Florida Medicaid Reform

Quarterly progress Report
January 1, 2007 – March 31, 2007

1115 Research and Demonstration Waiver

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

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

Key components of Medicaid Reform include the following:

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

Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the third quarterly report for the period of January 1, 2007 through March 31, 2007. In addition to outlining the events that occurred during the third quarter of operation, the report provides a high level summary of pre-implementation activities to ensure that there is a full accounting of activities. For detailed information about the activities that occurred during the first two quarters, please refer to the previous quarterly reports.

II. Status Update of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Background

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

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

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

Table 1
Health Plan Applicants

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

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

Current Activities

As of January 1, 2007, the beginning of the third quarter of operation, the Agency contracted with 16 health plans of which 10 are HMOs and 6 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date listed in Table 2 represents the date when the plan is available as a choice but does not represent the date on which the plan receives enrollment. There have been no new Reform health plan contracts since December 2006. However, the Children's Medical Services PSN, the first approved specialty plan to serve children with chronic conditions, was approved for expansion into Duval County on March 21, 2007, with the first enrollment to begin May 1, 2007. Table 1 indicates the 2 pending contracts from the initial set of health plan applicants that remain under review: Freedom Health Plan and Better Health Plan. Better Health Plan, which has applied to become a FFS PSN, has experienced a major change in network design and no date of expected approval is known. Freedom Health Plan is a new HMO applicant and it is still under review. The Agency continues to provide technical assistance to these applicants as appropriate.

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area**	
			Broward	**Duval**
AMERIGROUP Community Care	07/01/06	HMO	X	
Health Ease	07/01/06	HMO	X	X
Staywell	07/01/06	HMO	X	X
Preferred Medical Plan	07/0106	HMO	X	
United HealthCare	07/01/06	HMO	X	X

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area Broward**	**Duval**
Humana	07/01/06	HMO	X	
Phytrust dba Access Health Solutions	07/21/06	PSN	X	X
Total Health Choice	07/01/06	HMO	X	
South Florida Community Care Network	07/01/06	PSN	X	
Buena Vista	07/01/06	HMO	X	
Vista Health Plan SF	07/01/06	HMO	X	
Florida NetPASS	07/01/06	PSN	X	
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X
Pediatric Associates	08/11/06	PSN	X	
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	
Universal Health Care	12/01/06	HMO	X	X

The Agency posted a revised Reform Health Plan Application in December 2006 on the Agency's Medicaid Reform Website. At the beginning of the quarter, the Agency began accepting applications from health plans interested in participating in Baker, Clay and Nassau Counties with an application due date of February 1, 2007, for those applicants who expect to execute their contract by July 1, 2007. No health plan applications were received during this quarter.

In January, the Agency posted the Reform Health Plan Expansion Application on the Agency's Medicaid Reform Website with no official submission deadline. The Agency provided guidelines for application submission dates to ensure contracting by July 1, 2007. All prospective plans were informed that they had to submit a completed application by of April 2, 2007, in order to be considered for a contract effective date of July 1, 2007. During the quarter, the Agency also received ten non-binding Letters of Intent to submit an expansion application for Baker, Clay and Nassau Counties. Of the letters received, only Access Health Solutions (PSN) formally submitted an expansion application during the quarter on March 30, 2007. Three additional health plans which submitted a non-binding Letter of Intent did contact the Agency to verbally communicate they planned to submit an expansion application by April 2, 2007.

In addition, the Agency posted revised draft model Reform health plan contracts for FFS PSNs and prepaid health plan contracts for any new entities seeking to contract with the agency as Medicaid Reform health plans. The revised draft model health plan contracts consolidated the various health plan contract amendments executed during the first three quarters of operation of the 1115 Medicaid Reform Waiver. By the end of the quarter, the Agency was preparing a general amendment to the current prepaid health plan and FFS PSN contracts to incorporate various updates such as the revised list and

reporting date of the plan performance measures, the revised patient satisfaction survey requirements, and revised reporting requirements. The contract amendments are scheduled to be executed during the next quarter of operation.

2. Benefit Package

Background

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

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

The Agency made available a data book on April 10, 2006, to ensure the plans were familiar with the required coverage thresholds. The data book provided historic FFS utilization data for all of the target populations. This information assisted prospective plans in quickly identifying the specific coverage limits required to meet a specified threshold. Table 3 provides a summary of services categorized as sufficiency tested services. The table provides the threshold of historical utilization required for each population and the respective coverage limit in order to be approved.

Table 3 Sufficiency Tested Services					
Sufficiency Tested Services	**Threshold Percentage**	**Unit (TANF)**	**Services Unit (551)**	**Dollars (TANF)**	**Dollars (551)**
Hospital Outpatient Services (Not Otherwise Specified)	98.5 %			$ 146	$ 843
Home Health Services	99.85 %	2	36	$ 82	$ 1,338
Durable Medical Equipment	98.5 %			$ 57	$ 3,674
Pharmacy	98.5 %	9 per month/ 56 per year	16 per month/ 160 per year	$ 5,312	$ 24,473

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

Current Activities

During the third quarter, the Agency approved the Children's Medical Services PSN (the state's specialty plan for children with chronic conditions) to expand into Duval County. The Children's Medical Services PSN kept the FFS reimbursement payment methodology which was accepted last quarter for Broward County. As a FFS PSN, the Children's Medical Services could not develop a customized benefit package, and, like in Broward County, the plan did not choose to offer any expanded benefits. The plan's cost sharing is consistent with the FFS limits for children.

The health plans are able to change their benefit packages on an annual basis only after obtaining approval from the Agency. Therefore, as new plan are approved, the plan may create a benefit package that differs from the plan's previous approach. New beneficiaries, who have not made a choice or existing beneficiaries who are still in their open enrollment period, may select a new plan with a different benefit package. However, previously approved benefit packages will remain unchanged until the next contract year. All approved benefit packages changes that are made during the next contract year will become effective starting July 1, 2007.

In preparation for the new health plan contracting year beginning July 1, 2007, the Agency began the process of revising the data book that was originally released on April 10, 2006, and is described in the Benefit Package background section. The data book will be revised to include the most recent utilization data available and is expected to be released during the next quarter. In addition, the Agency began the annual

process of re-verification of the actuarial equivalency and sufficiency test standards. The re-verification process includes a complete review of the actuarial equivalency and sufficiency test standards and catastrophic coverage level including the most recent historical utilization data. During this quarter, the Agency also began revising the PET with an anticipated release date of mid-May along with the draft capitation rates.

3. Grievance Process

Background

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

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

1. General grievances will be reviewed by the state panel within 120 days.

2. Grievances that the state determines pose an immediate and serious threat to an enrollee's health will be reviewed by the state panel within 45 days.

3. Grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee will be review by the state panel within 24 hours.

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

Current Activities

During the third quarter, no formal grievances have been filed with the Agency for HMO or FFS PSNs. The second quarterly report on enrollee (or provider) grievances and appeals was received by the Agency February 15, 2007. The Agency will provide a summary of results in the next quarterly report.

4. Other Operational Issues

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

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

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

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

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

- Developing a health plan provider file format that could be used by multiple divisions within the Agency for varied uses, such as network adequacy, provider Medicaid eligibility, beneficiary choice selection, etc.

- Revising the referral process used by the Choice Counseling Program vendor, in order to electronically transmit data to the Florida Department of Health on Medicaid beneficiaries who indicate a special health care need and who request consideration for enrollment in the Children's Medicaid Services PSN.

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

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

- Revisiting the transition process for the current non-reform health plan and MediPass population located in Baker, Clay and Nassau Counties into Reform health plans, allowing appropriate time frames for choice and ensuring the Choice Counseling Program, including the Choice Counseling call center, would not be impacted beyond contract capacity. The final decision on this transition schedule is pending receipt of Reform Health Plan Expansion Applications. The Agency did

decide to transition the current non-reform health plan and MediPass populations over a three month period.

- Revising the process for health plan submission of kick payment claims to allow up to a nine month lag after the delivery or transplant occurred for the plan's to submit those kick payment claims to the Agency.

Outreach Activities for Baker. Clay. & Nassau Counties

During the quarter, the Agency continued its effort to communicate with the beneficiaries, providers and health plans in the Medicaid Reform Waiver expansion counties of Baker Clay and Nassau. Since January 1, 2007, the Agency conducted 8 Medicaid Reform workshops for interested Medicaid providers. Flyers were developed, mailed to every Medicaid enrolled provider in the expansion area, and posted to the Medicaid Reform website, announcing these workshops. A banner message (sent by fax and e-mailed) was also posted to remind all Medicaid providers in these counties of the expansion of Reform effective July 1, 2007, and to encourage them to attend one of the Medicaid Reform Workshops. Attachment I shows a detailed list of the outreach meetings, the target audience, the meeting location, and the number of attendees participating during this quarter. The list of topics covered during the outreach meetings is provided below.

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

For MediPass providers who have not yet attended one of the scheduled workshops, the Agency continues outreach efforts via the telephone in order to set up additional/individual workshop sessions. In addition, Medicaid Reform Brochures and training flyers were mailed to all beneficiaries required to participate in Medicaid Reform in Baker, Clay and Nassau Counties.

Next quarter, the Agency will offer additional Medicaid Reform workshops to interested beneficiaries located in each of the three expansion counties.

B. Choice Counseling Program

Current Activities

Public Meetings and Focus Groups

At the beginning of the third quarter, the Agency and the Agency's Choice Counseling vendor, Affiliated Computer Services (ACS), were in process of editing the call center and field scripts and re-designing the Choice Counseling enrollment packet as a result of feedback from the focus groups. A draft of these materials was created and shared during public meetings which were held in Broward and Duval counties to allow beneficiaries, advocates, providers and other interested parties the opportunity to comment on the new materials. For interested parties that could not attend the meeting, the Agency posted the draft of the new materials on the Medicaid Reform website and also posted the comments offered at each of the public meetings. The documents are posted at:
http://ahca.myflorida.com/Medicaid/medicaid reform/beneficiarv/index.shtmI

Based on the feedback received at the first round of public meetings, the new design of the materials was completed. By the end of the third quarter, the Agency was preparing to hold the final series of public meetings to obtain public input on the new design of the materials. The public meetings are scheduled to be held the first week in April.

In addition to the public meetings on the materials, the Agency and ACS continued collecting the feedback on the Choice Counseling process in Broward and Duval Counties. Another series of focus groups with beneficiaries who had engaged in the Choice Counseling process were conducted in Duval County during the third quarter. The attendance at the first two series of focus group meetings in Broward was strong compared to attendance in Duval County. In order to assure the comments/opinions of Duval County was adequately represented, another round of focus groups was held in Duval County in January 2007.

The meetings were again facilitated by representatives from the Agency's consulting group, Alicia Smith & Associates. The Agency's experience from the focus groups held during the second quarter demonstrated that attendees fully participated in the meeting. In general, the participants did not feel that the information shared could somehow have a negative impact. Since the response to the facilitator was positive, the Agency continued with the same facilitator during the third quarter groups. The questions from participants concentrated on the beneficiaries' experience with the Choice Counseling Program, beginning with the first mailing of materials through enrollment or auto-assignment to a plan. Extensive notes and an audio tape from each meeting were reviewed and discussed by the Agency and ACS.

Transition

During the third quarter, the transition of current non-reform health plan or MediPass beneficiaries into Reform plans was completed. At the end of the second quarter, over 106,000 Medicaid beneficiaries were enrolled in Reform health plans. Before the beginning of the third quarter, the transition of the Provider Service Network enrollees was completed and there was only one month remaining in the transition of the non-reform HMO members into Reform health plans. In the last two months of the third quarter, the Agency decided to send letters to beneficiaries who either lost eligibility during their transition window or had other activity on their case that prevented their enrollment into a reform plan.

