Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

Final Annual Report
Demonstration Year 9
July 1, 2014 – June 30, 2015

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I. Waiver History

On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by the Centers for Medicare and Medicaid Services (CMS) for the period July 1, 2006 until June 30, 2011. The program was initially implemented in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay, and Nassau counties on July 1, 2007. A three-year waiver extension of the waiver was granted by CMS on December 15, 2011 to continue program operations for the period July 1, 2011 through June 30, 2014.

On June 14, 2013, CMS approved an amendment to the waiver to implement the Managed Medical Assistance (MMA) program. The previously named waiver "Medicaid Reform" was renamed to "Managed Medical Assistance." The amendment approval documents can be viewed on the Agency for Health Care Administrations (Agency's) Web site at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_archive.shtml.

Approval of the MMA amendment allowed Florida to move from a fee-for-service system to managed care under the MMA program. The key components of the program include: choice counseling, competitive procurement of MMA plans, customized benefit packages, healthy behavior programs, risk-adjusted premiums based on enrollee health status, and continuation of the Low Income Pool (LIP). The MMA program increases consumer protections as well as quality of care and access for Floridians in many ways including:

- Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations.
- Ensures the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan.
- Ensures recipient complaints, grievances and appeals are reviewed immediately for resolution as part of the rapid cycle response system.
- Establishes healthy behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires plans offer a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan.
- Requires Florida's External Quality Assurance Organization to validate each plan's encounter data every three years.
- Enhances consumer report cards to ensure recipients have access to understandable summaries of quality, access and timeliness regarding the performance of each participating MMA plan.
- Enhances the plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health and reducing per capita Florida Medicaid expenditures.
- Enhances metrics on plan quality and access to care to improve plan accountability.
- Creates a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Florida Medicaid.

On July 31, 2014, CMS granted a three-year extension of the waiver and extended the LIP supplemental payment authority through June 30, 2015. The Agency's amendment requests submitted to CMS during this waiver period are outlined in Section VIII, Waiver Amendment Request, of this report.

Annual Report Requirement

The quarterly and annual reporting requirements for the waiver are specified in Special Terms and Conditions (STCs) #83 and #84 of the waiver. The Agency is required to submit quarterly and annual reports summarizing the events occurred or anticipated to occur in the near future that affect health care delivery, including, but not limited to, approval and contracting with new MMA plans, specifying coverage area, populations served, benefits, enrollment, and other operational issues as found in this report.

This report is the final annual report for demonstration year nine (DY9) covering the period of of the demonstration, refer to the quarterly and annual reports, which can be accessed at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

II. Operational Update

1. Delivery System

The following provides a summary for DY9 on health care delivery system activities for MMA plan contracting; benefit packages; plan readiness review and monitoring; plan reported complaints, grievances and appeals; and Agency - received complaints/issues.

a) MMA Plan Contracting

During DY9, the Agency completed its first year of operation of the MMA program which is a component of the Statewide Medicaid Managed Care (SMMC) program. Enrollee transition into the MMA program began on May 1, 2014 and was completed by August 1, 2014. The Agency also identified transitional reporting requirements for MMA plans and updated its SMMC Report Guide to include new reporting requirements.

Table 1 lists the contracted managed care organizations for the MMA program during DY9.

Table 1 MMA Plans	
Amerigroup Florida**	Molina**
Better Health	Positive Health Care*
Children's Medical Services Network*	Preferred
Clear Health Alliance*	Prestige Health Choice
Coventry**	Simply
Freedom Health*	South Florida Community Care Network
Humana Medical Plan**	Staywell
Integral Quality Care	Sunshine Health***
Magellan Complete Care*	UnitedHealthcare**
First Coast Advantage	

*This MMA plan is contracted to provide specialized services.
**This MMA plan is also contracted to provide long term-care (LTC) services under the 1915(b)(c) LTC Waiver.
***Sunshine Health is contracted to provide specialized services and is also contracted to provide LTC services under the 1915(b)(c) LTC Waiver.

During DY9, the Agency finalized several general contract amendments which included corrections and changes into the contracts, and plan-specific changes.

During the first quarter of DY9 (August 2014), the Agency finalized a rate amendment which updated rates for the MMA plans. During the second quarter of DY9, the Agency finalized a general contract amendment effective on October 1, 2014, as well as a plan-specific amendment transitioning First Coast Advantage plan's enrollment to the Molina plan. During the third quarter of DY9, the Agency finalized a general contract amendment effective on January 15, 2015, as well as a plan-specific amendment with Freedom Health, Inc., for services to enrollees with chronic conditions. During the fourth quarter of DY9, the Agency finalized a general contract amendment effective on April 15, 2015.

In addition, during DY9, the Agency finalized revisions to the report guide on a quarterly basis for corrections and new reporting requirements. A copy of the report guide and the most recent model contract can be viewed on the Agency's Web site at http://ahca.myflorida.com/SMMC.

b) Medicare-Medicaid Eligible Enrollees

During DY9, the Agency implemented several programs to promote alignment and integration for Florida Medicare-Medicaid eligible individuals, with MMA coverage beginning on January 1, 2015 for this population. When recipients are automatically assigned to a MMA plan, the Agency uses an algorithm to place the recipient in a plan that will best meet their needs. A determination is made if the individual has a current relationship with a Special Needs Plan (SNP) or Medicare Advantage plan. In February 2015, the Agency implemented the "Fully Liable Medicare Advantage Plan" which are Medicare Advantage Plans that are not Medicaid plans, but cover all Medicare and Medicaid wrap-around services at no cost to the Agency. There are currently two fully liable Medicare Advantage plans, HealthSun and Healthspring/Leon. The Agency also has Dual Eligible Special Needs Plans (D-SNP) that are Medicare plans covering Florida Medicaid services and include partial dual eligible enrollees. The recipient enrolls directly in a Medicare plan, and the Agency pays a wrap-around capitation payment for Florida Medicaid services to the Medicare D-SNP plan. This is the largest Medicare affiliated program, with over 100,000 enrollees. The Agency uses the monthly Medicare Modernization Act file from CMS to identify Medicare Advantage Plan information to facilitate coordination of enrollment date. The Agency continues to seek technical assistance from the CMS Medicare-Medicaid Coordination Office to further promote alignment and integration for Florida Medicare-Medicaid eligible individuals.

c) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment I of this report, the MMA plans will provide standard benefits in accordance with the Title XIX Florida Medicaid State Plan, the Florida Medicaid coverage and limitations handbooks, and the Florida Medicaid fee schedules. Table 2 lists the 28 standard benefits that will be provided under the contracts that were executed by the plans:

Table 2
Required MMA Services

(1)	Advanced Registered Nurse Practitioner
(2)	Ambulatory Surgical Center Services
(3)	Assistive Care Services
(4)	Behavioral Health Services
(5)	Birth Center and Licensed Midwife Services
(6)	Clinic Services
(7)	Chiropractic Services
(8)	Dental Services
(9)	Child Health Check Up
(10)	Immunizations
(11)	Emergency Services
(12)	Emergency Behavioral Health Services
(13)	Family Planning Services and Supplies
(14)	Healthy Start Services

Table 2 Required MMA Services	
(15)	Hearing Services
(16)	Home Health Services and Nursing Care
(17)	Hospice Services
(18)	Hospital Services
(19)	Laboratory and Imaging Services
(20)	Medical Supplies, Equipment, Protheses and Orthoses
(21)	Optometric and Vision Services
(22)	Physician Assistant Services
(23)	Podiatric Services
(24)	Practitioner Services
(25)	Prescribed Drug Services
(26)	Renal Dialysis Services
(27)	Therapy Services
(28)	Transportation Services

d) Plan Readiness Review and Monitoring

During DY9, Agency staff moved from implementing the program to preparing operationally for the ongoing monitoring of the plans. During this fiscal year, the Agency began working with the External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to develop tools that will be used to monitor the MMA plans. Monitoring of the plans using these tools began in late spring of DY9. The Agency continues to work with HSAG to develop tools that will be used to centrally record the results of monitoring of the plans. The Agency continues to hold monthly calls in the form of an "All-Plan" call, and also holds weekly calls with each individual plan. As the Agency works to finalize the monitoring tools, the Agency will continue to monitor the plans on a daily basis and handle issues as they arise. Staff continue to analyze complaints as they come in to the Agency and work with each plan to ensure timely resolution of these issues. In certain instances (request from Headquarters, in response to complaints, etc.), the Agency will perform ad hoc on-site visits to a plan or a plan's subcontractor to ensure compliance with their contract. The Agency's two field-based plan management offices also continue to work on marketing and claims oversight activities and also provide a staff presence in the areas where most of the plans' offices are located. Lastly, during DY9, the Agency collected $1,635,539 in sanctions and liquidated damages as the result of compliance actions against the MMA plans for non-compliance with their contract.

e) Plan Reported Complaints, Grievances and Appeals

Plan Reported Complaints

Table 3 provides the number of MMA plan reported complaints for DY9.

Table 3 **MMA Plan Reported Complaints** (July 1, 2014 – June 30, 2015)	
Waiver Period	**Total**
July 1, 2014 – June 30, 2015	49,783

Grievances and Appeals

Table 4 provides the number of MMA grievances and appeals for DY9.

Table 4 **MMA Grievances and Appeals** (July 1, 2014 – June 30, 2015)		
Waiver Period	**Total Grievances**	**Total Appeals**
July 1, 2014 – June 30, 2015	17,669	8,574

Medicaid Fair Hearing (MFH)

Table 5 provides the number of MMA MFHs requested and held during DY9.

Table 5 **MMA MFHs Requested and Held** (July 1, 2014 – June 30, 2015)		
Waiver Period	**MFHs Requested**	**MFHs Held**
July 1, 2014 – June 30, 2015	1,237	193

Subscriber Assistance Program (SAP)

Table 6 provides the number of requests submitted to the SAP during DY9.

Table 6 **MMA SAP Requests** (July 1, 2014 – June 30, 2015)	
Waiver Period	**Total**
July 1, 2014 – June 30, 2015	19

f) Agency-Received Complaints/Issues

Table 7 provides the number of complaints/issues related to the MMA program that the Agency received during DY9.

Table 7 Agency-Received MMA Complaints/Issues (July 1, 2014 – June 30, 2015)	
Quarter	**Total**
July 1, 2014 – June 30, 2015	7,945

g) Medical Loss Ratio (MLR)

The majority of Reform capitated plans submitted their MLR reports to the Agency on or before the due date during DY9. For the first quarter report for DY9, two of the eleven Reform capitated plans reported an MLR under 85% for the reporting period October 1, 2013 through December 31, 2013. For the second quarter report for DY9, one of the eleven Reform capitated plans reported an MLR below 85% for the reporting period January 1, 2014 through March 31, 2014. For the third quarter report for DY9, all eleven Reform capitated plans reported an MLR above 85% for the reporting period April 1, 2014 through June 30, 2014, and all 12 Reform capitated plans reported an MLR above 85% for the annual period of July 1, 2013 through June 30, 2014. Additionally, all seventeen MMA plans reported an MLR above 85% for the reporting period July 1, 2014 through September 30, 2014, including resubmitted MLR reports.

For the fourth quarter report for DY9, all sixteen MMA plans reported an MLR above 85% for the period October 1, 2014 through December 31, 2014, including resubmitted MLR reports.

2. Choice Counseling Program

The following provides a summary for DY9 on choice counseling program activities for the call center, self-selection rate, and auto assignments.

a) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During DY9, the call center had an average of 295 full time equivalent employees who can answer calls in English, Spanish, and Haitian Creole.

The choice counseling call center received 1,223,482 calls during DY9, which remains within the anticipated call volume. Table 8 provides the call volume for DY9.

Table 8
Call Volume for Incoming and Outgoing Calls
(July 1, 2014 – June 30, 2015)

Type of Calls	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Incoming Calls	470,640	244,574	257,756	250,512	1,223,482
Outgoing Calls	10,087	8,243	19,713	23,983	62,026

b) Self-Selection and Auto Assignment Rates

From July 2014 through June 2015, 49.84% of recipients enrolled in the demonstration self-selected a MMA plan and 50.16% were auto-assigned. Table 9 provides the current self-selection and auto-assignment rate for DY9.

Table 9
Self-Selection and Auto-Assignment Rate*
(July 1, 2014 – June 30, 2015)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Self-Selected	559,183	291,161	257,018	276,766	1,384,128
Auto-Assignment	775,399	255,846	194,183	167,795	1,393,223
Total Enrollments	1,334,582	547,007	451,201	444,561	2,777,351
Self-Selected %	41.90%	53.22%	56.96%	62.25%	49.84%
Auto-Assignment %	58.10%	46.77%	43.03%	37.74%	50.16%

* The Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate,"* the data is referred to as *"New Eligible Self-Selection Rate."* The term *"self-selection"* is now used to refer to recipients who choose their own plan and the term *"assigned"* is now used for recipients who do not choose their own plan. As of February 17, 2014, the self-selection and auto-assignment rate includes the LTC and MMA populations.

3. Quality

The following provides a summary for DY9 on quality activities for the EQRO and plan performance measure reporting.

a) EQRO

Quarterly Meetings

On August 26, 2014, HSAG conducted an external quality review quarterly educational webinar for the MMA plans, the Agency, and the Department of Elder Affairs. Presentations were provided by the Agency on *Prescribing Psychotherapeutic Medication to Children: A History of Policy Development and Quality Improvement;* the Director of the Florida Perinatal Quality Collaborative on *Perinatal Quality Improvement Efforts in Florida;* and the Agency provided an update to the plans regarding Florida's requirements for performance measures.

On November 18, 2014, HSAG conducted an external quality review quarterly on-site meeting in Tallahassee. The presentations included: “What is Infant and Early Childhood Mental Health?”; “School-based Dental Sealant programs”; “Increasing Prenatal, Post-Partum and Well Child Visits within the Florida Medicaid Managed Care System”; “Successes in Asthma Management: Case Studies from Boston and North Carolina”; “A Patient Care Business: Communications that Make a Difference; and “Health Plan Report Card – Opportunity for Plans to Provide Feedback”.

On February 24, 2015, HSAG conducted an external quality review quarterly educational webinar. Presentations were provided by staff with CMS on *Developing an Effective Oral Health Performance Improvement Project*. In addition, presentations were provided by the Agency on *Florida’s State Oral Health Action Plan* and *The Event Notification Service.*

On May 12, 2015, HSAG conducted an external quality review quarterly educational on-site meeting in Tallahassee. Presentations were provided by the Florida Renal Administrators Association on *The Benefits of Home Dialysis*; the Department of Health presented on their *Asthma Learning and Action Network Opportunity*; and HSAG’s Performance Improvement Project (PIP) experts presented on *Intervention Determination Using Process Mapping and Failure Modes Effect Analysis*, followed by breakout sessions for the plans to work on *Process Mapping and Failure Modes Effect Analysis* for each plan’s Dental PIP. In addition, HSAG offered one-on-one technical assistance sessions with the plans related to their PIPs.

Validation of Performance Improvement Projects

On November 3, 2014, HSAG, submitted the draft PIP Validation Reports for each of the MMA plans to the Agency for validation year 2014 – 2015. On November 20, 2014, the Agency approved the reports. On December 8, 2014, HSAG forwarded the draft PIP Validation Reports to the plans for their review. On January 15, 2015, all PIP Validation Reports were approved, finalized and posted on HSAG’s File Transfer Protocol (FTP) site.

On May 26, 2015 HSAG submitted their Annual PIP Validation Summary Report to the Agency. The purpose of this report was to present the status and results for the PIPs submitted for validation by the Agency’s MMA plans. Since the MMA program was phased in during 2013 and 2014, all PIPs validated by HSAG for state fiscal year (SFY) 2014 – 2015 had progressed through the Design Stage (Activities I-VI) only.

Validation of Performance Measures

On October 17, 2014, HSAG, submitted the Performance Measure Validation Findings Report to the Agency for calendar year 2013 data.

Deemed Compliance Crosswalk

During SFY 2014 – 2015, the Agency contracted with HSAG, for a Deemed Compliance Crosswalk Project. The Agency directed HSAG to review the MMA plans’ accreditation results and complete a deemed compliance crosswalk indicating which federal managed care standards could potentially be deemed. In addition, HSAG was asked to provide the Agency with recommendations for non-duplication deeming. The crosswalk and recommendations document was submitted to the Agency on June 8, 2015.

Encounter Data Validation

Beginning in SFY 2013 – 2014, the Agency contracted with HSAG, to conduct an annual encounter data validation study. The goal of this annual study is to examine the extent to which encounters submitted to the Agency by its contracted MMA plans are complete and accurate. SFY 2014 - 2015 was the second year of a five year contract with HSAG that included the completion of an encounter data validation study. The SFY 2014 – 2015 Encounter Data Validation Study Aggregate Report was submitted to the Agency on June 12, 2015.

Focused Study

During SFY 2014 – 2015, the Agency contracted with HSAG, to conduct a Focused Study on Cultural Competencies with the goal of assisting the Agency and its MMA plans in identifying areas and strategies for improvement. HSAG completed a review and analysis of each plan's cultural competency plan and each plan's evaluation of its cultural competency plan. The primary objective of this review was to provide information to the Agency regarding each plan's state and federal compliance, and consistency with National Culturally and Linguistically Appropriate Services (CLAS) standards in the area of cultural competency. On April 10, 2015, HSAG submitted their Cultural Competency Focused Study Report to the Agency. In addition, HSAG worked with the Agency to assist in the selection of Cultural Competency-Related Supplemental Items for inclusion in the CAHPS® 5.0 Florida Medicaid Health Plan Surveys to be administered by the plans. Based on this project, the Agency identified four supplemental items for possible inclusion in the plans' CAHPS® surveys, beginning July 2016.

