Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

2nd Quarter Report

October 1, 2015 – December 31, 2015
Demonstration Year 10

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I. Waiver History

On October 15, 2015, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver. The amendment allows:

- Medicaid-eligible children receiving prescribed pediatric extended care (PPEC) services and beneficiaries residing in group home facilities licensed under section 393.067, Florida Statutes (F.S.), to voluntarily enroll in managed care through the MMA program;
- Changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination and to allow changes to the auto-assignment criteria; and
- Extension of the Low Income Pool (LIP) program through the remainder of the demonstration ending June 30, 2017 as specified in the Special Terms and Conditions (STCs) of the MMA Waiver.

The approved Waiver amendment documents can be viewed on the Agency for Health Care Administrations (Agency's) Web site at the following link: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

On July 31, 2014, CMS approved a three-year extension of the Florida's 1115 Research and Demonstration Waiver authorizing the MMA) Program. The Waiver approval period is July 31, 2014 through June 30, 2017 with a one-year extension of the LIP program until June 30, 2015.

Federal approval of the MMA program 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 MMA plans, customized benefit packages, Healthy Behaviors programs, risk-adjusted premiums based on enrollee health status, and continuation of the LIP program. The MMA program increases consumer protections as well as quality of care and access for Floridians in many ways, including:

- Increasing recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;
- Ensuring the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan;
- Ensuring recipient complaints, grievances, and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishing Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires MMA plans offer a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan;
- Requiring Florida's external quality assurance organization to validate each MMA plan's encounter data every three years;
- Enhancing consumer report cards to ensure recipients have access to understandable summaries of quality, access, and timeliness regarding the performance of each participating MMA plan;

- Enhancing the MMA 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;
- Enhancing metrics on MMA plan quality and access to care to improve MMA plan accountability; and
- Creating a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy focusing on all aspects of quality improvement in Medicaid.

Quarterly Report Requirement

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 second quarterly report for Demonstration Year 10 (DY10) covering the period of October 1, 2015, through December 31, 2015. 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/statewide_mc/mma_federal_reports.shtml.

II. Operational Update

1. Health Care Delivery System

The following provides an update for this quarter on health care delivery system activities for MMA plan contracting; benefit packages; MMA plan reported complaints, grievances, and appeals; Agency-received complaints/issues; medical loss ratio (MLR); and MMA plan readiness review and monitoring.

a) MMA Plan Contracting

Table 1 lists the contracted plans for the MMA program. Please refer to Attachment III of this report, MMA Enrollment Report, for enrollment information for this quarter.

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

*Contracted as a specialty plan to serve a targeted population.

**Contracted to also provide long-term care services under the 1915(b)(c) Long-term Care Waiver.

***Contracted to provide specialized services and is also contracted to provide long-term care services under the 1915(b)(c) Long-term Care Waiver.

The Preferred plan contract ended on October 15, 2015, and the Integral plan contract ended on October 31, 2015.

Prestige health plan was acquired by Florida True Health effective October 1, 2015, and The Preferred and Integral plans were purchased by Molina Healthcare of Florida, Inc. on October 15, 2015 and October 31, 2015, respectively.

<u>Plan Contracting Status</u>

During this quarter, the Agency continued contracts with 12 MMA plans providing MMA services and six MMA specialty plans. The MMA specialty plans serve enrollees with HIV/AIDS, dual eligibles with chronic conditions, enrollees with serious mental illness, enrollees in the child welfare system, and children with chronic conditions.

During this quarter, the Preferred and Integral plans were purchased by Molina Healthcare of Florida, Inc., on October 15, 2015 and October 31, 2015, respectively. The Preferred plan contract ended on October 15, 2015; and the Integral plan contract ended on October 31, 2015. Prestige plan was acquired by Florida True Health effective October 1, 2015.

Critical Incidents

Each of the 16 MMA plans is required to submit an Adverse and Critical Incident Summary Report to the Agency. This report is due monthly, by the fifteenth calendar day of the month following the reporting month. The purpose of this report is to monitor all MMA plans' adverse and critical incident reporting and management system for adverse and critical incidents that negatively impact the health, safety or welfare of enrollees. The MMA plans are required to report critical incidents relating to enrollee abuse/neglect and exploitation to the following state agencies: Florida Department of Health (DOH), Florida Department of Children and Families (DCF) and Florida Department of Elder Affairs (DOEA).

The table below illustrates the data collected by the plans for the quarter October 1, 2015 – December 31, 2015.

QUARTERLY CRITICAL INCIDENTS SUMMARY OCTOBER 2015-DECEMBER2015

	Amerigroup	Better Health	Clear Health Alliance	CMS	Coventry	Freedom	Humana	Integral	Magellan	Molina	Positive	Prestige	SFCCN	Simply	Staywell	Sunshine	United	Total By Incident Type
Incident Type	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	
Enrollee Death	0	0	1	17	0	0	2	0	16	0	0	0	15	0	0	4	1	**56**
Enrollee Brain Damage	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Enrollee Spinal Damage	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Permanent Disfigurement	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Fracture or Dislocation of bones or joints	0	0	0	0	0	0	0	0	1	0	0	1	0	0	2	0	0	**4**
Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition	0	0	0	0	0	0	0	0	34	0	0	1	0	1	0	0	0	**36**

QUARTERLY CRITICAL INCIDENTS SUMMARY OCTOBER 2015-DECEMBER2015

	Amerigroup	Better Health	Clear Health Alliance	CMS	Coventry	Freedom	Humana	Integral	Magellan	Molina	Positive	Prestige	SFCCN	Simply	Staywell	Sunshine	United	Total By Incident Type
Incident Type	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	**# of Events**	
Any condition requiring surgical intervention to correct or control	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	**2**
Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	**2**
Any condition that extends the patient's length of stay	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total of all incidents:	**0**	**0**	**1**	**19**	**0**	**0**	**2**	**0**	**53**	**0**	**0**	**3**	**15**	**2**	**2**	**4**	**1**	**102**

Integration for Medicare-Medicaid Eligible Individuals

Florida has engaged in activities to better identify ways in which to integrate services for dual eligibles. These activities include participation on webinars and conference calls with the Centers for Health Care Strategies with their "Inside" Affinity groups and also participation in the Integrated Care Resource Center Study Hall calls. Additionally, the state is contracting with Dual Eligible Special Needs Plans (D-SNPs) and Fully Integrated Dual Eligibles (FIDE-SNPs) for our dually eligible population. The state is working toward automation of Medicare claim information for the Florida MMA plans to streamline Medicare crossover claims.

b) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment I of this report, the MMA plans 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 2 lists the standard benefits provided under the MMA contracts:

Table 2 Required MMA Services	
(1)	Advanced Registered Nurse Practitioner Services
(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, Prostheses 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 are required to cover most Florida Medicaid State Plan services and to provide access to additional services covered under early and periodic screening, diagnosis and treatment 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.