As the third quarter ended, over 165,000 Medicaid beneficiaries were enrolled into Reform health plans. The following numbers show the number of transition packets sent during the third quarter:

- January 2007: 13,247 Mandatory Packets and 1,580 Voluntary Packets
- February 2007: 473 Mandatory Packets and 10 Voluntary Packets
- March 2007: 2,725 Mandatory Packets and 512 Voluntary Packets

Call Center

During the third quarter, the Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers, and used a language line to assist with calls in over 100 languages. The hours of operation for the call center remained 8:00 a.m. - 7:00 p.m., Monday - Friday, and 9:00 a.m. -1:00 p.m. on Saturday with over 30 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

The biggest change for the call center during the third quarter was assisting beneficiaries in the Medicaid Reform expansion counties of Baker, Clay and Nassau. In mid-March 2007, the first mailing of materials on Reform to beneficiaries in Baker, Clay and Nassau Counties was completed and these materials included the number for the Choice Counseling Call Center. Beneficiaries will not be able to enroll in a Reform plan in the expansion counties until July 1, 2007, but Choice Counselors are available to answer questions beneficiaries may have on Medicaid Reform including the timeframes for enrollment.

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

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

Inbound Calls:	44,193
Outbound Calls:	9,173
Calls Abandoned:	
(The contract standard is <5% *monthly)*	.08%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call Answered in <15 seconds:	89.71%
Calls Answered in <60 seconds:	94.93%
Calls Answered in <180 Seconds:	99.32%

Mail

The volume of activity in the mailroom remained steady during the third quarter. With the first round of beneficiaries who will be entering their annual open enrollment period beginning in June 2007, the Agency and ACS began developing the mailing materials that will be sent to the beneficiaries who are in their annual change period.

Outbound Mail

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

New-Eligible Packets	17,261
Transition Packets	18,547
Auto-Assignment Letters	12,592
Confirmation Letters	14,813

To date, the percentage of mail that is returned is averaging about 6.7 percent per month. This average number has remained consistent throughout the first three quarters of Medicaid Reform. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary.

Inbound Mail:

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

Plan Enrollments	1,189
Plan Changes	1,038

Face-to-Face/Outreach and Education

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

In addition, in the third quarter, the field counselors began to support the outbound call campaign of the call center. This allowed the number of beneficiaries contacted through the outbound call campaign to increase and has helped increase the number of beneficiaries making their own plan choice instead of being assigned to a plan by the state. At the end of the third quarter, the enrollment activities processed by a field Choice Counselor increased from 1,181 to almost 4,000 activities.

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

As the third quarter was ending, the Agency and ACS began to prepare strategies for the outreach and field efforts for the expansion counties of Baker, Clay and Nassau. Due to the rural nature of especially two of these counties, the efforts will need to be changed to meet the needs of rural communities. Over the next few months, the Agency and ACS will finalize the strategy that will be used, but as with the first two counties of reform, the strategy will remain flexible to meet the needs of the population.

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

Group Sessions	731
Private & One-on-One Sessions	331
Home Visits & "No Phone List" Visits	2,007
Outbound Phone List	3,945
Enrollments	3,951
Plan Changes	338

Health Literacy

During the third quarter, the Agency and ACS continued to further develop the health literacy and health disparity function of the Choice Counseling Program. The registered nurse hired to serve in the special needs unit has created several tools for the Choice Counselors to assist them in their interaction with beneficiaries. These tools include definitions of the Medicaid benefits, guidance and explanations of medical terminology and health plan terms and processes that the Choice Counselor may not be familiar with to better answer questions of beneficiaries as they enroll in a health plan, and providing assistance to beneficiaries with complex conditions who do not understand the prior authorizations process for plan benefits. ACS continued their previous effort in the health literacy areas. These efforts included helping Medicaid beneficiaries understand what it means to be part of a managed care plan. The call center and field scripts include language that describes the role of a primary care doctor, how that doctor coordinates all other necessary care, how the beneficiary will use a network of doctors, and more. In addition, when a beneficiary enrolls, the follow-up confirmation letter encourages the beneficiary to make an appointment with his or her doctor and again provides a statement of understanding regarding what it means to be enrolled in managed care.

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

Voluntary Selection Data

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

During the third quarter, the first calculation of the voluntary enrollment rate contained three months of beneficiary enrollment into Medicaid Reform plans. For monitoring purposes, the voluntary selection rate is based on new enrollees only and does not include current beneficiaries who are transitioning to a Reform plan. The voluntary enrollment rate for both Reform counties was 67 percent of all new eligibles. For Duval County, the rate was 67.2 percent and for Broward County the rate was 66 percent. ACS was above the contract standard of 65 percent for the quarter, but the Agency is especially pleased with the March voluntary enrollment rate of 81 percent. A breakdown of the new-eligible enrollment figures for the second quarter is provided in Table 4.

Table 4
New Eligible Voluntary Enrollment Rate
Third Quarter

Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Broward County	
Voluntary Choice	8,730
Auto-Assigned	4,493
Duval County	
Voluntary Choice	5,123
Auto-Assigned	2,504
Voluntary Enrollment Rate:	
Broward and Duval Combined	67.0%
Broward only	66.0%
Duval only	67.2%

Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency head quarters or the Medicaid Area Office. During the third quarter, the Agency began preparations to implement local numbers where complaints against Choice Counseling can be filed. The Agency and ACS are in the process of changing specific letters to publicize these numbers once the numbers are available.

In the third quarter, there were 20 complaints filed related to the Choice Counseling Program. Table 5 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 5 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
1. Beneficiary called regarding incorrect information provided by a Choice Counselor and that the Choice Counselor was not pleasant to the caller.	➲ The beneficiary provided the name of the Choice Counselor and the Choice Counselor was coached and put on increased monitoring. The state was notified and requested a follow-up on the monitoring results of the Choice Counselor to ensure professionalism and accurate information is provided.
2. Beneficiary called stating they went to their provider office for a group session with a field counselor and was not assisted by a field counselor.	➲ A field counselor was present at the facility on the date and time specified by the beneficiary. The Field Supervisor will work with the field counselor to ensure facility staff can direct beneficiaries to the conference room where the sessions are held and also be sure the counselor is setting out the appropriate information to help beneficiaries locate the room they are using.
3. Beneficiary called to complain about being auto-assigned to a health plan.	➲ Beneficiary was mailed a transition packet about enrolling in a reform plan. This beneficiary did not have in a default plan. An auto-assignment letter was mailed after the beneficiary did not respond to the transition mailing. The system does not have any returned mail activity recorded. The beneficiary called after the 90-day change window had ended and the beneficiary has now lost eligibility.
4. Beneficiary called to complain that son was assigned to a plan their primary care physician (PCP) does not take.	➲ Beneficiary was mailed a transition letter and there is no returned mail recorded. A plan change was done to a plan the child's PCP works with.
5. Choice Counselor made an outbound call and the beneficiary stated they were sleeping and could not talk. Beneficiary wanted someone to come to his home and make the choice for him.	➲ The Choice Counselor informed the beneficiary that they could not make a plan choice for the beneficiary. A field counselor was contacted to work with the beneficiary to assist him in selecting a plan.
6. Beneficiary complained that DCF was contacted to update home address. The address in the Medicaid system still has the old address. The old address is in a different county.	➲ Choice Counselor referred the beneficiary to DCF. Since the call was so close to month-end processing, the Choice Counselor was coached about contacting a supervisor so the Agency could review the case and prevent an assignment into a plan in a wrong county if needed. The beneficiary did not get enrolled in the wrong county and an outbound enrollment has since been taken for May 1, 2007.
7. Concern that services for the disabled are provided through Choice Counseling.	➲ Provided the names of companies contracted to provide services for the disabled as part of the Choice Counseling Program. These include sign language, real-time captioning, Braille, large print and CD. The Choice Counseling Program also produces large print materials, and has multiple ways for the disabled to contact Choice Counseling that are printed in the materials on the website.

Table 5 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
8. Complaints from advocate groups about the Choice Counselors not having access to each plan's prescribed drug formulary	➲ Florida's Medicaid Director responded to these complaints via a separate letter. The Choice Counseling Program Special Needs Unit's registered nurse assists recipients with complex medical needs, including prescribed drug needs.
9. Concerns that the mentally ill and those in hospitals will not receive the mailing and thus not be able to respond.	➲ The 30-day choice period is established in Florida Statutes, so the timeframe can not be changed. The Choice Counselor utilizes several strategies: outbound call campaign, home visits and no phone list to reach all beneficiaries who need to make a choice.
10. Concern that beneficiaries will not recognize the return address organization which is the Agency for Health Care Administration.	➲ Due to the mailings being addressed to individuals, using Medicaid in the return address would be a violation of privacy laws. The Agency and ACS will be doing focus groups with beneficiaries on different options for the envelopes during the 4th quarter.
11. Materials and call center are not effective means for those with mental illness or complex medical needs to understand their choices.	➲ Agency and ACS completely agree that a one-size fits all approach does not work. That is why the Choice Counselor utilizes home visits, "no phone list", sessions at assisted living facilities, mental health provider offices and other locations to reach these populations. The addition of the Special Needs Unit provides additional services for the medically complex.
12. Mom called to state that she mailed in an enrollment form for one plan and her child was assigned to a different plan. Child has urgent health need and needs to see his doctor.	➲ There is no documentation in the Choice Counseling system that an enrollment form was received. T he Choice Counseling Program worked with the area office and managed care compliance unit to ensure continuity of care so the child could see their doctor for their health need. A plan change was also done for May 1, 2007, into the health plan the doctor works with.
13. Health plan reported that when beneficiaries hit option 2 for Spanish speaking they get an English speaking counselor.	➲ Due to the contract standard of beneficiaries not being on hold longer than 180 seconds, if there is a wait time in the Spanish queue that exceeds one minute, the call will be connected to an English counselor who will access the language line translation service to assist the beneficiary.
14. Complaint submitted by advocate regarding a beneficiary that was offered a gift to enroll in a plan.	➲ The payee called in December to enroll in the health plan the beneficiary was enrolled in. Information on the gift offer was given to the managed care compliance unit for investigation. Due to other concerns the payee had with the plan, a plan change to a new plan was completed in March.
15. Complaint that a beneficiary went to the area office for Choice Counseling and received no Choice Counseling.	➲ Medicaid Area Offices do not conduct Choice Counseling sessions. The Medicaid Area Office staff will refer a beneficiary to a field Choice Counselor for assistance. For this beneficiary, a home visit was conducted by a Choice Counselor to assist this beneficiary.

Table 5 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
16. Complaint that a beneficiary was enrolled in a plan that she was not aware of and because of this she could not access pregnancy services from the doctor she had been seeing.	➲ Beneficiary contacted the Choice Counseling Program on August 31 and September 13 to request information on a Provider Service Network. A packet was mailed to her and the plan change in the system was cancelled per the beneficiary's request. The beneficiary remained enrolled in the non-reform plan that she had been enrolled with since June 1, 2006. An enrollment form was received by the beneficiary requesting enrollment into the Provider Service Network. The enrollment was effective for October 1, 2006, which was the next effective month. A confirmation letter was mailed with the plan selection and effective date.
17. Complaint that a beneficiary can not receive all their medications and would not have chosen the plan if he/she knew they could not receive he/she medication.	➲ Beneficiary voluntarily selected the reform plan in October and was enrolled in the reform plan for November 1, 2006. The beneficiary was given 90 days to change plans if the plan did not meet his/her needs. As of the end of March, this beneficiary has not requested a plan change.
18. Beneficiary complained the plan would not provide needed vision services and that he/she was auto assigned to the plan.	➲ Payee on the case called the Choice Counseling Program and selected the reform plan the child was enrolled in effective October 1, 2006. The child remained in this plan until he/she lost eligibility. The child is now again eligible for Medicaid.
19. Beneficiary complained son was auto-assigned to a reform plan without being notified and the mother was not aware of the change.	➲ Beneficiary was enrolled in the non-reform plan in February 2006. In September 2006 a transition letter with the current health plan as the default plan was mailed. The letter provided the payee the choice to select a different plan. There is no record of returned mail and the payee did not respond so the child was enrolled in the default plan on November 1, 2006. The payee completed a plan change for the CMS Network that was effective March 1, 2007.
20. Beneficiary complained he/she was auto-enrolled in a plan without notice.	➲ The beneficiary was mailed a packet on October 23, 2006. There is no record of return mail and the only address change in the system occurred in February 2007. The letter informed the beneficiary he/she would follow their MediPass provider into a reform plan if he/she did not select another plan. The beneficiary was enrolled effective November 1, 2006. The beneficiary called stating he/she receive waiver services and should not be mandatory for reform. Beneficiary was not on the waiver list provided by the Agency for Persons with Disabilities and the waiver services could not be verified. The following month the beneficiary called again to change reform plans and that change was processed.

