Florida Medicaid Reform

Quarterly Progress Report
October 1, 2009 – December 31, 2009

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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Table of Contents

I. WAIVER HISTORY **1**

II. STATUS OF MEDICAID REFORM **2**

A. Health Care Delivery System 2

1. Health Plan Contracting Process *2*

2. Benefit Package *7*

3. Grievance Process *11*

4. Complaint/Issue Resolution Process *14*

5. On-Site Surveys & Desk Reviews *15*

B. Choice Counseling Program 17

1. Informed Health Navigator Solution (Navigator) *17*

2. Call Center *20*

3. Mail *22*

4. Face-to-Face/Outreach and Education *22*

5. Health Literacy *24*

7. Complaints/Issues *26*

8. Quality Improvement *26*

9. Summary *27*

C. Enrollment Data 29

1. Medicaid Reform Enrollment Report *31*

2. Medicaid Reform Enrollment by County Report *32*

3. Medicaid Reform Voluntary Population Enrollment Report *35*

D. Opt Out Program 37

E. Enhanced Benefits Account Program 48

1. Call Center Activities *48*

2. System Activities *49*

3. Outreach and Education for Beneficiaries *49*

4. Outreach and Education for Pharmacies *49*

5. Enhanced Benefits Advisory Panel *50*

6. Enhanced Benefits Statistics *50*

7. Complaints *50*

F. Low Income Pool 52

G. Monitoring Budget Neutrality 56

H. Encounter and Utilization Data 67

I. Demonstration Goals 71

J. Evaluation of Medicaid Reform 94

1. Evaluations Affiliated with the Agency or its Contractors *94*

2. Evaluations Commissioned by Governmental Agencies *94*

3. Independent Evaluation by the University of Florida *94*

4. Medicaid Reform Evaluation Advisory Committees *97*

K. Policy and Administrative Issues 99

ATTACHMENT I PSN COMPLAINTS/ISSUES **103**

ATTACHMENT II HMO COMPLAINTS/ISSUES **105**

List of Tables

Table 1 Health Plan Applicants 3
Table 2 Health Plan Contracts....... 4
Table 3 PSN Conversion to Capitation Implementation Dates 6
Table 4 PSN Conversion to Capitation Timeline 6
Table 5 Number of Copayments by Type of Service by Demonstration Year....... 9
Table 6 Number & Percent of Total Benefit Packages Requiring No Copayments by Demonstration Year....... 9
Table 7 Number of Benefit Packages Requiring No Copayments by Target Population & Area 10
Table 8 Grievances and Appeals July 1, 2009 - September 30, 2009....... 13
Table 9 Grievances and Appeals October 1, 2009- December 31, 2009 13
Table 10 Medicaid Fair Hearing Requests 14
Table 11 BAP and SAP Requests 14
Table 12 On-Site Survey Categories....... 16
Table 13 Choice Counseling Survey Results....... 20
Table 14 Comparison of Call Volume for 2nd Quarter (Demonstration Year Three & Year Four) 21
Table 15 Choice Counseling Outreach Activities 22
Table 16 Overall Field Choice Counseling Results....... 23
Table 17 Number of Referrals and Case Reviews Completed 25
Table 18 Medicaid Reform Enrollment Report Descriptions 31
Table 19 Medicaid Reform Enrollment Report....... 32
Table 20 Number of Reform Health Plans in Demonstration Counties 33
Table 21 Medicaid Reform Enrollment by County Report Descriptions 33
Table 22 Medicaid Reform Enrollment by County Report....... 34
Table 23 Medicaid Reform Voluntary Population Enrollment Report Descriptions 35
Table 24 Medicaid Reform Voluntary Population Enrollment Report....... 36
Table 25 Opt Out Statistics 46
Table 26 Enhanced Benefit Account Program Statistics 50
Table 27 Enhanced Benefit Beneficiary Complaints 51
Table 28 PCCM Targets....... 60
Table 29 MEG 1 Statistics: SSI Related....... 61
Table 30 MEG 2 Statistics: Children and Families 62
Table 31 MEG 1 & 2 Annual Statistics....... 64
Table 32 MEG 1 & 2 Cumulative Statistics....... 65
Table 33 MEG 3 Statistics: Low Income Pool....... 66
Table 34 Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)....... 73
Table 35 2008 – 2009 Comparison of Plan Measures 77
Table 36 Year 2 Plan Performance Measures....... 77
Table 37 2009 Reform to Non-Reform Comparison....... 78
Table 38 Plan Performance Measures....... 79
Table 39 HEDIS Ambulatory Care – Emergency Visits Per Member Month 80

List of Charts

Chart A Navigator Use by Session & Unique Recipient....... 18
Chart B Navigator Use by Call Type 18

I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Terms and Conditions # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to, approval and contracting with new plans, specifying coverage area, phase-in, populations served, benefits, enrollment, grievances, and other operational issues. This report is the second quarterly report in Year Four of the demonstration for the period of October 1, 2009, through December 31, 2009. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas[1]: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 10 through 14 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. Under current state law (as adopted during the 2009 Florida Legislative Session), Reform FFS PSNs are also required to become capitated after five years of operations (for most PSNs, this is September 1, 2011).

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

Current Activities

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 21 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by AHF MCO of Florida, a specialty plan (HMO) for beneficiaries living with HIV/AIDS. AHF MCO of Florida, doing business as Positive Health Care, submitted its application in January 2008. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of December 31, 2009, this specialty plan application was nearing completion of Phase IV (the final phase) of the application process.

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

During this quarter, Medica Health Plan of Florida, Inc. (HMO) began providing services in Broward County on November 1, 2009.

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

Table 1 **Health Plan Applicants**					
Plan Name	**Plan Type**	**Coverage Area**		**Receipt Date**	**Contract Date**
		Broward	**Duval**		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease***	HMO	X	X	04/14/06	06/29/06
Staywell***	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare *	HMO	X *	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista*	HMO	X *		04/14/06	06/29/06
Vista Health Plan SF*	HMO	X *		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates**	PSN	X **		05/09/06	08/11/06
Better Health Plan	PSN	X	X	05/23/06	12/10/08
AHF MCO dba Positive Health Care	HMO	X		01/28/08	***Pending***
Medica Health Plan of Florida	HMO	X		09/29/08	10/24/2009
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		1/14/09	05/20/09

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

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

Table 2 Health Plan Contracts					
Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care****	07/01/06	HMO	X****		
Health Ease***	07/01/06	HMO	X***	X***	
Staywell***	07/01/06	HMO	X***	X***	
Preferred Medical Plan****	07/0106	HMO	X****		
United HealthCare*	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista*	07/01/06	HMO	X*		
Vista Health Plan SF*	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X	
Pediatric Associates**	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	4/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		
Medica Health Plan of Florida, Inc.	11/01/2009	HMO	X		

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

Contract Amendments and Model Contracts

There were two general amendments executed during this quarter. The first implemented new benefit packages; the second fine-tuned language throughout the contract, primarily to correct citations or numbering issues. Three health plans requested and received Agency approval during this quarter to increase their maximum enrollment levels in various counties.

Contract Conversions/Terminations

Two HMOs (AMERIGROUP Community Care and Preferred Medical Plan) ceased operations in Broward County effective December 1, 2009. Each cited issues with hospital contract negotiations as the impetus for the withdrawal requests.

Enrollees were transitioned into other health plans in Broward County. For each plan withdrawal, enrollees were given written notification of the change and an opportunity to select another health plan. The health plan sent letters to their enrollees 60 days prior to the enrollment transition date and the Agency sent letters to the enrollees 30 days prior to the enrollment transition date. Beneficiaries impacted by the transition were given 90 days after the transition to change plans without cause.

In each scenario, the Agency carefully planned the transition of beneficiaries into other health plans. To mitigate disruption to affected enrollees as they enrolled with new plans and to assist beneficiaries through the health plan choice process, the Agency used the following multi-layered approach:

- Assessment of enrollment capacity in the remaining plans and determination of whether those plans were able to ensure all impacted beneficiaries had access to quality care.
- Working closely with the plans, the Choice Counseling Program, local Medicaid Area Office staff, and advocacy groups to ensure appropriate and timely notice to enrollees.
- Requiring the withdrawing plans to provide information about enrollees in active behavioral health care in need of a written care coordination plan. This information was then provided to the recipients' new health plans to ensure continuity of behavioral health care.
- Requiring the withdrawing plans to provide information about enrollees in the hospital just before the transition took effect. This information was then supplied to the recipients' new health plans to ensure continuity of care.
- Conducting weekly calls with the Agency's Medicaid Area Offices and the Choice Counseling vendor to ensure all transition issues were resolved quickly.

FFS PSN Conversion Process

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

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

Table 3 PSN Conversion to Capitation Implementation Dates	
FFS PSN Name	**Scheduled Capitation Implementation Date**
Access Health Solutions	09/01/2011
Better Health Plan	05/01/2014
Children's Medical Services Network, Florida Department of Health	12/01/2011
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2011
South Florida Community Care Network	09/01/2011

While most FFS PSNs have submitted conversion workplans and applications to the Agency in order to comply with the previous 3-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications with the additional experience gained from the additional years of experience achieved.

Table 4 provides the timeline for each step in the revised conversion process.

Table 4 PSN Conversion to Capitation Timeline	
Deadline for the FFS PSN to submit its conversion workplan to the Agency.	01/31/2010
Deadline for the FFS PSN to submit its conversion application to the Agency.	12/31/2010
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2011.	06/30/2011

FFS PSN Reconciliations

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

Systems Enhancements

With the conversion to the new Medicaid Fiscal Agent, changes to the new system continue to occur and continued technical assistance is provided to HMOs and PSNs during the quarter (see Section K of this report under the heading: FFS PSN Systems Monthly Conference Calls). As the new system has become fully operational, the

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

Agency continues to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to be more innovative in their health care delivery and achieve efficiencies not currently available.

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for all four years of the demonstration. Interested parties were notified that the data book would be emailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were then released on May 23, 2007, for Year Two, May 7, 2008, for Year Three, and September 15, 2009, for Year Four.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006, and updated versions

of the PET were released annually, shortly after the release of the latest data book. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

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

Current Activities

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

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

Table 5 lists the number of copayments for each service type by each demonstration year. Benefit packages approved for Demonstration Year Three were extended until December of 2009 in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, Demonstration Year Three has been divided into three columns – July 1, 2008, through December 31, 2008, January 1, 2009, through November 30, 2009, and December 2009. These different columns reflect the departure of health plans that

ceased operations during the third quarter of Demonstration Year Three and in December 2009.

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

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

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

Table 6 shows the number and percentage of benefit packages that do not require any copayments, separated by demonstration year.

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

	Year One	Year Two	Year Three			Year Four
			July-Dec	Jan-Nov	Dec	
Total Number of Benefit Packages	**28**	**30**	**28**	**24**	**20**	**20**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**	**20**	**17**	**16**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**	**83%**	**85%**	**80%**

Table 7 displays the number of Demonstration Year Four benefit packages not requiring copayments by population and area and shows that for each area and target population, there is at least one benefit package to choose from that does not require copayments.

Table 7 Number of Benefit Packages Requiring No Copayments by Target Population & Area 2nd Quarter of Demonstration Year Four		
Target Population	**List of Counties in Each Demonstration Area**	**Number of Benefit Packages Not Requiring Copayments**
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	3
SSI (Aged and Disabled)	Broward	6
TANF (Children and Families)	Duval, Baker, Clay and Nassau	1
TANF (Children and Families)	Broward	6

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

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

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

The Agency continues to review utilization and other data to establish options for allowing more customization and more flexibility in both Medicaid covered services and expanded services in the next operational years. Since the health plans can manage

enrollee health care through utilization management and case management expertise, plans are better able to offer resources to provide care that is better suited to individual members. Examples of benefits that are more valued by beneficiaries are individualized alternative treatment and additional benefits that are not covered under state plan services.

The PET submission procedure for Demonstration Year Four was similar to that of the three previous years. The benefit packages for Year Three of the demonstration were extended until December 31, 2009. This extension was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Four of the demonstration. The updated version of the data book was released by the Agency on September 15, 2009, and the new PET was emailed to the health plans on September 17, 2009. The health plans' Year Four benefit packages had an effective date of January 1, 2010.

3. Grievance Process

Overview

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

Tables 8 and 9 provide the number of grievances and appeals by health plan type for the first (July – September 2009) and second (October – December 2009) quarters of Demonstration Year Four. Under the previous contract, which ended September 30, 2009, the health plan grievance and appeals reporting cycle coincided with the due date for the quarterly reports. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report lagged one quarter in each quarterly report and was updated in the annual report to reflect the full year of data. Under the new health plan contract, which began October 1, 2009, the health plan grievance and appeals reporting is due to the Agency within fifteen days of the end of the quarter, so there will no longer be a lag in reporting.

Table 8 Grievances and Appeals July 1, 2009 - September 30, 2009					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
Total	127	15	80	39	259,173

* unduplicated enrollment count

Table 9 Grievances and Appeals October 1, 2009- December 31, 2009					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
Total	189	24	69	61	272,449

* unduplicated enrollment count

The number of grievances reported by PSNs increased in the first and second quarter of Year Four, from 62 in the fourth quarter of Year Three, to 127 in the first quarter and to 189 in the second quarter of Year Four. This increase was due to an increase in grievances for one PSN, whose membership increased significantly (by 45%) between June 2009 and September 2009, and by 9% between September and December 2009. A large number of these grievances were regarding transportation. The PSN ended its contract with one transportation vendor and began a contract with a new vendor in November 2009. The transition to the new transportation vendor appears to have been a contributing factor in the increase in plan grievances. To improve quality, the PSN's contract with the new transportation vendor includes penalties based on the number of grievances filed with the plan regarding transportation. The rise in grievances for this PSN also appears to be partially due to the handling of complaints by referring them to the grievance appeal unit rather than handling the complaints by the PSN, which the PSN is under corrective action to resolve. In the third quarter of Demonstration Year Four, the Agency will monitor the PSN to ensure that all corrective actions have been taken to address these grievances.

Medicaid Fair Hearings

Table 10 provides the number of Medicaid Fair Hearings (MFHs) requested during this quarter. MFHs are conducted through the Florida Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members. However, the Agency monitors the MFH process and tracks the number of fair hearings. Of the 2 MFH requests, one was related to denial of benefits/services and one was related to the reduction/suspension/termination of benefits/services. The member withdrew from one hearing and the other hearing was not held because the health plan reversed its decision and the outcome was therefore favorable to the beneficiary.

Table 10 Medicaid Fair Hearing Requests October 1, 2009 – December 31, 2009	
PSN	1
HMO	1

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances have been submitted to the SAP or the BAP for this quarter. Table 11 provides the number of requests to BAP and SAP for this quarter.

Table 11 BAP and SAP Requests October 1, 2009 – December 31, 2009	
BAP	0
SAP	0

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

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

During this quarter, the Agency received 8 complaints/issues related to PSNs and received 59 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) of this report. Attachment I provides the details on the complaints/issues related to PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

During this quarter, six (6) of the PSN complaints/issues were from members and two (2) were from providers. Member issues included needing assistance in accessing providers and assistance with ending balance billing. The provider issues were regarding claims payment and processing.

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

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

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

5. On-Site Surveys & Desk Reviews

During this quarter, the Agency did not conduct any on-site visits of health plans. The Agency did continue to review plan provider networks for adequacy, medical and behavioral health policies and procedures for 1 new HMO application (Preferred Care Partners), along with desk reviews of the existing plans, Cultural Competency Plans, Performance Improvement Projects, Quality Improvement Programs, Disease Management Programs, member materials and handbooks.

Table 12 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 12 On-Site Survey Categories
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Grievances & Appeals
➲ Financials

B. Choice Counseling Program

Overview

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

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

- Contract Procurement Process: The contract award to a new vendor is currently under protest and is pending final order. The performance of the current vendor has been the primary focus during this time of change.
- Amerigroup and Preferred Medical Plan withdrawals from Broward County: The withdrawal of these plans continued to impact the call center for the duration of the quarter.
- Fiscal Agent Implementation Challenges & Resolutions: The Agency, from the Choice Counseling Vendor (ACS) and the Agency's fiscal agent continue to work on efforts to correct system conflicts and errors.

