Florida Medicaid Reform

Quarterly progress Report
April 1, 2007 – June 30, 2007

1115 Research and Demonstration Waiver

Table of Contents

List of Tables

List of Charts

I. Waiver History

Background

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (CMS) on October 19, 2005. State authority to operate the program is located in Section 409.91211, Florida Statutes (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 is in the process of expanding to Baker, Clay and Nassau Counties.

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

Key components of Medicaid Reform include the following:

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

Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the fourth quarterly report for the period of April 1, 2007 through June 30, 2007. In addition to outlining the events that occurred during the fourth quarter of operation, the report provides a high level summary of previous quarter activities including implementation activities to ensure that there is a full accounting of activities. For detailed information about the activities that occurred during the first three quarters, please refer to the previous quarterly reports.

II. Status Update of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Background

All health plans, including current contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) PSN applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan for approval as part of the application process.

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

In April 2006, the Agency received 14 health plan applications, and another 4 after that date for a total of 18 applications. Seventeen of the 18 applicants sought to provide services to the TANF and SSI population; one application sought to render services as a specialty PSN. The Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in both Duval and Broward Counties.

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

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06

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

In January 2007, the Agency posted the Reform Health Plan Expansion Application on the Agency's Medicaid Reform Website with no official submission deadline. The Agency also provided guidelines for application submission dates to ensure contracting by July 1, 2007. All prospective plans were informed that they had to submit a completed application by of April 2, 2007, in order to be considered for a contract effective date of July 1, 2007.

Current Activities

As of April 1, 2007, the beginning of the fourth quarter of operation, the Agency contracted with 16 health plans of which 10 are HMOs and 6 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date listed in Table 2 represents the date when the plan is available as a choice but does not represent the date on which the plan receives enrollment. There have been no new Reform health plan contracts executed since December 2006. However, the Children's Medical Services PSN, the first approved specialty plan to serve children with chronic conditions, was approved for expansion into Duval County on March 21, 2007, and the first enrollment began May 1, 2007.

Table 1 indicates the two pending contracts from the initial set of health plan applicants and one of those remains under review. Freedom Health Plan, an HMO applicant, is in the final phase of contract execution and first enrollment is slated to begin in Broward County on October 1, 2007. Better Health Plan, which has applied to become a FFS PSN, has experienced a major change in network design and no date of expected approval is known. The Agency continues to provide technical assistance to Better

Health Plan and continues to receive inquiries from other interested health providers on the prospects of submitting an application to become a Reform PSN or HMO.

Table 2
Medicaid Reform Health Plan Contracts

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

As reported last quarter, the Agency received ten non-binding Letters of Intent to submit an expansion application for Baker, Clay and Nassau Counties. Of the letters received, only Access Health Solutions (PSN), Staywell Health Plan, Health Ease and United Health Plan formally submitted an expansion application to the Agency. During the fourth quarter, Staywell and Health Ease withdrew their applications for expansion, leaving one HMO (United) and one PSN (Access Health Solutions) expansion application for the rural expansion counties. In June, the Agency approved these two entities' applications for expansion and the resulting contract amendments were routed and executed. These two entities will provide beneficiaries located in the three rural expansion counties with a choice of enrolling in an HMO or a PSN, which are options that did not exist prior to Reform.

At the end of the quarter, the Agency executed contract amendments for the majority of Reform health plans and anticipates all remaining plan contract amendments will be executed prior to September 1, 2007. The contract amendments for capitated plans included the draft capitation rates and the Agency approved customized benefit packages for the time period of September 1, 2007, through August 31, 2008. The

contract amendments for FFS PSNs included the September 1, 2007, through August 31, 2008 draft capitation rates upon which each FFS PSN's contract reconciliation will be based, and the Agency approved expanded benefits for each FFS PSN. The Agency has submitted the contract amendments and the actuarial certification for the draft capitation rates to CMS for approval.

2. Benefit Package

A key aspect of Reform is a plan's ability to create a customized benefit package targeted to a specific population. Under the 1115 Medicaid Reform Waiver, capitated plans are provided the opportunity to create a customized benefit package by varying the amount, duration and scope of services for non-pregnant adults. Capitated plans can also vary the copayments and provide coverage of additional services to customize the benefit packages. Provider Service Networks (PSNs) that chose a fee-for-service (FFS) reimbursement payment methodology were given the opportunity to eliminate or reduce copayments and offer additional services but not reduce the amount, duration and scope of services. Likewise, specialty plans for Children with Chronic Conditions and for Individuals with HIV/AIDS may not reduce amount, duration and scope of services. All health plans are required to submit their customized benefit packages annually, whether or not there is a variation of benefits or change from the prior year.

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

In consultation with an actuarial firm, the Agency created a data book with the historic FFS utilization data for all targeted populations. In April 2006, interested parties were notified that the data book would be mailed immediately to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold. The Agency posted an online version of a Plan Evaluation Tool (PET) for evaluating plan benefit packages to the Medicaid Reform website. The tool allowed a preliminary determination as to whether the plan benefit packages would meet the Agency's actuarial equivalency and sufficiency tests before formal submission. The PET was updated May 26, 2006, to reflect the 2006 Florida

Legislature's decision to restore adult vision and adult hearing services, and the addition of an adult partial-dentures program to the standard Medicaid benefit. Health plans submitted their customized benefit packages based on the revised PET.

Current Activities

During the fourth quarter of operation, the Agency released the updated data book on May 23, 2007 to assure that the plans were familiar with the required coverage thresholds. Historic FFS utilization data for every target population was provided in an updated data book, which included the July 1, 2004 to June 30, 2006 data set. This information assisted prospective plans in quickly identifying the specific coverage limits required to meet a specified threshold for the September 1, 2007 through August 31, 2008 period.

The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous year. As described in the background, the PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency, sufficiency tests before submitting the benefit package. The annual process of verifying of the actuarial equivalency, sufficiency test standards and the tool (PET) was completed during this quarter. 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 Agency provided an Excel version of the PET to the plans of June 5, 2007. Each plan was required to submit a competed PET for approval of proposed customized benefit packages.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. It is only through this approval process that health plans are able to change their customized benefit packages on an annual basis. All approved health plan benefit package changes that were made this quarter for the upcoming contract year will become effective starting September 1, 2007.

During the fourth quarter, the Agency received and reviewed 28 proposed customized benefit packages from the HMOs and 13 different expanded benefits proposals from the FFS PSNs. The approved benefits are for the contract period September 1, 2007 to August 31, 2008. The FFS PSNs were permitted to vary their cost sharing by reducing or eliminating it altogether and to increase amount, duration, and scope of services. The submissions included 1 HMO and 1 FFS PSN for Reform expansion counties: Baker, Clay and Nassau. The 10 HMOs submitting different customized benefit packages for TANF and SSI targeted populations were AMERIGROUP Florida, HealthEase Health Plan of Florida, Humana Medical Plan, Wellcare of Florida d/b/a StayWell Health Plan of Florida, Preferred Medical Plan, Vista Health Plan of South Florida, Vista Health Plan d/b/a Buena Vista Healthplan, Total Health Choice, Universal and United Healthcare of Florida. The 6 FFS PSNs included First Coast Advantage,

Access, Pediatric Associates, Children's Medical Services, Florida Net Pass and South Community Care Network.

One of the significant changes this year was continued reduction in cost sharing. Finally, many plans choose to distinguish themselves by adding services not currently covered by Medicaid. In the contract these are referred to as expanded services. In total, there were 11 different expanded benefits offered by Reform health plans for the upcoming contract year beginning on September 1, 2007. The two most popular expanded services offered were the same as last year's, the over-the-counter (OTC) drug benefits and adult preventative dental benefits. Four of the customized benefit packages expanded their OTC value from $10 to $25, while another 4 added a $25 OTC benefit. The expanded services available to beneficiaries in September 2007 include the following, which were continued from last year:

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

The following expanded benefits were added this year:

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

One expanded benefit that was dropped this year was the Complimentary/Alternative Medicine benefit.

3. Grievance Process

Background

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

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

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

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

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

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

Current Activities

During the fourth quarter, no formal grievances were filed with the Agency for HMO or FFS PSNs. The fourth quarterly report on enrollee (or provider) grievances and appeals is due to the Agency on July 15, 2007.

4. Complaint/Issue Resolution Process

While the Agency receives requests for assistance and complaint resolution from beneficiaries and providers and processes these, there has been no formal process for the collection of this data. With the implementation of Medicaid Reform, the Agency put together a workgroup to develop a single database for housing and reporting on complaints and issues. The Agency currently defines complaints/issues as expressions of dissatisfaction, including dissatisfaction with the administration, claims, practices or provisions of services, which relates to the quality of care provided through health plan contracts; is submitted to the Agency; and cannot be resolved by speaking to the complainant. Managed care complaints/issues are not requests for customer service; however, if Agency staff judges such requests as requiring special treatment due to the

caller's demeanor or point of reference, then that would be considered a complaint/issue.

Complaints/issues provide the Agency with feedback regarding what is working and not working in managed care and Medicaid Reform. Complaints/issues come to the Agency from beneficiaries, advocates, providers and other stakeholders. They are worked by area and headquarters staff depending on the nature and complexity of the issue/complaint. Some complaints/issues are referred to the health plan for resolution. Tracking complaints/issues in a single database will provide the Agency with the ability to more easily identify trends in problem areas. While this has been done informally in the past, a more formal process is being developed to ensure that this information is tapped for all of its intrinsic value.

In the fourth quarter of operation, the Agency received 8 complaints/issues related to FFS PSNs and 37 complaints/issues received related to HMOs. The complaints/issues received during the fourth quarter are provided below, sorted by PSN or HMO. Table 3 provides the details on the complaints/issues related to FFS PSNs and outlines the action that was undertaken by the Agency or the Agency's Fiscal Agent, ACS, to address the issues raised.

Table 3
PSN Complaints/Issues

PSN Informal Issue	Action Taken
1. PSN provider issue regarding PSN lack of timely claims payment (020)	At the PSN's request, the Agency's Headquarters (HQ) staff submitted a customer service request (CSR) to allow provider to submit claims directly to Florida Medicaid's Fiscal Agent. The provider was advised to correct tax ID information on his Florida Medicaid provider file. HQ staff periodically checked with Medicaid Contract Management staff until CSR was implemented. Then, notified PSN and Area Office staff, who notified provider.
2. PSN provider issue regarding multiple PSNs' lack of timely claims payment (021)	The Agency's HQ staff facilitated review with each PSN and provider. The Agency's HQ and PSNs educated provider on how to properly reconcile payments received. Both PSNs educated the provider on how to properly and fully complete claim forms. The Agency's HQ staff provided information on how to order new CMS-1500 claim forms.
3. PSN provider issue regarding PSN lack of timely claims payment (022)	The Agency's HQ staff facilitated review with PSN, provider, and Medicaid Area Office staff. Provider was educated regarding timelines by which the PSN submits claims to Florida Medicaid's Fiscal Agent. Provider revised its billing process accordingly.
4. PSN provider issue regarding PSN lack of timely claims payment (023)	The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms.

Table 3 PSN Complaints/Issues	
PSN Informal Issue	**Action Taken**
5. PSN provider issue regarding multiple PSNs' lack of timely claims payment (024)	The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and the Medicaid Contract Management staff. Provider educated on how to properly and fully complete claim forms. PSNs submitted corrective action plan to ensure proper education and processing by their subcontracted claims managing entities.
6. PSN provider issue regarding multiple PSNs' lack of timely claims payment (025)	The Agency's HQ staff facilitated review with each PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Florida Medicaid's Fiscal Agent reprocessed claims impacted by a recent system issue. PSNs identified keying errors and resubmitted impacted claims.
7. PSN provider issue regarding PSN lack of timely claims payment (026)	The Agency's HQ staff facilitated review with PSN and provider. Provider educated on how to properly reconcile payments received. PSN identified keying errors and resubmitted impacted claims.
8. PSN provider issue regarding PSN lack of timely claims payment (027)	The Agency's HQ staff facilitated review with PSN, provider, Medicaid Area Office staff, and Medicaid Contract Management staff. Area Office staff processed backlog of paper claims. The PSN submitted corrective action plan to ensure proper education and processing by their subcontracted claims managing entities.

During the fourth quarter, PSN complaints/issues have involved mostly therapy providers and behavioral health providers. Complaints/issues indicate the need for increased provider training on claim completion and processing for these types of providers and an increased need for PSNs to ensure their systems continued to work correctly and notify providers of claims issues. The Agency facilitated conference calls between the providers and the PSNs in order to ensure that providers were appropriately informed and health plans revised their systems or processes and/or worked with subcontractors (particularly in the behavioral health area) to ensure all staff knew the appropriate procedures and processes involved. No PSN beneficiary complaints were received at the Agency.

Since the complaints/issues the Agency received regarding the PSNs involved claims processing, staff reviewed the expansion efforts of Access Health Solutions to ensure appropriate additions had been made in their provider training to address the claims processing activities and reporting that were unique to the fee-for-service PSN and would be helpful for new providers joining the PSN in the new expansion counties.

Table 4 provides the details on the complaints/issues related to HMOs and outlines the action that was undertaken by the Agency or the Agency's Fiscal Agent, ACS, to address the complaints/issues raised.

Table 4 HMO Complaints/Issues	
HMO Informal Issue	**Action Taken**
1. HMO member's mother wants to enroll her child into another plan because her PCP does not accept her current plan (7093-03)	HMO member's current HMO was contacted and has authorized two visits with member's PCP and agreed to give more if needed. Child will be enrolled into mother's plan of choice effective 5/1/07.
2. HMO member has been waiting enrollment into plan since January, 2007 (7093-04)	HMO member was enrolled in the plan effective 4/1/07.
3. HMO member is having issues receiving a referral to see a specialist. Member also wants to file a grievance with the plan (7095-04)	The HMO contacted member to assist in finding a specialist. An out of network provider was offered, but member did not want to travel that far. A grievance with the health plan was never filed.
4. HMO member is unable to finish ongoing treatment to his teeth because provider stopped accepting Medicaid (7096-03)	The HMO was contacted and they instructed the member to file a grievance with the dental network. The dental network was contacted and stated they did receive the grievance and are working on the issue.
5. HMO member needs authorization to go to Texas Children's Hospital for heart/lung transplant (7096-05)	The HMO was contacted and agreed to cover case management and transportation.
6. Hospital is having issues getting an authorization on a HMO member; member is not showing on the HMO's enrollment system (7101-02)	The HMO was contacted and stated that the member was in their system and the issue was human failure. Authorization for services has been approved.
7. HMO claim is being denied. (7101-03)	The HMO was contacted and stated the member was not enrolled with them. Our records indicate the member is enrolled in the plan and they were asked to update the member's file. The plan has updated their records and the claim was paid.
8. HMO member is in need of a liver transplant (7106-01)	The HMO was contacted and the member has been approved for a transplant and is currently the first on the transplant list.
9. HMO member is in need of a liver transplant (7106-02)	The HMO was contacted and confirmed that the member has been authorized and is in case management.

