Extension of the Florida Medicaid 1115 Waiver

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Public Input Meeting

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Authorization for Reform

- In 2005, the Florida Legislature authorized the Agency, through Section 409.91211, Florida Statutes, to:
  - Seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program.
  - Implement the Medicaid Managed Care Pilot program in Broward County and Duval County.
  - Expand into Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational.

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1115 Research and Demonstration Waivers

- Experimental, Pilot or Demonstration Projects.
  - Benefit Packages, Reimbursement Methodologies, Covering Expanded Groups.
  - States Commit to a Policy Experiment that must be formally evaluated.
- 1115(a)(1) allows the Secretary to waive compliance with most of the requirements in the Medicaid and SCHIP State Plans.
- 1115(a)(2) allows the Secretary to regard as expenditures costs that would not otherwise be matchable under Medicaid or SCHIP.
- If granted, the initial approval period is 5 years and the State may request two 3 year extensions of the program.

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Florida's 1115 Medicaid Reform Waiver

- Allows Florida Medicaid to conduct a demonstration Pilot requiring managed care plan enrollment for most Medicaid eligibles in certain areas of the state.
- Provides the State with the authority to mandatorily assign eligible beneficiaries.
- Provides authority to enroll additional populations not included under the 1915(b) Managed Care Waiver:
  - Individuals with Medicare Coverage
  - SOBRA Pregnant Women
  - Children in Foster Care
  - Children with Chronic Conditions

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Extension of the 1115 Waiver

- The current Medicaid Reform Waiver expires June 30, 2011.
- The Florida Legislature has directed the Agency, through SB 1484, to request an extension of the waiver and to ensure that the waiver remains active and current.
- The Agency is required to report monthly to the Legislature on progress in negotiating the terms of the waiver extension.
- The Governor has not yet signed this bill into law (and has until May 28th to take final action).

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Extension of the 1115 Waiver

- The Agency was not authorized to amend the waiver.
- An extension would maintain the program in the current geographic areas of operation.
- Any expansion into new geographic areas or substantial changes would require Legislative authorization.
- Experience to date shows that operational changes can be made within the framework of the approved waiver in response to public input.
- These public forums will continue that dialogue and provide the Agency with new opportunities to continually improve the program.

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Extension of the 1115 Waiver

- Federal Requirements for extension.
- (STC #8) - Florida is responsible for reviewing, complying and adhering to the timeframes and reporting requirements in Section 1115(e) of Social Security Act. In addition, Florida must submit documentation of:
  - How the state has met the demonstration objectives,
  - Complied with STCs of the waiver,
  - Summary of beneficiary satisfaction and quality of care,
  - Compliance with budget neutrality cap, and
  - Public process used to obtain stakeholder input.

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Reform Timeline

May 2005	Reform Pilot Authorized by Florida Legislature by SB 838
October 2005	Waiver request approved by federal Centers for Medicare and Medicaid Services
December 2005	Waiver approved by Legislature in HB 3-B
September 2006	Enrollment began for Duval and Broward Counties
September 2007	Enrollment began in Clay County
October 2007	Enrollment began in Baker and Nassau Counties
May 2010	Agency directed to request an extension of the Waiver by **July 1, 2010**
June 30, 2011	Current waiver expires unless extension approved

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Key Elements of Reform

- Low Income Pool (LIP)
- Outreach Efforts
- Delivery System:
  - Coordinated Systems of Care (Health Maintenance Organizations and Provider Service Networks)
- New Options / Choice:
  - Customized Plans
  - Enhanced Benefits
  - Opt-Out
- Financing:
  - Premium Based
  - Risk-Adjusted Premium
  - Comprehensive and Catastrophic Component
- Choice Counseling.

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Goals of Medicaid Reform

- Improve access to health care services.
- Provide more choices (plans and services) for Medicaid recipients.
- Provide opportunities for recipients to take a more active role in their health care decisions.
- Reduce the administrative complexity of managing the Florida Medicaid Program.
- Slow the rate of growth of expenditures:
  - Better care coordination
  - Reduction of over-utilization
  - Reduction of fraud

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Florida Medicaid Reform Does Not/ Is Not .

