Florida Medicaid Reform

Quarterly Progress Report
October 1, 2010 – December 31, 2010

1115 Research and Demonstration Waiver

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

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Table of Contents

List of Tables

List of Charts

I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, F.S., and Special Terms and Conditions # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to, approval and contracting with new plans, specifying coverage area, phase-in, populations served, benefits, enrollment, grievances, and other operational issues. This report is the second quarterly report in Year Five of the demonstration for the period of October 1, 2010, through December 31, 2010. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at:

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

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid Health Plan Application. In 2006, a single application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas[1]: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on Pages 6 through 10 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. The 2010 Florida Legislature amended Section 409.91211(3)(e), F.S., to allow the FFS PSNs to become capitated no later than the beginning of their last year of operation under the demonstration extension. If the demonstration extension is approved, this will require the PSNs to convert to capitation with a service date of September 1, 2013, unless the PSN opts to convert to capitation earlier.

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

Current Activities

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 23 applicants sought and received approval to provide services to the TANF and SSI population. The application of Preferred Care Partners d/b/a CareFlorida was approved this quarter and a contract was executed for this HMO to begin providing services next quarter. There are no currently pending applications.

During this quarter, the Agency processed a request from First Coast Advantage (PSN) to expand into Baker, Clay, and Nassau Counties. First Coast Advantage was approved to expand into these counties with an effective date of December 1, 2010.

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

Table 1 provides a comprehensive list, since the implementation of the demonstration, of all health plan applicants, the date each application was received, the date each application was approved, and the initial counties of operation requested by each applicant.

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
HealthEase	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista	HMO	X		04/14/06	06/29/06
Vista Health Plan SF	HMO	X		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center d/b/a First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	12/10/08
AHF MCO d/b/a Positive Health Care	HMO	X		01/28/08	02/18/10
Medica Health Plan of Florida	HMO	X		09/29/08	10/24/09
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		01/14/09	05/20/09
Preferred Care Partners, Inc.	HMO	X		01/21/10	***12/20/2010***

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

Table 2
Medicaid Reform Health Plan Contracts

Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care	07/01/06	HMO	X****		
HealthEase	07/01/06	HMO	X***	X***	
Staywell	07/01/06	HMO	X***	X***	
Preferred Medical Plan	07/0106	HMO	X****		
United HealthCare	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista	07/01/06	HMO	X*		
Vista Health Plan SF	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center d/b/a First Coast Advantage	07/01/06	PSN		X	X*****
Pediatric Associates	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO d/b/a Positive Health Care	05/01/10	HMO	X		

*During Fall of 2008, the plan amended its contract to withdraw from this county.
**During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.
***During Spring of 2009, the plan notified the Agency to withdraw from these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.
*****First Coast Advantage expanded into these counties effective 12/01/2010.

Contract Amendments and Model Contracts

This quarter, there was a general amendment to implement rates effective September 1, 2010, through August 31, 2011. In addition, four health plans executed amendments to change their benefit packages effective January 1, 2011. During this quarter, the Agency approved one request to increase maximum enrollment levels: Freedom Health Plan increased its maximum enrollment level in Broward County.

During last quarter, Sunshine State Health Plan requested and received Agency approval to increase its maximum enrollment level in Clay County and it was determined this quarter that the plan would have an effective date of February 1, 2010.

Contract Conversions/Terminations

Sunshine State Health Plan withdrew from Baker and Nassau Counties effective December 31, 2010. As of November 2010, Sunshine enrollment was 2,651 in Baker County and 4,569 in Nassau County. United Healthcare and First Coast Advantage remain as plan choices in Baker and Nassau Counties.

Sixty-day member and provider notices were mailed by Sunshine to enrolled recipients and network providers on November 1, 2010. A copy was shared with the Choice Counseling Program and the Florida Medicaid Area 4 Office. The final 30-day recipient notice was reviewed by advocacy groups (Florida CHAIN and Florida Legal Services) with no comments and was mailed by Florida Medicaid to Sunshine enrolled recipients on December 1, 2010.

Sunshine members were given the option to enroll in a different health plan. Recipients in assistance categories that are voluntary for managed care and who did not actively choose another plan reverted to fee-for-service Medicaid effective January 1, 2011. Recipients in assistance categories that are mandatory for managed care and who did not actively choose another plan were transitioned to First Coast Advantage effective January 1, 2011.

On December 1, 2010, Sunshine sent Florida Medicaid their lists of high-risk recipients. This included special needs members (including members receiving disease management or case management services), all pregnant members, members with prior authorizations to receive inpatient and outpatient services on or after January 1, 2011, and members in prior authorized or active behavioral health care. Medicaid provides United Healthcare and First Coast Advantage the high-risk recipient information after an assignment or voluntary choice is made.

Throughout the transition, Florida Medicaid held weekly internal meetings with multiple bureaus and the local area office. Weekly updates on choice counseling outreach efforts in Baker and Nassau Counties were provided by the Agency's contracted enrollment broker/choice counselor. Florida Medicaid outreach activities included:

- Additional choice counselors in the Medicaid area office and in community mental health centers in Baker and Nassau Counties.
- Outbound calls from Choice Counseling, initiated after Sunshine submitted the high-risk recipient lists on December 1, 2010.
- An informational flyer posted in the Medicaid Area 4 Office, Sunshine primary care provider offices, and local health care facilities. The flyer was reviewed by advocacy groups (Florida CHAIN and Florida Legal Services) with no comments.
- On-site visits to local Department of Children and Families and Department of Health offices.
- On-site visits to local County Health Departments.
- On-site visits to local Assisted Living Facilities.

FFS PSN Conversion Process

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

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

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

Table 3
PSN Conversion to Capitation Timeline

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

FFS PSN Reconciliations

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

Systems Enhancements

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

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

2. Benefit Package

Overview

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

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for all four-years of the demonstration. Interested parties were notified that the data book would be e-mailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were then released on May 23, 2007, for Demonstration Year Two, May 7, 2008, for Demonstration Year Three, September 15, 2009, for Demonstration Year Four and September 30, 2010, for Demonstration Year Five.

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 it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the

actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

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

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

Current Activities

The benefit packages customized by the health plans for Demonstration Year Four became operational on January 1, 2010, and remains valid until December 31, 2010, effectively overlapping Year Four and Year Five of the demonstration. These benefit packages include 21 customized benefit packages for the HMOs and 13 customized benefit packages for the FFS PSNs.

Providers submitted new customized benefit packages for review and approval based on the updated databook and revised PET during this second quarter and the approved benefit packages for Demonstration Year Five will become effective January 1, 2011.

Table 4 lists the number of co-payments for each service type by each demonstration year. Table 4 shows no changes for Year Five due to the overlapping of the effective dates for the benefit packages with the dates of the Pilot Year. In addition, Total Health Choice was acquired by Simply Healthcare (HMO) and ceased operations May 31, 2010. The Total Health Choice enrollees were transitioned into Better Health PSN (of which Simply is a minority owner) on June 1, 2010, but since Total had no co-payments for any category the number of co-payments have not changed. A new specialty plan for Medicaid Reform enrollees with HIV/AIDS, Positive Healthcare, began accepting voluntary enrollments on May 1, 2010, and has no co-payments. Table 4 will be updated in the next quarterly report to reflect the new approved benefit packages under review this quarter. The approved benefit packages will become effective January 2011.

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

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

Table 5 Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year								
	Year One	**Year Two**	**Year Three**			**Year Four**		**Year Five**
			July-Dec	**Jan-Nov**	**Dec**	**Jan**	**May**	
Total Number of Benefit Packages	**28**	**30**	**28**	**24**	**20**	**20**	**19**	**19**
Total Number of Benefit Packages Requiring No Co-payments	**12**	**16**	**20**	**20**	**17**	**16**	**15**	**15**
Percent of Benefit Packages Requiring No Co-payments	**43%**	**53%**	**71%**	**83%**	**85%**	**80%**	**79%**	**79%**

Table 6 displays the number of Demonstration Year Four benefit packages not requiring co-payments by population and area, and has been split into two time periods to reflect the loss of the Total Health Choice benefit package as a choice. Table 6 shows that for each area and target population, there is at least one benefit package to choose from

that does not require co-payments. A 'Year Five' column has been added to Table 6 below. When compared with the month of May in the fourth quarter of Year Four, it indicates no further changes occurred during the first two quarters of Year Five.

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

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

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

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

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

The PET submission procedure for Demonstration Year Five was similar to that of the four previous demonstration years. The updated version of the data book was released by the Agency on September 30, 2010, and the new PET was e-mailed to the health

plans during the second quarter of Demonstration Year Five. The health plans' Year Five benefit packages will have an effective date of January 1, 2011. This extension was made in order to provide adequate notification to the beneficiaries of any 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 Five of the demonstration.

3. Grievance Process

Overview

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

As defined in the health plan contracts:

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

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

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

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

Current Activities

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

Plan-Reported Complaints

Beginning with the second quarter of Demonstration Year Four, the Agency's new health plan contract required the health plans to report the number of complaints that they received from members in their Grievance and Appeal reports.

Table 7 provides the number of complaints reported by the PSNs and HMOs for the period of July 1, 2010 – December 31, 2010. The health plan contract defines Complaint as: any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Health Plan employee, failure to respect the enrollee's rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan's Contract. A complaint is an informal component of the grievance system.

Table 7
Plan-Reported Complaints
July 1, 2010 – December 31, 2010

Quarter	PSN Complaints	HMO Complaints	HMO & PSN Enrollment*
July – September 2010	367	686	270,159
October – December 2010	1,059	930	296,166
Total	**1,426**	**1,616**	**325,990**

*unduplicated enrollment count

Grievances & Appeals

Table 8 provides the number of grievances and appeals by health plan type for the second quarter of Demonstration Year Five.

Table 8 Grievances and Appeals October 1, 2010 – December 31, 2010					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
Total	34	36	40	100	296,166

*unduplicated enrollment count

During the second quarter of Demonstration Year Five, the number of grievances reported by PSNs and the HMOs dropped from the previous quarter. The number of appeals increased for the PSNs (from 22 in the first quarter to 36 in the second quarter of Year Five) and dropped slightly for the HMOs (from 110 in the first quarter to 100 in the second quarter of Year Five).

Medicaid Fair Hearings (MFHs)

Table 9 provides the number of MFHs requested during the second quarter of Demonstration Year Five. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members; however, the Agency monitors the Medicaid Fair Hearing process. Of the 15 MFH requests relating to demonstration participants: ten were related to denial of benefits/services, three were related to denial of prescription medication, and two were related to the reduction/suspension/ termination of benefits/services. Of the 9 hearings held: two were abandoned by members; two were resolved by the plan so the members abandoned; one was favorable to the HMO; one was favorable to the recipient; and three were pending a final decision/order at the end of the quarter. Of the 6 MFH requests without hearings: three were resolved by the plan so the member withdrew the request; one member withdrew the request; one request was rejected because it was not filed properly; and one was pending at the end of the quarter.

Table 9 Medicaid Fair Hearing Requests October 1, 2010 – December 31, 2010	
PSN	4
HMO	11

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level, as no grievances were submitted to the SAP or BAP during this quarter.

Table 10 provides the number of requests to BAP and SAP for the second quarter of Demonstration Year Five.

Table 10 BAP and SAP Requests October 1, 2010 –December 31, 2010	
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 Florida Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. This tracking was previously accomplished through a consolidated automated database, implemented October 1, 2007, that was used by all Agency staff housed in the above locations to track and trend complaints/issues received. Beginning on October 1, 2009, Medicaid staff in the above locations started using the new Complaints/Issues Reporting and Tracking System (CIRTS), which allows real-time, secure access through the Agency's web portal for headquarters and Medicaid Local 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 17 complaints/issues related to PSNs and received 44 complaints/issues related to HMOs, for a total of 61 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO) of this report. Attachment I provides the details on the complaints/issues related to PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues

related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

During this quarter, the majority of the PSN complaints/issues were from members. Member issues included needing assistance in accessing providers and assistance in getting services authorized. The provider issues were regarding claims payment.

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

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

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

5. On-Site Surveys & Desk Reviews

During this quarter, the Agency did not conduct any on-site surveys of the Medicaid HMOs and PSNs. All reviews for this contract year have been completed.

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

The Bureau of Medicaid Program Integrity did not conduct separate on-site fraud and abuse compliance reviews during this quarter; however, reviewed corrective action plans resulting from the first quarter reviews of the one HMO and three PSNs.

The Agency's External Quality Review Organization (EQRO) vendor continues to make minor refinements to the contract review tool based on testing the tool in the field. As health plan contract amendments are approved and implemented, the tool will be updated to reflect those changes.

Table 11 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 11 On-site Survey Categories
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Grievances & Appeals
➲ Financials

B. Choice Counseling Program

Overview

A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health care by providing them with the information and access needed to make the most informed decisions about health plan choices.

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

The following are key events and efforts that occurred during this quarter:

- Sunshine Health Plan withdrawal from Baker and Nassau Counties.
- First Coast Advantage health plan expansion into Baker and Nassau Counties.

