Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

1st Quarter Report
July 1, 2014 – September 30, 2014
Demonstration Year 9

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I. Waiver History

On July 31, 2014, the Centers for Medicare and Medicaid Services (CMS) approved a three-year extension of the Managed Medical Assistance (MMA) Waiver. The approved waiver extension documents can be viewed on the Agency's website at: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml. The approval of the extension continues the improvements established in the June 2013 amendment provided below and authorized a one-year extension of the Low Income Pool until June 30, 2015.

On June 14, 2013, CMS approved an amendment to the waiver to implement the MMA program.
The approved waiver amendment documents can be viewed on the Agency's website at: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_approved.shtml.

Federal approval of the MMA amendment permitted 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 managed care plans, customized benefit packages, Healthy Hehavior programs, risk-adjusted premiums based on enrollee health status and continuation of the Low Income Pool. 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 managed care 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 Medicaid expenditures;
- Enhances metrics on plan quality and access to care to improve plan accountability; and
- Creates a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

Quarterly Report Requirement

The quarterly and annual reporting requirements for the waiver are specified in Special Terms and Conditions (STCs) #84 and #85 of the waiver. The state is required to submit a quarterly

report summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery.

This report is the first quarterly report for Demonstration Year (DY) 9 covering the period of July 1, 2014 through September 30, 2014. For detailed information about the activities that occurred during previous quarters of the demonstration, please refer to the quarterly and annual reports at: http://ahca.myflorida.com/Medicaid/medicaid_reform/federal.shtml.

II. Operational Update

1. Status of Implementation

On May 1, 2014, the Agency began implementation of the MMA program as outlined in the following tables with full implementation completed on August 1, 2014 in accordance with Part IV of Chapter 409, Florida Statutes (F.S.) and the approved waiver. The Agency coordinated with the contracted MMA plans and the Agency's choice counseling vendor to create a transition that ensured the volume of recipients being transitioned occurred in an organized manner.

MMA Implementation Schedule		
Regions	**Enrollment Date**	**Status**
2, 3 and 4	May 1, 2014	Completed
5, 6 and 8	June 1, 2014	Completed
10 and 11	July 1, 2014	Completed
1, 7 and 9	August 1, 2014	Completed

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

a) Comprehensive Outreach and Education Strategy

A detailed description of the Agency's comprehensive outreach and education strategy for the MMA program is provided in the MMA Implementation Plan, available on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml. The comprehensive outreach schedule and activities for this quarter is provided in Attachment I of this report.

b) Medicare-Medicaid Eligible Enrollees

Please note, Medicare-Medicaid eligible enrollees who are enrolled in a Medicare Advantage plan will participate in an open enrollment period that coincides with the Medicare open

enrollment period (October 15 through December 7) to facilitate enrollees' choice of Medicare and Medicaid managed care plans. Therefore, MMA coverage will begin on February 1, 2015 for enrollees in both Medicare and Medicaid managed care plans. The Agency continues to seek technical assistance from the CMS Medicare-Medicaid Coordination Office to promote alignment and integration with Medicare for Medicare-Medicaid eligible individuals in the MMA program.

2. Health Care Delivery System

The following provides an update for this quarter on health care delivery system activities for managed care plan contracting, benefit packages, and plan readiness review and monitoring.

a) Managed Care Plan Contracting

Table 1 lists the contracted managed care plans for the MMA program. Please refer to Attachment IV, MMA Enrollment Report, of this report for the MMA plans that began providing services during this quarter.

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

*This MMA plan is contracted to provide specialized services.

**This MMA plan is also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.

***Sunshine Health is contracted to provide specialized services and is also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.

Contract Amendments

During this quarter, the Agency finalized a general contract amendment, effective July 1, 2014, which incorporated corrections and changes to the plan's contracts. The general amendment applied to the Long-term Care (LTC) plans, MMA plans and the MMA plans that are also contracted to provide LTC services. A copy of the model contract may be viewed on the Agency's website at: http://ahca.myflorida.com/SMMC. Also during this quarter, the Agency finalized revisions to the plan's Report Guide to include corrections and new reporting requirements, and also began to gather items for the next general contract amendment.

Agency Communications to Plans

There were four contract interpretations, seven policy transmittals and one "Dear Managed Care Plan" letters released to the managed care plans during this quarter.

The contract interpretation advised managed care plans of the following:

- Provided guidance on the Healthy Behaviors program requirements under the MMA component of the Statewide Medicaid Managed Care (SMMC) program.
- Provided guidance on the process of enrolling a newborn recipient when the mother is enrolled in a specialty plan in accordance with 409.977(3) and 409.969(1), F.S.
- Interpreted contract language relating to the provision of non-emergency transportation to Medicaid-covered services provided to MMA plan enrollees.
- Provided guidance to MMA plans related to the primary care provider (PCP) requirements for full benefit dual eligible enrollees.

The four policy transmittals advised the plans of the following:

- Notified plans of a change in date of the first submission of the first Hernandez Settlement Agreement (HSA) Survey Report under the contract.
- Informed the plans of a change in the submission requirements for the operative report and claim documentation for transplant kick payments.
- Explained that the Multiple Procedure Payment Reduction (MPPR) policy implemented by CMS applies to selected therapy services provided to Medicare beneficiaries and reimbursed under the Medicare Physician Fee Schedule (MPFS). Further explained that plans are not required to apply MPPR to Medicaid-covered services, and that MPPR is not a Medicaid policy.
- Notified plans of a new state law, The Florida Information Protection Act of 2014, which became effective on July 1, 2014, with which plans are required to comply, and that compliance will be monitored by the Agency.

The "Dear Managed Care Plan" letter advised managed care plans of the following:

- Reminded 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.

b) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment II of this report, the managed care plans provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid Coverage and Limitations Handbooks, and where applicable the Florida Medicaid fee schedules.

The table below lists the standard benefits are provided under the MMA contracts that were executed by the MMA plans:

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
(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

The MMA plans must comply with the requirements in the Child Health Check Up Services Coverage and Limitations Handbook (see Attachment II, Exhibit II-A, Section IV.A.1.a.(9).(b) of the MMA plan contract). The Handbook specifies on page 2-3 that, under federal law, Florida provides medically necessary treatment for all medical conditions that are diagnosed from a Child Health Check-Up. MMA plans are required to meet this standard and may not be more restrictive than the handbook in covering medically necessary services for children.

MMA plans are required to cover most Medicaid State Plan services and to provide access to additional services covered under early and periodic screening, diagnosis and treatment (EPSDT) through a special services request process. Services specialized for children in foster care include: specialized therapeutic foster care, comprehensive behavioral health assessment, behavioral health overlay services for children in child welfare settings, and medical foster care. All MMA plans have the option of implementing additional substitution services, which include a specialized therapeutic in-home service that was developed for use with the foster care population.