- Florida Medicaid Reform ***does not***:
  - Change who receives Medicaid.
  - "Cut" the Medicaid budget.
  - Limit medically necessary services for children.
  - Limit medically necessary services for pregnant women.
  - Permit Reform health plans to charge cost sharing.
- Medicaid Reform ***is not*** linked to the National Health Care Reform, Or Affordable Care Act passed by Congress
  - Does not contain mandate for individuals.
  - Does not contain mandates for employers.
  - Does not expand Medicaid coverage or cost the state additional money.

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Low Income Pool

- Low-Income Pool (LIP) was implemented effective July 1, 2006, under the 1115 Waiver.
- The LIP consists of an annual allotment of $1 billion, funded primarily by intergovernmental transfers from local governments matched by federal funds. Expenditures cannot exceed $5 Billion over 5 yr period (7/1/2006 – 6/30/2011).
- Payments are made to qualifying Provider Access Systems, including hospitals, federally qualified health centers and County Health Departments working with community partners.
- The objective of LIP is to ensure support for the provision of health care services to Medicaid, underinsured and uninsured population.

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Low Income Pool

- The LIP program is only available through and 1115 Waiver.
- If LIP is not continued, non-hospital based providers would not be eligible for payments.
- If LIP is not continued, the public providers would NOT be able to obtain funding for underinsured and uncompensated care expenditures, regardless of the availability of IGTs.
- The continuation of LIP will allow the providers and the Agency to keep the current level of funding.
- The Agency will request that the federal Centers for Medicaid and Medicare Services (CMS) authorize the current funding level of $1 billion a year. However, CMS may adjust the funding level.

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Low Income Pool

- Without extension of the waiver, the state would revert to the Upper Payment Limit methodology for payments to only hospital providers.
- The implementation of UPL would result in an anticipated total loss of $363 million in available funding to hospital and non-hospital providers.
- Due to category limits (cost limits) , public hospitals would suffer nearly a 100% loss in available supplemental funding currently available under LIP.

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Low Income Pool

- In the 2010 General Appropriations Act, the Florida Legislature providing $25 million in LIP funds to increase access to primary care services.
    - If additional federal funding is made available through an extension of the enhanced FMAP available under ARRA, funds for primary care increase to $49 million.

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Marketplace

- Reform has attracted new plans to the Florida Medicaid Marketplace.
- New plans provide increased choice for Medicaid recipients.
- Helps to ensure a variety of health care choices to better meet the needs of recipients.
- Prior to reform, there were no health plans participating in Baker, Clay or Nassau County.
- There has been plan consolidation and withdrawal of some plans from some counties.

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Marketplace

- Experience with plan transitions – processes in place to ensure continuity of care and recipient choice:
  - All enrollees received notice from both the plan and from Florida Medicaid of the upcoming transition.
  - Notification sent to enrollees 60 and 30 days prior to the transition.
  - Involvement of headquarters and local staff in assisting recipients.
  - Always provide 90 day choice period after plan enrollment.
  - In the 2009 contract, the agency increased the timeline for plans to notice the Agency of withdrawal in order to allow for additional recipient notification and transition time.
  - Plans must provide notice 120 days prior to withdrawal.

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Plan Benefit Design

- Health plans operating in Reform counties can offer differing benefit packages designed to appeal to recipients based on their individual needs.
- Some services are required to be covered at current state plan coverage levels.
- Some services are required to be offered but amount, scope and duration are flexible.
- Plans can, and do, offer additional benefits to their enrollees above state plan level of service.

