Florida Managed Medical Assistance Program

1115 Research and Demonstration Waiver

2nd Quarter Progress Report
(October 1, 2013 – December 31, 2013)
Demonstration Year 8

Agency for Health Care Administration

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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I. Waiver History

Background

On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by the Centers for Medicare and Medicaid Services (Federal CMS). Medicaid Reform was designed as a comprehensive demonstration with the following key components: comprehensive choice counseling, customized benefit packages, enhanced benefits for participating in healthy behaviors, risk-adjusted premiums based on enrollee health status, and a Low Income Pool. The program was initially implemented in Broward and Duval Counties on July 1, 2006 and expanded to Baker, Clay and Nassau Counties on July 1, 2007.

On June 30, 2010, a three-year waiver extension request was submitted to Federal CMS to maintain and continue operations of Medicaid Reform for the period July 1, 2011 through June 30, 2014. Federal CMS granted temporary extensions of program until December 15, 2011, when final approval of the waiver extension request was granted, for the period December 16, 2011 through June 30, 2014.

On August 1, 2011, an amendment request was submitted to Federal CMS to implement the Managed Medical Assistance (MMA) program as specified in Part IV of Chapter 409, Florida Statutes (F.S.). The amendment and related documents can be viewed on the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA.

On February 20, 2013, the Agency received a letter from Federal CMS stating an agreement in principle was reached regarding Federal CMS granting the amendment to implement the MMA program. On June 14, 2013, Federal CMS approved the amendment to implement the MMA program along with newly amended Special Terms and Conditions (STCs), waiver and expenditure authorities. The amendment approval documents can be viewed on the Agency's website at the link provided above.

Federal approval of the MMA amendment permits Florida Medicaid to move from a fee-for-service system to the MMA program. The key components of the program include: choice counseling, competitive procurement of managed care plans, customized benefit packages, healthy behavior programs, risk-adjusted premiums based on enrollee health status and a Low Income Pool. The MMA program will increase 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.

The existing Medicaid Reform program will be phased out as the MMA program is implemented in each region of the state no later than October 1, 2014, and as approved by Federal CMS. The state authority to operate the Medicaid Reform program is located in Section (s.) 409.91211, F.S., and will sunset October 1, 2014.

On November 27, 2013, the Agency submitted a three-year waiver extension request to Federal CMS to extend Florida's 1115 MMA Waiver for the period July 1, 2014 – June 30, 2017. Please refer to Section IV of this report for more information on the waiver extension request.

Quarterly Report Requirement

The reporting requirements for the demonstration are specified in Florida law and newly amended STCs #90 and #91 of the waiver. Newly amended STC #90 requires the state submit a quarterly progress report summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to, approval and contracting with new plans, specifying coverage area, populations served, benefits, enrollment, grievances, and other operational issues.

This report is the second quarterly report for Demonstration Year Eight covering the period of October 1, 2013 – December 31, 2013. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and annual reports, which can be accessed at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

Please note the state will continue to report on the Medicaid Reform program until the MMA program is fully implemented.

II. Status of the Demonstration

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans wanting to participate as Reform health plans were required to complete a Medicaid health plan application. The Agency used an open health plan application process with submission guidelines to ensure applicants understood the contract requirements. The application process consisted of four areas: (I) organizational and administrative structure; (II) policies and procedures; (III) on-site review; and (IV) contract execution, establishing a provider file in the Florida Medicaid Management Information System (FLMMIS), completing systems testing to ensure the health plan applicant is capable of submitting and retrieving HIPAA-compliant files and submitting accurate provider network files, and ensuring the health plan receives its first membership.

Current Activities

Health Plan Applications and Expansion Requests

Since the implementation of the demonstration, the Agency received 29 health plan applications [20 health maintenance organizations (HMOs) and nine fee-for-service (FFS) provider service networks (PSNs)], of which 27 applicants sought and received approval to provide services to both the Temporary Assistance for Needy Families (TANF) and the Supplemental Security Income (SSI) populations. Two applications were withdrawn.

Health plan application and expansion requests will not be processed through the implementation of the MMA program.

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Table 1 provides a comprehensive list since the implementation of the Reform demonstration of all health plan applicants, the date each application was received, the date each application was approved, and the initial counties of operation requested by each applicant.

Table 1
Health Plan Applicants

Plan Name	Plan Type	Coverage Area		Receipt Date	Contract Date
		Broward	Duval		
South Florida Community Care Network	PSN	X		04/13/06	06/29/06
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
HealthEase	HMO	X	X	04/14/06	06/29/06
Staywell	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare	HMO	X	X	04/14/06	06/29/06
Humana	HMO	X		04/14/06	06/29/06
Freedom Health Plan	HMO	X		04/14/06	09/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
Buena Vista	HMO	X		04/14/06	06/29/06
Vista Health Plan of South Florida	HMO	X		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Shands Jacksonville Medical Center d/b/a First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Pediatric Associates	PSN	X		05/09/06	08/11/06
Better Health Plan	PSN	X	X	05/23/06	12/10/08
AHF MCO d/b/a Positive Health Care	HMO	X		01/28/08	02/18/10
Medica Health Plan of Florida	HMO	X		09/29/08	10/24/09
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		01/14/09	05/20/09
Preferred Care Partners, Inc. d/b/a Care Florida	HMO	X		01/21/10	12/20/10
Community Health Plan of South Florida	PSN	X		06/14/11	Application Withdrawn
Simply Healthcare	HMO	X		02/29/12	09/01/12
Healthease/Staywell of Florida	HMO	X	X	03/23/12	01/10/13
Magellan Complete Care	HMO	X		03/30/12	05/25/13
Simply Healthcare d/b/a Clear Health Alliance	HMO	X		06/01/12	03/01/13
CareAccess PSN	PSN	X		11/20/12	Application Withdrawn

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area.

Table 2
Medicaid Reform Health Plan Contracts

Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care	07/01/06	HMO	X****		
HealthEase	07/01/06	HMO	X***	X***	
Staywell	07/01/06	HMO	X***	X***	
Preferred Medical Plan	07/0106	HMO	X****		
United HealthCare	07/01/06	HMO	X*	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South Florida Community Care Network	07/01/06	PSN	X		
Buena Vista	07/01/06	HMO	X*		
Vista Health Plan SF	07/01/06	HMO	X*		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center d/b/a First Coast Advantage	07/01/06	PSN		X	X******
Pediatric Associates	08/11/06	PSN	X**		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care ++	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	04/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X	X*****	X*****+
Medica Health Plan of Florida, Inc.	11/01/09	HMO	X		
AHF MCO d/b/a Positive Health Care	05/01/10	HMO	X		
Preferred Care Partners, Inc. d/b/a Care Florida	01/01/11	HMO	X		
Simply Healthcare	09/01/12	HMO	X+++		
Healthease/Staywell of Florida	01/01/13	HMO	X	X	X
Simply Healthcare d/b/a Clear Health Alliance	03/01/13	HMO	X		
Magellan Complete Care	06/01/13	HMO	X		

* During the Fall of 2008, the plan amended its contract to withdraw from this county. The United withdrawal was effective November 1, 2008. The Vista/Buena Vista withdrawal was effective December 1, 2008.

** During the Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.

*** During the Spring of 2009, the plan notified the Agency to withdraw from these counties. The withdrawals for Healthease and Staywell were effective July 1, 2010.

**** During the Summer of 2009, the plan notified the Agency of its intent to withdraw from this county. The withdrawals for Amerigroup and Preferred were effective December 1, 2009.

***** Sunshine began providing services in these counties effective September 1, 2009.

****** First Coast Advantage expanded into these counties effective December 1, 2010.

\+ Sunshine withdrew from Nassau and Baker Counties effective December 31, 2010.

++ Contract was terminated April 1, 2013, as a result of receivership order from Second Judicial Circuit Court in Leon County, Florida.

+++ Simply Healthcare withdrew from Broward County effective August 1, 2013.

Health Plan Capacity

Health plan capacity is monitored on an ongoing basis. Health plans must supply an up-to-date provider network information file each month. The Agency uses the file to monitor the health plans' compliance with required provider network composition and primary care physician (PCP)-to-member ratios. The choice counseling/enrollment broker contractor loads this information into its system for use as a choice selection tool and to enable PCP selection at the time of voluntary plan enrollment. Additionally, the Agency monitors overall capacity to ensure recipients have a choice of at least two health plans in each demonstration county.

Contract Conversions/Terminations

There were no contract conversions or terminations during this quarter.

FFS PSN Conversion Process

FFS PSNs are required to convert to capitation by the beginning of the final year of operation under the waiver extension, unless the FFS PSN opts to convert to capitation earlier as specified in s. 409.91211(3)(e), F.S. The Agency released an updated FFS PSN conversion application in April 2012 and continues to provide technical assistance to the FFS PSNs regarding conversion. Most FFS PSNs have submitted conversion applications. However, the conversion to capitation will occur through the implementation of the MMA program. Current FFS PSNs not participating in the MMA program are not expected to convert to capitation prior to contract termination.