Current Activities

1. Choice Selection Tools

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

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

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

- PDL Comparison: Each health plan’s PDL is compared against the beneficiary’s prescribed drug claims history, as well as any additional list of medications provided to the Choice Counselor by the beneficiary.
- PCP Comparison: Each health plan’s provider network file is searched simultaneously, for the name of PCP’s provided by the beneficiary.
- Specialist Comparison: Each health plan’s provider network file is searched simultaneously, for the name of specialists provided by the beneficiary.
- Hospital Comparison: Each health plan’s provider network file is searched simultaneously, for the name of hospitals provided by the beneficiary.

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

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

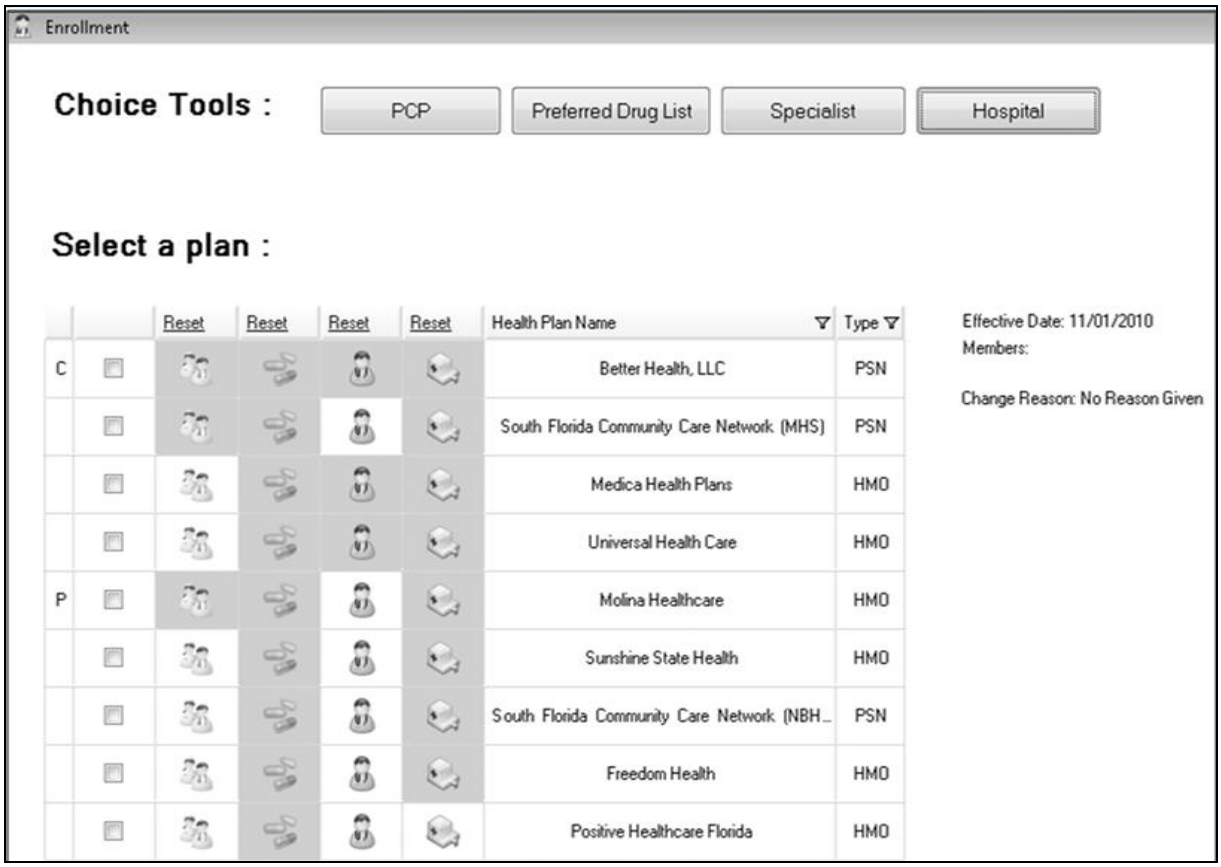
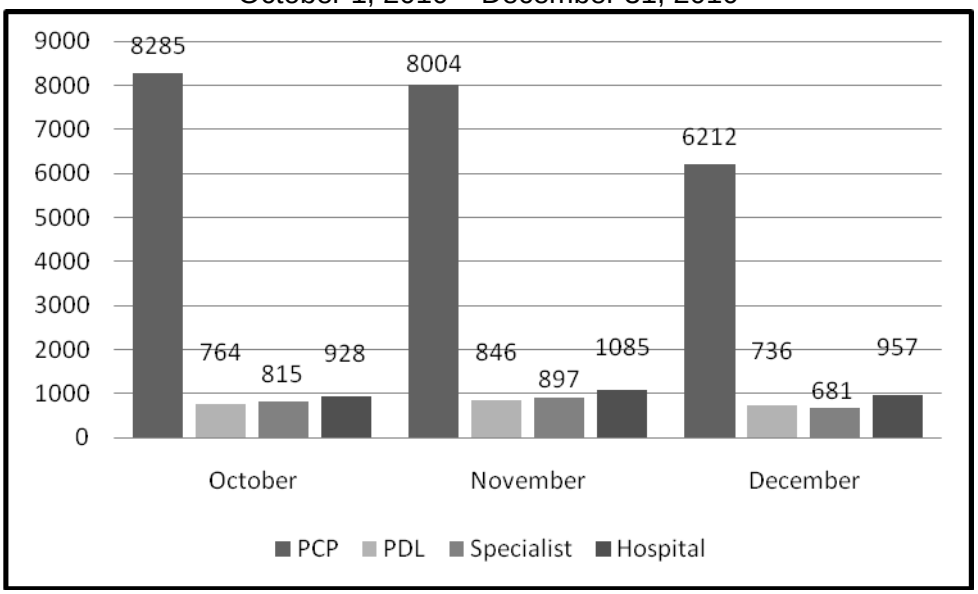


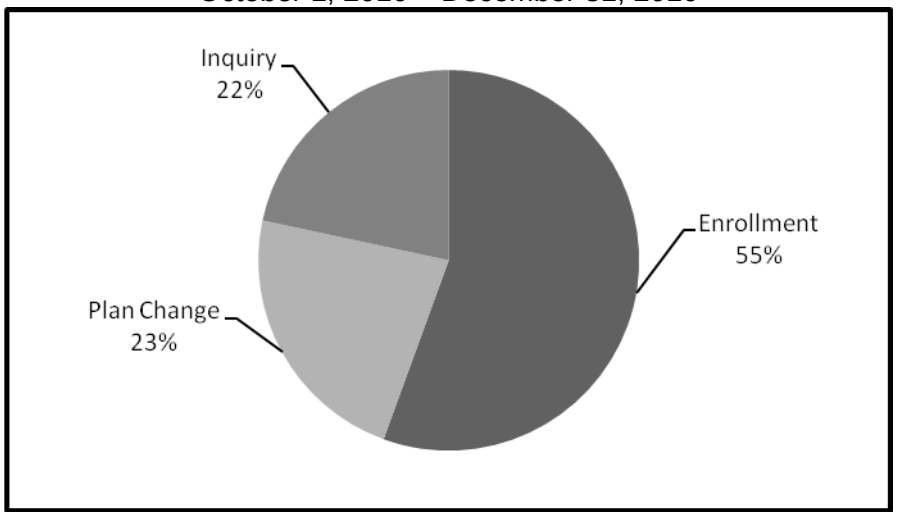
Chart A represents the number of times each Choice Selection Tool was utilized during the enrollment or plan change process for this quarter. The results are broken out by choice tool type.

Chart A
Choice Tool Use by Type
October 1, 2010 – December 31, 2010



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

Chart B
Navigator Use by Call Type
October 1, 2010 – December 31, 2010



Beneficiary Customer Survey[3]

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The Call Center has a set day of the week when the Choice Counselors offer the survey to callers. This helps to reach the goal of at least 400 completed surveys each month. During this quarter, a total of 908 beneficiaries completed the automated survey.

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

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

If a beneficiary scores a category between 1 and 3, the caller has the ability to leave a comment about why he or she left a low score. The caller also has the ability to request a supervisor call back so the beneficiary can provide even more feedback on his or her experience.

Table 12 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) during this quarter. The Survey was taken offline beginning the latter part of October for Agency requested survey maintenance and returned to operation during the latter part of November. The number of beneficiaries participating in the Survey this quarter was as follows: October – 372, November – 83, and December – 453 (totaling 908).

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

[3] Survey Maintenance occurred November 2, 2010, until November 29, 2010.

Table 12 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
October	*November*	*December*
How helpful do you find this counseling to be		
90%	87%	88%
Amount of time you waited		
85%	93%	91%
Ease of understanding information		
76%	77%	77%
Likelihood to recommend		
97%	98%	94%
Overall service provided by Counselor		
98%	100%	96%
Quickly understood reason		
98%	100%	96%
Ability to help choose plan		
97%	96%	96%
Ability to explain clearly		
98%	100%	96%
Confidence in the information		
95%	98%	95%
Being treated respectfully		
98%	100%	98%

2. Call Center

The Choice Counseling Call Center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The Call Center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., Friday 8:00a.m. – 7:00p.m., and Saturday 9:00a.m. – 1:00p.m. During this quarter, the Call Center had an average of 39 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls.

The Choice Counseling Call Center received 50,543 calls during this quarter. This represents approximately a 12% decrease in call volume from the previous quarter. The decrease in call volume for the quarter is mainly attributed to holiday call trends.

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

Table 13 Comparison of Call Volume for Second Quarter (Demonstration Year Four & Year Five)								
Type of Calls	**Oct. 2009**	**Oct. 2010**	**Nov. 2009**	**Nov. 2010**	**Dec. 2009**	**Dec. 2010**	**Year 4 2nd Quarter Totals**	**Year 5 2nd Quarter Totals**
Incoming Calls	26,121	18,626	19,566	17,398	16,914	14,519	**62,601**	**50,543**
Outgoing Calls	2,357	5,845	2,267	6,731	1,579	8,849	**6,203**	**21,425**
Totals	28,478	24,471	21,833	24,129	18,493	23,368	**68,804**	**71,968**

3. Mail

Outbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 21,917
- Confirmation Letters 20,460
- Open Enrollment Packets 27,720
- Transition Packets (mandatory and voluntary) 9
- Plan Transfer Letters (mandatory and voluntary) 3,874

When return mail is received, the Choice Counseling staff accesses the Choice Counseling Vendor's enrollment system and the Florida Medicaid Management Information System to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team also assists in efforts to contact the beneficiary. The Choice Counseling staff re-addresses the packets or letters when possible, with the newly eligible mailings taking top priority.

The amount of returned mail for this quarter, 9.7%, is slightly above the estimated 3-5% contract standard. The return mail volumes were higher this quarter due to programming changes in FMMIS, which impacted the data transferred to the AHS database, Health Track. The implementation of the National Change of Address database should assist with decreasing the volume of return mail.

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

Inbound Mail

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

- Plan Enrollments 708
- Plan Changes 39

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

The Online Enrollment Application was implemented on September 1, 2010. Since implementation, 686 enrollments and 157 plan changes have been processed through the Online Enrollment Application. The Agency is working to increase beneficiary awareness of online access and expects the number of enrollments to increase. The Agency is also reviewing the enrollment form to evaluate whether the mail-in enrollment option will be maintained.

4. Face-to-Face/Outreach and Education

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

Table 14 provides the Choice Counseling Field activities during this quarter:

Table 14
Choice Counseling Outreach Activities

Field Activities	2nd Quarter – Year 5
Group Sessions	376
Private Sessions	27
Home Visits & One-On-One Sessions	18
No Phone List	1,133
Outbound Phone List	9,400
Enrollments	6,715
Plan Changes	792

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

In October, the Field Choice Counselors began providing community support for those beneficiaries affected by the withdrawal of Sunshine Health Plan from Baker and Nassau counties.

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

The Mental Health Unit

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

The Mental Health Unit completed 27 Private Sessions. The Unit also completed 2 staff presentations. The Choice Counseling Field staff participated in 4 health fairs that resulted in a total of 211 contacts.

The Mental Health Unit also provided key support to the behavioral health communities of Nassau and Baker Counties during the transition due to the withdrawal of Sunshine Health Plan.

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

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

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

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse, and a Licensed Practical Nurse that have both earned their Choice Counseling certification.

Summary of cases taken by the Special Needs Unit

A 'case referral' is when a Choice Counselor refers a case to the Special Needs Unit through the Choice Counseling Vendor, enrollment system (Health Track) or verbally via phone transfer, for follow-up. The Special Needs Unit conducts the research and resolves the referral.

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

This quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as noted in Table 15.

