Florida Medicaid Reform

Quarterly Progress Report
January 1, 2008 – March 31, 2008

1115 Research and Demonstration Waiver

Agency for Health Care Administration

Table of Contents

List of Tables

I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Condition # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This quarterly report also includes the preliminary assessment of phase I roll-out of the demonstration as outlined below and in accordance with STC # 26 of the waiver.

- **Availability & Variation of Plans** – details provided in Section A. Health Delivery Systems and Section I. Demonstration Goals of this report.
- **Voluntary Selection Rates** – details provided in Section B. Choice Counseling of this report.

- **Consumer Satisfaction** – details provided in Section B. Choice Counseling and Section I. Demonstration Goals of this report.
- **On-Site Reviews of the Plans Authorized in Phase I** – details provided in Section A. Health Delivery Systems of this report.

This report is the third quarterly report in Year Two of the demonstration for the period of January 1, 2008 through March 31, 2008. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the previous quarterly reports and the annual report which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including current contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 7 through 9 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining approval state approval) eliminate or reduce co-payments and may offer additional services.

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

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

As of March 31, 2008, the Agency has received 19 health plan applications. Seventeen of the 19 applicants sought to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population; one application sought to render services as a specialty PSN. The Department of Health's Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in Duval and Broward Counties. On January 28, 2008, the Agency received its first application (Positive Health Care) for an HMO specialty plan to serve beneficiaries living with HIV/AIDS. Positive Health Care is the DBA (doing business as) plan name for AIDS Healthcare Foundation, Inc.

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

Table 1
Health Plan Applicants

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

Current Activities

Table 1 indicates two pending contracts from the initial set of health plan applicants, Better Health Plan, a FFS PSN, and Positive Health Care, an HMO applicant to become a specialty plan serving members with HIV or AIDS. Better Health Plan has experienced a major change in network design and, at this time, the Agency anticipates its Phase III site survey may occur in May or June of 2008. An expected date of application approval is unknown; however, the Agency continues to provide technical assistance to Better Health Plan. Positive Health Care's application was received at the end of January, it is in Phase I of its review. The Agency continues to receive inquiries from other interested health providers on the prospects of submitting an application to become a Reform PSN or HMO but no additional applications have been received to date.

As of March 31, 2008, the Agency has contracted with 17 health plans; 11 of these are HMOs and 6 are FFS PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date listed in Table 2 represents the date when the plan became available as a choice but does not represent the date on which the plan received enrollment. There have been no new Reform health plan contracts executed since September 2007.

Table 2
Medicaid Reform Health Plan Contracts

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

Transition – Baker, Clay and Nassau Counties

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

Rate Amendments and Model Contracts

The Agency is preparing for the rate amendments for the third contract year in Reform (September 2008 through August 2009). Draft capitation rates are scheduled to be

provided to the health plans in April 2008 and the health plans will be required to submit their new benefit packages for approval late May or early June 2008.

The Agency is also updating its model Prepaid Health Plan and FFS PSN contracts to incorporate the general amendments executed in December 2007 and January 2008.

FFS PSN Conversion Process

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

The conversion workplans were due to the Agency by January 31, 2008. The Agency is currently reviewing the workplans to offer technical assistance in any areas in which the plans might be lacking. Below is the timeline for each step in this conversion process:

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

FFS PSN Reconciliations

During this quarter, the Agency provided the PSNs with their initial reconciliation data for the first reconciliation period for their review. The Agency is providing assistance to the PSNs as they analyze the first set of reconciliation data. The Agency expects data for the second reconciliation period to be available to the PSNs during the next quarter.

2. Benefit Package

Overview

Customized benefit packages are one of the fundamental elements of Medicaid Reform. Medicaid beneficiaries are offered choices in health plan benefit packages customized to provide services that better suit health plan enrollees' needs. The 1115 Medicaid Reform Waiver authorizes the Agency to allow capitated plans to create a customized benefit package by varying certain services for non-pregnant adults, varying cost-sharing, and providing additional services. Capitated plans can also vary the co-payments and provide coverage of additional services to customize the benefit

packages. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package, but could eliminate or reduce the co-payments and offer additional services.

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

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

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

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

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

Current Activities

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

One of the significant changes in the demonstration Year Two benefit packages was the reduction of copayments. In total, there were 63 fewer copayments required during demonstration Year Two (9) than in Year One (72). Copayment reductions were made to 9 types of services: chiropractic, hospital inpatient, podiatrist, hospital outpatient (non-emergency), hospital outpatient surgery, mental health, home health, lab/x-ray, and vision.

	Number of Plans Requiring Copayments	
Services	**Year One** (7/1/2006 - 6/30/2007)	**Year Two** (7/1/2007 - 6/30/2008)
Chiropractic	10	0
Hospital Inpatient	18	2
Podiatrist	10	0
Hospital Outpatient Services (Non-Emergency)	7	1
Hospital Outpatient Surgery	7	1
Mental Health	7	3
Home Health	4	1
Lab/X-Ray	5	1
Vision	4	0
Total	**72**	**9**

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

- Over-the-counter drug benefit from $10 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Home-delivered meals for a period of time after surgery, providing nutrition essential for proper recovery for elderly and disabled;
- Respite care;
- Nutrition Therapy;
- Adult Hospital Inpatient – Additional 20 hospital inpatient days at Shands Jacksonville only (maximum 65 days combined); and
- Adult Hospital Outpatient – Additional $3,500/year for hospital outpatient services at Shands Jacksonville only (maximum $5,000/year combined).

Since implementation of the demonstration, no changes have been made to sufficiency thresholds that were established for the first contract period of, September 1, 2006 to August 31, 2007. The plans currently can limit the pharmacy benefit through 3 mechanisms: (a) establishing an annual dollar limit on the benefit; (b) establishing an annual script limit; or (c) establishing a monthly script limit. During this quarter, after reviewing the available data including data related to the plans' pharmacy benefit limits, the Agency decided to limit the pharmacy benefit via a monthly script limit only. This change was made to standardize the mechanism used to limit the pharmacy benefit. This change will be effective for the upcoming contract period of September 1, 2008 to August 31, 2009. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF at 98.5 percent.

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

3. Grievance Process

Overview

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

As defined in the Medicaid Reform health plan contracts:

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

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

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

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

Current Activities

Since the implementation of the demonstration on July 1, 2006, no grievances or appeals have been reported to the Agency through its SAP or BAP. While the Agency is pleased that grievances and appeals have not reached the SAP or BAP, to improve the demonstration, the Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. In an attempt to better understand the issues beneficiaries face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in our quarterly reports. The Agency will also use this information internally, as part of the Agency's continuous improvement efforts.

Table 3 provides the number of grievances and appeals by health plan type for last quarter ending December 31, 2007. The health plan grievance and appeals reporting cycle coincides with the due date for this quarterly report. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report will lag one quarter in each subsequent quarterly report and will be updated in the annual report to reflect the full year of data. Table 3 will be updated in the next quarterly report to provide the number of grievances and appeals for the reporting period January 1, 2008 through March 31, 2008.

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

	PSN	HMO
Grievances	26	99
Appeals	15	22

Table 4 provides the number of Fair Hearings and requests to BAP and SAP for this quarter ending March 31, 2008. In addition, BAP and SAP requests are also included.

Table 4
Fair Hearings; BAP and SAP
January 1, 2008 –March 31, 2008

	PSN	HMO
Fair Hearings	1	0
BAP or SAP, as applicable by plan type	0	0

BAP and SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances have been submitted to the SAP or BAP, and the number of fair hearings continues to be low.

Medicaid Fair Hearing

Medicaid fair hearings are conducted through the Department of Children and Families (DCF) and as a result, health plans are not required to report the number of fair hearings requested by enrolled members. The Agency does monitor the fair hearing process and one fair hearing involving a PSN enrolled member was held this quarter. The one fair hearing held was related to denial of benefits/services. The fair hearing outcome resulted in the plan actions being confirmed as accurate and having provided services appropriately.

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

4. Complaint/Issue Resolution Process

Effective October 1, 2007, the Agency implemented a single database for reporting on health plan complaints/issues. The consolidated complaint database includes an automatic referral process so that if complaints need to be referred from an area office to headquarters or to a different headquarters office, an email will automatically go to the unit with the referral.

The consolidated complaint database was developed utilizing the expertise of Agency staff. The staff worked diligently to define database fields and processes for capturing data. In addition, an Agency subgroup continues to work on creating quality control reports as well as trend reports. This subgroup includes technical systems personnel, Agency Bureau Chiefs, and Agency Administrators who use this data when trending over time to determine the volume of compliance issues and whether to recommend operational and policy changes.

In March 2008, the Agency's subgroup held two feedback meeting(s) with Medicaid headquarters and Medicaid area staff on the ease of using the database and to facilitate discussion on whether other training or changes are needed. All staff were pleased with the database process but wished to receive more timely database updates and acknowledgements that referred complaints were being worked. In response, database staff revised the system to automatically update the complaint/issue originating office when an analyst began review of the referred complaint. In addition, the Agency is reviewing how to more quickly update the area offices with the master database information. The Agency continues to hone the trend and quality control reports, and expects to have final versions of the draft reports in the upcoming quarter. The Agency tracks complaints by plan and by plan type (PSN and HMO) and continues to review particular complaint data with the individual plans as trends become apparent.

This quarter, the Agency received 13 complaints/issues related to FFS PSNs and received 72 complaints/issues related to HMOs, for a total of 85 complaints. The complaints/issues received during this quarter are provided in Attachments I and II, sorted by PSN or HMO. Attachment I provides the details on the complaints/issues related to FFS PSNs and outlines the action(s) taken by the Agency or the Agency's Fiscal Agent, ACS, to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency to address those issues raised.

This quarter, the majority of PSN complaints/issues are not provider claims issues (only two were claims related). The remaining complaints/issues were associated with member issues. Member issues included access to dental, durable medical and specialty referrals, authorizations and clarification of services. Provider issues included payment delays; however, the majority of issues stemmed from providers not submitting claims correctly. The Agency continues to facilitate conference calls between the providers and the PSNs to ensure providers are appropriately informed regarding claims processing requirements and PSNs are appropriately processing claims.

During the quarter, the majority of the HMO complaints/issues were related to member issues, with only 14 complaints/issues being related to provider issues. Member issues included dental, specialty referrals, incorrect enrollment/eligibility/member material and medications. Provider issues included payment delays/denials and eligibility confirmation.

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

5. On-Site Surveys

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

The State has begun surveying all Reform health plans for 2008. These reviews will be focused more on operational issues, and plan employee interviews. The surveys will be completed by the end of 2008.

B. Choice Counseling Program

Overview

Medicaid Reform is in the third quarter of demonstration Year Two. A goal of Medicaid Reform is the empowerment of beneficiaries to take control and responsibility for their own health by providing the information needed to make the best, most informed decisions about health plan choices.

Choice Counseling is achieving success in empowering beneficiaries' to make their own health plan choices at the highest rate in Florida's history. This allows the beneficiaries greater access to services that best meet their individual needs, which is a fundamental goal of Medicaid Reform.

The Choice Counseling program has offered a Customer Service Survey for approximately 8 months (since August of 2007) which allows the beneficiary to give feedback about their experience with the Choice Counseling process. The beneficiaries are utilizing the survey and responses continue to be very positive. The survey results are an important part of evaluating and improving the Choice Counseling program. One area identified for improvement is the Choice Counseling materials. The Agency's Choice Counseling vendor, Affiliated Computer Services (ACS), is currently working on draft changes to the materials that will be presented in public forums as demonstration enters Year Three of operation.

As the Agency continues to work to improve the Choice Counseling program, the input from Medicaid beneficiaries, advocates, providers, plans and other interested parties continues to play an integral role. The input provided by these key stakeholders continues to improve the program. The following highlights some of the major initiatives and achievements of the Choice Counseling program:

- The highest voluntary enrollment rate in the history of Florida Medicaid managed care.
- Certified Choice Counselors ensuring each counselor has the knowledge and interpersonal skills necessary to serve Florida's most vulnerable population. This certification program is the first in the nation.
- Special Needs Unit to serve the medically complex and their families which allows beneficiaries enrolling in managed care for the first time to receive the additional assistance their health status requires.
- Field Choice Counselor efforts to reach beneficiaries that are not responding to mailings, by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These changes resulted in over 38 percent of the enrollments being done at the local level. This enrollment level is significantly higher than the 10 percent estimated for field enrollment prior to implementation.
- Customer Service Survey which captures the beneficiaries' feedback about their experiences with Choice Counseling.

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

Current Activities

1. Public Meetings and Beneficiary Feedback

This quarter, the Agency held beneficiary focus groups and public meetings in the demonstration counties to solicit input on the Choice Counseling program. As a result of the feedback from the public meetings, the implementation of a preferred drug search functionality will be coming to the Choice Counseling program in 2008.

The Agency and ACS researched the options available to address this concern. The outcome of the feedback and research was the development of the Navigator solution.

Navigator is a Preferred Drug List (PDL) search system. The Navigator system will contain each Medicaid Reform health plan's PDL and prescribed drug claims data. For those beneficiaries that have prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator would pull their medication data and then provide detailed information on how each plan meets his or her current prescribed drug needs. This detail allows the system to provide more information to the beneficiary and does not require that the individual remember his or her current medications.

The Navigator system also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries that do not have prior claims history. This function would allow the Choice Counselor to provide basic information to the beneficiaries on how each plan meets beneficiaries' current prescribed drug needs. The Choice Counselor's role would not be counseling beneficiaries on the medications themselves, but stating the results based on their search in the PDL of which health plans covered their medication. This information will allow the beneficiary to select his or her plan more easily, as it will provide more information for selection.

As implementation of Navigator progressed, the Agency solicited comments at the public meetings in December 2007 and January 2008. The comments and questions that were expressed in the forums resulted in the Agency and ACS analyzing how to better display generic drugs in the Navigator system. Once the changes to the system are complete, another round of public meetings will be scheduled in the demonstration areas. The meetings will allow the Agency to present the updated system as well as how the Choice Counselors will present and discuss the information with beneficiaries.

As noted earlier, an automated beneficiary survey function in the call center was implemented in August 2007. Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. During this quarter, over 1,390 beneficiaries completed the automated survey.

