Florida Medicaid Reform

Quarterly Progress Report
April 1, 2008 – June 30, 2008

1115 Research and Demonstration Waiver

Agency for Health Care Administration

Table of Contents

List of Tables

I. Waiver History

Background

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

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

Key components of Medicaid Reform include:

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

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Condition # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the fourth quarterly report in Year Two of the demonstration for the period of April 1, 2008 through June 30, 2008. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly reports and the annual report which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including current contractors wishing to participate as Medicaid Reform health plans, are required to complete the Medicaid Reform Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 6 through 10 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. The FFS PSNs are required by law to become a capitated PSN no later than the beginning of the fourth year of operation (for most PSNs this occurs September 1, 2009).

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

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

As of June 30, 2008, the Agency has received 19 health plan applications. Seventeen of the 19 applicants sought to provide services to the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) population; one application sought to render services as a specialty PSN. The Department of Health’s Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in Duval and Broward Counties. On January 28, 2008, the Agency received its first application (Positive Health Care) for an HMO

specialty plan to serve beneficiaries living with HIV/AIDS. Positive Health Care is the DBA (doing business as) plan name for AIDS Healthcare Foundation, Inc. This application is also the most recent application received for a health plan applicant seeking to operate in Reform.

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

Table 1
Health Plan Applicants

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

Current Activities

Table 1 indicates two pending contracts, Better Health Plan, a FFS PSN, and Positive Health Care, an HMO applicant to become a specialty plan serving members with HIV or AIDS. Better Health Plan has experienced a major change in network design and, at this time, the Agency anticipates its Phase III site survey may occur in July 2008. An expected date of application approval is unknown; however, the Agency continues to provide technical assistance to Better Health Plan. Positive Health Care's application

was received at the end of January 2008, it is in the end stages of Phase I review and is in the midst of the concurrent Phase II review regarding the establishment and approval of the plan's policies and procedures and provider network. No site visit has been scheduled as of June 30, 2008. The Agency continues to receive inquiries from other interested health providers on the prospects of submitting an application to become a Reform PSN or HMO but no additional applications have been received to date.

As of June 30, 2008, the Agency has contracted with 17 health plans; 11 of these are HMOs and 6 are FFS PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date listed in Table 2 represents the date when the plan became available as a choice but does not represent the date on which the plan received enrollment. There have been no new Reform health plan contracts executed since September 2007.

Table 2
Medicaid Reform Health Plan Contracts

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

Transition – Baker, Clay and Nassau Counties

In December 2007, the Agency completed the transition of current recipients into the two Reform health plans approved for the three expansion counties (Baker, Clay and Nassau). These two health plans provide a choice of enrolling in an HMO (United

HealthCare) or a PSN (Access Health Solutions), options that did not exist for beneficiaries prior to the demonstration. As of June 30, 2008, the transition into these counties is complete.

Rate Amendments and Model Contracts

The Agency is preparing for the rate amendments for the third contract year in Reform (September 1, 2008 through August 31, 2009). Draft capitation rates are scheduled to be provided to the health plans in August and the health plans will be required to submit their new benefit packages for approval. The date for provision of draft rates was extended to allow the state's contracted actuaries to review state and plan documentation in order to ensure that the rates are actuarially sound. To allow proper notice to beneficiaries of the change in benefits, any changes to the health plans' benefits will take effect on November 1, 2008. This will allow 60-day notice to beneficiaries.

During this quarter, the Agency also posted its model Prepaid Health Plan and FFS PSN contracts to incorporate the general amendments executed in December 2007 and January 2008. The general amendments addressed the following areas:

- Medicaid redetermination date information,
- Quality improvement program,
- Performance improvement plan,
- Cultural competency plan,
- Disease management program enhancements,
- Deficit Reduction Act of 2005 requirements,
- Marketing,
- PSN claims processing,
- Encounter data and
- Capitation conversion requirements.

FFS PSN Conversion Process

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

The conversion workplans were due to the Agency by January 31, 2008. The Agency continues to review the workplans and provide technical assistance conference calls in any areas in which the plans might be lacking. Table 3 provides the timeline for each step in this conversion process.

Table 3 PSN Conversion to Capitation Timeline	
01/31/2008	Deadline for the FFS PSN to submit its conversion workplan to AHCA
12/31/2008	Deadline for the FFS PSN to submit its Conversion Application to AHCA
06/30/2009	AHCA and successful conversion applicants execute capitated contracts for service begin date of 09/01/2009
08/31/2009	Current Reform FFS PSN contracts expire

Table 5 provides the required capitation go-live date for the current FFS PSN contractors.

Table 4 PSN Conversion to Capitation Implementation Dates	
FFS PSN Name	**Scheduled Capitation Implementation Date**
Access Health Solutions	09/01/2009
Children's Medical Services Network, Florida Department of Health	12/01/2009
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2009
Florida NetPASS	09/01/2009
Pediatric Associates	10/01/2009
South Florida Community Care Network	09/01/2009

FFS PSN Reconciliations

During this quarter, the Agency began completing its review of the FFS PSNs second reconciliation period (March 1, 2007 through August 31, 2007). The Agency continues to provide technical assistance to those PSNs who have requested additional assistance as the health plan analyzes the first set of reconciliation data. The Agency expects data for the first final annual reconciliation period (September 1, 2006 through August 31, 2007) to be available to the PSNs during the first quarter of demonstration Year Three (July 1, 2008 – September 30, 2008).

2. Benefit Package

Overview

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

develop a customized benefit package, but could eliminate or reduce the co-payments and offer additional services.

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

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

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

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

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

Current Activities

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

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

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

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

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

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

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

Plan Evaluation Tool Submission Dates – Demonstration Year Three

During this quarter, the Agency notified the health plans of the PET submission procedures for Year Three of the demonstration. The PET submission procedure is similar to that of the two previous years. The updated version of the data book was released on May 7, 2008, and the new PET was emailed to all of the health plans and placed on the Agency's website on May 23, 2008. All health plans in Baker, Broward, Clay, Duval, and Nassau counties were initially required to complete the PET and submit their proposed benefit package (including any requested expanded benefits) to the Agency by June 2, 2008. However, the submission date of the PET was extended to August 13, 2008 due to the release of the draft rates on August 8, 2008. Therefore, the benefit package effective dates were revised to November 1, 2008 – August 31, 2009. Since the draft rates were not released until August, the change to the benefit package effective dates was made to provide adequate notice to the beneficiaries of any reduction in the plan benefit package and to allow time for printing and distribution of the revised choice materials that include the plan benefit packages for Year Three of the demonstration.

3. Grievance Process

Overview

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

As defined in the Medicaid Reform health plan contracts:

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

such as rudeness of a Provider or employee or failure to respect the Enrollee's rights.

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

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

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

Current Activities

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

Table 5 provides the number of grievances and appeals by health plan type for the previous quarter, ending March 31, 2008. The health plan grievance and appeals reporting cycle coincides with the due date for this quarterly report. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report will lag one quarter in each subsequent quarterly report and will be updated in the annual report to reflect the full year of data.

Table 5
Grievances and Appeals
January 1, 2008 –March 31, 2008

	PSN	HMO
Grievances	38	75
Appeals	3	61

Table 6 provides the number of Fair Hearings and requests to BAP and SAP for this quarter ending June 30, 2008. In addition, BAP and SAP requests are also included.

Table 6 Fair Hearings; BAP and SAP *April 1, 2008 –June 30, 2008*		
	PSN	**HMO**
Fair Hearings	1	0
BAP or SAP, as applicable by plan type	1	0

Medicaid Fair Hearing

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

BAP and SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only one grievance was been submitted to the BAP, and none to the SAP. The one BAP grievance issue was related to medical necessity of pharmacy and was resolved in favor of the health plan (PSN). The number of fair hearings continues to be low.

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

4. Complaint/Issue Resolution Process

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

The consolidated complaint database was developed using the expertise of Agency staff. Agency staff worked diligently to define database fields and processes for capturing data. In addition, at the end of this quarter a new Agency workgroup was established and charged to research and recommend database changes and initiatives to provide real-time complaint tracking and processing. In addition, the Agency bureaus of Health Systems Development and Managed Health Care continue to refine the trend reports for analysis and review during quarterly contract oversight meetings to determine any spikes in the volume of compliance issues and whether to recommend operational and policy changes.

The Agency tracks complaints by plan and by plan type (PSN and HMO) and continues to review particular complaint data with the individual plans. The data are now reviewed during monthly contract management oversight meetings that were initiated in May 2008.

This quarter, the Agency received 5 complaints/issues related to FFS PSNs and received 47 complaints/issues related to HMOs, for a total of 52 complaints. The complaints/issues received during this quarter are provided in Attachments I and II, sorted by PSN or HMO. Attachment I provides the details on the complaints/issues related to FFS PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address those issues raised.

This quarter, the majority of PSN complaints/issues were access related, with only one being a claim related issue. Member issues reported included access to dental, vision and specialty referrals, authorizations and an issue related to enhanced benefit credits. The one provider issue was regarding provider claim errors.

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

The Agency's staff worked directly with the members and with the PSNs and HMOs to resolve issues.

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

5. On-Site Surveys

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

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

B. Choice Counseling Program

Overview

Medicaid Reform is in the 4th quarter of demonstration Year Two. A goal of Medicaid Reform is to empower beneficiaries to take control and responsibility for their own health by providing them the information they need to make the best, most informed decisions about health plan choices.

Choice Counseling continues to achieve success in empowering beneficiaries' to make their own health plan choices at the highest rate in Florida's history. This allows the beneficiaries greater access to the services they need, which is a fundamental goal of Medicaid Reform.

Since August of 2007, Choice Counseling has been offering a Customer Service Survey. The survey allows the beneficiaries to give honest feedback about their experience with the Choice Counseling process. The beneficiaries are utilizing the survey and their responses continue to be very positive. The results from the Customer Service Survey have been an important part in evaluating and improving the Choice Counseling program.

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

- The highest voluntary enrollment rate in the history of Florida Medicaid managed care.
- Certified Choice Counselors ensuring each counselor has the knowledge and interpersonal skills necessary to serve Florida's most vulnerable population. This certification program is the first in the nation.
- Special Needs Unit to serve the medically complex and their families which allows beneficiaries enrolling in managed care for the first time to receive the additional assistance their health status requires.
- Field Choice Counselor efforts to find and reach beneficiaries that are not responding to mailings, by implementing outbound calling, leaving flyers at the individual's home, and use of community partners. These changes resulted in over 30 percent of the enrollments being done at the local level. This enrollment level is significantly higher than the 10 percent estimated for field enrollment prior to implementation.
- Customer Service Survey that can capture the beneficiaries' feedback about their experiences with Choice Counseling.

Current Activities

1. Public Meetings and Beneficiary Feedback

The Agency has held beneficiary focus groups and public meetings in the demonstration counties to solicit input on the Choice Counseling program. As a result of the feedback from previous public meetings, the implementation of a preferred drug search functionality is planned for the Choice Counseling program in the fall of 2008.

The Agency and the Choice Counseling vendor, Affiliated Computer Services (ACS), researched the options available to address this concern. The outcome of the feedback and research was the development of the Navigator solution.

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

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

The Agency solicited comments at a public meeting in December 2007 and in January 2008 when the proposed system was presented to all the Reform health plans. The comments and questions that were expressed in these forums resulted in the Agency and ACS analyzing how to better display generic drugs in the Navigator system. Follow up meetings held in Broward on May 28th and in Duval on June 3rd to "walk through the updated system." At the meetings, a mock call (including counselor talking points) with the Navigator panels (and their changes) was reviewed. The demonstration was very well received and there were additional suggestions made to add important information that can be displayed in the system. Overall the comments from the attendees were very positive. The comments are posted on the AHCA Agency website: (http://ahca.myflorida.com/Medicaid/medicaid_reform/medrefmeetings.shtml)
The Agency is working with ACS to finalize the screens and the Choice Counselor script in preparation for implementation of Navigator in late September or October '08.

Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. During the months of April through June of 2008, over 1,649 beneficiaries completed the automated survey. The survey seeks input regarding:

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

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

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

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

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

Florida Choice Counseling
Percentage of Delighted Callers for Each Question

How helpful is this counseling		
April	*May*	*June*
87.6%	*89.8%*	*88.5%*

Satisfaction with the amount of time you waited		
April	*May*	*June*
83.1%	*81.6%*	*80.7%*

How easy was it to understand the information		
April	*May*	*June*
80.5%	*77.3%*	*78.9%*

How likely are you to recommend Choice Counseling helpline to a friend or relative		
April	*May*	*June*
94.4%	*93.2%*	*94.7%*

Satisfaction with overall service of Choice Counselor		
April	*May*	*June*
96.9%	*95.5%*	*97.1%*

How quickly the Choice Counselor understood your reason for calling		
April	*May*	*June*
95.4%	*95.2%*	*97.3%*

The Choice Counselor's ability to help you choose a plan		
April	*May*	*June*
94.2%	*92.5.8%*	*96.1%*

The Choice Counselor's ability to explain the information clearly		
April	*May*	*June*
95.4%	*94.5%*	*96.5%*

Confidence in the information received		
April	*May*	*June*
95.4%	*94.6%*	*94.0%*

Satisfaction with being treated respectfully		
April	*May*	*June*
97.2%	*97.3%*	*97.5%*

The number of beneficiaries participating in the Survey was as follows: April - 604, May - 559, and June – 486 (totaling 1,649).

2. Call Center

Medicaid Reform Choice Counseling call center, located in Tallahassee, Florida, operates a toll-free number and a toll-free number for the hearing-impaired callers, using a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation were adjusted during the second quarter of year two to better align

the call center hours with beneficiary demand. The call center has over 32 full time equivalent (FTE) employees who speak English, Spanish and Haitian-Creole to answer calls.

Beginning January 2008, the call center hours were adjusted to Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., thus providing no Saturday hours. The Agency and ACS have continued to closely monitor call volume (both inbound and outbound) and the number of voice mail messages left over the weekends, to maximize access for beneficiaries. The amount of calls and number of voice mails left over weekends over the last 6 months (reported by ACS) indicates that the current weekday hours of operation are maximizing access for the beneficiaries.

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

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

Inbound Calls:	45,502
Outbound Calls:	13,473
Calls Abandoned:	
(The contract standard is <5% *monthly)*	2.9%
Calls Answered within 4 rings:	100.00%
Call Answer Rate:	
Call Answered in <15 seconds:	66.47%
Calls Answered in <60 seconds:	80.11%
Calls Answered in <180 Seconds:	95.46%

Calls answered in less then 180 seconds has a contract standard of 96%. The 15 and 60 second call rates do not have a contract standard, but are monitored as well because they are indications of customer service provided by the call center. The call center made some improvements in their workforce management during the third quarter. Incoming call history was analyzed and high volume call patterns in the call center were tracked. In reviewing that history the call center was able to implement a call pattern work schedule which allows more FTEs to be answering calls during peak time periods, thus handling more calls with less abandonment during those key hours of operation.

3. Mail

The mail room equipment and process has been evaluated by ACS and a plan for this area of the project will be proposed to the Agency in the near future.

Outbound Mail

During the quarter, the ACS mailroom mailed the following:

New-Eligible Packets	21,105
Auto-Assignment Letters	12,564
Confirmation Letters	19,210
Open Enrollment Packets	17,454
Transition Packets	901

ACS mailed 6,693 Annual Open Enrollment reminder notices to those that are exempt from Open Enrollment in April, 2008, informing beneficiaries (who are exempt from Open Enrollment) that they may change their health plan at any time. This is the second of two Annual Open Enrollment Reminder mailings that occur during the fiscal year (for those who are exempt).

During the quarter, the percentage of mail that is returned averaged 3.1 percent for the quarter. 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:

During the quarter, ACS processed the following:

Plan Enrollments	1098
Plan Changes	169

The percentage of enrollments processed through the mail-in enrollment forms has remained around 2.5% of enrollments. The Agency and ACS are exploring options to change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program to better serve beneficiaries if this option was discontinued.

4. Face-to-Face/Outreach and Education

During this quarter, the Field Choice Counseling Outreach was the best yet as the focus of outbound efforts on those beneficiaries with a pending assignment yielded the highest New Eligible Enrollment Rate (NER) so far in the project. In this quarter, the number of beneficiaries who actively chose a health plan reached an all time high in April of 88%, and 85% overall for the quarter. While the total enrollments secured through Outreach efforts was not as high as past months, the strategic focus on the truly “hard to reach” has yielded the best NER results so far.

While concentrating on finding and enrolling those who do not respond to the mailing has been the Field Choice Counselor’s primary focus with outbound activity, meeting

with those who are seeking face to face counseling remains a top priority. The Field Choice Counselors continue to complete a significant number of enrollments. During this quarter, the numbers of field enrollments continued to increase.

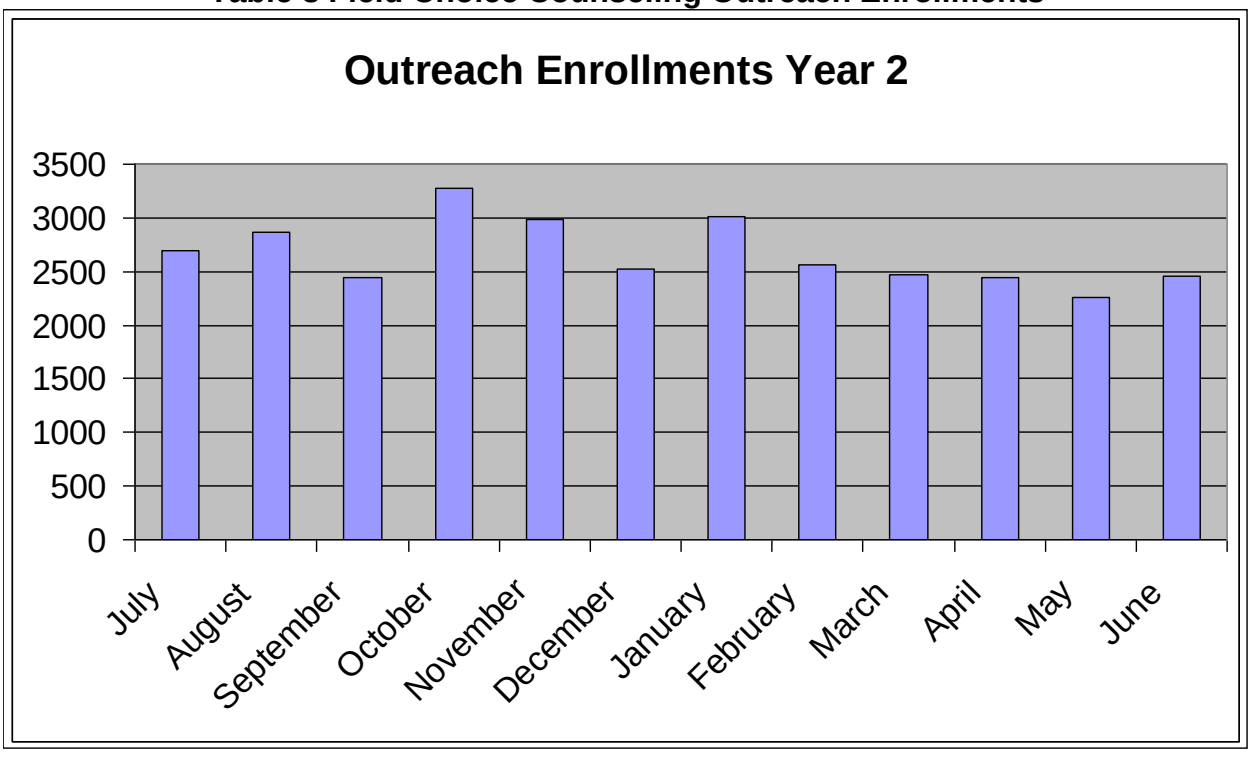
The major change in the Field Choice Counseling activities was the implementation of Quality Assurance Monitoring of the Field Choice Counselors. During the first year, the Field Choice Counseling supervisors handled most of the Field monitoring done by ACS. In September of 2007, the quality monitoring staff, located in Tallahassee, began calling, at random, beneficiaries who were served by Field Choice Counselors. The monitors asked four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 7 shows the beneficiaries' responses (in percentages) from 118 beneficiaries randomly called who participated in the survey (from April through June 2008). The same percentage range used in the call center is used in the field, with 100% being a perfect score.

Table 7 Overall Field Choice Counseling Results	
Able to complete enrollment/plan change at the session	97.90%
Felt the information provided by the Choice Counselor helped them make an informed decision	92.10%
The information was explained in a way that made it easy to understand	98.19%
The Choice Counselor was friendly/courteous	98.19%

ACS continues to evaluate the monitoring results and will make recommended changes to tools the Field Counselors use for both outbound calls and face-to-face sessions to better serve beneficiaries.

At the end of the quarter, the enrollment activities processed by Field Choice Counselors were 7,484 enrollment activities. Table 8 demonstrates the enrollment activity levels of the Field Choice Counselors during Year Two of the demonstration.

Table 8 Field Choice Counseling Outreach Enrollments



Another focus of the Field Choice Counselors is continuing to better reach the special needs and hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups have included providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities and other types of community based organizations that serve these population groups. During this quarter, the Field Choice Counselors continued to focus outbound calls on pending auto assignments (which is a list of beneficiaries who have not made a choice of health plans and are within a few weeks of being assigned to a health plan by the state). Contacting the beneficiaries from this list greatly helped increase the Field Choice Counseling enrollments and increased our customer service to beneficiaries.

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

During the quarter, the Field Choice Counselors completed the following activities:

Group Sessions	672
Private Sessions	93
Home Visits & One-On-One Sessions	236
"No Phone List"	952
Outbound Phone List	10,726
Enrollments	7,484
Plan Changes	136

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. In December 2007 a new registered nurse supervisor (RN) was hired, earned her certification in the Choice Counseling process, and began her duties in the Special Needs Unit with ACS. The RN supervisor has developed and implemented training for the Choice Counselors which outlines how the Special Needs Unit works and how to refer beneficiaries to the unit for help. In March 2008 a licensed practical nurse (LPN) was hired to work in the Special Needs Unit. The LPN completed her Choice Counseling certification course in April and is a valuable part of the Special Needs Unit.

The staffing goal of the unit, after a previous evaluation (performed in 2007), is to staff the Special Needs Unit with one RN supervisor, two LPNs and one social worker.

Additional nurses in the field will be hired after this initial group has been hired and trained.

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

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

6. New Eligible Self Selection Data

As reported last quarter, the Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. In Medicaid Reform, the term voluntary has been used to refer to both beneficiaries who can voluntarily participate in the demonstration and also to beneficiaries who voluntarily chose his or her own reform health plan. To avoid multiple uses of a single term, the Agency changed the terminology used when referring to beneficiaries who are making their own plan selection. Beginning with last quarter's report, instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate",* the data is referred to as *"New Eligible Self-Selection Rate"*. The term *"self-selection"* is now used to refer to beneficiaries who choose their own plan and the term *"assigned"* is now used for beneficiaries who do not choose their own plan.

To ensure the effectiveness of the Choice Counseling Program, the Agency requires that a minimum of 65% of the new Medicaid eligibles self-select their Medicaid Reform health plan. At the end of year two of operation, this requirement increases to 80%.

During this quarter, the average percentage of beneficiaries who were making a self-selection of a reform health plan was 83.32% (with a high of 87.78%). ACS was above the contract standard of 65% for the quarter. The Agency is especially pleased that the self-selection rate for each month of the quarter remained significantly above the 65 percent required by the contract.

Table 9 provides a breakdown of the new-eligible self-selection rate for this quarter.

Table 9 New Eligible Self-Selection Rate Fourth Quarter in Year 2				
Month	Self-Selection	Total Assigned	Total New Eligibles	Percentage
April	7,306	1,017	8,323	87.78%
May	6,244	1,734	7,978	78.27%
June	7,666	1,496	9,162	83.67%
Total	**21,216**	**4,247**	**25,463**	**83.32%**

7. Complaints/Issues

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

In this quarter, there were 4 complaints filed related to the Choice Counseling Program. Attachment III provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

8. Quality Improvement

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

The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries by striving to perfect all areas. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Counselor's ability to explain health plan choices clearly indicate that in April, 95.40% were satisfied, in May, 94.50% were satisfied, and in June, 96.50% were satisfied. ACS continues to focus on improving communication between Counselors and beneficiaries and evaluates comments left by beneficiaries to improve customer service.

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

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

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

C. Enrollment Data

Overview

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

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

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

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

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

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

Current Activities

Monthly Enrollment Reports

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

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

Below is a summary of the monthly enrollment in Medicaid Reform for this quarter, beginning April 1, 2008 and ending June 30, 2008. This section contains the following Medicaid Reform enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- Medicaid Reform Voluntary Population Enrollment Report
- Summary of Self-Selections, Assignments, & Disenrollment Data

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

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 10 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 10
Medicaid Reform Enrollment Report Descriptions

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

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 11 on the following page for the Fiscal Year 2007-08, 4th Quarter Medicaid Reform Enrollment Report.

