Florida’s Medicaid Reform

Health Plan Workshop

Baker, Clay, and Nassau Counties

October 16, 2006
Introductions

Lisa Broward
Field Office Manager
Medicaid Area 4
Medicaid Reform Overview

Thomas W. Arnold
Deputy Secretary for Medicaid
Why Do We Need Medicaid Reform?

- Under traditional fee-for-service Medicaid consumers have few choices – and few opportunities to participate in health care decisions.
- Lack of access to specialists.
- The traditional program is complex and hard to manage.
  - Florida operates 20 different “waiver” programs (examples include: Prepaid Mental Health, Healthy Start; and Prepaid Dental, etc.).
- In addition, the state covers over 44 services.
- We need to control the growth of expenditures – left unchecked by Medicaid will make up 59% of the state’s total budget by the year 2015.
- We need a system that focuses on improving the health of beneficiaries, not just paying claims when people are sick.
Reform Timeline

- **May 2005:** Reform authorized by Florida Legislature in SB 838.
- **August 2005:** Draft waiver request posted on AHCA website.
  - Agency for Health Care Administration (Agency), the state Medicaid Agency, received comments on the draft.
  - Agency reached agreement on Upper Payment Limit (UPL) program with Centers for Medicare and Medicaid Services (CMS).
- **October 2005:** Waiver request approved by CMS.
- **December 2005:** Approved by the Legislature.
- **July 2006:** Choice counseling hotline available for beneficiaries in Duval and Broward Counties.
- **September 2006:** Enrollment began for Duval and Broward Counties.
- **December 2006:** Application and Model Contract for Reform Plans in Baker, Clay and Nassau Counties available.
- **July 2007:** Choice counseling hotline available for beneficiaries in Baker, Clay and Nassau Counties.
- **September 2007:** Enrollment to begin for Baker, Clay and Nassau Counties.
Authorization for Reform

- The Agency has been authorized 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 program in Broward County and Duval County.
  - Expand into Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational.
What Will Medicaid Reform NOT DO?

- It will NOT:
  - Change who receives Medicaid.
  - “Cut” the Medicaid budget.
  - Waive Early and Periodic Screening Diagnosis and Treatment for children.
  - Limit medically necessary services for pregnant women.
  - Permit Reform health plans to charge higher cost sharing.
What Will Medicaid Reform DO?

- Increase beneficiary choice.
- Empower beneficiaries to participate in health care.
- Encourage benefits that better meet beneficiary needs.
- Allow access to services not traditionally covered by Medicaid.
- Reward beneficiary healthy behavior and choices.
- Bridge the gap to private insurance.
Mandatory Beneficiary Populations: Who Will Participate in Medicaid Reform?

- Beginning July 2007 we will offer Choice Counseling in Baker, Clay and Nassau Counties.
- Enrollment to begin September 2007:
  - Temporary Assistance for Needy Families (TANF).
  - TANF-Related Group.
  - Aged and Disabled (non dually eligible).
  - Children with Chronic Conditions (when a network is available).
  - HIV / AIDS Patients.
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 Will 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 Will Not Participate in Medicaid Reform?

- Individuals enrolled in the following programs:
  - 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).
Baker, Clay and Nassau Medicaid Enrollment as of October 2006

- **Baker:**
  - Eligible Beneficiaries: 3,684

- **Clay:**
  - Eligible Beneficiaries: 14,193

- **Nassau:**
  - Eligible Beneficiaries: 6,338
Reform Plans Per County
as of October 1, 2006

13 Plans in Broward County:
- Access Health Solutions.
- AMERIGROUP.
- Buena Vista.
- Florida NetPass.
- HealthEase.
- Humana.
- Pediatric Associates.
- Preferred Medical Plan.
- South Florida Community Care Network.
- Staywell.
- Total Health Choice.
- UnitedHealthcare.
- Vista Healthplan of South Florida.

5 Plans in Duval County:
- Access Health Solutions.
- HealthEase.
- Shands Jacksonville d/b/a First Coast Advantage.
- UnitedHealthcare.
- Staywell.
Baker, Clay and Nassau Plan/Application Timeline

- **December 2006:**
  - Non binding letters of Intent due from Plans.
  - Reform Plan Application and Model Contract available.

- **February 2007:**
  - Application deadline for new reform plans who do not currently have a Medicaid Reform Contract for July contract execution.

- **April 2007:**
  - Applications due from existing plans in current Reform counties (Broward and Duval) for expansion into Baker, Clay and Nassau Counties.