Table 4 HMO Complaints/Issues	
HMO Informal Issue	**Action Taken**
10. HMO member was mistreated by their HMO and had questions about over the counter drugs and reimbursement (7107-02)	A representative of the HMO contacted the member and assisted her with ordering her over the counter items and provided information about reimbursement.
11. HMO member was denied drugs (7109-01)	The HMO was contacted and agreed to provide enough medication to get the member through until his appointment. The doctor will then write a full prescription.
12. Complaint against transportation provider's phone line (7109-03)	A wrong number was being dialed in order to get in touch with transportation provider. The HMO member was sent the correct number and was able to get through.
13. HMO member is in need of a liver transplant (7110-01)	The HMO was contacted and confirmed that the member has been authorized and is in case management.
14. HMO member mother needs dental care for her children and is being denied by their current HMO because of county change (7116-03)	The HMO member's mother called Choice Counseling for a plan change but they were unable to process the request. We emailed Choice Counseling to look into this issue because the current plan is not covered in the member's new county. Member was contacted by Medicaid Options and a plan change has been made so they will be able to receive the dental care.
15. HMO member is having problems receiving drugs from their plan (7123-02)	The HMO was contacted and provided limited authorization for the medication with instruction for member to receive further evaluation. A representative from the plan contacted the guardian of the member about the concerns with the medication prescribed.
16. HMO member having issues getting authorization for dental needs (7124-01)	The HMO was contacted and sent a copy of the dental contract.
17. HMO member is not showing as being enrolled with the HMO (7124-04)	The HMO was contacted and has corrected their system to show member as enrolled.
18. HMO member has high risk pregnancy and the hospital does not accept her plan (7128-01)	The HMO member has changed her plan.
19. HMO member needs to see a specialist and none are available in area (7135-01)	The HMO member does not want to travel out of area to see a specialist. The HMO was contacted and has found a specialist within the area for the member to see.

Table 4 HMO Complaints/Issues	
HMO Informal Issue	**Action Taken**
20. HMO member wants to enroll into plan but is being declined (7137-01)	The HMO member was enrolled into desired plan effective June 1, 2007.
21. HMO member is being billed for services that should be covered by plan (7138-01)	The HMO was contacted and corrected eligibility, reprocessed the claims and contacted the member mom for closure.
22. HMO member is having problems receiving drugs (7142-02)	The prescribing physician did not obtain the prior authorization for the increase in the medication. The HMO was contacted and stated that the authorization is good for a year. The HMO contacted member's mother to inform her that the medication was ready for pick up at the pharmacy.
23. HMO member wants to change plans (7144-02)	The HMO was contacted and will be going to member's home to assist in the application process.
24. HMO member was removed from transplant list due to change in plan (7145-01)	The new HMO is case managing the member and is awaiting reactivation on the waiting list. At this point, no further action is required.
25. HMO member wants to change plans (7145-05)	The HMO member has been enrolled into a new plan effective June 1, 2007
26. HMO member is having problems continuing their care from a specialist (7145-06)	The HMO spoke with the specialist and he has agreed to continue treating patients that he was seeing prior to implementation of Medicaid Reform.
27. HMO provider's claims are being denied (7149-01)	HMO claims were adjusted by plan and paid.
28. HMO member was in the process of dental care when provider was banned from participation in Medicaid (7152-01)	The HMO member was unable to get in contact with the dental provider in the middle of his dental care. The dentist has been banned from participation in Medicaid or Medicare per Emergency Suspension Order on August 13, 2002. Member filed for a Medicaid Fair Hearing, but withdrew his request. The HMO member stated that he has gone through the grievance process with the plan, but the plan ended the process and retained counsel. The HMO member is considering a medical malpractice suit, but really just wants appropriate dental care. The dental network has referred this case to Medicaid Fraud.
29. HMO member wants clear fillings from dental provider (7152-04)	The HMO was contacted and explained that clear fillings are not covered. The dental network then contacted the member to explain what types of fillings are covered.
30. HMO member is having issues getting dental network to fund his procedures (7152-06)	The HMO was contacted and per dental network, the services the HMO member is seeking are not covered under the HMO. Member is no longer concerned with his dental issues and will be switching back to his previous plan.

Table 4 HMO Complaints/Issues	
HMO Informal Issue	**Action Taken**
31. HMO member needs ID card (7152-07)	The HMO contacted the member and verified address to send another ID card. The HMO also faxed member's eligibility verification to their PCP.
32. HMO member is having issues finding an Ob/Gyn that specializes in cancer treatment (7162-05)	The HMO member has filed a grievance with the HMO. The HMO contacted the member to refer her to an Ob/Gyn, but they do not specialize in her condition. The HMO found another Ob/Gyn that the member will be seeing.
33. HMO member is seeking a good cause plan change because current plan can not provide a specialist (7166-07)	The HMO contacted member via letter and informed her that there is no authorization on file and to contact her PCP. The HMO also contacted the member by phone and explained to her that they need an authorization request from her PCP. Information was forwarded to Choice Counseling to make final determination.
34. HMO member needs ID card and a member handbook (7169-06)	The HMO contacted the member and left several messages. The HMO has sent member a new ID card and member materials.
35. HMO member has reached his prescription cap and is in need of more medication (7170-22)	The pharmacy has re-run all of the claims and has contacted the member. For the entire month of May 2007, the member received case management and had his/her prescriptions filled. The recipient changed plans with an effective date of June 1, 2007.
36. HMO member needs to see a doctor and wants to file a grievance with her plan (7180-01)	The HMO contacted the member and informed her that she does not have a PCP (even though there is a name on her ID card) and to go to the emergency room. The member asked to speak to a supervisor to complain and was told no one was there and they would not let her speak to someone to file a grievance. The Agency HQ staff contacted the HMO and they stated the issue has been handled and resolved and the member reported she was satisfied.
37. HMO member is having issues getting drugs authorized (7190-01)	The HMO member's mother stated that she has submitted all necessary paperwork to the HMO in order for her son to receive this medication. E-mail was sent to the HMO requesting that they honor a 30 day prescription until further evaluation can be conducted. The HMO did honor the 30 day prescription and the authorization will be good for one year unless the doctor changes the dosage. Mother is satisfied with ending results.

During the fourth quarter, the complaints the Agency received regarding HMOs were largely member issues. These complaints centered around member enrollment, requests to disenroll from a plan, requests for assistance in obtaining a plan ID card and/or plan handbook. All HMO complaints regarding a member having difficulty selecting a primary care provider, or obtaining covered services were resolved promptly, most within one day, and the member received the necessary service and if indicated, was referred to an appropriate provider. There were few complaints regarding provider payment issues and those particular complaints were resolved with the provider

receiving payment. The types of HMO complaints reported are consistent with capitated managed health care plan performance in the non-reform areas and reflect operational issues rather than implementation issues.

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

5. Other Operational Issues

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

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

- Continuously updating the Medicaid Reform website to ensure the public, including beneficiaries and interested providers, have a place to obtain the most recent information available. Such information updates for this quarter included the Medicaid Reform Data Book, Florida Medicaid Reform Plan Evaluation Tool information, draft Reform capitation rates for September 1, 2007, and plan provider relations contact information.

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

- Finalizing the transition process for current beneficiaries in Baker, Clay and Nassau Counties to ensure that transition runs smoothly. While the volume of transitioning members is low compared to the first year of Reform, discussion occurred to ensure that the volume of transitioning beneficiaries in any given month would not be impeded by the limits of the Choice Counseling Program vendor. Ultimately, the Agency determined a three-month transition plan was appropriate for the number of beneficiaries transitioning.

- Determining the appropriate method of beneficiary notice for plans that changed their benefits beginning the second year of Reform (beginning September 1, 2007). The Agency determined that it would provide explicit language for health plans to use in their letters to their members advising them of benefit changes. The letters the health plans will use to notify members of any decrease or elimination of benefit(s) will include notice that the member may choose another health plan by calling the Medicaid Reform Choice Counseling Helpline.

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

- Providing additional technical assistance through regularly scheduled conference calls with the Reform plans to provide additional information on particular implementation topics such as: provider file and enrollment file transmissions, encounter data submission, enhanced benefit design, claims processing, prescribed pediatric extended care (PPEC) services and claims file submissions.

6. Outreach Activities for Baker, Clay, & Nassau Counties

During the quarter, the Agency continued its effort to communicate with the beneficiaries, providers and health plans in the Medicaid Reform Waiver expansion counties of Baker, Clay and Nassau. In April 2007, the Agency conducted the last scheduled general Medicaid Reform workshop for interested Medicaid providers. For MediPass providers who have not yet attended one of the scheduled workshops, the Agency continues the outreach efforts via the telephone in order to set up additional/individual workshop sessions. The Agency also published an article in the Medicaid Provider Bulletin to remind providers of the Medicaid Reform expansion date, inform providers of the current status of Reform activities, encourage providers to contact the health care plans who intend to participate in reform and explore network opportunities, and to encourage providers to contact the agency for more information.

The Agency also conducted an outreach campaign to target Medicaid beneficiaries. All beneficiaries required to participate in Medicaid Reform in the expansion counties of Baker, Clay, and Nassau were mailed a second letter, Medicaid Reform Brochure, and a training schedule to encourage attendance at local Medicaid Reform workshops. During the quarter, the Agency conducted 30 Medicaid Reform workshops for interested Medicaid beneficiaries. Attachment I shows a detailed list of the outreach meetings, the target audience, the meeting location, and the number of attendees participating during this quarter. The list of topics covered during the outreach meeting is provided below.

- General Overview of Medicaid Reform
- Choice Counseling
- Enrollment Process
- Preparation Process
- Participating Eligibility Categories
- Enhanced Benefits
- Opt-Out Option
- Customized Benefit Packages

Medicaid Reform information targeted at beneficiaries was also posted to the Agency website. The Agency has continued to provide technical assistance to potential health care plans.

Next quarter, the Agency will transition outreach efforts from an Agency directed outreach campaign to a choice counseling campaign conducted by the choice counseling vendor. Agency staff will continue to assist providers, beneficiaries, and advocates via the Agency call centers and in conjunction with choice counseling outreach events.

B. Choice Counseling Program

Current Activities

Public Meetings and Focus Groups

At the beginning of the fourth quarter, the Agency and the Agency's Choice Counseling vendor, Affiliated Computer Services (ACS), were in process of finalizing the call center and field scripts and the re-design of the Choice Counseling enrollment materials. During the third quarter, the Agency had conducted beneficiary focus groups and held public meetings in Broward and Duval counties to solicit input on the material re-design. As a result of the feedback from beneficiary focus groups and public meetings, a second design of the new materials was created and presented at a second round of public meetings in April 2007. For interested parties that could not attend the meeting, the Agency posted the draft of the new materials on the Medicaid Reform website and also posted the comments offered at each of the public meetings. The documents are posted at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/beneficiary/index.shtml

Following the April public meeting, the Agency made a final round of changes to the materials and posted the final design on the website. An email was sent to all individuals who attended the public meetings in February and April notifying them that the final design was now posted on the website for final comment. Following the comment period, the materials were printed and began being mailed to beneficiaries in June 2007.

In addition to the public meetings on the materials, the Agency and ACS continued collecting the feedback on the Choice Counseling process in Broward and Duval Counties. During the second and third quarter, the feedback was primarily collected through focus groups with beneficiaries. During the fourth quarter, the Agency focused on soliciting input from the field and call center Choice Counselors. This input was obtained through a series of focus groups with certified Choice Counselors. The focus groups were again facilitated by representatives from the Agency's consulting group, Alicia Smith & Associates.

Discussions during the focus group focused on an evaluation of the Choice Counseling Program from the counselors who interact with beneficiaries as a part of their daily work. The Choice Counselors were asked to discuss successes, obstacles, areas that need improvement, barriers that beneficiaries or the counselors have encountered and more. Several comments received during the focus groups resulted in modifications to the new script. The scripts were finalized in June 2007 and are now in use by the Choice Counselors. A follow-up meeting with the Choice Counselors is scheduled for July 2007 to evaluate the experience with the new script and to make any changes necessary.

Call Center

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

The biggest change for the call center during the fourth quarter was the implementation of the new call center script. The script contains many changes to the opt-out component, the section on how to pick a plan, enhanced benefits and caller verification. The new script will be used for a month before an evaluation meeting with be conducted to make any additional changes that are necessary.

The call center also continued to take calls from beneficiaries in Baker, Clay and Nassau counties. The call center will answer questions on Medicaid Reform, help a beneficiary understand if he/she would be required to enroll in reform and the timeframes for when the beneficiary can expect to receive the blue and green “check it out” packet. The call center will begin taking enrollment calls during July 2007.

During the fourth quarter, the Agency and ACS began discussion to evaluate the effectiveness of the hours of operation for the call center. In the first year of operation, the number of calls received on Saturdays remained very low. The Agency and ACS are evaluating whether extending the call center hours by one hour in the evenings and eliminating Saturday may better serve the needs of the beneficiaries.

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

The call center experienced a reduction in inbound calls during late May and early June 2007. The drop in calls resulted in fewer enrollment activities being processed through inbound calls. ACS had to quickly adapt strategies to conduct more outbound calls and utilize the field Choice Counselors to proactively try and reach more beneficiaries to maintain the contractual voluntary enrollment rate standard. ACS was able to exceed the contractual standard for the voluntary enrollment rate during the timeframe, but this inbound call trend during this timeframe will be tracked so during the next year ACS will be able to prepare for an anticipated drop in inbound calls. Attachment II details the call center activity for the entire fourth quarter. The following is a highlight of the call volume during the quarter and ACS's performance on key contract standards:

Inbound Calls:	37,074
Outbound Calls:	8,914

Calls Abandoned:
(The contract standard is <5% *monthly)* .38%

Calls Answered within 4 rings: 100.00%

Call Answer Rate:

Call Answered in <15 seconds:	89.23%
Calls Answered in <60 seconds:	97.32%
Calls Answered in <180 Seconds:	99.58%

Mail

The volume of activity in the mailroom remained steady during the fourth quarter. With the ending of transition the mailing of transition packets reduced volumes for two months, but by the end of the fourth quarter the first open enrollment mailings started for beneficiaries entering their annual right to change period.