Table 11
Medicaid Reform Enrollment Report
(Fiscal Year 2007-08, 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	13,086	1,645	3	181	**14,915**	**6.66%**	14,142	5.47%
Buena Vista	HMO	6,055	691	2	68	**6,816**	**3.04%**	6,802	0.21%
Freedom Health Plan	HMO	213	36	0	6	**255**	**0.11%**	172	48.26%
HealthEase	HMO	49,375	5,582	8	588	**55,553**	**24.79%**	54,923	1.15%
Humana	HMO	8,512	1,969	8	256	**10,745**	**4.80%**	10,654	0.85%
Preferred Medical Plan	HMO	1,387	436	1	52	**1,876**	**0.84%**	1,938	-3.20%
StayWell	HMO	32,565	3,195	11	337	**36,108**	**6.12%**	34,904	3.45%
Total Health Choice	HMO	1,645	342	2	42	**2,031**	**0.91%**	1,858	9.31%
United Health Care	HMO	25,168	3,083	5	480	**28,736**	**12.83%**	25,492	12.73%
Universal Health Care	HMO	705	120	1	11	**837**	**0.37%**	559	49.73%
Vista South Florida	HMO	5,516	499	6	68	**6,089**	**2.72%**	5,139	18.49%
HMO Total		**144,227**	**17,598**	**47**	**2,089**	**163,961**	**73.18%**	**156,583**	**4.71%**
Access Health Solutions	PSN	15,464	2,980	4	161	**18,609**	**8.31%**	18,928	-1.69%
CMS	PSN	1,948	2,228	0	15	**4,191**	**1.87%**	3,931	6.61%
First Coast Advantage	PSN	12,741	3,487	5	292	**16,525**	**7.38%**	16,389	0.83%
NetPass	PSN	2,693	1,424	1	137	**4,255**	**1.90%**	4,501	-5.47%
Pediatric Associates	PSN	9,715	523	0	1	**10,239**	**4.57%**	10,342	-1.00%
SFCCN	PSN	4,041	2,058	2	171	**6,272**	**2.80%**	6,425	-2.38%
PSN Total		**46,602**	**12,700**	**12**	**777**	**60,091**	**26.82%**	**60,516**	**-0.70%**
Reform Enrollment Totals		**190,829**	**30,298**	**59**	**2,866**	**224,052**	**100.00%**	**217,099**	**3.20%**

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

The enrollment figures for this quarter reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from non-reform health plans to Reform health plans. There were a total of 224,052 beneficiaries enrolled in the demonstration during this quarter. There were 17 Reform health plans with market shares ranging from 0.11 percent to 24.79 percent.

2. Medicaid Reform Enrollment by County Report

The demonstration is currently operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of Reform HMOs and Reform PSNs in each county is listed in Table 12.

Table 12
Number of Reform Health Plans in Demonstration Counties

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

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Medicaid Reform counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, Reform HMOs are listed first, followed by Reform PSNs. Table 13 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 13
Medicaid Reform Enrollment by County Report Descriptions

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

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 14 and located on the following page.

Table 14
Medicaid Reform Enrollment by County Report
(Fiscal Year 2007-08, 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				
United Health Care	HMO	Baker	658	94	0	4	**756**	**29.60%**	642	17.76%
Access Health Solutions	PSN	Baker	1,608	181	0	9	**1,798**	**70.40%**	1,787	0.62%
Total Reform Enrollment for Baker			**2,266**	**275**	**0**	**13**	**2,554**	**100.00%**	**2,429**	**5.15%**
Amerigroup	HMO	Broward	13,086	1,645	3	181	**14,915**	**11.71%**	14,142	5.47%
Buena Vista	HMO	Broward	6,055	691	2	68	**6,816**	**0.20%**	6,802	0.21%
Freedom Health Plan	HMO	Broward	213	36	0	6	**255**	**12.98%**	172	48.26%
HealthEase	HMO	Broward	14,758	1,622	7	153	**16,540**	**8.43%**	16,309	1.42%
Humana	HMO	Broward	8,512	1,969	8	256	**10,745**	**1.47%**	10,654	0.85%
Preferred Medical Plan	HMO	Broward	1,387	436	1	52	**1,876**	**25.70%**	1,938	-3.20%
StayWell	HMO	Broward	29,630	2,815	11	280	**32,736**	**1.59%**	31,525	3.84%
Total Health Choice	HMO	Broward	1,645	342	2	42	**2,031**	**7.13%**	1,858	9.31%
United Health Care	HMO	Broward	7,677	1,181	3	218	**9,079**	**0.19%**	8,449	7.46%
Universal Health Care	HMO	Broward	179	54	1	4	**238**	**5.35%**	200	19.00%
Vista South Florida	HMO	Broward	5,516	499	6	68	**6,089**	**4.78%**	5,139	18.49%
Access Health Solutions	PSN	Broward	1,987	786	2	53	**2,828**	**2.22%**	3,117	-9.27%
CMS North Broward	PSN	Broward	766	1,041	0	6	**1,813**	**1.42%**	1,722	5.28%
CMS South Broward	PSN	Broward	298	358	0	5	**661**	**0.52%**	633	4.42%
Netpass	PSN	Broward	2,693	1,424	1	137	**4,255**	**3.34%**	4,501	-5.47%
Pediatric Associates	PSN	Broward	9,715	523	0	1	**10,239**	**8.04%**	10,342	-1.00%
SFCCN	PSN	Broward	4,041	2,058	2	171	**6,272**	**4.92%**	6,425	-2.38%
Total Reform Enrollment for Broward			**108,158**	**17,480**	**49**	**1,701**	**127,388**	**100.00%**	**123,928**	**2.79%**
United Health Care	HMO	Clay	3,231	270	1	32	**3,534**	**39.12%**	3,063	15.38%
Access Health Solutions	PSN	Clay	4,792	681	0	26	**5,499**	**60.88%**	5,439	1.10%
Total Reform Enrollment for Clay			**8,023**	**951**	**1**	**58**	**9,033**	**100.00%**	**8,502**	**6.25%**
HealthEase	HMO	Duval	34,617	3,960	1	435	**39,013**	**47.96%**	38,614	1.03%
StayWell	HMO	Duval	2,935	380	0	57	**3,372**	**4.15%**	3,379	-0.21%
United Health Care	HMO	Duval	12,448	1,357	1	209	**14,015**	**17.23%**	12,190	14.97%
Universal Health Care	HMO	Duval	526	66	0	7	**599**	**0.74%**	359	66.85%
Access Health Solutions	PSN	Duval	4,977	1,060	1	68	**6,106**	**7.51%**	6,260	-2.46%
CMS	PSN	Duval	884	829	0	4	**1,717**	**2.11%**	1,576	8.95%
First Coast Advantage	PSN	Duval	12,741	3,487	5	292	**16,525**	**20.31%**	16,389	0.83%
Total Reform Enrollment for Duval			**69,128**	**11,139**	**8**	**1,072**	**81,347**	**100.00%**	**78,767**	**3.28%**
United Health Care	HMO	Nassau	1,154	181	0	17	**1,352**	**36.25%**	1,148	17.77%
Access Health Solutions	PSN	Nassau	2,100	272	1	5	**2,378**	**63.75%**	2,325	2.28%
Total Reform Enrollment for Nassau			**3,254**	**453**	**1**	**22**	**3,730**	**100.00%**	**3,473**	**7.40%**
Reform Enrollment Totals			**190,829**	**30,298**	**59**	**2,866**	**224,052**		**217,099**	**3.20%**

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

During this quarter there was an enrollment of 2,554 beneficiaries in Baker County, 127,388 beneficiaries in Broward County, 9,033 beneficiaries in Clay County, 81,347 beneficiaries in Duval County, and 3,730 beneficiaries in Nassau County. There were two Baker County Reform plans with market shares ranging from 29.60 percent to 70.40 percent, 17 Broward County Reform plans with market shares ranging from 0.19 percent to 25.70 percent, two Clay County Reform plans with market shares ranging from 39.12 percent to 60.88 percent, seven Duval County Reform plans with market shares ranging from 0.74 percent to 47.96 percent, and two Nassau County Reform plans with market shares ranging from 36.25 percent to 63.75 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 14 and 15 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who voluntarily chose to enroll in a Medicaid Reform health plan. Table 15 provides a description of each column in this report.

Table 15
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

Table 16 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 16
Medicaid Reform Voluntary Population Report
(Fiscal Year 2007-08, 4th Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	3	66	0	18	17	151	**255**	**1.77%**	**14,915**
Buena Vista	HMO	Broward	2	24	0	7	3	54	**90**	**1.09%**	**6,816**
Freedom Health Plan	HMO	Broward	0	0	0	0	0	4	**4**	**1.62%**	**255**
Healthease	HMO	Broward	6	111	1	30	12	128	**288**	**1.67%**	**16,540**
Healthease	HMO	Duval	16	441	0	63	41	356	**917**	**2.33%**	**39,013**
Humana	HMO	Broward	6	53	0	22	20	217	**318**	**2.66%**	**10,745**
Preferred Medical Plan	HMO	Broward	1	8	1	5	4	45	**64**	**2.85%**	**1,876**
Staywell	HMO	Broward	8	158	1	52	22	237	**478**	**1.40%**	**32,736**
Staywell	HMO	Duval	0	39	2	3	4	48	**96**	**2.80%**	**3,372**
Total Health Choice	HMO	Broward	3	6	0	2	4	39	**54**	**2.55%**	**2,031**
United Healthcare	HMO	Baker	0	8	0	0	0	5	**13**	**1.68%**	**756**
United Healthcare	HMO	Broward	2	48	3	22	21	179	**275**	**3.08%**	**9,079**
United Healthcare	HMO	Clay	0	20	0	8	9	19	**56**	**1.33%**	**3,534**
United Healthcare	HMO	Duval	9	140	2	26	34	157	**368**	**2.80%**	**14,015**
United Healthcare	HMO	Nassau	1	10	0	1	3	13	**28**	**2.65%**	**1,352**
Universal	HMO	Broward	0	1	0	0	2	1	**4**	**0.48%**	**238**
Universal	HMO	Duval	2	4	0	0	4	3	**13**	**1.56%**	**599**
Vista South Florida	HMO	Broward	3	32	2	16	9	57	**119**	**2.18%**	**6,089**
HMO Total	**HMO**		**62**	**1,169**	**12**	**275**	**209**	**1,713**	**3,440**	**2.10%**	**163,961**
Access Health Solutions	PSN	Baker	0	4	0	1	1	4	**10**	**0.45%**	**1,798**
Access Health Solutions	PSN	Broward	0	14	0	11	3	47	**75**	**2.41%**	**2,828**
Access Health Solutions	PSN	Clay	1	17	2	8	5	17	**50**	**0.78%**	**5,499**
Access Health Solutions	PSN	Duval	2	61	1	13	2	61	**140**	**2.05%**	**6,106**
Access Health Solutions	PSN	Nassau	0	13	0	1	0	5	**19**	**0.43%**	**2,378**
CMS	PSN	Duval	0	33	2	39	0	3	**77**	**4.88%**	**1,717**
CMS North Broward	PSN	Broward	0	24	0	82	0	4	**110**	**7.12%**	**1,813**
CMS South Broward	PSN	Broward	0	6	0	45	0	5	**56**	**8.99%**	**661**
First Coast Advantage	PSN	Duval	2	124	1	69	19	255	**470**	**2.65%**	**16,525**
NetPass	PSN	Broward	1	27	1	27	3	124	**183**	**3.78%**	**4,255**
Pediatric Associates	PSN	Broward	5	83	1	17	0	1	**107**	**0.87%**	**10,239**
SFCCN	PSN	Broward	2	117	1	34	17	142	**313**	**4.67%**	**6,272**
PSN Total	**PSN**		**13**	**523**	**9**	**347**	**50**	**668**	**1,610**	**2.68%**	**60,091**
Reform Enrollment Totals			**75**	**1,692**	**21**	**622**	**259**	**2,381**	**5,050**	**2.25%**	**224,052**

4. Summary of Self-Selections, Assignments, & Disenrollment Data

The Summary of Self-Selections, Assignments, and Disenrollment Data report lists the number of Medicaid Reform beneficiaries who were enrolled (either by self-selection or by assignment) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 17 provides a description of each column in this report.

