Florida Medicaid Reform

Quarterly Progress Report
January 1, 2011 – March 31, 2011

1115 Research and Demonstration Waiver

Agency for Health Care Administration

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I. Waiver History

Background

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (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 Five of the demonstration for the period of January 1, 2011, through March 31, 2011. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at:

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

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

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

The Agency currently 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 seven PSNs) of which 23 applicants sought and received approval to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population. There are currently no pending applications.

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

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

Table 1
Health Plan Applicants

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

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

Table 2 Medicaid Reform Health Plan Contracts					
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area**		
			Broward	**Duval**	**Baker, Clay, Nassau**
AMERIGROUP Community Care	07/01/06	HMO	X****		
HealthEase	07/01/06	HMO	X***	X***	
Staywell	07/01/06	HMO	X***	X***	
Preferred Medical Plan	07/0106	HMO	X****		
United HealthCare	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista	07/01/06	HMO	X*		
Vista Health Plan SF	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center d/b/a First Coast Advantage	07/01/06	PSN		X	X******
Pediatric Associates	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X	X*****	X*****+
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO d/b/a Positive Health Care	05/01/10	HMO	X		
Preferred Care Partners, Inc. d/b/a CareFlorida	01/01/11	HMO	X		

*During Fall of 2008, the plan amended its contract to withdraw from this county.
**During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.
***During Spring of 2009, the plan notified the Agency to withdraw from these counties.
****During Summer of 2009, the plan notified the Agency of its intent to withdraw from this county.
*****Sunshine began providing services in these counties effective September 1, 2009.
******First Coast Advantage expanded into these counties effective December 1, 2010.
+Sunshine withdrew from Nassau and Baker Counties effective December 31, 2010.

Contract Amendments and Model Contracts

This quarter, the Agency internally routed a general technical amendment to clarify and ensure consistency in the original contracts. Health plans will execute these amendments next quarter. Additional information regarding the contract amendment process is provided in Section K of this report. During this quarter, South Florida Community Care Network requested an increase to its maximum enrollment level in Broward County. This request is currently under review by the Agency.

Contract Conversions/Terminations

There were no conversions, terminations, or acquisitions during this quarter, and no requests are pending.

FFS PSN Conversion Process

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

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

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

Table 3 PSN Conversion to Capitation Timeline	
Deadline for the FFS PSN to submit its conversion workplan to the Agency.	09/01/2011
Deadline for the FFS PSN to submit its conversion application to the Agency.	09/01/2012
Successful conversion applicants and execution of capitated contracts for service begin date of 09/01/2013.	06/30/2013

FFS PSN Reconciliations

By the end of this quarter, the Agency completed work on the first, second and third contract year reconciliations[2] (September 2006 through August 2007, September 2007 through August 2008, and September 2008 through August 2009) for all but two FFS

[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.

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

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for all four-years of the demonstration. Interested parties were notified that the data book would be e-mailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold. The Agency released the first

data book on March 22, 2006. Subsequent updates to the data book were then released on May 23, 2007, for Demonstration Year Two, May 7, 2008, for Demonstration Year Three, September 15, 2009, for Demonstration Year Four and September 30, 2010, for Demonstration Year Five.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006, and updated versions of the PET were released annually, shortly after the release of the latest data book. The PET allows a plan to obtain a preliminary determination as to whether 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 health plans have used the opportunity to offer additional, alternative and attractive services. In addition, the health plan enrollees are receiving additional services that were not available under the regular Florida Medicaid State Plan. The value of each customized benefit package continues to meet or exceed the Florida Medicaid State Plan benefit package in Year Five of the demonstration.

Current Activities

The benefit packages customized by the health plans for Demonstration Year Four became operational January 1, 2011, and remain valid until December 31, 2011. These benefit packages include 20 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

Table 4 located on the following page lists the number of co-payments for each service type by each demonstration year.

Table 4 Number of Co-payments by Type of Service by Demonstration Year								
Type of Service	Year One	Year Two	Year Three			Year Four	Year Five	
			(July-Dec 08)	(Jan-Nov 09)	(Dec 09)		July-Dec	Jan
ARNP / Physician Assistant	0	0	5	1	0	0	0	0
Chiropractic	10	0	8	4	3	3	3	5
Clinic (FQHC, RHC)	0	0	6	2	1	0	0	0
Dental	4	4	4	0	0	2	2	2
Home Health	4	1	8	4	3	3	3	3
Hospital Inpatient: Behavioral Health	11	1	8	4	3	4	4	6
Hospital Inpatient: Physical Health	7	1	8	4	3	4	4	6
Hospital Outpatient Services (Non-Emergency)	7	1	7	3	3	2	2	2
Hospital Outpatient Surgery	7	1	8	4	3	2	2	2
Lab/X-Ray	5	1	7	3	3	2	2	2
Mental Health	7	3	6	2	1	4	4	4
Podiatrist	10	0	7	3	3	3	3	5
Primary Care Physician	0	0	5	1	0	0	0	0
Specialty Physician	1	1	6	2	1	0	0	2
Transportation	5	5	6	2	1	2	2	2
Vision	4	0	5	1	1	2	2	2
Total Number of Required Co-payments	**82**	**19**	**104**	**40**	**29**	**33**	**33**	**43**

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year. Year Five has now been separated into two sections, July 2010 and January 2011, to reflect the new benefit packages that became effective January 1, 2011.

Table 5 Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year									
	Year One	Year Two	Year Three			Year Four		Year Five	
			July-Dec	Jan-Nov	Dec	Jan	May	July-Dec	Jan
Total Number of Benefit Packages	**28**	**30**	**28**	**24**	**20**	**20**	**19**	**19**	**20**
Total Number of Benefit Packages Requiring No Co-payments	**12**	**16**	**20**	**20**	**17**	**16**	**15**	**15**	**14**
Percent of Benefit Packages Requiring No Co-payments	**43%**	**53%**	**71%**	**83%**	**85%**	**80%**	**79%**	**79%**	**70%**

Table 6 displays the number of Demonstration Year Four and Year Five benefit packages not requiring co-payments by population and area. Table 6 shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments.

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

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

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

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

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

The PET submission procedure for Demonstration Year Five was similar to that of the four previous years. The updated version of the data book was released by the Agency

on September 30, 2010, and the new PET was e-mailed to the plans during the second quarter of Demonstration Year Five. The health plans' Year Five benefit packages became effective January 1, 2011. This extension was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Five of the demonstration.

3. Grievance Process

Overview

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

As defined in the health plan contracts:

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

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

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

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

Current Activities

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

Plan-Reported Complaints

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

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

Table 7
Plan-Reported Complaints
July 1, 2010 – March 31, 2011

Quarter	PSN Complaints	HMO Complaints	HMO & PSN Enrollment*
July – September 2010	367	686	270,159
October – December 2010	1,059	930	296,166
January – March 2011	1,254	1,487	306,854
Total	**2,680**	**3,103**	**360,501**

*unduplicated enrollment count

Grievances & Appeals

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

Table 8 **Grievances and Appeals** January 1, 2011 – March 31, 2011					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
Total	44	33	87	111	306,854

*unduplicated enrollment count

During the second quarter of Demonstration Year Five, the number of grievances reported by PSNs and the HMOs increased from the previous quarter, but remain low relative to enrollment. The number of appeals dropped for the PSNs (from 36 in the second quarter to 33 in the third quarter of Year Five) and increased for the HMOs (from 100 in the second quarter to 111 in the third quarter of Year Five).

Medicaid Fair Hearings (MFHs)

Table 9 provides the number of MFHs requested during the third quarter of Demonstration Year Five. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members; however, the Agency monitors the Medicaid Fair Hearing process. Of the 14 MFH requests relating to demonstration participants, 13 were related to denial of benefits/services and one was related to denial of medication. Four cases were pending or continued as of the end of the quarter, one case was dismissed, four requests were withdrawn by the recipients, and five cases were abandoned by the recipients.

Table 9 **Medicaid Fair Hearing Requests** January 1, 2011 – March 31, 2011	
PSN	5
HMO	9

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level, as only two grievances were submitted to the SAP and none were submitted to the BAP during this quarter.

Table 10 located on the following page provides the number of requests to BAP and SAP for the quarter ending March 31, 2011. One request to the Subscriber Assistance

Program was withdrawn by the beneficiary. The other request resulted in a hearing, the final order from which is pending.

Table 10 BAP and SAP Requests January 1, 2011 – March 31, 2011	
BAP	0
SAP	2

4. Complaint/Issue Resolution Process

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

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

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

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

During this quarter, the Agency received 25 complaints/issues related to PSNs and received 45 complaints/issues related to HMOs, for a total of 70 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO) of this report. Attachment I provides the details on the complaints/issues related to PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues

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

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

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

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

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

5. On-Site Surveys & Desk Reviews

During this quarter, the Agency did not conduct any medical on-site surveys of the Medicaid HMOs and PSNs. All reviews for the 2010/2011 contract year have been completed. Health plan reviews for the 2011/2012 contract year will be initiated April 2011.

The Agency conducted six targeted on-site surveys of the health plans this quarter. The surveys targeted the health plan's behavioral health services. Specifically, the Agency reviewed the health plan's behavioral health policies and procedures, behavioral health provider networks, relationships between the contracted managed behavioral health organizations (MBHOs) and the health plans, as well as reviewing the contracted MBHO policies.

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

The Agency's External Quality Review Organization (EQRO) vendor made refinements to the contract review tool based on the recommendations of the medical unit's reviews of the preceding year. The tool will be utilized in on-site surveys beginning April 2011.

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

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

B. Choice Counseling Program

Overview

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

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

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

- New outreach flyer implemented and distributed to beneficiaries providing information on Choice Counseling in general, how to reach a Choice Counselor by phone or in the community, and how Choice Counselors can help, as well as providing an overview of the Enhanced Benefits Account Program.

Current Activities

1. Choice Selection Tools

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

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

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

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

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

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

Enrollment

Choice Tools : PCP | Preferred Drug List | Specialist | Hospital

Select a plan :

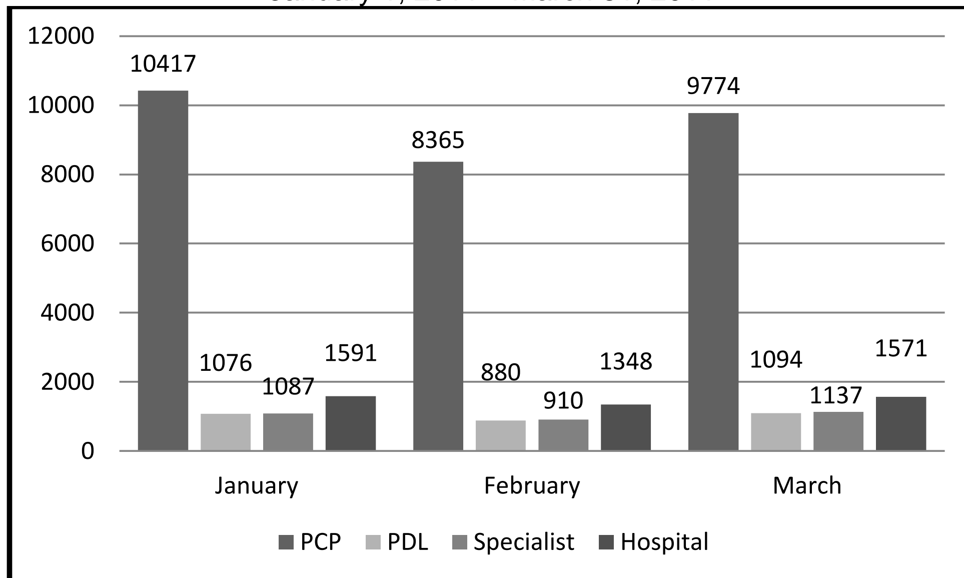
		Reset	Reset	Reset	Reset	Health Plan Name	Type
C						Better Health, LLC	PSN
						South Florida Community Care Network (MHS)	PSN
						Medica Health Plans	HMO
						Universal Health Care	HMO
P						Molina Healthcare	HMO
						Sunshine State Health	HMO
						South Florida Community Care Network (NBH...	PSN
						Freedom Health	HMO
						Positive Healthcare Florida	HMO

Effective Date: 11/01/2010
Members:

Change Reason: No Reason Given

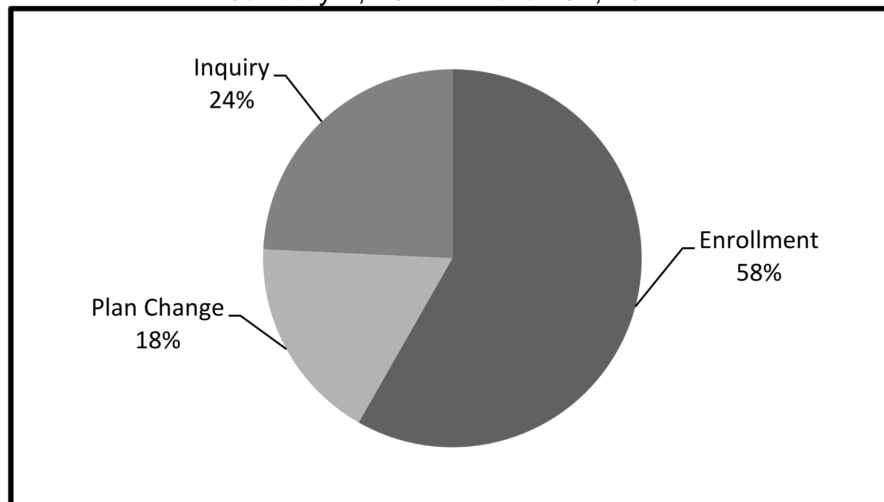
Chart A represents the number of times each Choice Selection Tool was utilized during the enrollment or plan change process for this quarter. The results are broken out by choice tool type.