2. Benefit Package

Overview

Customized benefit packages are one of the fundamental elements of the Reform demonstration. Medicaid recipients are offered choices in health plan benefit packages customized to provide services that better suit health plan enrollees' needs. The Reform demonstration authorizes the Agency to allow capitated plans to create a customized benefit package by varying certain services for non-pregnant adults, varying cost-sharing and providing additional services. PSNs that chose a FFS reimbursement payment methodology cannot develop a customized benefit package, but can eliminate or reduce the co-payments and offer additional services. For more information about the design of the customized benefit packages, please refer to the most recent annual report posted on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/annual.shtml.

Current Activities

Customized Benefit Packages

The customized benefit packages became operational on January 1, 2013 and will remain valid through the implementation of the MMA program, effectively overlapping Demonstration Years Seven and Eight. These benefit packages include 26 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs. Table 3 located on the following page lists the number of co-payments for each service type by each Demonstration Year and reflects the customized benefit packages that became operational on January 1, 2013.

Table 3 Number of Co-payments by Type of Service by Demonstration Year												
Type of Service	**Year One**	**Year Two**	**Year Three***			**Year Four**	**Year Five**		**Year Six**		**Year Seven**	**Year Eight**
	July 2006-June 2007	July 2007-June 2008	July-Dec 2008	Jan-Nov 2009	Dec-09	Jan-June 2010	July-Dec 2010	Jan-Aug 2011	July-Dec 2011	Jan-June 2012	July 2012-June 2013	July-Dec 2013
ARNP/Physician Assistant	0	0	5	1	0	0	0	0	0	0	0	0
Chiropractic	10	0	8	4	3	3	3	5	5	6	6	6
Clinic (FQHC, RHC)	0	0	6	2	1	0	0	0	0	0	0	0
Dental	4	4	4	0	0	2	2	2	2	2	2	2
Home Health	4	1	8	4	3	3	3	3	3	4	4	4
Hospital Inpatient: Behavioral Health	11	1	8	4	3	4	4	6	6	6	6	6
Hospital Inpatient: Physical Health	7	1	8	4	3	4	4	6	6	6	6	6
Hospital Outpatient Services (Non-Emergency)	7	1	7	3	3	2	2	2	2	2	2	2
Hospital Outpatient Surgery	7	1	8	4	3	2	2	2	2	2	2	2
Lab/X-Ray	5	1	7	3	3	2	2	2	2	2	2	2
Mental Health	7	3	6	2	1	4	4	4	4	5	5	5
Podiatrist	10	0	7	3	3	3	3	5	5	6	6	6
Primary Care Physician	0	0	5	1	0	0	0	0	0	0	0	0
Specialty Physician	1	1	6	2	1	0	0	2	2	2	2	2
Transportation	5	5	6	2	1	2	2	2	2	2	2	2
Vision	4	0	5	1	1	2	2	2	2	2	2	2
Total Number of Required Co-payments	**82**	**19**	**104**	**40**	**29**	**33**	**33**	**43**	**43**	**47**	**47**	**47**

* Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the recipients of any changes in their current health plan's benefit package as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, in Tables 3 and 4, Demonstration Year Three has been divided into three columns: July 1, 2008 through December 31, 2008; January 1, 2009 through November 30, 2009; and December 2009. These different columns reflect the departure of health plans that ceased operations during Demonstration Year Three.

Table 4 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year.

Table 4
Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year

	Year One	Year Two	Year* Three			Year Four		Year Five		Year Six		Year Seven			Year Eight
	July 2006-June 2007	July 2007-June 2008	July-Dec 2008	Jan-Nov 2009	Dec 2009	Jan-April 2010	May-June 2010	July-Dec 2010	Jan-June 2011	July-Dec 2011	Jan-June 2012	July-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	July-Dec 2013
Total Number of Benefit Packages	28	30	28	24	20	20	19	19	20	20	20	22	28	26	26
Total Number of Benefit Packages Requiring No Co-payments	12	16	20	20	17	16	15	15	14	14	13	15	21	19	19
Percent of Benefit Packages Requiring No Co-payments	43%	53%	71%	83%	85%	80%	79%	79%	70%	70%	65%	68%	75%	73%	73%

* Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the recipients of any changes in their current health plan's benefit package as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, in Tables 3 and 4, Demonstration Year Three has been divided into three columns: July 1, 2008 through December 31, 2008; January 1, 2009 through November 30, 2009; and December 2009. These different columns reflect the departure of health plans that ceased operations during Demonstration Year Three.

Table 5 shows the number of benefit packages for Demonstration Years Four through Eight not requiring co-payments by population and area. Table 5 shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments.

Table 5
Number of Benefit Packages Requiring No Co-payments by Target Population & Area

Target Population	List of Counties in Each Demonstration Area	Number of Benefit Packages Not Requiring Co-payments								
		Year Four		Year Five		Year Six	Year Seven			Year Eight
		Jan	May	July-Dec	Jan	July-June	July-Dec	Jan-March	Apr-June	July-Dec
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	3	3	3	1	1	1	1	1	1
SSI (Aged and Disabled)	Broward	6	5	5	6	6	7	7	8	8
TANF (Children and Families)	Duval, Baker, Clay and Nassau	1	1	1	1	1	1	1	1	1
TANF (Children and Families)	Broward	6	5	5	6	5	6	6	7	7

Expanded Services

In Year Eight of the demonstration, all of the capitated health plans continue to offer expanded or additional benefits that were not previously covered by the state under the Medicaid State Plan in order to meet the needs of new enrollees. In the health plan contract, these are referred to as expanded services. The following is a list of the expanded services currently offered by the capitated health plans of which the over-the-counter drug benefits and adult preventive benefits are the most frequently offered:

- Over-the-counter drug benefit – $25 per household per month
- Adult preventive dental
- Circumcisions for male newborns
- Additional adult vision
- Nutritional counseling.

Plan Evaluation Tool (PET)

Since the implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006 to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Demonstration Year Three to a monthly prescription limit only. Prior to Demonstration Year Three, plans had the option of having a monthly prescription limit or a dollar limit on the pharmacy benefit. This change was made to standardize the mechanism used to limit the pharmacy benefit. The Agency will continue to require the plans to maintain the sufficiency threshold level of pharmacy benefit for SSI and TANF at 98.5%. In addition, the Agency will ensure each plan's customized benefit package meets or exceeds, and maintains, a minimum threshold of 98.5% for benefits identified as sufficiency tested benefits as required by STC #31.

The PET submission procedure for Demonstration Year Seven was similar to that of the six previous years and it was released during the second quarter of Demonstration Year Seven. The health plans' Year Seven benefit packages were approved during the second quarter of Demonstration Year Seven and became effective January 1, 2013. The PET submission procedure for Demonstration Year Eight was treated different than in previous years. Previously, the PET was released, submitted and approved during the second quarter with a January effective date. However, for 2014 the current health plans' Year Seven benefit packages will be extended through the implementation of the MMA program.

3. Health Plan Reported Complaints, Grievances and Appeal Process

Overview

Health plan contracts include a grievance process, appeal process and Medicaid Fair Hearing (MFH) system. In addition, the health plan contracts include timeframes for submission, plan response and resolution of recipient grievances. This is compliant with federal grievance system requirements located in Subpart F of 42 CFR 438.

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the

failure to provide services in a timely manner, as defined by the state; the failure of the health plan to act within ninety (90) days from the date the health plan receives a grievance, or 45 days from the date the health plan receives an appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise his or her rights to obtain services outside the network.

- Appeal means a request for review of an action, pursuant to 42 CFR 438.400(b).
- Grievance means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

In accordance with s. 409.91211(3)(q), F.S., the Agency provides for an additional grievance resolution process for enrollees, upon completion of the health plan's internal grievance process, which is referred to as the Beneficiary Assistance Panel (BAP). The BAP will not consider a request that has already been to a MFH. The BAP reviews the requests within the following timeframes:

1. The state panel will review general grievances within 120 days.
2. The state panel will review grievances that the state determines pose an immediate and serious threat to an enrollee's health within 45 days.
3. The state panel will review grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee within 24 hours.

Enrollees in a health plan may file a request for a MFH at any time and are not required to exhaust the plan's internal appeal process or file with the BAP.

Current Activities

The Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. To better understand the issues recipients face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in the quarterly reports. The Agency also uses this information internally as part of the Agency's continuous improvement efforts.

Health Plan Reported Complaints

The health plan contract requires the health plans to report the number of member complaints received by plan by quarter.

Table 6 provides the number of complaints reported by plan type for this quarter. The health plan contract defines complaint as: any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day. The subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices or provision of services that relate to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system.