All MMA contracts now contain requirements pertaining to services for children in the dependency system. All dependent children are eligible to select from a standard managed care plan or to enroll in the statewide Child Welfare Specialty Plan, open only to children in the child welfare system. Additional specialty plans for HIV/AIDS, serious mental illness, and children with chronic conditions are also available to dependent children meeting the clinical eligibility requirements for those plans.

c) MMA Plan Reported Complaints, Grievances and Appeals

MMA Plan Reported Complaints

Table 2 provides the number of MMA plan reported complaints for this quarter.

Table 2
MMA Plan Reported Complaints
(July 1, 2014 – September 30, 2014)

Quarter	Total
July 1, 2014 – September 30, 2014	15,979

Grievances and Appeals

Table 3 provides the number of grievances and appeals for this quarter.

Table 3
MMA Grievances and Appeals
(July 1, 2014 – September 30, 2014)

Quarter	Total Grievances	Total Appeals
July 1, 2014 – September 30, 2014	3082	1846

Medicaid Fair Hearing (MFH)

Table 4 provides the number of MFHs requested and held during this quarter.

Table 4
MMA Medicaid Fair Hearings Requested and Medicaid Fair Hearings Held
(July 1, 2014 – September 30, 2014)

Quarter	MFHs Requested	MFHs Held
July 1, 2014 – September 30, 2014	147	22

Beneficiary Assistance Program (BAP)

Table 5 provides the number of requests submitted to the Beneficiary Assistance Program (BAP) during this quarter. The BAP will be discontinued on October 1, 2014 and all managed care cases will be processed by the Subscriber Assistance Program (SAP).

Table 5 MMA BAP Requests (July 1, 2014 – September 30, 2014)	
Quarter	**Total**
July 1, 2014 – September 30, 2014	2

d) Agency-Received Complaints/Issues

Table 6 provides the number of complaints/issues related to the MMA program that the Agency received this quarter. There were no trends discovered in the Agency-received complaints for this quarter.

Table 6 Agency-Received MMA Complaints/Issues (July 1, 2014 – September 30, 2014)	
Quarter	**Total**
July 1, 2014 – September 30, 2014	3,010

e) Medical Loss Ratio

During this quarter, all eleven capitated plans submitted their second quarter Medical Loss Ratio (MLR) reports for DY8 to the Agency on or before the due date. The Agency submitted the capitated plan's MLR results to CMS by August 15, 2014, as outlined in Table 11 of the second quarter report for DY8. Two of the eleven capitated plans reported an MLR below 85% for the reporting period. The capitated plans' MLR data is evaluated annually to determine compliance, and quarterly reports are provided for informational purposes. Seasonality and inherent claims volatility may cause MLR results to fluctuate somewhat from quarter to quarter, especially for smaller plans.

f) Plan Readiness Review and Monitoring

The Agency selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies through a competitive procurement process to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe mental illness, and dual eligibles with chronic conditions. The Agency also is contracting with the Children's Medical Services Network (CMSN) operated by the Florida Department of Health to serve children with chronic conditions.

During Q1 of DY9, the Agency completed implementation of the MMA program on August 1, 2014. As of September 30, 2014, all readiness activities have been completed and all on-site reviews for MMA plans have been completed, as shown in Table 7. The only MMA plan that has not completed the readiness process is Freedom Health, which isn't scheduled to "Go Live" until January 2015. As part of the implementation process, the Agency holds weekly calls with the plans in the form of an "All-Plan" call, and also holds weekly calls with each individual MMA plan. Additionally, the Agency continues to monitor the MMA plans on a daily basis now that the program has been operationalized statewide.

Table 7 MMA Plan Readiness Review				
MMA Plan	**Readiness Review Request Sent**	**Readiness Review Response Received**	**Desk Review Complete**	**Onsite Review Complete**
1. **AHF/Positive**	**X**	**X**	**X**	**X**
2. **Amerigroup**	**X**	**X**	**X**	**X**
3. **Better**	**X**	**X**	**X**	**X**
4. **Clear Health**	**X**	**X**	**X**	**X**
5. **Coventry**	**X**	**X**	**X**	**X**
6. **FCA**	**X**	**X**	**X**	**X**
7. **Freedom**				
8. **Humana**	**X**	**X**	**X**	**X**
9. **Integral**	**X**	**X**	**X**	**X**
10. **Magellan**	**X**	**X**	**X**	**X**
11. **Molina**	**X**	**X**	**X**	**X**
12. **Preferred**	**X**	**X**	**X**	**X**
13. **Prestige**	**X**	**X**	**X**	**X**
14. **SFCCN**	**X**	**X**	**X**	**X**
15. **Simply**	**X**	**X**	**X**	**X**
16. **Staywell**	**X**	**X**	**X**	**X**
17. **Sunshine**	**X**	**X**	**X**	**X**
18. **United**	**X**	**X**	**X**	**X**
19. **CMSN**	**X**	**X**	**X**	**X**

3. Choice Counseling Program

The following provides an update for this quarter on choice counseling program activities for online enrollment, the call center, self-selection rate and auto assignments.

a) Online Enrollment

Table 8 shows the number of online enrollments by month for this quarter.

Table 8 Online Enrollment Statistics (July 1, 2014 – September 30, 2014)				
	July	**August**	**September**	**Total**
Enrollments	79,288	41,981	24,005	145,274

b) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for 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 this quarter, the call center had an average of 256 full time equivalent employees who can answer calls in English, Spanish and Haitian Creole.

Table 9 provides the call center statistic for this quarter. The choice counseling calls remains within the anticipated call volume for the quarter.

Table 9
Call Volume for Incoming and Outgoing Calls
(July 1, 2014 – September 30, 2014)

Type of Calls	July	August	September	Totals
Incoming Calls	227,916	129,129	113,579	**470,640**
Outgoing Calls	2,592	3,603	3,892	**10,087**
Totals	**230,508**	**132,732**	**117,487**	**480,727**

Outbound and Inbound Mail

During this quarter, the choice counseling vendor mailed the following:

- New-Eligible Packets (mandatory and voluntary) 218,931
- Confirmation Letters 404,835
- Open Enrollment Packets 4,282
- Transition Packets (mandatory and voluntary) 5,698
- Plan Transfer Letters (mandatory and voluntary) 0

Face-to-Face/Outreach and Education

Table 10 provides the choice counseling outreach activities that were performed this quarter.

Table 10
Choice Counseling Outreach Activities
(July 1, 2014 – September 30, 2014)

Field Activities	1st Quarter – Year 9
Group Sessions	13
Private Sessions	8
Home Visits and One-On-One Sessions	28
No Phone List*	0
Outbound Phone List	0
Enrollments	2,213
Plan Changes	0

*Attempts made by field choice counselors to contact recipients who do not have a valid phone number in the Health Track System.

Quality Improvement

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rate their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the

survey to every recipient who calls to enroll in an MMA plan or to make a plan change. Due to the implementation of the MMA program, there were not enough surveys available for a statistically valid sample. The Agency is currently reviewing the survey for changes and improvements, as well as to assure all questions are still valid for the MMA program.

c) Self-Selection and Auto Assignment Rates

Table 11 provides the current self-selection and auto-assignment rate for this quarter.

