Florida Medicaid Reform

Quarterly Progress Report
January 1, 2010 – March 31, 2010

1115 Research and Demonstration Waiver

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

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I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

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

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

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

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

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

Current Activities

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. As of March 31, 2010, this plan application was in Phase II of the application review process.

This quarter, the Agency executed a contract with AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children

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

with chronic conditions which became operational in 2006). Services by Positive Health Care will begin next quarter.

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 one pending application.

Table 1
Health Plan Applicants

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

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

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

Table 2 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	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO dba Positive Health Care	05/01/10	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 effective February 1, 2009.
***During Spring of 2009, the plan notified the Agency to withdraw from this/these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this/these counties.

Contract Amendments and Model Contracts

There were no general amendments during this quarter. Three health plans requested and received Agency approval during this quarter to increase their maximum enrollment levels in various counties.

Contract Conversions/Terminations

There were no contract conversions or terminations during quarter three of Year Four.

FFS PSN Conversion Process

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

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

Table 3
PSN Conversion to Capitation Implementation Dates

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

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

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

Table 4
PSN Conversion to Capitation Timeline

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

FFS PSN Reconciliations

By the end of this quarter, the Agency completed work on the first and second contract

year reconciliations[2] (September 2006 through August 2006 and September 2007 through August 2008) for all but two FFS plans. The Agency continues to work with the FFS plans that have requested additional time for reconciliation data analysis.

Systems Enhancements

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

2. Benefit Package

Overview

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

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages to ensure 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.

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

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

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

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

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

Current Activities

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

The 8 HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Four of the demonstration are Freedom Health Plan, Humana, Medica Healthcare, Molina Healthcare, Total Health Choice, Sunshine State Healthplan,

United Health Care, and Universal Health Care. The 4 FFS PSNs are Better Health, Children's Medical Services, First Coast Advantage, and the South Florida Community Care Network.

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

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

Table 5
Number of Co-payments by Type of Service by Demonstration Year

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

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

Table 6
Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year

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

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

Table 7
Number of Benefit Packages Requiring No Co-payments by Target Population & Area
3rd Quarter of Demonstration Year Four

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

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

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

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

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

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

3. Grievance Process

Overview

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

As defined in the health plan contracts:

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

Under the demonstration, the Legislature required that the Agency develop a process similar to the SAP as enrollees in a FFS PSN do not have access to the SAP. In accordance with Section 409.91211(3)(q), 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 third quarter of Year Four.

Table 8
Grievances and Appeals
January 1, 2010 – March 31, 2010

	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO & PSN Enrollment*
Total	91	19	38	85	279,544

*unduplicated enrollment count

The number of grievances reported by PSNs increased in the first and second quarter of Year Four, from 62 in the fourth quarter of Year Three, to 127 in the first quarter of Year Four, to 189 in the second quarter of Year Four. As noted in the second quarterly report for Year Four, this increase was due to an increase in grievances for one PSN, whose membership increased significantly (by 45%) between June 2009 and September 2009, and by 9% between September and December 2009, and who had changed transportation vendors. There was a decrease in the number of grievances reported by both PSNs and HMOs in the third quarter of Year Four, and it appears that the issues contributing to the large increase in grievances for one PSN in the first and second quarters have largely been resolved. These issues were closely monitored by the Agency to ensure timely resolution.

Medicaid Fair Hearings (MFHs)

Table 9 provides the number of MFH requested during the quarter ending March 31, 2010. 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 7 MFH requests, one was related to denial of benefits/services, two were related to denial of prescription medication, and four were related to the reduction/suspension/ termination of benefits/services. The member withdrew from one hearing, one case was rejected by the Department of Children and Families due to the request not being filed correctly, one was abandoned due to the beneficiary not appearing at the hearing, and four hearings upheld the health plans' decisions.

Table 9
Medicaid Fair Hearing Requests
January 1, 2010 – March 31, 2010

PSN	4
HMO	3

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only one grievance has been submitted to the SAP or the BAP for this quarter. Table 10 provides the number of requests to BAP and SAP for the quarter ending March 31, 2010. The one request to the Subscriber Assistance Program was received at the end of this quarter and is currently pending.

Table 10 **BAP and SAP Requests** January 1, 2010 –March 31, 2010	
BAP	0
SAP	1

4. Complaint/Issue Resolution Process

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

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

The complaints/issues are worked by Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. This tracking was previously accomplished through a consolidated automated database, implemented October 1, 2007, that was used by all Agency staff housed in the above locations to track and trend complaints/issues received. Beginning on October 1, 2009, Medicaid staff in the above locations started using the new Complaints/Issues Reporting and Tracking System (CIRTS), which allows real-time, secure access through the Agency's web portal for headquarters and Area Office staff.

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

This quarter, the Agency received 15 complaints/issues related to PSNs and received 56 complaints/issues related to HMOs, for a total of 71 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 PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

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

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

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

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

5. On-Site Surveys & Desk Reviews

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

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

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

B. Choice Counseling Program

Overview

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

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

- Contract Procurement Process: The Choice Counseling Vendor contract has been awarded to Automated Health Systems (AHS). The contract was signed in early March 2010, and implementation efforts began the same quarter. The new vendor will assume full responsibility of the operation on June 18, 2010.
- The performance of the current Choice Counseling Vendor, ACS, has been the primary focus during this time of change. As noted in the previous quarterly report, a triage unit was created in December 2009. The triage unit continued this quarter to have a noticeable effect on the Choice Counseling Call Center performance, as the call abandonment rate continued to decrease during this quarter.
- The HIV/AIDS Specialty Plan became available to beneficiaries as a choice in late March 2010, with services beginning on May 1, 2010. Throughout this quarter, the Agency and the Choice Counseling Vendor made some changes to the call center script to add special language for this health plan. The choice brochure is also being reformatted so that this health plan will be added.
- Fiscal Agent Implementation Challenges & Resolutions: The Agency, the Choice Counseling Vendor and the Florida Medicaid Fiscal Agency (HP Enterprise Services, LLC (HP)) continue to work on efforts to resolved system conflicts and errors.

Current Activities

1. Informed Health Navigator Solution (Navigator)

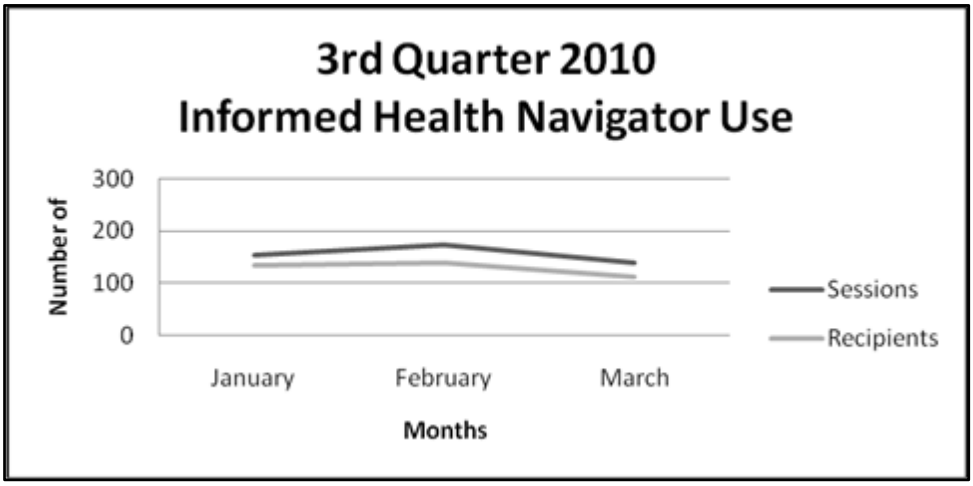
Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets his or her prescribed drug needs. This additional information is provided to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

share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications.

During the beginning of this quarter, there was a decrease in Navigator usage compared to the last month of the previous quarter. However, usage of the Navigator continued to decline over the remainder of this quarter. The decrease in call volume was a contributing factor to the decrease usage of Navigator.

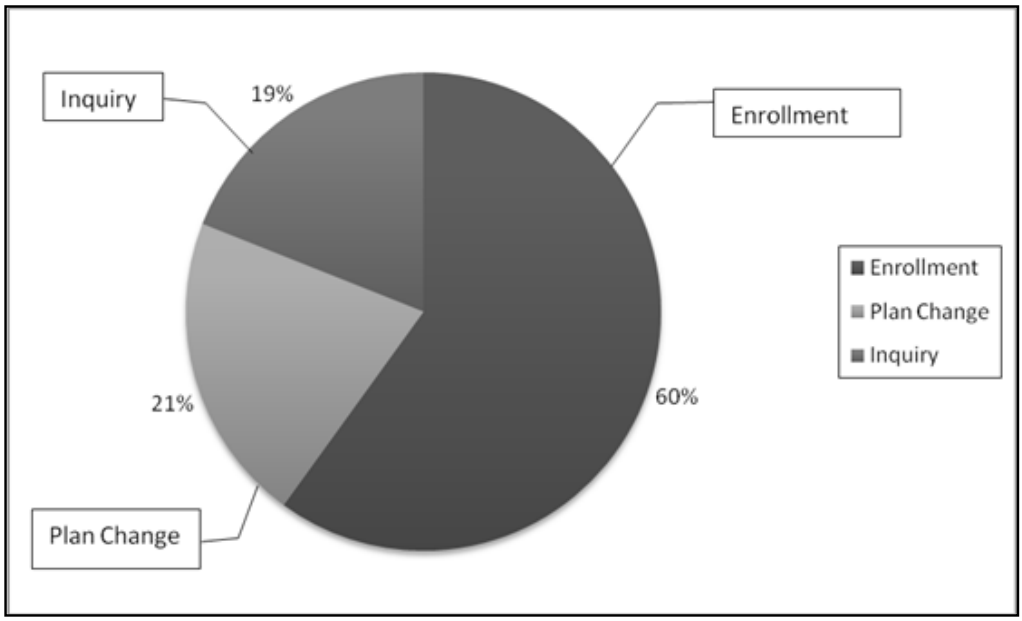
Chart A provides the Navigator statistics for the third quarter of Demonstration Year Four. "Sessions" represents the number of times the Navigator program was utilized, and "Recipients" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate session and recipient. This quarter, the total usage of the Navigator was 464 sessions and 386 unique recipients utilized the system.

Chart A
Navigator Use by Session & Unique Recipient
January 1, 2010 – March 31, 2010



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

Chart B
Navigator Use by Call Type
January 1, 2010 – March 31, 2010



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 set day of the week when the Choice Counselors offer the survey to callers. This helps to reach the goal of at least 400 completed surveys each month. During this quarter, a total of 1,269 beneficiaries completed the automated survey.

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

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

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

The scores for the amount of time the beneficiary had to “wait on hold” have increased a great amount this quarter, but was still one of the lowest scored categories. The reduction in the score for the hold time began in August 2008, and correlates with the

increased number of incoming calls to the Call Center due to issues with the new Fiscal Agent. Other factors, as outlined in the overview at the beginning of this section, also contributed to the increased call volume for this quarter. The Choice Counseling Vendor continues to utilize various mitigation efforts, as reported in the Call Center section of the report, to offset the caller's wait time.

Table 12 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) during this quarter. The number of beneficiaries participating in the Survey this quarter was as follows: January - 428, February - 423, and March - 418 (totaling 1,269).

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

Table 12
Choice Counseling Survey Results
Percentage of Delighted Callers Per Question

January	February	March
How helpful do you find this counseling to be		
84.6%	86.3%	81.6%
Amount of time you waited		
60.5%	73.8%	75.4%
Ease of understanding info		
75.9%	76.6%	76.5%
Likelihood to recommend		
91.4%	92.9%	89.5%
Overall service provided by Counselor		
96.5%	95.5%	94.7%
Quickly understood reason		
95.8%	95.0%	93.3%
Ability to help choose plan		
93.5%	93.6%	91.1%
Ability to explain clearly		
94.4%	94.1%	92.6%
Confidence in the information		
94.6%	94.3%	91.9%
Being treated respectfully		
97.2%	97.2%	95.7%

2. Call Center

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

The Choice Counseling call center received 58,440 calls during this quarter. This represents approximately a 7% decrease in call volume from the previous quarter. The Choice Counseling Call Center continued to improve in their performance as the average call talk time decreased by 4 minutes, from 12 minutes to the historical average of 8 minutes. The call abandonment rate decreased from 45.5% for the second quarter to 9.3% during this quarter.

The Agency and the Choice Counseling Vendor have been in continual communication regarding the call volume and vendor has worked very diligently to improve call center performance. Various mitigation efforts continue to be utilized and will remain in place for the duration of the contract.

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

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

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

Table 13 Comparison of Call Volume for 3rd Quarter (Demonstration Year Three & Year Four)								
Type of Calls	**Jan. 2009**	**Jan. 2010**	**Feb. 2009**	**Feb. 2010**	**Mar. 2009**	**Mar. 2010**	**Year 3 3rd Quarter Totals**	**Year 4 3rd Quarter Totals**
Incoming Calls	27,345	16,447	24,144	18,766	30,168	23,227	**81,657**	**58,440**
Outgoing Calls	3,522	1,922	3,772	2,957	5,240	3,289	**12,534**	**8,168**
Totals	30,867	18,369	27,916	21,723	35,408	26,516	**94,191**	**66,608**

3. Mail

Outbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 20,437
- Auto-Assignment Letters 17,420
- Confirmation Letters 18,158
- Open Enrollment Packets 35,681
- Transition Packets (mandatory and voluntary) 35,681
- Plan Transfer Letters (mandatory and voluntary) 0

The amount of returned mail increased this quarter, ranging around 8%, which was above the estimated 3-5%. When return mail is received, the Choice Counseling staff accesses the Choice Counseling Vendor‘s enrollment system and the Florida Medicaid Management Information System (FMMIS) to try to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team also assists in efforts to contact the beneficiary. The Choice Counseling staff re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail

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

- Plan Enrollments 775
- Plan Changes 153

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

The third quarter update of Florida Medicaid’s Welcome Brochures and Open Enrollment flyers was completed during this quarter and distribution began on February 19, 2010.