Chart A
Choice Tool Use by Type
January 1, 2011 – March 31, 2011



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

Chart B
Navigator Use by Call Type
January 1, 2011 – March 31, 2011



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 has a set day of the week when the Choice Counselors offer the survey to callers. This helps to reach the goal of at least 400 completed surveys each month. During this quarter, a total of 1,925 beneficiaries completed the automated survey.

The Customer Survey ratings consider 100 percent to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. One hundred percent, or a score of 9, reflect a truly satisfied caller. Table 12 translates the scoring range into the following percentages:

Table 12
Choice Counseling Survey Rating Scale

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

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

Table 13 located on the following page 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 – 729, February – 566, and March – 630 (totaling 1,925).

The top three survey categories for this quarter were: “Being treated respectfully,” “Ability to explain clearly,” and “Quickly understood reason.” The three lowest scoring survey categories were: “Ease of understanding information,” “How helpful do you find this counseling to be,” and “Amount of time you waited.”

Table 13 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
January 2011	*February 2011*	*March 2011*
How helpful do you find this counseling to be		
90%	91%	89%
Amount of time you waited		
88%	91%	90%
Ease of understanding information		
78%	80%	78%
Likelihood to recommend		
94%	96%	95%
Overall service provided by Counselor		
95%	98%	96%
Quickly understood reason		
97%	98%	97%
Ability to help choose plan		
95%	96%	96%
Ability to explain clearly		
97%	98%	97%
Confidence in the information		
96%	97%	95%
Being treated respectfully		
98%	99%	98%

2. Call Center

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

The Choice Counseling Call Center received 57,166 calls during this quarter. This represents approximately a 12 percent increase in call volume from the previous quarter. The increase is reflective of a return to normal call volumes after the holiday seasons.

Outbound calls increased significantly during this quarter, compared to the same quarter for Year Four of the demonstration. This is primarily due to increased staffing provided by the current vendor, which has improved the inbound call handling efficiency, allowing for a more active outbound calling campaign to reach beneficiaries who might otherwise not contact the Call Center for assistance. In addition, the Agency continues to work on strengthening the various methods used to inform beneficiaries of their health plan choices and options to enroll in the plan that best meets their needs.

Since the transition to the new Choice Counseling Vendor on June 18, 2010, the Agency has:

- Revised the new-eligible packet, open enrollment packet and auto-assignment letter;
- Implemented the online enrollment application;
- Implemented the Choice Selection Tools; and
- Implemented the National Change of Address database.

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

Table 14
Comparison of Call Volume for Third Quarter
(Demonstration Year Four & Year Five)

Type of Calls	Jan 2010	Jan 2011	Feb 2010	Feb 2011	Mar 2010	Mar 2011	Year 4 3rd Quarter Totals	Year 5 3rd Quarter Totals
Incoming Calls	16,447	20,669	18,766	16,507	23,227	19,990	**58,440**	**57,166**
Outgoing Calls	1,922	8,655	2,957	8,346	3,289	9,170	**8,168**	**26,171**
Totals	18,369	29,324	21,723	24,853	26,516	29,160	**66,608**	**83,337**

3. Mail

Outbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 24,823
- Confirmation Letters 27,638
- Open Enrollment Packets 61,099
- Transition Packets (mandatory and voluntary) 2,401
- Plan Transfer Letters (mandatory and voluntary) 0

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

The amount of returned mail for this quarter, 6.4 percent, is slightly above the estimated 3-5 percent contract standard. The Agency is currently working with the vendor to determine the cause.

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

Inbound Mail

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

- Plan Enrollments 638
- Plan Changes 29

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

The Online Enrollment Application was implemented on September 1, 2010. Since implementation, 2,806 enrollments and 484 plan changes have been processed through the Online Enrollment Application. The Agency is working to increase beneficiary awareness of online access and expects the number of enrollments to increase. The Agency is also reviewing the enrollment form to evaluate whether the mail-in enrollment option will be maintained.

4. Face-to-Face/Outreach and Education

The Field Choice Counseling Outreach Team enhanced the group session conducted this quarter by making additional Field Choice Counselors available after the session to assist beneficiaries in plan choices and, if needed, providing the option for a beneficiary to meet with a Choice Counselor one-on-one at the beneficiary's convenience. Table 15 provides the Choice Counseling Field activities during this quarter:

Table 15
Choice Counseling Outreach Activities

Field Activities	3rd Quarter – Year 5
Group Sessions	393
Private Sessions	34
Home Visits & One-On-One Sessions	31
No Phone List	1,129
Outbound Phone List	12,473
Enrollments	8,628
Plan Changes	950

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

The Mental Health Unit

The Mental Health Unit was created to provide more direct support to beneficiaries who access mental health services. The ongoing initiatives and efforts to build relationships with the organizations that serve these individuals continue to yield positive results.

During this quarter, the Mental Health Unit focused on strengthening current community partnerships with a number of behavioral health organizations in all five demonstration counties and developing new relationships within the Medicaid communities by increasing Private Sessions with beneficiaries. As a result, several positive developments occurred during this quarter including:

- Establishment of new community partnerships with River House in Duval County and House of Hope in Broward County.
- Participation in three health fairs in March 2011 that provided excellent networking opportunities for staff to meet other organizations serving Medicaid recipients.
- Completion of 34 Private Sessions, with 147 attendees (Medicaid beneficiaries).
- A new tri-fold flyer was created in late December and approved by the Agency for distribution during this quarter. The flyer provides information on Choice Counseling in general, how to reach a Choice Counselor by phone or in the community, and how they can help, as well as providing an overview of the Enhanced Benefits Account Program.
- As of the end of this quarter, 1,085 flyers have been distributed out of 21 display cases located within partner sites.

The Mental Health Unit continues to expand its efforts by promoting community partnerships and taking lead on event planning. To date, over 120 organizations have been identified and a contact attempt was made by a Field Choice Counselor. As a result, the Mental Health Unit has established several key relationships and developed strong working partnerships including several large organizations:

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

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

5. Health Literacy

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

Summary of cases taken by the Special Needs Unit

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

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

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

Table 16
Number of Referrals and Case Reviews Completed
January 1, 2011 – March 31, 2011

	January	February	March
Case Referrals	61	109	67
Case Reviews	120	208	143

The Special Needs Unit staff scope of work includes:

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

In February of this quarter, the Special Needs Unit began developing an information flyer to be placed in the enrollment packet mailers to inform enrollees of medical related issues that are pertinent to their continuity of care. A projected date of implementation has not been set by the Agency at this time.

6. New Eligible Self-Selection Data[3]

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

From January 2011 to March 2011, 71 percent of beneficiaries enrolled in the demonstration self-selected a health plan and 29 percent were auto-assigned. On average, the self-selection rate was 80 percent prior to July 2008, compared to the 69 percent that was reported for the period of July 2010 to March 2011. The change in the voluntary selection rate may be attributable to several factors including:

- Change in the Choice Counseling Welcome Packet, which may have resulted in beneficiaries not calling to verify the preselected health plan as beneficiaries are not required to do so. A description of the change in the Welcome Packet that was implemented during the fourth quarter of Year Four is provided below.
    - Prior to June 18, 2010, beneficiaries received a packet of written materials (the Choice Counseling Welcome Packet) welcoming them to Medicaid, advising them of the need to select a plan by a specified date, and a brochure of covered services and available plans. In follow-up to the Welcome Packet, beneficiaries were sent a (pending auto-assignment) letter. This letter notified beneficiaries, who had not yet voluntarily selected a plan, that they would be automatically enrolled in a health plan (plan name was specified in the letter) unless they voluntarily select a plan by the specified date.
    - Beginning June 18, 2010, beneficiaries receive a Choice Counseling Welcome Packet welcoming them to Medicaid, advising them of the need to select a health plan, the deadline for selecting a plan, and the name of the plan they will be assigned to if a self-selection is not made by the specified date. If the beneficiary is satisfied with the plan assignment provided in the Choice Counseling Welcome Packet, then the beneficiary does not need to take any action to select a plan. Should the beneficiary decide to select a different health plan, then they can refer to the brochure of covered services and available health plans that is also included in their Choice Counseling Welcome Packet.

[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.

Table 17 shows the current self-selection and auto-assignment rate for the current demonstration year.

Table 17 Self-Selection and Auto-Assignment Rate January 1, 2011 – March 31, 2011									
	July 2010	Aug 2010	Sept 2010	Oct 2010	Nov 2010	Dec 2010	Jan 2011	Feb 2011	Mar 2011
Self-Selected	8,588	8,756	8,652	11,914	9,532	7,337	12,597	11,306	10,418
Auto-Assignment	4,500	2,402	3,641	3,887	3,649	10,236	869	9,090	4,273
Total Enrollments	13,088	11,158	12,293	15,801	13,181	17,573	13,466	20,396	14,691
Self-Selected %	66%	78%	70%	75%	72%	42%	94%	55%	71%
Auto-Assignment	34%	22%	30%	25%	28%	58%	6%	45%	29%

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the Choice Counseling Call Center, Medicaid headquarters or the Medicaid Area Office. The Choice Counseling Vendor's automated beneficiary survey allows complaints about the Choice Counseling Program to be filed and voice comments can be recorded to describe what occurred on the call. There were no complaints received related to the Choice Counseling Program during the third quarter of Demonstration Year Five.

The primary contributing factor to the limited number of complaints is directly tied to the community presence the field choice counselors provide to resolve issues before they become a complaint.

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the Choice Counseling Vendor and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' satisfaction, with the overall service provided by the Choice Counselors, indicate that more than 98% are satisfied with the Choice Counseling experience during this quarter. Survey results also indicate that 97% are satisfied with the Choice Counselor's ability to clearly explain health plan choices and 98% felt they were treated respectfully. The Choice Counseling Vendor continues to focus on improving communication between the Choice Counselors and beneficiaries, as well as evaluating comments left by beneficiaries to improve customer service.

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

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

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

9. Summary

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

During this quarter, the Agency, AHS and HP made significant strides to resolve data transfer related discrepancy's and plan to have the remaining issues resolved by the next quarter.

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

C. Enrollment Data

Overview

In anticipation of Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population into the health plans located in the demonstration counties of Broward and Duval. The transition period for Broward and Duval lasted seven months, beginning in September of 2006 and ending in April of 2007. The plan staggered the enrollment of beneficiaries who were enrolled in various managed care programs (operated under Florida's 1915(b) Managed Care Waiver) into demonstration health plans. The types of managed care programs 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 Year One, enrollment in health plans was based on this transitional process. Specifically, the July 2006 transition period focused on enrollment of newly eligible beneficiaries as well as half of the MediPass population. Beneficiaries were given 30 days to select a plan. If the beneficiary did not choose a plan, the Choice Counselor assigned them to one. The earliest date of enrollment in a demonstration health plan was September 1, 2006. During the second, third, and fourth quarters of operation (Demonstration Year One), enrollment in the demonstration increased greatly as more existing Medicaid beneficiaries were transitioned into health plans.

The Agency also developed a transition plan for 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:

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[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.

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

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

Current Activities

Monthly Enrollment Reports

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

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

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning January 1, 2011, and ending March 31, 2011. 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 13 Medicaid Reform health plans – nine (9) HMOs and four (4) fee for service PSNs.

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 18 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 18
Medicaid Reform Enrollment Report Descriptions

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

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 19 located on the following page for State Fiscal Year 2010-11, Third Quarter Medicaid Reform Enrollment Report.

Table 19 Medicaid Reform Enrollment (Fiscal Year 2010-11, 3rd Quarter)										
Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share for Reform	Enrolled in Previous Quarter	% Increase from Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Care Florida	HMO	500	116	0	5	**621**	**0.20%**	81	666.67%
Freedom Health Plan	HMO	3,545	468	1	79	**4,093**	**1.33%**	3,790	7.99%
Humana	HMO	4,442	1,503	8	223	**6,176**	**2.01%**	6,934	-10.93%
Medica	HMO	2,645	522	0	78	**3,245**	**1.06%**	2,728	18.95%
Molina Healthcare	HMO	24,010	3,731	7	529	**28,277**	**9.22%**	26,261	7.68%
Positive Healthcare	HMO	7	76	0	4	**87**	**0.03%**	81	7.41%
Sunshine	HMO	86,699	8,230	15	879	**95,823**	**31.23%**	102,429	-6.45%
United Healthcare	HMO	8,640	1018	2	88	**9,748**	**3.18%**	8,170	19.31%
Universal Health Care	HMO	17,027	2,378	9	345	**19,759**	**6.44%**	18,632	6.05%
HMO Total	**HMO**	**147,515**	**18,042**	**42**	**2,230**	**167,829**	**54.69%**	**169,025**	-0.71%
Better Health, LLC	PSN	29,031	4,019	15	635	**33,700**	**10.98%**	33,795	-0.28%
CMS	PSN	4,439	3,451	0	24	**7,914**	**2.58%**	7,565	4.61%
First Coast Advantage	PSN	50,845	7,376	3	1038	**59,262**	**19.31%**	50,073	18.35%
SFCCN	PSN	33,411	4,133	7	598	**38,149**	**12.43%**	35,708	6.84%
PSN Total	**PSN**	**117,726**	**18,979**	**25**	**2,295**	**139,025**	**45.31%**	**127,141**	9.35%
Reform Enrollment Totals		**265,241**	**37,021**	**67**	**4,525**	**306,854**	**100.00%**	**296,166**	**3.61%**

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 306,854 beneficiaries enrolled in the demonstration during this quarter. There were 13 demonstration health plans with market shares ranging from 0.03 percent to 31.23 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 20 located on the following page.