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Plan Benefit Design

- Existing Reform plans offer a range of services:
  - For Example:
    - To meet the sufficiency standards, existing plans are required to provide a minimum of 9 prescriptions/month to the Children and Families group and a minimum of 16 prescriptions/month to the Aged and Disabled group.
      - Originally, plans could choose to provide a minimum number of prescriptions or a place a dollar amount limit on prescriptions.
    - However, many plans offered a prescription benefit above the minimum determined to be sufficient.
    - Podiatry services offered by different plans range from 6 visits to 24 visits per year.

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Plan Benefit Design

- Reform plans that choose to operate in counties that previously had no managed care presence can choose to provide comprehensive coverage only.
  - Plan chose to cover services up to $50,000.
  - If a recipient reaches $50,000, Medicaid would reimburse the plan for all claims at 90 percent of the Medicaid rate.
  - No plans have chosen this option

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Enhanced Benefits

- Recipients earn credits through participation in healthy behaviors.
- Credits may be used to purchase health related products and supplies.
- Beneficiaries may earn up to a maximum of $125 per year in credit dollars.
- While during the first year of the Pilot use of enhanced benefits credits was low in comparison to the number of credits earned - spending has remained steady through year four of the Pilot.
- Health plans have some concerns about the funding of the program.

Month of Purchases / Credits Earned	Recipient Count Credits Earned	Credit Amount Earned	Recipient Count Purchases	Dollar Amount Spent
Total (Fiscal Year 2006-2007)	102,144	$5,005,381.16	4,913	$113,158.97
Total (Fiscal Year 2007-2008)	179,917	$10,718,877.50	46,739	$2,431,769.30
Total (Fiscal Year 2008-2009)	195,332	$7,177,270	107,544	$6,385,036.60
Total (Fiscal Year 2009-2010) thru 5/5/10	174,386	$5,440,722.50	114,160	$5,262,539.59
Grand Total	*328,120	$28,342,251.16	*171,355	$14,192,504.46

Please note the recipient count grand total is an unduplicated count of the recipients who have utilized / earned enhanced benefits credits over the four year s the program has been in place.

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Enhanced Benefits

- The Enhanced Benefits Advisory Panel (Panel) was created to provide recommendations for healthy practices and/or behaviors.
- Experience since program implementation has lead to program changes.
- Outreach to recipients and pharmacies after a slow program start dramatically increased recipient and pharmacy participation in the program.
- Change to credits earned for non-preventative office visits changed effective July 1, 2008.
  - Allow for 1 visit ($7.50) per year vs. two visits per year ($15 adult, $25 kids).
  - Added behaviors such as 1st trimester pregnancy, PSA screening, diabetes lab tests/
  - Shift from credit award for passive behaviors to more active behaviors.

Risk Adjustment

- *Risk Adjustment:* Reimbursing plans based on the mix of patient acuity.
  - Risk adjustment is a process which predicts health care expenses from diagnoses, age, gender, and other factors.
  - Allows distribution of payments to health plans based on the health risk of their enrollees resulting in more efficient use of Medicaid dollars by better matching payment to risk.
  - Individuals are assigned a “risk score” and health plans are paid based on the collective risk scores of their enrollees.

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Encounter Data

- Encounter data are electronic records of covered services provided to the enrollees of a health plan.
- Encounter data document the patient's diagnosis and all of the services rendered to the patient during the visit.
- Encounter data will be used, in part, in the process of setting fully risk adjusted rates.
- All health plans have submitted their historical data and are submitting their current data.
- Data is partially validated.
- Encounter data will be used for rate setting, risk adjustment and other data analysis.

The Opt-Out Program

- Employed Medicaid recipients are offered the choice to opt-out of Medicaid and direct their premium paid by Medicaid to an employer-sponsored plan.
- If a beneficiary chooses to opt-out, the state pays up to the amount it would have paid a Medicaid Plan towards the employee's share of the premium.
- Families can combine premiums to purchase family coverage through their employer.
- There are currently 15 recipients enrolled in the program
- There have been a total of 75 recipients enrolled over the life of the program.