Annual Technical Report

On February 24, 2015, HSAG, submitted *the SFY 2013 – 2014 Annual Technical Report of External Quality Review Results* to the Agency. This Annual Technical Report was approved by the Agency on March 25, 2015. The Agency submitted the report to CMS on March 30, 2015, and posted this report on the Agency's Web site.

Pharmacy Encounter Data Validation Study

During SFY 2014 – 2015, the Agency contracted with HSAG, to conduct a pharmacy-based encounter data validation special study in support of the Agency's prescription drug rebate program. The purpose of this study was to examine the extent to which pharmacy encounters submitted to the Agency by its contracted MMA plans are an accurate reflection of the prescription data processed, collected and maintained within the prescription drug processing system. On August 11, 2014, HSAG submitted the *Pharmacy Encounter Data Validation Questionnaire Results Report* to the Agency. This report focused on the investigation and assessment of the different pharmacy encounter data transmission policies and procedures existing for and between each of the selected process agents in the prescription drug rebate system. On September 29, 2014, HSAG submitted the *Phase 1 Comparative Analysis Summary Findings Report* to the Agency. This report focused on the accuracy and completeness of pharmacy encounter data, and provided recommendations to the Agency on how to improve the overall quality of its pharmacy encounter data. On February 26, 2015, HSAG submitted the *Remittance Advice Analysis Results for Retail Pharmacies* report to the Agency. This final deliverable for this special pharmacy encounter data study focused on payment accuracy and agreement of remittance advice forms between retail pharmacies and encounter data.

b) Plan Performance Measure Reporting

During the first quarter of DY9, the Agency updated the Performance Measure Specifications Manuals for July 1, 2015 reporting for MMA plans. Agency staff sent these manuals to the plans at the end of August 2014, along with a Frequently Asked Questions document related to performance measure reporting.

During the first quarter, the Agency also received the seventh year of performance measure submissions from the plans which measure a time period, prior to MMA implementation. Results of the seventh year of performance measures (representing calendar year (CY) 2013, a pre-MMA time period) may be viewed in Attachments III and IV of this report. Attachment III is a table of the demonstration plans' performance measure rates for CY's 2007 through 2013, reported July 1st, 2014. Attachment IV is a table comparing the weighted mean rates for performance measures for the demonstration and non-demonstration plans. Highlights of the seventh year of performance measures include:

- Of the 42 Healthcare Effectiveness Data and Information Set (HEDIS) measure rates included in Attachments III and IV, the statewide average results for the demonstration plans improved for 10 of the measures compared to the previous year.

- Demonstration plans' rates for 31 of the measures stayed about the same (within less than two percentage points of the previous year's rate), while their performance on one measure dropped.

- For 10 of the 42 measures, the statewide weighted average results for the demonstration plans were at least two percentage points higher than the average results for the non-demonstration plans. For 25 of the measures, the demonstration plans' and non-demonstration plans' weighted average rates had differences of less than two percentage points.

- Performance measures with notable improvement include:

    - Controlling Blood Pressure: the statewide weighted average for demonstration plans increased from 45.4% in CY 2012 to 49.0% in CY 2013.
    - Adults' Access to Preventive Care – 20-44 years: the statewide weighted average for demonstration plans increased from 69.2% in CY 2012 to 75.9% in CY 2013.
    - Breast Cancer Screening: the statewide weighted average for demonstration plans increased from 52.5% in CY 2012 to 56.0% in CY 2013.
    - Adult BMI Assessment: the statewide weighted average for demonstration plans increased from 63.0% in CY 2012 to 77.0% in CY 2013.
    - Immunizations for Adolescents – Combo 1: the statewide weighted average for demonstration plans increased from 54.6% in CY 2012 to 63.0% in CY 2013.

- Other measures that had notable improvement in the past stayed relatively flat from CY 2012 to CY 2013, but their CY 2013 rates remain high above the plans' rates in earlier years.

    - Annual Dental Visit: the statewide weighted average for demonstration plans increased from 35.3% in CY 2011 to 40.4% in CY 2012, then increased to 42.3% in CY 2013.

- Appropriate Testing for Children with Pharyngitis: the statewide weighted average for demonstration plans increased from 64.0% in CY 2011 to 67.7% in CY 2012, then increased to 69.0% in CY 2013.
- Lead Screening in Children: the statewide weighted average for demonstration plans increased from 59.6% in CY 2011 to 61.7% in CY 2012, and to 63.2% in CY 2013.
- Frequency of Prenatal Care: the statewide weighted average for demonstration plans increased from 44% in CY 2010 to 54.4% in CY 2011, then decreased slightly to 53.7% in CY 2012 and remained there in CY 2013.

During the first and second quarters of DY9, Agency staff compared the plans' HEDIS performance measure rates for CY 2013 to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance (NCQA) for HEDIS 2013). These comparisons were used to assign performance measure category and individual performance measure ratings to each MMA plan for the Health Plan Report Card. These comparisons were also used to determine any liquidated damages related to performance measures.

During the second quarter of DY9, Agency staff prepared a communication to the MMA plans that clarified some performance measure reporting requirements for the report due July 1, 2015 (representing CY 2014). This communication went out to plans during the third quarter of DY9. Agency staff also revised the report guide instructions for the CMS-416/ CHCUP Report to mirror the revisions released by CMS in November 2014. A policy transmittal with the revised instructions was sent to the MMA plans in January 2015. The plans submitted their CHCUP reports to the Agency in late February 2015 and Agency staff reviewed the results and determined applicable liquidated damages.

During the third quarter of DY9, the Florida Medicaid Health Plan Report Card was posted on the Agency's Florida Health Finder web site at the following link: http://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5 .

During the fourth quarter of DY9, Agency staff made revisions to the Performance Measure Report template and made it available to the plans in May. Agency staff also responded to inquiries from the MMA plans and their NCQA-certified HEDIS auditors. The Performance Measure Report covering calendar/measurement year 2014 was due to the Agency by July 1, 2015.

c) Comprehensive Quality Strategy

During the first quarter of DY9, Agency staff made updates to the Comprehensive Quality Strategy and posted it on the Agency's internet site for public review and comment. The Comprehensive Quality Strategy was discussed at the September 2014 Medical Care Advisory Committee (MCAC) meeting and feedback was gathered from the MCAC subcommittees. The Agency staff compiled and reviewed all the feedback and comments that were received regarding the Comprehensive Quality Strategy during the second quarter of DY9. The Agency submitted the draft updated Comprehensive Quality Strategy to CMS at the end of October 2014.

d) Assessing Enrollee Satisfaction

During the first quarter of DY9, the Reform Demonstration evaluators submitted the draft final evaluation summary report to the Agency, which included enrollee satisfaction results over the course of the Reform demonstration, as measured through the CAHPS Survey. The report was submitted to CMS during the second quarter of DY9.

Under the MMA program, the MMA plans are required to contract with an NCQA-certified CAHPS Survey Vendor to conduct their CAHPS Surveys for Children and Adults on an annual basis. During the second quarter of DY9, Agency staff reviewed and approved the MMA plans' Enrollee Survey Proposals. During the second and third quarters, Agency staff reviewed and approved the MMA plans' survey materials. Between February and May 2015, the plans' survey vendors completed the CAHPS Health Plan 5.0 Survey for the plans. The results of the surveys were due to the Agency by July 1, 2015.

4. Policy and Administrative Issues

The Agency continues to identify and resolve various operational issues for the MMA plans. The Agency's internal and external communication processes play a key role in managing and resolving issues effectively and efficiently. These processes provide an opportunity for discussion and feedback on proposed changes, and often result in policy clarifications in the form of "Dear Managed Care Plan" informational letters, contract interpretations, and policy transmittals which are sent to the MMA plans.

During DY9, the Agency continued its initiatives on program and process improvement. Monthly conference calls were held with MMA plans to notify the plans of upcoming changes, and to obtain input from the plans regarding the changes.

a) Agency Communications to MMA Plans

During DY9, there were twelve contract interpretations, seventeen policy transmittals, and one "Dear Managed Care Plan" letter sent to the MMA plans.

- The twelve contract interpretations provided clarification to MMA plans on the following topics: Healthy Behaviors program requirements; the process for enrolling a newborn recipient when the mother is enrolled in a specialty plan; the provision of NET to Florida Medicaid-covered services provided to MMA enrollees; the PCP requirements for full benefit dual eligible enrollees; the primary payer of expanded benefits when the benefit is offered by both the LTC plan and the MMA plan; the provision of newborn hearing screening services

and the newborn screening services covered under the MMA contract; an exception regarding the use of authorization forms specified in the Specialized Therapeutic Services Coverage and Limitations Handbook; which drugs MMA plans may reimburse in addition to those listed on the Agency's Florida Medicaid Preferred Drug List (PDL); the MMA plan's responsibility to ensure that PASRR is completed prior to the enrollee's admission into a nursing facility; MMA plan medical/case record review requirements specific to PCP sites and MMA plan responsibilities related to submission of the written strategy for conducting medical/case record reviews; MMA plan claims payment provisions; and requirements for submission of the CAHPS survey vendor's final report to the Agency with an action plan to address the results of the survey by October 1, 2015.

- The seventeen policy transmittals advised MMA plans of the following topics: a change in date of the first submission of the first HSA Survey Report; a change in the submission requirements for the operative report and claim documentation for transplant kick payments; the application of the MPPR policy implemented by CMS to selected therapy services provided to Medicare beneficiaries and reimbursed under the MPFS and that plans are not required to apply MPPR to Florida Medicaid-covered services; a new ad hoc report requirement regarding the ASR Financial Report; a new ad hoc report requirement related to reporting plan performance on enrollee and provider help line standards; the reporting of procedure codes used to reimburse for tobacco cessation counseling for pregnant women; the Agency-prescribed Notice of Action template and instructions for implementation of the template; the Freedom of Choice Certification for SMMC program form and instructions for use; ad hoc request for financial reporting policies and procedures; ad hoc report requirement regarding the provider network for Statewide Inpatient Psychiatric program services; ad hoc report requirement regarding the ASR Financial Report; notification of an audit regarding payments made under the Affordable Care Act Primary Care Services Rate increase; instructions for completing CHCUP (Form CMS-416) and FL 80% Screening Report; ad hoc report requirement regarding the ASR Financial Report for the period of January 1 – December 31, 2014; ad hoc report requirement regarding the ASR Financial Report for the period of January 1 – March 31, 2015; ad hoc report requirement for current transition of care policies and procedures; ad hoc report requirement regarding CMS CSF's Provider Testing Results Report; and a change in frequency for the Emergency Room (ER) Visits for enrollees without PCP Appointment Report.

- The "Dear Managed Care Plan" letter informed MMA plans of the following topic: reminded MMA plans that they may contract directly with providers who render services using telemedicine for medical, behavioral health and dental services, if it provides value to plan enrollees, and that services must be provided in accordance with the contractual requirements and any state and federal regulations for services rendered using telemedicine.

5. Healthy Behaviors Program

a) *Healthy Behaviors Programs*

Each of the 18 MMA plans were required to submit three Healthy Behavior programs that addressed smoking cessation, weight loss, and alcohol or substance abuse. There were a total of 89 Healthy Behavior programs submitted by the plans that were approved by the Agency in 2014 for implementation January 1, 2015. Since the Healthy Behaviors programs were not

implemented until January 1, 2015, the data provided is only reflective of the third and fourth quarter for DY9 (July 1, 2014 – June 30, 2015).

Attachment VI of this report, Healthy Behaviors program Enrollment, provides the data collected by the plans for each of their Healthy Behaviors programs for DY9. The available Healthy Behaviors programs incorporate evidenced-based practices and are medically approved and/or directed. The Healthy Behaviors programs are voluntary programs and require written consent from each participant prior to enrollment into the program.

b) Enhanced Benefits Account Program

Attachment V of this report, Enhanced Benefits Account (EBA) program, provides the final update on the EBA program activities for the call center, EBA credits used and notices mailed informing recipients of program termination.

The EBA program was terminated June 30, 2014. Recipients in counties that transitioned from Florida Medicaid Reform to MMA continued to have access to their accrued credits under the EBA program until June 30, 2015.

6. Post Award Forum

The Agency held its annual Post Award Forum, which afforded the public an opportunity to provide meaningful comment on the progress of the Managed Medical Assistance (MMA) Program, on September 23, 2014. A summary of comments received during the Post Award Forum can be found in the second MMA quarterly report for demonstration year 9. The report can be found at the following link:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

III. Low Income Pool

One of the fundamental elements of the demonstration is the Low Income Pool (LIP) program. The LIP program was established and maintained by the State to provide government support to safety net providers in the State for the purpose of providing coverage to the Florida Medicaid, underinsured, and uninsured populations. The LIP program is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low-income populations, as well as increase access for select services for uninsured individuals.

1. LIP Council Meetings

During DY9, the Agency held no LIP Council meetings. Per Florida Statute 409.911, the LIP Council has sunset effective October 1, 2014.

2. LIP STCs - Reporting Requirements

The following provides a summary for LIP STCs that required action during DY9 in accordance with the DY8 STCs:

STC #84d – LIP Tier-One Milestones

This STC requires the submission of an annual *Milestone Statistics and Findings Report* and an annual *Primary Care and Alternative Delivery Systems Report*, which provide a summary of LIP payments received by hospital and non-hospital providers, the number and types of services provided, the number of recipients served, the number of service encounters, and also provides information relevant to the research questions associated with domain v of the 1115 MMA Waiver.

- The Agency submitted the annual *Primary Care and Alternative Delivery Systems Report* for DY8 to CMS on February 16, 2015.

- On March 16, 2015, the Agency submitted the encounter data to the University of Florida for the completion of the annual *Milestone Statistics and Findings Report* for DY8.

- The Agency submitted the annual Milestone Statistics and Findings Report for DY8 to CMS on May 1, 2015.

STC #85 – LIP Tier-Two Milestones

This STC requires the top 15 hospitals receiving LIP funds to choose three initiatives that follow the guidelines of the Three-Part Aim. These hospitals must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served. The three initiatives should focus on: infrastructure development; innovation and redesign; and population-focused improvement.

- On July 22, 2014, the Agency collected the fourth quarter reporting (last required submission) for SFY 2013-14 for the 44 hospital initiatives.

The following provides a summary for DY9 LIP STCs that required action:

STC #70 – Section XXI Schedule of State Deliverables

This STC requires the submission of a schedule for the LIP reconciliations for DYs 1-9 within 60 days of the acceptance of the STCs.

- On September 29, 2014, the Agency submitted the schedule for the LIP reconciliations for DYs 1-9 to CMS.

STC #70a – LIP Reimbursement and Funding Methodology Document (RFMD)

This STC requires the submission of a draft RFMD for CMS approval by September 29, 2014, that incorporates a cost review protocol that employs a modified Disproportionate Share Hospital (DSH) survey tool to report additional cost for the underinsured, and that includes cost documentation standards for new LIP provider types in DY9.

- On September 29, 2014, the Agency submitted the draft RFMD for DY9 to CMS. Once the report is approved it can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml
- On March 19, 2015, the Agency submitted the updated RFMD for DY9.
- On May 27, 2015 the Agency submitted the DY7 LIP Cost Limit Report to CMS.

STC #78 – LIP Provider Participation Requirements

Provider access systems (hospitals, County Health Departments, and Federally Qualified Health Centers) and Medical School Physician Practices who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds. The State may grant an exemption to a hospital of the requirement in (a)(ii) upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.

- On October 1, 2014, the LIP providers were required to meet the first LIP Participation Requirement Milestone in order to receive second quarter distributions.
- On January 30, 2015, the LIP providers were required to meet the second LIP Participation Requirement Milestone in order to receive third quarter distributions.
- On March 31, 2015, the LIP providers were required to meet the third LIP Participation Requirement Milestone in order to receive fourth quarter distributions.
- The LIP participation requirements have been met and the qualified LIP participants have been fully funded.

STC #79d – LIP Tier-One Milestones

This STC requires the submission of anticipated timelines for an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report" within 60 days following the acceptance of the terms and conditions.

- On September 29, 2014, the Agency submitted to CMS the anticipated timelines for the two annual reports.

IV. Demonstration Goals

The following provides an update for this waiver period on the five demonstration goals.

Objective 1(a): To ensure that there is access to services not previously covered.

For DY9, most plans offered expanded benefits that were not previously covered under the Florida Medicaid State Plan. Freedom Health and Children's Medical Services Network (CMSN) Plan do not offer expanded benefits. Please refer to Attachment I of this report, Expanded Benefits under the MMA program, for the expanded benefits under the MMA program by plan.

Objective 1(b): To ensure that there is improved access to specialists.

Each plan is required to provide documentation to the Agency to demonstrate contractual arrangements for a network of providers (including specialists) that will guarantee access to care for recipients. As Year One of the demonstration ended, the Agency completed the first intensive comparative analysis of the plans' provider network files to evaluate the effectiveness of the demonstration in improving access to specialists.

During the second quarter of DY2, the Agency began additional analysis of provider networks among the Florida Medicaid plans, including each demonstration plan. Beginning in October 2007, the Agency directed all Florida Medicaid MMA plans to update their web-based and paper provider directories, and to certify the provider network files submitted to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files were required to note any restrictions to recipient access (e.g., if the provider accepts only current patients, if they treat only children/women, etc.).