Current Activities

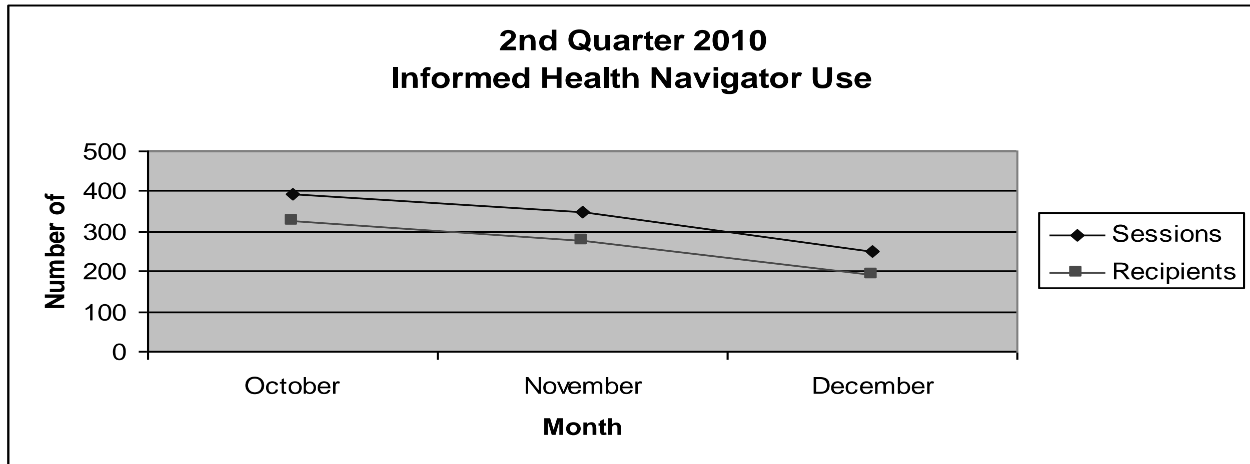
1. Informed Health Navigator Solution (Navigator)

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

During the beginning of this quarter, there was an increase in Navigator usage compared to the last month of the previous quarter. However, usage declined over the remainder of this quarter. The decrease in call volume, which is typical of this quarter, is a contributing factor.

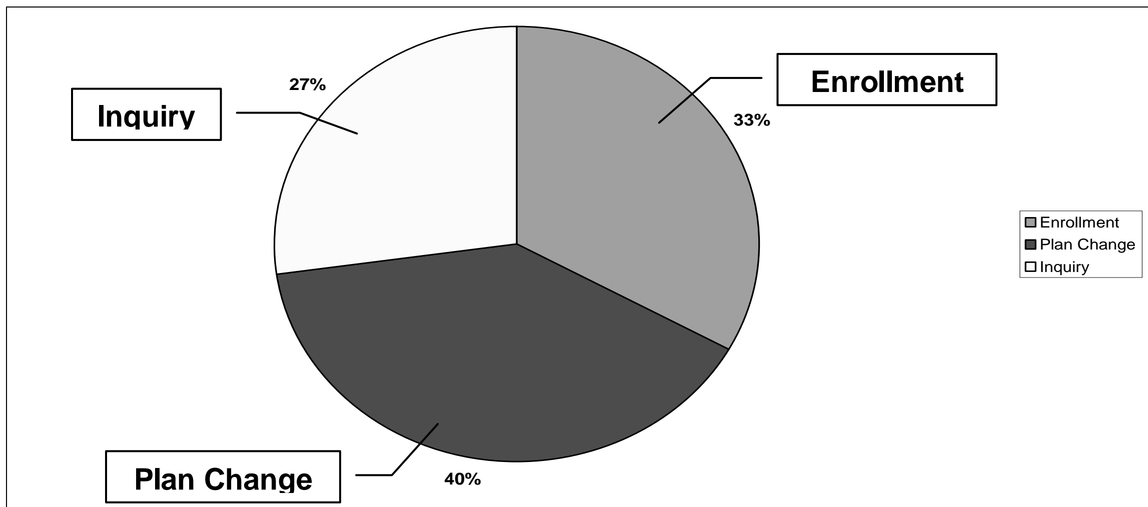
Chart A provides the Navigator statistics for the second quarter of Year Four. "Sessions" represents the number of times the Navigator program was utilized, and "Recipients" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it 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 session and recipient. This quarter, the total usage of the Navigator was 991 sessions and 793 unique recipients utilized the system.

Chart A
Navigator Use by Session & Unique Recipient
October 1, 2009 – December 31, 2009



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

Chart B
Navigator Use by Call Type
October 1, 2009 – December 31, 2009



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 through an automated voice prompt. The Call Center does have a set day of the week when the Choice Counselors offer the survey to callers in addition to the automated voice. This helps to reach the goal of at least 400 completed surveys each month. During this quarter, a total of 1,226 beneficiaries completed the automated survey.

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

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

If a beneficiary scores a category between 1 and 3, the caller has the ability to leave a comment about why 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.

The scores for the amount of time the beneficiary had to "wait on hold" continue to not meet the contract standard. The reduction in the score for the hold time began in August 2008, and correlates with the increased number of incoming calls to the Call Center due to issues with the new Fiscal Agent. Other factors, as outlined in the overview at the beginning of this section, also contributed to the increased call volume for this quarter. ACS, the Choice Counseling vendor, continues to utilize various mitigation efforts, as reported in the Call Center section of the report, to offset the caller's wait time.

Table 13 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) during this quarter. The number of beneficiaries participating in the Survey this quarter was as follows: October - 407, November - 359, and December - 460 (totaling 1,226).

The top three survey categories for the quarter were: "Being treated respectfully", "Overall service provided by counselor" and "Ability to explain clearly." The three lowest scoring survey categories were: "Amount of time waiting to speak with a Choice Counselor," "Ease of understanding information," and "Likelihood to recommend Choice Counseling."

Table 13 Choice Counseling Survey Results for Percentage of Delighted Callers Per Question October 1, 2009 – December 31, 2009		
October	**November**	**December**
How helpful do you find this counseling to be		
88.7%	88.7%	90.2%
Amount of time you waited		
33.7%	27.5%	17.6%
Ease of understanding info		
77.0%	79.6%	76.4%
Likelihood to recommend		
90.1%	87.7%	83.5%
Overall service provided by Counselor		
98.3%	95.8%	96.1%
Quickly understood reason		
96.9%	95.3%	95.0%
Ability to help choose plan		
95.4%	94.3%	94.1%
Ability to explain clearly		
97.6%	95.3%	95.5%
Confidence in the information		
94.9%	94.3%	95.3%
Being treated respectfully		
98.1%	96.3%	97.2%

2. Call Center

The Choice Counseling Call Center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The Call Center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday, 8:00a.m. – 8:00p.m. and Friday, 8:00a.m. – 7:00p.m., providing no Saturday hours. The Call Center had an average of 33 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls.

The Choice Counseling call center received 62,601 calls during this quarter. This represents approximately a 22% decrease in call volume from the previous quarter. Plan change requests continued to be a significant contributor to call volume; however, the call center continued to receive repeat enrollment/disenrollment requests related to the fiscal agent transition that began in July 2008.
The Agency and the Choice Counseling Vendor have been in continual communication about the call volume and the Choice Counseling Vendor has worked very diligently to

handle this increase in volume. Various mitigation efforts continue to be utilized and will remain in place for the duration of the contract.

- The Call Back Manager (CBM) gives the beneficiaries an alternative to physically waiting on the line. This feature allows beneficiaries to reserve their place in the call queue, without having to actually remain on the phone. The beneficiary receives an automatic return call when they are next in "line." The beneficiary may also designate a future date and time to receive a return call. When the specified date and time arrive, the system dials them and places them with the next available counselor. This feature is offered to the beneficiaries 20 seconds after making their initial options selection and approximately every 45 seconds thereafter.
- A modified phone script is used to allow agents to identify caller needs more quickly, separating normal calls from specialized needs due to other issues.
- Field staff is made available Monday through Friday at the Medicaid Area Offices to help handle walk-ins and callers who need assistance with plan changes or have questions.
- Beginning in December of 2009, a triage unit was implemented to assess caller needs and process requests of those who indicated that they did not want full choice counseling.

In addition, the Agency continues to work closely with the Choice Counseling Vendor to ensure the call center is sufficiently staffed, as well as to identify other methods to address the increased call volume.

Table 14 compares the call volume of incoming and outgoing calls during the second quarter of Demonstration Year Three and Year Four.

Table 14
Comparison of Call Volume for 2nd Quarter
(Demonstration Year Three & Year Four)

Type of Calls	Oct. 2008	Oct. 2009	Nov. 2008	Nov. 2009	Dec. 2008	Dec. 2009	Year 3 2nd Quarter Totals	Year 4 2nd Quarter Totals
Incoming Calls	26,295	26,121	19,422	19,566	28,333	16,914	**74,050**	**62,601**
Outgoing Calls	4,086	2,357	2,840	2,267	3,892	1,579	**10,818**	**6,203**
Totals	30,381	28,478	22,262	21,833	32,225	18,493	**84,868**	**68,804**

3. Mail

Outbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 21,382
- Auto-Assignment Letters 19,710
- Confirmation Letters 22,729
- Open Enrollment Packets 31,059
- Transition Packets 456
- Plan Transfer Letters (mandatory and voluntary) 12,578

The amount of returned mail increased this quarter. However, it is still within 3-5% range estimated for return mail. When returned mail is received, the Choice Counseling staff accesses the Choice Counseling Vendor enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team is a big help with this effort in contacting beneficiaries. The Choice Counseling staff work to re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail

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

- Plan Enrollments 1,944
- Plan Changes 929

The percentage of enrollments processed through the mail-in enrollment forms has remained 2-5% of total enrollments. The Agency is reviewing the enrollment form to evaluate whether the mail-in enrollment option is viable or not.

4. Face-to-Face/Outreach and Education

During this quarter, the Field Choice Counseling Outreach Team continued to be available in the Area Offices to assist those beneficiaries that are having trouble reaching the call center or have additional questions.

Table 15 provides a comparison of the Field activities for the first quarter and second quarter of Demonstration Year Four.

Table 15
Choice Counseling Outreach Activities

Field Activities	1st Quarter – Year 4	2nd Quarter - Year 4
Group Sessions	738	822
Private Sessions	96	124
Home Visits & One-On-One Sessions	141	60
No Phone List	818	676
Outbound Phone List	4,157	2,745
Enrollments	4,989	4,182
Plan Changes	480	852

Outreach efforts during the quarter have continued to focus on face-to-face counseling and providing more opportunities for Medicaid beneficiaries to meet with Field Counselors.

Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee, Florida. The quality monitoring staff randomly call beneficiaries who were served by Field Choice Counselors. The Choice Counseling monitors ask four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors.

Table 16 provides the responses in percentages from 149 beneficiaries who participated in the surveys during this quarter. The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 16 **Overall Field Choice Counseling Results** October 1, 2009 – December 31, 2009	
Able to complete enrollment/plan change at the session	99.67%
Felt the information provided by the Choice Counselor helped them make an informed decision	100.00%
The information was explained in a way that made it easy to understand	100.00%
The Choice Counselor was friendly/courteous	100.00%

The Choice Counseling Vendor 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.

The Field Choice Counselors continued their efforts 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.

The Mental Health Unit

During the second quarter of Year Three, the Outreach/Field team created the Mental Health Unit to provide more direct support to beneficiaries who access mental health services. Those beneficiaries in the special needs community remain a high priority within the unit. The efforts made earlier to build relationships with the organizations and people who serve these individuals are yielding positive results. The Mental Health Unit

continues to expand its efforts, now acting in a community relations role promoting community partnerships and taking the lead on event planning.

The Mental Health Unit was responsible for completing 55 Private Sessions for a total of 223 attendees, following up on 55 referrals and completing 15 staff presentations for community partners.

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

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

These groups 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 supervisor, and a Licensed Practical Nurse that have both earned their Choice Counseling certification.

Summary of cases taken by the Special Needs Unit

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

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

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

This quarter, the Special Needs Unit began documenting and reporting on the verbal reviews and referrals as outlined in Table 17.

Table 17 Number of Referrals and Case Reviews Completed October 1, 2009 – December 31, 2009			
	October 2009	November 2009	December 2009
Case Referrals	8	9	10
Case Reviews	9	10	7

The Special Needs Unit staff scope of work has expanded to include:

- Development of additional training for the Choice Counselors working with and serving the medically, mentally or physically complex;
- Enhancements to the scripts to educate beneficiaries on how to access care in a managed care environment;
- Development of health related reference guides to increase the Choice Counselors knowledge of Medicaid services (which is ongoing);
- Participation in the development of the Navigator Choice Counseling script; and
- Development and implementation of a tracking log to capture the number and type of counselor's verbal inquiries, which was done during the first portion of the quarter.

6. New Eligible Self Selection Data[3]

The new eligible numbers for self-selection have not been reported since July 2008 due to issues with daily file and month end processing transfers from Florida Medicaid's Fiscal Agent (EDS) and Choice Counseling Vendor. The Agency, the Choice Counseling Vendor and EDS have identified and created Customer Service Requests (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with the Medicaid system (FMMIS) and the Choice Counseling Vendor enrollment system (BESST). EDS will work through the program changes and should have the work complete within the next six (6) months. Some improvements have been made to the daily and monthly files that transfer from EDS to the Choice Counseling Vendor and some issues have been resolved. When the program changes are complete, and the month end information comes through consistently and correctly, it will allow Choice Counseling Vendor to determine the new eligibles and ensure the enrollment will be more successful. Prior to the Fiscal Agent transition, the Choice Counseling Vendor exceeded the self-selection standard. The Agency fully expects when the corrections are in place, the Choice Counseling Vendor will not only meet, but exceed the 80% minimum standard set in the Self Selection Rate for Demonstration Year Four.

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

The new eligible enrollments in this report are taken from the Choice Counseling Vendor records and are preliminary. There were 49,099 total enrollments for this quarter. Of those enrollments, those that self selected a plan were 19,214 (broken down by month: 8,788 for October; 4,870 for November; and 5,556 for December 2009). There were a total of 29,885 beneficiaries assigned to a plan for the quarter.

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the Call Center, Agency headquarters or the Medicaid Area Office. In August of 2007, the Agency and the Choice Counseling Vendor 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.

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

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the Choice Counseling Vendor and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Choice Counselor's ability to explain health plan choices indicate that more than 97% are satisfied with the Choice Counseling experience (both Field and Call Center). The Choice Counseling Vendor continues to focus on improving communication between Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

Included in this report are comments from beneficiaries who expressed their appreciation to either a Call Center or Field Supervisor for the Choice Counselors who helped them. The individual Choice Counselors that received this positive feedback have gone the extra mile and have offered a “helping hand” to those who they spoke with in person or on the phone. These beneficiaries have taken the initiative, on their own, to contact the Field Supervisors to compliment the work that the Choice Counselors have done. During this quarter, there were 25 reported compliments to supervisors about Choice Counselors offering exceptional customer service.

The Choice Counseling vendor distributes individual report cards to each Choice Counselor on their performance. Survey scores and beneficiary comments are also provided to Supervisors and Choice 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, the Choice Counseling vendor 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 E-mail 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 the Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between the Area Office Medicaid staff and the Choice Counseling Field staff. E-mail boxes on the Choice Counseling Vendor ' enrollment system enable the Agency staff and the Choice Counseling Vendor staff to share information directly from the system to resolve difficult cases and regularly scheduled conference calls. The Choice Counseling Vendor has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues 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

The Agency, the Choice Counseling Vendor and EDS remain committed to identifying, prioritizing and resolving challenges related to the Fiscal Agent transition and new data transfer issues. Recently, additional staffing resources were added to the EDS systems team, with the sole purpose of correcting identified issues and continuing a root cause analysis, as it relates to the demonstration.

The Choice Counseling Vendor 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. The beneficiary is treated with the highest regard and given the opportunity to make plan selections and changes through whatever process is necessary to help them (including Good Cause plan changes).

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

The Agency is planning a series of public meetings to occur over the course of the next three quarters. The Agency looks to communicate with the community regarding the current and future state of the program, as well as to gain vital input on communication tools used by beneficiaries.