Table 15
Number of Referrals and Case Reviews Completed
October 1, 2010 – December 31, 2010

	October	November	December
Case Referrals	53	41	91
Case Reviews	117	165	77

The Special Needs Unit staff scope of work includes:

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

6. New Eligible Self Selection Data[4]

The new eligible self-selection and auto-assignment rates for Demonstration Years Three and Four are not available due to the daily file and month end processing transfers between Hewlett Packard (HP), formerly EDS, and the Agency's former Choice Counseling vendor Affiliated Computer Services (ACS). On June 18, 2010, Automated Health Systems (AHS) began rendering services as the Agency's Choice Counseling Vendor. Programming changes to the system have allowed the Agency to collect more reliable, yet not fully validated, data regarding self-selection and auto-assignment rates for Demonstration Year Five. While provided, the self selection rate and auto-assignment rate cannot be validated at this time.

From July 2010 to November 2010, 72% of beneficiaries enrolled in the demonstration self selected a health plan and 28% were auto-assigned. On average, the self selection rate was 80% prior to July 2008, compared to the 72% that was reported for the period of July 2010 to November 2010. From July 2010 to November 2010, 72% of beneficiaries enrolled in the demonstration self selected a health plan and 28% were auto-assigned. On average, the self selection rate was 80% prior to July 2008, compared to the 72% that was reported for the period of July 2010 to November 2010. The change in the voluntary selection rate this quarter may be attributable to several factors including:

- Sunshine health plan withdrawal from Baker and Nassau Counties; and enrollment of beneficiaries into First Coast Advantage with the expansion of the plan in Baker, Clay and Nassau Counties.

- Change in the Choice Counseling Welcome Packet which may have resulted in beneficiaries not calling to verify the preselected health plan as beneficiaries are not required to do so. A description of the change in the Welcome Packet is provided below.

    - Prior to June 18, 2010, beneficiaries received a packet of written materials (the Choice Counseling Welcome Packet) welcoming them to Medicaid, advising them of the need to select a plan by a specified date, and a brochure of covered services and available plans. In follow-up to the Welcome Packet, beneficiaries were sent a (pending auto-assignment) letter. This letter notified beneficiaries, who had not yet voluntarily selected a plan; that they would be automatically enrolled in a health plan (plan name was specified in the letter) unless they voluntarily select a plan by the specified date.

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

- Beginning June 18, 2010, beneficiaries receive a Choice Counseling Welcome Packet welcoming them to Medicaid, advising them of the need to select a health plan, the deadline for selecting a plan, and the name of the plan they will be assigned to if a self-selection is not made by the specified date. The Welcome Packet also includes the brochure of covered services and available health plans.

Table 16 shows the current self-selection and auto-assignment rate for the current demonstration year.

Table 16
Self-Selection and Auto-Assignment Rate
July 1, 2010 – December 31, 2010

	July 2010	Aug 2010	Sept 2010	Oct 2010	Nov 2010	Dec 2010
Self-Selected	8,588	8,756	8,652	11,914	9,532	7,337
Auto-Assignment	4,500	2,402	3,641	3,887	3,649	10,236
Total Enrollments	13,088	11,158	12,293	15,801	13,181	17,573
Self-Selected %	66%	78%	70%	75%	72%	42%
Auto-Assignment	34%	22%	30%	25%	28%	58%

7. Complaints/Issues

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

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the Choice Counseling Vendor and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' satisfaction, with the overall service provided by the Choice Counselors, indicate that more than 98% are satisfied with the Choice Counseling experience during this quarter. Survey results also indicate that 98% are satisfied with the Choice Counselor's ability to clearly explain health plan choices and 99% felt they were treated respectfully. The

Choice Counseling Vendor continues to focus on improving communication between the Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

Survey scores and beneficiary comments are provided to supervisors and counselors. The positive comments encourage the Choice Counselor to keep up the good work and the negative comments help to point out possible weaknesses that may require coaching or training.

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

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

9. Summary

The Agency, the Choice Counseling Vendor and the Fiscal Agent remain committed to prioritizing and resolving identified data transfer issues. The Choice Counseling Vendor continues to work hard to provide excellent customer service and to play a key role in identifying and resolving issues. The new Choice Counseling Vendor, AHS, demonstrated consistent performance this quarter, meeting or exceeding all Service Level Agreements.

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

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

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

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning October 1, 2010, and ending December 31, 2010. This section contains the following enrollment reports:

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

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 12 Medicaid Reform health plans – eight (8) HMOs and four (4) fee-for-service PSNs. Sunshine State Health Plan withdrew from Baker and Nassau Counties effective December 31, 2010, and First Coast Advantage expanded into Baker, Clay and Nassau counties effective December 1, 2010.

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

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 17 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 17
Medicaid Reform Enrollment Report Descriptions

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

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 18 on the following page for State Fiscal Year 2010-11, second quarter Medicaid Reform Enrollment Report.

Table 18 Medicaid Reform Enrollment (Fiscal Year 2010-11, 2nd Quarter)									
Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share for Reform	Enrolled in Previous Quarter	% Increase from Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Freedom Health Plan	HMO	3,255	457	1	77	**3,790**	**1.28%**	3,221	17.67%
Humana	HMO	5,113	1,627	3	191	**6,934**	**2.34%**	7,287	-4.84%
Medica	HMO	2,258	401	0	69	**2,728**	**0.92%**	2,204	23.77%
Molina Healthcare	HMO	22,207	3,593	11	450	**26,261**	**8.87%**	22,391	17.30%
Positive Healthcare	HMO	10	66	0	5	**81**	**0.03%**	62	N/A
Sunshine	HMO	92,639	8,963	10	817	**102,429**	**34.58%**	93,126	9.99%
United Healthcare	HMO	7,187	922	0	61	**8,170**	**2.76%**	7,537	8.40%
Universal Health Care	HMO	16,132	2,187	1	312	**18,632**	**6.29%**	17,212	8.27%
HMO Total	**HMO**	**148,801**	**18,216**	**26**	**1,982**	**169,025**	**57.07%**	**153,040**	**10.45%**
Better Health, LLC	PSN	29,171	4,026	8	590	**33,795**	**11.41%**	32,188	5.00%
CMS	PSN	4,179	3,366	0	20	**7,565**	**2.55%**	6,811	11.07%
First Coast Advantage	PSN	42,698	6,455	3	917	**50,073**	**16.91%**	46,126	8.56%
SFCCN	PSN	31,253	3,903	4	548	**35,708**	**12.06%**	31,994	11.72%
PSN Total	**PSN**	**107,301**	**17,750**	**15**	**2,075**	**127,141**	**42.93%**	**117,119**	**8.59%**
Reform Enrollment Totals		**256,102**	**35,966**	**41**	**4,057**	**296,166**	**100.00%**	**270,159**	**9.65%**

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. There were a total of 296,166 beneficiaries enrolled in the demonstration during this quarter. There were twelve (12) demonstration health plans with market shares ranging from 0.03 percent to 34.58 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 19 on the following page.

Table 19 Number of Medicaid Reform Health Plans in Demonstration Counties (Fiscal Year 2010-11, 2nd Quarter)		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**1**
Broward	**7**	**3**
Clay	**2**	**1**
Duval	**3**	**2**
Nassau	**2**	**1**

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

Table 20 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, as shown in Table 21 and located on the following page.

Table 21
Medicaid Reform Enrollment by County Report
(Fiscal Year 2010-11, 2nd Quarter, October - December)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Previous Quarter	% Change From Previous Qtr.
				No Medicare	Medicare Part B	Medicare Parts A & B				
Sunshine	HMO	Baker	2,466	214	0	17	2,697	78.74%	2,716	-0.70%
United Healthcare	HMO	Baker	564	88	0	7	659	19.24%	483	36.44%
First Coast Advantage	PSN	Baker	58	10	0	1	69	2.01%	0	NA
Total Reform Enrollment for Baker			**3,088**	**312**	**0**	**25**	**3,425**	**100.00%**	**3,199**	**7.06%**
Freedom Health Plan	HMO	Broward	3,255	457	1	77	3,790	2.33%	3,221	17.67%
Humana	HMO	Broward	5,113	1,627	3	191	6,934	4.27%	7,287	-4.84%
Medica	HMO	Broward	2,258	401	0	69	2,728	1.68%	2,204	23.77%
Molina Healthcare	HMO	Broward	22,207	3,593	11	450	26,261	16.16%	22,391	17.28%
Positive Healthcare	HMO	Broward	10	66	0	5	81	0.05%	62	N/A
Sunshine	HMO	Broward	33,672	2,801	5	232	36,710	22.58%	32,672	12.36%
Universal Health Care	HMO	Broward	9,959	1,507	1	216	11,683	7.19%	10,668	9.51%
Better Health, LLC	PSN	Broward	29,171	4,026	8	590	33,795	20.79%	32,188	4.99%
CMS	PSN	Broward	2,616	2,227	0	14	4,857	2.99%	4,341	11.89%
SFCCN	PSN	Broward	31,253	3,903	4	548	35,708	21.97%	31,994	11.61%
Total Reform Enrollment for Broward			**139,514**	**20,608**	**33**	**2,392**	**162,547**	**100.00%**	**147,028**	**10.56%**
Sunshine	HMO	Clay	9,095	800	1	60	9,956	73.98%	9,547	4.28%
United Healthcare	HMO	Clay	3,209	232	0	14	3,455	25.67%	3,147	9.79%
First Coast Advantage	PSN	Clay	46	1	0	0	47	0.35%	0	NA
Total Reform Enrollment for Clay			**12,350**	**1,033**	**1**	**74**	**13,458**	**100.00%**	**12,694**	**6.02%**
Sunshine	HMO	Duval	43,171	4,725	4	474	48,374	43.69%	43,684	10.74%
United Healthcare	HMO	Duval	2,308	489	0	24	2,821	2.55%	2,948	-4.31%
Universal Health Care	HMO	Duval	6,173	680	0	96	6,949	6.28%	6,544	6.19%
CMS	PSN	Duval	1,563	1,139	0	6	2,708	2.45%	2,470	9.64%
First Coast Advantage	PSN	Duval	42,534	6,424	3	915	49,876	45.04%	46,126	8.13%
Total Reform Enrollment for Duval			**95,749**	**13,457**	**7**	**1,515**	**110,728**	**100.00%**	**101,772**	**8.80%**
Sunshine	HMO	Nassau	4,235	423	0	34	4,692	78.10%	4,507	4.10%
United Healthcare	HMO	Nassau	1,106	113	0	16	1,235	20.56%	959	28.78%
First Coast Advantage	PSN	Nassau	60	20	0	1	81	1.35%	0	#DIV/0!
Total Reform Enrollment for Nassau			**5,401**	**556**	**0**	**51**	**6,008**	**100.00%**	**5,466**	**9.92%**
Reform Enrollment Totals			**256,102**	**35,966**	**41**	**4,057**	**296,166**		**270,159**	**9.63%**

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

During this quarter, there was an enrollment of 3,425 beneficiaries in Baker County, 162,547 beneficiaries in Broward County, 13,458 beneficiaries in Clay County, 110,728 beneficiaries in Duval County, and 6,008 beneficiaries in Nassau County. There were three (3) Baker County health plans with market shares ranging from 2.01 percent to 78.74 percent, ten (10) Broward County health plans with market shares ranging from 0.05 percent to 22.58 percent, three (3) Clay County health plans with market shares ranging from .35 percent to 73.98 percent, five (5) Duval County health plans with market shares ranging from 2.45 percent to 45.04 percent, and three (3) Nassau County health plans with market shares ranging from 1.35 percent to 78.1 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 22 and 23 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those beneficiaries who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 22 provides a description of each column in this report.