Table 11
Self-Selection and Auto-Assignment Rate*
(July 1, 2014 – September 30, 2014)

	July	August	September
Self-Selected	285,603	167,834	105,746
Auto-Assignment	574,927	121,903	78,569
Total Enrollments	860,530	289,737	184,315
Self-Selected %	33%	58%	57%
Auto-Assignment %	67%	42%	43%

* 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 LTC and MMA populations.

4. Healthy Behaviors Programs

Healthy Behaviors Programs

The MMA plans will begin offering their Healthy Behaviors programs on October 1, 2014. The Agency has allowed the plans currently operating quality incentive programs to continue these programs in accordance with state and federal regulations until the Healthy Behaviors program is implemented. The Agency is reviewing the plan's Healthy Behaviors programs and will provide feedback as appropriate. Then, the plans will have the opportunity to submit final Healthy Behaviors program documents for Agency approval.

The Agency will provide a summary of the plan's Healthy Behaviors programs in the second quarter report of DY9 after implementation.

Enhanced Benefits Account Program

Attachment III of this report provides an update for this quarter on enhanced benefits account program activities for the call center, statistics, advisory panel, and phase-out of the enhanced benefits account program. The Agency will continue to provide EBA program statistics in the Quarterly Report until implementation of the Healthy Behaviors programs as specified in STC #84.

5. Plan and Regional Enrollment Data

Attachment IV of this report provides an update of MMA plan and regional enrollment for the period July 1 2014 through September 30, 2014, and contains the following enrollment reports:

- Number of MMA Plans, and
- Regional MMA Enrollment.

6. Policy and Administrative Issues

The Agency continues to identify and resolve various operational issues for the plans. The Agency's internal and external communication processes play a key role in managing and resolving issues effectively and efficiently. These forums provide an opportunity for discussion and feedback on proposed processes, and provide finalized policy in the form of “Dear Provider” letters and policy transmittals to the MMA plans. The following provides an update for this quarter on these forums as the Agency continues its initiatives on process and program improvement.

a) Weekly “All Plan Call” and Individual Calls with Plans

The Agency holds an “All-Plan” call with all plans that takes place every Friday, and participation is required by all MMA plans. The purpose of this call is to provide policy and programmatic updates to the plans. During this quarter, the Agency was completing implementation of the MMA program and held eight “All-Plan” calls. As we move from implementation to operations, the Agency has decided to move from the weekly calls to a monthly call with all plans. Additionally, an individual call is held with each MMA plan on a weekly basis to discuss operational issues and any other pressing issues for the week.

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 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.

a) LIP Council Meetings

During this quarter, the Agency held no LIP Council meetings.

b) LIP STCs - Reporting Requirements

The following provides an update of the LIP STCs that required action during this quarter.

STC #84d – LIP Tier-One Milestones

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

- On July 22, 2014, the Agency collected the fourth quarter reporting used in the submission of the annual *Milestones Statistics and Finding Report* for DY8.
- On August 30, 2014, the Agency collected the annual/cumulative reporting used in the submission of the annual *Milestones Statistics and Finding Report* for DY8.

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 for SFY 2013-14 for the 44 hospital initiatives.

c) Current LIP STCs - Reporting Requirements

The following provides an update of the current (DY9) LIP STCs that required action during this quarter.

STC #70 – Section XXI Schedule of State Deliverables

This STC requires the submission of a schedule for the LIP reconciliations for DYs 1-9 with in 60 day of the acceptance of the STCs.

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

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 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 to CMS the draft RFMD for DY9. The report can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml

STC #79d – LIP Tier-One Milestones

This STC requires the submission of an anticipated timeline for the 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 timeline for the two annual reports.

IV. Demonstration Goals

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

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

For the first quarter of DY9, all MMA plans offered expanded benefits that were not previously covered under Florida's Medicaid State Plan. Please refer to Attachment II of this report for the expanded benefits under the MMA program by plan.

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

Improved access to specialists will be demonstrated in the annual reports. The latest analysis on access to specialists can be found in the Final Annual Report for DY8 at the Agency's following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/annual.shtml.

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

A summary of results of the sixth year of performance measures is included in the second quarter report for DY8. During this quarter, the plans submitted Lessons Learned from their Performance Measure Action Plan activities, and the Agency sent out liquidated damages letters to the plans (based on the 2013 performance measure submission). The Agency also sent the plans the benchmarks against which their 2014 performance measure submissions will be compared. The Performance Measure Report covering calendar year 2013 was due to the Agency by July 1, 2014.

Performance measures for the MMA program are discussed in Section VIII B. 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 managed care delivery systems will enable a comparison by county or by MMA plan. The reports will include morbidity scoring for risk adjustment (Chronic Illness Disability Payment System/MedRx hybrid model), utilization per member per month (normalized to report per 1,000 recipients), and distribution by category of the QI's at the statewide level (including fee-for-service and managed care), as well as for each managed care plan. The model will be updated to support the latest version (4.5a) provided by Agency for Healthcare Research and Quality.

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 ED (emergency departments) algorithm to analyze the utilization of emergency departments. The Agency estimates it will be able to produce this report in the first quarter of year ten 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 Disability Payment System /MedRx hybrid model), utilization per member per month (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 managed care plan member utilization. The model will support the latest version (2.0) provided by New York University.

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

Objective 3: To ensure that enrollee satisfaction increases.

Refer to Section VIII D. of this report 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 #79 – Tier-One Milestones

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 website at the following link: http://www.ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml. Please refer to Section III, Low Income Pool, of this report for an update (if available) on both Tier-One Milestone reports.

Final Evaluation Plan

The required demonstration evaluation will include specific studies regarding access to care and quality of care as affected by the Tier-One and Tier-Two initiatives in accordance with the STCs of the waiver. On October 30, 2012, CMS approved the Agency's Final Evaluation Design. When available, the results of the evaluation will be reported under Section VI, Evaluation of the Demonstration, of this report.

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 V of this report are through the first quarter (July 1, 2014 – September 30, 2014) 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. During this quarter, the MMA program was still in the process of implementation therefore Medicaid Reform and Non-Reform were still operational in some regions of the State. For counties where Medicaid Reform was operating, the case months and expenditures reported were for enrolled mandatory and voluntary individuals. For counties where Medicaid Reform was not operational, the mandatory population and expenditures were captured and subject to the budget neutrality. However, these individuals received their services through the Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and/or providers of 1915(c) Home and Community Based Services Waivers.

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. The 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 V of this report for an update on Budget Neutrality figures through the first quarter (July 1, 2014 – September 30, 2014) of DY9.

VI. Encounter and Utilization Data

a) Encounter Data

Reviewing and refining the methodologies for editing, processing and extracting encounter data are ongoing processes for the Agency. During this quarter, several system modifications and data table upgrades were implemented to improve the quality of encounter data and encounter data analytics. Agency for Healthcare Research and Quality models for measuring quality of inpatient hospital care have been incorporated in the analyses of encounter data in order to determine missing values and process improvement needed. The gaps will be addressed and the analyses run reiteratively until a reliable data set is available for successfully running the program and reporting these quality measures. The Agency is developing a report for monitoring services, expenditures, and utilization of the newly implemented MMA program, based on the encounter data submitted and processed.