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

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

C. Enrollment Data

Overview

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

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

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

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning October 1, 2009, and ending December 31, 2009. This section contains the following Medicaid Reform enrollment reports:

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

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 14 health plans – ten HMOs and four fee-for-service PSNs. The PSNs, Access Health Solutions and NetPASS, which have been included in previous Medicaid Reform quarterly and annual reports, ceased operations during the first quarter of Year Four. Access Health Solutions was acquired by Sunshine State Health Plan and NetPASS was acquired by Molina Healthcare. Throughout the first quarter of Year Four, beneficiaries enrolled in Access Health Solutions were transitioned into Sunshine, while beneficiaries enrolled in NetPASS were transitioned into Molina. These transitions are now complete and as such, only the PSNs' previous quarterly enrollments are included in this quarter's reports. In addition, the Reform HMOs, Amerigroup and Preferred Medical Plan, both ceased operations in November 2009. Beneficiaries enrolled in these plans were transitioned into the remaining demonstration health plans.

There are two categories of Medicaid beneficiaries who are enrolled in the demonstration health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment

report for this quarter and the process used to calculate the data they contain are described on the following pages.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported.

Table 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 2009-10, Second Quarter Medicaid Reform Enrollment Report.

Table 19 Medicaid Reform Enrollment Report (Fiscal Year 2009-10, Second Quarter*)									
Plan Name	Plan Type	Number of TANF Enrolled	# SSI Enrolled			Total Number Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	Percent Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A and B				
Amerigroup	HMO	1,994	142	1	103	**2,240**	**0.82%**	21,534	-89.60%
Freedom Health Plan	HMO	654	141	0	19	**814**	**0.30%**	995	-18.19%
Humana	HMO	9,966	2,154	2	193	**12,315**	**4.52%**	14,481	-14.96%
Medica	HMO	28	10	0	1	**39**	**0.01%**	0	N/A
Molina Healthcare	HMO	16,176	2,734	1	190	**19,101**	**7.01%**	13,547	41.00%
Preferred Medical Plan	HMO	268	33	0	24	**325**	**0.12%**	2,550	-87.25%
Sunshine	HMO	76,263	7,824	2	317	**84,406**	**30.98%**	61,755	36.68%
Total Health Choice	HMO	28,425	3,289	2	363	**32,079**	**11.77%**	27,265	17.66%
United Healthcare	HMO	9,328	1,088	0	47	**10,463**	**3.84%**	11,293	-7.35%
Universal Health Care	HMO	14,212	2,018	0	197	**16,427**	**6.03%**	9,227	78.03%
HMO Total	**HMO**	**157,314**	**19,433**	**8**	**1,454**	**178,209**	**65.41%**	**162,647**	**9.57%**
Access Health Solutions	PSN	0	0	0	0	**0**	**0.00%**	15,593	-100.00%
Better Health, LLC	PSN	6,742	1,538	0	97	**8,377**	**3.07%**	4,853	72.61%
CMS	PSN	3,661	2,971	0	13	**6,645**	**2.44%**	6,317	5.19%
First Coast Advantage	PSN	41,997	6,241	1	743	**48,982**	**17.98%**	45,739	7.09%
NetPass	PSN	0	0	0	0	**0**	**0.00%**	889	-100.00%
SFCCN	PSN	26,236	3,569	1	430	**30,236**	**11.10%**	23,135	30.69%
PSN Total		**78,636**	**14,319**	**2**	**1,283**	**94,240**	**34.59%**	**96,526**	**-2.37%**
Reform Enrollment Totals		**235,950**	**33,752**	**10**	**2,737**	**272,449**	**100.00%**	**259,173**	**5.12%**

*As of December 2009, Amerigroup and Preferred no longer participate in the demonstration.

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 272,449 beneficiaries enrolled in the demonstration during this quarter. There were 14 demonstration health plans with market shares ranging from 0.01 percent to 30.98 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter the demonstration remained operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 20 on the following page.

Table 20 Number of Reform Health Plans in Demonstration Counties October 1, 2009 – December 31, 2009		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**0**
Broward	**9**	**3**
Clay	**2**	**0**
Duval	**3**	**2**
Nassau	**2**	**0**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 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 in Table 22 and located on the following page.

Table 22 Medicaid Reform Enrollment by County Report (Fiscal Year 2009-10, Second Quarter)										
Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Sunshine	HMO	Baker	2,450	215	0	4	2,669	80.13%	1,999	33.52%
United Health Care	HMO	Baker	573	83	0	6	662	19.87%	680	-2.65%
Access Health Solutions	PSN	Baker	0	0	0	0	0	0.00%	493	-100.00%
Total Reform Enrollment for Baker			**3,023**	**298**	**0**	**10**	**3,331**	**100.00%**	**3,172**	**5.01%**
Amerigroup	HMO	Broward	1,994	142	1	103	2,240	1.51%	21,534	-89.60%
Freedom Health Plan	HMO	Broward	654	141	0	19	814	0.55%	995	-18.19%
Humana	HMO	Broward	9,966	2,154	2	193	12,315	8.28%	14,481	-14.96%
Medica	HMO	Broward	28	10	0	1	39	0.03%	0	N/A
Molina Healthcare	HMO	Broward	16,176	2,734	1	190	19,101	12.84%	13,547	41.00%
Preferred Medical Plan	HMO	Broward	268	33	0	24	325	0.22%	2,550	-87.25%
Sunshine	HMO	Broward	25,805	2,361	0	87	28,253	18.99%	19,801	42.68%
Total Health Choice	HMO	Broward	28,425	3,289	2	363	32,079	21.56%	27,265	17.66%
Universal Health Care	HMO	Broward	9,197	1,528	0	143	10,868	7.30%	6,190	75.57%
Access Health Solutions	PSN	Broward	0	0	0	0	0	0.00%	4,045	-100.00%
Better Health, LLC	PSN	Broward	6,742	1,538	0	97	8,377	5.63%	4,853	72.61%
CMS	PSN	Broward	2,234	1,923	0	7	4,164	2.80%	3,837	8.52%
Netpass	PSN	Broward	0	0	0	0	0	0.00%	889	-100.00%
SFCCN	PSN	Broward	26,236	3,569	1	430	30,236	20.32%	23,135	30.69%
Total Reform Enrollment for Broward			**127,725**	**19,422**	**7**	**1,657**	**148,811**	**100.00%**	**143,122**	**3.97%**
Sunshine	HMO	Clay	8,295	766	0	25	9,086	70.03%	6,151	47.72%
United Health Care	HMO	Clay	3,627	251	0	10	3,888	29.97%	3,871	0.44%
Access Health Solutions	PSN	Clay	0	0	0	0	0	0.00%	2,073	-100.00%
Total Reform Enrollment for Clay			**11,922**	**1,017**	**0**	**35**	**12,974**	**100.00%**	**12,095**	**7.27%**
Sunshine	HMO	Duval	35,777	4,106	2	189	40,074	39.37%	30,808	30.08%
United Health Care	HMO	Duval	4,059	618	0	24	4,701	4.62%	5,562	-15.48%
Universal Health Care	HMO	Duval	5,015	490	0	54	5,559	5.46%	3,037	83.04%
Access Health Solutions	PSN	Duval	0	0	0	0	0	0.00%	7,997	-100.00%
CMS	PSN	Duval	1,427	1,048	0	6	2,481	2.44%	2,480	0.04%
First Coast Advantage	PSN	Duval	41,997	6,241	1	743	48,982	48.12%	45,739	7.09%
Total Reform Enrollment for Duval			**88,275**	**12,503**	**3**	**1,016**	**101,797**	**100.00%**	**95,623**	**6.46%**
Sunshine	HMO	Nassau	3,936	376	0	12	4,324	78.11%	2,996	44.33%
United Health Care	HMO	Nassau	1,069	136	0	7	1,212	21.89%	1,180	2.71%
Access Health Solutions	PSN	Nassau	0	0	0	0	0	0.00%	985	-100.00%
Total Reform Enrollment for Nassau			**5,005**	**512**	**0**	**19**	**5,536**	**100.00%**	**5,161**	**7.27%**
Reform Enrollment Totals			**235,950**	**33,752**	**10**	**2,737**	**272,449**		**259,173**	**5.12%**

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

During this quarter, there was an enrollment of 3,331 beneficiaries in Baker County, 148,811 beneficiaries in Broward County, 12,974 beneficiaries in Clay County, 101,797 beneficiaries in Duval County, and 5,536 beneficiaries in Nassau County. There were two Baker County health plans with market shares ranging from 19.87 percent to 80.13 percent, 12 Broward County health plans with market shares ranging from 0.03 percent to 21.56 percent, two Clay County health plans with market shares ranging from 29.97 percent to 70.03 percent, five Duval County health plans with market shares ranging from 2.44 percent to 48.12 percent, and two Nassau County health plans with market shares ranging from 21.89 percent to 78.11 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 2009-10, Second Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	0	71	0	31	0	104	**206**	**9.20%**	**2,240**
Freedom Health Plan	HMO	Broward	0	4	0	3	0	19	**26**	**3.19%**	**814**
Humana	HMO	Broward	0	77	0	33	0	195	**305**	**2.48%**	**12,315**
Medica	HMO	Broward	0	0	0	0	0	1	**1**	**2.56%**	**39**
Molina Healthcare	HMO	Broward	7	76	1	34	21	170	**309**	**1.62%**	**19,101**
Preferred Medical Plan	HMO	Broward	0	11	0	6	0	24	**41**	**12.62%**	**325**
Sunshine	HMO	Baker	0	29	0	1	2	2	**34**	**1.27%**	**2,669**
Sunshine	HMO	Broward	6	72	1	12	16	71	**178**	**0.63%**	**28,253**
Sunshine	HMO	Clay	4	50	0	3	6	19	**82**	**0.90%**	**9,086**
Sunshine	HMO	Duval	13	240	0	36	22	169	**480**	**1.20%**	**40,074**
Sunshine	HMO	Nassau	1	22	0	1	3	9	**36**	**0.83%**	**4,324**
Total Health Choice	HMO	Broward	13	215	4	46	32	333	**643**	**2.00%**	**32,079**
United Healthcare	HMO	Baker	0	9	0	1	1	5	**16**	**2.42%**	**662**
United Healthcare	HMO	Clay	0	26	0	9	0	10	**45**	**1.16%**	**3,888**
United Healthcare	HMO	Duval	0	112	0	15	0	24	**151**	**3.21%**	**4,701**
United Healthcare	HMO	Nassau	0	10	0	6	0	7	**23**	**1.90%**	**1,212**
Universal Health Care	HMO	Broward	4	39	0	10	14	129	**196**	**1.80%**	**10,868**
Universal Health Care	HMO	Duval	4	47	0	6	4	50	**111**	**2.00%**	**5,559**
HMO Total	**HMO**		**52**	**1,110**	**6**	**253**	**121**	**1,341**	**2,883**	**1.62%**	**178,209**
Better Health, LLC	PSN	Broward	1	29	0	7	15	82	134	1.60%	8,377
CMS	PSN	Broward	0	46	3	177	0	7	233	5.60%	4,164
CMS	PSN	Duval	0	52	0	80	0	6	138	5.56%	2,481
First Coast Advantage	PSN	Duval	7	640	2	131	14	730	1,524	3.11%	48,982
SFCCN	PSN	Broward	2	388	0	65	6	425	886	2.93%	30,236
PSN Total	**PSN**		**10**	**1,155**	**5**	**460**	**35**	**1,250**	**2,915**	**3.09%**	**94,240**
Reform Enrollment Totals			**62**	**2,265**	**11**	**713**	**156**	**2,591**	**5,798**	**2.13%**	**272,449**

Demonstration Year One and Year Two quarterly reports 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.

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.

Description of Opt Out Process

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 Research and Demonstration 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. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Current Activities

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

The Agency 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>

- 71 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 52 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 Demonstration Year Four, there are currently 19 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

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

2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of 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 children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.
3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment was during the third quarter of Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his four children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer’s health insurance plan effective December 31, 2007. As a result, the two children were disenrolled from the Opt Out Program. The mother has subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Year Two on January 1, 2008. The children’s Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program (Item Number 11).
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. One of the children’s Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program. The mother started the process to re-enroll the second child in the Opt Out Program. As a result, both children are now enrolled in the Opt Out Program (Item Number 36).
6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child’s Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child’s Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out program.
8. The caller began the process to enroll her three children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her three children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended September 30, 2009. As a result, the children have been disenrolled from the Opt Out program.
9. The caller began the process to enroll her two children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.
10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out program.
11. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.
12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's Medicaid eligibility ended March 31, 2009 and as a result, has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the

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

13. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out program.
16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The father lost his job effective September 26, 2008. As a result, the child has been disenrolled from the Opt Out Program.
17. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
18. The caller began the process to enroll his two children during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The father lost his job effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

19. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual's Medicaid eligibility ended September 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended May 31, 2008. As a result, the child has been disenrolled from the Opt Out Program.
21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended November 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
23. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.
25. The caller began the process to enroll during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

The individual lost his job effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out program.

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out program.
27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the first quarter of Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2009. As a result, the children have been disenrolled from the Opt Out program.
28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out program.
29. The caller began the process to enroll in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on October 1, 2008. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The child is still enrolled in the Opt Out Program.
30. The caller began the process to enroll her five children in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on December 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.
31. The caller began the process to enroll her child in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child's Medicaid eligibility ended November 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.

32. The caller began the process to enroll her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended July 31, 2009. As a result, the children have been disenrolled from the Opt Out Program.
33. The caller began the process to enroll herself and her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended June 30, 2009. As a result, they have both been disenrolled from the Opt Out program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program.
34. The caller began the process to enroll in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her family coverage. The individual's Medicaid eligibility ended December 31, 2009. As a result, the individual has been disenrolled from the Opt Out Program.
35. The caller began the process to enroll her child in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
36. The caller began the process to re-enroll her child in the Opt Out Program during the third quarter of Year Three. The effective date for enrollment was during the fourth quarter of Year Three on May 1, 2009. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
37. The caller began the process to enroll in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on July 1, 2009. The individual has health insurance available through her employer. The individual works for a small employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual is still enrolled in the Opt Out Program.
38. The caller began the process to enroll his child in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on July 1, 2009. The father has health insurance available

through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

39. The caller began the process to enroll her child in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on August 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out Program.
40. The caller began the process to enroll in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on August 1, 2009. The individual has health insurance available through her employer. The individual elected to use her Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual is still enrolled in the Opt Out Program.
41. The caller began the process to enroll her child in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on September 1, 2009. The child's legal guardian has health insurance available through her employer. The child's legal guardian elected to use the child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
42. The caller began the process to enroll his child in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on September 1, 2009. The father has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.
43. The caller began the process to enroll her three children in the Opt Out program during the first quarter of Year Four. The effective date for enrollment was during the first quarter of Year Four on September 1, 2009. The mother has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2009. As a result, they have been disenrolled from the Opt Out program.

Table 25 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending December 31, 2009. Current Opt Out enrollment, as of December 31, 2009, is 19.

Table 25 Opt Out Statistics September 1, 2006 – December 31, 2009						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Individual	1	02/28/07	Loss of Job
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	Still Enrolled	N/A

Table 25 Opt Out Statistics September 1, 2006 – December 31, 2009						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	12/01/08	Large Employer	Family	5	Still Enrolled	N/A
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	1 2	Still Enrolled 06/30/09	N/A Loss of Medicaid Eligibility
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	Still Enrolled	N/A
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	09/30/2009	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	3	12/31/2009	Loss of Medicaid Eligibility

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

E. Enhanced Benefits Account Program

Overview

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

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 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. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the EDS subcontractor First Health to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

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

The primary function of the Enhanced Benefits Call Center is to answer all inbound calls from beneficiaries relating to program questions, provide EBA account updates on credits earned/used, and assist beneficiaries with utilizing the web based OTC product list. Again this quarter, the majority of the calls were related to beneficiaries requesting information regarding their account balances. A total of 14,210 calls or 71% of all answered calls were related to account balances.