There have been no changes to standard benefits since the last quarterly report.

c) MMA Plan Readiness Review and Monitoring

Health Services Advisory Group, Inc. (HSAG), the Agency's External Quality Review Organization (EQRO), worked with both the Agency and DOEA to develop a Web-based monitoring tool that can be used to centrally record the results of monitoring the MMA plans. At the Agency's request, HSAG had been working to add further functionality to this monitoring tool, which they completed in late 2015.

As described in previous reports, the Agency continues to hold monthly calls in the form of an "All-Plan" call, and also holds weekly calls with each individual MMA plan. In addition, the Agency continues to monitor the MMA plans regularly and handle issues as they arise. Staff continues to analyze complaints as they come in to the Agency, and work with each MMA plan to ensure timely resolution of these issues.

The Agency has several other mechanisms in place to ensure the MMA plans are compliant with the contract. When non-compliance is found, the Agency will take compliance actions against the plan in the form of a Corrective Action Plan (CAP), Sanction, and/or Liquidated Damage. Since the beginning of the Statewide Medicaid Managed Care (SMMC) program, the Agency has issued 25 CAPs, 16 Sanctions totaling $55,000, and 122 Liquidated Damages totaling $1,665,039.

Lastly, the Agency's two field-based plan management offices continue to work on marketing and claims oversight activities, and also provide a staff presence in the areas where most of the MMA plans' offices are located.

d) Medical Loss Ratio (MLR)

During this quarter, seventeen capitated plans submitted their fourth-quarter MLR reports for DY9 on or before the due date. The Agency submitted the capitated plans' preliminary DY9 MLR results to CMS in August 2015. One of the seventeen capitated plans that submitted their fourth-quarter MLR reports for DY9 reported an MLR below 85%.

The capitated plans' MLR data are 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.

e) MMA Plan Reported Complaints, Grievances, and Appeals

MMA Plan Reported Complaints

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

Table 3
MMA Plan Reported Complaints
(October 1, 2015 – December 31, 2015)

Quarter	Total
October 1, 2015 – December 31, 2015	11,280

Grievances and Appeals

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

Table 4
MMA Grievances and Appeals
(October 1, 2015 – December 31, 2015)

Quarter	Total Grievances	Total Appeals
October 1, 2015 – December 31, 2015	4,569	3,096

Medicaid Fair Hearing (MFH)

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

Table 5
MMA MFHs Requested and Held
(October 1, 2015 – December 31, 2015)

Quarter	MFHs Requested	MFHs Held
October 1, 2015 – December 31, 2015	576	113

Subscriber Assistance Program (SAP)

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

Table 6
MMA SAP Requests
(October 1, 2015 – December 31, 2015)

Quarter	Total
October 1, 2015 – December 31, 2015	25

f) Agency-Received Complaints/Issues

Table 7 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 7
Agency-Received MMA Complaints/Issues
(October 1, 2015 – December 31, 2015)

Quarter	Total
October 1, 2015 – December 31, 2015	2,710

2. Choice Counseling Program

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

a) Online Enrollment

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

Table 8
Online Enrollment Statistics
(October 1, 2015 – December 31, 2015)

	October	November	December	Total
Enrollments	15,160	15,026	12,124	**42,310**

b) Disenrollment Breakout

Table 9 shows the number of disenrollment's by month for this quarter.

Table 9
Disenrollment Statistics
(October 1, 2015 – December 31, 2015)

	October	November	December	Total
Disenrollment's[1]	139,959	225,096	117,391	**482,446**
Good Cause[2]	9,247	8,397	6,973	**24,617**
Total Disenrollment's	**149,206**	**233,493**	**124,364**	**507,063**

[1] Disenrollment request processed during the recipients 1st 90 days of plan enrollment, are voluntary for plan enrollment or in open enrollment.
[2] Disenrollment requests processed for recipients who were locked into their plan and not in open enrollment.

c) 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 8:00 a.m. – 8:00 p.m., and Friday 8:00 a.m. – 7:00 p.m. During this quarter, the call center had an average of 159 full time equivalent employees available to answer calls.

Table 10 provides the call center statistics for this quarter. The choice counseling calls remain within the anticipated call volume for the quarter.

Table 10
Call Volume for Incoming and Outgoing Calls
(October 1, 2015 – December 31, 2015)

Type of Calls	October	November	December	Totals
Incoming Calls	91,470	76,012	79,119	**246,601**
Outgoing Calls	4,404	2,392	4,295	**11,091**
Totals	**95,874**	**78,404**	**83,414**	**257,692**

Mail

Table 11 provides the choice counseling mail activities for this quarter.

Table 11
Outbound Mail Activities
(October 1, 2015 – December 31, 2015)

Mail Activities	October	November	December	Totals
New-Eligible Packets*	57,410	46,433	53,142	156,985
Confirmation Letters	70,857	47,769	62,642	181,268
Open Enrollment Packets	65,285	59,501	60,463	185,249

*Mandatory and voluntary.

Face-to-Face/Outreach and Education

Table 12 provides the choice counseling outreach activities for this quarter.

Table 12
Choice Counseling Outreach Activities
(October 1, 2015 – December 31, 2015)

Field Activities	October	November	December	Totals
Group Sessions	14	11	11	36
Private Sessions	15	10	8	33
Home Visits and One-On-One Sessions	53	38	39	130

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. 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.

d) Self-Selection and Auto-Assignment Rates

Table 12 provides the current self-selection and auto-assignment rates for this quarter.

Table 13
Self-Selection and Auto-Assignment Rates
(October 1, 2015 – December 31, 2015)

	July	August	September
Self-Selected	182,046	70,636	70,729
Auto-Assignment	60,766	51,286	43,116
Total Enrollments	242,812	121,922	113,845
Self-Selected %	74.97%	57.94%	62.13%
Auto-Assignment %	25.03%	42.06%	37.87%

Note: 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 rates as *"Voluntary Enrollment Rate,"* the data are 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 rates include LTC and MMA populations.

3. Healthy Behaviors Programs

Healthy Behaviors Programs

Each of the 16 MMA plans was required to create a minimum of three Healthy Behavior programs that addressed smoking cessation, weight loss, and alcohol or substance abuse. There were a total of 81 Healthy Behavior programs submitted by the plans that were approved for implementation.

