Florida Medicaid Reform

Quarterly Progress Report
January 1, 2009 – March 31, 2009

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

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

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete 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 10 through 14 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. Under current state law, Reform FFS PSNs are also required to become capitated after three years of operations (for most PSNs, this is September 1, 2009).

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

Current Activities

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 19 applicants sought and received approval to provide services to the TANF and SSI population. The most recent application was received January 14, 2009 from Sunshine State Health Plan. Two of the approved applicants were also approved for expansion into Baker, Clay and Nassau Counties: Access Health Solutions (a PSN) and United Health Care (an HMO). The most recent health plan applications approved were: Molina Health Plan (an HMO) a and Better Health Plan (a FFS PSN). Both Molina Health Plan and Better Health Plan were approved in March 2009, with their first enrollment in May 2009. Of the 22 health plan applications received, all but three were approved as health plans as of December 31, 2008.

The three health plan applications still pending were submitted by HMOs: AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS, Medica Health Plans of Florida, and Sunshine State Health Plan. AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application to serve beneficiaries living with HIV/AIDS in January 2008. This application

is the second specialty plan application the Agency has received (the first being a specialty plan for children with chronic conditions). As of March 31, 2009, this specialty plan application was nearing completion of Phase III of the application process.

Medica Health Plans of Florida, Molina Health Plan and Sunshine State Health Plan are all HMOs with a national base. Molina Health Plan (HMO) has entered into an agreement with NetPass Health Plan (FFS PSN) and the NetPass membership is scheduled to be transitioned over a period of several months to Molina prior to September 1, 2009. During the staggered transition process, the NetPass enrollees will be given written notification of this change and an opportunity to select another health plan. Centene, Inc., doing business as Sunshine State Health Plan, intends to serve beneficiaries living in all Reform counties. Centene, Inc., has entered into an agreement with Access Health Solutions (Access) and the Access membership is expected to be transitioned over a period of several months once their provider networks are approved in the various Reform counties. The first county submitted in Sunshine's application is for Broward County and once that is approved, the organization intends to submit a request for expansion into Duval, Baker, Clay and Nassau counties.

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

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		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

Table 1 Health Plan Applicants					
Plan Name	**Plan Type**	**Coverage Area**		**Receipt Date**	**Contract Date**
		Broward	**Duval**		
Better Health	PSN	X	X	05/23/06	12/10/08
Positive Health Care	HMO	X		01/28/08	***Pending***
Medica Health Plans of Florida	HMO	X		09/29/08	***Pending***
Molina Health Plan	HMO	X		12/17/08	*03/06/09*
Sunshine State Health Plan	HMO	X		1/14/09	***Pending***

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

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area. There have been no new health plan contracts executed since March 2009 (Molina Health Plan, an HMO).

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

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

Contract Amendments and Model Contracts

During this quarter, several general amendments were executed by health plans: one amendment implemented legislatively mandated capitation rate reductions and one amendment implemented revisions in marketing and encounter data requirements, both had March 1, 2009 effective dates.

The general amendment for encounter data and marketing changes was implemented by most health plans on March 1, 2009. As the Agency's experience with Medicaid encounter data has increased, the Agency determined a general contract amendment was needed to provide the health plans with timelines for submission and remediation of encounter data, as well as, outlining corrective action measures and defining encounter data accuracy and completeness. In consultation with the health plans, the Agency eliminated direct marketing by the health plans effective March 1, 2009, and created a community outreach initiative through this general contract amendment process so the plans could continue to assist potential plan enrollees and the general public in community health care events.

During this quarter, Agency staff continued working on contract revisions for the 2009 consolidated model health plan contract. The consolidated model contract will be a streamlined version of the current separate model health plan contracts (non-Reform, Reform, FFS PSN, capitated PSN, HMO and Specialty Plan). The Agency is creating one core contract that a health plan will sign with plan type exhibits or riders depending on the unique requirements of the particular plan type (FFS PSN, capitated PSN, HMO, Reform or non-Reform). The Agency intends to use this new model contract with the contract period beginning September 1, 2009.

Additionally, the Agency reviewed and posted the results of the performance measures submitted by the health plans and held face-to-face meetings with each plan's executive leadership to discuss corrective action plans as needed. See Section K of this report for additional information. Agency staff continued work to develop minimum performance standard thresholds that will be incorporated into the September 2009 consolidated contract.

Contract Conversions/Terminations

During this quarter, two HMOs, HealthEase and Staywell, through its parent company notified the Agency of their intent to withdraw from the demonstration. Both health plans are owned by parent company, Wellcare. Wellcare stated reasons for pulling out of these counties were not specific to the demonstration but instead were related to the legislated March 1, 2009, capitation rates reduction.

To mitigate the disruption to Staywell and HealthEase enrollees as they enroll with new plans and to assist them through the choice process, the Agency followed a multi-layered approach to ensure proper and timely withdrawal notice to beneficiaries:

- Assessing the capacity of the remaining plans and determining if those plans were able to ensure all impacted beneficiaries have access to quality care.

- Working with the plans and the Choice Counseling vendor to create staggered withdrawal dates to ensure that the volume of beneficiaries being transitioned could occur in a organized manner.
- Working with the plans, Choice Counseling vendor, local area staff and advocacy groups in ensuring appropriate notice to enrollees.
- Working with the plans to provide primary care provider and service information to ensure continuity of care and minimize disruption to the recipients.

Assessing capacity

After notification of HealthEase/Staywell withdrawal from the demonstration, the Agency assessed capacity and notified the remaining health plans of the potential enrollments available to their health plans. Several health plans submitted requests to increase their allowed enrollment levels and Agency staff prioritized review of plan provider networks to ensure plans that had the capacity to enroll more members would have the ability to do so. As a result of enrollment level increases and with the addition of two new health plans in the Broward County area, there is more than ample capacity for the remaining health plans to absorb new members.

In an effort to ensure continuity of care, the Agency also undertook a review of the HealthEase and Staywell provider networks to determine the number of HealthEase and Staywell primary care providers (PCPs) that were available in other health plans. The majority of PCPs were enrolled in other health plans, thus promoting the enrollees' ability to enroll in plans in which their PCPs were enrolled (76% of HealthEase PCPs are currently enrolled with other health plans and over 86% of Staywell PCPs are currently enrolled with other health plans). The Agency is assisting the PCPs unique to Staywell/HealthEase that weren't currently in other health plan networks through the Medicaid provider enrollment process to facilitate their enrollment in other health plan networks.

Staggered withdrawal

Working with Staywell/HealthEase, in conjunction with the Choice Counseling vendor, the Agency reached an agreement to stagger HealthEase/Staywell withdrawal to ensure the volume of recipients transitioning would be appropriately managed. The withdrawal will occur as follows:

HMO	Withdrawal Date	County	Population to Transition
Staywell	May 1, 2009	Duval	@ 2,000
HealthEase	May 1, 2009	Broward	@ 13,000
Staywell	June 1, 2009	Broward	@ 27,000
HealthEase	July 1, 2009	Duval	@ 34,000

In March, the Agency began contract amendment activities with its Choice Counseling vendor to properly manage the increased call volume to the Choice Counseling Call

Center during the transition period from May through July as outlined above. The Choice Counseling vendor has begun the hiring and training process for additional Choice Counselors.

In addition, the Choice Counseling vendor has stationed Field Choice Counselors in the Medicaid Area Offices in Broward and Duval Counties to assist Staywell/HealthEase enrollees in their choice of a new plan. These Field Choice Counselors are conducting special face-to-face Choice Counseling sessions specifically geared to transition enrollees Monday through Friday beginning March 30 through June 18. Depending on the need, these sessions may continue beyond June 18.

To ensure the transition process is properly managed, the Agency is conducting weekly calls with the Florida Medicaid Area Offices and the Choice Counseling vendor to ensure all issues are resolved quickly. The Medicaid Area Offices and the Choice Counseling vendor are tracking the calls related to the Staywell and HealthEase transition to determine how many recipients made a plan choice and how many were assigned per month. In addition, the Field Choice Counselors have begun tracking the following activities:

- Number of on-site sessions.
- Number of telephone referrals to Field Choice Counselor.
- Number of enrollments completed by Field Choice Counselors as a result of Face to Face or Phone referrals.
- Number of plan changes completed by Field Choice Counselors as a result of Face to Face or Phone referrals.

<u>Enrollee and Provider Notice</u>

During this quarter, all beneficiaries and providers impacted by the Staywell and HealthEase withdrawal were provided written notification of this change in compliance with state and federal regulations. The Agency took additional measures outlined below to ensure that beneficiaries were well informed of the special enrollment sessions established to assist them in making appropriate health plan choices.

- The Agency reviewed and approved letters sent by Staywell and HealthEase to all enrollees stating their plan would no longer be available and advising them to contact Choice Counseling to enroll with other health plans. On March 14, 2009, letters were mailed to HealthEase enrollees in Broward and Staywell enrollees in Duval. On March 20, 2009, letters were mailed to Staywell enrollees in Broward and HealthEase enrollees in Duval.

- On March 27, 2009, the Agency sent the first set of 30-day notices to Staywell and HealthEase enrollees stating the plan they will be assigned to (effective May 1, 2009) if they do not choose a plan within the next 30 days. This process will occur each month of this transition period (May-July). The notices will be sent to enrollees who have not made a plan choice the month before the plan transition occurs.

- The Agency worked with its Choice Counseling vendor, the health plans and various advocacy groups to ensure the transition message being communicated would be easy to understand and available through many forums. The Agency developed flyers to be released to advocacy groups, the Department of Health, large Staywell/HealthEase providers, shelters for the homeless, homeless meal locations, as well as the Department of Children and Families to help ensure recipients understand the changes that are occurring. Medicaid Area Office staff researched HIV service providers/case worker locations to include them in the outreach activities. In addition, the flyers will be posted on the Choice Counseling website. The wording used in the flyer was revised to incorporate comments received from Florida CHAIN, a statewide advocacy group, and Florida Legal Services. Input and assistance from these advocacy groups continues to be helpful in the Agency's efforts to ensure beneficiaries are well informed. The Agency is working with the Florida Department of Children and Families to distribute information on the transition to staff who determine Medicaid eligibility.

Minimizing Disruption to Affected Enrollees

In order to minimize disruption of care, the Agency sought input from participating health plans in the Broward and Duval Counties. As a result of that input, the Agency will work with Staywell/HealthEase to receive PCP information and special needs information that can be shared with the plans once enrollment occurs.

In addition, the health plan contracts specifically provide for appropriate transition of care when a new enrollee joins a plan. This protection ensures that beneficiaries will continue to receive services through current providers until a new plan of care can be authorized.

Pediatric Associates Transition

As discussed in last quarter's report, the transition of Pediatric Associates Health Plan (FFS PSN) membership to Access Health Solutions (another FFS PSN) took effect February 1, 2009. The transition took place without issue; the Agency worked with both Pediatric Associates and Access Health Solutions to ensure that providers were trained regarding submission of claims through Access Health Solutions. No complaints were received by the Agency from enrollees relative to this transition.

FFS PSN Conversion Process

Pursuant to section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the 4th year of operation. This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2009, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing are appropriately discussed and resolved.

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

Table 3 PSN Conversion to Capitation Implementation Dates	
FFS PSN Name	**Scheduled Capitation Implementation Date**
Access Health Solutions	09/01/2009
Children's Medical Services Network, Florida Department of Health	12/01/2009
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2009
Florida NetPASS	09/01/2009
Pediatric Associates	10/01/2009
South Florida Community Care Network	09/01/2009

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

Table 4 PSN Conversion to Capitation Timeline	
Deadline for the FFS PSN to submit its conversion workplan to the Agency.	01/31/2008
Deadline for the FFS PSN to submit its conversion application to the Agency.	12/31/2008
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2009.	06/30/2009
Current Reform FFS PSN contracts expire.	08/31/2009

FFS PSN Reconciliations

During this quarter, the Agency continued work on two reconciliation[1] periods: one period for the first 6 months of the second contract year (September 2007 through February 2008) and the final reconciliation for the first contract year (September 2006 through August 2007). The Agency continues to provide technical assistance to PSNs that have requested additional time as they analyze their reconciliation data.

Systems Enhancements

With the conversion to the new Medicaid Fiscal Agent, new systems changes continue to occur and continued technical assistance is being provided for HMOs and PSNs during Demonstration Year Three (see Section K of this report under the heading: FFS PSN Systems Monthly Conference Calls). As the new system becomes fully operational, the Agency will continue to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to be more innovative in their health care delivery and achieve efficiencies not currently available.

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

2. Benefit Package

Overview

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

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

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

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

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

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

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

Current Activities

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

The 11 HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Three of the demonstration were Amerigroup, Buena Vista, Freedom Health Plan, HealthEase, Humana, Preferred Medical Plan, StayWell, Total Health Choice, United Health Care, Universal Health Care, and Vista South Florida. During this quarter, both Vista plans ceased operations. The 6 FFS PSNs are Access Health Solutions, Children's Medical Services, First Coast Advantage, NetPass, Pediatric Associates, and the South Florida Community Care Network.

One of the significant changes in the benefit packages for Year Three is the increase in the total number of copayments from Demonstration Year Two. In total, there are 85 more copayments required during Year Three (104) than in Year Two (19). From Year Two to Year Three, there were increases in the number of copayments in all categories except dental. However, despite the increase in the number of copayments, 20 benefit packages (71%) have no copayments in all 16 categories. Please note that copayments only apply to non-pregnant adults.

During the third quarter of Year Three, Buena Vista, Vista South Florida, and Pediatric Associates ceased operations within the demonstration counties. The beneficiaries who had been enrolled in these health plans were transitioned into the remaining plans. The departure of these plans, specifically the two Vista health plans, greatly changes the values regarding required copayments reported in Tables 5, 6 and 7. The Vista health plans required copayments, one for every type of service, and as a result of their

departure the total number of copayments required has decreased from 104 to 40. In addition, the percentage of benefit packages requiring no copayments has increased to 83% (see Table 5 and 6).

Table 5 lists the number of copayments for each service type by each demonstration year. Year Three has been divided into 2 columns (July 1, 2008 to December 31, 2008 and January 1, 2009 to March 31, 2009) to reflect the plans which ceased operations during the third quarter.

Table 6 indicates the number and percentage of each benefit package which in total does not require any copayments, also shown by demonstration year. Table 7 shows that for each area and target population there are at least 2 benefit packages to choose from with no copayments.

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

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

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

	Year One	Year Two	Year Three (July-Dec)	Year Three (Jan-March)
Total Number of Benefit Packages	**28**	**30**	**28**	**24**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**	**20**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**	**83%**

Table 7
Number of Benefit Packages Requiring No Copayments
By Target Population & Area
3rd Quarter of Demonstration Year Three

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

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

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

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

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

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

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

3. Grievance Process

Overview

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

As defined in the health plan contracts:

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

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

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

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

Current Activities

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

Grievances & Appeals

Table 8 provides the number of grievances and appeals by health plan type for the previous quarter ending December 31, 2008. The health plan grievance and appeals reporting cycle coincides with the due date for this quarterly report. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report will lag one quarter in each quarterly report and will be updated in the annual report to reflect the full year of data.

Table 8
Grievances and Appeals
October 1, 2008 – December 31, 2008

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	9	6	213	110	226,654

*unduplicated enrollment count

Medicaid Fair Hearings

Table 9 provides the number of MFH requested during the quarter ending March 31, 2009. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members. However, the Agency monitors the Medicaid Fair Hearing process. Of the 2 MFH requests, both were related to denial of benefits/services, with one outcome favorable to the beneficiary and one favorable to the HMO.

Table 9
Medicaid Fair Hearing Requests
January 1, 2009- March 31, 2009

PSN	1
HMO	1

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as no grievances have been submitted to the SAP and also none to the BAP for this quarter.

Table 10 provides the number requests to BAP and SAP for the quarter ending March 31, 2009.

Table 10 **BAP and SAP Requests** *January 1, 2009- March 31, 2009*	
BAP	0
SAP	0

4. Complaint/Issue Resolution Process

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

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

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

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

This quarter, the Agency received five complaints/issues related to FFS PSNs and received 74 complaints/issues related to HMOs, for a total of 79 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and

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

This quarter, four of the PSN complaints/issues were from members and one was from a provider. Member issues included access to providers and assistance with transportation. The one provider issue was regarding claims payment.

During the quarter, the majority of the HMO complaints/issues were related to member issues, with the majority being related to members needing assistance with finding/seeing a primary care provider and getting medications. Other member issues included access to and authorization of services (including obtaining specialty referrals), enhanced benefits, and members being mistakenly billed or balance-billed. Provider issues included payment delays/denials. The Agency continues to monitor enrollment complaint issues related to enrollment data provided to the health plans by the Fiscal Agent.

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

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

5. On-Site Surveys

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

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

The onsite survey of SFCCN in 2008 consisted of medical record, disease management and case management record review. The agency conducted an initial review of Better Health, a PSN scheduled to accept enrollees in 2009.

The survey process was consistent across health plan types (HMO and PSN). The State's survey team consisted of a team leader and at least two team members and lasted an average of three days. Health plan policies and procedures were reviewed prior to the onsite visit. The results of the surveys indicate that the health plans surveyed are in compliance with all state and federal regulations and there were no sanctions administered. Table 11 provides the list of on-site survey categories.

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

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

B. Choice Counseling Program

Overview

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

Choice Counseling continues to look for ways to reach the beneficiaries and offer services to help them make an informed choice. The Preferred Drug List (PDL) search functionality called the Informed Health Navigator Solution (Navigator) was implemented last quarter and this quarter use of the system by beneficiaries grew. The Field Choice Counselors also this quarter continue its efforts to reach out and provide support to beneficiaries that access mental health services, through their Mental Health Unit (MHU). The MHU (comprised of three Choice Counselors) held several presentations with community partners that offer mental health and substance abuse services. As a result of these presentations, community partners are increasing their referrals to Choice Counseling. Additional information on the MHU activities is provided in the Outreach/Field portion of this report.

As outlined in Section A of this report, Staywell and Healthease will begin transitioning out of the demonstration counties next quarter. In preparation for this transition, Agency staff met on a weekly basis (beginning in February 2009) with the Choice Counseling Program staff to develop and implement a plan to respond to the increased call volume anticipated with the Staywell / Healthease transition. Additional activities under taken by the Agency, health plans, and Choice Counseling to address the Staywell / Healthease transition are outlined in Section A. Highlights of the efforts undertaken by Choice Counseling Program to address the upcoming Staywell / Healthease transition are summarized below.

- Field Choice Counselors are available (by phone or in person) daily at the Medicaid Area Offices. The counselors can provide information about their plan choices and enroll them in a plan of their choice.
- Training provided to Medicaid Area Office staff on enrolling beneficiaries in a plan of their choice.
- Developed a plan to increase staff to address the anticipated increase in the call volume.
- Staggering the mailing of notices to beneficiaries about the upcoming Staywell / Healthease transition to help manage the anticipated increased call volume.
- Field Choice Counselors reached out to community partners and sister agencies to inform them about the transition and offer ways to get help for beneficiaries.
- Created and distributed, with input from stakeholders, posters/flyers to inform beneficiaries about the transition. This poster was made available to the Medicaid Area Offices and Field Choice Counselors for distribution and posting at key locations.

The new Fiscal Agent system was implemented in July, 2008. This transition continues to impact the Choice Counseling Program. The Enrollment Broker/Choice Counselor, Affiliated Computer Services (ACS), receives its newly eligible information, enrollment and all data from the new Fiscal Agent, Electronic Data Systems (EDS). The Agency, ACS and EDS continue to work together to ensure the transfer of correct and timely information from the Fiscal Agent to ACS. Great improvements were made over the last quarter as more issues have been corrected. Receiving correct data from the new Fiscal Agent is key for ACS to be able to meet contract standards for enrollment, call statistics, and mailroom standards, etc. ACS and EDS continue to demonstrate the ability to problem solve and made great efforts to work together along with the Agency to resolve these issues.

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

- Authorizing the Choice Counseling Call Center and Field Choice Counselors to allow Good Cause plan changes when a beneficiary has had any difficulty accessing choice counseling services or the information in the Choice Counseling System has been incorrect;
- Requesting the Field Choice Counselors reach out to community partners to help communicate with beneficiaries;
- Requiring the Field Choice Counselors to handle Choice Counselor Call Center call backs (from messages taken), and managing an increased amount of plan changes;
- Implementing a Mental Health Unit with certain Field Choice Counselors addressing questions specific to mental health; and
- Using special Needs Unit Nurses to reach out and help those that have complex health needs.

