizations and Agencies who provide services to this special needs group. (More on the MHU in the Outreach/Field portion of this report.)

The Florida Medicaid Program moved to a new system developed and implemented by the new Fiscal Agent, EDS (Electronic Data Systems). This new system incorporates both the Fiscal Agent support and the managed care non-reform enrollment broker functions under one system.

The transition to a new system has impacted the Choice Counseling Program operating under the demonstration (as mentioned in the previous quarterly report). The Choice Counselor, Affiliated Computer Services (ACS), receives its newly eligible information, enrollment and all data from the new Fiscal Agent, EDS. The Agency, ACS and EDS have worked diligently to make sure that the transfer of correct and timely information from the Fiscal Agent to ACS has been a top priority; there have been great improvements made over the last quarter as we have identified and rectified many issues. Receiving correct data from the new Fiscal Agent is key for ACS to be able to meet contract standards for enrollment, call statistics, and mailroom standards, etc. ACS and EDS have demonstrated the ability to problem solve and have made great efforts to work together along with the Agency to resolve these issues.

The Agency and ACS have worked together to ensure beneficiary's needs are addressed in a timely manner with actions such as:

- Authorizing the Choice Counseling Call Center and Field Choice Counselors to allow Good Cause plan changes when a beneficiary has had any difficulty accessing choice counseling services or the information in the Choice Counseling System has been incomplete;
- Requesting the Field Choice Counselors to reach out to community partners to help communicate with beneficiaries;

- Requiring the Field Choice Counselors to address Choice Counselor Call Center call backs (from messages taken), and handling an increased amount of plan changes and enrollments;
- Implementing a Mental Health Unit with certain Field Choice Counselors addressing questions specific to mental health; and
- Using special Needs Unit Nurses to reach out and help those that have complex health needs.

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

Beneficiary satisfaction levels with the Choice Counseling Program are monitored through the Customer Service Survey which continues to be utilized by the beneficiary. The Agency and ACS are closely monitoring their responses. The beneficiary's experience and feedback is very important especially during this transition time, and their responses continue to be positive (see Table 12 of this section for survey results). The positive Customer Service Survey responses received speak very highly about the efforts being made by the Choice Counselors.

Current Activities

1. Informed Health Navigator Solution (Navigator)

The Agency held beneficiary focus groups and public meetings in the demonstration counties to solicit input on the Choice Counseling program. As a result of the feedback from previous public meetings, the Agency implemented a preferred drug search functionality called "Navigator" which went live in the Choice Counseling Program October of 2008.

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

The Choice Counselor's role is to share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications. The Navigator provides additional information to assist the beneficiary in making a plan selection.

Table 11 provides the Navigator statistics from “Go Live” through December 31, 2008. “Sessions” represents the number of times the Navigator program was utilized, and “Recipients” represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate sessions and recipient.

Since the “Go Live” date of October 27, 2008 through December 31, 2008 for the Navigator, there have been a total of 1,365 sessions and 1,137 unique Recipients that have utilized the system.

Table 11
Navigator Statistics from “Go Live” through December 31, 2008

Week	Sessions	Recipients
10/27-10/31	184	131
11/03-11/07	142	116
11/10-11/14	151	133
11/17-11/21	206	170
11/24-11/28	116	100
12/01-12/05	141	127
12/08-12/12	139	123
12/15-12/19	145	120
12/22-12/26	70	58
12/29-12/31	71	59

Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. During the months of October through December of 2008, the automated survey has been completed by 1,569 beneficiaries. The survey seeks input regarding:

- How helpful the choice counseling program is in assisting with making a plan choice;
- Rating the amount of time the beneficiary must hold before talking with a counselor;
- How easy the information is to understand;
- Rating the customer service provided by the counselor, including confidence in the information provided; and
- Rating the likeliness of recommending the Choice Counseling helpline to someone else.

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

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

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

During this quarter, the overall beneficiary survey scores remain high, however the scores for the amount of time the beneficiary has to "wait on hold" has declined. This reduction in score for the hold time began in August, which correlates with the increase in incoming call volume to the ACS Choice Counseling Call Center. The increase in call volume is related to issues with the new Fiscal Agent and an increase in the number of new eligible beneficiaries. ACS is utilizing the "red alert" messaging system as an immediate response to offset the caller's wait time (this was started in August as reported previously). This allows a beneficiary on hold (for 5 minutes) to leave a message with a live person and receive a call back within 24 hours. This action has helped beneficiaries get the responses they need in a shorter amount of time. In addition, ACS has hired more choice counselors to handle the increased call volume.

The other areas reflected in the survey are continuing to show high scores. The one area that has consistently showed a medium score since the introduction of the customer service survey is the "How easy it was to understand information". The materials that illustrate the benefit plans are an area that the Agency and Choice Counseling vendor continue to look at for ways to convey the information in an easy to understand format. These materials will be reviewed again this year as we strive to improve the program.

Table 12 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from October through December of 2008. The number of beneficiaries participating in the Survey was as follows: October - 583, November - 400, and December - 586 (totaling 1,569).

Table 12 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
How helpful do you find this counseling to be		
October	**November**	**December**
86.60%	87.30%	85.30%
Amount of time you waited		
October	**November**	**December**
40.50%	38.30%	32.80%
How easy it was to understand info		
October	**November**	**December**
77.10%	74.10%	76.50%
Likelihood to recommend		
October	**November**	**December**
91.30%	89.80%	88.20%
Overall service provided by Counselor		
October	**November**	**December**
96.20%	95%	95.90%
Quickly understood reason		
October	**November**	**December**
95.50%	94.80%	94.90%
Ability to help choose plan		
October	**November**	**December**
93.80%	92.30%	92.70%
Ability to explain clearly		
October	**November**	**December**
94.90%	94.50%	94.00%
Confidence in the information		
October	**November**	**December**
93.10%	94.00%	92.20%
Being treated respectfully		
October	**November**	**December**
96.40%	97.00%	97.10%

2. Call Center

The Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida, operates a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., providing no Saturday hours. The call center has over 38 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls. An additional 7 full time FTEs and 3 part time employees joined the Choice Counseling team in November of 2008.

The Choice Counseling call center has reported a continually growing volume of incoming calls - particularly in October and December of 2008. The Agency and ACS have been in constant communication about the call volume and ACS has worked very diligently to handle this increase in volume with both short and long term solutions.

The following actions were implemented in August and have continued to cover the increase of call volume:

1. A "red alert" messaging system was implemented to give beneficiaries the opportunity to leave a message after 5 minutes of hold time. Call backs to these beneficiaries happen within 24 hours. This is a short term solution that will slowly be phased out as the need diminishes.
2. A total of 10 new staff (7 FTEs and 3 part time employees) have been hired and started on the phones November of 2008.

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

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

Table 13
Comparison of Call Volume for 2nd Quarter
(Year 2 & Year 3)

Type of Calls	Oct 2007	Oct 2008	Nov 2007	Nov 2008	Dec 2007	Dec 2008	Year 2 2nd Quarter Totals	Year 3 2nd Quarter Totals
Incoming Calls	16,165	26,295	13,124	19,422	10,674	28,333	**39,963**	**74,050**
Outgoing Calls	10,248	9,701	5,960	7,850	7,664	8,671	**23,872**	**26,222**
Totals	26,413	35,996	19,084	27,272	18,338	37,004	**63,835**	**100,272**

The Choice Counseling Program met and exceeded the contract standards in the Call Center for the first 2 years of the waiver. The statistics in Table 13 show the dramatic increase of calls in the second quarter of Year Three. There were 34,087 more incoming calls than were reported in the second quarter of demonstration Year Two. The incoming call volume in December 2008 increased to an all time high of 28,333 (compared to December of 2007 with 10,674 incoming calls). The outgoing calls also increased since the "red alert" system was added. The increase in calls is directly related to the system issues between the Fiscal Agent and ACS.

3. Mail

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

Outbound Mail

During the quarter, the ACS mailroom mailed the following:

New-Eligible Packets	22,055
Auto-Assignment Letters	27,165
Confirmation Letters	24,564
Open Enrollment Packets	28,870
Transition Packets	870

During this quarter, the amount of returned mail has improved but still exceeds the Year Two average of 2-3%. The amount of return mail has increased due to the system issues. The Agency and ACS have worked diligently to correct the address fields with the Fiscal Agent so the Reform Choice Counseling System would accept and read the data correctly. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary. The Choice Counseling staff work to re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail:

During the quarter, ACS processed the following:

Plan Enrollments	1700
Plan Changes	223

The percentage of enrollments processed through the mail-in enrollment forms has remained around 2% of enrollments. The Agency and ACS are exploring options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program to better serve beneficiaries if this option is discontinued.

4. Face-to-Face/Outreach and Education

During the quarter, the Field Choice Counseling Outreach team has continued to focus its efforts to reach those beneficiaries with a pending assignment. The data exchange between the new Fiscal Agent and the Reform Choice Counseling System is a continuing work in progress and the team has made great efforts to help with return calls from the call center, continuing public and private seminars, and adding the new

Mental Health Unit to reach beneficiaries. These efforts have resulted in an impressive number of enrollments as outlined below in Table 14.

Table 14 Choice Counseling Outreach Activities July 2008 – December 2008						
	July	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Public Seminars	248	214	276	240	186	192
Private Seminars	49	31	31	34	18	36
Home/No-phone Visits	462	264	211	189	174	112
Outbound List	4,407	4,021	4,484	4,554	3,668	4,009
Enrollments	**2,600**	**3,694**	**2,841**	**2,585**	**2,023**	**3,327**