Table 20 Number of Reform Health Plans in Demonstration Counties (Fiscal Year 2010-11, 3rd Quarter)		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**1**	**1**
Broward	**8**	**3**
Clay	**2**	**1**
Duval	**3**	**2**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. 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 21 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 21 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as in Table 22 located on the following page.

Table 22 Medicaid Reform Enrollment by County Report (Fiscal Year 2010-11, 3rd Quarter)									
Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Previous Quarter	% Increase From Previous Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Sunshine	HMO		-	-	-	-	-	2,697	
United Healthcare	HMO	937	115	-	7	1,059	31.10%	659	60.70%
First Coast Advantage	PSN	2,123	217	-	6	2,346	68.90%	69	3300.00%
Total Reform: Baker		**3,060**	**332**	**-**	**13**	**3,405**	**100.00%**	**3,425**	**-0.58%**
Freedom Health Plan	HMO	3,545	468	1	79	4,093	2.41%	3,790	7.99%
Humana	HMO	4,442	1,503	8	223	6,176	3.64%	6,934	-10.93%
Medica	HMO	2,645	522	0	78	3,245	1.91%	2,728	18.95%
Molina Healthcare	HMO	24,010	3,731	7	529	28,277	16.68%	26,261	7.68%
Positive Healthcare	HMO	7	76	0	4	87	0.05%	81	7.41%
Care Florida	HMO	500	116	0	5	621	0.37%		
Sunshine	HMO	34,887	2,905	5	256	38,053	22.44%	36,710	3.66%
Universal Health Care	HMO	10,204	1,538	6	238	11,986	7.07%	11,683	2.59%
Better Health, LLC	PSN	29,031	4,019	15	635	33,700	19.88%	33,795	-0.28%
CMS	PSN	2,859	2,291	0	15	5,165	3.05%	4,857	6.34%
SFCCN	PSN	33,411	4,133	7	598	38,149	22.50%	35,708	6.84%
Total Reform: Broward		**145,541**	**21,302**	**49**	**2,660**	**169,552**	**100.00%**	**162,547**	**4.31%**
Sunshine	HMO	8,832	770	1	70	9,673	64.25%	9,956	-2.84%
United Healthcare	HMO	3,776	261	1	20	4,058	26.95%	3,455	17.45%
First Coast Advantage	PSN	1207	115	0	2	1,324	8.79%	47	2717.02%
Total Reform: Clay		**13,815**	**1,146**	**2**	**92**	**15,055**	**100.00%**	**13,458**	**11.87%**
Sunshine	HMO	42,980	4,555	9	553	48,097	42.58%	48,374	-0.57%
United Healthcare	HMO	2,015	452	1	33	2,501	2.21%	2,821	-11.34%
Universal Health Care	HMO	6,823	840	3	107	7,773	6.88%	6,949	11.86%
CMS	PSN	1,580	1,160	0	9	2,749	2.43%	2,708	1.51%
First Coast Advantage	PSN	44,119	6,694	3	1021	51,837	45.89%	49,876	3.93%
Total Reform: Duval		**97,517**	**13,701**	**16**	**1,723**	**112,957**	**100.00%**	**110,728**	**2.01%**
Sunshine	HMO	-	-	-	-	-	-	4,692	
United Healthcare	HMO	1,912	190	-	28	2,130	36.19%	1,235	72.47%
First Coast Advantage	PSN	3,396	350	-	9	3,755	63.81%	81	4535.80%
Total Reform: Nassau		**5,308**	**540**	**-**	**37**	**5,885**	**100.00%**	**6,008**	**-2.05%**
Reform Enrollment Totals		**265,241**	**37,021**	**67**	**4,525**	**306,854**		**296,166**	**3.61%**

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

During this quarter, there was an enrollment of 3,405 beneficiaries in Baker County, 169,552 beneficiaries in Broward County, 15,055 beneficiaries in Clay County, 112,957 beneficiaries in Duval County, and 5,885 beneficiaries in Nassau County. There were two Baker County health plans with market shares ranging from 31.1 percent to 68.9 percent, 11 Broward County health plans with market shares ranging from 0.05 percent to 22.5 percent, three Clay County health plans with market shares ranging from 8.79 percent to 64.25 percent, five Duval County health plans with market shares ranging from 2.21 percent to 45.89 percent, and two Nassau County health plans with market shares ranging from 36.19 percent to 63.81 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 23 and 24 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those beneficiaries who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 23 provides a description of each column in this report.

Table 23
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 24 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 24
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2010-11, 3rd Quarter)

Plan Name	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
		Foster, Adoption Subsidy, and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
		New	Existing	New	Existing	New	Existing	Number	Percentage	
CareFlorida	Broward	1	-	-	-	5	-	**6**	**0.97%**	**621**
Freedom Health Plan	Broward	1	30	-	5	3	77	**116**	**2.83%**	**4,093**
Humana	Broward	-	35	-	27	-	231	**293**	**4.74%**	**6,176**
Medica	Broward	8	8	1	4	6	72	**99**	**3.05%**	**3,245**
Molina Healthcare	Broward	16	177	4	46	46	490	**779**	**2.75%**	**28277**
Positive Healthcare	Broward	-	-	-	-	-	4	**4**	**4.60%**	**87**
Sunshine	Broward	13	197	-	27	18	243	**498**	**1.31%**	**38,053**
Sunshine	Clay	1	97	-	9	6	65	**178**	**1.84%**	**9,673**
Sunshine	Duval	18	520	1	71	16	546	**1,172**	**2.44%**	**48,097**
United Healthcare	Baker	-	4	-	2	-	7	**13**	**1.23%**	**1059**
United Healthcare	Clay	1	35	-	3	3	18	**60**	**1.48%**	**4,058**
United Healthcare	Duval	-	66	-	12	-	34	**112**	**4.48%**	**2,501**
United Healthcare	Nassau	4	21	-	7	1	27	**60**	**2.82%**	**2,130**
Universal Health Care	Broward	10	84	-	9	13	231	**347**	**2.90%**	**11,986**
Universal Health Care	Duval	14	72	-	3	11	99	**199**	**2.56%**	**7,773**
HMO Total		**87**	**1,346**	**6**	**225**	**128**	**2,144**	**3,936**	**2.35%**	**167,829**
Better Health, LLC	Broward	12	233	4	60	15	635	**959**	**2.85%**	**33,700**
CMS	Broward	-	58	8	204	-	15	**285**	**5.52%**	**5,165**
CMS	Duval	4	80	6	101	3	6	**200**	**7.28%**	**2,749**
First Coast Advantage	Baker	5	9	-	1	-	6	**21**	**0.90%**	**2346**
First Coast Advantage	Clay	5	-	1	-	1	1	**8**	**0.60%**	**1324**
First Coast Advantage	Duval	48	623	3	141	35	989	**1,839**	**3.55%**	**51,837**
First Coast Advantage	Nassau	3	7	-	1	1	8	**20**	**0.53%**	**3755**
SFCCN	Broward	24	438	1	66	26	579	**1,134**	**2.97%**	**38,149**
PSN Total		**101**	**1,448**	**23**	**574**	**81**	**2,239**	**4,466**	**3.21%**	**139,025**
Reform Enrollment Totals		**188**	**2,794**	**29**	**799**	**209**	**4,383**	**8,402**	**2.74%**	**306,854**

D. Opt Out Program

Overview

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

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

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

Description of Opt Out Process

Medicaid beneficiaries interested in the Opt Out Program are either referred to the current vendor by the Choice Counseling Program or the beneficiary contacts the vendor directly. The beneficiary is provided the toll-free number for the Opt Out Program so he or she may follow-up directly with the vendor if preferred. A new Referral form requesting employer information is completed over the phone with an Opt Out specialist or is sent to the beneficiary for completion. A release form is also sent to the beneficiary, giving the vendor permission to contact 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? What is the insurance company? What is the premium amount and frequency? When is the open enrollment period?

After the required information from the employer is received, the Opt Out specialist follows-up with the beneficiary to discuss the insurance that is available through 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 problems were identified during this quarter that required the Agency to make any changes to the process.

Opt Out Program Statistics

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

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

Table 25 located on the following page provides the Opt Out Program statistics for each enrollment in the program beginning September 1, 2006, and ending March 31, 2011.

Table 25 Opt Out Statistics September 1, 2006 – March 31, 2011						
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 02/28/11	Loss of Medicaid Eligibility
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
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/10	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	02/28/10	Loss of Medicaid Eligibility
C & F	12/01/08	Large Employer	Family	5	01/19/10	Disenrolled from Commercial Insurance
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	2 1	06/30/09 01/27/10	Loss of Medicaid Eligibility Disenrolled from Commercial Insurance
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	02/28/11	Loss of Medicaid Eligibility
C & F	07/01/09	Small Employer	Individual	1	05/31/10	Loss of Medicaid Eligibility
C & F	07/01/09	Large Employer	Family	1	10/31/10	Disenrolled from Commercial Insurance
C & F	08/01/09	Small Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	11/30/10	Loss of Medicaid Eligibility
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Small Employer	Family	1	08/31/10	Loss of Medicaid Eligibility
C & F	09/01/09	Large Employer	Family	3	12/31/09	Loss of Medicaid Eligibility
SSI	01/01/10	Large Employer	Family	1	Still Enrolled	N/A
C & F	04/01/10	Large Employer	Family	3	Still Enrolled	N/A
C & F	05/01/10	Large Employer	Family	2	03/31/11	Loss of Medicaid Eligibility
C & F	06/01/10	Large Employer	Family	1	06/01/10	Never enrolled child in Commercial Insurance
C & F	07/01/10	Large Employer	Family	2	Still Enrolled	N/A
SSI	09/01/10	Large Employer	Individual	1	12/31/10	Disenrolled from Commercial Insurance
C & F	11/01/10	Large Employer	Family	5	Still Enrolled	N/A
C & F	02/01/11	Large Employer	Family	2	Still Enrolled	N/A
C & F	02/01/11	Large Employer	Family	2	Still Enrolled	N/A
C & F	02/01/11	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 the demonstration is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid beneficiaries who enroll in a health plan are eligible for the EBAP. No separate application or process is required to enroll in EBAP.

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

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

Current Activities

1. Call Center Activities

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

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

Table 26 highlights the Enhanced Benefits Call Center activities during this quarter.

Table 26 Highlights of the Enhanced Benefits Call Center Activities January 1, 2011 – March 31, 2011			
Enhanced Benefits Call Center Activity	**January**	**February**	**March**
Calls Received	5,399	3,951	5,076
Calls Answered	5,351	3,936	5,035
Abandonment Rate	0.89%	0.38%	0.81%
Average Talk Time (minutes)	4:12	4:15	4:02
Calls Handled by the AVRS	7,353	4,566	5,853
Outbound Calls	116	782	1,181
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	5,898	5,079	6,882

2. System Activities

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the tenth day of each month. The EBIS continues to operate effectively and efficiently in processing the enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each beneficiary who has activity for the month. The Agency has not generated a separate statement that is sent at least once per year for beneficiaries who have a balance with no new activity. The Agency is currently working to update addresses of the beneficiaries who no longer have address updates due to non-enrollment in a reform health plan.

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

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during this quarter. There were 137,924 coupon statements mailed to beneficiaries during this quarter. Along with the beneficiary coupon statements, a flyer and pharmacy billing instructions were included with the statement. The Choice Counselors continue to provide up-to-date information for beneficiaries regarding their Enhanced Benefits Account balances and the opportunity to earn healthy behavior credits. During this quarter, the Choice Counseling Vendor continues to call beneficiaries’ who have never utilized their Enhanced Benefits Account balance. The number of outbound calls made during the quarter is listed above in Table 26.

4. Outreach and Education for Pharmacies

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

5. Enhanced Benefits Advisory Panel

An Enhanced Benefits Advisory Panel meeting was held this quarter, on February 11, 2011. The Enhanced Benefits charter was approved which reflects a two-year rotation of member appointments and the addition of an HMO and PSN representative on the Panel. The next Panel meeting is scheduled for May 20, 2011.

6. Enhanced Benefits Statistics

As of the end of this quarter, 12,406 beneficiaries lost EBA eligibility for a total of $559,764.19 and they no longer have access to those credits. The Agency observed significant changes in the table below related to "Total dollar amount of credits used each month by date of service" and "Total unduplicated number of enrollees who used credits each month", compared to the previous quarter. At this time, the Agency is reviewing data to determine the cause of the decrease.

Table 27 provides the Enhanced Benefits Account Program statistics for this quarter.

Table 27
Enhanced Benefits Account Program Statistics

Third Quarter Activities – Year Five		January 2011	February 2011	March 2011
I.	Number of plans submitting reports by month in each county[5]	29	29	25
II.	Number of enrollees who received credit for healthy behaviors by month	39,033	34,902	41,371
III.	Total dollar amount credited to accounts by each month	$853,452.50	$780,087.50	$903,880.00
IV.	Total cumulative dollar amount credited through the end each month	$36,849,378.66	$37,629,466.16	$38,533,346.16
V.	Total dollar amount of credits used each month by date of service	$383,488.08	$383,253.87	$473,680.06
VI.	Total cumulative dollar amount of credits used through the month by date of service	$19,212,272.10	$19,595,525.90	$20,069,206.00
VII.	Total unduplicated number of enrollees who used credits each month	16,520	15,510	18,509

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

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 18,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and there were only two complaints recorded through the Call Center relating to the EBAP. The decrease in complaints is attributed to improved Call Center staff training and direct problem resolution through the EB Call Center lead and the Agency EB staff person. Table 28 provides a summary of the complaints received during this quarter and outlines the actions taken by the Enhanced Benefits Call Center, the Agency, or HP (through Magellan) to address the issues raised.