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

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

Current Activities

1. Informed Health Navigator Solution (Navigator)

Navigator is a Preferred Drug List (PDL) search system, was implemented in October of 2008. The Navigator system contains each health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims

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

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

Table 12 provides the Navigator statistics from January 1- March 31, 2009. "Sessions" represents the number of times the Navigator program was utilized, and "Recipients" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate session and recipient.

Since the "Go Live" date of October 27, 2008 through March 31, 2009 for the Navigator, there have been a total of 2,863 sessions and 2,251 unique recipients that have utilized the system.

Table 12
Navigator Statistics
(January 1, 2009 - March 31, 2009)

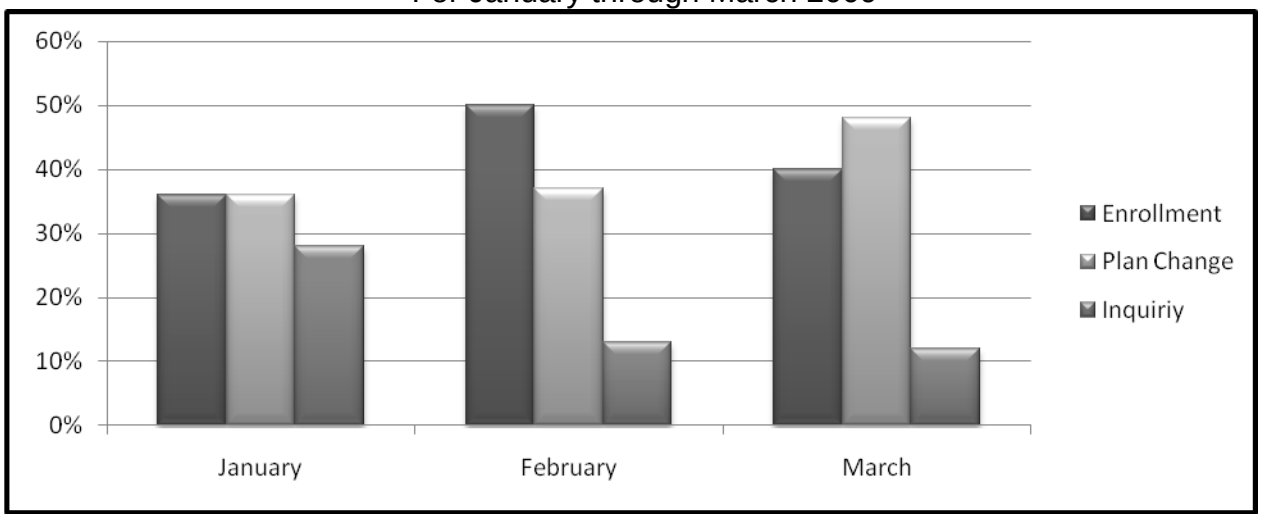
Week	Sessions	Recipients
01/01 - 01/02	17	14
01/05 - 01/09	126	111
01/12 - 01/16	126	110
01/19 - 01/23	94	80
01/26 - 01/30	97	86
02/02 - 02/06	125	109
02/09 - 02/13	97	77
02/16 - 02/20	121	109
02/23 - 02/27	94	77
03/02 - 03/06	90	82
03/09 - 03/13	89	81
03/16 - 03/22	127	110
03/23 - 03/27	222	191
03/30 - 03/31	77	68

This quarter totals for Navigator were 1,502 sessions and 1,305 unique recipients utilized the system.

Beginning this quarter, Choice Counseling started capturing data to tell whether a person was using the Navigator for an enrollment, plan change, or an inquiry. The following graph shows (by percentages) what types of calls were received using this program as a choice driver over the quarter (listed per month).

In January the same number of recipients used Navigator to both enroll and make a plan change (with almost as many inquiries). February half of the calls that utilized the Navigator used it as their choice driver to enroll in a plan, whereas in March the largest majority were for plan changes (which coincides with the Welllcare transition).

Informed Navigator Use by Call Type
For January through March 2009



Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The call center does have a scheduled day every week where the counselors are focused on making sure to offer the survey, this helps to reach the goal of at least 400 completed surveys each month. During the months of January through March 2009, the automated survey was completed by 1,297 beneficiaries.

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

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

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

During this quarter, the overall beneficiary survey scores remained high, however the scores for the amount of time the beneficiary has to "wait on hold" declined. This reduction in score for the hold time began in August, which correlates with the increase in incoming calls to the ACS Choice Counseling Call Center due to issues with the new Fiscal agent. The "wait on hold" percentages from beneficiaries were on a steady incline in February, but started to decline at the end of the month due to the increase in call volume with transition issues with Staywell and Healthease. The Agency is also aware that during this quarter, the FTE levels for the Call Center are down and need to be increased. The Agency is working with ACS to increase the number of FTEs as well as bring in temporary employees to cover the transitional calls.

ACS is utilizing the "red alert" messaging system as an immediate response to offset the caller's wait time (as reported in the next section of the report). This action has helped beneficiaries get the responses they need in a shorter amount of time.

Table 13 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from January through March of 2009. The number of beneficiaries participating in the Survey was as follows: January - 401, February - 376, and March - 520 (totaling 1,297).

The top three survey categories for the quarter were: "Being treated respectfully", "Overall service provided by counselor" and "Counselor quickly understood reason for call". The three lowest scoring survey categories were: "Amount of time waiting to speak with a Choice Counselor", "How easy was it to understand information received" and "How helpful do you find this counseling to be".

Table 13
Choice Counseling Survey Results
Percentage of Delighted Callers Per Question

How helpful do you find this counseling to be		
January	**February**	**March**
88.5%	87.5%	86.3%
Amount of time you waited		
January	**February**	**March**
41.4%	64.6%	46.5%
Ease of understanding info		
January	**February**	**March**
78.3%	75.3%	76.0%

Table 13 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
Likelihood to recommend		
January	**February**	**March**
92.5%	90.7%	91.9%
Overall service provided by Counselor		
January	**February**	**March**
95.8%	95.5%	96.3%
Quickly understood reason		
January	**February**	**March**
94.0%	94.7%	96.0%
Ability to help choose plan		
January	**February**	**March**
93.0%	94.7%	95.8%
Ability to explain clearly		
January	**February**	**March**
94. 0%	95.5%	96.2%
Confidence in the information		
January	**February**	**March**
93. 0%	93.4%	94.6%
Being treated respectfully		
January	**February**	**March**
96.8%	97.3%	97.3%

2. Call Center

The Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida, operates a toll-free number and a seperate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., providing no Saturday hours. The call center has over 32 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

The Choice Counseling call center has reported a continually growing volume of incoming calls - particularly at the end of February and into March of 2009, as the transition of Wellcare plans began. The Agency and ACS have been in continual communication about the call volume and ACS has worked very diligently to handle this increase in volume with both short and long term solutions. The “red alert” messaging system has been continued to give beneficiaries the opportunity to leave a message after 5 minutes of hold time. Call backs to these beneficiaries happen within 48 hours. This is a short term solution and will continue until the wait time to reach a counselor is back under the set standards.

The increase in calls, due to the transition of Staywell and Healthease, has made it clear that an increase in Call Center staff is the correct action to cover the volume. The

call center plans to bring in more staff to cover the transition (once their proposal is approved with the Agency).

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

Table 14
Comparison of Call Volume for 3rd Quarter
(Year Two & Year Three)

Type of Calls	Jan 2008	Jan 2009	Feb 2008	Feb 2009	Mar 2008	Mar 2009	Year 2 3rd Quarter Totals	Year 3 3rd Quarter Totals
Incoming Calls	14,245	26,741	12,465	24,144	13,973	30,168	**40,683**	**81,053**
Outgoing Calls	9,084	7,464	10,518	7,314	9,060	6,322	**28,662**	**21,100**
Totals	23,329	34,205	22,983	31,458	23,033	36,490	**69,345**	**102,153**

The Choice Counseling Program met and exceeded the contract standards in the Call Center for the first 2 years of the waiver. The statistics in Table 14 show the dramatic increase of calls in the third quarter of Year Three. There were 40,370 more incoming calls than were reported in the third quarter of demonstration Year Two. In March 2009, the incoming call volume increased by 216% compared to the incoming call volume a year ago. (The incoming call volume was 13,973 in March 2008; and the incoming call volume was 30,168 in March 2009). The outgoing calls have changed their focus to be return calls rather than outbound phone list contacts since the “red alert” system was added.

3. Mail

Outbound Mail

During the quarter, the ACS mailroom mailed the following:

New-Eligible Packets (mandatory and voluntary)	21,711
Auto-Assignment Letters	27,085
Confirmation Letters	25,894
Open Enrollment Packets	21,662
Transition Packets	721

During this quarter, the amount of returned mail has improved but still exceeds the Year Two average of 3%. The average this quarter is 5.2%. The amount of return mail has increased due to the system issues. The Agency continues to monitor the fiscal agent system functions that impact the Choice Counseling mailings.

When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary. The Choice Counseling staff work to re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail:

During the quarter, ACS processed the following:

Plan Enrollments	1,413
Plan Changes	197

The percentage of enrollments processed through the mail-in enrollment forms has remained 2-5% of total enrollments. The Agency and ACS are currently reviewing the enrollment form to make it easier to complete properly and change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program to better serve beneficiaries if this option is discontinued.

4. Face-to-Face/Outreach and Education

During the quarter, the Field Choice Counseling Outreach team has continued to reach those beneficiaries with a pending assignment as well as return calls from the call center, public and private sessions, and utilizing the new Mental Health Unit to reach beneficiaries. These efforts have resulted in an impressive number of enrollments through January as outlined below in Table 15. February and March show less enrollments which is consistent with the amount of call backs and plan changes that were made.

Table 15
Choice Counseling Outreach Activities
(January 2009 - March 2009)

	Oct	Nov	Dec	Jan	Feb	Mar
Public Seminars	240	186	192	197	188	218
Private Seminars	34	18	36	35	33	50
Home/No-phone Visits	189	174	112	224	45	40
Outbound List	4,554	3,668	4,009	3912	2089	1082
Enrollments	**2,585**	**2,023**	**3,327**	**2631**	**2151**	**1933**

Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff has been calling beneficiaries at random who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 16 shows the responses in percentages from 100 beneficiaries who were randomly called to

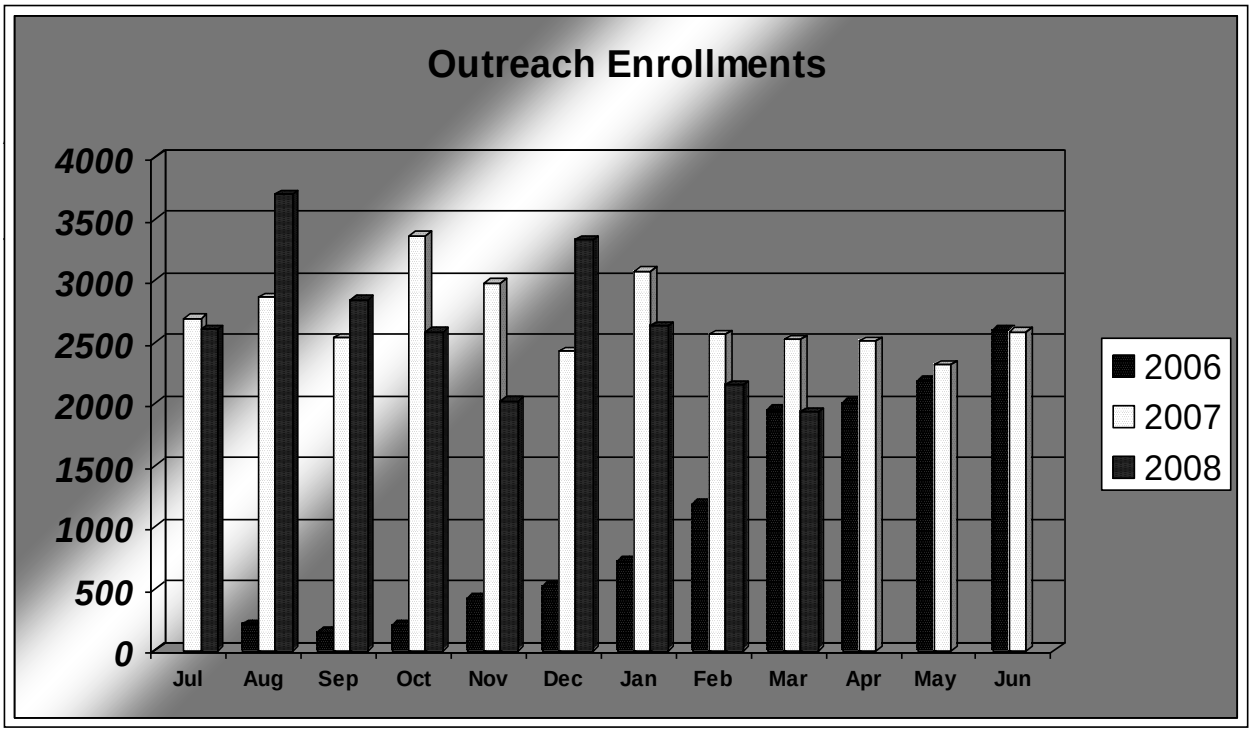
participate in the survey (from January and February 2009). The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 16 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	100.00%
Felt the information provided by the Choice Counselor helped them make an informed decision	96.50%
The information was explained in a way that made it easy to understand	96.00%
The Choice Counselor was friendly/courteous	99.50%

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

At the end of this quarter, the Field Choice Counselors had 6,827 enrollment activities. One note is that in March while enrollments were down and plan changes grew for the Field team, there were 1,084 plan changes processed by Field Choice Counselors which is an increase. This is as a result of increases in Public Sessions, face-to-face call center requests, return mail follow up and Red Alert message/ call backs. Return mail and Red Alert follow ups have risen from 375 in December to 3,168 in March. The following chart shows the enrollment activity levels of the Field Choice Counselors since implementation of the demonstration.

Field Choice Counseling Outreach Enrollments



Field Activities	2nd Quarter	3rd Quarter
Group Sessions	618	603
Private Sessions	88	118
Home Visits & One-On-One Sessions	251	176
No Phone List	475	288
Outbound Phone List	12,231	7,083
Enrollments	7,935	6,827
Plan Changes	1,315	1,769

The Mental Health Unit:

The previous quarter the Outreach/Field team created the Mental Health Unit (MHU) to provide more direct support to beneficiaries who access mental health services. Activity increased dramatically in the last part of February and all of March as the Mental Health Unit increased its efforts with community partners to help ease the transition for Healthease and Staywell members. Those beneficiaries in the special needs community who are the highest risk for adverse effects caused by continuity of care related issues have been a high priority within the unit. The efforts made earlier to build relationships with the organizations and people who serve them are yielding good results. 53 Private Sessions were completed during the quarter, 34 since the last week of February which were specifically targeting the transition. 126 beneficiaries have received individual choice counseling at these sessions and 22 staff presentations have provided 76 caseworkers and other staff members the information necessary to help direct their clients appropriately.

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

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

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

5. Health Literacy

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

Summary of cases taken by the Special Needs Unit:

During this quarter, 52 new case referrals were received and processed by the SNU.

January	February	March
13	19	20

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

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

Special Needs Unit training was conducted for the Field Choice Counselors in their quarterly refresher training in January that included a review of referral procedures and case scenarios.

6. New Eligible Self Selection Data[2]

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

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

The new eligible enrollments in this report are taken from ACS records. There were 41,169 total enrollments for the third quarter. Of those total enrollments those that self selected a plan were 23,979 (broken down by month: 8,970 for January; 8,155 for February; and 6,854 for March 2009) and a total of 17,190 beneficiaries were assigned to a plan for the quarter.

The Agency, ACS and EDS have identified and created a CSR to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with FMMIS. The daily and monthly files of information that transfer from EDS to ACS have been through several improvements and many of the issues have been resolved. With the month end information coming through consistently and correctly, it will allow ACS to determine the new eligible's and ensure the enrollment will be more successful. Prior to the fiscal agent transition, ACS exceeded the self-selection standard. The Agency fully expects when the corrections are in place, ACS will not only meet but exceed the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

7. Complaints/Issues

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

During the quarter, two complaints filed related to the Choice Counseling Program. Table 17 provides the details regarding the complaints filed and the action taken by ACS:

Table 17
Choice Counseling Beneficiary Complaints
January 1 – March 31, 2009

Beneficiary Complaint	Action Taken
1. A beneficiary called to complain about her child not getting enrolled into a health plan that she had requested.	➲ Research into the case found that the child has an exemption and is not able to enroll into managed care. The mother was referred to the child's case manager with Dept. of Children and Families.
2. A beneficiary spoke with a Field Choice Counselor to complain that the health plan they wanted was not accepting enrollments.	➲ The counselor apologized and explained the situation with the plan leaving the Reform County. She suggested alternative plans and offered the opportunity for public or private session to discuss in person if preferred.

8. Quality Improvement

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

Included in this report are comments from beneficiaries who expressed their appreciation to either a Call Center or Field Supervisor for the Choice Counselors who helped them. The individual counselors that received this positive feedback have gone the extra mile and have offered a "helping hand" to those who they spoke with in person or on the phone. These beneficiaries have taken the initiative on their own to contact the supervisors to compliment the work that the counselors have done. During this quarter, there were 50 reported compliments to supervisors about counselors offering exceptional customer service. Table 18 provides examples of positive feedback about Choice Counselors.

Table 18
Helping Hands
Examples of Positive Feedback about Choice Counselors
January 1 through March 31, 2009

A beneficiary called to compliment **Kerushel Rollins** for her professionalism. She stated that Kerushel was helpful assisting her. She was really frustrated but the agent was very understanding and explained everything. She said, "I never ever, ever received such good customer service when calling Medicaid. I am really grateful for the service I received."
A beneficiary who called to compliment **Alex Alas** and **Beverly Woodson** said, "I appreciate how nice both of these counselors were to me. They were very patient, concerned about helping and really listened. I appreciate their customer service and want to thank them again
A beneficiary who called to compliment **Demestra Davis** stated that Demestra was very pleasant and very polite. She said, "Demestra is a wonderful representative. I was unsure about the plan for my son, but she walked me through. She went the extra mile to help me." The beneficiary was really grateful for the services she received.
A beneficiary complimenting **Brandi Stroman** said that he wanted to let us know what a wonderfully, helpful person this counselor was in assisting him. He said she really made him comfortable with the information that she provided him and he felt that she went above and beyond most "normal' customer service personnel.
A beneficiary calling to compliment choice counselor, **April Hill**, and field counselor, **Nathalie Petit-Juene** said**,** "I made two phone calls to the Medicaid counseling line to pick a plan and I wanted to let you know that there are two great young ladies that are really great in customer

Table 18 Helping Hands Examples of Positive Feedback about Choice Counselors January 1 through March 31, 2009
service. They spent a lot of extra time answering all my questions. I spent 1 ½ with April and the other one is Nathalie that answered a couple of other questions I didn't know as well. I wanted to give Kudos to such great workers you have."
I just wanted to personally let you know how much it has helped having the choice counselors in house. They have been so good, professional, helpful and taken a heavy load off of us. I think they are doing an awesome job. Thank you.

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

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

The Agency Headquarters staff, the Medicaid Area Office staff, and ACS Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between Area Medicaid staff and ACS Field staff, e-mail boxes on ACS' enrollment system to enable the Agency staff and ACS to share information directly from the system to resolve difficult cases, and regularly scheduled conference calls. ACS has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the call center and field have been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

9. Summary

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

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

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

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

C. Enrollment Data

Overview

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

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

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

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

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

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

All 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 15 Medicaid Reform health plans – nine HMOs and six fee-for-service PSNs. Buena Vista and Vista South Florida both ceased operations before the quarter began. In addition, the Pediatric Associates PSN ceased operations in February 2009, but the January 2009 enrollment is still included in this report. 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 19 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 19 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 20 for the Fiscal Year 2008-09, 3rd Quarter Medicaid Reform Enrollment Report.

