Florida Medicaid Reform

Quarterly Progress Report
July 1, 2006 – September 30, 2006

1115 Research and Demonstration Waiver

Table of Contents

I. Waiver History 4

Background 4

II. Status Update of Medicaid Reform 5

A. Health Care Delivery System 5

1. Health Plan Contracting Process 5

2. Benefit Package 7

3. Grievance Process 9

4. Other Operational Issues 10

B. Choice Counseling Program 12

C. Enrollment Data 22

1. Medicaid Reform Enrollment Report 23

2. Medicaid Reform Enrollment Report by County 25

3. Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data 28

D. Opt Out Program 31

E. Enhanced Benefit Program 33

F. Low Income Pool 35

G. Monitoring Budget Neutrality 37

H. Encounter and Utilization Data 38

I. Demonstration Goals 40

J. Evaluation of Medicaid Reform 43

K. Policy and Administrative Issues 46

Attachment I Medicaid Reform Outreach Meetings November 2005 – June 2006 47

Attachment II Medicaid Reform Outreach Meetings July 2006 – September 2006 56

Attachment III Florida Medicaid Reform Choice Counseling 68

List of Tables

Table 1 Health Plan Applicants 6

Table 2 Medicaid Reform Health Plan Contracts 7

Table 3 Sufficiency Tested Services 8

Table 4 New Eligible Voluntary Enrollment Rate First Quarter 2006 18

Table 5 Beneficiary Complaints & Action Taken 19

Table 6 Medicaid Reform Enrollment Report Descriptions 23

Table 7 Medicaid Reform Enrollment Report (Fiscal Year 2006-07, 1st Quarter) 24

Table 9 Medicaid Reform Enrollment Report by County (Fiscal Year 2006-07, 1st Quarter) 26

Table 10 Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data 29

Table 11 Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data (Fiscal Year 2006-07, 1st Quarter) 30

List of Charts

Chart A Market Share for Medicaid Reform 25

Chart B Market Share for Medicaid Reform in Broward County 27

Chart C Market Share for Medicaid Reform in Duval County 28

I. Waiver History

Background

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

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

Key components of reform include the following:

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

Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues. This report is the first quarterly report for the period of July 1, 2006 through September 30, 2006. In addition to outlining the events that occurred during the first quarter of operation, the report provides a summary of pre-implementation activities to ensure that there is a full accounting of activities.

II. Status Update of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Background

In preparation for implementation, the Agency issued a request for non-binding letters of intent in February 2006 to determine prospective plans' interests in participating in Reform in Broward or Duval County. The Agency received 21 responses from prospective plans. Of those, 12 indicated interest in participating as a Health Maintenance Organization (HMO) and 9 indicated interest in participating as a Provider Service Network (PSN). While not all 21 organizations actually submitted an application, the Agency used the information to restructure the application process. Specifically, the Agency sought health plan participation through an open application process and contracted with any qualified plan that met all applicable requirements of state and federal regulations.

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

Under the open application process, there was no official due date for submission in order to participate as a plan in Broward or Duval County. Instead the Agency provided guidelines for submission dates in order to ensure contracting by July 1, 2006. Prospective plans were informed that they had to submit a completed application by April 17, 2006, in order to be considered for a July 1, 2006, effective date. The Agency received 14 applications by April 17, 2006, and another four after that date for a total of 18 applications. Seventeen of the 18 applicants sought to provide services to the TANF and SSI population; one application sought to render services as a specialty PSN. The Children's Medical Services Network submitted an application to provide services as a specialty PSN to children with chronic conditions in both Duval and Broward Counties.

The review process was restructured to make designated staff responsible for reviewing specified areas. Staff specialization reduced the processing time and ensured that all applications were reviewed uniformly. Of the 18 application submitted, the Agency contracted with 12 health plans effective July 1, 2006. Table 1 lists the Reform health

plan applicants, date the application was received and date of approval. The 6 Reform health plan applications which were not approved by July 1, 2006, either had not submitted all the necessary documentation or had inadequate provider networks.

Table 1
Health Plan Applicants

Plan Name	Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
AMERIGROUP Community Care	HMO	X		4/14/2006	6/29/2006
Health Ease	HMO	X	X	4/14/2006	6/29/2006
Staywell	HMO	X	X	4/14/2006	6/29/2006
Preferred Medical Plan	HMO	X		4/14/2006	6/29/2006
United HealthCare	HMO	X	X	4/17/2006	6/29/2006
Universal	HMO	X		4/17/2006	**Pending**
Humana	HMO	X		4/14/2006	6/29/2006
Phytrust dba Access Health Solutions	PSN	X	X	5/9/2006	7/21/06
Freedom	HMO	X		4/14/2006	**Pending**
Total Health Choice	HMO	X		4/14/2006	6/7/2006
South Florida Community Care Network	PSN	X		4/13/2006	6/29/2006
Buena Vista	HMO	X		4/14/2006	6/29/2006
Vista Health Plan SF	HMO	X		4/14/2006	6/29/2006
Florida NetPASS	PSN	X		4/14/2006	6/29/2006
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	4/17/2006	6/29/2006
Children Medical Services	PSN	X	X	4/21/2006	**Pending**
Pediatric Associates	PSN	X		5/9/2006	8/11/2006
Better Health	PSN	X	X	5/23/2006	**Pending**

Current Activities

As of July 1, 2006, the beginning of the first quarter of operation, the Agency contracted with 12 health plans of which 9 are HMOs and 3 are PSNs. Table 2 lists the Medicaid Reform health plan contract by plan name, effective date of the contract, type of plan and coverage area. Please note that the effective date represents the date when the plan is available as a choice but does not represent the date on which the plan receives enrollment. Since July 1, 2006, the State entered into two additional contracts with PSNs, Access Health Solutions and Pediatric Associates. As of September 30, 2006, The Agency has 14 Reform health plans under contract. Four applications are still under review. Table 1 indicates the pending contracts. The State anticipates two more plans, an HMO and a PSN, will be approved in the next quarter. The PSN will be the first specialty plan to serve children with chronic conditions.

Table 2 Medicaid Reform Health Plan Contracts				
Plan Name	**Date Effective**	**Plan Type**	**Coverage Area** Broward	Duval
AMERIGROUP Community Care	07/01/06	HMO	X	
Health Ease	07/01/06	HMO	X	X
Staywell	07/01/06	HMO	X	X
Preferred Medical Plan	07/01/06	HMO	X	
United HealthCare	07/01/06	HMO	X	X
Humana	07/01/06	HMO	X	
Phytrust dba Access Health Solutions	7/21/06	PSN	X	X
Total Health Choice	07/01/06	HMO	X	
South Florida Community Care Network (PSN)	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	8/11/06	PSN	X	

2. Benefit Package

Background

A key aspect of Reform is a plan's ability to create a customized benefit package targeted to a specific population. Specifically, under Reform capitated plans were provided the opportunity to create a customized benefit package by varying the amount, duration and scope of services for non-pregnant adults. Capitated plans can also vary the copayments and provide coverage of additional services to customize the benefit packages. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package but could eliminate or reduce the copayments 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 as follows: covered at the State Plan limits; covered at the sufficiency threshold, and flexible. For those services classified as "covered at the State Plan limit," the plan did

not have flexibility in varying the amount, duration or scope of services. For services classified under the category 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.

To ensure that plans were familiar with the required coverage thresholds, the Agency made available a data book on April 10, 2006. The data book provided historic FFS utilization data for all of the target populations. This information assisted prospective plans in quickly identifying the specific coverage limits required to meet a specified threshold. Table 3 provides a summary of services categorized as sufficiency tested services. The table provides the threshold of historical utilization required for each population and the respective coverage limit in order to be approved.

Table 3
Sufficiency Tested Services

Sufficiency Tested Services	Threshold Percentage	Unit (TANF)	Unit (SSI)	Dollars (TANF)	Dollars (SSI)
Hospital Outpatient Services (Not Otherwise Specified)	98.5%			$ 146	$ 843
Home Health Services	99.85%	2	36	$ 82	$ 1,338
Durable Medical Equipment	98.5%			$ 57	$ 3,674
Pharmacy	98.5%	9 per month/ 56 per year	16 per month / 160 per year	$ 5,312	$ 24,473

A Plan Evaluation Tool (PET) was developed by the Agency for use in evaluating plan benefit packages. In addition, the Agency released an online version of the PET. The tool allowed a plan to obtain a preliminary determination as to whether it would meet the Agency's actuarial equivalency and sufficiency tests before submitting the benefit package. The PET was revised on May 26, 2006, to reflect the Legislature's decision to restore adult vision and adult hearing services and the addition of an adult partial dentures program to the standard Medicaid benefit.

Current Activities

Of the 14 health plans approved during the 1st quarter, nine HMOs were authorized to create a customized benefit package. As indicated above, benefit package variation could be accomplished in one of three ways. Five of the nine capitated health plans elected to vary the amount of their services specific to the populations. The five are: Amerigroup Community Care; HealthEase; Humana Medical Plan; Staywell Health Plan

and United Health Care. In addition, plans were able to waive or decrease the copayment amounts required for select services.

Six capitated plans and one PSN choose to waive cost sharing, three plans imposed cost sharing for select services and three PSNs charged cost sharing consistent with the FFS limit.

Finally, many plans choose to distinguish themselves by adding services not currently covered by Medicaid. In the contract, these are referred to as expanded services. In total, there were nine different expanded benefits which were offered by all of the Reform health plans.

The most popular benefits were an over-the-counter (OTC) drug benefits and adult preventive dental benefits. New expanded services available to beneficiaries include the following:

- Over-the-counter drug benefit from $10-$25 per household, per month
- Adult Preventative Dental
- Circumcisions for 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.

The health plans are able to change their benefit packages only on an annual basis. Therefore, as new plans are approved, the plan may create another customized benefit package. New beneficiaries, who have not made a choice or who are still in their open enrollment period, may select a new plan with a different benefit packages. However, currently approved benefit packages will remain unchanged until the next contract year, starting September 1, 2007.

3. Grievance Process

Background

The grievance and appeals processes, which was specified in the Reform health plan contracts, was modeled after the existing managed care contractual process and includes a grievance process, appeal process, Medicaid Fair Hearing system, and

timeframes for submission, plan response and resolution. This is consistent with Federal Grievance System Requirements located at 42 CFR 400. In addition, the Medicaid Reform health plan contracts include a provision for the submission of unresolved grievances, upon completion of the health plans internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations. This provides an additional level of appeal.

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

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

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

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

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

Current Activities

During the first quarter, no formal grievances have been filed with the Agency for HMO or FFS PSNs. The first quarterly report on enrollee (or provider) grievances and appeals is due to the Agency November 15, 2006. The Agency will provide a summary of results in the next quarterly report.

4. Other Operational Issues

As with most demonstration projects, there may be significant issues that require resolution prior to implementation, and the identification of these items and the communication surrounding them throughout the resolution process are intensely important. The Agency identified various operational issues for both prepaid health plans and FFS PSNs regarding the September 1, 2006, initial enrollment. The Agency established effective internal and external communication processes to manage and resolve issues efficiently, which was the key element in maintaining a successful Medicaid Reform implementation schedule.