Table 22
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 23 lists the number of individuals in the voluntary populations who have chosen to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 23
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2010-11, 2nd Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
			Foster, Adoption Subsidy, and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Freedom Health Plan	HMO	Broward	4	31	1	4	14	64	**118**	**3.11%**	**3,790**
Humana	HMO	Broward	0	38	0	29	0	194	**261**	**3.76%**	**6,934**
Medica	HMO	Broward	2	9	1	6	15	54	**87**	**3.19%**	**2,728**
Molina Healthcare	HMO	Broward	14	156	7	42	64	397	**680**	**2.59%**	**26,261**
Positive Healthcare	HMO	Broward	0	0	0	0	0	5	**5**	**6.17%**	**81**
Sunshine	HMO	Baker	2	38	0	1	3	14	**58**	**2.15%**	**2,697**
Sunshine	HMO	Broward	13	170	3	25	35	202	**448**	**1.22%**	**36,710**
Sunshine	HMO	Clay	1	85	1	6	4	57	**154**	**1.55%**	**9,956**
Sunshine	HMO	Duval	22	534	5	64	57	421	**1,103**	**2.28%**	**48,374**
Sunshine	HMO	Nassau	0	44	2	3	2	32	**83**	**1.77%**	**4,692**
United Healthcare	HMO	Baker	0	3	0	2	0	7	**12**	**1.82%**	**659**
United Healthcare	HMO	Clay	1	31	0	3	0	14	**49**	**1.42%**	**3,455**
United Healthcare	HMO	Duval	0	71	0	12	0	24	**107**	**3.79%**	**2,821**
United Healthcare	HMO	Nassau	0	11	0	6	0	16	**33**	**2.67%**	**1,235**
Universal Health Care	HMO	Broward	6	77	0	11	17	200	**311**	**2.66%**	**11,683**
Universal Health Care	HMO	Duval	5	73	1	2	12	84	**177**	**2.55%**	**6,949**
HMO Total	**HMO**		**70**	**1,371**	**21**	**216**	**223**	**1,785**	**3,686**	**2.18%**	**169,025**
Better Health, LLC	PSN	Broward	13	239	2	58	25	573	**910**	**2.69%**	**33,795**
CMS	PSN	Broward	0	54	8	188	0	14	**264**	**5.44%**	**4,857**
CMS	PSN	Duval	5	71	4	99	1	5	**185**	**6.83%**	**2,708**
First Coast Advantage	PSN	Baker	0	0	0	0	0	1	**1**	**1.45%**	**69**
First Coast Advantage	PSN	Clay	0	0	0	0	0	0	**0**	**0.00%**	**47**
First Coast Advantage	PSN	Duval	21	637	3	141	31	887	**1,720**	**3.45%**	**49,876**
First Coast Advantage	PSN	Nassau	0	0	0	0	1	0	**1**	**1.23%**	**81**
SFCCN	PSN	Broward	17	431	3	67	31	521	**1,070**	**3.00%**	**35,708**
PSN Total	**PSN**		**56**	**1,432**	**20**	**553**	**89**	**2,001**	**4,151**	**3.26%**	**127,141**
Reform Enrollment Totals			**126**	**2,803**	**41**	**769**	**312**	**3,786**	**7,837**	**2.65%**	**296,166**

D. Opt Out Program

Overview

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

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

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

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 the beneficiary contacts the vendor directly. The beneficiary is provided the toll-free number for the Opt Out Program so he or she may follow-up directly with the vendor if preferred. A new Referral form requesting employer information is completed over the phone with an Opt Out specialist or is sent to the beneficiary for completion. A release form is also sent to the beneficiary, giving the vendor permission to contact the employer.

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

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

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

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

Current Activities

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

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

Opt Out Program Statistics

- 86 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 65 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 Five, there are currently 21 individuals enrolled in the Opt Out Program.

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

Table 24 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending December 31, 2010.

Table 24
Opt Out Statistics
September 1, 2006 – December 31, 2010

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

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

E. Enhanced Benefits Account Program

Overview

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

Beneficiaries enrolled in a demonstration health plan may earn up to $125.00 of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (HP Enterprise Services, LLC (HP)) Pharmacy Point of Sale System, currently maintained and managed by the HP subcontractor, Magellan (formally First Health). Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the beneficiary's Medicaid Gold Card or Medicaid Identification Number and a government issued photo ID.

The Agency approves credits for participation of approved healthy behaviors using date of service, eligibility, and approved behavior credits within a database referred to as the Enhanced Benefits Information System (EBIS). All health plans are required to submit monthly reports for their reform members who had paid claims for approved healthy behaviors within the prior month. These reports are uploaded into the EBIS database for processing and approval. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the HP subcontractor, Magellan, to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

During this quarter, the Enhanced Benefits Call Center, managed by the new Choice Counseling Vendor (Automated Health Systems (AHS)), located in Tallahassee, Florida, continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The operation hours are 8:00a.m. – 8:00p.m., Monday – Thursday, 8:00a.m. – 7:00p.m. on Friday, and 9:00a.m. – 1:00p.m on Saturday.

The primary function of the Call Center is to answer all inbound calls relating to program questions, provide Enhanced Benefits Account updates on credits earned/used, and assist beneficiaries with utilizing the web based over-the-counter product list. AHS implemented the Automated Voice Response System (AVRS) on June 18, 2010, for beneficiaries who need account balance information only. The new AVRS is available twenty-four hours per day, seven days per week and continues to be a success.

Table 25 highlights the Enhanced Benefits Call Center activities during this quarter.

Table 25
Highlights of the Enhanced Benefits Call Center Activities
October 1, 2010 – December 31, 2010[6]

Enhanced Benefits Call Center Activity	October	November	December
Calls Received	6,669	5,667	5,949
Calls Answered	6,576	5,610	5,925
Abandonment Rate	1.41%	1.01%	0.40%
Average Talk Time (minutes)	4:22	4:23	4:15
Calls Handled by the AVRS	9,196	8,057	8,318
Outbound Calls	380	376	285
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	7,338	12,088	14,397

2. System Activities

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day of each month. The EBIS continues to operate effectively and efficiently in processing the enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each beneficiary who has activity for the month and a separate statement, sent at least once per year for beneficiaries who have a balance with no new activity.

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

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during this quarter. There were 126,346 coupon statements mailed to beneficiaries during this quarter. Along with the beneficiary coupon statements, a flyer regarding smoking cessation and credit balance access via the AVRS was included with the statement. In December, no statements were generated because of system data issues which resulted in incorrect balance information. The Choice Counselors continue to provide up-to-date information for beneficiaries regarding their Enhanced Benefits Account balances and the opportunity to earn healthy behavior credits. During this quarter, the Choice Counseling Vendor continued to call beneficiaries' who have never utilized their Enhanced Benefits Account balance. The number of outbound calls made during this quarter is listed above in Table 25.

[6] The decrease in call volume during the second quarter of Demonstration Year Five is primarily related to the typical decrease experienced during the holiday season.

4. Outreach and Education for Pharmacies

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

5. Enhanced Benefits Advisory Panel

There was no Enhanced Benefits Advisory Panel meeting this quarter. The next Panel meeting is scheduled for February 11, 2011. The EB charter will be updated to reflect a two-year rotation of member appointments and the addition of an HMO and PSN representative on the Panel.

6. Enhanced Benefits Statistics

As of the end of this quarter, 12,112 beneficiaries lost EBA eligibility for a total of $544,943.59 and they no longer have access to those credits.

Table 26 provides the Enhanced Benefits Account Program statistics for this quarter.

Table 26
Enhanced Benefits Account Program Statistics

Second Quarter Activities – Year Five		October 2010	November 2010	December 2010
I.	Number of plans submitting reports by month in each county[7]	25	26	30
II.	Number of enrollees who received credit for healthy behaviors by month	58,401	35,111	37,216
III.	Total dollar amount credited to accounts by each month	$1,218,307.50	$680,947.50	$721,682.50
IV.	Total cumulative dollar amount credited through the end each month	$34,593,296.16	$35,274,243.66	$35,995,926.16
V.	Total dollar amount of credits used each month by date of service	$705,487.56	$655,995.63	$758,103.67
VI.	Total cumulative dollar amount of credits used through the month by date of service	$17,414,893.16	$18,070,888.79	$18,828,992.46
VII.	Total unduplicated number of enrollees who used credits each month	25,580	24,406	26,873

7. Complaints

A beneficiary can file a complaint about the EBAP through the Call Center and those complaints are documented in the system utilized by the Call Center and reported to the Agency on a weekly basis. The complaints are reviewed and worked by the Agency to resolve the issue the beneficiary is having regarding the program.

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

During this quarter, over 25,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and there was only 1 complaint recorded through the Call Center relating to the EBAP. The decrease in complaints is attributed to improved staff training and direct problem resolution through the Call Center lead and the EB staff person. Table 27 provides a summary of the complaint received during this quarter and outlines the actions taken by the Enhanced Benefits Call Center, the Agency, or HP (through Magellan) to address the issues raised.

Table 27
Enhanced Benefits Beneficiary Complaints
October 1, 2010 – December 31, 2010

Beneficiary Complaint	Action Taken
1. A beneficiary had a problem with the over-the-counter product list and the availability of products at the pharmacy.	➲ The Choice Counselor assisted the beneficiary with the list and contacted the pharmacy.

F. Low Income Pool

Overview

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

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

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

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

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

Current Activities

<u>October 20, 2010, Low Income Pool Council Meeting</u>

On October 20, 2010, a LIP Council meeting was held at the Winnie Palmer Hospital for Women and Children in Orlando, Florida. The Agency provided an update on the status of the pending 1115 Medicaid Reform Wavier Extension Request, and Intergovernmental Transfer (IGT) Panel. The Agency reminded the LIP Council members and those listening in the audience that the waiver extension request is being

reviewed by Federal CMS under Section 1115(a) waiver authority and not 1115(e) waiver authority, as the Agency originally requested. This means that Federal CMS may make changes to the demonstration, such as, amend the current waiver authorities. A clarification and explanation including a timeline of the waiver extension process was provided. The Agency informed the LIP Council of a general discussion with Federal CMS regarding hospital inpatient and outpatient UPL requirements as a starting point for the LIP funding negotiations.

Presentations

- A presentation by the Pinellas County Health Department which highlighted an increase in the number of uninsured individuals being served through a newly established partnership between key community health providers in Pinellas County. Through the partnership, the Pinellas County Health Department, Pinellas County Health and Human Services, Community Health Center of Pinellas, Suncoast Health Council, Bayfront Health System, BayCare Health System, Directions for Mental Health Care, Inc., and Suncoast Center, Inc. Pinellas County Health Department and Community Health Center of Pinellas (a Federally Qualified Health Center) being two of the main primary care providers. These two providers offered hospital services, dental services and social human services outreach among others. The presentation also mentioned Pinellas County was able to save money by incorporating all the services under one roof.
- A presentation by the Citrus County Health Department. Citrus County is one of the oldest counties in the nation with about 145,000 residents residing there. An estimated 34 percent of the population is over the age of 65. 33 percent of adults age 18 to 64 are uninsured with over 50 percent of the children living below the poverty level. The Citrus County presenter explained that the LIP funding received goes towards three Emergency Room (ER) diversion urgent care clinics and also funds the diabetes disease management care program. In SFY 2009-10 alone, over 6,000 clients were served through the LIP program and were provided over 24,000 primary care visits. While working closely with the two hospitals in the community, the clinics was able to use the provided LIP funding to divert unnecessary visits from the ER resulting in a savings of over 3 million dollars to the hospitals. Other programs and services such as orthopedics, chiropractics and a women's health program among others are also provided with the use of LIP funds. The Citrus County Health Department pharmacy fills over 20,000 prescriptions a year and also offers a case manager who helps patients sign up for free medications directly with the drug manufacturers.
- A presentation by the Primary Care Access Network (PCAN) for Orange County. The PCAN program is a system of care for the uninsured and is not an insurance plan. Goals of this program included a medical home for all uninsured people in Orange County and a comprehensive integrated family system of care that has evolved from simply primary care to include urgent care and secondary care. The PCAN program currently serves almost half of the uninsured population of Orange County. The program currently has 10 Federally Qualified Health Centers and 10 urgent care or acute care locations serving over 100,000 patients. The program

reported reducing non-urgent uninsured ER visits from 32 percent down to 25 percent. One clinic has reduced emergency room visits by being open after hours. The PCAN program was recognized by the John Kennedy School of Government at Harvard University. The PCAN program was also one of 16 out of 1,000 applications of the Innovations in Government Award.

Copies of these presentations can be found on the Agency's LIP website at:

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

Primary Care Application Update

The Agency reminded the LIP Council members and those listening in the audience of the LIP Enhanced Primary Care funding application that was posted to the Agency's LIP website in September 2010. LIP Council members were also reminded of the due date for applications, Monday, October 25, 2010. The Agency noted that it intends to award the grants to the selected applications by mid November 2010, and to make payments beginning in December 2010.

Status of Letters of Agreement for SFY 2010-11

The Agency reminded the LIP Council of the FMAP impact for non-executed Letters of Agreement and encouraged the participants to complete and return to the Agency as soon as possible. The Agency noted that every effort was being made to process submitted Letters of Agreement to the Agency.

Model Presentations

Various LIP Council members provided presentations on the LIP models being considered for inclusion in the LIP recommendations due to the Florida Legislature and Governor on February 1, 2011. The LIP models are proposals of how to distribute LIP funds for the upcoming year assuming the 1115 waiver extension request is approved.

November 17, 2010, Low Income Pool Council Meeting

The LIP Council meeting was conducted in Tallahassee, Florida.

Presentation

- A presentation was provided by the Legislative Office of Economic and Demographic Research on Florida's Economic Outlook. The presentation provided an overview of Florida's declining economic growth. The presentation noted the State Gross Domestic Product ranked Florida 48th in the nation in real growth with a decline of -1.6% in 2008 in comparison to being 2nd in the nation in 2005. The presentation also focused on issues such as personal income growth, employment outlook, job market and population growth among others relative to Florida's economy.
- LIP Council members provided presentations on various LIP models under consideration for inclusion in the LIP recommendations due to the Florida Legislature and Governor on February 1, 2011.