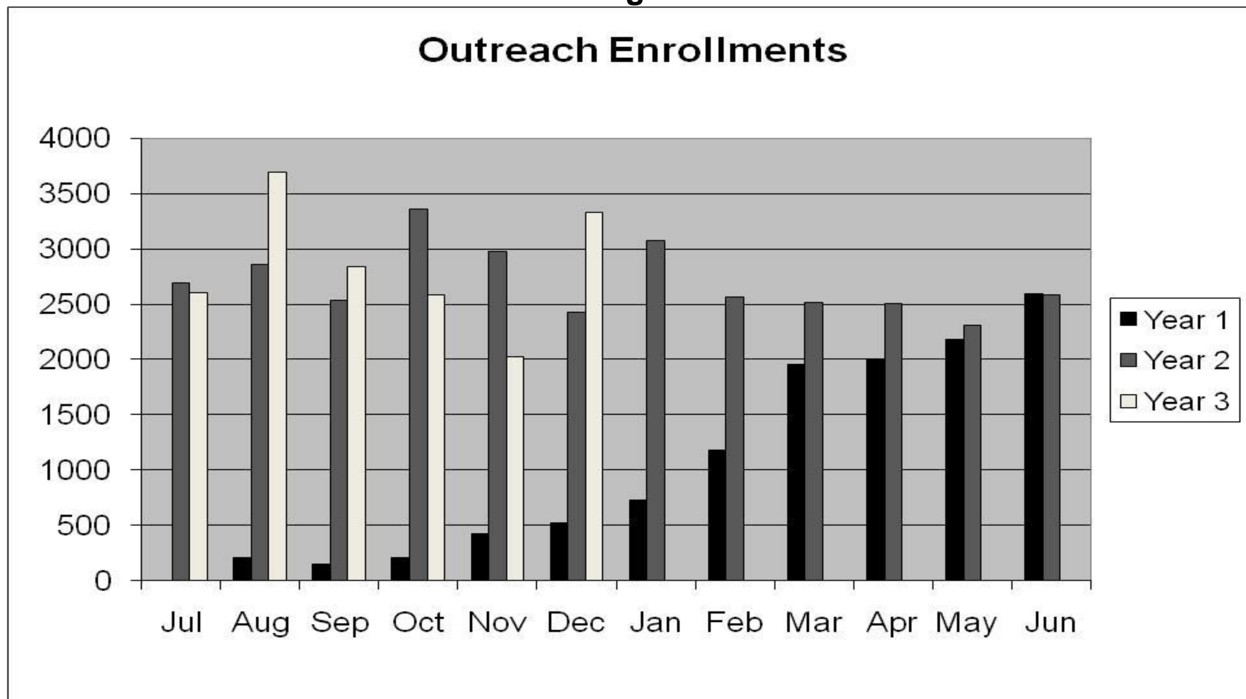
Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff has been calling beneficiaries at random who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 15 shows the responses in percentages from 150 beneficiaries who were randomly called to participate in the survey (from October- December 2008). The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 15 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	97.00%
Felt the information provided by the Choice Counselor helped them make an informed decision	95.00%
The information was explained in a way that made it easy to understand	98.67%
The Choice Counselor was friendly/courteous	99.67%

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

At the end of this quarter, the enrollments processed by Field Choice Counselors were 7,935 enrollment activities. The graph on the following page shows the enrollment activity levels of the Field Choice Counselors since implementation of the demonstration.

Field Choice Counseling Outreach Enrollments



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

During this quarter, the Field Choice Counselors continued to focus outbound calls from two main areas: the call backs provided from the Call Center and the pending auto assignments (which is a list of beneficiaries who have not made a choice of health plans and are within a few weeks of being assigned to a health plan by the state). ACS continues working on the development of relationships with many community based organizations and providers in the expansion counties of Baker, Clay and Nassau.

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

Group Sessions	618
Private Sessions	88
Home Visits & One-On-One Sessions	251
“No Phone List”	475
Outbound Phone List	12,231
Enrollments	7,935
Plan Changes	1,315

This past quarter the Outreach/Field team created the Mental Health Unit (MHU) to provide more direct support to beneficiaries who access mental health services. Three of the most experienced Field Counselors (2 in Broward and 1 in Duval) have focused their efforts on building relationships with Community Based Organizations and agencies who provide services to this special needs group. The Field Choice Counselor's have worked since the program began to establish a *partnership* and *open communication* so that case managers and other service providers have a local direct resource for enrollment counseling and support for their clients. The MHU have performed presentations to staff and assisted in coordinating ongoing Private Sessions with beneficiaries.

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

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

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

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse (RN) supervisor, and a Licensed Practical Nurse (LPN) that have both earned their Choice Counseling certification. The Special Needs Unit handled the following number of case referrals over the second quarter of Year Three: October = 20 cases, November = 16 cases, and December = 40 cases, totaling 76 cases.

The RN supervisor has developed and implemented training for the Choice Counselors which outlines how the Special Needs Unit works and how to refer beneficiaries to the unit for help. Both nurses were instrumental in the creation of the Navigator portion of the Choice Counseling script implemented in October of 2008.

The staffing goal of the Special Needs Unit, after an evaluation (performed in 2007), is to staff the unit with one RN supervisor, two LPNs and one social worker. In addition to the restructure of the Special Needs Unit staff, the scope of the work for the unit was expanded to include:

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

6. New Eligible Self Selection Data[2]

The new eligible numbers for self selection have not been reported since July 2008 due to issues with daily file and month end processing transfers from the Fiscal Agent and ACS Choice Counseling. Without the correct new eligible information being transferred in a timely manner, the new beneficiaries who need to select a plan cannot be successfully identified and contacted, and ACS Choice Counseling Call Center and field personnel cannot consistently have a target to reach.

The new eligible enrollments in this report are taken from ACS records. The second quarter enrollments were as follows: 6,296 for October; 8,230 for November; and 9,143 for December 2008; totaling 23,669 enrollments for those that self selected a plan. The total number of those that self selected a plan and were assigned was 44,449 for the quarter.

The Agency, ACS and EDS are having daily conversations and a corrective effort is in process to rectify the transfer of correct information. The daily and monthly files of information that transfer from EDS to ACS have been through several iterations/ improvements and many of the issues are resolved. With the month end information coming through consistently and correctly, it will allow ACS to determine who the new eligible's are, and ACS can contact those who need to make a plan selection in a timely manor, thus meeting (and exceeding) the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. In August of 2007, the Agency and ACS implemented an automated beneficiary survey where complaints against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call.

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

During the quarter, one complaint filed related to the Choice Counseling Program. Table 16 provides the details regarding the complaint filed and the action taken by ACS:

Table 16 **Choice Counseling Beneficiary Complaints** October 1, 2008 – December 31, 2008	
Beneficiary Complaint	**Action Taken**
1. A beneficiary called to file a complaint with a supervisor in Choice Counseling stating that a counselor was rude during a call	➲ The supervisor spoke with the beneficiary and apologized for the rudeness of the call. The supervisor has provided the counselor with customer service coaching and has increased the counselor's monitoring.

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Counselor's ability to explain health plan choices indicate that more than 94% are satisfied with the Choice Counseling experience. ACS continues to focus on improving communication between Counselors and beneficiaries and evaluating comments left by beneficiaries to improve customer service.

Included in this report are comments from beneficiaries who expressed their appreciation to a Call Center Supervisor for the Choice Counselors who helped them when they called the Choice Counseling Helpline. The individual counselors that received this positive feedback have gone the extra mile and have offered a "helping hand" to those who have called in. These beneficiaries have taken the initiative on their own to contact the supervisors to compliment the work that the counselors have done. During this quarter, there were 38 reported compliments to supervisors about counselors offering exceptional customer service. Table 17 provides examples of positive feedback about Choice Counselors.

Table 17 Helping Hands Examples of Positive Feedback about Choice Counselors October 1, 2008 - December 31, 2008
A beneficiary called to say, "I want to compliment **Demestra Davis** for her professionalism, she was very patient, she took the time to explain every detail that I needed to know. I'm very happy with the service she provided."
A beneficiary who called to compliment **Stephanie Hays** said, "Stephanie helped me a lot, thanks to her I was able to understand how everything works. I just want you to know how grateful I am that you have her
"A beneficiary who called to compliment **Tywanna Swain** said, "Tywanna provided excellent customer service, she was wonderful."
"A beneficiary calling to say **Felicia Bell** was amazing said, "I had a lot of questions about the health plans and enrolling—which Felicia answered to my complete, total satisfaction. She was very informative and helpful, the way a customer service representative should be—because you don't get that most places you call."
A beneficiary who called to say she had a really wonderful experience while speaking with **Demethra Jenkins** said, "She provided excellent customer service and she went above and beyond to help me. Thank you for having a person like Demethra."
A beneficiary calling to say **Beverly Woodson** was *Great* said, "She was the first person I spoke with that went beyond her called of duty. Beverly made the process very smooth and it was very comforting to have a patient person like her assisting me with my parents. She should be cloned because she was wonderful!"
A supervisor received a call from a customer espousing the wonderful talents and exceptional word class service provided by **Angela Reshard**. The caller complimented Angela's professionalism and caring attitude. "I work in a call center and I wish Angela worked for me, she was great," stated the recipient.

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

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

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

e-mail boxes on ACS' enrollment system to enable the Agency staff and ACS to share information directly from the system to resolve difficult cases, and regularly scheduled conference calls. ACS has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the call center and field have been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

9. Summary

Overall with a project as large as transitioning to a new Medicaid Fiscal Agent, there are bound to be challenges for everyone as we all learn and work in a new system. The issues that have developed are difficult but are not insurmountable. As noted in last quarter's report, the problems continue to be identified, prioritized, and are being systematically worked through with the help of ACS, EDS and the Agency. EDS continues to work hard to ensure that any Fiscal Agent activities that affect Choice Counseling are given a high priority, so that the beneficiary can receive the attention and care that is needed.

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

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

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

C. Enrollment Data

Overview

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

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

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

The Agency provides a comprehensive monthly enrollment report, which includes the enrollment figures for all health plans in the demonstration. This monthly enrollment data is available on the Agency's website at the following URL:

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

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning October 1, 2008 and ending December 31, 2008. This section contains the following Medicaid Reform enrollment reports:

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

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

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 18 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 18 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 19 for the Fiscal Year 2008-09, 2nd Quarter Medicaid Reform Enrollment Report.

Table 19
Medicaid Reform Enrollment Report
(Fiscal Year 2008-09, 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	14,596	1,889	5	82	**16,572**	**7.31%**	15,052	10.10%
Buena Vista	HMO	4,200	527	0	50	**4,777**	**2.1%**	6,725	-28.97%
Freedom Health Plan	HMO	936	185	1	2	**1,124**	**0.50%**	485	131.75%
HealthEase	HMO	46,829	5,460	7	152	**52,448**	**23.14%**	54,963	-4.58%
Humana	HMO	10,763	2,381	22	59	**13,225**	**5.83%**	10,781	22.67%
Preferred Medical Plan	HMO	2,149	587	5	14	**2,755**	**1.22%**	1,967	40.06%
StayWell	HMO	30,524	3,108	3	121	**33,756**	**14.89%**	35,087	-3.79%
Total Health Choice	HMO	3,348	652	7	15	**4,022**	**1.77%**	2,369	69.78%
United Health Care	HMO	15,026	1,749	2	87	**16,864**	**7.44%**	26,551	-36.48%
Universal Health Care	HMO	3,114	532	3	16	**3,665**	**1.62%**	1,876	96.36%
Vista South Florida	HMO	4,595	426	0	51	**5,072**	**2.24%**	6,698	-24.28%
HMO Total		**136,080**	**17,496**	**55**	**649**	**154,280**	**68.07%**	**162,554**	**-5.09%**
Access Health Solutions	PSN	19,418	3,340	6	337	**23,101**	**10.19%**	19,987	15.58%
CMS	PSN	2,305	2,386	0	17	**4,708**	**2.08%**	4,334	8.63%
First Coast Advantage	PSN	15,841	3,722	2	465	**20,030**	**8.84%**	17,430	14.92%
NetPass	PSN	3,754	1,517	5	199	**5,475**	**2.42%**	4,051	35.15%
Pediatric Associates	PSN	9,632	546	0	56	**10,234**	**4.52%**	9,673	5.80%
SFCCN	PSN	6,287	2,257	6	276	**8,826**	**3.89%**	6,801	29.78%
PSN Total		**48,078**	**12,808**	**13**	**1,377**	**62,276**	**27.70%**	**60,091**	**3.64%**
Reform Enrollment Totals		**193,317**	**31,264**	**74**	**1,999**	**226,654**	**100.00%**	**224,830**	**0.81%**

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

The enrollment figures for this quarter reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 226,654 beneficiaries enrolled in the demonstration during this quarter. There were 17 Reform health plans with market shares ranging from 0.50 percent to 23.14 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter the demonstration was 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 20 on the following page.