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 public meetings and beneficiary focus groups previously mentioned in this report. The forums allow the Agency to hear from beneficiaries the successes, complaints, as well as ideas for improvement of the Choice Counseling Program. Another important aspect is feedback from the advocates, providers, plans and others who work with and represent beneficiaries that is received during the public meetings.

The feedback process has resulted in many changes to the Choice Counseling process. In the third quarter, the Special Needs Unit began assisting beneficiaries with complex needs. The creation of this unit was a result of concerns about the expertise of the Choice Counselors to serve the medically complex. Other changes during the third quarter were the continued restructuring of the field Choice Counselors' responsibilities to increase contact with beneficiaries, evaluation of the beneficiaries being auto-assigned to identify if there are any trends or patterns that would help Choice Counseling reach these beneficiaries and changes to the call center script.

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

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

C. Enrollment Data

Background

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

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

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

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

This section below provides enrollment figures as well as voluntary and mandatory rates for the third quarter of operation (January 1, 2007 through March 31, 2007).

Current Activities

The Agency provides a monthly enrollment report for Medicaid Reform health plans. This monthly enrollment data is available on the Agency's website at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml

Below is a summary of the monthly enrollment reports for the third quarter. The third quarter report includes enrollment figures from January 1, 2007 through March 31, 2007. This report contains the following enrollment reports:

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

All Medicaid Reform health plans located in the two demonstration areas are included in each of the reports. During the third quarter, Medicaid Reform included a total of 16 HMOs and FFS PSNs. There are two categories of Medicaid beneficiaries who are enrolled in Reform health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiary's eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 6 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 6
Medicaid Reform Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
# TANF Enrolled	The number of TANF 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
% Change From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

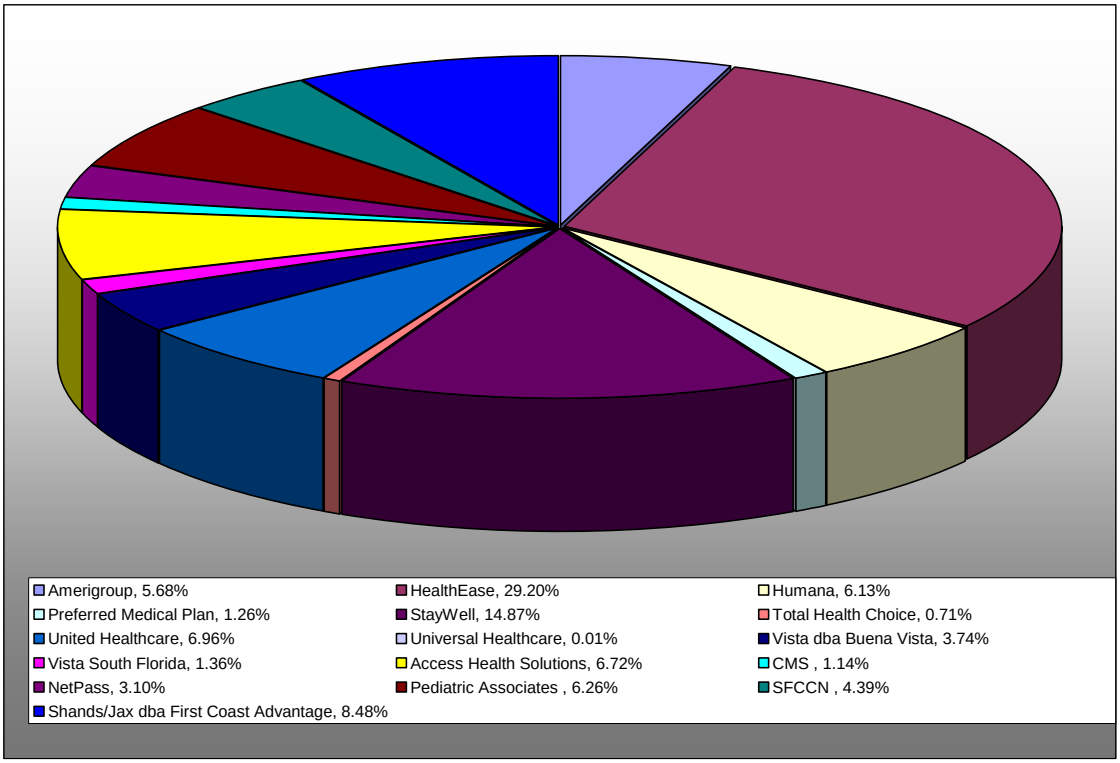
The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 7 for the State Fiscal Year 2006-07, 3rd Quarter Reform Enrollment Report.

Table 7
Medicaid Reform Enrollment Report (State Fiscal Year 2006-07, 3rd Quarter)

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	9,076	1,231	0	58	**10,365**	**5.68%**	4,756	118%
HealthEase	HMO	47,417	5,583	2	300	**53,302**	**29.20%**	24,907	114%
Humana	HMO	8,976	2,082	2	134	**11,194**	**6.13%**	4,507	148%
Preferred Medical Plan	HMO	1,771	501	1	29	**2,302**	**1.26%**	1,139	102%
StayWell	HMO	24,415	2,565	5	151	**27,136**	**14.87%**	12,665	114%
Total Health Choice	HMO	1,073	211	0	14	**1,298**	**0.71%**	738	76%
United Healthcare	HMO	10,963	1,588	2	143	**12,696**	**6.96%**	7,643	66%
Universal Healthcare	HMO	11	3	0	0	**14**	**0.01%**	0	N/A
Vista dba Buena Vista	HMO	6,144	654	0	27	**6,825**	**3.74%**	2,844	140%
Vista South Florida	HMO	2,169	280	0	25	**2,474**	**1.36%**	1,502	65%
HMO Totals		112,015	14,698	12	881	**127,606**	**69.91%**	60,701	110%
Access Health Solutions	PSN	9,959	2,247	0	57	**12,263**	**6.72%**	12,889	-5%
CMS	PSN	820	1,258	0	9	**2,087**	**1.14%**	141	1,380%
NetPass	PSN	4,029	1,562	2	65	**5,658**	**3.10%**	5,727	-1%
Pediatric Associates	PSN	10,843	580	0	0	**11,423**	**6.26%**	11,749	-3%
SFCCN	PSN	5,579	2,345	0	88	**8,012**	**4.39%**	7,436	8%
Shands/Jax dba First Coast Advantage	PSN	11,880	3,476	3	123	**15,482**	**8.48%**	14,678	5%
PSN Totals		43,110	11,468	5	342	**54,925**	**30.09%**	52,620	4%
Reform Enrollment Totals		**155,125**	**26,166**	**17**	**1,223**	**182,531**	**100.00%**	**113,321**	**61%**

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

Chart A
Market Share for Medicaid Reform



The enrollment figures for the third quarter of State Fiscal Year 2006-07, reflects those individuals who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, many Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 182,531 beneficiaries enrolled in Medicaid Reform during the third quarter of State Fiscal Year 2006-07. There were 16 Reform plans with market shares ranging from 0.01 percent to 29.20 percent.

2. Medicaid Reform Enrollment Report by County

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

Table 8 Medicaid Reform Enrollment Report by County Description	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in previous Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Change From Previous Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

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

Table 9
Medicaid Reform Enrollment Report by County
(State Fiscal Year 2006-07, 3rd Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	Broward	9,076	1,231	0	58	**10,365**	**9.31%**	4,756	118%
HealthEase	HMO	Broward	13,311	1,411	0	78	**14,800**	**13.29%**	7,422	99%
Humana	HMO	Broward	8,976	2,082	2	134	**11,194**	**10.05%**	4,507	148%
Preferred Medical Plan	HMO	Broward	1,771	501	1	29	**2,302**	**2.07%**	1,139	102%
StayWell	HMO	Broward	22,659	2,357	5	127	**25,148**	**22.59%**	11,306	122%
Total Health Choice	HMO	Broward	1,073	211	0	14	**1,298**	**1.17%**	738	76%
United Healthcare	HMO	Broward	4,060	788	1	87	**4,936**	**4.43%**	3,026	63%
Universal Healthcare	HMO	Broward	4	0	0	0	**4**	**0.00%**	0	N/A
Vista dba Buena Vista	HMO	Broward	6,144	654	0	27	**6,825**	**6.13%**	2,844	140%
Vista South Florida	HMO	Broward	2,169	280	0	25	**2,474**	**2.22%**	1,502	65%
Access Health Solutions	PSN	Broward	3,713	1,084	0	21	**4,818**	**4.33%**	5,110	-6%
CMS Network	PSN	Broward	820	1,258	0	9	**2,087**	**1.87%**	141	1,380%
Netpass	PSN	Broward	4,029	1,562	2	65	**5,658**	**5.08%**	5,727	-1%
Pediatric Associates	PSN	Broward	10,083	580	0	0	**11,423**	**10.26%**	11,749	-3%
SFCCN	PSN	Broward	5,579	2,345	0	88	**8,012**	**7.20%**	7,436	8%
Total Reform Enrollment for Broward			**94,227**	**16,344**	**11**	**762**	**111,344**	**100.00%**	**67,403**	**65%**
HealthEase	HMO	Duval	34,106	4,172	2	222	**38,502**	**54.09%**	17,485	120%
StayWell	HMO	Duval	1,756	208	0	24	**1,988**	**2.79%**	1,359	46%
United Healthcare	HMO	Duval	6,903	800	1	56	**7,760**	**10.90%**	4,617	68%
Universal Healthcare	HMO	Duval	7	3	0	0	**10**	**0.01%**	0	N/A
Access Health Solutions	PSN	Duval	6,246	1,163	0	36	**7,445**	**10.46%**	7,779	-4%
Shands/Jax dba First Coast Advantage	PSN	Duval	11,880	3,476	3	123	**15,482**	**21.75%**	14,678	5%
Total Reform Enrollment for Duval			**60,898**	**9,822**	**6**	**461**	**71,187**	**100.00%**	**45,918**	**55%**
Reform Enrollment Totals			**155,125**	**26,166**	**17**	**1,223**	**182,531**		**113,321**	**61%**