The survey questions are broken down into 5 main categories:

- Satisfaction or concerns with the Medicaid program as a whole;

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

The Customer Survey ratings consider 100 percent to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. 100 percent or 9 reflect a truly satisfied caller. The scores translate into percentages as follows:

1= 00.00%

2= 12.50%

3= 25.00%

4= 37.50%

5=50.00%

6=62.50%

7= 75.00%

8= 87.50%

9=100%

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

The following graph shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from January through March of 2008.

Florida Choice Counseling

Percentage of Delighted Callers for Each Question		
How helpful do you find this counseling to be		
Jan	**Feb**	**Mar**
90.80%	90.80%	88.90%
Satisfaction with the amount of time you waited to speak with a counselor		
Jan	**Feb**	**Mar**
77.90%	81.80%	82.10%
How easy it was to understand the information		
Jan	**Feb**	**Mar**
77.00%	81.10%	80.10%
How likely are you to recommend Choice Counseling helpline to friend or relative		
Jan	**Feb**	**Mar**
94.40%	95.60%	94.10%
Overall service provided by the Counselor		
Jan	**Feb**	**Mar**
96.80%	97.90%	96.00%
How quickly the Counselor understood why you called today		
Jan	**Feb**	**Mar**
95.90%	97.70%	95.50%
The Counselor's ability to help you choose your health plan		
Jan	**Feb**	**Mar**
95.00%	97.00%	93.40%
The Counselor's ability to explain things clearly		
Jan	**Feb**	**Mar**
95.50%	97.70%	95.50%
The confidence you have in the information given to you by the counselor		
Jan	**Feb**	**Mar**
95.70%	96.80%	95.50%
Satisfaction with being treated respectfully		
Jan	**Feb**	**Mar**
97.90%	99.10%	97.40%

The number of beneficiaries participating in the Survey was as follows: January: 533, February: 433, and March: 424 (totaling 1,390).

2. Call Center

Medicaid Reform Choice Counseling Call Center, located in Tallahassee, Florida, operates a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation were adjusted during the last quarter to better align the call center hours with beneficiary demand. The call center has over 30 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

Beginning in November 2007, the Choice Counseling Call Center hours were adjusted and the call center stayed open one additional hour on Monday and Thursdays (with those hours being 8:00 a.m. to 8:00 p.m.). Tuesday, Wednesday and Friday the call

center hours were 8:00 a.m. to 7:00 p.m. and Saturday hours were adjusted to 9:00 a.m. – 11:00 a.m. The pilot plan was operational November and December of 2007, and based on the continued low number of calls on Saturdays (both inbound and outbound) it was decided to continue the pilot into this quarter with more adjustments to the call center hours. Beginning January 2008, the call center hours were adjusted to Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., thus providing no Saturday hours. The Agency and ACS will continue to closely monitor call volume (both inbound and outbound) and the number of voice mail messages left over the weekends, to maximize access for beneficiaries.

The primary function of the Choice Counseling 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 health plan choice and have not yet contacted Choice Counseling.

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

Inbound Calls:	39,895
Outbound Calls:	13,800
Calls Abandoned:	
(The contract standard is <5% *monthly)*	1.9%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call Answered in <15 seconds:	74.00%
Calls Answered in <60 seconds:	83.50%
Calls Answered in <180 Seconds:	96.76%

Calls answered in less than 180 seconds have a contract standard of 96 percent. The 15 and 60 second call rates do not have a contract standard, but are monitored because they are indications of customer service provided by the call center.

The call center made some improvements in its workforce management during this quarter. Incoming call history was analyzed and high volume call patterns in the call center were tracked. In reviewing that history the call center was able to implement a call pattern work schedule which allows more FTEs to be answering calls during peak time periods, thus handling more calls with less abandonment during those key hours of operation.

3. Mail

The mail room equipment and process is currently being evaluated by ACS and a plan for this area of the project will be proposed in the coming months.

Outbound Mail

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

New-Eligible Packets	20,977
Auto-Assignment Letters	11,187
Confirmation Letters	19,231
Open Enrollment Packets	12,451
Transition Packets	1,028

During the quarter, the percentage of mail that is returned averaged 3.6 percent. 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	951
Plan Changes	146

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

4. Face-to-Face/Outreach and Education

During this quarter, the Field Choice Counseling Outreach was the best recorded to date as the focus of outbound efforts on those beneficiaries with a pending assignment yielded the highest New Eligible Enrollment Rate (NER) so far in the project. In this quarter, the number of beneficiaries that actively chose a health plan reached an all-time high of 85 percent and averaged 81 percent overall for the quarter. While the total enrollments secured through Outreach efforts was not as high as past months, the strategic focus on the truly “hard to reach” has yielded the best NER results so far.

While concentrating on finding and enrolling those who do not respond to the mailing has been the Field Choice Counselor’s primary focus with outbound activity, meeting with those who are seeking out face to face counseling remains a top priority. The Field Choice Counselor’s continue to complete a significant number of enrollments. During this quarter, the numbers of field enrollments continued to increase.

The major change in the Field Choice Counseling activities during the quarter was the implementation of Quality Assurance Monitoring of the Field Choice Counselors. During the first year, the Field Choice Counseling supervisors handled most of the Field monitoring done by ACS. In September of 2007, the quality monitoring staff, located in Tallahassee, began calling at random beneficiaries who were served by Field Choice

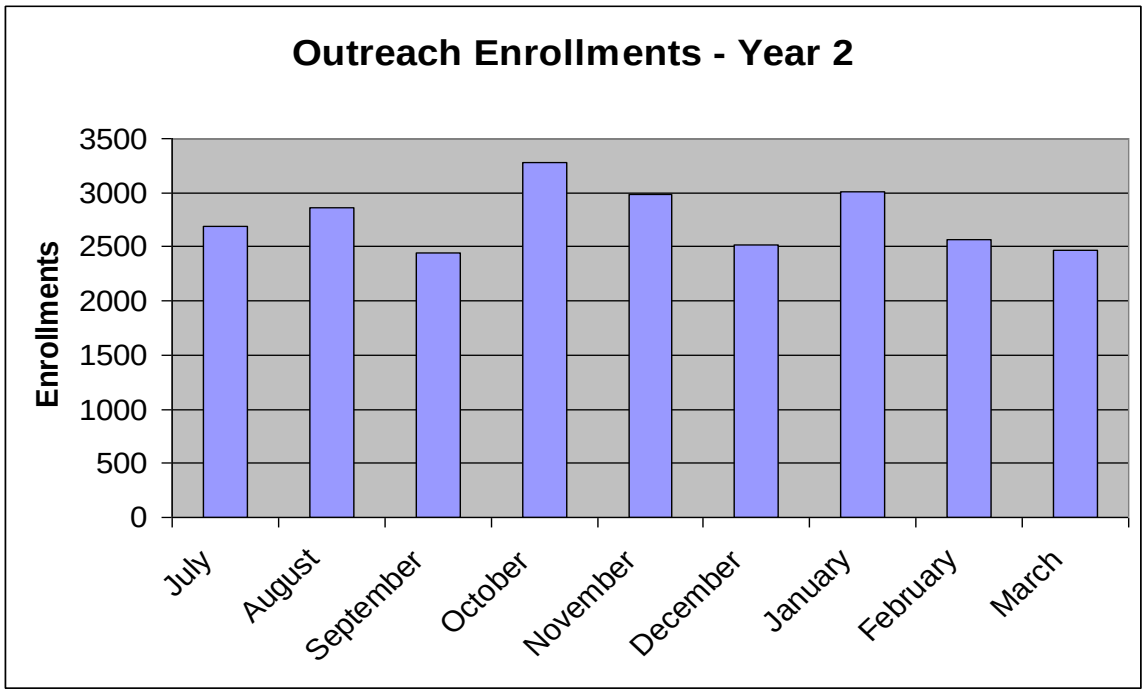
Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 5 shows the beneficiaries' responses (in percentages) from 141 beneficiaries randomly called that participated in the survey (from January through March 2008). The same percentage range used in the call center is used in the field, with 100 percent being a perfect score.

Table 5 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	97.35%
Felt the information provided by the Choice Counselor helped them make an informed decision	93.85%
The information was explained in a way that made it easy to understand	97.13%
The Choice Counselor was friendly/courteous	97.73%

With the new monitoring process now in place, ACS is evaluating results and will make recommended changes to tools the Field Counselors use for both outbound calls and face-to-face sessions to better serve beneficiaries.

At the end of the quarter, the enrollment activities processed by Field Choice Counselors were 8,153 enrollment activities. Table 6 demonstrates the dramatic increases in the Field Choice Counseling effort from implementation through the third quarter of year two.

Table 6 Field Choice Counseling Outreach Enrollments



Another focus of the Field Choice Counselors was continuing to better reach the special needs and hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups has

included providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities and other types of community based organizations that serve these population groups. During this quarter, the Field Choice Counselors continued to focus outbound calls on pending auto assignments (which is a list of beneficiaries that have not made a choice of health plans and are within a few weeks of being assigned to a health plan by the state). Contacting the beneficiaries from this list greatly helped increase the Field Choice Counseling enrollments and increased our customer service to beneficiaries.

Two special items were noted this quarter: (a) January Field Choice Counselor enrollments surpassed 3,000 for the second time since the inception of the pilot; and (b) two Field Choice Counselors became the first to enroll 100 plus beneficiaries in a week.

During the quarter, ACS continued working on the development of relationships with community based organizations and providers in the expansion counties of Baker, Clay and Nassau. Due to the rural nature of Baker and Clay Counties, the Agency and ACS will closely monitor the Field Choice Counseling efforts in these counties to identify issues and to change strategies if necessary to meet the needs of these rural communities.

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

Group Sessions	737
Private Sessions	138
Home Visits & One-On-One Sessions	173
"No Phone List"	1,287
Outbound Phone List	14,862
Enrollments	8,153
Plan Changes	218

5. Health Literacy

The Special Needs Unit has primary responsibility for the health literacy function. In December 2007, a new registered nurse (RN) supervisor was hired, earned her certification in the Choice Counseling process, and began her duties in the Special Needs Unit with ACS. The RN supervisor has developed training for the Choice Counselors which outlines how the Special Needs Unit works and how to refer beneficiaries to unit for help. The RN supervisor presented an outline of the training to the Agency in March 2008 and has begun the process of scheduling the training sessions. A licensed practical nurse (LPN) was hired to work in the Special Needs Unit in March 2008. The LPN began the Choice Counseling certification process this quarter.

The staffing goal of the Special Needs Unit, after a previous evaluation (performed in 2007), is to staff the unit with one RN supervisor, two LPNs and one social worker . Additional nurses in the field will be hired after this initial group has been hired and trained.

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

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

6. New Eligible Self-Selection Data

The Agency is revising the terminology used in describing voluntary enrollment data to improve clarity and understanding of how the demonstration is working. In the Medicaid Reform program, the term voluntary has been used to refer to both beneficiaries who can voluntarily participate in the demonstration and also to beneficiaries who voluntarily chose his or her own health plan. To avoid multiple uses of a single term, the Agency is changing terminology used when referring to beneficiaries who are making their own plan selection. Going forward, instead of referring to new eligible plan selection rate as "*Voluntary Enrollment Rate*", it will be referred to as the "*New Eligible Self-Selection Rate*". The term "self-selection" will be used to refer to beneficiaries who choose their own plan and the term "assigned" will be used for beneficiaries who do not choose their own plan.

To ensure the effectiveness of the Choice Counseling Program, the Agency requires that a minimum of 65 percent of the new Medicaid eligibles self-select their Medicaid Reform health plan. At the end of Year Two of the demonstration, this requirement will be increased to 80 percent.

During this quarter, the average percentage of beneficiaries who were making a self-selection of a health plan was 81 percent (with a high of 85 percent). ACS was above the contract standard of 65 percent for the quarter. The Agency is especially pleased that the self-selection rate for each month of the quarter remained significantly above the 65 percent required by the contract and in fact, in all three months of the quarter, the self-selection rate was above 80 percent. Another milestone achieved in this quarter (in the month of March) was that 100 percent of new eligibles in Nassau County self-selected their health plan. This was the first time ACS had achieved a 100 percent self-selection rate in any county.

Table 7 provides a breakdown of the new-eligible self-section rate for this quarter.

Table 7
New Eligible Self-Selection Rate
Third Quarter

Month	Self-Selection	Total Assigned	Total New Eligible	Percentage
January	6,913	1,173	8,086	85.49%
February	5,424	1,173	7,352	73.78%
March	6,190	1,096	7,286	84.96%
Total	**18,527**	**4,197**	**22,274**	**81.53%**

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. In August of 2007, the Agency and ACS implemented an automated beneficiary survey where complaints against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call. The Agency is working with ACS on an avenue to account for the complaint recordings left via the automated survey so those comments can be added to this report.

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

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves public meetings, beneficiary focus groups and the new automated survey previously mentioned in this report. The focus groups allow the Agency to hear from beneficiaries on the successes, complaints, as well as ideas for improvement of the Choice Counseling Program. Another important aspect is feedback that is received during the public meetings from the advocates, providers, plans and others who work with and represent beneficiaries.

The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries by striving to perfect all areas. It is imperative for beneficiaries to understand their health plan options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Counselors' ability to explain things clearly indicate that in January, 95.50 percent of beneficiaries were satisfied, in February, 97.70 percent, and in March, 95.50 percent of callers were satisfied. ACS continues to focus on improving communication between Counselors and beneficiaries and evaluates comments left by beneficiaries to improve customer service.

While focusing on explaining things more clearly, the beneficiaries' confidence in the information given to them by the Choice Counselor has also increased this quarter. As you can see, the Counselors earned a percentage rating of 95.70 percent in January, 96.80 percent in February, and 95.50 percent in March of 2008, with an overall quarterly average of 96 percent.

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

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

The Agency Headquarters staff, the Medicaid Area Office staff, and ACS Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between Area Medicaid staff and ACS Field staff, E-mail boxes on ACS' enrollment system to enable the Agency staff and ACS to share information directly from the system to resolve difficult cases, and regularly scheduled weekly conference calls.