Table 20 Number of Reform Health Plans in Demonstration Counties		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**1**	**1**
Broward	**11**	**5**
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Medicaid Reform counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, Reform HMOs are listed first, followed by Reform PSNs. Table 21 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 21 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as in Table 22 and located on the following page.

Table 22
Medicaid Reform Enrollment by County Report
(Fiscal Year 2008-09, 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	723	112	0	3	**838**	**30.24%**	847	-1.06%
Access Health Solutions	PSN	Baker	1,734	188	0	11	**1,933**	**69.76%**	1,853	4.32%
Total Reform Enrollment for Baker			**2,457**	**300**	**0**	**14**	**2,771**	**100.00%**	**2,700**	**2.63%**
Amerigroup	HMO	Broward	14,596	1,889	5	82	**16,572**	**13.23%**	15,052	10.10%
Buena Vista	HMO	Broward	4,200	527	0	50	**4,777**	**3.81%**	6,725	-28.97%
Freedom Health Plan	HMO	Broward	936	185	1	2	**1,124**	**0.90%**	485	131.75%
HealthEase	HMO	Broward	13,209	1,533	5	52	**14,799**	**11.81%**	15,960	-7.27%
Humana	HMO	Broward	10,763	2,381	22	59	**13,225**	**10.56%**	10,781	22.67%
Preferred Medical Plan	HMO	Broward	2,149	587	5	14	**2,755**	**2.20%**	1,967	40.06%
StayWell	HMO	Broward	27,974	2,747	3	114	**30,838**	**24.62%**	31,580	-2.35%
Total Health Choice	HMO	Broward	3,348	652	7	15	**4,022**	**3.21%**	2,369	69.78%
United Health Care	HMO	Broward	637	72	0	36	**745**	**0.59%**	8,184	-90.90%
Universal Health Care	HMO	Broward	692	201	1	9	**903**	**0.72%**	436	107.11%
Vista South Florida	HMO	Broward	4,595	426	0	51	**5,072**	**4.05%**	6,698	-24.28%
Access Health Solutions	PSN	Broward	2,247	828	3	91	**3,169**	**2.53%**	2,751	15.19%
CMS	PSN	Broward	1,223	1,502	0	14	**2,739**	**2.18%**	2,537	7.96%
Netpass	PSN	Broward	3,754	1,517	5	199	**5,475**	**4.37%**	4,051	35.15%
Pediatric Associates	PSN	Broward	9,632	546	0	56	**10,234**	**8.17%**	9,673	5.80%
SFCCN	PSN	Broward	6,287	2,257	6	276	**8,826**	**7.05%**	6,801	29.78%
Total Reform Enrollment for Broward			**106,242**	**17,850**	**63**	**1,120**	**125,275**	**100.00%**	**126,050**	**-0.61%**
United Health Care	HMO	Clay	3,318	264	0	7	**3,589**	**36.80%**	3,271	9.72%
Access Health Solutions	PSN	Clay	5,392	713	0	60	**6,165**	**63.20%**	6,071	1.55%
Total Reform Enrollment for Clay			**8,710**	**977**	**0**	**67**	**9,754**	**100.00%**	**9,342**	**4.41%**
HealthEase	HMO	Duval	33,620	3,927	2	100	**37,649**	**44.45%**	39,003	-3.47%
StayWell	HMO	Duval	2,550	361	0	7	**2,918**	**3.45%**	3,507	-16.79%
United Health Care	HMO	Duval	9,249	1,133	2	38	**10,422**	**12.31%**	12,979	-19.70%
Universal Health Care	HMO	Duval	2,422	331	2	7	**2,762**	**3.26%**	1,440	91.81%
Access Health Solutions	PSN	Duval	7,494	1,305	0	146	**8,945**	**10.56%**	6,581	35.92%
CMS	PSN	Duval	1,082	884	0	3	**1,969**	**2.32%**	1,797	9.57%
First Coast Advantage	PSN	Duval	15,841	3,722	2	465	**20,030**	**23.65%**	17,430	14.92%
Total Reform Enrollment for Duval			**72,285**	**11,663**	**8**	**766**	**84,695**	**100.00%**	**82,737**	**2.37%**
United Health Care	HMO	Nassau	1,099	168	0	3	**1,270**	**30.54%**	1,270	0.00%
Access Health Solutions	PSN	Nassau	2,551	306	3	29	**2,889**	**69.46%**	2,731	5.79%
Total Reform Enrollment for Nassau			**3,650**	**474**	**3**	**32**	**4,159**	**100.00%**	**4,001**	**3.95%**
Reform Enrollment Totals			**193,317**	**31,264**	**74**	**1,999**	**226,654**		**224,830**	**0.81%**

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

During this quarter there was an enrollment of 2,771 beneficiaries in Baker County, 125,275 beneficiaries in Broward County, 9,754 beneficiaries in Clay County, 84,695 beneficiaries in Duval County, and 4,159 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 30.24 percent to 69.76 percent, 16 Broward County Reform plans with market shares ranging from 0.59 percent to 24.62 percent, two Clay County Reform plans with market shares ranging from 36.80 percent to 63.20 percent, seven Duval County Reform plans with market shares ranging from 2.32 percent to 44.45 percent, and two Nassau County Reform plans with market shares ranging from 30.54 percent to 69.46 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 23 and 24 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. Table 23 provides a description of each column in this report.

Table 23
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 24 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 24
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2008-09, 2nd Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	4	99	2	27	2	4	**138**	**0.83%**	**16,572**
Buena Vista	HMO	Broward	1	37	0	11	0	4	**53**	**1.11%**	**4,777**
Freedom Health Plan	HMO	Broward	1	2	0	3	1	0	**7**	**0.62%**	**1,124**
Healthease	HMO	Broward	2	104	0	27	0	4	**137**	**0.93%**	**14,799**
Healthease	HMO	Duval	11	473	1	67	5	8	**565**	**1.50%**	**37,649**
Humana	HMO	Broward	4	69	0	32	7	10	**122**	**0.92%**	**13,225**
Preferred Medical Plan	HMO	Broward	4	17	1	6	1	1	**30**	**1.09%**	**2,755**
Staywell	HMO	Broward	6	163	2	56	2	7	**236**	**0.77%**	**30,838**
Staywell	HMO	Duval	0	34	0	4	0	0	**38**	**1.30%**	**2,918**
Total Health Choice	HMO	Broward	7	16	0	3	3	3	**32**	**0.80%**	**4,022**
United Healthcare	HMO	Baker	0	6	0	0	0	1	**7**	**0.84%**	**838**
United Healthcare	HMO	Broward	0	43	0	25	0	3	**71**	**9.53%**	**745**
United Healthcare	HMO	Clay	3	20	1	16	0	1	**41**	**1.14%**	**3,589**
United Healthcare	HMO	Duval	0	185	0	25	0	3	**213**	**2.04%**	**10,422**
United Healthcare	HMO	Nassau	2	8	0	2	1	1	**14**	**1.10%**	**1,270**
Universal	HMO	Broward	0	1	0	1	2	4	**8**	**0.89%**	**903**
Universal	HMO	Duval	9	12	0	3	3	0	**27**	**0.98%**	**2,762**
Vista South Florida	HMO	Broward	2	40	1	17	0	4	**64**	**1.26%**	**5,072**
HMO Total	**HMO**		**56**	**1,329**	**8**	**325**	**27**	**58**	**1,803**	**1.17%**	**154,280**
Access Health Solutions	PSN	Baker	0	11	0	3	2	8	**24**	**1.24%**	**1,933**
Access Health Solutions	PSN	Broward	2	21	0	13	12	67	**115**	**3.63%**	**3,169**
Access Health Solutions	PSN	Clay	2	33	0	15	5	41	**96**	**1.56%**	**6,165**
Access Health Solutions	PSN	Duval	6	93	2	21	33	89	**244**	**2.73%**	**8,945**
Access Health Solutions	PSN	Nassau	2	29	0	4	4	23	**62**	**2.15%**	**2,889**
CMS	PSN	Broward	0	37	3	143	0	10	**193**	**7.05%**	**2,739**
CMS	PSN	Duval	0	43	0	55	0	3	**101**	**5.13%**	**1,969**
First Coast Advantage	PSN	Duval	11	206	1	90	39	367	**714**	**3.56%**	**20,030**
NetPass	PSN	Broward	0	35	3	28	19	161	**246**	**4.49%**	**5,475**
Pediatric Associates	PSN	Broward	0	106	0	22	1	3	**132**	**1.29%**	**10,234**
SFCCN	PSN	Broward	7	127	2	38	36	207	**417**	**4.72%**	**8,826**
PSN Total	**PSN**		**30**	**741**	**11**	**432**	**151**	**979**	**2,344**	**3.24%**	**72,374**
Reform Enrollment Totals			**86**	**2,070**	**19**	**757**	**178**	**1,037**	**4,147**	**1.83%**	**226,654**

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

D. Opt Out Program

Overview

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

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

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

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

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

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

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

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

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

Current Activities

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

<u>Opt Out Program Statistics</u>

- 54 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 29 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the second quarter of Year Three, there were 25 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

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

father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The five children's Medicaid eligibility ended February 28, 2007, and they were subsequently disenrolled from the Opt Out Program.

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

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

5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. One of the children’s Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program.

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

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

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

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

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

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

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

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

13. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on

February 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

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

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

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

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

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

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

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

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

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

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

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

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

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's

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

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

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

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

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

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

Table 25 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending December 31, 2008. Current Opt Out enrollment, as of December 31, 2008, is 25.

Table 25 Opt Out Statistics (September 1, 2006 –December 31, 2008)						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Single	1	02/28/07	Loss of Employment
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Ins
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 N/A	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	N/A	N/A
C & F	10/01/07	Large Employer	Family	2	N/A	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Ins
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	N/A 02/29/08	N/A Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	N/A	N/A
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	09/30/08	Loss of Employment
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/31/08	Loss of Employment
C & F	04/01/08	Large Employer	Single	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	05/01/08	Large Employer	Family	1	05/31/08	Loss of Employment
C & F	05/01/08	Large Employer	Family	1	N/A	N/A
C & F	07/01/08	Large Employer	Family	4	N/A	N/A
C & F	11/01/08	Large Employer	Family	1	N/A	N/A
C & F	10/01/08	Large Employer	Single	1	N/A	N/A
C & F	12/01/08	Large Employer	Family	5	N/A	N/A
C & F	12/01/08	ERISA	Family	1	N/A	N/A

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

E. Enhanced Benefits Account Program

Overview

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

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 worth of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (EDS) pharmacy point of sale system currently maintained and managed by the EDS subcontractor First Health. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the beneficiary's Medicaid Gold Card or Medicaid identification number and a picture ID.