Outbound Mail

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

New-Eligible Packets	17,284
Auto-Assignment Letters	14,734
Confirmation Letters	7,975
Open Enrollment Packets	2,641

In the fourth quarter, the percentage of mail that is returned averaged 4.13 percent per month. This average number is lower than the approximately 6.7 percent return mail rate in the first three quarters of Medicaid Reform. ACS will continue to monitor the return mail rate to determine if the drop is a trend or just a temporary drop in percentage. When returned mail is received, the Choice Counseling staff accesses the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary.

Inbound Mail:

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

Plan Enrollments	964
Plan Changes	346

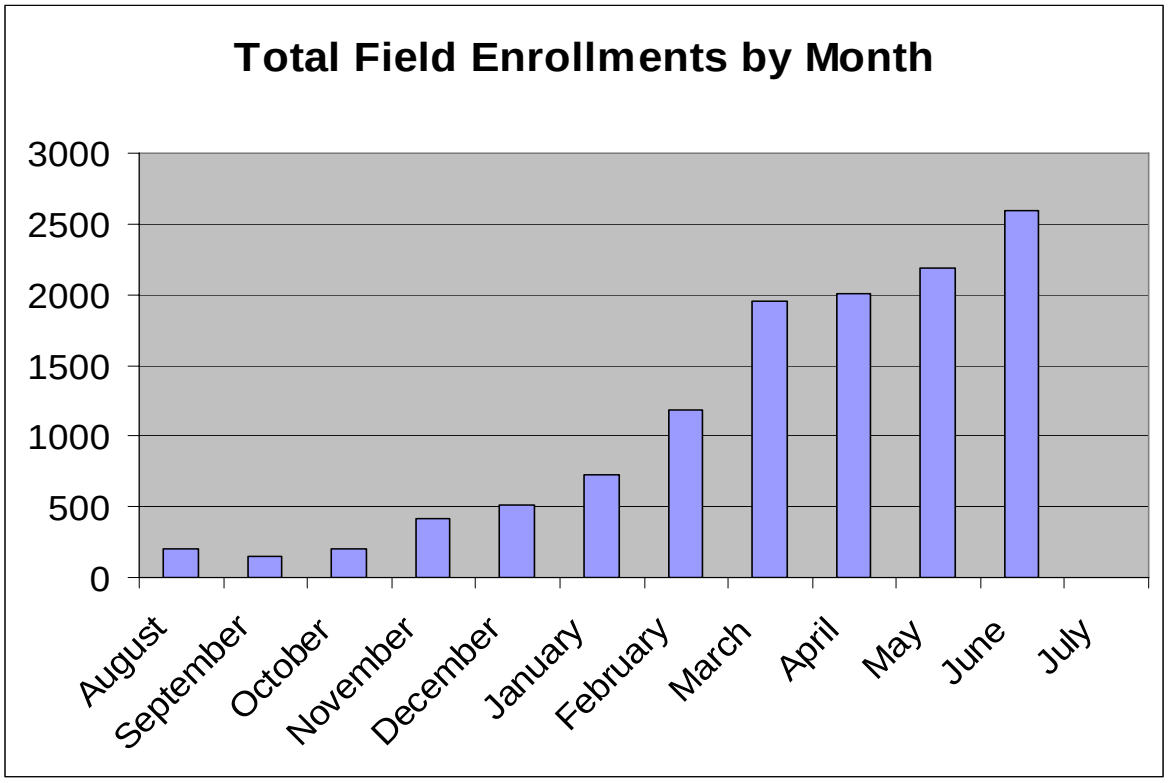
The percentage of enrollments processed through the mail-in enrollment forms has consistently remained around 5% of enrollments during the first year. The Agency and ACS are exploring options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of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

Face-to-Face/Outreach and Education

The fourth quarter continued the dramatic increase in the number of enrollments completed by the field Choice Counselors. During the second quarter, the face-to-face portion of the Choice Counseling Program began a major shift away from public or group sessions to one-on-one sessions, supporting the call center in conducting outbound calls and follow-up visits to the homes of beneficiaries who have no phone and have not responded to the mailings. This change in focus continued in the third and fourth quarters and the change continues to demonstrate outstanding results.

At the end of the fourth quarter, the enrollment activities processed by a field Choice Counselor increased from 3,951 enrollment activities to 6,921. The table 5 demonstrates the dramatic increases in the field Choice Counseling effort during the third and fourth quarters:

Table 5
Total Field Enrollments by Month



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

As the fourth quarter was ending, ACS began meeting with community based organizations and providers in the expansion counties of Baker, Clay and Nassau. ACS also created the initial schedule of field Choice Counseling sessions for beneficiaries. Due to the rural nature of especially two of these counties, the Agency and ACS will closely monitor the field efforts during the first few months of expansion to identify issues and change strategies if necessary to meet the needs of rural communities.

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

Group Sessions	834
Private Sessions	127
Home Visits & One-On-One Sessions	113
“No Phone List”	934
Outbound Phone List	8,473
Enrollments	6,921
Plan Changes	196

Health Literacy

During the fourth quarter, the Agency and ACS continued development of the health literacy and health disparity function of the Choice Counseling Program. The new script further developed the expertise of the Choice Counselors in educating the beneficiaries on how to pick a health plan. This information will be an asset to the beneficiaries whether they continue to participate in Medicaid or someday transition to commercial or private market insurance. The script also enhances the efforts to help Medicaid beneficiaries understand what it means to be part of a managed care plan. The call center and field scripts include language that describes the role of a primary care doctor, how that doctor coordinates all other necessary care, how the beneficiary will use a network of doctors, and more. In addition, when a beneficiary enrolls, the follow-up confirmation letter encourages the beneficiary to make an appointment with his or

her doctor and again provides a statement of understanding regarding what it means to be enrolled in managed care.

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

The work done by the Special Needs Unit continues to be one of the biggest areas where the Choice Counseling Program is addressing health disparities and health literacy. The registered nurse in this unit personally assists beneficiaries with complex needs understand how to make a health plan choice and understanding how to access care. The nurse will conduct a three-way call with the beneficiary and the health plan to assist the beneficiary in making a plan choice. The nurse will be on the phone to ensure the beneficiary understands the information being provided by the plan and knows how to access care once they are enrolled. ACS is now in the process of hiring a second registered nurse to serve complex beneficiaries.

Voluntary Selection Data

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

During the fourth quarter of operation, the voluntary enrollment rate for both Reform counties was 74.63 percent of all new eligibles. For Duval County, the rate was 70.13 percent and for Broward County the rate was 77.72 percent. ACS was above the contract standard of 65 percent for the quarter, but the Agency is especially pleased with the April voluntary enrollment rate of 82 percent. A breakdown of the new-eligible enrollment figures for the fourth quarter is provided in Table 5.

Table 5 New Eligible Voluntary Enrollment Rate Fourth Quarter	
Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Broward County	
Voluntary Choice	11,413
Auto-Assigned	3,271

Table 5 New Eligible Voluntary Enrollment Rate Fourth Quarter	
Duval County	
Voluntary Choice	7,082
Auto-Assigned	3,017
Voluntary Enrollment Rate:	
Broward and Duval Combined	74.63%
Broward only	77.72%
Duval only	70.13%

Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the call center, Agency headquarters or the Medicaid Area Office. During the fourth quarter, the Agency and ACS began preparations to implement an automated beneficiary survey where complaints against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call.

In the fourth quarter, there were 18 complaints filed related to the Choice Counseling Program. Table 6 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 6 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
1. Beneficiary called to complain that son's enrollment did not begin on April 1, 2007.	➲ The enrollment was submitted to the Florida Medicaid System for processing and encountered an error during processing. Enrollment was sent again for an effective date of May 1, 2007. The Agency is investigating why Medicaid system rejected the enrollment transaction.
2. Beneficiary called stating that a choice counselor had a bad attitude during the phone call.	➲ The counselor was required to complete refresher training and put on employee corrective action. Counselor will be placed on increased monitoring and if future incidents occur the appropriate management action will be taken.
3. Beneficiary called to complain they had to contact Choice Counseling three times to get the right information.	➲ Research revealed two counselors were involved. These counselors were coached and put on increased monitoring. Supervisors contacted the beneficiary to apologize and an apology letter was also sent to the beneficiary.
4. Consumer organization inquired about tracking of ADA requests and complaints, if any beneficiaries with disabilities have submitted a complaint and who is responsible for outreach to the disabled community.	➲ The Choice Counselor vendor (ACS) is responsible for tracking and providing ADA requests. ACS is also responsible for outreach to disabled beneficiaries. There have been no complaints received from disabled beneficiaries regarding ADA issues.

Table 6 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
5. Consumer organization expressed concerns about Choice Counselors not having access to each plan's Preferred Drug List. Also expressed concerns about beneficiary verification process that Choice Counseling uses and concerns about beneficiaries who are auto-assigned to a plan.	➲ Beneficiaries can access information on each plan's Preferred Drug List on the internet and also by contacting the plan. The Special Needs Unit will assist the medically complex beneficiaries. The Agency continues to explore if this component should be added to the Choice Counseling services. In addition, choice counselors are now capturing the drugs a beneficiary reports he/she is taking. That information is sent to the plan on the monthly enrollment report so the plan is aware just prior to the enrollment effective date the medications new members are currently taking. ➲ Explained the verification process and asked for specific examples of individuals who had trouble so research could be conducted. ➲ Explained that voluntary enrollment rate average is well above the 65 percent contract standard, but the Agency is analyzing individuals who are auto-assigned to see if any trends can be identified.
6. Consumer organization complained that foster care and other voluntary populations are being required to enroll in reform plans.	➲ In some cases updates from other Agencies on foster care status or other pertinent information is not received in a timely fashion which results in the system identifying these individuals as mandatory populations. There are manual processes the choice counselor and the Agency can complete to prevent enrollment if that is the beneficiaries wish. Asked for specific information on individuals who were required to enroll so research can be conducted.
7. Consumer organization expressed concerns about Choice Counselors not having access to each plan's Preferred Drug List and other information on plan benefit limits, prior authorizations processes, etc.	➲ Beneficiaries can access information on each plan's Preferred Drug List on the internet and also by contacting the plan. The Special Needs Unit will assist the medically complex beneficiaries. The Agency continues to explore if this component should be added to the Choice Counseling services. In addition, choice counselors are now capturing the drugs a beneficiary reports he/she is taking. That information is sent to the plan on the monthly enrollment report so the plan is aware just prior to the enrollment effective date the medications new members are currently taking. ➲ Explained the changes in the upcoming script to provide some additional detail/explanation on plan's benefits through the Choice Counselors, but that complete details will need to be received by prospective plans in order to ensure that the plan's procedures, limitations, etc., are explain accurately to the beneficiary.

Table 6 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
8. Consumer organization stated that choice counseling script did not provide enough information for non-mandatory populations, especially those that have developmental disabilities.	➲ Additional prompts and language was added to the script to address the developmental disabilities population.
9. Consumer organization inquired about the timeline for transition to the Children's Medical Services plan in Duval and language in the letters.	➲ Dates for the mailing and copies of the letters were provided.
10. Consumer organization expressed concern about lack of information on good cause plan change process.	➲ Process was explained and a list of reasons and what organization approves the good cause request was provided.
11. Consumer organization inquired about who had the authority to make plan enrollment decisions for foster care children.	➲ Provided language from the choice counseling script regarding foster care and adoption subsidy children which explains who has the authority to make enrollment decisions.
12. Consumer organization inquired about the status of the new material design.	➲ Provided an update on the status and referred them to the Agency website for copies of the drafts and also for comments from the public meetings conducted to discuss the materials.
13. Beneficiary complained that a session was scheduled with a field counselor and no one showed up.	➲ No record in the system of the request for a session by this beneficiary. Field supervisor contacted the beneficiary to follow-up on complaint and to assist the beneficiary.
14. Complaint that a plan change did not process.	➲ Choice Counselor used the multi-activity button when trying to cancel an activity for the caller. This caused the activity to be cancelled for all case members. Counselor was coached on appropriate use of multi-activity button.
15. Beneficiary states they are developmentally disabled and should not be required to enroll.	➲ Indicator for developmentally disabled is not populated. Field supervisor and special needs unit were asked to follow-up.
16. Beneficiary stated they were referred to Social Security Administration by a choice counselor to get a new Medicaid ID card.	➲ Choice Counselor was coached on incorrect referrals.
17. Beneficiary called regarding enrollment form being mailed in and not processed.	➲ Mother applied for KidCare and was contacting a Choice Counselor to follow-up on the application. KidCare application has a place for plan selection. Child was screened for Medicaid and the mother had not yet selected a plan through choice counseling.
18. Beneficiary complained that Choice Counselor was rude during the call.	➲ Choice Counselor was placed on employee corrective action and also placed on increased monitoring. Refresher training will be provided and additional incidents will result in appropriate management action being taken.

Quality Improvement

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

The feedback received in these various forums has resulted in issues being raised that have not been validated by beneficiaries. For example, many express concerns over the lack of pharmacy information being available through Choice Counseling. The beneficiary focus groups have not supported this concern, but the number of beneficiaries that can be reached through focus groups is not representative of the reform population. As a result of the issues, during the fourth quarter, the Agency and ACS began developing an automated survey that will be a part of the Choice Counseling call center. Beneficiaries who call the toll-free Choice Counseling helpline will be given the opportunity to participate in an automated survey at the end of the call. The survey will have questions relating to the quality of customer service provided by the Choice Counselors but will also contain questions on “hot topics” or areas of interest. Issues that have been raised that have not been validated will be included in the survey questions after implementation. This will allow the Agency to hear from hundreds of beneficiaries on particular issues and make changes necessary in the program and also provide valuable feedback to interested parties.