4. Face-to-Face/Outreach and Education

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

Table 14 provides a comparison of the Field activities for the second and third quarter of Demonstration Year Four:

Table 14
Choice Counseling Outreach Activities

Field Activities	2nd Quarter – Year 4	3rd Quarter – Year 4
Group Sessions	822	767
Private Sessions	124	106
Home Visits & One-On-One Sessions	60	115
No Phone List	676	611
Outbound Phone List	2,745	3,625
Enrollments	4,182	3,547
Plan Changes	852	263

The Field Choice Counseling Outreach Team efforts during this quarter continued to focus on face-to-face counseling to provide more opportunities for Medicaid beneficiaries to meet with Field Choice Counselors.

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 randomly calls beneficiaries who were served by Field Choice Counselors. The monitors ask four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 15 provides the responses, in percentage, from 125 beneficiaries who participated in the surveys from January – March 2010. The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 15
Overall Field Choice Counseling Results

Able to complete enrollment/plan change at the session	98.67%
Felt the information provided by the Choice Counselor helped them make an informed decision	99.33%
The information was explained in a way that made it easy to understand	100.00%
The Choice Counselor was friendly/courteous	100.00%

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

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

The Mental Health Unit

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

The Mental Health Unit completed 27 Private Sessions and followed up on 81 referrals as well as completing 10 staff presentations for the community partners. The Choice Counseling Spring Fair was held on March 27, 2010, which had about 50 attendees.

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

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

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

5. Health Literacy

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

Summary of cases taken by the Special Needs Unit

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

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

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

This quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as noted in Table 16.

Table 16
Number of Referrals and Case Reviews Completed
January 1, 2010 – March 31, 2010

	January	February	March
Case Referrals	6	9	12
Case Reviews	4	2	3

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

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

6. New Eligible Self Selection Data[3]

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

The new eligible enrollments numbers provided in this section of this report are taken from the Choice Counseling Vendor records and are considered preliminary. There were 30,172 total enrollments for this quarter. Of those enrollments, those who self selected a plan were 14,967 (broken down by month: 6,099 for January; 5,669 for February; and 3,199 for March 2010). There were a total of 15,205 beneficiaries assigned to a health plan during this quarter.

7. Complaints/Issues

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

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

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the Choice Counseling Vendor and the Agency improve customer

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

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 97% are satisfied with the Choice Counseling experience (both Field and Call Center). The Choice Counseling Vendor continues to focus on improving communication between the Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

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 Field Supervisors to compliment the work that the counselors have done. During this quarter, there were 27 reported compliments to supervisors about counselors offering exceptional customer service.

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

In addition to external feedback, the Choice Counseling Vendor has implemented an employee feedback e-mail 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 e-mail box allows the Choice Counselors to send information, which is reviewed by management and shared with the Agency.

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

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

9. Summary

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

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

The transition of the Choice Counseling Program to a new vendor has been the primary focus for all parties involved during this quarter. The continued effort currently being given by all will play a significant role in assuring that the future transition is a success.

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

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

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

C. Enrollment Data

Overview

In anticipation of Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population into the health plans located in the demonstration counties of Broward and Duval. The transition period for Broward and Duval lasted seven months, beginning in September of 2006 and ending in April of 2007. The plan staggered the enrollment of beneficiaries who were enrolled in various managed care programs (operated under Florida's 1915(b) Managed Care Waiver) into demonstration health plans. The types of managed care programs that beneficiaries transitioned from included 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[4]:** Phased in over 7 months (1/2 in Month 1, then 1/6 in each following month)
- **HMO Population:** 1/12 in Months 2, 3, and 4 and 1/4 in Months 5, 6, 7
- **PSN Population:** 1/3 in each of Months 2, 3, and 4.

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

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

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

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 12 health plans – eight HMOs and four FFS PSNs. Two HMOs, Amerigroup and Preferred Medical Plan, ceased operations in November of 2009. Beneficiaries enrolled in these plans were transitioned into the remaining demonstration health plans and as such, only the HMOs' previous quarterly enrollments are included in this quarter's reports.

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

1. Medicaid Reform Enrollment Report

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

Table 17
Medicaid Reform Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan and who have 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 18 on the following page for the Fiscal Year 2009-10, Third Quarter Medicaid Reform Enrollment Report.

Table 18 Medicaid Reform Enrollment Report (Fiscal Year 2009-10, 3rd Quarter)									
Plan Name	**Plan Type**	**Number of TANF Enrolled**	**# SSI Enrolled**			**Total Number Enrolled**	**Market Share For Reform**	**Enrolled in Prev. Qtr.**	**Percent Increase From Prev. Qtr.**
			No Medicare	**Medicare Part B**	**Medicare Parts A and B**				
Amerigroup	HMO	0	0	0	0	**0**	**0.00%**	2,240	-100.00%
Freedom Health Plan	HMO	798	179	0	31	**1,008**	**0.36%**	814	23.83%
Humana	HMO	8,282	2,010	0	200	**10,492**	**3.75%**	12,315	-14.80%
Medica	HMO	839	123	0	26	**988**	**0.35%**	39	2433.33%
Molina Healthcare	HMO	17,094	2,961	1	244	**20,300**	**7.26%**	19,101	6.28%
Preferred Medical Plan	HMO	0	0	0	0	**0**	**0.00%**	325	-100.00%
Sunshine	HMO	81,135	8,265	2	506	**89,908**	**32.16%**	84,406	6.52%
Total Health Choice	HMO	29,719	3,508	4	406	**33,637**	**12.03%**	32,079	4.86%
United Healthcare	HMO	8,449	1,047	0	49	**9,545**	**3.41%**	10,463	-8.77%
Universal Health Care	HMO	15,058	2,069	0	262	**17,389**	**6.22%**	16,427	5.86%
HMO Total	**HMO**	**161,374**	**20,162**	**7**	**1,724**	**183,267**	**65.56%**	**178,209**	**2.84%**
Better Health, LLC	PSN	6,627	1,339	0	126	**8,092**	**2.89%**	8,377	-3.40%
CMS	PSN	3,762	3,110	0	12	**6,884**	**2.46%**	6,645	3.60%
First Coast Advantage	PSN	42,313	6,353	3	799	**49,468**	**17.70%**	48,982	0.99%
SFCCN	PSN	27,663	3,713	3	454	**31,833**	**11.39%**	30,236	5.28%
PSN Total	**PSN**	**80,365**	**14,515**	**6**	**1,391**	**96,277**	**34.44%**	**94,240**	**2.16%**
Reform Enrollment Totals		**241,739**	**34,677**	**13**	**3,115**	**279,544**	**100.00%**	**272,449**	**2.60%**

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-demonstration health plans to demonstration health plans. There were a total of 279,544 beneficiaries enrolled in the demonstration during this quarter. There were twelve demonstration health plans with market shares ranging from 0.35 percent to 32.16 percent.

2. Medicaid Reform Enrollment by County Report

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

Table 19 Number of Reform Health Plans in Demonstration Counties January 1, 2010 – March 31, 2010		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**2**	**0**
Broward	**7**	**3**
Clay	**2**	**0**
Duval	**3**	**2**
Nassau	**2**	**0**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 20 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 20 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have 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 21 and located on the following page.

Table 21
Medicaid Reform Enrollment by County Report
(Fiscal Year 2009-10, 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				
Sunshine	HMO	Baker	2,564	224	0	12	**2,800**	**81.82%**	2,669	4.91%
United Healthcare	HMO	Baker	533	83	0	6	**622**	**18.18%**	662	-6.04%
Total Reform Enrollment for Baker			**3,097**	**307**	**0**	**18**	**3,422**	**100.00%**	**3,331**	**2.73%**
Amerigroup	HMO	Broward	0	0	0	0	**0**	**0.00%**	2,240	-100%
Freedom Health Plan	HMO	Broward	798	179	0	31	**1,008**	**0.66%**	814	23.83%
Humana	HMO	Broward	8,282	2,010	0	200	**10,492**	**6.87%**	12,315	-14.80%
Medica	HMO	Broward	839	123	0	26	**988**	**0.65%**	39	2433%
Molina Healthcare	HMO	Broward	17,094	2,961	1	244	**20,300**	**13.30%**	19,101	6.28%
Preferred Medical Plan	HMO	Broward	0	0	0	0	**0**	**0.00%**	325	-100%
Sunshine	HMO	Broward	28,298	2,525	0	129	**30,952**	**20.27%**	28,253	9.55%
Total Health Choice	HMO	Broward	29,719	3,508	4	406	**33,637**	**22.03%**	32,079	4.86%
Universal Health Care	HMO	Broward	9,357	1,499	0	181	**11,037**	**7.23%**	10,868	1.56%
Better Health, LLC	PSN	Broward	6,627	1,339	0	126	**8,092**	**5.30%**	8,377	-3.40%
CMS	PSN	Broward	2,305	2,025	0	8	**4,338**	**2.84%**	4,164	4.18%
SFCCN	PSN	Broward	27,663	3,713	3	454	**31,833**	**20.85%**	30,236	5.28%
Total Reform Enrollment for Broward			**130,982**	**19,882**	**8**	**1,805**	**152,677**	**100.00%**	**148,811**	**2.60%**
Sunshine	HMO	Clay	8,040	784	0	44	**8,868**	**70.31%**	9,086	-2.40%
United Healthcare	HMO	Clay	3,478	255	0	11	**3,744**	**29.69%**	3,888	-3.70%
Total Reform Enrollment for Clay			**11,518**	**1,039**	**0**	**55**	**12,612**	**100.00%**	**12,974**	**-2.79%**
Sunshine	HMO	Duval	38,084	4,333	2	299	**42,718**	**40.63%**	40,074	6.60%
United Healthcare	HMO	Duval	3,447	587	0	23	**4,057**	**3.86%**	4,701	-13.70%
Universal Health Care	HMO	Duval	5,701	570	0	81	**6,352**	**6.04%**	5,559	14.27%
CMS	PSN	Duval	1,457	1,085	0	4	**2,546**	**2.42%**	2,481	2.62%
First Coast Advantage	PSN	Duval	42,313	6,353	3	799	**49,468**	**47.05%**	48,982	0.99%
Total Reform Enrollment for Duval			**91,002**	**12,928**	**5**	**1,206**	**105,141**	**100.00%**	**101,797**	**3.28%**
Sunshine	HMO	Nassau	4,149	399	0	22	**4,570**	**80.29%**	4,324	5.69%
United Healthcare	HMO	Nassau	991	122	0	9	**1,122**	**19.71%**	1,212	-7.43%
Total Reform Enrollment for Nassau			**5,140**	**521**	**0**	**31**	**5,692**	**100.00%**	**5,536**	**2.82%**
Reform Enrollment Totals			**241,739**	**34,677**	**13**	**3,115**	**279,544**		**272,449**	**2.60%**

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

During this quarter, there was an enrollment of 3,422 beneficiaries in Baker County, 152,677 beneficiaries in Broward County, 12,612 beneficiaries in Clay County, 105,141 beneficiaries in Duval County, and 5,692 beneficiaries in Nassau County. There were two Baker County health plans with market shares ranging from 18.18 percent to 81.82 percent, ten Broward County health plans with market shares ranging from 0.65 percent to 22.03 percent, two Clay County health plans with market shares ranging from 29.69 percent to 70.31 percent, five Duval County health plans with market shares ranging from 2.42 percent to 47.05 percent, and two Nassau County health plans with market shares ranging from 19.71 percent to 80.29 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 22 and 23 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. Table 22 provides a description of each column in this report.

Table 22
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 23 on the following page 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 23
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2009-10, 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	
Freedom Health Plan	HMO	Broward	2	2	0	0	9	22	**35**	**3.47%**	**1,008**
Humana	HMO	Broward	0	65	0	5	0	200	**270**	**2.57%**	**10,492**
Medica	HMO	Broward	2	3	0	0	8	18	**31**	**3.14%**	**988**
Molina Healthcare	HMO	Broward	9	118	0	1	19	226	**373**	**1.84%**	**20,300**
Sunshine	HMO	Baker	0	28	0	0	4	8	**40**	**1.43%**	**2,800**
Sunshine	HMO	Broward	2	101	0	1	16	113	**233**	**0.75%**	**30,952**
Sunshine	HMO	Clay	0	82	0	1	6	38	**127**	**1.43%**	**8,868**
Sunshine	HMO	Duval	15	353	0	11	38	263	**680**	**1.59%**	**42,718**
Sunshine	HMO	Nassau	0	29	0	0	3	19	**51**	**1.12%**	**4,570**
Total Health Choice	HMO	Broward	0	202	0	13	11	399	**625**	**1.86%**	**33,637**
United Healthcare	HMO	Baker	0	5	0	0	0	6	**11**	**1.77%**	**622**
United Healthcare	HMO	Clay	0	29	0	3	2	9	**43**	**1.15%**	**3,744**
United Healthcare	HMO	Duval	0	93	0	4	0	23	**120**	**2.96%**	**4,057**
United Healthcare	HMO	Nassau	0	10	0	0	0	9	**19**	**1.69%**	**1,122**
Universal Health Care	HMO	Broward	0	53	0	0	14	167	**234**	**2.12%**	**11,037**
Universal Health Care	HMO	Duval	2	57	0	1	14	67	**141**	**2.22%**	**6,352**
HMO Total	**HMO**		**32**	**1,230**	**0**	**40**	**144**	**1,587**	**3,033**	**1.65%**	**183,267**
Better Health, LLC	PSN	Broward	1	45	0	0	8	118	**172**	**2.13%**	**8,092**
CMS	PSN	Broward	0	48	0	24	0	8	**80**	**1.84%**	**4,338**
CMS	PSN	Duval	1	55	1	16	0	4	**77**	**3.02%**	**2,546**
First Coast Advantage	PSN	Duval	13	596	0	24	20	782	**1,435**	**2.90%**	**49,468**
SFCCN	PSN	Broward	6	410	0	6	7	450	**879**	**2.76%**	**31,833**
PSN Total	**PSN**		**21**	**1,154**	**1**	**70**	**35**	**1,362**	**2,643**	**2.75%**	**96,277**
Reform Enrollment Totals			**53**	**2,384**	**1**	**110**	**179**	**2,949**	**5,676**	**2.03%**	**279,544**

Demonstration Year One and Year Two quarterly reports included an additional report that displays a summary of Self-Selection, Assignment Rates, and Disenrollment data. In July of 2008, the Agency transitioned to a new Fiscal Agent and subsequently, the entire Medicaid data system was overhauled. At this time, the data necessary to calculate the values of this report are not available.