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Choice Counseling: Key Elements

- Choice Counseling under the Pilot is an enhanced service that provides recipients with a comprehensive level of information and assistance in order to help them choose the health plan best suited to their individual needs.
- The Choice Counseling Call Center is the Central contact point for beneficiary enrollment, plan change, disenrollment and education/information.
- Outreach / field services include outbound calls, home visits, community site visits, and educational information on the Pilot.
- Special Needs Unit staffed with nurses to assist medically complex recipients (or anyone needing extra assistance) make their plan choice.

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Choice Counseling: Key Elements

- Mental Health Unit: Provide additional, direct support to beneficiaries with mental health needs.
- Navigator/ Plan prescription Drug Formulary comparison tool implemented in October 2008 to assist recipients in making a plan choice that best meets their needs by providing comprehensive information on each health plans' prescription drug coverage.
- Enhanced monitoring and continuous improvement part of the process.
- Contract ensures highly trained and certified choice counselors to serve the diverse Medicaid population.

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Choice Counseling: Beneficiary Satisfaction

- Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call.
- The survey went live in August of 2007, and since implementation 15,432 surveys have been completed, through last quarter.
- Overall satisfaction with Medicaid Reform averages 97.3%
- The average satisfaction regarding outreach/ field visits measures was 98%.
- The average satisfaction regarding the call center was 95%.

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New Vendor for Choice Counseling

- AHCA Invitation To Negotiate (ITN) 0904 was advertised on March 9, 2009 after receiving notification from the Center for Medicare and Medicaid Services (CMS) that the Agency issue a new procurement for Enrollment Broker Services in Baker, Broward, Clay, Duval and Nassau.
- The contract was awarded to Automated Health Systems (AHS) and implementation efforts began in March of 2010, at the conclusion of a bid protest.
- The current vendor, Affiliated Computer Services, will end live, operations on June 17, 2010, at 8 p.m.
- AHS assumes full responsibility of operations, effective June 18, 2010.

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New Operational Enhancements

- Health Track is the primary tool for processing beneficiary requests and includes the following functionality:
  - The **Integrated Choice Driver Comparison** function of the system provides plan comparison based on what is most important to the beneficiary in four key areas: Primary Care Provider, Medication, Specialist and Hospital
  - The **Integrated Beneficiary Information Screen**, provides call center agents with key, specific, clear, information about the beneficiary: Case Flags, Enhanced Benefits Balance, Current Plan, etc…
  - Familiar user interface

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New Operational Enhancements

- Beneficiary Web Enrollment and Information Portal
  - The tool will allow beneficiaries to enroll, disenroll and make plan changes online, using the same comparison tools available to the call center
- Enhanced Automated Voice Response System (AVRS) Functions
  - The Enhanced AVRS will allow beneficiaries to check their Enhanced Benefits credit balance anytime, 24 hours per day
- Use of the National Change of Address System (NCOA) to improve communication delivery

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Evaluation and Performance

- Patient Satisfaction
- Cost Savings
- Performance Measures
- Upcoming
  - Mental Health
  - Updated Patient Satisfaction
  - Further analysis of cost savings
  - Additional performance measures
  - Final Analysis 12/31/2010

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Public Input and Program Improvements

- Florida Medicaid has been continuously open to both positive and negative feedback on the Reform Pilot received from any and all stakeholders, including recipients, providers, advocates and researchers.
- Based on this feedback, the program has taken advantage of opportunities to adapt and improve components of Reform.

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Public Input and Program Improvements

- Adaptations and improvements made as a result of public input include:
  - Focus groups and public meetings
  - Revision of publications and call center scripts (most recently January 2010)
  - Choice Counseling Special Needs Unit & Mental Health Unit
  - Choice Counseling Navigator System
  - Centralized Complaint Tracking System
  - Performance Measure Baseline Established
  - Plan Withdrawal notice period lengthened from 90 to 120 days
  - Plans Marketing Restrictions
  - Provider Network Accuracy Review.