C. Enrollment Data

Overview

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

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

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

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

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

1. Medicaid Reform Enrollment Report

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

Table 8
Medicaid Reform Enrollment Report Descriptions

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

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 9 on the following page for the Fiscal Year 2007-08, 3rd Quarter Medicaid Reform Enrollment Report.

Table 9
Medicaid Reform Enrollment Report
(Fiscal Year 2007-08, 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	12,390	1,584	2	166	14,142	6.51%	13,242	6.80%
Buena Vista	HMO	6,047	699	1	55	6,802	3.13%	6,929	-1.83%
Freedom Health Plan	HMO	140	28	0	4	172	0.08%	44	290.91%
HealthEase	HMO	48,846	5,568	4	505	54,923	25.30%	55,382	-0.83%
Humana	HMO	8,467	1,955	3	229	10,654	4.91%	10,825	-1.58%
Preferred Medical Plan	HMO	1,442	448	0	48	1,938	0.89%	2,034	-4.72%
StayWell	HMO	31,492	3,089	5	309	34,904	16.08%	34,396	1.48%
Total Health Choice	HMO	1,497	317	2	42	1,858	0.86%	1,642	13.15%
United Health Care	HMO	22,234	2,815	4	439	25,492	11.74%	22,129	15.20%
Universal Health Care	HMO	481	73	0	5	559	0.26%	182	207.14%
Vista South Florida	HMO	4,618	447	2	72	5,139	2.37%	4,477	14.79%
HMO Total		**137,654**	**17,032**	**23**	**1,874**	**156,583**	**72.13%**	**151,282**	**3.50%**
Access Health Solutions	PSN	15,690	3,072	3	163	18,928	8.72%	19,143	-1.12%
CMS	PSN	1,766	2,149	0	16	3,931	1.81%	3,732	5.33%
First Coast Advantage	PSN	12,655	3,470	5	259	16,389	7.55%	16,408	-0.12%
NetPass	PSN	2,913	1,455	4	129	4,501	2.07%	4,672	-3.66%
Pediatric Associates	PSN	9,800	540	0	2	10,342	4.76%	10,179	1.60%
SFCCN	PSN	4,184	2,088	1	152	6,425	2.96%	6,779	-5.22%
PSN Total		**47,008**	**12,774**	**13**	**721**	**60,516**	**27.87%**	**60,913**	**-0.65%**
Reform Enrollment Totals		**184,662**	**29,806**	**36**	**2,595**	**217,099**	**100.00%**	**212,195**	**2.31%**

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

The enrollment figures for this quarter reflect those beneficiaries who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 217,099 beneficiaries enrolled in the demonstration during this quarter. There were 17 Reform health plans with market shares ranging from 0.08 percent to 25.30 percent.

2. Medicaid Reform Enrollment by County Report

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

Table 10
Number of Reform Health Plans in Demonstration Counties

County Name	# of Reform HMOs	# of Reform PSNs
Baker	**1**	**1**
Broward	**11**	**5**
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

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

Table 11
Medicaid Reform Enrollment by County Report Descriptions

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

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

Table 12
Medicaid Reform Enrollment by County Report
(Fiscal Year 2007-08, 3nd Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
United Health Care	HMO	Baker	548	87	0	7	642	26.43%	512	25.39%
Access Health Solutions	PSN	Baker	1,596	187	0	4	1,787	73.57%	1,690	5.74%
Total Reform Enrollment for Baker			**2,144**	**274**	**0**	**11**	**2,429**	**100.00%**	**2,202**	**10.31%**
Amerigroup	HMO	Broward	12,390	1,584	2	166	14,142	11.41%	13,242	6.80%
Buena Vista	HMO	Broward	6,047	699	1	55	6,802	5.49%	6,929	-1.83%
Freedom Health Plan	HMO	Broward	140	28	0	4	172	0.14%	44	290.91%
HealthEase	HMO	Broward	14,616	1,560	4	129	16,309	13.16%	16,383	-0.45%
Humana	HMO	Broward	8,467	1,955	3	229	10,654	8.60%	10,825	-1.58%
Preferred Medical Plan	HMO	Broward	1,442	448	0	48	1,983	1.56%	2,034	-4.72%
StayWell	HMO	Broward	28,540	2,731	5	249	31,525	25.44%	30,954	1.84%
Total Health Choice	HMO	Broward	1,497	317	2	42	1,858	1.50%	1,642	13.15%
United Health Care	HMO	Broward	7,137	1,105	3	204	8,449	6.82%	7,920	6.68%
Universal Health Care	HMO	Broward	158	40	0	2	200	0.16%	79	153.16%
Vista South Florida	HMO	Broward	4,618	447	2	72	5,139	4.15%	4,477	14.79%
Access Health Solutions	PSN	Broward	2,210	848	1	58	3,117	2.52%	3,377	-7.70%
CMS North Broward	PSN	Broward	692	1,021	0	9	1,722	1.39%	1,648	4.49%
CMS South Broward	PSN	Broward	279	350	0	4	633	0.51%	595	6.39%
Netpass	PSN	Broward	2,913	1,455	4	129	4,501	3.63%	4,672	-3.66%
Pediatric Associates	PSN	Broward	9,800	540	0	2	10,342	8.35%	10,179	1.60%
SFCCN	PSN	Broward	4,184	2,088	1	152	6,425	5.18%	6,779	-5.22%
Total Reform Enrollment for Broward			**105,130**	**17,216**	**28**	**1,554**	**123,928**	**100.00%**	**121,779**	**1.76%**
United Health Care	HMO	Clay	2,800	240	0	23	3,063	36.03%	2,334	31.23%
Access Health Solutions	PSN	Clay	4,716	697	0	26	5,439	63.97%	5,227	4.06%
Total Reform Enrollment for Clay			**7,516**	**937**	**0**	**49**	**8,502**	**100.00%**	**7,561**	**12.45%**
HealthEase	HMO	Duval	34,230	4,008	0	376	38,614	49.02%	38,999	-0.99%
StayWell	HMO	Duval	2,952	367	0	60	3,379	4.29%	3,442	-1.83%
United Health Care	HMO	Duval	10,782	1,221	1	186	12,190	15.48%	10,500	16.10%
Universal Health Care	HMO	Duval	323	33	0	3	359	0.46%	103	248.54%
Access Health Solutions	PSN	Duval	5,111	1,077	2	70	6,260	7.95%	6,506	-3.78%
CMS	PSN	Duval	795	778	0	3	1,576	2.00%	1,489	5.84%
First Coast Advantage	PSN	Duval	12,655	3,470	5	259	16,389	20.81%	16,408	-0.12%
Total Reform Enrollment for Duval			**66,848**	**10,954**	**8**	**957**	**78,767**	**100.00%**	**77,447**	**1.70%**
United Health Care	HMO	Nassau	967	162	0	19	1,148	33.05%	863	33.02%
Access Health Solutions	PSN	Nassau	2,057	263	0	5	2,325	66.95%	2,343	-0.77%
Total Reform Enrollment for Nassau			**3,024**	**425**	**0**	**24**	**3,473**	**100.00%**	**3,206**	**8.33%**
Reform Enrollment Totals			**184,662**	**29,806**	**36**	**2,595**	**217,099**		**212,195**	**2.31%**

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

During this quarter there was an enrollment of 2,429 beneficiaries in Baker County, 123,928 beneficiaries in Broward County, 8,502 beneficiaries in Clay County, 78,767 beneficiaries in Duval County, and 3,473 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 26.43 percent to 73.57 percent, 17 Broward County Reform plans with market shares ranging from 0.14 percent to 25.44 percent, two Clay County Reform plans with market shares ranging from 36.03 percent to 63.97 percent, seven Duval County Reform plans with market shares ranging from 0.46 percent to 49.02 percent, and two Nassau County Reform plans with market shares ranging from 33.05 percent to 66.95 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 13 and 14 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who voluntarily chose to enroll in a Medicaid Reform health plan. Table 13 provides a description of each column in this report.

Table 13
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 14 lists the number of individuals in the voluntary populations who chose to voluntarily enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 14
Medicaid Reform Voluntary Population Report
(Fiscal Year 2007-08, 3rd Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	4	67	0	23	22	133	249	1.77%	14,142
Buena Vista	HMO	Broward	1	14	1	9	3	46	74	1.09%	6,802
Freedom Health Plan	HMO	Broward	0	0	0	0	2	1	3	1.62%	172
Healthease	HMO	Broward	3	116	2	27	12	111	271	1.67%	16,309
Healthease	HMO	Duval	10	470	0	63	20	338	901	2.33%	38,614
Humana	HMO	Broward	0	51	0	24	26	184	285	2.66%	10,654
Preferred Medical Plan	HMO	Broward	0	10	0	5	4	38	57	2.85%	1,938
Staywell	HMO	Broward	4	153	1	49	23	210	440	1.40%	31,525
Staywell	HMO	Duval	0	35	0	4	8	49	96	2.80%	3,379
Total Health Choice	HMO	Broward	0	5	0	2	10	31	48	2.55%	1,858
United Healthcare	HMO	Broward	0	38	3	25	25	169	260	3.08%	8,449
United Healthcare	HMO	Duval	11	137	1	24	35	131	339	2.80%	12,190
United Healthcare	HMO	Baker	0	4	0	0	1	6	11	1.68%	642
United Healthcare	HMO	Clay	0	14	1	5	8	13	41	1.33%	3,063
United Healthcare	HMO	Nassau	1	11	1	0	10	7	30	2.65%	1,148
Universal	HMO	Broward	0	0	0	0	1	0	1	0.48%	200
Universal	HMO	Duval	2	1	0	0	3	0	6	1.56%	359
Vista South Florida	HMO	Broward	3	29	0	16	8	55	111	2.18%	5,139
HMO Total	**HMO**		**39**	**1,155**	**10**	**276**	**221**	**1,522**	**3,223**	**2.06%**	**156,583**
Access Health Solutions	PSN	Baker	0	3	0	1	0	4	8	0.45%	1,787
Access Health Solutions	PSN	Broward	0	15	0	13	1	47	76	2.41%	3,117
Access Health Solutions	PSN	Clay	3	9	0	8	1	21	42	0.78%	5,439
Access Health Solutions	PSN	Duval	1	50	1	12	5	60	129	2.05%	6,260
Access Health Solutions	PSN	Nassau	0	6	0	1	0	3	10	0.43%	2,325
CMS	PSN	Duval	4	30	2	36	0	3	75	4.88%	1,576
CMS North Broward	PSN	Broward	2	23	2	85	0	6	118	7.12%	1,722
CMS South Broward	PSN	Broward	1	4	0	45	0	4	54	8.99%	633
First Coast Advantage	PSN	Duval	2	123	3	67	13	225	433	2.65%	16,389
NetPass	PSN	Broward	0	29	0	26	8	108	171	3.78%	4,501
Pediatric Associates	PSN	Broward	1	67	2	16	1	3	90	0.87%	10,342
SFCCN	PSN	Broward	2	125	2	36	5	135	305	4.67%	6,425
PSN Total	**PSN**		**16**	**484**	**12**	**346**	**34**	**619**	**1,511**	**2.50%**	**60,516**
Reform Enrollment Totals			**55**	**1,639**	**22**	**622**	**255**	**2,141**	**4,734**	**2.18%**	**217,099**

4. Summary of Self-Selection and Assignment Rates and Disenrollment Data

The Summary of Self-Selection and Assignment Rates and Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either by self-selection or by assignment) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 15 provides a description of each column in this report.

Table 15
Summary of Self-Selection & Assignment Rates
& Disenrollment Data Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# Self-Selections	The number of unique beneficiaries who chose to enroll with the plan during the current reporting quarter
# Assigned	The number of unique beneficiaries who were assigned to the plan during the current reporting quarter
Total # Enrolled	The total number of unique beneficiaries who were enrolled with the plan during the current reporting quarter: self-selection and assigned to a plan combined
% Self-Selections	The percentage of the total number of beneficiaries who chose to enroll with the plan during the current reporting quarter
# 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 Reform health plan: by choosing the plan themselves or by being assigned to a plan. Self-selections include newly-eligible beneficiaries who chose 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 the demonstration began are included in the self-selection counts. Assigned enrollments include newly-eligible beneficiaries who have not made a choice and were assigned to a health plan.

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the current reporting quarter but then left the program. The count is performed by comparing two beneficiary lists: one for the current

reporting quarter and one for the first month after the current reporting quarter. If a beneficiary appears on the current reporting quarter enrollment list, but not on the enrollment list for the first month following the current reporting quarter, the beneficiary is counted as disenrolled. For example, disenrollments for the second quarter of state fiscal year 2007-08 are those beneficiaries who appear on the enrollment list for October 2007 to December 2007, but not on the enrollment list for January 2008.

The unique beneficiary counts in the Summary of Self-Selection and Assignment Rates and Disenrollment Data report are divided by plan type in Table 16. Plans are listed by plan type (Reform HMO first, then Reform PSN) and in alphabetical order. Total counts for the quarter are also provided for HMOs and PSNs as well as the entire Medicaid Reform demonstration.