Prior to implementation, the Agency instituted several mechanisms to facilitate the communication and resolution of Reform issues including:

- A Project Management team approach to Medicaid Reform to ensure that all areas of Reform were supported by teams devoted to the various Reform activities: choice counseling, managed care implementation, outreach, rate setting, encounter data, enhanced benefit, low income pool, quality, plan readiness, application readiness, opt out, and evaluation of Reform. Each team set objectives, tasks and deliverables, and each was tracked through completion. Team leads from each team met weekly with a Steering Committee made up of Medicaid Bureau Chiefs and executive management to ensure that tasks were completed timely, issues were appropriately addressed and final decisions voted on and documented through a decision log.
- Establishment of a Medicaid Reform website to ensure the public, including beneficiaries and interested providers, had a place to obtain the most recent information available. Such information included the Reform Health Plan Application, the Reform Capitated Health Plan Contract, Reform FFS PSN Network Contract, outreach meeting schedule for both Duval and Broward Counties, plan evaluation tool link, Reform application frequently asked question documents, etc.
- Assigning health plan application team leads for each FFS PSN and capitated health plan applicant to facilitate effective internal communications across bureaus, provide consistent communication with the applicants, and ensure a timely review of the applications.

Reform issues that were brought forward for resolution included the following:

- Transitioning the current health plan population and the MediPass population into Reform plans, allowing appropriate time frames for choice and ensuring that the choice counseling system and helpline would not be impacted beyond contract capacity.
- Coordination of the required systems changes needed in the affected information systems so that voluntary choices, mandatory assignments, enrollment and payment would appropriately occur.

  Systems changes were designed and submitted by each Reform Team for its applicable area and the systems log was reviewed at each weekly Reform Team Lead meeting and Reform Steering Meeting. As overlap and inconsistencies were identified, group team meetings occurred to ensure that affected areas were addressed. Due to the short time frame for implementation and due to the impending new fiscal agent system, some system workarounds for the current system were requested rather than full systems modifications.
- Technical Assistance Meetings and Conference Calls with the health plans.

  The Agency scheduled several technical assistance calls with the health plans to discuss particular implementation topics: provider file transmission, encounter data submission, enhanced benefit design.

B. Choice Counseling Program

Background

Choice Counseling/Health Literacy

The Agency appointed a team to develop and implement a comprehensive choice counseling program that would provide the education and outreach necessary to assist Medicaid beneficiaries in making a health plan choice. As part of the education effort, the choice counseling team felt that having health literacy integrated into the program was a necessity instead of having the literacy portion which is required in the waiver STCs and by Florida Statutes a separate or stand-alone function of the choice process.

As the choice counseling team began to lay out the vision for the program, it determined that including expertise of other states and input from Medicaid beneficiaries, advocates, providers, plans and other interested parties was critical.

The Agency researched the choice counseling and enrollment programs from other Medicaid programs across the country. Major components of each state's Medicaid choice counseling program were discussed and the applicability to Florida Medicaid considered.

Public Meetings and Focus Groups

The Agency began the effort to implement a choice counseling program in October 2005. The first step in the process was to conduct public meetings in Broward and Duval Counties asking potential plans, advocates and stakeholders how the program should be structured and how the choice counseling program should assist in improving health literacy. Following the public meetings, the Agency convened beneficiary focus groups to ask their views on how the choice counseling program should be structured and how it should assist in improving health literacy.

The meetings were facilitated by representatives from the Agency's consulting group. The Agency felt that a non-Medicaid facilitator might encourage attendees to participate fully in the meeting and not feel that the information shared could somehow have a negative impact. Extensive notes from each meeting were discussed by the team and incorporated into the vision of the program that was presented in the procurement document released by the Agency.

Major items from the meetings and focus groups included in the procurement document were community-based organizations in the choice counseling program, especially the face-to-face component; requiring that the choice counseling staff be certified to ensure knowledge and people skills necessary to serve beneficiaries; electronic access to the benefit packages offered by the plans; experience in serving diverse Medicaid populations; and experience in providing services for the disabled.

In addition to meetings focused on the structure of the choice counseling program, the Agency, in cooperation with Florida State University, held a series of focus groups and public meetings on the materials that would be mailed to beneficiaries. Three focus groups and one public meeting were held in each reform county. At these forums, draft materials were presented and comments and recommendations captured by the facilitator. The recommendations were reviewed by the Agency, and many were incorporated into the materials.

Procurement Process

The Agency issued an Invitation to Negotiate to secure a vendor to perform the choice counseling function under Reform. While the procurement process was under way, the choice counseling team continued to attend monthly public meetings in Broward and Duval Counties to learn about community concerns over hard-to-reach populations and other issues. The comments and feedback were captured so the team could identify the items the Agency wanted to ensure were included in the final structured choice counseling program.

In April 2006 when the Agency selected Affiliated Computer Services (ACS) as the choice counseling vendor under Reform.

Training

To ensure that the choice counselors who would be interacting and assisting Medicaid beneficiaries had the knowledge and the soft skills to work effectively with beneficiaries, the Agency worked with Florida State University to developed a Choice Counseling Certification Program. The Agency believes that Florida is the first state to develop such a specialized certification program for choice counselors.

The course is web-based and consists of 10 training modules. The first 9 modules focus on knowledge the choice counselor will need to interact effectively with beneficiaries and assist them with plan choice. The 10th module is a knowledge test. The prospective choice counselor must successfully complete the modules in order and then pass the knowledge test from module 10.

Upon completion of the web-based course, the prospective choice counselor must take a comprehensive final exam administered by Agency staff. Once the comprehensive test is completed, the prospective counselor takes an oral examination to test their knowledge and soft skills. The oral exams present the prospective counselor with real-life scenarios in a role-playing scenarios with a “beneficiary”. The oral exam is administered by Agency area office staff who work with Medicaid beneficiaries on a daily basis.

The prospective choice counselor must achieve a score of 80 percent or above on both the knowledge test and oral examination to become certified. If the prospective

counselor does not achieve the 80 percent on one or both the components, but scores more than a 50 percent on the part they failed to make standard, the prospective counselor will be considered a choice counseling associate. An associate can perform choice counseling duties, but must retake the test(s) within 30 days and achieve an 80 percent score or above. Failure to achieve an 80 percent score at that point disqualifies the person as a Reform choice counselor.

Outreach

Communication with the community stakeholders of Broward and Duval Counties was and still is a critical component to the success of Medicaid Reform. In September 2005, the Agency began attending or hosting monthly meetings in both Broward and Duval Counties. In the spring of 2006, as implementation neared, the Agency increased its outreach efforts extensively. The increased efforts included not only the continuation of the monthly outreach meetings, but multiple meetings or training sessions at the local area offices geared toward providers and beneficiaries. The focus of these meetings was to provide specific information to each of these groups on how Medicaid Reform would affect them. Attachment I shows all the outreach meetings and training session the Agency conducted prior to Reform implementation.

In May 2006 the Agency published a brochure written for Medicaid beneficiaries that provided an introduction to Medicaid Reform. Working with ACS, the Agency produced a blue and green envelope “Check It Out” envelope in which to mail that the Reform enrollment packets.

In June 2006, the Agency contracted with two minority public relations firms in Broward and Duval Counties to assist in increasing awareness in the local community that Medicaid Reform was near. The “Check It Out” envelope was a focus of this outreach and was displayed on posters, banners, t-shirts and other materials. The goal was to make Medicaid beneficiaries and the organizations that served them aware of the envelope they would receive in the mail and what action had to be taken when it arrived. In addition, the Agency mailed the Medicaid brochure to all Medicaid beneficiaries in Broward and Duval Counties who would be required to enroll in a Medicaid Reform Plan.

Current Activities

Transition

On July 1, 2006, Choice Counseling was implemented with the opening of the toll-free phone lines to respond to general questions about Medicaid Reform. On July 24, 2006, the choice counseling contractor sent enrollment materials to new eligibles and individuals identified in the transition plan required to enroll in a Reform health plan.

July transition focused on sending materials to half of the transitioning MediPass beneficiaries whose primary care doctor did not join a Reform PSN. In August and September 2006, the contractor mailed enrollment packets to one-third of current MediPass enrollees whose primary care provider (PCP) was joining a PSN and one twelfth of current HMO enrollees. The following numbers show the transition packets sent for the first quarter:

- July 2006: 10,935 Mandatory Packets and 820 Voluntary Packets
- August 2006: 17,992 Mandatory Packets and 1,302 Voluntary Packets
- September 2006: 19,346 Mandatory Packets and 1,464 Voluntary Packets:

Call Center

At 9 a.m. EDT on July 1, 2006, the ACS Choice Counseling call center was activated. It has a toll-free number (1-888-454-3959) as well as a number for the non-hearing impaired callers and a toll-free TDD/TTY number (1-888-467-4970) for the hearing impaired. The call center's operates 8:00 a.m. – 7:00 p.m., Monday – Friday and 9:00 a.m. – 1:00 p.m. on Saturday.

The call center has 43 FTEs to answer calls and has counselors who speak English, Spanish and Haitian-Creole. For beneficiaries who speak other languages, the call center uses a language line on a three-way call to serve the needs of the beneficiaries.

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

In July, the first month of the quarter, the call center received 2,660 calls and completed 1,068 outbound calls. Activity in September, the last month of the quarter, had increased dramatically: 18,859 calls received and completed 5,195 outbound calls completed. Attachment II details the call center activity for the entire first quarter and shows the dramatic increase in activity over the quarter.

Mail

The mailroom is located at the ACS Tallahassee office. This is also the location where all outbound mail for beneficiaries is processed.

The contract with ACS contains contract standards regarding the length of time the ACS mailroom has to ensure that mail is processed and in the postal service system. This is to ensure that all mail is delivered timely due to the 30-day enrollment window and timeframes for changing plans. In addition, the contract requires a quick turnaround on

the processing of enrollment forms received by mail and for mail returned as undeliverable. The following illustrate the nature of the standards:

New Eligible Packets: Must be mailed within 2 business days

Confirmation Letters: Must be mailed within 2 business days

Enrollment forms: Must be processed within 24 hours

Outbound Mail

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

13,472 New-Eligible Packets

51,859 Transition Packets

7,463 Auto-Assignment Letters

To date, the percentage of mail that is returned is 6.2 percent. When returned mail is received, the choice counseling staff access the ACS enrollment system and the State's Medicaid system to try to locate a telephone number of a new address in order to contact the beneficiary.

Inbound Mail:

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

674 Plan Enrollments

985 Plan Changes

Face-to-Face/Outreach and Education

In July, the primary outreach and education efforts moved from the Agency to ACS. During the quarter, ACS developed radio spots which are playing on a variety of stations in Broward and Duval Counties. In addition, the contractor developed posters for doctors' offices, health departments, eligibility offices, and other locations; billboards; and bus transit materials. The billboards posted in areas that have a high density of Medicaid beneficiaries and are on bus routes that serve those areas.

In addition to mass media, ACS has focused efforts on developing partnerships with local community-based organizations that serve Medicaid beneficiaries. At the beginning of the quarter, these relationships were just in the beginning stages and most of the face-to-face sessions with Medicaid beneficiaries had to be conducted in eligibility

offices and local work force offices. By the end of the quarter, most of the face-to-face sessions were held at community-based organizations, mental health assisted living facilities, homeless shelters, low-income housing complexes and other targeted locations.

The development of local level relationships has focused on organizations that work with special needs or hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and thus they may have changed addresses and phone numbers prior to entering the choice process.

By the end of the quarter, the field choice counselors have completed the following activities:

816 Group Sessions

205 Private and One-on-One Sessions

351 Enrollments

522 Plan Changes

After July 1, 2006, the Agency continued to conduct outreach workshops to various stakeholders located in Broward and Duval Counties. Attachment II provides a list of the dates, locations, topics and the target audiences for workshops conducted between July 1, 2006 and September 30, 2006.