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Public Input and Program Improvements

- Although the Agency was not given authority by the Florida Legislature to amend the waiver, public input and comments have great value.
  - Operational changes can be made within the framework of the approved waiver in response to public input.
  - Comment can advise future Legislature on program extension and/ or amendment.

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Public Input/ Public Forums

- Information and opportunity for written comment available through
- http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml
  - Extension Request will be posted
  - Opportunity for written comments via email will be provided

Questions?

Additional Information on Key Elements for Reference

Reform Plan Enrollment

Reform County Enrollment Totals for May 2010

County	HMO	PSN	Total Enrollment
Baker	3,131	0	3,131
Broward	99,986	41,678	141,664
Clay	12,454	0	12,454
Duval	50,299	48,372	98,671
Nassau	5,323	0	5,323
	171,193	**90,050**	**261,243**

Enrollment by Plan (for May 2010)

Broward: 8 HMO + 3 PSN

HMOs	Enrollment	PSNs	Enrollment
Freedom	1,600	Better Health, LLC	7,205
Humana	8,637	SFCCN	30,399
Medica	1,195	Children's Medical Services	4,074
Molina Healthcare	19,463		
Sunshine	29,691		
Total Health Choice	29,414		
Universal	9,986		
HMO Enrollment	99,986	PSN Enrollment	41,678

Please note: Positive is operational in Broward county beginning May 2010.

Enrollment by Plan (for May 2010)

Duval: 3 HMO + 2 PSN

HMOs	Enrollment	PSNs	Enrollment
Sunshine	40,779	Shands / Jax dba FCA	45,959
United Healthcare	3,455	Children's Medical Services	2,413
Universal	6,065		
HMO Enrollment	50,299	PSN Enrollment	48,372

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Enrollment by Plan (for May 2010)

Baker, Clay and Nassau: 2 HMO + 0 PSN

HMOs	Baker	Clay	Nassau	
Sunshine Health Plan	2,606	9,124	4,330	16,060
United Healthcare	525	3,330	993	4,848
Total Enrollment Baker, Clay and Nassau				**20,908**

Populations Eligible for Reform Enrollment

Mandatory Beneficiary Populations: Who Does Participate in Medicaid Reform?

- Temporary Assistance for Needy Families (TANF);
- TANF-Related Group;
- Aged and Disabled (non dually eligible); and
- Children with Chronic Conditions (when a network is available).

Voluntary Beneficiary Populations: Who May Participate in Medicaid Reform?

- The following individuals eligible under the below groups will be excluded from mandatory participation during the initial phase, however, they may voluntarily choose to participate:
  - Foster care children;
  - Individuals diagnosed with developmental disabilities;
  - Pregnant women with incomes above the TANF poverty level; and
  - Individuals with Medicare coverage.

Excluded Beneficiary Populations: Who Does Not Participate in Medicaid Reform?

- Medically Needy population.
- Aliens receiving emergency assistance.
- Enrollees diagnosed with breast and cervical cancer.
- Individuals enrolled in the following programs:
  - Family Planning Waiver,
  - Hospice and Institutional Care,
  - Residential commitment programs /facilities operated through the Department of Juvenile Justice (DJJ), and
  - Residential group care operated by the Family Safety & Preservation Program of the DCF.

Excluded Beneficiary Populations:
Who Does Not Participate in Medicaid Reform?

- Individuals in the following programs/ facilities:
  - Children's residential treatment facilities purchased through the Substance Abuse and Mental Health District Offices of the DCF (also referred to as Purchased Residential Treatment Services - PRTS),
  - Substance Abuse and Mental Health residential treatment facilities licensed as Level I and Level II facilities,
  - Residential Level I and Level II substance abuse treatment programs, and
  - Florida Assertive Community Treatment Team (FACT).