- The Department of Health (DOH) gave a presentation on the proposed General Appropriations Act (GAA) proviso language for Primary Care funding initiatives. DOH's presentation allowed the LIP Council to discuss the existing language in the 2010-2011 GAA which related to a three year limitation of funds on Primary Care projects. The LIP Council requested DOH modify the language to allow the successful programs to be funded for more than three years.
- A presentation from the Florida Association of Community Health Centers (CHCs) was made to the LIP Council. The presentation stressed that Florida's Federally Qualified Health Centers (FQHCs) serve as safety-net providers for all Floridians. These CHCs deliver health care services to the state's most vulnerable citizens regardless of their ability to pay. Other key points found within the presentation included service locations, growth data, provided services and other important notations about Florida's CHCs.

Copies of these presentations can be found on the Agency's LIP website at:

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

Updates

- The Agency provided an update to the LIP Council on the 1115 Medicaid Reform Wavier Extension Request. During the most recent conference call with Federal CMS, it was noted that the letter to the Agency requesting additional information on the waiver extension request will be forthcoming. It was also noted that the Agency submitted the required LIP reconciliations for Demonstration Year One and Two on October 31, 2010, as required in revised STC#105(1)(c).

Discussion of Model Parameters

Members of the LIP Council discussed modeling parameters to be included in the next LIP Council meeting. These parameters included General Revenue, Allocation Factor and Exemptions. Also noted was the deadline of November 29, 2010, for the submission of LIP funding distribution model requests to the Agency for the next Council meeting.

December 15, 2010, Low Income Pool Council Meeting

The LIP Council meeting was held at the Winnie Palmer Hospital for Women and Children in Orlando, Florida. LIP Council members provided presentations of the LIP funding distribution models.

Presentations

- A presentation by the Miami-Dade Premium Assistance Program provided an overview of their program. The presentation also included a broad overview of the Miami-Dade Health Insurance Utilization Program. Key points within the presentation included Target Population, Progress, Demographics and Strategic Enhancements of the program.

- A presentation by the Health Care District of Palm Beach County Premium Assistance Program. The presentation included an overview of the Vita Health and Coordinated Care programs.

Copies of these presentations can be found on the Agency's LIP website at:

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

Updates

The Agency updated the LIP Council on the 1115 Wavier Extension Request. In this update, the Agency reminded the LIP Council of the Agency's ongoing discussions with federal CMS. The Agency anticipates receiving a formal set of questions regarding the 1115 Medicaid Reform Wavier Extension request.

The Florida Department of Health presented to the LIP Council an update on the proposed LIP Proviso related to the county health initiatives emphasizing the expansion of primary care services and rural health networks. This update followed a request for modifications to the language from the previous LIP Council meeting. The Council made a motion to approve the new version of the Proviso language for inclusion into the LIP recommendations due to the Florida Legislature and Governor by February 1, 2011.

Presentations

A copy of the Health Intervention with Targeted Services (HITS) Evaluation was provided to the LIP Council. The HITS project is an outreach program of the Memorial Healthcare System (South Broward Taxing District).

Upcoming LIP Council meetings are scheduled for the following dates:
January 19, 2011; January 24, 2011; and January 27, 2011

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

Primary Care Grant

The 2010 Florida Legislature appropriated LIP funds to support projects designed to enhance access to primary care. An amount of $34 million has been appropriated by the Florida Legislature to fund these projects and is based on the September 14, 2010, Legislative Budget Commission budget modifications. Each new project award representing a combined total of state share and federal matching dollars and will be determined via a competitive solicitation that will be based on each applicant's ability to provide Primary Care Access Programs as defined in the SFY 2010-11 GAA.
The maximum awarded per project is anticipated to be $1.5 million. The projects will be selected based on the program's capability to achieve the following program goals:

- Reduce potentially avoidable emergency room visits by developing initiatives to identify persons inappropriately using hospital emergency rooms or other emergency care services and provide care coordination and referral to primary care providers.
- Reduce potentially avoidable hospitalizations for ambulatory care sensitive conditions, which involve admissions that evidence suggests could have been avoided.
- Expansion of primary care infrastructure to provide additional people with a medical home, thereby supporting meaningful emergency room diversion efforts while also improving overall health care in the community.
- Expansion of Primary care through expanded service hours (e.g., evening or weekend hours).
- Initiatives to increase self-management and adherence to treatment plans and self-management goals through the availability of disease management services for persons with ambulatory care sensitive conditions such as diabetes, asthma, hypertension, COPD, and high cholesterol.

Projects will be required to report qualitative and quantitative data relating to the various initiatives. The LIP Primary Care award recipient will also be expected to provide quarterly deliverables that will include financial accounting of how project funds have been expended and progress on implementing all aspects of the applications.

Timeline-Enhanced Primary Care Funding:

September 30, 2010	Project guidelines released and posted
October 25, 2010	Due date for project proposal submission
November 4, 2010	Agency review team begins review
November 18, 2010	Agency review of project proposals complete
November 30, 2010	List of proposed projects for funding submitted to OPB for 3-day consultation
December 9, 2010	OPB submits project funding list for 3-day consultation
December 14, 2010	Consultation period begins
December 17, 2010	Agency submits project list second time for 3-day consultation
December 20, 2010	OPB submits project for funding 3-day consultation
December 23, 2010	Consultation period ends
December 27, 2010	Agency sends out award notices
December 30, 2010	Agency releases Letters of Agreement to local government entities

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

- STC 105 (1)(a) was submitted to Federal CMS on April 30, 2010, and resubmitted to make a grammatical correction on June 14, 2010. The purpose of Amended STC 105 (1)(a) is to provide a review tool and instructions to be used for the reconciliation of the LIP expenditures to allowable provider costs. This milestone was set with a deadline submission of April 30, 2010. The purpose of this document is to meet

Milestone (1)(a) requirements of the terms of the amendment by providing a review tool and instructions to be used for the reconciliation of the LIP payments to provider costs limits.

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

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

- Refugee Eligibles
- Dual Eligibles
- Medically Needy
- Pregnant Women above the TANF eligibility (>27% FPL, SOBRA)
- ICF/DD Eligibles
- 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

Budget Neutrality figures for this quarter are not included in this report. The Agency is currently in the process of compiling the data for the CMS 64 report submission related to the individual waivers. The Agency has submitted the CMS 64 report in total; however, is currently in the process of separating the total expenditures into waivers where needed. The Agency has been in contact with the Federal CMS regarding the delayed 64 report submission related to the individual waivers. It was determined that it would be appropriate to hold this quarter's submission until the Agency has submitted the quarterly CMS 64 report related to the individual waivers. The Agency will continue to communicate with Federal CMS. The Agency will provide the Budget Neutrality submission for two quarters in the submission of the next quarterly report.

Based on the approved Budget Neutrality agreement, substantial savings have accrued since the inception of the demonstration. The Agency has no reason to believe that this quarter would reveal any negative change or impact to the current period within budget neutrality status that has been provided in previous quarters, and anticipates that substantial savings will accrue through the end of the demonstration.

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, Section 409.91211(3)(p), Florida Statutes, requires a risk-adjusted methodology be a component of the rate setting process for capitated payments to the demonstration health plans. Risk adjustment was phased in over a period of three years, using the Medicaid Rx (MedRx) model. The Agency plans to transition to a diagnosis-based model such as the Chronic Illness and Disability Payment System (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 operational activities of the Medicaid Encounter Data System (MEDS).

Current Activities

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

On October 1, 2010, the state notified health plans that the collection of quarterly pharmacy encounter data in a proprietary format for risk-adjusting demonstration health plans' capitation rates, which was needed in prior months, is no longer necessary and has been discontinued. The collection of medical and pharmacy encounter data for all Medicaid-covered services within FMMIS continues as in the past. (Planned uses for these data include, but are not limited to, health plan capitation rate setting, services and utilization analysis, supporting health plan quality and performance metrics, and supporting managed care fraud and abuse prevention and detection.) The National Council for Prescription Drug Programs (NCPDP) pharmacy claims collected as part of the effort above are now used as the basis for the MedRx risk adjustment model. Parallel testing was conducted for twelve (12) months with a risk score variance of less than 1%.

<u>Data Validation</u>

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

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

- Several plans were notified of shortages in their NCPDP pharmacy claims submissions. MEDS personnel assisted these plans in completing their submissions through December 2010 to facilitate the risk adjustment transition to NCPDP data. All plans completed the required submissions by December 31, 2010.
- On December 17, 2010, all plans received a list of their inpatient encounters for service dates beginning July 1, 2008, through November 30, 2010. Each plan was to validate this data and return the results to the Agency by January 25, 2011. Once this data is received, it will be processed and a second file will be sent to the plan for validation. That second validated file will then be used as part of the September 2011 rate setting process.
- All plans are now receiving monthly provider reports showing all providers associated with their plan who are currently registered with Florida Medicaid. All plans are then responsible for identifying missing providers and registering them.

The following are the highlights for this quarter:

- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans (i.e., MEDS and NCPDP Companion Guides, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions).
- Provided outreach and technical assistance to health plans to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Provided encounter data updates to Federal CMS as part of the monthly 1115 Reform Waiver conference call.
- Continued performing the encounter data analytic validation procedures.
- Continued planning of provider mass enrollment effort.
- Completed comparison and parallel testing using NCPDP and proprietary data in the MedRx model.
- Worked with Medicaid Program Integrity unit to begin identifying ways to use encounter data to assist in Medicaid fraud and abuse investigations.

Quarterly Pharmacy Encounter Data Collection for Risk Adjustment

To comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed to calculate individual risk scores for both the Medicaid fee-for-service and managed care populations. Using the MedRx model, the health plans were assigned plan risk factors for both TANF and SSI based on the aggregate risk scores of their enrolled populations in those categories under the demonstration.

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

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting demonstration capitation rates was April 1, 2009, through March 31, 2010, paid through June 30, 2010. This measurement period was used to generate risk-adjustment factors for the health plans operating in the five demonstration counties.

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

- Continued to collect and process NCPDP pharmacy encounter data and in proprietary format on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated, and any significant changes from the previous quarter's submission are reported to the health plans for corrective action, if necessary.
- Provided MEDS NCPDP-format pharmacy data for the April 1, 2009, through March 31, 2010, measurement period to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use. Completed parallel testing and comparison between the two data sources. This parallel testing showed less than a 1% discrepancy. The Agency will begin using NCPDP pharmacy claims as the basis for the MedRx risk scores beginning with the next 12-month measurement period (July 1, 2009 through June 30, 2010).
- For this period, risk adjustment plan factors were calculated for the following health plans:

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

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1-year-old' population, or specialty plans/populations such as HIV/AIDS and Childrens Medical Services (CMS). Plans such as Positive Health Care, an HIV/AIDS specialty plan, and CMS are included here only because they have additional enrollment outside the HIV/AIDS population (Positive Health Care) and outside the under 1-year-old (CMS – kids) population.

- Enrollment in the demonstration counties this quarter for the month of December 2010 for risk adjustment purposes totaled 245,963 and was distributed as follows:

September 2010	Broward	Duval, Baker, Clay, and Nassau
Children & Families	117,121	99,232
SSI	16,549	13,061
Totals	**133,670**	**112,293**

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

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

I. Demonstration Goals

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

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

The Agency currently has contracts with 7 HMOs and 3 PSNs for a total of 10 health plans in Broward County; 3 HMOs and 2 PSNs for at total of 5 health plans in Duval County; and 2 HMOs and 1 PSN for at total of 3 health plans in Baker, Clay, and Nassau Counties.

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 23 applicants sought and received approval to provide services to the TANF and SSI population. The application of Preferred Care Partners d/b/a CareFlorida was approved this quarter and a contract was executed for this HMO to begin providing services next quarter. There are no pending applications.

During this quarter, the Agency processed a request from First Coast Advantage (PSN) to expand into Baker, Clay, and Nassau Counties. First Coast Advantage was approved to expand into these counties with an effective date of December 1, 2010.

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

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

Access to Services Not Previously Covered

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

- Over-the-counter drug benefit $25 per household, per month;
- Adult Preventive Dental;

- Circumcisions for male newborns;
- Adult Vision Services; and
- Respite Care.

For Demonstration Year Five, the Agency approved 21 benefit packages for the HMOs and 13 benefit packages for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of January 1, 2010, to August 31, 2010, for eight HMOs and four PSNs.

Improving Access to Specialists

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

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

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

Also in October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 28 shows the results of these analyses.

Table 28
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

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

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

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

During the second half of Demonstration Year Two and in Demonstration Year Three (March 2008 through March 2009), the Agency conducted 11 monthly surveys. These surveys included both a sample of 300 providers across the state, 15 from each health plan, and a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist). Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the

survey, not just those who were surveyed and failed to confirm participation with a plan. The results of these surveys are provided in Table 29.

Table 29
Results of Provider Network Validation Surveys
March 2008 through March 2009

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

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

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

Table 30
Results of Provider Network Validation Surveys
July 2009 through May 2010

Survey Month/Year	Statewide Accuracy Rate
July 2009	95%
October 2009	98.4%
January 2010	96.6%
May 2010	97.4%

During this quarter, Agency staff finished the May survey follow-up and analysis. A total of 720 providers were sampled from the provider network files and 97.4% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. Beginning in October 2010, Agency staff conducted the first semi-annual survey.