Specialties identified by the Agency as areas of potential concern regarding access to care were subject to focused reviews of provider network files and provider surveys in DY2 through DY5. Results of these reviews and surveys were provided in earlier quarterly and annual reports.

Initiated in DY6, the Agency reviewed and refined methodologies for analyzing access to care in order to establish baselines and for identifying opportunities for managed care plans' performance improvements. Encounter data improvements intended to enhance these analyses are ongoing, but recent improvements can be attributed to two factors: (1) Increase in volume of encounter data in the database; and (2) Improvement in filtering and stratifying data to target demonstration plan enrollees.

In DY6 and DY7, the Agency began developing additional ways to analyze plan encounter data in order to assess health care access. The most recent analyses focused on three types of specialty care: orthopedics, neurology and dermatology. These analyses use encounter data to target the number of recipients receiving these specialty services in demonstration counties (measured as recipient utilization per 1,000 eligible recipients).

Attachment II of this report provides charts that demonstrate improving accessibility to orthopedic, neurology and dermatology services for Florida Medicaid recipients statewide and in the Reform demonstration counties over time, for SFY 2011-12, SFY 2012-13 and SFY 2013-14.

DY9 analysis concludes reporting on the Reform demonstration counties identified in Attachment II "Improved Access to Specialists."

The Agency is researching types of specialties on which to report, as well as various tools to utilize for measuring provider access improvements for future reports.

Objective 2(a): To improve enrollee outcomes as demonstrated by improvement in the overall health status of enrollees for select health indicators.

Performance measures for the MMA program are discussed in Section 2, Subsection 3.b), Plan Performance Measure Reporting, of this report.

Objective 2(b): To improve enrollee outcomes as demonstrated by reduction in ambulatory sensitive hospitalizations.

The Agency will be running its model quarterly to analyze the utilization of Ambulatory Care Sensitive Conditions (ACSCs) using quality indicators (QI) from the Agency for Healthcare Research and Quality. The Agency estimates it will be able to produce this report in the first quarter of DY10 due to the amount of time the MMA plans have been active. The Agency needs at least a year of enrollment and encounter data to provide a baseline for this model. Using this model, the Agency will analyze the prevalence of ACSCs that lead to potentially preventable hospitalizations. Aggregation of utilization data across multiple fee-for-service and MMA delivery systems will enable a comparison by county or by MMA plan. The reports will include morbidity scoring for risk adjustment (Chronic Illness and Disability Payment System/MedRx hybrid model), utilization PMPM (normalized to report per 1,000 recipients), and distribution by category of the QIs at the statewide level (including fee-for-service and managed care), as well as for each MMA plan. The model will be updated to support the latest version (4.5a) provided by Agency for Healthcare Research and Quality.

The Agency is assessing other models like the 3M™ Preventable suite of tools, and is assessing the requirements for data elements. The 3M™ Software has programs for measuring quality indicators and may be used for the utilization analysis in the near future.

Objective 2(c): To improve enrollee outcomes as demonstrated by decreased utilization of emergency room care.

The Agency will use a model based on the New York University emergency department (ED) algorithm to analyze the utilization of EDs. The Agency estimates it will be able to produce this report in the first quarter of DY10 due to the amount of time the MMA plans have been active. The Agency needs at least a year of enrollment and encounter data to provide a baseline for this model.

This model will be set up to process and compare results between fee-for-service recipients and managed care enrollees. These reports will also include a volumetric with morbidity scoring (Chronic Illness and Disability Payment System /MedRx hybrid model), PMPM (per 1,000 recipients), and distributions by ED utilization category at the statewide (fee-for-service and managed care) and plan-specific levels, as well as for the MMA plan groups. Portions of the report will be designed to show county comparisons based on utilization by managed care eligible recipients, or according to MMA plan member utilization. The model will support the latest version (2.0) provided by New York University.

The algorithm developed by New York University is used to identify conditions for which an emergency department visit may have been avoided, either through earlier primary care intervention or through access to non-ED care settings.

The Agency is assessing other models like the 3M™ Preventable suite of tools, and is assessing the requirements for data elements. The 3M™ Software has programs for measuring quality indicators and may be used for the utilization analysis in the near future.

Objective 3: To ensure that enrollee satisfaction increases.

Refer to Section 2, Subsection 3.d) of this report, Assessing Enrollee Satisfaction, for details regarding the enrollee satisfaction surveys.

Objective 4: To evaluate the impact of the low income pool (LIP) on increased access for uninsured individuals.

STC #84 – Tier-One Milestone

As reported under this STC, both the *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report* will show the increased access to medical care for the uninsured population in Florida. Both reports can be viewed on the Agency's Low Income Pool website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml. Please refer to Section VII, Evaluation of the Demonstration, of this report for an update on key findings and accomplishments from both *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report*.

STC #85 – Tier-Two Milestone

This STC requires that the top 15 LIP hospitals, which are allocated the largest annual amounts in LIP funding, participate in initiatives that broadly drive from the three overarching goals of CMS' Three-Part Aim. These initiatives focus on the following: infrastructure development; innovation and redesign; and population focused improvement.

Please refer to Section VII, Evaluation of the Demonstration, of this report for an update on key findings from the Evaluation Report of Domains v-ix for DY9 activities related to the LIP Tier-One and Tier-Two Milestone quality initiatives.

V. Monitoring Budget Neutrality

In accordance with the requirements of the approved Florida MMA Waiver, the State 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 waiver.

Updated Budget Neutrality

Budget Neutrality figures included in Attachment VIII of this report are through June 30, 2015 of DY9. The 1115 MMA Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For MMA, the case months and expenditures reported are for enrolled mandatory and voluntary individuals.

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by STC #88, is monitored using data based on date of service. Per-Member Per-Month PMPM) and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency will track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year. The current CMS 64 reporting methodology will continue through the implementation of the MMA program.

Please refer to Attachment VIII of this report for an update on Budget Neutrality figures through June 30, 2015 of DY9.

VI. Encounter and Utilization Data

1. Encounter Data

During DY9, the Agency continued reviewing and refining the methodologies for editing, processing and extracting encounter data. Multiple system modifications were implemented to improve the acceptance and quality of encounter data.

The Agency and its fiscal agent provided routine outreach and on-site visits with the MMA plans to discuss specific technical and policy issues related to encounter data. Through these outreach efforts, the plans and the Agency made significant progress in resolving encounter data issues and educating the plans on accurate completion of the encounter transactions.

Additionally, the Agency coordinated with its fiscal agent to produce accuracy and timeliness reports on original and resubmitted encounters. These reports are now produced using the Medicaid Management Information System (MMIS) and are available to report compliance of the MMA plans. The reports are distributed to the plans on a weekly and monthly basis.

The Agency continues to work toward additional system enhancements and reporting features through projects involving business and information technology staff.

The Agency has contracted with HSAG as its EQRO vendor since 2006. Beginning on July 1, 2013, the Agency's new contract with HSAG required that the EQRO conduct an annual encounter-type focused validation, using protocol consistent with the CMS protocol, "Validation of Encounter Data Reported by the Managed Care Organization." HSAG has worked closely with the Agency to design an encounter data validation process to examine the extent to which encounters submitted to the Agency by its contracted MMA plans are complete and accurate. HSAG also completed a pharmacy based encounter data validation special study. Please refer to the Section II, Subsection 3 of this report for more information on these performance measuring reports.

2. Rate Setting/Risk Adjustment

During DY9, the MMA program was implemented statewide. The rate setting process currently uses all encounter data submitted by the MMA plans.

During the first quarter of DY9, the Agency implemented a new validation process for MMA risk adjustment. Every quarter, the MMA plans receive twelve service months of Pharmacy and non-pharmacy encounter data for them to validate their encounters. The plans were given a month to review their data, and submit corrections, as needed through the standard FMMIS reporting process. Pharmacy and non-pharmacy fee-for-service, encounter, and behavioral health data for twelve service months were provided to the Agency's actuaries in order to generate risk scores using the CDPS/MedRx hybrid model (Chronic Illness & Disability Payment System +RX).

VII. Evaluation of the Demonstration

The evaluation of the demonstration is an ongoing process to be conducted during the life of the demonstration. The Agency is required under STCs #110 – 113 to complete an evaluation design that includes a discussion of the goals, objectives and specific hypotheses that are being tested to determine the impact of the demonstration during the period of approval. On April 21, 2015, the Agency submitted a response to CMS' comments regarding the draft evaluation design update for the waiver period 2014-2017.

Evaluation Design

STC 110 requires that the Agency submit to CMS for approval a Draft Evaluation Design update for the MMA program that builds and improves on the Final Evaluation Design that was approved on December 31, 2014. The Agency submitted a revised MMA evaluation design for the waiver period July 1, 2014 through June 30, 2017 to CMS on January 30, 2015. The Agency received comments from CMS in February 2015 and responded to those comments on April 21, 2015.

Reports and Findings during DY9

Draft Final Evaluation Report of the Florida Medicaid Reform Section 1115 Demonstration:

The Agency submitted the "Draft Final Evaluation Report of the Florida Medicaid Reform Section 1115 Demonstration" to CMS in October 2014. The draft final evaluation report includes a description of the Demonstration program as well as a description of the various components of the evaluation. The draft report presents evaluation findings regarding: enrollees' experiences with the Demonstration overall, the impact of the Demonstration on access to and quality of care, the impact of the EBA program, the impact of the Demonstration as a deterrent against Florida Medicaid fraud and abuse, the fiscal impact of the Demonstration, and the LIP. Key findings described in the evaluation report include:

- Overall, respondent self-reports indicate that enrollees in the Reform counties perceive services to be accessible. There were increases across several access measures in both Reform and Non-Reform counties between DY6 and DY8. In general, changes, whether increases or decreases, were not statistically significant.
- To some extent, there appear to be improvements in respondent self-report of obtaining health services. Over time, there was a significant increase in the percentage of enrollees having a personal doctor in urban Reform counties. Moreover, there was a statistically significant increase over time in the percentage of enrollees who saw a doctor for non-urgent care one to three times in the previous six months and a decrease in the percentage of enrollees with four or more non-urgent visits.
- The quality of care that enrollees receive has improved during the Demonstration for 10 of 12 HEDIS chronic disease measures. The measures that declined had minimal average annual decreases.
- CAHPS results indicate that in the urban Reform counties, there was a significant increase over time in enrollees reporting the highest level rating for their plans. Increases in other measures were not statistically significant.

- There is indication that there might be some improvement in the reports of being able to access care in a timely manner in the urban counties, where there was a statistically significant increase over time in the percentage of enrollees who were "Always" able to get urgent and non-urgent care as soon as they wanted. From DY6 to DY8 in Reform counties, there was a significant increase in the percentage of enrollees who reported "Always" getting urgent care right away and getting an appointment as soon as they needed.
- Overall, PMPM expenditures were greater in the Reform counties compared to the Control counties for Supplemental Security Income (SSI) enrollees. However, for SSI enrollees, the rate of growth was lower in the Reform counties relative to the Control counties, suggesting that the Reform counties will achieve savings over time if the current trend continues in the future.
- During DY2 – DY7, $63,820,095 in EBA credits were earned by enrollees, and 60% of the earned credits were spent on eligible purchases.
- Within the MMA programs, a variety of internal policies and procedures were identified related to detecting and deterring fraud and abuse. Overall, there was general agreement that data analysis and the use of pre-payment and post-payment fraud detection tools were the most effective methods for both prevention and detection. The use of fraud detection software is increasing both within plans and by the Agency itself.

Primary Care and Alternative Delivery Systems Expenditures Report for DY8 (2013-2014)

The "Primary Care and Alternative Delivery Systems Expenditures Report for DY8 (2013-2014)" was submitted to CMS in February 2015. This report is required as part of the LIP Tier-One Milestones in the STCs, and summarizes how new primary care projects or enhancements to existing primary care projects receiving LIP funds are meeting the intended goals of the program. While this report is not technically an evaluation report, it does summarize data and information to be used for answering some of the domain v-ix research questions related to the impact of the Tier-One milestone initiatives on access to care, quality of care, and the cost-effectiveness of care.

Per the STCs, Florida allocated $50 million in LIP funding in DY7 and DY8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. The initiatives were required to drive from the three overarching goals of CMS' Three-Part Aim.

i. Better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,

iii. Reducing per-capita costs.

This report is largely descriptive of the 30 projects that were funded. Key findings for the DY8 period include:

- Recipients served by the programs/projects included adults and children who were uninsured, underinsured, low income, Florida Medicaid eligible, and the homeless.
- Some programs/projects focused on specific groups of recipients, including pregnant

women and individuals with a particular chronic condition (such as heart failure, diabetes, or chronic obstructive pulmonary disease).

- Fifteen of the projects provided obstetrical and gynecological services.
- Four of the projects were Readmission Reduction programs, aimed at reducing the number of avoidable emergency department and inpatient visits by providing education, care coordination, and support services to patients who had recently been hospitalized for cardiovascular or pulmonary conditions.
- Four of the projects were Specialty Care Coordination programs aimed at providing care coordination services including follow-up, transportation, home health, patient education, laboratory and/or diagnostic testing, and disease management services to individuals with heart failure (acute myocardial infarction or congestive heart failure), chronic obstructive pulmonary disease, community-acquired pneumonia, or asthma.
- Providers of the projects reported the following figures regarding numbers of recipients served and associated costs:
    - Approximately 76,600 recipients were served through these projects in DY8. The maximum number of recipients served by a single project was approximately 20,300 individuals.
    - The amount spent per recipient ranged from $50 to $5,274. The average amount spent by reporting projects was $1,030 per recipient.

The Agency will submit the "Primary Care and Alternative Delivery Systems Expenditures Report for DY9 (2014-2015)" to CMS in 2016.

Low Income Pool Milestone Statistics and Findings Report for DY8: SFY 2013-14

The "LIP Milestone Statistics and Findings Report for DY8: SFY 2013-14" was submitted to CMS in May 2015. The report identified that in SFY 2013-2014, the LIP program included the following categories of providers and programs: primary care hospitals; rural hospitals; safety-net hospitals; hospital Provider Access System (PAS); hospitals that operate poison control centers; specialty pediatric hospitals; hospitals with designated trauma centers; primary care project awards; quality awards; and LIP-Other, which includes designated premium assistance programs, Federally Qualified Health Centers (FQHCs), County Health Initiatives as performed by County Health Departments (CHDs), and Rural Health Networks. The following is a summary of key findings:

- For all providers, total LIP payments were approximately $991.0 million, a decrease of $5.0 million from DY7: SFY 2012–13.
- Reporting hospitals receiving LIP supplemental payments served approximately 3.7 million Florida Medicaid, uninsured, and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served approximately 1.3 million Florida Medicaid, uninsured, and underinsured individuals.
- Reporting hospitals provided approximately 617,000 inpatient services and approximately 3.1 million outpatient services to Florida Medicaid, uninsured, and underinsured individuals.
- 108 hospitals that received LIP supplemental payments reported providing approximately

13.7 million service encounters to Florida Medicaid, uninsured, and underinsured individuals across six service categories.

- For all categories of encounters, 68 reporting non-hospital providers receiving LIP payments provided approximately 7.6 million encounters for specific services to Florida Medicaid, uninsured, and underinsured individuals.

- The Tier-Two Top 15 Hospitals provided inpatient and outpatient services to approximately 161,400 Florida Medicaid recipients and to 838,700 to uninsured or underinsured individuals.

The Agency will submit the "LIP Milestone Statistics and Findings Report for DY9: SFY 2014-15" CMS in 2016.

Status of Contracting with an independent evaluator

- The Agency sent an email to public state universities seeking an independent evaluator for the MMA 1115 waiver on January 16, 2015.

- The Agency received project proposals from interested universities on February 23, 2015.

- Agency staff reviewed the project proposals during March 2015 and made a recommendation to Agency management in April 2015 regarding with which university the Agency will work to initiate a contract for the evaluation.

- Agency staff held conference calls and follow-up emails with the selected university to obtain clarification during the months of April, May and June 2015.

- Agency staff created a draft scope of services for the evaluation contract, utilizing the maximum budget allocated for this work.

VIII. Waiver Amendment Request

During DY9 the Agency submitted three (3) amendment requests to CMS. Detailed information on each amendment request can be found at the following link: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_archive.shtml

1. November 24, 2014 Amendment Request

The waiver amendment requested authority to allow for Florida Medicaid-eligible recipients residing in group home facilities licensed under section (s.) 393.067, Florida Statutes (F.S.), as well as Florida Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services to voluntarily enroll in Florida's MMA program.

A summary of the amendment request, public notice document and comment period can be found on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver.shtml

2. May 4, 2015 Waiver Amendment Request

The waiver amendment requested federal authority to assign Florida Medicaid-eligible individuals who are mandated to participate in Florida's MMA program, to a MMA plan immediately after eligibility determination.

A summary of the waiver amendment request, public notice document, and comment period can be found on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2015-03.shtml

3. May 26, 2015 Waiver Amendment Request

The waiver amendment requested to amend Florida's 1115 MMA Waiver to redesign elements of the LIP and extend the program until June 30, 2017. The newly redesigned LIP ensures access to care for low income populations that are not eligible to participate in Florida Medicaid or other subsidized coverage programs and complements the MMA program by strengthening connections between critical safety net providers and the MMA program

A summary of the waiver amendment request, public notice document and comment period can be found on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2015-04.shtml

Attachment I
Expanded Benefits under the MMA program

Expanded benefits are those services or benefits not otherwise covered in the MMA program's list of required services, or that exceed limits outlined in the Florida Medicaid State Plan and the Florida Medicaid coverage and limitations handbooks and fee schedules. The MMA plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA plans, upon approval by the Agency. The MMA plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the Agency. Table 1 of Attachment I lists the expanded benefits approved by the Agency that are being offered by the MMA standard plans in 2015.