Table 28
Enhanced Benefits Beneficiary Complaints
January 1, 2011 – March 31, 2011

Beneficiary Complaint	Action Taken
1. Two beneficiaries reported the health plan did not report a healthy behavior to the Agency.	➲ The Agency contacted the health plans regarding the healthy behaviors not reported to the Agency. In most cases, the health plan will submit the behaviors in their next report submission. In a few cases, some beneficiaries had reached occurrence limits on some of the healthy behaviors; therefore, credit would not have been credited to the beneficiary account.

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

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

Current Activities

<u>January 19, 2011, Low Income Pool Council Meeting</u>

On January 19, 2011, a LIP Council meeting was held at the Agency for Health Care Administration (Agency) located in Tallahassee, Florida.

Facility Cost Limit Detail

The Agency provided an update to the LIP Council on LIP cost limits. A copy of State Fiscal Year (SFY) 2008-09 hospital cost limits was provided to the LIP Council for review. The Agency cautioned the LIP Council that the cost limit calculations for SFY 2006-07, 2007-08, and 2008-09 were made using historical data. SFY 2009-10 and 2010-11 cost limits will be calculated using cost reports from the time period the payments were received. The Agency further explained that the cost limit calculation methodology has been updated and is available to all providers on the Agency's LIP website at:

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

A question arose from the LIP Council concerning Low Income Pool cost limits. The Agency reminded the LIP Council that the Agency had to renegotiate the LIP cost limit with Federal CMS as part of the STC #105. The new LIP Cost limit is more detailed than the cost limit that was in place for the first three years of the demonstration waiver. The updated cost limit has new definitions that apply, as well as going from a hospital-wide cost to charge ratio, to a departmental cost and to charge ratio. The updated methodology can be found on the Agency's LIP web site at:

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

The Agency let the LIP Council know that one difference between the LIP and UPL limit is the fact that uninsured and underinsured cost are included with the LIP cost limit and the UPL limit is restricted to Medicaid cost.

1115 Medicaid Reform Waiver

The Agency provided an update on the status of the pending 1115 waiver extension request. The Agency stated we are having an on-going dialog with Federal CMS and providing data and answering questions as requested. The Agency reminded the LIP Council members and those listening in the audience that the waiver extension request is being reviewed by Federal CMS under Section 1115(a) waiver authority and not 1115(e) waiver authority, as the Agency originally requested. This means that Federal CMS may make changes to the demonstration, such as, amend the current waiver authorities. A clarification and explanation including a timeline of the waiver extension process was provided. The Agency informed the LIP Council of a general discussion with Federal CMS regarding hospital inpatient and outpatient UPL requirements as a starting point for the LIP funding negotiations.

Model Presentations

Various LIP Council members provided presentations on the LIP models being considered for inclusion in the LIP recommendations due to the Florida Legislature and Governor on February 1, 2011. The LIP models are proposals of how to distribute LIP funds for the upcoming year assuming the 1115 waiver extension request is approved. Copies of these various models can be found on the Agency's LIP website at:

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

January 24, 2011, Low Income Pool Council Meeting

On January 24, 2011, a LIP Council meeting was held at the Agency in Tallahassee, Florida.

A motion was made by the LIP Council members that instructed the Agency to see what is needed for them to seek greater than $1 billion per year LIP funding as part of the 1115 waiver extension request, or explore other means to maximize federal funding in Florida for treatment of low income individuals.

Discussion of Model Parameters

LIP Council members provided presentations on various LIP models under consideration for inclusion in the LIP recommendations due to the Florida Legislature and Governor on February 1, 2011. The LIP Council concluded that the remaining two models, Model 14D and Model 10A, are to be discussed and voted on at the January 27, 2011, LIP council meeting.

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

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

January 27, 2011, Low Income Pool Council Meeting

On January 27, 2011, a LIP Council meeting was held at the Agency in Tallahassee, Florida, with most Council members participating via conference call.

Model Discussion and Voting

There was extensive discussion among members of the two final models, the positives and negatives of the models, and member preferences.

After comments came to an end, the Chairman of the LIP Council asked how the Council would prefer to vote. An agreement was reached and each LIP Council member voted by voice for their preferred model.

The LIP Council recommendation on the approved funding model for SFY 2011-12 was not a unanimous decision. In adopting the final model for recommendation to the Agency, the Governor, and the Legislature, the LIP Council vote on January 27, 2011, was as follows:

- 18 votes in favor of the adopted model, Model 14D,
- 3 votes for an alternative model, Model 10A,
- 1 member who did not vote for or against either model,
- 1 absent LIP Council member, and
- 1 non-voting Agency representative serving as Chair.

Model 14D was selected by majority vote as the adopted model. As part of the wrap-up of the LIP Council's deliberations, the LIP Council made a motion regarding primary care funding within the Low Income Pool. In recognition of the recommendations from Governor Scott's Transition Team specific to reducing the primary care responsibilities of county health departments, and in recognition of the primary care funding needs in the state, the LIP Council unanimously agreed to the inclusion of the following recommendation in its report:

Should the decision be made by the Legislature to decrease the County Health Department primary care functions, those primary care funds within the LIP program that are currently allocated through the Department of Health should be reallocated through the LIP program to other primary care provider entities such as federally qualified health centers and those hospitals operating primary care programs.

LIP Council Report for SFY 2010-11 with Recommendations for SFY 2011-12

On February 1, 2011, the Agency submitted to the Governor and Legislature the *Low Income Pool Council Report for State Fiscal Year 2010-11 with Recommendations for State Fiscal Year 2011-12.* The report includes the following:

LIP Council Activities

The LIP Council held nine public meetings during SFY 2010-11 for the purpose of developing its recommendations and monitoring the implementation of the SFY 2010-11 programs. During these meetings, the LIP Council reviewed current funding and distributions for SFY 2010-11, received updates on the 1115 waiver renewal process, discussed STCs and related LIP reporting requirements (See Attachment B of the report), and reviewed various funding models and requests for SFY 2011-12.

Fourteen different funding models and variations of some of those models were reviewed and considered. Each LIP Council member was given the opportunity to propose funding models, and staff of the Agency prepared each of the models after consulting with the member proposing the model. Additionally, the LIP Council received status reports on currently-funded Department of Health and Federally Qualified Health Center (FQHC) projects, as well as status updates on premium assistance programs implemented in Miami-Dade County and the Health Care District of Palm Beach County.

In developing its recommendations for SFY 2011-12, the LIP Council faced a series of challenges which will likely carry forward to the legislative considerations regarding LIP funding allocations. These included:

- Declining state revenues and state matching funds and the resulting consideration of cuts to Medicaid reimbursement rates for hospitals and Medicaid funding in general.
- The phase down of the enhanced Federal Medical Assistance Percentage (FMAP) as initially authorized via the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) for the stimulus recovery period spanning October 2008 through December 2010, and the decreasing levels of federal funding available for January –

March 2011 and April – June 2011. This results in a return to the "regular" FMAP beginning with SFY 2011-12.

- Increased demand for non-federal funding: Given the changes in the FMAP, there is increased demand on non-federal funding needed to maximize the funding available for LIP and LIP related programs for SFY 2011-12. Given the State's current economic climate, a request for increased state General Revenue funds is not feasible. This places increased demands on local government funding sources. While the model adopted by the LIP Council for its SFY 2011-12 recommendations assumes that the currently participating 28 local governments can meet the increased need via their voluntary contributions of Internal Governmental Transfers (IGTs), there is no assurance that this is the case.
- Given the several State Fiscal Years which were impacted by the stimulus-enhanced FMAP (SFYs 2008-09, 2009-10, and 2010-11), there were differences in philosophy among LIP Council members as to what data to use as a "base" calculation for SFY 2011-12 distribution of LIP funds. The LIP Council decided to leave this issue up to each LIP Council member that requested a distribution model for consideration for SFY 2011-12.
- Status of the 1115 waiver extension request: The uncertainty of approval by Federal CMS of the requested extension to the 1115 waiver, the level of LIP funding included in an extension, and what the resulting changes might be to the Special Terms and Conditions included in an extension. For purposes of the SFY 2011-12 recommendations, the LIP Council assumed continuation of a LIP funding level of $1 billion per year.

Summary of Overall Recommendations

The LIP Council recommends continued full utilization of the federally authorized funding level of $1 billion for SFY 2011-12. Detailed schedules which show the distributions and calculations by Provider Access Systems are included in the report as Attachment C. For the programs related to LIP, the LIP Council recommends: maximize funding through the DSH Program at $260 million; continue the Exemptions Program under current policy and statutory guidelines at a level of $610.5 million (which includes $9.9 million for liver transplants); and provide the "buy-back" program with a funding level of $149.8 million. In order to accomplish this level of funding, an appropriation of $15.9 million in state General Revenue (GR) is continued and an increase of $117.1 million of local IGTs is proposed. A detailed description of each LIP component is presented in sections of the report.

Table 29 located on the following page is a brief financial summary by component (in millions) of the LIP Council's recommendations for SFY 2011-12 compared to SFY 2010-11 appropriations as modified by the Florida Legislative Budget Commission (LBC):

Table 29 **Comparison Summary of LIP Council Recommendations** for SFY 2011-12 & SFY 2010-11 Appropriations as Modified by the Florida LBC		
	Modified Appropriation SFY 2010-11	**LIP Council Recommendations SFY 2011-12**
Low Income Pool:		
LIP Hospital	$765.30	$848.00
Special LIP	138.50	96.00
LIP Non-Hospital	96.40	56.30
Total LIP	**$1,000.30**	**$1,000.30**
Related Programs:		
Disproportionate Share Hospital	$264.30	$260.00
Exemptions	714.00	610.50
Medicaid “Buy-Back” Program	158.40	149.80
Total LIP Related	$1,136.70	$1,020.30
Total LIP & Related Programs	**$2,137.00**	**$2,020.60**

The LIP Council reviewed several options and approaches for consideration of LIP funding at each LIP Council meeting. Models which utilized no additional state funds and maximized the use of local IGTs were considered. A summary of every model considered by the LIP Council is included in the report as Attachment D. Major LIP Council recommendations include a comprehensive proposal which:

- Fully allocates the $1 billion of the federally-approved LIP allocation authorized by the 1115 Medicaid Reform Waiver;
- Requests $15.9 million in continued state GR funding;
- Partially funds, via a tiered approach, the Exemption Program using SFY 2010-11 policy guidelines at a level of $610.5 million;
- Increases IGTs by $117.1 million to fully fund the recommended model;
- Uses a 10 percent Medicaid, charity, and bad debt threshold for general distributions; an 11 percent allocation factor; and a $2.4 million charity distribution pool for rural hospitals;
- Fully distributes available federally allotted DSH funding of $260 million;
- Continues the currently authorized self-exemption policy for public hospitals which can provide qualified IGTs and continues the same self-exemption policy to allow for the buy-back of the cost margin between the current exempt rate and 100 percent of Medicaid allowable costs for public hospitals; and
- Authorizes maximizing exemption and buy back authority for all qualifying hospital providers with access to qualified IGT matching funds.

Additional information regarding the LIP Council Recommendations, including detailed recommendations by program and distribution tables, can be found under the title *LIP*

Council Recommendations to Governor and Legislature for SFY 2011-12 on the Agency's LIP website at:

http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/LIP_Report_Feb_2011.pdf

STC #105 (d) and (e)

In compliance with Special Terms and Conditions #105.1 (d) and (e), on March 31, 2011, the Agency submitted the completed LIP reconciliations for all providers for Demonstration Year Three, and the LIP reconciliations for providers for Demonstration Year Four. In addition, the Agency has scheduled the LIP reconciliation submissions for Demonstration Year Four.

G. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved 1115 Medicaid Reform 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 1115 Medicaid Reform Waiver. Each of these groups is referred to as a MEG:

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

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

Explanation of Budget Neutrality

The Budget Neutrality for the 1115 Medicaid Reform Waiver is based on five closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method which is required for 1115 waivers. Using the templates provided by the Centers for Medicare and Medicaid Services, the historical expenditures and case-months are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five year trend for each MEG. This trend is then applied to the most recent year (fifth 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; and

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

All queries and work papers related to the quarterly reporting of waiver expenditures on the CMS 64 report are maintained by the Agency. In addition, all identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated and provided to the Agency’s Finance and Accounting unit which certifies

and submits the CMS 64 report. This check sum process allows the state to verify that no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

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

Definitions:

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

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. Without the adjustment of drug rebates, the quarterly expenditure reform totals match the corresponding quarterly CMS 64 Report submission, which details the amount that will be used in the monitoring process by the Centers for Medicare and Medicaid Services.

Current Activities

Budget Neutrality figures included in this report are for the second quarter of Demonstration Year Five (October 1, 2010 – December 31, 2010).

The third quarter (January 1, 2011 – March 31, 2011) budget neutrality information is not included in this report. The Agency is currently in the process of compiling the data for the CMS 64 report submission related to the individual waivers. The Agency has submitted the CMS 64 report in total; however, the Agency is currently in the process of separating the total expenditures into waivers where needed. The Agency has been in contact with representatives of Federal CMS regarding the delayed 64 report submission related to the individual waivers. It was determined that it would be

appropriate to hold the submission of the Budget Neutrality submission specific to the third quarter of Demonstration Year Five until the Agency has submitted the quarterly CMS 64 report related to the individual waivers for this same quarter. The Agency will continue to communicate with Federal CMS. The Agency will provide the Budget Neutrality submission for two quarters in the submission of the next quarterly report.