As the fourth quarter ended, the first draft of survey questions had been reviewed and edits provided to ACS. The anticipated date of implementation is late July 2007 and the anticipated date when the first “hot topic” will be added to the survey is late August 2007 or early September 2007.

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

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

C. Enrollment Data

Background

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

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

- **Noncommitted MediPass:** Phased in over 7 months (1/2 in Month 1, then 1/6th in each following month)
- **HMO Population:** 1/12 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 operation of the Medicaid Reform program, enrollment in Reform health plans was based on this transitional process. Specifically, the July 2006 transition focused on enrollment of newly eligible beneficiaries and half of the MediPass population who were required to transition to a Reform health plan. Beneficiaries had 30 days to select a plan. If the beneficiary did not choose a plan, then the Choice Counselor assigned them to a plan. The earliest date of enrollment in a Reform health plan was September 1, 2006. During the second, third, and fourth quarters of operation, enrollment in Medicaid Reform increased greatly as more existing beneficiaries were transitioned into the program.

Current Activities

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

Below is a summary of the monthly enrollment reports for the fourth quarter of the Medicaid Reform program – April 1, 2007 through June 30, 2007. This report contains the following enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment Report by County

- Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data

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

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 7 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 7
Medicaid Reform Enrollment Report Descriptions

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

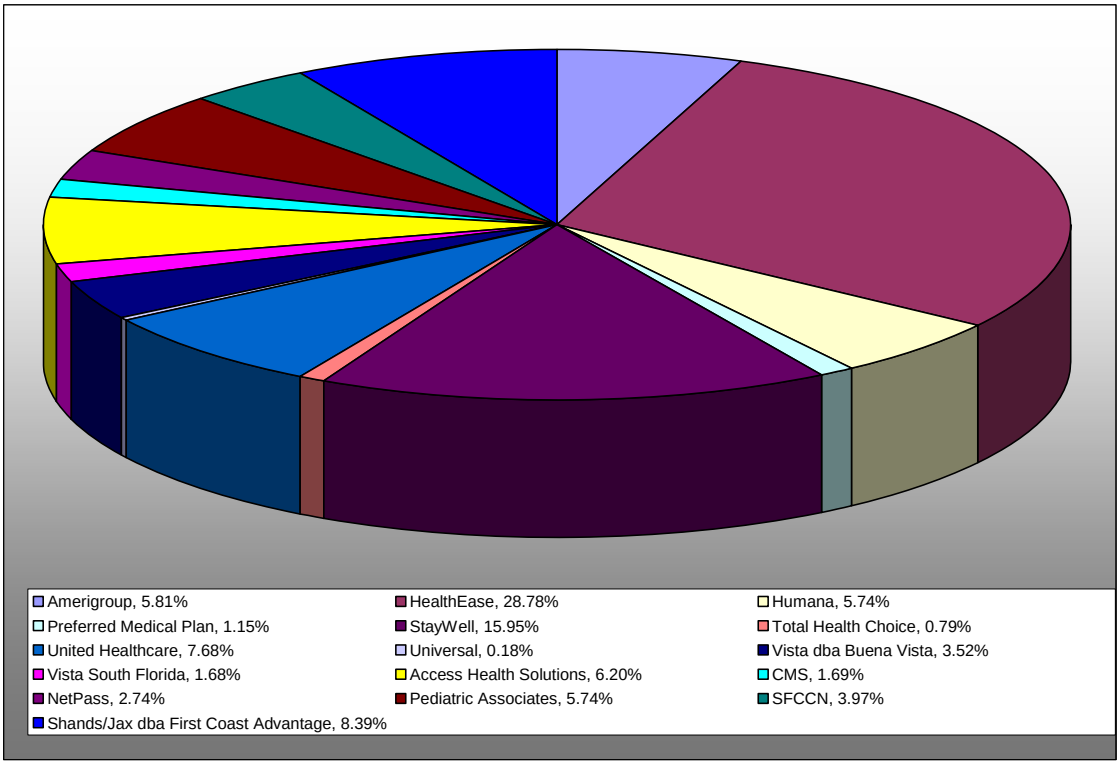
The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 8 for the State Fiscal Year 2006-07, 4th Quarter Reform Enrollment Report.

Table 8
Medicaid Reform Enrollment Report (State Fiscal Year 2006-07, 4th Quarter)

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	9,958	1,318	2	87	**11,365**	**5.81%**	10,365	10%
HealthEase	HMO	50,143	5,754	2	403	**56,302**	**28.78%**	53,302	6%
Humana	HMO	8,985	2,073	5	158	**11,221**	**5.74%**	11,194	0%
Preferred Medical Plan	HMO	1,725	494	0	35	**2,254**	**1.15%**	2,302	-2%
StayWell	HMO	28,151	2,813	3	227	**31,194**	**15.95%**	27,136	15%
Total Health Choice	HMO	1,239	274	0	23	**1,536**	**0.79%**	1,298	18%
United Healthcare	HMO	12,945	1,861	4	206	**15,016**	**7.68%**	12,696	18%
Universal Healthcare	HMO	310	44	0	1	**355**	**0.18%**	14	2,436%
Vista dba Buena Vista	HMO	6,160	682	1	40	**6,883**	**3.52%**	6,825	1%
Vista South Florida	HMO	2,887	353	1	41	**3,282**	**1.68%**	2,474	33%
HMO Totals		122,503	15,666	18	1,221	**139,408**	**71.27%**	127,606	9%
Access Health Solutions	PSN	9,791	2,243	1	86	**12,121**	**6.20%**	12,263	-1%
CMS	PSN	1,371	1,929	0	11	**3,311**	**1.69%**	2,087	59%
NetPass	PSN	3,705	1,555	0	92	**5,352**	**2.74%**	5,658	-5%
Pediatric Associates	PSN	10,647	586	0	0	**11,233**	**5.74%**	11,423	-2%
SFCCN	PSN	5,315	2,334	1	111	**7,761**	**3.97%**	8,012	-3%
Shands/Jax dba First Coast Advantage	PSN	12,653	3,587	2	174	**16,416**	**8.39%**	15,482	6%
PSN Totals		43,482	12,234	4	474	**56,194**	**28.73%**	54,925	2%
Reform Enrollment Totals		**165,985**	**27,900**	**22**	**1,695**	**195,602**	**100.00%**	**182,531**	**7%**

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

Chart A
Market Share for Medicaid Reform



The enrollment figures for the fourth quarter of State Fiscal Year 2006-07 reflect those individuals who voluntarily selected a health plan as well as those who were mandatorily assigned to one. In addition, many Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 195,602 beneficiaries enrolled in Medicaid Reform during the fourth quarter of State Fiscal Year 2006-07. There were 16 Reform plans with market shares ranging from 0.18 percent to 28.78 percent.

2. Medicaid Reform Enrollment Report by County

Medicaid Reform is currently operational in two counties: Broward and Duval. There are ten HMOs and five PSNs operating in Broward County, and there are four HMOs and three PSNs serving Duval County. The Medicaid Reform Enrollment Report by County section of this Quarterly Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Broward County plans are listed first, followed by Duval. Table 9 describes the columns of information that each Reform health plan provides to the Agency for this report.

Table 9 Medicaid Reform Enrollment Report by County Description	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled – No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in previous Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Change From Previous Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 10 and located on the following page.

Table 10
Medicaid Reform Enrollment Report by County
(State Fiscal Year 2006-07, 4th Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	Broward	9,958	1,318	2	87	**11,365**	**9.62%**	10,365	10%
HealthEase	HMO	Broward	14,203	1,492	1	93	**15,789**	**13.36%**	14,800	7%
Humana	HMO	Broward	8,985	2,073	5	158	**11,221**	**9.50%**	11,194	0%
Preferred Medical Plan	HMO	Broward	1,725	494	0	35	**2,254**	**1.91%**	2,302	-2%
StayWell	HMO	Broward	25,718	2,534	3	195	**28,450**	**24.08%**	25,148	13%
Total Health Choice	HMO	Broward	1,239	274	0	23	**1,536**	**1.30%**	1,298	18%
United Healthcare	HMO	Broward	5,259	960	1	128	**6,348**	**5.37%**	4,936	29%
Universal Healthcare	HMO	Broward	130	29	0	0	**159**	**0.13%**	4	3875%
Vista dba Buena Vista	HMO	Broward	6,160	682	1	40	**6,883**	**5.82%**	6,825	1%
Vista South Florida	HMO	Broward	2,887	353	1	41	**3,282**	**2.78%**	2,474	33%
Access Health Solutions	PSN	Broward	3,391	1,028	0	36	**4,455**	**3.77%**	4,818	-8%
CMS	PSN	Broward	805	1,270	0	9	**2,084**	**1.76%**	2,087	0%
Netpass	PSN	Broward	3,705	1,555	0	92	**5,352**	**4.53%**	5,658	-5%
Pediatric Associates	PSN	Broward	10,647	586	0	0	**11,233**	**9.51%**	11,423	-2%
SFCCN	PSN	Broward	5,315	2,334	1	111	**7,761**	**6.57%**	8,012	-3%
Total Reform Enrollment for Broward			**100,127**	**16,982**	**15**	**1,048**	**118,172**	**100.00%**	**111,344**	**6%**
HealthEase	HMO	Duval	35,940	4,262	1	310	40,513	52.32%	38,502	5%
StayWell	HMO	Duval	2,433	279	0	32	2,744	3.54%	1,988	38%
United Healthcare	HMO	Duval	7,686	901	3	78	8,668	11.19%	7,760	12%
Universal Healthcare	HMO	Duval	180	15	0	1	196	0.25%	10	1860%
Access Health Solutions	PSN	Duval	6,400	1,215	1	50	7,666	9.90%	7,445	3%
CMS	PSN	Duval	566	659	0	2	1,227	1.58%	0	
Shands/Jax dba First Coast Advantage	PSN	Duval	12,653	3,587	2	174	16,416	21.20%	15,482	6%
Total Reform Enrollment for Duval			**65,858**	**10,918**	**7**	**647**	**77,430**	**100.00%**	**71,187**	9%
Reform Enrollment Totals			**165,985**	**27,900**	**22**	**1,695**	**195,602**		**182,531**	**7%**

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

Chart B
Market Share for Medicaid Reform in Broward County

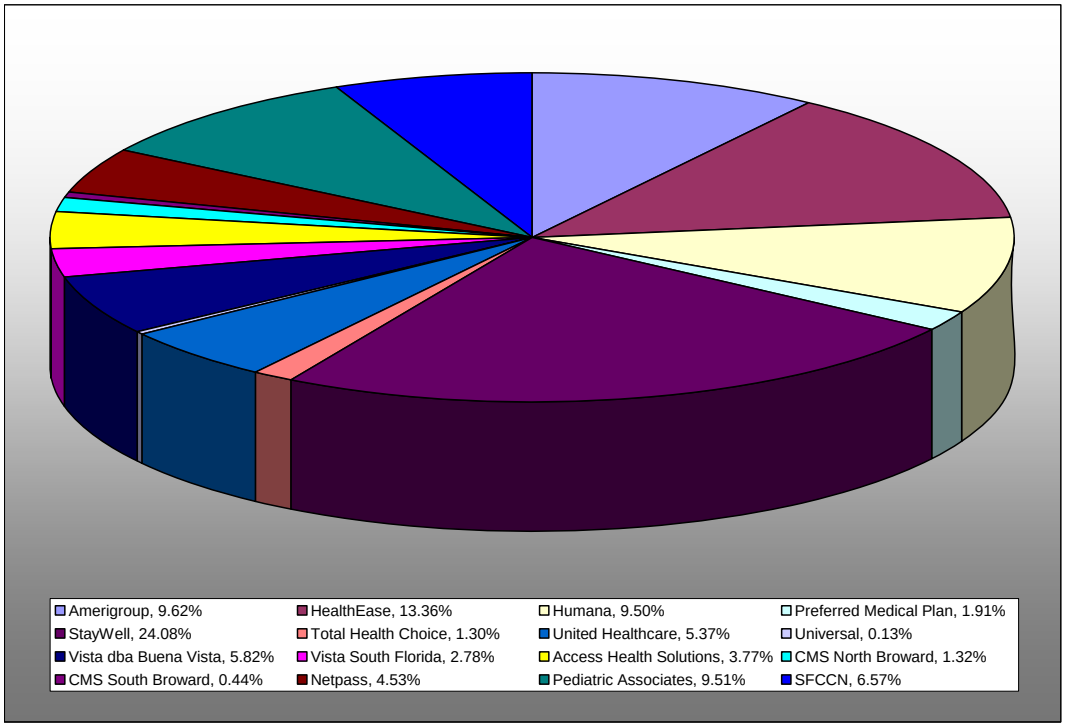
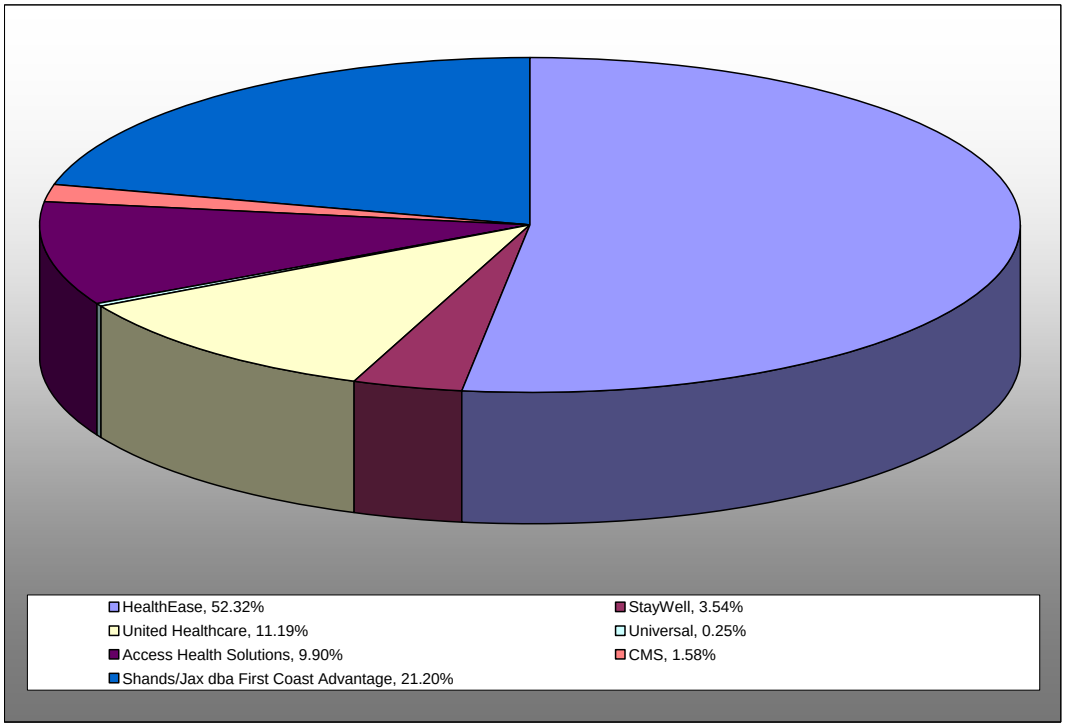


Chart C
Market Share for Medicaid Reform in Duval County



During the fourth quarter of operation, there was an enrollment of 118,172 beneficiaries in Broward County and 77,430 beneficiaries in Duval County. There were 15 Reform plans with enrollees in Broward County, with market shares ranging from 0.13 percent to 24.08 percent. In Duval County, there were 7 Reform plans with market shares ranging from 0.25 percent to 52.32 percent.