Table 1
Expanded Benefits Offered by MMA Standard Plans

Expanded Benefits	MMA Standard Plans													
	Amerigroup	Better Health	Coventry	First Coast*	Humana	Integral	Molina	Preferred	Prestige	SFCCN	Simply	Staywell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y			Y		Y					Y	Y		Y
Equine therapy											Y			
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y		Y	Y	Y		
Newborn circumcisions	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y		Y	Y		Y	Y		Y	Y	Y		Y
Outpatient hospital services (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Pet therapy				Y		Y					Y			
Physician home visits	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Post-discharge meals	Y	Y		Y	Y	Y	Y			Y	Y	Y	Y	Y
Prenatal/perinatal visits (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y
Waived co-payments	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*The First Coast Advantage, LLC contract terminated in January 2015.

Table 2 of Attachment I lists the expanded benefits approved by the Agency that are being offered by the MMA specialty plans in 2015.

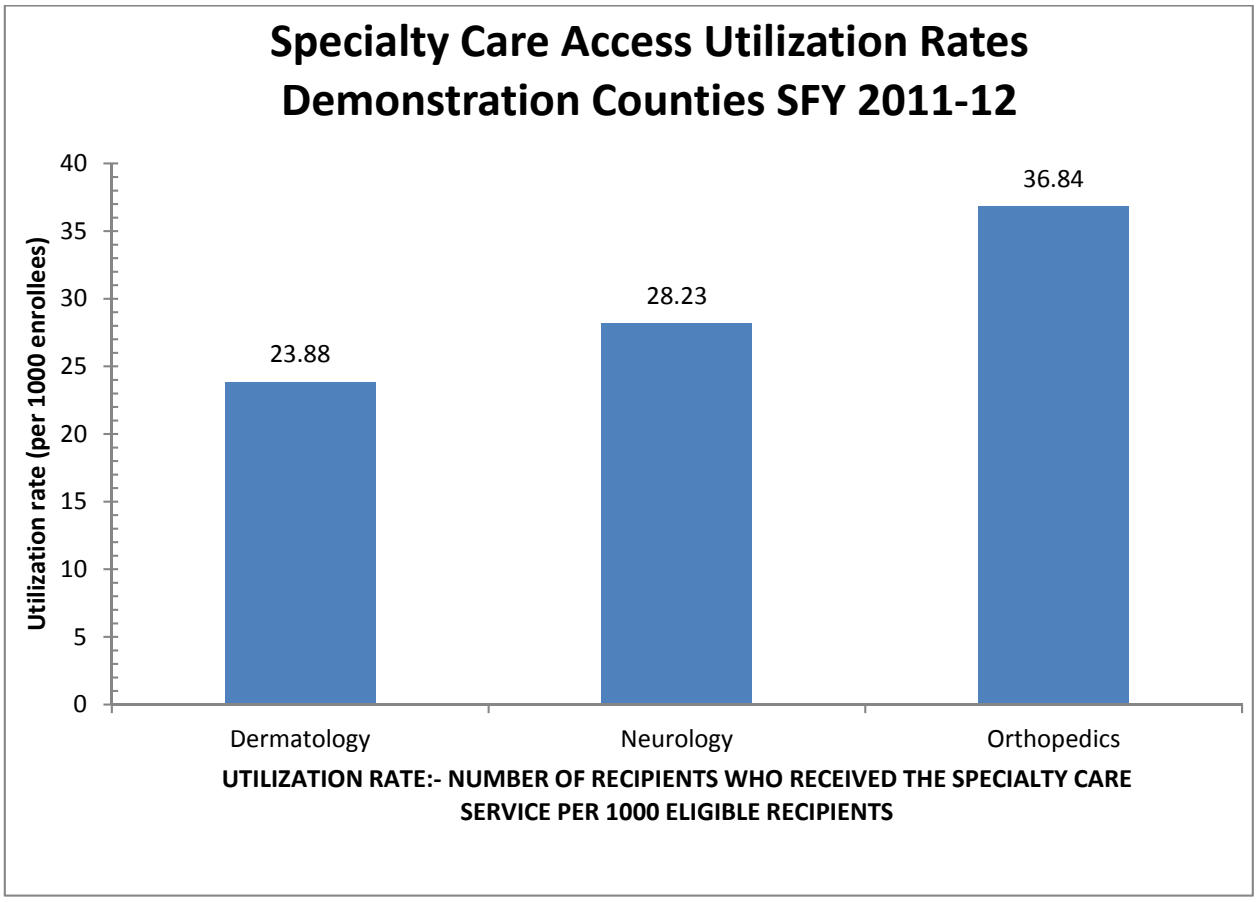
Table 2
Expanded Benefits Offered by MMA Specialty Plans

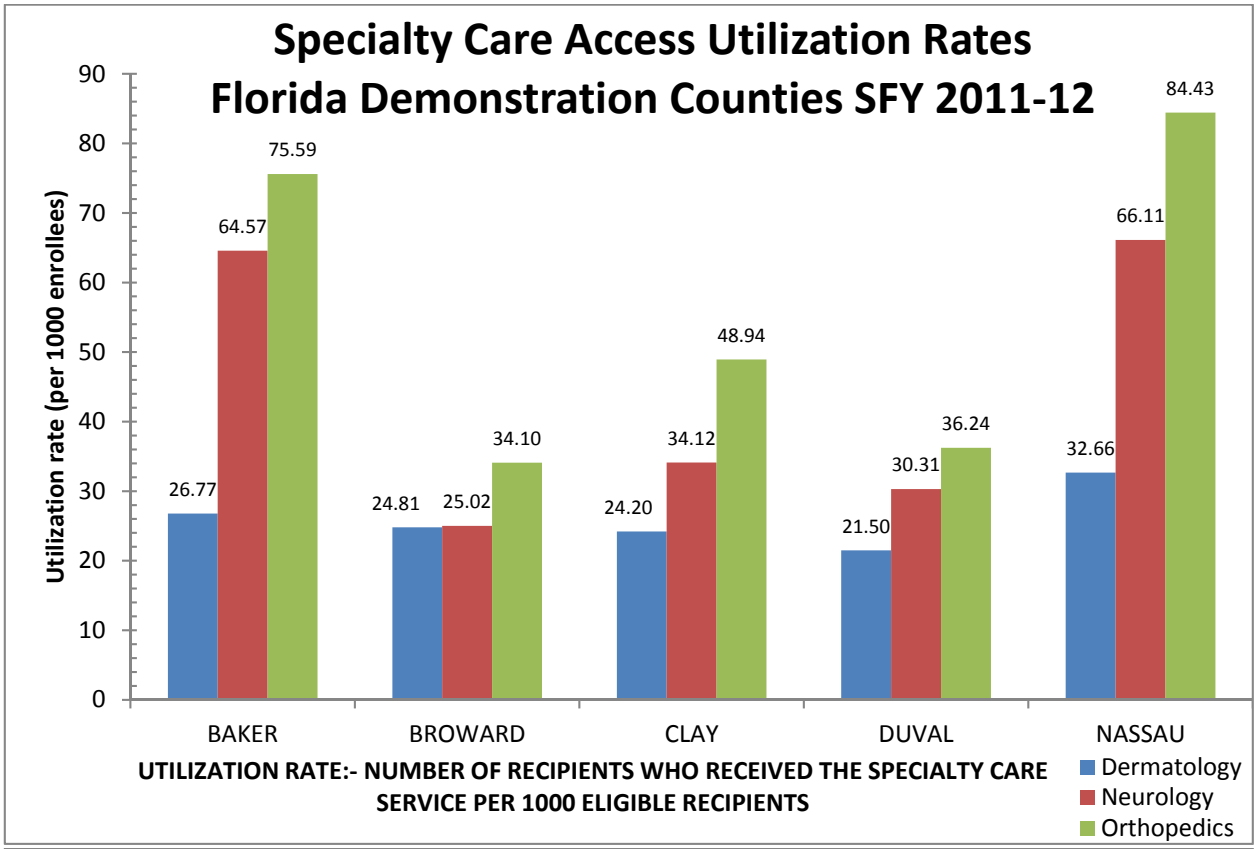
Expanded Benefits	MMA Specialty Plans					
	CMSN Plan	Magellan (Serious Mental Illness)	Freedom (Chronic/Duals)	Sunshine (Child Welfare)	Clear Health Alliance (HIV/AIDS)	Positive Health (HIV/AIDS)
Adult dental services (Expanded)		Y		*Y*	Y	Y
Adult hearing services (Expanded)				*Y*	Y	Y
Adult vision services (Expanded)		Y		*Y*	Y	Y
Art therapy				*Y*		
Equine therapy						Y
Home and Community-Based Services		Y			Y	
Home health care for non-pregnant adults (Expanded)		Y		*Y*	Y	
Influenza vaccine		Y		*Y*	Y	Y
Intensive Outpatient Therapy		Y			Y	
Medically related lodging & food		Y		*Y*	Y	Y
Newborn circumcisions		Y		*Y*	Y	Y
Nutritional counseling		Y		*Y*	Y	
Outpatient hospital services (Expanded)		Y		*Y*	Y	Y
Over the counter medication and supplies		Y		*Y*	Y	Y
Physician home visits				*Y*	Y	
Pneumonia vaccine		Y		*Y*	Y	Y
Post-discharge meals		Y		*Y*	Y	
Prenatal/Perinatal visits (Expanded)		Y		*Y*	Y	Y
Primary care visits for non-pregnant adults (Expanded)		Y		*Y*	Y	Y
Shingles vaccine		Y		*Y*	Y	Y
Waived co-payments		Y		*Y*	Y	Y

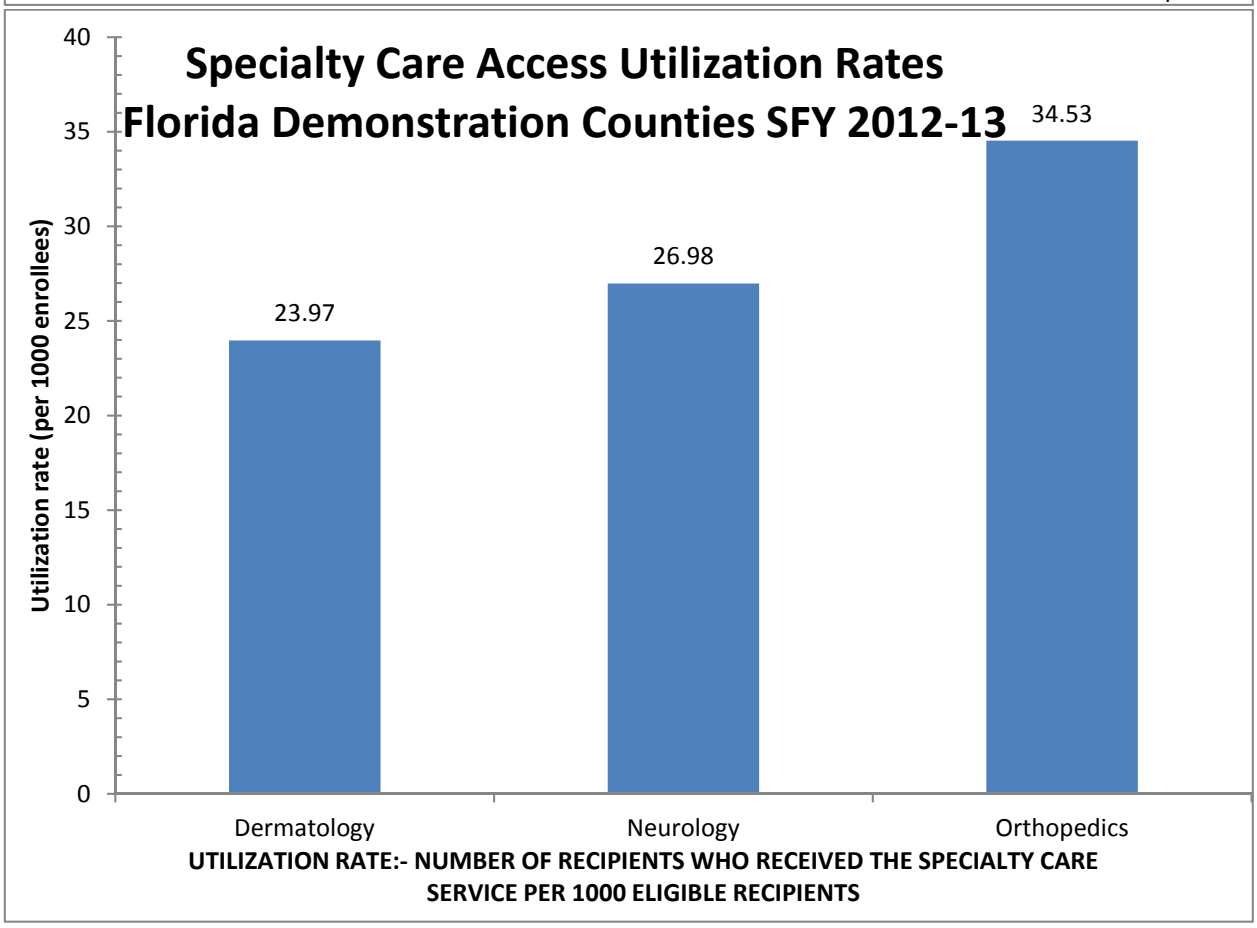
Attachment II
Improved Access to Specialists

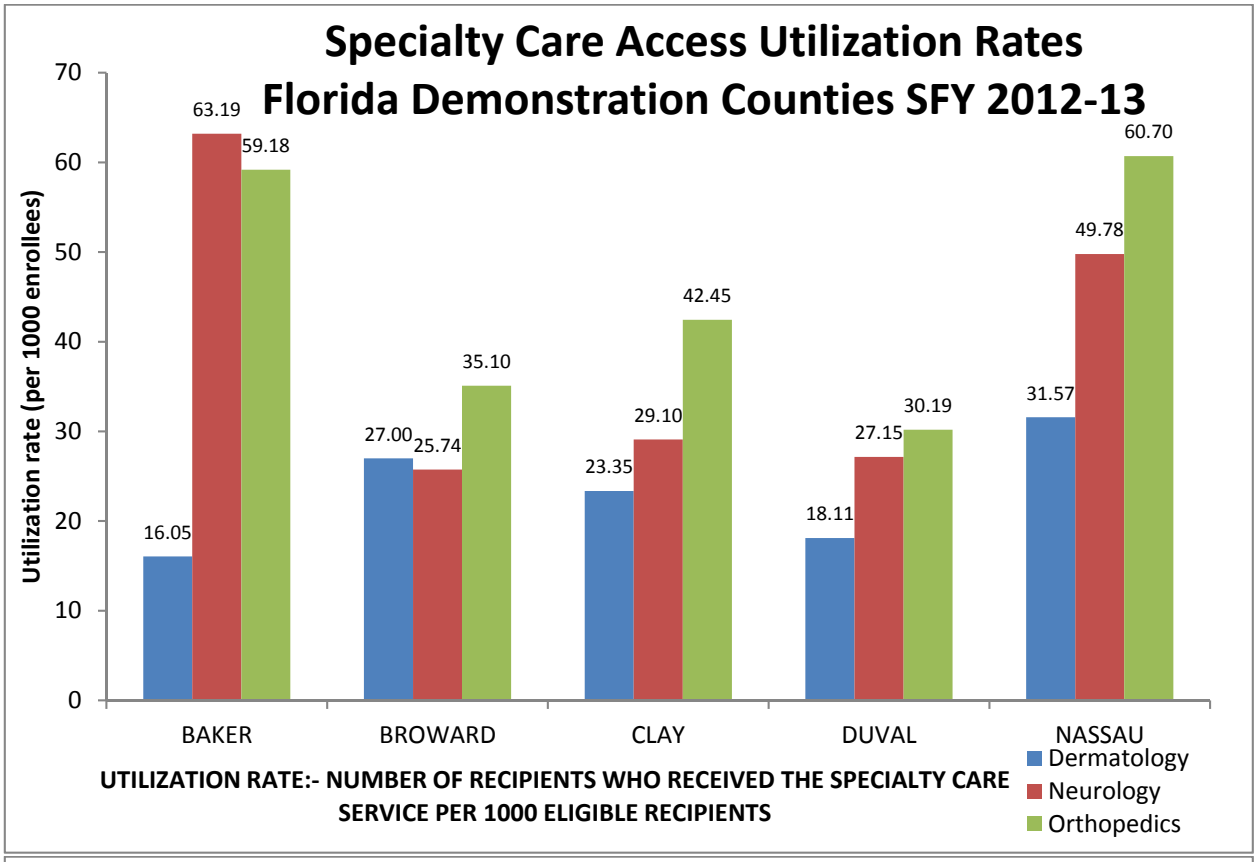
Objective 1(b): To ensure that there is improved access to specialists.