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

Chart B
Market Share for Medicaid Reform in Broward County

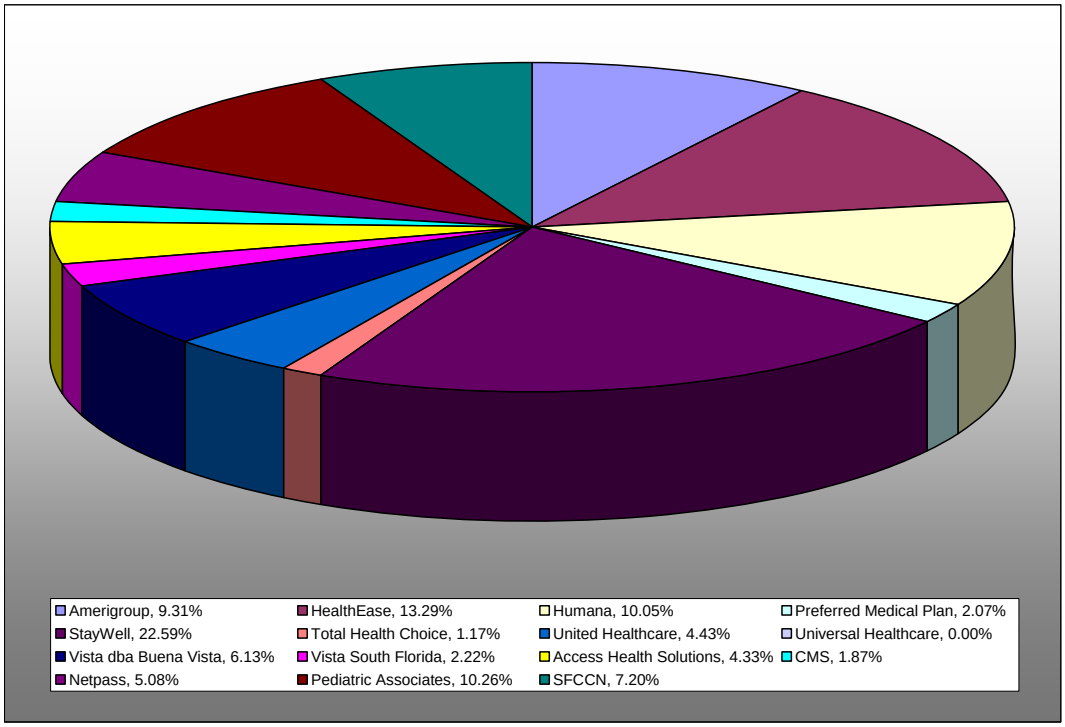
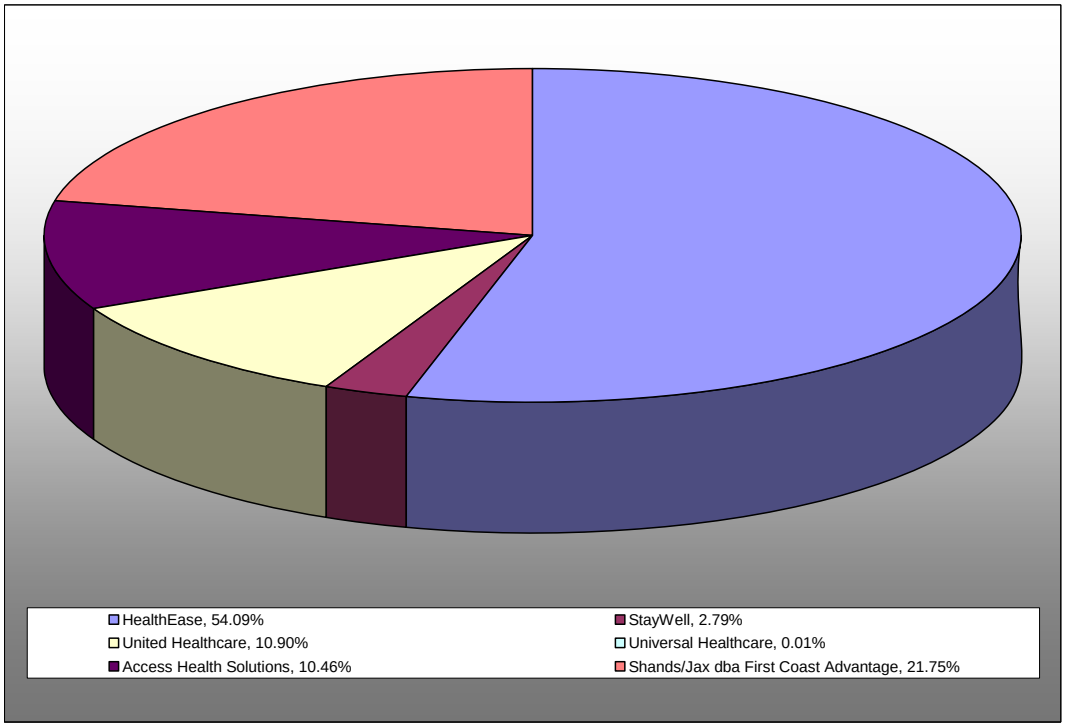


Chart C
Market Share for Medicaid Reform in Duval County



During the third quarter of operation, there was an enrollment of 111,344 beneficiaries in Broward County and 71,187 beneficiaries in Duval County. There were 15 Reform plans with enrollees in Broward County, with market shares ranging from 0.00 percent to 22.59 percent. In Duval County, there were six Reform plans with market shares ranging from 0.01 percent to 54.09 percent.

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

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

Table 10
Quarterly Summary of
Voluntary & Mandatory Selection Rates & Disenrollment Data

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

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

A. Medicaid Reform Enrollees

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

B. Medicaid Reform Disenrollees

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

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

Table 11
Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data (State Fiscal Year 2006-07, 3rd Quarter)

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	9,668 697	**10,365**	93%	1,328	
HealthEase	HMO	Broward	14,010 790	**14,800**	95%	1,843	
HealthEase	HMO	Duval	37,321	1,181	**38,502**	97%	4,975
Humana	HMO	Broward	10,550	644	**11,194**	94%	1,576
Preferred Medical Plan	HMO	Broward	1,780	522	**2,302**	77%	363
StayWell	HMO	Broward	24,183	965	**25,148**	96%	2,913
StayWell	HMO	Duval	1,247	741	**1,988**	63%	286
Total Health Choice	HMO	Broward	762	536	**1,298**	59%	193
United Healthcare	HMO	Broward	4,337	599	**4,936**	88%	659
United Healthcare	HMO	Duval	6,464	1,296	**7,760**	83%	1,323
Universal Healthcare	HMO	Broward	4	0	**4**	100%	0
Universal Healthcare	HMO	Duval	10	0	**10**	100%	2
Vista dba Buena Vista	HMO	Broward	6,453	372	**6,825**	95%	939
Vista South Florida	HMO	Broward	2,157	317	**2,474**	87%	291
HMO Total			**118,946**	**8,660**	**127,606**	93%	**16,691**
Access Health Solutions	PSN	Broward	6,298	1,147	**7,445**	**85%**	1,316
Access Health Solutions	PSN	Duval	4,354	464	**4,818**	**90%**	825
CMS	PSN	Broward	2,087	0	**2,087**	**100%**	213
Netpass	PSN	Broward	5,107	551	**5,658**	**90%**	909
Pediatric Associates	PSN	Broward	11,018	405 **1**	**1,423**	**96%**	2,147
SFCCN	PSN	Broward	7,072	940	**8,012**	**88%**	1,261
Shands/Jax dba First Coast Advantage	PSN	Duval	14,155	1,327	**15,482**	**91%**	1,845
PSN Total			**50,091**	**4,834**	**54,925**	**91%**	**8,516**
Reform Enrollment Totals			**169,037**	**13,494**	**182,531**	**93%**	**25,207**

For the third quarter of State Fiscal Year 2006-07, there were 169,037voluntary enrollments (93 percent) in Medicaid Reform. Of those, 118,946 beneficiaries were enrolled in an HMO and 50,091 were enrolled in a PSN.

D. Opt Out Program

Background

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

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

Description of Opt Out Process

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

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

After HMS receives the required information from the employer, HMS follows-up with the beneficiary to discuss the insurance that is available through the beneficiary's employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the

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

The HMS system has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The system tracks enrollee characteristics (eligibility category, type of employer-sponsored insurance and type of coverage). The system will also track the reason for an individual disenrolling 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 the third quarter, the Agency regularly held meetings with HMS to ensure the Opt Out process continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified during this quarter that required the Agency to make any changes to the process.

Opt Out Program Statistics

A total of 20 calls were received at the Opt Out toll-free call center since September 1, 2006, when the program began accepting enrollment.

- Eleven of the callers were determined not to have ESI available or were not interested in the program.

- Six of the callers requested and received information regarding the Opt Out Program (e.g. New Referral Letter and Release to contact employer) but have not followed through with enrollment into the program to date.

- Three of the calls resulted in enrollment into the Opt Out Program as described below. The three callers are in the Children and Family eligibility category.

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

2. The caller began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter.

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

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

By the end of the third quarter, a total of four individuals were enrolled in the Opt Out Program. Table 12 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending March 31, 2007.

Table 12
Opt Out Statistics
September 1, 2006 – March 31, 2007

Eligibility Category	Effective Date of Enrollment	Type of Employer Sponsored Plan	Type of Coverage	Number of Beneficiaries Enrolled	Effective Date of Disenrollment	Reason for Disenrollment
Children & Family	10/01/06	Large Employer	Single	1	2/28/07	Loss of Employment
Children & Family	01/01/07	Large Employer	Family	5	2/28/07	Loss of Medicaid Eligibility
Children & Family	02/01/07	Large Employer	Family	4	Still Enrolled	N/A

E. Enhanced Benefit Program

Background

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

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

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

Current Activities

At the beginning of the quarter, the Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day each month. The Enhanced Benefits Information System (EBIS) continues to operate effectively with minor modifications to ensure efficient processing of enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report as well as monthly statements that are mailed to each recipient who has activity for the month.

The EBIS information system was designed to allow participating health plans to obtain access to the system in an effort to allow the health plans to serve as a central point of contact for their members. In February 2007, the Agency held two workshops to provide high level access training to the interested health plans that operate as Medicaid Reform health plans. Most health plans attended the training and expressed interest in obtaining access to the system. The access forms will be submitted to the interested health plans in late April 2007 for completion. Once the forms are completed and returned to the Agency, the process to grant access and additional training will begin.

Outreach and Education for Beneficiaries

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

Outreach and Education for Pharmacies

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

A single page reference sheet is being finalized for approval within the Agency. Once approved, the Agency will have laminated copies provided to participating pharmacies and the call center. The reference sheet contains billing procedures and categories with examples of items included in each category. The goal of this document is to reduce the questions regarding types of products that may be purchased using the individual account credits.

The Enhanced Benefits Advisory Panel met on January 26, February 23, and March 23, 2007. The primary focus of the meetings has been to finalize recommendations related to the outreach documents, such as the monthly statement, and providing advice for relevant policy, such as defining guidelines for participation specific to disease management programs. In addition, the panel made a recommendation in January to add hearing aid batteries to the list of approved items available for purchase. The panel is scheduled to meet April 20, May 25, and June 22, 2007.

Table 13 provides the Enhanced Benefit Account Program statistics beginning January 1, 2007 and ending March 31, 2007.

Table 13 Enhanced Benefit Account Program Statistics				
Third Quarter Activity		**January**	**February**	**March**
I.	Number of plans submitting reports by month	19 of 21	21 of 23	23 of 23
II.	Number of enrollees who received credit for healthy behaviors by month	11,997	18,245	19,159
III.	Percentage of Reform enrollees who receive credits each month	19.37%	25.29%	29.95%
IV.	Number of enrollees who received credit and used credits by month	213	491	1,019
V.	I Total dollar amount credited to accounts by month	$331,822.50	$515,720.00	$524,172.00
VI.	I Total dollar amount of credits used by month	$3,142.26	$7,349.64	$14,534.19

The overall total amount credited to accounts as of March 30, 2007, is $1,704,847.50.

The overall total amount of credits used as of March 30, 2007, is $34,189.11.

F. Low Income Pool

Background

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

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

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

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

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

Current Activities

On January 26, 2007, the Agency received an e-mail from CMS with questions regarding the Reimbursement and Funding Methodology document that was submitted on November 22, 2006. The Agency e-mailed responses to CMS on March 16, 2007. On March 19, 2007, CMS acknowledged they received the Agency's responses on March 19, 2007, and reminded the Agency that the e-mail was to be considered an

internal document. CMS also explained that the final submission of questions and comments regarding the Reimbursement and Funding Methodology document would be forthcoming. As of the end of the third quarter, the Agency has not received any additional questions or comments from CMS.

At the beginning of the quarter, the LIP Council members continued to meet to finalize the State Fiscal Year (SFY) 2007-08 LIP, Disproportionate Share Hospital (DSH), and hospital reimbursement recommendations. The LIP Council meeting dates for this quarter were: January 11 and January 24, 2007. The LIP Council submitted its funding and distribution recommendation for LIP, DSH, and hospital reimbursement to the Agency on February 5, 2007. The Agency then provided the LIP Council recommendations to the Governor and Legislature, on the same date.