Table 16
Summary of Self-Selection* & Assignment Rates & Disenrollment Data
(Fiscal Year 2007-08, 3rd Quarter)

Plan Name	Plan Type	Plan County	# Self-Selections	# Assigned	Total # Enrolled	% Self-Selections*	# Disenrolled
Amerigroup	HMO	Broward	13,223	919	**14,142**	**94%**	1,808
Buena Vista	HMO	Broward	6,337	465	**6,802**	**93%**	920
Freedom Health Plan	HMO	Broward	74	98	**172**	**43%**	29
HealthEase	HMO	Broward	15,238	1,071	**16,309**	**93%**	2,084
HealthEase	HMO	Duval	36,692	1,922	**38,614**	**95%**	5,036
Humana	HMO	Broward	9,906	748	**10,654**	**93%**	1,309
Preferred Medical Plan	HMO	Broward	1,439	499	**1,938**	**74%**	329
StayWell	HMO	Broward	30,031	1,494	**31,525**	**95%**	4,072
StayWell	HMO	Duval	2,166	1,213	**3,379**	**64%**	598
Total Health Choice	HMO	Broward	1,337	521	**1,858**	**72%**	297
United Health Care	HMO	Baker	7,781	668	**8,449**	**92%**	1,283
United Health Care	HMO	Clay	10,624	1,566	**12,190**	**87%**	1,818
United Health Care	HMO	Broward	506	136	**642**	**79%**	80
United Health Care	HMO	Duval	2,699	364	**3,063**	**88%**	486
United Health Care	HMO	Nassau	1,014	134	**1,148**	**88%**	171
Universal Health Care	HMO	Broward	94	106	**200**	**47%**	30
Universal Health Care	HMO	Duval	70	289	**359**	**19%**	72
Vista South Florida	HMO	Broward	4,765	374	**5,139**	**93%**	714
HMO Total			**143,996**	**12,587**	**156,583**	**92%**	**21,136**
Access Health Solutions	PSN	Baker	1,681	106	**1,787**	**94%**	260
Access Health Solutions	PSN	Clay	2,677	440	**3,117**	**86%**	436
Access Health Solutions	PSN	Broward	5,069	370	**5,439**	**93%**	893
Access Health Solutions	PSN	Duval	4,913	1,347	**6,260**	**78%**	909
Access Health Solutions	PSN	Nassau	2,240	85	**2,325**	**96%**	397
CMS North Broward	PSN	Broward	1,576	0	**1,576**	**100.00%**	126
CMS South Broward	PSN	Broward	1,722	0	**1,722**	**100.00%**	138
CMS	PSN	Duval	633	0	**633**	**100.00%**	50
First Coast Advantage	PSN	Duval	14,813	1,576	**16,389**	**90%**	2,072
Netpass	PSN	Broward	4,019	482	**4,501**	**89%**	558
Pediatric Associates	PSN	Broward	9,959	383	**10,342**	**96%**	1,325
SFCCN	PSN	Broward	5,511	914	**6,425**	**86%**	765
PSN Total			**54,813**	**5,703**	**60,516**	**91%**	**7,929**
Reform Enrollment Totals			**198,809**	**18,290**	**217,099**	**92%**	**29,065**

* Self-selection totals include newly-eligible beneficiaries who chose which plan to enroll in, as well as beneficiaries who chose to stay in the health plan they were transitioned into.

For this quarter, there were 198,809 self-selections (92 percent) in Medicaid Reform. Of those, 143,996 beneficiaries were enrolled in an HMO and 54,813 were enrolled in a PSN.

D. Opt Out Program

Overview

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

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

Description of Opt Out Process

Medicaid beneficiaries interested in the Opt Out Program are referred to HMS by 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 he or she 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. Monitoring includes reviewing the HMS invoices to ensure all Opt Out enrollees are currently Medicaid eligible and premium payment amounts are accurate. In addition, the Agency reviews Opt Out enrollee files to ensure they are complete and include required documentation (e.g., release to contact employer, employment questionnaire and enrollment letter).

Current Activities

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

In addition, an Invitation to Negotiate was released during the third quarter of Year Two on January 22, 2008 for Third Party Liability Recovery Services that included the Opt Out Program. The current Opt Out contract with HMS will expire on April 30, 2008. The Agency plans to contract with one Vendor for Third Party Liability Recovery Services and the Opt Out Program beginning May 1, 2008.

<u>Opt Out Program Statistics</u>

- Over 100 calls have been received at the Opt Out toll-free call center since September 1, 2006 when the program began accepting enrollment.
- 32 of the calls have resulted in enrollment into the Opt Out Program.
- At the end of the third quarter of Year Two, 13 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance.
- At the end of the third quarter of Year Two, there are currently 19 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

1. The caller was enrolled in the Opt Out Program during the second quarter of Year One with a coverage effective date of October 1, 2006. This caller lost her

job during the third quarter of Year One and was subsequently disenrolled from the Opt Out Program on February 28, 2007. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

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

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

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

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

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

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

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

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

Table 17 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending March 31, 2008. Current Opt Out enrollment, as of March 31, 2008, is 19.

Table 17
Opt Out Statistics
September 1, 2006 –March 31, 2008

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	12/31/07	Loss of Medicaid Eligibility
Children & Family	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance

Table 17 Opt Out Statistics September 1, 2006 –March 31, 2008						
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	06/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	08/01/07	Large Employer	Family	1	Still Enrolled	N/A
Children & Family	09/01/07	Small Employer	Family	1	Still Enrolled	N/A
Children & Family	10/01/07	Large Employer	Family	3	Still Enrolled	N/A
Children & Family	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	11/01/07	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	01/01/08	Large Employer	Family	2	Still Enrolled	N/A
Children & Family	01/01/08	Large Employer	Family	1 1	Still Enrolled 02/29/08	NA Loss of Medicaid Eligibility
Children & Family	02/01/08	Large Employer	Family	1	02/01/08	N/A
SSI	02/01/08	Large Employer	Family	1	02/01/08	N/A
Children & Family	03/01/08	Large Employer	Family	1	03/01/08	N/A
Children & Family	03/01/08	Large Employer	Family	1	03/01/08	N/A
Children & Family	03/01/08	Large Employer	Family	1	03/01/08	N/A

E. Enhanced Benefits Program

Overview

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

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

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

Current Activities

1. Call Center Activities

During this quarter, the Medicaid Reform Enhanced Benefits Call Center, located in Tallahassee, Florida, continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The call center hours of operation changed January 1, 2008. The new hours are 8:00 a.m. - 8:00 p.m., Monday – Thursday, and on Friday 8:00 a.m. - 7:00 p.m. The Saturday hours have been discontinued on a trial period and will be evaluated to determine if the new call center hours of operation are effective.

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

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

2. System Activities

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

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day each month. The Enhanced Benefits Information System (EBIS) continues to operate effectively with minor modifications to ensure efficient processing of enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each recipient who has activity for the month and a quarterly statement process for recipients who have a balance only with no new activity. The Enhanced Benefits Advisory Panel is working on making changes to the statement to reflect a more user-friendly product that will also entice the beneficiary to utilize their earned credits.

With the upcoming transition to the new Florida Medicaid fiscal agent, the vendor of EBIS has been working with the new fiscal agent in testing the credit file which occurs monthly and the debit files that occurs weekly between EBIS and the Pharmacy Point of Sale system.

3. Outreach and Education for Beneficiaries

The welcome packets continue to be mailed to new Medicaid Reform enrollees every month, which provides detailed information regarding their eligibility for the program and the benefits provided through the program. The package contains an EBAP brochure and a letter to the enrollee regarding the program. Feedback from call center staff and review of enhanced benefits activities indicates that the packets may not be achieving the intended educational outcome. The Agency reviewed the welcome packet, in conjunction with the Enhanced Benefits Panel, to evaluate if the packet is being used as originally intended and if modifications are needed. The Panel recommended that the brochure no longer be sent and instead a two page letter would be mailed to beneficiaries. The money saved from the brochure printing cost will be used for additional outreach to beneficiaries to increase usage. The Panel also took additional action to promote usage of the program and those actions are highlighted in the Enhanced Benefits Panel section.

The statement inserts continue to generate positive results. In the second quarter of demonstration Year Two, the Agency began inserting one-page flyers with the Enhanced Benefit statements. These flyers promoted specific products beneficiaries could purchase. Each month the inserts promote a theme, such as heart health for February. The Agency is looking at additional uses for these flyers, such as making available for pharmacies to use in their stores. New and innovative ideas will continue

to be pursued to increase usage of the credits earned. The steps the Agency has under taken to increase the amount of credits that beneficiaries use has been very successful. This quarter is the highest number of credits used in a quarter to date (total of $703,818.62) and the highest call volume at the Enhanced Benefits Call Center.

4. Outreach and Education for Pharmacies

The Agency continues to provide EBAP outreach and education to pharmacies regarding the new billing process for the program. The Enhanced Benefit Call Center has also assisted in fielding call regarding the new billing procedures by faxing over instructions and referring pharmacies to receive assistance.

Agency staff received push back from many corporate pharmacies regarding the recent system change to disallow the dispensing fee. Pharmacy participation is crucial in the success of beneficiaries purchasing over-the-counter (OTC) products. Because of this feedback, the Agency is considering some changes in the manner that an Enhanced Benefit claim processes within Florida Medicaid. The intention is to reimburse pharmacies the "shelf price" of an OTC item instead of the Medicaid pricing. This process would require a managerial over-ride or some other intervention to submit a usual and customary price for an OTC item to Florida Medicaid that matches the posted shelf price for that item.

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

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel held meetings on February 1, 2008 and March 28, 2008. The primary focus of the meetings was to discuss the welcome packet materials, health plan utilization of the healthy behavior credits, and beneficiary usage of credits. Highlights of the Panel meetings are described below:

- Analysis of data from the first year of operating the EBAP (September 1, 2006 through June 2007) indicated that 49 percent of the dollars earned were for regular office visits or for non-preventive type services. Therefore, the Panel decided to decrease the credit amount and occurrence limit for those types of behaviors beginning July 1, 2008.
- The Panel decided to change the program name from Enhanced Benefits Account Program to Enhanced Benefits Rewards Program. This change was based on feedback received during the public meetings held in November and December of 2007.
- The Panel decided to discontinue mailing the brochure with the welcome packet materials and instead send a welcome letter developed by the Agency’s Enhanced

Benefits Quality Team. This change was made as beneficiaries were not utilizing the brochure; many didn't recall receiving the brochure.

All of these new initiatives, along with other outreach material that will be developed by the Agency's Enhanced Benefits Quality Team, are scheduled to be implemented July 1, 2008.

6. Enhanced Benefits Statistics

Table 18 provides the Enhanced Benefit Account Program statistics beginning January 1, 2008 and ending March 31, 2008.

Table 18
Enhanced Benefit Account Program Statistics

3rd Quarter Activity – Year Two		January 08	February 08	March 08
I.	**Number of plans submitting reports by month**	30 of 31	30 of 31	30 of 31
II.	**Number of enrollees who received credit for healthy behaviors by month**	32,927	35,280	36,397
III.	**Total dollar amount credited to accounts by each month**	$853,935.00	$893,972.50	$925,917.50
IV.	**Total cumulative dollar amount credited through the end each month**	$10,699,226.16	$11,593,198.66	$12,519,116.16
V.	**Total dollar amount of credits used each month by date of service**	$192,645.31	$201,582.12	$310,262.53
VI.	**Total cumulative dollar amount of credits used through the month by date of service**	$710,094.49	$911,658.98	$1,221,121.51
VII.	**Total cumulative number of enrollees who used credits through the end of each month**	18,097	21,716	27,140

7. Complaints

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

In April 2007, when the operation of the EBAP was transitioned to the Medicaid Choice Counseling Unit of the Agency, a tracking system for Enhanced Benefits complaints was put in place. The fourth quarter report of demonstration Year One contained the first reporting of Enhanced Benefits complaints that were identified without a central

reporting structure. This is the second quarterly report that has contained a complete reporting of Enhanced Benefits complaints.

During this quarter, over 9,000 beneficiaries purchased one or more products with his or her Enhanced Benefits credits, and 101 complaints were recorded through the call center, the Enhanced Benefits mailbox, or sent directly to the Agency related to the EBAP. Table 19 provides a summary of the complaints and outlines the actions taken by either the Agency or ACS to address the issues raised.

Table 19
Enhanced Benefit Beneficiary Complaints

Beneficiary Complaint	Action Taken
1. Sixty-three beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical assistance to pharmacies regarding Enhanced Benefit Account Program.
2. Twenty-one beneficiaries complained about pricing differences between shelf price and what is charged.	➲ Pharmacy Services followed up on some, possible customer service request (CSR) to allow usual and customary price for an OTC item to be shelf price.
3. Seventeen beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching at the pharmacy.	➲ The Agency has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list. Enhanced Benefits Quality Team is working on a solution.

F. Low Income Pool

Overview

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

- On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. On March 16, 2006, CMS requested additional information of these sources and the Agency submitted a revised source of non-Federal share funding to be used to access the LIP funding to CMS on April 7, 2006.
- On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement. CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006.
- On June 27, 2006, Florida submitted a State Plan Amendment (SPA) # 06-006 to CMS to terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. In the event of termination of the Florida Medicaid 1115 Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State has agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

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

Current Activities

During the third quarter of State Fiscal Year (SFY) 2007-2008, the Low Income Pool (LIP) Council held two meetings.

January 11, 2008 Meeting

The LIP Council held its first meeting of the quarter at Tampa International Airport on January 11, 2008, from 10:00 am to 4:00 pm. The members listened to presentations from six counties where monies were requested for various health care initiatives. The

remainder of the meeting was dedicated to review of the exemption costs, three funds distribution models (Models 12, 13 and 14) for SFY 2008-2009 and LIP alternatives. The meeting closed with the reminder of the tight schedule for reviewing the current and proposed models at the next and last LIP Council meeting prior to making recommendations, January 30, 2008.

January 30, 2008 Meeting

The LIP Council held its second meeting of the quarter at the Hyatt Regency Orlando International Airport on January 30, 2008 from 10:00 a.m. to 4:00 p.m. All Low Income Pool Council members were present and were presented with one final request for funds from a participating county. The remainder of the meeting was spent reviewing the seven models requested during and after the January 11, 2008 LIP Council meeting. All seven models incorporated $43 million in new State General Revenue Funds (GR) for the LIP program and $639 million as the cost of exemptions. After much discussion, the LIP Council members voted, selecting Model 21B as the model to be sent to the Governor and Legislature. This model was not selected unanimously, as three council members were against this recommendation.

The LIP Council recommendations for SYF 2008-09 include a request for a $43.1 million increase in GR above the base funding to allow for full utilization of the federal LIP authorization of $1 billion. In addition to the GR increases, local matching funds have increased by $54.3 million. The recommendations also provide for full funding of the Disproportionate Share Program (DSH) and the Exemptions Program. While many current policies were maintained, a policy change was made to eliminate the current LIP distribution models LIP 1, LIP 2 and LIP 3. The Council recommends a modified version of LIP 2, which maintained current percentage distributions at 20% and increased the allocation of funding based on Medicaid, Charity and Bad Debt as a distribution model. Other policy modifications include the limited use of public hospital operating funds as part of the local match, shifts of funding from the Special Medicaid Payments component to the Disproportionate Share program, a restricted hold-harmless on payments to rural hospitals and an increased funding level for local health care projects.