Table 20
Medicaid Reform Enrollment Report
(Fiscal Year 2008-09, 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	15,598	1,993	2	70	**17,663**	**7.47%**	16,572	6.58%
Buena Vista	HMO	0	0	0	0	**0**	**0.00%**	4,777	-100.00%
Freedom Health Plan	HMO	1,396	251	0	1	**1,648**	**0.70%**	1,124	46.62%
HealthEase	HMO	44,698	5,343	4	120	**50,165**	**21.22%**	52,448	-4.35%
Humana	HMO	15,014	2,769	7	122	**17,912**	**7.58%**	13,225	35.44%
Preferred Medical Plan	HMO	3,181	687	0	24	**3,892**	**1.65%**	2,755	41.27%
StayWell	HMO	28,972	2,978	0	99	**32,049**	**13.56%**	33,756	-5.06%
Total Health Choice	HMO	6,817	1,073	7	66	**7,963**	**3.37%**	4,022	97.99%
United Health Care	HMO	12,297	1,344	1	45	**13,687**	**5.79%**	16,864	-18.84%
Universal Health Care	HMO	5,552	789	2	50	**6,393**	**2.70%**	3,665	74.43%
Vista South Florida	HMO	0	0	0	0	**0**	**0.00%**	5,072	-100.00%
HMO Total		**133,525**	**17,227**	**23**	**597**	**151,372**	**64.04%**	**154,280**	**-1.88%**
Access Health Solutions	PSN	32,845	4,303	6	393	**37,547**	**15.88%**	23,101	62.53%
CMS	PSN	2,536	2,528	0	16	**5,080**	**2.15%**	4,708	7.90%
First Coast Advantage	PSN	18,759	4,120	2	496	**23,377**	**9.89%**	20,030	16.71%
NetPass	PSN	5,550	1,682	9	226	**7,467**	**3.16%**	5,475	36.38%
Pediatric Associates	PSN	503	12	0	0	**515**	**0.22%**	10,234	-94.97%
SFCCN	PSN	8,395	2,338	5	279	**11,017**	**4.66%**	8,826	24.82%
PSN Total		**68,588**	**14,983**	**22**	**1,410**	**85,003**	**35.96%**	**72,374**	**17.45%**
Reform Enrollment Totals		**202,113**	**32,210**	**45**	**2,007**	**236,375**	**100.00%**	**226,654**	**4.29%**

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

The enrollment figures for this quarter reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from Non-Reform health plans to Reform health plans. There were a total of 236,375 beneficiaries enrolled in the demonstration during this quarter. There were 15 Reform health plans with market shares ranging from 0.22 percent to 21.22% percent.

2. Medicaid Reform Enrollment by County Report

During this quarter the demonstration was operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of Reform HMOs and Reform PSNs in each county is listed in Table 21 on the following page.

Table 21 Number of Reform Health Plans in Demonstration Counties		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**1**	**1**
Broward	**9**	**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 22 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 22 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as in Table 23 and located on the following page.

Table 23
Medicaid Reform Enrollment by County Report
(Fiscal Year 2008-09, 3rd Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
United Health Care	HMO	Baker	677	97	0	1	**775**	**26.24%**	838	-7.52%
Access Health Solutions	PSN	Baker	1,966	200	0	12	**2,178**	**73.76%**	1,933	12.67%
Total Reform Enrollment for Baker			**2,643**	**297**	**0**	**13**	**2,953**	**100.00%**	**2,771**	**6.57%**
Amerigroup	HMO	Broward	15,598	1,993	2	70	**17,663**	**13.61%**	16,572	6.58%
Buena Vista	HMO	Broward	0	0	0	0	**0**	**0.00%**	4,777	-100.00%
Freedom Health Plan	HMO	Broward	1,396	251	0	1	**1,648**	**1.27%**	1,124	46.62%
HealthEase	HMO	Broward	12,013	1,439	2	40	**13,494**	**10.40%**	14,799	-8.82%
Humana	HMO	Broward	15,014	2,769	7	122	**17,912**	**13.80%**	13,225	35.44%
Preferred Medical Plan	HMO	Broward	3,181	687	0	24	**3,892**	**3.00%**	2,755	41.27%
StayWell	HMO	Broward	26,742	2,644	0	88	**29,474**	**22.71%**	30,838	-4.42%
Total Health Choice	HMO	Broward	6,817	1,073	7	66	**7,963**	**6.14%**	4,022	97.99%
United Health Care	HMO	Broward	0	0	0	0	**0**	**0.00%**	745	-100.00%
Universal Health Care	HMO	Broward	2,240	418	0	24	**2,682**	**2.07%**	903	197.01%
Vista South Florida	HMO	Broward	0	0	0	0	**0**	**0.00%**	5,072	-100.00%
Access Health Solutions	PSN	Broward	11,407	1,524	3	118	**13,052**	**10.06%**	3,169	311.86%
CMS	PSN	Broward	1,395	1,605	0	14	**3,014**	**2.32%**	2,739	10.04%
Netpass	PSN	Broward	5,550	1,682	9	226	**7,467**	**5.75%**	5,475	36.38%
Pediatric Associates	PSN	Broward	503	12	0	0	**515**	**0.40%**	10,234	-94.97%
SFCCN	PSN	Broward	8,395	2,338	5	279	**11,017**	**8.49%**	8,826	24.82%
Total Reform Enrollment for Broward			**110,251**	**18,435**	**35**	**1,072**	**129,793**	**100.00%**	**125,275**	**3.61%**
United Health Care	HMO	Clay	3,452	254	0	12	**3,718**	**35.49%**	3,589	3.59%
Access Health Solutions	PSN	Clay	5,944	748	0	67	**6,759**	**64.51%**	6,165	9.64%
Total Reform Enrollment for Clay			**9,396**	**1,002**	**0**	**79**	**10,477**	**100.00%**	**9,754**	**7.41%**
HealthEase	HMO	Duval	32,685	3,904	2	80	**36,671**	**41.43%**	37,649	-2.60%
StayWell	HMO	Duval	2,230	334	0	11	**2,575**	**2.91%**	2,918	-11.75%
United Health Care	HMO	Duval	7,014	844	0	31	**7,889**	**8.91%**	10,422	-24.30%
Universal Health Care	HMO	Duval	3,312	371	2	26	**3,711**	**4.19%**	2,762	34.36%
Access Health Solutions	PSN	Duval	10,577	1,486	0	168	**12,231**	**13.82%**	8,945	36.74%
CMS	PSN	Duval	1,141	923	0	2	**2,066**	**2.33%**	1,969	4.93%
First Coast Advantage	PSN	Duval	18,759	4,120	2	496	**23,377**	**26.41%**	20,030	16.71%
Total Reform Enrollment for Duval			**75,718**	**11,982**	**6**	**814**	**88,520**	**100.00%**	**84,695**	**4.52%**
United Health Care	HMO	Nassau	1,154	149	1	1	**1,305**	**28.17%**	1,270	2.76%
Access Health Solutions	PSN	Nassau	2,951	345	3	28	**3,327**	**71.83%**	2,889	15.16%
Total Reform Enrollment for Nassau			**4,105**	**494**	**4**	**29**	**4,632**	**100.00%**	**4,159**	**11.37%**
Reform Enrollment Totals			**202,113**	**32,210**	**45**	**2,007**	**236,375**		**226,654**	**4.29%**

As with the Medicaid Reform Enrollment Report, the 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 2,953 beneficiaries in Baker County, 129,793 beneficiaries in Broward County, 10,477 beneficiaries in Clay County, 88,520 beneficiaries in Duval County, and 4,632 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 26.24 percent to 73.76 percent, 15 Broward County Reform plans with market shares ranging from 0.40 percent to 22.71 percent, two Clay County Reform plans with market shares ranging from 35.49 percent to 64.51 percent, seven Duval County Reform plans with market shares ranging from 2.33 percent to 41.43 percent, and two Nassau County Reform plans with market shares ranging from 28.17 percent to 71.83 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 24 and 25 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. Table 24 provides a description of each column in this report.

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

Table 25
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2008-09, 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	3	104	0	30	4	17	**158**	**0.89%**	**17,663**
Freedom Health Plan	HMO	Broward	1	4	0	3	0	0	**8**	**0.49%**	**1,648**
Healthease	HMO	Broward	1	104	0	27	3	14	**149**	**1.10%**	**13,494**
Healthease	HMO	Duval	14	530	0	67	7	33	**651**	**1.78%**	**36,671**
Humana	HMO	Broward	7	85	2	46	31	51	**222**	**1.24%**	**17,912**
Preferred Medical Plan	HMO	Broward	2	30	0	9	7	8	**56**	**1.44%**	**3,892**
Staywell	HMO	Broward	9	189	4	56	3	25	**286**	**0.97%**	**29,474**
Staywell	HMO	Duval	0	32	0	3	0	4	**39**	**1.51%**	**2,575**
Total Health Choice	HMO	Broward	9	28	1	6	33	31	**108**	**1.36%**	**7,963**
United Healthcare	HMO	Baker	0	4	0	0	0	0	**4**	**0.52%**	**775**
United Healthcare	HMO	Clay	5	33	3	13	2	0	**56**	**1.51%**	**3,718**
United Healthcare	HMO	Duval	0	181	0	23	0	8	**212**	**2.69%**	**7,889**
United Healthcare	HMO	Nassau	1	13	1	2	0	1	**18**	**1.38%**	**1,305**
Universal	HMO	Broward	3	4	0	2	12	6	**27**	**1.01%**	**2,682**
Universal	HMO	Duval	7	18	0	3	10	12	**50**	**1.35%**	**3,711**
HMO Total	**HMO**		**62**	**1,359**	**11**	**290**	**112**	**210**	**2,044**	**1.35%**	**151,372**
Access Health Solutions	PSN	Baker	1	16	0	3	1	10	**31**	**1.42%**	**2,178**
Access Health Solutions	PSN	Broward	2	33	0	10	16	86	**147**	**1.13%**	**13,052**
Access Health Solutions	PSN	Clay	4	48	0	17	10	46	**125**	**1.85%**	**6,759**
Access Health Solutions	PSN	Duval	11	129	0	23	31	117	**311**	**2.54%**	**12,231**
Access Health Solutions	PSN	Nassau	3	47	1	3	1	27	**82**	**2.46%**	**3,327**
CMS	PSN	Broward	2	42	6	151	0	12	**213**	**7.07%**	**3,014**
CMS	PSN	Duval	3	47	1	60	0	2	**113**	**5.47%**	**2,066**
First Coast Advantage	PSN	Duval	12	275	2	95	22	435	**841**	**3.60%**	**23,377**
NetPass	PSN	Broward	4	36	2	36	28	191	**297**	**3.98%**	**7,467**
Pediatric Associates	PSN	Broward	0	112	0	23	0	4	**139**	**26.99%**	**515**
SFCCN	PSN	Broward	7	155	1	42	6	248	**459**	**4.17%**	**11,017**
PSN Total	**PSN**		**49**	**940**	**13**	**463**	**115**	**1,178**	**2,758**	**3.24%**	**85,003**
Reform Enrollment Totals			**111**	**2,299**	**24**	**753**	**227**	**1,388**	**4,802**	**2.03%**	**236,375**

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

D. Opt Out Program

Overview

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

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

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

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

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

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

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

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

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

Current Activities

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

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

Opt Out Program Statistics

- 61 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 37 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the third quarter of Year Three, there are currently 24 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

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

2. The caller began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment 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 December 31, 2007 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 effective December 31, 2007. 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. The children's Medicaid eligibility ended March 31, 2008 and they were subsequently disenrolled from the Opt Out Program (Item Number 11).

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

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

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

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

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

10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan during the third quarter of Year Two effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out program.

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

12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's Medicaid eligibility ended March 31, 2009 and as a result has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the fourth quarter of Year Two and subsequently re-enrolled in the

Opt Out Program effective May 1, 2008. The child's Medicaid eligibility ended March 31, 2009, and as a result, has been disenrolled from the Opt Out Program (Item Number 26).

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

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

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan during the third quarter of Year Three effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out program.

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

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

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

August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

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

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

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

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

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

31. The caller began the process to enroll her child in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during

the second quarter of Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child is still enrolled in the Opt Out Program.

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

Table 26 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending March 31, 2009. Current Opt Out enrollment, as of March 31, 2009, is 24.

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

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

E. Enhanced Benefits Account Program

Overview

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

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

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

Current Activities

1. Call Center Activities

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

The primary function of the call center is to handle inbound calls from beneficiaries and answer questions on the program and provide information on credits earned and used by beneficiaries. During this quarter, the majority of the calls related to beneficiaries requesting information regarding their account balances. A total of 16,876 calls or 78% of all answered calls were related to account balances.

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

Inbound Calls:	**23,675**
Calls Abandoned:	**2,173**
Average Talk Time:	**4.39**

2. System Activities

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

The Agency continues to receive the monthly healthy behavior reports from the plans by the 10th day of the month, as scheduled. Each month, an eligibility file is uploaded into the EBIS. There was an error in the February 2009 eligibility file, which caused it to reject during the March 2009 processing. This caused beneficiaries not to receive credit for their healthy behavior, with dates of service in February 2009. The file was corrected and uploaded in April 2009. The Agency continues to work on the completeness of the eligibility file and will continue to communicate the progress to CMS.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during the quarter. The calls received this quarter were primarily related to beneficiaries seeking current balance information. The counselors are able to provide up to date information to each beneficiary, covering the latest weekly balances. The Agency has asked for proposals from the pharmacy vendor (First Health) and the choice counseling vendor (ACS) to handle balance related calls through an Automated Voice Response System (AVRS). The Agency continues to monitor the call volume of balance inquiries, after mailing the balance only statements to beneficiaries.

4. Outreach and Education for Pharmacies

The change in reimbursement to pharmacies for the "shelf price" for an EB over the counter (OTC) item instead of the Medicaid pricing was successfully implemented on January 16, 2009. The “shelf price” is the normal store shelf pricing of the product. Beneficiaries now pay the “shelf price” for OTC products, which allow them to budget their earned credits more effectively. This new billing change was implemented because many corporate pharmacies complained when the Agency disallowed the dispensing fee (January 2007) that was charged for some OTC items. Disallowing the dispensing fee resulted in many OTC products paying below their “shelf price”. There was a positive impact of this billing change. January 2009, represented the highest purchase month with a total amount of $756,557.34 in purchases. Purchases have now stabilized to an average monthly amount of $560,000.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel met on March 20, 2009. The panel asked for further analysis on the cost and benefit of processing balance only calls by an automated voice response system (AVRS). The panel members felt that the AVRS would allow beneficiaries to receive balance information without having to speak to a counselor. Implementing this system would also free counselors to respond to other types of EB calls, such as locating OTC products, explaining the EB program, or assisting those having problems at the pharmacy. EB Counselors, who are cross-

trained to handle choice counseling calls, would then be able to assist with those calls when needed.

6. Enhanced Benefits Statistics

Table 27 provides the Enhanced Benefit Account Program statistics beginning January 1, 2009 and ending March 31, 2009.

Table 27
Enhanced Benefit Account Program Statistics

2nd Quarter Activities – Year Three		January 2009	February 2009	March 2009
I.	Number of plans submitting reports by month in each county	28 of 28	28 of 28	28 of 28
II.	Number of enrollees who received credit for healthy behaviors by month	22,665	12,422	28,949
III.	Total dollar amount credited to accounts by each month	$427,037.50	$250,290.00	$614,042.50
IV.	Total cumulative dollar amount credited through the end each month	$19,354,878.66	$19,605,168.66	$20,219,211.16
V.	Total dollar amount of credits used each month by date of service	$756,557.34	$537,555.60	$490,937.63
VI.	Total cumulative dollar amount of credits used through the month by date of service	$6,396,653.27	$6,934,208.87	$7,425,146.50
VII.	Total cumulative number of enrollees who used credits through the end of each month	95,127	99,726	103,596

7. Complaints

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

During this quarter, over 8,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 79 (less than 1%) complaints were recorded through the call center related to the EBAP. Table 28 provides a summary of the complaints

received this quarter and outlines the actions taken by either the Agency or EDS to address the issues raised.

Table 28 Enhanced Benefit Beneficiary Complaints	
Beneficiary Complaint	**Action Taken**
1. Fifty-five beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program. Call center also refers beneficiaries to an actively participating pharmacy in their area.
2. Twenty-four beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching products at the pharmacy.	➲ The Agency has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list not in the particular pharmacy of choice. Call center also refers beneficiaries to an actively participating pharmacy in their area.

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) 2008-2009, there were two LIP Council meetings.

January 9, 2009

On January 9, 2009 the LIP Council held its fifth meeting of SFY 2008-2009 via conference call at the Agency for Health Care Administration located in Tallahassee, Florida from 10:00 a.m. to 1:00 p.m.

The LIP Council heard presentations from Miami-Dade Blue Premium Assistance Program and Health Care District of Palm Beach County Premium Assistance program, for request to participate in the LIP program as part of the LIP "Special Projects" category. Both innovative programs were included in the LIP Recommendations (SFY 2009-2010). The presentations on these programs can be viewed at http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml, scroll down to the January 9, 2009, Low Income Pool Council Meeting. For the remainder of the meeting, the council reviewed and discussed in detail four additional LIP funding and distribution models.

January 22, 2009

On January 22, 2009 the LIP Council held its sixth and final meeting of SFY 2008-2009 at the Tampa Airport Marriott, in Tampa, Florida.

Agency staff provided brief updates regarding completion of hospital reimbursement rates, and the status of the Reimbursement and Funding Methodology document. The LIP Council reviewed seven LIP funding and distribution models prior to voting. The final vote was not unanimous and funding and distribution model 16 with changes was chosen by the LIP Council to be used as SFY 2009-2010 LIP recommendations.

LIP Council Recommendations – State Fiscal Year 2009-2010

On February 3, 2009, LIP Council Chair sent the Agency the LIP Council's recommendation for SFY 2009-2010 funding and distribution to be forwarded to the Governor and Legislature. On February 16, 2009, LIP Council Chair followed up the LIP Council's SFY 2009-2010 LIP funding and distribution recommendations with a detailed report provided to the Agency, Governor, and Legislature. The SFY 2009-2010 LIP recommendations and the detail report are posted on the Agency's website at http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml, toward the bottom of the page under the heading "LIP Council Recommendations to Governor and Legislature for SFY 2009-10".

The SFY 2009-2010 LIP Council recommendations continued the trend of increasing LIP funding for LIP projects outside of the Provider Access System (PAS) hospital providers as outlined in the chart below.

State Fiscal Year	Total UPL/ LIP to Hospitals	Total UPL/ LIP to Non Hospital
2006-2007	$979,352,587	$19,305,630
2007-2008	$978,550,936	$21,449,060
2008-2009	$975,250,000	$26,200,000
2009-2010 - LIP Recommendations	$948,833,333	$51,416,666

Agency Activities

During this quarter, the Agency continued to work with counties and taxing districts to finalize any outstanding issues with Letters of Agreement. Also during this quarter, the Agency released $248,152,977 to Provider Access Systems.

SFY 2008-2009 Low Income Pool Projects

Attachment IV provides an overview of the activities undertaken by the Department of Health affiliated Provider Access Systems with funding provided from the Low Income Pool during SFY 2008-2009. These PAS entities include the County Health Departments (listed below) and the St. Johns River Rural Health Network. Subsequent reports will focus on other PAS entity activities.

- Citrus County Health Department
- Dixie County Health Department (Dixie and Gilchrist Counties)
- Duval County Health Department
- Jefferson & Madison County Health Departments (Jefferson & Madison Counties)
- Lake County Health Department
- Okaloosa County Health Department (Focus on the service area of the Fort Walton Beach Medical Center)
- Orange County Health Department
- Pinellas County Health Department (PinCHD)
- Polk County Health Department
- Sarasota County Health Department

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.

Current Activities

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

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

As noted in previous quarterly reports, Florida Medicaid transitioned to a new fiscal agent on July 1, 2008, and the Florida Bureau of Medicaid Program Analysis had to modify the data base to receive downloads from the new system. Due to variances in case months and expenditures, the Agency contacted the Centers for Medicare and Medicaid Services to discuss the data situation. It was determined to be appropriate to hold the budget neutrality submission of these figures until the Agency had identified and corrected all issues related to the variances. As such, budget neutrality figures were not included in the quarterly report for the period July 1 to September 30, 2008. The quarterly report for October 1 to December 31, 2008, included quarterly case

months and expenditures for two reporting periods, July 1 to September 2008, and October 1 to December 31, 2008.

Subsequent to the submission of the last quarterly report, the Florida Bureau of Medicaid Program Analysis determined that not all the effects of the transition to the new system had been identified at the time the data was extracted to prepare the quarterly report for October 1 to December 1, 2008. Therefore, case months and expenditures were not correctly reported on previous quarterly reports. In addition to reporting case months and expenditures for the current reporting period, the figures in this report reflect corrected case months and expenditures for the three previous reporting periods: April 1 to June 30, 2008 (correction affects June 2008 only); July 1 to September 30, 2008; and October 1 to December 31, 2008.