- **July 2007:**
  - First Reform contracts executed for Plans to serve Baker, Clay and Nassau.

- **September 2007:**
  - Enrollment to begin for Baker, Clay and Nassau Counties.
Beneficiary Timeline

- **February 2007:**
  - Brochures and training flyers mailed to beneficiaries.
- **May 2007:**
  - Second mailing of brochures and training flyers to beneficiaries.
- **July 2007:**
  - Choice Counseling hotline available.
  - Choice Counseling for enrollment begins.
- **September 2007:**
  - Enrollment to begin for Baker, Clay and Nassau Counties.
- **October 2007:**
  - Mandatory assignments for beneficiaries who have not voluntarily chosen a plan begins.
**Outreach to Plans and Providers**

- Targeted outreach to potential health care plans, Medicaid providers, beneficiaries, advocates, agencies and elected officials/community leaders.
- Announcements of public meetings broadcast in the Florida Administrative Weekly and to an interested parties list.
- Technical Assistance Meetings with focused topics to guide the plans through the Reform process.
- Training sessions, specific to provider audiences such as MediPass Providers; Pharmacy Providers, Behavioral Health Providers, and other Specialty Providers.
Outreach to Plans and Providers

- RV Banners.
- Articles in The Florida Medicaid Provider Bulletin.
- Community advertisements.
- Additional public access to information about Reform through Medicaid Website:
  
  http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

- Outreach workshops to continue through start of enrollment.
Key Elements of Reform

- **New Options / Choice:**
  - Customized Plans.
  - Opt-Out.
  - Enhanced Benefits.

- **Delivery System:**
  - Coordinated Systems of Care (HMOs and PSNs).

- **Financing:**
  - Premium Based.
  - Risk-Adjusted Premium.
  - Comprehensive and Catastrophic Component.

- **Choice Counseling.**
- **Outreach Efforts.**
- **Low Income Pool (LIP).**
New Options/Choice

- **Health Plan Choices:**
  - Reform will attract Medicaid health plans to your area.
  - In each area beneficiaries will choose from:
    - At least 2 Reform plans: managed care plans, provider service networks –
      or
    - One Reform plan and MediPass – in areas where there is only one Reform plan.
New Options/Choice

As of October 1 in Broward and Duval Counties:

- Total of 14 Plans
  - Broward - 9 HMOs, 4 PSNs.
  - Duval - 3 HMOs, 2 PSNs.
Customized Benefit Packages

- Reform health plans will create benefits to meet beneficiaries’ needs so that they can choose the right package.
- Benefit packages will include all Federally required benefits – and may include some services not currently covered by Medicaid.
- Benefit packages must have the same value as the current Medicaid benefit package.
- Benefits must meet State defined standards of “sufficiency” – based on the health plan’s target population – not just the “average” member.
Customized Benefit Packages
Plan Design Guidelines

- Plan services:
  - Certain services must be provided at least to current coverage levels.
  - Other services must be provided at least to meet standards set by the Agency.
  - Remaining services must be offered, but amount, scope and duration are flexible within boundaries established by the Agency.

- Reform plans can offer services above current levels.
  - For Example: Several existing Reform plans offer expanded adult dental benefit (cleanings, x-rays, fillings, etc.).

- Reform plans can add services not currently covered.
  - For Example: Several existing Reform plans offer over the counter drug benefit ($10-25/Month).
**Customized Benefit Packages**

**Plan Design Guidelines (continued)**

- 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 (emergency and non-emergency).
- Outpatient mental health services.
Customized Benefit Packages
Plan Design Guidelines (continued)

- Required and tested for benefit sufficiency:
  - Hospital outpatient services.
  - Durable medical equipment.
  - Home health care.
  - Prescription drugs.

- Existing Reform plans offer a range of services:
  - For Example:
    - To meet the sufficiency standards, existing plans were 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.
    - However, many plans offered a prescription benefit above the minimum determined to be sufficient.
Customized Benefit Packages

Plan Design Guidelines (continued)

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

- Existing Reform plans offer a range of services:
  - *For Example:* Podiatry services offered by different plans range from 6 visits to 24 visits per year.
**Opt - Out**

- Employed Medicaid beneficiaries will be offered the choice to opt-out of Medicaid and direct their premium paid by Medicaid to an employer-sponsored plan.
- The state will pay up to the amount it would have paid a Medicaid Plan for the employee’s share of the premium.
- Families can combine premiums to purchase family coverage through their employer.
- The Opt-Out program will help bridge the gap to independence as Medicaid beneficiaries who work now have a new option for health insurance.
**Opt - Out**