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

Current Activities

1. Call Center Activities

During this quarter, the Medicaid Reform Enhanced Benefits Call Center, located in Tallahassee, Florida, continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The operation hours are 8:00 a.m. - 8:00 p.m., Monday – Thursday, and 8:00 a.m. - 7:00 p.m. on Friday.

The primary function of the call center is to handle inbound calls from Medicaid beneficiaries and answer questions on the program and provide information on credits earned and used by beneficiaries. During this quarter, the majority of the calls related to beneficiaries requesting information regarding their account balances. Calls this quarter have significantly increased in comparison to Demonstration Year Two, second quarter. The call volume has gone from 6,120 (2nd quarter, Year Two) to a high of 28,033 (2nd quarter, Year Three). The increased call volume can be attributed to several factors including but not limited to: increased utilization of the credits, more effective outreach materials, and Fiscal Agent transition issues.

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

Inbound Calls:	**28,033**
Calls Abandoned:	**4,000**
Average Talk Time:	**5.02**

2. System Activities

System activities revolved around continued refinement of the eligibility file generated from data collected by and passed through the new Fiscal Agent.

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day of the month. Each month, an eligibility file is uploaded into the EBIS. November 2008 health plan reports (for October claims) were processed along with the December 2008 health plan reports (for November claims) because of the continued work on the eligibility file. Work on the completeness of the eligibility file continues and is projected to be resolved next quarter. The Agency will continue to communicate with CMS as progress is made.

3. Outreach and Education for Beneficiaries

Beneficiary coupon statements were mailed to beneficiaries in October and December of 2008. The coupon statement provides the beneficiary with current balance information. Beneficiary purchases have steadily increased over the quarter. The calls received this quarter were primarily related to beneficiaries seeking current balance information. The Call Center is able to provide this information to each caller covering the latest weekly balances.

4. Outreach and Education for Pharmacies

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

Much effort was focused on the work to reimburse pharmacies at the "shelf price" of an over the counter (OTC) item instead of the Medicaid pricing. The Agency anticipates this change will occur next quarter on January 16, 2009. Outreach to pharmacies about this change occurred during the month of December 2008 with a mass mailing to participating pharmacies, e-mail blasts to corporate pharmacy chains, updating Agency web sites, mail out with beneficiary statements, and banner notices attached to the payment remittance voucher.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel did not meet during this quarter. The panel's next meeting is scheduled to be held next quarter.

6. Enhanced Benefits Statistics

Table 26 provides the Enhanced Benefit Account Program statistics beginning October 1, 2008 and ending December 31, 2008.

Table 26
Enhanced Benefit Account Program Statistics

2nd Quarter Activities – Year Three		October 2008	November 2008	December 2008
I.	Number of plans submitting reports by month in each county	30 of 31	30 of 30	28 of 28
II.	Number of enrollees who received credit for healthy behaviors by month	34,743	27,707	26,826
III.	Total dollar amount credited to accounts by each month	$698,770.00	$517,755.00	$527,315.00
IV.	Total cumulative dollar amount credited through the end each month	$17,882,771.16	$18,400,526.16	$18,927,841.16
V.	Total dollar amount of credits used each month by date of service	$447,085.77	$621,774.16	$687,968.97
VI.	Total cumulative dollar amount of credits used through the month by date of service	$4,331,191.72	$4,952,965.88	$5,640,934.85
VII.	Total cumulative number of enrollees who used credits through the end of each month	70,429	78,805	87,873

7. Complaints

A beneficiary can file a complaint about the EBAP through the call center and those complaints are documented in the system utilized by the call center and reported to the Agency on a weekly basis. The complaints are reviewed and worked by the Agency to resolve the issue the beneficiary is having regarding the program. The primary reason for complaints remains to be issues surrounding the pharmacies processing enhanced benefits claims. A total of 18,562 beneficiaries requested their credit balances through the call center. The Agency is researching the option of adding an automated voice response system to provide beneficiaries the current balances rather than having a counselor provide this information, allowing for better use of resources.

During this quarter, over 17,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 30 complaints were recorded through the call center related to the EBAP. Table 27 provides a summary of the complaints received this quarter and outlines the actions taken by either the Agency or EDS to address the issues raised.

Table 27 Enhanced Benefit Beneficiary Complaints	
Beneficiary Complaint	**Action Taken**
1. Twenty-two beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program.
2. Eight beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching at the pharmacy.	➲ The Agency has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list not in the particular pharmacy of choice.

F. Low Income Pool

Overview

In accordance with Special Term and Condition # 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 will limit the inpatient hospital payments for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. In the event of termination of the Florida Medicaid 1115 Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State has agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

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

Current Activities

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

<u>November 14, 2008 Meeting</u>
On November 14, 2008, a LIP Council meeting was held via conference call from 9:00 a.m. to 12:00 p.m. at the Agency in Tallahassee, Florida. This was the third LIP Council meeting of SFY 2008-2009.

The LIP Council members were informed of the ongoing dialogue that the Agency has with CMS regarding a final approval of the Reimbursement and Funding Methodology. The Agency is currently awaiting feedback from CMS on the most recent revisions to the Reimbursement and Funding methodology submitted. The Agency also provided an update of Letters of Agreements and Low Income Pool payments to date.

The LIP Council Chair discussed the current state of economy in Florida reminding everyone participating that revenue estimates were down. The LIP Council Chair and the Agency offered estimated deficits from the most recent Legislative Social Services Estimating Conference. Keeping potential shortfalls in General Revenue in mind, the LIP Council Chair asked the council members to focus on creative alternatives to solve some of the LIP program's most pressing issues.

The LIP Council also received an update from Florida Department of Health on current LIP funded projects.

The remainder of the council meeting entailed discussion regarding the distribution and overall funding priorities of LIP funds for State Fiscal Year 2009-2010.

December 15, 2008

On December 15, 2008 the LIP Council held their fourth meeting of SFY 2008-2009 at Tampa International Airport in Tampa, Florida from 10:00 a.m. to 4:00 p.m.

The LIP Council heard presentations from representatives from Federally Qualified Health Centers, the Florida Department of Health, and Pinellas County. The presentations included updates on current LIP projects for SFY 2008-09 as well as requests for continued funding and additional funding for SFY 2009-2010.

The Agency updated the LIP Council on several ongoing LIP issues with CMS including the recent communications regarding the LIP Reimbursement and Funding Methodology document and specifically the cost limit calculations. On November 24, 2008, the Agency received an e-mail from CMS asking the Agency for a revised Reimbursement and Funding Methodology no later than December 17, 2008. This revised document was necessary to ensure compliance with the new cost limit guidelines that CMS recently established and to ultimately receive final approval from CMS on the Reimbursement and Funding Methodology Document.

The remainder of this LIP Council meeting entailed discussion regarding the distribution and overall funding priorities of LIP and DSH funds.

Agency Activities

The Agency continues to work with Counties and Taxing Districts to complete Letters of Agreements for SFY 2008-2009; LIP payments are being released as Letters of Agreements are executed and IGTs are received.

The Agency submitted an updated Reimbursement and Funding Methodology Document on December 17, 2008. The update document included the modified LIP cost limit calculation requested by CMS. On December 22, 2008, CMS and the Agency had a follow up call to discuss the submission of the updated document and reconciliation of prior years.

The Agency is working with the LIP Council to submit the LIP Council recommendations to the Governor and Legislature by the February 1 annual deadline set forth in Florida Statutes. The LIP Council has publicly noticed two additional meetings for January 2009. During those meetings, the council will review distribution and funding models and vote on the final recommendations for State Fiscal Year 2009-2010.

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 (5th year), which is known as the base year, and projected forward through the waiver period. Additional negotiations were involved in the final Budget Neutrality calculations set forth in the approved waiver packet.

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

Definitions:

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

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

Current Activities

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

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

As noted in the previous quarterly report, Florida Medicaid transitioned to a new fiscal agent on July 1, 2008, and the Florida Bureau of Medicaid Program Analysis had to modify the data base to receive downloads from the new system. Due to variances in case months and expenditures, the Agency contacted the Centers for Medicare and Medicaid Services to discuss the data situation. It was determined to be appropriate to hold the budget neutrality submission of these figures until the Agency had identified and corrected all issues related to the variances. As such, budget neutrality figures were not included in the previous quarterly report.

The figures in this report reflect case months and expenditures for each quarter of the last two reporting periods, July 1 to September 30, 2008, and October 1 to December 31, 2008. These figures also correct a reporting error in the April 1, 2008 to June 30, 2008 report and the Year Two Annual report. The tables that listed the annual and cumulative statistics for MEGs 1 and 2 inadvertently double counted the MEG 2 case month totals for the April to June 2008 period. The actual MEG 2 case months for April 1, 2008, to June 30, 2008, period were correctly itemized and reported in the MEG 2 Statistics: Children and Families table.

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

In the following tables (Tables 28 through 33), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

Table 28 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC #116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 28
PCCM Targets

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

Tables 29 through 33 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending December 31, 2008. Case months provided in the tables 29 and 30 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 29
MEG 1 Statistics: SSI Related

Quarter Actual MEG 1	Case months	MCW Reform Spend*	Reform Enrolled Spend*	Total Spend*	PCCM
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
Q8 Total	**764,701**	**$655,801,882**	**$114,515,897**	**$770,317,779**	**$1,007.35**
July 2008	277,846	$200,722,971	$30,341,176	$231,064,147	$831.63
August 2008	270,681	$160,856,882	$19,088,505	$179,945,386	$664.79
September 2008	270,033	$249,753,130	$43,245,431	$292,998,561	$1,085.05
Q9 Total	**818,560**	**$621,982,366**	**$93,225,602**	**$715,207,968**	**$873.74**
October 2008	266,157	$344,932,887	$56,677,606	$401,610,493	$1,508.92
November 2008	263,789	$168,299,543	$27,033,622	$195,333,165	$740.49
December 2008	261,097	$341,950,432	$56,667,850	$398,618,282	$1,526.71
Q10 Total	**791,043**	**$869,452,609**	**$140,379,078**	**$1,009,831,687**	**$1,276.58**
MEG 1 Total	**7,621,987**	**$6,524,554,756**	**$893,708,885**	**$7,418,263,642**	**$973.27**

Table 30
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
Q8 Total	**3,856,584**	**$560,208,722**	**$70,729,589**	**$630,938,310**	**$163.60**
July 2008	1,343,457	$172,283,219	$22,905,266	$195,188,485	$145.29
August 2008	1,358,765	$105,192,091	$5,401,390	$110,593,481	$81.39
September 2008	1,378,085	$201,358,674	$22,862,437	$224,221,111	$162.70
Q9 Total	**4,080,307**	**$493,217,716**	**$51,350,778**	**$544,568,495**	**$133.46**
October 2008	1,393,235	$318,750,055	$40,702,050	$359,452,105	$258.00
November 2008	1,397,296	$130,646,097	$7,397,407	$138,043,504	$98.79
December 2008	1,384,149	$325,293,842	$39,262,050	$364,555,891	$263.38
Q10 Total	**4,174,680**	**$786,165,580**	**$87,361,507**	**$873,527,087**	**$209.24**
MEG 2 Total	**38,247,797**	**$5,650,039,003**	**$525,204,553**	**$6,175,243,556**	**$161.45**

* Quarterly expenditure totals do not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments.