Table 17
Summary of Self-Selections, Assignments, & Disenrollment Data Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# Self-Selections	The number of unique beneficiaries who chose to enroll with the plan during the current reporting quarter
# Assigned	The number of unique beneficiaries who were assigned to the plan during the current reporting quarter
Total # Enrolled	The total number of unique beneficiaries who were enrolled with the plan during the current reporting quarter: self-selection and assigned to a plan combined
% Self-Selections	The percentage of the total number of beneficiaries who chose to enroll with the plan during the current reporting quarter
# Disenrolled	The number of unique beneficiaries who disenrolled from the plan during the current reporting quarter

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

A. Medicaid Reform Enrollees

There are two ways a beneficiary can enroll in a Reform health plan: by choosing the plan themselves or by being assigned to a plan. Self-selections include newly-eligible beneficiaries who chose which plan or program to enroll in. In addition, beneficiaries who were already enrolled in a managed care plan (including MediPass) and then were transitioned into a plan when the demonstration began are included in the self-selection counts. Assigned enrollments include newly-eligible beneficiaries who have not made a choice and were assigned to a health plan.

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the current reporting quarter but then left the program. The count is performed by comparing two beneficiary lists: one for the current reporting quarter and one for the first month after the current reporting quarter. If a beneficiary appears on the current reporting quarter enrollment list, but not on the enrollment list for the first month following the current reporting quarter, the beneficiary is counted as disenrolled. Disenrollments for the fourth quarter of state fiscal year 2007-08 are those beneficiaries who appear on the enrollment list for April 2008 to June 2008, but not on the enrollment list for July 2008.

The unique beneficiary counts in the Summary of Self-Selections, Assignments, and Disenrollment Data report is shown in Table 18. Plans are listed by plan type (Reform HMO first, then Reform PSN) and in alphabetical order by county. Total counts for the quarter are also provided for HMOs and PSNs as well as the entire Medicaid Reform demonstration.

Table 18 Summary of Self-Selections*, Assignments, & Disenrollment Data
(Fiscal Year 2007-08, 4th Quarter)

Plan Name	Plan Type	Plan County	# Self-Selections	# Assigned	Total # Enrolled	% Self-Selections*	# Disenrolled
Amerigroup	HMO	Broward	14,018	897	**14,915**	**94%**	2,014
Buena Vista	HMO	Broward	6,366	450	**6,816**	**93%**	884
Freedom Health Plan	HMO	Broward	83	172	**255**	**33%**	44
HealthEase	HMO	Broward	15,471	1,069	**16,540**	**94%**	2,126
HealthEase	HMO	Duval	36,876	2,137	**39,013**	**95%**	5,047
Humana	HMO	Broward	10,001	744	**10,745**	**93%**	1,471
Preferred Medical Plan	HMO	Broward	1,419	457	**1,876**	**76%**	281
StayWell	HMO	Broward	31,271	1,465	**32,736**	**96%**	3,990
StayWell	HMO	Duval	2,092	1,280	**3,372**	**62%**	580
Total Health Choice	HMO	Broward	1,544	487	**2,031**	**76%**	350
United Health Care	HMO	Baker	594	162	**756**	**79%**	102
United Health Care	HMO	Broward	8,433	646	**9,079**	**93%**	1,471
United Health Care	HMO	Clay	3,171	363	**3,534**	**90%**	574
United Health Care	HMO	Duval	12,352	1,663	**14,015**	**88%**	2,243
United Health Care	HMO	Nassau	1,243	109	**1,352**	**92%**	189
Universal Health Care	HMO	Broward	108	130	**238**	**45%**	39
Universal Health Care	HMO	Duval	133	466	**599**	**22%**	105
Vista South Florida	HMO	Broward	5,706	383	**6,089**	**94%**	823
HMO Total			**150,881**	**13,080**	**163,961**	**92%**	**22,333**
Access Health Solutions	PSN	Baker	1,671	127	**1,798**	**93%**	211
Access Health Solutions	PSN	Broward	2,432	396	**2,828**	**86%**	351
Access Health Solutions	PSN	Clay	4,927	572	**5,499**	**90%**	860
Access Health Solutions	PSN	Duval	4,802	1,304	**6,106**	**79%**	816
Access Health Solutions	PSN	Nassau	2,128	250	**2,378**	**89%**	333
CMS	PSN	Broward	2,474	0	**2,474**	**100%**	197
CMS	PSN	Duval	1,717	0	**1,717**	**100%**	154
First Coast Advantage	PSN	Duval	14,982	1,543	**16,525**	**91%**	1,822
Netpass	PSN	Broward	3,845	410	**4,255**	**90%**	520
Pediatric Associates	PSN	Broward	9,882	357	**10,239**	**97%**	1,395
SFCCN	PSN	Broward	5,348	924	**6,272**	**85%**	718
PSN Total			**54,208**	**5,883**	**60,091**	**90%**	**7,377**
Reform Enrollment Totals			**205,089**	**18,963**	**224,052**	**92%**	**29,710**

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

For this quarter, there were 205,089 self-selections (92 percent) in Medicaid Reform. Of those, 150,881 beneficiaries were enrolled in an HMO and 54,208 were enrolled in a PSN.

D. Opt Out Program

Overview

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

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

Description of Opt Out Process

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

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

After HMS receives the required information from the employer, HMS follows up with the beneficiary to discuss the insurance that is available through the beneficiary's employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the employer. After enrollment into Opt Out Program, the beneficiary is sent an Enrollment Letter that confirms the beneficiary is enrolled in the Opt Out Program. HMS then begins to process the premiums according to the required frequency. If the beneficiary is unable to enroll in the Opt Out Program (e.g., not open enrollment), the beneficiary is

sent an Opt Out denial letter. The HMS system is flagged to contact the beneficiary when he or she is eligible for the Opt Out Program.

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

Year Two at a Glance

During the second year of operation, the Agency contacted HMS on a regular basis to ensure the Opt Out process continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified this year that required the Agency to make any changes to the process.

An Invitation to Negotiate was released during the third quarter of Year Two on January 22, 2008 for Third Party Liability Recovery Services that included the Opt Out Program. The current Opt Out contract with HMS will expire on October 31, 2008. The Agency plans to contract with one Vendor for Third Party Liability Recovery Services and the Opt Out Program beginning November 1, 2008.

<u>Opt Out Program Statistics</u>

- 42 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 19 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.

A description of the Opt Out enrollees is provided below.

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

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

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

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

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

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

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

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

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

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

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

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

12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child remained Medicaid eligible and is still enrolled in the Opt Out Program. The disenrolled child became Medicaid eligible again during the fourth quarter of Year Two and subsequently re-enrolled in the Opt Out Program effective May 1, 2008 (Item Number 26).

13. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third

quarter of Year Two on February 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

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

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

17. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage.

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

19. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

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

21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the child has health

insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage.

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

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

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

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

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

Table 19 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2008. Current Opt Out enrollment, as of June 30, 2008, is 23.

Table 19 Opt Out Statistics September 1, 2006 –June 30, 2008						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Single	1	02/28/07	Loss of Employment
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	3	Still Enrolled	N/A
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	Still Enrolled 02/29/08	N/A Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	N/A	N/A
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	2	N/A	N/A
C & F	04/01/08	Large Employer	Single	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	05/01/08	Large Employer	Family	1	05/31/08	Loss of Employment
C & F	05/01/08	Large Employer	Family	1	N/A	N/A

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

E. Enhanced Benefits Program

Overview

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

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

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

Current Activities

1. Call Center Activities

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

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

Inbound Calls:	**22,877**
Calls Abandoned:	**1665**
Average Talk Time	**5.35**

2. System Activities

Much of the system activities revolved around the transition to the new fiscal agent. EBIS sends monthly credit files and receives weekly debit files from the PDCS system which will be automated processes via secure FTP rather than the manual process.

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 and efficiently in processing the enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each recipient who has activity for the month and a quarterly statement process for recipients who have a balance only with no new activity. The Enhanced Benefits Advisory Panel, with input from the Enhanced Benefits Quality Team has made changes to the statement to reflect a more user-friendly product which we envision will entice the beneficiary to utilize their earned credits. The switch to the new statement will occur during the SFY 2008-09.

3. Outreach and Education for Beneficiaries

The welcome packets continue to be mailed to new Medicaid Reform enrollees every month, which provides detailed information regarding their eligibility for the program and the benefits provided through the program. The package contains an EBAP brochure and a letter to the enrollee regarding the program. Feedback from call center staff and review of enhanced benefits activities indicates the packets have not achieved the intended educational outcome. After the Enhanced Benefits Quality Team and the Enhanced Benefits Panel reviewed and evaluated the success of the welcome packet, the EB Quality Team created a double sided one page document which encompasses much of the information in the original brochure. This change will be made in the new state fiscal year which begins July 1, 2008. The Panel and Quality Team also approved a name change for the Program to the Enhanced Benefits Reward$ Program; all outreach and marketing materials will be transitioned to the new name July 1, 2008.

The statement inserts continue to generate positive results. In the second quarter of demonstration Year Two, the Agency began inserting one-page flyers with the Enhanced Benefit statements. These flyers promoted specific products beneficiaries could purchase. Each month the inserts promote a theme, such as women's health awareness heart health for April. The inserts have consistently increased the amount of credits beneficiaries use each week. This quarter is the highest number of credits used in a quarter to date (total of $1,325,162.67) and the highest call volume at the Enhanced Benefits Call Center.

4. Outreach and Education for Pharmacies

The Agency continues to provide EBAP outreach and education to pharmacies regarding the billing process for the program. The Enhanced Benefit Call Center has continued to assist with fielding calls regarding the billing procedures by faxing over instructions and referring pharmacies to the Agency to receive assistance.

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

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

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel was held meetings on May 16, 2008. The primary focus of the meetings was to discuss the changes the Program would be implementing in the new fiscal year which are mentioned previously. The Panel decided to begin meeting quarterly unless there was a need to meet more frequently.

6. Enhanced Benefits Statistics

Table 20 provides the Enhanced Benefit Account Program statistics beginning April1, 2008 and ending June 30, 2008.

Table 20
Enhanced Benefit Account Program Statistics

	4th Quarter Activity – Year Two	April 08	May 08	June 08
I.	Number of plans submitting reports by month	31 of 31	31 of 31	31 of 31
II.	Number of enrollees who received credit for healthy behaviors by month	35,540	30,227	35,485
III.	Total dollar amount credited to accounts by each month	$850,887.50	711,277.50	$974,177.50
IV.	Total cumulative dollar amount credited through the end each month	$13,370,003.66	$14,081,281.16	$15,055,458.66
V.	Total dollar amount of credits used each month by date of service	$353,028.35	$471,482.12	$500,677.53
VI.	Total cumulative dollar amount of credits used through the month by date of service	$1,573,765.07	$2,045,247.19	$2,545,924.72
VII.	Total cumulative number of enrollees who used credits through the end of each month	32,591	40,378	47,379

7. Complaints

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

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

During this quarter, almost 15,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 83 complaints were recorded through the call center, the Enhanced Benefits mailbox, or sent directly to the Agency related to the EBAP. Table 21 provides a summary of the complaints and outlines the actions taken by either the Agency or ACS to address the issues raised.

Table 21
Enhanced Benefit Beneficiary Complaints

Beneficiary Complaint	Action Taken
1. Forty-nine beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding Enhanced Benefits.
2. Ten beneficiaries complained about pricing differences between shelf price and what is charged.	➲ Pharmacy Services followed up on some, possible customer service request (CSR) to allow usual and customary price for an OTC item to be shelf price.
3. Seventeen beneficiaries complained about the over-the-counter products on the Enhanced Benefits web site, or products on the web site not matching at the pharmacy.	➲ The Agency has developed a more user friendly over the counter (OTC) Products list on the Enhanced Benefits web site; there are still complaints regarding the items on each category list. Enhanced Benefits Quality Team is working on a solution.
4. Seven beneficiaries reported their healthy behaviors were not reported.	➲ Call center directed the recipient back to the health plan for further research.

F. Low Income Pool

Overview

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

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

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

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

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

Current Activities

During this quarter, there were no LIP Council meetings. The next LIP Council meeting is scheduled to be held July 28, 2008.

On April 21, 2008, in accordance with STC #102, the Agency submitted the Evaluation for the Low-Income Pool Program Using Milestone Data: SFY 2005-06 and SFY 2006-07, as the study to evaluate the cost effectiveness of various Provider Access Systems. The Agency and CMS held a conference call on April 21 regarding STC #102 and the

submission of the evaluation. On June 30, 2008, the Agency submitted the Low Income Pool Program *Highlights: Year One (SFY 2006-07)* as prepared by the University of Florida Evaluation Team. The Low Income Pool Highlights document was submitted to CMS as a supplemental document to amplify some key results from Demonstration Year One of the Florida Low Income Pool program.

On May 12, 2008, the Agency received an email from CMS with feedback on the Reimbursement and Funding Methodology document that was submitted to CMS on March 20, 2008. The Agency continues to work with CMS to finalize the Reimbursement and Funding Methodology document.