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

Inbound Calls:	**21,102**
Calls Abandoned:	**1,056**
Average Talk Time:	**4.26 minutes**
Average Abandonment Rate	**4.9%**
Enhanced Benefits Reward$ Welcome Letters	**51,738**

2. System Activities

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

System activities related to preparing both the pharmacy benefits manager system and EBIS to report beneficiaries who have been without Medicaid eligibility for three consecutive years has been ongoing; however, identification of those beneficiaries have been successful. As of December 2009, 622 beneficiaries lost EBA eligibility for a total of $20,123.72 and no longer have access to the accumulated credits.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during the quarter. There were 164,940 beneficiary coupon/quarterly statements mailed to beneficiaries. Again, the calls received this quarter were primarily related to beneficiaries seeking current balance information. The Choice Counselors are able to provide up to date information to each beneficiary, covering the latest weekly balances. During the October and November mailing, the flyers focused on smoking cessation and healthy start visits during the first three months of pregnancy. Creation of both flyers was in coordination with the Florida Department of Health and Healthy Start Coalition. The Healthy Start Coalition in Duval County also did a press release in several area newspapers promoting the new credit.

4. Outreach and Education for Pharmacies

Pharmacy outreach was completed during November 2009 regarding a change to policy which requires beneficiaries to show a government issued ID at the time of any EBA purchase of OTC products at the pharmacy. Outreach was accomplished through direct mail via the pharmacy/beneficiary flyer of instructions. Notice was also sent directly to pharmacies through a remittance voucher banner notice. The pharmacy benefits manager, First Health, provides ongoing technical assistance to pharmacies as needed related to all billing aspects of the Program.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel meeting was cancelled in December due to scheduling conflicts of some of the panel meetings. A meeting is scheduled for January 22, 2010.

6. Enhanced Benefits Statistics

Table 26 provides the Enhanced Benefit Account Program statistics beginning October 1, 2009 and ending December 31, 2009.

Table 26
Enhanced Benefit Account Program Statistics

Second Quarter Activities – Year 4		October 2009	November 2009	December 2009
I.	Number of plans submitting reports by month in each county*	34 of 35	34 of 35	35 of 35
II.	Number of enrollees who received credit for healthy behaviors by month	40,118	33,135	34,323
III.	Total dollar amount credited to accounts by each month	$718,847.50	$630,752.50	$675,107.50
IV.	Total cumulative dollar amount credited through the end each month	$25,320,966.16	$25,951,718.66	$26,626,826.16
V.	Total dollar amount of credits used each month by date of service	$705,799.57	$646,435.01	$606,689.30
VI.	Total cumulative dollar amount of credits used through the month by date of service	$11,033,321.04	$11,679,756.05	$12,286,445.35
VII.	Total unduplicated number of enrollees who used credits each month	27,717	26,265	24,9816

* Count includes Health Plans that have recently merged and exited Reform

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.

During this quarter, over 27,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 53 (less than 1%) 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 the EB Call Center, the Agency, or HP (through First Health) to address the issues raised.

Table 27 Enhanced Benefit Beneficiary Complaints	
Beneficiary Complaint	**Action Taken**
1. Twenty-one beneficiaries called to complain the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program. The call center also refers beneficiaries to an actively participating pharmacy in their area if they are experiencing problems with purchasing items.
2. Twenty two beneficiaries complained about healthy behaviors not submitted by the health plan on behalf of the beneficiary.	➲ The Agency researches with each health plan regarding healthy behaviors not submitted. In most cases, the health plan submitted the behaviors in the next report submission. In a few cases, some beneficiaries had already reached occurrence limits on some of the behaviors; therefore, credit would not have been credited to the beneficiary account.
3. Ten beneficiaries complained about the balance in their account, either regarding pricing of products or duplicate pricing of one item.	➲ The Agency researched along with the pharmacy vendor regarding these complaints. The vendor was able to resolve issues with the pharmacy.

F. Low Income Pool

Overview

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

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

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

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

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

Current Activities

During the second quarter of Demonstration Year Four, three LIP Council meetings were held.

<u>October 2, 2009 Meeting</u>

On October 29, 2009, the LIP Council held its first meeting for State Fiscal Year (SFY) 2009-2010 at the Agency in Tallahassee, Florida. At this meeting, Mr. Tom Arnold was introduced as the new Secretary of the Agency.

A Legislative update was given notifying of the changes made during the 2009 Legislative Session. The LIP Council membership was changed from 17 to 24 members. None of the responsibilities of the LIP Council were changed.

The 9th version of the Reimbursement and Funding Methodology Document was reviewed. As of the date of this meeting, the Agency was awaiting the final approval of the document from the federal CMS financial team.

The LIP letter dated September 2, 2009 that was submitted to federal CMS requesting clarification on the final $300 million in LIP funding specific to Demonstration Year 5 was reviewed. The Agency had not received a response from federal CMS at the time of this LIP Council meeting.

An update on obtaining a LIP consultant was given. Following the meeting, an email introducing the selected consultant would be sent to the LIP Council members and interested parties.

The remainder of the council meeting entailed discussion on proposed distribution model deadlines and future meeting places and times.

December 2, 2009 Meeting

The December 2, 2009, LIP Council meeting was held at the Agency in Tallahassee, Florida. This meeting was the second LIP Council meeting of SFY 2009-10.

The LIP Council heard presentations from representatives of the Florida Department of Health and Federally Qualified Health Centers. These presentations included updates on LIP projects by the county health departments and Safety Net providers. The presentation materials and related documents for this meeting and all LIP Council meetings are posted on the Agency's website (see link below).

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

The Florida Department of Health provided a presentation on Emergency Room Alternative Projects. This presentation was designed to illustrate the need to reduce the financial and operational burden on hospitals. Improving the health status of low-income uninsured persons by increasing access to appropriate care was also a key point in this presentation. A project goal presented was being able to redirect persons with low acuity of health problems away from hospital emergency rooms to primary care clinics. Other goals included providing a primary care medical home to the low-income uninsured and providing disease management services to low-income persons with ambulatory care sensitive conditions. Cost saving estimates were given as a result of achieving the project goals.

The Florida Association of Community Health Centers (FACHC) provided an update to the LIP Council. The presentation noted that there are now 44 FQHCs operating in Florida in approximately two hundred and sixty locations. Based on 2008 data, FQHCs

have seen nearly 300,000 new patients of which approximately 130,000 were uninsured; FQHCs provide a special focus on making health care available and accessible to low income families, uninsured and Florida's most vulnerable groups. Recommendations presented before the Council included an increase in funding for services and patient care, showing accountability for funds received.

The remainder of the council meeting entailed presentations and discussions on the proposed distribution models for the LIP Council to review.

December 17, 2009 Meeting

On December 17, 2009, a LIP Council meeting was held via conference call from 9:00a.m. – 1:25p.m. at the Agency for Health Care Administration in Tallahassee, Florida. This was the third LIP Council meeting of SFY 2009-10

The LIP Council was given an update stating the 9th version of the Reimbursement and Funding Methodology document submitted to federal CMS had been approved. An update on the requested amendment to Special Term and Condition #105 was also given.

The Miami-Dade Premium Assistance Program provided an update on its Premium Incentive Initiative to the Council. Goals of the program include: providing incentives for the purchase of low cost insurance, encouraging working uninsured individuals to have insurance and improving the overall health of Miami-Dade residents. The presentation gave a description on how the Premium Assistance program worked and also what was needed for the program to function. Details were also given for a continuation of the project after its three year pilot period from the available funds provided.

The Agency introduced North Highland, the consultants hired per SFY 2009-10 General Appropriations Act (GAA). The independent consultant has been hired to prepare recommendations on the financing and the distribution of funds for the Low Income Pool, Disproportionate Share Hospital Program and adjustments to hospital outpatient and inpatient rates, rebased rates or otherwise exempt hospitals for Fiscal Year 2010-11.

The remainder of the council meeting allowed for discussions on Safety Net allocations, buyback information and discussions of presented distribution models. Member comments followed the presentations and allowed for extended discussion on topic matters.

Agency Activities

As a result of executed Letters of Agreement, the Agency was able to distribute $172,524,655 in LIP funding to participating providers in the second quarter of Demonstration Year Four.

On December 1, 2009, the Agency was notified of the federal CMS approval of the Reimbursement and Funding Methodology document that was submitted June 26, 2009. This was the ninth version of the document submitted to federal CMS.

At the request of federal CMS, a waiver amendment request to Special Term and Condition #105 was submitted to federal CMS on November 25, 2009. This was a request to receive the additional $300 million in Demonstration Year Five. Federal CMS notified the Agency that the formal process of review had begun.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

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

Definitions:

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

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

Current Activities

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

Budget Neutrality is calculated on a statewide basis. For counties where the demonstration is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where the demonstration is not operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive their services through the

Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and/or providers of 1915(c) Home and Community Based Waivers.

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

In the following tables (Tables 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, 2009. 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		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
Q8 Total	**764,701**	**$661,690,100**	**$115,119,581**	**$776,809,682**	**$1,015.83**
Q9 Total	**818,560**	**$708,946,109**	**$116,915,711**	**$825,861,820**	**$1,008.92**
Q10 Total	**791,043**	**$738,232,869**	**$128,483,862**	**$866,716,731**	**$1,095.66**
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
October 2009	275,733	$169,233,974	$30,153,422	$199,387,395	$723.12
November 2009	277,577	$252,330,497	$45,182,664	$297,513,161	$1,071.82
December 2009	277,220	$348,404,305	$61,931,546	$410,335,851	$1,480.18
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
MEG 1 Total	**10,915,052**	**$9,562,330,800**	**$1,443,879,288**	**$11,006,210,088**	**$1,008.35**

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

Table 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**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$ 164.78**
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
October 2009	1,634,683	$134,315,902	$10,464,027	$144,779,929	$88.57
November 2009	1,657,122	$250,553,059	$29,249,216	$279,802,275	$168.85
December 2009	1,667,649	$383,516,409	$50,010,230	$433,526,639	$259.96
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
MEG 2 Total	**56,750,632**	**$8,502,655,645**	**$851,649,513**	**$9,354,305,158**	**$164.83**

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

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 31), compared to WOW of $948.79 (Table 28), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 31), compared to WOW of $199.48 (Table 28), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,019.83 (Table 31), compared to WOW of $1,024.69 (Table 28), which is 99.53% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.75 (Table 31), compared to WOW of $215.44 (Table 28), which is 78.79% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,039.60 (Table 31), compared to WOW of $1,106.67 (Table 28), which is 93.94% of the target PCCM for MEG 1. MEG 2 has a PCCM of $165.06 (Table 31), compared to WOW of $232.68 (Table 28), which is 70.94% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $991.11 (Table 31), compared to WOW of $1,195.20 (Table 28), which is 82.92% of the target PCCM for MEG 1. MEG 2 has a PCCM of $164.10 (Table 31), compared to WOW of $251.29 (Table 28), which is 65.30% of the target PCCM for MEG 2.

Tables 30 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 STCs are also weighted using the actual case months.

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

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 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 $314.13. Comparing the calculated weighted averages, the actual PCCM is 89.02% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $304.75. Comparing the calculated weighted averages, the actual PCCM is 81.86% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $389.17. 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 $284.91. Comparing the calculated weighted averages, the actual PCCM is 73.21% 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	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 Total	3,033,969	$2,649,240,390	$444,877,584	$3,094,117,975	$1,019.83
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(14,759,720)	
% of WOW PCCM MEG 1					99.53%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,252,795,650	$264,650,836	$2,517,446,487	$169.75
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(677,526,774)	
% of WOW PCCM MEG 2					78.79%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,887,157,941	$491,277,076	$3,378,435,017	$1,039.60
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(217,956,962)	
% of WOW PCCM MEG 1					93.94%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,542,707,000	$278,902,500	$2,821,609,499	$165.06
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,156,017,872)	
% of WOW PCCM MEG 2					70.94%

Table 31 Continued MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	1,652,926	$1,394,366,081	$234,873,083	$1,638,239,164	$991.11
WOW DY4 Total	1,652,926			$1,975,577,155	$1,195.20
Difference				$(337,337,992)	
% of WOW PCCM MEG 1					82.92%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	9,662,982	$1,413,496,804	$172,231,467	$1,585,728,271	$164.10
WOW DY4 Total	9,662,982			$2,428,210,747	$251.29
Difference				$(842,482,476)	
% of WOW PCCM MEG 2					65.30%

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	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,902,036,041	$709,528,421	$5,611,564,461	$314.13
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(692,286,494)	
% Of WOW					89.02%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,429,864,941	$770,179,576	$6,200,044,517	$304.75
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,373,974,834)	
% Of WOW					81.86%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	11,315,908	$2,807,862,885	$416,104,549	$3,223,967,434	$284.91
WOW	11,315,908			$4,403,787,902	$389.17
Difference				$(1,179,820,468)	
% Of WOW					73.21%

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	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Total Paid	**$3,121,914,828**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$245,982,795	$1,000,000,000	24.60%
Total MEG 3	$3,121,914,828	$5,000,000,000	62.44%

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

The expenditures for the first fourteen quarters for MEG 3, the Low Income Pool (LIP), were $3,121,914,828 (62.44% 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 the demonstration health plans. Risk adjustment is to be phased in over a period of three years, beginning with the Medicaid Rx (MedRx) model and transitioning to a diagnosis-based model such as the Chronic Illness and Disability Payment System (CDPS).

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

Current Activities

From October 1, 2009, through December 31, 2009, the Agency continued collecting and verifying encounter data from all capitated health plans statewide for all Medicaid covered services. At the end of the quarter, there are two concurrent collection efforts: the collection of encounter data for all Medicaid covered services within the Florida Medicaid Management Information System (FMMIS), and the collection of quarterly pharmacy encounter data for risk adjustment.

The Agency continued processing production medical services and pharmacy encounter data statewide this quarter. Although some health plans lagged behind their approved historical encounter data submission schedules, intensified work with those plans helped most of them meet the established October 31, 2009, deadline.

The health plans were required to certify the completeness and accuracy of their own historical encounter data submissions at October 31, 2009, based upon the provider encounter data they received. Estimates provided by the health plans (in a June 2009 survey) indicated AHCA would receive 9.98 million to 14.08 million historical encounter claims statewide. AHCA received approximately 14.05 million historical encounter claims. According to the October 31 certifications, health plans state the Agency has received 85% to 100% of the plans historical encounters. The Agency is currently validating these estimates and reconciling encounter data submissions to the associated data certifications.

The health plans are now submitting their ongoing (current day) encounter data beginning with July 1, 2009, paid dates. The majority of the health plans are submitting current day encounters as required by the Medicaid HMO contracts. Current day encounter claims are routinely processing in both claims systems and moving to claims

history as they are processed. The Agency has received in excess of 20 million encounter claims (medical services and pharmacy), both historical and current day, as of December 31, 2009. The following are the highlights for this quarter:

- Continued collecting and processing HIPAA-compliant (X12) medical services encounter data through the Fiscal Agent in the new FMMIS.
- Continued collecting and processing HIPAA-compliant (NCPDP) pharmacy services encounter data through the Pharmacy Benefits Manager.
- Continued updating the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans i.e., MEDS and NCPDP Companion Guides, Data Submission Strategy Guidelines, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions.
- Participated in encounter data submission meetings with each health plan to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Continued to refine the MEDS SQL Server environment to support encounter data analysis. Encounter data in SQL will help identify underreporting; track encounter volume and PMPM by plan by service; and facilitate plan provider analytics such as National Provider Identifiers (NPI), not registered with State, network providers not providing services, types of providers in network, etc.
- Continued to test and refine reports and HIPAA-compliant Electronic Data Interchange (EDI) processes used to communicate errors and invalid transaction content to health plans for their remediation of encounters failing FMMIS edits.
- Worked with the Fiscal Agent to refine the Medicaid Decision Support System (DSS) to support data quality validation through analysis of the volume, accuracy, and completeness of encounter data reported in the data warehouse as compared to the raw claims data.
- Held weekly update meetings for Medicaid management to discuss the progress of encounter data submission and receipt and any system issues that may impact processing and reporting.
- Conducted weekly MEDS Team meetings to discuss project progress, risks, and issues that needed to be addressed to keep the Agency on track.
- Met with the Agency Encounter Data Utilization Team and identified some preliminary uses for the MEDS data during the validation period.

To comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed to calculate individual risk scores for both the fee-for-service and managed-care Medicaid populations. Using the MedRx model, the health plans were assigned plan risk factors

for both TANF and SSI based on the aggregate risk scores of their enrolled populations in those categories under the demonstration.

Health plan factors, budget neutrality, and the derived risk corridor plan factor were applied to capitated premium rates for Medicaid-enrolled populations in the demonstration counties monthly from October 2006 through June 2008. As mentioned in previous reports, Legislation required that capitation premiums be fully risk adjusted and health plan corridor factors were no longer to be applied effective with Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting the demonstration plan's capitation rates was April 1, 2008, through March 31, 2009, paid through June 30, 2009. This measurement period was used to generate risk adjustment factors for the health plans operating in the five demonstration counties.

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

- Continued to collect and process pharmacy encounter data on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated, and any significant changes from the previous quarter's submission are reported to the health plans for corrective action, if necessary.
- Implemented the updated MedRx 5.1 for payment adjustments effective with the October 2009 payments.
- For this period, risk adjustment plan factors were calculated for the following health plans:

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

* Effective December 1, 2010, Amerigroup and Preferred no longer participate in the demonstration as described in Section A of this report.

- 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 in the demonstration counties for the month of December 2009 for risk adjustment purposes totaled 224,528 and was distributed as follows:

December 2009	Broward	Duval, Baker, Clay, and Nassau
Children & Families	104,712	91,716
SSI	15,762	12,338
Totals	**120,474**	**104,054**

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

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

I. Demonstration Goals

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

Prior to the implementation of the demonstration, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two 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 7 HMOs and 3 PSNs for a total of 10 health plans in Broward County; and 3 HMOs and 2 PSNs for at total of 5 health plans in Duval County.

As noted in Section A of this report, two HMOs withdrew from the demonstration effective December 1, 2009. Each health plan cited issues with hospital contract negotiations as the impetus for the withdrawal requests.

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 21 applicants sought and received approval to provide services to the TANF and SSI population. Of the 22 health plan applications received, all but one were approved as health plans as of December 31, 2009.

This quarter, Medica Health Plan of Florida, Inc. (HMO) began providing services in Broward County on November 1, 2009.

The one health plan application still pending was submitted by AHF MCO of Florida, a specialty plan (HMO) for beneficiaries living with HIV/AIDS. AHF MCO of Florida, doing business as Positive Health Care, submitted its application in January 2008. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of December 31, 2009, this specialty plan application was nearing completion of Phase IV of the application process.

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

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

Access to Services Not Previously Covered

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

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

In Demonstration Year Four, the Agency approved 20 benefit packages for the HMOs and 12 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010, to August 31, 2010, for 8 HMOs and 4 PSNs.

Improving Access to Specialists

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

1. Identifying the number of unduplicated providers that participate in Reform;
2. Identifying providers that were not fee-for-service providers, but now serve beneficiaries as a part of Reform;
3. Comparison of plan networks that were operational prior to Reform with the Reform health plan networks at the end of Year One of the waiver; and
4. Comparison of Reform provider networks to the active fee-for-service providers.

During the second quarter of Year Two, the Agency began additional provider network analyses of the Medicaid health plans, including each Medicaid Reform health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers'

types and specialties, these provider network files must include any restrictions on beneficiary access to providers (e.g., if the provider only accepts current patients, or if they only treat children and women, etc.).

Also in October 2007, the Agency did a preliminary analysis 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-demonstration with the post-demonstration health plan networks. Table 34 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 beneficiary needs based on national benchmarks.

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

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

contract on file for those providers whose office managers did not confirm participation. This follow-up resulted in a finding that 99% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

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

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

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

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

During the second quarter of Year Three, the Agency followed up on and analyzed the June 2008 survey results. As mentioned above, the Agency's follow-up now includes all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the June 2008 statewide survey, the combined results from the survey and the follow-up indicate that 288 (96%) of the 300

sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 9 in June 2008, 114 (97%) had current contracts with the health plans from which they were sampled. Surveys were conducted in August, September, October, and November 2008.

During the third quarter of Year Three, the Agency followed up on and analyzed the August and September surveys. In the August 2008 statewide survey, the combined results from the survey and follow-up indicate that 291 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk Counties) in August 2008, all 117 (100%) had current contracts with the health plans from which they were sampled. The September survey results were very similar, with 297 (99%) of the 300 providers in the statewide sample having current contracts with the health plan; and with 99 (99%) of the 100 providers in the Medicaid Area 3 sample having current contracts with the health plans for which they were surveyed. The Medicaid Area 3 (Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, and Sumter Counties) sample contained 100 provider records rather than 117 due to there being 22 provider records for dentists rather than 39.

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

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

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

During this quarter, Agency staff followed up on and analyzed the results of the first quarterly provider network survey, which was conducted in July through September 2009. A total of 651 providers were sampled from the health plan provider network files. The survey results and follow-up by Agency staff indicated that 95% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. The second quarterly provider network survey was conducted during the second quarter of Demonstration Year Four as well, from October through December 2009. During the third quarter of Year Four, Agency staff will follow up on and analyze the results of the October survey and the next quarterly survey will be conducted.

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) Improvement in the Overall Health Status of Enrollees for Select Health Indicators

The demonstration health plans are required to report plan performance measure data to the Agency on July 1 each year, for the measurement period January 1 through December 31. The demonstration plans were required to report their 2nd year of performance measures on July 1, 2009, for the period January 1, 2008 through December 31, 2008. Two health plans were granted extensions due to unforeseen issues with their data systems. All data was submitted to the Agency by July 28, 2009.

Compared to the first year of performance measure data (for the period January 1, 2007 through December 31, 2007) submitted to the Agency on July 1, 2008, the statewide average performance showed improvement in all measures with the exception of one. Of particular note are gains achieved in the Annual Dental Visit, Controlling Blood Pressure, and the Follow-Up after Hospitalization for Mental Illness-30 day measures. It should be noted that these improvements occurred prior to the implementation of the Agency's performance measure improvement strategy.

Table 35 lists the statewide average results for each performance measure that was submitted in year one (January 2007-December 2007) and year two (January 2008-December 2008) for the health plans statewide.

Table 35 2008 – 2009 Comparison of Plan Measures			
Plan Measure	2008 Statewide Average	2009 Statewide Average	Difference
Annual Dental Visit	15.2%	28.5%	13.3%
Adolescent Wellcare	44.2%	46.5%	2.3%
Controlling Blood Pressure	46.3%	55.9%	9.6%
Cervical Cancer Screening	48.2%	52.2%	4.0%
Diabetes – HbA1c Testing	78.9%	80.1%	1.2%
Diabetes - HbA1c Poor Control INVERSE	48.3%	46.8%	-1.5%
Diabetes - Eye Exam	35.7%	44.0%	8.3%
Diabetes - LDL Screening	80.0%	80.2%	0.2%
Diabetes - LDL Control	29.3%	35.9%	6.6%
Diabetes – Nephropathy	79.2%	80.3%	1.1%
Follow-Up after Mental Health Hospital – 7 day	20.6%	29.3%	8.7%
Follow-Up after Mental Health Hospital – 30 day	35.5%	46.6%	11.1%
Prenatal Care	66.6%	67.4%	0.8%
Postpartum Care	53.0%	51.5%	-1.5%
Well-Child First 15 Months – Zero Visits (INVERSE)	4.9%	1.6%	-3.3%
Well-Child First 15 Months – Six Visits	44.4%	49.3%	4.9%
Well-Child 3-6 years	71.3%	75.7%	4.4%

Seven additional performance measures (eleven with sub-measures counted separately) were submitted by health plans in 2009 as planned in the Agency's three year phase-in schedule. Of those new measures, most have statewide averages near or above the national mean (see Table 36).

Table 36 Year 2 Plan Performance Measures (January 1, 2008 – December 31, 2008)		
Measure	**National Mean**	**2009 Statewide Average**
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 20-44 years	76.8%	71.8%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 45-64 years	82.4%	84.7%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 65 years and older	78.8%	83.6%
Antidepressant Medication Management (AMM) Acute	42.8%	52.0%
Antidepressant Medication Management (AMM) Continuation	27.4%	29.8%
Use of Appropriate Medications for People with Asthma (ASM)	86.9%	83.6%
Breast Cancer Screening (BCS)	50.0%	51.4%
Childhood Immunization Status (CIS) Combo 2	72.3%	63.6%
Childhood Immunization Status (CIS) Combo 3	65.6%	53.8%
Frequency of Prenatal Care (FPC)	59.3%	52.6%
Lead Screening in Children (LCS)	61.5%	54.8%

Health plans were also required to submit performance measure data for their populations outside of the demonstration project. Again using statewide average data, the demonstration plans outperformed non-demonstration plans in 20 of 27 measures (see table 37).

Table 37
2009 Reform to Non-Reform Comparison

Measure	2009 Non-Reform	2009 Reform	Difference
Adolescent Well-Care	46.0%	46.5%	0.5%
Controlling Blood Pressure	51.6%	55.9%	4.3%
Cervical Cancer Screening	53.8%	52.2%	*
Diabetes – HbA1c Testing	75.1%	80.1%	5.0%
Diabetes - HbA1c Poor Control INVERSE	51.7%	46.8%	-4.9%
Diabetes - Eye Exam	41.9%	44.0%	2.1%
Diabetes - LDL Screening	76.3%	80.2%	3.9%
Diabetes - LDL Control	29.4%	35.9%	6.5%
Diabetes – Nephropathy	76.1%	80.3%	4.2%
Follow-Up after Mental Health Hospital – 7 day	37.2%	29.3%	*
Follow-Up after Mental Health Hospital – 30 day	51.7%	46.6%	*
Prenatal Care	69.1%	67.4%	*
Postpartum Care	50.1%	51.5%	1.4%
Well-Child First 15 Months – Zero Visits INVERSE	3.0%	1.6%	-1.4%
Well-Child First 15 Months – Six Visits	51.0%	49.3%	*
Well-Child 3-6 years	72.5%	75.7%	3.2%
Adults' Access to Preventive Care – 20-44 Years	69.3%	71.8%	2.5%
Adults' Access to Preventive Care – 45-64 Years	82.2%	84.7%	2.5%
Adults' Access to Preventive Care – 65+ Years	74.7%	83.6%	8.9%
Antidepressant Medication Mgmt – Acute	45.6%	52.0%	6.4%
Antidepressant Medication Mgmt -- Continuation	31.2%	29.8%	*
Appropriate Medications for Asthma	87.0%	83.6%	*
Breast Cancer Screening	47.5%	51.4%	3.9%
Childhood Immunization Combo 2	61.8%	63.6%	1.8%
Childhood Immunization Combo 3	52.0%	53.8%	1.8%
Frequency of Prenatal Care	51.6%	52.6%	1.0%
Lead Screening	46.0%	54.8%	8.8%

* = a difference is shown only for measures where demonstration plans outperformed non-demonstration plans.

During the first quarter of Demonstration Year Four, the Agency continued implementation of the performance measure improvement strategy. Construction of the Access database to track health plan progress was completed. Health plans submitted their first quarterly reports detailing their activities since inception of the corrective action plans, referred to as Performance Measure Action Plans. Most health plans reported that they were on track with their chosen interventions and reinforced their commitment to dedicating resources toward improvements. A select few health plans, however, struggled with their own internal timelines due to personnel and technology resource deficits. Agency Quality staff scheduled teleconferences will all health plans to discuss their progress and begin to identify best practices that could be shared with all health

plans. Most calls were completed this quarter and a few were scheduled for the first week in October.

During the second quarter of Demonstration Year Four, the Agency continued working on the Performance Improvement Strategy for performance measures, by conducting the remaining telephone conferences with health plans to discuss their quarterly progress reports on their Performance Measure Action Plans. Most health plans continue to show a commitment to their chosen improvement strategies and appear to be in position to yield improved scores for this year's submission (January 2009-December 2009), which is due to the Agency on July 1, 2010.

Also in the second quarter of Year Four, the Agency finalized the list of required performance measures for the measurement year 2010 (January 2010-December 2010) submission and made changes to the specifications for the Agency-Defined measures in response to comments from health plans and HEDIS auditors. The amended list of measures is provided in Table 38 below. Specifications for the Agency-Defined measures may be viewed on the following webpage:

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

Table 38
Plan Performance Measures

	HEDIS	Note	Benchmark Year
1	Adolescent Well Care Visits (AWC)		HEDIS 2007
2	Adults' Access to Preventive /Ambulatory Health Services (AAP)		HEDIS 2008
3	Ambulatory Care (AMB)		N/A**
4	Annual Dental Visits (ADV)		HEDIS 2007
5	Antidepressant Medication Management (AMM)		HEDIS 2008
6	BMI Assessment (ABA)		HEDIS 2009
7	Breast Cancer Screening (BCS)		HEDIS 2008
8	Cervical Cancer Screening (CCS)		HEDIS 2007
9	Childhood Immunization Status (CIS) – Combo 2 and 3		HEDIS 2008
10	Comprehensive Diabetes Care (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy		HEDIS 2007
11	Controlling High Blood Pressure (CBP)		HEDIS 2007
12	Follow-up Care for Children Prescribed ADHD Medication (ADD)		HEDIS 2009
13	Immunizations for Adolescents (IMA)	new	HEDIS 2011
14	Lead Screening in Children (LSC)		HEDIS 2008
15	Mental Health Utilization – Inpatient, Intermediate, & Ambulatory Services (MPT)		N/A**
16	Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)		HEDIS 2009
17	Prenatal and Postpartum Care – (PPC)		HEDIS 2007
18	Use of Appropriate Medications for People With Asthma (ASM)		HEDIS 2008

Table 38 Plan Performance Measures			
19	Well-Child Visits in the First 15 Months of Life (W15)		HEDIS 2007
20	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		HEDIS 2007
Agency-Defined Performance Measures			
21	Follow-Up after Hospitalization for Mental Illness (FHM)		CY 2009
22	Mental Health Readmission Rate (RER)		CY 2008
23	Lipid Profile Annually (LPA)		CY 2009
24	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy (ACE)		CY 2008
25	Prenatal Care Frequency (PCF)	new	CY 2009
26	Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)		CY 2009
27	Highly Active Anti-Retroviral Treatment (HAART)		CY 2009
28	HIV-Related Medical Visits (HIVV)		CY 2009
29	Percentage of Enrollees Participating in Disease Management Program (DM)		N/A
30	Transportation Timeliness (TRT)	new	CY 2010
31	Transportation Availability (TRA)	new	CY 2010

(b) Reduction in Ambulatory Sensitive Hospitalizations;

The Medicaid database used to conduct the Ambulatory Sensitive Hospitalization analysis will be updated when hospital data is available.

(c) Decreased Utilization of Emergency Room Care

Within the array of performance measures the health plans are required to report is a measure that targets emergency room utilization. Health plans are required to report an array of performance measures one of which is a measure which targets emergency room utilization. The Ambulatory Care measure which requires the plans to report emergency room visits per 1000 member months. The Agency received data for this measure in 2008 and 2009. In the demonstration counties for 2009, the statewide aggregate rate per 1000 member months was 72.6. This rate was an increase from the reported rate in 2008 of 66.3. Table 39 compares the results of the demonstration and non-demonstration plan performance for 2008 and 2009.

Table 39 HEDIS Ambulatory Care – Emergency Visits Per Member Month			
	2008	**2009**	**Change**
Demonstration	66.3	72.6	+6.3
Non-Demonstration	59.9	61.3	+1.4

Due to the delay in having available full encounter data, the Agency is investigating the use of alternate data sources to further examine emergency room utilization in the demonstration counties. The Agency will be able to assess continued progress toward this objective with the next submission of performance measure data in July 2010.

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 individual or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the Agency enters in the Opt Out Program's database the reason why an individual, who initially expressed an interest in and was provided information on the Opt Out Program from a Choice Counselor, decided not to opt out of Medicaid.

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

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

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

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.

The most recent study, *Enrollee Satisfaction: Year One Follow-Up Survey Report*, was finalized on March 9, 2009, and can be viewed on our website at:

http://ahca.myflorida.com/Medicaid/quality_management/pdf/cahps_report_final_03-12-09.pdf

A follow up to this study, *Enrollee Satisfaction: Year Two Follow-Up Survey Report - Volumes 1, 2, and 3*, are scheduled to be submitted to the Agency in the Spring of 2010. Volume 1 will focus on demonstration county estimates, Volume 2 will speak to enrollee satisfaction differences by plan type, and Volume 3 will assess enrollee satisfaction differences by enrollee subgroup.