The Agency has contracted with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (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 managed care plans are complete and accurate. HSAG will compare encounter data with the plan's administrative data and will also validate provider-reported encounter data against a sample of medical records. During this quarter, HSAG delivered its first draft encounter data report which contained an analysis of encounter data field validity and completeness, a review of the Agency's and plan's encounter data systems and processes, and recommendations of future improvement opportunities.

During this quarter, the Agency developed a plan in conjunction with its contractor, HSAG to conduct next year's EQRO validation study. The goal of the study is to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate.

During the demonstration year, HSAG will review encounter data submitted by plans that are actively participating in the MMA Program. A component of the study will include the comparison of encounter data to the actual medical record. The study period will include encounter data submitted between January 2013 and March 2014.

b) Rate Setting/Risk Adjustment

The rate setting process currently uses hospital inpatient, hospital outpatient, physician/other, pharmacy and mental health encounter data.

During this quarter, the Agency implemented a new process for MMA risk adjustment. The Agency sent plans participating in the MMA program pharmacy and non-pharmacy encounter data for three service months. 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 #104 – 107 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. During the first quarter of DY9, the Agency made revisions to the updated evaluation design for the MMA program, based on comments received from CMS at the end of May 2014. Agency staff held calls with CMS in July and August to obtain clarification on some of the written comments, and finished revising the evaluation design. The revised design will be submitted to CMS during the second quarter of DY9. Once CMS approves the updated evaluation design, the Agency will solicit proposals for conducting the evaluation from Florida state universities.

To view the Final Evaluation Design for the current waiver period December 16, 2011 – June 30, 2014 and to view the Final Evaluation Report that covers the initial five-year demonstration period, please visit the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/index.shtml.

Pending and Upcoming Evaluation Reports and Activities

The following provides an update of the pending and upcoming Reform waiver evaluation reports and activities during this quarter:

- During this quarter, the University of Florida evaluation team submitted the draft Final Evaluation Summary Report to the Agency for review. The Agency provided feedback and the revised report is due to the Agency at the beginning of the second quarter of DY9.
- The Florida International University evaluation team submitted the final report of the evaluation of domain iv during this quarter. The findings from this report were incorporated into the draft Final Evaluation Summary Report.
- The Agency will be submitting the draft Final Evaluation Summary Report to CMS by October 28, 2014.

VIII. Quality

The following provides an update on quality activities for the External Quality Review Organization (EQRO), MMA plan performance measure reporting, the Comprehensive Quality Strategy, and assessing enrollee satisfaction.

a) EQRO

On August 1, 2014, HSAG, Florida's contracted EQRO, submitted a preliminary proposal for a focused study on cultural competencies. The Agency has requested that HSAG conduct a statewide focused study during SFY 2014-2015 on cultural competencies, with the goal of assisting the Agency and its managed care plans in identifying areas and strategies for improvement.

On August 7, 2014, HSAG submitted the final version of their annual Encounter Data Validation Study related to the review of the Agency's and its contracted managed care plans' information systems. On August 27, 2014, HSAG submitted the final version of the Medical Record Review report, for which HSAG collected and reviewed a sample of medical records for the Medicaid managed care plans' enrollees, in order to assess the accuracy and completeness of Florida's encounter data.

On August 26, 2014, HSAG conducted an external quality review quarterly educational meeting for the SMMC plans, the Agency, and the Department of Elder Affairs. Presentations were given by the Agency's Bureau of Pharmacy Services on *Prescribing Psychotherapeutic Medication to Children: A History of Policy Development and Quality Improvement* and by the Director of the Florida Perinatal Quality Collaborative on *Perinatal Quality Improvement Efforts in Florida*. The Agency also provided an update to the plans regarding performance measure reporting requirements.

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. This study examines the extent to which pharmacy encounters submitted to the Agency by its contracted managed care plans are an accurate reflection of the prescription data processed, collected, and maintained within the prescription drug processing system. On August 11, 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, 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 provides recommendations to the Agency on how to improve the overall quality of its pharmacy encounter data.

In addition to the above activities, during the first quarter of DY9, the managed care plans' 2014 performance measure submissions (representing calendar year 2013) were sent to HSAG by the Agency, and HSAG began performing the performance measure validation activities. The SMMC plans submitted their performance improvement project (PIP) proposals to the Agency and to HSAG at the beginning of August, and HSAG began validating the PIP proposals during this quarter.

b) Plan Performance Measure Reporting

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

During the first quarter of DY9, the Agency received the seventh year of performance measure submissions from the plans prior to MMA implementation. Results of the seventh year of performance measures (representing calendar year 2013) may be viewed in Attachments VI and VII of this report. Attachment VI is a table of the demonstration plans' performance measure rates from 2008 through 2014 reporting. Attachment VII 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 VI and VII, 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 2013 (representing measurement year 2012) to 49.0% in 2014 (representing measurement year 2013).
    - Adults' Access to Preventive Care – 20-44 years: the statewide weighted average for demonstration plans increased from 69.2% in 2013 to 75.9% in 2014.
    - Breast Cancer Screening: the statewide weighted average for demonstration plans increased from 52.5% in 2013 to 56.0% in 2014.
    - Adult BMI Assessment: the statewide weighted average for demonstration plans increased from 63.0% in 2013 to 77.0% in 2014.
    - Immunizations for Adolescents – Combo 1: the statewide weighted average for demonstration plans increased from 54.6% in 2013 to 63.0% in 2014.
- Other measures that had notable improvement in the past stayed relatively flat from 2013 to 2014, but their 2014 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 2012 to 40.4% in 2013, then increased to 42.3% in 2014.

- Appropriate Testing for Children with Pharyngitis: the statewide weighted average for demonstration plans increased from 64.0% in 2012 to 67.7% in 2013, then increased to 69.0% in 2014.
- Lead Screening in Children: the statewide weighted average for demonstration plans increased from 59.6% in 2012 to 61.7% in 2013, and to 63.2% in 2014.
- Frequency of Prenatal Care: the statewide weighted average for demonstration plans increased from 44% in 2011 to 54.4% in 2012, then declined to 53.7% in 2013 and remained there in 2014.

During the first quarter of DY9, Agency staff began comparing managed care plans' HEDIS performance measure rates to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance for HEDIS 2013). This activity will continue in the second quarter, and the results will be used for the managed care plan report card as well as to determine any liquidated damages related to performance measures.

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 Medical Care Advisory Committee (MCAC) meeting and feedback was gathered from the MCAC subcommittees. During the second quarter of DY9, Agency staff will compile and review all the feedback and comments that have been submitted regarding the Comprehensive Quality Strategy. The Agency will be submitting the draft updated Comprehensive Quality Strategy to CMS during the next quarter.

d) Assessing Enrollee Satisfaction

During the first quarter of DY9, the evaluators submitted the draft final evaluation summary report to the Agency, which includes enrollee satisfaction results over the course of the Reform demonstration, as measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. This report will be submitted to CMS during the second quarter of DY9.