During the week of May 12-16, 2008, CMS met with Agency staff in Tallahassee regarding LIP distribution calculations. During the visit, CMS reviewed data used to calculate the LIP distributions, interviewed Agency staff and reviewed LIP Cost Limits.

On June 18, 2008, the Agency received an email from CMS stating CMS would be performing audits on six of the LIP hospital based provider access systems to review documentation in support of uncompensated care.

The Agency continues to work with local governments and taxing districts to complete all outstanding Letters of Agreement.

A total of $329,734,446 in LIP distributions were made to Provider Access Systems during the fourth quarter of SFY 2007-08.

G. Monitoring Budget Neutrality

Overview

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

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

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

Excluded Eligibles:

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

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

Excluded Services:

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

Expenditure Reporting:

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

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

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

Definitions:

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

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

Current Activities

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

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

The figures in this report reflect minor corrections to Quarter 5 and Quarter 6. Through the process of imputing the data into the previous report, the formula for the rebate did not update. This has been corrected in this report, however, there is no change to the 64 report since the formula change only impacted this report. The change caused the PCCM for MEG 1 to change from the previously reported $969.86 to $969.60 for Quarter 5 and from $999.25 to $999.07 for Quarter 6. The changes did not affect the

PCCM for MEG 2 for Quarter 5 and Quarter 6.

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

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

Table 22 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC # 116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 22
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 23 through 27 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2008. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 23
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
April 2008	254,500	$302,204,899	$52,469,635	$354,674,534	$1,393.61
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$197,361,740	$35,312,356	$232,674,096	$912.58
Q8 Total	**764,701**	**$655,801,882**	**$114,515,897**	**$770,317,779**	**$1,007.35**
MEG 1 Total	**6,012,384**	**$5,033,119,781**	**$660,104,205**	**$5,693,223,987**	**$946.92**

Table 24
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$285,330,549	$40,858,333	$326,188,882	$255.46
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$162,745,780	$22,261,241	$185,007,021	$143.82
Q8 Total	**3,856,584**	**$560,208,722**	**$70,729,589**	**$630,938,310**	**$163.60**
MEG 2 Total	**29,992,810**	**$4,370,655,707**	**$386,492,267**	**$4,757,147,974**	**$158.61**

* 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.

For Demonstration Year One, MEG 1 has a PCCM of $969.52 (Table 25), compared to WOW of $948.79 (Table 22), which is 102.19% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.08 (Table 25), compared to WOW of $199.48 (Table 22), which is 80.25% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $924.72 (Table 25), compared to WOW of $1,024.69 (Table 22), which is 90.24% of the target PCCM for MEG 1. MEG 2 has a PCCM of $157.11 (Table 25), compared to WOW of $215.44 (Table 22), which is 72.93% of the target PCCM for MEG 2.

Tables 25 and 26 provide cumulative expenditures and case-months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case-months. In addition, the PCCM targets as provided in the Special Terms and Conditions are also weighted using the actual case-months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 26) is $322.50. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 26 is $292.97. Comparing the calculated weighted averages, the actual PCCM is 90.84% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case-months and the MEG specific targets in the Special Terms and Conditions (Table 26) is $352.88. The actual PCCM weighted for the reporting period using the actual case-months and the MEG specific actual PCCM as provided in Table 26 is $287.48. Comparing the calculated weighted averages, the actual PCCM is 81.47% of the target PCCM.

Table 25
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,625,165,889	$262,476,239	$2,887,642,128	$969.52
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$61,751,761	
% of WOW PCCM MEG 1					102.19%
DY01 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162.819	$2,291,520,276	$135,672,077	$2,427,192,353	$160.08
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				($597,486,781)	
% of WOW PCCM MEG 2					80.25%
DY02 – MEG 1	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,407,953,892	$397,627,966	$2,805,581,858	$924.72
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				($303,295,837)	
% of WOW PCCM MEG 1					90.24%
DY02 – MEG 2	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
MEG 2 - DY02 Total	18,686,575	$2,079,135,431	$250,820,190	$2,329,955,621	$157.11
WOW DY2 Total	18,686,575			$3,194,973,261	$215.44
Difference				($865,017,640)	
% of WOW PCCM MEG 2					72.93%

Table 26
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend		Total	PCCM
Meg 1 & 2	18,141,234	$4,916,686,165	$398,148,316	$5,314,834,482	$292.97
WOW	18,141,234			$5,850,569,502	$322.50
Difference				($535,735,020)	
% Of WOW					90.84%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend**		**Total**	**PCCM**
Meg 1 & 2	21,720,544	$4,487,089,323	$648,448,156	$5,135,537,479	$287.48
WOW	21,720,544			$6,303,850,956	$352.88
Difference				($1,168,313,476)	
% Of WOW					81.47%

Table 27
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Total Paid	**$1,921,383,741**

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$922,577,692	$1,000,000,000	92.26%
Total MEG 3	$1,921,383,741	$5,000,000,000	38.43%

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

The expenditures for the first eight quarters for MEG 3, the Low Income Pool (LIP), were $1,921,383,741 (38.43% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

The Agency is required to capture encounter data in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes. The interim pharmacy data and future medical services encounter data will be used to support 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. Moreover, risk adjustment is to be phased in over a period of three years beginning with the Medicaid Rx model and transitioning to a diagnostic based model such as the CDPS (Chronic Illness and Disability Payment System).

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

Current Activities

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

- Medicaid continues collecting and processing pharmacy encounter data on a quarterly basis. The recent 12-month measurement period used in the Medicaid Rx methodology for risk-adjusting Reform capitation rates was October 1, 2006 through September 30, 2007 paid through December 31, 2007. This measurement period was used to generate risk adjustment factors for the health plans operating in the demonstration counties.
- Pharmaceutical data will continue to be collected and processed through Medicaid Rx to support risk adjustment capitation rate premium calculations until encounter data for all services is of sufficient quality and completeness to transition to the CDPS (Chronic Illness and Disability Payment System) risk adjustment model.

For this quarterly period, risk adjustment plan factors were calculated for the following health plans:

ACCESS	Amerigroup	Buena Vista
Freedom Health	United Healthcare	Universal
HealthEase	Humana	Preferred
Staywell	NetPass	Pediatric Associates
Vista Health SF	Total Health Choice	North Broward Hospital Dist.
Memorial Healthcare	CMS North Broward	CMS South Broward

Enrollment[1] in the demonstration counties for the month of May 2008 (impacting risk adjustment payment in June 2008) was:

Broward		Duval, Baker, Clay and Nassau	
Children & Families	87,685	Children & Families	65,585
SSI	14,304	SSI	11,093
Total	101,989	Total	76,678

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

- The Florida Medicaid Management Information System (FMMIS) is being used to capture, validate, and adjudicate encounter claims received from health plans during this period.
- The MEDS team continues to work with health plans and the Agency's PBM (First Health under EDS) to coordinate the collection of pharmacy encounters using the NCPDP format beginning July 2008. Throughout this period, seven (7) HMOs have submitted test files for certification; four (4) HMOs are in various states of testing preparation.
- The MEDS team is continually updating and maintaining relevant information contained on the MEDS website which is used to facilitate communications with the health plans.
- Participation of the MEDS team in "stand-alone" meetings with health plans and biweekly technical and operations meetings continued during this period.
- Reports and HIPAA compliant EDI processes used to communicate various operational errors and invalid transaction content were disseminated to health plans for remediation of any encounters failing FMMIS edits.
- The Medicaid Decision Support System (DSS) is being used to support validation, accuracy, and completeness of encounter data.
- HMOs remain in various states of readiness; two (2) HMOs are attempting to submit X12 837 encounter claims for Sept 2006, four (4) HMOs are submitting X12 837 encounter claims for the period September – December 2007, four (4) HMOs are submitting X12 837 encounter claims for the period January - December 2008, and two (2) HMOs are submitting current day encounter data.
- PSNs remain in various states of readiness; one (1) PSN has submitted capitated transportation encounter claims through December 2007, two (2) PSNs have

[1] Medicaid Reform enrollment subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty plans/populations such as HIV/AIDS and CMS.

submitted X12 837P test files for certification and two (2) PSNs are continuing to develop test files.

- The MEDS team is continuing to work with health plans to resolve technical and X12 transaction format and content questions

- The MEDS team continues to participate in testing of encounter processing through the new FMMIS.

At the end of the quarter, the process of providing plan risk factors for rate setting, encompassing the generation of risk factors accounting for budget neutrality and the risk corridor, will continue. Scheduled activities as defined within the MEDS project plan associated with the collection and validation of encounters are continuing. This encompasses technical support with capitated health plans, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection of encounter data.

I. Demonstration Goals

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

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

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

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

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

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

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

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

By the end of the first quarter of demonstration Year Two, the Agency had approved 30 health plan customized benefit packages for the HMOs and 13 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits are effective for the contract period September 1, 2007 to August 31, 2008. These included 1 HMO and 1 FFS PSN for the counties: Baker, Clay and Nassau. Although benefit packages for the upcoming year have typically been reviewed and approved during the fourth quarter of a fiscal year in the past, no new plan benefit packages were reviewed or approved this quarter. The deadline for the plans to submit their updated benefit packages was extended to August 8, 2008.

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

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

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

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

Improving Access to Specialists

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

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

In the fall of 2007, the Agency began additional provider network analysis of Medicaid health plans, including Medicaid Reform health plans. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on recipient access to providers (e.g., the provider only accepts current patients, children and women). In October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County, based on the provider network files that health plans submitted. In order to assure appropriate inferences, the Agency will present these results in the annual report, after it has assessed the accuracy of the provider network files for 6 months.

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

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

and this follow-up resulted in a finding that 99% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

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

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

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

The Agency is currently analyzing the May 2008 survey results and just received the June 2008 survey results. In the first quarter of demonstration Year Three, the Agency will analyze and report on the May and June 2008 survey results.

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

Objective 3: *To improve enrollee outcomes as demonstrated by: a) improvement in the overall health status of enrollees for select health indicators; b) reduction in*

ambulatory sensitive hospitalizations; and c) decreased utilization of emergency room care.

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

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

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

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

During the fourth quarter of demonstration Year Two, the Agency responded to questions submitted by the Reform health plans in preparation of performance measure data submission on July 1, 2008. The performance measure data is for the period January 1, 2007 – December 31, 2007. As of June 30, 2008, seven of the 17 health plans submitted their performance measure data in anticipation of the July 1, 2008 due date. Two of the 17 health plans were granted extensions until July 15, 2008, due to unforeseen circumstances in their performance measure preparations. The remainder of the health plans was expected to submit data on the July1, 2008.

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

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

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

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

The individuals who decided not to opt out:

(a) were not employed,

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

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

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

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

Future surveys will yield more information regarding patient satisfaction and a description these surveys are provided below.

<u>Benchmark Survey (Broward and Duval Counties)</u>

The "benchmark" or baseline satisfaction survey data were collected during the fall of 2006 and winter of 2007. The survey results were reported in the quarterly report for the period July 1, 2007 to September 30, 2007. The beneficiaries surveyed were enrolled in MediPass, Florida's primary care case management program, and non-Reform Medicaid HMOs in Broward and Duval counties. This survey was designed to measure

the level of patient satisfaction with their health care prior to the implementation of the demonstration. The survey results serve as baseline data and will be compared to future patient satisfaction surveys to be conducted during the demonstration.

Follow-Up Surveys (Broward and Duval Counties)

The Year One follow-up survey was designed to assess enrollees' experiences and satisfaction with their health care after enrollment in a Reform health plan. Year One follow-up survey will be to be submitted to the Agency in July 2008. The beneficiaries surveyed were enrolled in a Reform health plan located in Broward and Duval Counties, and this report will contain the first comparison of pre- and post-Reform survey data.

The chart below shows the projected timeline for the future follow-up surveys to be conducted in Broward and Duval Counties for the duration of the demonstration.

Patient Satisfaction Surveys – Broward and Duval (Projected Timeline)		
Survey	**Description**	**Timeline**
Year Two Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Two.	Fall 2008
Year Three Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Three.	Fall 2009
Year Four Follow-Up Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan located in Broward and Duval Counties during demonstration Year Four.	Fall 2010

Patient Satisfaction Surveys in Baker, Clay & Nassau Counties

The benchmark satisfaction survey data of beneficiaries located in Baker, Clay and Nassau Counties were collected during the fall of 2007 and winter of 2008, and the results will be submitted to the Agency in July 2008. The beneficiaries surveyed were enrolled in MediPass, Florida's primary care case management program in the expansion counties. The follow-up survey will be conducted in the fall of 2008. This survey is designed to capture an assessment of enrollees' experiences with their health care after enrollment in a Reform health plan. The follow-up survey is scheduled to be conducted in the fall of 2008.