On March 21, 2007, the Agency received CMS's approval of the Medicaid inpatient hospital State Plan Amendment (SPA). The approval of this SPA included the removal of the hospital inpatient Upper Payment Limit program and provided the language limiting inpatient Medicaid reimbursement to inpatient Medicaid cost, as required by STC #100.

During the third quarter of State Fiscal Year (SFY) 2006-07, the Agency provided CMS with twenty-three (23) additional Letters of Agreements. The total LIP Provider Access System distributions processed during the third quarter were $284,838,612. At the end of the quarter, the Agency continued working with the local governments and health care taxing districts regarding any Letters of Agreement that remain to be executed.

G. Monitoring Budget Neutrality

Background

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

MEGS

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

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

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

Explanation of *Budget Neutrality*

The Budget Neutrality for the 1115 Medicaid Reform Waiver is based on five closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method which is required for 1115 waivers. Using the templates provided by the Centers for Medicare and Medicaid Services, the historical expenditures and case-months were 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 (5thyear), 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 1115 Medicaid Reform Waiver. If the person has one of the identified categories and is not an excluded eligible, he or she is then flagged as eligible for the 1115 Medicaid Reform Waiver. Dual eligibles and pregnant women above the TANF eligibility may voluntarily enroll in a Medicaid Reform health plan. All voluntary enrollment member months and expenditures subject to the 1115 Medicaid Reform Waiver are included in the reporting and monitoring of budget neutrality of the waiver.

Excluded Eligibles:

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

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

Excluded Services:

- AIDS Waiver Services
- DO 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.

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

Definitions:

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

The quarterly totals do not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. The quarterly totals match the expenditures reported on the CMS 64 report which is the amount that will be used in the monitoring process by the Centers for Medicare and Medicaid Services.

Current Activities

For the first three quarters, the 1115 Medicaid Reform Waiver is budget neutral as required by the Special Terms and Conditions of the Waiver. MEG 1 has a PCCM of $801.88 compared to WOW of $948.79, which is 84.52% of the target PCCM for MEG 1. MEG 2 has a PCCM of $152.19 compared to WOW of $199.48, which is 76.29% of the target PCCM for MEG 2.

The expenditures for the first three quarters of year 1 for MEG 3, the Low Income Pool (LIP), were $586 million. The expenditures are contingent upon securing the state, non-federal, share through local governments and health care taxing districts. Due to the fact that the LIP was a new program to many local governments, the executing of Letters of Agreement for the state, non-federal, share took slightly longer than anticipated. The Agency did not release any LIP payments to Provider Access Systems until the appropriate documents were secured. By the end of the third quarter the majority all Letters of Agreement were executed and Provider Access System distributions were made accordingly.

Table 14 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116.

Table 14
PCCM Targets

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

The Tables 15, 16, and 17 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2007. Case months provided in the tables are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 15
MEG 1 Statistics: SSI Related

DY01		MCW Reform	Reform Enrolled & Non-MCW		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Jul-06	261,613	$ 109,390,027	$ 600,241	$ 109,990,268	$ 420.43
Aug-06	260,641	$ 290,239,642	$ 2,569,296	$ 292,808,939	$1,123.42
Sep-06	258,963	$ 151,632,644	$ 1,917,184	$ 153,549,828	$ 592.94
Q1 Total	**781,217**	**$ 519,254,108**	**$ 5,086,722**	**$ 524,340,829**	**$ 671.18**
Oct-06	260,493	$ 218,143,288	$ 4,673,965	$ 222,817,252	$ 855.37
Nov-06	259,752	$ 312,799,991	$ 13,335,318	$ 326,135,309	$1,255.56
Dec-06	260,065	$ 168,324,557	$ 5,249,437	$ 173,573,994	$ 667.43
Q2 Total	**780,310**	**$ 652,099,335**	**$ 23,108,145**	**$ 675,207,480**	**$ 865.31**
Jan-07	260,390	$ 301,700,335	$ 19,269,886	$ 320,970,221	$ 1,232.65
Feb-07	261,186	$ 225,983,270	$ 10,729,527	$ 236,712,797	$ 906.30
Mar-07	266,681	$ 162,942,196	$ 7,256,963	$ 170,199,159	$ 638.21
Q3 Total	**788,257**	**$ 648,942,138**	**$ 35,753,583**	**$ 684,695,721**	**$ 868.62**
DY01 Total	**2,349,784**	**$1,820,295,580**	**$ 63,948,450**	**$1,884,244,031**	**$ 801.88**
MEG 1 Measurement of Budget Neutrality					
% of WOW PCCM MEG1					**84.52%**

***** Quarterly expenditure totals do not equal the sum of the monthly expenditures due to quarterly adjustments such as rebates. The quarterly expenditure totals match the CMS 64 Report submissions.

Table 16
MEG 2 Statistics: Children and Families

DY01		MCW Reform	Reform Enrolled & Non-MCW		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Jul-06	1,295,214	$ 116,458,910	$ 127,380	$ 116,586,290	$ 90.01
Aug-06	1,286,292	$ 273,890,601	$ 1,278,032	$ 275,168,632	$213.92
Sep-06	1,276,974	$ 101,678,854	$ 310,378	$ 101,989,233	$ 79.87
Q1 Total	**3,858,479**	**$ 483,647,931**	**$ 1,715,790**	**$ 485,363,721**	**$125.79**
Oct-06	1,273,251	$ 191,457,471	$ 4,041,139	$ 195,498,611	$153.54
Nov-06	1,252,855	$ 299,005,334	$13,001,406	$ 312,006,740	$249.04
Dec-06	1,246,544	$ 123,282,253	$ 1,763,262	$ 125,045,515	$100.31
Q2 Total	**3,772,650**	**$ 599,558,936**	**$19,101,155**	**$ 618,660,091**	**$163.99**
Jan-07	1,216,944	$ 284,440,302	$21,346,634	$ 305,786,936	$251.27
Feb-07	1,219,671	$ 196,269,428	$ 9,240,222	$ 205,509,650	$168.50
Mar-07	1,296,192	$ 119,706,461	$ 5,627,070	$ 125,333,531	$ 96.69
Q3 Total	**3,732,807**	**$ 589,773,186**	**$35,638,442**	**$ 625,411,629**	**$167.54**
DY01 Total	**11,363,936**	**$1,672,980,053**	**$56,455,387**	**$1,729,435,440**	**$152.19**
MEG 2 Measurement of Budget Neutrality					
% of WOW PCCM MEG2	**76.29%**				

***** Quarterly expenditure totals do not equal the sum of the monthly expenditures due to quarterly adjustments such as rebates. The quarterly expenditure totals match the CMS 64 Report submissions.

Table 17
MEG 3 Statistics: Low Income Pool

DY01	
Actual MEG 3	
Q1 Total	**$ 1,645,533**
Q2 Total	**$ 299,648,658**
Q3 Total	**$ 284,838,612**
DY01 Total	**$ 586,132,803**
DY01 Limit	**$ 1,000,000,000**
% of Limit Used	**58.61%**

H. Encounter and Utilization Data

Background

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

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

Current Activities

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

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

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

- Continuous updating of the MEDS website to ensure relevant information is available to facilitate communications with the MCOs.

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

- Validation and testing by the MEDS team and incumbent Fiscal Agent continues for reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content to capitated health plans.

- Certifications from HMOs were received demonstrating their capability to generate one or more X12 HIPAA compliant transactions (e.g., 8371, 837P, 837D, or NCPDP).

- Test files for encounter claims for one or more X12 HIPAA compliant transactions (e.g., 837P, 8371, 837D or NCPDP) were received by eight of twelve HMOs.

- Technical assistance continues to be provided to HMOs to resolve X12 transaction format and content questions.

- Development of strategy and provided to PSNs for the submission of encounter claims data for capitated transportation (emergency and non-emergency). One PSN has submitted a certification demonstrating its capacity to generate an X12 HIPAA compliant 837P transaction, while other PSNs continue to complete tasks associated with certification and submission of test files.

- Participation by the MEDS team in the design and development of MEDS in the new Florida MMIS.

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

I. Demonstration Goals

Current Program

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

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

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

As reported last quarter, the Agency established contracts with 10 HMOs and 5 PSNs for a total of 15 Reform health plans in Broward County; and 4 HMOs and 2 PSNs for a total of 6 Reform health plans in Duval County. The number of health plans that beneficiaries can chose from in Broward and Duval Counties has increased considerably with the implementation of the Medicaid Reform Waiver. The Agency continues to review and provide technical assistance to two additional health plan applicants: 1 HMO and 1 PSN. The Agency believes that individuals were provided more choice as Reform plans offered benefit packages that included services not previously covered by Medicaid.

During the second quarter, the Agency also established the first specialty plan PSN with the Children's Medical Services (CMS) to serve children with chronic conditions in Broward County. During the third quarter, this specialty plan expanded into Duval County. This plan is limited to children with serious medical, developmental, behavioral or emotional conditions and will provide health care services that meet the child's unique needs. With the addition of this specialty plan PSN in Duval and Broward Counties, the Agency was able to increase the types of health plans being offered in Reform.

As reported last quarter, it is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida to

conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The results of the survey will serve as a baseline against which to compare future surveys throughout the demonstration period. The Agency intends to provide the survey results obtained in the fall of 2007 to the beneficiaries in the form of Choice Counseling materials so that they will have comparable information relative to how satisfied enrollees are with their Reform health plan. The health plans will also use the survey results for their quality improvement programs to improve health outcomes of their beneficiaries.

In addition to the CAHPS surveys, the Agency intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. For Broward and Duval Counties, the disease management patient satisfaction surveys will be conducted in September 2007, to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for 6 months.

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

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

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

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

   The Agency will monitor the Medicaid Reform health plan enrollees through the HEDIS performance measures and the plan's disease management enrollees through Agency-defined disease management measures. The Medicaid Reform health plan contract specifies the performance measures that will be collected starting January 1, 2007 through December 31, 2007, and reported to the Agency October 1, 2008, including the ones identified above. The contract language provides that the Agency may add or remove requirements with 30 days' advance notice.

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

   After a full review, the Agency identified a total of 33 proposed performance measures of which 21 Agency-defined measures would be applicable to the disease management enrollees that are not currently listed in the contract. These measures will be collected over a three-year period. During the first year, the Agency will collect 13 performance measures. The Agency finalized these changes during the second quarter by conducting public meetings to obtain input from the Reform health plans and all interested parties on the proposed performance measures and the timeline for implementation of the measures. The Agency presented the changes to the performance measures currently listed in the contract including the additional disease management measures and the timeline for implementation of the measures to health plans during a public workshop held on October 26, 2006. The Agency then provided the Reform plans with the formal written notification on December 8, 2006. The first set of performance measures will be reported to the Agency on July 1, 2008, for the measurement year beginning January 1, 2007 and ending December 31, 2007.

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

   For individuals who chose to opt out of Medicaid Reform, the Agency has established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the

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

Based on the information gathered during the first three quarters of operation, the reasons individuals have chosen to opt out of Medicaid Reform include: (1) primary care physician was not enrolled with a Medicaid Reform health plan and (2) elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance. The individuals who decided not to opt out were: (a) not employed, (b) did not have access to employer sponsored insurance, or (c) after hearing about opt out decided to remain with their Medicaid Reform plan where there were not co-pays and deductibles.

5. To ensure that patient satisfaction increases.

Please refer to the response to objective #1.

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

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

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

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

As required under STC # 102 in demonstration year 2, the State is conducting a study of the cost-effectiveness of the various Provider Access Systems (hospital and non-hospital providers). The State has contracted with the University of Florida to

conduct the evaluation of LIP including cost-effectiveness and the impact of LIP on increased access for uninsured individuals. During the second quarter, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for the study required in year 2 of the demonstration.

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

J. Evaluation of Medicaid Reform

Background

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

In addition to the contract with UF, several other evaluations are being conducted as described below.

- UF established a subcontract with the Urban Institute (with funding from the Kaiser Family Foundation) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver.