Attachment II of this report, Healthy Behaviors Program Enrollment, provides the data collected by the plans for each of their Healthy Behaviors programs for this quarter (October 1, 2015 – December 31, 2015). The Healthy Behaviors programs incorporate evidenced-based practices and are medically approved and/or directed. The Healthy Behaviors programs are voluntary programs and require written consent from each participant prior to enrollment into the program.

4. MMA Plan and Regional Enrollment Data

Attachment III of this report, MMA Enrollment Report, provides an update of MMA plan and regional enrollment for the period October 1, 2015 – December 31, 2015 and contains the following enrollment reports:

- Number of MMA; plans and
- Regional MMA enrollment.

5. Policy and Administrative Issues

The Agency continues to identify and resolve various operational issues for the MMA program. 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 contract interpretation 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.

Contract Amendments

During this quarter, the Agency finalized a general contract amendment for the MMA plans, effective November 1, 2015, which incorporated technical corrections and changes to MMA plans' contracts. A copy of the model contract may be viewed on the Agency's Web site at http://ahca.myflorida.com/SMMC. In addition, the Agency finalized a contract amendment effective October 1, 2015, related to the acquisition of Prestige health plan by Florida True Health. Also, the Agency finalized a contract amendment effective October 15, 2015 ending the Preferred plan contract, and the Agency finalized a contract amendment effective October 31, 2015 ending the Integral plan contract. The Preferred and Integral plans were purchased by Molina Healthcare of Florida, Inc., and the Molina plan contract was amended accordingly in the November 1, 2015 general contract amendment. Also during this quarter, the Agency finalized revisions to the SMMC Report Guide to include corrections and new reporting requirements, and also began to gather items for the next general contract amendment.

Agency Communications to MMA Plans

There were five policy transmittals released to the MMA plans during this quarter. There were no contract interpretations or Dear MMA Plan letters released during this quarter.

The policy transmittals advised the MMA plans of the following:

- Clarified the MMA plans' responsibilities for reporting completed Pre-admission Screening and Resident Reviews (PASRR).
- Informed MMA plans of upcoming changes and plan responsibilities associated with the implementation of Express Enrollment.
- Notified MMA plans that, effective immediately, the Critical Incident Summary Report, Critical Report – Individual, and the Code 15 Report have been discontinued, and that the Critical Incident Summary Report has been replaced with the Adverse and Critical Incident Summary Report.
- Notified MMA plans of revised performance measures and Child Health Check-Up (CHCUP) related contract requirements for the July 1, 2016 performance measure submission and submission of the federal fiscal year 2014-2015 Child Health Check-Up report.
- Notified MMA plans of an ad hoc reporting requirement pertaining to enrollees under the age of 21 receiving inpatient residential psychiatric treatment (e.g., Statewide Inpatient Psychiatric Program services and services in other comparable treatment settings).

III. Low Income Pool

One of the fundamental elements of the demonstration is the 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.

Demonstration Year 10 (DY10) LIP STCs – Reporting Requirements

The following provides an update of the DY10 LIP STCs that required action during this quarter.

LIP Related STCs

During the second quarter of DY10, the Agency received approval of the STCs from CMS on October 15, 2015.

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

This STC requires the submission of a DY10 draft RFMD and a DY11 draft RFMD for CMS approval by November 30, 2015.

- The Agency submitted the DY10 draft RFMD to CMS on November 24, 2015.
- The Agency submitted the DY11 draft RFMD to CMS on November 25, 2015.

IV. Demonstration Goals

The following table provides the activities the state undertakes to measure its progress toward the demonstration goals.

Table 13
Demonstration Goals

Demonstration Goals	How Goals are Measured
Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility	• Beneficiary self-selection rate (how many actively choose a plan) • Consumer Assessment of Healthcare Providers and Systems (CAHPS) results • Beneficiaries actively participating in Healthy Behaviors programs
Improving program performance	• Plan Performance Measures (HEDIS, adult and child core set measures, and other Agency-defined performance measure scores) • Compliance Actions (e.g., corrective action plans, liquidated damages, sanctions) • Transparency of program information (e.g., Health Plan Report Card, Quarterly SMMC Reports) • Monitoring activities (e.g., network adequacy, complaints monitoring)
Improving access to coordinated care	• Percentage of eligible recipients enrolled in health plans
Enhancing fiscal predictability and financial management	• MLR • Achieved Savings Rebate • Monitoring of financial statements and comparing to encounter data

V. Monitoring Budget Neutrality

In accordance with the requirements of the approved 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 IV of this report are through the second quarter (October 1, 2015 – December 31, 2015) of DY10. 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 operational in all regions of the State. The case months and expenditures reported are for enrolled mandatory and voluntary recipients.

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 #87, is monitored using data based on date of service. The 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.

Please refer to Attachment IV of this report for an update on Budget Neutrality figures through the second quarter (October 1, 2015 – December 31, 2015) of DY10.

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. Several system modifications and data table upgrades were implemented to improve the quality of encounter data and encounter data analytics. The 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 needs. 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 HSAG as its EQRO vendor since 2006. Beginning on July 1, 2013, the Agency's new contract with HSAG required that the EQRO conduct an annual encounter-type focused validation, using protocol consistent with the CMS protocol, "Validation of Encounter Data Reported by the Managed Care Organization." HSAG has worked closely with the Agency to design an encounter data validation process to examine the extent to which encounters submitted to the Agency by its MMA plans are complete and accurate. HSAG will compare encounter data with the MMA plans' administrative data and will also validate provider-reported encounter data against a sample of medical records.

Hewlett Packard (HP) Encounter Support Team continues to work with the plans to offer on-site visits, training, and technical assistance. During this quarter improvements were implemented to encounter data monitoring tools for timeliness and accuracy monitoring. The Support Team provided updates and webinars on the new Provider Limited Enrollment and Federally Qualified Health Center and Rural Health Clinic Wraparound Payment processes. A new encounter testing environment is fully activated and plans are encouraged to use this environment for testing their enhancements. During this quarter the agency began development of a process to direct submission of Medicare crossover claims from CMS to the plans and a pilot of the project has begun with one of the plans.

b) Collection and Verification of Encounter Data

MMA plans are required to submit encounter data to the Florida Medicaid Management Information System (FMMIS). The encounter data is verified by applying validity edits. The encounters are maintained and viewable in the FMMIS and in the Decision Support System (Data Warehouse).

c) Rate Setting/Risk Adjustment

The rate setting process currently uses all encounter data submitted by the MMA plans.