Qualitative Study

In addition to the patient satisfaction surveys, the Agency contracted with UF to conduct a qualitative study that is designed to help understand Medicaid Reform enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under Medicaid Reform. UF conducted interviews and focus groups with Reform health plan enrollees between July 2007 and December 2007. A total of 45 health plan enrollees participated in 14 in-depth telephone interviews and four focus groups in Broward, Duval, Baker, Clay, and Nassau Counties.

While these findings cannot be used to assess the success or failure of Reform due to the small number of participants, this study adds underlying context to the findings of the CAHPS-like survey, and somewhat demonstrates how health plan enrollees are responding to the demonstration. Key findings from the qualitative study are summarized in Section J of the quarterly report for the period October 1, 2007 – December 31, 2007.

Disease Management Patient Satisfaction Surveys

The Agency intends to evaluate patient experiences with care for those who are in disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. For Broward and Duval counties, beneficiaries' experiences with care will be assessed during 2008 to ensure the transition of enrollees to health plans is complete, and that beneficiaries have been enrolled in the plan for at least six months.

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

In December 2007, the Agency amended the Reform health plan contracts to require that disease management programs follow NCQA standards and guidelines for disease management. On April 1, 2008, the health plans re-submitted their disease management program descriptions and Agency staff are reviewing these materials. Rather than beginning the disease management-specific patient satisfaction surveys in the fall of 2008, the Agency will be identifying several descriptive measures for the health plans to report to the Agency (e.g., number of beneficiaries engaged in each disease management program, the types and levels of contact that beneficiaries are receiving under the disease management programs). Once we acquire better understanding of the disease management program operations and may better gauge their comparability across plans, we will focus on patient satisfaction with these programs.

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

Prior to the implementation of the Medicaid Reform Waiver, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special

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

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

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

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

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

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the University of Florida LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to the University of Florida LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year 2005-2006) by July 31, 2007. The LIP Milestone data for Year One of LIP (State Fiscal Year 2006-2007) was due to the Agency from all Providers Access Systems no later than August 15, 2007. This information was shared

with the University of Florida LIP Evaluation team in September 2007. The University of Florida and the Agency is using the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC # 102).

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

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

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

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

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

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

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

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

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

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

J. Evaluation of Medicaid Reform

Overview

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

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

A. Evaluations Affiliated with the Agency or its Contractors

Agency Internal Review

As requested by the Agency's Secretary, the Office of the Inspector General conducted a review of Medicaid Reform implementation. The final report was published on September 28, 2007, and can be viewed at http://ahca.myflorida.com/Executive/Inspector_General/IG_Report_Page.shtml.

Urban Institute – Early Impact of Transitioning to Medicaid Reform

UF established a subcontract with the Urban Institute (with funding from the Henry J. Kaiser Family Foundation [KFF]) to study the early impact of transitioning individuals enrolled in the 1115 Medicaid Reform Waiver. The reports will be disseminated through the accepting journal's website and the KFF website.

University of Oregon – Impact of Incentivizing Healthy Behaviors

UF established a subcontract with the University of Oregon (with funding from the Center for Health Care Strategies, Inc.) to study the impact of incentivizing healthy behaviors for Medicaid Reform beneficiaries. The report compared the Enhanced Benefits Programs in Florida and Idaho, and is available at the University of Oregon website: http://pppm.uoregon.edu/index.cfm?mode=news&id=506.

Florida State University – Choice Counseling Program

Florida State University (FSU) evaluated the Choice Counseling Program's materials given to individuals who are eligible to enroll in the 1115 Medicaid Reform Waiver. The

report is posted on AHCA's website at http://ahca.myflorida.com/Medicaid/quality_management/mrp/index.shtml.

University of Florida – Low Income Pool Study

The Agency contracted with the University of Florida to conduct an evaluation of the Low Income Pool (LIP), including cost-effectiveness and the impact of LIP on increased access for uninsured individuals as required by STC # 102 of the waiver. The report "Evaluation of Low-Income Pool Program Using Milestone Reporting Data: SFY 2005-06 and SFY 2006-07" completed by UF was submitted to CMS this quarter and is posted at: http://mre.phhp.ufl.edu/publications/.

B. Evaluations Commissioned by Governmental Agencies

The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) has conducted several reviews of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. The law requires the reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. OPPAGA released the following reports in June 2008:

- Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program, Report Number 08-37, June 2008;
- Medicaid Reform: More Managed Care Options Available; Differences Limited by Federal and State Requirements, Report Number 08-38, June 2008; and
- Medicaid Reform: Two-Thirds of the Initial Pilot Counties Beneficiaries Are Enrolled in Reform Plans, Report Number 08-40, June 2008.

General Accounting Office

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

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

Current Activities

Highlights of this quarter's activities include patient satisfaction survey data collection for future analysis and reporting. Benchmark (baseline) patient satisfaction surveys were conducted in the expansion counties (Baker, Clay, and Nassau). First-year patient

satisfaction survey data were collected in the two initial counties, Broward and Duval, to compare to the benchmark surveys administered prior to receiving services in Reform.

Data Collection

Patient Satisfaction Survey Data

Over several months late in 2006, the UF evaluation team conducted a Consumer Assessment of Healthcare Providers and Systems (CAHPS)-like survey of Florida Medicaid enrollees who were eligible for inclusion into the Reform initiative, and who would, over the course of several months, be transitioned into a Reform health plan. This is referred to the “pre-Reform” or “benchmark” survey because it measures satisfaction levels of Florida Medicaid beneficiaries prior to receiving services from a Reform health plan, giving us a benchmark against which later survey findings can be compared.

UF conducted a follow-up patient satisfaction survey in the first few months of 2008 to ask beneficiaries enrolled in a Medicaid Reform health plan about their experiences. This survey is referred to as the “One-Year Follow-Up Survey.” The comparisons of results from the two surveys and appropriate methodological details will be provided in a report to be submitted to the Agency from UF on July 15, 2008.

K. Policy and Administrative Issues

Current Activities

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

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

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

In nearly all these forums, the transition of Florida Medicaid's Management Information System from the legacy system to the new fiscal agent, Electronic Data Systems, Inc., computer system has been foremost in time and preparation. These forums continue to provide excellent discussion and feedback on proposed processes, and providing finalized policy in the form of our Dear Provider letters and policy transmittals. Through these forums the Agency continues its initiatives on process and program improvement that were also addressed in the Inspector General's program review of the Medicaid Reform pilot.

Medicaid Reform Technical Advisory Panel (TAP)

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

Policy Transmittals and Dear Provider Letters/Emails

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

- Advisement to Reform HMOs on discontinuation of the default provider identification number; thus clarifying for health plans that the Medicaid identification number must be provided on all network files no later than July 1, 2008. This transmittal also confirmed the requirement that providers' National Provider Numbers (NPIs) must also be reported on the plan network files submitted to the Agency.
- Advisement to the Reform health plans on revisions to the process for the provision of Medicaid redetermination date information to the health plans and an

announcement that the first files would be available for health plan distribution during May 2008.

- Advisement to Reform health plans regarding the Agency's final modifications to health plan performance measures for Year Two and Year Three.
- Advisement to Reform health plans regarding the anticipated rate/benefit amendment timeline for Year Three.
- Advisement to Reform health plans regarding changes in the health plan contract requirements for behavioral health medical record reviews and behavioral health staff reporting. These changes were based on a series of meetings and conference calls between the Agency, health plans and behavioral health providers in order to implement administrative efficiencies and reduce administrative burdens on health plans and providers alike.

Biweekly Technical and Operations Calls

The Agency conducted seven (7) biweekly Technical and Operational Issues Conference Calls with health plans and health plan applicants during this quarter. The Technical and Operation Issues Conference Calls continue to provide an avenue for direct communication between the health plans' operations and technical experts and the Agency's experts in the respective subject matter. Though some of the same issues are addressed at a higher level in the Technical Advisory Panel meetings, the Agency has the opportunity through this forum to respond to detailed questions posed through email, telephone inquiries, and previous technical calls.

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

This quarter there was a wide variance in attendance. In person, 20 to 30 people attended while approximately 120 to 200 people participate by phone (approximately 150 call lines), depending on the agenda. With the transition of Medicaid fiscal agents to occur during June 2008 (final implementation July 1), there has been an increase in the number of participants on the call. Typical agenda items included:

- Discussion on Medicaid fiscal agent transition issues, including file transfer testing;
- Discussion of upcoming Year 3 rate and benefit amendment timeline;
- Update information on Choice Counseling Program activities, including the upcoming pharmacy drug finder program that will allow choice counselors to view beneficiary drug information and what the health plans provide, and discussion on disenrollment file submission processes;

- Health plan network provider registration processes;
- National Provider Identification (NPI) registration technical assistance;
- Medicaid Enhanced Benefit Account Program updates;
- Performance measures reporting updates and review of recent policy transmittals;
- Compliance issues, such as, reminding plans to submit accurate and up-to-date provider network files, updating the provider lists on their respective websites and privacy and security of data;
- Medicaid Encounter Data Systems updates and formal questions and answers;
- External Quality Review Organization Contract Updates and Notification of Webinars and other meeting opportunities.

Fee-for-Service PSN Systems Implementation Issues Calls

The Agency staff continued with the monthly PSN systems implementation calls; however, the content of these calls continues with the revised focus on issues relating to transition to the new Medicaid fiscal agent system rather than issues relating to the legacy Medicaid fiscal agent system. Items that continue to be addressed include the following:

- National Provider Identification requirements;
- PSN Proprietary Electronic Remittance Voucher revisions; and
- Crosswalk of files received under the current Medicaid fiscal agent system to files that will be received under the new Medicaid fiscal agent system.

In order to keep the FFS PSNs informed about changes in the Medicaid Management Information System under the new fiscal agent, the Agency agreed to modify these calls from monthly to biweekly for (at least) the month of July, 2008.

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

Continuous Improvement Team

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

This quarter, the Agency conducted the last of its continuous improvement forums for Year Two of the demonstration. These forums were designed for the Agency to receive

feedback from the Reform health plans on lessons learned during Year One of the demonstration regarding the following issues:

- communication,
- PSN claims processing,
- rural county expansion and
- Medicaid Encounter Verification System (MEVS).

These forums were held in Tallahassee on April 28, 2008. The morning session included panel discussion among PSNs and the Agency. The focus of the PSN session was to gain feedback on lessons learned regarding Reform implementation from a PSN perspective. The afternoon session included a panel discussion for PSNs and HMOs with the Agency. The PSN and HMO session was structured to gain feedback on expansion and Medicaid Encounter Data System implementation, as well as to gain input from the HMOs regarding Reform implementation. Fifty-eight interested stakeholders attended the PSN session and 58 also attended the PSN and HMO session. Most of the stakeholders were health plan representatives. Public notices for the public meetings were included in the Florida Administrative Weekly and the Agency's website. In addition, notices were sent to the Agency's interested parties list as well as to provider attendees at previous forums.