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

The Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either voluntarily or mandatorily) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 11 describes the information that each Reform health plan provides to the Agency for this report.

Table 11
Quarterly Summary of
Voluntary & Mandatory Selection Rates & Disenrollment Data

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

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

A. Medicaid Reform Enrollees

There are two ways a beneficiary can enroll in a Medicaid Reform program: voluntarily and mandatorily. Voluntary enrollments include newly-eligible beneficiaries who made a voluntary choice of which plan or program to enroll in. In addition, beneficiaries who were already enrolled in a managed care plan (including MediPass) and then were transitioned into a plan when Medicaid Reform began are included in the voluntary enrollment counts. The calculation of the mandatory

enrollment percentage includes only newly-eligible beneficiaries who have not made a choice and who were assigned to a plan.

B. Medicaid Reform Disenrollees

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

The unique beneficiary counts in the Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report are divided by plan type in Table 12. Total counts for the quarter are also provided for HMOs and PSNs as well as the entire Medicaid Reform program.

Table 12
Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data (State Fiscal Year 2006-07, 4th Quarter)

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	10,439	926	**11,365**	92%	1,639
HealthEase	HMO	Broward	14,839	950	**15,789**	94%	2,273
HealthEase	HMO	Duval	39,518	995	**40,513**	98%	6,469
Humana	HMO	Broward	10,468	753	**11,221**	93%	1,810
Preferred Medical Plan	HMO	Broward	1,681	573	**2,254**	75%	445
StayWell	HMO	Broward	27,160	1,291	**28,451**	95%	3,946
StayWell	HMO	Duval	2,220	523	**2,743**	81%	399
Total Health Choice	HMO	Broward	918	618	**1,536**	60%	288
United Healthcare	HMO	Broward	5,657	691	**6,348**	89%	952
United Healthcare	HMO	Duval	7,961	707	**8,668**	92%	1,648
Universal Healthcare	HMO	Broward	90	69	**159**	57%	47
Universal Healthcare	HMO	Duval	35	161	**196**	18%	40
Vista dba Buena Vista	HMO	Broward	6,416	467	**6,883**	93%	1,237
Vista South Florida	HMO	Broward	2,911	371	**3,282**	89%	389
HMO Total			**130,313**	**9,095**	**139,408**	**93%**	**21,582**
Access Health Solutions	PSN	Broward	6,296	1,370	**7,666**	82%	1,539
Access Health Solutions	PSN	Duval	3,948	507	**4,455**	89%	857
CMS	PSN	Broward	2,084	0	**2,084**	100%	206
CMS	PSN	Duval	1,227	0	**1,227**	100%	77
Netpass	PSN	Broward	4,753	599	**5,352**	89%	875
Pediatric Associates	PSN	Broward	10,795	438	**11,233**	96%	2,248

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
SFCCN	PSN	Broward	6,652	1,109	**7,761**	86%	1,210
Shands/Jax dba First Coast Advantage	PSN	Duval	14,843	1,573	**16,416**	90%	1,999
PSN Total			**50,598**	**5,596**	**56,194**	**90%**	**9,011**
Reform Enrollment Totals			**180,911**	**14,691**	**195,602**	**92%**	**30,593**

For the fourth quarter of State Fiscal Year 2006-07, there were 180,911 voluntary enrollments (92 percent) in Medicaid Reform. Of those, 130,313 beneficiaries were enrolled in an HMO and 50,598 were enrolled in a PSN.

D. Opt Out Program

Background

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

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

Description of Opt Out Process

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

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

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

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

The HMS system has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The system tracks enrollee characteristics (eligibility category, type of employer-sponsored insurance and type of coverage). The system will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Current Activities

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

Opt Out Program Statistics

A total of 36 calls were received at the Opt Out toll-free call center since September 1, 2006, when the program began accepting enrollment.

- Sixteen of the callers were determined not to have ESI available or did not want to pay out-of-pocket expenses.
- Fifteen of the callers requested and received information regarding the Opt Out Program (e.g. New Referral Letter and Release to contact employer) but have not followed through with enrollment into the program to date.
- Five of the calls resulted in enrollment into the Opt Out Program as described below. The five callers are in the Children and Family eligibility category.

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

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

   The father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee

portion for their family coverage. The five children's Medicaid eligibility ended February 28, 2007, and they were subsequently disenrolled from the Opt Out Program.

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

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

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

By the end of the fourth quarter, a total of eight individuals were enrolled in the Opt Out Program. Table 13 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2007.

Table 13
Opt Out Statistics
September 1, 2006 – June 30, 2007

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

E. Enhanced Benefit Program

Background

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

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

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

Current Call Center Activities

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

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

Inbound Calls:	6,357
Calls Abandoned:	1.21%
Average Talk Time	5.33 minutes

Current System Activities

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

The monthly statement sent to beneficiaries had increased in size to the point where many beneficiaries were receiving multiple page statements. The statements had become cumbersome and confusing to beneficiaries. The statement was streamlined to provide only critical information for a beneficiary to see credits earned and spent. The updated statement has significantly reduced the number of pages per statement. In the last statement run, most beneficiaries received a one page statement.

In the third quarter, the Agency intent was to allow participating health plans to obtain access to the system in an effort to allow the health plans to serve as a central point of contact for their members. In February 2007, the Agency held two workshops to provide high level access training to the interested health plans that operate as Medicaid Reform health plans. Most health plans attended the training and expressed interest in obtaining access to the system. After completing the training, the Agency's evaluation of the system revealed that the current eligibility file that is used in the system is one month behind current plan enrollment. This could result in privacy violations due to health plans being allowed access to information on individuals no longer enrolled in their plan. The Agency is working on a system fix and also working with the Agency's privacy officer so issues can be resolved and plans can be provided access.

Outreach and Education for Beneficiaries

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

Now that the Enhanced Benefits program is six months old, the Agency has data and other information on the successes and challenges to this new and innovative program. The number of beneficiaries earning credits is well within the estimates the Agency had developed prior to implementation. Unfortunately, the number of credits being spent by beneficiaries remains low. To increase beneficiaries' usage of their credits, the Agency developed a list of strategies that will begin being implemented in the next quarter. Those initiatives include a rewrite of the call center script, development of a user friendly product purchase list, list of pharmacies successfully processing Enhanced Benefit purchases to provide to beneficiaries who need to find a pharmacy, an outreach program utilizing the expertise of the Choice Counseling field counselors and a review

of all enhanced benefits materials. To assist in these activities, the Agency has assembled a team to provide the necessary support to this effort.

Outreach and Education for Pharmacies

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

While the outreach and education to pharmacies had resulted in a reduction in the number of billing questions, the Agency is committed to streamlining the process for pharmacies when processing an enhanced benefits purchase. A system change request to the Agency's pharmacy system was in development in the fourth quarter. This change will allow the enhanced benefits purchases to be identified by a two-digit identifying code. The system will also be changed to eliminate some of the edits and other processing features of the pharmacy system that are not needed in the Enhanced Benefits environment. Once these changes are in place, outreach and education to the pharmacies will be completed. In addition, a single page reference sheet will be developed. Once approved, the Agency will have laminated copies provided to participating pharmacies and the call center. The reference sheet will contain billing procedures and categories with examples of items included in each category. The goal of this document is to reduce the questions regarding types of products that may be purchased using the individual account credits.

Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel met on May 25, 2007. The primary focus of the meetings has been to finalize recommendations related to the outreach documents, such as the monthly statement, and providing advice for relevant policy, such as defining guidelines for participation specific to disease management programs. Upcoming meetings of the Panel will focus on beneficiary strategies mentioned previously in the document. The panel will provide technical assistance and guidance in the development and finalization of the strategies to increase beneficiary usage of their accounts.

Enhanced Benefits Statistics

Table 14 provides the Enhanced Benefit Account Program statistics beginning January 1, 2007 and ending March 31, 2007.

Table 14 Enhanced Benefit Account Program Statistics				
Fourth Quarter Activity		**April**	**May**	**June**
I.	Number of plans submitting reports by month	23 of 23	21 of 23	23 of 23
II.	Number of enrollees who received credit for healthy behaviors by month	23184	27934	22326
III.	Percentage of Reform enrollees who receive credits each month*	41.31%	47.97%	52.55%
IV.	Number of enrollees who received credit and used credits by month	2025	3103	4432
V.	Total dollar amount credited to accounts by month	$619,397.50	$787,382.50	$572,367.50
VI.	Total dollar amount of credits used by month	$44,649.98	$72,893.65	$109,975.26

***** Represents the total number of beneficiaries from September 2006 thru end of month divided by total number of beneficiaries enrolled in a Reform health plan.

Complaints

A beneficiary can file a complaint about the Enhanced Benefits Account Program 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.

In the fourth quarter, there were 42 complaints recorded through the call center related to the Enhanced Benefits Account Program. Table 15 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 15 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
1. Beneficiary called to complain that she was overcharged for a bottle of vitamins.	➲ The Agency contacted the pharmacy and also reviewed the beneficiary purchase on the Medicaid system. Beneficiary was charged the appropriate amount. Beneficiary called back to explain dollar amount of purchase.
2. Beneficiary called stating that the pharmacy staff was rude and that they did not allow her to purchase items on the list.	➲ The Agency contacted the pharmacy to offer technical assistance. Beneficiary was provided assistance on purchasing items and presented the option of returning to original pharmacy to attempt purchase again or using a different Medicaid pharmacy.

Table 15 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
3.-30. Twenty-eight beneficiaries called to complain that he or she had trouble using their enhanced benefits credits at a pharmacy.	➲ The Agency actions for each of the beneficiaries were follows: The Agency contacted the pharmacy to offer technical assistance. Each beneficiary was provided the option of returning to the original pharmacy to attempt to make the purchase again or the option of using a new Medicaid pharmacy. The Agency is creating a list of pharmacies that are successfully processing enhanced benefits credits and this pharmacy was marked on the list as having an issue. The list of successful pharmacies will be provided to the call center so they can provide beneficiaries the name and address of pharmacies that are successfully processing enhanced benefits credits.
31. Beneficiary complained that credit deducted from her enhanced benefit account was not authorized.	➲ The Agency investigating to determine if the account had unauthorized use.
32. Beneficiary complained about treating rudely at the pharmacy and also that Medicaid had no smaller list of products that could be sent.	➲ The Agency is working on creating smaller product lists that will be broken down by category, such as cough and cold medicine to make it easier for beneficiaries to identify items they wish to purchase.
33. Beneficiary called to complaint about a typo on the brochure	➲ Typo was fixed for the next month's printing.
34. Beneficiary called to inquire why a credit was not appearing on his statement.	➲ The call center explained the process for plan's reporting credits and the timeframe it may take for a credit to be reported. Referred beneficiary to health plan for more information.
35. Beneficiary called to complaint that there was no easy list of products.	➲ The Agency is working on creating smaller product lists that will be broken down by category, such as cough and cold medicine to make it easier for beneficiaries to identify items they wish to purchase.
36. Beneficiary complained that it took too long at the pharmacy to process her enhanced benefits purchases and that items were difficult to find to purchase because there was no list available.	➲ There was not system downtime so the Agency is unable to verify why it took so long for the enhanced benefits purchase to process. Agency is working on creating smaller product lists that will be broken down by category, such as cough and cold medicine to make it easier for beneficiaries to identify items they wish to purchase.
37. Beneficiary complained that her statement said she had $50 in credits and when she went to purchase items she was told by the pharmacy she had no credits available.	➲ The system shows $75 in credits. The Agency contacted the pharmacy to provide technical assistance.
38. Beneficiary complained that the pharmacy informed her that she and her son were ineligible for Medicaid.	➲ The system shows that the mother and son are both eligible for Medicaid. The mother was provided the correct information on Medicaid eligibility.

Table 15 Beneficiary Complaints and Action Taken	
Beneficiary Complaint	**Action Taken**
39. Beneficiary complained pharmacy overcharged for products.	➲ The Agency explained enhanced benefits product pricing to the beneficiary.
40. Beneficiary complained they had trouble understanding what products they could buy with their credits.	➲ The Agency is working on creating smaller product lists that will be broken down by category, such as cough and cold medicine to make it easier for beneficiaries to identify items they wish to purchase.
41. Beneficiary asked for a credit review of her account. Beneficiary thought she had $75 in credits and the pharmacy told her she only had $30.	➲ The account information was reviewed with the beneficiary.
42. Beneficiary complained the pharmacy told her she did not have credits.	➲ The beneficiary had credits. The Agency will provide technical assistance to pharmacy.

F. Low Income Pool

Background

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

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

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

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

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

Current Activities

During the quarter, the LIP web-based reporting tool was made available for Provider Access Systems to input their LIP Cost Limit data and LIP Milestone data on May 24, 2007. The LIP Cost Limit data is the detail of permissible expenditures, as explained in the Reimbursement and Funding Methodology document, in adherence to Special Terms and Conditions # 97 and # 98.

The LIP Milestone data will be used to measure the numbers of individuals served and types of services provided by the Provider Access Systems that receive LIP funding. The Agency requested all Provider Access Systems to submit “pre-LIP” milestone data, referred to as the base year data. This data was due to the Agency on June 1, 2007. The milestone data representing year 1 of LIP is due August 15, 2007. The base year and year 1 LIP Milestone data will be provided to all Provider Access Systems and the University of Florida LIP evaluator. This information will be used as part of the cost effectiveness study, STC # 102.