The Agency continues the process for MMA risk adjustment by sending plans participating in the MMA program all their Florida Medicaid encounter data for 12 service months. Encounter data validation is a major part of the MMA risk adjustment process. Every quarter, according to a defined timetable of events, MMA plans receive all their FMMIS reported encounters for a 12 month measurement period. The plans are given a month to review their data, and submit

corrections, as needed through the standard FMMIS reporting process. After a month, all Florida Medicaid encounter data for the same 12 month measurement period are extracted from FMMIS and provided to the Agency's actuaries in order to generate risk scores using the Chronic Illness & Disability Payment System +RX (CDPS/MedRx hybrid model). This process is repeated the next quarter using a rolling 12 month measurement period, by adding the next three months to replace the three earlier months removed.

VII. Evaluation of the Demonstration

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 #103 – 105 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.

Pending and Upcoming Evaluation Reports and Activities

The following provides an update of the pending and upcoming MMA Waiver evaluation activities as of the second quarter of DY10:

- Agency staff participated in a conference call with CMS staff to review changes to the draft MMA evaluation design on October 6, 2015.
- The Agency submitted a revised draft evaluation design update to CMS on October 14, 2015, reflecting the changes discussed during the October 6 conference call.
- Agency staff participated in a conference call with CMS staff on November 3, 2015 to discuss the October 14, 2015 draft evaluation design.
- Agency staff held a conference call with the potential evaluation team to discuss the status of the draft evaluation design.
- Agency staff modified the draft contract with the evaluation team and submitted the draft contract to Agency management for review.

VIII. Quality

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

a) EQRO

Health Services Advisory Group, Inc. submitted the draft plan-specific performance improvement project (PIP) validation reports to the Agency on November 3, 2015. The Agency provided feedback and approved all draft PIP reports on December 8, 2015. HSAG sent the reports to the MMA plans for their review on December 9, 2015.

On November 20, 2015, HSAG submitted the draft Annual Performance Measure Validation Findings Report to the Agency. The Agency provided comments and recommended edits to HSAG on December 8, 2015. The Agency approved the final version of the report on December 23, 2015.

On November 17, 2015, HSAG and the Agency hosted an external quality review quarterly educational on-site meeting in Tampa, Florida. Judette Louis, MD, MPH with the Florida Perinatal Quality Collaborative at the University of South Florida presented on Perinatal Quality Improvement Efforts in Florida. Megan Thompson, MSW with the Agency, presented on Modern Technology: Improving the Quality of Care. Rachel La Croix, Ph.D. with the Agency, provided an update to the plans on the Agency's future strategies related to performance measures, PIPs, and the Health Plan Report Card.

Beginning in November 2015, the Agency contracted with HSAG to conduct a network adequacy review of the SMMC plans' hospital networks. During the first phase of the project, HSAG will compare network data submitted to the Agency by the plans, to licensure data in FloridaHealthFinder.gov, identify discrepancies in the plans' network data, and produce a report describing the results. During Phase 2 of the project, HSAG will compare the CY 2016 Medicare Advantage Reference File to the Agency's hospital network standards, identify the differences in the two sets of standards, and produce a report describing the results.

The Agency contracts with HSAG to conduct an annual encounter data validation study. The goal of this annual study is to examine the extent to which encounters submitted to the Agency by its contracted MMA plans are complete and accurate. SFY 2015 - 2016 is the third year of a five year contract with HSAG that requires the completion of an encounter data validation study. During the first two years of the EQRO encounter data validation study, HSAG reviewed all encounter claim types, with very few exceptions. During SFY 2015 – 2016 the Agency determined that it would be most beneficial to the State to have HSAG focus on certain areas where there are known encounter data concerns. The Agency has directed HSAG to focus their encounter data validation study this year on Long-term Care, Dental Services and Therapy Services. During this past quarter, the Agency worked closely with HSAG to determine the appropriate data elements to be extracted and analyzed in this year's study. During the last week of December, the Agency provided HSAG the necessary data for completion of this study. On December 10 and 11, 2015, HSAG held technical assistance calls with the MMA plans and provided information on the data needed from the plans. The plans were given until February 12, 2016 to submit all required data to HSAG for this year's encounter data validation study.

b) Plan Performance Measure Reporting

During the first quarter of DY10, the Agency received the first year of performance measure submissions from the MMA plans. Results and highlights of the first year of MMA performance measure submissions (representing calendar year 2014) were included in the first quarter report for DY10.

During the second quarter of DY10, the Agency sent out a policy transmittal to the MMA plans that clarified performance measure reporting requirements for the report due July 1, 2016 (representing calendar year 2015). Also included in the policy transmittal was notification of a change in due dates for the CMS-416 Report. The Agency notified plans that there will no longer be an unaudited report due on or before January 15th of each year, and that plans are to submit one audited report covering the previous federal fiscal year on or before July 1 of each year.

During the first and second quarters of DY10, Agency staff compared the MMA plans' HEDIS performance measure rates to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance for HEDIS 2014). These comparisons were used to assign performance measure category and individual performance measure ratings to each MMA plan for the Florida Medicaid Health Plan Report Card, which was posted on the FloridaHealthFinder Web site in December 2015 at http://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5.

c) Comprehensive Quality Strategy

There is no update to this section for the second quarter of DY10.

d) Assessing Enrollee Satisfaction

During the first and second quarters of DY10, Agency staff compiled and reviewed the MMA plans' CAHPS survey results that were submitted to the Agency in July 2015. The statewide averages for the adult and child surveys as well as the plan-specific rates were posted on FloridaHealthFinder.gov during the second quarter of DY10.

Highlights of the Adult CAHPS survey results for MMA plans statewide include:

- 74% of respondents rated their health plan an 8, 9, or 10 out of 10.
- 76% of respondents rated their health care an 8, 9, or 10 out of 10.
- 85% of respondents rated their personal doctor an 8, 9, or 10 rating out of 10.
- 85% of respondents rated their specialist an 8, 9, or 10 out of 10.
- 82% of respondents reported it was usually or always easy for them to get needed care.
- 83% of respondents reported it was usually or always easy to get care quickly.
- 92% of respondents reported their doctor usually or always communicates well with them (e.g., explains things well, listens carefully, shows respect, and spends enough time with them).

The Child CAHPS survey is conducted by asking parents about the health care their children have received. Highlights of the Child CAHPS survey results for MMA plans statewide include:

- 81% of respondents rated their child's health plan an 8, 9, or 10 out of 10.