Plan Participation and Plan Design

Marketplace

- 14 Plans participating in the Reform Pilot (May 2010)
  - 9 Health Maintenance Organizations Participating
  - 5 Provider Service Networks Participating
- Specialty plan for children with special health care needs established. (Children's Medical Services)
- Specialty plan for recipients with HIV/ AIDS established. (Positive Heath Care)
- 9 new health plans participating in Florida Medicaid since beginning of Pilot

Plan Benefit Design

- Health plans operating in Reform counties can offer differing benefit packages designed to appeal to recipients based on their individual needs. Plans have responded by offering additional services not available in traditional Medicaid.
- Additional Services provided by many plans – and examples include:
  - Over the Counter Pharmacy
  - Adult Dental
  - Adult Vision
- Benefit packages differ for Children and Families and Aged and Disabled populations and for specialty plans.

Plan Benefit Design

- Required at least to current coverage levels:
  - Physician and physician extender services
  - Hospital inpatient care
  - Emergency care
  - EPSDT and other services to children
  - Maternity care and other services to pregnant women
  - Transplant services
  - Medical/drug therapies (chemo, dialysis)
  - Family planning
  - Outpatient surgery
  - Laboratory and radiology
  - Transportation (emergent and non-emergent)
  - Outpatient mental health services

Plan Benefit Design

- These services are required and must meet sufficiency standards set by the Agency:
  - Hospital outpatient services.
  - Durable medical equipment.
  - Home health care.
  - Prescription drugs.

Plan Benefit Design

- Required to be offered, but amount, scope and duration are flexible:
  - Chiropractic services.
  - Podiatry services.
  - Outpatient therapy services for adults.
  - Adult dental services.
  - Adult vision services.
  - Adult hearing services.

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Plan Benefit Design

- Reform plans that choose to operate in counties that previously had no managed care presence can choose to provide comprehensive coverage only.
  - Comprehensive Coverage:
    - Plan chose to cover services up to $50,000.
    - If a recipient reaches $50,000, Medicaid would reimburse the plan for all claims at 90 percent of the Medicaid rate.
    - Service Delivery would be uninterrupted for recipient if they reach the $50,000 level
- Since implementation, no plan has chosen this coverage option.

Plan Benefit Design

- All Reform plans are required to cover services up to a catastrophic threshold
  - Catastrophic Threshold:
    - Recipients receive services up to an annual amount of $550,000.
    - If a recipient reaches this level, neither Medicaid or the plan would cover medical services for the remainder of the year.
    - Since implementation of reform in 2006, no recipient has exceeded the catastrophic threshold.

Enhanced Benefits Awards Program

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Enhanced Benefits : Top Healthy Behaviors

- Credits were earned most frequently by completing the following healthy behaviors:
  1. Childhood Preventative Care
  2. Office Visit – Adult/Child
  3. Dental Preventative Services – Adult/Child
  4. Maintenance Drug
  5. Vision Exam Adult/ Child
  6. PAP Smear
  7. Preventative Care Child/ Adult
  8. Preventative Care Adult
  9. Mammogram
  10. Colorectal Screening

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Enhanced Benefits : Frequently Purchased Items

- The most frequently purchased items under the Enhanced Benefits program include:

Category	Supplies
Diapering and other baby supplies	•Diapers •Wipes •Baby Powder •Baby Bath Products and Baby Oil
Dental Supplies	•Mouthwash •Toothpaste
First Aid Products	•Ibuprofen •Band-Aids •Rubbing Alcohol •Cold Remedies

Evaluation and Performance

Patient Satisfaction

- As part of University of Florida's (UF) evaluation of the Demonstration, UF completed an analysis to measure health care experiences and satisfaction levels of Reform enrollees.
- Before Medicaid Reform was implemented, satisfaction levels for those enrolled in the MediPass program has historically been high.
- The evaluation showed that enrollee satisfaction has remained relatively unchanged with over 60% rating their overall satisfaction with care at the highest level (9 or 10).
  - A higher percentage of enrollees reported high level of satisfaction with their personal doctor than prior to the pilot.
  - Anticipated decline in satisfaction due to normal negative reaction to change did not occur.