- The University of Oregon's Centers for Health System Change is conducting an evaluation of the 1115 Medicaid Reform Waiver with funding from the Robert Wood Johnson Foundation.

- The Health Policy Institute at the Georgetown University is conducting an evaluation of the 1115 Medicaid Reform Waiver with funding from the Jessie Ball DuPont Foundation.

- The Florida Legislature's Office of Program Policy Analysis and Government Accountability is conducting an evaluation of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida.

- Florida State University is evaluating the Choice Counseling Programs materials which are given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver.

- The General Accounting Office is conducting an evaluation of Florida’s 1115 Medicaid Reform Waiver.

- The Agency is conducting an internal evaluation of the processes during the implementing of the 1115 Medicaid Reform Waiver.

[1] Note: Contract deliverables are routinely submitted to the Agency in draft form; the Agency returns comments; UF submits a final version; an Agency Technical Assistance Group formally reviews and approves the deliverable; and an invoice for it is submitted and paid. Unless specified otherwise, any deliverable mentioned as submitted means the final version.

The MRE Team consists of UF professors and staff in charge of the contract and various aspects of the evaluation. The Team consists of the following people: Paul Duncan (Principal Investigator); Lilly Bell (Project Manager); Christy Lemak and Amy Yarbrough (Investigators, Organizational Analyses); Allyson Hall (Investigator, Quality of Care, Outcomes, and Enrollee Experience Analyses); Jeffrey Harman (Investigator, Fiscal Analyses); and Niccie McKay (Investigator, Low-Income Pool Analyses).

Pre-Implementation Activities: [2]

Additional activities the UF Medicaid Reform Evaluation team members conducted prior to implementation of Reform included:

- Obtaining IRB (Institutional Review Board) approval for the evaluation, allowing human subjects (Medicaid recipients) to be part of the research for the evaluation.
- Submitting a detailed work plan, providing a step-by-step map of the tasks they will take to complete the evaluation over year one.
- Producing two reports: a summary report on the Medicaid Reform Section 1115 Waiver Process; and a report describing managed care organizations and other Reform Health Plans in the two Reform counties, Broward and Duval.
- Conducting baseline (pre-implementation) key informant interviews with various groups (Agency management, Reform plans, Choice Counselors, etc.).
- Hiring local liaisons in Broward and Duval Counties to coordinate activities in those areas and to report on items that happened between visits by UF.
- Gathering baseline information on the various aspects of Medicaid Reform, including customized benefit packages, Opt-Out, funding methodology of the Low Income Pool, development and implementation of pilot programs, etc.
- Developing, in consultation with the Agency, the initial enrollee satisfaction survey instrument, based on the CAHPS (Consumer Assessment of Healthcare Providers and Systems). Information collected from this survey will serve as a baseline against which to compare future surveys throughout the demonstration period.

Current Activities

During the third quarter, UF Medicaid Reform Evaluation Team conducted various evaluation activities in compliance with the timeframes specified in the evaluation plan. The activities included:

[2] For more information and detail, see previous quarterly reports submitted by AHCA to CMS.

- Launching the Community Stakeholder Survey, a web-based questionnaire of key stakeholders in various community entities, using Survey Monkey software.

- Completing the focus groups for the Longitudinal Panel Survey of Medicaid Recipients. These focus groups were conducted to assist the MRE Team design and refine its Longitudinal Survey, which will be used to study recipients throughout years two through five of the study. UF then initiated the Longitudinal Survey in February 2007.

- Conducting the first annual meeting of the Technical Advisory Council, a team of national experts in evaluation and Medicaid issues, in March. The annual meeting was held in person to enhance information exchange. Members include Dr. Robert Hurley (Medical College of Virginia), Dr. Marsha Gold (Mathematica Policy Research, Inc.), Dr. Bryan Dowd (University of Minnesota), and Dr. Genevieve Kenney, (Urban Institute Health Policy Center).

- Producing reports, including: a progress report on the evaluation to date, a report on the Medicaid Reform health plans and networks as of July 1, 2006. The reports submitted by UF to the Agency can be viewed by visiting the Agency's website at http://ahca.myflorida.com/Medicaid/quality-management/mrp/contracts/med027/med027.shtml

- Continually updating the Data Needs Matrix Report that shows measures, data elements to be collected, in what data system(s) the elements reside, and who at the Agency is the main contact for that data system. This process includes meeting with various stakeholders to determine data sources and extraction protocols; collecting data where they exist; and establishing benchmarks against which to compare the data for the remainder of the demonstration period. Data collection and analysis will continue throughout the five-year contract period.

- Conducting academic presentations using information from the evaluation and UF's annual report on the evaluation of Medicaid Reform.

- Collecting organizational data on each of the Medicaid Reform health plans.

- Analyzing the CAHPS-based enrollee satisfaction survey data. The results of the surveys are expected next quarter.

- Beginning the process of qualitatively evaluating the first round of key informant interviews (pre-implementation). Other key informant interviews continue to be conducted. This quarter, the team focused on the second round (post-implementation) interviews of Agency officials.

- Launching a Medicaid Reform Evaluation site, including an "MREWiki" only available to Medicaid Reform Evaluation Team members from UF, Agency staff, and the

Technical Advisory Committee. This website will continue to be updated as further information is collected and analyzed during the evaluation.

- Submitting a plan for the evaluation of the Low Income Pool Program including cost-effectiveness and the impact of the Low Income Pool Program on increased access for uninsured individuals.

K. Policy and Administrative Issues

Current Activities

During the third quarter, the 2007 Florida Legislative Session began March 6, 2007, and is scheduled to end May 4, 2007. Several Florida Legislative Committee meetings preceded the Legislative session, and involved Agency staff providing data to fulfill information requests pertaining to Medicaid health plans and the 1115 Medicaid Reform Waiver. There were several bills proposed by the Florida Legislature that, if passed, have the potential to impact Florida's 1115 Medicaid Reform Waiver. The Agency is monitoring the legislative process closely to determine which bills are passed by the Legislature to determine the impact on the 1115 Medicaid Reform Waiver.

The Agency released two policy transmittals during this quarter to the Medicaid Reform health plans as follows:

- Notified the PSNs how to notify the Agency when enrollees have other creditable coverage. This policy transmittal was sent to the PSNs on February 19, 2007.
- Advised the Reform health plans on March 30, 2007, that the Agency, rather than the health plans, would conduct the Disease Management Patient and Provider Satisfaction Surveys for their enrollees for the first survey year. The policy transmittal was sent in response to the Reform health plan contract language that specified the Agency would notify the health plans if the Agency or the plans would be required to conduct these surveys.

Additional policy transmittals are expected to be released in the fourth quarter. The Agency mails and e-mails policy transmittals to the health plans, and posts final policy transmittals on the Agency Website.

The Agency continued to conduct Technical and Operational Issues Conference Calls on a biweekly basis. During this quarter, there were a total of 7 calls with approximately 20 participants in attendance at headquarters and an average of 74 occupied telephone lines. The Agency estimates that there are between100 to 150 participants from the Reform health plans on each call. These calls were initiated to communicate the Agency's response to: (a) issues raised during the Technical Advisory Panel meetings and (b) questions posed through email and telephone inquiries. All health plans are invited to participate on the Technical and Operational Issues Conference Calls, whether or not they are currently operating in Reform counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly. The Agency staffs these calls with administrative experts in all areas, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers and health plan subcontractors. Topics and agenda items included:

- Various file formatting and submission requirements,
- Choice Counseling Program activities,

- Network provider registration processes,
- Medicaid Enhanced Benefits documents and data systems,
- Medicaid Encounter Data Systems,
- Provider and member information,
- Accessing data exchange and secured file transmission servers,
- Reports, enrollment rosters, reimbursement,
- Performance measures reporting requirements,
- Best practices in HIV/AIDS disease management programs,
- Claims payment and kick payment processing.

Feedback indicates that the calls are well received and a good forum for discussion of the technical and operational issues. In addition, this forum is used to provide updated information to the plans regarding topics that affect them, such as the implementation of the National Provider Identification under the Health Insurance Portability and Accountability Act (HIPAA).

In addition to the Technical and Operational Issues Conference Calls, the Agency continues to hold separate conference calls with PSNs to facilitate communication regarding claims processing and systems issue resolution. During the previous two quarters, these calls had been biweekly in nature but as the number of systems issues has lessened, these calls have gone to a monthly format. In addition, our local Medicaid Area offices located in the Reform counties conducted training sessions on billing practices and the local Medicaid fiscal agent staff was included.

During this quarter, the Agency also continued to ready itself and all stakeholders for the second year of operation of Reform to begin on July 1, 2007, through the use of project management, team lead meetings, the Steering Committee and the Technical Advisory Panel. The Agency modified the transition plan for beneficiaries located in Baker, Clay and Nassau Counties to occur over a three month period based on the smaller volume of beneficiaries going through transition process. Whereas, the number of beneficiaries located in Broward and Duval Counties that were transitioned into a Reform health plan between September 1, 2006 and March 31, 2007, was close to 200,000 beneficiaries, the Agency estimates the number of beneficiaries located in Baker, Clay and Nassau Counties who will be transitioned into a Reform health plan is under 20,000. Specific operational activities conducted this quarter are included in this report under the particular program headings (such as, Health Care Delivery System, Choice Counseling Program, and Enhanced Benefit Program).

Attachment I
Outreach Meetings
January 1, 2007 – March 31, 2007

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
01/03/07	Twin Lakes Medical	Senator Evelyn Lynn, Healthy Start Coalition and several Local Doctors	Informative	General Reform	15
02/15/07 AM	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	10
02/15/07 PM	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	7
02/20/07	Nassau County Council on Aging	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	5
02/28/07	Baker County Health Department	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	6
03/05/07 AM	Orange Park Town Hall	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	14

Attachment I Outreach Meetings January 1, 2007 – March 31, 2007					
03/05/07 PM	Orange Park Town Hall	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	17
03/14/07	Baker County Health Department	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	9
03/19/07	Clay County Administrative Offices (Board of County Commissioners)	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	7
03/20/07	Nassau County Council on Aging	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	8

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Enrollment and Plan Change (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Enrollment and Plan Change Abandon	Other Abandons	Total Calls Abandoned (#)
Standard											
								87,731			
MON	1/1/2007		0	0		0	0	87,731			0
TUE	1/2/2007		839	823		0	823	88,554			16
WED	1/3/2007		892	882		0	882	89,436			10
THU	1/4/2007		892	888		0	888	90,324			4
FRI	1/5/2007		1,097	1,072		0	1,072	91,396			25
SAT	1/6/2007		132	132		0	132	91,528			0
	Week Ending	0	3,852	3,797	0	0	3,797		0	0	55
MON	1/8/2007		1,294	1,236		0	1,236	92,764			58
TUE	1/9/2007		982	949		0	949	93,713			33
WED	1/10/2007		955	928		0	928	94,641			27
THU	1/11/2007		889	880		0	880	95,521			9
FRI	1/12/2007		598	591		0	591	96,112			7
SAT	1/13/2007		0			0	0	96,112			0
	Week Ending	0	4,718	4,584	0	0	4,584		0	0	134
MON	1/15/2007		0			0	0	96,112			0
TUE	1/16/2007		1,110	1,095		0	1,095	97,207			15
WED	1/17/2007		920	903		0	903	98,110			17
THU	1/18/2007		853	850		0	850	98,960			3