D. Opt Out Program

Overview

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

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

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

Description of Opt Out Process

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

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

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

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

The Opt Out database has been designed to comply with the Special Terms and Conditions of the 1115 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. 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

- 72 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 59 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 Demonstration Year Four, there are currently 13 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 Demonstration Year One with a coverage effective date of October 1, 2006. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.

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

portion for their family coverage. The child's Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

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

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

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

family coverage. The father lost his job effective August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

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

Demonstration Year Two on May 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out program.

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

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

28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended September 30, 2009. As a result, the child has been disenrolled from the Opt Out program.

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

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

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

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

33. The caller began the process to enroll herself and her two children in the Opt Out program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended June 30, 2009. As a result, the mother and child were disenrolled from the Opt Out Program. The other child remained eligible and enrolled in the Opt Out Program. The mother has now discontinued her employer's health insurance plan due to high cost and now she is looking into private insurance. As a result, the other child has also been disenrolled from the Opt Out Program effective January 27, 2010.

34. The caller began the process to enroll in the Opt Out program during the third quarter of Demonstration Year Three. The effective date for enrollment was during the third quarter of Demonstration Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual 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 December 31, 2009. As a result the individual has been disenrolled from the Opt Out Program.

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

36. The caller began the process to re-enroll her child in the Opt Out Program during the third quarter of Demonstration Year Three. The effective date for enrollment was

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

37. The caller began the process to enroll in the Opt Out program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on July 1, 2009. The individual has health insurance available through her employer. The individual works for a small employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual is still enrolled in the Opt Out Program.

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

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

40. The caller began the process to enroll in the Opt Out program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on August 1, 2009. The individual has health insurance available through her employer. The individual elected to use her Medicaid Opt Out medical premium to pay the employee portion for her individual coverage. The individual is still enrolled in the Opt Out Program.

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

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

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

44. The caller began the process to enroll his child in the Opt Out program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the third quarter of Year Four on January 1, 2010. The father has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

Table 24 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending March 31, 2010. Current Opt Out enrollment, as of March 31, 2010, is 13.

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

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

Table 24 Opt Out Statistics September 1, 2006 – March 31, 2010						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	02/28/10	Loss of Medicaid Eligibility
C & F	12/01/08	Large Employer	Family	5	1/19/2010	Disenrolled from Commercial Insurance
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	1 2	06/30/09 01/27/10	Loss of Medicaid Eligibility Disenrolled from Commercial Insurance
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	Still Enrolled	N/A
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	09/30/2009	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	3	12/31/2009	Loss of Medicaid Eligibility
SSI	01/01/10	Large Employer	Family	1	Still Enrolled	N/A

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

E. Enhanced Benefits Account Program

Overview

The Enhanced Benefits Account Program (EBAP) component of 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 (HP) pharmacy point of sale system currently maintained and managed by the HP 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 demonstration health plans are required to submit monthly reports for their Reform members who had paid claims for approved healthy behaviors within the prior month. These reports are uploaded into the EBIS database for processing and approval. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the HP subcontractor, First Health, to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

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

The primary function of the Enhanced Benefits Call Center is to answer all inbound calls relating to program questions, provide EBA account updates on credits earned/used, and assist beneficiaries with utilizing the web based OTC product list. Again this quarter, the majority of the calls were related to beneficiaries requesting information regarding their account balances. A total of 12,528 calls or 70% of all answered calls were related to account balances.

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

Inbound Calls:	**18,764**
Calls Abandoned:	**740**
Average Talk Time:	**4.1 minutes**
Average Abandonment Rate	**3.8%**
Enhanced Benefits Reward$	**32,626**
Welcome Letters	

2. System Activities

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

System activities related to automation of the reporting of beneficiaries who have been without Medicaid eligibility for three consecutive years. Automation of the process was successful during the month of March. As of March 2010, 2349 beneficiaries lost EBA eligibility for a total of $92,644.16 and no longer have access to the accumulated credits.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during the quarter. There were 320,042 coupon/quarterly statements were mailed to beneficiaries. Seventy percent of 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.

4. Outreach and Education for Pharmacies

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

5. Enhanced Benefits Advisory Panel

An Enhanced Benefits Advisory Panel meeting was held on January 22, 2010. Program updates were provided to panel members. The next panel meeting is scheduled for May 6, 2010.

6. Enhanced Benefits Statistics

Table 25 provides the Enhanced Benefit Account Program statistics beginning January 1, 2010 and ending March 31, 2010.

Table 25
Enhanced Benefit Account Program Statistics

Third Quarter Activities – Year Four		Jan 2010	Feb 2010	March 2010
I.	Number of plans submitting reports by month in each county*	35 of 35	35 of 35	35 of 35
II.	Number of enrollees who received credit for healthy behaviors by month	26,171	26,214	31,208
III.	Total dollar amount credited to accounts by each month	$529,807.50	$531,817.50	$653,792.50
IV.	Total cumulative dollar amount credited through the end each month	$27,156,633.66	$27,688,451.16	$28,342,243.66
V.	Total dollar amount of credits used each month by date of service	$484,716.30	$344,676.94	$460,186.21
VI.	Total cumulative dollar amount of credits used through the month by date of service	$12,791,138.13	$13,135,815.07	$13,596,001.28
VII.	Total unduplicated number of enrollees who used credits each month	21,039	15,329	19,505

*Count includes Health Plan who have recently merged and exited Reform

7. Complaints

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

During this quarter, over 21,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 76 (less than 1%) complaints were recorded through the call center related to the EBAP. Table 26 provides a summary of the complaints received this quarter and outlines the actions taken by the Call Center, the Agency, or HP (through First Health) to address the issues raised.

Table 26 Enhanced Benefit Beneficiary Complaints January 1, 2010 – March 31, 2010	
Beneficiary Complaint	**Action Taken**
1. Thirty 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 EBAP, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the EBAP. Call Center also refers beneficiaries to an actively participating pharmacy in their area.
2. Thirty-seven beneficiaries complained about healthy behaviors not submitted by the health plan on behalf of the beneficiary.	➲ The Agency researches with each health plan regarding healthy behaviors not submitted. In most cases the plan submitted the behaviors in the next report submission. In a few cases, some beneficiaries had already reached occurrence limits on some of the behaviors, therefore credit would not have been credited to the beneficiary account.
3. Nine beneficiaries complained about the balance in their account, either regarding pricing of products or duplicate pricing of one item.	➲ The Agency researched along with the pharmacy vendor regarding these complaints. The vendor was able to resolve issue with the pharmacy.

F. Low Income Pool

Overview

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

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

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

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

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

Current Activities

On January 29, 2010, federal CMS sent a letter to the Agency approving the amendment request to STC #105 of the waiver. Amended STC #105 is posted on the Agency's website at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml. The amendment was requested to allow for the release of an additional $300 million in LIP funds to the State that would have otherwise been retained by the federal government. Amended STC #105 modified the way cost limits must be calculated for

SFYs 2009-10 and SFY 2010-11, and all future years; and requires provider access system (PAS) entities to report data quarterly. In addition, the amendment calls for retroactive adjustment and reconciliation of all previous demonstration year cost limit calculations using a regressive trend percentage.

During the third quarter of SFY 2009-10, two LIP Council meetings were held.

January 8, 2010 LIP Council Meeting

On January 8, 2010, a LIP Council meeting was held at the Winnie Palmer Hospital for Women and Children in Orlando, Florida. This was the fourth LIP Council meeting of SFY 2009-10.

During the meeting, an update was given on the ongoing dialogue with federal CMS regarding the amendment request to STC #105 to allow for the release of the additional $300 million in year five of the demonstration. The Agency also informed the LIP Council that the Agency was providing follow up information to federal CMS as needed.

Also, presentations from the Sarasota County Health Department (CHD), the Duval CHD and the Health Care District of Palm Beach County were made to the Council.

A representative from the Sarasota CHD made a presentation on the Sarasota Health Care Access (SHCA). The SHCA was designed to impact the Medicaid, uninsured, and underinsured populations. The SHCA presentation discussed key points such as emergency room utilization, in-patient hospitalizations, and access to affordable medications.

The Hospital Emergency Room Alternatives Program (HERAP) was presented to the Council on behalf of the Duval CHD. The HERAP targets the uninsured, underinsured and other low income patients who are at risk for overusing emergency rooms. The presentation also described how LIP funds benefited the HERAP in Duval County.

The Health Care District of Palm Beach County presented its Premium Assistance Demonstration Project to the Council. Within this presentation, a request was made for additional LIP funds for the program that would benefit uninsured residents by granting them greater access to health care services. The presentation also gave examples on how the funding received would be used for the targeted population.

The Healthcare Delivery in Public Schools project was also presented to the Council by a representative from the Health Care District of Palm Beach County. Background highlights and accomplishments in health care delivery in public schools were noted in the presentation. Examples were given on how the program would benefit from additional LIP funds received.

The remainder of the LIP Council meeting allowed for discussions on other items on the agenda as well. Such topics as distribution of funds to Safety Net recipient hospitals, an update of the Medicaid Reimbursement Rate, information on the LIP hospital cost limits

and an update on the progress of the LIP Council recommendations were discussed. New distribution models were discussed and members were allowed to follow up with comments.

January 22, 2010 LIP Council Meeting

On January 22, 2010, the fifth and final LIP Council meeting for SFY 2009-10 was held at the Agency's Headquarters Office in Tallahassee, FL.

An update on the Jackson Memorial Health System was brought before the LIP Council. A brief description was given on the background of which led up to the current status of the Jackson Health System. Within the update given, the fiscal challenges that Jackson is facing was reviewed and the need to take control of the financial deficit was explained in detail.

The status of the amendment request to STC #105 was reviewed with the Council including the 2009 legislation that directed the Agency to seek the amendment.

Exemptions and Buybacks with January 2010 rates were explained. Elaborate details and a spreadsheet illustrated key information regarding the current hospital reimbursement rates.

Among the models presented to the LIP Council, the top three models were selected to be voted on. After the three selected models were reviewed, the Council voted on which distribution model would be recommended to the legislature for SFY 2010-11.

Other Activities

Also during this quarter, the Agency submitted to the Governor, House Speaker and Senate President, on February 1, 2010, as directed by Florida Statute, the Low Income Pool Council Report for State Fiscal Year 2009-10 with Recommendations for State Fiscal Year 2010-11. This report can be viewed on the Agency's website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/pdf/lip_report_feb_2010.pdf

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

The Budget Neutrality for the 1115 Demonstration Waiver is based on five closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method which is required for 1115 waivers. Using the templates provided by the Centers for Medicare and Medicaid Services, the historical expenditures and case-months are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five year trend for each MEG. This trend is then applied to the most recent year (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 may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. Without the adjustment of drug rebates, the quarterly expenditure reform totals match the corresponding quarterly CMS 64 Report submission, which details the amount that will be used in the monitoring process by the Centers for Medicare and Medicaid Services.

Current Activities

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

Budget Neutrality is calculated on a statewide basis. For counties where the demonstration is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where the demonstration is not

operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive their services through the Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and / or providers of 1915(c) Home and Community Based Waivers.

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

In the following tables (Tables 27 through 33), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

Table 27 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 27
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

Quarters 7, 8, 9 and 10 were affected by prior period adjustments reported on the CMS 64 Report for the quarter ending March 31, 2010. The changes are included in Table 28 below.