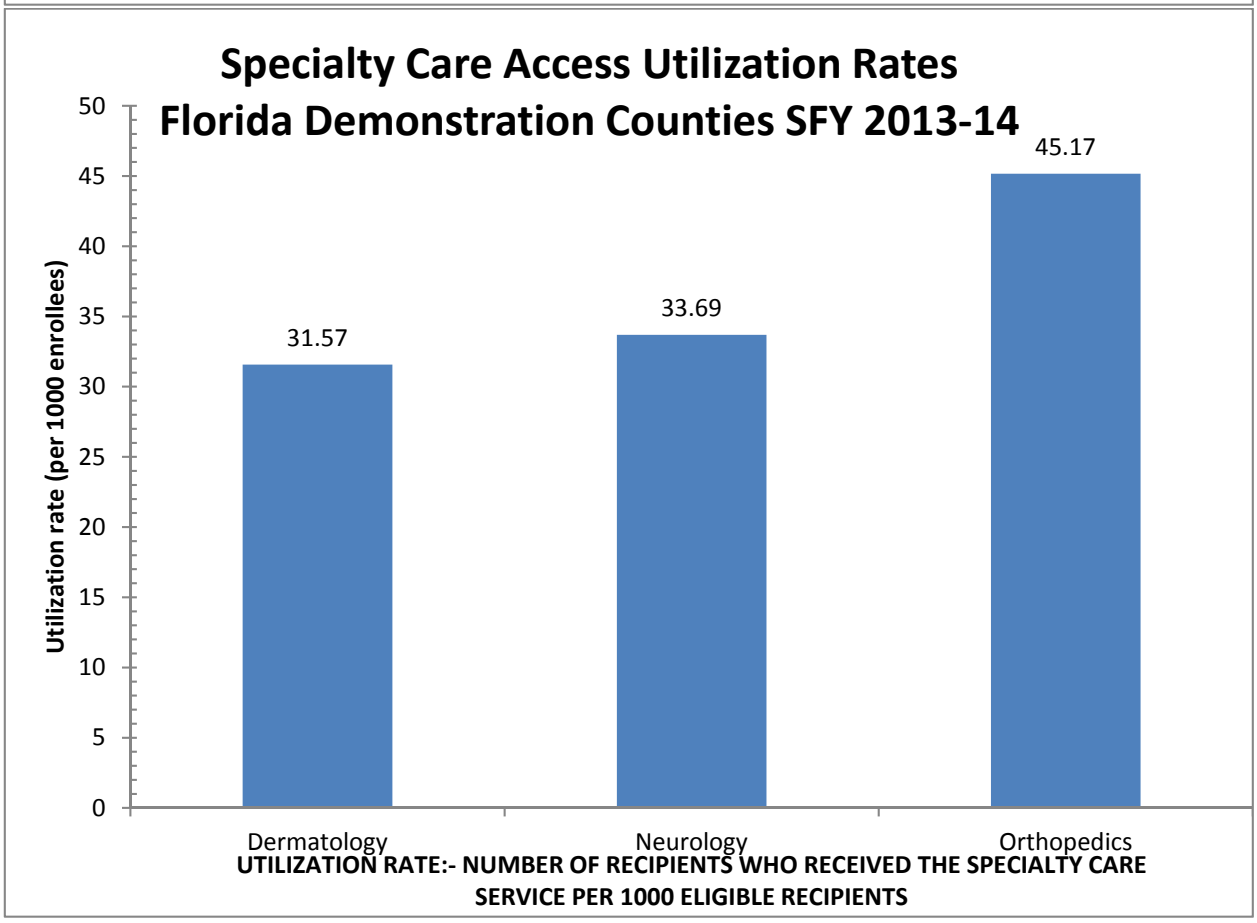
The following charts demonstrate improving accessibility to orthopedic, neurology and dermatology services for Medicaid recipients statewide and in the demonstration counties over time, for SFY 2011-12, SFY 2012-13, and SFY 2013-14.

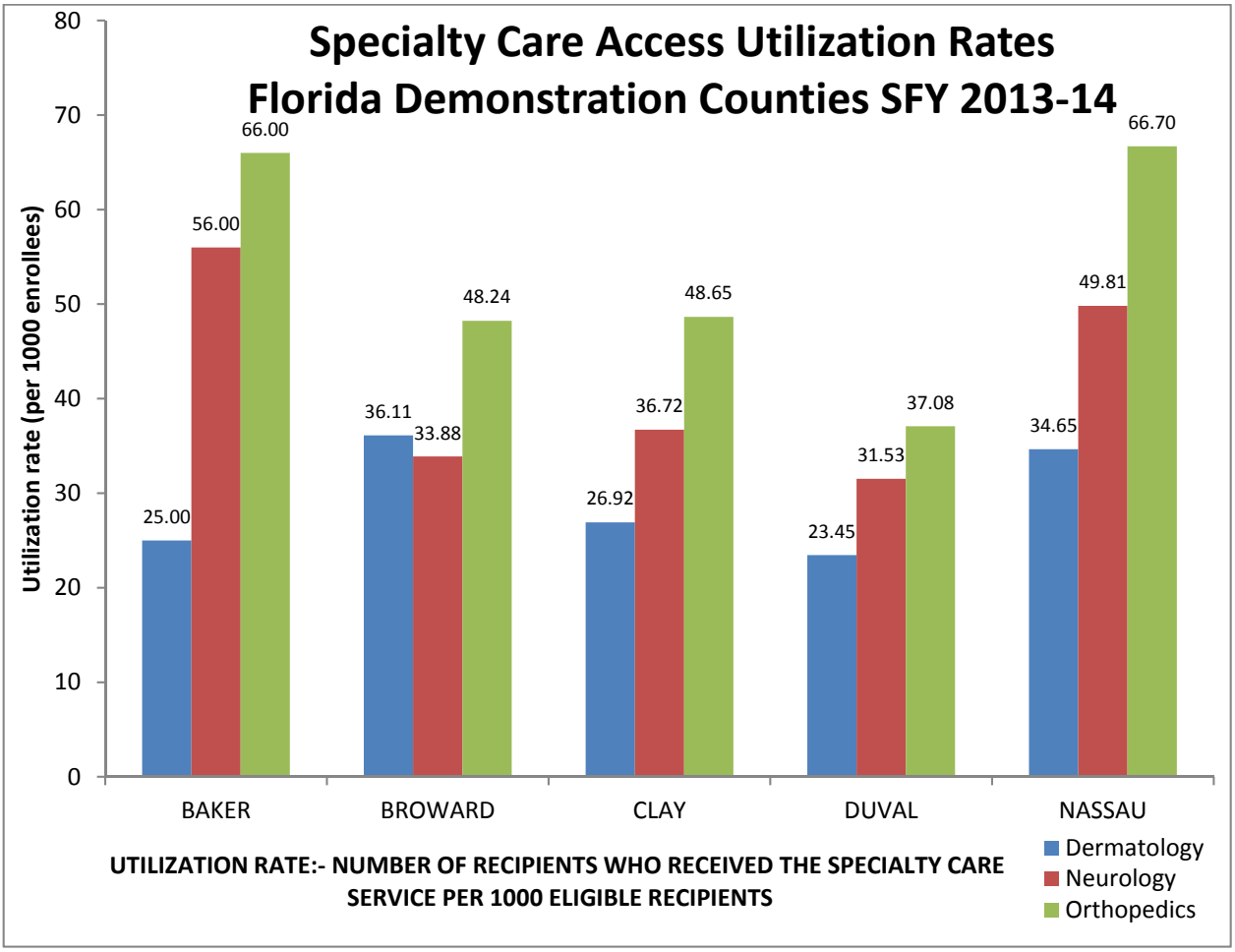



Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2011-12
Utilization rate (per 1000 enrollees)
90
80
70
60
50
40
30
20
10
0
26.77
64.57
75.59
24.81
25.02
34.10
24.20
34.12
48.94
21.50
30.31
36.24
32.66
66.11
84.43
BAKER
BROWARD
CLAY
DUVAL
NASSAU
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2012-13
Utilization rate (per 1000 enrollees)
40
35
30
25
20
15
10
5
0
23.97
26.98
34.53
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2012-13
Utilization rate (per 1000 enrollees)
70
60
50
40
30
20
10
0
63.19
59.18
16.05
27.00
25.74
35.10
23.35
29.10
42.45
18.11
27.15
30.19
31.57
49.78
60.70
BAKER
BROWARD
CLAY
DUVAL
NASSAU
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2013-14
Utilization rate (per 1000 enrollees)
50
45
40
35
30
25
20
15
10
5
0
31.57
33.69
45.17
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2013-14
Utilization rate (per 1000 enrollees)
80
70
60
50
40
30
20
10
0
25.00
56.00
66.00
36.11
33.88
48.24
26.92
36.72
48.65
23.45
31.53
37.08
34.65
49.81
66.70
BAKER
BROWARD
CLAY
DUVAL
NASSAU
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS

Attachment III
Calendar Year 2007–2013 Performance Measures
Reform Plans

	Reform Plans*							
Measure	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**Trend from 2012-2013**
Annual Dental Visit	15.2%	28.5%	33.4%	34.0%	35.3%	40.4%	42.3%	flat
Adolescent Well-Care	44.2%	46.5%	46.3%	46.2%	47.6%	48.5%	49.5%	flat
Controlling Blood Pressure	46.3%	55.9%	53.4%	46.3%	52.9%	45.4%	49.0%	improve
Cervical Cancer Screening	48.2%	52.2%	50.8%	53.2%	56.8%	58.2%	56.4%	flat
Diabetes - HbA1c Testing	78.9%	80.1%	82.8%	81.9%	82.2%	79.5%	81.9%	improve
Diabetes - HbA1c Poor Control (INVERSE)	48.3%	46.8%	44.9%	48.6%	43.6%	48.9%	47.8%	flat
Diabetes - HbA1c Good Control	32.2%	48.0%	47.5%	43.7%	47.9%	43.6%	44.5%	flat
Diabetes - Eye Exam	35.7%	44.0%	45.4%	49.3%	50.2%	48.7%	48.2%	flat
Diabetes - LDL Screening	80.0%	80.2%	83.5%	81.8%	81.9%	80.1%	82.4%	improve
Diabetes - LDL Control	29.3%	35.5%	36.1%	36.9%	37.8%	32.1%	32.8%	flat
Diabetes - Nephropathy	79.2%	80.3%	81.9%	83.1%	82.3%	80.2%	83.7%	improve
Follow-up after Hospitalization for Mental Illness - 7 day	20.6%	29.3%	25.4%	23.1%	22.7%	23.5%	22.4%	flat
Follow-up after Hospitalization for Mental Illness - 30 day	35.5%	46.6%	41.3%	44.3%	41.2%	40.8%	39.3%	flat
Prenatal Care	66.6%	67.4%	75.2%	68.4%	72.1%	67.2%	67.2%	flat
Postpartum Care	53.0%	51.5%	52.1%	49.3%	52.9%	51.4%	52.3%	flat
Well-Child First 15 Mos. - 0 Visits (INVERSE)	4.9%	1.6%	6.0%	3.0%	2.1%	1.6%	2.2%	flat
Well-Child First 15 Mos. - 6(+) Visits	44.4%	49.3%	35.4%	46.5%	58.4%	55.6%	54.2%	flat
Well-Child 3-6 Years	71.3%	75.7%	72.7%	75.0%	75.5%	75.6%	75.0%	flat
Adults' Access to Preventive Care - 20-44 Yrs	n/a	71.8%	71.2%	71.2%	69.8%	69.2%	75.9%	improve

	Reform Plans*							
Measure	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**Trend from 2012-2013**
Adults' Access to Preventive Care - 45-64 Yrs	n/a	84.7%	84.9%	85.5%	84.9%	85.0%	86.6%	flat
Adults' Access to Preventive Care - 65+ Yrs	n/a	83.6%	83.7%	84.2%	73.9%	76.2%	78.4%	improve
Adults' Access to Preventive Care - total	n/a	77.2%	77.6%	77.0%	75.0%	74.7%	76.1%	flat
Antidepressant Medication Mgmt - Acute	n/a	52.0%	56.3%	56.3%	57.4%	55.1%	54.6%	flat
Antidepressant Medication Mgmt - Continuation	n/a	29.8%	43.8%	44.0%	43.1%	41.7%	40.7%	flat
Appropriate Medications for Asthma**	n/a	83.6%	87.6%	86.0%	81.1%	79.3%	81.3%	improve
Breast Cancer Screening	n/a	51.4%	56.9%	59.2%	52.3%	52.5%	56.0%	improve
Childhood Immunization Combo 2	n/a	63.6%	70.0%	74.0%	74.8%	77.8%	74.9%	decline
Childhood Immunization Combo 3	n/a	53.8%	62.7%	66.9%	69.2%	71.6%	70.5%	flat
Frequency of Prenatal Care	n/a	52.6%	46.9%	44.0%	54.4%	53.7%	53.7%	flat
Lead Screening in Children	n/a	54.8%	52.0%	54.1%	59.6%	61.7%	63.2%	flat
Adult BMI Assessment	n/a	n/a	41.9%	52.7%	47.9%	63.0%	77.0%	improve
Follow-up Care for Children Prescribed ADHD Medication - Initiation***	n/a	n/a	43.6%	44.5%	44.4%	45.0%	44.1%	flat
Immunizations for Adolescents Combo 1	n/a	n/a	44.1%	43.6%	47.3%	54.6%	63.0%	improve
Chlamydia Screening - 16-20 years	n/a	n/a	n/a	56.2%	56.4%	58.6%	57.4%	flat
Chlamydia Screening - 21-24 years	n/a	n/a	n/a	67.8%	68.2%	70.9%	69.6%	flat
Chlamydia Screening - total	n/a	n/a	n/a	60.2%	60.6%	62.9%	61.8%	flat
Appropriate Testing for Children with Pharyngitis	n/a	n/a	n/a	65.0%	64.0%	67.7%	69.0%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	n/a	n/a	n/a	n/a	94.8%	94.5%	95.8%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	n/a	n/a	n/a	n/a	88.4%	88.3%	89.0%	flat

	Reform Plans*							
Measure	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**Trend from 2012-2013**
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	n/a	n/a	n/a	n/a	85.0%	86.2%	87.3%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	n/a	n/a	n/a	n/a	81.2%	82.3%	84.1%	flat
Call Answer Timeliness	n/a	n/a	n/a	n/a	94.9%	95.4%	95.7%	flat

*Data are submitted to the Agency by HMOs and PSNs and are audited by NCQA-certified HEDIS auditors. Data do not include Florida Medicaid FFS or MediPass. Each rate presented for Reform is the weighted mean across Reform health plans, weighted by the number of eligible members each plan has per measure.

**The specifications for the Appropriate Medications for People with Asthma measure changed for CY 2011 reporting, so it may not be appropriate to compare results reported for CY 2011 and subsequent years to prior years.

***Follow-up Care for Children Prescribed ADHD Medication - Continuation: the rate is not displayed as only 4 of the 15 Reform plans had sufficient eligible members to report this measure.

Attachment IV
Calendar Year 2013 Performance Measures Comparison of Reform and Non-Reform Plans

Measure	Non-Reform Plans*	Reform Plans*	Reform Rate relative to Non-Reform***
Annual Dental Visit***	30.5%	42.3%	Higher
Adolescent Well-Care	50.3%	49.5%	Same
Controlling Blood Pressure	53.7%	49.0%	Lower
Cervical Cancer Screening	56.8%	56.4%	Same
Diabetes - HbA1c Testing	80.1%	81.9%	Same
Diabetes - HbA1c Poor Control (INVERSE)	48.1%	47.8%	Same
Diabetes - HbA1c Good Control	43.2%	44.5%	Same
Diabetes - Eye Exam	49.5%	48.2%	Same
Diabetes - LDL Screening	79.2%	82.4%	Higher
Diabetes - LDL Control	32.7%	32.8%	Same
Diabetes - Nephropathy	79.6%	83.7%	Higher
Follow-up after Hospitalization for Mental Illness - 7 day	28.5%	22.4%	Lower
Follow-up after Hospitalization for Mental Illness - 30 day	46.8%	39.3%	Lower
Prenatal Care	71.6%	67.2%	Lower
Postpartum Care	50.7%	52.3%	Same
Well-Child First 15 Mos. - 0 Visits (INVERSE)	2.4%	2.2%	Same
Well-Child First 15 Mos. - 6(+) Visits	54.4%	54.2%	Same
Well-Child 3-6 Years	74.4%	75.0%	Same
Adults' Access to Preventive Care - 20-44 Yrs	66.7%	75.9%	Higher
Adults' Access to Preventive Care - 45-64 Yrs	82.2%	86.6%	Higher
Adults' Access to Preventive Care - 65+ Yrs	71.9%	78.4%	Higher
Adults' Access to Preventive Care - total	71.6%	76.1%	Higher
Antidepressant Medication Mgmt - Acute	52.1%	54.6%	Higher
Antidepressant Medication Mgmt - Continuation	37.2%	40.7%	Higher
Appropriate Medications for Asthma	80.9%	81.3%	Same

Measure	Non-Reform Plans*	Reform Plans*	Reform Rate relative to Non-Reform***
Breast Cancer Screening	54.2%	56.0%	Same
Childhood Immunization Combo 2	76.8%	74.9%	Same
Childhood Immunization Combo 3	71.6%	70.5%	Same
Frequency of Prenatal Care	61.5%	53.7%	Lower
Lead Screening in Children	59.6%	63.2%	Higher
Adult BMI Assessment	83.3%	77.0%	Lower
Follow-up Care for Children Prescribed ADHD Medication - Initiation****	48.6%	44.1%	Lower
Immunizations for Adolescents Combo 1	63.3%	63.0%	Same
Chlamydia Screening - 16-20 years	58.2%	57.4%	Same
Chlamydia Screening - 21-24 years	69.8%	69.6%	Same
Chlamydia Screening - total	62.7%	61.8%	Same
Appropriate Testing for Children with Pharyngitis	62.5%	69.0%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95.3%	95.8%	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	88.2%	89.0%	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	86.6%	87.3%	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	83.6%	84.1%	Same
Call Answer Timeliness	94.9%	95.7%	Same

*Data are submitted to the Agency by HMOs and PSNs and are audited by NCQA-certified HEDIS auditors. Data do not include Florida Medicaid FFS or MediPass. Each rate presented for Non-Reform and for Reform is the weighted mean across Non-Reform and Reform health plans, weighted by the number of eligible members each plan has per measure.