- The Opt Out Program is a completely voluntary program.
- The individual may opt out of Medicaid at any time to participate in their employer sponsored program.
- An enrollee will have the option to reenroll in Medicaid at the time of their Medicaid open enrollment period, their employer’s open enrollment period, or due to loss of their job.
- The Agency has contracted with a vendor to administer the opt-out program who will communicate directly with Medicaid beneficiaries and employers to establish a process by which premium payments will be made.
Enhanced Benefits Overview

- The goal of the Enhanced Benefits program is to promote self involvement in one’s health care needs.
- To achieve this, participation in healthy behaviors that have positive outcomes and can improve one’s health status will be rewarded.
- Rewards are in the form of “credit dollars” that may be used to purchase health related OTC products and supplies.
- Beneficiaries may earn up to a maximum of $125 per year in “credit dollars.”
Enhanced Benefits Overview

- The current Medicaid Gold card will be used to access the accounts and may be used at any Medicaid participating pharmacy.
- Program is up and running, beneficiaries are earning “credit dollars” now.
- Most beneficiaries will be able to use funds for up to 3 years after losing Medicaid eligibility.
**Enhanced Benefits**  
**Access to the Accounts**

- All beneficiaries enrolled in a Medicaid Reform Health plan are eligible for the Enhanced Benefit program.
- An account will be established for each beneficiary at the time of the first credit deposit in the account.
- Account statements will be mailed to the beneficiary on a monthly basis (credits and debits).
## Enhanced Benefits
### Approved Healthy Behaviors and Credits for 2006

<table>
<thead>
<tr>
<th>Children: Behavior Name</th>
<th>Credit Amount Per Occurrence</th>
<th>Annual Occurrence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood dental exam</td>
<td>$25.00</td>
<td>2</td>
</tr>
<tr>
<td>Childhood vision exam</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Childhood preventive care (age-appropriate screenings and immunizations)</td>
<td>$25.00</td>
<td>Any combination, up to 5</td>
</tr>
<tr>
<td>Childhood wellness visit</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Keeps all primary care appointments</td>
<td>$25.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults: Behavior Name</th>
<th>Credit Amount Per Occurrence</th>
<th>Annual Occurrence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeps all primary care appointments</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Mammogram</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>PAP Smear</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal Screening</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Adult Vision Exam</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Adult Dental Exam</td>
<td>$15.00</td>
<td>2</td>
</tr>
</tbody>
</table>
## Enhanced Benefits
### Approved Healthy Behaviors and Credits for 2006

<table>
<thead>
<tr>
<th>ALL: Behavior Name</th>
<th>Credit Amount Per Occurrence</th>
<th>Annual Occurrence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease management participation</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol and/or drug treatment program participation</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol and/or drug treatment program 6 month success</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Smoking cessation program participation</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Smoking cessation program 6 month success</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Weight loss program participation</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Weight loss program 6 month success</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Exercise program participation</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Exercise program 6 month success</td>
<td>$15.00</td>
<td>2</td>
</tr>
<tr>
<td>Flu Shot when recommended by physician</td>
<td>$25.00</td>
<td>1</td>
</tr>
<tr>
<td>Compliance with prescribed maintenance medications</td>
<td>$7.50</td>
<td>4</td>
</tr>
</tbody>
</table>
# Enhanced Benefits