- 85% of respondents rated their child's health care an 8, 9, or 10 out of 10.
- 90% of respondents rated their child's personal doctor an 8, 9, or 10 out of 10.
- 83% of respondents rated their child's specialist an 8, 9, or 10 out of 10.
- 82% of respondents reported it was usually or always easy for them to get needed care for their child.
- 89% of respondents reported it was usually or always easy to get care for their child quickly.
- 93% of respondents reported that their child's doctor usually or always communicates well with them.

Attachment I
Expanded Benefits under the MMA Program

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

There were no changes to these benefits in the second quarter of DY10.

Expanded Benefits Offered by MMA Standard Plans

Expanded Benefits	MMA Standard Plans													
	Amerigroup	Better Health	Coventry	First Coast	Humana	Integral[3]	Molina	Preferred	Prestige	SFCCN	Simply	Staywell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y			Y		Y					Y	Y		Y
Equine therapy											Y			
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y		Y	Y	Y		
Newborn circumcisions	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y		Y	Y		Y	Y		Y	Y	Y		Y
Outpatient hospital services (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Pet therapy				Y		Y					Y			
Physician home visits	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Post-discharge meals	Y	Y		Y	Y	Y	Y			Y	Y	Y	Y	Y
Prenatal/perinatal visits (Expanded)	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y
Waived co-payments	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

The First Coast Advantage plan contract ended February 28, 2015; the Preferred plan contract ended October 15, 2015; and the Integral plan contract ended October 31, 2015.

Attachment II
Healthy Behaviors Program Enrollment

Chart A of Attachment II provides a summary of enrollees in Healthy Behaviors Programs for this quarter. Chart B of Attachment II provides a summary of enrollees that have completed a Healthy Behaviors Program for this quarter.

For this quarter (October 1, 2015 – December 31, 2015), 2 out of 16 MMA plans reported no enrollment in any of the Healthy Behaviors Programs offered and 13 of the 16 plans reported enrollees had completed at least one Healthy Behaviors Program.

Chart A
Healthy Behaviors Program
Enrollment Statistics
(October 1, 2015 – December 31, 2015)

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Amerigroup Florida							
Smoking Cessation	18	2	16	0	3	10	5
Weight Management	61	6	55	4	19	31	7
Alcohol and/or Substance Abuse	2	2	0	0	0	1	1
CDC Performance Measure Incentive	0	-	-	-	-	-	-
Performance Measure Incentives	0	-	-	-	-	-	-
Maternal Child Incentive	0	-	-	-	-	-	-
Better Health							
Smoking Cessation	10	4	6	0	2	6	2
Weight Management	36	10	26	3	11	17	5
Substance Abuse	0	-	-	-	-	-	-
Maternity	6	0	6	0	6	0	0
Well Child Visits	241	138	103	241	0	0	0
Children's Medical Services							
Tobacco Cessation	1	1	0	1	0	0	0
Overcoming Obesity	93	34	59	93	0	0	0
Changing Lives*	4	2	2	4	0	0	0
Clear Health Alliance							
Quit Smoking Healthy Behaviors Rewards	16	5	11	0	0	15	1
Weight Management Healthy Behaviors Rewards	8	0	8	0	0	8	0
Alcohol & Substance Abuse	2	1	1	0	0	2	0
Maternity Healthy	0	-	-	-	-	-	-

Chart A Healthy Behaviors Program Enrollment Statistics (October 1, 2015 – December 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Behaviors Rewards							
Well Child Visit Healthy Behaviors Rewards	0	-	-	-	-	-	-
Coventry							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Substance Abuse	0	-	-	-	-	-	-
Baby Visions Prenatal & Postpartum Incentive	0	-	-	-	-	-	-
Freedom Health							
Smoking Cessation	2	2	0	0	0	2	0
Weight Loss	4	2	2	0	0	2	2
Alcohol or Substance Abuse	1	1	0	0	0	1	0
Humana Medical Plan							
Smoking Cessation	0	-	-	-	-	-	-
Family Fit	45	5	40	2	11	26	6
Substance Abuse	0	-	-	-	-	-	-
Mom's First Prenatal & Postpartum	6859	0	6859	530	6071	258	0
First Baby Well Visit Incentive	6379	3352	3027	6379	0	0	0
Children's Nutrition Incentive	134162	67528	66634	134162	0	0	0
Lead Screening & Well-Child Visit Incentive	52483	26915	25568	52483	0	0	0
Adolescent Well-Child Visits Incentive	73908	36130	37778	73908	0	0	0
Magellan Complete Care							
Smoking & Tobacco Cessation	342	98	244	8	122	186	26
Weight Management	477	94	383	26	205	218	28
Substance Abuse	56	21	35	3	22	26	5
Molina							
Smoking Cessation	25	7	18	0	7	10	8
Weight Loss	17	3	14	3	6	7	1
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Pregnancy Health	220	0	220	26	190	4	0

Chart A Healthy Behaviors Program Enrollment Statistics (October 1, 2015 – December 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Management							
Pediatric Preventative Care	1496	733	763	1496	0	0	0
Positive Health Care							
Quit for Life Tobacco Cessation	0	-	-	-	-	-	-
Weight Management	10	5	5	0	0	9	1
Alcohol Abuse	0	-	-	-	-	-	-
Prestige Health Choice							
Smoking Cessation	17	3	14	0	3	12	2
Weight Loss	20	4	16	3	9	7	1
Alcohol & Substance Abuse – “Changing Lives Program”	4	1	3	0	1	2	1
Behavioral Health Follow-Up Program	2	1	1	2	0	0	0
Comprehensive Diabetes Care Program	235	62	173	1	14	134	86
Maternity Program	5	0	5	1	4	0	0
Well-Child Program	120	64	56	120	0	0	0
Simply							
Quit Smoking Healthy Behaviors Rewards	11	9	2	0	0	4	7
Weight Management Healthy Behaviors Rewards	11	2	9	3	4	1	3
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	2	0	2	0	2	0	0
Well Child Visit Healthy Behaviors Rewards	108	65	43	108	0	0	0
South Florida Community Care Network							
Tobacco Cessation	0	-	-	-	-	-	-
Obesity Management	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Staywell							
Smoking Cessation	609	253	356	8	187	353	61
Weight Management	24274	9413	14861	9146	7615	6193	1320
Substance Abuse	1	0	1	0	0	1	0