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

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 30 through 35), 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 30 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 30 PCCM Targets		
WOW PCCM	**MEG 1**	**MEG 2**
DY01	$ 948.79	$ 199.48
DY02	$ 1,024.69	$ 215.44
DY03	$ 1,106.67	$ 232.68
DY04	$ 1,195.20	$ 251.29
DY05	$ 1,290.82	$ 271.39

Tables 31 through 35 located on the following pages provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending December 31, 2010. Case months provided in the Tables 31 and 32 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 31 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
Q15 Total	847,324	$781,783,604	$141,815,963	$923,599,567	$1,090.02
Q16 Total	852,445	$811,240,631	$142,745,339	$953,985,969	$1,119.12
Q17 Total	868,873	$801,543,979	$150,327,146	$951,871,125	$1,095.52
October 2010	290,791	$178,740,566	$32,141,420	$210,881,986	$725.20
November 2010	292,081	$259,494,453	$49,145,534	$308,639,987	$1,056.69
December 2010	293,692	$385,127,339	$66,518,308	$451,645,646	$1,537.82
Q18 Total	876,564	$823,362,358	$147,720,232	$971,082,591	$1,107.83
MEG 1 Total	14,360,258	$12,780,261,373	$2,026,437,982	$14,806,699,354	$1,031.09

* 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 32 MEG 2 Statistics: Children and Families					
Quarter Actual MEG 2	Case months	MCW Reform Spend*	Reform Enrolled 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
Q15 Total	5,098,381	$773,609,163	$93,647,855	$867,257,018	$170.10
Q16 Total	5,203,143	$793,529,141	$90,471,922	$884,001,063	$169.90
Q17 Total	5,356,742	$766,604,001	$91,544,719	$858,148,719	$160.20
October 2010	1,821,814	$136,151,894	$13,264,711	$149,416,605	$82.02
November 2010	1,823,878	$269,927,226	$32,202,089	$302,129,316	$165.65
December 2010	1,824,704	$442,615,707	$53,974,674	$496,590,381	$272.15
Q18 Total	5,470,396	$848,694,828	$99,937,769	$948,632,597	$173.41
MEG 2 Total	77,879,294	$11,685,092,777	$1,227,251,778	$12,912,344,555	$165.80

* 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 33), compared to WOW of $948.79 (Table 30), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 33), compared to WOW of $199.48 (Table 30), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 (Table 33), compared to WOW of $1,024.69 (Table 30), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 33), compared to WOW of $215.44 (Table 30), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.81 (Table 33), compared to WOW of $1,106.67 (Table 30), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.94 (Table 33), compared to WOW of $232.68 (Table 30), which is 71.75% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,072.76 (Table 33), compared to WOW of $1,195.20 (Table 30), which is 89.76% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.57 (Table 33), compared to WOW of $251.29 (Table 30), which is 66.29% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,017.43 (Table 33), compared to WOW of $1,290.82 (Table 30), which is 78.82% of the target PCCM for MEG 1. MEG 2 has a PCCM of $164.83 (Table 33), compared to WOW of $271.39 (Table 30), which is 60.74% of the target PCCM for MEG 2.

Tables 33 and 34 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 34) 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 34 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 34) 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 34 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% 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 34) 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 34 is $309.25. Comparing the calculated weighted averages, the actual PCCM is 83.07% 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 34) is $387.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 34 is $296.87. Comparing the calculated weighted averages, the actual PCCM is 76.71% of the target PCCM.

For the first two quarters of Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 34) is $412.92. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 34 is $283.20. Comparing the calculated weighted averages, the actual PCCM is 68.58% of the target PCCM.

Table 33 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	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,937,390,598	$500,223,984	$3,437,614,582	$1,057.81
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(158,777,397)	
% of WOW PCCM MEG 1					95.59%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,572,053,758	$281,798,244	$2,853,852,002	$166.94
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,123,775,369)	
% of WOW PCCM MEG 2					71.75%

Table 33 Continued MEG 1 & 2 Annual Statistics					
DY04 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY04 Total	3,352,695	$3,049,920,605	$546,726,556	$3,596,647,161	$1,072.76
WOW DY4 Total	3,352,695			$4,007,141,064	$1,195.20
Difference				$(410,493,903)	
% of WOW PCCM MEG 1					89.76%
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 Total	19,964,506	$2,976,333,522	$349,138,348	$3,325,471,871	$166.57
WOW DY4 Total	19,964,506			$5,016,880,713	$251.29
Difference				$(1,691,408,842)	
% of WOW PCCM MEG 2					66.29%
DY05 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY05 Total	1,745,437	$1,506,203,156	$269,664,597	$1,775,867,753	$1,017.43
WOW DY5 Total	1,745,437			$2,253,044,988	$1,290.82
Difference				$(477,177,235)	
% of WOW PCCM MEG 1					78.82%
DY05 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY05 Total	10,827,138	$1,588,978,157	$195,664,010	$1,784,642,166	$164.83
WOW DY5 Total	10,827,138			$2,938,376,982	$271.39
Difference				$(1,153,734,815)	
% of WOW PCCM MEG 2					60.74%

Table 34 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	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	20,344,582	$5,509,444,356	$782,022,228	$6,291,466,584	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,552,766)	
% Of WOW					83.07%
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	23,317,201	$6,026,254,128	$895,864,904	$6,922,119,032	$296.87
WOW	23,317,201			$9,024,021,777	$387.01
Difference				$(2,101,902,745)	
% Of WOW					76.71%
DY 05	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	12,572,575	$3,095,181,313	$465,328,607	$3,560,509,920	$283.20
WOW	12,572,575			$5,191,421,970	$412.92
Difference				$(1,630,912,050)	
% Of WOW					68.58%

Table 35 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**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Total Paid	**$4,461,517,125**

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	$1,122,122,816	$1,000,000,000	112.21%
DY05	$463,462,276	$1,000,000,000	46.35%
Total MEG 3	$4,461,517,125	$5,000,000,000	89.23%

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

The expenditures for the first eighteen quarters for MEG 3, the Low Income Pool (LIP), were $4,461,517,125 (89.23 percent of the $5 billion cap).

During Demonstration Year Three, the Florida Legislature directed the Agency to carry forward approximately $123 million dollars from the Demonstration Year Three LIP appropriation until an amendment of the STC #105 could be negotiated. Upon approval of the amendment, approximately $123 million dollars in carry forward funding was provided to the Agency through appropriations for Demonstration Year Four. The appropriations for Demonstration Year Four totaled $1,001,250,000 plus the $123,577,163 of carry forward LIP funds for a grand total of $1,124,827,163. Due to the payment process and the reporting period, payments made after June 30, 2010, were not captured in the Fourth Quarter report of Year Four or the Year Four Annual Report. The report for the first quarter of Demonstration Year Five included the final LIP payment totals for Demonstration Year Four.

H. Encounter and Utilization Data

Overview

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

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

Current Activities

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

Data Validation

Analytic validation continues for all encounter data received to date and for all future submissions by plan by month. A feedback loop allows the Agency to communicate results to the health plans using a series of standard reports. Data validation efforts during the third quarter of Demonstration Year Five included the following:

- The second round of the inpatient encounter data extract was provided to capitated MCOs on March 3, 2011. Each plan was to validate this data and return the results to the Agency by March 15, 2011, although a general extension was granted until March 25, 2011. Almost all plans returned the validated inpatient data with few exceptions. Initial internal review of the returned data indicates a sound data set worthy of further review. The data set will be forwarded to the Agency's actuaries for further analysis regarding potential incorporation in the rate setting process for September 1, 2011, rates.
- Distribution of the monthly provider reports portraying all associated servicing providers continues in an effort to assist capitated MCOs in the registration of their providers.

- Standardized encounter data validation reports are in development.
- Discussions were initiated with other state Medicaid encounter data teams regarding data collection and validation techniques.

The following are the highlights for this quarter:

- Provided outreach and technical assistance to health plans to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operational calls with the health plans to respond to questions and technical issues.
- Continued performing the encounter data analytic validation procedures.
- Continued work with Medicaid Program Integrity unit to begin identifying ways to use encounter data to assist in Medicaid fraud and abuse investigations.
- Began creation of encounter data utilization teams.

Risk Adjustment

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

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

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

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

- Provided MEDS NCPDP pharmacy claims for the July 1, 2009, through June 30, 2010, measurement period to the risk adjustment vendor for comparison in the MedRx model to risk score results from the proprietary pharmacy format currently in use.

- Parallel testing and comparison between the two data sources is complete and the results portray less than a 1 percent discrepancy. The Agency will begin using NCPDP pharmacy claims as the basis for the MedRx risk scores beginning with the next 12-month measurement period (October 1, 2009 through September 30, 2010).
- For the current period, risk adjustment plan factors were calculated for the following health plans:

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

- The demonstration enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1-year-old' population, or specialty plans/populations such as HIV/AIDS and Childrens Medical Services (CMS). Plans such as Positive Health Care, an HIV/AIDS specialty plan, and CMS are included here only because they have additional enrollment outside the HIV/AIDS population (Positive Health Care) and outside the under 1-year-old (CMS – kids) population.
- Enrollment in the demonstration counties this quarter for the month of March 2010 for risk adjustment purposes totaled 255,840 and was distributed as follows:

March, 2011	Broward	Duval, Baker, Clay, and Nassau
Children & Families	123,591	101,496
SSI	17,370	13,383
Totals	**140,961**	**114,879**

- The Agency has transitioned to NCPDP pharmacy data using the MedRx model beginning with the third quarter of Demonstration Year Five. It is the longer-term goal to transition from a pharmacy-based model to a diagnostic risk-adjustment model such as CDPS or use a combination of pharmacy and diagnostic data in a model such as CDPS – Rx.

The process of providing plan risk factors for the demonstration rate setting and budget neutrality will continue into the next quarter. Another dry run of the CDPS model using diagnosis-based encounter data will occur during the July – September 2011 quarter and the results will be analyzed. The Agency will continue to test and compare results between CDPS and MedRx until the quality and completeness of the diagnosis-based encounter data support transitioning to a diagnostic risk-adjustment model, such as CDPS.

I. Demonstration Goals

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

Prior to the implementation of the demonstration, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two Minority Physician Networks (MPNs), for a total of 12 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 eight HMOs and three PSNs for a total of 11 health plans in Broward County; three HMOs and two PSNs for a total of five health plans in Duval County; two HMOs and one PSN for a total of three health plans in Clay County; and one HMO and one PSN for a total of two health plans in Baker and Nassau Counties.

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs and seven PSNs) of which 23 applicants sought and received approval to provide services to the TANF and SSI population. There are no pending applications.

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

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

Access to Services Not Previously Covered

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

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

For Demonstration Year Five, the Agency approved 20 benefit packages for the HMOs and 10 benefit packages for the FFS PSNs. The customized benefit packages and

expanded benefits were effective for the contract period of January 1, 2011, to August 31, 2011, for nine HMOs and four PSNs.

Improving Access to Specialists

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

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

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

Also in October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 36 located on the following page shows the results of these analyses.

Table 36
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

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

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

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

In December 2007, the Agency pulled a random sample of 713 providers; 39 from each health plan's provider network file that was submitted to the Agency. This sample was divided among 21 Agency staff members, who conducted the surveys in the middle of the month. Of the 713 providers in the sample, 58.5 percent participated in the survey. Of those who participated, 84.4 percent 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 percent of the providers sampled were in fact contracted with the health plan for which they were surveyed.

During the second half of Demonstration Year Two and in Demonstration Year Three (March 2008 through March 2009), the Agency conducted 11 monthly surveys. These surveys included both a sample of 300 providers across the state, 15 from each health plan, and a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist). Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. The results of these surveys are provided in Table 37 located on the following page.

Table 37 Results of Provider Network Validation Surveys March 2008 through March 2009			
Survey Month/Year	**Statewide Accuracy Rate**	**Geographic Medicaid Area**	**Medicaid Area Accuracy Rate**
March 2008	88%*	10	95%*
April 2008	88%*	4	84%*
May 2008	97%	11	99%
June 2008	96%	9	97%
August 2008	97%	6	100%
September 2008	99%	3	99%
October 2008	100%	5	100%
November 2008	100%	8	100%
January 2009	99%	7	100%
February 2009	99%	2	100%
March 2009	99%	1	100%

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

As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area had been sampled, the Agency has moved to quarterly provider network surveys, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) when possible. The survey focus is on statewide samples rather than the Medicaid Area-focused samples each quarter. The quarterly survey results that have been analyzed to date are in Table 38.

Table 38 Results of Provider Network Validation Surveys July 2009 through May 2010	
Survey Month/Year	**Statewide Accuracy Rate**
July 2009	95%
October 2009	98.4%
January 2010	96.6%
May 2010	97.4%

Beginning in October 2010, Agency staff conducted the first semi-annual survey. During this quarter, Agency staff followed-up on and analyzed the October survey results. A total of 689 providers were sampled from the provider network files and 96 percent of the providers sampled statewide had current contracts with the health plans for which they were surveyed.

Agency staff will prepare for the next semi-annual survey during the fourth quarter of Demonstration Year Five, which will be fielded in April 2011. The follow-up and analysis of the April survey will begin at the end of the fourth quarter and, if the demonstration extension is approved, be completed during the first quarter of Demonstration Year Six.