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

In the following tables (Tables 29 through 34), 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 29 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 29
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 30 through 34 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2009. Case months provided in the Tables 30 and 31 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 30
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
April 2008	254,500	$302,204,899	$52,469,635	$354,674,534	$1,393.61
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,119,581**	**$776,809,682**	**$1,015.83**
July 2008	277,846	$192,176,160	$32,392,732	$224,568,891	$808.25
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,915,711**	**$825,861,820**	**$1,008.92**
October 2008	266,157	$232,318,022	$41,009,801	$273,327,823	$1,026.94
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58
Q10 Total	**791,043**	**$738,232,869**	**$128,483,862**	**$866,716,731**	**$1,095.66**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
MEG 1 Total	**8,432,740**	**$7,269,233,098**	**$1,031,848,906**	**$8,301,082,004**	**$984.39**

Table 31
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,569,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$ 164.78**
July 2008	1,343,457	$167,028,012	$23,597,521	$190,625,534	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
January 2009	1,425,771	$119,386,179	$8,007,586	$127,393,766	$89.35
February 2009	1,440,339	$228,220,385	$24,038,667	$252,259,052	$175.14
March 2009	1,432,269	$361,013,917	$41,788,973	$402,802,890	$281.23
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
MEG 2 Total	**42,546,194**	**$6,329,225,666**	**$602,465,812**	**$6,931,691,478**	**$162.92**

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

For Demonstration Year One, MEG 1 has a PCCM of $971.79 (Table 32), compared to WOW of $948.79 (Table 29), which is 102.42% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.22 (Table 32), compared to WOW of $199.48 (Table 29), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,010.27 (Table 32), compared to WOW of $1,024.69 (Table 29), which is 98.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.16 (Table 32), compared to WOW of $215.44 (Table 29), which is 78.52% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $967.44 (Table 32), compared to WOW of $1,106.67 (Table 29), which is 87.42% of the target PCCM for MEG 1. MEG 2 has a PCCM of $158.82 (Table 32), compared to WOW of $232.68 (Table 29), which is 68.25% of the target PCCM for MEG 2.

Tables 31 and 33 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 33) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $293.47. Comparing the calculated weighted averages, the actual PCCM is 91.00% 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 33) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $312.01. Comparing the calculated weighted averages, the actual PCCM is 88.42% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the Special Terms and Conditions (Table 33) is $373.95. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $289.52. Comparing the calculated weighted averages, the actual PCCM is 77.42% of the target PCCM.

Table 32
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,630,601,047	$263,795,407	$2,894,396,455	$971.79
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$68,506,087	
% of WOW PCCM MEG 1					102.42%
DY01 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162,819	$2,293,590,379	$135,861,345	$2,429,451,724	$160.22
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,227,410)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,625,149,221	$439,992,156	$3,065,141,377	$1,010.27
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(43,736,317)	
% of WOW PCCM MEG 1					98.59%
DY02 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY02 Total	14,829,991	$2,244,430,831	$264,139,197	$2,508,570,028	$169.16
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(686,403,233)	
% of WOW PCCM MEG 2					78.52%
DY03 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY03 Total	2,420,356	$2,013,482,829	$328,061,343	$2,341,544,172	$967.44
WOW DY3 Total	2,420,356			$2,678,535,375	$1,106.67
Difference				$(336,991,203)	
% of WOW PCCM MEG 1					87.42%
DY03 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY03 Total	12,553,384	$1,791,204,456	$202,465,270	$1,993,669,726	$158.82
WOW DY3 Total	12,553,384			$2,920,921,389	$232.68
Difference				$(927,251,663)	
% of WOW PCCM MEG 2					68.25%

Table 33
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,924,191,426	$399,656,752	$5,323,848,178	$293.47
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(526,721,324)	
% Of WOW					91.00%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,863,960	$4,869,580,052	$704,131,353	$5,573,711,405	$312.01
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(730,139,551)	
% Of WOW					88.42%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	14,973,740	$3,804,687,285	$530,526,613	$4,335,213,898	$289.52
WOW	14,973,740			$5,599,456,764	$373.95
Difference				$(1,264,242,866)	
% Of WOW					77.42%

Table 34
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,736
Q5	$114,252,478
Q6	$191,429,386
Q7	$319,005,892
Q8	$329,734,446
Q9	$165,186,640
Q10 *	$226,555,016
Q11	$248,152,977
Total Paid	$2,561,278,374

***Note**: This amount reflects an increase of $11,951,097 for Q10 from the previous quarterly report. Payments of $12,076,097 with a date of payment of December 31, 2008, were inadvertently omitted from the previous report, and a payment of $125,000 was erroneously included in the previous report. The adjustment was made as a prior period adjustment on the CMS 64 Report for the Quarter Ended 03/31/2009.

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$562,839,399	$1,000,000,000	56.28%
Total MEG 3	$2,561,278,374	$5,000,000,000	51.23%

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

The expenditures for the first eleven quarters for MEG 3, the Low Income Pool (LIP), were $2,561,278,374 (51.23% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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

Current Activities

During the quarter January 1, 2009 – March 31, 2009, to comply with the requirements of the Medicaid Reform Waiver, the Agency continued with its efforts to collect and verify encounter data from all capitated health plans on a statewide basis for all Medicaid-covered services. There are two collection efforts occurring concurrently: the collection of all encounter data for all Medicaid-covered services within our Florida Medicaid Management Information System (FMMIS), and the collection of quarterly pharmacy encounter data for risk adjustment purposes.

HMOs remain in various states of readiness to submit encounter claims to the Agency. In addition PSNs remain in various states of readiness to submit transportation encounter claims. Due to continued transition activities and tasks associated with the new Fiscal Agent operations, no encounters have been processed through the new FMMIS for this reporting period.

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

- Ongoing testing activities associated with the new FMMIS under EDS to support encounter data collection and processing.
- Ongoing efforts with the health plans, the new Fiscal Agent, and the Agency's Pharmacy Benefits Manager (First Health) to coordinate the collection of pharmacy and medical services encounter data within new FMMIS using the HIPAA compliant formats.
- Ongoing MEDS website updates, including the maintenance of relevant information used to facilitate communications with the health plans.

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

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

Health plan factors, budget neutrality and the derived risk corridor plan factor have been applied to capitated premium rates beginning in October 2006 and for each subsequent month thereafter for Medicaid-enrolled populations in Reform counties. As mentioned in previous reports, Legislation required that capitation premiums be fully risk adjusted and health plan corridor factors were no longer to be applied effective with Year Three of the demonstration.

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

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

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

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

Access Health Solutions	Humana	Shands Jacksonville
Amerigroup	SFCCN – Memorial Healthcare System	StayWell
Children's Medical Services	NetPass	Total Health Choice
Freedom Health Plan	SFCCN – North Broward Hospital Districts	Universal Health Care
HealthEase	Preferred Medical Plan	

Note: Effective July 1, 2009, HealthEase and StayWell will no longer participate in the demonstration as described in Section A of this report.

- The demonstration enrollment that is subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty plans/populations such as HIV/AIDS and CMS. Enrollment for risk adjustment purposes in the demonstration counties for the month of March 2009 totaled 196,193 and was distributed as follows:

March 2009	Broward	Duval, Baker, Clay, and Nassau
Children & Families	91,842	77,242
SSI	15,100	12,009
Totals	**106,942**	**89,251**

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

The process of providing plan risk factors for Medicaid Reform rate setting and budget neutrality will continue into the next quarter. Scheduled activities in the MEDS project

plan associated with the collection and validation of encounters will also continue. These activities encompass technical support with capitated health plans, reviewing end-to-end testing results, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection, validation and utilization of encounter data.

I. Demonstration Goals

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

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

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

The Agency currently has contracts with 9 HMOs and 5 PSNs for a total of 14 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. As noted in Section A of this report, United Health Plan, Vista, and Vista Health Plan of South Florida ceased operations in Broward County during the previous quarter. The health plans stated reasons for pulling out of these counties was not specific to the demonstration or to the September 1, 2008, capitation rates; rather the plans stated their withdrawal was related to network provider contracting issues. This quarter, two HMOs, HealthEase and Staywell notified the Agency of their intent to ceased operations in the demonstration area. Both health plans are owned by parent company, Wellcare. Wellcare stated reasons for pulling out of these counties were not specific to the demonstration but instead were related to the legislated March 1, 2009, capitation rates reduction. Please see Section A of the report for detailed information about the HealthEase and Staywell transition process.

The most recent health plan application was received January 14, 2009: Sunshine State Health Plan. Three HMO applications are still pending (AIDS Healthcare Foundation, Inc., Medica Health Plans of Florida, and Sunshine State Health Plan). AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, this application is the second specialty plan application the Agency has received (the first being a specialty plan for children with chronic conditions). As of March 31, 2009, this

specialty plan application was nearing completion of Phase III of the application process.

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

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

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

Access to Services Not Previously Covered

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

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

In Year Three, the Agency approved 28 customized benefit packages for the HMOs and 14 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of November 1, 2008 to August 31, 2009 for 11 HMOs and 6 PSNs. In the 3rd quarter of Year Three of the demonstration two HMOs, Buena Vista and Vista South Florida, and one PSN, Pediatric Associates), ceased operations in the demonstration areas. As a result there are now 24 customized benefit packages approved for 9 HMOs and 12 for the remaining 5 PSNs.

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for beneficiaries. Through the contracting process, each health plan is required to provide documentation

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

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

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

Also in October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 35 shows the results of these analyses.

Table 35
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

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

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

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

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

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

In the April 2008 statewide survey, 273 of the 300 providers were surveyed or could not be surveyed due to inaccurate information (e.g. the provider phone number was incorrect or disconnected). Of these 273 providers, 79% confirmed participation with a health plan. Agency follow-up with the health plans resulted in a finding that 88% of the

providers sampled were in fact contracted with the health plan for which they were surveyed. In the April 2008 survey focusing on Area 4, 103 of the 117 providers were surveyed or could not be due to inaccurate information. Of the 103 providers, 83% confirmed participation with a health plan, and Agency follow-up indicated that 84% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

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

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

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

Surveys were conducted in January, February, and March 2009. During the fourth quarter of Year Three, the Agency will follow up on and analyze the October and November 2008 surveys, and the January through March 2009 surveys. These results will be included in the report for the fourth quarter. As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once.

Since each geographic area has been sampled, the Agency will now move to quarterly provider network surveys.

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

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

(a) The Agency finalized its performance improvement strategy to increase health plan performance on contracted performance measures this quarter (see Attachment III). To achieve the goal established by the Agency, the health plans are required to complete corrective action plans for all performance measures that fall below the 50th percentile as calculated in the HEDIS 2007 National Means and Percentiles, published by the National Committee for Quality Assurance. The corrective action plans must be designed to achieve performance at the 75th percentile in two years for measures falling below the 25th percentile and three years for measures above the 25th percentile but below the 50th percentile. The Agency selected the 75th percentile as its performance goal for all contracted performance measures. It should be noted that this improvement strategy applies to both Reform and Non-Reform health plans as the Agency has committed to improving quality throughout our managed care system.

Almost all health plans met with the Secretary during this quarter to discuss their performance, participated in workshops with quality staff to discuss and improve their corrective action plans, and submitted final corrective action plans to the Agency on March 31, 2009. The remaining health plans will participate in corrective action plan workshops during the next quarter. The health plan data was included in the last quarterly report and can also be viewed on our website at the following link: http://ahca.myflorida.com/Medicaid/quality_mc/perform_measure.shtml.

To move forward with the next phase of the improvement strategy, the Agency will develop a corrective action plan quarterly monitoring reporting form and database tracking system. The expectations for quarterly reporting will be communicated to the health plans during the next quarter.

The final list of Year Three performance measures and specifications has been finalized and is being prepared within the Agency for dissemination to health plans. Comments from health plans, the EQRO, and HEDIS auditors were reviewed and incorporated.

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

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

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

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

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

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

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

The individuals who decided not to opt out:

(a) were not employed,

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

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

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

The Agency has contracted with the University of Florida (UF) to conduct patient satisfaction surveys throughout the five-year demonstration period. The survey instrument used by UF is based on the *Consumer Assessment of Healthcare Providers*

and Systems (CAHPS) *Survey*. The CAHPS Survey is one of a family of standardized instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care. UF has adapted the CAHPS telephone survey component by adding questions specific to the Reform demonstration. The Enrollee Satisfaction: Year One Follow-Up Survey report can be viewed on our website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml.

Caution must be made in making generalizations and conclusions regarding the impact of Reform on enrollee experiences. The data presented in this report represent only a subset of the available information, and additional multivariate analyses are necessary to achieve a more complete understanding. In addition, only one year of follow-up data have been presented for Broward and Duval Counties, and the follow-up survey for the rural counties is just now being fielded. Therefore, additional years of data will allow for a clearer identification of trends.

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

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

The Year One Follow-Up Survey was designed to assess enrollees' experiences and satisfaction with their health care after one year of enrollment in a Reform health plan. The beneficiaries who participated in the Year One Follow-up Survey were enrolled in a Reform health plan located in Broward and Duval Counties, and this survey report contains the first and earliest comparison of pre- and post-Reform survey data. Summary information and tables depicting individual satisfaction measures collected one-year "post" Reform from Broward and Duval Counties are provided on pages 81 through 84 of this report.

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

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

Benchmark Satisfaction Survey (Baker, Clay & Nassau Counties)

The benchmark satisfaction survey data of beneficiaries located in Baker, Clay and Nassau Counties were collected during the fall of 2007 and winter of 2008. The beneficiaries surveyed were enrolled in MediPass, which is Florida's primary care case management program in these expansion counties. During this quarter, the first year one follow-up survey for the rural counties was initiated, and will continue through the winter of 2009. This survey is designed to capture an assessment of enrollees' experiences with their health care after one year of enrollment in a Reform health plan in these three rural counties. The Year Two Follow-Up Survey is projected to be conducted in the winter of 2010.

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

The goal of the *Medicaid Reform Enrollee Satisfaction: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey* is to measure health care experiences and satisfaction levels prior to and throughout the implementation of Medicaid Reform.

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

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

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

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

Broward County:

- The percentage rating their overall health care at the highest level declined for the overall, SSI and non-SSI populations.
- For the overall population and among the non-SSI enrollees, the proportion giving their personal doctor the highest rating increased.

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

Duval County:

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

Select Demographic Characteristics: Broward and Duval Counties:

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

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

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

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

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

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

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

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

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

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

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

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

Prior to the implementation of the Medicaid Reform Waiver, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The Medicaid Reform Waiver created the Low Income Pool (LIP) program which provides for payments to Provider Access Systems (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 (PAS) 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 contracted with the University of Florida to conduct the evaluation of LIP, including cost-effectiveness and the impact of LIP on increased access for uninsured individuals. During the second quarter of Year One, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for the study required in Year Two of the demonstration.

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

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

During the first quarter of Year Two, the Agency and the University of Florida (UF) LIP Evaluation team continued their work together regarding the overall LIP evaluation, with an emphasis on STC #102. 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 Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the Provider Access Systems. A sample of the LIP Milestone report is provided in the Reimbursement and Funding Methodology

document. It should be noted that the LIP Milestone reports represent a snapshot of a 12 month period of time.

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

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

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

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

The Provider Access Systems input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed

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

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

The UF LIP Evaluation was received from the University of Florida on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the Provider Access Systems. This document includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

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

During the third quarter of Year Three, the Agency continues to work on gathering and evaluating the SFY 2007-08 Milestone data collected during the first and second quarter of Year Three, to be shared with the University of Florida in order for it to continue its annual evaluation on the Low Income Pool Program (LIP). The Milestone data will be used in accordance with STC #102 of the waiver. The Agency looks forward to receiving SFY 2007-08 Milestone report from the University of Florida in the next quarter. This quarter, the Agency received and is reviewing the first draft of the Pre- Reform Evaluation of the Low Income Pool Program using FHURS data.

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). This evaluation was designed to incorporate criteria in the waiver, plus those in the Special Terms and Conditions. The Agency developed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to 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. CMS approval was received on June 13, 2006.

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

1. Evaluations Affiliated with the Agency or its Contractors

Urban Institute – Early Impact of Transitioning to Medicaid Reform

Specific to this reporting period, UF is in the process of completing field work on a cross-sectional study in "follow up" to one that was published in Health Affairs on October 14, 2008. This study http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w523, was conducted by the Urban Institute (funded by the Henry J. Kaiser Family Foundation), and looked at the impact of transitioning individuals enrolled in the 1115 Reform Waiver. Additionally, the Kaiser Commission on Medicaid and the Uninsured issued Policy Brief #7823 entitled, *Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status*. This policy brief can be found at, http://www.kff.org/medicaid/upload/7823.pdf.

Findings are not yet available from UF on the Urban Institute's follow up study, but we will continue to provide updates on their progress as the study's findings are submitted to the Agency for review. A projected date on the official release of the final report from the Urban Institute has not yet been established.

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

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

reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. During this quarter, OPPAGA did not release any new reports on the Reform Demonstration. However, their ninth and final report is scheduled to be released next quarter.

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

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

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

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

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

University of Florida - Qualitative Survey

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

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. This has now been accomplished, so the Agency will be initiating communications with CMS and the University of Florida regarding the evaluation of another component of the demonstration that needs to be assessed in order to further enhance the pilot program.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as

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

representatives from the state's hospital and managed care industries, the medical association, other health professional groups, advocacy organizations, legislative leadership, or other entities. The FAC meets annually over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on the demonstration and the evaluation efforts. The third annual meeting is scheduled for August 18, 2009, at the Agency for Health Care Administration in Tallahassee, Florida.

Technical Advisory Committee

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

The purpose of this committee is to, over the five-year demonstration period, provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary. This year's annual TAC meeting took place on March 27, 2009, at the University of Florida in Gainesville. In addition to the TAC representatives, all project areas of the evaluation were represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focused on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

K. Policy and Administrative Issues

Current Activities

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

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

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

All of these forums provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of the Agency's Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement.

Medicaid Reform Technical Advisory Panel

One Technical Advisory Panel (TAP) meetings was held during this quarter on February 27, 2009. Discussion topics included:

- Health plan rates, particularly on the 3 percent reduction legislated in special session and rate certification;
- Updates on encounter data collection, enhanced benefit expenditures and choice counseling efforts, including a request by TAP for an evaluation for the potential of expanding the Navigator system for use by providers;
- Plan performance measures, including the agency's receipt of the first year of performance measures under Reform and the Agency's setting of performance benchmarks and corrective action plans to increase plan scores; and
- A discussion of the transition of Staywell and HealthEase members to other Reform health plans and the Agency's strategic plan for notice, choice and assignment.

Policy Transmittals and Dear Provider Letters

During this quarter, there were no policy transmittals and no mass Dear Provider letters released to the health plans this quarter; however, there were individualized health plan emails and letters sent by the Agency to each health plan regarding its Year One performance measure results. The Secretary of the Agency and representatives of the Quality Team met with each health plan regarding its performance as reported to the agency and to inform the health plan of the Florida Medicaid benchmarking goals, corrective action planning, and how the reported performance measure results would be

reported to the public. With few exceptions, the Agency's Quality Team held workshops with each health plan in February to review draft corrective action plans and provide technical assistance as needed. These workshops were collaborative and provided both the Agency and the health plan the opportunity to ask questions and for the plan to provide feedback as well as the Agency learning about the plan's particular areas of concern. Final corrective action plans were due by March 31 except for health plans whose workshops occurred later. The Agency posted results of the performance measures on its website on January 23, 2009. See Section I Objective 3, of this report for more information on the performance measures review process.

Biweekly Technical and Operations Calls

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

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

Approximately 20 to 30 participants attended in person and the popularity of the calls is shown by the number of phone lines in active use during the calls. On average 150 phone lines are in active use during the biweekly conference call. During the quarter, the majority of issues discussed continued to be operational in nature. While the transition to the new Medicaid Fiscal Agent and system continued to be a key item, other quality operational issues continued to be popular subjects. Such items include the Agency's performance measures initiative, external quality review updates, proposed marketing and encounter amendment review, the Staywell/HealthEase transition, the pharmacy Navigator program and the Agency's efforts to consolidate and revise its health plan contracts for September 1, 2009.

Other agenda items included:

- Choice Counseling Program updates, including Enhanced Benefit updates;
- 2009 Legislative session update;
- Unborn activation process changes;
- March 1, 2009, rate amendment;
- County Health Department Model Agreement; and
- Medicaid Encounter Data Systems update.

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

FFS PSN Systems Monthly Conference Calls

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

During the quarter, working through issues with the new Florida Medicaid Fiscal Agent system continued to be the prime focus of the calls. The Agency moved from biweekly calls (at the beginning a fiscal agent implementation) back to monthly systems implementation issues calls as the issues became more operational in nature.