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

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

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

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

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

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

During the fourth quarter of Demonstration Year One, the Agency received a letter on June 8, 2007, from UF LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to UF LIP Evaluation team along with the pre-LIP Milestone data (SFY 2005-06) by July 31, 2007. The LIP Milestone data for Year One of LIP (SFY 2006-07) was

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

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

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

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

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges
- Case Mix Index
- Hospital Inpatient days
- Hospital Emergency Department Encounters (categorized by HCPC codes)
- Hospital Outpatient Ancillary Encounters (includes services such as diagnostic, surgical, therapy)

- Affiliated Services (includes services such as hospital owned clinic encounters, home health care, nursing home)
- Prescriptions filled

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

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

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

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

The UF LIP Evaluation was received from UF on April 16, 2008; it was then forwarded to federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the PAS entities. This document includes an evaluation of the impact

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

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

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

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

The Agency looks forward to the review of the SFY 2008-09 Milestone report from UF during the third quarter of Demonstration Year Four. The report will illustrate the qualitative impact on the implemented indicators in Demonstration Year Three on uninsured individuals as referenced in STC# 104.

Low Income Pool Program Success Stories

Alachua County Low Income Pool Program

Expanded primary care services: The Alachua LIP program offers extended hours for medical services and accepts walk-ins for primary and urgent care. In the first six months, the program has provided an estimated 5000 walk in visits. Results of patient surveys indicate: 27% would have gone to the emergency room (ER) if they could not have come to the Alachua County Health Department (ACHD), and 59.6% were uninsured. Applying survey results to all walk-in visits suggests that in six months, access to outpatient services through the LIP program averted 1350 visits to the ER, of which 805 would have been uninsured.

Emergency room referrals: The Alachua LIP program accepts referrals from Shands hospital for patients who used ER services and have no primary care physician (PCP). The clients meet with a medical home coordinator (MHC) who facilitates access to needed medical care, including short term follow up of therapies begun in the hospital. The MHC also assists them to enroll in a medical home and, if uninsured, screens and helps them to apply for possible financial assistance.

In the first three months of the program, 42 referrals were received for patients who had been hospitalized. The majority have one or more chronic conditions such as diabetes or hypertension. The average age was 48 years-old, 26% were homeless and 50% were uninsured. In addition to preventing further unnecessary use of ER services through enrollment in a medical home, the program reduces length of hospital stays by accepting patients who cannot be discharged without a physician willing to accept responsibility for managing immediate medical needs, such as anticoagulant therapy. In the first three months, 19% of clients needed this type of follow-up care.

Disease management: In the first two months, the program provided disease management education to 24 adult clients with diabetes. Clients are recruited from the Health Department clinic, and from the emergency room referrals. Most of the patients are uninsured and unable to purchase the supplies needed to effectively home monitor blood glucose levels. They receive supplies and self management education on a monthly basis.

Case History: A 47 year old man who was homeless and uninsured. He was admitted to the hospital because he was vomiting blood due to an unmanaged GI disorder. Because of the LIP program he: received medical care at ACHD to stabilize his condition; and was able to enroll in Medicaid, which will be retroactive to include the hospital stay. He has selected an internal medicine practice as his permanent PCP, reduced his tobacco use and is permanently living with a family member.

Hospital Perspective: The hospital case managers were asked for feedback on the LIP program ER referral service. This is a quote from one of them, “GREAT! They took a chronic pt and managed to somewhat (sic) avoid ER return and assist pt with finally getting his Medicaid! They also assisted in f/u for pain management clinic and are trying to get pt into a drug rehab program! They are responsive and helpful and wonderful!”

Citrus County Health Department (CCHD) Project

The Citrus County Health Department (CCHD) project is designed to improve access to and ensure appropriate utilization of health care. Through three distinct program initiatives the CCHD LIP Project has proven to be very successful.

Diabetes Disease/Case management program: Program data for the past year indicates that over eighty percent (81.4%) of the new diabetics seen have made the Citrus County Health Department their medical home. Additionally, patient outcome measures indicate that clients enrolled in the program have improved diabetes management. This past month, the CCHD Diabetes management program has instituted group care which will provide additional support and management tools for these clients.

Emergency Room Diversion Clinics: CCHD now provides ER Diversion/Urgent Care Services at 3 sites Citrus County. These clinics provide an invaluable service for Citrus

County. Data indicates that over 38% of the clients seen would either go without care or would utilize the ER for care. Over the past year the CCHD ER diversion clinics have saved an average of $500,000.00 in ER cost. Additionally, over 72% of ER diversion clients have made the CCHD their medical home. These clients are provided with primary care and chronic disease prevention services and have access to all CCHD services including, dental care, mental health, and pharmacy services. During the previous year, CCHD provided over 2 million dollars of prescription medications through the Drug Manufacturers' Indigent Drug Program.

Department of Children and Family (DCF) Benefits Access: CCHD works collaboratively with DCF to provide on-site eligibility assistance at all CCHD clinical sites. There are 4 out-posted DCF workers and ACCESS Computers available to assist residents so they can apply for Medicaid, Food and temporary cash assistance. This partnership enables community members to get face-to-face assistance to assess coverage.

The following stories show how important the LIP funding is to the Citrus County Health Department:

- A CCHD client in her 40's had a diagnosis of cervical cancer. She had no idea that coverage was available to her until our nursing staff talked to her about Medicaid. She had a teenager at home and qualified for care. After our DCF workers processed her application, we were able to refer her to Moffitt Cancer Center for treatment.
- An unemployed client in his 40's, who took care of his ailing parents, lost his dad and his mother was admitted to a nursing home. With our assistance and expertise, he was able to qualify for food stamps (Supplemental Nutritional Assistance Program).
- A CCHD client in her 40's, with a teenager at home, needed a hysterectomy because of concerns about ovarian cancer. She had no idea she might qualify for medical coverage. With quick attention, we were able to help her get on Medicaid, and she is now at Shands receiving the medical care she needs.
- A 63 year old man had worked for the past 48 years as an electrician, until he recently became unemployed and uninsured. After going without care for sometime, he became a patient at CCHD. This man suffers from high blood pressure, chronic heart failure and pulmonary disease. CCHD is now his medical home, where he is provided with primary care and is able to obtain the many prescription medications that he needs.

<u>Jefferson and Madison County Health Departments – Low Income Pool Project</u>

Utilizing Low Income Pool funds, Jefferson and Madison County Health Departments have increased access to care for the uninsured through a variety of approaches, the most notable being the establishment of new primary care access points within the County Health Department (CHD). Both CHDs have enhanced their capacity to provide

care through the hiring of Advanced Registered Nurse Practitioners to provide primary care, family planning and OB services. In addition, both CHDs have expanded primary care clinic hours as well as offering an *After Hours* clinic. Both sites have increased "open access" through changes to scheduling procedures to provide services to walk-ins.

Both CHDs employ full-time Eligibility Specialists who conduct the following activities:

- Screen patients for eligibility for public health insurance and assist them in applying if they are potentially eligible. Public health insurances include Medicaid, Cover Florida, KidCare, and Social Security Disability.
- Refer patients who are uninsured to free or low-cost primary care,
- Coordinate medical appointments, and
- Promote the assignment of a medical home.

Through a partnership with Tallahassee Memorial Healthcare (TMH), the LIP project utilizes a Patient Navigator located at the Bixler Emergency Department to:

- Identify Jefferson and Madison County patients who utilize TMH ER for non-emergent conditions,
- Coordinate community health care resources to support care, and
- Promote the assignment of a medical home.

The coordination of community health care resources includes education, referral, follow-up, and case management services to identified patients.

Each project site provides Pharmacy Assistance Program services that serve CHD providers and community providers to ensure uninsured patients receive needed medications. The LIP project employs one full-time Prescription Assistance Specialist to provide these services.

Lastly, specialty coordination for chronic medical conditions is funded through the project. MCHD and JCHD share a Senior LPN that provides disease management services to those patients who have been identified as having diabetes or hypertension. Disease management services include the monitoring of compliance with standards of care, case management, facilitation of support groups, and coordination of care.

Project Data

- Increased access to health care for the uninsured and underinsured in Jefferson and Madison Counties through the expansion of County Health Department primary care capacity (January 2009 through March 2010 the project provided services to 945 new patients). Diverted 79 from the emergency room, estimated saving of $132,720.00 in ER charges (January 1, 2009 – March 31, 2010).

- After Hours Clinic in Madison County alone served: 758 total patients seen, diverted 110 from the ER, an estimated saving of $184,800.00 in ER charges (May 6, 2009 – March 31, 2010).

- LIP funding provided the means to continue Jefferson and Madison County's prescription assistance program. July 2008 through December 2009 the project provided assistance to 331 uninsured individuals with 1,069 prescriptions with a value of $406,633.00.

Lake County Health Department (LCHD) – Low Income Pool Project

According to the 2010 Florida County Health Ranking, 27% of Lake County Adults (roughly 62,500) are uninsured and 27% of Lake County's population (78,417) does not have a primary care home.

Lake Primary Care Project (Lake PCP)

- Increased access to care including one evening a week
- Increased provider access by allowing all LCHD providers to see Lake PCP clients for sick visits
- Has enrolled 466 clients into a primary care home since starting in 2009. There are 425 active clients
- Disease management care coordination including creating a care plan account for over 3,760 services and currently managing 72 high severity clients with weekly follow-up. Low severity clients receive monthly follow-up
- Increased access to alternate geographical locations through partnerships with 2 local hospital indigent clinics; has enrolled 116 clients into a primary care home since starting in March 1, 2010. There are 116 active clients
- Partnership with a Mental Health Provider to see clients on-site has decreased referral time from 2 months to 1 week (45 clients have been referred)
- Prescription Assistance Program has assisted 148 clients in receiving 1851 prescriptions
- Compassionate Care Program assisted 67 clients in receiving 117 prescriptions at no cost
- Mammogram and cervical cancer screening is available as needed
- Value of in-kind services to Lake PCP clients: $70,564.17

Community Partnerships

- Assisted clients with lodging needs, helping them get back on their feet
- Provided assistance to all clients needing food/meal assistance

- Access to specialty services for Lake PCP clients through referrals
- Eye exams and glasses from local charitable organizations

Case Example:

- A homeless female, age 35, suffering from diabetes, high cholesterol and high blood pressure was provided assistance in finding temporary lodging long enough to get back on her feet while improving her health
- A client presented with a persistent cough was sent for a chest x-ray indicating abnormalities. Client was immediately referred to a pulmonologist and diagnosed with stage IV lung cancer. Oncologist immediately began treatment

Impact on Local Hospitals

- Hospital referrals account for 23% of enrollment into the Lake PCP Program
- Successful Emergency Room diversion program through Lake PCP Program

Program	ER Diversion	Average Cost	Total ER Savings
Lake County Health Department	867	$ 2,293.03	$ 1,985,430.00
Partnership with Indigent Clinics	86	$ 2,293.03	$ 197.200.58

Pinellas County Health Department LIP Project

The Pinellas County LIP project provides disease management and outreach services and two primary care clinics for uninsured clients. Clients receiving services provided through the LIP are very appreciative of the staff and services that would otherwise be inaccessible to them. We have received many positive comments from clients for staff going above and beyond in providing client care.

Diabetes disease management is provided by two RN diabetes disease managers who focus on monitoring clients' care plans and conducting weekly self management education classes for a target population of 752 diabetics. The diabetes disease managers collaborate closely with the primary care team including nutritionists and disease managers for COPD, asthma, hypertension, and obesity. Quarterly, the diabetes disease managers provide 600 services, including more than 90 new care plans and 435 care coordination services. Additionally, the disease managers teach weekly diabetes self management education classes in collaboration with the nutritionists at the medical homes. A cardiovascular disease manager began in March 2010 as part of the LIP grant project to serve 200 identified clients with cardiovascular disease.

The outreach team includes an RN and Eligibility Specialist who provide nursing assessments and eligibility screenings at five sites within the County and attends various community events. The outreach team receives regular referrals of uninsured

discharged patients from local hospitals (inpatient and emergency room) who they assist in establishing a medical home. The team also works to establish a medical home for individuals who receive a 30-day prescription card when discharged from St. Anthony's Hospital through a pilot program with Pinellas County Health and Human Services. Quarterly, this team processes an average of 670 emergency room referrals, 100 hospital inpatient referrals, 375 eligibility field assessments and 300 nursing field screening assessments.

Primary care clinics include a Saturday clinic at Pinellas CHD, St. Petersburg, from 8:00a.m. – 3:00p.m. and a Thursday clinic at Pinellas CHD, Pinellas Park, from 2:30p.m. – 6:00p.m. These clinics provide a primary care medical home option for clients without insurance who would otherwise utilize emergency rooms as their method of receiving care. Currently, there are 347 unduplicated clients participating in these LIP clinics. On average, 85 medical encounters are provided monthly to these clients. Because of their association with the LIP Clinics, these clients have access to the specialty care network of the Pinellas County Health Department Volunteer Program. These clients have access to continued specialty care by referral from the LIP clinic examiners to the following clinics: Acupuncture Clinic, Cardiologist (in private office), Dermatologist (in private office), Diabetic Dental Clinic, Gastroenterology Clinic, General Surgery Clinic, Gynecology and Annual Exam Clinic, Ophthalmology Clinic, Nephrology and Hypertension Clinic, Osteo Manipulation Therapy Clinic, Physical Therapy Rehabilitation Clinic, Podiatry Clinic and Urology Clinic.

The LIP team focuses on primary, secondary and tertiary prevention with physicians and mid-level providers managing the entire continuum of care. Unnecessary emergency room usage is being impacted for the LIP clients by identifying the low income and uninsured Pinellas County residents through the outreach team, by offering alternative medical care through the LIP Clinics, and by providing education and disease management through the Disease Managers.

Sarasota Healthcare Access (a LIP Funded Program) – Success Stories

During a typical week, Sarasota Healthcare Access (SHCA), a LIP funded program, receives between 40 and 50 referrals from seven area emergency rooms and hospital in-patient units in Sarasota County. During calendar year 2009, SHCA received 2,148 new referrals and 548 repeat referrals. Of these, SHCA staff were able to contact and provide services to 1,444 patients. During this same time period, there were 5,979 unduplicated patients who received primary care at one of the Sarasota County Health Department sites and who originally entered care through SHCA. During March 2010, SCHD saw the highest number of patients at their four sites, logging in 8,392 clinical encounters. Of these, 1,054 were unduplicated patients who entered care through SHCA.

The following case studies provide a sample of the services SHCA provides:

A Caucasian woman in her mid-forties was admitted to SMH with nausea and vomiting. She was diagnosed with diabetes, having a blood sugar in the 800s. A Social Worker

from the hospital made a referral to SHCA. The SHCA nurse case manager contacted this patient and helped her set up an appointment with Sarasota CHD Adult Health. This lady was unaware of the existence of the Health Department and the availability of primary care. The nurse case manager taught her how to inject herself with insulin and contacted the patient at least weekly regarding diet, exercise and diabetic care. She also helped her straighten out her chaotic work schedule. This lady eventually lost 50-60 pounds, and through proper nutrition, was able to eliminate her need for insulin. Her diabetes is now controlled through diet and oral medication and her blood sugar is under control.

A 51 year-old male Caucasian was referred to Sarasota Healthcare Access (SHCA) from Sarasota Memorial Hospital, where he was inpatient. He was discharged after having had multiple strokes. The patient was unemployed, had no income, transportation or medical coverage. The SHCA Social Worker/Case Manager initiated eligibility for him to access primary care through the Sarasota County Health Department (SCHD). A follow-up appointment was scheduled for him at Adult Health at the Venice site. He was brought to his primary care visit by an aunt who was the only family member he had as support. After his initial visit he was provided with information on how to apply for SSD. He was also referred to our RN Chronic Disease case manager so that she could provide him with one-to-one health education and counseling. Several months later, the patient returned for a re-check and notified staff that he had been approved for SSD. The patient is compliant, friendly and stated, "he appreciates all the support and help he receives from the nice ladies who helped set him up with primary care services."