Table 28
MEG 1 Statistics: SSI Related

Quarter		Amounts on Prior Reports		Adjusted Amounts	
Actual MEG 1	**Case months**	**Total Spend**	**PCCM**	**Total Spend**	**PCCM**
Q7 Total	**758,014**	**$763,505,352**	**$1,007.24**	**$763,459,242**	**$1,007.18**
Q8 Total	**764,701**	**$776,809,682**	**$1,015.83**	**$776,896,750**	**$1,015.95**
Q9 Total	**818,560**	**$825,861,820**	**$1,008.92**	**$825,339,746**	**$1,008.28**
Q10 Total	**791,043**	**$866,716,731**	**$1,095.66**	**$867,147,861**	**$1,096.21**

Tables 29 through 33 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2010. Case months provided in the Tables 29 and 30 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 29
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$111,968,931**	**$763,459,242**	**$1,007.18**
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
Q13 Total	**822,396**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,216.58**
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
January 2010	282,575	$159,062,482	$29,470,651	$188,533,134	$667.20
February 2010	283,235	$249,307,944	$44,581,877	$293,889,821	$1,037.62
March 2010	281,514	$373,413,178	$67,763,434	$441,176,612	$1,567.16
Q15 Total	**847,324**	**$781,783,604**	**$141,815,963**	**$923,599,567**	**$1,090.02**
MEG 1 Total	**11,762,376**	**$10,344,114,405**	**$1,585,645,265**	**$11,929,759,669**	**$1,014.23**

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

Table 30 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$ 164.78**
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
Q13 Total	**4,703,528**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$196.16**
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
January 2010	1,682,493	$116,073,248	$9,104,061	$125,177,309	$74.40
February 2010	1,700,550	$248,374,376	$29,806,739	$278,181,115	$163.58
March 2010	1,715,338	$409,161,539	$54,737,055	$463,898,594	$270.44
Q15 Total	**5,098,381**	**$773,609,163**	**$93,647,855**	**$867,257,018**	**$170.10**
MEG 2 Total	**61,849,013**	**$9,276,264,807**	**$945,297,368**	**$10,221,562,176**	**$165.27**

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

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 31), compared to WOW of $948.79 (Table 27), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 31), compared to WOW of $199.48 (Table 27), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,020.78 (Table 31), compared to WOW of $1,024.69 (Table 27), which is 99.62% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.78 (Table 31), compared to WOW of $215.44 (Table 27), which is 78.80% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,049.23 (Table 31), compared to WOW of $1,106.67 (Table 27), which is 94.81% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.10 (Table 31), compared to WOW of $232.68 (Table 27), which is 71.39% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,010.94 (Table 31), compared to WOW of $1,195.20 (Table 27), which is 84.58% of the target PCCM for MEG 1. MEG 2 has a PCCM of $164.94 (Table 31), compared to WOW of $251.29 (Table 27), which is 65.64% of the target PCCM for MEG 2.

Tables 30 and 32 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $314.31. Comparing the calculated weighted averages, the actual PCCM is 89.07% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $307.17. Comparing the calculated weighted averages, the actual PCCM is 82.51% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 32) is $388.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 32 is $287.48. Comparing the calculated weighted averages, the actual PCCM is 74.09% of the target PCCM.

Table 31 MEG 1 & 2 Annual Statistics					
DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 Total	3,033,969	$2,651,751,857	$445,267,012	$3,097,018,869	$1,020.78
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(11,858,825)	
% of WOW PCCM MEG 1					99.62%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,253,068,544	$264,693,878	$2,517,762,423	$169.78
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(677,210,838)	
% of WOW PCCM MEG 2					78.80%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,913,812,534	$495,906,978	$3,409,719,511	$1,049.23
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(186,672,468)	
% of WOW PCCM MEG 1					94.81%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,558,667,339	$280,798,552	$2,839,465,891	$166.10
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,138,161,480)	
% of WOW PCCM MEG 2					71.39%

Table 31 Continued MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	2,500,250	$2,146,983,626	$380,619,731	$2,527,603,356	$1,010.94
WOW DY4 Total	2,500,250			$2,988,298,800	$1,195.20
Difference				$(460,695,444)	
% of WOW PCCM MEG 1					84.58%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	14,761,363	$2,170,872,733	$263,940,228	$2,434,812,961	$164.94
WOW DY4 Total	14,761,363			$3,709,382,908	$251.29
Difference				$(1,274,569,947)	
% of WOW PCCM MEG 2					65.64%

Table 32 MEG 1 & 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,904,820,402	$709,960,890	$5,614,781,292	$314.31
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(689,069,663)	
% Of WOW					89.07%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,472,479,873	$776,705,529	$6,249,185,402	$307.17
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,324,833,948)	
% Of WOW					82.51%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,261,613	$4,317,856,359	$644,559,958	$4,962,416,317	$287.48
WOW	17,261,613			$6,697,681,708	$388.01
Difference				$(1,735,265,391)	
% Of WOW					74.09%

Table 33 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Total Paid	**$3,293,737,339**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$417,805,306	$1,000,000,000	41.78%
Total MEG 3	$3,293,737,339	$5,000,000,000	65.87%

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

The expenditures for the first fifteen quarters for MEG 3, the Low Income Pool (LIP), were $3,293,737,339 (65.87% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

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

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

Current Activities

Encounter data collection in FMMIS is operational and plans are making regular monthly submissions. Current day encounter claims are routinely processing in the claims systems and move to claims history (Decision Support System/DSS) as they are processed. The Agency continues to reconcile monthly data submissions to the encounter data certifications provided by the plans. The Agency has processed in excess of 51 million encounter claims (medical services and pharmacy). Encounter claim volume reflects the number of unduplicated encounter claims processed and not the number of services provided. Many claims contain information on multiple services.

At present there are two concurrent encounter data collection efforts:

- The collection of medical and pharmacy encounter data for all Medicaid-covered services within FMMIS. (Planned uses for these data include, but are not limited to, health plan capitation rate setting, services and utilization analysis, supporting health plan quality and performance metrics, and supporting managed care fraud and abuse prevention and detection.)
- The collection of quarterly pharmacy encounter data in a proprietary format for risk adjusting demonstration health plans' capitation rates.

<u>Data Validation – Internal</u>

Data validation is essential to identifying statistical anomalies and evaluating data integrity and reasonableness. The submission process itself includes a number of data validation steps.

1. Initial data validation is performed by the plans using Edifecs Ramp Manager, which checks encounter claim formatting and HIPAA compliance. The plans are given access to Ramp Manager in order to check their encounter data validity before submitting the encounter claims to the fiscal agent. Theoretically, files approved by Ramp Manager should pass all inbound file system edits. Once the encounter data receive Ramp Manager approval, they can be submitted to the fiscal agent.
2. Inbound file system edits examine file format and overall data validity. They check for such things as: monetary field entries are formatted correctly; beneficiary Medicaid identification (Medicaid ID) numbers are included and are the correct length; diagnosis codes and/or procedure codes are included in the claims; file structure meets HIPAA requirements, etc. Files that do not pass all inbound system edit checks are rejected and must be corrected and resubmitted. Each of the 51 million encounter claims in claims history has successfully passed this validation step.
3. Subsequent validation edits occur at the transaction level as the system processes the claims. Threshold claims processing edits are designed to completely reject the encounter claims and prevent them from moving to the next processing step. These failed claims are reported to the health plans and must be corrected and resubmitted. Examples include:

    - **General validity** - Initial checks are made against central tables, including diagnosis code and dates of service, to determine if those required elements are present in the claim and are valid values.
    - **Beneficiary Medicaid ID** - Checks are performed to determine whether the beneficiary Medicaid ID is a valid value and is on file with Florida Medicaid.
    - **Duplication of records** - Each encounter claim is checked against those already accepted into the system to ensure that the same encounter data exists only once. If a claim has already been processed, any claim containing identical information is rejected.

    A separate set of system edits are considered repairable. These edits allow the encounter claims to continue processing but are labeled on the claims and reported to the plans for correction and resubmission. Examples of repairable edits are:

    - **Provider eligibility** - Provider numbers are checked against the provider file to determine whether the provider is registered with Florida Medicaid and was part of the plan's network at the time of service.
    - **Beneficiary eligibility** - Checks are performed to determine whether the beneficiary was both eligible for Medicaid and enrolled in the plan at the time of service.

The Agency is augmenting the system validation by performing analytic procedures on the encounter data to help determine its reliability by pinpointing possible gaps or other deficiencies that should be corrected. These procedures are designed to instill

confidence in the data's ability to accurately describe the services provided by the health plans. Examples of analytic validation procedures are listed below:

- Key data elements submitted within each encounter claim, i.e., diagnosis and procedure codes, provider types reported, services by counter, and recipients receiving services, are examined across time and by plan to identify correlations and trends.
- Time series analyses of each plan's historical submissions are used to forecast future encounter claim submission volumes. Actual submission volumes are compared to forecasts and variances analyzed.
- All data are evaluated by key data fields to identify and interpret any possible data gaps within encounter claims, such as missing plan payment information, place of service, EPSDT indicator, etc., that could impact analyses and conclusions drawn.
- Provider Medicaid IDs and National Provider Identifiers (NPIs) within the encounter data submissions are compared to each plan's Provider Network File to identify invalid NPIs, providers not registered with the State, network providers not submitting encounter data, and specialty services provided by the plans by areas of the State.

Analytic validation will be performed for all encounter data received to date and for all future submissions by plan by month. For each set of analytic procedures, a feedback loop allows the Agency to communicate results from the procedures to the health plans using a series of standard reports, including a dashboard. These reports are currently under development. Analytic procedure results may require the plans to respond formally to questions from the Agency and/or to perform corrective action, such as when the variance between forecast and actual submissions for a particular claim type and month is more than 2 standard deviations (a 95% confidence interval).

Validation Reports:

- In January 2010 the Agency initiated a preliminary analysis of encounter data with dates of service during SFY 2008-2009. Encounter claims were extracted from claims history and the following comparisons were made across all capitated health plans:

  - Submission volume by MCO
  - Total volume by claim type (medical, inpatient, outpatient, and pharmacy)
  - Claim type distribution by MCO

  From this preliminary analysis, the Agency identified data submission issues that were subsequently researched and corrected.

- During the 2010 Legislative session, staff completed a very specific comparative analysis of the performance of Medicaid managed care plans to the MediPass

program. Specific requirements for the analysis were provided, which compared four service delivery models, MCO-Non Reform, MCO-Reform, MediPass, and Provider Service Networks, for six specified disease states. Also requested was the frequency of hospitalizations/re-hospitalizations as well as the top five surgical CPT codes for the service delivery models.

Data Validation – External

In addition to the analytic validation procedures performed within the Agency, three external vendors, Mercer, Milliman, Inc., and Health Services Advisory Group (HSAG) will assist the Agency. Mercer and Milliman are the Agency's contracted actuaries and HSAG is the Agency's External Quality Review Organization (EQRO). Mercer and Milliman will perform validation procedures to help determine the encounter data completeness and accuracy and to what extent (percentage) they will be used as part of the base data for setting the health plan capitation rates. The Agency is in discussions with HSAG about their role in validating encounter data.

As part of a larger project, Mercer has developed data intake processes and sets of general validation reports that summarize the quality and completeness of the various data sources. Validation activities include, but are not limited to, the following:

- Using eligibility and encounter claims to determine the percentage of recipients who used services within the period. A lower than normal user percentage could indicate underreporting by the plans.
- Analyzing the dollars paid by month of service and month of payment to determine if there are any missing encounter data.
- Analyzing the percentage of diagnosis codes populated by position (Dx1, Dx2, etc.) on the encounter claims, as well as the average number of diagnoses populated per encounter across the health plans.
- Analyzing the missing values in encounter claims and the percentage of total encounter claims this represents to determine the completeness of the encounter data.

Using Encounter Data

The Agency's confidence in using the encounter data is dependent upon complete and accurate submissions of historical and current ongoing encounter data by the health plans. As confidence in the data increases, the Agency will use the data extensively to monitor health plans through fiscal and quality analyses. Current and projected encounter data uses are described below:

Current encounter data uses:

- Health plan capitation rates for SFY 2010-2011 will use encounter claims data as a portion of the base data used in the rate setting process, in conjunction with FFS claims data and enhanced plan financial data. The Agency is providing the SFY

2008-2009 encounter data to two independent actuaries for review and validation by June 2010, as part of the rate-setting process. The percentage of encounter data used for the capitation rates will be determined after the actuaries review the encounter data in conjunction with the health plan financial information and comparable FFS claims data.

- MEDS NCPDP-format pharmacy data for SFY 2008-09 were given to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use. The comparison is to see if the risk scores are similar between the two data sources.

  - Preliminary analysis indicates the results are tracking well except for a volume discrepancy between the two data sources for one plan.
  - If the scores remain substantially equivalent during parallel testing, the Agency will transition to NCPDP pharmacy data for risk adjusted rates in the Reform counties while testing the CDPS model using diagnosis-based encounter data.

- To test and perform a dry run of the CDPS model using diagnosis-based encounter data for comparison to results from the current pharmacy-based Medicaid Rx model results. (The Agency plans to transition to a diagnosis-based model.)

Examples of expected encounter data uses in the future:

- To risk-adjust the demonstration county capitation rates using a diagnosis-based model such as CDPS.
- For identifying the health plan network specialty provider types in the state in order to determine if there is interest in enrollment as Medicaid fee-for-service providers.
- To analyze the services and utilization across the health plans in comparison to one another.
- For comparative analysis of the services reported on encounter claims to services on the FFS claims.
- To support the electronic health record.
- To analyze the overall volume of services per beneficiary and service utilization for specific diagnoses.
- To verify health plan compliance with contract requirements, such as tracking History and Physical procedure codes in the plan encounter claims to verify automatic beneficiary disenrollment if the initial primary care physician visit does not occur within 180 days of plan enrollment.
- To support managed care fraud and abuse prevention and detection, including but not limited to:

  - Comparative analysis of managed care plan utilization, performance, outcomes, referrals, and disenrollment;

- Profile managed care plan practice patterns as compared to their peers;
- Compare managed care plan services to fee for services to identify potential access barriers and under-utilization; and
- Detect practices that could inflate rate setting, e.g., upcoding, unbundling services.

The following are the highlights for this quarter:

- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans, i.e., MEDS and NCPDP Companion Guides, Data Submission Strategy Guidelines, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions.
- Provided outreach and technical assistance with health plans to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Continued to test and refine reports and HIPAA-compliant Electronic Data Interchange (EDI) processes used to communicate errors and invalid transaction content to health plans for their remediation of encounters failing FMMIS edits.
- Worked with the Fiscal Agent to refine the Medicaid Decision Support System (DSS) to support data quality validation through analysis of the volume, accuracy, and completeness of encounter data reported in the data warehouse as compared to the raw claims data.
- Held weekly update meetings for Medicaid management to discuss the progress of encounter data submission and receipt and any system issues that may impact processing and reporting.
- Conducted weekly MEDS Team meetings to discuss project progress, risks, and issues that needed to be addressed to keep the team on track.
- Met with the Agency Encounter Data Utilization Team and identified some preliminary uses for the MEDS data during the validation period.
- Performed comparative analyses requested by the State legislature.
- Developed and implemented the encounter data analytic validation procedures.