Health Literacy

At the beginning of the quarter, the choice counseling staff's primary health literacy function was helping Medicaid beneficiaries understand what it means to be part of a managed care plan. The Agency felt this was a primary function since it is through the choice counseling process that a beneficiary will become associated with a managed care organization, and knowing how to access care is critical for the beneficiary. The call center and field scripts include language that describes the role of a primary care doctor, how that doctor coordinates all other necessary care, how the beneficiary will use a network of doctors, and more. In addition, when a beneficiary enrolls, the follow-up confirmation letter encourages the beneficiary to make an appointment with their doctor and again provides a statement of understanding regarding what it means to be enrolled in managed care.

In addition to explaining managed care, the choice counseling staff also provide information and education on the enhanced benefits program. As part of the enhanced benefits description, the counselor also talks about how engaging in the healthy behaviors will help overall health in addition to earning credits toward the purchase of health-related items.

By the end of the quarter, the field choice counselors had taken on an expanded role in health literacy. The Agency and ACS have been and continue to obtain copies of health-related brochures, especially those related to appropriate screenings, such as immunizations, mammograms, prostate screenings, pre-natal care, and more. These brochures are provided at no cost to the beneficiary during the face-to-face meeting with the field counselor. In addition, when the field counselors attend health fairs and other public events, they will have these brochures available for attendees to take home.

Voluntary Selection Data

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

The first quarter of implementation, the first voluntary rate calculation was performed in September after the close of the choice window for the first group of new eligibles that were required to enroll in a Medicaid Reform plan. For monitoring purposes, the voluntary selection rate is based on new enrollees only and does not include current beneficiaries who are transitioning to a Reform plan. The voluntary enrollment rate for both Reform counties was 68 percent of all new eligibles. For Duval County, the rate was 65 percent and for Broward County the rate was 70 percent. Therefore, ACS met the contract standard in the first quarter. Refer to Table 4, provides a breakdown of the new-eligible enrollment figures for the first quarter.

Table 4
New Eligible Voluntary Enrollment Rate
First Quarter 2006

Voluntary Enrollment Numbers for Newly Eligible Enrollees:	
Broward County	
Voluntary Choice	3,299
Auto-Assigned	1,397
Duval County	
Voluntary Choice	2,188
Auto-Assigned	1,176
Voluntary Enrollment Rate:	
Broward and Duval Combined	68%
Broward only	70%
Duval only	65%

Complaints/Issues

A beneficiary can file a complaint about choice counseling either through the call center, Agency headquarters or the area Medicaid Office. In the first quarter, there were 15

complaints filed related to choice counseling. Table 5 provides the details on the complaints and outlines the action that was undertaken by either the Agency or ACS to address the issues raised.

Table 5
Beneficiary Complaints & Action Taken

Beneficiary Complaint	Action Taken
1. Duval County dental providers not showing up in health plan's provider networks.	• The Agency headquarters and Area Office staff are working with the Reform plans to include the information in the provider files.
2. Beneficiary enrolled in a plan that is not in their county.	• Zip codes and county codes for some beneficiaries are not correct, i.e. system shows them living in Duval County, but they live in neighboring county. This also an issue in non-Reform counties and has been resolved. Medicaid Reform Choice Counseling and the Agency will use the same process used in the non-Reform counties.
3. Under Reform, beneficiaries diagnosed with developmental disabilities are a voluntary population. To identify these beneficiaries, the Agency requires that the individual be identified and included on a list maintained by the Florida Agency for Persons with Disabilities (APD). Beneficiaries not on the list insist they should be.	• This was largely a timing issue as the Agency was receiving a file on a monthly basis. The Florida APD which serves the developmentally disabled has begun submitting the file weekly instead of monthly to keep the information current. In addition, future calls will be referred to the area office for follow-up. The Agency will work with these beneficiaries and Florida APD to rectify the problem. If needed, choice counseling will manually populate the required field to ensure that these beneficiaries are a volunatary population and not required to select a Reform plan.
4. Beneficiary angry that she has to choose a Reform plan. She felt Governor Bush was forcing her to do something she didn't want to do.	• Referred to Medicaid Area Office in Broward County to work with beneficiary.
5. Beneficiary complained that the choice counselor was rude on the phone.	• The choice counselor's supervisor asked for specifics and the beneficiary was unable to provide any. The Choice Counselor's supervisor placed the choice counselor on increased monitoring.
6. Complaint from a grandfather that the enrollment for grandson did not process.	• Enrollment activity erred off of Florida MMIS during month-end processing. Choice counselor explained options to the grandfather and processed an enrollment for next effective date.
7. Florida Legal Services Representative, Anne Swerlick, provided information from a mother who called after receiving a post card from her Shands provider.	• Choice counselor provided incorrect information to the Reform plan that the Beneficiary was mandatory for Reform. Beneficiary was voluntary. Mother talked with choice counseling supervisor and got correct information. Agency headquarters also followed up with mother. Choice counselor was coached on identifying voluntary and mandatory beneficiaries and put on increased monitoring.

Table 5 Beneficiary Complaints & Action Taken	
Beneficiary Complaint	**Action Taken**
8. Complaint that a beneficiary that was dually-eligible was told they could not voluntarily enroll. Dual eligibles are not mandatory, but can voluntarily choose.	• Choice counseling supervisor called beneficiary back and completed the enrollment. Choice counselor was coached and put on increased monitoring.
9. Complaint that beneficiary wanted Staywell and was going to be enrolled in the PSN.	• Beneficiary had previously been mailed an auto-assignment letter for a PSN. Beneficiary then called and voluntarily chose Staywell. Explained to beneficiary that since a voluntary choice was made the auto-assignment letter does not apply.
10. Letter mailed to Governor Bush stating that none of her children's doctors participate with a Reform plan. Letter did not provide names or IDs, but did have a phone number for the mother.	• Choice counseling supervisor has attempted to reach the mother multiple times to assist the Mother.
11. Beneficiary called to enroll in a Reform plan before receiving a transition mailing.	• The choice counselor advised the beneficiary could not enroll until a choice counseling packet arrived. The choice counselor was coached and put on increased monitoring. A procedure flash was sent out to all counselors to remind them of what is in the script and the policy for enrolling beneficiaries into a Reform plan before their transition period.
12. Beneficiary stated they called to enroll in a Reform plan and the Choice Counselor would not enroll them.	• The beneficiary case was accessed in the choice counseling system and the beneficiary had called Medicaid Options. Medicaid Options had provided the beneficiary with the correct phone number for Medicaid Reform Choice Counseling.
13. Beneficiary complained that she received a transition letter assigning her child to Pediatric Associates and the enclosed comparison chart did not list the plan.	• The choice cCounselor explained to the mother that the plan had been approved after the materials were printed, but Pediatrics Associates was a plan and that it specifically serves children under age 21.
14. Beneficiary called and requested a specialist. Specialist was not listed by name in the plan's provider file.	• Choice counselor should have asked if the provider was with a group and for the group's name. The choice counselor was coached, and a procedure flash was sent to all choice counselors reminding them to ask about group affiliations when completing provider searches.
15. Beneficiary called to request a primary care provider and that doctor was coded as not being a primary care provider at the location the beneficiary wanted to see the provider.	• Agency is working with the plan so the provider can be identified and selected as a primary care provider.

Quality Improvement

At the beginning of the quarter, ACS implemented the choice counseling program and began serving beneficiaries. A key component of the implementation was a quality improvement feedback loop between ACS choice counseling staff, the Agency headquarters staff, and the Agency area office staff. This feedback loop involves face-to-face meetings between area Medicaid staff and ACS field staff, e-mail boxes on ACS' enrollment system so Agency staff and ACS can share information directly from the system to work difficult cases, and regularly scheduled conference calls.

By the end of the first quarter, changes had been made to the choice counseling program as a result of the feedback loop. The field counselor group session schedule was reduced to allow time for more private and one-on-one sessions. The private and one-on-one sessions allow the counselor to better meet the needs of beneficiaries who have special needs or other considerations. In addition, coaching of counselors has occurred to address some deficiencies and changes have been made to the training program to make the course better reflect "live" experience with the program.

C. Enrollment Data

Background

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

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

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

During the first quarter of operation of the Medicaid Reform Program, enrollment in Reform health plans was based on a transitional process. Specifically, the July transition focused on enrollment of newly eligible beneficiaries and half of the MediPass population who were required to transition to a Reform health plan. Beneficiaries had 30 days to select a plan. If the beneficiary did not choose a plan, then the choice counselor assigned them to a plan. The earliest date of enrollment was September 1.

This section provider enrollment figures and voluntary and mandatory rate for the first quarter of operation.

Current Activities

The Agency provides a monthly enrollment report for Medicaid Reform health plans. This monthly enrollment data is available on the Agency's website at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml
Below is a summary of the monthly enrollment reports for the first quarter. The first quarter report includes only enrollment figures from September 2006, as this was the first month of enrollment under the transition schedule. This report contains the following enrollment reports:

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

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

All Medicaid Reform health plans located in the two demonstration areas are included in each of the reports. During this quarter, Medicaid Reform included 14 HMOs and FFS PSNs. There are two categories of Medicaid beneficiaries who are enrolled in Reform health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiary's eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 6 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 6
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 recipients enrolled with the plan
# SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled- Medicare Part B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled- Medicare Parts A & B	The number of SSI recipients who are enrolled with the plan and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of recipients enrolled with the plan; TANF and SSI combined
Market Share For Reform	The percentage of the total Medicaid Reform population that the plan's recipient pool accounts for
Enrolled in Prev. Qtr.	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Change From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

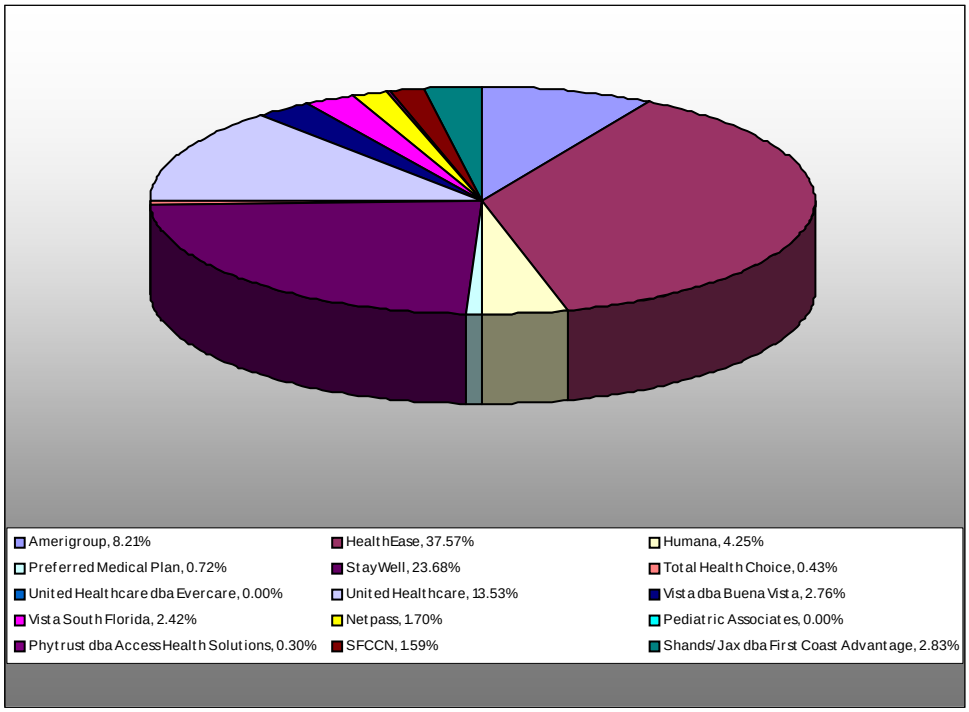
The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 7 for the Fiscal Year 2006-07 Quarter 1 Reform Enrollment Report.