Under the MMA program, the managed care 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. Plans are required to submit their survey results to the Agency by July 1 of each year, beginning with 2015.

Attachment I
Comprehensive MMA Outreach Schedule (July – Sept 2014)

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 7/1/2014				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC/MMA Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	General Public / Media	Communications Office	Press Release	Press Release for Phase 3 Regions Go Live Date.
Week of 7/7/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	AHCA Staff	Executive Management	PowerPoint	Monthly AHCA Staff update on SMMC/MMA.
	Network Providers	Area Office Staff	Calls/Webinars	Area office staff will conduct trainings for network providers for six weeks starting two weeks before go live.
Week of 7/14/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 7/21/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Weeks of 8/1/2014				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC/MMA Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
	General Public / Media	Communications Office	Press Release	Press Release for Phase 4 Regions Go Live Date.
Week of 8/11/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	AHCA Staff	Executive Management	PowerPoint	Monthly AHCA Staff update on SMMC.
Week of 8/18/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 8/25/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 9/1/2014				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC/MMA Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 9/8/2014				
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 9/15/2014				
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 9/22/2014				
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.

Attachment II
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 Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules. The managed care plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA plans and Comprehensive LTC plans, and the LTC Exhibit for Comprehensive LTC plans and LTC plans, upon approval by the Agency. The managed care plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the Agency. The chart below lists the expanded benefits approved by the Agency that are being offered by the MMA standard plans in 2014.

Expanded Benefits Offered by MMA Standard Plans														
List of Expanded Benefits	**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
Adult hearing services (Expanded)	Y	Y			Y	Y (Region 1 only)	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	
Equine therapy												Y		
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y (Region 1 only)	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 (Region 1 only)	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	
Outpatient hospital services (Expanded)	Y	Y			Y	Y (Region 1 only)	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
Pet therapy					Y		Y					Y		
Physician home visits	Y	Y			Y	Y (Region 1 only)	Y		Y		Y	Y	Y	Y
Pneumonia vaccine	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
Prenatal/Perinatal visits (Expanded)	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 (Region 1 only)	Y		Y		Y	Y	Y	Y
Waived co-payments	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NOTE: Details regarding scope of covered benefit may vary by managed care plan.														

Attachment III
Enhanced Benefits Account Program

The following provides an update for this quarter on enhanced benefits account program activities for the call center, statistics, advisory panel, and phase-out of the enhanced benefits account program. The Agency will continue to provide EBA program statistics in the Quarterly Report until implementation of the Healthy Behaviors programs as specified in STC 84.

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 earned/used, and assists recipients with utilizing the web-based over-the-counter product list. The call center is staffed with employees who speak English, Spanish and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The 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 21,108 calls during this quarter. Chart A of Attachment III below highlights the enhanced benefits call center and mailroom activities during this quarter.

Chart A
Highlights of the Enhanced Benefits Call Center Activities
(July 1, 2014 – September 30, 2014)

Enhanced Benefits Call Center Activity	**April**	**May**	**June**
Calls Received	2,606	2,224	1,774
Calls Answered	2,601	2,220	1,772
Average Talk Time (minutes)	4:57	4:23	4:18
Calls Handled by the AVRS	5,595	4,431	3,744
Outbound Calls	8	5	3
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	0	0	0

Outreach and Education

During this quarter, the call center did not mail any welcome letters. 56,371 coupon statements were mailed during this quarter. The choice counselors continue to provide up-to-date information for recipients regarding their enhanced benefits account balances.

Complaints

Chart B of Attachment III located on the following page provides a summary of the complaints received and actions taken during this quarter.

Chart B Enhanced Benefits Recipient Complaints (July 1, 2014 – September 30, 2014)	
Recipient Complaint	**Action Taken**
1. There were no complaints reported by the EB Call center this quarter	N/A

Enhanced Benefits Statistics

As of the end of this quarter, 14,361 recipients lost EBA eligibility resulting in losing EBA credits, totaling $644,933.90. Chart C below provides the EBA program statistics during this quarter.

Chart C Enhanced Benefits Account Program Statistics (July 1, 2014 – September 30, 2014)				
Fourth Quarter Activities – Year Eight		**April**	**May**	**June**
I.	Number of plans submitting reports by month in each county	*	32**	23**
II.	Number of enrollees who received credit for healthy behaviors by month	*	9,819**	1,739**
III.	Total dollar amount credited to accounts by each month	*	$263,685.00**	$40,200.00**
IV.	Total cumulative dollar amount credited through the end each month	*	$83,467,083.66	$83,507,283.99
V.	Total dollar amount of credits used each month by date of service	$525,364.57	$462,606.07	$295,524.32
VI.	Total cumulative dollar amount of credits used through the month by date of service	$48,806,182.94	$49,268,789.01	$49,564,313.33
VII.	Total unduplicated number of enrollees who used credits each month	16,335	14,626	10,219

*** July reporting is reflective of dates of services through June 2014 and is reported in the Year 8 4th Quarter Report.**
**** August and September reporting is reflective of months the Enhanced Benefits Report is due by reform plans (no longer reflective of dates of service).**

Enhanced Benefits Advisory Panel

There was no EB Advisory Panel meeting held during this quarter. To view information on previous panel meetings, please visit the Agency's EBA website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml.

Notice of EBA Program Phase Out

During this quarter, there were no notices mailed regarding the phase-out of the EBA program.

Attachment IV
MMA Plan and Regional Enrollment Report

Number of MMA Plans in Regions Report

The following provides the eleven 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

Chart A of Attachment IV provides the number of standard, specialty, CMSN and child welfare MMA plans in each region that the MMA program was implemented during this quarter.

Chart A
Number of MMA Plans by Region
(July 1, 2014 – September 30, 2014)

Region	Standard	Specialty
1	2	4
2	2	5
3	4	4
4	4	4
5	4	5
6	7	5
7	6	5
8	4	4
9	4	5
10	4	6
11	10	6
Unduplicated Totals	**14**	**6**

MMA Enrollment by Region Report

There are two categories of Medicaid recipients who are enrolled in the MMA plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the MMA Enrollment by Region report, based on the recipients' eligibility for Medicare. The MMA Enrollment by Region report is a complete look at the entire enrollment for the MMA program for the quarter being reported. Chart B of Attachment IV provides a description of each column in the MMA Enrollment by Region report that is located on the following page in Charts C and D of Attachment IV.

Chart B MMA Enrollment by Region Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the MMA plan
Plan Type	The plan's type (Standard, Specialty or Child Welfare)
Plan Region	The number of the region the plan operates in
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan in the region listed
Number of SSI Enrolled - No Medicare	The number of SSI recipients enrolled with the plan in the region listed and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients enrolled with the plan in the region listed 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 in the region listed and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of enrollees with the plan in the region listed; TANF and SSI combined
Market Share for MMA by Region	The percentage of the MMA population in the region listed that the plan's recipient pool accounts for
Enrolled in Previous Quarter	The total number of recipients (TANF and SSI) who were enrolled in the plan in the region listed during the previous reporting quarter
Percent Change from Previous Quarter	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the region listed)

Chart C of attachment IV located on the following page lists, by MMA plan and type, for this quarter and compared to last quarter, 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.