A tearful and depressed uninsured black gentleman in his late thirties came to the health department after being seen at the Sarasota Memorial ER. The Sarasota Healthcare Access RN case manager helped him through the clinic eligibility process and he was given an appointment for our adult primary care clinic. By working with his physician, he was given appropriate medications and referrals help him with his depression. He routinely takes his medication and has been able to secure a job and maintain a place to live.

A 44 year old patient was referred to SCHD subsequent to hospitalization at SMH and having stents placed. He was head of a household and had been providing for family with 2 children. He lost his job and was on the way to losing his home. SCHD was able to secure this gentleman a clinic card and establish him with a primary care provider. This family was extremely appreciative, stating that they have never had to use our resources. The patient's mandatory Plavix prescription was obtained through the needymeds.org resource. This patient is part of the SHCA's Chronic Disease Case Management program and this has become self sufficient with the resources we have provided.

SHCA access case managers receive numerous daily calls from people who have lost their jobs and health insurance and have no idea how to navigate the complex system of health care access. Many have chronic conditions and don't know how to they will

continue to obtain their medications. If they have children, our case mangers lead them to Medicaid web-site on their computer. These individuals are educated on the eligibility process including the documents they need, who to contact and how to make appointments. Many have chronic conditions and don't know how they will continue to obtain their medications.

Through the pharmacy case manager, SHCA is able to secure high cost medications not on the Health Department formulary, which the patient needs. An example is Plavix, which is prescribed to prevent blood clots from forming after a patient with a cardiac blockage has been stinted. Other medications provided under medication assistance include those for seizures, asthma and diabetes. The pharmacy case manager works with the patient to complete the application, obtains the physician's signature and contacts the drug provider. This process allows the patient to receive the necessary medications which they could not otherwise afford and keeps their condition under control. An example of cost savings for two patients is outlined below. Both of these middle aged patients had been working for many years. When they lost their jobs and health insurance, they stopped taking their medications and landed in the ER. They entered primary care through the SHCA program and are supported in obtaining their medications, some of which are on the Health Department formulary and others need to be accessed through our Medication Program. This support had resulted in significant cost savings to these patients.

Patient A, a diabetic, was established with Sarasota Healthcare Access in August of 2009. She was prescribed 11 formulary monthly maintenance medications and along with 4 medications that are accessed through our Medication Assistance Program. Total medication costs for the patient for her first month of treatment would have been $2536.16 for the following drugs:

- Januvia 495.39
- Lamictal 1111.42
- Actos 512.77
- Advair Diskus 416.58

Patient B, diagnosed with congestive heart failure, was established with Sarasota Healthcare Access in July of 2007. He is prescribed 14 monthly maintenance formulary medications along with 5 non-formulary medications. The cost of his non-formulary medications for one month of treatment would have been $1595.04, had he not received Medication Assistance support.

- Coreg 268.20
- Bidil 324.09
- Altace 170.73
- Welchol 452.76
- Nexium 379.26

Because of their chronic conditions, both patients now receive chronic disease case management.

J. Evaluation of Medicaid Reform

Overview

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

The Medicaid Reform Evaluation is a five-year "over-arching" study that will present its major findings in 2010-2011. However, due to the increasing interest in observing preliminary findings much sooner, the Agency, as well as several other external entities, has continued to conduct short term studies to look at specifically identified Medicaid Reform issues. These "interim" assessments will likely continue to occur throughout the five-year evaluation period. Descriptions of the evaluation reports that were received or approved by the Agency during the second quarter of Year Four are provided below.

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

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

3. Independent Evaluation by the University of Florida

UF will continue to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency. There were no semi-annual study reports due to be submitted to the Agency by the researcher during this quarterly reporting period; however, there are two semi-annual reports due to be submitted to the Agency by the researcher in the third quarter of Demonstration Year Four. These reports will be submitted to federal CMS once the Agency has reviewed and approved them. The following areas of UF's independent evaluation conducted and/or produced reports during this quarter.

University of Florida – Mental Health Analysis

In addition to the studies already initiated, the Agency is evaluating the mental and behavioral health services provided in the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). The mental health analysis has three primary objectives:

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

Studies for Objectives 1 and 3 are being conducted by UF, and USF is conducting the Objective 2 study (see below). Results from the final report for Objective 2 will be approved by the Agency during the third quarter reporting period, and will also be submitted to federal CMS during this period. A preliminary draft for the Objective 1 report was submitted to the Agency during this quarter. The final report should be available towards the end of the third quarter of Demonstration Year Four.

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

Objective 2 of the mental health analysis is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF. Results from the final report of Objective 2: *Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services – The Effect of Medicaid Reform on Baker Act and Criminal Justice Encounters,* should be final and available during the third quarter of Demonstration Year Four.

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. This report, *An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*, addresses two years pre- and two years post implementation, and can be found at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_viii_d_fisca_analysis_report_07-10-09.pdf.

In follow up to the first fiscal analysis, a preliminary draft of the multivariate analyses report was delivered to the Agency for review during the second quarterly reporting period. *Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analyses,* provides an update to the univariate report findings, and also looks at demonstration data by various subgroups

(gender, race, etc.) against specific controls. The Agency has begun validation of health plan encounter data, and this data will be useful in determining precisely what services were purchased with expenditures on individual enrollees over time. The un-validated data will be shared with UF so they can begin conducting this analysis.

University of Florida – Low-Income Pool (LIP)

In July 2006, the State of Florida introduced broad-ranging reform of the Florida Medicaid Program, with the establishment of the Low-Income Pool (LIP) Program being one of several components of the demonstration. The LIP consists of a capped annual allotment of $1 billion (the "pool"), with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.[5] The conditions of the LIP are discussed in the Special Terms and Conditions (STC's) of the Medicaid 1115 demonstration waiver, as approved by the federal Centers for Medicare and Medicaid Services (CMS).[6]

The *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2005-2006 Florida Hospital Uniform Reporting System (FHURS) Data* was approved by the Agency at the end of this quarterly reporting period. This report evaluates the link between payments from the LIP-related programs and the provision of services to Medicaid, underinsured, and uninsured populations over the pre-Reform period from July 2005 through June 2006, using data from FHURS. This evaluation measures services along **four** dimensions—adjusted days, gross revenue, and operating expense, in order to gain a more complete picture of the amount of services obtained from a given amount of LIP-related payments. Key findings from the *Evaluation of the Low-Income Pool Report Using SFY 2005-2006 FHURS Data* can be found at the link below:

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

This report is one of a series of reports that will evaluate the Low-Income Pool Program throughout the demonstration period. All evaluation studies will use data on LIP-related payments as provided by the Agency, but two different data sets will be used to assess the amount of services provided—data from FHURS and data from the LIP Milestone Reporting Requirements. These studies will cover periods both before and after implementation for purposes of comparison.

University of Florida - Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[7]) study designed to help understand demonstration enrollees' attitudes and

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[5] State of Florida, Agency for Health Care Administration (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml, accessed September 12, 2009).
[6] *CMS Special Terms & Conditions* (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf, accessed October 26, 2007).
[7] 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, maintaining the true longitudinal nature of the study was difficult because enrollees were hard to reach or decided they did not wish to continue study participation.

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. The qualitative study did achieve its objective during the demonstration's implementation period, but due to the nature of qualitative research the study could not successfully be sustained over time. With this particular component of the evaluation reaching its conclusion, the Agency will work with the independent evaluator and CMS about conducting an analysis on another area of the demonstration. The *Qualitative Study Summary Report* is anticipated to be final in the third quarter of Year Four.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state's hospital and managed care industries, the medical association, other health professional groups, advocacy organizations, legislative leadership, or other entities. A list of the FAC members and their demographic information can be found here:

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

The FAC meets annually over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on the demonstration and the evaluation efforts. The next meeting of the FAC is scheduled to occur on April 16, 2010, at the Agency for Health Care Administration in Tallahassee, Florida.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. A list of the TAC members and their expertise can be found here:

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

The purpose of this committee is, over the five-year demonstration period, 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.

This year's annual TAC meeting will take place in the Spring of 2010 at the University of Florida in Gainesville, FL. The exact date of this meeting is yet to be determined. In addition to the TAC representatives, all project areas of the evaluation are represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focuses on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

K. Policy and Administrative Issues

Current Activities

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

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

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

In the conference call forums, the transition of Florida Medicaid's Management Information System from the legacy system to the new fiscal agent, Electronic Data Systems, Inc., computer system and the consolidated contract for 2009 – 2012 has continued to be a popular topic. However, the focus in the second quarter was more on clarification regarding the new 2009 – 2012 Health Plan Contract. These forums continue to provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement.

Medicaid Reform Technical Advisory Panel

There was only one TAP meeting that took place this quarter. The nine member TAP, created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration, met in October to discuss the following topics:

- Choice Counseling update, including report on the beneficiary survey, pharmacy navigator tool and choice counseling performance standards;
- Enhanced Benefits update on credits earned, credits spent and the changes in policy regarding the types of behaviors that may earn credits;
- Health plan risk-adjusted capitation rates development, and rate setting period and reimbursement workgroup updates;
- Medicaid encounter data collection and processing, including the focus on historical data submissions; and

- An update on the next set of deliverables from the University of Florida on their Medicaid Reform evaluation.

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

Policy Transmittals

During this quarter, there were two policy transmittals, one Report Guide Revision Transmittal and no Dear Provider letters released to the health plans. The two policy transmittals covered the following topics:

- Vaccination procedures and processes for the 2009 H1N1 Swine Flu vaccine, and
- Guidelines and resources for FFS PSNs to develop their comprehensive plans for transitioning to capitated models.

The Report Guide Revision Transmittal was provided on December 31, 2009, and provided notice on reporting changes effective April 1, 2010.

Biweekly Technical and Operations Calls

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

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

Approximately 20 to 30 participants attended in person and the popularity of these calls is shown by over 100 phone lines in active use on the calls. Items that have made an appearance at almost all calls includes: updates and statuses on Medicaid encounter data submissions; EDS transition issues, including enrollment transmissions, claims processing, and the transmission of primary care provider choices; and updates on the 2009-2012 health plan contract, report guide and benefits amendments.

Other agenda items included:

- Enhanced Benefit account information;
- H1N1 Swine Flu vaccine availability updates;

- External Quality Review Organization meeting/conference call/webinar updates;
- Lead poisoning prevention;
- Performance measures;
- Provider fee schedule posting;
- Medicaid Program Integrity fraud and abuse reporting;
- Health plan transition updates; and
- My Florida Health eBook and eBaby Book Announcement.

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

Fee-for-Service PSN Systems Implementation Issues Calls

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

During this quarter, unresolved issues are either waiting for systems changes to occur or for concrete examples to be received from PSNs in order to research whether provider education or a systems changes is needed. Additional items related to Medicare crossover claims and chiropractic claims were also discussed.

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

- Medicaid fiscal agent transition issues relative to PSN enrollees, claims vouchers, and enrollment file formats;
- Claims issues in the queue but still unaddressed as they work their way through systems change priorities; and
- Reporting issues.

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

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

General Amendment/Contract Overview Calls

During this quarter, the Agency held several conference calls with health plans regarding an upcoming general amendment regarding performance measures incentives and sanctions and other fine-tuning items relative to return mail and reporting. These calls provided the Agency with an opportunity to provide an overview of the contract changes and a forum for health plans to provide feedback. Based on these calls and feedback provided, the Agency decided to extend time for feedback regarding performance measure sanctions and incentives prior to finalizing a contract amendment regarding that topic.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues October 1, 2009 – December 31, 2009	
PSN Informal Issue	**Action Taken**
1. A PSN member reported to the Agency that the PSN will not assist him with multiple health issues.	➲ The PSN reported to the Agency that staff have tried to work with the member but he has rejected their offers of assistance. The PSN provided documentation to Agency staff of ongoing attempts to help the member, with which the member has been non-compliant. The member continues to claim the PSN will not assist him, but the PSN has continued to attempt assisting him and the member has remained non-compliant. This issue has been closed.
2. A PSN member's parent requested disenrollment from the PSN to straight Medicaid because the member (infant) has multiple medical problems and is unable to get the specialists she needs.	➲ The PSN reported to the Agency that it assigned a Disease Manager to assist the member's mother in coordinating care of the infant. The PSN also suggested that the member's mother look into placement in Children's Medical Services, of which the PSN is a local subnetwork.
3. A PSN member reported needing a specialist but the PSN told her it has no specialist in that field and that the member should switch to another plan.	➲ The PSN reported to the Agency that a case manager identified a specialist and made an appointment for the member.
4. A PSN member's parent contacted the Agency and stated that the member needs a referral to a new specialist but that the PSN has not been helpful.	➲ The PSN reported to the Agency that PSN staff had spoken to the member's parent and agreed to continue authorizing services with the current provider, who has also been notified. The PSN member's parent is satisfied.
5. A provider reported that claims have gone unpaid due to a lack of effective communication by the PSN. The provider stated that claims were submitted as requested by the PSN, but have not been accepted and processed.	➲ Agency staff communicated with the provider's representative and the PSN. The PSN resolved the problem by working with the provider to resubmit the claims with the correct Medicaid Provider ID.
6. A PSN member contacted the Agency to report that she is unable to get a proper referral to a specialist from the PSN.	➲ The PSN reported to the Agency that the member had not gone through her primary care provider to get a referral. The PSN set up an appointment for the member with her primary care provider who will issue a referral to an appropriate specialist. PSN staff advised the member to call the PSN after seeing the primary care provider so the plan may assist her in setting up the specialist appointment. The member is satisfied.

7. A PSN member's parent reported to the Agency that he would like the PSN to reimburse him for charges paid to a non-participating provider who saw the member.	➲ The PSN reported to the Agency that the provider was in the PSN network and that PSN staff instructed the provider to reimburse the member's parent and submit the claim to the PSN. The provider agreed and PSN staff advised the member's parent to pick up the reimbursement check. The member's parent is satisfied.
8. A provider reported to the Agency that the PSN has not paid the provider's claims and that the PSN has not resolved the issue.	➲ The PSN reported to the Agency that PSN staff determined that the provider's office computer is unable to access the correct webportal to submit claims to the PSN. PSN staff are working with the provider's office to correctly submit claims.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
1. An HMO member reported receiving orthodontic treatment with former health plan, but current HMO is denying the claims for services rendered. The member needs further services scheduled and is concerned that the HMO will not cover the services.	➲ The HMO reported to the Agency that it contacted the member and is allowing orthodontic care to continue. The HMO has resolved the claims issues.
2. A provider contacted the Agency and reported that the HMO denied claims.	➲ The HMO reported to the Agency that the provider did not obtain authorization. The claims remain denied and the appeal was denied for not meeting filing time requirements.
3. A provider reported not being paid by the HMO for claims for services that were authorized and rendered.	➲ The HMO reported to the Agency that it paid the provider's claims.
4. An HMO member reported receiving a bill for dental services rendered to the member.	➲ The HMO reported to the Agency that it conducted a three-way call with the member's father and a representative from the dentist's office explaining that this is not an HMO issue. The member had seen a dentist under "Med-Waver" so the HMO advised the office representative to contact the member's support coordinator.
5. An HMO member contacted the Agency and reported paying a non-participating provider for services. She stated she would like the HMO to reimburse her because she was new to Florida and did not understand how Medicaid works here.	➲ The HMO reported to the Agency that the member had agreed in advance to pay the provider for any charges that the HMO would not cover. As a courtesy, the HMO reimbursed the member at the Medicaid rate for the Medicaid covered services.
6. An HMO member contacted the Agency and reported that the HMO's specialty subcontractor did not assist her in obtaining emergency services so she was forced to pay a non-participating provider to get services. She stated that the HMO is unwilling to reimburse her.	➲ The HMO obtained documentation from the non-participating provider to assess the situation. The HMO reported to the Agency that the subcontractor was attempting to arrange services for the member when the member notified the subcontractor that she had obtained services on her own and paid for them. After the plan subcontractor reviewed the work done by the non-participating provider, the subcontractor agreed to reimburse the member for out-of-pocket expenses.
7. A former HMO member reported to the Agency that the HMO refused to pay a claim for durable medical equipment (DME) that she received while she was a member.	➲ The HMO reported to the Agency that the DME provider made errors on the claim submission, which is why it was not paid. The HMO worked with the provider to correct the problems and