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

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

Once operational systems changes are resolved, the Agency intends to work with the PSNs, key stakeholders and the Medicaid fiscal agent to modify the current claims process for FFS PSNs. The modification is designed to streamline the claims processing function by removing the claims processing step that includes the providers submitting claims to the FFS PSNs and the FFS PSNs having to accept and transmit the authorized claims to the Medicaid Fiscal Agent; and instead allow providers to submit claims directly to the Medicaid Fiscal Agent and have the FFS PSNs authorize the claims through the Medicaid Fiscal Agent for payment.

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

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues January 1, 2009 – March 31, 2009	
PSN Informal Issue	**Action Taken**
1. A PSN member contacted Agency staff, reporting that a provider billed the member's family for claims that the health plan had not yet paid.	➲ The PSN worked with the provider to alleviate claims filing issues and obtained an immediate refund for the member's family.
2. A PSN member contacted Agency staff, reporting that a provider will not see the member because the health plan has not paid previous claims.	➲ The PSN immediately arranged for the member to see another provider. The PSN also worked with the provider to assist with claims submission issues. Agency staff confirmed that the member's family and provider are satisfied.
3. A PSN member contacted Agency staff, reporting that the PSN is denying the beneficiary is a member. The member needs a new primary care provider and authorizations for services.	➲ The PSN identified a new primary care provider and obtained necessary authorizations for services for the member. Agency staff confirmed that the member is satisfied.
4. A PSN member contacted the Agency, reporting a lack of adequate assistance to and from the vehicle by the transportation provider.	➲ The PSN and transportation vendor explained to the member that the transportation provider is contractually prohibited from assisting the wheelchair-bound member up and down steps and into a building out of sight of the vehicle and other passengers. Agency staff confirmed that the member, PSN, and transportation vender are discussing alternatives.
5. A community mental health center reported that a PSN's third-party administrator incorrectly submitted the treating doctor's provider ID to the fiscal agent for reimbursement, rather than the community mental health center's provider ID.	➲ Agency staff instructed the community mental health center to direct the issue to the PSN and its third-party administrator for resolution and compensation.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
1. A provider contacted Agency staff, stated that the HMO says a member was disenrolled. The provider checked eligibility and says the member is active, but a claim has denied.	➲ The HMO reported to Agency staff that it corrected the database and processed and paid the previously denied claim. Agency staff confirmed that the provider is satisfied.
2. A provider contacted Agency staff, reporting that the HMO denied a claim due to the provider using a member's active Medicaid ID number rather than the inactive number that was in the HMO's database.	➲ The HMO reported to Agency staff that it updated the member database with the correct Medicaid ID number, then reprocessed and paid the previously denied claim.
3. An HMO member contacted the Agency and reports being balance billed by a provider even though the HMO states the matter was resolved.	➲ The HMO reported to Agency staff that it contacted the collection agency and verified that the claim was paid. The HMO advised the collection agency to stop trying to bill the member. The member was notified that the issue is resolved and is satisfied.
4. A provider states that the HMO denied a claim because the beneficiary was not a member on the date of service. The provider checked eligibility which indicated that the member was active on that date.	➲ The HMO reported to the Agency that it updated the member database and paid the claim.
5. A provider reported asking the HMO to consider authorizing an out-of-network claim.	➲ The HMO agreed to authorize the out-of-network claim payment because it maintained continuity of care for the member. The Agency confirmed that the provider is satisfied.
6. An HMO member's mother contacted the Agency, stating that she wants the member to see a primary care provider for follow-up, but this primary care provider is no longer in the plan network. The HMO also states that the member and a sibling are no longer enrolled.	➲ The HMO reported to the Agency that it verified the member's active status and confirmed the primary care provider is available. The sibling remains in the plan through the end of January, but the member's mother agreed to see a newly assigned primary care provider in January 2009 if necessary. The mother is satisfied.
7. An HMO member contacted the Agency and reports that the HMO has not issued healthy behavior credits to the account of the member and two other siblings.	➲ The HMO reported to the Agency that it did extensive research to confirm the healthy behavior credits and these were sent to the Agency for posting.
8. A former HMO member's parent contacted the Agency, reporting that the HMO would not assist the parent with balance billing by a provider for services received by the former member.	➲ The HMO reported to the Agency that it verified with the provider that the claim had paid. The provider adjusted the former member's account and stopped the balance billing effort. The HMO notified the parent of former member that the issue was resolved.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
9. An HMO member was unable to obtain a referral to a specialty provider from the HMO subcontractor.	➲ The HMO reported to the Agency that it arranged for the member to see a specialty provider. The member is satisfied.
10. A provider reports being unable to submit claims for service because the HMO cannot verify the beneficiary was a member on the dates of service.	➲ The HMO reported to the Agency that it updated the database to reflect the former member's eligibility on the dates of service and notified the provider that claims may be submitted.
11. An HMO member contacted the Agency and reports being unable to obtain plan authorization for services.	➲ The HMO reported to the Agency that it spoke to the member and the member said he is receiving necessary services through the HMO. The member had been obtaining additional services through a non-Medicaid, non-network provider which is why he was paying out-of-pocket. The member agreed to have an HMO case manager/nurse review his healthcare needs.
12. An HMO member reports the HMO is not authorizing services required to maintain the member's health.	➲ The HMO reported to the Agency that it had received no authorization requests, so the HMO contacted the provider and asked the provider to submit the requests. The HMO notified the mother, who was satisfied.
13. An HMO member contacted the Agency and reported that he is unable to obtain services because the HMO says he is not a member.	➲ The HMO reported to the Agency that it updated its member database and addressed the outstanding issues and concerns directly with the member.
14. An HMO member stated that she was being balance billed by a provider because the HMO refuses to pay claims.	➲ The HMO reported to the Agency that the member is legally responsible for the provider bills because there are third party liability funds available to pay those claims. The HMO has advised the member of this and the member has not provided documentation to show that these claims are unrelated to the third party liability issue.
15. An HMO member contacted the Agency and reported that she was enrolled in a new plan in whose network her provider does not participate. The member would like out-of-network service authorization until she changed into a new plan the next month.	➲ The HMO reported to the Agency that it issued authorization for services for the member. The provider confirms the issue is resolved.
16. A provider states that a claim was denied because the HMO states that the beneficiary is not a member. The provider's eligibility checks show that the beneficiary is an HMO member.	➲ The HMO reported to the Agency that it updated its member database and processed the previously denied claim.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
17. An HMO member reported being unable to obtain necessary services because the HMO states that he is not in its member database.	➲ The HMO reported to the Agency that the member's information was updated in the plan database and services were provided.
18. An HMO member stated he is being balance billed for claims not paid by the HMO. The member does not want to continue urgently needed services because he cannot pay the provider bills.	➲ Agency staff researched this case and found the dates of service for unpaid claims were during the member's enrollment in a previous plan. That plan has since paid the claims. The previous plan advised the provider to stop balance billing the former member. The member is satisfied and will continue accessing needed services.
19. An HMO member contacted the Agency and stated that the HMO denied an out-of-network claim and the member cannot see a provider until the claims issue is resolved.	➲ The HMO reported to the Agency that it will pay the claim per contract requirements once the provider submits the claim. The member's mother and provider were apprised of this resolution.
20. An HMO member contacted the Agency, reporting being unable to obtain services because the HMO subcontractor would not provide necessary authorizations.	➲ The HMO reported to the Agency that it assisted the subcontractor in working with the provider. After receiving the required information, authorizations were issued and services were made available. The HMO member's mother is satisfied.
21. An HMO member reported being unable to obtain a necessary specialty referral from the HMO.	➲ The HMO reported to the Agency that it coordinated a referral to a specialist for the member and the member had an appointment scheduled.
22. An HMO member's mother would like a replacement ID card for the member but reports that the HMO was unresponsive to her request.	➲ The HMO reported to the Agency that it issued a new ID card for the member and notified the parent that it was being mailed immediately.
23. An HMO member's parent contacted the Agency, stated that a provider was balance billing the parent because the HMO denied the provider's claims.	➲ The HMO reported to the Agency that it advised the provider to stop balance billing the member's parent. The HMO made arrangements for the claims to be paid.
24. An HMO member's mother reported that she is paying out of pocket for services because the member is not in the HMO's database.	➲ The HMO reported to the Agency that it added the member to its database and arranged for the parent to be reimbursed for out-of-pocket payments. It appears that a system error caused the member to activate early in FMMIS.
25. An advocate contacted the Agency and stated that the HMO was not providing necessary services to the member.	➲ The HMO reported to the Agency that it is providing necessary services as authorized. The member's mother wished to use an out-of-network provider for additional services and will coordinate visits to avoid duplication.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
26. A provider reported that the HMO denied the provider's claim because the beneficiary was not showing as a member on the date of service.	➲ Agency staff checked the member's eligibility in FMMIS—the member was active on the date of service. The HMO reported to the Agency that it corrected the member database and advised the provider to resubmit claims for payment.
27. A provider stated that the HMO is paying claims slowly or not at all and this is adversely affecting her practice's finances.	➲ The HMO reported to the Agency that all outstanding claims payments have been made to the provider. The provided states that she has attended claims submission training and agreed to use electronic funds transfer (EFT) in the future.
28. An HMO member was unable to obtain services because the HMO stated he was not an active member.	➲ The HMO verified that the member is active and worked with the member's primary care provider to obtain a prior authorization request. The HMO reported to the Agency that the member has now received all requested services.
29. An HMO member contacted the Agency and reported that the member's HMO was changed and the member's primary care physician is not in the new HMO's provider network.	➲ The HMO reported to the Agency that it was able to find a primary care physician within the network that met the member's needs. The member's mother is satisfied.
30. A provider stated the HMO is denying a member is active in the HMO.	➲ The HMO reported to the Agency that it verified the member is active. The HMO attempted multiple times to reach the provider to confirm eligibility, but was not successful.
31. An HMO member contacted the Agency and stated that the HMO told her they do not cover what should be a covered service.	➲ The HMO reported to the Agency that it worked with the provider and member to ensure that services would be delivered promptly. The member is satisfied.
32. An HMO member's parent reported that the HMO will not authorize a procedure for the member because it is scheduled at an out-of-network facility.	➲ The HMO reported to the Agency that it authorized all requested services and procedures and notified the member's parent to go ahead with scheduled healthcare activities.
33. An HMO member's parent reported that the member switched to a new HMO and is unsure if the member's PCP participates in the HMO network. The member's parent would like the HMO to authorize services until the situation is clarified.	➲ The HMO reported to the Agency that it has confirmed that the member may continue to see the current primary care provider.
34. A provider contacted the Agency and reported that they furnished equipment to a former member but never received payment for it. The provider would like the equipment back but the former member will not return it, so the provider wants the HMO to pay for the equipment.	➲ The HMO reported to the Agency that the provider admitted never having filed a prior authorization with the plan or having requested any payments. The HMO advised the provider to write off the equipment and the provider agreed to this suggestion.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
35. A provider contacted the Agency and reported that the HMO will not pay the provider's claim because they have no record that the member was active on the date of service.	➲ The HMO reported to the Agency that it verified that the member was active on the date of service. The HMO reprocessed the provider's claims for payment.
36. An HMO member's parent reported that the HMO told them that a specialty service was not covered for children.	➲ The HMO reported to the Agency that they contacted the member's mother to arrange for necessary services. The member's mother is satisfied.
37. An HMO member's guardian contacted the Agency and reported that the HMO subcontractor has not arranged a specialty care referral for the member.	➲ The HMO reported to the Agency that the subcontractor provided the necessary referral and authorization. The HMO member's guardian has been educated on the process of obtaining referrals, authorizations, and necessary services.
38. A provider reported that the HMO says the beneficiary is not a member, but the provider's eligibility checks confirm he is active and the member needs services.	➲ The HMO reported to the Agency that the member was using an old inactive Medicaid number. The HMO authorized the member to see the provider and educated the member on his new active number.
39. An HMO member reported that the HMO says no provider is available to give urgent specialty treatment but the HMO will not authorize out-of-network treatments.	➲ The HMO reported to the Agency that it has local providers in the network to provide the services needed, but that the member has been non-compliant with most appointments and has filed a grievance with the HMO that was denied. The HMO continued to work with the member and network providers to make sure that necessary treatments are available.
40. An HMO member's guardian contacted the Agency and reported that the HMO denied claims on the basis that the former member was disenrolled on the dates of service. The former member's guardian says this is not correct.	➲ The HMO reported to the Agency that it corrected the member's information and processed claims for payment.
41. An HMO member reported that he was unable to obtain services because the HMO states he was disenrolled.	➲ The HMO reported to the Agency that it updated its member database and authorized the requested services. The HMO advised the member's primary care provider that a pre-authorization will be needed for one of the services in the future.
42. A provider contacted the Agency and stated that the HMO is denying a claim despite having approved prior authorization for the service.	➲ The HMO reported to the Agency that the provider had billed using the wrong procedure code. The code was corrected and the claim was paid. The HMO notified the provider.
43. An HMO member's mother contacted the Agency, reported that she did not receive an HMO card for the member although she received membership cards for all the	➲ The HMO reported to the Agency that it updated its member database and sent out the membership card.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
member's siblings. When she called the HMO, she was informed that the beneficiary was not in their system.	
44. An HMO member's mother reported that the HMO will not authorize items the member needs.	➲ The HMO reported to the Agency that it corrected the member's file and reached out to the member's mother to inform her that the issue was resolved.
45. An HMO member's mother reported that the HMO told her that the requested specialty care is not offered. The member's mother says care is needed urgently.	➲ The HMO reported to the Agency that it spoke to the member's parent and primary care provider and immediately arranged for a specialty referral. The primary care provider and parent are satisfied.
46. A provider contacted the Agency and stated that the HMO's reason for denying claims is not correct.	➲ The HMO reported to the Agency that it worked with the provider and showed that the member had reached the limit of service because other providers had previously provided the service. The provider will seek fee-for-service payment of outstanding claims.
47. An HMO member contacted the Agency and reported being denied services.	➲ The HMO reported that the request was denied because it did not meet appropriate criteria. The member was advised to see a specialist and to file an appeal with the Subscriber Assistance Panel or to request a Medicaid Fair Hearing.
48. A provider contacted the Agency and reported receiving denied claims for 2 HMO members citing the members were not active during the dates of service. The provider had verified eligibility and the members were active on the dates of service.	➲ The HMO reported to the Agency that the provider claims have been reprocessed for payment and the HMO will be contacting the provider to advise.
49. A provider contacted the Agency and reported claims being denied.	➲ The HMO researched the claims and reprocessed them for payment.
50. An HMO member contacted the Agency and reported that she requires 14 medications each month but the HMO limits her to 9 prescriptions per month.	➲ The HMO reported to the Agency that it updated the member's file to reflect the pre-approved override of the member's prescriptions each month.
51. An HMO member contacted the Agency and reported being unable to obtain an appointment to see his physician since enrolling in the health plan over three months ago.	➲ The HMO set up an appointment for the member to see his physician.
52. An HMO member contacted the Agency and stated he would like to change his primary care provider and needs medication.	➲ The HMO reported to the Agency that the member's PCP was changed and sent authorization for the prescription.
53. An HMO member contacted the Agency and reported being denied prescriptions.	➲ The HMO reported to the Agency that the member is currently in case management. The

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
	member's PCP has recommended another medication for the member but the member is refusing to use it. The PCP has recommended DETOX for the member. The member had a follow-up appointment scheduled.
54. An HMO member contacted the Agency and reported having problems picking up his medication.	➲ The HMO reported to the Agency that the member was able to pick up his medications.
55. An HMO member's mother contacted the Agency and reported that the HMO is denying speech therapy services for the member.	➲ The HMO reported to the Agency that it has contacted the member and resolved the issue.
56. An HMO member contacted the Agency and reported being unable to get prescriptions filled.	➲ The HMO reported to the Agency that the member's information was updated. The HMO contacted the member's mother and advised that the son's two medications were ready to be picked up. The HMO also told the mother that she could be reimbursed for the pills purchased from the pharmacy.
57. A provider contacted the Agency and said she feels that some of the HMO requirements for completion of claims forms are outside of Medicaid regulations.	➲ The HMO reported to the Agency that it reached out to the provider to find out what the issue is. The HMO sent a provider relations field representative to the provider's office to re-educate staff on how to fill out claims forms.
58. An HMO member contacted the Agency and reported being unsuccessful in her attempts to secure a primary care provider in her area.	➲ The HMO reported to the Agency that it has at least two primary care providers in the member's area. The HMO attempted to contact the member to aid her in selecting a primary care provider.
59. An HMO member contacted the Agency and reported needing a blood pressure medication.	➲ The HMO reported to the Agency that it authorized a 30-day supply of the medication.
60. A provider contacted the Agency and reported having a claim denied by the HMO.	➲ The HMO reported to the Agency that the claim was denied because the provider failed to obtain an authorization for the procedure code, which is required. The HMO made multiple attempts to reach the provider's office and left messages for the provider.
61. A provider contacted the Agency and denied being able to contact the HMO to get assistance in submitting and getting claims paid.	➲ Agency staff spoke with the provider and confirmed that the HMO contacted the provider and that all claims have been paid. Agency staff told the provider that a check was written and sent to the provider. The provider appreciated the Agency's help.
62. An HMO member contacted the Agency and reported needing to change her PCP and to see a specialist.	➲ The HMO reported to the Agency that it tried to schedule an appointment for the member and the member declined.

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
63. An HMO member contacted the Agency and reported being unable to locate a specialist.	➲ The HMO reported to the Agency that it contacted the member and assisted him in finding a specialist.
64. A provider contacted the Agency and reported not being satisfied with the way the HMO processes payments and denies claims.	➲ The Agency had advised the HMO that it is deviating from the Medicaid Handbook by requiring the provider to submit the patient address on the claim form when the handbook states this information is not required. The HMO was advised to change this requirement.
65. An HMO member reported that he was unable to pick up his diabetes supplies and cholesterol medication.	➲ The HMO reported to the Agency that it has contacted the member and resolved the issues.
66. A provider contacted the Agency and reported needing information on procedure codes.	➲ The HMO reported to the Agency that it contacted the provider's office and answered her questions. The Agency analyst also contacted the provider to ensure that her issues were resolved, which the provider confirmed.
67. An HMO member contacted the Agency and reported problems in obtaining his medication.	➲ The HMO reported to the Agency that it contacted the member. It appears that the member has moved to Georgia.
68. An HMO member contacted the Agency and reported needing a medication.	➲ The HMO reported to the Agency that the medication has been authorized.
69. An HMO member contacted the Agency and reported being prescribed a medication that needs prior authorization by the health plan.	➲ The HMO reported to the Agency that the member was seen by a psychiatrist and was prescribed the medication.
70. A provider contacted the Agency and reported that the HMO denied a claim.	➲ The HMO reported to the Agency that it is working with the provider to get the claim paid.
71. An HMO member's mother contacted the Agency and reported that a provider is refusing services to the member because the HMO refused to pay an out-of-network claim. The member's mother switched the member to a new plan but wants to have access to the provider prior to the new plan enrollment period. The mother would like the HMO to do an out-of-network authorization to pay the claim.	➲ The HMO reported to the Agency that it agreed to accept an out-of-network claim from the provider. The member ended up not needing to see the provider until after the plan change.
72. A provider contacted the Agency and reported that the HMO will not authorize requested services because the member's current address of record does not match the address in the HMO database.	➲ The HMO reported to the Agency that it worked with the provider and custodial agency to get authorization and updated the member's address information in the HMO database.
73. A provider contacted the Agency and reported that members are unable to get service authorization from the plan because the	➲ The HMO reported to the Agency that it changed addresses in its system and notified the care provider and specialty provider. The

HMO Complaints/Issues January 1, 2009 – March 31, 2009	
HMO Informal Issue	**Action Taken**
members' current address does not match the HMO's address of record.	members received services.
74. An HMO member's mother contacted the Agency and reported that the HMO needs to facilitate speech/language and occupational therapy for the member.	➲ Agency staff contacted the HMO and spoke with a case manager, who stated that the referral for therapy was pending while awaiting additional clinical information. The member ended up switching to MediPass and Agency staff have confirmed that the member is receiving occupational therapy services.

Attachment III
Health Plan Performance Improvement Strategy
STATE OF FLORIDA- AGENCY FOR HEALTH CARE ADMINISTRATION

Key Terms

1. Health plan – for purposes of this document, includes Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs) operating across the state in "pilot/reform" and "traditional/non-reform" counties.

2. Performance measure (measure; PM) – for purposes of this document, the term is used as defined in the Health Plan Contracts. Performance Measures are based on standard definitions developed by NCQA for Health Employer Data and Information Set (HEDIS) measures[5].