For Demonstration Year One; MEG 1 has a PCCM of $970.96 (Table 31), compared to WOW of $948.79 (Table 28), which is 102.34% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.13 (Table 31), compared to WOW of $199.48 (Table 28), which is 80.28% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,003.33 (Table 31), compared to WOW of $1,024.69 (Table 28), which is 97.92% of the target PCCM for MEG 1. MEG 2 has a PCCM of $168.57 (Table 31), compared to WOW of $215.44 (Table 28), which is 78.25% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $920.89 (Table 31), compared to WOW of $1,106.67 (Table 28), which is 83.21% of the target PCCM for MEG 1. MEG 2 has a PCCM of $151.09 (Table 31), compared to WOW of $232.68 (Table 28), which is 64.93% of the target PCCM for MEG 2.

Tables 31 and 32 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting

MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the Special Terms and Conditions are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 32) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $293.25. Comparing the calculated weighted averages, the actual PCCM is 90.93% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 32) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $310.35. Comparing the calculated weighted averages, the actual PCCM is 87.95% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 32) is $375.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $276.70. Comparing the calculated weighted averages, the actual PCCM is 73.73% of the target PCCM.

Table 31
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,628,507,992	$263,404,639	$2,891,912,631	$970.96
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$66,022,263	
% of WOW PCCM MEG 1					102.34%
DY01 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162,819	$2,292,269,641	$135,808,285	$2,428,077,926	$160.13
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(596,601,208)	
% of WOW PCCM MEG 2					80.28%
DY02 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,610,587,583	$433,495,752	$3,044,083,334	$1,003.33
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(64,794,360)	
% of WOW PCCM MEG 1					97.92%
DY02 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY02 Total	14,829,991	$2,237,650,699	$262,275,416	$2,499,926,115	$168.57
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(695,047,146)	
% of WOW PCCM MEG 2					78.25%
DY03 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY03 Total	1,609,603	$1,285,459,182	$196,808,494	$1,482,267,676	$920.89
WOW DY3 Total	1,609,603			$1,781,299,352	$1,106.67
Difference				$(299,031,676)	
% of WOW PCCM MEG 1					83.21%
DY03 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY03 Total	8,254,987	$1,120,118,662	$127,120,852	$1,247,239,515	$151.09
WOW DY3 Total	8,254,987			$1,920,770,375	$232.68
Difference				$(673,530,861)	
% of WOW PCCM MEG 2					64.93%

Table 32
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,920,777,633	$399,212,924	$5,319,990,558	$293.25
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(530,578,944)	
% Of WOW					90.93%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,863,960	$4,848,238,282	$695,771,167	$5,544,009,449	$310.35
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(759,841,506)	
% Of WOW					87.95%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	9,864,590	$2,405,577,844	$323,929,346	$2,729,507,190	$276.70
WOW	9,864,590			$3,702,069,727	$375.29
Difference				$(972,562,537)	
% Of WOW					73.73%

Table 33
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,736
Q5	$114,252,478
Q6	$191,429,386
Q7	$319,005,892
Q8	$329,734,446
Q9	$165,186,640
Q10	$214,603,919
Total Paid	$2,301,174,300

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,050	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$302,735,325	$1,000,000,000	30.27%
Total MEG 3	$2,301,174,300	$5,000,000,000	46.02%

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

The expenditures for the first ten quarters for MEG 3, the Low Income Pool (LIP), were $2,301,174,300 (46.02% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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 medical encounter data collection processes, continues to support the implementation and operational activities of the Medicaid Encounter Data System.

Current Activities

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

The HMOs remain in various states of readiness in terms of submitting encounter data through June 2008. With the numerous transition activities and tasks associated with the new Fiscal Agent operations, no encounters for this reporting period have been processed through the new FMMIS.

PSNs also remain in various states of readiness for submission of transportation encounter claims. During the quarter, no transportation encounters were processed for this reporting period for the same reason mentioned previously.

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

- Ongoing testing activities associated with the new FMMIS under EDS to support encounter data collection and processing.
- Ongoing effort with the health plans, the new Fiscal Agent, and the Agency's Pharmacy Benefit Manager (First Health) to coordinate the collection of pharmacy and medical services encounter data within new FMMIS using the HIPPAA compliant formats.

- Ongoing MEDS website updates, including the maintenance of relevant information used to facilitate communications with the health plans.
- Participated in "stand-alone" meetings with health plans, as well as biweekly technical and operations meetings, which were continued during this period to help resolve technical and X12 transaction format and content questions.
- Ongoing analysis of encounter data, in aggregate and at the MCO level, collected during the period September 2007 through June 2008. The purpose of the analysis is to identify trends, statistically significant defects, and anomalies. The outcome of this research will be used in corrective action recommendations to be discussed within the Agency, and with MCO management.
- Continued testing and refinement of reports and HIPAA compliant Electronic Data Interchange (EDI) processes used to communicate various operational errors and invalid transaction content to health plans for remediation of any encounters failing FMMIS edits.
- Continued the use of the Medicaid Decision Support System (DSS) to support validation, accuracy, and completeness of encounter data. Ongoing refinement of processes and measures to validate the quality and volume of the data received from health plans.

During the quarter, to comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid populations. Using the Medicaid Rx model, the Reform health plans were assigned plan risk factors, for TANF and SSI, based on the aggregate risk scores of their enrolled populations in those categories under 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 for each subsequent month thereafter for Medicaid-enrolled populations in Reform counties. As mentioned in last quarter's report, Legislation required that capitation premiums be fully risk adjusted and health plan corridor factors were no longer to be applied effective with Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting Reform capitation rates was April 1, 2007 through March 31, 2008, paid through June 30, 2008. This measurement period was used to generate risk adjustment factors for the health plans operating in the five demonstration counties.

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

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

- Initiated a test use of the CDPS (Chronic Illness and Disability Payment System) diagnostic risk adjustment model to evaluate the feasibility of using medical and diagnosis code data that was collected through MEDS for risk adjustment purposes. Preliminary activities included the extract of encounter data from two (2) HMOs and (5) PSNs for the period of January 1, 2007 through December 31, 2008, with a six (6) month run-out through June 30, 2008.
- For this period, risk adjustment plan factors were calculated for the following health plans:

Access Health Solutions	Amerigroup	Buena Vista through 12/01/08
Freedom Health Plan	United Health Care in Broward through 12/01/08	Universal Health Care
HealthEase	Humana	Preferred Medical Plan
StayWell	NetPass	Pediatric Associates
Vista South Florida through 12/01/08	Total Health Choice	SFCCN – North Broward Hospital District
SFCCN – Memorial Healthcare	Children's Medical Services	

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty plans/populations such as HIV/AIDS and CMS. Enrollment for risk adjustment purposes in the demonstration counties for the month of December 2008 totaled 177,882 and was distributed as follows:

December 2008	Broward	Duval, Baker, Clay, and Nassau
Children & Families	80,251	72,265
SSI	13,712	11,654
Totals	**93,963**	**83,919**

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

The process of providing plan risk factors for Medicaid Reform rate setting and budget neutrality will continue into the next quarter. Scheduled activities in the MEDS project plan associated with the collection and validation of encounters will also continue. These activities encompass technical support with capitated health plans, reviewing end-to-end testing results, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection, validation and utilization of encounter data.

I. Demonstration Goals

Medicaid Reform is fundamentally changing the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of Medicaid Reform, and anticipates using the evaluation as a means to inform policy decisions in both the short and long term. As lessons are learned on an incremental basis, these data will be used to shape further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation. There are six (6) key design elements of Medicaid Reform tracked by the Agency in order to evaluate progress towards achieving its goals. These objectives are specified in the approved 1115 Medicaid Reform Waiver. 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.

The Agency currently has contracts with 8 HMOs and 5 PSNs for a total of 13 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. As noted in Section A of this report, United Health Plan, Vista, and Vista Health Plan of South Florida terminated their contracts in Broward County during this quarter. The health plans stated reasons for pulling out of these counties was not specific to the demonstration or to the September 1, 2008, capitation rates; rather the plans stated their withdrawal was related to network provider contracting issues.

One of the Reform health plans is a specialty PSN plan which serves children with chronic conditions in both Broward and Duval Counties. The number and types of health plans that beneficiaries can choose from in Broward and Duval Counties increased considerably since the implementation of the demonstration. Additionally, the Agency has contracts with 1 HMO and 1 PSN in Baker, Clay and Nassau counties and enrollment began in September 2007. None of these health plan options previously had a presence in these three counties.

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

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

Access to Services Not Previously Covered

All of the capitated health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year Three of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter (OTC) drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Year Three include:

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

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

Improving Access to Specialists

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

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

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

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

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

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

That same month the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 28 shows the results of these analyses.

Table 34
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

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

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

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

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

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

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

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

During the second quarter of Demonstration Year Three, the Agency followed up on and analyzed the June 2008 survey results. As mentioned above, the Agency's follow-up now includes all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the June 2008 statewide survey, the combined results from the survey and the follow-up indicate that 288 (96%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 9 in June, 114 (97%) had current contracts with the health plans from which they were sampled.

Surveys were conducted in August, September, October, and November 2008. During the third quarter of Year Three, the Agency will continue to follow up and analyze these survey results. Findings from these surveys should be available to report on in the next quarterly report.

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

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

(a) The Agency received the first set of performance measure data this quarter. This performance measure data was for the reporting period January 1, 2007 to December 31, 2007. Although these submissions were due to the Agency on July 1, 2008, several health plans were granted extensions due to unforeseen issues with data systems and HEDIS vendors. The final set of data was submitted to the Agency on October 1, 2008. Please see Table 29 below for a list of the performance measures. Note that only those measures designated for Year One were submitted during this quarter.

Table 35
Plan Performance Measures – Over Three Year Period

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

The health plan data was compiled for review and analysis. Attachment III provides the list of the rates for each required performance measure by health plan. The health plan data can also be viewed on our website at the following link: http://ahca.myflorida.com/Medicaid/quality_mc/perform_measure.shtml.

With the submission of the first year data for review, the Agency was able to discuss performance goals and strategies for improvement with greater specificity. The state contracted with a national consulting firm to assist with the development of a performance improvement strategy related to the health plan performance measures. As a first step, the state will meet with each health plan individually during the next quarter to discuss plan performance measures and to request corrective action plans. A final overall improvement strategy will also be completed during the third quarter.

In November 2008, the Agency disseminated draft specifications for the Year 3 Agency – Defined Measures to the health plans for review and comment. The correspondence also communicated the state's intent to modify the performance measures for the disease management population so that data for disease management participants can be compared to enrollees in the general plan population with specific disease states. The Agency intends to formalize changes during the next quarter following receipt and review of health plan responses.

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

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

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

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

The reasons individuals have chosen to opt out of demonstration include:

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

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

The individuals who decided not to opt out:

(a) were not employed,

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

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

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

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

Future surveys will begin to yield additional information regarding patient satisfaction, and a description of the year one follow up survey findings is provided below. A total of 7,206 survey interviews were conducted during the fall of 2007 and winter of 2008.