Table 6 Health Plan Reported Complaints (October 1, 2013 – December 31, 2013)		
Quarter	**PSN Complaints**	**HMO Complaints**
October 1, 2013 – December 31, 2013	131	357

PSN plan reported complaints decreased from 157 reported last quarter to 131 in this quarter. HMO plan reported complaints decreased from 379 reported last quarter to 357 in this quarter.

Grievances and Appeals

Table 7 provides the number of grievances and appeals by health plan type for this quarter.

Table 7 Grievances and Appeals (October 1, 2013 – December 31, 2013)				
Quarter	**PSN Grievances**	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**
October 1, 2013 – December 31, 2013	18	69	233	118

PSN grievances increased from 17 reported last quarter to 18 in this quarter; the PSN appeals decreased from 91 reported last quarter to 69 in this quarter. HMO grievances decreased from 264 reported last quarter to 233 in this quarter; the HMO appeals increased from 101 reported last quarter to 118 in this quarter.

Medicaid Fair Hearings (MFH)

Table 8 provides the number of MFHs requested and held during this quarter. MFHs are conducted through the Florida Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members; however, the Agency monitors the MFH process. There were a total of eight MFHs requested this quarter, five for HMOs and three for PSNs. There were a total of three MFHs held during this quarter, all of which were from the MFH requests received during the last quarter. In regards to outcomes, two of the MFHs held received a mixed result meaning that the outcome was found partially in favor of the demonstration participant and the other issue was withdrawn by the demonstration participant during the hearing.

Table 8 Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held (October 1, 2013 – December 31, 2013)			
Quarter	**Plan Type**	**Medicaid Fair Hearings Held**	**Medicaid Fair Hearings Requested**
October 1, 2013 – December 31, 2013	**HMO**	1	5
	PSN	2	3
	Total	**3**	**8**

Beneficiary Assistance Program

Table 9 provides the number of requests submitted to the BAP during this quarter. There were no requests submitted to the BAP this quarter.

Table 9
BAP Requests
(October 1, 2013 – December 31, 2013)

Quarter	HMO	PSN	Total
October 1, 2013 – December 31, 2013	0	0	**0**

4. Agency-Received Complaints/Issues Resolution Process

Overview

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on the operation of managed care under the demonstration. Complaints/issues come to the Agency from recipients, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received by the Agency are as follows:

- Medicaid Local Area Offices,
- Medicaid Headquarters Bureau of Managed Health Care,
- Medicaid Headquarters Bureau of Health Systems Development, and
- Medicaid Choice Counseling Helpline. Health plan complaints received by the Choice Counseling Helpline are referred to the Florida Medicaid headquarters offices specified above for resolution.

The complaints/issues are processed by Florida Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks them to ensure resolution. Medicaid staff use the Complaints/Issues Reporting and Tracking System (CIRTS), which allows for real-time, secure access through the Agency's web portal. In addition, the Agency tracks the complaints by plan and plan type to review complaint data on individual plans on a monthly while also reviewing complaint trends on a quarterly basis at the management level.

Table 10 provides the number of complaints/issues the Agency received by type of health plan during the quarter. Attachments I (PSN Complaints) and II (HMO Complaints) of this report provide a description of each complaint/issue the Agency received and the action(s) taken by the Agency and/or the health plan to resolve the issue.

Table 10
Agency-Received Complaints/Issues
(October 1, 2013 – December 31, 2013)

Quarter	HMO	PSN	Total
October 1, 2013 – December 31, 2013	18	8	**26**

This quarter, the complaints/issues received from recipients, advocates and other stakeholders primarily related to enrollees needing assistance in accessing providers, obtaining medications and getting services authorized. The Agency worked with the enrollees and health plans to resolve these issues. The complaints/issues received from providers related to claims processing or payment delays/denials. The health plans were informed of the complaints/issues received this quarter and, in most cases, the health plans were instrumental in obtaining the information or service the enrollee or provider needed.

The Agency will continue to monitor the complaints/issues received for contractual compliance, plan performance, and trends that may require policy or operational changes.

5. Medical Loss Ratio

Overview

On June 25, 2012 and in accordance with newly amended STC #17c, the Agency submitted to Federal CMS the revised MLR instructions and templates, reporting schedule and the report guide that incorporated comments from the health plans and Federal CMS. The substantive change made to this policy was to extend the reporting deadline from 45 days to seven months after the end of each quarter or year for which the health plan is reporting. This change was made based on comments received by Federal CMS on June 15, 2012 to allow for the initial claims filing and claims adjudication to conclude so that the incurred but not reported (IBNR) ratio is lower. The revised MLR reporting schedule is outlined in Table 11, and became effective October 1, 2012. This information is posted on the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/Special_Terms_Conditions_14_03-13-2012.pdf.

Table 11
Health Plan Medical Loss Ratio Reporting Schedule

Demonstration Year	Quarter	Due to Agency	Due to CMS
Demonstration Year 7 (07/01/12 – 6/30/13)	**Q1:** 07/01/12 – 09/30/12	04/30/2013	05/15/2013
	Q2: 10/01/12 – 12/31/12	07/31/2013	08/15/2013
	Q3: 01/01/13 – 03/31/13	10/31/2013	11/15/2013
	Q4: 04/01/13 – 06/30/13	01/30/2014	02/14/2014
	DY 7 Annual Report	01/30/2014	02/14/2014
Demonstration Year 8 (07/01/13 – 06/30/14)	**Q1:** 07/01/13 – 09/30/13	04/30/2014	05/15/2014
	Q2: 10/01/13 – 12/31/13	07/31/2014	08/15/2014
	Q3: 01/01/14 – 03/31/14	10/31/2014	11/15/2014
	Q4: 04/01/14 – 06/30/14	01/30/2015	02/14/2015
	DY 8 Annual Report	01/30/2015	02/14/2015

In addition, the draft plan contract amendment language was posted on the Agency's managed care website and provided to the health plans on July 1, 2012. After reviewing comments from

Federal CMS and the health plans, the Agency revised the core contract provisions that became effective September 1, 2012 to reflect the following:

> In accordance with the Florida's Section 1115 Demonstration STCs, capitated health plans shall maintain an annual (July 1 through June 30) MLR of eighty-five percent (85%) for operations in the demonstration counties beginning July 1, 2012. The health plan shall submit data to the Agency quarterly to show ongoing compliance. The Federal CMS will determine the corrective action for non-compliance with this requirement.

Note: The capitated plans' MLR data is evaluated annually to determine compliance, and quarterly reports are provided primarily for informational purposes. Seasonality and inherent claims volatility may cause MLR results to fluctuate somewhat from quarter to quarter, especially for smaller plans.

The updated Health Plan Report Guide was posted July 1, 2012 and became effective 90 days later on October 1, 2012. As provided in the updated Report Guide, health plans will be expected to submit quarterly and annual MLR reports using the Agency supplied template and in accordance with the filing instructions of Chapter 38. Quarterly MLR reports will be due to the Agency no later than 7 months following the close of the quarter. The first Annual MLR report, for the waiver Demonstration Year Seven (July 1, 2012 – June 30, 2013), is due to the Agency on January 30, 2014.

The MLR calculation shall utilize uniform financial data collected from all capitated health plans operating in the demonstration areas and shall be computed for each plan on a statewide basis. For the purpose of calculating the MLR, "health care covered services" are defined as services provided by the health plan to Medicaid recipients in the demonstration area in accordance with the Health Plan Medicaid Contract and as outlined in Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I (see below).

> "The method for calculating the MLR shall meet the following criteria:
>
> a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 CFR Part 158.
>
> b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.
>
> c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period."

Current Activities

The third quarterly MLR report for Demonstration Year Seven was due to the Agency on October 31, 2013 in accordance with newly amended STC #17c. During this quarter, all eleven capitated health plans submitted their MLR reports to the Agency on or before the due date. The Agency submitted the capitated plan's MLR results to Federal CMS by

November 15, 2013 as outlined in Table 11, the Health Plan Medical Loss Ratio Reporting Schedule. Three of the eleven capitated plans reported an MLR below 85% for the reporting period from January 1, 2013 to March 31, 2013. As noted earlier in the report, the capitated plans' MLR data is evaluated annually to determine compliance, and quarterly reports are provided primarily for informational purposes. Seasonality and inherent claims volatility may cause MLR results to fluctuate somewhat from quarter to quarter, especially for smaller plans.

The fourth quarter and annual MLR reports for Demonstration Year Seven are due to the Agency on January 30, 2014.