Table 7
Medicaid Reform Enrollment Report
(Fiscal Year 2006-07, 1st Quarter)

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Change From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	554	67	1	2	**624**	**8.21%**	N/A	N/A
HealthEase	HMO	2,572	270	3	12	**2,857**	**37.57%**	N/A	N/A
Humana	HMO	247	71	0	5	**323**	**4.25%**	N/A	N/A
Preferred Medical Plan	HMO	41	14	0	0	**55**	**0.72%**	N/A	N/A
StayWell	HMO	1,659	138	1	3	**1,801**	**23.68%**	N/A	N/A
Total Health Choice	HMO	26	7	0	0	**33**	**0.43%**	N/A	N/A
United Healthcare dba Evercare	HMO	0	0	0	0	**0**	**0.00%**	N/A	N/A
United Healthcare	HMO	830	195	0	4	**1,029**	**13.53%**	N/A	N/A
Vista dba Buena Vista	HMO	190	19	0	1	**210**	**2.76%**	N/A	N/A
Vista South Florida	HMO	151	28	0	5	**184**	**2.42%**	N/A	N/A
Netpass	PSN	72	57	0	0	**129**	**1.70%**	N/A	N/A
Pediatric Associates	PSN	0	0	0	0	**0**	**0.00%**	N/A	N/A
Phytrust dba Access Health Solutions	PSN	21	2	0	0	**23**	**0.30%**	N/A	N/A
SFCCN	PSN	82	39	0	0	**121**	**1.59%**	N/A	N/A
Shands/Jax dba First Coast Advantage	PSN	167	48	0	0	**215**	**2.83%**	N/A	N/A
Reform Enrollment Totals		**6,612**	**955**	**5**	**32**	**7,604**	**100.00%**	**N/A**	**N/A**

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

Chart A
Market Share for Medicaid Reform



The enrollment figure for September only reflects only those individuals who voluntarily selected a health plan. In addition, many Medicaid beneficiaries transferred from non-reform plans to Reform plans. This resulted in an initial enrollment of 7,604 recipients on September 1, 2006. There were 14 Reform plans with market shares ranging from 0.00 percent to 37.57 percent.

Note: The Fiscal Year 2006-07 Quarter 1 version of the Medicaid Reform Enrollment Report does not contain any data relating to previous enrollment since the Medicaid Reform Wavier did not become operational until September 1, 2006.

2. Medicaid Reform Enrollment Report by County

Medicaid Reform is operational in two counties: Broward and Duval. There are 10 HMOs and 4 PSNs operating in Broward County, and there are 3 HMOs and 2 PSNs serving Duval County. The Medicaid Reform Enrollment Report by County section of this Quarterly Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. Broward County plans are listed first, followed by Duval. Table 8 describes the columns of information that each Reform health plan provides to the Agency for this report

Table 8 Medicaid Reform Enrollment Report by County Description	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI recipients 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 recipients 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 recipients 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 recipients enrolled with the planin 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 recipient pool accounts for
Enrolled in Prev. Qtr.	The total number of recipients (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Change From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as Table 9.

Table 9
Medicaid Reform Enrollment Report by County
(Fiscal Year 2006-07, 1st Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Change From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	Broward	554	67	1	2	**624**	**12.14%**	N/A	N/A
HealthEase	HMO	Broward	1,012	91	1	3	**1,107**	**21.54%**	N/A	N/A
Humana	HMO	Broward	247	71	0	5	**323**	**6.28%**	N/A	N/A
Preferred Medical Plan	HMO	Broward	41	14	0	0	**55**	**1.07%**	N/A	N/A
StayWell	HMO	Broward	1,617	131	1	2	**1,751**	**34.07%**	N/A	N/A
Total Health Choice	HMO	Broward	26	7	0	0	**33**	**0.64%**	N/A	N/A
United Healthcare dba Evercare	HMO	Broward	0	0	0	0	**0**	**0.00%**	N/A	N/A
United Healthcare	HMO	Broward	452	136	0	2	**590**	**11.48%**	N/A	N/A
Vista dba Buena Vista	HMO	Broward	190	19	0	1	**210**	**4.09%**	N/A	N/A
Vista South Florida	HMO	Broward	151	28	0	5	**184**	**3.58%**	N/A	N/A
Netpass	PSN	Broward	72	57	0	0	**129**	**2.51%**	N/A	N/A
Pediatric Associates	PSN	Broward	0	0	0	0	**0**	**0.00%**	N/A	N/A
Phytrust dba Access Health Solutions	PSN	Broward	11	2	0	0	**13**	**0.25%**	N/A	N/A
SFCCN	PSN	Broward	82	39	0	0	**121**	**2.35%**	N/A	N/A

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Change From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
Total Reform Enrollment for Broward			**4,455**	**662**	**3**	**20**	**5,140**	**100.00%**	N/A	N/A
HealthEase	HMO	Duval	1,560	179	2	9	**1,750**	**71.02%**	N/A	N/A
StayWell	HMO	Duval	42	7	0	1	**50**	**2.03%**	N/A	N/A
United Healthcare	HMO	Duval	378	59	0	2	**439**	**17.82%**	N/A	N/A
Phytrust dba Access Health Solutions	PSN	Duval	10	0	0	0	**10**	**0.41%**	N/A	N/A
Shands/Jax dba First Coast Advantage	PSN	Duval	167	48	0	0	**215**	**8.73%**	N/A	N/A
Total Reform Enrollment for Duval			**2,157**	**293**	**2**	**12**	**2,464**	**100.00%**	N/A	N/A
Reform Enrollment Totals			**6,612**	**955**	**5**	**32**	**7,604**		**N/A**	**N/A**

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

Chart B
Market Share for Medicaid Reform in Broward County

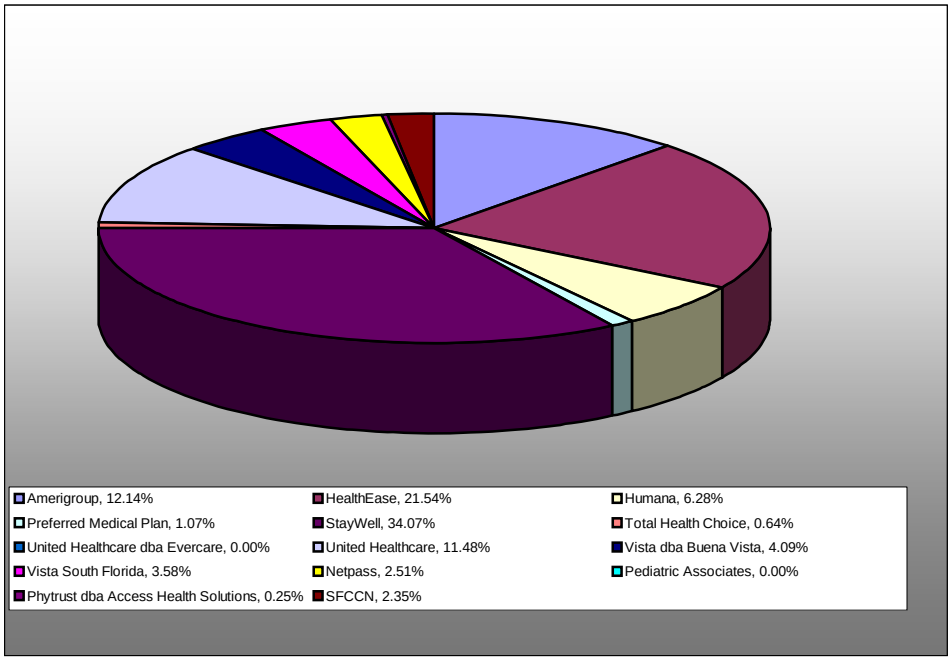
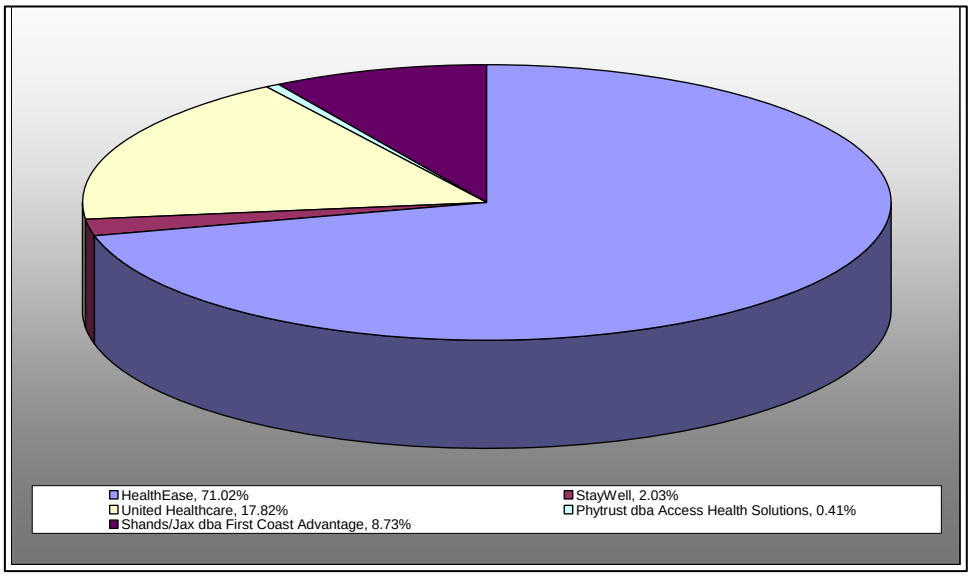


Chart C
Market Share for Medicaid Reform in Duval County



During the first quarter of operation, enrollment in the Reform health plans was based on a transitional process. Many Medicaid recipients transferred from non-reform plans to Reform plans. This resulted in an initial enrollment of 5,140 recipients in Broward County and 2,464 recipients in Broward County in September, 2006. There were 14 Reform plans in Broward County, with market shares ranging from 0.00 percent to 34.07 percent. In Duval County, there were 5 Reform plans with market shares ranging from 0.41 percent to 71.02 percent.

Note: The Fiscal Year 2006-07 Quarter 1 version of the Medicaid Reform Enrollment Report by County does not contain any data relating to previous enrollment since Medicaid Reform did not become operational until September 1, 2006.

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

The Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report lists the number of Medicaid Reform recipients who were enrolled (either voluntarily or mandatorily) with a plan at some point during the current reporting quarter, as well as those who were disenrolled during the same time period. Table 10 describes the information that each Reform health plan provides to the Agency for this report.

Table 10 Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Broward or Duval)
# Voluntary Enrolled	The number of unique recipients who voluntarily enrolled with the plan during the current reporting quarter
# Mandatory Enrolled	The number of unique recipients who were mandatorily enrolled with the plan during the current reporting quarter
Total # Enrolled	The total number of unique recipients enrolled with the plan during the current reporting quarter; voluntary and mandatory combined
% Enrolled Voluntary	The percentage of the total number of recipients enrolled with the plan during the current reporting quarter who were enrolled voluntarily
# Disenrolled	The number of unique recipients 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 with the Medicaid Reform program: voluntarily and mandatorily. Voluntary enrollments include newly-eligible beneficiaries who made a voluntary choice of which plan or program to enroll in. In addition, beneficiaries who were already enrolled in a managed care plan (including MediPass) and then were transitioned into the program when Medicaid Reform began are included in the voluntary enrollment counts. The calculation of the mandatory enrollment percentage includes only newly-eligible beneficiaries who have not made a choice and who were assigned to the plan that they are enrolled in. As previously indicated, for the 1st Quarter Enrollment Report, all enrollments were voluntary as the earliest enrollment of September 1 reflected only individuals who made a voluntary selection. The earliest effective date for individuals who were assigned to a plan is October 1, 2006.