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

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

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

During this quarter, the Agency continued work developing an enhanced auto-assignment methodology to reward higher performing health plans. The Agency received formal, written recommendations from the health plans on the Agency's proposed methodology in January 2011. There was a high level of agreement on most of the components of the methodology; however, there were some points where there were disagreements. The Agency reviewed each comment and is preparing a decision document for Agency management to resolve those areas where plans did not reach consensus.

Health plans submitted Performance Measure Action Plan quarterly reports to the Agency in February 2011. The quarterly reports indicated that, overall, plans remain committed and on target with those interventions selected to improve performance measures that fell below the 50th national percentile.

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

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

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

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

In addition, the Agency is working with the state's contracted External Quality Review Organization, Health Services Advisory Group (HSAG), regarding a collaborative project with health plans on reduction of emergency department visits. The Agency is preparing a file for HSAG containing the Agency's emergency department encounter data for reform counties. HSAG will determine the feasibility of using the data for the study. A kick-off meeting with participating health plans is scheduled for June 2011.

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

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

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

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

The individuals who decided not to opt out:

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

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

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

During the third quarter of Demonstration Year Five, the *Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey, Volume 2: Plan Type Estimates* which addresses enrollee satisfaction differences by plan type, was finalized and is available on the Agency's website at the link below:

http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol2_PlanType_Estimates.pdf

Volume 3 will assess enrollee satisfaction differences by enrollee subgroup (race/ethnicity demographics). This volume has been submitted and is being finalized by the UF. The Agency anticipates receipt of Volume 3 no later than May 31, 2011. The

results of past reports and all other evaluation reports conducted by the UF can also be viewed at this link:

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

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

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

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

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

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

Special Term and Condition #102, Demonstration Year Two Milestones, states that, “the State will conduct a study to evaluate the cost effectiveness of various provider access systems.” This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team provided the cost-effectiveness study to the Agency by the third quarter of Demonstration Year Two (January 2008). The cost-effectiveness study is based on the measurements of the LIP Milestone reports provided by the 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 PAS entities 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 (Demonstration Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PAS entities with fiscal years different than July 1 – June 30 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, Intergovernmental Transfers (IGTs), charge, cost, and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports were used for the

cost-effectiveness study. The UF provided a "Plan for Evaluation of the Low Income Pool Program" to the Agency. The cost-effectiveness will be measured in the method described below.

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

The UF LIP Evaluation was received from UF on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the 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 Medicaid Reform Waiver, the Agency submitted a letter to Federal CMS along with the LIP Program Highlights: Year 1 (SFY 2006-07) as prepared by UF. The LIP Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida LIP Program, previously submitted to Federal CMS.

In accordance STC #23, paragraph three, the State is submitting the following information for provider qualitative and quantitative data, which describes the impact the Low Income Pool:

> "The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted to CMS.
>
> "Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.

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

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

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

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

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

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

- The number of hospitals receiving LIP funding increased in comparison to those receiving funding from the SMP program: 87 hospitals received Special Medicaid Payments (SMP) funding in SFY 2005-06, with 163, 160, and 162 hospitals receiving LIP funding in SFY 2006-07, 2007-08, and 2008-09, respectively.
- Non-hospital providers began receiving funding under the LIP program: 43 and 44 non-hospital providers received LIP payments in SFY 2006-07 and SFY 2007-08, respectively, increasing to 59 non-hospital providers receiving LIP payments in SFY 2008-09.
- Total funding increased under the LIP program in comparison to the SMP program: total SMP payments were approximately $666.9 million in SFY 2005-06, with total LIP payments being approximately $998.7 million in SFY 2006-07, approximately $1 billion in SFY 2007-08, and approximately $876.3 million in SFY 2008-09.

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

Current Activities

During the third quarter of Demonstration Year Five, the Agency provided the SFY 2009-10 Milestone data for further research and evaluation with the LIP evaluation team at the University of Florida.

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 Federal CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to Federal CMS May 24, 2006. Federal CMS approval was received June 13, 2006.

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

1. Evaluations Affiliated with the Agency or its Contractors

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

2. Evaluations Commissioned by Governmental Agencies

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

3. Independent Evaluation by the University of Florida

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

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

University of Florida – Administrative Report: Key Events and Activities/Progress Reports

This annual administrative report provides a synopsis and status information about the Medicaid Reform Evaluation. Progress is reported for all associated tasks identified in the work plan categorized by major evaluation subprojects. During this quarter, the annual report was finalized and posted to the Agency's web site.

http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/Key_Events_and_Activities_in_2009.pdf

The UF also prepares a semi-annual summary progress report on key aspects of the evaluation. Prior to the close of the demonstration contract (June 30, 2011) the Agency anticipates receiving a final progress report, as well as a final report on key events and activities summary annual report for Demonstration Year Five. Upon receipt and Agency approval, these reports will be posted on the Agency's website at:

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

University of Florida – Mental Health Analysis

This series of studies has been described in prior quarterly reports to Federal CMS. During this quarter, the second subproject, *the Effect of Medicaid Reform on Baker Act Rates and Criminal Justice Encounters,* has received its final round of Agency revisions and edits. The Agency anticipates posting this report to its website in May 2011.

University of Florida – Fiscal Analysis

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

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

In follow-up to the first fiscal analysis, a preliminary draft of the multivariate analyses report, *Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analyses,* was reviewed by the Agency and sent back to the UF with suggested revisions. The UF is currently adding an additional year of data to this report. The Agency anticipates that the findings in both the univariate and multivariate analysis will be significant components in the demonstration's final report.

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 state share of funding coming primarily from intergovernmental transfers from local governments matched by federal funds. 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).

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

During this quarter, the Agency provided the UF with Milestone data from SFY 2009-10 and anticipates receipt of this report prior to the end of the demonstration contract (June 30, 2011).

Additional LIP information is available on the Agency's website at:

http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml

Special Terms and Conditions are also available on the Agency's website at:

http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf

University of Florida – Organizational Analyses

The UF is producing an ongoing series of reports that summarize organizational aspects of Florida's Medicaid Reform activities. Through a combination of qualitative and quantitative study designs, these reports address a broad range of structural and policy issues raised by the demonstration process. Data are collected from Agency sources and from informant interviews.

The UF is finalizing the report, *Medicaid Reform Organizational Analyses: April 2009 – March 2010.* It is anticipated that a final version of the report will be available in May 2011. Other Organizational Analyses are available on the Agency's website in the "Other Evaluation Reports" section at:

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

University of Florida – Medicaid Reform Evaluation Final Report

During the third quarter of Demonstration Year Five, the University has begun the process of drafting a final evaluation report. The final report is expected to include a summary of key findings of the five-year Demonstration in the following important areas:

- Background on the Demonstration
- Components Specific to the Evaluation:
    - The participating managed care organizations
    - Enrollee Experiences
    - Enrollee Satisfaction

  - The Enhanced Benefits Account Program
  - Fiscal Impact
  - The Low-Income Pool
  - Mental and Behavioral Health
- Conclusions

The final report will provide a review of prior studies with key findings that were completed during the life of the five year demonstration.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee (FAC) and the Technical Advisory Committee (TAC)

Both the FAC and TAC have been described in prior quarterly reports presented to Federal CMS. There was no FAC meeting held during this quarter. The Agency does not anticipate a meeting for either committee prior to the end of the Reform Evaluation contract (June 30, 2011).

K. Policy and Administrative Issues

Current Activities

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

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

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

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

This quarter, an additional forum for communication occurred: training was held by the Agency for all health plans on February 22 and 23, 2011, regarding medical necessity under EPSDT, unborn activation process, and fraud and abuse. The fraud and abuse training included overviews provided by various state agencies involved with the collection and review of fraud and abuse data, including the Medicaid Program Integrity Bureau, Medicaid Fraud Control Unit, the Division of Insurance Fraud, and the Public Assistance Fraud Unit. Over 140 persons attended the training. A tentative date has been set for June 2011 for additional fraud and abuse discussion.

Medicaid Reform Technical Advisory Panel

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

- Choice Counseling update, including reports on call center statistics, and an update on the Enhanced Benefits Account Program;
- Medicaid encounter data update, including notice that the transition to National Council for Prescription Drug Programs (NCPDP) format is complete, a review of quarterly report summaries that will be sent to the plans regarding the NCPDP data, and discussion of risk-adjustment plans for the 2011;

- Overview of the current risk-adjustment process (Medicaid Rx model) used for the demonstration (provided by Milliman staff);
- Overview of the Florida Medicaid Intergovernmental Transfer (IGT) Technical Advisory Panel Report, discussion on potential changes in the health plan capitation rate setting methodology, including the use of encounter data and how to identify specific issues regarding hospital payments and hospital trends used for calculating managed care rates, and a general update regarding the 2011 timeline;
- University of Florida Medicaid Reform evaluations update, including discussion on the Consumer Assessment of Health Care Providers and Systems (CAHPS) satisfaction survey, and new analyses adding the third year of the demonstration fiscal data to the 'before and after' fiscal analyses; and
- An update on the 1115 waiver extension request.

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 no policy transmittal and no Dear Provider letters released to the health plans. However, there were several Dear Provider e-mails sent to provide updated information on the Medicaid program. Issues addressed included:

- Review of the upcoming fine-tuning general technical amendment that corrected table and minor inconsistencies, modified fraud and abuse requirements for state statutory compliance, clarified behavioral health requirements regarding emergency services and transition requirements, and added social networking specifications;
- Information on managed care training regarding medical necessity, unborn activation processing and fraud and abuse overviews;
- Changes in Medicaid physician and practitioner fee schedules;
- Information on enrollment and capitation payment file reprocessing;
- 5010 X12 Companion Guides postings;
- Notice regarding the Centers for Medicare and Medicaid Services national provider call addressing how to register for the Medicaid Electronic Health Records (EHS) Incentive Program;
- Information regarding the new web-based quarterly fraud and abuse reporting, including reminder about the deadline for registration and submitting new user account agreements;
- Changes in third party liability audit selection criteria and audit information updates; and
- Updated information regarding the spreadsheet for reporting births of beneficiaries in the unborn activation process.

Technical and Operational Issues Conference Calls

The purpose of these calls is to communicate the Agency's response to issues addressed at a higher level in the TAP meetings and to respond to plan questions posed through e-mail, telephone inquiries, and previous technical calls. Previously these calls occurred biweekly, but with the demonstration being fully operational, the need for biweekly calls has significantly lessened. As discussed with the health plans in June 2010, a decision was made to change to monthly calls beginning in July 2010. Unless a particular need arises for calls to occur more often, the Technical and Operations calls are now monthly. During this quarter, however, the Agency conducted one Technical and Operational Issues Conference Call with health plans and health plan applicants. The monthly call for February was cancelled as the health plans attended a two-day training/meeting at the Agency. The monthly call for March was cancelled due to a subsequent call scheduled with the health plans relative to changes with the provider network file and a lack of other agenda items.

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

Approximately 20 participants attended in person and the popularity of these calls continues to be shown by over 100 phone lines in active use on the calls. The agenda items discussed on this quarter's call were as follows:

- Choice Counseling update;
- National Provider Identification and 5010 implementation timeliness and notice of provider alerts;
- Reminder on February training/meeting and fine-tuning general amendment update;
- Update on Medicaid Program Integrity activities and reporting changes, including target dates and requirements for the new web-based quarterly fraud and abuse report; and
- Update on encounter data and risk-adjustment reporting.

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

Fee for Service PSN Systems Implementation Issues Calls

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

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

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

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

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

General Amendment/Contract Overview Calls

During this quarter, there were two amendment and contract overview calls:

- Call on January 24, 2011, to review the next general amendment. This amendment provided revised fraud and abuse specifications required as a result of the 2010 Florida Legislative Session, clarified behavioral health requirements for emergency services and transition services, added social networking specifications and corrected minor inconsistencies.
- Call on March 30, 2011, to review report guide changes relative to change in the provider network file effective July 2011.

L. Waiver Extension Request

Legislative Direction

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

Development of Waiver Extension Request

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

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

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

Schedule of Public Meetings				
Location	**Date**	**Time**	**FAW Notice**	**Agenda/Presentation**
Clay County Clay County Agricultural Center 2463 SR 16 W Green Cove Springs, FL 32043	6/11/10	10:00a.m. - 12:00p.m.	Notice	Final Agenda Final Presentation Meeting Video
Baker County Baker County Health Department 480 W. Lowder Street Macclenny, FL 32063	6/11/10	2:00p.m. - 4:00p.m.	Notice	Final Agenda Final Presentation Meeting Video

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

Submission of the Waiver Extension Request

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

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

Request for Additional Information

On December 16, 2010, the Agency received a letter from Federal CMS requesting additional information on Florida's 1115 waiver extension request. Please click on the link above to view this letter.

On January 11, 2011, the Agency responded to Federal CMS's request for additional information on Florida's 1115 waiver extension request. Please click on the link above to view the Agency's response and attachments.