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
	the claim was scheduled to pay. The member was notified that the issue is resolved.
8. An HMO member contacted the Agency and reported that she has multiple health issues and is switching into fee-for-service next month because of complications. In the meantime, the member stated that she needed the HMO's help in getting a CT scan approved, appropriate medications and dental needs.	➲ The HMO contacted the beneficiary and followed up with an additional phone call. The member told HMO staff that she had the flu and asked them to call at a later date. The HMO has continued outreach to the member but the member did not respond.
9. An HMO member reported being confused about how to access care through her health plan.	➲ The HMO reported to the Agency that a case manager was assigned to work directly with the member. The case manager worked with the member to get her health care needs taken care of and arranged for necessary DME services to be delivered to the member's home.
10. An HMO member contacted the Agency and reported that her current DME provider does not participate in her new HMO and plans to remove equipment that she needs. The member had not yet contacted to the plan.	➲ The HMO corrected the Medicaid ID number that it had for the member and contacted the member. The member reported that she had received the new equipment and was satisfied.
11. An HMO member reported to the Agency that his primary care provider referred him to a specific non-participating specialist and that the HMO is refusing to help him set up an appointment.	➲ The HMO reported to the Agency that HMO staff had spoken to the member and helped him identify a participating specialist. The specialist agreed to see the member once a referral is received from the member's primary care provider. The member is satisfied.
12. An HMO member reported to the Agency that she needs referrals to specialists but the HMO is not assisting her.	➲ The HMO reported to the Agency that staff had assisted the member in obtaining one specialist but that they had been unable to reach her to confirm that another specialist was lined up for her. The HMO sent the member a letter with the information and further instructions.
13. An HMO member and sibling reported not being able to continue ongoing treatments because the provider said he had not been paid by the HMO.	➲ The HMO reported to the Agency that when the treatments began, the provider was participating with another plan but not this HMO. The HMO worked on referring the member and sibling to a participating specialist to re-evaluate the children and develop a plan of care. The HMO referred the members' parent to two possible providers. The HMO ended up making an out-of-network referral to the original provider. Treatments have resumed and the members' parent is satisfied.
14. An HMO member reported needing a new wheelchair and an authorization for a prescription drug.	➲ The HMO reported to the Agency that the member received a new wheelchair and the requested prescription drug.
15. An HMO member's pain management specialist reported being unable to obtain the	➲ The HMO reported to the Agency that it faxed the prior authorization form to the provider.

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
proper prior authorization forms from the HMO.	
16. An HMO member reported to the Agency that she needs a medication that is not on the HMO's drug formulary.	➲ The Agency helped place the beneficiary in fee-for-service Medicaid due to special needs. The beneficiary is satisfied with the change.
17. An HMO member reported having problems getting authorization for a specialist since she changed residency to another county and is leaving the HMO at the end of the month.	➲ Agency staff talked to the beneficiary and encouraged her to make another appointment with the doctor and contacted the HMO to discuss. The beneficiary scheduled an appointment to occur after she left the HMO and was enrolled in fee-for-service.
18. An HMO member reported being unable to obtain necessary equipment from the HMO's contracted DME supplier and would like a referral to another DME supplier.	➲ The HMO reported to the Agency that the member wanted equipment other than what he had been prescribed. The member accepted the prescribed equipment and the issue was resolved.
19. An HMO member contacted the Agency and reported trying to access necessary DME supplies but not knowing whether her current DME provider is participating with the HMO.	➲ The HMO reported to the Agency that the member's current DME provider is not participating with the HMO. An HMO case manager has worked with the member and the service provider to explain which DME company will provide supplies and how to request them. The member is satisfied.
20. An HMO member contacted the Agency and stated that the HMO will not approve his provider's prior authorization request for a necessary medication.	➲ The HMO reported to the Agency that the HMO has been discussing this issue with Agency staff, as the HMO believes this request is for a service which is not covered by Medicaid. Because the HMO feels it is not covered, the HMO is refusing the prior authorization and has informed the member. The HMO anticipates that the member will file for a Medicaid Fair Hearing.
21. A specialty provider reported being unable to continue an ongoing procedure for an HMO member because the HMO's subcontractor will not honor the authorization for services obtained from the member's previous plan.	➲ The HMO reported to the Agency that HMO staff did a lot of research to fully document the situation. The specialty provider only accepts straight Medicaid and had gotten out-of-network authorization from the member's previous plan. After reviewing the situation, the HMO approved the out-of-network services with the provider and the member is receiving services again.
22. An HMO member reported that she was unaware she had been assigned to a plan in which her current specialist is not participating. An out-of-network authorization submitted by the member's specialist has not been approved by the HMO. The member wishes to retain her specialist until the course of treatment is complete.	➲ The HMO reported to the Agency that the out-of-network authorization request was approved.

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
23. An HMO member's parent reported to the Agency that a provider is refusing to complete services for the member because the provider has not been paid for previous work.	➲ Agency staff worked with the HMO to resolve the issue. The HMO's research indicated that the provider had been paid in full in advance. The HMO reported to the Agency that after further discussion with the provider, the provider agreed to complete the services for the member. The member's parent is satisfied.
24. An HMO member reported a recurring problem getting his prescription medication approved by the HMO.	➲ The HMO approved the medication and contacted the member.
25. An HMO member reported that the HMO would not assist her with a medication issue.	➲ The HMO assisted the member to get medications through the end of the month, when her eligibility ended. The member is satisfied.
26. A provider contacted the Agency to report a claim being denied by the HMO. The provider asked the Agency to help them get the claim paid.	➲ The HMO reported to the Agency that the provider is part of the HMO network and that the claim had denied because of errors on the claim. An HMO representative spoke to the provider's office staff and advised them to make corrections and re-submit the claim.
27. An HMO member's parent reported being balance billed by a company because the member's provider sent lab test materials to the wrong company. The HMO will not pay the claim and has told the member's parent she is responsible.	➲ The HMO reported to the Agency that HMO staff had spoken to the provider who will accept responsibility for the bill. The HMO contacted the lab company and told it to cease and desist billing of the member's family. The member's parent is satisfied.
28. An HMO member's parent is being balance billed by a non-participating provider for services received by the member	➲ The HMO reported that HMO staff contacted the provider who acknowledged making an error and will write off the services. The HMO contacted the member's parent to advise her not to pay the bill.
29. A provider reported to the Agency that the HMO erroneously denied a claim, stating that the HMO member was in a different program on the date of service. The provider says this is incorrect.	➲ The HMO did further research and reported to the Agency that HMO staff confirmed that the member was in the plan on the date of service. The claim was processed to pay and the provider is satisfied.
30. A provider contacted the Agency to inquire about how to become part of an HMO's network and asked about continuity of care for members.	➲ Agency staff provided names of HMOs and PSNs available in the provider's area, continuity of care information per the Medicaid contract, and contact information for the HMO's Provider Relations and Provider Services Departments.
31. The HMO's dental subcontractor is having issues with its providers. Referrals and claim payments are particular concerns.	➲ The HMO has approached both the dental subcontractor and its provider to address communications issues and claims issues. All parties agreed to work closely in the future.
32. An HMO member reported to the Agency that	➲ The HMO arranged for a specialist to see the

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
the HMO gave her contact information for specialists that are not contracted with the HMO. The member needed to get an appointment with a specialist as soon as possible.	member and contacted the member to verify the appointment. The member is satisfied with the action by the HMO.
33. An HMO member was erroneously assigned to the HMO and her current provider does not participate in the HMO network. The member would like out-of-network authorization until she leaves the plan at the end of the month.	➲ The HMO reported to the Agency that it discussed the situation with the member's provider who agreed to accept payment from the HMO for any services he provided during the month. The member was notified and is satisfied.
34. An HMO member's mother reported being unable to get a viable specialist referral from the HMO	➲ The HMO reported to the Agency that an HMO representative obtained an appointment for the member with an appropriate specialist. The date, location, and provider name were confirmed with the member's mother.
35. An HMO member's mother reported to the Agency that the member had authorization for services under a previous health plan but that the new HMO is not honoring the authorization.	➲ The HMO reported to the Agency that the member was previously in fee-for-service. The provider who was providing the services does not participate with any Medicaid health plan and declines to continue providing services. The HMO's sub-contractor arranged for the member to receive ongoing services from a participating provider.
36. An HMO member's social worker had made arrangements for the member to receive treatments from a non-participating provider before assignment to the HMO. The social worker requested the HMO to approve out-of-network care for the member.	➲ The HMO reported to the Agency that the out-of-network authorization will be approved. The HMO has a standing agreement with this non-participating provider so the authorization will go forward. The member is satisfied.
37. An HMO member's grandparent reported that the member needs a follow-up appointment with a specialist at a facility that is not participating with the member's current HMO.	➲ The HMO reported to the Agency that the member's grandparent did not understand the HMO's referral process because the member was previously in MediPass. The grandparent has taken the member to the HMO PCP and has gotten the appropriate referral to the specialist. The HMO has an agreement with the specialist's facility and will pay the claim. The member's grandparent is satisfied.
38. An HMO member was erroneously assigned to the HMO and would like to continue seeing a non-participating specialist until the problem is corrected at the end of the month.	➲ The HMO reported to the Agency that the HMO had arranged with the specialist to continue seeing the member through the end of the month. The member is satisfied.
39. An HMO member reported needing to see non-participating specialists for an ongoing health issue.	➲ The HMO reported to the Agency that HMO staff are making arrangements for the member to see the requested specialists. Additional issues involving medications and durable medical equipment have also been resolved.

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
	The member is satisfied.
40. An HMO member's parent reported to the Agency that the member is not receiving needed services because the provider states the HMO has not paid claims for treatments already provided.	➲ The HMO reported to the Agency that the provider stated there had been a billing mix-up but that the provider had been paid. The actual issue was that the provider determined a referral to another specialist was needed, and that specialist referred the member to another specialist. HMO staff set up an appointment for the member with the new specialist. The member's parent is satisfied.
41. An HMO member's parent reported to the Agency that the HMO would not authorize a prescription that the member needs.	➲ The Agency contacted the HMO, who authorized the member's medication and notified the member of this.
42. A provider contacted the Agency to report having a claim denied by the HMO.	➲ The HMO reported to the Agency that the claim was reprocessed and paid.
43. An HMO member's parent reported to the Agency that the member's family is being balance billed by a hospital for claims that the HMO has not paid.	➲ The HMO reported to the Agency that HMO staff advised the hospital to stop balance billing the family. The HMO reported that the claims were denied for timely filing and that the HMO will not reconsider the decision.
44. An HMO member's parent reported that she is concerned they will be balance billed by a provider after the HMO denied a claim for services.	➲ The HMO reported to the Agency that the HMO's membership files were corrected to show the member was active on the date of service. The HMO contacted the hospital and asked them not to balance bill the member's family. The hospital stated they would resubmit the claim to the HMO. HMO staff have contacted the member's parent to report the resolution of this issue.
45. A provider reported to the Agency that the HMO denied a claim on the basis that the member was not active on the date of service.	➲ Agency staff determined that the member was active on the date of service and referred the issue to the HMO to research and resolve. The HMO reported that the provider had entered an erroneous Medicaid number on the original claim. The provider has resubmitted the claim with the correct information and the claim has paid.
46. A provider reported to the Agency that the HMO has not paid some claims and has not paid others at the appropriate amount. The provider stated that the HMO's claim manager has failed to respond to the provider's inquiries on the status of claims needing reprocessing.	➲ Agency staff contacted the HMO's director of compliance to inform him of the issue. HMO staff reported to the Agency that they finished researching the issue and reprocessed the underpaid claims. The HMO contacted the provider's office to let them know that payment would be sent that week.
47. A provider reported to the Agency that their claims were denied by the HMO because the provider used the incorrect Medicaid ID number that their verification system generated	➲ The HMO reported to the Agency that HMO staff spoke to the provider and the provider will resubmit the corrected claims to the HMO for payment. The provider is satisfied.

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
in error.	
48. An HMO member's parent reported to the Agency that the member was approved for ongoing treatments by a previous plan, but that the provider will not continue treatments because the current HMO has not paid claims. The provider does not participate with the HMO.	➲ The HMO reported to the Agency that its specialty subcontractor confirmed that the authorization is correct and current—HMO staff contacted the provider to see what must be done to get treatments started again. After further discussion with the member's parent, the HMO and parent agreed that the treatments would be continued with a participating provider. An appointment was made for the member and the parent is satisfied. HMO staff also determined that the previous provider was paid in full by the previous plan.
49. A former HMO member's parent reported that provider claims have not been paid because the HMO denies the member was eligible on the date of service.	➲ The HMO reported to the Agency that the former member's file was corrected but that after speaking to a hospital representative it was determined the date of service was after the member had left the HMO. The hospital agreed to bill Medicaid directly and to cease balance billing the former member's parent.
50. An HMO member reported to the Agency that he has not received his credits for the enhanced benefits program.	➲ Research by Agency staff found that HMO staff have submitted the correct information. The issue was referred to enhanced benefit program staff at the Agency.
51. A provider reported to the Agency that their credentialing enrollment application needs to be finalized and approved by the HMO so they may provide continued care to their patients. The provider has not received a response from the HMO.	➲ The HMO reported to the Agency that HMO staff called the provider office and gave a status of the provider's application. The approval should be finalized by mid-January.
52. An HMO member reported to the Agency that the HMO is unable to provide her with a referral to a specialist.	➲ The HMO reported to the Agency that HMO staff had made multiple attempts to contact the member and set up a referral, but she has not answered or returned voice mail messages. HMO staff finally reached the member and confirmed referrals to a primary care provider and the requested specialist. The member is satisfied.
53. An HMO member reported to the Agency that the HMO cannot provide him with proper referrals to specialists and will not authorize out-of-network specialists. The member also stated that the HMO will not authorize medications for him.	➲ The HMO reported to the Agency that a case manager was assigned to work with the member but that the member has refused to cooperate and demanded to be disenrolled from managed care. Of the medications that the member says have not been authorized, HMO staff said that one of them has been authorized each month for the past four months. The other two medications have generic alternatives, so HMO staff have

HMO Complaints/Issues October 1, 2009 – December 31, 2009	
HMO Informal Issue	**Action Taken**
	advised the member to have his primary care provider submit the required prior authorization requests for the non-generic medications, but to date no prior authorization requests have been received. Agency staff advised the member to work with the HMO staff to resolve these issues.
54. An HMO member's guardian reported to the Agency that the member needed transportation to a specialist appointment but that the guardian could not reach the HMO to make arrangements for the trip.	➲ The HMO reported to the Agency that HMO staff arranged for the trip and provided the guardian with the confirmation information.
55. An HMO member's parent contacted the Agency and stated that the HMO refused to continue previous authorization for a specialized service and the member needs to have the procedure completed.	➲ The HMO reported to the Agency that HMO staff worked with the specialty subcontractor to ensure that the previous authorization is honored. The specialty provider has been notified to proceed and the member's parent has been notified of the resolution.
56. An HMO member contacted the Agency to report that the HMO has not approved authorization for two medications for which his primary care provider had submitted a prior authorization request.	➲ The HMO reported to the Agency that the HMO had authorized a 3-month supply of one medication but had not received a request for the other medication. HMO staff reached out to the member and the primary care provider to get the necessary information to process the request for the medication.
57. An HMO member contacted the Agency and stated that the HMO would not authorize necessary medications because their system erroneously showed the member has Third Party Liability coverage.	➲ The HMO reported to the Agency that it had corrected its internal member file and authorized the provider to dispense the medications to the member. The member contacted the Agency again to report that she was still unable to obtain some medications. After further research, HMO staff discovered that the member had tried to get medications that had previously been approved on an emergency basis for a month. The member understood what happened.
58. An HMO member's parent reported to the Agency that the HMO denied authorization for a medication needed by the member.	➲ The HMO reported to the Agency that HMO staff reviewed the situation and authorized the medication. The member's parent was notified of this and advised to go pick up the medication.
59. An HMO member contacted the Agency and stated he has MRSA and has not been able to obtain a prescription for treatment.	➲ The HMO reported to the Agency that HMO staff contacted the member and provided a supply of the medication for the member the same day.

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