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Standard											
								87,731			
FRI	1/19/2007		587	587		0	587	99,547			0
SAT	1/20/2007		33	33		0	33	99,580			0
	Week Ending	0	3,503	3,468	0	0	3,468		0	0	35
MON	1/22/2007		843	839		0	839	100,419			4
TUE	1/23/2007		617	616		0	616	101,035			1
WED	1/24/2007		594	593		0	593	101,628			1
THU	1/25/2007		636	636		0	636	102,264			0
FRI	1/26/2007		602	601		0	601	102,865			1
SAT	1/27/2007		35	35		0	35	102,900			0
	Week Ending	0	3,327	3,320	0	0	3,320		0	0	7
MON	1/29/2007		1,045	1,039		0	1,039	103,939			6
TUE	1/30/2007		975	973		0	973	104,912			2
WED	1/31/2007		806	798		0	798	105,710			8
THU			0			0	0	105,710			0
FRI			0			0	0	105,710			0
SAT			0			0	0	105,710			0
	Week Ending	0	2,826	2,810	0	0	2,810		0	0	16
MON			0				0	105,710			
TUE			0				0	105,710			

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Standard											
								87,731			
WED			0				0	105,710			
THU			0				0	105,710			
FRI			0				0	105,710			
SAT			0				0	105,710			
	Week Ending	0	0	0	0	0	0		0	0	0
	Month End	**0**	**18,226**	**17,979**	**0**	**0**	17,979		**0**	**0**	**247**

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
MON	1/1/2007	0.0%	0.0%	0.0%	100%						
TUE	1/2/2007	0.0%	0.0%	1.9%	100%				2.7%	259.00	508.00
WED	1/3/2007	0.0%	0.0%	1.1%	100%				2.5%	322.00	480.00
THU	1/4/2007	0.0%	0.0%	0.4%	100%				0.5%	113.00	268.00
FRI	1/5/2007	0.0%	0.0%	2.3%	100%				9.9%	323.00	495.00
SAT	1/6/2007	0.0%	0.0%	0.0%	100%				0.0%	121.00	59.00
	Week Ending	0.0%	0.0%	1.4%	100%	0%	0.0				
MON	1/8/2007	0.0%	0.0%	4.5%	100%				17.4%	550.00	993.00
TUE	1/9/2007	0.0%	0.0%	3.4%	100%				9.6%	738.00	981.00
WED	1/10/2007	0.0%	0.0%	2.8%	100%				5.9%	372.00	663.00
THU	1/11/2007	0.0%	0.0%	1.0%	100%				2.2%	245.00	292.00
FRI	1/12/2007	0.0%	0.0%	1.2%	100%				1.4%	152.00	386.00
SAT	1/13/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	2.8%	100%	0%	0.0				
MON	1/15/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE	1/16/2007	0.0%	0.0%	1.4%	100%				0.9%	181.00	560.00
WED	1/17/2007	0.0%	0.0%	1.8%	100%				3.6%	375.00	369.00

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Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
THU	1/18/2007	0.0%	0.0%	0.4%	100%				0.5%	187.00	214.00
FRI	1/19/2007	0.0%	0.0%	0.0%	100%				0.2%	1.00	99.00
SAT	1/20/2007	0.0%	0.0%	0.0%	100%				0.0%	161.00	0.00
	Week Ending	0.0%	0.0%	1.0%	100%	0%	0.0				
MON	1/22/2007	0.0%	0.0%	0.5%	100%				1.1%	219.00	600.00
TUE	1/23/2007	0.0%	0.0%	0.2%	100%				0.8%	173.00	255.00
WED	1/24/2007	0.0%	0.0%	0.2%	100%				0.3%	248.00	230.00
THU	1/25/2007	0.0%	0.0%	0.0%	100%				0.0%	86.00	150.00
FRI	1/26/2007	0.0%	0.0%	0.2%	100%				1.4%	237.00	191.00
SAT	1/27/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.2%	100%	0%	0.0				
MON	1/29/2007	0.0%	0.0%	0.6%	100%				1.0%	442.00	293.00
TUE	1/30/2007	0.0%	0.0%	0.2%	100%				0.3%	113.00	190.00
WED	1/31/2007	0.0%	0.0%	1.0%	100%				1.0%	260.00	524.00
THU		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
FRI		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
SAT		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.6%	100%	0%	0.0				

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
MON		0.0%	0.0%	0.0%					0.0%		
TUE		0.0%	0.0%	0.0%					0.0%		
WED		0.0%	0.0%	0.0%					0.0%		
THU		0.0%	0.0%	0.0%					0.0%		
FRI		0.0%	0.0%	0.0%					0.0%		
SAT		0.0%	0.0%	0.0%					0.0%		
	Week Ending				0%	0%	0.0				
	Month End	**0.0%**	**0.0%**	**1.4%**	**100%**	**0%**	**0.0**	**0.00**			

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds) 180 seconds	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard				>=90%					<=1% monthly
MON	1/1/2007		0.00				0		0.0%
TUE	1/2/2007	790.00	5.53				80		0.0%
WED	1/3/2007	127.00	6.05				259		0.0%
THU	1/4/2007	257.00	5.38				409		0.0%
FRI	1/5/2007	790.00	5.88				306		0.0%
SAT	1/6/2007	0.00	5.90				18		0.0%
	Week Ending		5.7	0.0%	0.0%		1,072		0%
MON	1/8/2007	953.00	5.75				176		0.0%
TUE	1/9/2007	561.00	5.72				210		0.0%
WED	1/10/2007	356.00	5.48				192		0.0%
THU	1/11/2007	293.00	5.55				234		0.0%
FRI	1/12/2007	321.00	5.57				125		0.0%
SAT	1/13/2007	0.00							0.0%
	Week Ending		5.6	0.0%	0.0%		937		0%
MON	1/15/2007	0.00							0.0%
TUE	1/16/2007	443.00	5.92				282		0.0%
WED	1/17/2007	499.00	6.22				202		0.0%
THU	1/18/2007	472.00	5.78				175		0.0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds) 180 seconds	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard				>=90%					<=1% monthly
FRI	1/19/2007	259.00	6.13				212		0.0%
SAT	1/20/2007	0.00	5.00				25		0.0%
	Week Ending		6.0	0.0%	0.0%		896		0%
MON	1/22/2007	247.00	5.53				213		0.0%
TUE	1/23/2007	0.00	6.02				253		0.0%
WED	1/24/2007	126.00	5.63				260		0.0%
THU	1/25/2007	73.00	5.18				376		0.0%
FRI	1/26/2007	219.00	6.13				286		0.0%
SAT	1/27/2007	0.00	5.00				0		0.0%
	Week Ending		5.7	0.0%	0.0%		1,388		0%
MON	1/29/2007	413.00	6.18				156		0.0%
TUE	1/30/2007	246.00	6.17				216		0.0%
WED	1/31/2007	385.00	5.98				192		0.0%
THU		0.00							0.0%
FRI		0.00							0.0%
SAT		0.00							0.0%
	Week Ending		6.1	0.0%	0.0%		564		0%
MON									
TUE									
WED									

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard				>=90%					<=1% monthly
THU									
FRI									
SAT									
	Week Ending		0.0	0.0%	0.0%		0		0%
	Month End		5.8	0.0%	0.00%	0.0%	4,857	0.0	0.0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Enrollment and Plan Change (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Enrollment and Plan Change Abandon	Other Abandons	Total Calls Abandoned (#)
Standard											
								105,710			
MON			0	0		0	0	105,710			0
TUE			0	0		0	0	105,710			0
WED			0	0		0	0	105,710			0
THU	2/1/2007		712	708		0	708	106,418			4
FRI	2/2/2007		525	523		0	523	106,941			2
SAT	2/3/2007		45	45		0	45	106,986			0
	Week Ending	0	1,282	1,276	0	0	1,276		0	0	6
MON	2/5/2007		892	885		0	885	107,871			7
TUE	2/6/2007		784	782		0	782	108,653			2
WED	2/7/2007		679	678		0	678	109,331			1
THU	2/8/2007		539	539		0	539	109,870			0
FRI	2/9/2007		521	521		0	521	110,391			0
SAT	2/10/2007		35	35		0	35	110,426			0
	Week Ending	0	3,450	3,440	0	0	3,440		0	0	10
MON	2/12/2007		747	739		0	739	111,165			8
TUE	2/13/2007		774	764		0	764	111,929			10
WED	2/14/2007		625	620		0	620	112,549			5

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Enrollment and Plan Change (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Enrollment and Plan Change Abandon	Other Abandons	Total Calls Abandoned (#)
Standard											
								105,710			
THU	2/15/2007		621	618		0	618	113,167			3
FRI	2/16/2007		435	435		0	435	113,602			0
SAT	2/17/2007		42	42		0	42	113,644			0
	Week Ending	0	3,244	3,218	0	0	3,218		0	0	26
MON	2/19/2007		446	446		0	446	114,090			0
TUE	2/20/2007		587	587		0	587	114,677			0
WED	2/21/2007		598	594		0	594	115,271			4
THU	2/22/2007		658	657		0	657	115,928			1
FRI	2/23/2007		480	480		0	480	116,408			0
SAT	2/24/2007		27	27		0	27	116,435			0
	Week Ending	0	2,796	2,791	0	0	2,791		0	0	5
MON	2/26/2007		1,013	994		0	994	117,429			19
TUE	2/27/2007		796	795		0	795	118,224			1
WED	2/28/2007		645	644		0	644	118,868			1
THU			0	0		0	0	118,868			0
FRI			0	0		0	0	118,868			0
SAT			0	0		0	0	118,868			0
	Week Ending	0	2,454	2,433	0	0	2,433		0	0	21

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Enrollment and Plan Change (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Enrollment and Plan Change Abandon	Other Abandons	Total Calls Abandoned (#)
Standard											
								105,710			
MON			0	0			0	118,868			0
TUE			0	0			0	118,868			0
WED			0	0			0	118,868			0
THU			0	0			0	118,868			0
FRI			0	0			0	118,868			0
SAT			0	0			0	118,868			0
	Week Ending	0	0	0	0	0	0		0	0	0
	Month End	**0**	**13,226**	**13,158**	**0**	**0**	13,158		**0**	**0**	**68**

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
MON		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
WED		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
THU	2/1/2007	0.0%	0.0%	0.6%	100%				0.0%	107.00	92.00
FRI	2/2/2007	0.0%	0.0%	0.4%	100%				0.0%	138.00	80.00
SAT	2/3/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.5%	100%	0%	0.0				
MON	2/5/2007	0.0%	0.0%	0.8%	100%				1.1%	330.00	257.00
TUE	2/6/2007	0.0%	0.0%	0.3%	100%				0.0%	92.00	151.00
WED	2/7/2007	0.0%	0.0%	0.1%	100%				0.2%	255.00	122.00
THU	2/8/2007	0.0%	0.0%	0.0%	100%				0.0%	130.00	69.00
FRI	2/9/2007	0.0%	0.0%	0.0%	100%				0.0%	99.00	63.00
SAT	2/10/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	30.00
	Week Ending	0.0%	0.0%	0.3%	100%	0%	0.0				
MON	2/12/2007	0.0%	0.0%	1.1%	100%				0.5%	173.00	301.00
TUE	2/13/2007	0.0%	0.0%	1.3%	100%				0.3%	240.00	167.00

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
WED	2/14/2007	0.0%	0.0%	0.8%	100%				0.6%	241.00	244.00
THU	2/15/2007	0.0%	0.0%	0.5%	100%				0.5%	301.00	218.00
FRI	2/16/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
SAT	2/17/2007	0.0%	0.0%	0.0%	100%				0.0%	45.00	0.00
	Week Ending	0.0%	0.0%	0.8%	100%	0%	0.0				
MON	2/19/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE	2/20/2007	0.0%	0.0%	0.0%	100%				0.0%	133.00	87.00
WED	2/21/2007	0.0%	0.0%	0.7%	100%				0.3%	553.00	88.00
THU	2/22/2007	0.0%	0.0%	0.2%	100%				0.0%	113.00	23.00
FRI	2/23/2007	0.0%	0.0%	0.0%	100%				0.0%	1.00	0.00
SAT	2/24/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.2%	100%	0%	0.0				
MON	2/26/2007	0.0%	0.0%	1.9%	100%				4.0%	899.00	605.00
TUE	2/27/2007	0.0%	0.0%	0.1%	100%				0.0%	92.00	56.00
WED	2/28/2007	0.0%	0.0%	0.2%	100%				0.6%	243.00	258.00
THU		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
FRI		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
SAT		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.9%	100%	0%	0.0				
MON		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
WED		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
THU		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
FRI		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
SAT		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%			100%	0%	0.0				
	Month End	0.0%	**0.0%**	**0.5%**	**100%**	**0%**	**0.0**	**0.00**			