B. Medicaid Reform Disenrollees

A Medicaid Reform Disenrollee is defined as a beneficiary who was enrolled in the program at some point during the current reporting quarter but then left the program. The count is performed by comparing two beneficiary lists: one for the current reporting quarter and one for the first month after the current reporting quarter. If a beneficiary appears on the current reporting quarter enrollment list but not on the enrollment list for the first month following the current reporting quarter, the beneficiary is counted as disenrolled. For example, disenrollments for the Fiscal

Year 2006-07 quarter are those beneficiaries, who appear on the enrollment list for July, 2006 to September, 2006 but not on the enrollment list for October, 2006.

The unique beneficiary counts in the Quarterly Summary of Voluntary & Mandatory Selection Rates & Disenrollment Data report are divided by plan type in Table 11. Total counts for the quarter are also provided for both HMOs and PSNs, as well as the entire Medicaid Reform program.

Table 11
Quarterly Summary of Voluntary and Mandatory Selection Rates and Disenrollment Data
(Fiscal Year 2006-07, 1st Quarter)

Plan Name	Plan Type	Plan County	# Voluntary Enrolled	# Mandatory Enrolled	Total # Enrolled	% Enrolled Voluntary	# Disenrolled
Amerigroup	HMO	Broward	624	0	**624**	100.00%	15
HealthEase	HMO	Broward	1,107	0	**1,107**	100.00%	57
HealthEase	HMO	Duval	1,750	0	**1,750**	100.00%	78
Humana	HMO	Broward	323	0	**323**	100.00%	14
Preferred Medical Plan	HMO	Broward	55	0	**55**	100.00%	2
StayWell	HMO	Broward	1,751	0	**1,751**	100.00%	79
StayWell	HMO	Duval	50	0	**50**	100.00%	2
Total Health Choice	HMO	Broward	33	0	**33**	100.00%	6
United Healthcare dba Evercare	HMO	Broward	0	0	**0**	N/A	0
United Healthcare	HMO	Broward	590	0	**590**	100.00%	37
United Healthcare	HMO	Duval	439	0	**439**	100.00%	23
Vista dba Buena Vista	HMO	Broward	210	0	**210**	100.00%	8
Vista South Florida	HMO	Broward	184	0	**184**	100.00%	6
HMO Total			**7,116**	**0**	**7,116**	**100.00%**	**327**
Netpass	PSN	Broward	129	0	**129**	**100.00%**	9
Pediatric Associates	PSN	Broward	0	0	**0**	**N/A**	0
Phytrust dba Access Health Solutions	PSN	Broward	13	0	**13**	**100.00%**	0
Phytrust dba Access Health Solutions	PSN	Duval	10	0	**10**	**100.00%**	1
SFCCN	PSN	Broward	121	0	**121**	**100.00%**	6
Shands/Jax dba First Coast Advantage	PSN	Duval	215	0	**215**	**100.00%**	8
PSN Total			**488**	**0**	**488**	**100.00%**	**24**
Reform Enrollment Totals			**7,604**	**0**	**7,604**	**100.00%**	**351**

For the first quarter of Fiscal Year 2006-07, there were no mandatory enrollments. Each Medicaid beneficiary was transitioned into the program from a previous plan; because each beneficiary was notified of the transition, this counts as a voluntary enrollment. There were 7,604 voluntary enrollments in Medicaid Reform during the first quarter of fiscal year 2006-07. Of those, 7,166 beneficiaries were enrolled in an HMO and 488 were enrolled in a PSN.

D. Opt Out Program

Background

In January 2006, the Agency began developing a process to ensure all beneficiaries who have access to employer-sponsored insurance are provided the opportunity to opt out of Medicaid and select an employer-sponsored insurance 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~~their~~ proposal on March 31, 2006. The Statement of Work described the Opt Out work flow which included the process for contacting beneficiaries, contacting employers, establishing the premium payment process and maintaining the Opt Out database. The Agency entered into a contract with HMS to conduct the Opt Out Program on July 1, 2006.

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

In accordance with the Special Terms and Conditions #72, the Agency submitted the Opt Out Guidelines to CMS within 30 days of implementation on May 31, 2006.

Current Activities

During the first quarter of the waiver on July 28, 2006, the Agency held a meeting with HMS to discuss the specifics of the opt out process. During the meeting, HMS demonstrated its case tracking system for the Opt Out Program and reviewed all correspondence that would be used for the Opt Out Program (new referral letter, employer questionnaire, etc.).

Medicaid beneficiaries interested in the Opt Out Program are referred to HMS by Choice Counseling and/or the Medicaid beneficiary contacts HMS directly. The beneficiary is provided the toll-free number for the Opt Out Program so they may follow-up directly with HMS if they prefer. 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 their employer, how much the premium will be and how payment of the premium will be processed. The beneficiary then decides whether or not 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, the beneficiary is sent an Enrollment Letter that confirms the beneficiary is enrolled in Opt Out. HMS then begins to process the premiums according to the required frequency. If the beneficiary is unable to enroll in Opt Out (e.g., not open enrollment), the beneficiary is sent an Opt Out denial letter. The HMS system is flagged to contact the beneficiary when s/he is eligible for Opt Out.

The HMS system has been designed to comply with the federal special terms and conditions. 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 employer sponsored insurance (ESI) program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out vendor's performance under the contract.

OPT OUT PROGRAM STATISTICS

As of the end of the quarter (September 29, 2006), 12 calls have been received at the Opt Out toll-free call center. Five of the callers requested and received information regarding the Opt Out program (e.g. New Referral Letter and Release to contact employer). One person has enrolled in Opt Out effective October 1, 2006. The Opt Out enrollee is in the Children and Family eligibility category. The individual works for a large employer and has elected to use the medical premium to pay the employer portion for single coverage.

Four of the five callers have not returned their forms to date, or after receiving additional details about the program decided not to participate. The other calls received were not considered "potential enrollees". They were requesting general information regarding the Medicaid program and were referred back to Choice Counseling or their eligibility determination office.

E. Enhanced Benefit Program

Background

The Enhanced Benefits Account Program (EBAP) component of Reform is designed as an incentive program to reward and promote 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 who participate may earn up to $125.00 worth of credit per state fiscal year. Credits are posted to individual accounts that are established and maintained within Florida's fiscal agent's pharmacy point of sale system known as Prescription Drug Claims System (PDCS). Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the beneficiary's Medicaid Gold card or their Medicaid identification number and a picture ID.

The Agency will approve credits for participation of approved healthy behaviors using date of service, eligibility, and approved behavior edits within a new database name Enhanced Benefits Information System (EBIS). EBIS is currently under development and will be implemented November 1, 2006. All 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.

Statistics:

The first health plan 'healthy behavior report' was due to the Agency October 10, 2006. Therefore, no statistics are available for this report. Statistics that will be included in future reports are as follows:

- Number of Health Plans submitting reports by month
- Number of recipients who receive credit for healthy behaviors by month
- Percentage of Reform enrollees who receive credits each month
- Number of recipients who receive credit and use credits by month
- Percentage of those with credit balance that used available credit
- Total dollar amount credited to accounts by month
- Total dollar amount used by month

Current Activities

During the quarter, the Agency developed and mailed welcome letters to beneficiaries who were enrolled in a Medicaid Reform Plan as of September 1, 2006. The welcome

letter provides general information about the program including samples of approved healthy behaviors and products eligible for purchase using earned credits and contact information for the AHCA Area Offices and the Reform Website. Approximately 7,500 letters were mailed to beneficiaries providing an explanation of the program. The current Enhanced Benefits Universal Form and Enhanced Benefits Brochure were also completed and approved.

The Enhanced Benefits Advisory Panel has met at least monthly since May 2006. Accomplishments of the 7-member, Agency-appointed panel include adoption of the operating charter, list of approved healthy behaviors, and the list of approved items for purchase. The EB panel has also proven to be a sound resource to review and discuss outreach efforts and documentation such as the welcome letters and brochures for the beneficiaries. Ongoing tasks of the panel include review and consideration of the healthy behavior and health related products and supplies lists.

The Agency contracted with ACS, the Agency's vendor providing choice counseling, to also provide the services of an Enhanced Benefit Call Center. The call center will begin training in October 2006 and go live November 1, 2006. The primary responsibility of the call center will be to serve as the central point of contact for beneficiaries enrolled in Reform health plans. The call center will be able to access individual accounts to assist in the understanding and tracking of account activity. In addition, the call center will be responsible for providing general information about the program, mailing of welcome packets to new enrollees, and mailing of requested documents to beneficiaries.

The enrollment packet will be mailed each month after the Reform health plan enrollment is processed. The packet will include a welcome letter providing general information for the program, a brochure, and a Enhanced Benefit (EB) Universal Form. Contact information is provided in the letter and the brochure. Detailed instructions are provided on the EB Universal Form.

In addition, the Agency contracted with I.S. Consulting to develop a specialized database to track and process healthy behaviors, credit approval, and purchase activity, was initialized during the quarter. The first two phases of the database will be completed October 30, 2006 and the final two stages are anticipated to be completed November 30, 2006. The final stage which is scheduled for November 30, 2006, is full implementation, which is designed to allow secure access to interested health plans that wish to provide customer service related to the Enhanced Benefits Account program.

F. Low Income Pool

Background

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

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

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

On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP to CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. 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 to CMS on April 7, 2006.

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

At the beginning of the quarter, the LIP Council members, as appointed by the Agency, scheduled the first two meetings for State Fiscal Year 06-07. The first meeting, scheduled for August 30, 2006, was cancelled due to Tropical Storm Ernesto. The second LIP Council meeting was an all-day meeting, held at the Agency, on September 27, 2006.

The LIP Council members reviewed their responsibilities in accordance to s. 409.911 and s. 409.91211, F.S. The LIP Council members reviewed the current Reimbursement and Funding Methodology document, anticipated provider distributions for SFY 06-07, in

addition to Special Terms and Conditions #101 and #102. An update was provided by the Agency to the LIP Council members on the status of the Letters of Agreement, which were sent to local governments/taxing districts during the first quarter, and the requirements of the local governments/taxing districts to submit to the Agency copies of any provider agreements executed regarding the LIP funds. The next meeting date was set for October 20, 2006, via conference call.

At the end of the quarter, the Agency is continuing to work with the local governments/taxing districts regarding the execution of Letters of Agreement. A review of permissible expenditures (referred to as the LIP Cost Limit) is being finalized to assure no provider receives a LIP distribution in excess of its cost for serving the Medicaid, underinsured and uninsured population.

During the first quarter of SFY 06-07, the Agency received a transfer of funds from the Department of Health for Medicaid programs, including the Low Income Pool program. This transfer allowed for one LIP distribution to be made in the amount of $1,645,533.

G. Monitoring Budget Neutrality

Background

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

Pre-Implementation

Prior to implementation, the Agency maintained communication with CMS to discuss the expectation and requirements of the CMS 64 report for both administrative and service expenditures. Communication was primarily via conference calls with CMS.

Current

During the reporting quarter, test reports and analysis were conducted and additional clarification regarding the templates was obtained from CMS by the State. The State is preparing the required CMS 64 report. The specific contents of the report that relate to the 1115 Medicaid Reform Demonstration Waiver include seven individual 64 templates.