Chard D of Attachment IV lists enrollment by region and plan type, for this quarter and compared to last quarter, 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.

Chart C
MMA Enrollment by Plan and Type
(July 1, 2014 – September 30, 2014)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	STANDARD	273,135	29,201	44	15,832	**318,212**	11.0%	**172,468**	**84.5%**
Better Health	STANDARD	78,614	8,905	15	4,177	**91,711**	3.2%	**19,155**	**378.8%**
Coventry Health Care Of Florida	STANDARD	37,103	4,170	13	3,790	**45,076**	1.6%	**0**	**N/A**
First Coast Advantage	STANDARD	58,628	7,289	4	1,791	**67,712**	2.4%	**66,928**	**1.2%**
Humana Medical Plan	STANDARD	215,525	32,303	118	24,290	**272,236**	9.5%	**26,254**	**936.9%**
Integral Quality Care	STANDARD	78,369	7,946	8	5,324	**91,647**	3.2%	**59,584**	**53.8%**
Molina Healthcare Of Florida	STANDARD	80,573	8,141	14	7,100	**95,828**	3.3%	**0**	**N/A**
Preferred Medical Plan	STANDARD	23,292	3,628	16	3,172	**30,108**	1.0%	**0**	**N/A**
Prestige Health Choice	STANDARD	246,756	30,613	20	19,747	**297,136**	10.3%	**195,968**	**51.6%**
South Florida Community Care Network	STANDARD	38,859	3,650	5	1,885	**44,399**	1.5%	**0**	**N/A**
Simply Healthcare	STANDARD	57,212	12,087	95	11,105	**80,499**	2.8%	**0**	**N/A**
Staywell Health Plan	STANDARD	557,302	63,619	48	28,363	**649,332**	22.5%	**421,506**	**54.1%**
Sunshine State Health Plan	STANDARD	321,922	35,209	47	42,902	**400,080**	13.9%	**183,715**	**117.8%**
United Healthcare Of Florida	STANDARD	198,697	27,163	48	28,956	**254,864**	8.8%	**122,755**	**107.6%**
Standard Plans Total		**2,265,987**	**273,924**	**495**	**198,434**	**2,738,840**	**95.1%**	**1,268,333**	**115.9%**
Positive Health Plan	SPECIALTY	242	1,017	-	625	**1,884**	0.1%	**0**	**N/A**
Magellan Complete Care	SPECIALTY	20,522	23,485	9	334	**44,350**	1.5%	**0**	**N/A**
Clear Health Alliance	SPECIALTY	1,200	4,789	1	3,275	**9,265**	0.3%	**3,004**	**208.4%**
Sunshine State Health Plan	SPECIALTY	20,689	1,888	-	-	**22,577**	0.8%	**10,419**	**116.7%**
Children's Medical Services Network	SPECIALTY	37,185	25,683	-	115	**62,983**	2.2%	**0**	**N/A**
Specialty Plans Total		**79,838**	**56,862**	**10**	**4,349**	**141,059**	**4.9%**	**13,423**	*****
MMA TOTAL	**MMA**	**2,345,825**	**330,786**	**505**	**202,783**	**2,879,899**	**100%**	**1,281,756**	**124.7%**

Chart D
MMA Enrollment by Region and Type
(July 1, 2014 – September 30, 2014)

REGION	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	MMA	75,168	10,949	5	6,185	92,307	3.2%	0	N/A
02	MMA	86,920	14,409	9	8,577	109,915	3.8%	100,246	9.6%
03	MMA	201,044	29,067	14	16,294	246,419	8.6%	225,103	9.5%
04	MMA	243,086	30,443	14	17,732	291,275	10.1%	268,198	8.6%
05	MMA	141,275	21,322	7	14,054	176,658	6.1%	155,779	13.4%
06	MMA	334,829	45,999	31	20,525	401,384	13.9%	354,855	13.1%
07	MMA	301,006	43,042	29	17,859	361,936	12.6%	0	N/A
08	MMA	171,903	18,005	20	12,857	202,785	7.0%	177,575	14.2%
09	MMA	200,055	23,478	13	13,978	237,524	8.2%	0	N/A
10	MMA	202,134	26,018	66	14,936	243,154	8.4%	0	N/A
11	MMA	388,405	68,054	297	59,786	516,542	17.9%	0	N/A
MMA TOTAL		2,345,825	330,786	505	202,783	2,879,899	100.0%	1,281,756	124.7%
01	STANDARD	73,263	9,954	5	6,105	89,327	3.1%	0	N/A
02	STANDARD	81,494	11,217	8	8,472	101,191	3.5%	99,249	2.0%
03	STANDARD	195,001	26,206	14	16,077	237,298	8.2%	222,721	6.5%
04	STANDARD	233,075	24,774	14	17,675	275,538	9.6%	266,033	3.6%
05	STANDARD	134,764	17,013	6	13,488	165,271	5.7%	153,368	7.8%
06	STANDARD	323,445	37,251	31	20,199	380,926	13.2%	351,258	8.4%
07	STANDARD	290,273	34,535	26	17,372	342,206	11.9%	0	N/A
08	STANDARD	166,917	15,832	20	12,628	195,397	6.8%	175,704	11.2%
09	STANDARD	192,778	18,558	13	13,502	224,851	7.8%	0	N/A
10	STANDARD	194,322	19,991	65	14,373	228,751	7.9%	0	N/A
11	STANDARD	380,655	58,593	293	58,543	498,084	17.3%	0	N/A
STANDARD TOTAL		2,265,987	273,924	495	198,434	2,738,840	95.1%	1,268,333	115.9%

Chart D
MMA Enrollment by Region and Type
(July 1, 2014 – September 30, 2014)

			Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
REGION	Plan Type	Number of TANF Enrolled	No Medicare	Medicare Part B	Medicare Parts A and B				
01	SPECIALTY	1,905	995	-	80	**2,980**	**0.1%**	**0**	*
02	SPECIALTY	5,426	3,192	1	105	**8,724**	**0.3%**	**997**	*
03	SPECIALTY	6,043	2,861	-	217	**9,121**	**0.3%**	**2,382**	*
04	SPECIALTY	10,011	5,669	-	57	**15,737**	**0.5%**	**2,165**	*
05	SPECIALTY	6,511	4,309	1	566	**11,387**	**0.4%**	**2,411**	*
06	SPECIALTY	11,384	8,748	-	326	**20,458**	**0.7%**	**3,597**	*
07	SPECIALTY	10,733	8,507	3	487	**19,730**	**0.7%**	**0**	*
08	SPECIALTY	4,986	2,173	-	229	**7,388**	**0.3%**	**1,871**	*
09	SPECIALTY	7,277	4,920	-	476	**12,673**	**0.4%**	**0**	*
10	SPECIALTY	7,812	6,027	1	563	**14,403**	**0.5%**	**0**	*
11	SPECIALTY	7,750	9,461	4	1,243	**18,458**	**0.6%**	**0**	*
SPECIALTY TOTAL		**79,838**	**56,862**	**10**	**4,349**	**141,059**	**4.9%**	**13,423**	*

*Most Specialty Plans were not operational in the previous quarter

Attachment V
Budget Neutrality Update

In the following charts (Charts A through H of Attachment V), both date of service and date of payment data are presented. Charts that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Charts 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 Charts B through E of Attachment V in accordance with STC #89(a).