Cost Savings

- *Cost Savings*: Evidence shows that the pilot is achieving its stated goals. The independent evaluation being conducted by the University of Florida has published findings that show a cost savings.
  - PSN: Expenditures in the pilot counties declined while expenditures in comparison counties increased.
  - HMOs: Expenditures in the pilot counties either declined or increased more slowly than expenditures in the comparison counties.
  - It is clear that expenditures are, for the most part, lower in the pilot counties than they likely would have been without the pilot.
  - More appropriate utilization of services. (Example: Ambulatory Sensitive Hospitalizations)

Performance Measures

- Reform plans outperformed Non-Reform in 20 of 27 plan performance measures.
- Improvement was noted in all but one performance measure in the Reform plans compared to last year, while there was no significant improvement overall between 2008 and 2009 for Non-Reform plans.
- Reform plans demonstrate a measurably lower Ambulatory Sensitive Conditions admission rate than other delivery systems over time. Ambulatory Sensitive (avoidable) Hospitalizations are those hospitalizations that could have been avoided through proper outpatient/ambulatory care. Results suggest that Reform has had a positive effect on ambulatory sensitive hospitalizations.

Choice Counseling

Choice Counseling: Beneficiary Satisfaction

Beneficiary Satisfaction: Call Center Enrollment Process

- There are 7 key factors measured in beneficiary satisfaction, related to the enrollment process within the call center.
  - How likely are you to recommend Choice Counseling helpline to a friend or relative?
  - Satisfaction with overall service of Choice Counselor?
  - How quickly the Choice Counselor understood your reason for calling?
  - The Choice Counselor's ability to help you choose a plan?
  - The Choice Counselor's ability to explain the information clearly?
  - Confidence in the information received?
  - Satisfaction with being treated respectfully?
- The average satisfaction on the 7 categories measures from August 2007 through March 31, 2010 was 95%.
  - Satisfaction with being treated respectfully consistently rated above 97% each year.

Choice Counseling: Beneficiary Satisfaction

Beneficiary Satisfaction – Outreach/ Field Operations

- There are 4 key factors measured in beneficiary satisfaction related to their interaction with the field staff and the enrollment process.
  - Ability to complete enrollment/plan change at the session
  - Felt the information provided by the Choice Counselor helped them make an informed decision
  - The information was explained in a way that made it easy to understand
  - The Choice Counselor was friendly/courteous
- The average satisfaction on the 4 categories measured from October 2007 through March 31 of 2010 was 98%.
  - The Choice Counselor was friendly/courteous was consistently rated above 98% each year.

Choice Counseling: Outreach Activity

	FY 09/10	FY 08/09	FY 07/08	FY 06/07
Public Sessions	2,327	2,537	3,001	3,021
Private Sessions	326	415	400	860
Home/No-phone visits	2,421	1,740	4,511	3,608
Outbound list calls	10,527	33,339	50,375	12,418
Outreach Enrollments	12,718	27,583	32,410	12,138

Choice Counseling ~ Navigator

- Navigator/ Plan Prescription Drug Formulary comparison tool.
- Implemented in October 2008 to assist beneficiaries in making a plan choice that best meets their needs by providing comprehensive information on each health plans' prescription drug coverage.
- Utilizes Medicaid claims history to ensure accurate information regarding beneficiary drug needs
  - If the Navigator does not have current drug history for the beneficiary, the counselors can enter known drugs by the beneficiary.
- Choice Counseling website: http://www.flmedicaidreform.com/

Choice Counseling ~ Navigator

- The Informed Health Navigator provides drug detail so that Choice Counselors see:
  - How many drugs an individual beneficiary is taking are covered by each plan,
  - What coverage limits are in place,
  - What drugs require prior authorization,
  - Compares the plans by their pharmacy network coverage
  - Compares plans in terms of covered drugs, preferred drugs, drugs requiring prior authorization and the number of “in-network” pharmacies.