3. In-scope performance measure: PMs which will be addressed by this strategy.

4. Measurement year (MY) – year for which actual PM values are collected. For purposes of this document, MYs equal calendar years (i.e. MY2008=CY2008) per the term's definition in the Health Plan Contracts.

5. Benchmark data – performance measure statistics collected by NCQA during a measurement year for *Medicaid health plans nationwide*.

6. Baseline performance – for purposes of this document, each health plan's reported performance by PM for MY2007.

7. Performance improvement period – for purposes of this document and as proposed therein, the three-year period beginning in MY2009. During this period health plan performance for the in-scope PMs will be managed as described in this document. Subsequent performance improvement periods may be warranted and established based on (a) health plan performance during the first period, or (b) health plan performance on PMs which are <u>first</u> reviewed in calendar year 2009.

8. Contract year – runs from September to August for all health plans. For instance, Contract Year 2010 runs from September 2009 to August 2010.

[5] AHCA is in the process of implementing agency-specific measures, also known as "agency-defined" measures. The methodology for collecting data and reporting on these measures will be prescribed by AHCA. Performance expectations for these measures will also be established by AHCA, based on actual performance data collected from the health plans or on goals/standards set by trade organizations (e.g. the American Academy of Pediatrics) or government entities (e.g. the Centers for Disease Control and Prevention). While agency-defined measures may be added to the list of in-scope measures in future years, initially in-scope performance measures will be limited to HEDIS-based measures.

In-Scope Performance Measures

- Every performance measure where individual plan performance in MY07 fell below the MY2007 national median (50th percentile) for Medicaid health plans[6].

- Tier 1 Measures: PMs for which in MY2007 a health plan's performance fell below the **25th** percentile based on MY2007 benchmark data[7].

    1. Prenatal care – all health plans
    2. Postpartum care – all health plans
    3. Cervical cancer screening – all health plans
    4. Dental visits – all health plans in Medicaid pilot counties
    5. Other measures - for a particular health plan based on its performance

- Tier 2 Measures: PMs for which in MY2007 a health plan's performance fell at or above the 25th percentile but below the median based on MY2007 benchmark data.

Notes about certain measures

- Behavioral health/follow up after hospitalization for behavioral health condition (two measures) – these measures may be added to this performance improvement process once their design is revised and baseline data for them can be collected.

  We recognize there are significant concerns regarding the delivery of behavioral health services; as such we want to ensure that this performance improvement strategy reflects those concerns.

- Well child visits, first 15 months of life (two measures): based on reported health plan performance this PM would be considered to be in-scope. However every health plan is already operating under a collaborative *performance improvement project (PIP)* for these two measures.

[6] Measures for which in MY2007 a health plan's performance fell above the national median are not in-scope as it relates to the performance improvement strategy described in this document. Nonetheless, health plans will be expected to demonstrate progressive performance improvement in these measures and to adhere to all contract stipulations regarding performance measures. In part, these contract stipulations will include the requirement that the health plan develop a CAP if there is not progressive performance improvement.

[7] For a health plan that is operating in a pilot and a non-pilot region, a performance measure will be treated as "Tier 1" if its reported baseline performance fell below the 25th percentile in either region.

Performance improvement period duration

- Recommending three-year performance improvement periods with aggressive targets.

- The three-year timeline is largely determined by how PMs are defined and the frequency of measurement:
  - Measures as defined require accumulation of data over an entire measurement year.
  - Results must be audited prior to submission.

- A key benefit of the three-year period: it will enable us to confirm that progress reported in one year is sustained over multiple years.

About targets

- Targets will be based on benchmark data collected for MY2007.

- Targets for each measure will be based on actual percentiles (50th, 60th, 75th, etc.) of national performance for Medicaid health plans in MY2007, but they will be expressed as actual rates or numbers.

  Example: *72% of eligible women "will have one or more Pap tests during the Measurement Year or the two years prior to the Measurement Year"*[8].

  Rationale:

  - ✓ Facilitate communications - make targets more meaningful to beneficiaries.
  - ✓ Facilitate management - less confusion and debate about targets.
  - ✓ "Reality checked" targets – provides solid justification for the targets.

- For **Tier 1 measures**, AHCA expects all health plans to reach the 75th percentile in **Year 2** of the performance improvement period. This expectation reflects the importance and high visibility of these measures. Health plans should concentrate their efforts on improving the performance of these measures without compromising their ability to improve their performance on Tier 2 measures.

- For **Tier 2 measures**, AHCA expects all health plans to reach the 75th percentile by the end of the performance improvement period.[9]

[8] Description of measure is per HEDIS.
[9] AHCA expects all health plans to reach the 75 th percentile on all performance measures (not just in-scope measures) by the end of the performance improvement period.

- No variation in targets by health plan, county or service delivery model ("pilot" vs. "traditional").

  Rationale:

  - ✓ Performance consistency - the agency expects consistent performance (i.e. no performance disparities) from a health plan regardless of where it operates within the state.
  - ✓ Sends the right message – the agency does not accept that a health plan enrollee in one part of the state will receive less effective health care than an enrollee in the same health plan in another part of the state.

- Secretary's stated **ultimate goal** = 90th percentile based on MY2007 benchmark data. Health plans that perform at the 90th percentile for at least two consecutive years *may* be eligible for performance incentives to be defined (ref. Sanctions and Related Considerations section).

- Target resetting will not occur during the first performance improvement period. That notwithstanding, if the national benchmark data shows greater improvement than the Florida statistics during this period, a new performance improvement period with more aggressive targets may be instituted.

- This health plan performance improvement initiative should be seen as a <u>continuous</u> quality improvement (CQI) effort.

  <u>Proposed timeline and targets</u>

Sanctions become progressively sterner ↓

In:	Achieve the following target:	
	Tier 1 Measures	Tier 2 Measures
MY2009 *As reflected in reports submitted by 7/2010*	50th percentile	50th percentile
MY2010 *As reflected in reports submitted by 7/2011*	75th percentile	60th percentile
MY2011 *As reflected in reports submitted by 7/2012*	75th percentile	75th percentile

Corrective Action Plans (CAPs)

- Health plans will be asked to produce CAPs for each in-scope performance measure.

- **Progress objectives**: in their CAPs, and for each in-scope measure, each health plan will articulate how it will meet the target for each measure through actions which have specific, measurable, time-based *progress objectives*.

> Example: *To meet the Dental Visits target we propose to*
> *1) Expand dental provider network by 30% or 100 providers by 12/31/09.*
> *2) Build a mobile dental services operation by 12/31/09 that can provide "basic" dental services to up to 20,000 enrollees per year.*

- Expected content of CAP:
  - → Progress objectives with the expected impact of each objective on the actual measure.
  - → Specific actions which the health plan will pursue to ensure that the progress objectives are met.
  - → Projected start and completion dates for these actions.
  - → The owners of each action, from the health plan's perspective.
  - → "Control limits": specific points in time when the health plan will assess whether expected progress is being achieved.
  - → Risk management considerations: how will the health plan respond to progress being insufficient based on its internal assessments.

- The agency will develop the template for these CAPs; health plans will be required to adhere strictly to the templates (templates will not allow for non-value-adding verbiage).

- A health plan may be able to submit one CAP for multiple, related measures (e.g. prenatal and postpartum care), at AHCA's direction.

- An organization operating both "pilot" and "traditional" health plans may be able to submit one CAP per measure (or multiple, related measures, as noted above) as warranted by the organization's baseline performance across "pilot" and "traditional managed care" regions of the state, at AHCA's direction.

- Progress reporting: initially health plans will report quarterly on progress objectives. The frequency of reporting may shift to semi-annually after Year 1 of the performance improvement period.

Sanctions and Related Considerations

- Sanctions for "administrative" matters (e.g. progress reports or PM data not submitted on time, incomplete PM data): adhere to current processes and contract stipulations.

- Target-related sanctions:
  - Sanctions will be assessed for a health plan's failure to meet a prescribed target.
  - Sanctions could also be assessed if a health plan fails to meet progress objectives or implement related actions as outlined in its CAP.
  - Sanctions would become progressively more severe if targets are not met.
  - Sanctions must be substantial enough so that they strike the right balance between incentivizing desired behaviors, plans opting to pay fines as opposed to working on actually improving performance, and encouraging plans to do business in Florida.
  - Sanctions may escalate to include cutting off auto-assignments and/or reducing the capitation rates to a sanctioned health plan.
  - Future performance incentive consideration: revise the auto-assignment algorithm so that a health plan with excelling performance (e.g. at the 90th percentile for two or more straight years) would receive favorable treatment in auto-assignments.
  - Allow for some flexibility in the sanctions regime to account for extenuating circumstances:
    - Force majeure
    - Achievement of progress objectives
    - Every health plan fails to meet a target despite all of them achieving some of their progress objectives

Implementation Considerations

Key next steps

1. Develop a CAP template with examples along with a 'guideline document' that would go along with the template.

2. Draft Policy Transmittal for issuance within the next 2-3 weeks: call to action "now".

3. Following the Secretary's meetings with the health plans (currently scheduled for the week of January 19th), AHCA will conduct 'workshops' to brief the health plans on the CAP template and process.

4. The health plans will be given 3-4 weeks to produce and submit a draft CAP.

5. A multidisciplinary team of AHCA resources (4-5 staff) will review the draft CAPs and interact with the health plans thereafter to share its feedback and to finalize the CAPs. The intent is for this team to work closely with the health plans on the construction of CAPs.

6. The agency would not actually "approve" a CAP but review for completeness, adequacy and reasonability (particularly with regards to progress objectives).

Other considerations

1. Not contemplating changes in the frequency of PM reporting: inherent limits to how frequently these statistics can be generated and reported.

2. Develop communications strategy: legislature, advocates, public at large, and other interested stakeholders.

3. Draft contract amendment for Contract Year 2010.

Attachment IV
Department of Health affiliated Provider Access Systems

Low Income Pool Projects (State Fiscal Year 2008-2009)

Citrus County Health Department

The Citrus County Health Department (CCHD) project is designed to improve access to, and ensure appropriate utilization of health care. This project focuses on the following three areas:

- Increased access to primary and preventive care services with the addition of an ER diversion (second urgent care) clinic and expansion of primary family care services.
- Enhanced disease/case management with a focus on four specific chronic disease states.
- Establish a referral system for urgent care clients that do not have a primary care medical home.

The CCHD provides primary and preventive care services at four locations throughout the county, the Lecanto North, Lecanto Main, Crystal River, and Inverness campuses. Located on the coast of the Gulf of Mexico in west central Florida, semi-rural Citrus County has a population of 142,431 residents of which 33.2% are below 200% of the federally established poverty guideline. Citrus County's population density of 211 persons per square mile is substantially lower than Florida's 309 persons per square mile.

It is estimated that over 30,000 people in Citrus County are uninsured. Inappropriate hospital emergency room utilization can be the result of a lack of adequate primary care providers. Individuals without a regular source of comprehensive, coordinated primary care can resort to hospital emergency room care. Low-income residents of Citrus County frequently use the hospital emergency rooms for non-emergency conditions. Currently, CCHD is the only provider of primary and preventive services, including mental and dental health services for the low income uninsured/underinsured population of Citrus County. CCHD is struggling to meet the primary care needs of this growing population of uninsured/underinsured residents.

The Low Income Pool project funding will augment and supplement existing services, resources and providers by expanding services to improve access and availability of primary health care services. The services provided address the priority health care needs of the population and address the health disparities for the low-income population of Citrus County.

CCHD will provide a medical home that consists of cultural and linguistically appropriate primary, preventive, dental, mental health and behavioral health services, through systematic case management. Access to primary care medical homes will be enhanced

though the addition of a second urgent care clinic and extended hours of operation at both urgent care sites.

Currently, CCHD has one urgent care site that is open Monday through Friday 7am till 6pm. The clinic is staffed full time with a nurse and eligibility specialist. A nurse practitioner provides direct client services 40 hours a week, and a physician provides services 10 hours per week. The urgent care facility provides services to walk-in clients, where the patient is assessed and treatment is provided. These clients are then scheduled for continued primary care services at one of the CCHD clinical sites. This urgent care facility provides over 600 medical encounters per month.

The Inverness CCHD campus currently houses a Women's Health Clinic, a Family Practice Clinic, WIC, Healthy Start, the Car Seat Safety program and a DIS worker. This facility has approximately 4000 square feet of unused space. CCHD intends to create a second urgent care clinic and expanded family primary care services at this site.

The addition of a second urgent care site will result in more clients being introduced into the CCHD primary care program necessitating an additional CCHD primary care provider. The current Inverness Family Primary Care Clinic renovated and staffed with an additional health care team will meet this need. The urgent care facilities will also provide same day sick visit services to current CCHD clients. This service enhances the primary care program by providing emergent care to clients without over taxing the primary care clinics or local ERs.

By expanding its current capacity CCHD will increase access to the low-income, uninsured/underinsured medically underserved population of Citrus County.

There is only one publicly supported hospital in Citrus County, Citrus Memorial Hospital (CMH). Charity-care at CMH was estimated at $30.5 million in 2007 roughly tripled the level of $10 million in 2003. The uncompensated write off is expected to increase by 17% in 2008 to $35 million. Approximately 37,000 patients were treated in the emergency room in 2007, many of whom may not have needed emergency services and could have been treated if affordable and accessible primary care services were available in Citrus County. CCHD will fill this gap by providing greater access to available and affordable primary and preventive care by establishing walk-in appointments for non-life threatening conditions at the Inverness site (Urgent Care), only a short distance from CMH. CCHD has already begun negotiating with the CMH to facilitate a partnership in developing an ER diversion clinic on the Inverness CCHD campus.

The disease management system includes case management to plan for and arrange for services, and to monitor both client progress and provider compliance with the care plan. Major components include health assessment, coordination of service between the primary care provider and the specialty care provider, and the delivery of ongoing care. Case managers will also work to refer clients to appropriate social services such

as assistance with housing, transportation, food stamps and other social services as necessary. The disease management team will be composed of a Provider (MD, ARNP), a Nurse, a Health Support Technician, and an exit clerk. The disease management plan will target diabetes.

CCHD recently initiated participation in the Diabetes Master Clinician Program (DMCP), created by the Florida Academy of Family Physicians Foundation. Three CCHD practice teams consisting of a provider (MD or ARNP), nurse and health support technician participated in DMCP training. This diabetes management program includes a diabetes registry where all diabetic patients are entered into the data base and information is updated at each clinic visit. The registry includes evidence-based quality indicators obtained from the ADA guidelines, the National Cholesterol Education Project, and the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. The diabetes registry provides reports that enhance care for one-on-one office visits and facilitates population management of all diabetic patients in the practice. The registry also provides the client with a patient report card, which tracks quality indicators and established goals. The population management tools of the program help to identify patients who have not returned for follow-up or who have not completed periodic evaluations. CCHD also provides one-on-one nutritional counseling and on-going group diabetes education.

Onsite case management provides the primary link with the client and serves as an important link for client feedback on the health care service delivery system. Primary health care and nursing providers will be responsible for medical case management and will utilize many existing protocols developed by the Florida Department of Health and the Agency for Health Care Administration (AHCA). The case management system will include arrangements for referrals, hospital admissions, discharge planning, and patient tracking. The case management team will ensure care coordination through the following:

- Use of an integrated, centralized medical record system;
- Clear division among the members of the case management team, and close communication among health care providers and case management team;
- Quarterly client satisfaction surveys;
- Financial counseling and eligibility screening;
- Linkage and integration of medical care and behavioral health care;
- Linkage with other health and social systems; and
- Referral tracking system and follow up.

CCHD also has the infrastructure and experience to link patients to needed follow-up appointments, specialty care and diagnostic services. Each clinic has an exit clerk who is responsible for “exiting” every patient. This process involves scheduling follow-up appointments, clarifying provider instructions, scheduling diagnostic procedures and specialty care. The exit clerk in collaboration with nursing staff provides case management on all referrals.

Finally, CCHD has a comprehensive We Care program. The We Care program is a network of specialty providers who accept uninsured patient referrals from the CCHD on a space available basis. Services available through We Care include: cardiology, chiropractic, dentistry, oral surgery, dermatology, gastroenterology, internal medicine, ophthalmology, retinology, podiatry, pulmonology, urology, hematology, oncology, pediatrics, radiation, plastic surgery, prosthetics, orthopedics and general surgery.

Dixie County Health Department (Dixie and Gilchrist Counties)

The purpose of this project will be to coordinate care through case management to expand and increase primary care services. Dixie and Gilchrist counties propose a dual county project to provide primary care services through extended clinic hours (4 days a week), for two counties that do not have a hospital/urgent care center. Other services will include community outreach, case management and chronic disease identification and treatment, with emphasis on diabetes.

The closest hospital to these counties is in Gainesville with Dixie County being 50 miles away and Gilchrist County 30 miles away. There are also some residents in the outlying areas of each county that live even further. There is not a medical practice open in Dixie County after 5pm, Monday-Friday or on weekends, and in Gilchrist County no medical practice is open after 5pm during the week.

Budget for this Project:	$650,000
Primary Care and Extended hour's clinics	
Physician- 1.0 FTE-to work at Dixie CHD-	$140,000
RN-1.0 FTE- to assist Physician	$ 55,274
OPS-Medical Support Staff- .13 FTE	$ 4,200
Front desk clerk/Interpreter-1.0 FTE	$ 30,000
Referral/ Indigent Drug Clerk-1.0 FTE	$ 30,000
Case management/Outreach	
RN Supervisor/Project Coordinator-1.0 FTE	$ 60,801
Two (2 FTE's) outreach specialists	$ 60,000
OPS-Nutritionist- 0.5 FTE	$ 28,000
Administrative/Other Support	
Data, Billing, reporting support staff- 1.0 FTE (total)	$ 40,000
Administrative Indirect- 7%	$ 45,500
Expenses	
Equipment/supplies to monitor blood glucose A1C	$ 5,000
Other diabetic supplies	$ 5,000
Expenses-printing, travel, phones, conferences, etc.	$146,225

Case manager/Project Coordinator (RN Supervisor) is a critical need for this project. Many of these patients only visit a physician when acute illnesses require treatment and encounter difficulty when coordinating care between multiple providers. A nurse case manager would be hired to coordinate primary care visits, referrals to specialty care, follow up on “no shows” for medical appointments, arranging for transportation and assist with indigent drug requests from pharmaceutical companies. This case manager would arrange for appointments with the Dixie CHD Clinical Psychologist as well as Meridian Mental Health Care for their mental health needs.

Two outreach specialists will go into the communities to inform individuals about this project. They will also identify health needs and provide linkage to needed resources. Screenings conducted by these clerks would include whether or not the medically uninsured individual has a primary care provider or a medical home.

A part-time nutritionist will be hired to provide on- site education and nutritional counseling. Diabetic patients will receive a focused case management approach from this project.

Physician and support staff would be hired to work at the Dixie County Health Department to expand primary care services on Wednesday, Thursday, and Friday evenings and Saturday. This additional physician would increase access to primary care during normal business hours and would provide access to care after hours diverting clients from going to the emergency room for primary care visits. In addition, Dixie CHD will purchase equipment from these grant funds to monitor Hemoglobin A1C for diabetic patients while they are in for their clinic visits.

The staff of this project would augment the existing medical providers at the Dixie and Gilchrist County Health Departments for individuals in need of primary care services. After hours on-call service would be available to ensure medical questions were answered during the holidays, evenings and weekends. Phone triaging would be provided by on-call medical staff to determine whether a referral to an emergency room would be necessary or whether the patient could receive instructions and return to their medical provider the next working day.

Individuals, who could benefit by applying for Medicaid, will be assisted by Dixie and Gilchrist CHD staff using the “Access” Medicaid computers at the Dixie and Gilchrist CHDs. Information about KidCare applications, “Believe in Miracles” referrals for women (who qualify for breast and cervical cancer screenings) and Children’s Medical Services will be made a priority. Tobacco cessation classes conducted at the Dixie and Gilchrist CHDs will be available for individuals who would like to stop using tobacco products and nicotine patches will be available for patients whose physician will concur this treatment as an option.

The overwhelming cost of preventative health care prevents most individuals without insurance from obtaining services, particularly when they feel healthy. Early detection and intervention can significantly reduce cancer mortality for some cancers, including

cancer of the breast, uterine, colorectal and skin. Colorectal mortality rates for Dixie County (30.9) and Gilchrist (17.8) is higher than the state rate (15.6/100,000). The mortality for breast cancer in Gilchrist County (24.7) is higher than the state rate (22/100,000). The death rate for cervical cancer is higher in Gilchrist (6.2) and Dixie (2.8) than the state rate (2.6/100,000). Mortality from skin cancer in Dixie County (9.5) is greater than three times the state rate (2.8/100,000). Age appropriate cancer screenings are offered at both CHDs. These include breast exams, prostate/colorectal exams accompanied by a (PSA) prostate specific antigen level, Pap smear and pelvic exams and inspection of the skin for abnormal lesions. The death rates from complications of diabetes are higher in Dixie (32.3) and Gilchrist (48.9) than the state rate (21.2/100,000). The hospitalization for amputation due to diabetes and percent of adults who have been diagnosed with diabetes in Dixie and Gilchrist Counties is considerably higher than the state rate.