Chart A Healthy Behaviors Program Enrollment Statistics (October 1, 2015 – December 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Healthy Diabetes Behaviors	0	-	-	-	-	-	-
New Member Healthy Behavior Engagement	0	-	-	-	-	-	-
Well Woman Healthy Behavior	0	-	-	-	-	-	-
Children's Healthy Behavior Engagement	0	-	-	-	-	-	-
Sunshine Health							
Tobacco Cessation Healthy Rewards	14	5	9	0	3	8	3
Weight Loss Healthy Rewards	35	7	28	2	20	11	2
Substance Abuse Healthy Rewards	3	0	3	0	0	3	0
Preventive Adult Primary Care Visits	0	-	-	-	-	-	-
Preventative Well Child Primary Care Visits	0	-	-	-	-	-	-
Start Smart for your Baby (perinatal management)	0	-	-	-	-	-	-
Post Behavioral Health Discharge Visit in 7 Days	0	-	-	-	-	-	-
Preventive Dental Visits for Children	0	-	-	-	-	-	-
Diabetic Healthy Rewards	0	-	-	-	-	-	-
Female Cancer Screening	0	-	-	-	-	-	-
UnitedHealthcare							
Tobacco Cessation – text2quit	4	0	4	0	0	3	1
Florida Population Health/Health Coaching for Weight Loss	14	1	13	1	5	7	1
Substance Abuse Incentive	0	-	-	-	-	-	-
Baby Blocks	2,428	0	2,428	186	2,173	69	0

*Alcohol and/or substance abuse program.

Chart B Healthy Behavior Programs Completion Statistics (October 1, 2015 – December 31, 2015)							
Program	**Total Completed**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Amerigroup							
Smoking Cessation	33	9	24	0	10	19	4
Weight Loss	149	22	127	7	57	69	16
Alcohol & Substance Abuse – “Changing Lives Program”	1	1	0	0	0	0	1
Better Health							
Weight Loss	1	1	0	0	0	0	1
Well Child Visits	5	3	2	5	0	0	0
Children’s Medical Services							
Tobacco Cessation	0	0	0	0	0	0	0
Overcoming Obesity	10	3	7	10	0	0	0
Changing Lives*	1	1	0	1	0	0	0
Clear Health							
Smoking Cessation	1	0	1	0	0	1	0
Freedom							
Alcohol or Substance Abuse	1	0	1	0	0	0	1
Humana							
Family Fit	16	0	16	1	4	8	3
Mom’s First Prenatal & Postpartum	329	0	329	41	284	4	0
First Baby Well Visit Incentive	2701	1416	1285	2701	0	0	0
Children’s Nutrition Incentive	11938	6033	5905	11938	0	0	0
Lead Screening & Well-Child Visit Incentive	2589	1347	1242	2589	0	0	0
Adolescent Well-Child Visits Incentive	11291	5652	5639	11291	0	0	0
Molina							
Pregnancy Health Management	769	0	769	54	703	12	0
Pediatric Preventative Care	7	4	3	7	0	0	0
Prestige Health Choice							
Smoking Cessation	1	0	1	0	1	0	0
Weight Loss	2	0	2	0	0	1	1

Chart B Healthy Behavior Programs Completion Statistics (October 1, 2015 – December 31, 2015)							
Simply							
Well Child Visit Healthy Behaviors Rewards	5	4	1	5	0	0	0
Staywell							
Smoking Cessation	410	165	245	6	114	246	44
Weight Management	1517	477	1040	382	424	570	141
Sunshine Health							
Tobacco Cessation Healthy Rewards	10	4	6	0	1	8	1
Weight Loss Healthy Rewards	14	2	12	0	3	8	3
Substance Abuse Healthy Rewards	0	0	0	0	0	0	0
UnitedHealthcare							
Baby Blocks	31	0	31	1	29	1	0

Attachment III
MMA Enrollment Report

Number of MMA Plans in Regions Report

The following table provides each region established under Part IV of Chapter 409, F.S.

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

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

Table 2 Number of MMA Plans by Region (October 1, 2015 – December 31, 2015)		
Region	General	Specialty
01	2	3
02	2	4
03	4	4
04	4	3
05	4	5
06	7	5
07	6	5
08	4	4
09	4	5
10	4	6
11	10	6
Unduplicated Totals	12	6

MMA Enrollment

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

Table 3
MMA Enrollment by Plan and Type Report Descriptions

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

Table 3A located on the following page lists, by health 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.

Table 3B 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.

Table 3 A
MMA Enrollment by Plan and Type[4]
(October 1, 2015 – December 31, 2015)

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	GENERAL	**312,405**	32,474	62	16,007	**360,948**	11.1%	357,732	0.90%
Better Health	GENERAL	**87,089**	8,929	14	4,312	**100,344**	3.1%	99,621	0.73%
Coventry Health Care Of Florida	GENERAL	**47,158**	4,706	35	3,434	**55,333**	1.7%	53,409	3.60%
Humana Medical Plan	GENERAL	**282,119**	37,590	203	28,848	**348,760**	10.7%	345,996	0.80%
Integral Quality Care**	GENERAL	**86,735**	8,136	17	5,397	**100,285**	3.1%	100,347	-0.06%
Molina Healthcare Of Florida	GENERAL	**182,744**	19,557	60	11,479	**213,840**	6.6%	181,005	18.14%
Preferred Medical Plan*	GENERAL	**-**	-	-	-	**0**	0.0%	24,777	-100.00%
Prestige Health Choice	GENERAL	**282,902**	31,277	54	19,952	**334,185**	10.2%	333,985	0.06%
South Florida Community Care Network	GENERAL	**39,536**	3,471	9	1,811	**44,827**	1.4%	44,730	0.22%
Simply Healthcare	GENERAL	**59,978**	13,604	152	12,398	**86,132**	2.6%	86,512	-0.44%
Staywell Health Plan	GENERAL	**626,921**	70,253	84	30,103	**727,361**	22.3%	722,204	0.71%
Sunshine State Health Plan	GENERAL	**371,257**	37,204	67	44,181	**452,709**	13.9%	448,202	1.01%
United Healthcare Of Florida	GENERAL	**239,169**	27,956	68	29,059	**296,252**	9.1%	293,977	0.77%
General Plans Total		**2,618,013**	**295,157**	**825**	**206,981**	**3,120,976**	**95.7%**	**3,092,497**	**0.92%**
Positive Health Plan	SPECIALTY	**197**	904	-	785	**1,886**	0.1%	1,883	0.16%
Magellan Complete Care	SPECIALTY	**22,880**	20,125	12	388	**43,405**	1.3%	40,483	7.22%
Freedom Health	SPECIALTY	**-**	-	-	68	**68**	0.0%	72	-5.56%
Clear Health Alliance	SPECIALTY	**1,316**	4,934	-	3,259	**9,509**	0.3%	9,556	-0.49%
Sunshine State Health Plan	SPECIALTY	**29,551**	2,115	-	2	**31,668**	1.0%	22,252	42.32%
Children's Medical Services Network	SPECIALTY	**30,489**	24,545	-	148	**55,182**	1.7%	63,959	-13.72%
Specialty Plans Total		**84,433**	**52,623**	**12**	**4,650**	**141,718**	**4.3%**	**138,205**	**2.54%**
MMA TOTAL	**MMA**	**2,702,446**	**347,780**	**837**	**211,631**	**3,262,694**	**100%**	**3,230,702**	**0.99%**