**Approved Health Related Products and Supplies that can be purchased**

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics/anti-inflammatory agents</td>
<td>Advil, Aspirin</td>
</tr>
<tr>
<td>Cough and Cold OTC</td>
<td>Cough and Cold Medications that do not require a prescription</td>
</tr>
<tr>
<td>Cough and Cold by Rx only</td>
<td>Cough and Cold Medications that require a prescription and are not covered by Medicaid</td>
</tr>
<tr>
<td>Ear</td>
<td>Debrox, Ear drops, Nurine ear drops</td>
</tr>
<tr>
<td>Eye</td>
<td>Visine, Refresh, Tears Naturale</td>
</tr>
<tr>
<td>First Aid Products</td>
<td>Bandages, braces, ointments</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Antacids, Pepto-Bismol, Prilosec OTC</td>
</tr>
<tr>
<td>Laxatives</td>
<td>Phillip's Milk of Magnesia, Metamucil Fiber Wafer</td>
</tr>
<tr>
<td>Nose</td>
<td>Simple Saline, Sinus Nasal Spray</td>
</tr>
<tr>
<td>Orthopedic aids</td>
<td>Arthritis Relief Gloves, Arch Supports, Heating Pad</td>
</tr>
<tr>
<td>Topical</td>
<td>Sunscreens, medicated shampoos, lotion</td>
</tr>
<tr>
<td>Topical Antifungal</td>
<td>Clotrimazole, Desenex, Lamisil</td>
</tr>
<tr>
<td>Topical Vaginal</td>
<td>Summers Eve Cream, Vagasil</td>
</tr>
<tr>
<td>Vitamin</td>
<td>Vitamin A, Vitamin B, Vitamin C, Multi-vitamin tablet(s), Stress B tablet(s)</td>
</tr>
<tr>
<td>Dental Supplies</td>
<td>Toothpaste, Tooth brushes, Mouthwash, Floss, etc.</td>
</tr>
</tbody>
</table>
Enhanced Benefits Credit Process

- The Enhanced Benefits program will be administered by the Agency, with cooperation from the health plans.
- The health plans are required to submit a monthly report to the Agency identifying all members of the plan that met the criteria for a healthy behavior for the reporting period.
- The reporting period is based on paid claims with corresponding procedure codes.
- Once the report is received by the Agency, the process to credit the account begins.
- In addition, the Agency has developed a universal form that may be submitted to document participation in an approved healthy behavior that is not tracked through the health plan claims database.
**Premium Based**

- Premiums based on fee-for-service experience.
- Encounter data will become a major component of the premium calculation:
  - **Kick payments:**
    - Separate payments will be made on behalf of the beneficiary for labor and delivery cost and transplant services. These costs are no longer included in the calculation of the premium.
    - Kick payments for these services allow the agency to more appropriately reimburse the plan for services provided to these beneficiaries.
  - **HIV/AIDS:**
    - Premiums for beneficiaries that meet the Agency definition of an HIV/AIDS beneficiary will be based on a methodology using HIV/AIDS historical data only.
Risk Adjustment

- The Agency will risk adjust plan premiums in accordance with Florida Statute.
- **Risk Adjusted Rates:**
  - A process to predict health care expenses based on chronic diagnoses.
  - Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.
  - Captures adverse selection without using experience rating (health status, not health use).
  - Rate allocation, not rate setting.
- **Risk Adjustment Process:**
  - Better matches payment to risk.
  - Pay for the risk enrolled.
- The Agency will initially use Medicaid Rx model to risk adjust rates and will move to Chronic Illness and Disability Payment Systems (CDPS), diagnostic based risk adjustment model.
How Florida is Doing Risk Adjustment

- **Rx Encounter Data Collection and Rx Risk Model:**
  - Collecting Rx encounter data quarterly from all Health Plans statewide.
  - Validating Rx encounter data.
  - Processing Rx encounters and FFS claims through a pharmacy based risk adjustment model (Medicaid Rx).
  - The Medicaid Rx model and risk process calculates risk scores for individual plan enrollees.
  - Monthly risk adjusted premiums are generated based on individuals enrolled in Reform Plans.
  - Individual risk scores are updated quarterly using new pharmaceutical information received quarterly from FFS claims and encounters.
Why Introduce the Catastrophic Component (Reinsurance)?

- To encourage new managed care entities to enter the market:
  - All capitated PSNs and HMOs in areas where there has been no managed care may limit their financial risk by electing to take financial responsibility only for the Comprehensive component.
    - If so, they get less premium, and the state acts as reinsurer for the Catastrophic component.
- To encourage managed care entities to participate in rural and medically underserved areas.
Low Income Pool (LIP)

- Under Medicaid Reform, Upper Payment Limit (UPL) becomes the Low Income Pool.
- Statute mandated the Low Income Pool be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations.
- The low income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period. Roll over provision allows to exceed $1 billion in a given year.
- A Low Income Pool Council was created, per statute, to advise the Agency, the Governor and the Legislature on funding methodology and allocation of the LIP funds.
- Low Income Pool funds will be allocated to provider access systems serving a significant portion of Florida’s Medicaid, uninsured and underinsured populations.
Florida Medicaid Reform
Choice Counseling

Chris Osterlund
Director of Choice Counseling

Scott Ettaro
Outreach Manager, ACS
Florida Medicaid Reform
Choice Counseling
Different Ways to Receive Help

- Helpful Support Each Step of the Way:
  - By Phone:
    - Monday – Friday, 8:00am - 7:00pm.
    - Saturday, 9:00am – 1:00pm.
  - By Mail:
    - Blue/Green “Check It Out” Envelope.
  - In Person, in the Communities:
    - Offices located near residences of Medicaid beneficiaries.
    - Home visits available, if needed by the individual.
  - By Internet.
Helping Beneficiaries Make a Choice

- **Provider Search:**
  - by PCP.
  - by Specialist.
  - Updated weekly.