Year One "Follow-Up" Surveys (Broward & Duval Counties)

The Year One Follow-Up Survey was designed to assess enrollees' experiences and satisfaction with their health care after one year of enrollment in a Reform health plan. The beneficiaries who participated in the Year One Follow-up Survey were enrolled in a Reform health plan located in Broward and Duval Counties, and this survey report contains the first and earliest comparison of pre- and post-Reform survey data. Summary information and tables depicting individual satisfaction measures collected one-year "post" Reform from Broward and Duval Counties are provided on pages 76 through 79.

Find below the projected timeline for the follow-up surveys to be conducted in Broward and Duval Counties.

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

Benchmark Satisfaction Survey (Baker, Clay & Nassau Counties)

The benchmark satisfaction survey data of beneficiaries located in Baker, Clay and Nassau Counties were collected during the fall of 2007 and winter of 2008. The beneficiaries surveyed were enrolled in MediPass, which is Florida's primary care case management program in these expansion counties. The benchmark survey report can be viewed when finalized on our website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml. A Year One Follow-Up Survey will be conducted during the winter of 2009 for the three counties. This survey is designed to capture an assessment of enrollees' experiences with their

health care after one year of enrollment in a Reform health plan in three rural counties. The Year Two Follow-Up Survey is projected to be conducted in the winter of 2010.

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

The goal of the *Medicaid Reform Enrollee Satisfaction: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey* is to measure health care experiences and satisfaction levels prior to and throughout the implementation of Medicaid Reform. When finalized and published, the full report can be viewed on our website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml

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

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

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

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

Broward County:

- The percentage rating their overall health care at the highest level declined for the overall, SSI and non-SSI populations.
- For the overall population and among the non-SSI enrollees, the proportion giving their personal doctor the highest rating increased.
- For SSI enrollees, the percentage giving overall plan satisfaction the highest rating declined.
- There was no change in specialty care ratings.
- The percentage of PSN and HMO enrollees rating their personal doctor at the highest level increased.

Duval County:

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

Select Demographic Characteristics: Broward and Duval Counties:

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

The following tables contain the percentage of program enrollees that reported the "Highest Level of Satisfaction," or a "9 or 10" on a Rating Scale of "1 to 10."

Select Satisfaction Measures: Broward and Duval Counties		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.10	57.37
Overall Satisfaction with Care	66.54	59.63
Personal Doctor Rating	70.19	73.41
Specialist Rating	60.39	63.32

Select Satisfaction Measures: SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	53.39	45.76
Overall Satisfaction with Care	56.41	48.68
Personal Doctor Rating	67.09	67.01
Specialist Rating	64.56	64.35

Select Satisfaction Measures: Non-SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	59.88	60.10
Overall Satisfaction with Care	68.98	62.53
Personal Doctor Rating	70.97	76.64
Specialist Rating	60.29	62.58

Select Satisfaction Measures: SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.91	53.12
Overall Satisfaction with Care	59.19	55.38
Personal Doctor Rating	69.41	68.82
Specialist Rating	63.80	58.65

Select Satisfaction Measures: Non-SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.57	58.74
Overall Satisfaction with Care	68.40	60.87
Personal Doctor Rating	70.29	71.88
Specialist Rating	55.0	65.88

Select Satisfaction Measures: PSN (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.96	56.11
Overall Satisfaction with Care	63.67	60.82
Personal Doctor Rating	70.56	76.19
Specialist Rating	61.93	62.72

Select Satisfaction Measures: HMO (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: PSN (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: HMO (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.33	56.72
Overall Satisfaction with Care	64.01	59.54
Personal Doctor Rating	66.98	69.67
Specialist Rating	49.11	62.07

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, 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 Provider Access Systems distribution methodology and has worked with these Provider Access Systems entities establishing agreements with the local governments or health care taxing districts.

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

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

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the University of Florida LIP Evaluation team confirming receipt of the electronic

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

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

STC #102, Demonstration Year Two Milestones, states that, "the State will conduct a study to evaluate the cost effectiveness of various provider access systems." This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost effectiveness study to the Agency by the third quarter of Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the Provider Access Systems. A sample of the LIP Milestone report is provided in the Reimbursement and Funding Methodology document. It should be noted that the LIP Milestone reports represent a snapshot of a 12 month period of time.

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

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges
- Case Mix Index
- Hospital Inpatient days
- Hospital Emergency Department Encounters (categorized by HCPC codes)

- Hospital Outpatient Ancillary Encounters (includes services such as diagnostic, surgical, therapy)
- Affiliated Services (includes services such as hospital owned clinic encounters, home health care, nursing home)
- Prescriptions filled

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

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

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

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

The UF LIP Evaluation was received from the University of Florida on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the Provider Access Systems. This document includes

an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

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

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

During the second quarter of Year Three, the Agency continues to work on gathering and evaluating the SFY 2007-08 Milestone data, to be shared with the University of Florida in order for it to continue its annual evaluation on the Low Income Pool Program (LIP). The Milestone data will be used in accordance with STC #102 of Florida's 1115 Medicaid Reform Waiver. The Agency looks forward to receiving SFY 2007-08 Milestone in the report form from The University of Florida during the fourth quarter of Year Three.

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

1. Evaluations Affiliated with the Agency or its Contractors

Urban Institute – Early Impact of Transitioning to Medicaid Reform

During the earlier implementation period, UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]), to study the impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. This study was subsequently published by Health Affairs on October 14, 2008, and can be viewed at http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w523. Additionally, the Kaiser Commission on Medicaid and the Uninsured issued Policy Brief #7823 entitled, *Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status*. This policy brief can be found at, http://www.kff.org/medicaid/upload/7823.pdf.

Specific to this report period, UF is conducting field work on a cross-sectional study in "follow up" to the one that was published in October 2008. Findings are not yet available from UF, but we will continue to provide updates on their progress as the report findings are provided to the Agency for review. A projected date on the official release of findings from the Urban Institute has not yet been established.

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

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

reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. During this quarter, OPPAGA released their latest report on the demonstration entitled, *Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers,* Report No. 08-64, November 2008.

All eight OPPAGA reports on the Medicaid Reform Demonstration can be found at their website link: http://www.oppaga.state.fl.us/reports/health/r08-64s.html.

3. UF Independent Evaluation in State Fiscal Year 2008-2009

UF will continue to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities are described by individual study/report timeframes per the MRE contract between UF and the Agency.

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

In addition to the studies already initiated, the Agency is evaluating the mental and behavioral aspects of Medicaid in the Reform and expansion counties (Broward, Duval, Baker, Clay, and Nassau). This study is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF. A comparison group has been included in this study, which will provide a typical “picture” of mental health service provision in a non-Reform county. This will allow UF to evaluate the impact of the Reform Demonstration on beneficiaries who are receiving mental health services.

University of Florida - Qualitative Survey

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

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. This has now been accomplished, so the Agency will initiate communications with CMS regarding a possible “replacement” study.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state’s hospital and managed care industries, the medical

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

association, other health professional groups, advocacy organizations, legislative leadership, or other entities. The FAC meets annually (usually in December or January), over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on Medicaid Reform and the evaluation. The third annual meeting is scheduled for May 15, 2009, at the Agency for Health Care Administration in Tallahassee, Florida.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. The purpose of this committee is to provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary. The next TAC meeting is scheduled for March 27, 2009 at the University of Florida in Gainesville.

K. Policy and Administrative Issues

Current Activities

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

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

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

In the technical assistance conference calls, the transition of Florida Medicaid's Management Information System from the legacy system to the new Fiscal Agent, Electronic Data Systems, Inc., computer system has continued to be foremost in time and preparation. All of these forums provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of the Agency's Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement.

Medicaid Reform Technical Advisory Panel

Two Technical Advisory Panel (TAP) meetings were held during this quarter: October 9 and December 18, 2008. Discussion topics included health plan rates, particularly on maintaining budget neutrality and risk adjustment; updates on the Fiscal Agent implementation, encounter data collection, enhanced benefit expenditures and choice counseling efforts, including the implementation of the Navigator system on October 27, 2008; discussion of changes in health plan benefit packages; and an update from the Medicaid Director on upcoming budget reduction exercises. Key in these topics were the implementation of the Fiscal Agent contract and the possible effects of continued budget reductions. In addition, the December meeting included a presentation by the University of Florida on the Medicaid Reform evaluation.

Policy Transmittals

During this quarter, there was one policy transmittal and one Dear Provider letter released to the health plans. The policy transmittal released to both HMOs and PSNs provided the health plans with new procedures for the activation of Medicaid identification numbers for newborns enrolled in Medicaid through the unborn activation process. These new procedures were required due to administrative simplifications made by the Florida Department of Children and Families relative to the unborn activation process. The Dear Provider letter sent to the HMOs and PSNs provided them

with an opportunity for review and comment on updates the Agency intended to make in the Medicaid Health Plan Performance Measures for Year Three (the measurement period is calendar year 2009). Once adopted, these Performance Measures will become effective January 1, 2009. The updated measures reflect the following:

- Changes by the National Committee for Quality Assurance (NCQA) in the Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Aligning mental health-related measures to be more similar to those being reported by the prepaid mental health plans (PMHPs);
- Specifications for the Year Three disease management measures, including a shift from Agency-defined measures to more standardized measures, where available; and
- The need for a standard way of reporting participation rates in disease management programs.

Biweekly Technical and Operations Calls

This quarter, the Agency conducted six biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants. The purpose of the calls are to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of the demonstration, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers and health plan subcontractors.

Approximately 20 to 30 participants attended in person and the popularity of the calls is shown by over 270 phone lines in active use during the calls. During the quarter, the majority of issues discussed continued to be operational in nature. While the transition to the new Medicaid Fiscal Agent and system continued to dominate call time, quality enhancement items began to emerge as standard themes for discussion. Such items include performance measure changes, external quality review updates, proposed marketing and encounter amendment review and fraud and abuse updates.

Other agenda items included:

- Choice Counseling Program updates, including implementation of the Navigator PDL search system this quarter;
- Process for submission of plan-identified HIV/AIDS enrollees to the Agency;
- Conversion application process for FFS PSNs;
- Plan withdrawals and transitions; and

- Medicaid Encounter Data Systems update.

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

Fee-for-Service PSN Systems Implementation Issues Calls

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

During the quarter, working through issues with the new Florida Medicaid Fiscal Agent system became the prime focus of the calls. The Agency moved from biweekly calls back to monthly systems implementation issues calls as the issues became more operational in nature.

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

- Medicaid Fiscal Agent transition issues relative to claims denial and clarification of denial edits;
- National Provider Number identification and Medicaid provider identification matching issues;
- Conversion of providers authorized by the PSNs to bill directly;
- Potential duplicate claim processing;
- Claims not appearing on the plan-specific electronic remittance voucher; and
- Issues relative to the systems freeze due to the transition of the Florida Medicaid Management Information System (FMMIS).