Statistics:

The following statistics will be included in the 64 report each quarter:

1) Enrollment - By MEG, by Month

2) Growth of Enrollment - Eligibles and Enrollees by MEG, by Month

3) Monthly Expenditures - By MEG, by Month

4) Average Cost Per Member Per Month - By MEG, by Month and for waiver as a whole

5) Average Cost Per Enrollee Per Month - By MEG, by Month and for waiver as a whole

6) Average PMPM compared to Budget Neutrality Projected PMPM

7) Total cost compared to the projected total cost

The State will submit the first CMS 64 report for the quarter beginning July 1, 2006 and ending September 30, 2006 by November 1, 2006. The report will contain the two required templates, one for each Reform MEG, and the additional five templates, to account for the population enrolled in the current 1915(b) Managed Care waiver that is eligible for reform participation and that will be monitored under the 1115 Reform budget neutrality.

H. Encounter and Utilization Data

Background

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

The Medicaid Encounter Data System (MEDS) / Risk Adjustment Team was established to support the requirements defined in the pre-implementation activities and comprises internal subject matter experts and external consultants with experience in the risk adjustment and encounter collection processes.

Current Activities

At the beginning of the quarter, to comply with the requirements of the Medicaid Reform Wavier, health care pharmacy and Medicaid enrollee information was collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid population. The Reform health plans were assigned a plan risk factor based on the aggregate risk scores of their enrolled populations under Medicaid Reform. Health plan factors, budget neutrality and the final derived risk corridor plan factor will be applied to capitated premium rates beginning in October 2006 for September's Medicaid enrolled population in Reform counties.

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

- Development of MEDS companion guide that covers 837 I, P, and D in addition to NCPDP for pharmacy services. Specific instructions related to submission requirements, transaction content, and processing are discussed in detail with this document.

- Creation of the MEDS website that contains supporting documentation accessible by health plans required to submit encounter data was deployed and updated with relevant information.

- Provision of the MEDS technical assistance sessions with Reform health plans that are responsible for submitting encounter data were held either as "stand-alone" meetings or as agenda topics in technical and operations meetings.

- A letter was sent from the Agency informing capitated Reform health plans of the requirement to collect encounter data beginning on September 1, 2006, with the

initial submission for the period of September 1 – December 31, 2006, to be transmitted January 1, 2007.

- Established the initial MEDS communications mechanism whereby Reform health plans can forward questions and issues for resolution.

- The requirements and associated activities necessary to process encounter claims through the fiscal agent (FA) were initiated with the culmination scheduled for December 1, 2006 with the beginning of health plan testing.

- Design of reports and processes used to communicate various operational errors and invalid transaction content to capitated health plans were completed.

- System edits and quality assurance processes to review and analyze encounter claim data received from capitated health plans were developed.

- Design of processes to extract encounter claims to the Medicaid Decision Support System (DSS).

- Participation in the design and development from MEDS in the new FMMIS.

At the end of the quarter, the processes supporting the continuing requirements of providing plan Rx risk factors for Medicaid Reform rate setting, which encompasses the generation of risk factors accounting for budget neutrality and the risk corridor, will continue. The scheduled activities associated with the implementation of MEDS on January 1, 2007, are continuing. This encompasses technical support with capitated health plans, deployment of enhancements within the Florida FMMIS system, and the creation and dissemination of operational documentation to support MEDS testing through December 31, 2006.

I. Demonstration Goals

Current Program

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

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

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

During the first quarter, the Agency established contracts with 9 HMOs and 4 PSNs for a total of 13 Reform health plans in Broward County; and 3 HMOs and 2 PSNs for a total of 5 Reform health plans in Duval County. This is a considerable increase in the number of health plans that beneficiaries can chose. The Agency is currently reviewing two additional PSN applicants. In addition, the Agency believes that individuals were provide more choice as Reform health plans offered benefit packages that included services not previously covered by Medicaid.

It is too early to determine the impact on beneficiary satisfaction; however, the Agency has contracted with the University of Florida to conduct CAHPS surveys. In addition, the Agency intends to evaluate patient satisfaction of the disease management programs operated by the Medicaid Reform plans. At a minimum, Medicaid Reform health plans are required to have disease management programs for enrollees diagnosed with HIV/AIDS, congestive heart failure, diabetes, asthma, and hypertension. The Reform plans will not begin conducting the disease management patient satisfaction surveys until September 2007, to ensure the transition of enrollees to the plans is complete and beneficiaries have been enrolled in the plan for 6 months.

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

   All of the capitated Reform health plans offered expanded or additional benefits which were not previously covered by the State under the State Plan.

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

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

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

   After a full review, the Agency identified a total of 34 proposed performance measures of which 21 Agency-defined measures would be applicable to the disease management enrollees that are not currently listed in the contract. These measures will be collected over a three-year period. During the first year, the Agency will collect 13 measures. Before finalizing these changes, the Agency held public meetings to obtain input from the Reform health plans and all interested parties on the proposed performance measures and the timeline for implementation of the measures. At the end of the quarter, the Agency had scheduled two public workshops to be held during October. The Agency intends to finalize the changes to the performance measures currently listed in the contract, add disease management measures, establish a timeline for implementation and notify the Reform health plans by November 30, 2006.

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

   For individuals who chose to opt out of Medicaid during the first quarter, the Agency has established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the Agency is entering in the Opt Out Program's database the reason why an individual, who initially expressed an interest in and was provided information on the Opt Out Program from a choice counselor, decided not to opt out of Medicaid. In the first quarter, one person chose to opt out because her primary care physician was not enrolled with a Medicaid Reform health plan. The individuals who decided not to opt out were either not employed or after hearing about opt out decided to remain with their Medicaid Reform plan where there were not co-pays and deductibles.

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

   Please refer to the response to objective #1.

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

   The Agency has identified how certain provider types, such as county projects, federally qualified health centers, and the St. Johns River Rural Health Network, intend to use their funds to enhance service capability and availability in specified parts of the state.

J. Evaluation of Medicaid Reform

Background

The Agency designed and submitted the draft evaluation design of the Medicaid Reform Waiver to CMS on February 15, 2006. The Agency incorporated comments from CMS and submitted the final evaluation design of Medicaid Reform to CMS on May 24, 2006, receiving approval on June 13, 2006. Prior to implementation of Reform, many evaluation tasks were undertaken; some were completed, many are ongoing. Specifically, in November 2005, the Agency contracted for the required evaluation with an independent entity, the University of Florida (UF). This evaluation was designed to incorporate criteria in the waiver, plus those in the special terms and conditions. On May 25, the Agency submitted, as required by CMS, the draft evaluation design for approval within 120 days of waiver approval. During the review period, Agency staff held a conference call with CMS quality improvement staff to obtain guidance, then used suggestions given to produce a final evaluation design. That final evaluation design was submitted within 60 days as required, and accepted by CMS.

During the quarter, UF applied for and obtained IRB (Institutional Review Board) approval for the evaluation. During this quarter, three deliverables were submitted to the Agency in draft for comment, and again in final format after revision. These included:

1. Deliverable 1 (Detailed Workplan) This was a step-by-step map of the process and tasks to be undertaken by UF staff to complete the evaluation over year one, with estimates included for subsequent years.

2. Deliverable 2 (Summary Report on the Medicaid Reform Section 1115 Waiver Process). This report explains the Medicaid Section 1115 Waiver Process, and how it fits together with Medicaid Reform in Florida.

3. Deliverable 3 (Medicaid Reform Health Plans and Networks) describes managed care organizations and other Reform Health Plans from the two Reform counties, Broward and Duval, in detail.

Other items begun during the quarter include baseline (pre-implementation) key informant interviews begun with various groups (Agency management, Reform plans, choice counselors, etc.). Local liaisons were hired in Broward and Duval Counties to coordinate activities in those areas and to report on items that happened between visits by faculty. The evaluation team gathered baseline information on the various aspects of Medicaid Reform, including customized benefit packages, Opt-Out, funding methodology of the Low Income Pool, development and implementation of pilot programs, etc.

In addition, to the contract with UF, several other evaluations are being done. During this first quarter, a subcontract was developed with the Urban Institute (with funding from the Kaiser Family Foundation) to study the early impact of transition for Medicaid Reform enrollees.

A Technical Advisory Council, a team of national experts in evaluation and Medicaid issues, was appointed and held its initial meeting via conference call during this quarter. Those selected include Dr. Robert Hurley (Medical College of Virginia), Dr. Marsha Gold (Mathematica Policy Research, Inc.), and Dr. Bryan Dowd (University of Minnesota). Discussions regarding one or perhaps two other possible participants continue.

Dr. Paul Duncan (Principal Investigator) attended a meeting of the Miami-Dade Medicaid Evaluation Working Group to discuss the project scope of work and methodology, work plan, and potential subcontracting and collaboration.

Current Activities

There are many activities related to the evaluation of Medicaid Reform that are ongoing. For example, the Contract Manager and Principal Investigator meet by phone weekly to discuss the evaluation's progress. In addition, an Agency Technical Advisory Group (TAG) composed of program experts from various bureaus meets biweekly to give input on deliverables and make sure the evaluation is proceeding as intended. UF is conducting baseline CAHPS (Consumer Assessment of Health Plans Survey) satisfaction surveys in Broward and Duval Counties. Other current activities are explained below.

The Agency sent out appointment letters for the Florida Advisory Committee, comprising of statewide health care experts. Invitations were issued to the following people:

- Dr. Bob Brooks, Florida State University College of Medicine;
- Bonnie Sorenson, Medical Director, Florida Department of Health;
- Andy Behrman, President/CEO, Florida Association of Community Health Centers;
- Ralph Gladfelter, Senior Vice President, Florida Hospital Association;
- Dr. Troy Tippett, President, Florida Medical Association;
- Steven Marcus, President/CEO, Health Foundation of South Florida;
- Steve Burgess, Insurance Consumer Advocate, Office of Insurance Regulation;
- Randy Kammer, Vice President, Regulatory Affairs and Public Policy, Blue Cross and Blue Shield of Florida;
- Bob Wychulis, President/CEO, Florida Association of Health Plans, Inc.; and
- Lisa Margulis, Executive Director, Florida Community Health Action Information Network.

The Agency is in the process of receiving acceptances from potential members and arranging the initial meeting.

Three other organizations are working with the Agency to set up subcontracts through UF to study the effects of Reform on certain special populations. The Florida Mental Health Institute at the University of South Florida will study the effect of Medicaid Reform on mental/behavioral health. The College of Medicine at Florida State University will study the effect of Medicaid Reform on rural health. The Broward Regional Health Planning Council will study the effect of Medicaid Reform on the Pediatric Emergency Room Diversion Project.

Dr. Christy Lemak, University of Florida, was invited to attend the State Coverage Initiatives Workshop for State Officials: State Innovations in Health Coverage (http://www.statecoverage.net/meetings.htm) on August 4, 2006 to discuss the Medicaid Reform Waiver Evaluation.

Dr. Niccie McKay, University of Florida, presented at the Fall Conference of the Florida Chapter of Healthcare Financial Management Association in Jacksonville on September 20th, 2006. Her presentation highlighted the organization and methodology of UF's evaluation of Medicaid Reform.

At the end of the quarter, UF was in the process of confirming data needs, sampling methodology, and data extraction protocols necessary for conducting the evaluation over the next five years.

K. Policy and Administrative Issues

During the quarter, the Agency released one Policy Transmittal to the Reform health plans to clarify the 2006 legislative changes that added adult partial denture services and restored adult vision as well as hearing services. The legislative changes require Reform health plans to cover adult vision, hearing and dental services effective September 1, 2006. The Agency categorizes these 3 services listed above as flexible services. As a result, the Reform health plans were able to customize the coverage level for adult vision, hearing and dental services. The one exception is for adult hearing aid services, which the plans must provide at the State Plan level of coverage and may not customize.