Public comments related to the 1115 waiver extension request can be mailed to:

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

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues January 1, 2011 – March 31, 2011	
PSN Informal Issue	**Action Taken**
1. A PSN member's parent reported to the Agency that she is being balance billed by a non-participating provider for the amount of a claim denied by the PSN.	➲ The PSN contact reported that the PSN contacted the provider and asked them to submit the claim for payment. The claim was paid and the provider agreed to cease any further collection efforts.
2. A PSN member's parent reported being balance billed by a provider because the PSN denied claims. The parent reported that the member was erroneously assigned to the PSN and should have gone into a plan in which the provider participates.	➲ The PSN contact reported to the Agency that PSN staff advised the provider to submit the claims for payment.
3. A PSN member's parent reported that the PSN has not provided good specialist referrals for the member.	➲ The PSN contact reported that a case manager worked with the member's parent to obtain a confirmed appointment for the member with the type of specialist he needs. The parent is satisfied.
4. A PSN member's parent reported that the PSN is unable to provide a necessary specialist referral.	➲ The PSN contact reported to the Agency that authorization had been given for the member to see a local specialist and an appointment was made. PSN staff advised the member's parent of the arrangements.
5. A PSN member's parent reported needing follow-up dental work but that the provider is no longer with the plan and the parent does not want the PSN's referral to a new provider, who is too far away.	➲ The PSN contact reported to the Agency that a new referral was arranged with a provider whose office was closer, along with transportation for the member and parent. The PSN contact reported that another appointment was made for the member to see the provider and to have transportation. The member and parent accepted this new referral.
6. A provider contacted the Agency and stated he was having problems obtaining prior authorizations and submitting documentation to a subcontractor of the PSN.	➲ The PSN contact reported to the Agency that she worked with the subcontractor, who spoke with the provider. The subcontractor advised the provider to submit documentation directly to the fiscal agent and the issue has been resolved.
7. A PSN member reported to the Agency that she wants additional services from a specialist but that the provider is no longer in the PSN's network.	➲ The PSN contact reported that numerous attempts were made to contact the member but that the calls have not been returned. A PSN case manager reached the family and told the member that the vision subcontractor would review the member's case and approve any necessary care. The member agreed to follow through with the subcontractor and to call the plan back. As of two weeks later, the member's family had not called the plan or returned calls from the plan regarding updates.

PSN Complaints/ Issues January 1, 2011 – March 31, 2011	
PSN Informal Issue	**Action Taken**
8. A PSN member's representative reported to the Agency that the PSN will not deal with him as he does not appear in the member's file and that the PSN delayed the member's request for DME.	➲ The PSN contact reported that the plan files were updated to show the correct member's representative. PSN staff authorized necessary medications and set up an evaluation concerning the DME requested by the member.
9. A PSN member reported to the Agency that she is being balance billed by a hospital for a claim denied by the PSN.	➲ The PSN contact reported to the Agency that the claim was held up due to lack of authorization, but was processed for payment. PSN staff advised the hospital not to continue collection efforts and advised the member that the claim was being paid.
10. A PSN member reported to the Agency that she has not received Enhanced Benefit credits.	➲ The PSN contact reported to the Agency that PSN staff assisted the member in obtaining the Enhanced Benefit credits that she should have.
11. A PSN member reported to the Agency that she needs a surgical procedure but that the PSN has not made arrangements with a non-network provider to do the procedure.	➲ The PSN contact reported to the Agency that the plan finalized an agreement with the non-participating provider to do the procedure. PSN staff notified the member and she is satisfied.
12. A PSN member's PCP reported to the Agency that the member's specialist provider no longer participates with the PSN. The PCP requested that the member be disenrolled from the PSN to continue treatments with the specialist.	➲ The PSN contact reported to the Agency that the PSN authorized the specialist to see the member at 150% of the Medicaid allowable rate but that the specialist refused. PSN staff located another specialist and the member's parent said they would only see that specialist if there is an emergency. The member ended up entering a new plan and will continue visits to the preferred specialist.
13. A PSN member contacted the Agency and stated that the PSN will not authorize an urgently needed procedure because the provider is not in the plan network.	➲ The PSN contact provided Agency staff with a detailed summary of the PSN's ongoing efforts to work with the member to provide services. The member has been habitually non-compliant with medical advice and pre-surgical requirements which has resulted in cancellation of the requested surgery on several occasions. In addition, PSN staff reported that the member's spouse has been threatening and abusive to plan staff. The PSN is ready to work with the member when she is willing to follow necessary medical directives. Agency staff directed the member to work with the plan so that she may receive the necessary services.
14. A provider reported to the Agency that the PSN inappropriately reduced PPEC services for a member.	➲ Agency staff spoke with the PSN Medical Director and it was determined that the PSN had acted appropriately. Agency staff notified the provider.
15. A provider reported to the Agency that the PSN decided PPEC services were no longer necessary for the member; the PPEC provider disagreed.	➲ Agency staff reviewed the PSN's medical records in this case and determined that the PSN had acted appropriately. Agency staff notified the provider.

PSN Complaints/ Issues January 1, 2011 – March 31, 2011	
PSN Informal Issue	**Action Taken**
16. A PSN member's mother reported to the Agency that the member is no longer approved to see an out-of-network provider but needs one more procedure to be completed by the provider.	➲ The PSN contact reported to the Agency that all requested services have now been approved. PSN staff notified the member's mother and she is satisfied.
17. A PSN member's parent reported to the agency that the member ran out of medication and that the pharmacy will not fill it until the due date in a week.	➲ The PSN contact reported to the Agency that they contacted Medicaid Pharmacy, who agreed to allow an early refill on the medication. Agency staff notified the mother that the prescription was being filled.
18. A PSN member contacted the Agency and stated that he is unable to get his pain medication covered by the PSN.	➲ The PSN contact reported to the Agency that the member turned down the PSN's offers of assistance and will look for alternative methods of getting pain medication. The PSN will keep an open line of communication with the member.
19. A PSN member reported to the Agency that she is unable to get a good pain management referral from the PSN.	➲ The PSN contact reported to the Agency that a PSN case manager has been working with the member but the member is unwilling to see doctors to be examined before medication prescriptions are provided. The case manager set up an appointment with a pain management specialist and transportation for the member but the member refused to go and stated she wanted to see a non-participating provider. The PSN contacted the non-participating provider but he would not accept the standard Medicaid rate. The PSN scheduled the member to see pain management providers but the member refused to go and to have a physical examination and drug test. Agency staff determined that the PSN had provided adequate referrals to the member, who will need to decide if she will cooperate. Agency staff will direct the member to the PSN for assistance if she calls again.
20. A provider reported to the Agency that the PSN incorrectly entered the provider's claim information into the system so the claim was denied.	➲ The PSN contact reported to the Agency that PSN staff worked with the provider to get the claims paid.
21. A PSN member reported to the Agency that pre-arranged transportation did not show up so he had to pay out-of-pocket for transportation to his medical appointment. He wants the PSN to reimburse him.	➲ The PSN contact reported to the Agency that the member had called the transportation vendor less than 72 hours prior to the requested date of service; therefore by policy a ride could not be guaranteed. The transportation vendor had explained this to the member prior to putting him on a waiting list for a possible ride on the requested date. The PSN and transportation vendor decided to reimburse the member anyway for the out-of-pocket expenses.

PSN Complaints/ Issues January 1, 2011 – March 31, 2011	
PSN Informal Issue	**Action Taken**
22. A PSN member's parent reported that the PSN is unable to provide a good specialist referral for the member.	➲ The PSN contact reported that the case manager contacted the member's parent and advised her that an appointment had been made with a specialist. The member's parent was very pleased.
23. A PSN member's parent reported that the PSN has not provided a good specialist referral. The member's parent is dissatisfied with the specialist to whom the PSN referred the member.	➲ The PSN contact reported to the Agency that the only other specialist of the type the member needs who accepts Medicaid is in another county. The member's parent agreed to go to this provider but it took several days for the PSN to negotiate an out-of-network agreement with the provider. PSN staff reported that the agreement is complete and that an appointment was set for the member. The member's parent is satisfied.
24. A PSN member's mother contacted the Agency to state that the PSN needs to coordinate the member's care through her and that the member's health care needs are urgent.	➲ The PSN contact reported to the Agency that the case manager assigned to the member spoke with the member's mother. The mother now understands the process to request an out-of-network referral once the medical necessity for such a referral is established. The member was scheduled to see a specialist who will determine if a referral is needed and the member's mother will follow through and work with the PSN case manager.
25. A PSN member reported to the Agency that the PSN only authorized partial dentures and now he cannot eat.	➲ The PSN contact reported to the Agency that there was miscommunication between the member and the dental subcontractor. PSN staff set an appointment for the member with the dentist to complete the dentures and notified the member.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
1. A former HMO member reported to the Agency that she may not be able to continue with her treating provider. She reported that the HMO denied claims due to the provider not being in the plan network.	➲ The HMO contact reported to Agency staff that the provider had not submitted any claims. HMO staff contacted the provider and requested that claims be submitted for processing and payment. The provider agreed.
2. An HMO member's parent reported to the Agency that she is being balance billed by a provider even though the HMO was supposed to have approved the services.	➲ The HMO contact reported to the Agency that the claims were reviewed and processed for payment. HMO staff advised the member's parent that the bills were paid by the plan.
3. An HMO member reported to the Agency that she was having difficulties in obtaining prescriptions.	➲ The HMO contact reported to the Agency that the member had called them as well. The HMO updated the member's information in their system and advised the member that her medications were filled and available that day.
4. An HMO member's parent reported having problems locating a pediatric orthopedic provider.	➲ The HMO contact reported to the Agency that HMO staff spoke with the member's parent and completed a non-participating authorization for the member to see a pediatric orthopedic provider.
5. An HMO member reported being erroneously assigned to the HMO, in which her PCP does not participate. She reported being scheduled to disenroll from the plan but needs care from her PCP before the disenrollment.	➲ The HMO contact reported to the Agency that the HMO authorized continuing care of the member by the non-participating provider for the month. HMO staff notified the member and the provider of this.
6. An HMO member reported to the Agency that her eligibility code was changed in error and she was assigned to the HMO. She stated that her usual PCP does not participate with the HMO but she wishes to continue with him.	➲ The HMO contact reported to the Agency that the member was authorized to continue seeing the requested provider.
7. An HMO member reported to the Agency that he has serious health conditions and needs to be treated by providers who do not participate in his current HMO.	➲ The HMO staff reported to the Agency that a case manager worked with the family to provide necessary authorizations. The member later switched to a health plan in which his specialist providers participate.
8. An HMO member's parent and provider reported to the Agency that the member needs a DME item that the HMO says is not covered.	➲ Agency staff researched this issue and found that the item should be covered. The HMO contact reported to the Agency that she spoke with the provider and found that the provider and parent were unaware that they needed to order the item from the plan's contracted DME company. HMO staff explained the process to the provider and the parent and told them the item would be provided through the proper channels. The parent is satisfied.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
9. An HMO member's parent reported to the Agency that the member needs hospital services immediately but that the facility she prefers is now non-participating with the HMO and the HMO wants the member to go to a participating hospital.	➲ The HMO contact reported multiple attempts to contact the member and parent regarding this issue but their calls were not returned. The HMO contact made additional attempts to contact the member including a letter but received no response. The member enrolled in another health plan, in which the preferred hospital participates, at the beginning of the next month.
10. An HMO member's parent reported that the HMO is denying authorization for a medication prescribed to the member.	➲ The HMO contact reported to the Agency that the medication request and the member's medical records were reviewed and HMO staff determined that the medication was not medically necessary. An HMO case manager explained the decision to the member's parent and assisted with the member's other health needs. The parent is satisfied.
11. A former HMO member's parent reported that she is unable to take the member to a preferred provider because the HMO did not pay post-natal claims.	➲ The HMO contact reported to the Agency that she spoke to the former member's parent and obtained details of the denied claims. HMO staff notified the provider to resubmit the claims for payment.
12. A provider reported to the Agency that claims for services to an HMO member were denied by the plan because the provider is non-participating.	➲ The HMO contact reported that HMO staff had worked with the provider and agreed that claims should be paid. The provider submitted the claims for payment.
13. An HMO member's parent reported to the Agency that she is being balance billed by providers whose claims were denied by the HMO.	➲ The HMO contact reported that the plan contacted all the providers involved and arranged for them to submit all claims for payment. HMO staff advised the providers to cease attempts to balance bill the member's parent. The parent is satisfied.
14. A provider reported to the Agency that the HMO denied claims for services to a member who was retroactively enrolled in the HMO several weeks after birth.	➲ The HMO contact reported to the Agency that claims were reviewed and processed for payment.
15. An HMO member reported having trouble obtaining his diabetes testing supplies.	➲ The HMO contact reported to the Agency that diabetes supplies were shipped to the member.
16. An HMO member contacted the Agency and stated that she could not see a provider because the HMO's member database did not show her as active.	➲ The HMO contact reported that the member's file was updated to show she is active. HMO staff helped her select a new PCP convenient to her home and made an appointment for her. The member is satisfied.
17. An HMO member reported to the Agency that she wants the HMO to change her PCP because she was unhappy with her current one.	➲ The HMO contact reported that an HMO case manager worked with the member to find a new PCP. The case manager continues to assist the member with other health related issues.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
18. An HMO member's parent reported to the Agency that the member is scheduled for a surgical procedure at a facility and with a provider that do not participate in the member's new HMO. The parent reports that the facility and provider will not reach an agreement with the member's new plan.	➲ The HMO contact reported to the Agency that they offered referrals to two other specialists in the network to the member's parent but that she refused them, saying they could not perform the necessary procedure. HMO staff continued working with the member's parent and the non-participating provider until an agreement was reached. The parent scheduled a pre-surgical evaluation for the member with the non-participating provider.
19. An HMO member contacted the Agency because the specialists that the health plan has referred her to are not able to see her.	➲ The HMO contact reported to the Agency that HMO staff spoke with the member and found that the member was not established with her PCP. HMO staff coordinated with the member and her PCP and an appointment was scheduled for the member. The PCP's office told the member that they will assist her in accessing the specialty care she needs.
20. An HMO member's parent reported to the Agency that she was referred to Agency for a dental referral when this should have been handled by the HMO.	➲ The HMO contact reported to the Agency that HMO staff gave the member a referral and made an appointment for the member. The member's parent is satisfied.
21. An HMO member's parent reported to the Agency that the HMO will not authorize treatment for the member at an out-of-network facility.	➲ The HMO contact reported to the Agency that it had already authorized out-of-network care at the facility. The HMO is awaiting medical records from the facility in order to approve additional care, but will approve all care once the medical records are received.
22. An HMO member's parent contacted the Agency because he wants the HMO to authorize a procedure for the member that was previously scheduled in a non-participating facility.	➲ The HMO contact reported to the Agency that the procedure was authorized and the facility and that HMO staff notified the member's parent.
23. An HMO member's spouse reported that the member has multiple health issues and that the HMO is not authorizing necessary care.	➲ The HMO contact reported that the HMO completed an out-of-network agreement with a facility that can treat the member's health issues. HMO staff notified the member that a full evaluation was scheduled for the member and that treatment will follow based on the assessment.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
24. An HMO member reported to the Agency that the new HMO is denying his heart medications even though he is a heart transplant recipient.	➲ The HMO contact reported to the Agency that HMO staff called the PCP to advise her to prescribe the generic version of one drug and the PCP did. HMO staff advised the member that the medication was ready for pick-up at the pharmacy. The HMO reported that the member had picked up a month's supply of the second medication a week before and has a sufficient supply—the medications had not and will not be denied to the member.
25. An HMO member contacted the Agency and stated that she was unable to obtain authorization from the HMO for medical supplies and medication.	➲ The HMO contact reported to the Agency that HMO staff contacted the member and received more detailed information on her needs. The HMO provided a transitional supply of medication to use until the issue was fully resolved. The member's PCP verified medical necessity for specific medications and the HMO authorized them for the member. The member is satisfied.
26. An HMO member reported having difficulties obtaining two medications that were prescribed for him by non-participating providers.	➲ The HMO contact reported to the Agency that they had not received documentation of step therapy and medical necessity—once the plan received the appropriate documentation, the HMO authorized one of the medications. The HMO issued a transitional one-month supply of the other medication to the member and requested documentation of the medical necessity for it from the member's PCP.
27. An HMO member reported having problems obtaining a prescription in a dosage form that is acceptable.	➲ The HMO contact reported to the Agency that the HMO pharmacy team adjusted the dosage form to better meet the needs of the member.
28. A provider reported to the Agency that the HMO has denied claims from the provider's office.	➲ The HMO contact reported to the Agency that the HMO Provider Relations Advocate contacted the provider's office and advised them that they must bill under the valid contract that the provider has with the health plan and not through a separate office. If the provider bills through the valid contract, the claims will be processed and paid.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
29. A provider contacted the Agency because he has not received payment for claims he submitted to the HMO.	➲ The HMO contact reported to the Agency that the HMO Network Development Director spoke with the provider and emailed him. The provider is a non-participating, hospital-based provider and has never called for authorization for providing services to members, so their claims are denied. The HMO's Provider Research and Dispute Unit also spoke to the provider and worked on his claims with him, processing many of them for payment. Of the 15 outstanding claims from the provider, there was no appeal/dispute from the provider for five of them, nine were denied due to no authorization, and one was paid. HMO staff will continue to work with the provider to reach an agreement on claims payment.
30. An HMO member's parent reported to the Agency that she is being balance billed by a non-participating provider who did not check eligibility before providing services.	➲ The HMO contact reported that HMO staff checked with the provider, who confirmed they did not check eligibility prior to providing the services. The HMO is making a one-time exception and paying the provider's claim. HMO staff advised the member's parent and the provider that the member must be seen by a network provider in the future.
31. An HMO member's parent reported being unable to take the member to a provider because they are non-participating with the member's previous plan and the HMO denied the provider's claims.	➲ The HMO contact reported that HMO staff contacted the member's parent and the provider and that after some delay, the provider submitted the claims, which had not previously been submitted as reported. The HMO processed and paid the claims.
32. A provider reported to the Agency that the HMO had denied claims for an incorrect CPT code.	➲ Agency staff researched the issue and found that the CPT code is valid for the service provided and reached out to the HMO. The HMO contact reported that HMO staff reviewed the claim again and issued payment.
33. An HMO member's mother contacted the Agency and said that her son was recently assigned to the HMO and needed a refill of a particular medication immediately.	➲ The HMO contact reported that the member's mother called the HMO a week prior to calling the Agency and asked whether the HMO covered compound medications, but did not ask any further questions or provide additional information to the HMO. The member's mother then called the Agency to disenroll although her son's medication had not been denied. The HMO contact reported that the medication was filled for the member and the mother picked it up at the pharmacy without any problems.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
34. An HMO member's mother reported to the Agency that she had just moved to another part of the state and needed to take the infant to a physician for immunizations. The parent said that she had updated her change of address online but it was not appearing in the fiscal agent system.	➲ Agency staff obtained the updated address from the member's mother and updated it in the fiscal agent system. Medicaid Options staff called the parent and scheduled an appointment for the member with the physician of the parent's choice.
35. An HMO member reported to the Agency that she is unable to obtain a good referral to a specialist from the HMO.	➲ The HMO contact reported that an appointment was made for the member with the appropriate specialist. HMO staff notified the member and her PCP.
36. An HMO member's parent reported being unable to obtain necessary specialist care since being assigned to a new HMO.	➲ The HMO contact reported that a case manager was assigned to work with the member and parent. The case manager located a network specialist and advised the member's parent to make an appointment. The case manager will follow up to make sure the member has the appointment scheduled.
37. An HMO member reported to the Agency that she was supposed to be disenrolled from the HMO but that the system re-enrolled her in error. The member needs to see an out-of-network provider to treat her medical condition until the enrollment issue is resolved.	➲ The HMO contact reported that the out-of-network specialist agreed to see the member and that an appointment was scheduled. The HMO contact notified the member of the appointment and Agency staff scheduled the member to be disenrolled from the plan at the beginning of the next month.
38. An HMO member's wife contacted the Agency because she needed assistance in obtaining behavioral health services for the member.	➲ The HMO contact reported that the HMO's behavioral health subcontractor provided two referrals to the member's wife, who will follow through on the referrals. The HMO case manager gave their direct phone number to the member's wife in case she needs any further assistance.
39. An HMO member's parent reported to the Agency that she had moved out of the HMO's service area and that now the HMO will not authorize services for the member.	➲ The HMO contact reported to the Agency that the HMO has no network in the area to which the member's parent moved and will not authorize out-of-network services because the desired services are not considered an emergency. The Agency worked with the member's parent to have her address corrected so that the member may be enrolled in a plan in the new service area.
40. A provider contacted the Agency to request a fair hearing in order to obtain more units of psychosocial rehabilitation for an HMO member.	➲ Agency staff discussed this issue with the provider and the HMO and all parties agreed to slowly reduce the number of units for the member and to monitor the member's stability and ability to be self-sufficient. The provider requested that the hearing be dismissed and will continue to work with the HMO regarding the member's care.