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard		180 seconds		>=90%					<=1% monthly
MON		0.00	0.00				0		0.0%
TUE		0.00	0.00				0		0.0%
WED		0.00	0.00				0		0.0%
THU	2/1/2007	154.00	5.52				201		0.0%
FRI	2/2/2007	91.00	5.47				119		0.0%
SAT	2/3/2007	0.00	5.87				31		0.0%
	Week Ending		5.5	0.0%	0.0%		351		0%
MON	2/5/2007	76.00	5.92				171		0.0%
TUE	2/6/2007	73.00	5.57				304		0.0%
WED	2/7/2007	9.00	5.47				137		0.0%
THU	2/8/2007	0.00	5.92				69		0.0%
FRI	2/9/2007	87.00	6.37				79		0.0%
SAT	2/10/2007	0.00	7.45				52		0.0%
	Week Ending		5.8	0.0%	0.0%		812		0%
MON	2/12/2007	301.00	5.95				166		0.0%
TUE	2/13/2007	166.00	6.18				115		0.0%
WED	2/14/2007	168.00	5.67				72		0.0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard		180 seconds		>=90%					<=1% monthly
THU	2/15/2007	769.00	6.03				128		0.0%
FRI	2/16/2007	45.00	6.73				41		0.0%
SAT	2/17/2007	0.00	7.95				5		0.0%
	Week Ending		6.1	0.0%	0.0%		527		0%
MON	2/19/2007	0.00	6.68				90		0.0%
TUE	2/20/2007	144.00	6.43				135		0.0%
WED	2/21/2007	24.00	6.85				88		0.0%
THU	2/22/2007	48.00	6.11				181		0.0%
FRI	2/23/2007	0.00	6.02				81		0.0%
SAT	2/24/2007	0.00	5.02				1		0.0%
	Week Ending		6.4	0.0%	0.0%		576		0%
MON	2/26/2007	47.00	6.33				90		0.0%
TUE	2/27/2007	3.00	6.58				66		0.0%
WED	2/28/2007	0.00	6.63				59		0.0%
THU		0.00	0.00				0		0.0%
FRI		0.00	0.00				0		0.0%
SAT		0.00	0.00				0		0.0%
	Week Ending		6.5	0.0%	0.0%		215		0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard		180 seconds		>=90%					<=1% monthly
MON		0.00	0.00				0		
TUE		0.00	0.00				0		
WED		0.00	0.00				0		
THU		0.00	0.00				0		
FRI		0.00	0.00				0		
SAT		0.00	0.00				0		
	Week Ending		0.0	0.0%	0.0%		0		0%
	Month End		6.1	0.0%	0.00%	0.0%	2481	0.0	0.0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard											
MON			0	0		0	0	105,710			0
TUE			0	0		0	0	105,710			0
WED			0	0		0	0	105,710			0
THU	3/1/2007		694	693		0	693	106,403			1
FRI	3/2/2007		506	506		0	506	106,909			0
SAT	3/3/2007		44	43		0	43	106,952			1
	Week Ending	0	1,244	1,242	0	0	1,242		0	0	2
MON	3/5/2007		843	840		0	840	107,792			3
TUE	3/6/2007		693	693		0	693	108,485			0
WED	3/7/2007		575	573		0	573	109,058			2
THU	3/8/2007		601	601		0	601	109,659			0
FRI	3/9/2007		481	481		0	481	110,140			0
SAT	3/10/2007		40	38		0	38	110,178			2
	Week Ending	0	3,233	3,226	0	0	3,226		0	0	7
MON	3/12/2007		690	689		0	689	110,867			1
TUE	3/13/2007		608	608		0	608	111,475			0
WED	3/14/2007		562	561		0	561	112,036			1
THU	3/15/2007		513	505		0	505	112,541			8

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard											
FRI	3/16/2007		458	455		0	455	112,996			3
SAT	3/17/2007		24	24		0	24	113,020			0
	Week Ending	0	2,855	2,842	0	0	2,842		0	0	13
MON	3/19/2007		738	730		0	730	113,750			8
TUE	3/20/2007		599	588		0	588	114,338			11
WED	3/21/2007		588	583		0	583	114,921			5
THU	3/22/2007		623	621		0	621	115,542			2
FRI	3/23/2007		454	453		0	453	115,995			1
SAT	3/24/2007		30	30		0	30	116,025			0
	Week Ending	0	3,032	3,005	0	0	3,005		0	0	27
MON	3/26/2007		650	646		0	646	116,671			4
TUE	3/27/2007		573	571		0	571	117,242			2
WED	3/28/2007		526	525		0	525	117,767			1
THU	3/29/2007		484	482		0	482	118,249			2
FRI	3/30/2007		364	364		0	364	118,613			0
SAT	3/31/2007		27	27		0	27	118,640			0
	Week Ending	0	2,624	2,615	0	0	2,615		0	0	9
MON			0	0			0	118,640			0
TUE			0	0			0	118,640			0

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

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Standard											
WED			0	0			0	118,640			0
THU			0	0			0	118,640			0
FRI			0	0			0	118,640			0
SAT			0	0			0	118,640			0
	Week Ending	0	0	0	0	0	0		0	0	0
	Month End	**0**	**12,988**	**12,930**	**0**	**0**	12,930		**0**	**0**	**58**

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
MON		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
WED		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
THU	3/1/2007	0.0%	0.0%	0.1%	100%				0.1%	148.00	197.00
FRI	3/2/2007	0.0%	0.0%	0.0%	100%				0.2%	81.00	6.00
SAT	3/3/2007	0.0%	0.0%	2.3%	100%				0.0%	81.00	0.00
	Week Ending	0.0%	0.0%	0.2%	100%	0%	0.0				
MON	3/5/2007	0.0%	0.0%	0.4%	100%				1.0%	266.00	336.00
TUE	3/6/2007	0.0%	0.0%	0.0%	100%				0.0%	46.00	162.00
WED	3/7/2007	0.0%	0.0%	0.3%	100%				1.0%	266.00	410.00
THU	3/8/2007	0.0%	0.0%	0.0%	100%				0.0%	119.00	0.00
FRI	3/9/2007	0.0%	0.0%	0.0%	100%				0.0%	120.00	162.00
SAT	3/10/2007	0.0%	0.0%	5.0%	100%				0.0%	166.00	170.00
	Week Ending	0.0%	0.0%	0.2%	100%	0%	0.0				
MON	3/12/2007	0.0%	0.0%	0.1%	100%				0.0%	72.00	14.00
TUE	3/13/2007	0.0%	0.0%	0.0%	100%				0.0%	61.00	64.00
WED	3/14/2007	0.0%	0.0%	0.2%	100%				0.2%	101.00	196.00

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Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
THU	3/15/2007	0.0%	0.0%	1.6%	100%				3.7%	432.00	452.00
FRI	3/16/2007	0.0%	0.0%	0.7%	100%				1.8%	377.00	324.00
SAT	3/17/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.5%	100%	0%	0.0				
MON	3/19/2007	0.0%	0.0%	1.1%	100%				1.0%	275.00	188.00
TUE	3/20/2007	0.0%	0.0%	1.8%	100%				1.7%	424.00	485.00
WED	3/21/2007	0.0%	0.0%	0.9%	100%				2.2%	358.00	294.00
THU	3/22/2007	0.0%	0.0%	0.3%	100%				0.8%	220.00	392.00
FRI	3/23/2007	0.0%	0.0%	0.2%	100%				0.0%	95.00	117.00
SAT	3/24/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.9%	100%	0%	0.0				
MON	3/26/2007	0.0%	0.0%	0.6%	100%				0.0%	250.00	146.00
TUE	3/27/2007	0.0%	0.0%	0.3%	100%				0.0%	155.00	94.00
WED	3/28/2007	0.0%	0.0%	0.2%	100%				0.0%	86.00	88.00
THU	3/29/2007	0.0%	0.0%	0.4%	100%				0.0%	83.00	207.00
FRI	3/30/2007	0.0%	0.0%	0.0%	100%				0.0%	1.00	0.00
SAT	3/31/2007	0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending	0.0%	0.0%	0.3%	100%	0%	0.0				

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Abandon Rate EN+PC (%)	Abandon Rate Other (%)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% Answered in <=60 Seconds (%)	Agent Hrs Logged On # (Hours)	Avg. Calls Per FTE (#)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)
Standard		<=10%	<=15%	<5% Monthly	100%	100%				180 seconds	180 seconds
MON		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
TUE		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
WED		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
THU		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
FRI		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
SAT		0.0%	0.0%	0.0%	100%				0.0%	0.00	0.00
	Week Ending				100%	0%	0.0				
	Month End	**0.0%**	**0.0%**	**0.4%**	**100%**	**0%**	**0.0**	**0.00**			

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard		180 seconds		>=90%					<=1% monthly
MON		0.00	0.00				0		0.0%
TUE		0.00	0.00				0		0.0%
WED		0.00	0.00				0		0.0%
THU	3/1/2007	93.00	5.98				116		0.0%
FRI	3/2/2007	371.00	6.13				81		0.0%
SAT	3/3/2007	0.00	7.37				5		0.0%
	Week Ending		6.1	0.0%	0.0%		202		0%
MON	3/5/2007	399.00	6.05				107		0.0%
TUE	3/6/2007	0.00	6.30				128		0.0%
WED	3/7/2007	106.00	6.78				108		0.0%
THU	3/8/2007	0.00	6.46				84		0.0%
FRI	3/9/2007	0.00	7.35				64		0.0%
SAT	3/10/2007	0.00	8.07				15		0.0%
	Week Ending		6.5	0.0%	0.0%		506		0%
MON	3/12/2007	0.00	7.05				98		0.0%
TUE	3/13/2007	30.00	6.73				105		0.0%
WED	3/14/2007	108.00	6.80				67		0.0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard		180 seconds		>=90%					<=1% monthly
THU	3/15/2007	435.00	6.88				95		0.0%
FRI	3/16/2007	87.00	6.63				50		0.0%
SAT	3/17/2007	0.00	9.45				0		0.0%
	Week Ending		6.9	0.0%	0.0%		415		0%
MON	3/19/2007	375.00	6.78				111		0.0%
TUE	3/20/2007	126.00	6.88				52		0.0%
WED	3/21/2007	175.00	6.32				38		0.0%
THU	3/22/2007	15.00	6.28				74		0.0%
FRI	3/23/2007	0.00	6.28				81		0.0%
SAT	3/24/2007	0.00	8.58				0		0.0%
	Week Ending		6.5	0.0%	0.0%		356		0%
MON	3/26/2007	125.00	7.25				107		0.0%
TUE	3/27/2007	22.00	7.37				106		0.0%
WED	3/28/2007	122.00	7.05				54		0.0%
THU	3/29/2007	68.00	6.85				57		0.0%
FRI	3/30/2007	0.00	6.90				16		0.0%
SAT	3/31/2007	0.00	8.97				16		0.0%
	Week Ending		7.1	0.0%	0.0%		356		0%

Attachment II
Florida Medicaid Reform Choice Counseling
Call Center Activity Report

Day of the Week	Date	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Answer Rate (%)	Agent Active Avail % (%)	Occupancy Rate (%)	Total Outbound Calls (#)	Avg. Outbound Calls per FTE (#)	% Capacity (%)
Standard		180 seconds		>=90%					<=1% monthly
MON		0.00	0.00				0		
TUE		0.00	0.00				0		
WED		0.00	0.00				0		
THU		0.00	0.00				0		
FRI		0.00	0.00				0		
SAT		0.00	0.00				0		
	Week Ending		0.0	0.0%	0.0%		0		0%
	Month End		6.7	0.0%	0.00%	0.0%	1835	0.0	0.0%