Agency staff will prepare for the next semi-annual survey during the third quarter of Demonstration Year Five, which will be fielded in April 2011. The October survey follow-up and analysis will be completed as well.

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

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

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

During this quarter, the Agency continued work developing an enhanced auto-assignment methodology to reward higher performing health plans. The Agency held a workshop with health plans on December 1, 2010, to review a draft proposal for a scoring methodology that incorporated both HEDIS performance measures and other performance metrics to be used in order to rank health plans for assignments. The health plans expressed thoughts on the proposal and will send formal, written recommendations to the Agency in January 2011.

The Agency finalized changes to the list of required performance measures and made minor modifications to the specifications for the Agency-defined measures in response to questions posed during the 2010 measure collection and reporting cycle. The revised list and measures may be viewed on the Agency's Quality in Managed Care web page at: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Health plans submitted their Performance Measure Action Plan reports to the Agency in response to identified improvement opportunities in their 2010 performance measure reports. The most common improvement strategies proposed by health plans focused on identification of non-compliant enrollees and coordination with the primary care physician to encourage necessary care. Other proposed interventions focused on removing barriers to accessing care, such as facilitating transportation and recruiting additional providers. Health plans are also promoting the Enhanced Benefits Rewards program with a special focus on services that are a performance measure, such as mammograms.

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

The Agency is currently analyzing encounter data to measure reduction of ambulatory sensitive hospitalizations according to the conditions proposed by the Agency for Healthcare Research and Quality. Completion of the analysis is pending the results of the encounter data completeness study.

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

The Agency is preparing an analysis of emergency room utilization in the encounter data. Similar to the ambulatory sensitive hospitalization project, this analysis is pending the results of the encounter data completeness study.

In addition, the Agency is working with the state's contracted External Quality Review Organization, Health Services Advisory Group, regarding a collaborative project with health plans on reduction of emergency department visits. HSAG will determine the feasibility of using encounter data to support this project which may be augmented with claims data from the plans.

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

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

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

(1) elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer-sponsored insurance, and
(2) primary care physician was not enrolled with a Medicaid Reform health plan

The individuals who decided not to opt out:

(1) were not employed,
(2) did not have access to employer sponsored insurance, or
(3) after hearing about opt out decided to remain with their Medicaid Reform health plan where there were not co-pays and deductibles.

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

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

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

The Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey, Volume 1, has been posted on the Agency's website at the link below. The results of past reports and all other evaluation reports conducted by UF can also be viewed at this link.

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

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

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

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

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

As required under STC #102 in Demonstration Year Two, the State conducted a study of the cost-effectiveness of the various PASs (hospital and non-hospital providers). The State has contracted with the University of Florida (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.

Special Term and Condition #102, Demonstration Year Two Milestones, states that, "the State will conduct a study to evaluate the cost effectiveness of various provider access systems." This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost effectiveness study to the Agency by the third quarter of Demonstration Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the PASs. 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 PASs completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Demonstration Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PASs with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

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

- Specialty Encounters
- Care Coordination Encounters

The PASs 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, Intergovernmental Transfers (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 PASs. This document includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost-effectiveness study (STC #102).

On June 30, 2008, in accordance with STC #102 of Florida's 1115 Medicaid Reform Waiver, the Agency submitted a letter to 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 accordance STC #23, paragraph three, we are submitting the following information for provider qualitative and quantitative data which describes the impact the Low Income Pool:

> "The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30

days of receipt of comments from CMS, a final annual report shall be submitted to CMS.

Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.

Beginning with the annual report for demonstration year four, the State must include a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the demonstration."

The Agency received the "*Evaluation of the Low-Income Pool Program Using Milestone Data: SFY 2008-09*" provided by the University of Florida last quarter. The report can be found on the Agency's Low Income Pool website at:

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

This report provided several key findings for SFY 2008-09:

- A total of 221 PAS in Florida received LIP funding – 162 hospitals and 59 non – hospital providers.
- Total LIP funding for SFY 2008-09 was approximately $876.3 million.
- Reporting hospitals receiving LIP Payments served a total of approximately 3.4 million Medicaid, uninsured, and underinsured individuals.
- Reporting non hospital providers receiving LIP payments served a total of approximately 692,000 Medicaid, uninsured, and underinsured individuals.
- On average, hospitals received $167 in LIP payments for each Medicaid, uninsured, and underinsured individual served.
- On average, non hospital providers received $73 in LIP payments for each Medicaid, uninsured, and underinsured individual served.
- LIP payments supported a variety of Florida Department of Health Emergency Room Alternative projects.

The UF report also included key findings comparing SFYs 2005-06, 2006-07, 2007-08, and 2008-09:

- The number of hospitals receiving LIP funding increased in comparison to those receiving funding from the SMP program: 87 hospitals received Special Medicaid Payments (SMP) funding in SFY 2005-06, with 163, 160, and 162 hospitals receiving LIP funding in SFY 2006-07, 2007-08, and 2008-09, respectively.

- Non-hospital providers began receiving funding under the LIP program: 43 and 44 non-hospital providers received LIP payments in SFY 2006-07 and SFY 2007-08, respectively, increasing to 59 non-hospital providers receiving LIP payments in SFY 2008-09.
- Total funding increased under the LIP program in comparison to the SMP program: total SMP payments were approximately $666.9 million in SFY 2005-06, with total LIP payments being approximately $998.7 million in SFY 2006-07, approximately $1.0 billion in SFY 2007-08, and approximately $876.3 million in SFY 2008-09.
- When adjusted for inflation (2005=100), total SMP payments were approximately $666.9 million, with total LIP payments being approximately $967.2 million in SFY 2006-07, approximately $941.7 million in SFY 2007-08, and approximately $807.8 million in SFY 2008-09.
- Hospitals receiving LIP payments served an estimated total of approximately 3.6 – 3.8 million Medicaid, uninsured, and underinsured individuals in each of the first three years of Medicaid Reform.
- Non-hospital providers receiving LIP payments served an estimated total of approximately 800,000 – 1 million Medicaid, uninsured, and underinsured individuals in the first three years of Medicaid reform.
- For hospitals, the average (SMP or) LIP payment received for each Medicaid, uninsured, and underinsured individual served declined during Medicaid Reform in comparison to the year prior to Medicaid Reform: in nominal terms, $ per individual was $267 in SFY 2005-06, $176 in SFY 2006-07, $166 in SFY 2007-08, and $167 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $267 in SFY 2005-06, $171 in SFY 2006-07, $156 in SFY 2007-08, and $154 in SFY 2008-09.
- For non-hospital providers, the average LIP payment for each Medicaid, uninsured, and uninsured individual served declined between SFY 2006-07 (first year in which non-hospital providers received funding) and SFY 2008-09: in nominal terms, $ per individual was $102 in SFY 2006-07, $91 in SFY 2007-08, and $73 in SFY 2008-09; adjusted for inflation (2005=100), $ per individual was $98 in SFY 2006-07, $85 in SFY 2007-08, and $67 in SFY 2008-09.
- Results based on individuals served must be used with caution given that they are based only on data for hospitals and non-hospital providers that reported milestone data in a given year. The percentage of providers receiving payments that reported milestone data varied across years from 84 – 96% for hospitals and from 63 – 89% for non-hospital providers. Particularly in years with a low reporting percentage, results might demonstrate a different pattern if all providers had reported milestone data.

Current Activities

During the second quarter of Demonstration Year Five, the Agency collected the SFY 2009-10 Milestone data for further research and evaluation of the LIP. This information will be shared with the LIP evaluation team at the University of Florida during the third quarter of Demonstration Year Five.

J. Evaluation of Medicaid Reform

Overview

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

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

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

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

3. Independent Evaluation by the University of Florida

UF continues to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency.

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

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

These semi-annual administrative reports provide summary and status information about the MRE. Progress is reported for all associated tasks identified in the work plan categorized by major evaluation subprojects. During this quarter, one progress report (January – June 2010) was finalized. This progress report is available on the Agency's website at:

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

The Agency is also reviewing the July – December 2010 draft progress report.

University of Florida – Mental Health Analysis

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

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

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

Objective 1: This report, *Enrollee Experiences with Mental Health and Substance Abuse Counseling Services,* is complete and can be found on the Agency's website at:

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

Objective 2: The final report for Objective 2, *Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services – The Effect of Medicaid Reform on Baker Act and Criminal Justice Encounters,* is at the UF undergoing final revisions.

Objective 3: This report is being reviewed by the Agency. UF and the Agency are working through methodological issues. A date for this delieverable has not been established.

University of Florida – Fiscal Analysis

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

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

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

University of Florida – Low Income Pool (LIP)

In July 2006, the State of Florida introduced broad-ranging reform of the Florida Medicaid Program, with the establishment of the Low Income Pool (LIP) Program being one of several components of the demonstration. The LIP consists of a capped annual allotment of $1 billion (the "pool"), with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.[8] The conditions of the LIP are discussed in the Special Terms and Conditions (STCs) of the waiver, as approved by the Centers for Medicare and Medicaid Services (Federal CMS).[9]

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

During this quarter, the *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2006-2007 Florida Hospital Uniform Reporting System (FHURS) Data* and the *Medicaid Reform Evaluation of the Low-Income Pool Using Milestone Data: SFY 2008-2009* were made available on the Agency's website at:

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

University of Florida – Organizational Analyses

The University of Florida is producing an ongoing series of reports that summarize organizational aspects of Florida's Medicaid Reform Pilot. Through a combination of qualitative and quantitative study designs, these reports address a broad range of structural and policy issues raised by the demonstration process. Data are collected from Agency sources and from informant interviews. The report, *Medicaid Reform Organizational Analyses: April 2009 – March 2010,* is in its final review stages. It is anticipated that a final version of the report will be available during the third quarter of Demonstration Year Five.

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

Other Organizational Analyses are available on the Agency's website in the "Other Evaluation Reports" section at:

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

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, medical associations, other health professional groups, advocacy organizations, legislative leadership, or other entities. A list of the FAC members and their demographic information can be found on the Agency's website at:

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

There was no FAC meeting held during this quarter.

Technical Advisory Committee

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

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

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

In addition to the TAC representatives, all project areas of the evaluation are represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focuses on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

K. Policy and Administrative Issues

Current Activities

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

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

- Technical Advisory Panel regular meetings;
- Policy Transmittals and Dear Provider Letters and E-mails;
- Health Plan Technical and Operational Conference Calls;
- PSN Systems Implementation Monthly Conference Calls; and
- General Amendment/Contract Overview Calls.

These forums continue to provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement. In conference call forums, the focus during this quarter has been on operational updates and information exchange.

Medicaid Reform Technical Advisory Panel

The Technical Advisory Panel (TAP) was created by the 2005 Florida Legislature, and appointed by the Agency with the directive of advising the Agency on various implementation issues relative to the demonstration. The seven-member TAP held two meetings this quarter: one in-person meeting in October and one teleconference meeting in December. The following topics were discussed:

- Choice Counseling update, including reports on call center statistics, and an update on the Enhanced Benefits Account Program;
- Medicaid encounter data collection, including a review of validation results, discussion on a draft report received from Mercer regarding data validation, continued monitoring of encounters submitted and using encounter data as base data for rates, for risk-adjusted rate application and for trend development, and transition to National Council for Prescription Drug Programs (NCPDP) data for risk adjustment;
- Health plan capitation rate setting and September 2010 rates summary, including discussion on a 2011 timeline, data sources used, reporting templates, discussion regarding intergovernmental transfers (IGTs) and notice that the Agency was continuing to accept comments regarding rate setting;

- Changes to the Florida Medicaid pharmacy program due to rebate changes required by section 2501 of the Affordable Care Act;
- University of Florida Medicaid Reform evaluations, including discussion on the Consumer Assessment of Health Care Providers and Systems (CAHPS) enrollment satisfaction survey, potential for survey on the Enhanced Benefits program and a clinical effectiveness study; and
- Status on the 1115 waiver extension request and next steps.

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

Policy Transmittals and Dear Provider Letters

During this quarter, there was one policy transmittal and three Dear Provider letters released to the health plans. The policy transmittal provided formal notice to the FFS PSNs regarding conversion to capitation by June 30, 2013, and first fully capitated services beginning September 1, 2013. The Dear Provider letters covered the new annual fraud, abuse and overpayment reporting required by Section 409.91212, F.S.; notice of a change in the submission site for provider network files; and notice to the plans on the Agency's use of NCPDP pharmacy claims as the basis for calculating risk scores and risk-adjusted rates and deadlines for submission of any encounters for the March 1, 2009, through April 30, 2010, study period.

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

- Final September 2011- August 2012 capitation rates and Plan Evaluation Tool submission instructions for 2010-11 benefit changes effective January 1, 2011;
- Instructions on how to correctly submit encounter data for vaccines;
- Notice of capitation rates reprocessing;
- Availability of FFS PSN reconciliation data CDs;
- Notice to FFS PSNs that the Agency would allow them to capitate for behavioral health services on an individual plan basis;
- Changes in Medicaid physician and practitioner fee schedules;
- General information on the National Correct Coding Initiative;
- Clarification of submission instructions for kick payment claims; and
- Notices of changes to the 2009-2012 Medicaid Health Plan Contract Report Guide, effective January 1, 2011, and April 1, 2011, respectively.