<u>Quarterly Pharmacy Encounter Data Collection For Risk Adjustment</u>

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

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

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

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

- Continued to collect and process pharmacy encounter data on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated, and any significant changes from the previous quarter's submission are reported to the health plans for corrective action, if necessary.
- Provided MEDS NCPDP-format pharmacy data for SFY 2008-09 to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use.
- Provided MEDS diagnosis-based encounter data for SFY 08-09 to the risk adjustment vendor on March 31, 2010, for use in a dry run comparison of the Chronic Illness & Disability Payment System (CDPS) model risk score results to the MedRx risk score results based on pharmacy encounter data.
- For this period, risk adjustment plan factors were calculated for the following health plans:

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

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty

plans/populations such as HIV/AIDS and CMS. Enrollment in the demonstration counties for the month of March 2010 for risk adjustment purposes totaled 232,208 and was distributed as follows:

December 2009	Broward	Duval, Baker, Clay, and Nassau
Children & Families	109,104	94,483
SSI	15,994	12,627
Totals	**125,098**	**107,110**

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

The process of providing plan risk factors for the demonstration rate setting and budget neutrality will continue into the next quarter. A dry run of the CDPS model using diagnosis-based encounter data will occur next quarter and the results analyzed. The Agency will continue to test and compare results between CDPS and MedRx until the quality and completeness of the diagnosis-based encounter data support transitioning to a diagnostic risk-adjustment model, such as CDPS. Scheduled activities in the MEDS project plan associated with the collection and processing of encounters will also continue. These activities include providing technical support to capitated health plans, reviewing end-to-end processing results, reporting on encounter submission adjudication results, analyzing and reporting on encounter data validation results.

I. Demonstration Goals

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

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

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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and 7 PSNs) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. The one health plan application still pending was submitted by Preferred Care Partners in January 2010. As of March 31, 2010, this plan application was in Phase II of the application review process.

This quarter, the Agency executed a contract with AIDS Healthcare Foundation of Florida (AHF MCO) of Florida, doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). Services will begin next quarter.

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

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

Access to Services Not Previously Covered

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

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

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

Improving Access to Specialists

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

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

During the second quarter of Demonstration Year Two, the Agency began additional provider network analysis of the Medicaid health plans, including each Medicaid Reform health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on 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 34 shows the results of these analyses.

Table 34
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

After factoring in estimates of need for each specialty, the Agency concluded that access to care for the five identified specialties in Duval County has either improved under Medicaid Reform or is more than adequate to meet 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 divided among 21 Agency staff members, who conducted the surveys in the middle of the month. Of the 713 providers in the sample, 58.5% participated in the survey. Of those who participated, 84.4% of the providers confirmed participation in the health plans. Agency staff followed up with the health plans to see if they had a provider contract on file for those providers whose office managers did not confirm participation. This follow-up resulted in a finding that 99% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

During the second half of Demonstration Year Two, the Agency finished analyzing the March 2008 and April 2008 survey data and continued to conduct surveys. In each month, the Agency pulled a sample of 300 providers across the state, 15 from each health plan, to be surveyed. Additionally, a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist) was pulled from Area 10

(Broward County) in March 2008 and from Area 4 (Duval, Baker, Clay, Nassau, St. Johns, Flagler, and Volusia counties) in April 2008.

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

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

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

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

Surveys were conducted in August, September, October, and November 2008. During the third quarter of Year Three, the Agency followed up on and analyzed the August and September surveys. In the August 2008 statewide survey, the combined results from the survey and follow-up indicate that 291 (97%) of the 300 sampled providers have

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

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

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

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

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

conducted during the second quarter of Demonstration Year Four as well, from October through December 2009.

During the third quarter of Demonstration Year Four, Agency staff followed up on and analyzed the results of the second quarterly provider network survey. A total of 630 providers were sampled from the provider network files, and 98.4% of the providers sampled statewide had current contracts with the health plans for which they were surveyed. The third quarterly provider network survey was conducted during the third quarter as well, from January through March 2010.

During the fourth quarter of Demonstration Year Four, Agency staff will follow up on and analyze the results of the January survey and the next quarterly survey will be conducted.

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

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

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

During this quarter, health plans continued to report quarterly on their progress toward improving performance measure scores. With few exceptions, health plans maintained a strong commitment to the interventions selected and are expected to show significant improvement in the measures that are due to the state on July 1, 2010.

The state completed the final phase of the Performance Improvement Strategy by finalizing incentive and sanctions language for the health plan contracts. Non-monetary incentives were created to acknowledge high performance. A quality designation system will be developed that will highlight those health plans that have achieved the state standards for excellence. A quality award program will also be put in place that allows health plans to compete for the top rankings to foster continual improvement. Details can be viewed in Attachment IV of this report.

A sanctions strategy was developed to ensure that no health plan continues to operate below a floor threshold established by the state. Based on comparisons to HEDIS national benchmarks, the sanctions will be levied if a plan fails to improve after being

given the opportunity to institute corrective action. The full sanctions strategy can be viewed in Attachment V of this report. The health plans were given opportunity for input prior to finalizing the language. A staggered implementation schedule was included in response to their comments.

Because incentives with a fiscal impact are more desirable than non-monetary incentives, the state has formed a Value-Based Purchasing/Pay for Performance workgroup to develop additional incentives for high performance. The first task of the workgroup is to recommend a new auto-assignment methodology for recipients who do not select a health plan that disproportionately awards higher performing health plans with a greater portion of the available recipients. The existing system operates via a round-robin process that attempts to provide health plans with an equal number of recipients.

The second task of the workgroup will be to recommend a methodology and funding source to provide financial incentives to high performing health plans. Unlike the auto-assignment task that already has statutory authority for implementation, the financial incentive will result in a recommendation to the Florida Legislature for implementation authorization.

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

As noted in the previous report, the Medicaid database used to conduct the Ambulatory Sensitive Hospitalization analysis will be updated when hospital data is available.

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

As reported in last quarter's report, the Agency has traced the HEDIS measure, Ambulatory Care, as a measure of the reduction in Emergency Department utilization. The Agency will assess continued progress toward this goal with the health plans' next submission of data in July 2010.

Another source of information available to the Agency on Emergency Department utilization is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The state has three years of CAHPS survey results for the demonstration project. One year serves as the benchmark year and was administered to MediPass recipients prior to the transition into the managed care plans. Two follow-up surveys were administered in Broward and Duval counties and one follow-up survey was administered in the rural counties. When comparing emergency department utilization via CAHPS across the three years, from county to county, and by plan type (HMO or PSN), there are no statistically significant differences. The Agency will continue to monitor responses to CAHPS survey items related to emergency department utilization.

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

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

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

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

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

The individuals who decided not to opt out:

(1) were not employed,

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

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

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

The Agency has contracted with the University of Florida 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. The University of Florida has adapted the CAHPS telephone survey component by adding questions specific to the demonstration. The most recent study, *Enrollee Satisfaction: Year One Follow-Up Survey Report*, was finalized on March 9, 2009 and can be viewed on our website at:

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

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

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

Prior to the implementation of the demonstration, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The demonstration

waiver created the Low Income Pool (LIP) program which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of the non-hospital PAS entities allows for increased access to services for the Medicaid, underinsured, and uninsured populations.

During the Year One of the LIP, the following PASs received State appropriations for LIP distributions: Hospitals, County Health Departments (CHDs), the St. John's River Rural Health Network (SJRRHN), and Federally Qualified Health Centers (FQHCS).

During the first two quarters of Demonstration Year One, the State approved a PAS distribution methodology and worked with these PAS entities establishing Letters of Agreement with the local governments or health care taxing districts.

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

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

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

During the fourth quarter of Demonstration Year One, the Agency received a letter on June 8, 2007, from UF LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to UF LIP Evaluation team along with the pre-LIP Milestone data (SFY 2005-06) by July 31, 2007. The LIP Milestone data for Year One of LIP (SFY 2006-07) was due to the Agency from all PAS entities no later than August 15, 2007. This information was shared with the UF LIP Evaluation team in September 2007. The University of Florida and the Agency are using the LIP Milestone data for the evaluation of the impact

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

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

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

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

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

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

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

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

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

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

On June 30, 2008, in accordance with STC #102 of Florida's 1115 Demonstration Waiver, the Agency submitted a letter to federal CMS along with the LIP Program

Highlights: Year 1 (SFY 2006-07) as prepared by UF. The LIP Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to federal CMS.

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

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

Low Income Pool Program Success Stories

As provided in the previous quarterly report, Attachment III of this report provides information of programs and services impacted by the LIP.

Current Activities

The Agency is scheduled to receive the final SFY 2008-09 Milestone report from UF during the first quarter of Demonstration Year Five. The report will illustrate the qualitative impact on the implemented indicators in Demonstration Year Three on uninsured individuals as referenced in STC# 104.

J. Evaluation of Medicaid Reform

Overview

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

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

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

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

3. Independent Evaluation by the University of Florida

UF will continue to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency. There were two semi-annual reports submitted to the Agency by the researcher in the third quarter of Demonstration Year Four. These reports will be submitted to federal CMS once the Agency has reviewed and approved them. The following areas of UF's independent evaluation conducted and/or produced reports during the third quarter of Demonstration Year Four.

University of Florida – Mental Health Analysis

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

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

Studies for Objectives 1 and 3 are being conducted by UF, and USF is conducting the Objective 2 study (see below). Results from the final report for Objective 2 are scheduled to be approved by the Agency during the fourth quarterly reporting period of Demonstration Year Four. A second draft for the Objective 1 report was submitted to the Agency by the researcher during the current quarterly reporting period. An approved report should be submitted to federal CMS for review towards the end of the fourth quarter of demonstration Year Four.

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

University of Florida – Fiscal Analysis

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

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

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

University of Florida – Low Income Pool (LIP)

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

The *Evaluation of the Low-Income Pool Using State Fiscal Year (SFY) 2006-2007 Florida Hospital Uniform Reporting System (FHURS) Data* is currently under review by the Agency. The report evaluates the link between payments from the LIP-related programs and the provision of services to Medicaid, underinsured, and uninsured populations using data from FHURS. This evaluation measures services along four dimensions—adjusted days, gross revenue, net revenue, and operating expense, in order to gain a more complete picture of the amount of services obtained from a given amount of LIP-related payments. This report is one of a series of reports that will evaluate the Low-Income Pool Program throughout the demonstration period. All evaluation studies will use data on LIP-related payments as provided by the Agency, but two different data sets will be used to assess the amount of services provided—data from FHURS and data from the LIP Milestone Reporting Requirements for CMS. These studies will cover periods both before Reform was implemented and during implementation and operation for purposes of comparison. Evaluations of the LIP utilizing Milestone data (for SFYs 2007-2008 and 2008-2009) and FHURS data (SFY 2006-2007) will be available in separate reports before the end of the first quarter of Year Five.

University of Florida - Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[7]) study designed to help understand demonstration enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. The qualitative study did achieve its objective during the demonstration's implementation period, but due to the nature of qualitative research the study could not successfully be sustained over time. With this particular component of the evaluation reaching its conclusion, the independent evaluator will now move forward

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[5] State of Florida, Agency for Health Care Administration (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml, accessed September 12, 2009).

[6] *CMS Special Terms & Conditions* (http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf, accessed October 26, 2007).

[7] This study was originally intended to be longitudinal; that is, it would follow the same recipients over time from before implementation through the end of the study period. However, maintaining the true longitudinal nature of the study was difficult because enrollees were hard to reach or decided they did not wish to continue study participation.

with conducting an analysis from another area of the demonstration that needs to be assessed in order to further enhance the demonstration. The Agency has approved a summary report of these activities which will be made available on the Agency's website in the fourth quarter of Demonstration Year Four.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

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

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

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

Technical Advisory Committee

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

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

The purpose of this committee is 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.

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

K. Policy and Administrative Issues

Current Activities

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

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

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

These forums continue to provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement. In conference call forums, while the transition of Florida Medicaid's Management Information System from the legacy system to the new fiscal agent, and the consolidated contract for 2009 – 2012 have continued to be popular topics, the focus in the third quarter has been more on contract enhancements and information exchange.

Medicaid Reform Technical Advisory Panel

There was only one Technical Advisory Panel (TAP) meeting that took place this quarter. The nine-member TAP created by the 2005 Florida Legislature, appointed by the Agency, with the directive of advising the Agency on various implementation issues relative to the demonstration, met in March and discussed the following topics:

- Medicaid encounter data collection and processing, including the focus on submission of current encounter data, passing systems and the different uses for the data;
- Health plan risk-adjusted capitation rate setting timeline for September 2010 rates, including discussion on what portion may be based on encounter data and how rates would be affected by enhanced benefits credits;
- Choice Counseling update, including reports on the beneficiary survey results and on the transition to the new Choice Counseling Vendor effective in June 2010;

- Enhanced Benefits update on credits earned, credits spent and the highest volume purchases (baby wipes and diapers);
- Legislative proposals, including an expected increase in the Medicaid caseload and possible expansion of managed care and the demonstration; and
- An update on national health care reform and how Florida may be affected.

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

Policy Transmittals and Dear Provider Letters

During this quarter, there were three policy transmittals and one Dear Provider letter released to the health plans. The two policy transmittals covered the following topics:

- Third party liability reporting changes for HMOs and PSNs; and
- Paper claims processing updates for PSNs, including revisions in claims review processes.