On February 4, 2008, the LIP Council Chair, Paul Belcher, sent the LIP Council recommendations for SFY 2008-09 with a letter to Secretary Andrew Agwunobi to forward to the Governor and Legislature on behalf of the LIP Council. This letter and attachment can be accessed by clicking on the links below:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/pdf/lip_recommendation_sfy_08-09.pdf

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/pdf/21b_amended_final.pdf

On February 25, 2008, LIP Council Chair Belcher sent a detailed report regarding the LIP Council recommendations to Secretary Holly Benson. The letter can accessed by clicking on the link below.

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/pdf/letter_to_sec_benson_lip_report_sfy_2008-09.pdf

Distribution of LIP Funds

The Agency is continuing to work with local governments and taxing districts to complete all outstanding Letters of Agreement. A total of $319,005,892 in LIP distributions were made to Provider Access Systems during the Third Quarter of SFY 2007-08.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

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

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

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

Budget Neutrality figures were not included in the previous quarterly report as the Agency was researching unexpected variances in the case months for the eligible but not enrolled population, which are recipients who are a mandatory population but are located in non-reform counties. The Agency contacted the Centers for Medicare and Medicaid Services (CMS) to discuss the variance and possible changes. It was

determined by the Agency and CMS that it would be appropriate to hold the submission of these figures until the Agency had identified and corrected all issues pertaining to the variance(s).

The figures in this report reflect case months and expenditures for each quarter of the reform period revised to account for accurately capturing persons and expenditures that are subject to the calculation and monitoring of the Budget Neutrality for the waiver. In previous quarters, expenditures and case months were inadvertently reported and used in the calculation of the Budget Neutrality report for populations that receive services through the reform providers but were not subject to the Budget Neutrality. These populations include children in foster care and Medikids enrollees. Appropriate adjustments have been made to realign system queries in order to generate case month and expenditure data that reflect the case month and expenditure data that were used to establish the Budget Neutrality benchmarks as defined in the Special Terms and Conditions.

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

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

Table 20 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 20
PCCM Targets

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

Tables 21 through 25 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2008. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 21
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$631,026,668**	**$101,625,698**	**$732,652,367**	**$969.86**
Q6 Total	**755,837**	**$648,854,499**	**$106,417,494**	**$755,271,992**	**$999.25**
January 2008	252,534	$287,896,155	$50,059,242	$337,955,397	$1,338.26
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
MEG 1 Total	**5,247,683**	**$4,377,504,708**	**$545,739,923**	**$4,923,244,632**	**$938.17**

Table 22
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,322,235**	**$57,361,588**	**$577,683,823**	**$160.99**
Q6 Total	**3,648,832**	**$553,767,997**	**$63,871,154**	**$617,639,151**	**$169.27**
January 2008	1,231,168	$273,615,263	$39,329,414	$312,944,677	$254.19
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
MEG 2 Total	**26,136,226**	**$3,810,457,311**	**$315,763,932**	**$4,126,221,243**	**$157.87**

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

For Demonstration Year One; MEG 1 has a PCCM of $965.41 (Table 23), compared to WOW of $948.79 (Table 20), which is 101.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $159.85 (Table 23), compared to WOW of $199.48 (Table 20), which is 80.13% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $902.42 (Table 23), compared to WOW of $1,024.69 (Table 20), which is 88.07% of the target PCCM for MEG 1. MEG 2 has a PCCM of $155.14 (Table 23), compared to WOW of $215.44 (Table 20), which is 72.01% of the target PCCM for MEG 2.

Tables 23 and 24 provide cumulative expenditures and case-months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case-months. In addition, the PCCM targets as provided in the Special Terms and Conditions are also weighted using the actual case-months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 24) is $328.24. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 24 is $292.11. Comparing the calculated weighted averages, the actual PCCM is 88.99% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 24) is $354.11. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 24 is $283.20. Comparing the calculated weighted averages, the actual PCCM is 79.97% of the target PCCM.

Table 23
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,614,783,986	$260,619,852	$2,875,403,838	$965.41
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$49,513,470	
% of WOW PCCM MEG 1					101.75%
DY01 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162.819	$2,288,455,951	$135,323,294	$2,423,779,246	$159.85
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				($600,899,889)	
% of WOW PCCM MEG 2					80.13%
DY02 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY02 Total	2,269,268	$1,762,720,723	$285,120,071	$2,047,840,794	$902.42
WOW DY2 Total	2,269,268			$2,325,296,227	$1,024.69
Difference				($277,455,433)	
% of WOW PCCM MEG 1					88.07%
DY02 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	10,973,407	$1,522,001,360	$180,440,638	$1,702,441,997	$155.14
WOW DY2 Total	10,973,407			$2,364,110,804	$215.44
Difference				($661,668,807)	
% of WOW PCCM MEG 2					72.01%

Table 24
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
Meg 1 & 2	18,141,234	$4,903,239,937	$395,943,147	$5,299,183,084	$292.11
WOW	18,141,234			$5,850,569,502	$328.24
Difference				($551,386,418)	
% Of WOW					88.99%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	13,242,675	$3,284,722,082	$465,560,708	$3,750,282,791	$283.20
WOW	13,242,675			$4,689,407,031	$354.11
Difference				($939,124,240)	
% Of WOW					79.97%

Table 25
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,737**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Total Paid	**$1,591,649,296**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,050	$1,000,000,000	99.88%
DY02	$592,843,246	$1,000,000,000	59.28%
Total MEG 3	$1,591,649,296	$5,000,000,000	31.83%

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

The expenditures for the first seven quarters for MEG 3, the Low Income Pool (LIP), were $1,591,649,296 (31.83% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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

Current Activities

During the quarter January 1, 2008 - March 31, 2008, to comply with the requirements of the Medicaid Reform Waiver, health care pharmacy and Medicaid enrollee information were collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid population. The Reform health plans were assigned a plan risk factor based on the aggregate risk scores of their enrolled populations under Medicaid Reform. Health plan factors, budget neutrality and the derived risk corridor plan factor have been applied to capitated premium rates beginning in October 2006 and each subsequent month thereafter for Medicaid enrolled populations in Reform counties. This quarter's activities included:

- Medicaid continues collecting and processing pharmacy encounter data on a quarterly basis. The recent 12-month measurement period used in the Medicaid Rx methodology for risk-adjusting Reform capitation rates was July 1, 2006 through June 30, 2007 paid through September 30, 2007. This measurement period was used to generate risk adjustment factors for the health plans operating in the demonstration counties.
- Pharmaceutical data will continue to be collected and processed through Medicaid Rx to support risk adjustment capitation rate premium calculations until encounter data for all services is of sufficient quality and completeness to transition to the CDPS (Chronic Illness and Disability Payment System) risk adjustment model.

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

- Health Plans are in various stages of production readiness to submit X12 encounter data. Three (3) HMOs have submitted test files and received certifications to submit X12 837 encounter claims. Additionally, encounter data for the period of September 2006 through December 2007 is being collected under the incumbent Fiscal Agent / FMMIS from six (6) HMOs. A total of 1,981,663 encounter claims for the period September 2006 – December 2007 has been received and processed. One (1) HMO has not submitted X12 837 encounter data but successfully demonstrated the capability to generate X12 837P transactions, and one (1) HMO has not submitted test files for certification.
- Two (2) PSNs have submitted test files demonstrating their capability to generate X12 HIPAA compliant 837P transportation claims. One of these two PSNs has submitted a total of 687 capitated transportation encounter claims for the period September 2006 through December 2007. Other PSNs continue to complete tasks associated with certification and submission of test files.
- The MEDS team continues to participate in the development of the new Florida MMIS for encounter processing.
- During this quarter, the MEDS team focused on working with health plans and the Agency's future PBM (First Health) under the new fiscal agent (EDS) to coordinate the collection of encounter pharmacy claims using the NCPDP format beginning July 2008. Throughout this period, seven (7) HMOs have submitted test files for certification; six (6) of these are in various states of testing readiness.
- The MEDS team is continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the health plans.
- Participation of the MEDS team in "stand-alone" meetings with health plans and biweekly technical and operations meetings continued during this period.
- Reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content to capitated health plans is continuing to be validated and tested by the MEDS team and incumbent Fiscal Agent.
- Design of the data structure and supporting processes to extract encounter claims to the Medicaid Decision Support System (DSS) is continuing.
- The MEDS team is continuing to work with health plans to resolve technical and X12 transaction format and content questions.

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, will continue. The scheduled activities associated with the testing and subsequent implementation of MEDS is also continuing. The activities include 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.

Independent Evaluation of the Medicaid Rx model

In October 2007, Senate Bill 2-C General Appropriations Act (also known as Chapter 2007-326 Laws of Florida) was passed during the Florida Legislative Special Session. This bill allocated $400,000 to the Agency for an independent evaluation of the MedRx methodology for risk-adjusting Medicaid Reform capitation rates. Specifically, the bill requires the evaluation to:

- Analyze and compare the predictive accuracy of MedRx for HMO and fee-for-service populations.
- Identify and quantify any effect as a result of the implementation of pharmacy management systems or other management tools by HMOs on the measurement of expected health care costs or health service utilization. If such an effect is found to exist, recommend specific adjustments to the methodology or its results that will assure the capitation rates fairly and reliably predict resource needs.
- Report on the Reform plans' medical expense and other financial data related to the first contract year of Medicaid reform in each county.
- Assess the impact of MedRx and Chronic Illness and Disability Payment System (CDPS) both during the initial implementation of Medicaid Reform and prospectively, on the financial viability of capitated HMOs and PSNs.

During this quarter, the Agency released a Scope of Work document for this mandated evaluation to potential vendors identified from the Florida State Term Contracts listing. Since there were no respondents and the allocated funds are for SFY 2007 - 2008, the Agency is currently awaiting direction from the Legislature on this evaluation.

I. Demonstration Goals

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

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

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

As reported previously, the Agency has established contracts with 11 HMOs and 5 PSNs for a total of 17 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. One of the plans is a specialty PSN plan which serves children with chronic conditions in both Broward and Duval Counties. The number and types of health plans that beneficiaries can choose from in Broward and Duval Counties increased considerably with the implementation of the Medicaid Reform Waiver. Additionally, the Agency established contracts with 1 HMO and 1 PSN in Baker, Clay and Nassau counties and enrollment began in September 2007. None of these health plan options previously had a presence in these three counties.

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

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

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

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

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

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

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

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

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

Improving Access to Specialists

The 1115 Medicaid Reform Waiver is designed to improve access to specialty care for beneficiaries. Through the contracting process, each Reform health plan is required to provide documentation to the Agency of a network of providers including specialists that will guarantee access to care for beneficiaries. As the first year of the demonstration ended, the Agency had begun the first intensive review of the Reform health plan provider network files to evaluate the effectiveness of Reform in improving access. The analysis includes the following steps.

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

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

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

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

During this quarter, the Agency finished analyzing the December 2007 survey data and worked to improve the survey and validation process. This quarter the survey tool was revised and Agency staff were trained on the new tool. In March 2008, the Agency pulled a sample of 300 providers across the state, 15 from each health plan, to be surveyed. Additionally, a focused sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist), was pulled from Area 10 (Broward County). The Agency is currently analyzing the March 2008 survey results. In the fourth quarter of demonstration Year Two, the Agency will analyze and report on the March and April 2008 survey results.

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

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

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

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

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

Last quarter, the Agency became aware that the National Committee for Quality Assurance had retired two HEDIS measures that were included on the Agency's list of 33 performance measures required for Medicaid Reform. During this quarter, the Agency modified the measure selection based on NCQA's changes. Both the health plans and Florida's contracted External Quality Review Organization were asked to review and comment on the Agency's proposed replacement measures. Specifications for the Year Two disease management measures were provided to the plans as well. No comments or concerns were submitted to the Agency by the health plans, and the Agency adopted the replacement measures.

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

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

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

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

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

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

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

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

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

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

While these findings cannot be used to assess the success or failure of Reform at this time, they demonstrate some aspects of how Medicaid enrollees are responding to the program changes. Key findings from the longitudinal qualitative study are summarized in Section J of the last quarterly report (October 1, 2007 – December 31, 2007).

The Agency also intends to evaluate patient experiences with care for those who are in 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, beneficiaries' experiences with care will be assessed during 2008 to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for at least six months.

The Agency originally planned to conduct the disease management patient satisfaction surveys in the fall of 2007. In June and July 2007, the Reform plans submitted disease management enrollment figures to the Agency. These data showed variability in the plans' identification and enrollment of beneficiaries, making it difficult to compare the Reform plans' disease management programs. That is, the number of enrollees varied greatly across Reform plans, preventing statistically valid comparisons between the enrollees' rates of satisfaction by plan. At this time, the Agency is determining how best to measure patient experiences with care for their chronic conditions under Reform, in order to have the most meaningful and useful results.

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

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

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

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

As required under STC # 102 in Demonstration Year Two, the State 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 of demonstration Year One, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for the study required in Year Two of the demonstration.

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

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

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

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

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

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

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

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

The Provider Access Systems input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the UF LIP Evaluation team. The UF LIP Evaluation team will use the data (along with data previously submitted such as pre-LIP payments, IGTs, charge, cost, and utilization information) to perform their annual evaluations of

LIP. In addition, the LIP Milestone reports were used for the cost effectiveness study. The UF provided a “Plan for Evaluation of the Low Income Pool Program” to the Agency. The cost effectiveness will be measured in the method described below.

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

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

The Agency continued to work with the UF LIP Evaluation team during this quarter and anticipates receiving the final “Evaluation of The Low-Income Pool Program Using Milestone Data: SFY 2005-06 and SFY 2006-07” during the fourth quarter of demonstration Year Two. The final document will include an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC # 102).

J. Evaluation of Medicaid Reform

Overview

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

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

A. Evaluations Affiliated with the Agency or its Contractors

Agency Internal Review

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

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

Some of the conclusions of this report are as follows:

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

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

Highlights of recommendations from the report are listed below.