HMO Complaints/Issues January 1, 2011 – March 31, 2011	
HMO Informal Issue	**Action Taken**
41. An HMO member reported to the Agency that his physician changed his prescription but that the HMO will not authorize the new dosage prescription until the previous prescription expires.	➲ The HMO contact reported to the Agency that the member had not actually obtained a new prescription from his provider. HMO staff worked with the provider and member to get the prescription and arrange for shipment of the needed items. The HMO authorized a 30-day supply at the new dosage for the member until the new prescription is obtained and processed.
42. A Department of Children and Families (DCF) worker contacted the Agency regarding the HMO member being unable to get approval for requested therapy services.	➲ The HMO contact reported to the Agency that the requested therapy service is not a covered benefit in Medicaid. Agency staff advised the member to apply for a waiver program in which such services are covered. The member stated that he will apply to the waiver program.
43. An HMO member's parent reported to the Agency that the member was enrolled in the HMO without her knowledge and that the member is now unable to obtain his medications.	➲ The HMO contact reported to the Agency that the medications were approved and the member's parent was advised that they were ready for pick-up. The member's mother also told HMO staff that she wants to take the member to an out-of-network provider who has been treating him. The HMO contact reported that an out-of-network agreement was completed with the provider so that the member may continue to see the desired provider.
44. An HMO member reported to the Agency that she has been unable to obtain a medication because the HMO has not received a prior authorization request from the member's provider.	➲ The HMO contact reported to the Agency that the provider had written a prescription for a drug not on the PDL. HMO staff asked the provider to write a prescription for the drug on the approved PDL or submit evidence that the non-PDL drug was required. The HMO contact reported that the provider wrote a new prescription for the PDL drug and the member successfully picked up her medication.
45. A provider reported to the Agency that the HMO is paying the provider under the Medicaid rate.	➲ Agency staff provided the HMO with the correct Medicaid rate for the services and the HMO paid the facility the correct amount for their claims.

Attachment III
Description of Opt Out Enrollees

A description of the Opt Out enrollees is provided below.

1. The caller began the process to enroll in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the second quarter of Demonstration Year One on October 1, 2006. The individual has health insurance available through her employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The individual lost her job effective February 28, 2007. As a result, the individual has been disenrolled from the Opt Out Program.
2. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on January 1, 2007. The father has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2007. As a result, the children have been disenrolled from the Opt Out Program.
3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Demonstration Year One. The effective date for enrollment was during the third quarter of Demonstration Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended December 31, 2007. As a result, the children have been disenrolled from the Opt Out Program.
4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Demonstration Year One. The effective date for enrollment was during the fourth quarter of Demonstration Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer’s health insurance plan effective December 31, 2007. As a result, the children were disenrolled from the Opt Out Program. The mother subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Demonstration Year Two on January 1, 2008. (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, the child has been disenrolled from the Opt Out Program. The mother re-enrolled the child in the Opt Out Program during the fourth quarter of Demonstration Year Three on May 1, 2009 (Item Number 36). The other child's Medicaid eligibility ended on February 28, 2011. As a result, the child has been disenrolled from the Opt Out Program.

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

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

8. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Two. The effective date for enrollment was during the second quarter of Demonstration Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended on September 30, 2009. As a result, the children were disenrolled from the Opt Out Program. The mother re-enrolled her children in the Opt Out Program during the fourth quarter of Demonstration Year Four on April 1, 2010 (Item Number 45).

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

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

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

use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The father lost his job effective September 26, 2008. As a result, the child has been disenrolled from the Opt Out Program.

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

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

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

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

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

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

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

23. The caller began the process to enroll in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.
25. The caller began the process to enroll in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The individual has health insurance available through his employer. The individual elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.
26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the fourth quarter of Demonstration Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.
27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Demonstration Year Two. The effective date for enrollment was during the first quarter of Demonstration Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2009. As a result, the children have been disenrolled from the Opt Out Program.
28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother

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

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

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

31. The caller began the process to enroll her child in the Opt Out Program during the second quarter of Demonstration Year Three. The effective date for enrollment was during the second quarter of Demonstration Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out medical 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 premium 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 premium 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 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 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's Medicaid eligibility ended on February 28, 2011. As a result, the child has been disenrolled from the Opt Out Program.

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

38. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on July 1, 2009. The father 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 chose not to reenroll into his employer health insurance on November 1, 2010. As a result, the child has been disenrolled from 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 individual coverage. The individual's Medicaid eligibility ended on November 30, 2010. As a result, the individual was disenrolled from the Opt Out Program.

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

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

43. The caller began the process to enroll her three children in the Opt Out Program during the first quarter of Demonstration Year Four. The effective date for enrollment was during the first quarter of Demonstration Year Four on September 1, 2009. The mother 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 children's Medicaid eligibility ended December 31, 2009. As a result, they have been disenrolled from the Opt Out Program.

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

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

46. The caller began the process to enroll her two children in the Opt Out program during the third quarter of Demonstration Year Four. The effective date for enrollment was during the fourth quarter of Demonstration Year Four on May 1, 2010. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended March 31, 2011. As a result, they have been disenrolled from the Opt Out Program.
47. The caller began the process to enroll her child in the Opt Out program during the fourth quarter of Demonstration Year Four. The effective date for enrollment was during the fourth quarter of Demonstration Year Four on June 1, 2010. The mother of the child did not enroll her child in her employer's insurance. As a result, the child has been disenrolled from the Opt Out Program.
48. The caller began the process to enroll his two children in the Opt Out program during the fourth quarter of Demonstration Year Four. The effective date of enrollment was during the first quarter of Demonstration Year Five on July 1, 2010. The father 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 are still enrolled in the Opt Out Program.
49. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Demonstration Year Five. The effective date for enrollment was during the first quarter of Demonstration Year Five on September 1, 2010. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's ESI coverage ended on December 31, 2010. As a result, the child has been disenrolled from the Opt Out Program.
50. The caller began the process to enroll his five children in the Opt Out Program during the second quarter of Demonstration Year Five. The effective date for enrollment was during the second quarter of Demonstration Year Five on November 1, 2010. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The children are still enrolled in the Opt Out Program.
51. The caller began the process to enroll herself and her child in the Opt Out Program during the third quarter of Demonstration Year Five. The effective date for enrollment was during the third quarter of Demonstration Year Five on February 1, 2011. The mother of the child has health insurance available through her employer. The mother elected to use her and her child's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother and child are still enrolled in the Opt Out Program.

52. The caller began the process to enroll himself and his wife in the Opt Out Program during the third quarter of Demonstration Year Five. The effective date for enrollment was during the third quarter of Demonstration Year Five on February 1, 2011. The husband has health insurance available through his employer. The husband elected to use his and his wife's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The husband and wife are still enrolled in the Opt Out Program.

53. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Demonstration Year Five. The effective date for enrollment was during the third quarter of Demonstration Year Five on February 1, 2011. 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.

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