The forums gave health plans a unique opportunity to provide input and ask questions relative to implementation. In addition, attendees and Agency staff discussed processes that could be improved. The dialogue was very productive and the Agency received many positive comments and requests for a continuation of dialogue between all parties. Agency staff is in the process of compiling the data from the forums to produce a Reform continuous improvement team annual report. In addition, the Agency is using plan feedback in considering systems and other implementation changes needed to enhance the Reform experience.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues	
PSN Informal Issue	**Action Taken**
1. A PSN member called plan to access a provider. The member phoned the PSN and was told she was not on their system. The vision provider will see member but wants to know what is happening.	➲ The PSN representative emailed AHCA staff that contacted ACS and confirmed that the PSN member is eligible this month with the PSN. Agency staff contacted the member and explained there was a delay in receiving their eligibility file from Medicaid this month. Member was assured the update would occur the next day and she is in fact enrolled in plan. PSN member inquired about a new ID card and was told the system will automatically generate a new one. The member's address was verified and PSN representative provided the member phone number to contact should the member require any further assistance regarding this issue.
2. A PSN member's mother contacted AHCA staff for assistance in locating a specialist. The mother called the PSN's Customer Service line and was told they do not have that specialist in their plan.	➲ The PSN representative contacted PSN member's mother and gave the name and telephone number of a specialist that could see the member.
3. A provider states that plan is not properly processing claims leading to a large backlog of unpaid claims submitted during 2007 and 2008.	➲ The provider claims' errors have been identified and they are now being approved for payment by the plan.
4. A member did not receive Enhanced Benefits credit for a healthy behavior.	➲ The plan verified the member's healthy behavior and will issue a credit.
5. A PSN member is having trouble getting dental services.	➲ The PSN was advised of the issue and took necessary steps to arrange an appointment for the member for 5/21/08. The father was contacted and he is happy for the assistance and resolution.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues April 1, 2008 – June 30, 2008	
HMO Informal Issue	**Action Taken**
1. An HMO member is having trouble getting appointment with a doctor.	➲ The HMO representative contacted AHCA staff to inform that their Case Manager contacted member and obtained necessary information regarding medical condition. The HMO Case Manager found provider and will provide transportation to and from appointments. The HMO will continue to follow member until coverage converts to straight/Fee-For-Service Medicaid and/or has received medical care.
2. A mother of a member contacted AHCA staff. She cannot find certain specialists for her handicapped son and is having transportation issues. She wanted to change plans and was given phone number to do that.	➲ The HMO was emailed and someone was to contact her to assist. Representative from HMO has called and left messages numerous times for the member's mom to call, but have not received a call back. Representatives from HMO and AHCA staff have tried to contact the member's mother numerous times and to date there have been no calls back to either.
3. An HMO member contacted AHCA staff. The member is high risk patient. She cannot be seen by specialists due to them not participating with HMO.	➲ The HMO contacted the member and authorized all visits to a non-participating specialist. The HMO representative assured BMHC that the member would be followed up on through delivery.
4. An HMO member has appointment the next day for a provider that does not take accept the HMO's members. When she contacted the HMO, they stated they might be able to do an out-of-network authorization within 24 hours.	➲ The HMO Customer Service Department personnel contacted a department that would remit an authorization. The member was seen by provider and was further given the HMO staff's phone number if had any further problems/questions.
5. An HMO member's spouse contacted AHCA staff stating the member was having trouble obtaining provider services.	➲ The HMO contacted the member directly and provided the needed provider's telephone number to call for an appointment.
6. An HMO member called and is in great deal of pain due to not being able to get an appointment through the HMO call center.	➲ The HMO contacted provider and the member now has an appointment.
7. An HMO member contacted AHCA staff because she is high risk and cannot find a specialty provider.	➲ The HMO contacted the member. Specialists in the county will be provided to member. The member will then be followed by The HMO's Case Management office to coordinate care.
8. A plan representative referred mother of the beneficiary to the Medicaid Office to obtain a prior authorization for specialist.	➲ The plan worked with the member's mother to secure a new primary dentist who will assist her in obtaining the necessary authorization for the necessary specialty care.

HMO Complaints/Issues April 1, 2008 – June 30, 2008	
HMO Informal Issue	**Action Taken**
9. A plan member did not receive scheduled transportation to a medical appointment, resulting in great hardship for the member.	➲ The plan arranged for a transportation provider representative to work with the member to resolve the problem. The member is now satisfied.
10. A provider states that plan is denying beneficiary was a plan member on the claim's dates of service.	➲ The plan corrected its membership database to reflect that the beneficiary was a member on the dates of service and will now pay the provider's claim.
11. A plan was not able to assist member who had just moved in obtaining a new provider in this area.	➲ The plan found a specialist provider and new local primary care physician for the member. The plan also helped the member set up an initial appointment with s specialist. The plan database was updated to reflect the member now resides in this area.
12. A provider indicated that HMO states the beneficiary was not a plan member on date of service and therefore denied the provider's claim. The provider states that the beneficiary was a plan member on that date.	➲ The plan representative confirmed that the beneficiary was a plan member on the date of service and contacted the provider to instruct them to resubmit the claim for payment.
13. A mother of a beneficiary states that the plan is not assisting her to obtain a dental provider for her three children. One child has an emergent dental issue.	➲ The plan had dental sub-contractor work with the mother to find a primary dental provider and to set up an appointment for the child experiencing tooth pain.
14. A member stated that he was unable to get the plan to agree to allow him to use an out-of-network hospital and physician for a surgical procedure.	➲ The plan contacted member and worked with him to identify a choice of plan specialists who treat his condition. The member was satisfied with this solution.
15. The plan states that it will not pay provider claims because beneficiaries were not plan members on the dates of service.	➲ The plan corrected its member database and called the provider to walk the provider through the claims submission process. The plan also called the assisted living facility administrator where this member resided to confirm the issue has been resolved.
16. A plan member was referred to a specialist for emergency services. The provider staff informed the member that he would be solely responsible for payment.	➲ The plan has arranged for the member to see a network provider for a full evaluation to develop treatment plan. The member agrees with the proposed course of action. The plan will follow through with member during the appointment process.
17. A hospital provided a specific inpatient treatment to a plan member but the plan denied claim because it was not a covered service. The hospital believes the plan should pay claim because this is a Medicaid covered service.	➲ The plan contract manager at AHCA confirmed that the plan had correctly interpreted the contract. The hospital was advised to submit a fee-for-service claim directly to the Medicaid fiscal agent for payment.

HMO Complaints/Issues April 1, 2008 – June 30, 2008	
HMO Informal Issue	**Action Taken**
18. A member states he was told by the plan that required service is not covered.	➲ The plan acknowledged that the requested service is covered. The plan gave immediate authorization to the provider and followed up with the member.
19. A member stated they received no member materials from the plan and had to pay for services out-of-pocket.	➲ Agency staff made the plan aware of issue and contacted the member immediately. The issue was resolved to the member's full satisfaction. Member called Area office to state issue resolved and to thank Medicaid staff for their assistance.
20. A provider states a plan is offering service reimbursement rate below standard Medicaid rate.	➲ The plan contacted the provider and is working with provider to submit an application to enter the plan's network.
21. A member wanted to see a non-network specialist but plan insists that the member pick a network specialist.	➲ The plan worked with the member to accept the plan's referral to a network specialist but will appeal the plan's actions in this matter.
22. Per a member's mother, the plan is refusing to pay the member claims, stating the provider was not in their network. The member's mother states the plan authorized her to choose this provider. Unpaid bills are now in collection.	➲ The plan reported that they had never received the claims. The provider sent claims and they are being processed for payment. The member's mother will be advised that situation is resolved.
23. A provider states the plan is denying claim because the beneficiary was not a plan member on the date of service.	➲ The plan verified that the beneficiary was a member on the date of service and paid the provider's claim.
24. A plan denied a beneficiary was a plan member when a provider called to verify membership.	➲ The provider had called the Medicare eligibility verification line at the plan and the plan representative gave erroneous information. The plan has contacted the provider to verify the member is enrolled in the plan.
25. A provider states that the plan assigned three members to other network providers when they wished to have this provider as their PCP.	➲ The plan stated the enrollment error occurred within their system and that the members were being enrolled with the network PCP that they had requested.
26. A beneficiary says the plan will not authorize a medically necessary visit to a specialist and also will not pay for certain medications.	➲ The plan authorized the out-of-network specialist and is working with the member to make necessary medications available. Member is satisfied with resolution.
27. The plan is denying claim for services provided to member because member has third party insurance. The member's mother states the third party insurance was cancelled even before the member was Medicaid eligible.	➲ The plan had updated third party insurance information in April 2008 but the claim failed to pay. The plan has contacted the provider and arranged to pay the claim. The plan notified the member's mother that the issue is resolved. The mother is satisfied.

HMO Complaints/Issues April 1, 2008 – June 30, 2008	
HMO Informal Issue	**Action Taken**
28. A plan has not paid provider claims or approved a prior authorization request for emergency procedure on member.	➲ The plan has arranged for claims to be paid and the provider has furnished necessary documentation to support the prior authorization request. The provider is satisfied and feels issue is resolved.
29. The provider states a plan has not paid claims for previously authorized services and has not issued a prior authorization for essential services the member needs immediately.	➲ The plan subcontractor worked with the provider to correct errors on the claims and these claims will now pay. The prior authorization was issued and the necessary services have now been provided to the member.
30. A member's mother states plan is denying provider's claims because the member was not in the plan on the dates of service. The mother is being billed directly by provider.	➲ The plan agreed to pay all member claims through covered period. The member subsequently chose a new plan.
31. Plan is denying claim for transportation services stating that member was deceased before the date of service. Family was subsequently billed by the provider.	➲ The plan acknowledged that member was alive at the time service was provided and has paid the provider's claim.
32. A member's family is being billed for provider services that the plan has failed to pay despite assurances that the claim would be paid.	➲ The plan had paid the Medicaid allowable and the provider was attempting to balance bill the member's family. The plan educated the provider who will write off the balance due after the Medicaid allowable.
33. Four plan members were not credited for healthy behaviors or credited incorrectly.	➲ The plan's research showed the provider either submitted a claim twice, causing the double credit, or had not yet submitted the other claims. The mother was informed of these findings by the plan.
34. A member states that the plan representatives have not been able to find the specialists she needs in the plan's provider network.	➲ The plan representative contacted the member's mother and identified specialists in the member's area. He explained the referral process and left his name and phone number for the member if she had future questions or concerns.
35. A provider states the plan subcontractor has withheld prior authorization to complete necessary services and the member is suffering because of the delay.	➲ The plan worked with the member's family, provider and the subcontractor to ensure the correct data was made available to complete the prior authorization immediately.
36. A member wants assistance to get out of the plan because she states plan does not cover a specific piece of durable medical equipment (DME) she needs.	➲ The member's PCP completed necessary prior authorization paperwork for the DME and this was provided to the member. The member is now satisfied.

HMO Complaints/Issues April 1, 2008 – June 30, 2008	
HMO Informal Issue	**Action Taken**
37. A plan denied claims on four members submitted by the provider.	➲ The plan researched the claims and established the reasons for denial were valid. The provider was instructed on how to resubmit most of the claims to receive payment.
38. A plan is denying provider claims because they state the beneficiary was not a plan member on the dates of service.	➲ The plan corrected an error in their enrollment database and processed the provider's claims for payment.
39. A complaint about timely HMO claims payment was received from a pharmacy provider.	➲ Agency staff researched the complaint and the provider was advised that the claims were paid timely and within contract requirements.
40. A member stated she had to wait over four hours for the HMO's contracted transportation provider to pick her up from a doctor's appointment.	➲ The plan reported the driver arrived but was told member was no longer there and they left. The Transportation Company plans to schedule in-service meetings with the facilities in all of the reform counties to ensure that the facilities have an understanding of transportation procedures and requirements.
41. An HMO referred a member for an appointment. When the member went to the appointment, the provider no longer accepted the plan.	➲ The HMO worked with the member and arranged an expedited appointment with a new provider.
42. An HMO member unable to find oral surgeon and unable to reach Member Services.	➲ The member was referred to an oral surgeon by the HMO, and she appreciated the help.
43. A provider at a hospital called regarding denial of claim for and HMO member.	➲ Agency staff researched the issue and determined there was a system problem that has been corrected and the claim will be processed.
44. An HMO member is having difficulty obtaining authorization for DME and Home Services after the member moved.	➲ Agency Staff updated the Florida Medicaid Management Information System to reflect the new status of the Medicaid recipient as a fee-for-service recipient due to the county move.
45. An HMO member needs assistance obtaining an orthopedic doctor for her son.	➲ The HMO contacted the member's family to arrange the needed care.
46. An HMO member's mother requested assistance for member/daughter.	➲ The plan was contacted and agreed to provide day treatment for the member.
47. An HMO member claims she needs to have teeth extracted and the Plan is only willing to pay for six.	➲ Agency staff contacted the member. The member stated the plan has been in contact with her and have assisted with this matter.

Attachment III
Choice Counseling Beneficiary Complaints

Beneficiary Complaints and Action Taken April 1, 2008- June 30, 2008	
Beneficiary Complaint	Action Taken
1. Advocacy group reported concerns about the inability of individuals with mental illness to pick a plan.	➲ The Choice Counseling Program has a special needs unit staffed by nurses to assist beneficiaries with complex needs.
2. Advocacy group concerned that choice counselors do not have access to the health plan's preferred drug lists.	➲ The preferred drug list search capacity is in the process of being added to the choice counseling program. Anticipated implementation date is September 2008.
3. Advocacy group concerned about that the choice counseling letters are confusing in describing the open enrollment process.	➲ The Choice Counseling Program has worked with the advocacy group to make changes to the open enrollment letters.
4. Advocacy group concerned that the plan benefit comparison charts are hard to understand.	➲ Based on beneficiary feedback, the Choice Counseling Program will make revisions to the comparison charts. The purposed changes will be presented during public meetings before being implemented.