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

In addition to these calls, the Agency continued to coordinate technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, only a couple of providers have used it this quarter.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues October 1, 2008 – December 31, 2008	
PSN Informal Issue	**Action Taken**
1. The PSN denied a provider's claim because the plan states the member was not eligible on the date of service.	➲ Agency staff found that PSN had incorrect Medicaid number for beneficiary. The number was corrected and the provider was advised to resubmit the claim for payment.
2. A PSN member contacted Agency staff, reporting that the member had not been credited for healthy behaviors performed several months ago.	➲ The PSN researched all of the member's claims involving healthy behavior credits and ensured that all credits were issued for healthy behaviors.
3. Agency staff received a call from PSN member, who has been unable to obtain specialty provider authorization from plan.	➲ The PSN worked with the member to identify the specialist the member wanted to see. The PSN authorized ongoing care even though this provider is outside the plan network.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
1. An HMO member needed medications authorized.	➲ The HMO reported to Agency staff that the needed medications were prior authorized and the issue was resolved.
2. An HMO member contacted Agency staff and reported difficulties getting medications, and being told by the HMO Customer Call Center that member was not in the HMO.	➲ The HMO reported to Agency staff that it contacted the member and resolved the enrollment issue. The HMO's Escalation Unit contacted the member and pharmacy to confirm eligibility and resolve the medication issue.
3. An HMO member's parent stated the HMO will not provide a specialist for the member.	➲ The HMO reported to Agency staff that it contacted the mother of the HMO member and scheduled an appointment. Any referrals that need to be made will be made. The issue is resolved.
4. An HMO denied a provider claim because the billing code used is obsolete.	➲ Research indicated the billing code is active. The HMO reported to Agency staff that is had confirmed the code was active and resubmitted the claim for payment. The claim was paid in August.
5. Provider left HMO member's health plan panel but member needed to remain with provider through October 2008.	➲ The HMO reported to Agency staff that it agreed to an out-of-network arrangement. The provider and member were satisfied.
6. An HMO provider states eligibility check showed the beneficiary was a plan member on the dates of service, but the HMO denied beneficiary was a plan member.	➲ The HMO reported to Agency staff that it had confirmed the member was active on the dates of service and that it had advised the HMO provider to submit all claims for processing.
7. An HMO member's primary care provider had a claim denied because he is not in the HMO's provider network. The HMO member wanted to continue to see this primary care provider.	➲ The HMO reported to Agency staff that it authorized emergency service and worked with the HMO member. The member will choose a new plan with which the primary care provider participates. The current HMO will cover services through the transition.
8. An HMO member stated that the HMO will not authorize the provider to dispense a needed medication to the member.	➲ The HMO reported to Agency staff that it advised the member that he had tried to obtain the medication too early in the month. The refill is now available and the member was advised that he can pick it up.
9. An HMO member's mother stated that the HMO will not approve specialty services that the member urgently needed.	➲ The HMO reported to Agency staff that it worked with the member's family to find an acceptable solution so the member could receive necessary services. The family of the member is satisfied with the outcome.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
10. An HMO member stated he is unable to find a specialty provider within the HMO network even though he has a referral from his primary care provider.	➲ The HMO reported to Agency staff that it identified a specialty provider that will see the member and then notified the HMO member and his primary care provider.
11. The HMO stated that the member is not active and the primary care provider was not authorized to see the member when member was sick.	➲ The HMO reported to Agency staff that it verified the member's eligibility, and then contacted the primary care provider and member's mother to authorize immediate services.
12. An HMO member's mother stated that the member's healthy behavior has not yet been credited to his Enhanced Benefits Account. The HMO has no information.	➲ The HMO reported to Agency staff that it obtained the necessary information to update the member's file so credits will appear on 11/10/2008. The member's mother is satisfied.
13. An HMO provider said the HMO reports denying claims because the provider is using an incorrect NPI number. The provider reported using the correct number.	➲ The HMO reported to Agency staff that the provider had submitted some claims with an incorrect NPI number. The HMO contacted the provider and corrected claims were re-submitted, and are now processing for payment.
14. The HMO denied a provider claim, stating that the beneficiary was never a plan member. Eligibility checks showed the beneficiary was a member on the date of service.	➲ The HMO reported to Agency staff that it acknowledged the error and has corrected its member database so claims will pay.
15. An HMO member had seen an out-of-network specialty provider and wished to continue seeing that provider until a health situation resolves.	➲ The HMO reported to Agency staff that it agreed to allow the member to continue seeing the out-of-network specialist.
16. An HMO member was unable to obtain necessary health care items because the HMO denied authorization.	➲ The HMO reported to Agency staff that it worked with the member's primary care provider to determine the most appropriate health care items for the member and then approved the provider's decisions. The HMO member is satisfied.
17. An HMO subcontractor told specialty provider that a beneficiary was not an active member in the HMO and the HMO would not authorize services.	➲ The HMO reported to Agency staff that it immediately updated its member database and contacted the provider to authorize the visit. The HMO member was seen immediately and is satisfied.
18. An HMO member needed services but the HMO stated the member was not in the Reform plan. Due to a plan clerical error, the member was incorrectly placed in the plan's non-Reform product line.	➲ The HMO reported to Agency staff that it immediately authorized services and advised the member. The HMO member has corrected their address with the Social Security Administration and will choose a new plan before the next month's enrollment date.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
19. An HMO subcontractor denied authorization for services recommended by the HMO member's specialty provider.	➲ The HMO reported to Agency staff that it educated the subcontractor on its benefits package and authorized the requested services for the member.
20. An HMO provider stated that the HMO denied a claim because the member was not actively enrolled in a plan on the date of service.	➲ The HMO reported to Agency staff that the member was eligible on the date of service and directed the provider to resubmit the claim for payment.
21. An HMO member stated that the HMO denied services on the grounds that she was not an active member in the plan. .	➲ Eligibility checks by Agency staff confirmed she was an active member. The HMO reported to Agency staff that it confirmed eligibility and authorized the provider to prepare services for the member. The HMO contacted the member to inform her that services were ready.
22. Provider attempted to balance bill member. The HMO denied the claim because it says the member has third party insurance.	➲ The HMO reported to Agency staff that it corrected its database and that it instructed the provider to resubmit claims for payment. The member is satisfied.
23. An HMO member's caregiver stated the HMO had not given the caregiver the name of a network provider and the member urgently needed services.	➲ The HMO reported to Agency staff that it found a local provider for the member and changed the member's primary care provider assignment. Caseworker notified and appreciated prompt resolution of issue.
24. An HMO member's mother selected a primary care provider but the HMO assigned the member to another primary care provider. The member's mother was being balance billed for services by the primary care provider she selected and the member could not be seen until the issue was resolved.	➲ The HMO reported to Agency staff that it made a retroactive change of primary care provider to be effective 11/1/2008. The HMO counseled the member's mother and primary care provider staff and resolved the balance billing issue. The HMO member's mother is satisfied.
25. An HMO member had not yet received credit for healthy behaviors 10 months after services were provided.	➲ The HMO reported to Agency staff that it researched the issue and verified all claims were properly submitted and healthy behaviors were identified. The Fiscal Agent should be issuing credits shortly.
26. The HMO stated a beneficiary was not active on dates of service and denied provider's claims.	➲ The HMO reported to Agency staff that it confirmed the beneficiary was an active plan member on the dates of service. The HMO contacted the provider and told the provider to resubmit claims for prompt payment.
27. An HMO provider stated the HMO was attempting to recoup co-payments the provider was required to collect from children in the Medicaid HMO. The provider says this is a violation of Medicaid policy.	➲ The HMO reported to Agency staff that it had a system error regarding co-pays and corrected it immediately. The HMO advised the provider not to collect co-pays on Medicaid-eligible children.