The one Dear Provider letter was sent by the Medicaid Encounter Data System team and was regarding data remediation and exception reports. In addition, there were several Dear Provider emails providing updated information relative to the Medicaid program during this time period. Issues addressed included:

- Changes in Florida fraud and abuse policy and law, allowing rewards for reporting fraud and abuse and providing posters and brochures for printing and dissemination;
- Florida Medicaid coverage of disposable incontinence supplies for children ages 4 through 20;
- Updates on internal control numbers adjustment reason codes used by the fiscal agent; and
- Paper claims processing updates for PSNs, including revisions in claims review processes.

Biweekly Technical and Operations Calls

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

All health plans are invited to participate, whether or not they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs

these calls with administrative experts in all areas of the demonstration, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers, and health plan subcontractors.

Approximately 20 participants attended in person and the popularity of these calls is shown by over 100 phone lines in active use on the calls. Items that have made an appearance at almost all calls include updates on Medicaid encounter data submissions; fiscal agent transition issues, including enrollment transitions, claims processing, and the transitions of primary care provider choices; and updates on the 2009-2012 health plan contract, report guide updates and benefits amendments. At the last call in March, the health plans were advised that due to the decrease in fiscal agent transition issues, fiscal agent transition would be removed as a standing agenda item and would return only if there was an identified need.

Other agenda items included:

- H1N1 Swine Flu vaccine availability updates;
- External Quality Review Organization meeting/conference call/webinar updates;
- Third party creditable coverage reporting;
- Provider fee schedule posting;
- Medicaid Program Integrity fraud and abuse reporting;
- Health plan reporting/submission reminders:
- Health plan transition updates;
- Returned mail retention reminder; and
- ADA accommodations reminder.

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

Fee-for-Service PSN Systems Implementation Issues Calls

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

forum for unresolved issues and the Agency responded by scheduling an additional call with association members. Unresolved issues include those that are in the systems change queue for implementation and anecdotal issues pending examples to be submitted from PSNs for Agency research. Additional items related to Medicare crossover claims and chiropractic claims were also discussed.

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

- Medicaid fiscal agent transition issues relative to PSN enrollees, claims remittance advice, and enrollment file formats; and
- Claims systems changes in the queue until their priority status for systems change reaches a higher priority level.

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

General Amendment/Contract Overview Calls

During this quarter, the Agency held one follow-up conference call with health plans regarding an upcoming general contract amendment specific to performance measures incentives and sanctions and other fine-tuning items relative to return mail and reporting. This call provided the Agency with an opportunity for follow-up dialogue with the health plans regarding proposed contract changes and a forum for health plans to provide feedback. Based on this call and feedback received, the Agency decided to move forward with an amendment to be effective May 1, 2010, to add performance measure sanctions and incentives.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues January 1, 2010 – March 31, 2010	
PSN Informal Issue	**Action Taken**
1. A provider reported to the Agency that the PSN has not paid claims that the provider has submitted since February 2009, totaling over $18,000. The provider reported having contacted the PSN but not seeing any results so far.	➲ The PSN reported to the Agency that the provider's submissions were electronic claims that were submitted incorrectly, which resulted in denial of claim payments. This was explained to the provider and the provider reported that the claims will be resubmitted correctly.
2. A PSN member reported needing a referral to a specialist but the PSN has not assisted the member.	➲ The PSN contact reported to the Agency that the member had visited the assigned primary care provider and was referred to a specialist, but was not given any specific provider to contact. The PSN assisted the member in obtaining an appointment with a specialist.
3. A PSN member's sibling and guardian reported being unable to arrange care for the member because the PSN refused to accept him as the member's representative.	➲ The PSN contact reported that the PSN immediately reached out to the member's sibling and furnished lists of network providers. The member's sibling said he would make an appointment for services.
4. A PSN member reported needing a provider referral and that the PSN has not helped. The PSN member said that the PSN referred her to the Medicaid Area Office for assistance.	➲ The PSN contact reported to the Agency that the member worked out difficulties with her primary care provider and has been making appointments. The member is now satisfied with care.
5. A PSN member reported needing equipment for a health condition that the PSN will not approve because the item is indicated for a child, not an adult.	➲ The PSN contact reported to the Agency that the same item, but for adult use, has been approved. The PSN notified the member and the DME provider that the item should be dispensed to the member.
6. A provider reported to the Agency that the PSN denied a claim, stating that the beneficiary was not a member.	➲ The PSN contact reported to the Agency that the member was active in their database; however, the PSN had no record of receiving any claims from the provider. The PSN said it will accept claims if the provider submits them. Medicaid Area Office staff notified the provider of this.
7. A PSN member's mother contacted the Agency to request disenrollment for cause—she reported feeling misled into selecting the plan and that it cannot provide the medical care her son needs.	➲ The PSN contacted the member's mother and assisted her with her concerns. The member's mother is content for her son to remain in the PSN.
8. A new PSN member reported being unable to get a prescription refilled and being unable to get assistance from the PSN's member services.	➲ The PSN reported to the Agency that they have attempted to contact the member to resolve these issues but that the member has not returned their calls. The PSN will assist her when they hear from her again.

PSN Complaints/ Issues January 1, 2010 – March 31, 2010	
PSN Informal Issue	**Action Taken**
9. A PSN member's mother reported to the Agency that she was told she could only change her daughter's primary care provider during open enrollment.	➲ The PSN customer service contact reported to the Agency that they called the member's mother and changed the daughter's primary care provider.
10. A PSN member's parent reported to the Agency that the member urgently needs specialist services but that the providers listed by the PSN will not see the member for 3-6 months.	➲ The PSN contact reported to the Agency that a case manager arranged for immediate care for the child with an appropriate specialist. The member's parent is satisfied.
11. A PSN member's parent reported to the Agency that the PSN was unable to provide timely referral to a specialist for the member.	➲ The PSN contact reported to the Agency that they identified a specialist able to see the member. The PSN notified the member's parent and the parent made an appointment. The member's parent is satisfied.
12. A PSN member's parent reported needing home health services, but says the PSN initially denied them.	➲ The PSN reported to the Agency that a case manager immediately called the member's parent for detailed information and then worked with a home health agency. The PSN arranged services for the member and the parent is satisfied.
13. A provider reported to the Agency that claims she submitted to the PSNs have not been paid.	➲ Agency staff researched this issue and determined that the provider has not submitted claims. The PSNs are working with the provider and Agency staff to get the claims submitted correctly and paid.
14. A PSN member's parent reported to the Agency that the PSN's subcontracted home health agency failed to provide a nurse to care for the member.	➲ The PSN contact reported to the Agency that the home health agency explained that the assigned nurse had car trouble. The member's parents will only accept two of the home health agency's nurses in the home and the second nurse was not available. The home health agency had offered to send another nurse to the home but the parents refused. The home health agency is training a third nurse to provide specialized care to the member, but so far the parents have been unwilling to accept another nurse. A PSN case manager visited the family to explain their options.
15. A PSN member's parent reported being told by the PSN that the member would need a particular surgery before speech therapy would be provided.	➲ The PSN reported to the Agency that the provider had used the wrong diagnosis code and was advised by the PSN which code should be used. The member received the necessary services.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
1. An HMO member was unable to access services with a provider because the HMO does not show her as being a member.	➲ The HMO contact reported to the Agency that the member's status was corrected. The HMO notified the provider that the member can receive services. The HMO also made internal corrections to prevent this issue from arising in the future.
2. An HMO member reported to the Agency that he needs ongoing services from a provider who did not participate with the HMO.	➲ The HMO contact reported to the Agency that the HMO authorized the out-of-network services and notified both the member and the provider.
3. An HMO member contacted the Agency and reported not being able to see the provider who has been treating her because she was mistakenly enrolled in the HMO and the provider does not participate in the health plan.	➲ The HMO contact reported to the Agency that the plan has authorized the member to continue seeing the provider. The HMO contact notified both the provider and the member.
4. A provider reported to the Agency that a claim was denied because the HMO erroneously showed that the member was not active on the date of service.	➲ The HMO contact reported to the Agency that the claim was paid and the issue was closed out.
5. An HMO member's parent reported being balance billed by a provider because the member was in a plan with which the provider did not participate.	➲ The HMO contact reported that they advised the provider not to bill the parent. The HMO advised the parent that she is not liable for payment and that she should no longer be billed by the provider.
6. A former HMO member's parent reported being balance billed by a provider for a claim the HMO denied.	➲ The HMO contact reported that the claim was not paid because the provider is capitated and the member was not assigned to them on the date of service. The HMO advised the provider and the parent in writing that the parent cannot be balance billed.
7. Medicaid Area Office staff called on behalf of a provider's office and reported that the Choice Counseling information for a provider needs to be updated.	➲ Choice Counseling staff correctly updated the provider's information in the system.
8. An HMO member reported to the Agency that her OB/GYN was no longer with the plan and the member had a surgical procedure scheduled with the provider in a week.	➲ The HMO contact reported to the Agency that the provider had been contacted and authorized to deliver all prenatal care and the surgical procedure on an out-of-network basis.
9. An HMO member contacted the Agency and reported being assigned to a new plan. The member's specialist does not participate with the HMO and the member states that she urgently needs a surgical procedure that the	➲ The HMO contact reported to the Agency that the plan received the authorization request and reviewed and approved it. The HMO notified the member and the physician's office that they should proceed with treatment.

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
plan will not authorize.	
10. An HMO member's parent reported to the Agency that the member could not get necessary tests done because the parent had switched her to another health plan.	➲ The HMO reported to the Agency that it authorized the necessary testing and notified the providers as well as the member's parent.
11. An HMO member's parent reported to the Agency that the HMO gave her a referral to a dental provider but later denied the provider's claim due to lack of prior authorization.	➲ The HMO contact reported to the Agency that the subcontractor had explained the situation to the parent. The HMO reported that the authorization issue is between the subcontractor and the provider and the member does not need to be involved because the service is covered. The parent is satisfied.
12. An HMO member reported to the Agency that the HMO will not authorize a surgical procedure for the member.	➲ The HMO contact reported to the Agency that the surgeon had not requested an authorization because he is aware that the procedure is not covered by Medicaid. Thus, the HMO had not denied the service. The HMO had informed the member's parents and they are aware that the service is not covered.
13. An HMO member reported being authorized for services by a previous health plan but this authorization did not follow the member to the new HMO because the provider does not participate in the current plan. The member reported needing additional services.	➲ The HMO contact reported to the Agency that the HMO authorized the required services for the member. The HMO reported that pertinent documentation had to be obtained prior to authorization and that the documentation was lost in the transition from the previous plan.
14. An HMO member reported to the Agency that the HMO will not authorize an item needed to monitor the member's health condition.	➲ The HMO contact reported to the Agency that the HMO representative held a three-way call with the member and a DME representative to authorize the necessary item.
15. An HMO member's parent reported to the Agency that the HMO refused to authorize prescriptions for the member.	➲ The HMO contact reported to the Agency that initially a medication was requested that required a prior authorization. Eventually a prior authorization request was submitted but the HMO denied the request and sent a letter to both the member and the primary care provider explaining the denial.
16. An HMO member reported being unable to obtain medications because they are not on the HMO's drug formulary.	➲ The HMO contact reported to the Agency that the requested medication had been reviewed and approved. The member's parent was notified that the medication was available for pick-up.
17. An HMO member's mother reported to the Agency that the HMO denied authorization for a psychotropic medication that her son had been taking for several years. Agency staff contacted the health plan and explained the situation.	➲ The HMO reported to the Agency that it lifted the denial and authorized the refill of the member's prescription.

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
18. A provider reported having problems getting claim payments from the HMO. The provider reported that the HMO is working with her but that there are still issues.	➲ Agency staff contacted the HMO to closely follow the HMO's claim payments to the provider. The HMO communicated with the provider and paid older claims including an advance payment. The HMO finalized outstanding payments with the provider.
19. A provider reported that the HMO owed the provider a significant amount of money for claims submitted after services were rendered.	➲ The HMO reported to the Agency that the provider was paid for the outstanding claims.
20. A provider reported to the Agency that the HMO recouped payment for member, stating that he was not enrolled with the health plan.	➲ The HMO reported to the Agency that it resolved the eligibility issue and was reissuing a new check to the provider. The HMO gave the provider a direct telephone number to call if there were any problems.
21. A provider reported to the Agency that the HMO denied claims because the member did not show up as being active on the date of service.	➲ Agency staff researched the issue in FMMIS and found that the member was active in the HMO. The HMO contact reported to the Agency that their member database was corrected and the provider's claims would be paid.
22. An HMO member's parent reported being balance billed by an out-of-network provider after the HMO denied the claim.	➲ The HMO contact reported that they consulted with the provider. The HMO member's parent was advised in advance by the provider that they did not participate with the plan and the parent signed a financial liability statement assuming liability for any unpaid balance of the charges. Therefore, the HMO will not pay for the claim and the parent is financially responsible. The HMO contacted the member's parent and explained this to her.
23. An HMO member's parent reported to the Agency that the HMO authorized a procedure but the provider is insisting on prepayment from the parent because the HMO is slow in paying claims.	➲ The HMO contact reported to Agency staff that the procedure requested is considered cosmetic in nature and therefore not covered by Medicaid. The HMO had previously asked the provider to explain this to the member's parent as the HMO will not approve the procedure. The HMO contacted the member's parent and explained this to him.
24. A provider reported to the Agency that the HMO denied a claim even though the member was enrolled when the services were received.	➲ The HMO contact reported to the Agency that the claim was paid three months previously. The check number was given for verification and the issue was resolved.
25. An HMO member reported to the Agency that she could not locate an ear, nose, and throat specialist in her area that accepts the HMO.	➲ The HMO contact reported that their case management staff contacted the member and explained the process for obtaining referrals. An HMO case manager will continue to monitor the member and ensure that the member is