6. On-Site Surveys and Desk Reviews

During this quarter, the Agency did not conduct on-site surveys of the health plans. The Agency continued to conduct desk reviews of health plan provider networks for adequacy; review financial reports; review medical, behavioral health, and fraud and abuse policies and procedures; and review and approve performance improvement projects, quality improvement plans, disease management programs, member and provider materials and handbooks. Table 12 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 12
On-Site Survey Categories

➲ Services	➲ Provider Coverage/Services
➲ Marketing/Community Outreach	➲ Provider Records/Credentialing
➲ Utilization Management	➲ Claims Process
➲ Quality of Care	➲ Grievances and Appeals
➲ Member Services	➲ Financials

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B. Choice Counseling Program

Overview

A continual goal of the demonstration is to empower recipients to take responsibility for their own health care by providing information needed to make the most informed decisions about health plan choices.

Current Activities

1. Choice Selection Tools

The current enrollment system, referred to as Health Track, allows the choice counselor to provide basic information to the recipients on how well each plan meets his or her health needs when making a health plan selection. The system compares the preferred drug list (PDL), as well as primary care physician (PCP), specialist and hospital network information. This feature is also available to recipients by accessing the online enrollment website.

A brief description of each choice selection tool is outlined as follows:

- **PDL Comparison**: Each health plan's PDL is compared against the recipient's prescribed drug claims history, as well as any additional list of medications provided to the choice counselor by the recipient.
- **PCP Comparison**: Each health plan's provider network file is searched simultaneously for the name of PCPs provided by the recipient.
- **Specialist Comparison**: Each health plan's provider network file is searched simultaneously for the name of specialists provided by the recipient.
- **Hospital Comparison**: Each health plan's provider network file is searched simultaneously for the name of hospitals provided by the recipient.

PDL information is updated quarterly, prescription claims information is updated daily and provider network files are updated monthly, at a minimum.

Upon entering the search criteria for each choice selection tool, the system returns the results in an easy to read format, which sorts the health plans by those that meet the most of the recipients' criteria to those that meet the least amount of criteria, as shown in Chart A located on the following page.

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Chart A: Illustration of Choice Selection Tools in Health Track Enrollment System

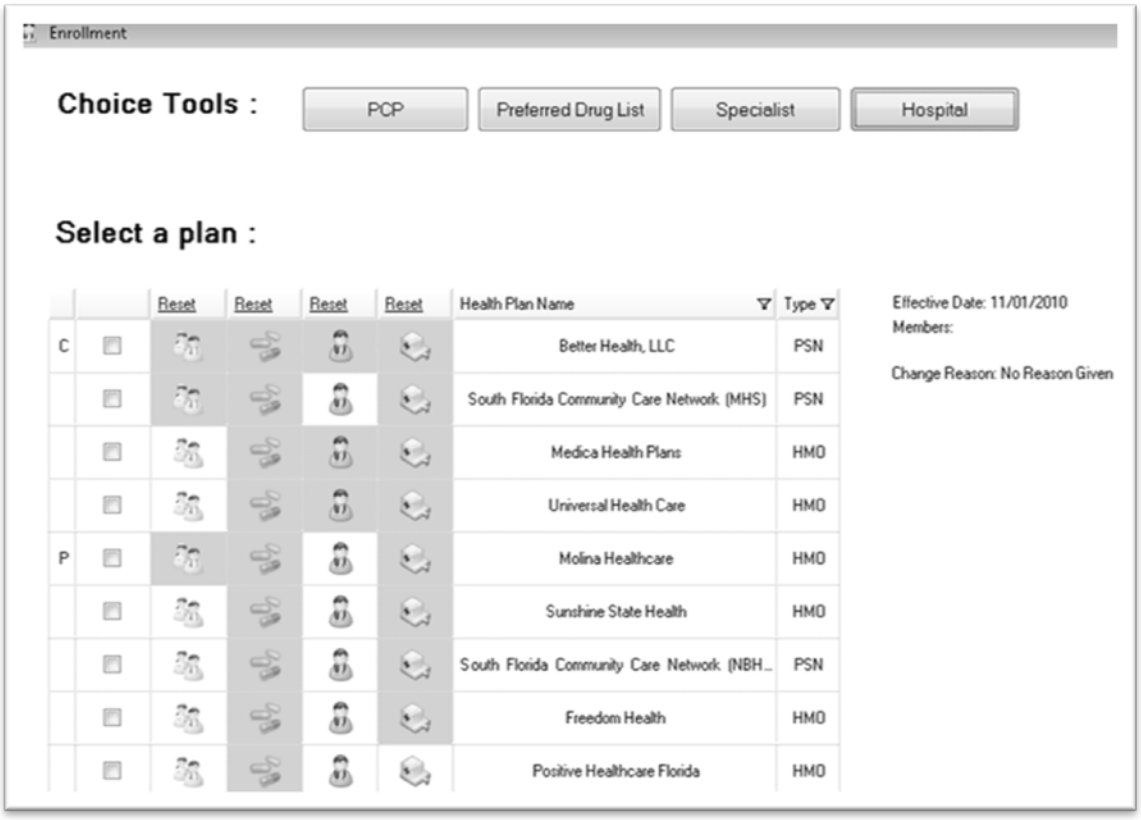
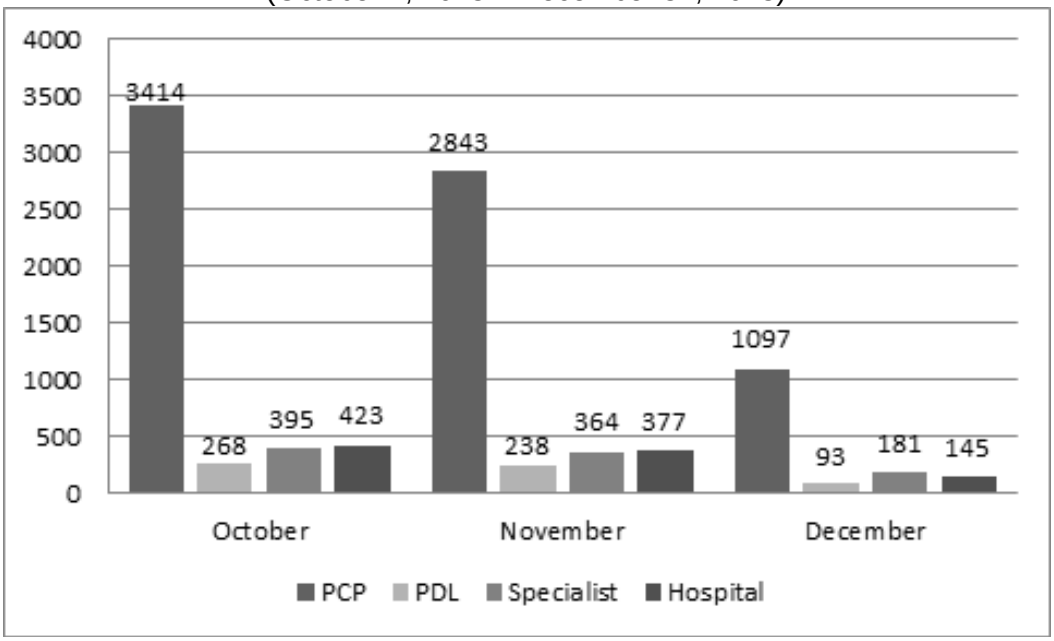


Chart B represents the number of times each choice selection tool was utilized during the enrollment or plan change process for this quarter. The results are broken out by choice tool type.

Chart B
Choice Tool Use by Type
(October 1, 2013 – December 31, 2013)



2. Online Enrollment

Table 13 shows the number of online enrollments by month for this quarter. The Agency continues to work on increasing recipient awareness of the availability of online enrollment.

Table 13
Online Enrollment Statistics
(October 1, 2013 – December 31, 2013)

	October	November	December
Enrollments	1,203	1,216	618

3. Call Center

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During this quarter, the call center had an average of 36 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls.

The choice counseling call center received 37,760 calls during this quarter, which remains within the normal call volume. Table 14 compares the call volume of incoming and outgoing calls during the second quarter of Demonstration Years Seven and Eight.

Table 14
Comparison of Call Volume for Second Quarter
(Demonstration Years Seven and Eight – 2nd Quarter)

Type of Calls	October 2012	October 2013	November 2012	November 2013	December 2012	December 2013	Year 7 2nd Quarter Totals	Year 8 2nd Quarter Totals
Incoming Calls	17,193	14,199	13,800	11,596	13,204	11,965	**44,197**	**37,760**
Outgoing Calls	4,675	2,782	3,992	2,800	4,924	3,335	**13,591**	**8,917**
Totals	21,868	16,981	17,792	14,396	18,128	15,300	**57,788**	**46,677**

Outbound and Inbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 19,554
- Confirmation Letters 19,338
- Open Enrollment Packets 58,611
- Transition Packets (mandatory and voluntary) 2,187
- Plan Transfer Letters (mandatory and voluntary) 0

When return mail is received with no forwarding address from the post office, staff accesses the choice counseling vendor's enrollment system and the FLMMIS to locate a telephone number or a new address in order to contact the recipient. The choice counseling staff re-addresses the packets or letters when possible, with the newly eligible mailings taking top priority.