On June 27, 2007, the Agency received an email from CMS with comments for discussion regarding the Reimbursement and Funding Methodology Document that was submitted on November 22, 2006. The Agency and CMS held a conference call July 12, 2007 to discuss the comments. After the conference call, it was agreed that the Agency will provide a response to CMS’s email within the next quarter.

During the fourth quarter of State Fiscal Year (SFY) 2006-2007, the Agency provided CMS with copies of 15 Letters of Agreement from local governments and/or health care taxing districts, for LIP matching funds. The Agency distributed a total of $ 380,828,737 to LIP Provider Access Systems during the fourth quarter of SFY 2006-07.

G. Monitoring Budget Neutrality

Background

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

MEGS

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

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

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

Explanation of *Budget Neutrality*

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

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

To determine if a person is eligible for the 1115 Medicaid Reform Waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted Medicaid eligibility is assigned an eligibility category by the Florida Department of Children and Families. Specific categories are identified for each MEG under the 1115 Medicaid Reform Waiver. If the person has one of the identified categories and is not an excluded eligible, he or she is then flagged as eligible for the 1115 Medicaid Reform Waiver. Dual eligibles and pregnant women above the TANF eligibility may voluntarily enroll in a Medicaid Reform health plan. All voluntary enrollment member months and expenditures subject to the 1115 Medicaid Reform Waiver are included in the reporting and monitoring of budget neutrality of the waiver.

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

The 1115 Medicaid Reform Waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to capture the expenditures by service type paid during the quarter that are subject to the monitoring of the Budget Neutrality. There are three MEGs within the 1115 Medicaid Reform Waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, an additional five templates (one for each of the 1915(b) Managed Care Waiver MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

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

Definitions:

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

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

Current Activities

For the fourth quarter of operation, the 1115 Medicaid Reform Waiver is budget neutral as required by the Special Terms and Conditions of the waiver. MEG 1 has a PCCM of $875.74 (Table 17), compared to WOW of $948.79 (Table 16), which is 92.30% of the target PCCM for MEG 1. MEG 2 has a PCCM of $158.80 (Table 18), compared to WOW of $199.48 (Table 16), which is 79.61% of the target PCCM for MEG 2.

Table 19 provides cumulative expenditures and case-months for the reporting period. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case-months. In addition, the PCCM targets as provided in the special terms and conditions are also weighted using the actual case-months. The weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the special terms and conditions (Table 16) is $328.24. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided on Tables 17 and 18 is $281.99. Comparing the calculated weighted averages, the actual PCCM is 85.91% of the target PCCM.

Table 16 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116.

Table 16
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 17 through 20 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2007. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Other Issues

Due to an oversight in reporting the non-enrolled reform eligible expenditures, the State reported expenditures for non-enrolled dual eligibles on the CMS 64 for the first two quarters of Demonstration Year 01. These expenditures have been identified and the prior periods have been adjusted through the CMS 64 reporting process for the quarter ending June 30, 2007. The 3rd quarterly report included the correct amounts for the impacted months and therefore no changes are required.

The quarter total expenditures reported in the 3rd quarterly report (Tables 15 and 16) were net of rebates. Since the PCCM targets provided in the Special Terms and Conditions #116 were not calculated net of rebates, the PCCM targets reported in this report were revised to include the collection of rebates. No changes were made to the CMS 64 report, as the rebate amounts are provided on the CMS 64 templates for each MEG.

Table 17
MEG 1 Statistics: SSI Related

DY01		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**781,217**	**$557,259,673**	**$ 5,086,722**	**$562,346,395**	**$719.83**
Q2 Total	**780,310**	**$706,715,609**	**$24,690,376**	**$731,405,985**	**$937.33**
Q3 Total	**788,257**	**$700,393,754**	**$38,038,470**	**$738,432,224**	**$936.79**
Apr – 07	267,563	$206,811,966	$23,638,822	$230,450,788	$861.30
May – 07	268,130	$295,089,378	$34,658,736	$329,748,114	$1,229.81
Jun - 07	268,522	$149,052,964	$13,847,948	$162,900,912	$606.66
Q4 Total	**804,215**	**$657,121,159**	**$72,784,392**	**$729,905,551**	**$907.60**
DY01 Total	**3,153,999**	**$2,621,490,195**	**$140,599,960**	**$2,762,090,155**	**$875.74**
WOW DY1 Total				**$2,975,596,229**	**$948.79**
Difference				**$ (213,506,074)**	
% of WOW PCCM MEG1					**92.30%**

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

Table 18
MEG 2 Statistics: Children and Families

DY01		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,858,479**	**$498,189,408**	**$1,715,790**	**$499,905,198**	**$129.56**
Q2 Total	**3,772,650**	**$623,448,816**	**$19,606,645**	**$643,055,462**	**$170.45**
Q3 Total	**3,732,807**	**$612,194,137**	**$36,444,373**	**$648,638,510**	**$173.77**
Apr – 07	1,289,543	$182,303,461	$17,518,977	$199,822,438	$154.96
May - 07	1,277,379	$269,355,204	$33,253,849	$302,609,053	$236.90
Jun - 07	1,270,325	$105,916,963	$6,513,132	$112,430,095	$88.50
Q4 Total	**3,837,247**	**$564,828,924**	**$57,487,857**	**$622,316,780**	**$162.18**
DY01 Total	**15,201,183**	**$2,298,661,285**	**$115,254,665**	**$ 2,413,915,950**	**$158.80**
WOW DY1 Total				**$ 3,902,199,885**	**$199.48**
Difference				**$(1,488,283,935)**	
% of WOW PCCM MEG2					**79.61%**

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

Table 19
MEG 1& 2 Cumulative Statistics

	Actual CM	MEG 1&2 Actual Spend		Total	PCCM
DY 1 Meg 1&2	**18,355,182**	**$4,701,805,568**	**$264,694,849**	**$ 4,966,500,417**	**$281.99**
WOW	**18,355,182**			**$ 6,877,796,114**	**$328.24**
Difference				**$(1,911,295,697)**	
% Of WOW					**85.91%**

Table 20
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount DY 01
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,737
Total Paid	$966,961,540
Limit	$1,000,000,000
% of Limit Used	96.70%

The expenditures for the first four quarters of year 1 for MEG 3, the Low Income Pool (LIP), were $966,961,540.

H. Encounter and Utilization Data

Background

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

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

Current Activities

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

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

- Changes to Florida's incumbent Medicaid Management Information System (MMIS) system to support the capture, validation, and adjudication of encounter claims received from Managed Care Organizations (MCOs) were implemented in late June 2007.

- Continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the MCOs.

- Participation of the MEDS team in "stand-alone" and biweekly technical and operations meetings with MCOs continued during this period.

- Reports and HIPAA complaint EDI processes used to communicate various operational errors and invalid transaction content to capitated health plans is continuing to be validated and tested by the MEDS team and incumbent Fiscal Agent (FA).

- Design of the data structure and supporting processes to extract encounter claims to the Medicaid Decision Support System (DSS) is being updated to support NPI.

- All MCOs have submitted one of more certifications demonstrating their capability to generate one or more X12 HIPAA compliant transactions (e.g., 8371, 837P, 837D, or NCPDP).

- Nine (9) of Twelve (12) HMOs have submitted encounter claim test files for one or more X12 HIPAA compliant transactions (e.g., 8371, 837P, 837D, or NCPDP) and preparations are now being made to begin the submission of "production status" encounter claims.

- Continually working with HMOs to resolve technical and X12 transaction format and content questions.

- Provider Service Networks (PSNs) have been contacted and a strategy to submit encounter claim data for capitated transportation (emergency and non-emergency) has been requested. To that end, two (2) PSNs have submitted certification and test files demonstrating their capability to generate X12 HIPAA compliant 837P transportation claims. Other PSNs continue to complete tasks associated with certification and submission of test files.

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

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

I. Demonstration Goals

Current Program

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

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

Number and Type of Plans

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

Prior to and during the first quarter, the Agency established contracts with 10 HMOs and 5 PSNs for a total of 15 Reform health plans in Broward County; and 4 HMOs and 2 PSNs for a total of 6 Reform health plans in Duval County. With the addition of the first specialty plan during the second quarter, the Agency established contracts with 16 health plans of which 10 are HMOs and 6 are PSNs. The specialty PSN began enrollment in Broward County during the third quarter and then expanded to Duval County with enrollment beginning in the fourth quarter. Additionally, the Agency approved the expansion of 1 HMO and 1 PSN into Baker, Clay and Nassau counties during the fourth quarter with enrollment scheduled to begin in September 2007.

The Medicaid Reform Waiver has considerably increased the number and types of health plans that beneficiaries can chose from in Broward and Duval Counties. The Agency believes that individuals were provided more choice as Reform plans offered benefit packages that included services not previously covered by Medicaid. With the addition of this specialty plan PSN in Duval and Broward Counties and the expansion of 1 HMO and 1 PSN in the 3 rural expansion counties, the Agency was able to further increase the number and types of health plans being offered in Reform.

Patient Satisfaction

It is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The beneficiaries surveyed were enrolled in MediPass, Florida's primary care case management program, and non-reform Medicaid HMOs in Broward and Duval counties to measure the level of patient satisfaction present prior to the implementation of the Medicaid Reform Waiver. The results of the survey will serve as a baseline against which to compare future surveys throughout the demonstration period. Preliminary results of the CAHPS survey conducted in 2006 were submitted to the Agency during the fourth quarter with a full analytical report due from the University of Florida in the fall of 2007.

The Agency will conduct the CAHPS survey of beneficiaries enrolled in Medicaid Reform health plans on an annual basis. The Agency intends to provide the survey results obtained in the fall of 2007 to the beneficiaries in the form of Choice Counseling materials so that they will have comparable information relative to how satisfied enrollees are with their Reform health plan. The health plans will also use the survey results for their quality improvement programs to improve health outcomes of their beneficiaries.

In addition to surveying beneficiaries in Duval and Broward, the Agency plans to conduct a benchmark CAHPS survey of beneficiaries located in Baker, Clay, and Nassau counties. The Agency plans to establish benchmark data for those beneficiaries located in these 3 rural counties to measure the level of patient satisfaction present prior to the implementation of the Medicaid Reform Waiver. The results of this survey will serve as a baseline against which to compare future surveys in rural counties throughout the demonstration period.

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

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

During the fourth quarter, the Agency reviewed 28 proposed customized benefit packages from the HMOs and 13 different expanded benefits proposals from the FFS PSNs. The approved benefits are for the upcoming contract period September 1, 2007 to August 31, 2008. These submissions also included 1 HMO and 1 FFS PSN for the Reform expansion counties: Baker, Clay and Nassau.

One of the significant changes in benefits for the upcoming contract period was continued reduction in cost sharing. Many plans choose to offer expanded or additional benefits which were not previously covered by the State under the State Plan. The two most popular expanded services offered were the same as last year's, the over-the-counter (OTC) drug benefits and adult preventative dental benefits. Four of the customized benefit packages expanded their OTC value from $10 to $25, while another 4 added a $25 OTC benefit. The expanded services available to beneficiaries in September 2007 include the following, which were continued from last year:

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

The following expanded benefits were added this year:

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

The one expanded benefit that was dropped for the upcoming contract year was the Complimentary/Alternative Medicine benefit.

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

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

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

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

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

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

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

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

5. To ensure that patient satisfaction increases.

Please refer to the response to objective #1.

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

Prior to the implementation of the Medicaid Reform Waiver, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid 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 realized through these PAS entities include, but are not limited to, the implementation of case management for emergency room diversion efforts and/or chronic disease management, increased hours and medical staff to allow for increased access to primary care services and pediatric services, and the inclusion of increased services for breast cancer and cervical screening services.

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

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

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

During the fourth quarter, the Agency received a letter on June 8, 2007 from the University of Florida LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information will be provided to the University of Florida LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year 2005-2006) by July 31, 2007. The LIP Milestone data for year 1 of LIP (State Fiscal Year 2006-2007) will be due to the Agency from all Providers Access Systems no later than August 15, 2007. This information will be shared with the University of Florida LIP Evaluation team by September 2007. The University of Florida and the Agency will utilize the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

J. Evaluation of Medicaid Reform

Background

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

In addition to the contract with UF, there are several other evaluations being conducted, some by the Agency or its contractors, and others by outside entities. Descriptions are below.

<u>Affiliated with the Agency or its Contractors</u>

- As requested by the Florida Agency for Health Care Administration's Secretary, the Office of the Inspector General is conducting a review of the implementation of the 1115 Medicaid Reform Waiver. The objectives of this review are as follows:
  - Document the current status of Medicaid Reform impact from the perspectives of stakeholders, coupled with available performance data.
  - Provide recommendations, as indicated, that will assist executive leadership in decision-making regarding expansion of Medicaid Reform.
  - Provide recommendations regarding self-evaluative activities for new projects.

  The final report is due to the Agency's Secretary in September 2007.
- Florida State University is evaluating the Choice Counseling Programs materials given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver. The report is due to the Agency in July 2007.
- UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. A total of 1,850 interviews were

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

completed. All data sets were delivered to the Urban Institute in May 2007. Following the normal review procedures, reports will be disseminated by the KFF.

- UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid Reform beneficiaries. Data collection was by means of focus groups and telephone surveys. All data sets were delivered to the University of Oregon earlier this year. Following normal review procedures, reports will be disseminated.

Conducted by Entities Independent of the Agency

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

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

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

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

Pre-Implementation Activities: [2]

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

- Obtaining IRB (Institutional Review Board) approval for the evaluation, allowing human subjects (Medicaid recipients) to be part of the research for the evaluation.

- Submitting a detailed work plan, providing a step-by-step map of the tasks to complete the evaluation over year one.

[2] For more information and detail on these and the post-implementation activities below, see previous quarterly reports submitted by AHCA to CMS.

- Producing two reports: a summary report on the Medicaid Reform Section 1115 Waiver Process; and a report describing managed care organizations and other Reform Health Plans in the two Reform counties, Broward and Duval.

- Conducting baseline (pre-implementation) key informant interviews with various groups (Agency management, Reform plans, Choice Counselors, etc.).