In accordance with STC #94(d)(iv), the Agency has initiated the development of the new CMS64 reporting operation that will be required to support the 1115 MMA Waiver. The APS Healthcare company (a subcontractor under the FMMIS fiscal agent: HP Enterprise, Inc.) has been assigned the task of designing and constructing the new CMS64 waiver software application. In preparation for this task, APS is operating the current CMS64 software system. APS's understanding of the current operation will facilitate its development and design of the new application. Agency staff is working with APS to address application requirements and general design concepts. The new reporting operation will become effective in January, 2015.

Chart A of Attachment V shows the Primary Care Case Management (PCCM) Targets established in the waiver as specified in STC #76. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Chart A
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
DY09	$786.70	$324.13
DY10	$818.95	$339.04
DY11	$852.53	$354.64

Charts B through H of Attachment V contain the statistics for MEGs 1, 2 and 3 for the period beginning July 1, 2006, and ending September 30, 2014. Case months provided in Charts B and C 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.

Chart B MEG 1 Statistics: SSI Related					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
Q1 Total	737,829	$534,465,763	$13,022,287	$547,488,050	$742.03
Q2 Total	741,024	$656,999,737	$40,270,607	$697,270,344	$940.96
Q3 Total	746,739	$627,627,027	$74,363,882	$701,990,909	$940.08
Q4 Total	752,823	$627,040,703	$98,024,915	$725,065,618	$963.13
Q5 Total	755,417	$630,937,251	$101,516,732	$732,453,983	$969.60
Q6 Total	755,837	$648,757,106	$106,374,845	$755,131,951	$999.07
Q7 Total	758,014	$651,490,311	$111,968,931	$763,459,242	$1,007.18
Q8 Total	764,701	$661,690,100	$115,206,649	$776,896,750	$1,015.95
Q9 Total	818,560	$708,946,109	$116,393,637	$825,339,746	$1,008.28
Q10 Total	791,043	$738,232,869	$128,914,992	$867,147,861	$1,096.21
Q11 Total	810,753	$783,046,121	$125,741,442	$908,787,564	$1,120.92
Q12 Total	829,386	$676,381,576	$120,999,077	$797,380,652	$961.41
Q13 Total	826,842	$846,747,351	$153,763,674	$1,000,511,025	$1,210.04
Q14 Total	830,530	$769,968,776	$137,267,631	$907,236,407	$1,092.36
Q15 Total	847,324	$781,783,604	$141,815,963	$923,599,567	$1,090.02
Q16 Total	852,445	$732,226,661	$129,489,247	$861,715,907	$1,010.88
Q17 Total	868,873	$880,557,949	$163,583,238	$1,044,141,187	$1,201.72
Q18 Total	876,564	$823,362,358	$147,720,232	$971,082,591	$1,107.83
Q19 Total	851,488	$793,116,969	$137,115,775	$930,232,743	$1,092.48
Q20 Total	902,833	$730,735,500	$137,409,896	$868,145,395	$961.58
Q21 Total	933,661	$897,184,808	$165,500,587	$1,062,685,395	$1,138.19
Q22 Total	916,713	$780,812,437	$149,928,159	$930,740,596	$1,015.30
Q23 Total	871,050	$806,728,589	$161,201,346	$967,929,935	$1,111.22
Q24 Total	932,443	$878,147,146	$168,609,996	$1,046,757,142	$1,122.60
Q25 Total	939,670	$876,968,622	$168,972,615	$1,045,941,236	$1,113.09
Q26Total	953,518	$865,669,039	$218,704,121	$1,084,373,159	$1,137.24
Q27 Total	964,650	$749,820,061	$229,337,800	$979,157,860	$1,015.04
Q28 Total	973,098	$855,023,277	$235,487,639	$1,090,510,916	$1,120.66
Q29 Total	982,712	$879,236,988	$234,142,785	$1,113,379,773	$1,132.97
Q30 Total	991,303	$894,044,760	$230,694,425	$1,124,739,185	$1,116.89
Q31 Total	1,007,552	$841,069,140	$201,039,197	$1,042,108,337	$1,034.30
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
MEG 1 Total	28,630,036	25,401,390,043	4,777,027,664	30,178,417,707	1,054.08

* 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.

Chart C MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
Q1 Total	3,944,437	$491,214,740	$1,723,494	$492,938,235	$124.97
Q2 Total	3,837,172	$590,933,703	$21,021,285	$611,954,988	$159.48
Q3 Total	3,728,063	$559,579,323	$44,697,737	$604,277,060	$162.09
Q4 Total	3,653,147	$524,161,918	$57,096,383	$581,258,301	$159.11
Q5 Total	3,588,363	$520,316,242	$57,360,334	$577,676,576	$160.99
Q6 Total	3,648,832	$553,763,665	$63,871,154	$617,634,819	$169.27
Q7 Total	3,736,212	$570,477,394	$69,992,290	$640,469,684	$171.42
Q8 Total	3,856,584	$564,601,990	$70,899,271	$635,501,261	$ 164.78
Q9 Total	4,080,307	$586,455,736	$70,031,931	$656,487,667	$160.89
Q10 Total	4,174,698	$659,100,473	$71,936,704	$731,037,178	$175.11
Q11 Total	4,298,379	$708,620,481	$73,835,227	$782,455,708	$182.04
Q12 Total	4,541,456	$581,030,798	$60,822,514	$641,853,312	$141.33
Q13 Total	4,772,864	$824,013,811	$98,637,714	$922,651,526	193.31
Q14 Total	4,959,454	$768,385,369	$89,723,473	$858,108,842	$173.02
Q15 Total	5,098,381	$773,609,163	$93,647,855	$867,257,018	$170.10
Q16 Total	5,203,143	$793,529,141	$90,471,922	$884,001,063	$169.90
Q17 Total	5,356,742	$766,604,001	$91,544,719	$858,148,720	$160.20
Q18 Total	5,470,396	$848,694,828	$99,937,769	$948,632,597	$173.41
Q19 Total	5,247,390	$787,922,115	$91,638,763	$879,560,878	$167.62
Q20 Total	5,611,671	$673,700,632	$90,712,877	$764,413,510	$136.22
Q21 Total	5,695,156	$965,461,910	$121,274,250	$1,086,736,159	$190.82
Q22 Total	5,773,020	$778,633,250	$99,802,883	$878,436,134	$152.16
Q23 Total	5,592,756	$860,576,398	$115,331,882	$975,908,280	174.50
Q24 Total	5,895,265	$922,979,983	$122,296,078	$1,045,276,061	$177.31
Q25 Total	6,013,128	$884,131,387	$121,673,666	$1,005,805,053	$167.27
Q26 Total	6,092,265	$1,016,884,642	$131,066,964	$1,147,951,606	$188.43
Q27 Total	6,117,120	$915,201,600	$133,635,131	$1,048,836,732	$171.46
Q28 Total	6,125,887	$1,018,851,885	$133,876,042	$1,152,727,927	$188.17
Q29 Total	6,179,797	$1,059,131,680	$75,589,844	$1,193,254,080	$193.09
Q30 Total	6,237,710	$1,070,712,185	$144,755,094	$1,215,467,279	$194.86
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
MEG 2 Total	167,516,522	25,446,856,153	3,054,814,898	28,501,671,051	170.14

* 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.