During this quarter, the choice counseling vendor processed the following inbound mail:

- Plan Enrollments 666
- Plan Changes 45

The percentage of enrollments processed through the mail-in enrollment forms continues to be slightly less than the historical trend of 2 – 5%. Use of the form continues to decline with increased use of the Online Enrollment Application.

Health Literacy

The choice counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse and a Licensed Practical Nurse who have both earned their choice counseling certification.

Summary of cases taken by the Special Needs Unit

A 'case referral' is when a choice counselor refers a case to the Special Needs Unit through the choice counseling vendor's enrollment system (Health Track) or verbally via phone transfer, for follow-up. The Special Needs Unit conducts the research and resolves the referral.

A 'case review' is when the Special Needs Unit helps with questions from a choice counselor as they are on a call. Most reviews can be handled verbally and quickly. Some case reviews may end up as a referral if there is more research and follow-up required by the Special Needs Unit.

During this quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as shown in Table 15.

Table 15
Number of Referrals and Case Reviews Completed
(October 1, 2013 – December 31, 2013)

	October	November	December
Case Referrals	94	145	194
Case Reviews	91	117	143

The Special Needs Unit staff scope of work includes:

- Development of additional training for the choice counselors working with and serving the medically, mentally or physically complex;
- Enhancements to the scripts to educate recipients on how to access care in a managed care environment;
- Development of health related reference guides to increase the choice counselor's knowledge of Medicaid services (which is ongoing); and
- Participation in the development of the Health Track choice selection tool script.

Face-to-Face/Outreach and Education

The Outreach Team conducts group sessions and makes choice counselors available after the session to assist recipients in plan choices and, if needed, provides the option for face-to-face choice counseling at the recipient's convenience. Table 16 provides the outreach activities that were performed this quarter.

Table 16
Choice Counseling Outreach Activities
(October 1, 2013 – December 31, 2013)

Field Activities	2nd Quarter – Year 8
Group Sessions	0
Private Sessions	4
Home Visits and One-On-One Sessions	36
No Phone List*	0
Outbound Phone List	16
Enrollments	640
Plan Changes	191

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

The Mental Health Unit

The Mental Health Unit was created to provide more direct support to recipients who access mental health services. This unit provides, upon request, face-to-face choice counseling specifically focused on recipients identified as having a mental health or a substance abuse related diagnosis. This unit partners with various organizations (listed below) that serve this special population to provide training to their staff members on Medicaid managed care. Additionally, the unit partners with these organizations to perform public presentations related to Medicaid managed care. The ongoing initiatives and efforts to build relationships with the following organizations continue to yield positive results. The Mental Health Unit has increased the number of community partners to over 200 organizations including the following key partnerships:

- Susan B. Anthony Recovery Center in Broward County,
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County,
- Mental Health Resource Center and River Region Human Services in Duval County,
- Clay County Behavioral Health, and
- Wolfson's Children's Hospital/Community Health in Duval County.

The Mental Health Unit completed seven private sessions for a total of seven attendees and one community partner visit, as well as completed 24 calls to community partners in an effort to strengthen and build relationships. Seventeen partner staff members were trained during this quarter.

Complaints/Issues

A recipient can file a complaint about the Choice Counseling program either through the choice counseling call center, Medicaid headquarters or the Medicaid area office. The choice counseling vendor's automated recipient survey allows complaints about the Choice Counseling program to be filed and voice comments can be recorded to describe what occurred on the call. There were no complaints received related to the Choice Counseling program during this quarter. The primary contributing factor to the limited number of complaints is directly tied to the stability of the demonstration and the community presence the field choice counselors provide to resolve issues before they become a complaint, as well as efforts taken by the Agency field staff.

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 rank 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 a plan or to make a plan change. A total of 1,075 recipients completed the automated survey this quarter.

Table 17 shows a list of all questions that are asked during the survey and how recipients ranked their satisfaction (represented in percentages) with the choice counseling call center and the overall service provided by the choice counselors during this quarter. The number of recipients participating in the survey this quarter was as follows: October – 494, November – 342 and December – 239 (totaling 1,075).

Table 17
Choice Counseling Caller Satisfaction Results
Percentage of Satisfied Callers per Question

October 2013	*November 2013*	*December 2013*
How helpful do you find this counseling to be		
90%	90%	92%
Amount of time you waited		
80%	80%	64%
Ease of understanding information		
78%	79%	76%
Likelihood to recommend		
95%	97%	95%
Overall service provided by counselor		
97%	97%	97%
Quickly understood reason		
97%	98%	96%
Ability to help choose plan		
96%	96%	95%
Ability to explain clearly		
96%	96%	96%
Confidence in the information		
95%	96%	95%
Being treated respectfully		
97%	98%	98%

A key component of the Choice Counseling program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help the choice counseling vendor and the Agency improve customer service to Medicaid recipients.

During this quarter, the survey results indicate that on average 97% of the respondents are satisfied with the overall service provided by the counselor. In addition, the results indicate that 96% are satisfied with the choice counselor's ability to clearly explain health plan choices, and 97% felt they were treated respectfully.

Survey scores and recipient comments are provided to supervisors and counselors. The positive comments encourage the choice counselor to keep up the good work and the negative comments help to point out possible weaknesses that may require coaching or training. The choice counseling vendor has an internal e-mail box, which enables the Agency and the choice counseling vendor to share information directly to resolve difficult cases and hold regularly scheduled conference calls.

4. New Eligible Self-Selection Data

From July 2010 to December 2013, 66% of recipients enrolled in the demonstration self-selected a health plan and 34% were auto-assigned.

Table 18 shows the current self-selection and auto-assignment rate for this quarter.

Table 18
Self-Selection and Auto-Assignment Rate*
(October 1, 2013 – December 31, 2013)

	October	November	December
Self-Selected	10,046	9,820	5,239
Auto-Assignment	8,884	5,852	4,118
Total Enrollments	18,930	15,672	9,357
Self-Selected %	53%	63%	56%
Auto-Assignment %	47%	37%	44%

* 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.

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C. Enrollment Data

Current Activities

Monthly Enrollment Reports

The Agency provides a comprehensive monthly enrollment report, which includes the enrollment figures for all health plans in the Reform demonstration. This monthly enrollment data is available on the Agency's website at the following link: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml.

The following is a summary of the monthly enrollment for this quarter, beginning October 1, 2013 and ending December 31, 2013. This section contains the following enrollment reports:

- Medicaid Reform Enrollment Report,
- Medicaid Reform Enrollment by County Report, and
- Medicaid Reform Voluntary Population Enrollment Report.

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 15 health plans – 11 HMOs and 4 FFS PSNs.

There are two categories of Medicaid recipients who are enrolled in the health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the recipients' eligibility for Medicare. Each enrollment report and the process used to calculate the data it contains are described on the following pages.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the demonstration program for the quarter being reported. Table 19 provides a description of each column in Medicaid Reform Enrollment Report.

Table 19
Medicaid Reform Enrollment Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled – No Medicare	The number of SSI recipients who are enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled – Medicare Part B	The number of SSI recipients who are 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 who are enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population 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 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 20 provides an unduplicated count of the recipients enrolled in each Reform health plan at any time during this quarter. There were a total of 351,697 recipients enrolled in the Reform demonstration during this quarter. There were 15 Reform demonstration health plans active during this quarter with market shares ranging from 0.08% to 26.2%.

Table 20
Medicaid Reform Enrollment
(October 1, 2013 – December 31, 2013)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for Reform	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
Care Florida	HMO	3,109	680	2	127	**3,918**	**1.11%**	3,921	-0.08%
Clear Health	HMO	10	41	-	1	**52**	**0.01%**	49	6.12%
Freedom	HMO	3,703	599	1	105	**4,408**	**1.25%**	4,433	-0.56%
Humana	HMO	11,373	2,096	5	373	**13,847**	**3.94%**	13,093	5.76%
Magellan	HMO	459	88	-	9	**556**	**0.16%**	243	128.81%
Medica	HMO	3,711	891	-	170	**4,772**	**1.36%**	4,865	-1.91%
Molina	HMO	27,988	3,531	8	562	**32,089**	**9.12%**	31,922	0.52%
Positive	HMO	23	242	-	9	**274**	**0.08%**	250	9.60%
Staywell	HMO	18,960	1,902	2	144	**21,008**	**5.97%**	18,090	16.13%
Simply	HMO	-	-	-	-	**-**	**0.00%**	133	-100.00%
Sunshine	HMO	82,334	8,700	4	1,096	**92,134**	**26.20%**	91,998	0.15%
United	HMO	9,178	1,405	-	189	**10,772**	**3.06%**	9,966	8.09%
HMO Total	**HMO**	**160,848**	**20,175**	**22**	**2,785**	**183,830**	**52.27%**	**178,963**	2.72%
Better Health	PSN	40,077	5,021	2	640	**45,740**	**13.01%**	45,335	0.89%
CMS	PSN	5,416	4,138	-	26	**9,580**	**2.72%**	9,398	1.94%
FCA	PSN	63,119	9,243	-	1,616	**73,978**	**21.03%**	75,025	-1.40%
SFCCN	PSN	33,546	4,405	-	618	**38,569**	**10.97%**	38,590	-0.05%
PSN Total	**PSN**	**142,158**	**22,807**	**2**	**2,900**	**167,867**	**47.73%**	**168,348**	-0.29%
Reform Enrollment Totals		**303,006**	**42,982**	**24**	**5,685**	**351,697**	**100.00%**	**347,311**	1.26%

The demonstration market share percentage for each plan is calculated once all recipients have been counted and the total number of recipients enrolled is known. The enrollment figures for this quarter reflect those recipients who self-selected a health plan, as well as those who were assigned. In addition, some Medicaid recipients transferred from non-demonstration health plans to demonstration health plans.