At the end of the quarter, a second Policy Transmittal was being routed for Agency approval for release to the Reform health plans. This Policy Transmittal clarifies that the plan's network providers located in adjacent counties may be included on the health plan provider files submitted to the choice counselor and that these providers may be an enrollee's primary care provider or specialist, but the 60-minute transit requirements remain in place and the plan is responsible for transportation.

Additional Policy Transmittals are expected to be released in the second quarter. The Agency intends to release a Policy Transmittal that specifies the quality performance measures that will be added to or removed from the current list of quality performance measures specified in the Reform health plan contract. During the second quarter, the Agency will hold workshops in October with the Reform health plans and all interested parties to obtain input on the quality performance measures. The Agency also intends to release a Policy Transmittal to clarify the Newborn Enrollment utilizing the Unborn Activation Process that was released prior to July 1, 2006.

The Agency began conducting Technical and Operational Issues Conference Calls on a biweekly basis, beginning August 10, 2006. There were a total or four calls with at least 70 participants. These calls were initiated in response to issues being addressed at higher level in the Technical Advisory Panel meetings and to questions posed through email and telephone inquiries. All health plans are invited to participate, whether or not they are currently operating in Reform counties. The Agency staffs these calls with administrative experts in all areas, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers and health plan subcontractors. Topics and agenda items have included various file formatting and submission requirements, choice counseling activities, network provider registration processes, Medicaid Enhanced Benefits documents and data systems, Medicaid Encounter Data Systems, provider and member information, accessing data exchange and secured file transmission servers, reports, enrollment rosters, reimbursement. Feedback indicates that the calls are well received and a good forum for discussion of the technical and operational issues.

Attachment I
Medicaid Reform Outreach Meetings
November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
11/22/05	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • Choice Counseling	60
12/12/05	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	45
12/13/05	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	50
01/31/06	Duval County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	95
02/01/06	Broward County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	110
02/28/06	Duval County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • What will Reform plans look like? • Enrollment Introduction (high level)	110
02/28/06	Duval County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	45
03/01/06	Broward County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	60
03/01/06	Broward County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	85

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Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
03/01/06	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview (basic) • What will Reform plans look like? • Enrollment Introduction (high level)	110
03/15/06	Duval County	Advocates Health Advisory Council – Baker County	Area Office Outreach	• Materials were provided, and followed up with discussion with discussion.	20
03/16/06	Duval County	Advocates Health Advisory Council – Clay County	Area Office Outreach	• Materials were provided, and followed-up with discussion.	15
03/20/06	Broward County	One Community Partnership / Governance Board Meeting	Area Office Outreach	• Medicaid Reform Overview	75
03/21/06	Duval County	Advocates Diabetic Services and Supplies	Area Office Outreach	• Medicaid Reform	1
03/23/06	Duval County	Potential Plans	Technical Assistance	• Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	42
03/24/06	Broward County	Potential Plans	Technical Assistance	• Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	44
03/28/06	Duval County	Advocates Robert F. Kennedy Community Center	Area Office Outreach	• Materials were provided on Medicaid Reform	1

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November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
03/29/06	Duval County	Advocates Ronald MacDonald House	Area Office Outreach	• No presentation. • Materials provided on Medicaid Reform and its general effects.	1
03/29/06	Duval County	Medicaid Beneficiaries Mary Singleton Center	Area Office Outreach	• Exhibitor only	100
03/30/06	Duval County	Advocates Riverside Presbyterian Apartments/Residences	Area Office Outreach	• Medicaid Reform	2
04/04/06	Duval County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	50
04/05/06	Duval County	Advocates Patient Educators	Area Office Outreach	• Materials provided on Medicaid with Reform discussion. • Reform and its general effects.	15
04/06/06	Duval County	Medicaid Beneficiaries Campus Towers	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	15
04/06/06	Duval County	Advocates ARC Parent Forum	Area Office Outreach	• No presentation given by AHCA. • Materials provided on Medicaid Reform and its general effects. • Discussion ensued in response to the materials.	10
04/10/06	St. John's County	St. John's Civic Roundatble	AHCA Invited	• Medicaid Reform Overview	30

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Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
04/10/06	Duval County	Advocates Florida Christian Apartments / Sundale Manor	Area Office Outreach	• Medicaid Reform Overview	2
04/11/06	Duval County	Advocates KIDS Council	Area Office Outreach	• Medicaid Reform Overview	15
04/11/06	Broward County	Home Health Provider	Area Office Outreach	• Medicaid Reform Overview	18
04/13/06	Broward County	MediPass Providers	Area Office Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	60
04/18/06	Broward County	MediPass Providers	Area Office Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	55
04/20/06	Broward County	Sister Agencies	Area Office Outreach	• Medicaid Reform Overview	65
04/20/06	Duval County	Advocates SAGES Coalition	Area Office Outreach	• Medicaid Reform Overview	14
04/25/06	Broward County	Therapy Providers	Area Office Outreach	• Medicaid Reform Overview	74
04/25/06	Duval County	Beneficiaries Riverside Presbyterian Apartments	Area Office Outreach	• Medicaid Reform Overview	35
05/01/06	Duval County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	13

Attachment I
Medicaid Reform Outreach Meetings
November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
05/03/06	Duval County	Specialty Hospital / Health Educators	Area Office Outreach	• Medicaid Reform Overview	20
05/04/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	10
05/04/06	Broward County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	40
05/08/06	Duval County	Neighborhood Partnership for the Protection of Children (Beaches)	Area Office Outreach	• Medicaid Reform Overview	Cancelled
05/08/06	Nassau County	Advocates and Providers and Potential Plans	AHCA Invited	• Medicaid Reform, roll out to rural counties • Development of PSNs	50
05/12/06	Broward County	SFHHA/Healthcare Summit	Area Office Outreach	• Choice Counseling	20
05/12/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 40 total
05/15/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	35
05/16/06	Duval County	Behavioral Health Industry and Providers	AHCA Invited	• Medicaid Reform, effects on the behavioral health industry	40
05/16/06	Duval County	Potential Plans	General Outreach	• Choice Counseling • Marketing	120
05/17/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
05/17/06	Broward County	Potential Plans	General Outreach	• Choice Counseling • Marketing	194

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November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
05/18/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	8
05/18/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
05/24/06	Broward County	Providers	Area Office Outreach	• Medicaid Reform Overview	12
05/25/06	Duval County	DCF Call Center	Area Office Outreach	• Medicaid Reform Overview	54
05/30/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 70 total
06/01/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/02/06	Duval County	Medicaid Providers	Area Office Outreach	• Medicaid Reform Overview	20
06/05/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/05/06	Duval County	Independent Living Resource Center	Area Office Outreach	• Medicaid Reform Overview	15
06/06/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/06/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
06/09/06	Duval County	Jacksonville Area Service Coordinators	Area Office Outreach	• Medicaid Reform Overview	15
06/12/06	Duval County	Jacksonville Townhouse Apartments	Area Office Outreach	• Medicaid Reform Overview	25

Attachment I
Medicaid Reform Outreach Meetings
November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/12/06	Duval County	Integrated Services Team Meeting	Area Office Outreach	• Medicaid Reform Overview	35
06/13/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	6
06/14/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/15/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/15/06	Duval County	Neighborhood Partnership for the Protection of Children (Jacksonville)	Area Office Outreach	• Medicaid Reform Overview	Cancelled
06/15/06	Duval County	DCF Caseworkers	Area Office Outreach	• Medicaid Reform Overview	30
06/16/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	20
06/20/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
06/21/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	42
06/21/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	35
06/21/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
06/21/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5

Attachment I
Medicaid Reform Outreach Meetings
November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/22/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
06/23/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	45
06/23/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	30
06/23/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	18
06/23/06	Broward County	Children's Diagnostic and Treatment Center (CDTC)	Area Office Outreach	Medicaid Reform Overview	75
06/26/06	Duval County	Professionals	Area Office Outreach	• Medicaid Reform Overview	45
06/27/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9
06/27/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
06/27/06	Duval County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	62
06/27/06	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	64
06/27/06	Duval County	Beneficiaries	General Outreach	• Choice Counseling	55
06/28/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9

Attachment I
Medicaid Reform Outreach Meetings
November 2005 – June 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/28/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
06/28/06	Broward County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	36
06/28/06	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	55
06/28/06	Broward County	Beneficiaries	General Outreach	• Choice Counseling	79
06/30/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
10/05/05	Duval County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • Choice Counseling	45
11/22/05	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • Choice Counseling	60
12/12/05	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	45
12/13/05	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Special Session HB 3B provisions • Reform Benefit Packages • Data Book	50
01/31/06	Duval County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	95
02/01/06	Broward County	Potential Plans	General Outreach	• Rate Setting • Risk Adjustment	110
02/28/06	Duval County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview • What will Reform plans look like? • Enrollment Introduction (high level)	110
02/28/06	Duval County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	45

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
03/01/06	Broward County	Potential Plans	Technical Assistance	• Introduction of the multi-purpose application for submitting a Reform plan	60
03/01/06	Broward County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	85
03/01/06	Broward County	Medicaid Beneficiaries	General Outreach	• Medicaid Reform Overview (basic) • What will Reform plans look like? • Enrollment Introduction (high level)	110
03/15/06	Duval County	Advocates Health Advisory Council – Baker County	Area Office Outreach	• Materials were provided, and followed up with discussion with discussion.	20
03/16/06	Duval County	Advocates Health Advisory Council – Clay County	Area Office Outreach	• Materials were provided, and followed-up with discussion.	15
03/20/06	Broward County	One Community Partnership / Governance Board Meeting	Area Office Outreach	• Medicaid Reform Overview	75
03/21/06	Duval County	Advocates Diabetic Services and Supplies	Area Office Outreach	• Medicaid Reform	1

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
03/23/06	Duval County	Potential Plans	Technical Assistance	• Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	42
03/24/06	Broward County	Potential Plans	Technical Assistance	• Data Book • Demonstration of the Plan Design Evaluation Tool • FFS PSN Reconciliation Process	44
03/28/06	Duval County	Advocates Robert F. Kennedy Community Center	Area Office Outreach	• Materials were provided on Medicaid Reform	1
03/29/06	Duval County	Advocates Ronald MacDonald House	Area Office Outreach	• No presentation. • Materials provided on Medicaid Reform and its general effects.	1
03/29/06	Duval County	Medicaid Beneficiaries Mary Singleton Center	Area Office Outreach	• Exhibitor only	100
03/30/06	Duval County	Advocates Riverside Presbyterian Apartments/Residences	Area Office Outreach	• Medicaid Reform	2
04/04/06	Duval County	MediPass Providers	General Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	50

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
04/05/06	Duval County	Advocates Patient Educators	Area Office Outreach	• Materials provided on Medicaid with Reform discussion. • Reform and its general effects.	15
04/06/06	Duval County	Medicaid Beneficiaries Campus Towers	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	15
04/06/06	Duval County	Advocates ARC Parent Forum	Area Office Outreach	• No presentation given by AHCA. • Materials provided on Medicaid Reform and its general effects. • Discussion ensued in response to the materials.	10
04/10/06	St. John's County	St. John's Civic Roundatble	AHCA Invited	• Medicaid Reform Overview	30
04/10/06	Duval County	Advocates Florida Christian Apartments / Sundale Manor	Area Office Outreach	• Medicaid Reform Overview	2
04/11/06	Duval County	Advocates KIDS Council	Area Office Outreach	• Medicaid Reform Overview	15
04/11/06	Broward County	Home Health Provider	Area Office Outreach	• Medicaid Reform Overview	18
04/13/06	Broward County	MediPass Providers	Area Office Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	60