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

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

Urban Institute – Early Impact of Transitioning to Medicaid Reform

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

In March 2008, a longitudinal follow-up survey was initiated in Broward and Duval Counties. These Medicaid enrollees completed the pre-Reform baseline surveys one year ago, and are now being asked to share their experiences one year into Reform. In April 2008, a cross-sectional survey will be fielded with Medicaid enrollees in Broward and Duval Counties to understand their experiences with Medicaid Reform. These enrollees will be interviewed for the first time.

University of Oregon – Impact of Incentivizing Healthy Behaviors

UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid Reform beneficiaries. Data collection was by means of focus

groups and telephone surveys. All data sets were delivered to the University of Oregon during 2007. The report compared the Enhanced Benefits Programs in Florida and Idaho, and is available at the University of Oregon website: http://pppm.uoregon.edu/index.cfm?mode=news&id=506.

Florida State University – Choice Counseling Program

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

University of Florida – Low Income Pool Study

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

As of March 2008, the following LIP reports were completed:

- Pre-Reform Evaluation of Low-Income Pool Program Using FHURS Data: SFY 2004-05, and
- Evaluation of Low-Income Pool Program Using Milestone Reporting Data: SFY 2005-06 and SFY 2006-07.

B. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

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

General Accounting Office

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

The General Accounting Office conducted an additional review of Florida's 1115 Medicaid Reform Waiver and the Vermont 1115 Demonstration Waiver. The report entitled "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns (GAO-08-87)" was released in January 2008 and available on the GAO website: http://www.gao.gov/index.html.

Current Activities

Highlights of this quarter's activities include data collection for future analysis and reporting. A summary of the evaluation activities conducted during this quarter include:

Data Collection

Rural Expansion Counties
Baseline or benchmark CAHPS survey data from the rural expansion counties of Baker, Clay, and Nassau were collected in 2007. All surveys were administered prior to beneficiaries receiving services under Reform.

Broward and Duval Counties
The beneficiary satisfaction data collected in the first year of the demonstration will be compared to the benchmark or baseline data collected (pre-Reform implementation). This preliminary report scheduled to be released in the summer of 2008 will start to yield some comparison of beneficiary satisfaction with health care services provided under Medicaid Reform and non-reform.

Annual Community Stakeholder Survey
From January to March 2008, UF conducted the second annual Community Stakeholder Survey using SurveyMonkey, a web-based survey tool. The survey includes questions on the individual overall experiences, cost, challenges, and successes of Medicaid Reform. The completed report will also include a comparative analysis of the 2007 and 2008 surveys.

Reports

In January 2008, UF released the following reports and Issue Briefs to AHCA:

- Progress Report on Key Aspects of the Evaluation Phase 4: July - December 2007,
- Medicaid Reform in Florida, Key Events and Activities in 2007,
- Medicaid Reform Interim Findings from Round 2 of the Longitudinal Study,
- MRE Draft Issue Brief 1 Reform Organizations,
- MRE Draft Issue Brief 2 Enhanced Benefits Accounts & Choice Counseling,
- MRE Draft Issue Brief 3 Longitudinal Study,
- MRE Draft Issue Brief 4 Expenditures, and
- MRE Draft Issue Brief 5 CAHPS Survey.

The reports are available on the MRE website at http://mre.phhp.ufl.edu/.

K. Policy and Administrative Issues

Current Activities

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

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

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

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

Medicaid Reform Technical Advisory Panel (TAP)

The Medicaid Reform Technical Advisory Panel (TAP) in the third quarter of Year Two focused on updates on risk-adjusted rates, choice counseling, enhanced benefit and Medicaid encounter data collection updates as well as a discussion of the upcoming transition in Medicaid fiscal agents.

Policy Transmittals and Dear Provider Letters

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

- Advisement to Reform PSNs on how to submit enrollment level increases to the Agency.
- Advisement to the Reform health plans on the process and file formats for the Agency's provision of Medicaid redetermination date information to the health plans, and a request for response from health plans on whether or not they would participate in providing reminder notices to recipients regarding their upcoming Medicaid redetermination dates.
- Advisement to health plans regarding the intent of the Agency to revise the performance measures for Year 2 and Year 3, and soliciting comments.

- Advisement to Reform PSNs that the Agency would provide a National Identification Number (NPI) crosswalk to PSNs so the plans would know how their participating providers had registered their NPI with Florida Medicaid.

Biweekly Technical and Operations Calls

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

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

This quarter there was a wide variance in attendance. In person, 20 to 30 people attended while approximately 120 to 200 people participate by phone, depending on the agenda. With the transition of Medicaid fiscal agents, there has been an increase in the number of participants on the call. Typical agenda items included:

- Discussion on Medicaid fiscal agent transition issues;
- Update information on Choice Counseling Program activities, including the upcoming pharmacy drug finder program that will allow choice counselors to view beneficiary drug information and what the health plans provide, and discussion on disenrollment file submission processes;
- Health plan network provider registration processes;
- National Provider Identification (NPI) registration technical assistance;
- Medicaid Enhanced Benefit Account Program updates;
- Performance measures reporting updates and technical assistance;
- Compliance issues, such as, reminding plans to submit accurate and up-to-date provider network files, updating the provider lists on their respective websites and privacy and security of data;
- Medicaid Encounter Data Systems updates and formal questions and answers;
- External Quality Review Organization Contract Updates and Notification of Webinars and other meeting opportunities.

Fee-for-Service PSN Systems Implementation Issues Calls

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

- National Provider Identification requirements;
- Claims processing provider issues; and
- Crosswalk of files received under the current Medicaid fiscal agent system to files that will be received under the new Medicaid fiscal agent system.

In addition to the monthly PSN systems calls, the Agency continues to coordinate technical assistance calls between a small number of providers and their PSNs to assist providers in getting claims issues addressed. The majority of these efforts focus on providing technical assistance to the providers on correct submission of claims.

Continuous Improvement Team

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

As reported last quarter, the first public forums were held in Broward and Duval counties for providers and beneficiaries in November 2007. This quarter, the Agency conducted forums for providers in Broward and Duval counties on March 5 and 6, 2008, regarding claims processing and service authorizations. These meetings were done in panel format with providers, health plans and Agency staff participating. Separate panel sessions were held for behavioral health providers. Issues for discussion were collected in advance from providers and public notices for the public meetings were included in the Florida Administrative Weekly and the Agency's website. In addition, notices were sent to the Agency's interested parties list as well as to provider attendees at previous forums.

In Duval County, approximately 20 providers and other interested stakeholders attended the general provider session and approximately 35 behavioral health providers and other interested stakeholders attended the behavioral health provider session. In Broward County, approximately 70 providers and other interested stakeholders attended the general provider session and approximately 90 behavioral health providers and other interested stakeholders attended the behavioral health provider session.

Agency staff is in the process of compiling the data from the forums and providing responses back to issues raised. The forums gave providers an opportunity to ask

questions, health plans an opportunity to provide responses, the Agency the opportunity to provide updated information on Medicaid Reform relative to the topics discussed. In addition, attendees and Agency staff discussed processes that could be improved. The dialogue was very productive and the Agency received many positive comments and requests for a continuation of dialogue between all parties.

The last of these forums is scheduled to be held next quarter. There will be sessions for PSNs and sessions for PSNs and HMOs. The PSN and HMO sessions will be used to gain feedback on expansion and Medicaid Encounter Data System implementation, as well as gain input from the HMOs regarding Reform implementation. The PSN session will also be used to gain feedback on lessons learned regarding implementation of Medicaid Reform from a PSN perspective.

Attachment I
PSN Complaints/Issues

PSN Complaints/Issues January 1, 2008 – March 31, 2008	
PSN Informal Issue	**Action Taken**
1. Received email from Social Security Administration advising that beneficiary cannot get desperately needed DME.	➲ In 4 minutes, received email back from PSN that issue would be resolved. No further email received from beneficiary.
2. PSN member called provider's office to make an appointment. Member was very sick but was told earliest appointment would be first week of February. Receptionist put on hold several times and seemed unprofessional and did not show much concern for the member's condition.	➲ Plan representative spoke with provider's office director, who advised his staff will NOT, if a patient is sick, provide them with an appointment a month away. He further states his office policy is to have patient come as a walk-in and/ or provide same day/next day appt. for sick visit. Only reason why patient would be asked to come in for the following month, is If the patient wouldn't be assigned to the facility until then. According to records, member has never come to establish herself nor do they have record that she called. Member is adamant that she called and spoke with someone at the facility; however, doesn't have a name. She requested to change PCPs and confirmed new PCP would be close and convenient. She was advised effective date of change; however, should she obtain a sooner appointment, the plan agreed to authorize services. Member was satisfied.
3. Member is pregnant but is established with a non-participating OB. OB saw her but now has unpaid bills and refuses to see her until she is FFS Medicaid.	➲ PSN Plan will assist provider with unpaid claims. Member was given the option to see a participating provider but prefers to wait until February 1 when she is disenrolled from plan.
4. Received email from PSN member who had surgery and whose Medicaid is ending and is unsure what is covered by Medicaid and would like someone to call and clarify.	➲ AHCA staff contacted PSN member by phone. Staff directed member to contact Shands for clinic card. PSN member stated she has some ill feelings about Reform and the way she was treated.
5. PSN member called to complain about dental services. Member has been with PSN since October 2006. Member has spoken with customer service who told him to contact local Medicaid office.	➲ PSN member contacted. PSN representative had dental subcontractor advised provider that co-payments do not apply to and cannot be collected for PSN members per the contract. Member was contacted and will receive a refund from provider's office. The Area Office is still working on this with the member and the plan.