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

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

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

For DY4, MEG 1 has a PCCM of 1077.30 (Chart D), compared to WOW of $1,195.20 (Chart A), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Chart D), compared to WOW of $251.1 (Chart A), which is 66.42% of the target PCCM for MEG 2.

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

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

For DY7, MEG 1 has a PCCM of $1,097.52 (Chart D), compared to WOW of $1,425.84 (Chart A), which is 76.97% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.75 (Chart D), compared to WOW of $300.92 (Chart A), which is 59.73% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1056.27 (Chart D), compared to WOW of $1,498.56 (Chart A), which is 70.49% of the target PCCM for MEG 1. MEG 2 has a PCCM of $173.13 (Chart D), compared to WOW of $316.87 (Chart A), which is 54.64% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $804.04 (Chart D), compared to WOW of $786.70 (Chart A), which is 102.20% of the target PCCM for MEG 1. MEG 2 has a PCCM of $153.90 (Chart D), compared to WOW of $324.13 (Chart A), which is 47.48% of the target PCCM for MEG 2.

Charts D and E provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For DY1, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart E) 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 Chart E 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 (Chart E) 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 Chart E 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 (Chart E) 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 Chart E 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 (Chart E) 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 Chart E 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 (Chart E) 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 Chart E 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 (Chart E) 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 Chart E 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 (Chart E) 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 Chart E is $304.52. Comparing the calculated weighted averages, the actual PCCM is 67.10% 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 (Chart E) 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 Chart E is $295.51. Comparing the calculated weighted averages, the actual PCCM is 61.49% of the target PCCM.

For DY9, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart E) is $386.87. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Chart E is $242.09. Comparing the calculated weighted averages, the actual PCCM is 62.57% of the target PCCM.

Chart D MEG 1 and 2 Annual Statistics					
DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 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 - DY01 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%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 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%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 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%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 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%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 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%
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 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

Chart D MEG 1 and 2 Annual Statistics					
Difference				**$(395,790,377)**	
% of WOW PCCM MEG 1					**90.14%**
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 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%**
DY05 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
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%**
DY05 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY05 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%**
DY06 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY06 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%**
DY06 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY06 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%**
DY07 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY07 Total	**3,830,936**	**$3,330,902,447**	**$872,460,169**	**$4,203,362,616**	**$1,097.22**
WOW DY7 Total	**3,830,936**			**$5,462,301,786**	**$1,425.84**
Difference				**$(1,258,939,170)**	
% of WOW PCCM MEG 1					**76.95%**

Chart D MEG 1 and 2 Annual Statistics					
DY07– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY07 Total	24,348,400	$3,890,893,353	$483,915,369	$4,374,808,722	$179.68
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,952,111,806)	
% of WOW PCCM MEG 2					59.71%
DY08 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY08 Total	4,000,390	$3,414,538,645	$810,943,657	$4,225,482,301	$1,056.27
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,769,342,137)	
% of WOW PCCM MEG 1					70.49%
DY08– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY08 Total	24,867,309	$3,783,670,392	$521,640,879	$4,305,311,270	$173.13
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,574,392,932)	
% of WOW PCCM MEG 2					54.64%
DY09– MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY09 Total	1,025,818	$731,155,792	$93,645,182	$824,800,974	$804.04
WOW DY9 Total	1,025,818			$807,011,021	$786.70
Difference				$17,789,953	
% of WOW PCCM MEG 1					102.20%
DY09– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY09 Total	6,536,925	$889,324,630	$116,703,774	$1,006,028,404	$153.90
WOW DY9 Total	6,536,925			$2,118,813,500	$324.13
Difference				$(1,112,785,096)	
% of WOW PCCM MEG 2					47.48%

Chart E 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	$7,221,795,800	$1,356,375,538	$8,578,171,338	$304.41
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,211,050,976)	
% Of WOW					67.07%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,867,699	$7,198,209,036	$1,332,584,535	$8,530,793,572	$295.51
WOW	28,867,699			$13,874,528,641	$480.62

Chart E MEG 1 and 2 Cumulative Statistics					
Difference				**$(5,343,735,069)**	
% Of WOW					**61.49%**
DY 09	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	**7,562,743**	**$1,620,480,421**	**$210,348,956**	**$1,830,829,377**	**$242.09**
WOW	**7,562,743**			**$2,925,824,521**	**$386.87**
Difference				**$(1,094,995,143)**	
% Of WOW					**62.57%**

Commencing with the January-March 2014 quarter, 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. Chart F of Attachment V 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 DY9 in Chart E above.

Chart F WW/WOW Difference Less CNOM Costs	
DY09 Difference July 2014 - September 2014:	**($1,094,995,143)**
CNOM Costs July 2014 –September 2014:	
Healthy Start	**$407,676**
PACC	**$91,796**
DY09 Net Difference:	**($1,094,495,671)**

Chart G 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**
Q27	**$277,637,763**
Q28	**$308,722,821**
Q29	**$163,925,949**
Q30	**$316,726,485**
Q31	**$374,225,087**
Q32	**$301,519,921**
Total Paid	**$7,978,670,743**

Chart H of Attachment V shows that the expenditures for the 32 quarters for MEG 3, Low Income Pool (LIP), were $7,978,670,743 (78.47% of the $10,167,968,340 cap).

Chart H 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	-	$2,167,968,340	0.00%
Total MEG 3	$7,978,670,743	$10,167,968,340	78.47%

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

Attachment VI
2008 – 2014 Managed Care Performance Measures
Reform Plans

	Reform Plans*							
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Trend from 2013-2014**
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

	Reform Plans*							
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Trend from 2013-2014**
Adults' Access to Preventive Care - 20-44 Yrs	n/a	71.8%	71.2%	71.2%	69.8%	69.2%	75.9%	improve
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	n/a	n/a	n/a	60.2	60.6	62.9	61.8	flat

	Reform Plans*							
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**Trend from 2013-2014**
- total				%	%	%	%	
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
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 Medicaid FFS or MediPass. Each rate presented for Reform is the weighted mean across Reform 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 2012 reporting, so it may not be appropriate to compare results reported in 2012 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 VII
2014 Managed Care 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
Breast Cancer Screening	54.2%	56.0%	Same

Measure	Non-Reform Plans*	Reform Plans*	Reform rate relative to Non-Reform?**
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 Medicaid FFS or MediPass. Each rate presented for Non-Reform and for Reform is the weighted mean across Non-Reform and Reform 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.

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