Technical and Operational Issues Conference Calls

During this quarter, the Agency conducted three monthly Technical and Operational Issues Conference Calls with health plans and health plan applicants. The purpose of these calls is to communicate the Agency's response to issues addressed at a higher level in the TAP meetings and to respond to plan questions posed through e-mail,

telephone inquiries, and previous technical calls. Previously these calls occurred biweekly, but with Reform being fully operational, the need for biweekly calls had significantly lessened. As discussed with the health plans in June 2010, a decision was made to change to monthly calls beginning in July 2010. Unless a particular need arises for calls to occur more often, the technical and operations calls are now monthly.

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

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

- Several data/systems updates regarding the following:
    - Choice counseling initiatives/changes,
    - Encounter data submissions,
    - Capitation rate reprocessing,
    - Pharmacy rebate program changes,
    - Outstanding fiscal agent systems change requests,
    - National Provider Identifier registration requirements, and
    - The National Correct Coding Initiative;
- Review of changes in performance measure requirements;
- Reminder of in-person external quality review organization meeting;
- Review of Medicaid therapy services coverage and limitations handbook requirements;
- Update on Medicaid Program Integrity activities and reporting changes, including announcement regarding revising a current Excel quarterly fraud and abuse report to an online report.
- Health Plan Report Guide revisions.

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

Fee-for-Service PSN Systems Implementation Issues Calls

The purpose of these calls is to provide a forum to discuss claims processes and enrollment file issues that are unique to the FFS PSN model. The PSNs are encouraged to submit questions and/or issues in advance in order for systems research

to occur internally at the Agency (or between the Agency and the Agency's Medicaid fiscal agent). Agency participants included management and key technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Bureau of Contract Management, Area Office staff, and Bureau of Managed Health Care staff responsible for monitoring the health plans. PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs' contracted TPAs. Unresolved issues include those that are in the systems change queue for implementation and anecdotal issues pending examples to be submitted from PSNs for Agency research.

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

- Medicaid fiscal agent transition issues relative to PSN enrollment and claims processing;
- Revisions requested by the PSNs in terms of the electronic remittance advice that they receive, and
- Claims systems changes in the queue until their priority status for systems change reaches a higher priority level, including items related to Medicare crossover claims and chiropractic claims, and manual workarounds until such changes are made.

In addition to these calls, the Agency continued to coordinate technical assistance between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, it has been needed only occasionally. Modification of the current claims process (to streamline the claims processing function) for FFS PSNs remains under consideration.

General Amendment/Contract Overview Calls

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

L. Waiver Extension Request

Legislative Direction

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

Development of Waiver Extension Request

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

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

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

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

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

Submission of the Waiver Extension Request

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

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

Request for Additional Information

On December 16, 2010, the Agency received a letter from Federal CMS requesting additional information on Florida's 1115 waiver extension request. Please click on the link above to view this letter. The Agency is working to respond to Federal CMS's request and will post the Agency's response on the Agency's website when completed.

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

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

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues October 1, 2010 – December 31, 2010	
PSN Informal Issue	**Action Taken**
1. A provider reported to the Agency that the PSN was repeatedly denying claims and had not paid the provider's claims since the provider joined the PSN network.	➲ Agency staff researched this issue with the provider and the PSN and found that the claims were denied due to the provider using invalid and inaccurate NPI and taxonomy numbers. Agency staff educated the provider on requirements regarding NPI and taxonomy numbers and the provider and PSN updated their systems for processing the claims. The claims were reprocessed for payment.
2. A provider reported to the Agency that the PSN had not paid 10 claims that she had submitted.	➲ Agency staff researched the 10 claims and gave the provider information on why each of the 10 claims had denied. The provider made the needed changes to the claims and resubmitted them for payment.
3. A provider reported to the Agency that they had received numerous claim denials. The provider reported having tried to work it out with the PSN but that no resolution had been reached.	➲ The PSN's subcontractor reported to the Agency that they have corrected information in their system and have reprocessed and paid the provider's claims.
4. A provider reported to the Agency that they have outstanding claims payments with the PSN.	➲ Agency staff spoke with the provider and determined that the provider's claims issues are related to NPI and taxonomy numbers. Agency staff worked with the provider's office and the Agency's fiscal agent representative to correct the provider's claim submissions so that their claims may be reprocessed and paid.
5. A PSN member reported to the Agency that the PSN was unable to give her good referrals to two specialists.	➲ The PSN contact reported to the Agency that authorization for the member to see a specialist had been issued previously but that the member was not aware of it until PSN staff notified her. A second specialist referral will not be needed until after the member sees the first specialist. The member is satisfied.
6. A PSN member's parent reported to the Agency that the member's plan would not previously approve a service for the member, and is now saying that the member is too old to be approved for the services.	➲ The PSN contact reported to the Agency that the member's parent was advised to have the PCP request the procedure again and the PSN would review and make a decision. The PSN's medical director confirmed that the plan will authorize the procedure. The PSN notified the parent and the parent is satisfied.

PSN Complaints/ Issues October 1, 2010 – December 31, 2010	
PSN Informal Issue	**Action Taken**
7. A PSN member reported to the Agency that she cannot get dentures completed because the PSN's dental subcontractor has not approved the final step in the process.	➲ The PSN contact reported to the Agency that PSN staff notified the provider of the PSN's authorization and approval for the procedure but the provider did not want to proceed without having the actual authorization documents. The PSN's dental subcontractor furnished the provider with the authorization documentation and the provider completed work on the dentures. The member is satisfied.
8. A PSN member's parent reported to the Agency that she would like the PSN to approve a surgical procedure on the member that is not a covered Medicaid service but which the plan will cover up to three months after birth.	➲ The PSN contact reported to the Agency that once the PSN receives a prior authorization request from the member's PCP, stating the medical necessity of the procedure, it will be approved. The PSN member understands the plan's policy and scheduled an appointment with the member's PCP.
9. An attorney reported to the Agency that a PSN member's parent is being balance-billed by the member's PCP for services provided before the member was assigned to the PCP. The PSN has denied claims submitted by the provider for those services.	➲ The PSN contact reported to the Agency that the current PCP agreed to accept capitation payment for the member for the month when services were provided before the member was assigned to the PCP. The provider has agreed to cease attempting to collect from the member's parent. PSN staff notified the parent and the parent is satisfied.
10. A PSN member's son reported to the Agency that the member is being balance-billed by a provider for services which the PSN authorized. The PSN is denying the provider claims.	➲ The PSN contact reported to the Agency that the PSN had not denied the claims because the provider failed to submit the claims. A follow-up claims for a later visit to the provider had been paid. PSN staff contacted the provider, who will submit the claim for payment and stop billing the member.
11. A PSN member reported to the Agency that she needs a follow-up visit with a specialist but the PSN denied authorization because the specialist is not in its network. The member stated that the PSN does not have a specialist of this type in its network.	➲ The PSN contact reported that a plan case manager spoke with the member to obtain the information needed to approve the authorization so that the member may see the specialist for follow-up. The member also advised the case manager of an unrelated health issue and the case manager will work with the member to get any medically necessary treatment from a network provider.
12. A PSN member reported to the Agency that the PSN was unable to provide a specialist referral so that she can be treated for an acute condition.	➲ The PSN contact reported that a plan case manager contacted the member and assessed her needs. The member was given a referral to an appropriate specialist and was seen by the specialist.
13. A PSN member reported to the Agency that the PSN denied outpatient medical tests that she needs to be performed and that her doctor has ordered.	➲ The PSN contact reported to the Agency that the PSN medical director counseled the member's doctor, who agreed to complete less invasive tests prior to ordering more invasive procedures. The member's doctor notified the member of this.