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
04/18/06	Broward County	MediPass Providers	Area Office Outreach	• Medicaid Reform Overview • Provider Enrollment • Patient Enrollment	55
04/20/06	Broward County	Sister Agencies	Area Office Outreach	• Medicaid Reform Overview	65
04/20/06	Duval County	Advocates SAGES Coalition	Area Office Outreach	• Medicaid Reform Overview	14
04/25/06	Broward County	Therapy Providers	Area Office Outreach	• Medicaid Reform Overview	74
04/25/06	Duval County	Beneficiaries Riverside Presbyterian Apartments	Area Office Outreach	• Medicaid Reform Overview	35
05/01/06	Duval County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	13
05/03/06	Duval County	Specialty Hospital / Health Educators	Area Office Outreach	• Medicaid Reform Overview	20
05/04/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	10
05/04/06	Broward County	Advocates and Medicaid Beneficiaries	Focus group	• Choice Counseling brochure	40
05/08/06	Duval County	Neighborhood Partnership for the Protection of Children (Beaches)	Area Office Outreach	• Medicaid Reform Overview	Cancelled

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
05/08/06	Nassau County	Advocates and Providers and Potential Plans	AHCA Invited	• Medicaid Reform, roll out to rural counties • Development of PSNs	50
05/12/06	Broward County	SFHHA/Healthcare Summit	Area Office Outreach	• Choice Counseling	20
05/12/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 40 total
05/15/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	35
05/16/06	Duval County	Behavioral Health Industry and Providers	AHCA Invited	• Medicaid Reform, effects on the behavioral health industry	40
05/16/06	Duval County	Potential Plans	General Outreach	• Choice Counseling • Marketing	120
05/17/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
05/17/06	Broward County	Potential Plans	General Outreach	• Choice Counseling • Marketing	194
05/18/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	8
05/18/06	Duval County	Senior Expo	Area Office Outreach	• No presentation given by AHCA. • Exhibitor only.	1500
05/24/06	Broward County	Providers	Area Office Outreach	• Medicaid Reform Overview	12

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
05/25/06	Duval County	DCF Call Center	Area Office Outreach	• Medicaid Reform Overview	54
05/30/06	Duval County	Advocates	Area Office Outreach	• Medicaid Reform Overview	(2 Sessions) 70 total
06/01/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/02/06	Duval County	Medicaid Providers	Area Office Outreach	• Medicaid Reform Overview	20
06/05/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/05/06	Duval County	Independent Living Resource Center	Area Office Outreach	• Medicaid Reform Overview	15
06/06/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/06/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
06/09/06	Duval County	Jacksonville Area Service Coordinators	Area Office Outreach	• Medicaid Reform Overview	15
06/12/06	Duval County	Jacksonville Townhouse Apartments	Area Office Outreach	• Medicaid Reform Overview	25
06/12/06	Duval County	Integrated Services Team Meeting	Area Office Outreach	• Medicaid Reform Overview	35
06/13/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	6

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/14/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/15/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/15/06	Duval County	Neighborhood Partnership for the Protection of Children (Jacksonville)	Area Office Outreach	• Medicaid Reform Overview	Cancelled
06/15/06	Duval County	DCF Caseworkers	Area Office Outreach	• Medicaid Reform Overview	30
06/16/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	20
06/20/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
06/21/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	42
06/21/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	35
06/21/06	Tallahassee	PSN Third Party Administrators	Technical Assistance	• Overview and Policy • Technical Parameters to FMMIS	20
06/21/06	Duval County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	5
06/22/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/23/06 AM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	45
06/23/06 PM	Duval County	Providers	Area Office Outreach	• Medicaid Reform Overview	30
06/23/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	18
06/23/06	Broward County	Children's Diagnostic and Treatment Center (CDTC)	Area Office Outreach	Medicaid Reform Overview	75
06/26/06	Duval County	Professionals	Area Office Outreach	• Medicaid Reform Overview	45
06/27/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9
06/27/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
06/27/06	Duval County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	62
06/27/06	Duval County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	64
06/27/06	Duval County	Beneficiaries	General Outreach	• Choice Counseling	55
06/28/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	9

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
06/28/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	4
06/28/06	Broward County	Pharmacy Providers	General Outreach	• Medicaid Reform, effects on pharmacy services	36
06/28/06	Broward County	Potential Plans	General Outreach	• Medicaid Reform Overview • Transitioning into Medicaid Reform • Enhanced Benefits	55
06/28/06	Broward County	Beneficiaries	General Outreach	• Choice Counseling	79
06/30/06	Broward County	Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
07/05/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	6
07/06/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	14
07/07/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	13
07/07/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	16
07/11/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
07/11/06 PM	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	16

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
07/12/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
07/12/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	8
07/13/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
07/17/06 PM	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	10
07/17/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	13
07/17/06	Broward County	Medicaid Providers	Area Office Outreach	• Medicaid Reform Overview	80
07/19/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	14
07/20/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	15
07/21/06	Broward County	PAC Case Managers	Area Office Outreach	• Medicaid Reform Overview	23
07/21/06	Broward County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview	48
07/27/06	Broward County	Behavioral Health Providers	Area Office Outreach with Representatives from Headquarters	• Behavioral Health in Medicaid Reform	

Attachment II
Medicaid Reform Outreach Meetings
July 2006 – September 2006

Date	Location	Target Audience	Type of Meeting	Subject	Approximate Number of Attendees
08/05/06	Duval County	Medicaid Beneficiaries	Area Office Outreach	• Medicaid Reform Overview • Health Fair @ Shands	800
8/17/06	DCF – District 4	Access Health Solutions	Area Office Outreach	• Medicaid Reform Overview	
8/18/06	Published 8/18		Article	”Verifying Medicaid Eligibility under Reform"	
8/18/06	Broward County	Cleveland Clinic (MediPass PCP Staff)	Area Office Out Reach	• Medicaid Reform Overview	
8/24/06	DCF – District 4	United Healthcare	Area Office Outreach	• Medicaid Reform Overview	16
08/26/06	Duval County	VOICE Conference	Area Office Outreach	• Medicaid Reform Overview	
8/30/06	HealthEase Conference Room	HealthEase and Staywell	Area Office Outreach	• Medicaid Reform Overview	
8/30/06	DCF – District 4	First Coast Advantage-Shands	Area Office Outreach	• Medicaid Reform Overview	
09/13/06	Duval County	VOICE Community Meeting	Area Office Outreach	• Medicaid Reform Overview	

Attachment III
Florida Medicaid Reform Choice Counseling

ACS

CALL CENTER ACTIVITY REPORT

Month: **July-06**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard								**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
MON		0			0	0		0.0%					
TUE		0			0	0		0.0%					
WED		0			0	0		0.0%					
THU		0			0	0		0.0%					
FRI		0			0	0		0.0%					
SAT	7/1/2006	78	78	0	78	78	0	0.0%	100%	0.00	2.57	28	0.0%
	Week Ending	78	78	0	78		0	0.0%	100%	0.0	2.6	28	0%
MON	7/3/2006	29	29	0	29	29	0	0.0%	100%	0.00	4.06	147	0.0%
TUE	7/4/2006	0			0	29		0.0%					
WED	7/5/2006	42	42	0	42	71	0	0.0%	100%	0.00	5.36	120	0.0%
THU	7/6/2006	107	107	0	107	178	0	0.0%	100%	0.00	5.55	72	0.0%
FRI	7/7/2006	65	65	0	65	243	0	0.0%	100%	0.00	6.76	23	0.0%
SAT	7/8/2006	6	6	0	6	249	0	0.0%	100%	0.00	6.03	1	0.0%
	Week Ending	249	249	0	249		0	0.0%	100%	0.0	5.7	363	0%

Attachment III
Florida Medicaid Reform Choice Counseling

ACS

CALL CENTER ACTIVITY REPORT

Month: **July-06**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard								**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
MON	7/10/2006	84	84	0	84	333	0	0.0%	100%	0.00	6.41	63	0.0%
TUE	7/11/2006	96	95	0	95	428	1	1.0%	100%	0.00	6.03	15	0.0%
WED	7/12/2006	82	82	0	82	510	0	0.0%	100%	0.00	6.21	10	0.0%
THU	7/13/2006	86	86	0	86	596	0	0.0%	100%	15.00	5.68	21	0.0%
FRI	7/14/2006	47	47	0	47	643	0	0.0%	100%	15.00	5.26	17	0.0%
SAT	7/15/2006	5	5	0	5	648	0	0.0%	100%	15.00	5.40	54	0.0%
	Week Ending	400	399	0	399		1	0.3%	100%	5.2	6.0	180	0%
MON	7/17/2006	129	129	0	129	777	0	0.0%	100%	15.00	6.21	107	0.0%
TUE	7/18/2006	88	88	0	88	865	0	0.0%	100%	15.00	6.50	13	0.0%
WED	7/19/2006	97	97	0	97	962	0	0.0%	100%	15.00	5.43	13	0.0%
THU	7/20/2006	108	108	0	108	1,070	0	0.0%	100%	15.00	5.91	10	0.0%
FRI	7/21/2006	115	115	0	115	1,185	0	0.0%	100%	15.00	6.55	5	0.0%
SAT	7/22/2006	7	7	0	7	1,192	0	0.0%	100%	15.00	5.37	0	0.0%
	Week Ending	544	544	0	544		0	0.0%	100%	15.0	6.1	148	0%

Attachment III
Florida Medicaid Reform Choice Counseling

ACS

CALL CENTER ACTIVITY REPORT

Month: **July-06**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard								**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
MON	7/24/2006	194	194	0	194	1,386	0	0.0%	100%	15.00	8.83	13	0.0%
TUE	7/25/2006	252	252	0	252	1,638	0	0.0%	100%	15.00	9.61	72	0.0%
WED	7/26/2006	195	195	0	195	1,833	0	0.0%	100%	15.00	9.10	44	0.0%
THU	7/27/2006	192	192	0	192	2,025	0	0.0%	100%	15.00	9.63	25	0.0%
FRI	7/28/2006	192	192	0	192	2,217	0	0.0%	100%	15.00	9.88	54	0.0%
SAT	7/29/2006	15	15	0	15	2,232	0	0.0%	100%	15.00	14.05	4	0.0%
	Week Ending	1,040	1,040	0	1,040		0	0.0%	100%	15.0	9.5	212	0%
MON	7/31/2006	349	349	0	349	2,581	0	0.0%	100%	15.00	9.66	137	0.0%
TUE		0			0	2,581		0.0%					
WED		0			0	2,581		0.0%					
THU		0			0	2,581		0.0%					
FRI		0			0	2,581		0.0%					
SAT		0			0	2,581		0.0%					
	Week Ending	349	349	0	349		0	0.0%	100%	15.0	9.7	137	0%

Attachment III
Florida Medicaid Reform Choice Counseling

ACS

CALL CENTER ACTIVITY REPORT

Month: **July-06**

Day of the Week	Date	Incoming Calls Received (#)	Total Incoming Calls Answered (#)	Voice Mail Calls (#)	Total Calls and VM Answered (#)	Cumulative Calls Answered (#)	Total Calls Abandoned (#)	Abandon Rate Total (%)	% Answered in 4 Rings (%)	Longest wait in queue # (Seconds)	Avg. Talk Time (ATT) # (Minutes)	Total Outbound Calls (#)	% Blocked calls (%)
Standard								**<5% Monthly**	**100%**	**180 seconds**			**<=1% monthly**
	Month End	**2,660**	**2,659**	**0**	2,659		**1**	**0.0%**	**100%**	**11.7**	**7.7**	**1068**	**0.0%**