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
	communicated with effectively.
26. An HMO member's parent reported to the Agency that the HMO was unwilling to provide a specialist referral and told her to call the Medicaid Area Office.	➲ The HMO contact reported that they called the parent and gave a proper referral. The member had an appointment scheduled with a specialist and was directed to contact a specific plan analyst if she encountered any additional problems. The parent is satisfied.
27. An HMO member reported to the Agency that he wants to see a specific provider at a certain facility but says these providers do not accept the HMO. The member would like to be exempted from managed care.	➲ The HMO contact reported that they spoke with the member and he agreed to accept referrals to network specialists who can treat his medical condition. The member is satisfied.
28. An HMO member reported to the Agency that the HMO would not authorize services for her pain management needs. The member requested a review of why the HMO made this decision.	➲ Agency staff contacted the HMO to request and investigate the reason of denial of services for this member. After additional research was done by HMO staff, the HMO contacted the member and encouraged her to work with her primary care provider to determine the best rehabilitation plan. The member agreed and was scheduled for a rehabilitative session to address her condition.
29. An HMO member reported to the Agency that she needs a procedure done in an out-of-state hospital but the HMO will not authorize it and directed her to the Medicaid Area Office.	➲ The HMO contact reported that they had researched the situation and the necessary procedure can be done in many places. The HMO arranged for a specialist at Shands Hospital in Gainesville to do the procedure. At first the member refused to go there but then agreed to go and the HMO helped her with travel arrangements.
30. An HMO member reported to the Agency that the HMO would not authorize necessary medications for the member and that the HMO disclosed confidential health information to a provider.	➲ The HMO contact reported to the Agency that of the member's six medications, five were not due for refills yet and one required prior authorization, which was given. The HMO contacted the member and researched the potential inappropriate disclosure of confidential information, and determined that no confidential information had been disclosed to any outside party.
31. An HMO member's mother reported to the Agency that the HMO denied coverage for an ADHD medication that her son has been taking routinely. The member's mother reported that she was denied the opportunity to file an expedited appeal by telephone and that the HMO was requiring it in writing.	➲ The HMO reported to the Agency that the prescription required prior authorization. The HMO approved authorization of the prescription for six months and called the member's mother to notify her.
32. Hospital staff contacted the Agency and reported having claims denied by the HMO.	➲ Agency staff determined that the HMO is responsible for the member during the dates of service. Agency staff notified the HMO of this

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
	decision and notified the hospital provider so it can move forward and take legal action if necessary.
33. A provider reported to the Agency that the HMO denied claims.	➲ The HMO contact reported to the Agency that the denials were in error and they have corrected the system issue. The HMO contacted the provider and directed the provider to resubmit the claims for payment.
34. An HMO member's parent reported being balance billed by a provider because the member was assigned to another plan and that plan denied the claim.	➲ The HMO contact reported to the Agency that there was no record of any claims being filed by the provider. The HMO contacted the provider, got the necessary information, and authorized out-of-network payment. The provider will resubmit the claim for payment.
35. An HMO member reported being unable to receive a prescription at a pharmacy and needs it as soon as possible.	➲ The HMO contact reported to the Agency that it resolved the prescription issue and the member was able to get the medication at the pharmacy.
36. An HMO member reported to the Agency that the HMO denied prescription drugs he needs and that the HMO had not properly credited the Enhanced Benefit credits that he has earned.	➲ The HMO case manager who is working with the member reported to the Agency that the member has not had problems obtaining his medications since the case manager started working with him. The HMO has submitted all Enhanced Benefit credits earned by the member to the state, but the case manager reported that she pulled all the credit-related claims for the member from their system and re-submitted them to the state.
37. An HMO member's father reported to the Agency that the HMO told him his child was not enrolled.	➲ Agency staff verified in FMMIS that the member is enrolled in the HMO. The HMO contact reported to the Agency that the member's mother had no problem accessing services at the dentist's office the previous day but has had problems at a pharmacy in the past. The member's parents are changing pharmacies. The HMO contact reported that they verified the member's information in the system with the member's mother and advised the mother to call the HMO call center if they ran into any other difficulties.
38. Pharmacy staff contacted the Agency to inquire on behalf of an HMO member using cancer prescriptions. The prescriptions were rejected and the member and pharmacy need to know the reason and if pre-authorization is required.	➲ The HMO reported to the Agency that it authorized the cancer prescriptions for the member and provided a direct line for a specialist if additional questions came up in the future. The HMO contacted the member to ensure that there are no other issues that need resolution.

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
39. An HMO member's parent reported to the Agency that the HMO would not authorize inpatient care and had no providers to treat the member's condition.	➲ The HMO contact reported to the Agency that the member has been seeing a network specialist who treats his condition and had seen the specialist the same day the complaint was reported. The HMO stands by the plan of care for the member and notified the member of this.
40. An HMO member's parent reported to the Agency that she had requested a specific primary care provider for the member but the HMO assigned another primary care provider. The requested provider was authorized to see the member, but subsequently the claim was denied by the HMO because the primary care provider change was not made.	➲ The HMO contact reported to the Agency that the primary care provider change was made. The member's parent and the provider were notified. The HMO advised the provider to resubmit the claim for payment. The parent and provider are satisfied.
41. A provider reported to the Agency that an HMO member needs a referral to an inpatient treatment program but that the HMO has not provided any successful referrals so far.	➲ Agency staff contacted the provider for additional information and she stated that the HMO had approved out-of-network treatment at her facility. The member received care and the HMO contact confirmed this arrangement.
42. An HMO member reported to the Agency that she needs additional treatment for a medical condition but that the HMO has not assisted with referrals and care.	➲ The HMO contact reported to the Agency that the member spoke with HMO staff as well as the HMO's CEO. The member admitted not following the recommendations of her treating specialist and the HMO's CEO suggested that she seek a second opinion. The HMO gave the member authorization to see another specialist per her request and has aided and guided her, but the member has chosen to be non-compliant and has not followed through with the referrals and guidance.
43. An HMO member reported that the HMO approved a procedure with a specific specialist but after the specialist left the HMO network, the HMO was unable or unwilling to provide another referral.	➲ The HMO contact reported to the Agency that the member was given a referral to the stated specialist but that the procedure requires a two-step evaluation and screening process by other specialists to make sure the member is qualified for the procedure. The member failed to follow through with the appointments with the other specialists. HMO medical staff spoke with the member and explained the requirements. The member now understands the process and agreed to keep the newly made appointments with the other specialists. The HMO explained to the member that final approval for the procedure is contingent upon the evaluation findings by the specialists.
44. An HMO member's mother reported having trouble finding a specialist who participates in	➲ The HMO contact reported to the Agency that the HMO scheduled an appointment for the

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
the HMO and who will perform a surgical procedure on her daughter.	member with an ocular plastic surgeon who has performed similar surgeries.
45. An HMO member reported to the Agency that the HMO has not provided services on the grounds that the services are not covered by Medicaid. The member reported filing a grievance with the HMO but has heard nothing and would like an update.	➲ The HMO contact reported to the Agency that the member did file a grievance 10 days before the member reported the issue to the Agency, however, the HMO has up to 90 days to issue a response to the grievance. The HMO reported that it notified the member of the 90-day window at the time she filed the grievance. The HMO notified the member that she retains the right to file for a hearing if the HMO denies the grievance.
46. An HMO member reported to the Agency that she has been unable to obtain necessary medications because the HMO has not authorized them.	➲ The HMO contact reported to the Agency that one medication was authorized for a year the day that the member issued the complaint. The HMO authorized the second medication after receiving additional information from the member's primary care provider. The HMO attempted to contact the member but the member's phone number is no longer in service. The HMO reported to the Agency that the member's prescriptions are available for pickup at the pharmacy, and asked Agency staff to pass this information along to the member if she calls again, since the member has not contacted them or provided an updated phone number.
47. An HMO member's mother reported to the Agency that her daughter needs residential treatment specializing in eating disorders.	➲ Agency staff contacted the HMO and the HMO contact reported that the member was evaluated while at the hospital and it was determined that residential treatment was not medically necessary at this time. The HMO's behavioral health subcontractor set up an intensive outpatient therapy program for the member. Agency staff are continuing to monitor this case.
48. An HMO member's aid category was erroneously changed, making her eligible for a managed care assignment. The member's specialist does not participate with the HMO and she urgently requires his services.	➲ Agency staff was able to remove the member from the HMO retroactively and advised the HMO that it is no longer responsible for her care. The HMO notified the member that she was no longer enrolled in the HMO.
49. An HMO member reported that the HMO's dental subcontractor was unable to provide a referral to a specialist.	➲ The HMO contact reported to the Agency that they had advised the dental subcontractor that the requested services are covered for the member if medically necessary. The HMO subcontractor reviewed the member's dental records and authorized the services. The subcontractor scheduled an appointment for the member to have the procedure.

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HMO Informal Issue	**Action Taken**
50. An HMO member reported that the HMO would not approve prior authorization requests for urgently needed treatments.	➲ The HMO contact reported that the prior authorization requests were approved timely. The HMO contacted the member to notify him that authorization was given.
51. An HMO member's parent reported that she is unable to get the member's hearing devices repaired.	➲ Agency staff determined that the member's parent had never contacted the HMO for assistance, so the member was referred to the HMO and Agency staff helped coordinate. The HMO contact reported that the device had a 6-month warranty and the HMO approved repairs by the durable medical equipment vendor. The member's parent was notified and is satisfied.
52. An HMO member's sister reported to the Agency that the member needs a referral to a specific facility for treatment of a medical condition but the HMO will not authorize this care.	➲ The HMO contact researched the issue and reported to the Agency that it located a facility that is well equipped to handle the type of treatment the member needs and the HMO approved a referral to that facility. The member has kept appointments at the facility and seems to be happy with the care he is receiving.
53. An HMO member reported that the HMO's pharmacy third party administrator would not approve his lung cancer medications, creating unwanted health risks.	➲ The HMO contact reported to the Agency that the member's specialist had not properly filed the prescription forms sent to the pharmacy third party administrator. The HMO handled the member's concerns regarding medications and other issues. The member was able to pick up his medications.
54. An HMO member reported to the Agency that the HMO will not approve necessary medications and will only provide an ineffective generic version of another medication.	➲ The HMO contact reported to the Agency that its records show that the member has received both requested medications for the month and has authorizations that are good for one year. The HMO contact spoke with the member, who was upset because she only wants brand name drugs, not generics, but the HMO informed the member that the prescriptions her provider wrote were for generic medications. The HMO stands by the service provided.
55. An HMO member reported to the Agency that she had problems getting the HMO to authorize prescriptions.	➲ The HMO contact reported to the Agency that an HMO case manager contacted the member and took note of her concerns. The case manager notified the member that one of the two prescriptions had been approved two months ago for one year and that the member could pick up the medication at any time. The HMO had not received a prior authorization request for the other medication from the member's primary care provider, so the case manager contacted the provider again to ask

HMO Complaints/Issues January 1, 2010 – March 31, 2010	
HMO Informal Issue	**Action Taken**
	for the authorization request. The case manager told the member that the HMO would contact her as soon as the other medication is approved. The member was given the case manager's direct line for future questions or issues she might have.
56. An HMO member reported to the Agency that he is unable to get necessary services from his new primary care provider assigned by the HMO.	➲ The HMO reported to the Agency that they had been in touch with the member and that the member had an appointment with a new primary care provider later the same day the member reported the issue. The HMO reported that the member saw his new primary care provider and received the prescriptions he needed. The member is very satisfied with the services he is receiving.

Attachment III
Low Income Pool Success Stories

Alachua County Low Income Pool Project

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

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

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

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

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

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

Citrus County Health Department (CCHD) LIP Project

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

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

Emergency Room Diversion Clinics: CCHD now provides ER Diversion/Urgent Care Services at 3 sites Citrus County. These clinics provide an invaluable service for Citrus County. Data indicates that over 38% of the clients seen would either go without care or would utilize the ER for care. Over the past year the CCHD ER diversion clinics have saved an average of $500,000.00 in ER cost. Additionally, over 72% of ER diversion clients have made the CCHD their medical home. These clients are provided with primary care and chronic disease prevention services and have access to all CCHD services including, dental care, mental health, and pharmacy services. During the previous year, CCHD provided over 2 million dollars of prescription medications through the Drug Manufacturers' Indigent Drug Program.

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

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

- A CCHD client in her 40’s had a diagnosis of cervical cancer. She had no idea that coverage was available to her until our nursing staff talked to her about Medicaid. She had a teenager at home and qualified for care. After our DCF workers processed her application, we were able to refer her to Moffitt Cancer Center for treatment.

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

Jefferson and Madison County Health Departments LIP Project

Utilizing Low Income Pool funds, Jefferson and Madison County Health Departments have increased access to care for the uninsured through a variety of approaches, the most notable being the establishment of new primary care access points within the County Health Department (CHD). Both CHDs have enhanced their capacity to provide care through the hiring of Advanced Registered Nurse Practitioners to provide primary care, family planning and OB services. In addition, both CHDs have expanded primary care clinic hours as well as offering an *After Hours* clinic. Both sites have increased "open access" through changes to scheduling procedures to provide services to walk-ins.

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

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

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

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

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

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

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

Project Data

- Increased access to health care for the uninsured and underinsured in Jefferson and Madison Counties through the expansion of County Health Department primary care capacity (January 2009 through March 2010 the project provided services to 945 new patients). Diverted 79 from the emergency room, estimated saving of $132,720.00 in ER charges (January 1, 2009 – March 31, 2010).
- After Hours Clinic in Madison County alone served: 758 total patients seen, diverted 110 from the ER, an estimated saving of $184,800.00 in ER charges (May 6, 2009 – March 31, 2010).
- LIP funding provided the means to continue Jefferson and Madison County's prescription assistance program. July 2008 through December 2009 the project provided assistance to 331 uninsured individuals with 1,069 prescriptions with a value of $406,633.00.