- Hiring local liaisons in Broward and Duval Counties to coordinate activities in those areas and to report on items that happened between visits by UF.

- Gathering baseline information on the various aspects of Medicaid Reform, including customized benefit packages, Opt-Out, funding methodology of the Low Income Pool, development and implementation of pilot programs, etc.

- Developing, in consultation with the Agency, the initial enrollee satisfaction survey instrument, based on the CAHPS (Consumer Assessment of Healthcare Providers and Systems). Information collected from this survey will serve as a baseline against which to compare future surveys throughout the demonstration period.

Post-Implementation Activities from Previous Quarters:

Post-implementation activities begun or completed in previous quarters include:

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

- Completing the focus groups for the Longitudinal Study Survey of Medicaid Recipients, and initiating the Longitudinal Study Survey in February 2007.

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

- Producing reports, including: two quarterly progress reports on the evaluation to date; a report on the Medicaid Reform health plans and networks as of July 1, 2006; an updated data needs matrix specifying variables to be used and specific data sources; copies of academic presentations made regarding Reform; and a report describing the final form of quantitative analyses to be used. Reports submitted by UF to the Agency can be viewed by visiting the Agency's website at http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml.

- Continually updating the above-referenced Data Needs Matrix Report that shows measures, data elements to be collected, in what data system(s) the elements

reside, and who at the Agency is the main contact for that data system. This process includes meeting with various stakeholders to determine data sources and extraction protocols; collecting data where they exist; and establishing benchmarks against which to compare the data for the remainder of the demonstration period. Data collection and analysis will continue throughout the five-year contract period.

- Collecting organizational data on each of the Medicaid Reform health plans.
- Analyzing the CAHPS-based enrollee satisfaction survey data.
- Beginning the process of qualitatively evaluating the first round of key informant interviews (pre-implementation). Other key informant interviews continue to be conducted.
- Developing a Medicaid Reform Evaluation site, including an "MREWiki" only available to Medicaid Reform Evaluation Team members from UF, Agency staff, and the Technical Advisory Committee. The website will be updated as further information is collected and analyzed during the evaluation.
- Submitting a plan for the evaluation of the Low Income Pool Program, including cost-effectiveness and the impact of the Low Income Pool Program on increased access for uninsured individuals.

Current Quarter Activities

Activities conducted during the current quarter include:

- Completing the first Medicaid Reform Evaluation Annual Report. Although not a contractually specified deliverable product, it was determined that a general summary document describing the progress of the Reform demonstration to date should be prepared on an annual basis. This report was the first installment in that planned series.
- Coordination with the Florida State University (FSU) professor who is evaluating the Choice Counseling materials.
- Completing qualitative analysis of key informant interviews with AHCA officials (including those at the area offices), representatives from the Medicaid Reform Health Plans and Networks, and community stakeholders.
- Continuing to conduct Key informant interviews. This quarter, the MRE team focused on interviews with Reform health plans and networks.
- Producing a draft report on the results of the survey of community stakeholders.
- Beginning a literature review of risk adjustment use in other states.
- Collecting baseline data for expenditure measures for the ongoing fiscal analysis.

- Beginning analyses of the Upper Payment Limit (UPL) and Disproportionate Share (DSH) and Exemptions Programs to be compared to Low-Income Pool (LIP) data being collected throughout the five-year study period.
- Completing baseline interviews for the Longitudinal Study Panel. Three focus groups and ten in-depth interviews were conducted. Preliminary baseline findings are being prepared.

K. Policy and Administrative Issues

Current Activities

The Florida Legislature ended its regular session on May 4, 2007. While there were several bills introduced during the session that may have impacted Medicaid Reform relative to risk-adjusted rates, populations eligible to enroll, and entities able to be considered health plans, none of these bills passed. The only legislative change which impacted Reform health plans was the appropriation of specific funds which will allow Florida Medicaid to comply with Social Security Act 1902(n) and 1905(p) and HCFA Program Issuance (Transmittal Notice) Region IV, MCD-003-00, July 28, 2000, and pay Medicare providers for deductibles and coinsurance on crossover services that Medicaid does not cover.

Policy Transmittals

During the fourth quarter of operation, the Agency released one policy transmittal to the Reform health plans regarding the contractually required disease management patient and provider satisfaction surveys. The policy transmittal informed the health plans that an Agency vendor would conduct the patient and provider satisfaction surveys for the participants in the health plans' disease management programs. It also alerted the health plans that the time frame for these surveys was modified from a quarterly to an annual basis. The policy transmittals are posted on the Agency's website.

Technical and Operations Calls

The Agency continues to conduct Technical and Operational Issues Conference Calls on a biweekly basis. The purpose of the Technical and Operation Issues Conference Calls is to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether or not they are currently operating in the Medicaid Reform counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of Reform, 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.

During this quarter, there were a total of 6 calls with approximately 20 participants in attendance in person and an estimated total of 100 to 150 participants on each call. For this quarter, the topics and agenda items have included the following:

- Electronic file formatting and submission requirements, including accessing data exchange and secured file transmission servers, fiscal agent processing of HIPAA compliant transactions and reports, and enrollment issues;
- Choice Counseling Program activities;
- Health plan network provider registration processes;
- National Provider Identification (NPI) implementation updates;
- New Medicaid Management Information System (MMIS) implementation updates;
- Medicaid Enhanced Benefit Account Program updates;
- Medicaid Encounter Data Systems updates;
- Review of performance measures reporting requirements;
- Claims payment; and
- Kick payment processing.

During one of the calls held this quarter, representatives of the Prescribed Pediatric Extended Care (PPEC) industry presented an overview of the services available through the PPEC industry to health plan enrollees. The PPEC representatives also provided anecdotal feedback to the health plans regarding areas where care coordination and delivery could be streamlined, particularly when a PPEC could provide transportation services, medical attendant services and therapy services all through the PPEC's own system thus creating some efficiencies that may have been unnoticed by the health plans. They also cited administrative burdens when they have several PPEC members from different health plans all requiring medical attendants through different transportation providers. These areas require continued focus to ensure that care does not become fragmented.

Feedback from call participants indicates that the calls are well received and a good forum for discussion of technical and operational issues.

Fee-for-Service PSN Systems Issues Calls

The Agency continues to provide monthly systems issues calls with the FFS PSNs. The purpose of these targeted calls is to provide a forum to discuss claims processes and enrollment file issues that are unique to the fee-for-service 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). Items that were addressed during this quarter include the following:

- Denials of PSN paper claims for multiple home health services (this identified a need for training of new fiscal agent staff regarding home health and paper claims processing);

- Inclusion of a required pharmacy field in the PSNs' electronic remittance voucher (ERV) so that PSNs could comply with Enhanced Benefits data requirements;

- Problems related providers submitting incorrect tax identification information to PSNs resulting in claims denials; and

- Requests by PSNs to have the Agency provide network NPI information so the PSNs can ensure that the NPI they have received from their network providers match what the providers have on file with Medicaid.

NPI implementation and implementation of the new UB-04 and CMS-1500 claims forms is of great importance to the FFS PSNs. Since the FFS PSNs' claims processing system has to operate in concert between the provider and the Medicaid fiscal agent, much time is dedicated on the provision of technical assistance in these areas.

In addition, the Agency continues to work with the current Medicaid fiscal agent to install a systems change that will cause claims submitted by the following provider types to deny unless authorization is provided by the fee-for-service PSN:

- Home Health,
- Independent laboratory,
- Dental,
- Community Mental Health, and
- Targeted Case Management.

Due to problems these providers have incurred in home health, community mental health and targeted case management, the Agency formally requested that each FFS PSN submit a claims processing certification prior to implementing that systems change. The certification requires that FFS PSNs attest that their claims authorization and processing system were ready to accept and process these claims and that they had trained all such providers. Once the Agency receives this certification, the Agency will enter the implementation process for this systems change. Based on feedback received from all FFS PSNs, the Agency agreed to remove independent laboratory services from the change request. Since independent laboratory services are mostly connected to other services requiring authorization, the FFS PSNs felt more comfortable allowing those claims to pay without holding them up in a possibly duplicative authorization process.

Transition to New Medicaid Management Information System (MMIS)

The Agency continues the critical work with Florida Medicaid's fiscal agent transition team relative to how Florida's MMIS will operate for the Reform health plans. As the new MMIS programming is near completion, Medicaid staff continues to provide the fiscal agent transition team with policy clarification and systems change orders which cannot be fixed in the current MMIS and were not included in the initial design phase of the new MMIS. So far, only systems enhancements have been identified and the new MMIS will be able to handle those change orders once the new system is fully implemented.

The new Florida Medicaid fiscal agent system is expected to go live on March 1, 2008. In order to reduce the risk of unsuccessfully implementing the new MMIS, change requests (also known as change orders) for the current MMIS were limited this quarter and notification was provided that only file maintenance changes would be processed through the end of September 2007. An example of a systems change 'on hold' is that current policy requires private duty nursing and PPEC services to be prior authorized by the specialty FFS PSN for children with chronic conditions, the current MMIS, however, does not prevent claims payment from occurring if the specialty FFS PSN does not authorize the services. The systems edit for this will not be incorporated until the new MMIS is implemented in March 2008.

Fraud and Abuse Summit

On June 26, 2007, the Agency conducted a Fraud and Abuse Summit and invited all health plans to attend. The summit provided an opportunity for the Agency to share with the plans the results of its fraud and abuse efforts and provided the health plans with an informal environment in which to exchange ideas. The following areas were discussed:

- Status of the Agency's project to notify health plans of Medicaid involuntary-terminated providers at the time that the Medicaid termination occurs. This project entrails matching existing health plan network providers to FFS Medicaid providers, and providing notice to the health plans of specific providers in their networks that the FFS Medicaid program is involuntarily terminating from Medicaid participation.

- Results of site visits by Medicaid Program Integrity. Medicaid Program Integrity staff shared an overview of findings: possible fraud and abuse information needs to be shared on terminated providers, health plans need to ensure communication regarding fraud and abuse is communicated to all levels of the health plan organization, and eliminate discrepancies between policies and procedures and activities taking place. When contract requirements were not being met, the plans were required to submit corrective action plans for approval. It was also shared that Medicaid Program Integrity staff had seen an increase in fraud and abuse referrals since the site visits occurred.

- Program Integrity staff advised that they would continue to provide the Medicaid plans with increased communications to help ensure that the plans' fraud and abuse policies, procedures and detection activities continue to both mature and remain aligned with Agency policy. The next planned meeting with the HMOs and PSNs is slated to be held in September of 2007.

External Quality Review Organization Quarterly Meetings with Reform Health Plans

Florida Medicaid's external quality review organization (EQRO), Health Services Advisory Group (HSAG) and the Agency's staff conduct quarterly technical assistance meetings with managed care organizations and prepaid inpatient health plans including the Medicaid Reform health plans. This quarter's topics included the following:

- Collaborative Performance Improvement Plan (PIP);

- Summary of findings from focused studies on adolescent well care and children with special needs;

- 'One on one' health plan technical assistance sessions with HSAG staff on performance improvement plans and other required quality assessment and improvement activities; and

- Round table discussion of upcoming contract issues relative to the Agency's quality initiatives.

Attachment I
Outreach Meetings
April 1, 2007 – June 30, 2007

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
04/10/07	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	11 total, from 3 sessions
04/16/07	Clay County Administrative Offices (Board of County Commissioners)	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	16 total, from 3 sessions
04/24/07	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	7 total, from 3 sessions
04/30/07	Nassau County Children and Family Education Center	Providers – Baker, Clay and Nassau Counties	Informative	General Reform	4 total, from 2 sessions
05/08/07	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	2 total, from 2 sessions
05/09/07	Clay County	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	20 total, from 3 sessions
05/16/07 AM	Westside Senior Center – Hilliard, FL	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	5 total, from 2 sessions
05/23/07	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	3 total, from 3 sessions

Attachment I
Outreach Meetings
April 1, 2007 – June 30, 2007

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/05/07 AM	Clay County Administrative Offices (Board of County Commissioners)	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	13 total, 3 sessions
06/13/07 10:00am	Baker County Health Department	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	11 total, from 3 sessions
06/19/07 10:00am	Nassau County Council on Aging	Beneficiaries - Baker, Clay and Nassau	Informative	General Reform	30 total, from 3 sessions

Attachment II
Florida Medicaid Reform Choice Counseling
CALL CENTER ACTIVITY REPORT

Month: April-07

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							<5% Monthly	100%
MON	4/2/2007		672	668	132,535	4	0.6%	100%
TUE	4/3/2007		595	593	133,128	2	0.3%	100%
WED	4/4/2007		631	631	133,759	0	0.0%	100%
THU	4/5/2007		542	540	134,299	2	0.4%	100%
FRI	4/6/2007		429	429	134,728	0	0.0%	100%
SAT	4/7/2007		0	0	134,728	0	0.0%	100%
	Week Ending	0	2,869	2,861		8	0.3%	100%
MON	4/9/2007		1,015	1,015	135,743	0	0.0%	100%
TUE	4/10/2007		788	787	136,530	1	0.1%	100%
WED	4/11/2007		621	620	137,150	1	0.2%	100%
THU	4/12/2007		612	611	137,761	1	0.2%	100%
FRI	4/13/2007		540	538	138,299	2	0.4%	100%
SAT	4/14/2007		38	36	138,335	2	5.3%	100%
	Week	0	3,614	3,607		7	0.2%	100%

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							<5% Monthly	100%
	Ending							
MON	4/16/2007		647	646	138,981	1	0.2%	100%
TUE	4/17/2007		580	579	139,560	1	0.2%	100%
WED	4/18/2007		581	581	140,141	0	0.0%	100%
THU	4/19/2007		647	645	140,786	2	0.3%	100%
FRI	4/20/2007		396	396	141,182	0	0.0%	100%
SAT	4/21/2007		28	28	141,210	0	0.0%	100%
	Week Ending	0	2,879	2,875		4	0.1%	100%
MON	4/23/2007		589	589	141,799	0	0.0%	100%
TUE	4/24/2007		526	526	142,325	0	0.0%	100%
WED	4/25/2007		490	490	142,815	0	0.0%	100%
THU	4/26/2007		499	499	143,314	0	0.0%	100%
FRI	4/27/2007		490	490	143,804	0	0.0%	100%
SAT	4/28/2007		40	40	143,844	0	0.0%	100%
	Week Ending	0	2,634	2,634		0	0.0%	100%
MON	4/30/2007		906	899	144,743	7	0.8%	100%
TUE			0	0	144,743	0	0.0%	100%
	Week Ending	0	906	899		7	0.8%	100%
MON			0	0	144,743	0	0.0%	100%