PSN Complaints/Issues January 1, 2008 – March 31, 2008	
PSN Informal Issue	**Action Taken**
6. Beneficiary unable to see dentist or Ear Nose and Throat (ENT) specialist. She has called providers listed on health plan provider list and none are accepting Medicaid members.	➲ Beneficiary has referral for two dental providers. Mother will select one and call for an appointment. ENT specialist visit scheduled. Mother was using another health plan provider directory and now has correct/current health plan directory.
7. Beneficiary denied authorization for specialist several times. Grandmother asked clinic staff to call her when lab results were received by Doctor. Staff did not call her when the results came back.	➲ Health plan has second child with exact name and birth date. Staff member made an error with authorizations to other child. Correct authorization and appointment have been scheduled.
8. Provider is having issues with timely claims payment.	➲ AHCA staff facilitated review with PSN, provider and Medicaid Contract Management staff. Medicaid Contract Management staff had claims entered as priority at the fiscal agent and the claims in question paid the following week. The provider was also educated on how to properly complete claim forms to prevent denials from occurring in the future.
9. Problem with PSN member who is in the process of moving out of County.	➲ The PSN investigated and issued a referral to the out-of-county provider to resolve the issue.
10. PSN Provider is having difficulty obtaining payment.	➲ The PSN was contacted. There has been an on-going process to have the provider correctly complete claims forms. Claims were processed and the provider paid. Assistance is being provided with the billing issues for payment of the remainder of claims.
11. PSN member's mother called in regards to developing a treatment plan for her daughter with the PSN.	➲ The Agency's staff facilitated the coordination of services for a PSN member, between the member and her mother, the PSN, and the behavioral subcontractor.
12. MediKids member is unable to access services through the health plan because the PSN has no record of the member according to the mother.	➲ The PSN was contacted. They contacted the mother and are in the process of selecting a PCP for the child who is now showing as a member in their files.
13. A PSN member called regarding the denial of private duty nursing without adequate notice.	➲ The PSN was able to show that notice was given to the caregiver on a month prior to conclusion of service. Member was evaluated and found to not meet the criteria for private duty nursing.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
1. HMO enrollee required specific product due to the medical condition. This product/service is not covered by the Medicaid program and the beneficiary's health plan was initially unable to assist.	➲ Plan representatives determined that the plan would cover this service. All parties notified were notified of the plan's determination.
2. Provider states that plan has rejected claims submitted in January 2008 because recipient does not show up in their system. Provider checked eligibility and says recipient is enrolled in plan.	➲ Plan researched the issue and determined that the beneficiary was an enrolled member as of the date of service. The plan is processing the claims for payment. The provider was notified of this resolution to the issue.
3. Provider states plan denied claim because recipient does not show up in their system. Provider checked eligibility and recipient showed as being in plan.	➲ After extensive research and discussion between the plan, provider and this office it was determined that the provider's claims were appropriate and should be resubmitted for payment.
4. Provider stated HMO is denying claims for services provided.	➲ Plan claims department representative worked with provider to give them correct billing codes. Provider will resubmit claims for payment.
5. Mother stated HMO representative had told her the plan did not cover dental care for her child.	➲ Plan acknowledged error and corrected it. Plan called family to set up a dental appointment for beneficiary.
6. HMO enrollee and plan have conflicting information on whether the beneficiary's selection for PCP is a plan provider.	➲ Plan agreed to authorize beneficiary to see psychologist without a referral from a plan PCP.
7. HMO enrollee states plan is unwilling to give her a regular pick-up schedule and requires her to call each time she needs a ride.	➲ Plan contacted enrollee to let her know that she is scheduled for regular pick-ups and there is no need to call them each time she needs a ride
8. HMO enrollee requires 24/7 private duty nursing care which was denied by the plan.	➲ After review the plan agreed to provide private duty nursing services to the beneficiary.
9. Provider states plan is denying claim payment because the billing code modifier used is not allowed.	➲ Plan reviewed the claim denial and reversed its decision. According to the provider the claim has paid.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
10. Provider states that plan is denying claim because the billing code had an improper modifier added. Provider says that Medicaid policy allows the modifier.	➲ In previously submitted credentialing information the individual performing the service was listed in the wrong provider category. The plan worked with the provider to correct the category and the provider then resubmitted the claim.
11. Provider stated that a plan representative informed them the beneficiary was not a member on the date of service, therefore plan would not accept claim.	➲ Plan acknowledged beneficiary was a member of the plan on the date of service and agreed to pay the provider's claim.
12. Provider stated that a plan rep informed them that beneficiary was not a member on the date of service. Therefore the plan would not accept claim.	➲ Plan has corrected its member list and advised provider to resubmit claim for payment.
13. Beneficiary states plan is unable or unwilling to provide her with a referral to a local surgeon for a procedure or an out-of-network authorization to see another surgeon.	➲ Plan arranged for a local in-network hand surgeon to do the required surgery and the PCP gave the necessary referral. Beneficiary has been contacted and agrees with this solution.
14. Beneficiary unable to obtain new PCP from plan after moving to Broward County.	➲ Plan representative contacted the beneficiary immediately to get this person assigned to a local PCP.
15. Plan denied beneficiary was a member of the plan despite the Medicaid showing the beneficiary is an active member.	➲ Plan has corrected its member database to show the beneficiary is a member and has arranged for the beneficiary to receive the necessary medications.
16. Beneficiary called plan for a PCP referral and received an incorrect phone number for the provider.	➲ Plan was contacted to provide updated phone number for the healthcare clinic and to let them know physician is no longer practicing at that location. Plan corrected the clinic phone number, removed physician from their network list and called beneficiary to assist with finding a new PCP.
17. HMO enrollee complaint regarding obtaining prescription drugs.	➲ Beneficiary contacted. Confirmed that he had contacted Choice Counseling and requested reassignment to a plan that better meets his needs. Reassignment effective date will be next month.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
18. HMO enrollee with concerns about eligibility status and receiving medical care.	➲ Clarified with beneficiary the HMO enrollment dates. HMO's records show recipient given names of two orthopedic physicians. Beneficiary contacted and advised of this and that she is no longer enrolled in the HMO. She is however still Medicaid eligible as medically needy. Referred to DCF for eligibility changes.
19. Recipient with a complaint regarding behavioral health services and prescription drugs.	➲ In order to receive prescription drugs, a recipient must see a physician. Recipient referred to the HMO and her physician.
20. HMO enrollee having problem obtaining transportation services.	➲ Recipient received appointment for transportation services.
21. HMO enrollee with problem obtaining access to specialist.	➲ HMO advised recipient has been seen by ophthalmologist and samples of medications provided until authorization is received as the medication is not on the plan's formulary. Plan case manager is working directly with beneficiary.
22. HMO enrollee with problem obtaining access to specialist.	➲ HMO enrollee changed health plans. Current HMO assisted with finding a specialist for the interim until plan change is processed.
23. HMO enrollee needs authorization for dental services.	➲ HMO provided authorization for the dental appointment.
24. HMO enrollee denied ever receiving a provider directory and member handbook.	➲ The provider handbook was mailed again to the member.
25. Problem with obtaining payment for services for an HMO member.	➲ Claims were received for the dates of service, and they have already been paid.
26. HMO enrollee is having difficulty obtaining an authorization for continued services.	➲ The HMO authorized continued services for another year and put in an authorization for those services already provided. The plan also provided the doctor's office with the appropriate contact number for future authorizations.
27. Received e-mail message from CEO of health care facility indicating a large amount of unpaid claims and requesting immediate resolution with the HMO.	➲ Agency staff spoke with network manager at the HMO, who assisted in resolution of the issue. A check was received by the health care facility.
28. HMO enrollee is having problems obtaining a specialist.	➲ Member was seen by a specialist and is doing well as of today.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
29. Hospital representative was unable to make contact with the HMO regarding a claims issue. The Medicaid Area Office was unsuccessful as well.	➲ The HMO contacted the provider with the necessary information and provided additional contact information.
30. HMO enrollee is enrolled in a Duval county plan but lives in Clay County. Duval is too far for her to travel and she states that the HMO will not assist her in seeing an OB in Clay County even though their plan is also available in Clay. She says she will be disenrolled as of 2/1/08 but cannot wait until then to see an OB.	➲ The HMO OB Case Manager contacted the member about an appointment that was made for her. The OB Case Manager indicated that the member also made an appointment for a PCP. The member plans on seeing her PCP first and then will determine if she will keep the appointment with the OB provider. We are strongly encouraging this member to keep up with her prenatal care and see the OB.
31. The HMO denied a claim stating the wrong code was used.	➲ The claim has been reprocessed for payment in full, and the complainant was informed of this.
32. HMO enrollee called about obtaining a provider directory.	➲ The HMO will mail the recipient a Provider Directory.
33. HMO enrollee needs a referral for diabetic shoes.	➲ A referral was give to the recipient.
34. HMO enrollee is unable to find a participating dentist in his area.	➲ The member was scheduled with an appointment to see a dentist thru the County Health Department.
35. HMO enrollee is unable to find a Neurosurgeon in her area.	➲ The HMO has overturned the denial and approved a physician to perform the surgery. They have also contacted the member to advise her, adding they would be in contact with her again this afternoon when the necessary authorization has been faxed and received by the doctor's office.
36. HMO enrollee reports being unable to find a OB/GYN in her area and the hospital will not see her.	➲ The member was retro-disenrolled from the plan effective 1/31/08.
37. Provider states an HMO is denying a claim.	➲ Claims have been re-processed.
38. HMO enrollee is having difficulty finding a pain management specialist.	➲ The HMO made contact with the member. She was given the names of specialists and direct contact information of the HMO's case management unit for further assistance if necessary.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
39. Provider is inquiring as to why his patient, an HMO member, has not received needed medication.	➲ The HMO updated the member's enrollment status allowing the member's prescriptions to be filled.
40. HMO enrollee in a Duval County HMO and needs an Obstetrician in Clay County where she lives. The HMO does not provide transportation for Duval County.	➲ The HMO's OB Case Manager contacted the member about an appointment that was made for her. The OB provider office contacted this member and registered the member in their system. The member also made an appointment for a Primary Care Physician (PCP). The member plans on seeing her PCP first, and then will determine if she will keep the appointment with the OB provider. The HMO is strongly encouraging this member to keep up with her prenatal care and see the OB.
41. HMO enrollees are having problems obtaining a general surgeon and pediatrician that would accept the HMO. All of the providers that the member was given by the HMO Member Services Representative, once contacted, stated they were not contracted with nor accepted the HMO.	➲ The HMO found a general surgeon for the mom, and she will schedule an appointment with him. The son will see his pediatrician, and mom will request a referral to a specialist. The HMO will continue to assist this member to ensure the appointments are scheduled.
42. HMO enrollee no longer on Fee For Service nor Managed Health Care. Dentures are giving her trouble.	➲ Enrollee advised that because she is no longer eligible for Medicaid, the HMO is not responsible for denture maintenance.
43. HMO enrollee needs to be assigned to a Primary Care Physician (PCP).	➲ Case management at the HMO has contacted the member and assisted the member in identifying potential new PCPs in the area. The member has an appointment with a selected physician. Information on alternate neurologists was also provided. Case management will be following up to confirm the appointment took place.
44. HMO enrollee is having a problem obtaining a dermatologist.	➲ The HMO has arranged for the member to be seen by a specialist and mom has been notified and provided with the contact information for the doctor's office. The HMO also provided a contact person for her at the plan in the event that she has any more concerns regarding this matter.
45. HMO enrollee needs dental services.	➲ The enrollee's partial and the root tip extraction will be taken care of, and enrollee is very happy.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
46. Mother of HMO enrollee called concerning dental services for her child.	➲ Mother of HMO enrollee called needing dental services. Enrollee's mother stated she has been trying to get dental services for her son and was told by HMO that enrollees son was not enrolled in the plan. AHCA staff informed mother that child is enrolled in the HMO. Mother advised that dental services are available through the health plan.
47. HMO enrollee needs medications and equipment for sleep machine.	➲ HMO enrollee is going to be seen by a physician. The HMO's case management office is going to work with the Primary Care Physician's office tomorrow to coordinate the appointment. The DME (Durable Medical Equipment) needs will be addressed subsequent to the visit and a prescription for the needed items will be written and authorized.
48. HMO enrollee needs assistance obtaining a dental provider.	➲ Health Plan was able to make the member an appointment with a dentist to receive composite fillings.
49. HMO enrollee is requesting orthodontic services for her two children.	➲ The mother was contacted several times, but never returned any phone calls.
50. HMO member reports there are no providers in Duval County for Home Health Services and Physical Therapy and denied ever receiving a response relating to her filed grievance.	➲ The HMO was contacted and the Case Management Nurse Home Health Services were approved. The nurse will advise the member today of the start of services and the specific services approved. In regards to the grievance, the HMO had attempted to contact the enrollee several times by phone and followed up with a formal letter advising they needed additional information, could not perform the disenrollment requested, and referred her to Choice Counseling for the disenrollment request.
51. HMO Provider Claim Payment denial due to member not being enrolled during the dates of service.	➲ The enrollment span for the HMO member has been corrected. The claim has been adjusted, and the check has been sent to the provider.
52. The provider is claiming the HMO has denied payment for claims regarding (5) members.	➲ Resolution in progress

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
53. HMO enrollee was prescribed medication that was denied by the plan when she attempted to pick it up at the pharmacy. The child has been on two other medications since then that have not been as effective as the originally prescribed medicine.	➲ Agency staff received verification that the mother picked up the prescription, as the HMO authorized the medication.
54. A provider at a health facility is having continuing problems receiving payments from the HMO.	➲ The provider has confirmed receipt of two checks from the HMO.
55. HMO enrollee is unable to obtain medications.	➲ HMO was contacted and enrollee was issued a 5-day pharmacy authorization for medications, so he can get the prescriptions while issue is being resolved.
56. HMO enrollee's mother called HMO and was told they do not cover children for dental services.	➲ The HMO has verified that this child was seen by a dentist. Agency staff assisted in arranging the appointment and have verified that enrollee was treated.
57. HMO enrollee is pregnant and needs an appointment with a specialist. She is getting the run-around from the health plan's customer service.	➲ This has been resolved; the HMO found a specialist at a medical facility and confirmed the appointment. The HMO's Case Manager spoke to the member and sent her educational materials. She was given the Case Manager's direct telephone number if she needs further assistance.
58. HMO enrollee is in need of specialized services.	➲ The recipient will be Fee-For-Service effective April 1, 2008.
59. HMO enrollee taken to ER of hospital. HMO enrollee told the hospital did not accept her HMO. HMO enrollee later transported to different facility in Duval county. Member received a bill from original hospital. HMO enrollee asking if HMO is responsible.	➲ The provider has submitted a bill to the HMO recently. The HMO is reviewing it for payment now. The HMO is also calling the member to let her know that she should not pay the bill and that they are working on resolving the claim with the hospital to be able to get the claim paid today, but regardless they will advise the provider to cease billing the HMO member.
60. HMO enrollee would like to be disenrolled from the plan because she does not want to see a new Primary Care Physician (PCP). Enrollee has been seeing her current PCP for years.	➲ The plan was able to assist the enrollee and she has an appointment scheduled with a new doctor on Friday 4/4/08. Agency staff have also contacted the enrollee to verify the information. The member states that she is satisfied with the services received.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
61. Mom called in & spoke with specialist. HMO member went to dental provider for services. Member needs deep cleaning and crown but provider told her they are not covered and will cost $2000.	➲ HMO does not cover deep cleaning. For adults the plan offers an expanded benefit that includes simple cleanings, fillings and extractions as well as applicable x-rays. The plan will have someone contact member and advise.
62. Mom called in to report HMO member was in Emergency Room all night with dental issues. Needs extensive work and is in great deal of pain. Called an in-network provider and was told there would be a 5 week wait for an appointment. She called a dentist in her area and has an appointment tomorrow but will have to pay out of pocket for it.	➲ HMO plan representative contacted dental provider and member has appointment scheduled for tomorrow. HMO plan is looking into why member was not given an emergency appointment with an in-network provider.
63. HMO member has had some oral surgery done, now needs periodontal services. Member called HMO and was told the plan could not provide services and to contact Medicaid.	➲ Per HMO plan representative, the adult dental benefit doesn't cover periodontal services.
64. HMO member's father called plan and was told there are no dental providers for his 2 year old child.	➲ Plan contacted father and provided dentist names and phone numbers. Medicaid Area 4 specialist contacted father to confirmed the fther was pleased.
65. Mom of HMO member called reform plan and was told they do not provide dental services for child.	➲ HMO plan representative contacted parent with name and phone number of dental provider for member.
66. CBC (Community Based Care foster care agency) reported to Medicaid Area Office that foster parents of HMO member had paid $134 out of pocket for prescriptions.	➲ HMO plan representative contacted CBC for contact information on foster parents in order to provide them with instructions to obtain reimbursement.
67. HMO enrollee is in need of an oral surgeon. Enrollee stated she has waited two months, in pain, to see an oral surgeon. Enrollee went in today and was told they will not see her, she needs to speak with her HMO. Enrollee had a referral from her PCP.	➲ HMO representative emailed they would contact member, immediately and update later. HMO's dental provider contacted member and has given her the information on an oral surgeon who will be taking care of the extraction.

HMO Complaints/Issues January 1, 2008 – March 31, 2008	
HMO Informal Issue	**Action Taken**
68. HMO member's mother having trouble accessing providers/services after recent move. She has already changed plans for April 2008, but needs assistance from current plan until April 2008, as her two children are ill.	➲ Member disenrolled from HMO with effective date of 3/31/08. Issue resolved.
69. HMO member's grandmother stated child has been out of school for a week waiting for approval for his asthma treatment by his Nemours doctor. She has been calling HMO and feels she is getting run around. She stated she has spoken with several representatives and none of them have been helpful. Child has a case manager.	➲ HMO case manager contacted HMO member's relative. Child had been receiving treatments through a non-participating provider. The case manager will follow the child from now on. She will contact the proper providers to make sure treatment medication is ordered through a participating provider and is provided ASAP.
70. HMO member and son received member cards with errors.	➲ HMO representative sent matter to their enrollment department to re-issue cards and send as priority mail. They are checking vendor to see what occurred. HMO representative spoke with HMO member and told her they are addressing issue and new cards will be sent as soon as possible.
71. HMO member's child is in an HMO but lives in county where that HMO is not offered. Member's mother tried to contact dental providers to make an appointment but they refuse to see member because she does not live in Duval county.	➲ Agency staff spoke with HMO member's mother to call choice counseling to change plans. Issue should be resolved by 5/1/08.
72. Member is in need of pediatric dentist. Received list of dental providers from HMO, however, every provider grandmother contacted no longer is accepting HMO. Member has some pain and needs to see dental provider as soon as possible.	➲ Non-par authorization to a pediatric dental provider was granted for member to receive the care she needs. Grandmother of member was contacted to let her know to call provider to set up an appointment.