Lake County Health Department (LCHD) LIP Project

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

Lake Primary Care Project (Lake PCP)

- Increased access to care including one evening a week
- Increased provider access by allowing all LCHD providers to see Lake PCP clients for sick visits
- Has enrolled 466 clients into a primary care home since starting in 2009. There are 425 active clients
- Disease management care coordination including creating a care plan account for over 3,760 services and currently managing 72 high severity clients with weekly follow-up. Low severity clients receive monthly follow-up

- Increased access to alternate geographical locations through partnerships with 2 local hospital indigent clinics; has enrolled 116 clients into a primary care home since starting in March 1, 2010. There are 116 active clients
- Partnership with a Mental Health Provider to see clients on-site has decreased referral time from 2 months to 1 week (45 clients have been referred)
- Prescription Assistance Program has assisted 148 clients in receiving 1851 prescriptions
- Compassionate Care Program assisted 67 clients in receiving 117 prescriptions at no cost
- Mammogram and cervical cancer screening is available as needed
- Value of in-kind services to Lake PCP clients: $70,564.17

Community Partnerships

- Assisted clients with lodging needs, helping them get back on their feet
- Provided assistance to all clients needing food/meal assistance
- Access to specialty services for Lake PCP clients through referrals
- Eye exams and glasses from local charitable organizations

Case Example:

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

Impact on Local Hospitals

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

Program	ER Diversion	Average Cost	Total ER Savings
Lake County Health Department	867	$ 2,293.03	$ 1,985,430.00
Partnership with Indigent Clinics	86	$ 2,293.03	$ 197,200.58

Pinellas County Health Department LIP Project

The Pinellas County LIP project provides disease management and outreach services and two primary care clinics for uninsured clients. Clients receiving services provided through the LIP are very appreciative of the staff and services that would otherwise be

inaccessible to them. We have received many positive comments from clients for staff going above and beyond in providing client care.

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

The outreach team includes an RN and Eligibility Specialist who provide nursing assessments and eligibility screenings at five sites within the County and attends various community events. The outreach team receives regular referrals of uninsured discharged patients from local hospitals (inpatient and emergency room) who they assist in establishing a medical home. The team also works to establish a medical home for individuals who receive a 30-day prescription card when discharged from St. Anthony's Hospital through a pilot program with Pinellas County Health and Human Services. Quarterly, this team processes an average of 670 emergency room referrals, 100 hospital inpatient referrals, 375 eligibility field assessments and 300 nursing field screening assessments.

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

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

alternative medical care through the LIP Clinics, and by providing education and disease management through the Disease Managers.

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

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

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

- A Caucasian woman in her mid-forties was admitted to SMH with nausea and vomiting. She was diagnosed with diabetes, having a blood sugar in the 800s. A Social Worker from the hospital made a referral to SHCA. The SHCA nurse case manager contacted this patient and helped her set up an appointment with Sarasota CHD Adult Health. This lady was unaware of the existence of the Health Department and the availability of primary care. The nurse case manager taught her how to inject herself with insulin and contacted the patient at least weekly regarding diet, exercise and diabetic care. She also helped her straighten out her chaotic work schedule. This lady eventually lost 50-60 pounds, and through proper nutrition, was able to eliminate her need for insulin. Her diabetes is now controlled through diet and oral medication and her blood sugar is under control.

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

- A tearful and depressed uninsured black gentleman in his late thirties came to the health department after being seen at the Sarasota Memorial ER. The Sarasota

Healthcare Access RN case manager helped him through the clinic eligibility process and he was given an appointment for our adult primary care clinic. By working with his physician, he was given appropriate medications and referrals help him with his depression. He routinely takes his medication and has been able to secure a job and maintain a place to live.

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

SHCA access case managers receive numerous daily calls from people who have lost their jobs and health insurance and have no idea how to navigate the complex system of health care access. Many have chronic conditions and don't know how to they will continue to obtain their medications. If they have children, our case mangers lead them to Medicaid web-site on their computer. These individuals are educated on the eligibility process including the documents they need, who to contact and how to make appointments. Many have chronic conditions and don't know how they will continue to obtain their medications.

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

- Patient A, a diabetic, was established with Sarasota Healthcare Access in August of 2009. She was prescribed 11 formulary monthly maintenance medications and along with 4 medications that are accessed through our Medication Assistance Program. Total medication costs for the patient for her first month of treatment would have been $2,536.16 for the following drugs:

- Januvia $495.39
- Lamictal $1,111.42
- Actos $512.77
- Advair Diskus $416.58

Patient B, diagnosed with congestive heart failure, was established with Sarasota Healthcare Access in July of 2007. He is prescribed 14 monthly maintenance formulary medications along with 5 non-formulary medications. The cost of his non-formulary medications for one month of treatment would have been $1,595.04, had he not received Medication Assistance support.

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

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

Attachment IV
Performance Measure Incentives

Health Maintenance Organizations and Provider Service Networks reporting demonstration and non-demonstration plan performance measures are eligible to receive incentives described within this document. Incentives will be awarded based on the scoring methodology described later in this document.

Quality Designation

Using the scoring methodology, high performing health plans may earn a quality designation based on their overall score. Those health plans achieving an overall score below the 50th percentile equivalent will not be eligible for a designation. Those plans that receive a performance measure sanction will also be ineligible for a designation, even if their point total would qualify them for the designation. The available categories are as follows:

Designation	Score Equivalent to the National Percentile
Platinum	90th percentile
Gold	75th percentile (Agency goal)
Silver	60th percentile
Bronze	50th percentile

The quality designation may be used in the following circumstances:

- As a logo in approved printed materials sent to enrollees, potential enrollees, and providers;
- As a logo in choice counseling materials distributed by the Agency;
- In the choice counseling script;
- Acknowledgement on AHCA Website;
- Acknowledgement on FloridaHealthFinder.com

The Agency will provide the logo for health plan use. The logo will be a winner's cup with both the color of the designation category as well as the word of the color printed on the cup for black and white printing. An example of the type of cup is:

Health plans may publicize the receipt of a quality designation for prior years.

For example, a health plan may wish to indicate that they have been a Gold rated plan for three consecutive years. However, choice counseling materials and scripts will only indicate current year designations.

Quality Awards

Annually, the Agency will select health plans to receive one of several quality awards. These awards will be determined using the scoring methodology. Awards will be announced in a group venue, such as an External Quality Review Quarterly Meeting or other statewide meeting with health plans in attendance. Health plans receiving a performance measure sanction will not be eligible for a quality award.

The Agency will publicize the list of award recipients in available venues and will request provider associations publish the list in their newsletters. Health plans will not be permitted to include quality awards in their community outreach materials.
The list of awards is:

- Overall best performance.
- Best performance in performance measure groupings (see list below).

Scoring of Performance Measures

Performance on each performance measure (PM) will be scored according to the following:

PM Ranking	Score
≥90th percentile	6
75th-89th percentile	5
60th-74th percentile	4
50th-59th percentile	3
25th-49th percentile	2
10th-24th percentile	1
≤10th percentile	0

- A health plan will also receive an N/A for any PM for which there is insufficient data to provide a score.
- All health plans will receive an N/A for any PM included for the first time.
- All new health plans will receive N/As for all PMs and will not be scored.

Performance Measure Incentives

Performance Measure Groups

PM groups will be used to award incentives.

Mental Health and Substance Abuse

- Follow-Up Hospitalization After Mental Illness (7 day)
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication

Well-Child

- Childhood Immunization Status
- Well-Child Visits in the First 15 Months of Life (6 or more)
- Well-Child Visits 3rd, 4th, 5 th, and 6th Years of Life
- Adolescent Well-Care Visits
- Lead Screening in Children

Other Preventive Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Adults' Access to Preventive/Ambulatory Health Services
- Annual Dental Visits
- BMI Assessment

Prenatal/Postpartum

- Prenatal and Postpartum Care (includes 2 measures)
- Frequency of Ongoing Prenatal Care

Chronic Care

- Use of Appropriate Medications for People with Asthma
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack

Diabetes

- Comprehensive Diabetes Care (includes 6 of the 7 HEDIS diabetes measures)

HIV/AIDS (Agency-Defined Measures)

- Frequency of HIV Disease Monitoring Lab Tests
- Highly Active Anti-Retroviral Treatment
- HIV-Related Medical Visits

Agency-Defined

- Mental Health Readmission Rate
- Use of ACE Inhibitors/ARB Therapy
- Lipid Profile Annually
- Use of Beta Agonist

For each *PM group*, a health plan will receive *a PM group score* which is the average score for all PMs in that *PM group*.

Attachment V
Health Plan Performance Measure Sanctions Strategy
STATE OF FLORIDA – AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)

Key Provisions

- Each performance measure (PM) will be assessed a score based upon its ranking relative to the national benchmarks. A 7 point scoring system will be used (0-6).
- √ The PMs will be placed into *PM groups* comprised of similar PMs (e.g., well-child). The *PM groups* will receive an average *PM group score*.
- √ AHCA will not apply sanctions on any PM during its first year of inclusion.
- √ A performance measure action plan (PMAP) will be required for poor performance. PMs will only be included in determinations of sanctions after the health plan has developed and implemented a PMAP and operated under it for at least one full year.

Scoring of Performance Measures

Performance on each performance measure (PM) will be scored according to the following:

PM Ranking	Score
≥90th percentile	6
75th-89th percentile	5
60th-74th percentile	4
50th-59th percentile	3
25th-49th percentile	2
10th-24th percentile	1
≤10th percentile	0

- A health plan will also receive an N/A for any PM for which there is insufficient data to provide a score.
- All health plans will receive an N/A for any PM included for the first time.
- All new health plans will receive N/As for all PMs and will not be scored.

Performance Measure Groups

PM groups will be developed and used to apply sanctions to address the concern that a health plan can simultaneously be a poor performer on one PM while performing well on a related PM.

Mental Health and Substance Abuse
- Follow-Up Hospitalization After Mental Illness (7 day)
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication

Well-Child
- Childhood Immunization Status
- Well-Child Visits in the First 15 Months of Life (6 or more)
- Well-Child Visits 3rd, 4th, 5 th, and 6th Years of Life
- Adolescent Well-Care Visits
- Lead Screening in Children

Other Preventive Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Adults' Access to Preventive/Ambulatory Health Services
- Annual Dental Visits
- BMI Assessment

Prenatal/Postpartum

- Prenatal and Postpartum Care (includes 2 measures)
- Frequency of Ongoing Prenatal Care

Chronic Care

- Use of Appropriate Medications for People with Asthma
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack

Diabetes

- Comprehensive Diabetes Care (includes 6 of the 7 HEDIS diabetes measures)

HIV/AIDS (Agency-Defined Measures)

- Frequency of HIV Disease Monitoring Lab Tests
- Highly Active Anti-Retroviral Treatment
- HIV-Related Medical Visits

Agency-Defined

- Mental Health Readmission Rate
- Use of ACE Inhibitors/ARB Therapy
- Lipid Profile Annually
- Use of Beta Agonist

For each *PM group*, a health plan will receive *a PM group score* which is the average score for all PMs in that *PM group*. Agency-defined measures do not currently have benchmarks and, therefore, will not be included in the scoring initially. Once the Agency develops benchmarks for those measures, they will be incorporated into the scoring.

As the list of PMs required for Medicaid is amended, the above groups will be similarly amended.

For health plans in both the non-Reform and Reform programs, AHCA will create PM group scores for each program. That is, a health plan operating in both programs will receive two *PM group scores* for each *PM group*.

Health Plan Performance Measure Sanctions Strategy

Performance Measure Groups

The health plans will be sanctioned for each *PM group* where the *PM group score* is 2 or lower. This is the equivalent of a health plan performing, on average, below the HEDIS 50th percentile (median) of national Medicaid health plans for all PMs within that group. Failure to meet the *sanctions threshold* for a *PM group* would result in the health plan receiving a monetary sanction of $10,000. For health plans in both the non-Reform and Reform programs, AHCA will apply sanctions independently based on the *PM group scores* for each program.

Individual Measures

AHCA will use the following to apply sanctions for failure to provide medically necessary services the health plan is required to provide to an enrollee. The only PMs that will be included are those in the following groups:

- Mental Health and Substance Abuse;
- Chronic Care; and
- Diabetes.

For each PM in one of the above PM groups for which the health plan falls below the 10th percentile of the national median, AHCA will apply a sanction of $500 for each person that should have received services but did not receive these services. For example:

- The denominator in the PM is 411 people (the minimum sample size for compiling data on the particular indicator; alternatively this number could be as large as the health plan's Medicaid membership if the data used to compute the indicator are "administrative");
- The health plan is below the 10th percentile based on the health plan only providing the in-scope service to 200 members;
- The health plan should have provided this service to all 411 people, or 211 more members than it did (411 – 200);
- The health plan will be sanctioned $500 for each of the 211 people; the total sanction will be $105,500.

If the health plan fails to improve performance on a measure that was sanctioned using this methodology in the subsequent year, the sanction will be increased to $1,000 per person for that year and any subsequent years that the PM remains below the 10th percentile.

Implementation

The provisions described above will be implemented on a phase-in schedule.

2010 Submission	PMAP assessed for all measures scored at two (2) or below
2011 Submission	Individual measure sanctions assessed.
2012 Submission	Group sanctions assessed for group scores that fall below the equivalent of the 40th percentile
2013 Submission	Group sanctions assessed for group scores that fall below the equivalent of the 50th percentile

For the 2012 submission, the scoring methodology will be temporarily altered to assess health plans against the 40th percentile equivalent. The scoring will be amended as follows for the 2012 submission only.

PM Ranking	Score
≥90th percentile	6
75th-89th percentile	5
50th-74th percentile	4
40th-49th percentile	3
25th-39th percentile	2
10th-24th percentile	1
≤10th percentile	0

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