**Reform rate relative to Non-Reform is identified as “Same” if there is less than a two percentage point difference between the Reform and Non-Reform rates. Differences of two percentage points or more are identified as “Higher” or “Lower.”

***Annual Dental Visits - only 9 of 23 Non-Reform plans cover dental services. Only 5 of the plans had sufficient denominators to report on this measure in 2014.

****Follow-up Care for Children Prescribed ADHD Medication - Continuation is not displayed as less than half of the Non-Reform (7 of 24) and Reform (4 of 15) plans had sufficient eligible members to report this measure.

Attachment V
Enhanced Benefits Account Program

The following provides a summary for DY9 on EBA program activities for DY9 including summary of call center activities, mailings and credits used. During DY9, 556,356 notices were mailed to recipients informing them of the termination of the program on June 30, 2014 and ability to access credits until June 30, 2015.

a) Call Center Activities

The enhanced benefits call center, managed by the choice counseling vendor [Automated Health Systems (AHS)], located in Tallahassee, Florida, operates a toll-free number and a toll-free number for hearing impaired callers. The call center answers all inbound calls relating to program questions, provides enhanced benefits account updates on credits used, and assists recipients with utilizing the web-based over-the-counter product list. The call center is staffed with employees who can answer calls in English, Spanish and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The hours of operation are Monday – Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m.

The Automated Voice Response System (AVRS) that provides recipients balance-only information handled 77,446 calls during DY9. Table 1 of Attachment V provides the call center activities during DY9.

Table 1
Enhanced Benefits Call Center Activities
(July 1, 2014 – June 30, 2015)

Center Activity	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Calls Received	6,604	3,901	6,984	3,409	20,898
Calls Answered	6,593	3,892	6,970	3,406	20,861
Average Talk Time (minutes)	4:32	4:28	4:33	4:59	4:38
Calls Handled by the AVRS	18,235	9,617	5,952	4,919	38,723
Outbound Calls	16	8	8	7	39

Enhanced Benefit Mailings

During DY9, the fiscal agent mailed 77,646 coupon statements. The choice counselors continued to provide up-to-date information for recipients regarding their EBA balances.

Complaints

There were no complaints received during DY9.

b) Enhanced Benefits Statistics

As of the end of DY9, 556,833 recipients lost EBA eligibility resulting in losing EBA credits, totaling $32,270,568.93. Table 2 of Attachment V provides the EBA program statistics during DY9.

Table 2
Enhanced Benefits Account Program Statistics
(July 1, 2014 – June 30, 2015)

DY9	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Total dollar amount of credits used each month by date of service	$1,283,494.96	$497,585.99	$677,455.59	$547,315.13
Total cumulative dollar amount of credits used through the month by date of service	$49,564,313.33	$50,061,720.92	$50,738,987.17	$51,286,302.30

Attachment VI
Healthy Behaviors Program Enrollment

Table 1 of Attachment VI provides a summary of enrollees in Healthy Behaviors programs for DY 9. Table 2 of Attachment VI provides a summary of enrollees that have completed a Healthy Behaviors program in DY9.

For DY9, 4 out of 18 MMA plans reported no enrollment in any of the Healthy Behaviors programs offered and of the 18 plans reported enrollees had completed at least one Healthy Behaviors program. The plans were not approved to implement their Healthy Behaviors program until after January 1, 2015. The following data is third and fourth quarter data only.

Table 1
Healthy Behaviors Program - Enrollment Statistics
(July 1, 2014 – June 30, 2015)

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Amerigroup Florida							
Smoking Cessation	12	2	10	0	1	9	2
Weight Management	61	9	52	2	16	35	8
Alcohol and/or Substance Abuse	1	1	0	0	0	0	1
CDC Performance Measure Incentive	0	-	-	-	-	-	-
Performance Measure Incentives	0	-	-	-	-	-	-
Maternal Child Incentive	0	-	-	-	-	-	-
Better Health							
Smoking Cessation	6	3	3	0	1	2	3
Weight Management	28	9	19	0	6	16	6
Substance Abuse	0	-	-	-	-	-	-
Maternity	0	-	-	-	-	-	-
Well Child Visits	11	9	2	11	0	0	0
Children's Medical Services							
Tobacco Cessation	0	-	-	-	-	-	-
Overcoming Obesity	0	-	-	-	-	-	-
Changing Lives*	0	-	-	-	-	-	-
Clear Health Alliance							
Quit Smoking Healthy Behaviors Rewards	7	2	5	0	0	7	0
Weight Management Healthy Behaviors Rewards	7	0	7	0	0	7	0
Alcohol & Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	0	-	-	-	-	-	-
Well Child Visit Healthy Behaviors Rewards	0	-	-	-	-	-	-
Coventry							
Smoking Cessation	0	-	-	-	-	-	-

Table 1 Healthy Behaviors Program - Enrollment Statistics (July 1, 2014 – June 30, 2015)							
Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Weight Loss	0	-	-	-	-	-	-
Substance Abuse	0	-	-	-	-	-	-
Baby Visions Prenatal & Postpartum Incentive	0	-	-	-	-	-	-
Freedom Health							
Smoking Cessation	1	1	0	0	0	0	1
Weight Loss	1	0	1	0	0	0	1
Alcohol or Substance Abuse	1	0	1	0	0	0	1
Humana Medical Plan							
Smoking Cessation	0	-	-	-	-	-	-
Family Fit	157	22	135	4	61	71	21
Substance Abuse	0	-	-	-	-	-	-
Mom's First Prenatal & Postpartum	5,181	0	5,181	534	4,557	90	0
First Baby Well Visit Incentive	11,928	6,113	5,815	11,928	0	0	0
Children's Nutrition Incentive	252,930	127,392	125,538	252,930	0	0	0
Lead Screening & Well-Child Visit Incentive	88,120	44,990	43,130	88,120	0	0	0
Adolescent Well-Child Visits Incentive	135,112	65,768	69,344	135,112	0	0	0
Integral Quality Care							
Smoking Cessation	0	-	-	-	-	-	-
Weight Management	0	-	-	-	-	-	-
Substance Abuse Counseling	0	-	-	-	-	-	-
Adult Health Maintenance	0	-	-	-	-	-	-
Child Health Maintenance	0	-	-	-	-	-	-
Magellan Complete Care							
Smoking & Tobacco Cessation	281	82	199	6	95	161	19
Weight Management	463	80	383	29	205	204	25
Substance Abuse	76	38	38	4	24	40	8
Molina							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Pregnancy Health Management	0	-	-	-	-	-	-
Pediatric Preventative Care	0	-	-	-	-	-	-
Positive Health Care							
Quit for Life Tobacco Cessation	0	-	-	-	-	-	-
Weight Management	31	17	14	0	8	20	3
Alcohol Abuse	0	-	-	-	-	-	-

Table 1 Healthy Behaviors Program - Enrollment Statistics (July 1, 2014 – June 30, 2015)							
Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Preferred							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Cervical Cancer Screening	0	-	-	-	-	-	-
CHCUP Preventive & Wellness Care	174	85	89	174	0	0	0
Mammogram	0	-	-	-	-	-	-
Pre-Natal/Preferred Kids Safety & Postpartum	42	0	42	2	40	0	0
Prestige Health Choice							
Smoking Cessation	112	21	91	0	25	71	16
Weight Loss	165	22	143	15	42	79	29
Alcohol & Substance Abuse – “Changing Lives Program”	7	2	5	0	3	4	0
Simply							
Quit Smoking Healthy Behaviors Rewards	10	8	2	0	0	5	5
Weight Management Healthy Behaviors Rewards	5	1	4	3	1	0	1
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	1	0	1	0	1	0	0
Well Child Visit Healthy Behaviors Rewards	13	9	4	13	0	0	0
South Florida Community Care Network							
Tobacco Cessation	1	1	0	0	0	1	0
Obesity Management	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Staywell							
Smoking Cessation	498	198	300	10	134	304	50
Weight Management	17,812	6,715	11,097	6,297	5,734	4,799	982
Substance Abuse	0	-	-	-	-	-	-
Healthy Diabetes Behaviors	0	-	-	-	-	-	-
New Member Healthy Behavior Engagement	0	-	-	-	-	-	-
Well Woman Healthy Behavior	0	-	-	-	-	-	-
Children’s Healthy Behavior Engagement	0	-	-	-	-	-	-
Sunshine Health							
Tobacco Cessation Healthy	74	30	44	0	10	52	12

Table 1 Healthy Behaviors Program - Enrollment Statistics (July 1, 2014 – June 30, 2015)							
Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Rewards							
Weight Loss Healthy Rewards	114	19	95	15	38	48	13
Substance Abuse Healthy Rewards	16	6	10	3	7	6	0
Preventive Adult Primary Care Visits	0	-	-	-	-	-	-
Preventative Well Child Primary Care Visits	0	-	-	-	-	-	-
Start Smart for your Baby (perinatal management)	0	-	-	-	-	-	-
Post Behavioral Health Discharge Visit in 7 Days	0	-	-	-	-	-	-
Preventive Dental Visits for Children	0	-	-	-	-	-	-
Diabetic Healthy Rewards	0	-	-	-	-	-	-
Female Cancer Screening	0	-	-	-	-	-	-
UnitedHealthcare							
Tobacco Cessation – text2quit	5	0	5	0	0	3	2
Florida Population Health/Health Coaching for Weight Loss	18	2	16	1	8	8	1
Substance Abuse Incentive	0	-	-	-	-	-	-
Baby Blocks	1,013	0	1,013	135	858	20	0
*Alcohol and/or substance abuse program.							

Table 2 Healthy Behavior Programs - Completion Statistics (July 1, 2014 – June 30, 2015)							
Program	**Total Completed**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Amerigroup							
Smoking Cessation	29	9	20	0	10	17	2
Weight Loss	104	13	91	3	37	51	13
Alcohol & Substance Abuse – “Changing Lives Program”	1	1	0	0	0	0	1
Freedom							
Alcohol or Substance Abuse	1	0	1	0	0	0	1
Humana							
Family Fit	12	2	10	1	7	2	2
Mom’s First Prenatal &	32	0	32	3	29	0	0

Table 2 Healthy Behavior Programs - Completion Statistics (July 1, 2014 – June 30, 2015)							
Postpartum							
First Baby Well Visit Incentive	2,788	1,441	1,347	2,788	0	0	0
Children's Nutrition Incentive	6,949	3,509	3,440	6,949	0	0	0
Lead Screening & Well-Child Visit Incentive	2,733	1,414	1,319	2,733	0	0	0
Adolescent Well-Child Visits Incentive	6,515	3,015	3,500	6,515	0	0	0
Magellan Complete Care							
Alcohol & Substance Abuse – "Changing Lives Program"	2	1	1	0	1	1	0
Preferred							
CHCUP Preventive & Wellness Care	171	83	88	171	0	0	0
Pre-Natal/Preferred Kids Safety & Postpartum	34	0	34	2	32	0	0
Prestige Health Choice							
Smoking Cessation	5	0	5	0	1	3	1
Weight Loss	72	5	67	6	16	41	9
Alcohol & Substance Abuse – "Changing Lives Program"	2	0	2	0	2	0	0
Simply							
Well Child Visit Healthy Behaviors Rewards	1	1	0	1	0	0	0
Staywell							
Smoking Cessation	208	77	131	5	55	126	22
Weight Management	838	257	581	198	238	311	91
Sunshine Health							
Tobacco Cessation Healthy Rewards	8	3	5	0	1	6	1
Weight Loss Healthy Rewards	5	0	5	0	0	4	1
Substance Abuse Healthy Rewards	2	2	0	0	0	2	0

Attachment VII
MMA Enrollment Report Update

Number of MMA Plans by Region

Table 1 of Attachment VII provides each region established under Part IV of Chapter 409, F.S.

Table 1 Regions established under Part IV of Chapter 409, F.S.	
Region	**Counties**
1	Escambia, Okaloosa, Santa Rosa, Walton
2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia
5	Pasco, Pinellas
6	Hardee, Highlands, Hillsborough, Manatee, Polk
7	Brevard, Orange, Osceola, Seminole
8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
10	Broward
11	Miami-Dade, Monroe

Table 2 of Attachment VII provides the number of general and specialty MMA plans in each region.

Table 2 Number of MMA Plans by Region (April 1, 2015 – June 30, 2015)		
Region	General	Specialty
1	2	3
2	2	4
3	4	4
4	4	3
5	4	5
6	7	5
7	6	5
8	4	4
9	4	5
10	4	6
11	10	6
Unduplicated Totals	13	6

MMA Enrollment

There are two categories of Florida Medicaid recipients who are enrolled in the MMA plans: Temporary Assistance for Needy Families (TANF) and SSI. The SSI category is broken down further in the MMA Enrollment reports, based on the recipients' eligibility for Medicare. The MMA Enrollment reports are a complete look at the entire enrollment for the MMA program for the DY being reported. Table 3 of Attachment VII provides a description of each column in the MMA Enrollment reports that are located on the following pages in Tables 3A and 3B of Attachment VII.

Table 3
MMA Enrollment by Plan and Type Report Descriptions

Column Name	Column Description
Plan Name	The name of the MMA plan
Plan Type	The plan's type (General or Specialty)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled - No Medicare	The number of SSI recipients enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients enrolled with the plan and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of enrollees with the plan; TANF and SSI combined
Market Share for MMA	The percentage of the MMA population compared to the entire enrollment for the year being reported
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year

Tables 3A located on the following page lists, by plan and type the total number of TANF and SSI individuals enrolled, and the corresponding market share. Total Number Enrolled is for DY9 (July 1, 2014 – June 30, 2015) and Enrolled in Previous Year is for May and June 2014 when MMA was first rolled out. In addition, the total MMA enrollment counts are included at the bottom of the report. First Coast Advantage has ceased operations effective November 30, 2014 and enrollees have been transitioned to Molina Healthcare effective December 1, 2014.

Table 3B lists enrollment by region and plan type, for this year and compared to last year, the total number of TANF and SSI individuals enrolled and the corresponding market share. In addition, the total MMA enrollment counts are included at the bottom of the report.

Table 3A
MMA Enrollment by Plan and Type*
(July 1, 2014 – June 30, 2015)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in May & June 2014	Percent Change from Previous Year[12]
			Medicaid Only	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	GENERAL	342,710	33,733	63	19,322	**395,828**	11.0%	**172,567**	'N/A'
Better Health	GENERAL	95,709	9,655	33	5,081	**110,478**	3.1%	**19,166**	'N/A'
Coventry Health Care Of Florida	GENERAL	49,037	4,587	33	4,455	**58,112**	1.6%	**0**	'N/A'
First Coast Advantage	GENERAL	5,024	348	0	181	**5,553**	0.2%	**66,946**	'N/A'
Humana Medical Plan	GENERAL	298,571	39,051	238	34,299	**372,159**	10.3%	**26,276**	'N/A'
Integral Quality Care	GENERAL	96,576	8,682	7	6,389	**111,654**	3.1%	**59,605**	'N/A'
Molina Healthcare Of Florida	GENERAL	163,576	16,729	41	10,622	**190,968**	5.3%	**0**	'N/A'
Preferred Medical Plan	GENERAL	26,911	3,717	28	3,618	**34,274**	1.0%	**0**	'N/A'
Prestige Health Choice	GENERAL	314,150	34,419	34	24,059	**372,662**	10.4%	**196,071**	'N/A'
South Florida Community Care Network	GENERAL	45,123	3,809	6	2,257	**51,195**	1.4%	**0**	'N/A'
Simply Healthcare	GENERAL	76,900	13,483	165	13,804	**104,352**	2.9%	**0**	'N/A'
Staywell Health Plan	GENERAL	692,923	73,905	72	35,963	**802,863**	22.3%	**421,707**	'N/A'
Sunshine State Health Plan	GENERAL	408,519	40,226	68	53,635	**502,448**	14.0%	**183,783**	'N/A'
United Healthcare Of Florida	GENERAL	262,339	30,223	90	36,418	**329,070**	9.1%	**122,818**	'N/A'
General Plans Total		**2,878,068**	**312,567**	**878**	**250,103**	**3,441,616**	**95.6%**	**1,268,939**	**'N/A'**
Positive Health Plan	SPECIALTY	247	983	1	888	**2,119**	0.1%	**0**	'N/A'
Magellan Complete Care	SPECIALTY	26,669	22,376	18	502	**49,565**	1.4%	**0**	'N/A'
Freedom Health	SPECIALTY	0	0	0	99	**99**	0.0%	**0**	'N/A'
Clear Health Alliance	SPECIALTY	1,548	5,451	2	3,652	**10,653**	0.3%	**3,001**	'N/A'
Sunshine State Health Plan	SPECIALTY	21,835	1,935	0	4	**23,774**	0.7%	**10,418**	'N/A'
Children's Medical Services Network	SPECIALTY	42,050	28,450	0	176	**70,676**	2.0%	**0**	'N/A'
Specialty Plans Total		**92,349**	**59,195**	**21**	**5,321**	**156,886**	**4.4%**	**13,419**	'N/A'
MMA TOTAL	**MMA**	**2,970,417**	**371,762**	**899**	**255,424**	**3,598,502**	**100%**	**1,282,358**	'N/A'

* During the year, an enrollee is counted only once in the plan of earliest enrollment. Please refer to http://ahca.myflorida.com/SMMC for actual monthly enrollment totals.