[1] During the quarter, an enrollee is counted only once in the plan of earliest enrollment. Please refer to http://ahca.myflorida.com/SMMC for actual monthly enrollment totals.
*Preferred Medical Plan ceased operations effective July 31, 2015.
**Integral Quality Care ceased operations effective October 31, 2015.

Table 3 B
MMA Enrollment by Region and Type
(October 1, 2015 – December 31, 2015)

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	89,982	11,410	5	6,626	108,023	3.3%	105,918	1.99%
02	MMA	96,807	14,668	10	8,790	120,275	3.7%	119,362	0.76%
03	MMA	229,145	30,603	19	16,857	276,624	8.5%	273,433	1.17%
04	MMA	274,987	31,768	26	18,162	324,943	10.0%	319,523	1.70%
05	MMA	157,059	22,223	15	14,932	194,229	6.0%	194,574	-0.18%
06	MMA	372,441	48,104	63	22,007	442,615	13.6%	442,886	-0.06%
07	MMA	367,521	46,647	71	19,671	433,910	13.3%	427,066	1.60%
08	MMA	191,948	18,627	41	13,789	224,405	6.9%	225,636	-0.55%
09	MMA	243,969	25,432	35	15,726	285,162	8.7%	280,259	1.75%
10	MMA	235,530	27,270	72	16,326	279,198	8.6%	274,414	1.74%
11	MMA	443,057	71,028	480	58,745	573,310	17.6%	567,631	1.00%
MMA TOTAL		2,702,446	347,780	837	211,631	3,262,694	100%	3,230,702	0.99%
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	GENERAL	88,096	10,525	5	6,549	105,175	3.4%	103,211	1.90%
02	GENERAL	91,759	11,891	10	8,670	112,330	3.6%	111,387	0.85%
03	GENERAL	222,505	27,801	19	16,634	266,959	8.6%	263,739	1.22%
04	GENERAL	264,096	26,891	26	18,111	309,124	9.9%	305,065	1.33%
05	GENERAL	150,273	18,451	14	14,400	183,138	5.9%	184,095	-0.52%
06	GENERAL	360,479	40,433	59	21,660	422,631	13.5%	423,609	-0.23%
07	GENERAL	355,720	38,915	69	19,170	413,874	13.3%	407,070	1.67%
08	GENERAL	188,204	16,801	41	13,567	218,613	7.0%	219,404	-0.36%
09	GENERAL	235,884	20,591	34	15,219	271,728	8.7%	266,857	1.83%
10	GENERAL	226,972	21,284	72	15,683	264,011	8.5%	259,294	1.82%
11	GENERAL	434,025	61,574	476	57,318	553,393	17.7%	548,766	0.84%
GENERAL TOTAL		2,618,013	295,157	825	206,981	3,120,976	100.0%	3,092,497	0.92%

Table 3 B
MMA Enrollment by Region and Type
(October 1, 2015 – December 31, 2015)

01	SPECIALTY	1,886	885	-	77	2,848	2.0%	2,707	5.21%
02	SPECIALTY	5,048	2,777	-	120	7,945	5.6%	7,975	-0.38%
03	SPECIALTY	6,640	2,802	-	223	9,665	6.8%	9,694	-0.30%
04	SPECIALTY	10,891	4,877	-	51	15,819	11.2%	14,458	9.41%
05	SPECIALTY	6,786	3,772	1	532	11,091	7.8%	10,479	5.84%
06	SPECIALTY	11,962	7,671	4	347	19,984	14.1%	19,277	3.67%
07	SPECIALTY	11,801	7,732	2	501	20,036	14.1%	19,996	0.20%
08	SPECIALTY	3,744	1,826	-	222	5,792	4.1%	6,232	-7.06%
09	SPECIALTY	8,085	4,841	1	507	13,434	9.5%	13,402	0.24%
10	SPECIALTY	8,558	5,986	-	643	15,187	10.7%	15,120	0.44%
11	SPECIALTY	9,032	9,454	4	1,427	19,917	14.1%	18,865	5.58%
SPECIALTY TOTAL		84,433	52,623	12	4,650	141,718	100.0%	138,205	2.54%

Attachment IV
Budget Neutrality Update

In Charts A through H of Attachment IV, 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 H of Attachment IV in accordance with STC #88.

In accordance with STC #87(d)(ii), the Agency initiated the development of the new CMS-64 reporting operation that will be required to support the MMA Waiver. The new reporting operation was effective October 2014 (Q34 - date of payment), which is the first complete quarter under the MMA program.

Chart A of Attachment IV shows the Primary Care Case Management (PCCM) Targets established in the MMA Waiver as specified in STC #99(b). 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
DY1	$948.79	$199.48
DY2	$1,024.69	$215.44
DY3	$1,106.67	$232.68
DY4	$1,195.20	$251.29
DY5	$1,290.82	$271.39
DY6	$1,356.65	$285.77
DY7	$1,425.84	$300.92
DY8	$1,498.56	$316.87
DY9	$786.70	$324.13
DY10	$830.22	$339.04
DY11	$864.26	$354.64

The quarter beginning October 2014 (Q34 - date of payment) is the first complete quarter under MMA. Historical data prior to this quarter will no longer be reported but is available upon request.

Charts B through J of Attachment IV contain the statistics for MEGs 1, 2 and 3 for date of payment beginning with the period October 1, 2015, and ending December 31, 2015. 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.

Charts D and F will reflect prior DY periods (Reform), and Charts E and G will reflect current (MMA) DY periods since those are date of service driven expenditures. The Agency will report the three most recent DYs in these Charts.