According to Healthy People 2010, “Americans are taking a more active interest in their health and in the meaning of good health.” Good health can be defined as a state of physical, mental and social well being rather than the absence of disease or infirmity. Numerous factors have a significant impact on good health: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as the individual’s access to adequate and appropriate health care and medical services. Studies by the American Society of Internal Medicine conclude that up to 70 percent of an individual’s health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, who drink in moderation (if at all), use automobile seat belts, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities and premature death.” This project will focus on the relationship of lifestyle/behavior as well as access to medical care.

Lifestyle behavior counseling provided in this project:

Lifestyle	Primary Disease Factor
Smoking	Lung Cancer, Emphysema, Chronic Bronchitis
Alcohol/Drug Abuse	Cirrhosis of the Liver, Motor Vehicle Accidents, Malnutrition, Suicide, Homicide, Mental Illness, Non-Motor Vehicle Accidents (Drowning/Falls)
Poor Nutrition	Obesity, Digestive disease, Depression
Driving at Excessive Speeds	Trauma, Motor Vehicle Accidents
Lack of Exercise	Cardiovascular Disease, Depression
Overstressed	Mental Illness, Alcohol/Drug Abuse, Cardiovascular Disease

Duval County Health Department

The Duval County Health Department (DCHD) will expand and tailor its current LIP funded Hospital Emergency Room Alternatives Program (HERAP). This will be done to incorporate additional elements of Governor Crist's Health Access System, and to more efficiently integrate the present program's disease management and "medical home" connection with innovative safety net developments in Duval County. The revised HERAP will provide:

- Targeted outreach eligibility and assessment services for up to 2,000 households in zip codes identified with high ER use for Ambulatory Care Sensitive (ACS) conditions, particularly chronic diseases, and with very high number of uninsured ER users.
- Expansion of and connection of up to 3,000 persons who frequent ERs, because they have no routine source of primary care, especially those facing financial barriers to care.
- Expansion of professionally supervised medical condition management of diabetes, pulmonary, and cardio-vascular and other chronic illness for persons, who unnecessarily rely on emergency departments for such management.
- Expansion of primary care clinic hours to evenings, Monday through Friday, and on Saturday.
- Expanded pharmaceutical access by training 20 new community-based, medication assistance program navigators to access pharmaceutical manufacturer compassionate medication programs.
- Expansion of access to medical specialists for uninsured and frequent ER users through a new partnership with We Care, the Duval County Medical Society, and the new First Coast Medical Homes program (FCMH).
- Connection of DCHD's FQHC and CHD clinics with the Jacksonville Health Information system (JHIN), a regional health information exchange operated by the new First Coast Medical Homes program.

The DCHD HERAP's outreach plan is an enhancement over the previous HERAP program. DCHD will begin with two outreach teams, with a total of two financial eligibility specialists and two registered nurses. One of the registered nurses will have advanced training and will be responsible for coordinating team activities to:

- Provide 2,000 households in ER hot spot zip codes with preventive health information, mini clinical assessments to identify health conditions that should be referred to a medical home and/or medical condition management.
- Offer financial eligibility screening for those same households to facilitate access to health services with minimal financial barriers, and application assistance to those who may be eligible for resources.
- Offer connection to primary care medical homes through DCHD's and Agape Community Health Center's (DCHD's FQHC) system of eleven primary care clinics.

While the primary focus of primary care medical homes will be to connect clients to the DCHD and FQHC clinical networks, DCHD proposes to provide two hours of extended evening access Monday through Friday, and six hours on Saturday at either one clinic location, or alternately at two clinics, one on each side of the St. Johns River. The expanded primary care access after hours would be staffed by a medical team consisting of a Family Practice physician, registered nurse, and ancillary support staff.

HERAP's disease management program is dubbed "medical conditions management" to better reflect preventive and abatement strategies in dealing with traditional chronic diseases. Specific medical condition programs will be offered for diabetes, cardiovascular diseases, and pulmonary diseases. Hypertension, hyperlipidemia and COPD will be managed as subsets in the main three categories.

HERAP will consolidate two disease management teams and offer medical condition management through four registered nurses, one of which will be a registered nurse consultant and coordinate services. The final member of the team is a part-time clinical pharmacologist (PharmD).

HERAP will also establish geographic, hospital specific plans to deal with avoidable ER use for ACS, especially by uninsured and low income populations. This strategy reflects that each hospital has a differing mission, vision, service focus, programming, and staff resources. Effective ER alternative programs are complementary to each hospital and encourage a continuity of services along the lines of traditional hospital service areas.

A business service agreement has been established with each participating hospital, which includes a baseline ER use component, specific outcome measures, referral processes, communication plan, and evaluative process. Each of these hospital-specific plans is incorporated into the overall HERAP, and project evaluation reflects achievement of the specific benchmarks and outcomes of each of the participants.

Jefferson & Madison County Health Departments (Jefferson & Madison Counties)

The project will focus on emergency room diversion in both Jefferson and Madison counties through primary and secondary interventions that utilize each of the three basic program components: targeted community outreach, expansion of primary care services, and disease management. The project will use both patient focused interventions and population focused interventions to reach targeted residents and direct them to a medical home. The project will also utilize an extensive network of African American churches and faith-based and community organizations in the target communities to distribute information about alternative health care venues. Big Bend Rural Health Network (BBRHN), a DOH-certified rural health network, will partner with the health departments on the project. BBRHN will be contracted to provide training services and coordination with local hospitals and physicians. Funding received for this project will provide a mid-level clinician position and community health workers at the health departments to provide primary care and disease management, thus offering a

clear alternative to inappropriate hospital based ER care. The project will work closely with Madison Hospital and Tallahassee Memorial Hospital to develop procedures to identify and refer patients from these communities who need a medical home.

The project will use patient and community focused outreach and education to address the problem of uncompensated care provided through hospital ED services, and to appropriately serve patients with chronic illness. Both intervention points are needed to address patients who have recently experienced an inappropriate ED visit, and to educate and direct the general public to expanded primary care services offered at the health departments and the Federally Qualified Health Center (FQHC) located in Greenville in Madison county.

The project will address two levels of outreach: patients who seek a non-emergent ED visit; and general community outreach through existing faith-based and community-level networks.

The first level of outreach will focus on patients who have had a recent ED visit, have been identified by the hospital as having non-emergent care needs, and who do not have a medical home. These individuals will be contacted by the community health worker and encouraged to visit the primary care provider at the CHD or FQHC to establish a medical home. Repeat ED users, who disregard the offer of a medical home, will be counseled by hospital and CHD staff in a persistent effort to change this behavior.

The second level of outreach will occur in the community using the extensive network of African American churches, as well as faith-based and community-level organizations in both counties. This network of active community partners will be used to disseminate information to the target population regarding the need for a medical home, primary care services offered at the CHDs, changes in operating hours and patient scheduling and other improvements.

The project will address expansion of primary care in three related ways: recruiting and training additional primary care staff; expanding office hours by modifying shift coverages; and increasing the number of “open schedule” hours to accept walk-ins. Project funding will be used to recruit and hire one mid-level clinician who will serve in both counties on a rotating basis, one LPN in each county to assist the clinician as a medical assistant and who will also serve as a disease management trainer and assist with patient self-management education. The team will also include a project funded self management coach.

The Jefferson CHD will expand operating hours at least two days per week, and the Madison CHD will partner with Madison Hospital to staff a new rural health care clinic, created to provide ER diversion services.

The project will expand a disease management program already in place within the two counties. Based on our assessment of critical areas of concern, diabetes and cardio-

vascular diseases will be the focus for this project. Patients will be referred to disease management through both outreach paths – diversion at the ED level, and community outreach.

Currently in the two counties, three physicians and their medical assistants are involved in the Diabetes Master Clinician Program (DMCP). The program will be expanded in the first year to include five additional clinicians; the ARNP hired with project funding, the physicians assistant and medical doctors at Four Freedoms Rural Health Clinic in Madison, and two newly recruited physicians who will staff Madison Hospital's rural health clinic. Big Bend Rural Health Network will assist the project by coordinating DMCP activities, including clinician and medical assistant training and data entry at the sites.

Lake County Health Department

Lake County Health Department (Lake CHD) proposes the Lake County Health Department Outreach and Primary Care Coordination Project in order to reinstitute primary care services in the newly opened Umatilla Clinic in north Lake County. The program will also include expanded outreach, case management, and disease management services to adult patients served at the clinic.

Recently, the Mt. Dora site was closed and staff transferred to the larger Umatilla clinic. Continuing budget cuts and growth in other clinical services such as maternity and pediatrics resulted in the reinstitution of adult primary care services at Lake CHD to be permanently placed "on hold". The Low Income Pool (LIP) project would allow Lake CHD to again provide primary care to this population of underserved citizens. The clinic is located in north Lake County and has recently been renovated as a "Green Building ". It was expanded from 4600 square feet to 15,600 and can easily accommodate a large number of new patients.

The LIP grant money would allow the Lake County Health Department Outreach and Primary Care Coordination Project to reestablish primary care at Lake CHD and:

- Increase general access of care to a currently underserved population and support meaningful ER diversion efforts by providing a medical home to minimally ill ambulatory patients now going to the area's ER's.
- Increase Lake CHD hours of operation: now Monday to Friday 8 AM to 5 PM will be extended to allow "after hours" care and weekend appointments.
    - Evening clinic hours at a minimum of 2 days per week
    - One Saturday clinic per month
- 24 hour telephone access
    - On a rotating basis a Lake CHD nurse will carry an electronic signaling device and be assigned to "on-call" duties
    - Calls to the clinic after hours will be forwarded to the on-call nurse

- The nurse will respond, via phone, to any individual needing to speak to a medical person when clinic is closed
- Caller will be triaged to urgent care or be given next day appointment, as appropriate

The outreach portion of the plan will consist of a team which will be hired and trained to find underserved, hard to reach populations. They will assist this population to navigate within an established health care system which may be unfamiliar to them. The team will consist of a non clinical Community Health Navigator (CHN), an Outreach Nurse Case Manager (ONCM), and an Eligibility Specialist.

The ONCM has the responsibility of overseeing the CHN. The eligibility specialist will support the CHN, the ONCM, and the entire outreach/referral program. All three will work with the local hospitals, healthcare providers, and others to link patients to services at Umatilla clinic.

Lake County Health Department Outreach and Primary Care Coordination Project will contain a chronic Disease Management and Care Coordination Program (DMCCP). It will provide comprehensive disease management to patients admitted to primary care. Diseases to be monitored have been chosen based on CHARTS statistics and those illnesses which were in the 3rd or 4th Quartile (see Attachment II). Therefore, disease management will focus on diabetes, hypertension, coronary artery disease, obesity/inactivity, and hyperlipidemia. It will be based on education, follow up, and coordination of care. Patient educational tools and resources and clinical practice recommendations from the American Heart Association and American Diabetes Association will be utilized.

Patients can be referred to the program by clinic-based primary care provider (physician or nurse practitioner), clinic nurse, or community providers such as pharmacists, podiatrists, hospital case manager, and discharge planners. Once referred, patients will be classified by their primary care provider into 2 groups – low severity and high severity.

Okaloosa County Health Department (Focus on the service area of the Fort Walton Beach Medical Center)

Okaloosa County historically has had limited to no access to free or low-cost health care services for low-income patients, especially adults. Without a primary care medical home, low-income individuals are forced to go without care, or access care through a variety of walk-in clinics, urgent care centers, or local emergency rooms that are willing to see patients on a fee for care basis. Often, the fees charged for such care to individuals in the self-pay category are some of the highest fees assessed for care. For the past several years, the Health Department has provided weekday emergency room diversion for children by accommodating same day sick care visits. However, lack of access to care for low-income adults has led to overuse of hospital emergency rooms for basic outpatient care, inadequate primary disease management causing complicated

chronic disease states, and preventable hospital admissions in that population. In response to these identified problems, the Okaloosa County Health Department along with many community partners, seeks to utilize the Low Income Pool funds to expand the successful Crossroads Center- Medical Clinic. The partnership addresses primary care access for low-income patients by cooperative efforts of the faith-based Crossroads Center- Medical Clinic, the Okaloosa County Health Department, and the Fort Walton Beach Medical Center to name a few of the partners. The partnership developed over the past 2 years was greatly enhanced with the initial Low Income Pool dollars received by the Health Department in FY07 and FY08. Without the continuation of the Low Income Pool dollars the Health Department will have to decrease our commitment to this successful clinic from 3-days a week to 2-days a week.

This project is to build on past success and to expanded access to primary care at the Crossroads Center- Medical Clinic. This will involve coordinating appropriate patient linkages with health department services to maximize expertise and assure no duplication of services, provide enhanced disease management services, and develop a community outreach program targeting a neighborhood identified as producing the largest number of uninsured hospital discharges for Fort Walton Beach Medical Center.

We propose expansion of the services and capacity offered through the Crossroads Center – Medical Clinic in order to provide more low-income adult patients with a medical home, divert patients needing basic primary care from the emergency room to more appropriate outpatient primary care clinics, and improve disease state management through the use of registered nurses. This expansion is in addition to the Health Department commitment to provide midlevel providers 2 days per week, licensed practical nurse support 4 days per week, nursing leadership/supervision 4 days a week, and medical director supervision at least 3 days a week. In addition, the program will be augmented with community outreach and eligibility determination directed towards an identified neighborhood with high rates of poverty and uninsured hospital discharges which will link individuals in the community to necessary medical care and social services.

To accomplish these goals, we propose:

1) Hiring a contract physician (OPS) to work in the Crossroads Clinic 3-4 days a week as well as one ARNP (OPS) 1-day a week in addition to the existing 2 midlevel providers at one day a week each to increase clinic access and capacity.
2) Offer evening hours of operation for clinic services on Tuesdays from 10am to 7pm. Continue the 5-hour Saturday clinic hours on a reliable basis.
3) Formalize E.R. diversion plan from Fort Walton Beach Medical Center (FWBMC).
4) Develop and implement a case management program for the clinic. This proposal will fund two RN case managers. In addition to this nursing expertise, we will add social work expertise on the team which will allow these patients access to information and services such as transportation, job training, and

assistance which optimally enhance their ability to be healthy and comply with the requests of healthcare providers.

5) Develop a community outreach and assessment team to target census tract 220, identifying individuals within that neighborhood in need of care and linking them to care.
6) Expand existing volunteer specialist physicians providing care at the Crossroads Clinic or in their private offices to Crossroads patients.

Orange County Health Department

The Orange County Health Department (Orange CHD) proposes to implement the "Orange Primary Access Coordination Team (Orange PACT)" project that is designed in alignment with Governor Charlie Crist's Florida Health Care Access Program (Florida HCAP). This project is critical to supporting our local efforts to address health care access for the uninsured, inappropriate utilization of hospital ERs to provide primary care, and to reduce health care system costs. It includes components of the successful Health Intervention and Targeted Services (HITS) program piloted in south Florida. As such it employs a process that addresses the continuum of services needed to improve a community's health status and reduce uncompensated hospital costs.

Project components are:

- Aggressive targeted outreach to identify persons without a medical home, link them to primary care, identify persons with health risk factors and arrange for early intervention and identify persons potentially eligible for health insurance such as Medicaid and assist them in enrolling.
- Increase utilization of community health center (CHC) and Orange CHD sites, including co-located sites to provide primary care homes for target populations. These centers are already conveniently located in high risk neighborhoods. Six CHC locations have expanded evening and Saturday hours.
- Provide a robust disease management program that includes education, health status monitoring, referrals and pharmaceutical assistance.

The project also includes an evaluation component to collect and analyze data to document project impact on communities served and health system costs. Orange PACT will use requested resources in conjunction with existing community resources and community partners to improve capacity and establish a functionally integrated and linked system of primary care providers.

The Orange PACT project has identified several target areas in Orange County with high levels of under and un-insurance, chronic illness including diabetes, COPD and risk factors for cardiovascular disease including hypertension and high cholesterol. These areas are in North, South, Southeast, Central and West Orange County. According to CHARTS data for 2004-06, 21.8% of Orange county residents are

uninsured. This number is substantially higher in target areas where levels of uninsured can be as high as 23.6%.

Neighborhoods targeted for the Orange PACT intervention are located in areas of the county demonstrating the highest amount of uninsured as well as specific health issues. Three two person teams consisting of a Nurse and Eligibility Specialist will complete face-to-face contact with every household in target neighborhoods. We anticipate each team will make contact with approximately 400 homes each and complete eligibility assessments and health screening for each home. The purpose of the outreach effort is to facilitate timely and appropriate access to care for persons without a medical home. Teams will identify persons without health insurance, without a primary care medical home and persons with risk factors such as hypertension, high cholesterol and diabetes. The eligibility specialist will assess persons for potential eligibility for insurance programs like Medicaid, KidCare and CHC/CHD eligibility. The Nurses will complete health screenings to assess the health status and health care needs of the family and initial access to services. The team initiates the eligibility, intake and health care access process and links the family to providers by making referrals to Orange County CHCs and CHDs. Teams will also use vans donated by Florida hospital to do large scale assessments at housing complexes within target neighborhoods to ensure community access is optimal.

Orange County already has an active collaborative network of providers to ensure clients in need (once identified) are able to access health care. The Primary Care Access Network is a collaborative whose composition includes health care providers, government and hospital representation as well as a broad base of community partners. One of the accomplishments of PCAN was their recent ability to access funding to expand service availability at CHC partner sites. The Orange PACT project will build on this effective collaborative partnership to enhance efforts to link those in need to a medical home.

A recent assessment on clinic capacity has determined that the CHC providers are operating under capacity with the potential of providing services to 10,000 additional clients system wide. Currently six Orange County CHC sites have extended hours as of 2008. It is anticipated that extended hours may need to be provided at a site that does not currently have this service to address increased access resulting from ER diversion efforts to a particular community. The Orange CHD will partner with the CHC to track increased usage and determine through preliminary outreach results if expansion of clinic hours is needed. To accommodate anticipated expansion needs, $72,000 in primary care funding is required.

Disease management services will be provided for persons with health issues that can be managed on an outpatient basis such as diabetes, asthma, hypertension, high cholesterol and COPD. Disease management clients will be identified through outreach process or referrals from providers. The team will educate people about how to manage their condition, monitor their health status, and arrange for higher levels of intervention such as specialty services.

The Disease Management Team composition is designed to address the immediate needs of the Orange County chronic disease community. The team consists of 3 individuals specializing in various components of disease management. Team members are: 1) a Nurse who will have primary responsibility for coordinating all specialty referrals as well as disease education, monitoring health status, and access pharmaceuticals via compassion programs and/or CHC pharmacy. 2) a Registered/Licensed Dietician whose functions include Medical Nutrition Therapy (MNT) as prescribed by physician. MNT includes nutrition assessment, development of a nutrition care plans, counseling and education. Nutrition plays an integral part in the disease management of diabetes, hypertension, COPD and high cholesterol. Improved nutrition status of clients does result in improved health. 3) a Senior Health Educator who will increase implementation of the Stanford University Chronic Disease Self Management curriculum among Orange County residents in the Eastside, particularly targeting Hispanic male and females currently suffering from a chronic disease, i.e., diabetes, cardiovascular disease, COPD.

The third team member, health educator, is part of a collaborative partnership with Florida Hospital known as Cuídate to provide linguistically and culturally appropriate services to clients experiencing an unusually high incidence of chronic illnesses, especially diabetes and heart disease. Services include: 1) free health classes for chronic illnesses such as diabetes and heart disease through the six-week Chronic Disease Self Management curriculum (an evidence based approach) developed by Stanford University which targets healthy lifestyles and physical activity; 2) educates people about health care resources by providing useful information on how to apply for Medicaid or Florida KidCare; and 3) assists them with the often confusing process of applying for financial assistance with health care through the development and distribution of a bilingual Resource Guide. The senior health educator will increase implementation of the curriculum to at least 40 residents per quarter (currently reaches 20/quarter).