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							**<5% Monthly**	**100%**
	Week Ending	0	0	0		0		100%
	Month End	**0**	**12,902**	**12,876**		**26**	**0.2%**	**100%**

Month: **May-07**

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							**<5% Monthly**	**100%**
					144,743			
MON			0	0	144,743	0	0.0%	100%
TUE	5/1/2007		768	768	145,511	0	0.0%	100%
WED	5/2/2007		797	797	146,308	0	0.0%	100%
THU	5/3/2007		657	650	146,958	7	1.1%	100%
FRI	5/4/2007		500	498	147,456	2	0.4%	100%
SAT	5/5/2007		40	40	147,496	0	0.0%	100%
	Week Ending	0	2,762	2,753		9	0.3%	100%
MON	5/7/2007		737	734	148,230	3	0.4%	100%
TUE	5/8/2007		648	647	148,877	1	0.2%	100%
WED	5/9/2007		571	571	149,448	0	0.0%	100%
THU	5/10/2007		498	495	149,943	3	0.6%	100%
FRI	5/11/2007		422	422	150,365	0	0.0%	100%
SAT	5/12/2007		36	36	150,401	0	0.0%	100%
	Week Ending	0	2,912	2,905		7	0.2%	100%
MON	5/14/2007		583	582	150,983	1	0.2%	100%
TUE	5/15/2007		560	558	151,541	2	0.4%	100%
WED	5/16/2007		631	629	152,170	2	0.3%	100%
THU	5/17/2007		599	599	152,769	0	0.0%	100%
FRI	5/18/2007		390	390	153,159	0	0.0%	100%

Month: **May-07**

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							**<5% Monthly**	**100%**
SAT	5/19/2007		22	22	153,181	0	0.0%	100%
	Week Ending	0	2,785	2,780		5	0.2%	100%
MON	5/21/2007		565	563	153,744	2	0.4%	100%
TUE	5/22/2007		557	553	154,297	4	0.7%	100%
WED	5/23/2007		486	486	154,783	0	0.0%	100%
THU	5/24/2007		456	454	155,237	2	0.4%	100%
FRI	5/25/2007		357	357	155,594	0	0.0%	100%
SAT	5/26/2007		0	0	155,594	0	0.0%	100%
	Week Ending	0	2,421	2,413		8	0.3%	100%
MON	5/28/2007		0	0	155,594	0	0.0%	100%
TUE	5/29/2007		720	716	156,310	4	0.6%	100%
WED	5/30/2007		622	619	156,929	3	0.5%	100%
THU	5/31/2007		540	536	157,465	4	0.7%	100%
FRI			0	0	157,465	0	0.0%	100%
	Week Ending	0	1,882	1,871		11	0.6%	100%
MON			0	0	157,465	0	0.0%	100%
	Month End	**0**	**12,762**	**12,722**		**40**	**0.3%**	**100%**

Month: June-07

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							<5% Monthly	100%
MON			0	0	157,465	0	0.0%	100%
FRI	6/1/2007		434	431	157,896	3	0.7%	100%
SAT	6/2/2007		25	25	157,921	0	0.0%	100%
	Week Ending	0	459	456		3	0.7%	100%
MON	6/4/2007		712	706	158,627	6	0.8%	100%
TUE	6/5/2007		593	589	159,216	4	0.7%	100%
WED	6/6/2007		578	576	159,792	2	0.3%	100%
THU	6/7/2007		511	508	160,300	3	0.6%	100%
FRI	6/8/2007		420	418	160,718	2	0.5%	100%
SAT	6/9/2007		38	37	160,755	1	2.6%	100%
	Week Ending	0	2,852	2,834		18	0.6%	100%
MON	6/11/2007		640	633	161,388	7	1.1%	100%
TUE	6/12/2007		596	591	161,979	5	0.8%	100%
WED	6/13/2007		479	477	162,456	2	0.4%	100%
THU	6/14/2007		439	435	162,891	4	0.9%	100%
FRI	6/15/2007		472	470	163,361	2	0.4%	100%
SAT	6/16/2007		34	34	163,395	0	0.0%	100%
	Week Ending	0	2,660	2,640		20	0.8%	100%
MON	6/18/2007		722	716	164,111	6	0.8%	100%

Month: June-07

Day of the Week	Date	Projected Incoming Calls	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)
Standard							<5% Monthly	100%
TUE	6/19/2007		544	540	164,651	4	0.7%	100%
WED	6/20/2007		536	532	165,183	4	0.7%	100%
THU	6/21/2007		530	527	165,710	3	0.6%	100%
FRI	6/22/2007		354	352	166,062	2	0.6%	100%
SAT	6/23/2007		23	23	166,085	0	0.0%	100%
	Week Ending	0	2,709	2,690		19	0.7%	100%
MON	6/25/2007		627	626	166,711	1	0.2%	100%
TUE	6/26/2007		529	526	167,237	3	0.6%	100%
WED	6/27/2007		524	520	167,757	4	0.8%	100%
THU	6/28/2007		425	424	168,181	1	0.2%	100%
FRI	6/29/2007		573	568	168,749	5	0.9%	100%
SAT	6/30/2007		52	52	168,801	0	0.0%	100%
	Week Ending	0	2,730	2,716		14	0.5%	100%
MON			0	0	168,801	0	0.0%	100%
	Month End	**0**	**11,410**	**11,336**		**74**	**0.6%**	**100%**

Month: April-07

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
MON	4/2/2007	0.2%	246.00	65.00	33.00	5.97	31	0.0%
TUE	4/3/2007	0.0%	147.00	123.00	77.00	7.30	103	0.0%
WED	4/4/2007	0.0%	122.00	168.00	0.00	6.88	98	0.0%
THU	4/5/2007	0.6%	201.00	92.00	148.00	6.95	36	0.0%
FRI	4/6/2007	0.0%	13.00	0.00	0.00	6.45	42	0.0%
SAT	4/7/2007	0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending					6.7	310	0%
MON	4/9/2007	0.0%	158.00	117.00	0.00	4.73	74	0.0%
TUE	4/10/2007	0.0%	165.00	122.00	136.00	7.58	161	0.0%
WED	4/11/2007	0.0%	83.00	62.00	0.00	7.28	164	0.0%
THU	4/12/2007	0.0%	66.00	47.00	0.00	7.25	127	0.0%
FRI	4/13/2007	0.0%	69.00	0.00	0.00	7.43	123	0.0%
SAT	4/14/2007	0.0%	173.00	60.00	0.00	10.80	26	0.0%
	Week Ending					6.7	675	0%
MON	4/16/2007	0.0%	71.00	48.00	78.00	8.08	112	0.0%
TUE	4/17/2007	0.0%	74.00	38.00	0.00	7.35	140	0.0%
WED	4/18/2007	0.0%	5.00	10.00	0.00	6.73	125	0.0%
THU	4/19/2007	0.0%	95.00	65.00	161.00	7.67	166	0.0%

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
FRI	4/20/2007	0.0%	18.00	0.00	0.00	6.90	58	0.0%
SAT	4/21/2007	0.0%	0.00	0.00	0.00	8.45	0	0.0%
	Week Ending					7.4	601	0%
MON	4/23/2007	0.0%	157.00	29.00	0.00	6.47	94	0.0%
TUE	4/24/2007	0.0%	59.00	13.00	0.00	6.33	102	0.0%
WED	4/25/2007	0.0%	0.00	0.00	72.00	6.57	46	0.0%
THU	4/26/2007	0.0%	9.00	0.00	0.00	6.68	71	0.0%
FRI	4/27/2007	0.0%	82.00	75.00	11.00	6.77	151	0.0%
SAT	4/28/2007	0.0%	48.00	0.00	0.00	8.30	1	0.0%
	Week Ending					6.6	465	0%
MON	4/30/2007	0.0%	109.00	73.00	135.00	5.75	98	0.0%
TUE		0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending					5.8	98	0%
MON		0.0%	0.00	0.00	0.00	0.00	0	
	Week Ending					0.0	0	0%
	Month End					**6.8**	**2149**	**0.0%**

Month: May-07

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
MON		0.0%	0.00	0.00	0.00	0.00	0	0.0%
TUE	5/1/2007	0.0%	65.00	0.00	0.00	5.70	136	0.0%
WED	5/2/2007	0.0%	127.00	99.00	68.00	5.33	165	0.0%
THU	5/3/2007	0.0%	103.00	99.00	70.00	5.88	163	0.0%
FRI	5/4/2007	0.0%	76.00	59.00	0.00	6.62	197	0.0%
SAT	5/5/2007	0.0%	103.00	0.00	0.00	5.42	13	0.0%
	Week Ending					5.8	674	0%
MON	5/7/2007	0.0%	105.00	77.00	11.00	6.25	102	0.0%
TUE	5/8/2007	0.0%	143.00	78.00	123.00	5.93	148	0.0%
WED	5/9/2007	0.0%	88.00	114.00	0.00	7.38	109	0.0%
THU	5/10/2007	0.0%	174.00	77.00	17.00	7.20	91	0.0%
FRI	5/11/2007	0.2%	137.00	80.00	229.00	7.32	89	0.0%
SAT	5/12/2007	0.0%	0.00	0.00	0.00	7.43	19	0.0%
	Week Ending					6.7	558	0%
MON	5/14/2007	0.0%	93.00	70.00	0.00	7.27	95	0.0%
TUE	5/15/2007	0.0%	98.00	41.00	80.00	7.08	111	0.0%
WED	5/16/2007	0.0%	116.00	108.00	0.00	6.73	117	0.0%
THU	5/17/2007	0.0%	106.00	69.00	86.00	6.70	118	0.0%

Month: **May-07**

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
FRI	5/18/2007	0.0%	76.00	20.00	0.00	6.17	44	0.0%
SAT	5/19/2007	0.0%	0.00	0.00	0.00	5.92	3	0.0%
	Week Ending					6.8	488	0%
MON	5/21/2007	0.0%	143.00	60.00	56.00	6.68	83	0.0%
TUE	5/22/2007	0.2%	227.00	91.00	68.00	6.45	138	0.0%
WED	5/23/2007	0.0%	139.00	0.07	0.00	6.40	100	0.0%
THU	5/24/2007	0.0%	193.00	87.00	43.00	6.63	168	0.0%
FRI	5/25/2007	0.0%	152.00	22.00	0.00	6.48	94	0.0%
SAT	5/26/2007	0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending					6.5	583	0%
MON	5/28/2007	0.0%	0.00	0.00	0.00	0.00	0	0.0%
TUE	5/29/2007	0.0%	154.00	90.00	72.00	7.50	109	0.0%
WED	5/30/2007	0.8%	397.00	0.00	0.00	7.55	86	0.0%
THU	5/31/2007	0.0%	89.00	47.00	10.00	7.30	174	0.0%
FRI		0.0%	0.00	0.00	0.00	0.00	0	0.0%
	Week Ending					7.5	369	0%
MON		0.0%	0.00	0.00	0.00	0.00	0	
	Month End					**6.6**	**2672**	**0.0%**

Month: June-07

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
MON		0.0%	0.00	0.00	0.00	0.00	0	0.0%
FRI	6/1/2007	0.0%	80.00	66.00	91.00	7.32	108	0.0%
SAT	6/2/2007	0.0%	46.00	96.00	0.00	8.13	4	0.0%
	Week Ending					7.4	112	0%
MON	6/4/2007	0.0%	132.00	163.00	76.00	6.92	129	0.0%
TUE	6/5/2007	0.0%	125.00	75.00	81.00	6.48	143	0.0%
WED	6/6/2007	0.0%	103.00	59.00	56.00	6.97	186	0.0%
THU	6/7/2007	0.0%	152.00	99.00	73.00	7.60	172	0.0%
FRI	6/8/2007	0.0%	122.00	71.00	121.00	7.95	161	0.0%
SAT	6/9/2007	0.0%	41.00	52.00	0.00	11.28	45	0.0%
	Week Ending					7.2	836	0%
MON	6/11/2007	0.0%	118.00	104.00	91.00	6.42	131	0.0%
TUE	6/12/2007	0.0%	92.00	60.00	64.00	7.10	234	0.0%
WED	6/13/2007	0.2%	194.00	74.00	69.00	6.68	200	0.0%
THU	6/14/2007	0.0%	85.00	84.00	62.00	7.42	200	0.0%
FRI	6/15/2007	0.0%	167.00	120.00	101.00	6.80	195	0.0%
SAT	6/16/2007	0.0%	69.00	0.00	0.00	10.07	64	0.0%
	Week Ending					6.9	1024	0%

Month: June-07

Day of the Week	Date	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard			180 seconds	180 seconds	180 seconds			<=1% monthly
MON	6/18/2007	0.1%	165.00	114.00	218.00	6.92	243	0.0%
TUE	6/19/2007	0.0%	109.00	77.00	100.00	6.78	210	0.0%
WED	6/20/2007	0.0%	129.00	77.00	201.00	6.57	239	0.0%
THU	6/21/2007	0.0%	88.00	136.00	84.00	6.88	226	0.0%
FRI	6/22/2007	0.0%	106.00	121.00	28.00	7.35	197	0.0%
SAT	6/23/2007	0.0%	0.00	0.00	0.00	8.63	3	0.0%
	Week Ending					6.9	1118	0%
MON	6/25/2007	0.0%	110.00	166.00	13.00	7.03	118	0.0%
TUE	6/26/2007	0.0%	141.00	97.00	92.00	6.93	225	0.0%
WED	6/27/2007	0.0%	78.00	70.00	55.00	7.67	208	0.0%
THU	6/28/2007	0.0%	77.00	73.00	47.00	7.25	192	0.0%
FRI	6/29/2007	0.0%	143.00	82.00	0.00	7.33	226	0.0%
SAT	6/30/2007	0.0%	86.00	59.00	31.00	8.62	34	0.0%
	Week Ending					7.3	1003	0%
MON		0.0%	0.00	0.00	0.00	0.00	0	
	Month End					**7.1**	**4093**	**0.0%**