Please note, the Broward County members of Simply Healthcare were transitioned into Better Health, LLC, via an asset purchase agreement, effective August 1, 2013.

2. Medicaid Reform Enrollment by County Report

During this quarter, the Reform demonstration remained operational in five counties: Baker, Broward, Clay, Duval and Nassau. The number of HMOs and PSNs in each of the Reform demonstration counties is listed in Table 21.

Table 21
Number of Reform Health Plans in Demonstration Counties
(October 1, 2013 – December 31, 2013)

County Name	Number of Reform HMOs	Number of Reform PSNs
Baker	**2**	**1**
Broward	**10**	**3**
Clay	**3**	**1**
Duval	**3**	**2**
Nassau	**2**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The Reform demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 22 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 22
Medicaid Reform Enrollment by County Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval or Nassau)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
Number of SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan in the county listed and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan in the county listed; TANF and SSI combined
Market Share for Reform by County	The percentage of the demonstration population in the county 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 county 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 county listed)

Table 23 located on the following page lists, by plan and county, for this quarter and compared to last quarter, the total number of TANF and SSI individuals enrolled and the market share for each county. In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report.

Table 23
Medicaid Reform Enrollment by County Report
(October 1, 2013 – December 31, 2013)

Plan Name	Plan Type	Plan County	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share For Reform by County	Enrolled in Previous Quarter	Percent Change from Previous Quarter
				No Medicare	Medicare Part B	Medicare Parts A and B				
United	HMO	Baker	686	94	-	11	791	21.33%	720	9.86%
Staywell	HMO	Baker	92	12	-	3	107	2.88%	68	57.35%
FCA	PSN	Baker	2,514	277	-	20	2,811	75.79%	2,898	-3.00%
Baker			**3,292**	**383**	**0**	**34**	**3,709**	**100.00%**	**3,686**	**0.62%**
Clear Health	HMO	Broward	10	41	-	1	52	0.03%	49	6.12%
Freedom	HMO	Broward	3,703	599	1	105	4,408	2.23%	4,433	-0.56%
Humana	HMO	Broward	11,373	2,096	5	373	13,847	6.99%	13,093	5.76%
Magellan	HMO	Broward	459	88	-	9	556	-	243	128.81%
Medica	HMO	Broward	3,711	891	-	170	4,772	2.41%	4,865	-1.91%
Molina	HMO	Broward	27,988	3,531	8	562	32,089	16.20%	31,922	0.52%
Positive	HMO	Broward	23	242	-	9	274	0.14%	250	9.60%
Care Florida	HMO	Broward	3,109	680	2	127	3,918	1.98%	3,921	-0.08%
Staywell	HMO	Broward	5,663	429	1	40	6,133	3.10%	4,470	37.20%
Sunshine	HMO	Broward	37,168	3,628	3	421	41,220	20.81%	40,841	0.93%
Better Health	PSN	Broward	40,077	5,021	2	640	45,740	23.09%	45,335	0.89%
CMS	PSN	Broward	3,489	2,990	-	18	6,497	3.28%	6,354	2.25%
SFCCN	PSN	Broward	33,546	4,405	-	618	38,569	19.47%	38,590	-0.05%
Broward			**170,319**	**24,641**	**22**	**3,093**	**198,075**	**99.72%**	**194,499**	**1.84%**
Sunshine	HMO	Clay	7,128	652	-	68	7,848	44.89%	7,827	0.27%
Staywell	HMO	Clay	806	84	-	6	896	5.12%	526	70.34%
United	HMO	Clay	3,263	374	-	44	3,681	21.05%	3,671	0.27%
FCA	PSN	Clay	4,568	442	-	49	5,059	28.94%	5,171	-2.17%
Clay			**15,765**	**1,552**	**0**	**167**	**17,484**	**100.00%**	**17,195**	**1.68%**
Staywell	HMO	Duval	12,003	1,351	1	94	13,449	10.71%	12,786	5.19%
Sunshine	HMO	Duval	38,038	4,420	1	607	43,066	34.29%	43,330	-0.61%
United	HMO	Duval	3,870	746	-	97	4,713	3.75%	3,920	20.23%
CMS	PSN	Duval	1,927	1,148	-	8	3,083	2.45%	3,044	1.28%
FCA	PSN	Duval	51,692	8,080	-	1,499	61,271	48.79%	62,074	-1.29%
Duval			**107,530**	**15,745**	**2**	**2,305**	**125,582**	**100.00%**	**125,154**	**0.34%**
Staywell	HMO	Nassau	396	26	-	1	423	6.18%	240	76.25%
United	HMO	Nassau	1,359	191	-	37	1,587	23.18%	1,655	-4.11%
FCA	PSN	Nassau	4,345	444	-	48	4,837	70.64%	4,882	-0.92%
Nassau			**6,100**	**661**	**0**	**86**	**6,847**	**100.00%**	**6,777**	**1.03%**
Reform Enrollment Totals			**303,006**	**42,982**	**24**	**5,685**	**351,697**		**347,311**	**1.26%**

As with the Medicaid Reform Enrollment Report, the number of recipients is extracted from the monthly Medicaid eligibility file and is then counted uniquely based on the most recent month in which the recipient was enrolled in a health plan. The unique recipient counts are separated by the counties in which the plans operate.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 24 and 25 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing recipients in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those recipients who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 24 provides a description of each column in this report.

Table 24
Medicaid Reform Voluntary Population Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval or Nassau)
Foster, SOBRA and Refugee	The number of unique Foster Care, SOBRA, or Refugee recipients who voluntarily enrolled in a plan during the current reporting quarter
Developmental Disabilities	The number of unique recipients diagnosed with a developmental disability who voluntarily enrolled in a plan during the current reporting quarter
Dual-Eligibles	The number of unique dual-eligible recipients who voluntarily enrolled in a plan during the current reporting quarter
Total	The total number of voluntary population recipients who enrolled in Medicaid Reform during the current reporting quarter
Medicaid Reform Total Enrollment	The total number of Medicaid Reform recipients enrolled in the health plan during the reporting quarter

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Table 25 lists the number of individuals in the voluntary populations who chose to enroll in the Reform demonstration, as well as the percentage of the Medicaid Reform population they represent.

Table 25
Medicaid Reform Voluntary Population Enrollment Report
(October 1, 2013 – December 31, 2013)

Plan Name	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
		Foster, Adoption Subsidy, and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
HMO's		New	Existing	New	Existing	New	Existing	Number	Percentage	
Care Florida	Broward	2	34	1	3	11	118	**169**	**4.31%**	**3,918**
Clear Health	Broward	-	-	-	-	-	1	**1**	**1.92%**	**52**
Freedom	Broward	1	41	-	10	8	98	**158**	**3.58%**	**4,408**
Humana	Broward	8	113	1	32	29	349	**532**	**3.84%**	**13,847**
Magellan	Broward	-	1	-	-	3	6	**10**	**0.00%**	**556**
Medica	Broward	1	18	-	9	6	164	**198**	**4.15%**	**4,772**
Molina	Broward	11	260	3	42	22	548	**886**	**2.76%**	**32,089**
Positive	Broward	-	1	-	-	-	9	**10**	**3.65%**	**274**
Staywell	Broward	3	35	1	6	6	35	**86**	**1.40%**	**6,133**
Staywell	Baker	-	-	-	-	2	1	**3**	**2.80%**	**107**
Staywell	Clay	3	3	-	-	2	4	**12**	**1.34%**	**896**
Staywell	Duval	11	72	3	4	22	73	**185**	**1.38%**	**13,449**
Staywell	Nassau	1	4	-	-	1	-	**6**	**1.42%**	**423**
Sunshine	Broward	6	378	2	53	25	399	**863**	**2.09%**	**41,220**
Sunshine	Clay	7	75	-	7	3	65	**157**	**2.00%**	**7,848**
Sunshine	Duval	15	543	1	62	14	594	**1,229**	**2.85%**	**43,066**
United	Baker	-	11	-	1	-	11	**23**	**2.91%**	**791**
United	Clay	1	38	-	5	1	43	**88**	**2.39%**	**3,681**
United	Duval	5	92	3	19	12	85	**216**	**4.58%**	**4,713**
United	Nassau	-	23	-	5	1	36	**65**	**4.10%**	**1,587**
HMO Total		**75**	**1,742**	**15**	**258**	**168**	**2,639**	**4,897**	**2.66%**	**183,830**
PSN's										
Better Health	Broward	13	381	2	90	32	610	**1,128**	**2.47%**	**45,740**
CMS	Broward	5	88	8	239	1	17	**358**	**5.51%**	**6,497**
CMS	Duval	29	537	-	126	-	8	**700**	**22.71%**	**3,083**
FCA	Baker	-	35	-	4	-	20	**59**	**2.10%**	**2,811**
FCA	Clay	2	66	1	4	1	48	**122**	**2.41%**	**5,059**
FCA	Duval	20	785	7	152	20	1,479	**2,463**	**4.02%**	**61,271**
FCA	Nassau	3	33	1	5	1	47	**90**	**1.86%**	**4,837**
SFCCN	Broward	11	527	2	75	16	602	**1,233**	**3.20%**	**38,569**
PSN Total		**83**	**2,452**	**21**	**695**	**71**	**2,831**	**6,153**	**3.67%**	**167,867**
Reform Totals		**158**	**4,194**	**36**	**953**	**239**	**5,470**	**11,050**	**3.14%**	**351,697**