- **Easy to Understand Question and Answers.**

- **The information offered to beneficiaries will be unbiased.**

- **Choice counselors are monitored to ensure they do not steer individuals.**
Florida Medicaid Reform
Choice Counseling

- Teaming with State and Local Stakeholders:
  - Community Based Organizations.
  - Faith Based Organizations.
  - Health Planning Councils.
  - Healthy Start Coalitions.
  - Department of Children and Families.
  - WorkForce Centers.
  - Consumer Advocacy Groups.
Group and Face-to-Face Counseling:
- Counseling sessions when and where needed.
- Sixty-five percent voluntary enrollment rate, is the goal for year one.
- Community Ambassador Program.
- Oral and written translation services.
- Focus on unbiased information.
- Understanding and accommodating “Special Needs” population.
- Flexibility in approach to diverse groups.
Florida Medicaid Reform
Choice Counseling
Help and Information

- “Check It Out” outreach and media campaign.
- Outbound call to alert beneficiary “Check It Out” envelope is on the way.
- Choice Counseling envelope received by every beneficiary who must enroll in Reform.
- It will include:
  - Brightly Colored “Check It Out” Envelope.
  - Plan information.
  - Choice Counseling Help line phone number.
  - Choice Counseling website address.
Outreach Strategies to Beneficiaries, Advocates, Agencies, Local Officials, Community Leaders

- Community Events.
- Public Meetings.
- Mass Media ~ May include:
  - Local Newspaper Ads.
  - Local Radio Spots.
  - Billboards.
Ensuring Performance
Choice Counseling Certification

- Certified Choice Counselors.
  - Florida has the only program in the nation.
- On-line 10 module course.
- Comprehensive written exam.
- Oral examination with live scenarios.
Ensuring Performance Choice Counseling (continued)

- Agency has remote call-in capabilities to monitor calls with beneficiaries.
- Agency will conduct surprise visits to face-to-face sessions to ensure compliance.
- Performance Standards:
  - 65 percent will choose in year one.
  - Increase to 80 percent by year three.
- ACS Monitoring:
  - Software records call and takes snapshot of screen.
  - Field staff supervisors perform on-site monitoring of field staff.
  - Individual system activities can be monitored for each call center and field staff if needed.
Rural Provider Service Network Start Up Funds

Lisa Gill
AHC Administrator
Medicaid Health Systems Development

FLORIDA MEDICAID
Rural Provider Service Network
Start Up Funds

- $600,000 appropriated in Specific Appropriation 197 to assist entities in developing clinical and admin infrastructure necessary to become a Provider Service Network in a rural county(ies).
- Must be non-profit organizations.
- Maximum of $200,000 per award.
- Defined deliverables and performance measures.
October 2006:
- Develop Funds Application Process and Application and Evaluation Criteria.

November 2006:
- Draft Application and Award Timeline.

December 2006:
- Release Application.

June 2007:
- All funds must be expended.
Unique Needs in Baker, Clay and Nassau Counties

Open Discussion
What Can Providers and Plans do to Get Ready for Reform?

Lisa Broward
Field Office Manager
Medicaid Area 4
Upcoming Workshops

- November 2006:
  - Beneficiary and Provider Outreach meetings for Duval and Broward Counties.
  - Provider outreach meeting for Baker, Clay and Nassau Counties.
  - Beneficiary/ Advocate Outreach meeting for Nassau County.

- December 2006
  - Provider outreach meeting for Baker, Clay and Nassau Counties.
  - Beneficiary/ Advocate Outreach meeting for Baker County.

- Additional workshops to be held through July 2007.
How to Obtain More Information

Area Four Medicaid Office:
Lisa Broward
Field Office Manager
Area4MedicaidHelp@ahca.myflorida.com
904-353-2100
904-353-2198  Fax
1-800-273-5880 (toll free)

Medicaid Website:
http://ahca.myflorida.com/Medicaid/index.shtml
Florida’s Medicaid Reform

Questions and Answers