Attachment IV
Choice Counseling Call Center Activity Report

ACS

Month: April-08

Choice Counseling Call Center Activity Report

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
					97,208										
MON		0	0	0	97,208	0	0.0%	100%	0.00%	0.00	0.00	0.00	0:00	0	0.0%
TUE	4/1/2008	716	700	0	97,908	16	2.2%	100%	0.1%	244.00	159.00	175.00	8:38	281	0.0%
WED	4/2/2008	691	678	0	98,586	13	1.9%	100%	1.9%	357.00	173.00	0.00	8:47	167	0.0%
THU	4/3/2008	630	624	0	99,210	6	1.0%	100%	0.0%	152.00	150.00	78.00	9:04	171	0.0%
FRI	4/4/2008	544	532	0	99,742	12	2.2%	100%	2.6%	425.00	396.00	222.00	9:12	133	0.0%
SAT	4/5/2008	0	0	3	99,745	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,581	2,534	3		47	1.8%	100%	1.7%				8:53	1053	0%
MON	4/7/2008	807	774	0	100,519	33	4.1%	100%	7.8%	580.00	610.00	759.00	9:32	301	0.0%
TUE	4/8/2008	626	623	0	101,142	3	0.5%	100%	0.3%	185.00	178.00	:03	9:07	185	0.0%
WED	4/9/2008	573	572	0	101,714	1	0.2%	100%	0.2%	180.00	221.00	77.00	9:47	163	0.0%
THU	4/10/2008	657	650	0	102,364	7	1.1%	100%	0.0%	126.00	153.00	137.00	9:47	159	0.0%
FRI	4/11/2008	594	591	0	102,955	3	0.5%	100%	2.4%	371.00	263.00	113.00	9:33	124	0.0%
SAT	4/12/2008	0	0	2	102,957	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,257	3,210	2		47	1.4%	100%	2.39%				9:33	932	0%
MON	4/14/2008	788	764	0	103,721	24	3.0%	100%	4.7%	339.00	625.00	265.00	10:38	131	0.0%
TUE	4/15/2008	715	702	0	104,423	13	1.8%	100%	0.7%	448.00	191.00	118.00	9:09	194	0.0%
WED	4/16/2008	733	725	0	105,148	8	1.1%	100%	1.4%	650.00	202.00	253.00	8:57	171	0.0%

Month: **April-08**

Choice Counseling Call Center Activity Report

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU	4/17/2008	880	852	0	106,000	28	3.2%	100%	3.0%	271.00	224.00	223.00	10:53	526	0.0%
FRI	4/18/2008	502	501	0	106,501	1	0.2%	100%	0.0%	172.00	161.00	91.00	9:51	165	0.0%
SAT	4/19/2008	0	0	3	106,504	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,618	3,544	3		74	2.0%	100%	2.16%				9:56	1187	0%
MON	4/21/2008	888	860	0	107,364	28	3.2%	100%	5.3%	399.00	456.00	157.00	9:51	174	0.0%
TUE	4/22/2008	651	635	0	107,999	16	2.5%	100%	4.0%	342.00	355.00	102.00	9:20	153	0.0%
WED	4/23/2008	513	510	0	108,509	3	0.6%	100%	0.0%	120.00	87.00	61.00	8:29	155	0.0%
THU	4/24/2008	591	589	0	109,098	2	0.3%	100%	0.17%	126.00	150.00	212.00	8:50	141	0.0%
FRI	4/25/2008	641	618	0	109,716	23	3.6%	100%	7.3%	480.00	503.00	196.00	10:04	304	0.0%
SAT	4/26/2008	0	0	0	109,716	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,284	3,212	0		72	2.2%	100%	3.59%				9:23	927	0%
MON	4/28/2008	885	853	0	110,569	32	3.6%	100%	6.8%	665.00	701.00	440.00	9:27	191	0.0%
TUE	4/29/2008	756	733	0	111,302	23	3.0%	100%	2.7%	315.00	346.00	214.00	8:46	381	0.0%
WED	4/30/2008	654	653	0	111,955	1	0.2%	100%	0.0%	142.00	194.00	0.00	8:21	109	0.0%
THU		0	0	0	111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI		0	0	0	111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT		0	0	0	111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,295	2,239	0		56	2.4%	100%					8:54	681	0%
MON		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	

Month: April-08

Choice Counseling Call Center Activity Report

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		111,955	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0		100%					0:00	0	0%
	Month End	**15,035**	**14,739**	**8**		**296**	**2.0%**	**100%**					**9:23**	**4780**	**0.0%**

ACS

Florida Medicaid Reform Choice Counseling
CALL CENTER ACTIVITY REPORT

Month: May-08

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
					134,975										
MON		0	0	0	134,975	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE		0	0	0	134,975	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	0	134,975	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU	5/1/2008	606	597	0	135,572	9	1.5%	100%	1.2%	216.00	221.00	409.00	8:26	143	0.0%
FRI	5/2/2008	559	546	0	136,118	13	2.3%	100%	5.2%	346.00	433.00	193.00	8:29	126	0.0%
SAT	5/3/2008	0	0	5	136,123	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	1,165	1,143	5		22	1.9%	100%					8:27	269	0%
MON	5/5/2008	871	859	0	136,982	12	1.4%	100%	2.1%	296.00	247.00	213.00	8:26	445	0.0%
TUE	5/6/2008	720	712	0	137,694	8	1.1%	100%	0.7%	222.00	312.00	220.00	8:14	281	0.0%
WED	5/7/2008	644	641	0	138,335	3	0.5%	100%	0.9%	312.00	164.00	150.00	8:47	266	0.0%
THU	5/8/2008	550	550	0	138,885	0	0.0%	100%	0.0%	138.00	38.00	0.00	7:59	168	0.0%
FRI	5/9/2008	558	557	0	139,442	1	0.2%	100%	0.2%	162.00	217.00	:54	7:49	125	0.0%
SAT	5/10/2008	0	0	3	139,445	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,343	3,319	3		24	0.7%	100%					8:16	1285	0%
MON	5/12/2008	802	776	0	140,221	26	3.2%	100%	6.6%	804.00	434.00	123.00	9:20	227	0.0%
TUE	5/13/2008	677	659	0	140,880	18	2.7%	100%	2.8%	339.00	245.00	238.00	8:36	227	0.0%
WED	5/14/2008	689	686	0	141,566	3	0.4%	100%	0.3%	182.00	226.00	0.00	8:00	414	0.0%

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU	5/15/2008	613	588	0	142,154	25	4.1%	100%	10.0%	456.00	490.00	706.00	9:20	182	0.0%
FRI	5/16/2008	518	505	0	142,659	13	2.5%	100%	1.7%	281.00	142.00	109.00	9:04	118	0.0%
SAT	5/17/2008	0	0	7	142,666	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,299	3,214	7		85	2.6%	100%					8:51	1168	0%
MON	5/19/2008	965	890	0	143,556	75	7.8%	100%	14.5%	487.00	581.00	501.00	9:41	191	0.0%
TUE	5/20/2008	820	789	0	144,345	31	3.8%	100%	5.7%	386.00	287.00	467.00	9:29	175	0.0%
WED	5/21/2008	883	848	0	145,193	35	4.0%	100%	4.2%	318.00	645.00	391.00	11:00	200	0.0%
THU	5/22/2008	822	802	0	145,995	20	2.4%	100%	0.6%	201.00	200.00	115.00	10:31	390	0.0%
FRI	5/23/2008	482	479	0	146,474	3	0.6%	100%	0.0%	167.00	101.00	0.00	8:48	130	0.0%
SAT	5/24/2008	0	0	2	146,476	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,972	3,808	2		164	4.1%	100%					9:59	1086	0%
MON	5/26/2008	0	0	0	146,476	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
TUE	5/27/2008	985	903	0	147,379	82	8.3%	100%	11.0%	489.00	661.00	1502.00	9:45	425	0.0%
WED	5/28/2008	777	750	0	148,129	27	3.5%	100%	2.1%	220.00	267.00	472.00	9:20	164	0.0%
THU	5/29/2008	670	666	0	148,795	4	0.6%	100%	0.0%	135.00	120.00	23.00	8:00	110	0.0%
FRI	5/30/2008	639	634	0	149,429	5	0.8%	100%	1.3%	245.00	279.00	101.00	8:42	250	0.0%
SAT	5/31/2008	0	0	0	149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,071	2,953	7		118	3.8%	100%					9:01	949	0%
MON		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**	**100%**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
THU		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		149,429	0	0.0%	100%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0		100%					0:00	0	0%
	Month End	**14,850**	**14,437**	**24**		**413**	**2.8%**	**100%**					**9:01**	**4757**	**0.0%**

ACS

Month: June-08

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon RateTotal (%)	% of calls holding above 180 seconds (%)	English longest wait in queue # (Seconds)	Spanish longest wait in queue # (Seconds)	Creole longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Capacity (%)
Standard							**<5% Monthly**		**180 seconds**	**180 seconds**	**180 seconds**			**<=1% monthly**
MON	6/2/2008	1,037	974	0	974	63	6.1%	10.6%	549.00	620.00	86.00	8:38	161	0.0%
TUE	6/3/2008	795	774	0	1,748	21	2.6%	1.8%	176.00	303.00	201.00	8:05	171	0.0%
WED	6/4/2008	963	890	0	2,638	73	7.6%	10.8%	463.00	444.00	575.00	9:11	180	0.0%
THU	6/5/2008	803	760	0	3,398	43	5.4%	10.3%	354.00	622.00	553.00	9:12	143	0.0%
FRI	6/6/2008	618	608	0	4,006	10	1.6%	1.3%	244.00	598.00	255.00	9:04	281	0.0%
SAT	6/7/2008	0	0	6	4,012	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	4,216	4,006	6		210	5.0%	7.6%				8:49	936	0%
MON	6/9/2008	885	846	0	4,858	39	4.4%	7.6%	309.00	475.00	325.00	9:23	196	0.0%
TUE	6/10/2008	718	705	0	5,563	13	1.8%	1.0%	247.00	436.00	0.00	9:37	196	0.0%
WED	6/11/2008	695	675	0	6,238	20	2.9%	3.0%	381.00	769.00	255.00	9:06	291	0.0%
THU	6/12/2008	648	637	0	6,875	11	1.7%	2.3%	242.00	416.00	351.00	9:44	161	0.0%
FRI	6/13/2008	525	524	0	7,399	1	0.2%	0.0%	159.00	96.00	73.00	9:05	70	0.0%
SAT	6/14/2008	0	0	3	7,402	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,471	3,387	3		84	2.4%					9:23	914	0%
MON	6/16/2008	834	757	0	8,159	77	9.2%	22.0%	469.00	458.00	551.00	10:36	214	0.0%
TUE	6/17/2008	776	689	0	8,848	87	11.2%	22.8%	528.00	986.00	228.00	9:54	167	0.0%
WED	6/18/2008	766	754	0	9,602	12	1.6%	1.6%	269.00	243.00	241.00	9:29	148	0.0%
THU	6/19/2008	820	789	0	10,391	31	3.8%	10.0%	382.00	508.00	311.00	10:02	345	0.0%
FRI	6/20/2008	280	280	0	10,671	0	0.0%	0.0%	64.00	120.00	0.00	9:53	57	0.0%

SAT	6/21/2008	0	0	1	10,672	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	3,476	3,269	1		207	6.0%					9:59	931	0%
MON	6/23/2008	394	391	0	11,063	3	0.8%	0.5%	101.00	453.00	0.00	10:21	78	0.0%
TUE	6/24/2008	378	376	0	11,439	2	0.5%	0.0%	166.00	67.00	0.00	9:48	266	0.0%
WED	6/25/2008	272	272	0	11,711	0	0.0%	0.0%	78.00	297.00	0.00	8:54	176	0.0%
THU	6/26/2008	967	904	0	12,615	63	6.5%	7.0%	455.00	562.00	360.00	9:06	142	0.0%
FRI	6/27/2008	702	666	0	13,281	36	5.1%	13.0%	366.00	710.00	494.00	8:50	108	0.0%
SAT	6/28/2008	0	0	3	13,284	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	2,713	2,609	3		104	3.8%					9:17	770	0%
MON	6/30/2008	862	845	0	14,129	17	2.0%	1.3%	218.00	238.00	145.00	8:08	385	0.0%
TUE		0	0	0	14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
WED		0	0	0	14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
THU		0	0	0	14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
FRI		0	0	0	14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
SAT		0	0	0	14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	0.0%
	Week Ending	862	845	0		17	2.0%					8:08	385	0%
MON		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
TUE		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
WED		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
THU		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
FRI		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
SAT		0	0		14,129	0	0.0%	0.0%	0.00	0.00	0.00	0:00	0	
	Week Ending	0	0	0		0						0:00	0	0%
	Month End	**14,738**	**14,116**	**13**		**622**	**4.2%**					**9:16**	**3936**	**0.0%**