Table 3B
MMA Enrollment by Region and Type*
(July 1, 2014 – June 30, 2015)

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in May & June 2014	Percent Change from Previous Year[2]
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	MMA	98,866	12,443	2	7,778	119,089	3.3%	0	'N/A'
02	MMA	107,904	15,853	2	10,421	134,180	3.7%	100,309	'N/A'
03	MMA	251,121	32,821	22	20,309	304,273	8.5%	225,170	'N/A'
04	MMA	305,894	34,350	27	22,117	362,388	10.1%	268,358	'N/A'
05	MMA	177,880	24,315	20	18,008	220,223	6.1%	155,856	'N/A'
06	MMA	417,109	51,551	54	26,459	495,173	13.8%	355,037	'N/A'
07	MMA	397,150	49,416	38	23,584	470,188	13.1%	0	'N/A'
08	MMA	215,428	20,500	32	16,040	252,000	7.0%	177,628	'N/A'
09	MMA	257,879	26,894	36	18,274	303,083	8.4%	0	'N/A'
10	MMA	255,500	29,413	110	19,552	304,575	8.5%	0	'N/A'
11	MMA	485,686	74,206	556	72,882	633,330	17.6%	0	'N/A'
MMA TOTAL		2,970,417	371,762	899	255,424	3,598,502	100%	1,282,358	'N/A'

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in May & June 2014	Percent Change from Previous Year[2]
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	GENERAL	96,995	11,441	2	7,691	116,129	3.4%	0	'N/A'
02	GENERAL	102,106	12,799	2	10,304	125,211	3.6%	99,312	'N/A'
03	GENERAL	243,988	29,654	22	20,050	293,714	8.5%	222,788	'N/A'
04	GENERAL	294,662	28,832	27	22,053	345,574	10.0%	266,193	'N/A'
05	GENERAL	170,690	20,164	18	17,367	208,239	6.1%	153,446	'N/A'
06	GENERAL	404,215	43,220	53	26,034	473,522	13.8%	351,442	'N/A'
07	GENERAL	383,344	40,405	36	22,990	446,775	13.0%	0	'N/A'
08	GENERAL	210,728	18,268	32	15,783	244,811	7.1%	175,758	'N/A'

Table 3B MMA Enrollment by Region and Type* (July 1, 2014 – June 30, 2015)									
09	GENERAL	249,000	21,446	36	17,698	288,180	8.4%	0	'N/A'
10	GENERAL	246,104	22,696	105	18,827	287,732	8.4%	0	'N/A'
11	GENERAL	476,236	63,642	545	71,306	611,729	17.8%	0	'N/A'
GENERAL TOTAL		2,878,068	312,567	878	250,103	3,441,616	100.0%	1,268,939	'N/A'
01	SPECIALTY	1,871	1,002	0	87	2,960	1.9%	0	'N/A'
02	SPECIALTY	5,798	3,054	0	117	8,969	5.7%	997	'N/A'
03	SPECIALTY	7,133	3,167	0	259	10,559	6.7%	2,382	'N/A'
04	SPECIALTY	11,232	5,518	0	64	16,814	10.7%	2,165	'N/A'
05	SPECIALTY	7,190	4,151	2	641	11,984	7.6%	2,410	'N/A'
06	SPECIALTY	12,894	8,331	1	425	21,651	13.8%	3,595	'N/A'
07	SPECIALTY	13,806	9,011	2	594	23,413	14.9%	0	'N/A'
08	SPECIALTY	4,700	2,232	0	257	7,189	4.6%	1,870	'N/A'
09	SPECIALTY	8,879	5,448	0	576	14,903	9.5%	0	'N/A'
10	SPECIALTY	9,396	6,717	5	725	16,843	10.7%	0	'N/A'
11	SPECIALTY	9,450	10,564	11	1,576	21,601	13.8%	0	'N/A'
SPECIALTY TOTAL		92,349	59,195	21	5,321	156,886	100.0%	13,419	'N/A'

* Previous year is composed of 2 months (MMA phased-in schedule started May 2014), so percentage of the plan's enrollment from the previous reporting year to the current reporting year is 'N/A'.

Attachment VIII
Budget Neutrality Update

In the following tables (Tables 1 through 7 of Attachment VIII), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Tables 2 through 5 in accordance with STC #88).

In accordance with STC #88(d)(ii), the Agency initiated the development of the new CMS-64 reporting operation that was required to support the MMA Waiver. The new reporting operation was effective October 2014 (Q34 - date of payment), which was the first complete quarter under the MMA program.

Table 1 shows the Primary Care Case Management (PCCM) Targets established in the waiver as specified in STC #100(b). These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 1
PCCM Targets

WOW* PCCM	MEG** 1	MEG 2
DY01	$948.79	$199.48
DY02	$1,024.69	$215.44
DY03	$1,106.67	$232.68
DY04	$1,195.20	$251.29
DY05	$1,290.82	$271.39
DY06	$1,356.65	$285.77
DY07	$1,425.84	$300.92
DY08	$1,498.56	$316.87
DY9	$786.70	$324.13
DY10	$818.95	$339.04
DY11	$852.53	$354.64

*Without waiver.
**Medicaid eligibility group.

Tables 2 through 8 contain the statistics for MEGs 1, 2, and 3 for date of payment beginning July 1, 2006, and ending June 30, 2015. Case months provided in Tables 4 and 5 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 2
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$115,206,670	$909,045	$116,115,714	$470.48
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$212,114,488	$10,499,950	$222,614,438	$900.90
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$289,253,764	$30,144,893	$319,398,657	$1,287.63
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$204,909,087	$32,432,588	$237,341,675	$946.31
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$194,519,903	$31,707,197	$226,227,100	$899.27
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$301,165,314	$48,429,002	$349,594,316	$1,385.28
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$292,515,280	$50,864,554	$343,379,834	$1,359.74
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$111,968,931**	**$763,459,242**	**$1,007.18**
April 2008	254,500	$307,160,089	$52,986,151	$360,146,240	$1,415.11
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
July 2008	277,846	$192,176,160	$31,991,699	$224,167,859	$806.81
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**
October 2008	266,157	$232,318,022	$41,440,930	$273,758,952	$1,028.56
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
July 2009	277,093	$319,718,390	$52,941,079	$372,659,469	$1,344.89
August 2009	274,819	$168,336,551	$33,437,914	$201,774,466	$734.21
September 2009	274,930	$358,692,409	$67,384,681	$426,077,090	$1,549.77
Q13 Total	**826,842**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,210.04**
October 2009	275,733	$169,233,974	$30,153,422	$199,387,395	$723.12
November 2009	277,577	$252,330,497	$45,182,664	$297,513,161	$1,071.82
December 2009	277,220	$348,404,305	$61,931,546	$410,335,851	$1,480.18

Table 2 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
January 2010	282,575	$159,062,482	$29,470,651	$188,533,134	$667.20
February 2010	283,235	$249,307,944	$44,581,877	$293,889,821	$1,037.62
March 2010	281,514	$373,413,178	$67,763,434	$441,176,612	$1,567.16
Q15 Total	**847,324**	**$781,783,604**	**$141,815,963**	**$923,599,567**	**$1,090.02**
April 2010	280,909	$253,666,997	$48,259,799	$301,926,796	$1,074.82
May 2010	283,942	$174,652,397	$31,571,736	$206,224,133	$726.29
June 2010	287,594	$303,907,266	$49,657,712	$353,564,978	$1,229.39
Q16 Total	**852,445**	**$732,226,661**	**$129,489,247**	**$861,715,907**	**$1,010.88**
July 2010	289,450	$245,111,199	$45,804,917	$290,916,116	$1,005.07
August 2010	288,959	$257,400,660	$50,362,126	$307,762,786	$1,065.07
September 2010	290,464	$378,046,090	$67,416,195	$445,462,285	$1,056.69
Q17 Total	**868,873**	**$880,557,949**	**$163,583,238**	**$1,044,141,187**	**$1,201.72**
October 2010	290,791	$178,740,566	$32,056,390	$210,796,956	$725.42
November 2010	292,081	$259,494,453	$49,145,534	$308,639,987	$1,054.89
December 2010	293,692	$385,127,339	$66,518,308	$451,645,646	$1,537.82
Q18 Total	**876,564**	**$823,362,358**	**$147,720,232**	**$971,082,591**	**$1,107.83**
January 2011	286,758	$169,087,404	$30,705,047	$199,792,451	$696.73
February 2011	283,891	$254,801,466	$45,756,956	$300,558,423	$1,058.71
March 2011	280,839	$369,228,098	$60,653,771	$429,881,870	$1,530.71
Q19 Total	**851,488**	**$793,116,969**	**$137,115,775**	**$930,232,743**	**$1,092.48**
April 2011	302,990	$172,927,438	$34,444,241	$207,371,679	$684.42
May 2011	301,388	$262,943,250	$48,035,560	$310,978,811	$1,031.82
June 2011	298,455	$294,864,812	$54,930,094	$349,794,906	$1,172.03
Q20 Total	**902,833**	**$730,735,500**	**$137,409,896**	**$868,145,395**	**$961.58**
July 2011	312,416	$259,712,742	$48,660,712	$308,373,454	$987.06
August 2011	311,787	$394,898,931	$68,931,416	$463,830,347	$1,487.65
September 2011	309,458	$242,573,135	$47,908,459	$290,481,594	$938.68
Q21 Total	**933,661**	**$897,184,808**	**$165,500,587**	**$1,062,685,395**	**$1,138.19**
October 2011	307,662	$185,681,455	$37,250,558	$222,932,013	$724.60
November 2011	305,786	$405,816,970	$77,239,455	$483,056,425	$1,579.72
December 2011	303,265	$189,314,012	$35,438,146	$224,752,158	$741.11
Q22 Total	**916,713**	**$780,812,437**	**$149,928,159**	**$930,740,596**	**$1,015.30**
January 2012	290,381	$239,317,133	$49,116,158	$288,433,291	$993.29
February 2012	290,339	$389,776,652	$76,272,631	$466,049,284	$1,605.19
March 2012	290,330	$177,634,805	$35,812,556	$213,447,361	$735.19
Q23 Total	**871,050**	**$806,728,589**	**$161,201,346**	**$967,929,935**	**$1,111.22**
April 2012	312,916	$275,686,028	$54,220,241	$329,906,270	$1,054.30
May 2012	311,290	$416,163,778	$78,399,857	$494,563,635	$1,588.76
June 2012	308,237	$186,297,339	$35,989,898	$222,287,237	$721.16
Q24 Total	**932,443**	**$878,147,146**	**$168,609,996**	**$1,046,757,142**	**$1,122.60**
July 2012	315,498	$280,532,187	$53,658,168	$334,190,356	$1,059.25
August 2012	313,545	$410,042,922	$78,756,160	$488,799,082	$1,558.94
September 2012	310,627	$186,393,513	$36,558,286	$222,951,799	$717.75
Q25 Total	**939,670**	**$876,968,622**	**$168,972,615**	**$1,045,941,236**	**$1,113.09**
October 2012	319,808	$417,728,365	$81,517,587	$499,245,952	$1,561.11
November 2012	318,070	$256,347,435	$71,981,598	$328,329,034	$1,032.25
December 2012	315,640	$191,593,238	$65,204,935	$256,798,173	$813.58
Q26Total	**953,518**	**$865,669,039**	**$218,704,121**	**$1,084,373,159**	**$1,137.24**
January 2013	323,474	$323,122,183	$99,191,870	$422,314,054	$1,305.56
February 2013	321,784	$259,288,289	$74,996,618	$334,284,906	$1,038.85

Table 2 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
March 2013	319,392	$167,409,589	$55,149,312	$222,558,900	$696.82
Q27Total	**964,650**	**$749,820,061**	**$229,337,800**	**$979,157,860**	**$1,015.04**
April 2013	326,137	$269,942,718	$74,397,891	$344,340,609	$1,055.82
May 2013	324,747	$421,765,664	$103,646,815	$525,412,478	$1,617.91
June 2013	322,214	$163,314,895	$57,442,933	$220,757,828	$685.13
Q28 Total	**973,098**	**$855,023,277**	**$235,487,639**	**$1,090,510,916**	**$1,120.66**
July 2013	329,320	$294,156,429	$74,397,891	$368,554,320	$1,119.14
August 2013	327,794	$421,765,664	$102,301,961	$524,067,625	$1,598.77
September 2013	325,598	$163,314,895	$57,442,933	$220,757,828	$678.01
Q29 Total	**982,712**	**$879,236,988**	**$234,142,785**	**$1,113,379,773**	**$1,132.97**
October 2013	333,834	$416,763,833	$99,507,989	$516,271,821	$1,546.49
November 2013	329,927	$183,905,627	$58,732,842	$242,638,469	$735.43
December 2013	327,542	$293,375,301	$72,453,594	$365,828,895	$1,116.89
Q30 Total	**991,303**	**$894,044,760**	**$230,694,425**	**$1,124,739,185**	**$1,116.89**
January 2014	335,444	$406,154,119	$95,754,688	$501,908,807	$1,496.25
February 2014	335,837	$272,744,863	$64,939,737	$337,684,601	$1,005.50
March 2014	336,271	$162,170,158	$40,344,772	$202,514,929	$602.24
Q31 Total	**1,007,552**	**$841,069,140**	**$201,039,197**	**$1,042,108,337**	**$1,034.30**
April 2014	339,717	$439,021,196	$88,913,591	$527,934,787	$1,554.04
May 2014	339,557	$158,552,323	$32,054,482	$190,606,805	$561.34
June 2014	339,549	$284,472,380	$54,916,699	$339,389,079	$999.53
Q32 Total	**1,018,823**	**$882,045,900**	**$175,884,772**	**$1,057,930,671**	**$1,038.39**
July 2014	341,643	$408,520,411	$99,106,366	$507,626,777	$1,485.84
August 2014	341,965	$209,901,910	$26,775,262	$236,677,172	$692.11
September 2014	342,210	$272,103,115	$10,678,944	$282,782,059	$826.34
Q33 Total	**1,025,818**	**$890,525,436**	**$136,560,571**	**$1,027,086,007**	**$1,001.24**
October 2014	502,757			$555,474,500	$1,104.86
November 2014	501,310			$196,181,190	$391.34
December 2014	496,305			$555,849,242	$1,119.98
Q34 Total	**1,500,372**			**$1,307,504,932**	**$871.45**
January 2015	408,646			$213,316,912	$522.01
February 2015	531,282			$385,253,606	$725.14
March 2015	522,429			$535,785,514	$1,025.57
Q35 Total	**1,462,357**			**$1,134,356,032**	**$775.70**
April 2015	293,244			$379,195,669	$1,293.11
May 2015	527,900			$228,855,224	$433.52
June 2015	516,482			$391,120,951	$757.28
Q36 Total	**1,337,626**			**$999,171,844**	**$746.97**
MEG 1 Total	**32,930,391**	**$25,401,390,043**	**$4,777,027,664**	**33,619,450,515**	**1,020.92**

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

Table 3
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	1,343,704	$122,231,743	$122,430	$122,354,173	$91.06
August 2006	1,292,330	$272,615,188	$1,255,306	$273,870,494	$211.92
September 2006	1,308,403	$96,367,809	$345,759	$96,713,568	$73.92
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
October 2006	1,293,922	$193,175,740	$5,068,653	$198,244,393	$153.21
November 2006	1,277,102	$287,043,912	$13,069,579	$300,113,491	$235.00
December 2006	1,266,148	$110,714,051	$2,883,053	$113,597,104	$89.72
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
January 2007	1,252,859	$277,959,312	$23,489,568	$301,448,880	$240.61
February 2007	1,240,860	$176,632,680	$13,010,558	$189,643,238	$152.83
March 2007	1,234,344	$104,987,331	$8,197,611	$113,184,942	$91.70
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
April 2007	1,230,451	$177,538,314	$17,859,854	$195,398,168	$158.80
May 2007	1,218,171	$252,644,634	$32,885,813	$285,530,447	$234.39
June 2007	1,204,525	$93,978,970	$6,350,716	$100,329,686	$83.29
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
July 2007	1,198,205	$165,939,175	$18,185,330	$184,124,505	$153.67
August 2007	1,195,369	$257,178,317	$34,274,917	$291,453,235	$243.82
September 2007	1,194,789	$97,198,750	$4,900,087	$102,098,837	$85.45
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
October 2007	1,211,534	$274,566,880	$37,109,258	$311,676,138	$257.26
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$279,664,231	$39,614,594	$319,278,825	$259.33
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$291,385,556	$41,006,725	$332,392,281	$260.32
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,569,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$164.78**
July 2008	1,343,457	$167,028,012	$23,630,815	$190,658,827	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
January 2009	1,425,771	$119,386,179	$8,007,586	$127,393,766	$89.35
February 2009	1,440,339	$228,220,385	$24,038,667	$252,259,052	$175.14
March 2009	1,432,269	$361,013,917	$41,788,973	$402,802,890	$281.23
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
July 2009	1,650,790	$333,483,694	$34,533,935	$368,017,629	$222.93
August 2009	1,583,503	$119,609,810	$13,057,173	$132,666,984	$83.78
September 2009	1,538,571	$370,920,307	$51,046,606	$421,966,913	$274.26
Q13 Total	**4,772,864**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$193.31**
October 2009	1,634,683	$134,315,902	$10,464,027	$144,779,929	$88.57
November 2009	1,657,122	$250,553,059	$29,249,216	$279,802,275	$168.85
December 2009	1,667,649	$383,516,409	$50,010,230	$433,526,639	$259.96