HMO Complaints/Issues **October 1, 2008 – December 31, 2008**	
HMO Informal Issue	**Action Taken**
28. An HMO provider stated the HMO denied a claim stating the member was not active on the date of service.	➲ The HMO reported to Agency staff that it verified the member's eligibility but found the provider had billed for the wrong Medicaid ID number. After this was corrected, the claim was paid. The provider is satisfied.
29. A provider needed out-of-network authorization to provide services but the HMO is denying it.	➲ The HMO reported to Agency staff that it was able to locate the member and adoptive parent. The HMO authorized necessary services using the out-of-network provider.
30. An HMO member needed a referral to a specialist and the HMO was unable to provide necessary information.	➲ The HMO reported to Agency staff that the HMO member's guardian was given the proper referral to an HMO subcontractor. The HMO will re-educate staff on how to handle this type of request.
31. The HMO denied a member is active and did not authorize the provider to give services. .	➲ FMMIS eligibility checks by Agency staff showed the member was active. The HMO informed Agency staff of system failure with 12/08 enrollments and immediately agreed to update their member database and call the provider to authorize the services. The HMO member received services.
32. The HMO did not authorize specialty care for a member because it said the beneficiary was no longer a member.	➲ FMMIS eligibility checks by Agency staff showed the member was active. The HMO reported to Agency staff that it corrected the member database and notified the member's mother to go ahead and arrange for necessary specialty care.
33. An HMO provider stated the HMO denied claims because the plan stated the beneficiary was not a member.	➲ The HMO reported to Agency staff that it was using the member's inactive Medicaid number. The correct number was entered in the HMO member database and the claims were resubmitted for payment. The provider is satisfied.
34. A former HMO member's parent was being balance billed by providers for amounts not reimbursed by the HMO.	➲ The HMO reported to Agency staff that it worked with providers to have balance billing withdrawn and to get the family out of collections. The former member's parent is satisfied.
35. An HMO member wanted a specific specialist but the provider is no longer in the HMO network.	➲ The HMO reported to Agency staff that it worked with the member and specialist to find the best resolution. In January 2009, the member will switch to a plan in which the specialist participates. The member's procedure was rescheduled for early January. The member is satisfied.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
36. An HMO member was denied services because the HMO subcontractor did not show the member in their system. The HMO did show member as active.	➲ The HMO reported to Agency staff that it verified the member's eligibility with the subcontractor. The provider was authorized to provide services and the member was notified that items were ready. The member is satisfied.
37. An HMO member's mother stated that the member was not showing up in the HMO database and the provider could not get authorization to dispense items.	➲ The HMO reported to Agency staff that it updated the member database and authorized the provider to give services. The member's mother was notified by the plan and is satisfied.
38. An HMO member needed services but the HMO stated the beneficiary was not enrolled in the plan.	➲ The HMO reported to Agency staff that it updated its member database and made immediate calls to guardian and provider to authorize service. Services were provided that day.
39. An HMO member attempted to get services but the HMO stated the beneficiary was not currently active in the plan.	➲ The HMO reported to Agency staff that it updated its member database and worked with the member to explain the process by which she can obtain the requested item. The member is satisfied.
40. An HMO member was denied services because the HMO did not show her in active status.	➲ The HMO reported to Agency staff that it updated its database and the member obtained the necessary services without incident.
41. An HMO member's mother stated the HMO was denying authorizations for urgently needed services.	➲ The HMO reported to Agency staff that it made numerous attempts for over three weeks to contact the member or member's family but the family never called back. The family did not contact the Area Office again either. The issue is closed out.
42. An HMO member's mother stated that the member needed services immediately, but that the HMO did not show the member in its database.	➲ The HMO reported to Agency staff that it updated its member database and arranged an immediate appointment with a specialist. The member and parent are satisfied.
43. An HMO member moved but the new enrollment did not get processed. The current HMO did not assist because the member was out of its coverage area.	➲ The HMO reported to Agency staff that it updated the member's file and assigned the member to a primary care provider in the local area. The member's parent was given a referral to the primary care provider and is satisfied.
44. An HMO member's mother stated the HMO denied the member was active in the plan.	➲ The HMO reported to Agency staff that its research showed the member's mother was calling the wrong phone number to obtain membership information. The HMO verified that the member is currently active and notified the member's parent.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
45. An HMO member was unable to receive services because the HMO did not have information showing that she was an active member.	➲ The HMO reported to Agency staff that it added the member's information and gave provider authorization to dispense services. The HMO notified the member.
46. An HMO provider is had claims denied by the HMO because it stated the member was not active in the plan.	➲ The HMO reported to Agency staff that it updated the member information and had the provider resubmit the claims for payment. The provider is satisfied.
47. An HMO member stated the HMO did not authorize necessary services and he had to pay out-of-pocket for these items.	➲ The HMO reported to Agency staff that research by current and former HMOs showed the member has always received authorizations for required items and has never paid out-of-pocket for those items. The HMO member acknowledged that this information is accurate.
48. An HMO member stated she was unaware she was enrolled in the plan. The providers she was seeing for urgent specialized treatments were not in the HMO network.	➲ The HMO reported to Agency staff that it arranged for out-of-network services for the member and will work closely with her through the course of treatment. The member is satisfied.
49. An HMO provider stated the HMO denied claims for services to a member.	➲ Agency staff determined that due to failed enrollment change by the Medicaid Fiscal Agent, the member was not removed from the HMO. The HMO is not responsible for the claims, which will be sent to the Area Office for force payment. The provider was notified.
50. An HMO member asked for referral to a specialist, but was told by the HMO that neither she nor her children were active in the plan.	➲ The HMO reported to Agency staff that it corrected all three files in the member's family and arranged for plan subcontractor to make appropriate referrals. The HMO member has been informed.
51. An HMO member stated that he was unable to obtain services because the plan would not provide necessary authorizations.	➲ The HMO reported to Agency staff that it updated member information and verified that the member received the necessary services. Numerous attempts to contact the member directly were unsuccessful so the HMO sent an outreach letter to the member.
52. An HMO member's mother stated that the HMO said a requested procedure is not a covered service. The mother believed the procedure is medically necessary.	➲ The HMO reported to Agency staff that it made numerous attempts to verify medical necessity of procedure but the physician had no information to support mother's request, and the member's mother did not return any calls asking for more information. The complaint is closed.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
53. An HMO member reported not getting prior authorization for medically necessary medications.	➲ The HMO reported to Agency staff that it approved the prior authorization and Agency staff followed up with the member to confirm that he received the medications.
54. An HMO provider could not verify member eligibility through the HMO's member database.	➲ Agency staff confirmed with the provider that the HMO contacted the provider and verified member eligibility. The HMO is working to resolve the verification issue on the plan's provider-based website.
55. An HMO member received a bill for services.	➲ Agency staff confirmed with the member that the HMO paid the claims.
56. An HMO member reported being denied pharmacy medication.	➲ Research by Agency staff indicated the beneficiary was not enrolled in the HMO and staff are working with the beneficiary to get medications through Fee-for-Service.
57. An advocacy group reported that an HMO was being overly restrictive in authorizing anti-psychotic medications. One example was submitted.	➲ Agency staff informed the advocacy group that the HMO investigated and discovered a system error, which the HMO has corrected. The HMO authorized the requested medication.
58. An HMO member was in need of a specialist.	➲ Agency staff confirmed with the member that the HMO assisted the member with finding a provider.
59. An HMO member was in need of medications that were denied. The pharmacist stated that the member is not showing active with the HMO.	➲ Agency staff confirmed with the member that the HMO authorized the prescription.
60. An HMO provider reported not being able to get authorization for services and that the HMO has not paid the provider for services rendered.	➲ Agency staff confirmed with the provider that the HMO authorized services and is in the process of paying the provider for all the services provided.
61. An HMO member could not get long-time psychiatric prescriptions filled by his new HMO.	➲ Agency staff contacted the HMO, which immediately resolved the member's prescription issue. Agency confirmed with the member that the issue was resolved.
62. An HMO member's mother was denied a prescription for her son that is covered by Medicaid.	➲ Agency staff confirmed with the member's mother that the HMO approved an override and the member was notified.
63. A caller requested the dental provider contract between an HMO and its provider in Duval County.	➲ Agency staff faxed the contract between the HMO and its dental provider to the requestor twice. The fax confirmation sheets have been retained.

HMO Complaints/Issues October 1, 2008 – December 31, 2008	
HMO Informal Issue	**Action Taken**
64. An HMO provider requested that his patients be allowed to move to health plans that he currently accepts due to another HMO terminating him from its networks. The provider sent a letter to the Agency with his request.	➲ The Agency sent a letter to the provider letting him know the conditions under which his patients could continue to see him, and letting him know that his patients could select a new health plan through choice counseling or Medicaid options.

Attachment III
2007 Performance Measure Data

Health Plan Name	Annual Dental Visits - Total	Adolescent Well Care	Controlling Blood Pressure – Total	Cervical Cancer Screening	Comprehensive Diabetes – HbA1C Testing
Access Health	21.0%	55.6%	53.1%	32.3%	76.6%
Amerigroup	29.3%	50.6%	55.8%	46.6%	71.5%
Buena Vista	0.2%	50.9%	50.0%	49.3%	64.5%
CMS	27.4%	39.7%	■	■	■
First Coast Adv	33.2%	38.0%	45.7%	28.9%	86.4%
HealthEase	8.6%	41.1%	55.2%	57.7%	79.3%
Humana	16.1%	36.5%	23.4%	49.2%	78.6%
NetPASS	27.9%	36.5%	37.7%	41.9%	84.9%
Ped. Associates	36.4%	58.3%	■	■	■
Preferred Medical	13.5%	40.3%	69.6%	32.9%	86.3%
SFCCN	22.8%	41.4%	52.6%	47.4%	82.4%
Staywell	16.2%	48.7%	54.0%	52.3%	76.8%
Total Health Choice	17.3%	32.5%	◆	25.9%	◆
United HealthCare	4.9%	35.0%	39.4%	54.5%	73.0%
Universal HealthCare	36.0%	◆	◆	◆	◆
Vista South Florida	0.1%	55.5%	35.2%	38.7%	68.9%

◆- Not Measurable/Small Population **■- Not Applicable/Not Available**

2007 Performance Measure Data

Health Plan Name	Comprehensive Diabetes – HbA1C Poor Control (Inverse Measure)	Comprehensive Diabetes – Good Control	Comprehensive Diabetes – Eye Exam	Comprehensive Diabetes – LDL Screening	Comprehensive Diabetes – LDL-C Control
Access Health	42.2%	40.6%	35.9%	70.3%	30.5%
Amerigroup	50.4%	26.8%	48.0%	73.4%	29.3%
Buena Vista	56.5%	17.7%	27.4%	67.7%	24.2%
CMS	■	■	■	■	■
First Coast Adv	54.5%	24.3%	52.1%	82.2%	31.9%
HealthEase	40.9%	39.7%	33.6%	81.8%	32.4%
Humana	49.6%	30.8%	28.6%	83.1%	25.2%
NetPASS	58.5%	29.3%	46.2%	87.3%	26.4%
Ped. Associates	■	■	■	■	■
Preferred Health	43.2%	29.6%	65.9%	90.9%	31.8%
SFCCN	44.6%	32.7%	28.9%	83.3%	26.2%
Staywell	46.8%	33.6%	26.6%	76.5%	34.9%
Total Health Choice	◆	◆	◆	◆	◆
United HealthCare	52.3%	30.7%	30.4%	74.9%	26.0%
Universal HealthCare	◆	◆	◆	◆	◆
Vista South Florida	37.8%	44.4%	28.9%	80.0%	26.7%

◆- Not Measurable/Small Population ■- Not Applicable/Not Available

2007 Performance Measure Data

Health Plan Name	Comprehensive Diabetes – Nephropathy	Follow-Up after Hospitalization for Mental Illness – 7 days	Follow-Up after Hospitalization for Mental Illness – 30 days	Number of Enrollees Admitted to the State Mental Health Treatment Facility	Prenatal Care
Access Health	76.6%	10.0%	15.5%	0.00%	64.3%
Amerigroup	75.6%	26.3%	50.9%	0.00%	62.0%
Buena Vista	79.0%	19.2%	26.9%	0.00%	68.2%
CMS	■	■	■	0.00%	■
First Coast Adv	82.5%	28.8%	35.6%	0.20%	55.9%
HealthEase	78.8%	19.8%	37.8%	0.00%	67.6%
Humana	85.3%	3.3%	16.7%	0.00%	63.2%
NetPASS	80.2%	21.5%	33.7%	◆	◆
Ped. Associates	■	◆	◆	◆	◆
Preferred Health	61.4%	17.5%	27.5%	◆	◆
SFCCN	83.6%	9.1%	15.6%	■	25.6%
Staywell	77.4%	29.9%	49.5%	0.00%	71.8%
Total Health Choice	◆	◆	◆	0.00%	◆
United HealthCare	73.5%	21.0%	40.2%	0.00%	71.8%
Universal HealthCare	◆	◆	◆	◆	◆
Vista South Florida	75.6%	◆	◆	0.93%	75.8%

◆- Not Measurable/Small Population ■- Not Applicable/Not Available

2007 Performance Measure Data

Health Plan Name	Postpartum Care	Use of Beta Agonist	Well-Child 0 Visits (Inverse Measure)	Well-Child 6+ Visits	Well-Child Visits in the third, fourth, Fifth, and Sixth Years of Life
Access Health	35.7%	92.3%	17.7%	4.3%	61.7%
Amerigroup	40.9%	◆	2.0%	37.3%	78.1%
Buena Vista	68.2%	◆	4.1%	54.1%	76.3%
CMS	◆	80.4%	◆	◆	63.6%
First Coast Adv	31.6%	■	13.8%	10.3%	55.0%
HealthEase	63.5%	42.3%	2.7%	55.7%	71.3%
Humana	52.2%	■	4.6%	12.9%	64.7%
NetPASS	◆	◆	◆	◆	68.8%
Ped. Associates	◆	81.4%	◆	◆	79.8%
Preferred Health	◆	◆	◆	◆	59.8%
SFCCN	41.0%	77.1%	10.0%	60.0%	67.0%
Staywell	58.3%	34.3%	1.7%	52.3%	81.0%
Total Health Choice	◆	◆	◆	◆	67.4%
United HealthCare	45.3%	◆	4.1%	48.7%	70.6%
Universal HealthCare	◆	◆	◆	◆	◆
Vista South Florida	66.7%	◆	◆	◆	72.2%

◆- Not Measurable/Small Population **■- Not Applicable/Not Available**