Attachment III
Choice Counseling Beneficiary Complaints

Beneficiary Complaints and Action Taken January 1, 2008- March 31, 2008	
Beneficiary Complaint	Action Taken
1. Advocacy group requested changes to the Choice Counseling script regarding Good Cause plan changes.	➲ The Agency agreed to edit the script.
2. Advocacy group requested changes to the Choice Counseling letters regarding Good Cause changes.	➲ The Agency agreed to make some changes to the letters to address the concerns raised.
3. Advocacy group raised concerns that the Navigator implementation for Choice Counseling would not include system availability to beneficiaries on the internet.	➲ The Agency responded with a letter stating that for HIPPA and other privacy issues, the internet version of Navigator would not include as much detail as the system used by the Choice Counselors. The primary reason for the system is to assist beneficiaries with more information to make health plan choices through Outreach in the Field and Call Center Choice Counseling.
4. Lawsuit brought upon the Agency from a beneficiary through an Advocacy group stating that the beneficiary did not receive disclosure about their open enrollment period and Good Cause reason for Plan change.	➲ Update: The first three beneficiaries in the lawsuit were not subject to open enrollment. Three additional beneficiaries were added and the Agency is reviewing those records. The Agency maintains it is in compliance with requirements and is providing adequate notice.
5. Agency is developing an administrative rule on the Good Cause plan change reasons. Advocacy group requested that the rule be a “stand alone rule” instead of included in the broader managed care rule.	➲ The Agency agreed to create a stand alone rule and began the rule-making process over.

Attachment IV
Choice Counseling Call Center Activity Report

ACS

Month: **January-08**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
					80,250										
MON		0	0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE	1/1/2008	0	0	0	80,250	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED	1/2/2008	845	796	0	81,046	49	5.8%	100%	16.9%	523.00	609.00	260.00	11:23	321	0.0%
THU	1/3/2008	642	623	0	81,669	19	3.0%	100%	8.6%	389.00	517.00	487.00	10:50	137	0.0%
FRI	1/4/2008	621	608	0	82,277	13	2.1%	100%	1.8%	202.00	203.00	131.00	10:30	159	0.0%
SAT	1/5/2008	0	0	14	82,291	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,108	2,027	14		81	3.8%	100%					10:56	617	0%
MON	1/7/2008	921	881	0	83,172	40	4.3%	100%	6.5%	348.00	374.00	184.00	10:25	421	0.0%
TUE	1/8/2008	677	673	0	83,845	4	0.6%	100%	2.4%	281.00	193.00	0.21	10:16	112	0.0%
WED	1/9/2008	602	601	0	84,446	1	0.2%	100%	0.0%	179.00	114.00	91.00	9:59	130	0.0%
THU	1/10/2008	555	550	0	84,996	5	0.9%	100%	1.8%	308.00	219.00	82.00	10:38	156	0.0%
FRI	1/11/2008	456	456	0	85,452	0	0.0%	100%	0.0%	56.00	52.00	0.00	12:02	188	0.0%
SAT	1/12/2008	0	0	15	85,467	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,211	3,161	15		50	1.6%	100%					10:34	1007	0%
MON	1/14/2008	952	901	0	86,368	51	5.4%	100%	12.5%	512.00	749.00	312.00	11:06	147	0.0%
TUE	1/15/2008	675	657	0	87,025	18	2.7%	100%	2.7%	317.00	434.00	284.00	11:46	205	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
WED	1/16/2008	677	671	0	87,696	6	0.9%	100%	1.2%	349.00	206.00	153.00	11:07	153	0.0%
THU	1/17/2008	659	653	0	88,349	6	0.9%	100%	0.3%	214.00	186.00	168.00	11:46	340	0.0%
FRI	1/18/2008	461	458	0	88,807	3	0.7%	100%	0.2%	135.00	0.50	0.00	9:22	68	0.0%
SAT	1/19/2008	0	0	7	88,814	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,424	3,340	7		84	2.5%	100%					11:07	913	0%
MON	1/21/2008	0	0	0	88,814	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE	1/22/2008	860	802	0	89,616	58	6.7%	100%	20.2%	667.00	726.00	348.00	10:39	311	0.0%
WED	1/23/2008	681	679	0	90,295	2	0.3%	100%	1.8%	327.00	369.00	258.00	10:11	105	0.0%
THU	1/24/2008	542	541	0	90,836	1	0.2%	100%	0.0%	0.00	0.00	0.00	10:02	84	0.0%
FRI	1/25/2008	566	566	0	91,402	0	0.0%	100%	0.0%	0.00	0.00	0.00	9:42	142	0.0%
SAT	1/26/2008	0	0	7	91,409	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,649	2,588	7		61	2.3%	100%					10:11	642	0%
MON	1/28/2008	928	903	0	92,312	25	2.7%	100%	3.6%	355.00	381.00	252.00	9:59	139	0.0%
TUE	1/29/2008	702	701	0	93,013	1	0.1%	100%	0.14%	0.00	0.00	239.00	10:22	153	0.0%
WED	1/30/2008	612	608	0	93,621	4	0.7%	100%	1.5%	389.00	259.00	0.05	9:36	365	0.0%
THU	1/31/2008	611	610	0	94,231	1	0.2%	100%	0.0%	0.00	0.00	204.00	9:38	418	0.0%
FRI		0	0	0	94,231	0	0.0%	100%	0.00%	0.00	0.00	0.00	0:00	0	0.0%
SAT		0	0	0	94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,853	2,822	0		31	1.1%	100%					9:55	1075	0%
MON		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0		100%					0:00	0	0%
	Month End	**14,245**	**13,938**	**43**		**307**	**2.2%**	**100%**					**10:33**	**4254**	**0.0%**

ACS

Florida Medicaid Reform Choice Counseling
CALL CENTER ACTIVITY REPORT

Month: **February-08**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
					94,231										
MON		0	0	0	94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE		0	0	0	94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	0	94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU		0	0	0	94,231	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI	2/1/2008	574	572	0	94,803	2	0.3%	100%	0.17%	198.00	16.00	0.00	9:19	280	0.0%
SAT	2/2/2008	0	0	6	94,809	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	574	572	6		2	0.3%	100%	1.7%				9:19	280	0%
MON	2/4/2008	766	756	0	95,565	10	1.3%	100%	5.8%	353.00	559.00	65.00	10:21	166	0.0%
TUE	2/5/2008	648	642	0	96,207	6	0.9%	100%	0.5%	173.00	190.00	185.00	9:58	380	0.0%
WED	2/6/2008	532	531	0	96,738	1	0.2%	100%	0.2%	225.00	0.00	0.00	9:55	280	0.0%
THU	2/7/2008	550	540	0	97,278	10	1.8%	100%	0.0%	387.00	187.00	174.00	8:51	128	0.0%
FRI	2/8/2008	508	505	0	97,783	3	0.6%	100%	0.0%	184.00	131.00	0.00	10:42	222	0.0%
SAT	2/9/2008	0	0	2	97,785	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,004	2,974	2		30	1.0%	100%	2.13%				9:58	1176	0%
MON	2/11/2008	762	760	0	98,545	2	0.3%	100%	0.6%	209.00	175.00	85.00	10:42	181	0.0%
TUE	2/12/2008	683	682	0	99,227	1	0.1%	100%	0.15%	225.00	75.00	129.00	10:14	281	0.0%
WED	2/13/2008	621	618	0	99,845	3	0.5%	100%	0.5%	211.00	142.00	140.00	11:18	247	0.0%
THU	2/14/2008	609	600	0	100,445	9	1.5%	100%	2.3%	845.00	280.00	129.00	10:59	438	0.0%
FRI	2/15/2008	398	396	0	100,841	2	0.5%	100%	1.0%	253.00	0.00	0.00	9:36	95	0.0%
SAT	2/16/2008	0	0	5	100,846	0	0.0%	100%	0.0%	0.00		0.00	0:00	0	0.0%
	Week Ending	3,073	3,056	5		17	0.6%	100%	0.88%				10:37	1242	0%
MON	2/18/2008	486	486	0	101,332	0	0.0%	100%	0.0%	169.00	0.01	0.00	10:22	297	0.0%
TUE	2/19/2008	625	618	0	101,950	7	1.1%	100%	0.8%	269.00	170.00	0.00	11:28	233	0.0%
WED	2/20/2008	596	593	0	102,543	3	0.5%	100%	0.0%	174.00	74.00	0.00	10:13	326	0.0%
THU	2/21/2008	552	536	0	103,079	16	2.9%	100%	6.5%	439.00	289.00	263.00	11:18	135	0.0%
FRI	2/22/2008	477	474	0	103,553	3	0.6%	100%	0.2%	183.00	176.00	0.41	9:50	382	0.0%
SAT	2/23/2008	0	0	1	103,554	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week	2,736	2,707	1		29	1.1%	100%	1.34%				10:40	1373	0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
	Ending														
MON	2/25/2008	817	808	0	104,362	9	1.1%	100%	2.2%	282.00	192.00	84.00	10:26	353	0.0%
TUE	2/26/2008	667	653	0	105,015	14	2.1%	100%	3.9%	356.00	254.00	0.00	10:15	311	0.0%
WED	2/27/2008	608	605	0	105,620	3	0.5%	100%	2.3%	308.00	278.00	:14	10:43	183	0.0%
THU	2/28/2008	517	512	0	106,132	5	1.0%	100%	4.1%	401.00	290.00	177.00	9:49	240	0.0%
FRI	2/29/2008	469	468	0	106,600	1	0.2%	100%	0.9%	221.00	135.00	233.00	10:01	282	0.0%
SAT		0	0	4	106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,078	3,046	4		32	1.0%	100%	2.60%				10:16	1369	0%
MON		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
THU		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		106,604	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0		100%					0:00	0	0%
	Month End	**12,465**	**12,355**	**18**		**110**	**0.9%**	**100%**					**10:20**	**5440**	**0.0%**
	MTD							1.7%	98.3%						

ACS

Florida Medicaid Reform Choice Counseling
CALL CENTER ACTIVITY REPORT

Month: **March**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
					106,604										
MON	3/3/2008	856	805	0	107,409	51	6.0%	100%	11.9%	445.00	463.00	446.00	10:06	145	0.0%
TUE* **	3/4/2008	449	447	0	107,856	2	0.4%	100%	0.4%	260.00	92.00	0.00	8:38	184	0.0%
WED	3/5/2008	624	623	0	108,479	1	0.2%	100%	0.3%	187.00	124.00	0.33	9:50	137	0.0%
THU	3/6/2008	591	564	0	109,043	27	4.6%	100%	2.0%	353.00	159.00	72.00	9:27	105	0.0%
FRI	3/7/2008	469	460	0	109,503	9	1.9%	100%	1.3%	225.00	191.00	118.00	8:59	237	0.0%
SAT	3/8/2008	0	0	4	109,507	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,989	2,899	4		90	3.0%	100%	4.04%				9:30	808	0%
MON	3/10/2008	799	718	0	110,225	81	10.1%	100%	25.8%	562.00	518.00	444.00	11:50	182	0.0%
TUE	3/11/2008	599	591	0	110,816	8	1.3%	100%	1.0%	249.00	92.00	118.00	11:27	270	0.0%
WED	3/12/2008	617	613	0	111,429	4	0.6%	100%	0.8%	200.00	132.00	91.00	10:27	209	0.0%
THU	3/13/2008	619	603	0	112,032	16	2.6%	100%	0.8%	396.00	310.00	340.00	11:00	140	0.0%
FRI	3/14/2008	549	537	0	112,569	12	2.2%	100%	3.5%	511.00	691.00	286.00	10:54	188	0.0%
SAT	3/15/2008	0	0	8	112,577	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,183	3,062	8		121	3.8%	100%	4.04%				11:09	989	0%
MON	3/17/2008	818	790	0	113,367	28	3.4%	100%	3.7%	397.00	281.00	101.00	10:20	157	0.0%
TUE	3/18/2008	675	660	0	114,027	15	2.2%	100%	1.6%	233.00	179.00	72.00	9:53	176	0.0%
WED	3/19/2008	709	700	0	114,727	9	1.3%	100%	0.6%	237.00	166.00	141.00	10:11	200	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU	3/20/2008	778	765	0	115,492	13	1.7%	100%	0.4%	246.00	219.00	0.24	11:41	331	0.0%
FRI	3/21/2008	421	420	0	115,912	1	0.2%	100%	0.1%	145.00	89.00	0.00	10:16	114	0.0%
SAT	3/22/2008	0	0	8	115,920	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,401	3,335	8		66	1.9%	100%	1.38%				10:30	978	0%
MON	3/24/2008	902	877	0	116,797	25	2.8%	100%	2.0%	299.00	282.00	161.00	10:01	241	0.0%
TUE	3/25/2008	651	642	0	117,439	9	1.4%	100%	0.0%	176.00	147.00	0.00	9:13	141	0.0%
WED	3/26/2008	584	583	0	118,022	1	0.2%	100%	0.0%	129.00	152.00	32.00	9:38	223	0.0%
THU	3/27/2008	780	761	0	118,783	19	2.4%	100%	0.9%	236.00	251.00	181.00	9:53	255	0.0%
FRI	3/28/2008	604	590	0	119,373	14	2.3%	100%	0.5%	240.00	150.00	170.00	9:28	170	0.0%
SAT	3/29/2008	0	0	2	119,375	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,521	3,453	2		68	1.9%	100%	0.74%				9:40	1030	0%
MON	3/31/2008	879	853	0	120,228	26	3.0%	100%	3.0%	272.00	206.00	306.00	9:58	301	0.0%
TUE		0	0	0	120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	0	120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU		0	0	0	120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI		0	0	0	120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT		0	0	0	120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	879	853	0		26	3.0%	100%					9:58	301	0%
MON		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
THU		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
FRI		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		120,228	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0		100%					0:00	0	0%
	Month End	**13,973**	**13,602**	**22**		**371**	**2.7%**	**100%**	**3.60%**				**10:11**	**4106**	**0.0%**

***** Avaya CMS down on 3/4/08-call stats incomplete/not available**