D. Enhanced Benefits Account Program

Overview

The Enhanced Benefits Account (EBA) program is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid recipients who enroll in a Reform health plan are eligible for the EBA program. No separate application or process is required to enroll in the EBA program.

Recipients enrolled in a health plan may earn up to $125.00 of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Medicaid Fiscal Agent's [HP Enterprise Services, LLC (HP)] pharmacy point of sale system, currently maintained and managed by the HP subcontractor, Magellan. Earned credits may be used to purchase approved health related products and supplies at a Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the recipient's Medicaid Gold Card or Medicaid identification number and a government issued photo ID.

The credits earned may be carried forward each demonstration year so the recipient does not lose access to accrued credits. Recipients who have earned credits prior to December 2011, and lose Medicaid eligibility for three consecutive years will lose access to their credits. Beginning January 2012, recipients who have earned credits and lose Medicaid eligibility for one year will lose access to their credits.

The Agency approves credits for participation of approved healthy behaviors using date of service, eligibility and approved behavior edits within a database referred to as the Enhanced Benefits Information System (EBIS). All health plans are required to submit monthly reports for their enrollees who have paid claims for an approved healthy behavior within the prior month. These reports are uploaded into the EBIS database for processing and approval. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the HP subcontractor, Magellan, to be loaded in the pharmacy point of sale system.

Current Activities

1. 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), implemented in June 2010, provides recipients only balance information. The AVRS continues to be a success as 29,563 calls were handled during this quarter. The call center continues to perform outbound calls to recipients who have not spent any of their enhanced benefits account credits or who leave voice messages.

Table 26 highlights the enhanced benefits call center activities during this quarter.

Table 26
Highlights of the Enhanced Benefits Call Center Activities
(October 1, 2013 – December 31, 2013)

Enhanced Benefits Call Center Activity	October	November	December
Calls Received	4,934	3,662	3,980
Calls Answered	4,410	3,296	3,413
Abandonment Rate	10.62%	9.99%	14.25%
Average Talk Time (minutes)	5:01	5:19	6:00
Calls Handled by the AVRS	9,896	9,673	9,994
Outbound Calls	80	16	22
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	13,624	10,452	10,106

Program Credit

The Agency receives monthly program credit reports from the health plans as scheduled by the tenth day of each month. The reports are uploaded each month as designed for processing and credit approval. The monthly credit report is then made available to recipients who have completed healthy behavior activities during the month.

Outreach and Education

During this quarter, the call center mailed 34,182 welcome letters and 219,788 coupon statements. A flyer or pharmacy billing instructions is periodically included with the coupon statement. The choice counselors continue to provide up-to-date information for recipients regarding their enhanced benefits account balances and the opportunity to earn healthy behavior credits.

The pharmacy benefits manager, Magellan, provides ongoing technical assistance to pharmacies as needed related to all billing aspects of the EBA program.

Complaints

During this quarter, over 32,000 recipients purchased one or more products with their enhanced benefits credits, and the EBA program received one recipient complaint. Table 27 provides a summary of the complaints received and action taken to address those complaints.

Table 27
Enhanced Benefits Recipient Complaints
(October 1, 2013 – December 31, 2013)

Recipient Complaint	Action Taken
1. A recipient called about their health plan not reporting a healthy behavior.	➲ The recipient was contacted and explained the reporting timeline. Health plans report the healthy behavior the month following the occurrence of the activity; the recipient was credited the following month for the behavior.

2. Enhanced Benefits Statistics

As of the end of this quarter, 14,145 recipients lost EBA eligibility resulting in losing EBA credits, totaling $634,257.16. Table 28 provides the EBA program statistics for this quarter.

Table 28
Enhanced Benefits Account Program Statistics
(October 1, 2013 – December 31, 2013)

Second Quarter Activities – Year Eight		October	November	December
I.	Number of plans submitting reports by month in each county	31	31	31
II.	Number of enrollees who received credit for healthy behaviors by month	68,046	49,037	51,535
III.	Total dollar amount credited to accounts by each month	$1,539,222.50	$1,113,127.50	$1,199,195.00
IV.	Total cumulative dollar amount credited through the end each month	$75,330,258.66	$76,443,386.16	$77,642,581.16
V.	Total dollar amount of credits used each month by date of service	$1,080,632.97	$958,284.51	$1,105,749.12
VI.	Total cumulative dollar amount of credits used through the month by date of service	$41,716,583.21	$42,674,867.72	$43,780,616.84
VII.	Total unduplicated number of enrollees who used credits each month	32,116	28,905	32,000

3. 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.

4. Notice of EBA Program Phase Out

During this quarter, 227,685 recipients in Baker, Clay, Duval, and Nassau counties received notification regarding the phase-out of the EBA program. Broward County recipients will be notified regarding the phase-out of the EBA program on January 31, 2014

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E. Low Income Pool

Overview

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.

The LIP funds are distributed to safety net providers that meet certain state and federal requirements outlined in the STCs of the waiver. The LIP program consists of a capped annual allotment of $1 billion total computable for each year of the demonstration. Availability of funds for the LIP program in the amount of $1 billion per year is contingent upon milestones being met during each demonstration year in order for the state and providers to have access to 100% of LIP funds. Funds in the LIP program are subject to any penalties that are assessed by Federal CMS for the failure to meet the milestones described in the STCs. The milestones established are intended to enhance the delivery of health care to low-income populations in Florida.

The LIP permissible expenditures, state authorized expenditures, and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology Document (RFMD). The RFMD limits LIP payments to allowable costs incurred by providers and require the state to reconcile LIP payments to auditable costs. By February 1, 2012, and each successive February 1st of the renewal period of the waiver, the state must submit an RFMD protocol to ensure that the payment methodologies for distributing LIP funds to providers support the goals of the LIP and those providers receiving LIP payments do not receive payments in excess of their cost of providing services.

The Agency established the LIP Council in accordance with s. 409.911(10), F.S. The LIP Council's purpose is to advise the Agency and Florida Legislature on the financing and distributions of the LIP and related funds. The 2009 Legislature amended the statutory provisions specific to the LIP Council to increase the number of members appointed, as well as specified criteria for the membership. The LIP Council is statutorily directed to:

- Make recommendations on the financing of the LIP and the disproportionate share hospital program and the distribution of their funds.
- Advise the Agency on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
- Advise the Agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Current Activities

1. Future LIP Council Meetings

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

2. LIP STCs - Reporting Requirements

The following is an abbreviated list of the LIP STCs that required action during the second quarter. The newly amended STCs effective June 14, 2013, for the period December 16, 2011 to June 30, 2014, are posted on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA.

Newly Amended STC #75 – LIP Funds Distributed – All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.