Chart B MEG 1 Statistics: SSI Related				
DY/Quarter	**Actual MEG 1**	**Case months**	**Total Spend***	**PCCM**
DY10/Q38	October 2015	540,256	$396,641,992	$734.17
DY10/Q38	November 2015	534,625	$383,794,953	$714.68
DY10/Q38	December 2015	527,229	$431,413,200	$818.27
DY10/Q38	Total[5]	1,604,502	$1,211,850,145	$755.28
	MMA - MEG 1 Total[6]	36,131,097	35,985,499,690	995.97

* 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				
DY/Quarter	**Actual MEG 2**	**Case months**	**Total Spend***	**PCCM**
DY10/Q38	October 2015	2,502,365	$723,144,057	$288.98
DY10/Q38	November 2015	2,508,310	$677,311,141	$270.03
DY10/Q38	December 2015	2,479,177	$766,194,124	$309.05
DY10/Q38	Total[1]	7,489,852	$2,166,649,322	$289.28
	MMA - MEG 2 Total[2]	203,009,348	37,600,067,936	185.21

* 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.

[5] MMA MEG1 Quarter Total
[6] MMA MEG1 Totals (from DY01 on)

Charts D, E, F and G 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.

Chart D MEG 1 and MEG2 Annual Statistics					
DY08 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY08 Total	**4,000,390**	**$3,414,538,645**	**$945,905,305**	**$4,360,443,950**	**$1,090.00**
WOW DY8 Total	**4,000,390**			**$5,994,824,438**	**$1,498.56**
Difference				**$(1,634,380,488)**	
% of WOW PCCM MEG 1					**72.74%**
DY08– MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY08 Total	**24,867,309**	**$3,783,670,392**	**$631,919,342**	**$4,415,589,734**	**$177.57**
WOW DY8 Total	**24,867,309**			**$7,879,704,203**	**$316.87**
Difference				**$(3,464,114,469)**	
% of WOW PCCM MEG 2					**56.04%**
DY09 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY09 Total	5,326,173	**$731,155,792**	**$3,485,153,834**	**$4,216,309,626**	**$791.62**
WOW DY9 Total	5,326,173			**$4,190,100,299**	**$786.70**
Difference				**$26,209,327**	
% of WOW PCCM MEG 1					**100.63%**
DY09– MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY09 Total	27,169,344	**$889,324,630**	**$5,275,474,087**	**$6,164,798,717**	**$226.90**
WOW DY9 Total	27,169,344			**$8,806,399,471**	**$324.13**
Difference				**$(2,641,600,754)**	
% of WOW PCCM MEG 2					**70.00%**

For DY8, MEG 1 has a PCCM of $1,090.00 (Chart D), compared to WOW of $1,498.56 (Chart A), which is 72.74% of the target PCCM for MEG 1. MEG 2 has a PCCM of $177.57 (Chart D), compared to WOW of $316.87 (Chart A), which is 56.04% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $791.62 (Chart D), compared to WOW of $786.70 (Chart A), which is 100.63% of the target PCCM for MEG 1. MEG 2 has a PCCM of $226.90 (Chart D), compared to WOW of $324.13 (Chart A), which is 70.00% of the target PCCM for MEG 2.

Chart E MMA Enrolled			
DY10– MEG 1	**Actual CM**	**Total**	**PCCM**
MEG 1 - DY09 Total	**3,200,706**	**$2,237,218,982**	**$698.98**
WOW DY9 Total	**3,200,706**	**$2,657,290,135**	**$830.22**
Difference		**$(420,071,153)**	
% of WOW PCCM MEG 1			**84.19%**
DY10– MEG 2	**Actual CM**	**Total**	**PCCM**
MEG 2 - DY09 Total	**14,860,407**	**$3,822,776,521**	**$257.25**
WOW DY9 Total	**14,860,407**	**$5,038,272,389**	**$339.04**
Difference		**$(1,215,495,869)**	
% of WOW PCCM MEG 2			**75.87%**

For DY10, MEG 1 has a PCCM of $698.98 (Chart E), compared to WOW of $830.22 (Chart A), which is 84.19% of the target PCCM for MEG 1. MEG 2 has a PCCM of $257.25 (Chart E), compared to WOW of $339.04 (Chart A), which is 75.87% of the target PCCM for MEG 2.

Chart F MEG 1 and MEG2 Cumulative Statistics					
DY 08	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	**28,867,699**	**$7,198,209,036**	**$1,577,824,647**	**$8,776,033,684**	**$304.01**
WOW	**28,867,699**			**$13,874,528,641**	**$480.62**
Difference				**$(5,098,494,958)**	
% Of WOW					**63.25%**
DY 09	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	**32,495,517**	**$1,620,480,421**	**$8,760,627,921**	**$10,381,108,343**	**$319.46**
WOW	**32,495,517**			**$12,996,499,770**	**$399.95**
Difference				**$(2,615,391,427)**	
% Of WOW					**79.88%**

For DY8, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart F) 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 F is $304.01. Comparing the calculated weighted averages, the actual PCCM is 63.25% 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 F) is $399.95. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Chart F is $319.46. Comparing the calculated weighted averages, the actual PCCM is 79.88% of the target PCCM.

Chart G MMA Enrolled			
DY 10	**Actual CM**	**Total**	**PCCM**
Meg 1 & 2	**18,061,113**	**$6,059,995,503**	**$335.53**
WOW	**18,061,113**	**$7,695,562,525**	**$426.08**
Difference		**$(1,635,567,022)**	
% Of WOW			**78.75%**

For DY9, the weighted target PCCM for the reporting period using the actual case months and the MMA specific targets in the STCs (Chart G) is $426.08. The actual PCCM weighted for the reporting period using the actual case months and the MMA specific actual PCCM as provided in Chart G is $335.53. Comparing the calculated weighted averages, the actual PCCM is 78.75% of the target PCCM.

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 H identifies the DY10 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 DY10 in Chart G above.

Chart H WW/WOW Difference Less CNOM Costs	
DY09 Difference July 2014 - December 2014:	**$(1,635,567,022)**
CNOM Costs July 2014 – December 2014:	
Healthy Start	**$18,247,899**
PACC	**$380,144**
DY09 Net Difference:	**($1,616,938,979)**

Chart I MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
DY10/Q38	**$303,368,192**
Total Paid	**$10,359,178,675**

Chart I of Attachment IV shows that the expenditures for the 38 quarters for MEG 3, Low Income Pool (LIP), were $10,359,178,675.

Chart J MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY10	$303,368,192	$1,000,000,000	30.34%
Total MEG 3	$10,359,178,675	$11,167,718,341	92.76%

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

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Mission Statement
Better Healthcare for All Floridians.