Table 3
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
January 2010	1,682,493	$116,073,248	$9,104,061	$125,177,309	$74.40
February 2010	1,700,550	$248,374,376	$29,806,739	$278,181,115	$163.58
March 2010	1,715,338	$409,161,539	$54,737,055	$463,898,594	$270.44
Q15 Total	**5,098,381**	**$773,609,163**	**$93,647,855**	**$867,257,018**	**$170.10**
April 2010	1,720,938	$369,963,534	$30,906,075	$400,869,609	$232.94
May 2010	1,737,239	$137,689,965	$11,390,819	$149,080,785	$85.81
June 2010	1,744,966	$285,875,642	$48,175,029	$334,050,671	$191.49
Q16 Total	**5,203,143**	**$793,529,141**	**$90,471,922**	**$884,001,063**	**$169.90**
July 2010	1,760,314	$119,876,307	$11,136,093	$131,012,400	$74.43
August 2010	1,785,641	$242,522,154	$29,130,986	$271,653,141	$152.13
September 2010	1,810,787	$404,205,540	$51,277,639	$455,483,179	$251.54
Q17 Total	**5,356,742**	**$766,604,001**	**$91,544,719**	**$858,148,719**	**$160.20**
October 2010	1,821,814	$136,151,894	$13,761,006	$149,912,900	$82.02
November 2010	1,823,878	$269,927,226	$32,202,089	$302,129,316	$165.65
December 2010	1,824,704	$442,615,707	$53,974,674	$496,590,381	$272.15
Q18 Total	**5,470,396**	**$848,694,828**	**$99,937,769**	**$948,632,597**	**$173.41**
January 2011	1,765,702	$136,138,730	$11,522,305	$147,661,035	$83.63
February 2011	1,741,315	$257,027,907	$30,781,930	$287,809,837	$165.28
March 2011	1,740,373	$394,755,478	$49,334,529	$444,090,007	$255.17
Q19 Total	**5,247,390**	**$787,922,115**	**$91,638,763**	**$879,560,878**	**$167.62**
April 2011	1,873,928	$126,334,678	$16,832,953	$143,167,631	$76.40
May 2011	1,877,042	$255,956,821	$33,906,598	$289,863,419	$154.43
June 2011	1,860,701	$291,409,133	$39,973,326	$331,382,459	$178.10
Q20 Total	**5,611,671**	**$673,700,632**	**$90,712,877**	**$764,413,510**	**$136.22**
July 2011	1,894,919	$259,656,357	$32,638,562	$292,294,919	$154.25
August 2011	1,908,952	$435,988,483	$55,271,229	$491,259,713	$257.35
September 2011	1,891,285	$269,817,069	$33,364,459	$303,181,528	$160.30
Q21 Total	**5,695,156**	**$965,461,910**	**$121,274,250**	**$1,086,736,159**	**$190.82**
October 2011	1,927,438	$152,385,612	$17,583,568	$169,969,180	$88.18
November 2011	1,928,774	$468,337,497	$66,128,240	$534,465,738	$277.10
December 2011	1,916,808	$157,910,141	$16,091,075	$174,001,216	$90.78
Q22 Total	**5,773,020**	**$778,633,250**	**$99,802,883**	**$878,436,134**	**$152.16**
January 2012	1,974,661	$252,551,795	$33,783,082	$286,334,877	$145.00
February 2012	1,811,968	$457,595,125	$63,262,036	$520,857,161	$287.45
March 2012	1,806,127	$150,429,478	$18,286,764	$168,716,242	$93.41
Q23 Total	**5,592,756**	**$860,576,398**	**$115,331,882**	**$975,908,280**	**$174.50**
April 2012	1,966,756	$292,598,685	$38,771,593	$331,370,279	$168.49
May 2012	1,970,680	$481,066,431	$66,493,796	$547,560,228	$277.85
June 2012	1,957,829	$149,314,866	$17,030,689	$166,345,554	$84.96
Q24 Total	**5,895,265**	**$922,979,983**	**$122,296,078**	**$1,045,276,061**	**$177.31**
July 2012	2,005,046	$285,197,648	$38,426,279	$323,623,927	$161.40
August 2012	2,012,553	$463,745,803	$66,342,696	$530,088,499	$263.39
September 2012	1,995,529	$135,187,936	$16,904,691	$152,092,627	$76.22
Q25 Total	**6,013,128**	**$884,131,387**	**$121,673,666**	**$1,005,805,053**	**$167.27**
October 2012	2,038,168	$495,559,037	$67,296,676	$562,855,713	$276.16
November 2012	2,034,764	$342,640,459	$40,926,904	$383,567,363	$188.51
December 2012	2,019,333	$178,685,146	$22,843,384	$201,528,530	$99.80
Q26Total	**6,092,265**	**$1,016,884,642**	**$131,066,964**	**$1,147,951,606**	**$188.43**
January 2013	2,043,580	$446,870,543	$72,582,993	$519,453,536	$254.19

Table 3
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
February 2013	2,041,439	$318,241,573	$43,134,442	$361,376,015	$177.02
March 2013	2,032,101	$150,089,484	$17,917,697	$168,007,181	$82.68
Q27Total	**6,117,120**	**$915,201,600**	**$133,635,131**	**$1,048,836,732**	**$171.46**
April 2013	2,048,478	$319,987,180	$41,439,325	$361,426,505	$176.44
May 2013	2,045,418	$545,847,163	$74,045,032	$619,892,195	$303.06
June 2013	2,031,991	$153,017,542	$18,391,686	$171,409,228	$84.36
Q28 Total	**6,125,887**	**$1,018,851,885**	**$133,876,042**	**$1,152,727,927**	**$188.17**
July 2013	2,058,208	$557,312,597	$73,872,340	$631,184,938	$306.67
August 2013	2,067,890	$165,413,504	$18,308,331	$183,721,835	$88.85
September 2013	2,053,699	$336,405,579	$41,941,729	$378,347,308	$184.23
Q29 Total	**6,179,797**	**$1,059,131,680**	**$134,122,400**	**$1,193,254,080**	**$193.09**
October 2013	2,084,154	$551,423,510	$75,589,844	$627,013,354	$300.85
November 2013	2,074,065	$171,934,136	$23,274,841	$195,208,977	$94.12
December 2013	2,079,491	$347,354,539	$45,890,409	$393,244,949	$189.11
Q30 Total	**6,237,710**	**$1,070,712,185**	**$144,755,094**	**$1,215,467,279**	**$194.86**
January 2014	2,058,035	$481,915,539	$62,296,533	$544,212,072	$264.43
February 2014	2,068,819	$286,629,453	$38,948,927	$325,578,380	$157.37
March 2014	2,071,206	$132,621,415	$21,041,358	$153,662,773	$74.19
Q31 Total	**6,198,060**	**$901,166,406**	**$122,286,818**	**$1,023,453,224**	**$165.12**
April 2014	2,073,461	$485,506,218	$74,562,670	$560,068,887	$270.11
May 2014	2,075,518	$113,845,160	$16,741,937	$130,587,098	$62.92
June 2014	2,102,763	$302,019,241	$42,753,483	$344,772,725	$163.96
Q32 Total	**6,251,742**	**$901,370,619**	**$134,058,091**	**$1,035,428,710**	**$165.62**
July 2014	2,141,584	$447,552,034	$84,149,642	$531,701,676	$248.27
August 2014	2,164,777	$228,094,690	$6,564,149	$234,658,839	$108.40
September 2014	2,230,564	$329,391,960	$40,318,388	$369,710,347	$165.75
Q33 Total	**6,536,925**	**$1,005,038,684**	**$131,032,178**	**$1,136,070,862**	**$173.79**
October 2014	2,238,870			$862,195,930	$385.10
November 2014	2,290,489			$327,068,249	$142.79
December 2014	2,329,001			$808,718,242	$347.24
Q34 Total	**6,858,360**			**$1,997,982,421**	**$291.32**
January 2015	2293805			$313,542,190	$136.69
February 2015	2,487,261			$580,734,739	$233.48
March 2015	2,513,081			$826,263,254	$328.78
Q35 Total	**7,294,147**			**$1,720,540,183**	**$235.88**
April 2015	1,391,829			$543,984,163	$390.84
May 2015	2,552,622			$298,395,017	$116.90
June 2015	2,535,461			$619,370,033	$244.28
Q36 Total	**6,479,912**			**$1,461,749,214**	**$225.58**
MEG 2 Total	**188,148,941**	**$25,446,856,153**	**$3,054,814,898**	**33,681,942,869**	**179.02**

*Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

Table 4 MEG 1 and 2 Annual Statistics					
DY1 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY1 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY1 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY2 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY2 Total	3,033,969	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY2 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY2 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY3 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY3 Total	3,249,742	$2,937,427,184	$500,344,974	$3,437,772,158	$1,057.86
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(158,619,822)	
% of WOW PCCM MEG 1					95.59%
DY3 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY3 Total	17,094,840	$2,572,390,668	$281,844,467	$2,854,235,134	$166.96
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,123,392,237)	
% of WOW PCCM MEG 2					71.76%
DY4 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY4 Total	3,357,141	$3,066,429,103	$550,235,443	$3,616,664,546	$1,077.30
WOW DY4 Total	3,357,141			$4,012,454,923	$1,195.20
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY4 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY4 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY5 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM

Table 4 MEG 1 and 2 Annual Statistics					
MEG 1 - DY05 Total	3,499,758	$3,247,599,951	$590,194,459	$3,837,794,411	$1,096.59
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(679,763,211)	
% of WOW PCCM MEG 1					84.95%
DY5 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY5 Total	21,686,199	$3,225,551,490	$398,406,833	$3,623,958,323	$167.11
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,261,459,223)	
% of WOW PCCM MEG 2					61.58%
DY6 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY6 Total	3,653,867	$3,385,729,683	$649,065,772	$4,034,795,456	$1,104.25
WOW DY6 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(922,223,210)	
% of WOW PCCM MEG 1					81.40%
DY6 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY6 Total	22,956,197	$3,543,588,406	$499,575,622	$4,043,164,027	$176.13
WOW DY6 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,517,028,389)	
% of WOW PCCM MEG 2					61.63%
DY7 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY7 Total	3,830,936	$3,331,762,672	$916,168,033	$4,247,930,705	$1,108.85
WOW DY7 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,214,371,081)	
% of WOW PCCM MEG 1					77.77%
DY7– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY7 Total	24,348,400	$3,892,512,229	$490,792,975	$4,383,305,204	$180.02
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,943,615,324)	
% of WOW PCCM MEG 2					59.82%
DY8 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY8 Total	4,000,390	$3,414,538,645	$937,066,111	$4,351,604,756	$1,087.80
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,643,219,682)	
% of WOW PCCM MEG 1					72.59%
DY08– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY08 Total	24,867,309	$3,783,670,392	$627,829,104	$4,411,499,496	$177.40
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,468,204,707)	
% of WOW PCCM MEG 2					55.99%
DY09 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY09 Total	5,326,173			$4,096,318,627	$769.09
WOW DY8 Total	5,326,173			$4,190,100,299	$786.70
Difference				$(93,781,673)	

Table 4 MEG 1 and 2 Annual Statistics					
% of WOW PCCM MEG 1					97.76%
DY09– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY09 Total	27,169,344			$6,073,540,409	$223.54
WOW DY8 Total	27,169,344			$8,806,399,471	$324.13
Difference				$(2,732,859,062)	
% of WOW PCCM MEG 2					68.97%

For DY1, MEG 1 has a PCCM of $972.13 (Table 4), compared to WOW of $948.79 (Table 1), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 4), compared to WOW of $199.48 (Table 1), which is 80.32% of the target PCCM for MEG 2.

For DY2, MEG 1 has a PCCM of $1,022.14 (Table 4), compared to WOW of $1,024.69 (Table 1), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 4), compared to WOW of $215.44 (Table 1), which is 78.84% of the target PCCM for MEG 2.

For DY3, MEG 1 has a PCCM of $1,057.86 (Table 4), compared to WOW of $1,106.67 (Table 1), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 4), compared to WOW of $232.68 (Table 1), which is 71.76% of the target PCCM for MEG 2.

For DY4, MEG 1 has a PCCM of $1,077.30 (Table 4), compared to WOW of $1,195.20 (Table 1), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 4), compared to WOW of $251.1 (Table 1), which is 66.42% of the target PCCM for MEG 2.

For DY5, MEG 1 has a PCCM of $1,096.59 (Table 4), compared to WOW of $1,290.82 (Table 1, which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 (Table 4), compared to WOW of $271.39 (Table 1), which is 61.58% of the target PCCM for MEG 2.

For DY6, MEG 1 has a PCCM of $1,104.25 (Table 4), compared to WOW of $1,356.65 (Table 1), which is 81.40% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.13 (Table 4), compared to WOW of $285.77 (Table 1), which is 61.63% of the target PCCM for MEG 2.

For DY7, MEG 1 has a PCCM of $1,108.85 (Table 4), compared to WOW of $1,425.84 (Table 1), which is 77.77% of the target PCCM for MEG 1. MEG 2 has a PCCM of $180.02 (Table 4), compared to WOW of $300.92 (Table 1), which is 59.82% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1,087.80 (Table 4), compared to WOW of $1,498.56 (Table 1), which is 72.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $177.40 (Table 4), compared to WOW of $316.87(Table 1), which is 55.99% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $769.09 (Table 4), compared to WOW of $786.70 (Table 1), which is 97.76% of the target PCCM for MEG 1. MEG 2 has a PCCM of $223.54 (Table 4), compared to WOW of $324.13 (Table 1), which is 68.97% of the target PCCM for MEG 2.

Table 5 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.27
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 06	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					70.14%
DY 07	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$7,224,274,901	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% Of WOW					67.49%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,867,699	$7,198,209,036	$1,564,895,215	$8,763,104,252	$303.56
WOW	28,867,699			$13,874,528,641	$480.62
Difference				$(5,111,424,389)	
% Of WOW					63.16%
DY 09	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	32,495,517			$10,169,859,035	$312.96
WOW	32,495,517			$12,996,499,770	$399.95
Difference				$(2,826,640,735)	
% Of WOW					78.25%

For DY1, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For DY2, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For DY3, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $309.27. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For DY4, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $297.57. Comparing the calculated weighted averages, the actual PCCM is 76.94% of the target PCCM.

For DY5, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $296.27. Comparing the calculated weighted averages, the actual PCCM is 71.73% of the target PCCM.

For DY6, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $303.57. Comparing the calculated weighted averages, the actual PCCM is 70.14% of the target PCCM.

For DY7, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $453.85. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $306.30. Comparing the calculated weighted averages, the actual PCCM is 67.49% of the target PCCM.

For DY8, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 5) is $480.62. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $303.56. Comparing the calculated weighted averages, the actual PCCM is 63.16% of the target PCCM.

For DY9, the weighted target PCCM for the reporting period using the actual case months and the MMA specific targets in the STCs (Table 5) is $399.95. The actual PCCM weighted for the reporting period using the actual case months and the MMA specific actual PCCM as provided

in Table 5 is $312.96. Comparing the calculated weighted averages, the actual PCCM is 78.25% of the target PCCM.

The Healthy Start program and the program for All-inclusive Care for Children (PACC) are authorized as Cost Not Otherwise Matchable (CNOM) services under the 1115 MMA Waiver. Table 6 identifies the DY9 costs for these two programs. For budget neutrality purposes, these CNOM costs are deducted from the savings resulting from the difference between the With Waiver costs and the With-Out Waiver costs identified for DY09 in Table 5 above.

Table 6 WW/WOW Difference Less CNOM Costs	
DY09 Difference July 2014 - June 2015:	**($2,826,640,735)**
CNOM Costs July 2014 - June 2015:	
Healthy Start	**$31,628,984**
PACC	**$622,731**
DY09 Net Difference:	**($2,794,389,020)**

Table 7 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Q19	**$180,732,289**
Q20	**$353,499,776**
Q21	**$57,414,775**
Q22	**$346,827,872**
Q23	**$175,598,167**
Q24	**$227,391,753**
Q25	**$189,334,002**
Q26	**$243,596,958**

Table 7 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q27	**$277,637,763**
Q28	**$308,722,821**
Q29	**$163,925,949**
Q30	**$316,726,485**
Q31	**$374,225,087**
Q32	**$301,519,921**
Q34	**$690,421,416**
Q35	**$556,474,290**
Q36	**$830,244,034**
Total Paid	**$10,055,810,483**

Table 8 shows that the expenditures for the DY9 MEG 3, LIP, were $2,077,139,740 (95.82%) of the $2,167,718,341 cap.

Table 8 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$807,232,567	$1,000,000,000	80.72%
DY07	$1,019,291,544	$1,000,000,000	101.93%
DY08	$1,156,397,442	$1,000,000,000	115.64%
DY09	$2,077,139,740	$2,167,718,341	95.82%
Total MEG 3	**$10,055,810,483**	**$10,167,718,341**	**98.90%**

*DY totals are calculated using date of service data as required in STC #70.

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State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

2727 Mahan Drive
Tallahassee, FL 32308
ahca.myflorida.com

Mission Statement
Better Healthcare for All Floridians.