As previously mentioned, the expanded CHC clinic hours have already resulted in initial success and is expected to save upwards of $312,000 annually. The Orange PACT project is anticipated to increase these savings upwards of an additional $100,000. In order to affect this level of success in ER diversion efforts, the Orange PACT project must also have a coordination and management component. The project coordinator/evaluator will coordinate and support project activities including serving as liaison among providers, monitoring referral processes and agreements and track project progress. This individual will be in charge of ensuring that the staff in each component are implementing each component as proposed and gathering the necessary data to document the project. The Project Coordinator/Evaluator will also maintain communication with project staff on a weekly basis and schedule quarterly meetings to discuss the project's progress. This position will also track and report project progress and be in charge of the evaluation of the project.

Pinellas County Health Department (PinCHD)

The Pinellas County Health Department 2008-09 Low Income Pool (LIP) project is designed to improve access to, and appropriate utilization of, health care.

An estimated 80,000 to 140,000 Pinellas county residents are uninsured and only 7,000 are served by the county indigent health plan. As a result of recent county budget cuts, the Pinellas County Department of Health and Human Services (DHHS) is reorganizing its indigent care system to increase capacity and move toward "prevention" and creation of a medical home network. The two main providers of primary care services will be Community Health Centers of Pinellas Inc. (CHC), the local federally qualified health centers and the newly added PinCHD. DHHS will be funding the PinCHD to start primary care services in July 2008 for uninsured residents 18-64. Two teams will provide primary care services at three PinCHD medical homes to an estimated 3,000 unduplicated clients a year. Funding will support 8,400 encounters per year at $110 per medical encounter. The three medical homes are:

- Willa Carson Health Resource Center/PinCHD Clearwater Health Center
- PinCHD Pinellas Park Health Center
- PinCHD St. Petersburg Health Center

PinCHD LIP Project proposes to expand the services by adding:

- A community nurse/eligibility specialist outreach team
- Weekend primary care services
- A two nurse disease management team

The project will work closely with the three existing PinCHD medical homes and other county funded medical homes such as Community Health Centers. The county plan includes out-posting of case managers/social workers in medical homes and in local emergency rooms (ER) to divert uninsured clients from the ER, but does not have any provision to fund targeted community outreach.

The project proposes to add a targeted community outreach team to identify an estimated 1,400 uninsured clients and/or without a medical home. Data from DHHS estimates that fifty percent of the uninsured population has at least one chronic disease. Subsequently, a disease management team is needed to serve an estimated 1,500 clients with chronic disease(s).

The goals of the PinCHD LIP Project are aligned with Healthy People 2010:

1-1. Increase the proportion of persons with health insurance.

1-5. Increase the proportion of persons with a usual primary care provider.

1-6. Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

5-10. Reduce the rate of lower extremity amputations in persons with diabetes.

12-7. Reduce stroke deaths.

19-2. Reduce the proportion of adults who are obese.

The nurse/eligibility specialist team will provide targeted community outreach in the areas of highest need identified by Geographic Information Systems (GIS).

The team will reach out to:

- Small businesses such as hair/nail salons, small retail stores, convenience stores, restaurants, thrift/discount stores, car wash/automotive shops
- Faith based organizations
- Neighborhood centers
- Non-traditional venues located in the ZIP Code area previously listed.

The eligibility specialist will determine the client's eligibility for a health care plan (Medicaid, Medicare, VA benefits, FL KidCare and others), assist the client with enrollment into the plan and refer them to a medical home for primary care services. If the client is 18-64 years old and not eligible for the previously listed health insurances, the client will be screened for eligibility for the Pinellas County uninsured health plan.

The nurse will perform a health assessment on each client to identify health risk factors and arrange for early intervention for chronic disease prevention and management. All clients will be referred to a medical home regardless of their eligibility status.

The capacity of the nurse/eligibility specialist team is estimated to be 1,400 client encounters per year at an average of six clients per day receiving eligibility, health risks assessment and referral to a medical home at an estimated unit cost of $84 per client.

Access to primary care medical homes will be expanded adding Saturday 8:00am-3:00pm primary care services at the Clearwater site. The primary care team consists, at a minimum, of an examiner, nurse, medical assistant and clerks. Expanded hours on Saturdays will provide "open-access" with up to 75% of the schedule for same day or "walk-in" services and up to 25% may be utilized for scheduled appointments.

The capacity of the Saturday expansion is an estimated additional 675 medical encounters per year.

A two registered nurse (RN) team will be hired to provide disease management to clients with chronic diseases. Referrals to disease management team will come from the community outreach team, the PinCHD primary care teams and other community

health care providers serving the uninsured population. Disease management services will be available for most common chronic diseases such as asthma, diabetes, hypertension, overweight/obesity, lipid problems and other heart/lung diseases.

PinCHD will use the health management system (HMS) electronic care coordination model to assign, track, and document disease management services. HMS is currently used by PinCHD for Healthy Start Care Coordination, Tuberculosis and Hepatitis Disease Management. The system offers care coordination templates for diabetes (see pages 12-14) and cardiovascular disease, allowing the examiner to load the standards of care protocols for specific diseases or individual clients; and assign the case to a disease manager (nurse). Additional templates may be designed for other chronic diseases. Monthly reports will be reviewed by the disease managers and medical team. The review will include the number of clients managed, their disease types, their progress with planned/provided services, and the results of their laboratory/diagnostic tests. The disease managers and case managers will track the client's location, use of the ER and disease progression.

PinCHD has designed a memorandum of agreement between all interested parties to work on the Pinellas County Uninsured Health Care Collaborative. The goal of the collaborative is to increase access to health care through establishing a medical home and decreasing costs by ER diversion. The collaborative includes three local hospital groups which have agreed to co-locate County DHHS case managers in their ER's to identify the uninsured and refer them to medical homes. County HHS will also co-locate case managers in PinCHD and Community Health Centers medical homes. The three hospital groups also operate medical residency programs which provide out-patient primary care services to the uninsured on a sliding-fee scale. Another important collaboration is with county's Emergency Medical Services (EMS) system. EMS is the primary transporter to local ER's. EMS responds to many calls that aren't assessed as emergencies. Instead of transport to the ER, EMS will refer clients to a medical home. PinCHD works very closely with Community Health Centers of Pinellas Inc. (CHC) which is the local federally qualified health centers. CHC has five primary care centers located throughout the county. Two of them are co-located in the PinCHD health centers. Local free clinics are also part of the collaborative as well as Suncoast Health Council, the lead for the compassionate drug programs. It is important to note that the system has yet to start disease management for the uninsured population or identify clients before they present to the facility for care.

Evaluation of the program will be provided by the PinCHD quality assurance program under the Office of Planning and Performance Improvement and the primary care services QA coordinator. This Evaluation Team will document Project benchmarks and outcomes which are aligned with Healthy People 2010.

Data will be provided from the 3 Project components:

A. Targeted Community Outreach
B. Primary Care Services
C. Disease Management Services

Additionally consumer feedback will be obtained from customer satisfaction surveys.

Polk County Health Department

The primary target populations for this project include uninsured and underinsured Polk County residents eligible for services at Lakeland Volunteers in Medicine (LVIM), Polk HealthCare Plan, and Central Florida Health Care (CFHC). For the disease management component, the target population will be clients receiving care at CFHC and LVIM who also meet the eligibility criteria.

The services to be funded by LIP funds are as follows:
Targeted community outreach team(s) – Expansion of existing outreach services provided by the county's Community Health and Social Services division, Central Florida Health Care, and the Polk County Health Department, to include offering the Governor's Cover Florida Health Care Access Program, the Florida Drug Discount Program, and KidCare. Outreach services will include a mobile unit, health expos, and multi-site eligibility determinations.

Expansion of primary care service team(s) – Opening a federally qualified health center clinic (CFHC) in Winter Haven, to increase the total number of clinics in Polk County to five. The clinic will provide after hours care in the evenings and on weekends. Funding to support the establishment of pharmacy services in the Lakeland Primary Care Center.

Disease management team(s) – Implementation of a pilot program based on the successful Chronic Disease Self Management program of the Stanford University School of Medicine in the Lakeland area. In addition, funding will be requested to support a more specific diabetes education program for the target population.

Additional activities that are included in this proposal are to promote the use of the eligibility and referral module of the county's shared client information system called Carescope.

The opening of the Winter Haven clinic is scheduled for year 2 of this project, while funding for the start-up of the Lakeland Primary Care Center pharmacy will be provided during year 1.

The health department will serve as the lead agency for the project, developing and implementing contracts with project partners for the purposes of accomplishing the goals, objectives, and activities of this proposal.

Matching funds will be provided by the Board of County Commissioners local half-cent sales tax for indigent health care. The county's director of Community Health and Social Services, which implements the Polk HealthCare Plan, is supportive of this

project because it is consistent with goals, objectives, and strategies of the Polk HealthCare Plan.

The Polk County Health Department's role in the community outreach plan will include promoting the Governor's Cover Florida Health Care Access Program. As information about the plan becomes available, the health department will communicate this with community partners within the Polk Health Care Alliance. In addition, this program will be promoted within our health department clinic sites and outreach programs along with KidCare, Medicaid, and the Polk Health Care Plan.

The health department will also enhance its process and will coordinate with other safety net providers to link the uninsured and underinsured to medical homes. Currently, clients needing primary health care services are offered the following referral options for establishing a medical home: 1) Polk Health Care Plan; 2) LVIM clinic; and 3) CFHC centers. To augment our referral capabilities, the health department telephone operators will be trained in the Carescope Community Module.

The overarching goal of the disease management program is to provide eligible clients with education and support services to effectively reduce the risk of unnecessary hospital inpatient or emergency room care. This will be accomplished through:

- Improving patient self-care and adherence to their treatment plan through patient education, monitoring, and communication.
- Establishing and maintaining communication on patient progress between providers and disease management team.
- Collection and analysis of data for tracking and evaluating behavior changes, clinical changes and more appropriate health care system utilization.

The Polk County Health Department will partner with LRMC, CFHC, LVIM, and the Polk HealthCare Plan to pilot a chronic disease management program in the Lakeland area. Eligible patients who have medical homes with CFHC and LVIM will be enrolled in disease management.

CFHC has been participating in a self-management program of HRSA's Disparities Collaborative since 2001. This collaborative is part of a national effort to document improved health outcomes for underserved populations, transform clinical practice through new evidenced-based models of care, and build strategic partnerships to improve health status. CFHC has been focusing on diabetes care using the Collaborative's Chronic Care Model. CFHC's Chronic Disease Model has an emphasis on a multi-pronged team approach, the use of evidence-based interventions, and patient self-management which are major factors in effective treatment and management of diabetic patients. The team approach permits CFHC to address simultaneously a number of factors critical to successful control of diabetes. Evidence-based interventions facilitate achievement of desired patient outcomes. Client participation in their health care through selection of self-management goals has been shown to be an important factor in the successful treatment/management of diabetes.

LRMC, CFHC, LVIM, and the Polk HealthCare Plan will identify clients meeting the eligibility criteria and initiate referral to the Polk Health Care Assess Program Manager.

Clients referred to the Polk Health Care Assess Program Manager will receive case management and health education to enhance their self-care.

Case management services will include: Reminders to clients of diagnostic and monitoring tests, follow-up to ensure adherence to medication regimens and treatment plans, individual counseling about their chronic disease condition(s), communication with client's primary health care provider, and enrollment in health education classes related to their condition(s).

Currently, CFHC works in partnership with LRMC to increase access in Polk County and divert non-urgent care cases from the hospital emergency room to a more appropriate primary care setting.

Identification of those most in need can be found by cross-referencing the data banks of CFHC, LVIM, Polk HealthCare Plan and LRMC, to find those individuals who show high ER utilization rates for chronic diseases, and those referred from the ER who do not follow up with a medical home.

LRMC, CFHC, LVIM, and the Polk HealthCare Plan will identify clients meeting the eligibility criteria for the chronic disease management program and initiate referral to the Polk Health Care Assess Program Manager.

The Polk Health Care Assess Program Manager will provide case management for those enrolled in the chronic disease management program and will use self-reporting and cross reference it with information obtained from the safety net providers in the Lakeland area in this project.

Since 2001, CFHC has been operating a pharmacy in the Avon Park Clinic in Highlands County to serve their clinic patients. In November 2007, CFHC opened a Lakeland primary care clinic, which included designated space for a pharmacy. Start-up funds are needed to open a pharmacy at this site to serve their clients.

As medications account for a larger portion of medical expense every year, expansion of primary care access will not improve health outcomes if affordable medications are not provided. CFHC can provide pharmacy services to its patients with savings of 30-90% compared to local retail prices. As CFHC is the largest provider of federal 340b Program discount medications in Polk County, as well as having the volume to provide steep discounts on most all medications, establishing a pharmacy access in Lakeland Primary Care first would provide this critical service to both Lakeland and Winter Haven sites. They are anticipating over 20,000 patients between the 2 sites would utilize such a pharmacy in 2009.

Thousands of patients visit the LRMC emergency room solely for medications. Often, they are given a 30-day supply of these medicines. However, they frequently return. With an affordable, accessible pharmacy, in-house within CFHC's primary care center their medication needs, regardless of ability to pay, provides continuity of care and avoids unnecessary emergency room visits.

Polk HealthCare Plan patients who receive medical care from CFHC obtain their medications through the Plan's pharmacy program(s). For uninsured patients, CFHC enlists the support of several pharmaceutical companies' indigent drug programs.

CFHC will continue to utilize and promote its multiple patient assistant and discount drug programs. This currently includes a full-time Patient Assistant Coordinator. They will also begin sharing information about the Florida Discount Drug program, will offer NACo Prescription Drug Discount Cards, and make referrals to MEDNET© for their uninsured patients.

Sarasota County Health Department

Sarasota Health Care Access is an integrated, county wide system of care for uninsured and medically underserved populations in Sarasota County. The model concept was developed and based on the successful systems of care operating in Orange and Marion Counties.

Primary project objectives include:

- Improving access to primary care, specialty care, oral health services and affordable medications for low income, uninsured and medically underserved individuals
- Reducing unnecessary utilization of hospital inpatient and emergency room resources by the uninsured
- Key strategies employed to meet these objectives include:
- Strengthening linkages and communications among area safety net providers
- Capitalizing and building on existing health care system capacity
- Improving access to free and /or low cost medications through SCHD's pharmacy program and other pharmacy assistance programs
- Improving access to system navigation and disease case management services
- Improving access to eligibility and Medicaid application services

The Sarasota Health Care Access model currently encompasses four components:

- Direct service provider network
- Hospital Diversion Program
- Expanded Eligibility Program
- Community Outreach

Direct Service Provider Network

Sarasota Health Care Access network providers collectively provide access to a wide array of services for low income uninsured and medically undeserved individuals in the community including:

- hospital based in patient and emergency room care
- primary care
- specialty care
- oral health services
- free and/or low cost medications
- affordable diagnostic and imaging services

This network is supported by more than 20 area non-profit health, human and social services organizations. Patients are referred through any of the network providers and/or organizations. Eligible clients receive primary care through SCHD, Senior Friendship Centers or one of several other primary care network providers. Access to specialty care services is available through three volunteer based programs that include Sarasota Memorial Hospital's Community Medical Clinic, Senior Friendship Centers and the South County Community Clinic project in Venice, Florida. Sarasota County's mobile medical unit, Health in Motion, provides community based preventive health services, health information and referrals for primary care.

Hospital Diversion Program

The hospital diversion component of the Sarasota Health Care Access model is supported through a web based electronic referral and fax system, the Extended Care Information Network (ECIN). A team of three case managers, two in north county and one in south county, including one Registered Nurse (R.N.) disease case manager, provide patients referred by area hospital inpatient and emergency department case managers with real time access to primary care, system navigation case management, eligibility and Medicaid application services as well as access to free and/or low cost medications. Patients with selected ambulatory sensitive conditions receive ongoing disease case management services for selected ambulatory sensitive conditions to improve their ability to self manage their illness(es). Nearly 2,000 patients were referred to the case management team for care and services by area hospitals in the 11 month period between 4/20/07 and 5/31/08. This patient population received 13,388 free or low cost prescriptions through SCHD's Pharmacy Program during the same period.

Expanded Eligibility Program

In June of 2007, Sarasota County Health Department launched an eligibility expansion pilot program to allow individuals with household incomes up to 300% of federal poverty level to receive primary care and oral health services. The pilot was launched in response to the needs of an emerging population of newly uninsured in the community surrounding downturns in the housing and construction industry. This population was

identified by our own internal eligibility team who reported an influx of newly uninsured/unemployed individuals needing health care in the spring of 2007. As of 5/31/08, approximately 340 individuals have been enrolled in the Health Department's primary care and oral health programs through this pilot.

Community Outreach

SCHD's internal project management team and Health Promotions Team, network partners, and the Health in Motion mobile medical unit staff are actively engaged in community outreach and instrumental in promoting community awareness of the Sarasota Health Care Access project and the availability of affordable health care in Sarasota County. While it is impossible to directly measure and quantify the impact of these efforts, since many patients self refer and do not identify how they learned about the project and related services, SCHD new patient registrations and clinical encounters serve as reliable proxy measures and are tracked using the Health Management System (HMS). During the most recent five quarter reporting period (January l, 2007-March 31, 2008), which roughly equates to the post implementation project period, SCHD new patient registrations increased by 41%, or some 4,000 additional patients, when compared to the previous five quarter (pre-implementation) period (September l, 2006-December 31, 2007). The average number of new patient registrations per quarter in the pre-implementation period was 1,970 patients. The average for the five quarter post project implementation period increased to 2,780 patients per quarter. During the same five quarter comparison period, SCHD primary care visits increased from 73,711 encounters in the five quarters preceding implementation to 85,451 in the five quarter post implementation period, an increase of 16% or some 11,740 visits. Unduplicated primary care patient count trends were similar, increasing by 33 percent in 2007 when compared to 2006.

Current challenges include maintaining a balance between the demand and need for primary care, specialty care, oral health, Medicaid application assistance, disease and system navigation case management, and prescription assistance services and system capacity surrounding the unanticipated overwhelming response to outreach and coordination efforts. FY 2009 LIP funds will be used to sustain and build additional system capacity to the extent possible with available funding and other resources.

St. Johns River Rural Health Network (Baker, Bradford, Clay, Nassau, & Union Counties)

This project supports a regional program for low-income, uninsured residents from a multi-county rural area that has been operational for the last one and a half years through LIP funding. This Northeast Florida LIP Program represents a partnership among five county health departments and the St. Johns River Rural Health Network (SJRRHN). The SJRRHN is one of nine rural health networks in Florida whose mission is to promote access to health care for residents of rural areas.

The program includes: identification and outreach to high risk, uninsured adults; screening and eligibility determination; increased access to primary care services; and disease management. The following services are provided to enrolled individuals in the LIP program:

- Primary care by participating county health departments;
- Expanded access to pharmaceuticals and medical supplies;
- Access to diagnostic services and specialty care;
- Disease management and care coordination, including patient education programs and other useful tools and resources to support patient adherence.

The outreach plan for the program is designed to be appropriate for the rural areas included in the program area. SJRRHN plans to partner with community organizations that serve these rural populations in order to identify and enroll individuals in the primary care clinics in each program county. Outreach will be done by the participating CHDs, and outreach staff includes health educators, social workers, and other health care personnel in the CHDs who identify clients without health insurance thru outreach activities for Healthy Start, Healthy Families, WIC, WeCare, Chronic Disease and Tobacco Prevention, and other community outreach initiatives.

All patients have access to consultation regarding urgent care needs 24/7 thru the health departments. Primary care is provided by the CHDs and the disease management program offers access to enhanced services not available at the health departments.

As part of this project, Baker CHD will expand clinic hours one Saturday a month, and one evening a month. Clay CHD has extended hours on weekdays, and Nassau CHD will also offer extended hours at two of their clinics on weekdays.

The services available to LIP clients also include an annual exam, quarterly check-ups, urgent care as needed, all recommended labs and diagnostics, an annual foot and eye exam, and prescribed medications and medical supplies. It includes access to outpatient specialty and wound care, as needed.

The Northeast Florida LIP Program has targeted its services to diabetes, and the provision of diabetes disease management services is a key program component. The disease management program will be staffed by two nursing personnel and a medical social worker.

Program enrollment includes collection of baseline health data, including diagnosis, co-morbidities, and key health indicators. This data is provided to the disease manager who conducts an in-depth assessment during an interview with the patient to collect additional information regarding health status, history, their understanding of their disease, and self care behaviors. The disease manager develops a care plan, and begins to provide counseling on a schedule determined by the enrollee’s condition at program entry.

The disease management services are provided in person, at the person's home, or other location selected by the client, and by phone. Patient management tools such as glucose testing logs, food logs, and pedometers are also provided to each client. The disease manager reviews program reports and medical records to track participation in services and consults with the provider on the enrollee's issues and management.

The disease management program also provides a series of four educational classes in each county on the management of diabetes.