PSN Complaints/ Issues October 1, 2010 – December 31, 2010	
PSN Informal Issue	**Action Taken**
14. A PSN member reported to the Agency that the PSN will not authorize additional treatments that she needs.	➲ The PSN contact reported to the Agency that the member has Medicare, so the provider must bill that insurance first, which is why claims have been denied. PSN staff contacted the provider, who was unaware that the member had Medicare coverage. The provider will bill Medicare as the primary insurance and the PSN will review crossover claims to see if any additional payments are required. The provider notified the member and both are satisfied.
15. A PSN member reported to the Agency that the PSN will not authorize an MRI requested by his PCP.	➲ The PSN contact reported that it had already approved the authorization and contacted the PCP's office to confirm that they received the authorization. The provider scheduled the MRI for the member and notified him.
16. A PSN member reported to the Agency that the PSN has been unable to provide her with a good referral for specialist care.	➲ The PSN contact reported to the Agency that the PSN authorized four visits to a non-network specialist that the member asked to see. The member is satisfied.
17. A PSN member's parent reported to the Agency that the PSN has been unable to provide a referral to the type of specialist the member needs.	➲ The PSN contact reported to the Agency that the parent wanted to take the member to a specific facility but there were no appointments available until the next week. The member's parent then called a specialist who said he was not taking new patients. The PSN representative spoke with that specialist and the specialist agreed to see the member. The PSN will help set up an appointment for the member. The member's parent is satisfied.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
1. A provider reported to the Agency that he is very dissatisfied working with the HMO's dental subcontractor.	➲ Agency staff asked the provider to send them an email including specific complaints but the provider has not done so yet. Agency staff have sent the dental subcontractor's provider handbooks for references on grievance and appeal processes to the provider. Agency staff also contacted the dental subcontractor and asked them to have a provider representative contact the provider and work with him.
2. An HMO member reported to the Agency that her entire family was enrolled in the HMO in error and wanted to be disenrolled so that she will not be liable for unpaid claims to a non-participating provider.	➲ Agency staff confirmed with Choice Counseling that the member had been notified in advance that her family would be enrolled in the HMO. The HMO reported to the Agency that it would not pay claims for the non-participating provider but arranged for the family to see participating providers as needed. The family is satisfied with the outcome.
3. An HMO member reported to the Agency that she was put in collections because the HMO had not paid an inpatient claim.	➲ The HMO contact reported to the Agency that the plan reviewed the claim and that it will be reprocessed and paid.
4. An HMO member reported to the Agency that she was being balance-billed for a lab work claim not paid by her previous plan.	➲ The HMO contact reported to the Agency that the member's primary care provider (PCP) sent lab work to a non-participating lab, which is why the claim was not paid. The HMO has authorized payment to the non-participating lab to resolve the issue. The member has been notified.
5. A provider reported to the Agency that the HMO did not pay a claim during a month in which the HMO received capitation for the member.	➲ The HMO contact reported to the Agency that the HMO denied the claim and that they will contact the provider to explain why the claim was denied.
6. A provider reported to the Agency that the HMO denied payment for a claim and that she needed additional information from the HMO in order to be able to bill the service as fee-for-service.	➲ An HMO contact reported to the Agency that the claim was denied in error—there had been a data entry error for the authorization at the HMO. The claim has been reprocessed and will be paid. The provider is satisfied with the outcome.
7. An HMO member's parent reported to the Agency that she was being balance-billed by a provider for services to the member. The HMO denied the claims because the provider is not in its network.	➲ The HMO contact reported that HMO staff had contacted the provider and asked the provider to submit the claims for review. The HMO paid the claims.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
8. A provider reported to the Agency that claims were denied because the HMO stated the member was not active on the dates of service.	➲ Agency staff verified in FMMIS that the member was active on the dates of service and forwarded this information to the HMO. The HMO contact reported to the Agency that its member files were updated and that the claims were paid.
9. An HMO member reported to the Agency that the HMO is assigning her to PCPs who do not really want to help her and will not give her refills for pain medications.	➲ The HMO contact reported to the Agency that the member told HMO staff that her specialist will no longer provide her with prescriptions for pain medication so she needs a PCP who will. HMO staff advised the member to establish herself with the PCP that the HMO has arranged for her so that he may evaluate her medical needs and refer her to pain management if needed. The member continues to see her specialist for a chronic condition, which is well managed.
10. An HMO member's mother reported to the Agency that the HMO has not provided a needed specialist referral.	➲ The HMO contact reported to the Agency that the mother had identified a network specialist but was unhappy with the glasses frames that was available at no charge to the member. The HMO advised the mother that she could choose other frames instead if she was willing to pay for them, the member's mother stated that she would do so.
11. An HMO member reported to the Agency that the HMO was unable to provide her with an urgent referral to a specialist.	➲ The HMO contact reported to the Agency that they arranged an appointment for the member with a specialist but the member refused it. The HMO contact reported that the member wants to go to a pain management clinic that is non-participating with the plan. An HMO case manager discussed the situation with the member and made an appointment with another specialist whom the member agreed to see. The member is satisfied.
12. A provider reported to the Agency that the HMO's dental subcontractor had not authorized services urgently needed by a member.	➲ The HMO contact reported to the Agency that the dental subcontractor had requested an X-ray from the member's regular dentist, which had not been submitted so the subcontractor could not authorize the services. The dental subcontractor contacted the member's regular dentist again and the X-ray was submitted. The subcontractor approved the requested services and instructed the oral surgeon to proceed with the procedure.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
13. An HMO member's daughter reported to the Agency that she wants a fair hearing because the HMO has reduced home health services since the member went into the HMO.	➲ The HMO contact reported to the Agency that the HMO evaluated the member after she joined the plan and that this was furnished to the PCP. To date the PCP had not put in a request for home health services. HMO staff advised the daughter to discuss the situation with the member's PCP. The HMO did another evaluation of the member and authorized skilled nursing and physical therapy services as well as providing the daughter with community resource information. The member's daughter contacted the Agency again and expressed still being dissatisfied with the amount of services and requested a fair hearing. The request was processed and the hearing is pending.
14. A school representative reported to the Agency that an HMO member needed diabetic medications.	➲ The HMO contact reported to the Agency that they spoke with the school representative and advised her that they cannot discuss the member's health information with her without a signed release from the member's parent. HMO staff spoke with their subcontractor regarding providing insulin pump supplies to the member and those supplies were delivered to the member. An HMO case manager will continue to communicate with the member's father.
15. An HMO member reported to the Agency that the HMO is unable to provide him with necessary medication or appropriate referrals.	➲ The HMO contact sent extensive case notes to Agency staff and reported that the member has been provided with many of the medications that he claimed not to have received. The member has refused to go into rehabilitation as recommended by his previous PCP, who asked the member to leave his office after becoming verbally abusive. An HMO case manager counseled the member and arranged for a new PCP whom the member agreed to see.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
16. An HMO member reported to the Agency that she received an outstanding hospital bill for when her son was born prematurely out of the service area. The member said the HMO is denying the claim because the mother did not receive prior authorization.	➲ The HMO contact reported to the Agency that the claim from the provider did not bill the service as an admission through the emergency room. The claim indicated that it was a newborn admit and there were no ER charges to support paying the claim without an authorization. Plan staff checked and no authorization request had been submitted and the provider did not request an appeal. The HMO asked the provider to send all the records and information on the member to them so that they may review. After reviewing the records, the HMO approved payment in full and notified the provider.
17. An HMO member's parent reported to the Agency that she is being balance-billed by a non-participating provider who has seen the member after birth.	➲ The HMO contact reported to the Agency that they have contacted the provider and agreed to pay the claims. The HMO has contacted the parent and will assist her in finding a network provider to see the member. All parties are satisfied with the outcome.
18. An HMO member's parent reported to the Agency that she was being balance-billed by a non-network provider because the HMO denied the claims.	➲ The HMO contact reported to the Agency that the claims were received from the provider and were being processed for payment.
19. An HMO member reported to the Agency that the HMO cannot give her a specialist referral that is convenient to her home.	➲ The HMO contact reported to the Agency that it negotiated an agreement with the member's previous specialist, who is not in the plan network. The HMO notified the member and she is satisfied.
20. A specialty provider reported to the Agency that an HMO member has an upcoming appointment but that the clinic does not participate in the member's HMO network.	➲ The HMO contact reported to the Agency that numerous attempts were made to contact the member but he had not responded to messages. The specialty provider reported that the member initiated the appointment and has not been seen at the clinic previously. An HMO representative was finally able to reach the member and an HMO case manager was assigned to the member, who will help the member with his pain management needs. The member agreed to see a network provider and has been referred to a pain management specialist.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
21. An HMO member's mother reported to the Agency that the member needs a referral to a non-participating specialist out-of-area because this is the only provider who can do a necessary procedure.	➲ The HMO contact reported to the Agency that they had referred the member to a specialist and that the member's mother said that this specialist was unacceptable. The HMO contact said that the medical information submitted by the member does not indicate that the procedure needed is beyond the scope of the assigned specialist. The member saw the assigned specialist and had the necessary testing and a follow-up appointment. The HMO case manager explained to the member's mother that if the specialist recommends an out-of-network referral for the procedure, it will be considered. The member's mother now understands the process.
22. An HMO member reported to the Agency that she was having difficulty getting approval for health services and would like to change to another health plan.	➲ Agency staff updated the system and changed the member to the health plan that she requested.
23. An HMO member reported to the Agency that he needed a medication that the HMO denied.	➲ The HMO contact reported to the Agency that after researching this case with the member's previous physician, it authorized the medication for the member for one year.
24. An HMO member reported to the Agency that she wants to have a procedure in a non-participating facility in Miami but that the HMO wants her to have the procedure done in a participating facility nearer to the member's home.	➲ The HMO contact reported to the Agency that the requested procedure must be done in a hospital setting because the member has some allergies. The HMO assigned a case manager to coordinate the member's care with in-network specialties and facilities. The member had never requested the non-participating provider and the HMO reported that it has many specialists who handle the member's health issues. Agency staff advised the member to continue working with the HMO case manager to access services.
25. An HMO member's mother reported to the Agency that the HMO will not authorize dental treatments for the member because it is not a covered service.	➲ The HMO contact reported to the Agency that its dental subcontractor had requested all of the member's dental records to determine if the requested services are necessary and covered. The HMO reported to the Agency that the services are covered and contacted the member's mother to set up an appointment. The requested services were provided.
26. An HMO member's parent reported to the Agency that the HMO will not authorize a prescription for a special baby formula.	➲ The HMO contact reported to the Agency that the prescription for the special formula was received but it did not specify the amount needed. HMO staff worked with the mother and provider to ensure that the formula was approved.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
27. An HMO member reported to the Agency that the HMO would not authorize a necessary medication.	➲ The HMO contact reported to the Agency that they contacted the member's PCP, who stated that he had not requested additional prescriptions for the member at this time. All of the member's regular medications were authorized and ready to be picked up at the pharmacy. HMO staff notified the member.
28. An HMO member reported to the Agency that the HMO will not authorize a procedure or necessary medications.	➲ The HMO contact reported that they are working with the pain management provider who ordered the procedure to determine medical necessity. The provider did not feel that the procedure requested by the member was necessary at this time. The HMO referred the member for a physical therapy evaluation and assisted the member to complete the evaluation so that a plan of care may be determined.
29. An HMO member's parent reported to the Agency that she is being balance-billed by a provider because the plan denied claims, stating the member was not active on the dates of service.	➲ The HMO contact reported that the member files were updated and the provider has re-submitted the claims for payment. The member's parent will not be billed again.
30. A former HMO member's parent reported to the Agency that she is being balance-billed by a provider for claims that were denied by the HMO.	➲ The HMO contact reported that HMO staff told the provider to send in the claims and that they are being processed for payment.
31. A former HMO member's parent reported to the Agency that she is being billed for services after the HMO denied a provider's claims.	➲ The HMO contact reported that the member files were corrected and that they contacted the provider. The provider sent the claims in for payment and has withdrawn the billing to the parent.
32. An HMO member reported not being able to get a prescription refilled.	➲ The HMO contact reported to the Agency that they are awaiting a faxed copy of the prescription from the member's doctor's office. Once it is received, the HMO will approve the early refill request. HMO staff notified the member of this.
33. An HMO member's mother reported to the Agency that her daughter was unable to see a dental provider in her area due to her address change not being made in the HMO's system.	➲ The HMO contact reported to the Agency that they spoke with the dental provider regarding the member's address change. The HMO updated the member's address in its system and helped the member to make an appointment with a dental provider.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
34. An HMO member's parent reported to the Agency that the member needs assistance with an injury but that the HMO has not provided good referrals.	➲ The HMO contact reported to the Agency that they had contacted the member's parent and confirmed that the member had an appointment with a specialist that day. The HMO contact also confirmed the appointment with the provider.
35. An HMO member reported to the Agency that the HMO was unable to provide the member with a referral to a specialist.	➲ The HMO contact reported to the Agency that case managers worked with the member and her PCP to obtain appointments with two specialists. The member is satisfied.
36. An HMO member reported to the Agency that the HMO is not providing necessary services to address her health conditions.	➲ The HMO contact reported to the Agency that a case manager was immediately assigned to work with the member. The case manager provided referrals to several specialists and verified that the member had adequate medications and supplies to last through the holidays. The member is satisfied.
37. An HMO member's parent reported to the Agency that she is unable to find network providers who can treat the member's health issues.	➲ The HMO contact reported to the Agency that a case manager is working with the member's parent and PCP to coordinate necessary specialist care. A non-participating specialist has already been authorized to perform a needed procedure. The member's parent is satisfied.
38. An HMO member's parent reported to the Agency that the HMO's dental subcontractor would not let her make an appointment for the member because she was not listed as payee in the member's file.	➲ The HMO contact reported that the member's file was corrected and a case manager assisted the parent in obtaining a dental appointment for the member. The parent is satisfied.
39. An HMO member reported to the Agency that the HMO has been unable to provide her with good referrals to specialists.	➲ The HMO contact reported to the Agency that a case manager worked with the member and appointments had been made for the member to see the two types of specialists requested. The case manager will continue to coordinate the member's care.
40. A midwife reported to the Agency that the HMO will not authorize her services for the member until the member visits her assigned PCP.	➲ The HMO contact reported that the decision was made to authorize all midwife services for the member. HMO staff faxed an out-of-network agreement and authorization documents to the midwife.
41. An HMO member reported to the Agency that the HMO will not authorize urgently needed services.	➲ The HMO contact reported to the Agency that the HMO's dental subcontractor worked with the member and a specialist dental provider to arrange for services to be provided as soon as possible. The member is satisfied.

HMO Complaints/Issues October 1, 2010 – December 31, 2010	
HMO Informal Issue	**Action Taken**
42. An HMO member reported to the Agency that the HMO will not authorize necessary treatments for his medical condition.	➲ The HMO contact reported to the Agency that the HMO had not received any requests for treatments from the facility where the member was previously admitted or from his treating specialist. The member's PCP stated that the member kept his last scheduled appointment and at that time no treatments were ordered. An HMO case manager spoke to the member and assured him that the HMO will work with him to schedule any future treatments ordered by his providers. The member is satisfied.
43. An HMO member reported to the Agency that she was unable to get two prescriptions authorized by the HMO.	➲ The HMO contact reported to the Agency that the medications are no longer on the health plan's formulary and that no authorization request for the medications had been submitted by the provider. Once the request was received, the HMO's medical director reviewed and approved both medications through 2011. HMO staff notified the member.
44. An HMO member reported to the Agency that the HMO will not authorize medications because they say the member is not active in the plan.	➲ The HMO contact reported to the Agency that the HMO updated the member's file to show that he is active. HMO staff contacted the pharmacy and authorized the member's prescriptions, then contacted the member's group home to notify them that the member's medications were ready to pick up at the pharmacy. The member is satisfied.

Attachment III
Description of Opt Out Enrollees

A description of the Opt Out enrollees is provided below.

1. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the second quarter of Demonstration Year One on October 1, 2006. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.
2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on January 1, 2007. The father has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.
3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer’s health insurance plan effective December 31, 2007. As a result, the children were disenrolled from the Opt Out Program. The mother subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Demonstration Year Two on January 1, 2008. The children’s Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program (Item Number 11).
5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical

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

6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.
8. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended on September 30, 2009. As a result, the children were disenrolled from the Opt Out Program. The mother re-enrolled her children in the Opt Out Program during the fourth quarter of Demonstration Year Four on April 1, 2010 (Item Number 45).
9. The caller began the process to enroll her two children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.
10. The caller began the process to enroll her two children in the Opt Out Program during the second quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother

of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended November 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

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

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

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

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

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

28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother

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

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

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

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

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

33. The caller began the process to enroll herself and her two children in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended effective June 30, 2009. As a result, the mother and child were disenrolled from the Opt Out Program. The other child remained eligible and enrolled in the Opt Out Program. The mother has now

discontinued her employer's health insurance plan due to high cost and now she is looking into private insurance. As a result, the other child has also been disenrolled from the Opt Out Program effective January 27, 2010.

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

35. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on March 1, 2009. The mother 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.

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

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

38. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on July 1, 2009. The father 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.

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

40. The caller began the process to enroll in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on August 1, 2009. The individual has health insurance available through her employer. The individual elected to use her Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual's Medicaid eligibility ended on November 30, 2010. As a result, the individual has been disenrolled from the Opt Out Program.

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

42. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on September 1, 2009. The father 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 August 31, 2010. As a result, the child has been disenrolled from the Opt Out Program.

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

44. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the third quarter of Demonstration Year Four on January 1, 2010. The father 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.

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

46. The caller began the process to enroll her two children in the Opt Out program during the third quarter of Demonstration Year Four. The effective date for

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

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

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

49. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Five. The effective date of enrollment was during the first quarter of Demonstration Year Five on September 1, 2010. The mother 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 ESI coverage ended on December 31, 2010. As a result the child has been disenrolled from the Opt Out Program.

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

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