Newly Amended STC #76 – LIP Reimbursement and Funding Methodology (RFMD)

- **DY1 – DY3 LIP Reconciliations Finalized –** Federal CMS has determined that payments made to providers are in excess of the allowable costs; therefore, the state is required to return the federal portion of $104,351,578 total computable expenditures claimed in excess of allowable cost and/or in excess of applicable cost limits. This will be achieved through a reduction of the amount available to be claimed under the pool by $104 million the first year of the state's intended renewal period in the event the demonstration is renewed or, by issuing a disallowance to the state.
- **DY4 LIP Reconciliations –** The Agency submitted the LIP reconciliations for DY4 to Federal CMS on May 30, 2012. On September 20, 2013 Federal CMS requested additional information regarding DY4 LIP reconciliations. The additional information was provided to CMS on the following dates: October 23, 2013, and December 12, 2013.
- **DY5 LIP Reconciliations –** The Agency submitted the LIP reconciliations for DY5 to Federal CMS on May 31, 2013. Federal CMS did not provide the Agency any feedback or request additional information regarding DY5 LIP reconciliations during this quarter.
- **Finalize Modifications to RFMD –** By February 1 of each Demonstration Year, the Agency must submit an RFMD that ensures the payment methodologies for distributing LIP funds to providers supports the goals of the LIP program.
    - On January 31, 2012, the Agency submitted the revised RFMD for DY6 to Federal CMS, which only included updated references since the results of Federal CMS's review of DY1-DY3 LIP reconciliations were not available prior to the February 1st submission due date specified in the STCs.
    - On May 5, 2012 and June 6, 2012, the Agency submitted a revised RFMD for DY6 to Federal CMS. The revisions to the document were made based on comments from Federal CMS.
    - On August 7, 2012, the Agency submitted a revised RFMD for DY6 to Federal CMS. This version included additional changes requested by Federal CMS.
    - On September 27, 2012, Federal CMS indicated that the final version of the RFMD for DY6 was routing for final approval.
    - On October 16, 2012, Federal CMS gave written approval of the RFMD for DY6.

- On January 29, 2013, the Agency submitted a revised RFMD for DY7 to Federal CMS.

- **Claiming LIP Payments –** The Agency may claim LIP payments based on the existing methodology during the 60-day reconciliation finalization period. Claims after that period can only be made on the final RFMD for DY6 as approved by Federal CMS. Changes to the RFMD for DY6 requested by the Agency must be approved by Federal CMS and are only applicable for DY6 LIP expenditures.
    - On October 16, 2012, Federal CMS gave written approval of the RFMD for DY6. The Agency then begun the distribution of DY7 LIP payments.
- **RFMD Protocol –** By February 1, 2012, and each successive February 1st of the waiver renewal period, the state must submit an RFMD protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP.
    - As noted earlier, on October 16, 2012, Federal CMS gave written approval of the RFMD for DY6.

Newly Amended STC #83 – Aggregate LIP Funding – At the beginning of each demonstration year, $1 billion in LIP funds will be available to the state. These amounts will be reduced by any milestone penalties that are assessed by Federal CMS. Penalties will be determined by December 31st of each demonstration year and assessed to the state in the following demonstration year.

Newly Amended STC #84 – LIP Tier-One Milestone

84.a. – Allocation of Funds, Program Development, Implementation for DY7 – DY8

Newly Amended STC #84.a. references $50 million in LIP funds. A total of $35 million appears in the Other Provider Access System category, also known as the non-hospital section, in the SFY 2012-13 General Appropriations Act (GAA) (Primary Care Initiatives per Tier-One Milestone). A total of $20 million will be used for the start-up of new primary care programs and the remaining total of $15 million will be used to meaningfully enhance existing primary care programs. There is a cap of $4 million per grant proposal. The Agency will determine the distribution and requirements for these programs.

The remaining $15 million (Quality Measures) of the $50 million falls under the Special LIP for Hospital Provider Access System category listed in the GAA. This $15 million, or Quality Measures, category is broken down into three smaller amounts. Of the total, $400,000 is provided for the specialty children's hospitals to be distributed based on an allocation methodology incorporating quality measures that shall be developed by the Agency. The second amount is $7,300,000 and shall be allocated using the core measures as determined by Federal CMS. The remaining amount of $7,300,000 shall be distributed equally using the following six outcome measures:

1. Mortality Hospital Risk Adjusted Rate (HRAR) Acute Myocardial Infarction (AMI) without transfers;
2. Mortality HRAR Congestive Heart Failure (CHF);
3. Mortality HRAR Pneumonia;
4. Risk Adjusted Readmission Rate (RARR) AMI;
5. RARR CHF; and
6. RARR Pneumonia.

Hospitals receiving an allocation in the $35 Million Primary Care Award category are required to enhance existing, or initiate new, quality-or-care initiatives to improve their quality measures and identified patient outcomes. Hospitals are also required to provide documentation of this to the Agency.

- On June 29, 2012, the Agency posted the LIP Primary Care Application for the $35 million (SFY 2012-13) up for bid on the Agency's LIP website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml.
- During the first quarter of Demonstration Year Seven, the Agency received 50 applications for the $35 million LIP Primary Care Award and reviewed the proposals.
- During the third quarter of Demonstration Year Seven, the Agency awarded the $35 million LIP Primary Care Award and began the contracting for state share and distributions of the new and enhanced provider projects. For new projects, the Agency awarded seven hospitals, three Federally Qualified Health Centers (FQHCs) and three County Health Departments (CHDs). For enhanced projects, the Agency awarded seven hospitals, five FQHCs and six CHDs.

84.b. – Proposed and Final Schedule for DY6 – DY8 Reconciliations – The state will provide timely submission of all hospital, FQHC and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The state is required to submit to Federal CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. Federal CMS will provide comments to the state on the reconciliation schedules within 30 days. The state will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

- On January 14, 2012, the Agency submitted a proposed schedule to Federal CMS. Federal CMS accepted the proposed schedule with no edits on February 27, 2012.

84.c. – Timely Submission of Deliverables – Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.

- As of September 30, 2013, the Agency submitted all deliverables on schedule as specified in the STCs.

84.d. – Reporting Templates – Within 60 days following the acceptance of the STCs, the state is required to submit templates for the development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report".

- On February 9, 2012, the Agency sent the draft templates to Federal CMS.
- On March 13, 2012, the Agency submitted the final templates to Federal CMS.
- On March 14, 2012, the Agency was notified that Federal CMS had no comments and the final templates were posted on the Agency's LIP website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml.
- The PAS providers are required to submit individual Milestone Reports to the Agency on October 31, 2012. The Agency received all the Milestone Reports. The data was reviewed, compiled and given to University of Florida (UF) for data analysis.
- The Agency sent the final annual Milestone Statistics and Findings Report to Federal CMS on April 1, 2013.
- During this quarter, the Agency submitted the Primary Care and Alternative Delivery Systems Expenditure Report for Demonstration Year Seven to Federal CMS on December 31, 2013.

Newly Amended 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.

- During the third quarter of Demonstration Year Six, the Agency worked with the top 15 hospitals in developing the Three-Tier Initiatives. Each of the 15 hospitals were required to submit three proposals to the Agency, for a total of 45 proposals.
- On April 9, 2012, the Agency submitted 44 proposals to Federal CMS; the 45th proposal was exempted. Federal CMS approved the proposals on June 29, 2012.
- On October 15, 2012, the Agency received the first quarter reporting for the 44 hospital initiatives.
- On November 20, 2012, the Agency submitted the first quarter reporting for the 44 hospital initiatives to Federal CMS.
- On December 31, 2012, Federal CMS approved the first quarter reporting for the 44 hospital initiatives.
- During the fourth quarter of Demonstration Year Seven, the Agency reviewed the second quarter reporting for the 44 hospital initiatives.
- During the first quarter of Demonstration Year Seven, the Agency reviewed the third and fourth quarter reporting for the 44 hospital initiatives.
- During this quarter, the Agency submitted the third and fourth quarter reporting for the 44 hospital initiatives on October 31, 2013 and on December 18, 2013.

F. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved Florida MMA Waiver (previously called the Medicaid Reform Waiver as noted earlier in the report), 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.

MEGS

There are three Medicaid Eligibility Groups established through the budget neutrality of waiver. Each of these groups is referred to as a MEG.

MEG #1 – SSI Related
MEG #2 – Children and Families
MEG #3 – Low Income Pool program

It should be noted that for MEG 3, the Low Income Pool, there is no specific eligibility group and no per capita measurement. Distributions of funds are made from the Low Income Pool to a variety of Provider Access Systems.

Explanation of Budget Neutrality

The budget neutrality for the waiver is based on closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method, which is required for 1115 waivers. Using the templates provided by Federal CMS, the historical expenditures and case-months are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five-year trend for each MEG. This trend is then applied to the most recent year (5^{th} year), which is known as the base year, and projected forward through the waiver period. Additional negotiations were involved in the final budget neutrality calculations set forth in the approved waiver packet.

Florida's Medicaid Reform program provides all services to the specified populations. If a person is eligible for the waiver, he or she is eligible to receive all waiver services that would otherwise be available under the traditional Medicaid program. It is important to note there are a few services and populations excluded from the waiver.

To determine if a person is eligible for the waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted Medicaid eligibility is assigned an eligibility category by the Florida Department of Children and Families. Specific categories are identified for each MEG under the waiver. If the person has one of the identified categories and is not an excluded eligible, he or she is then flagged as eligible for the waiver. Dual eligibles and pregnant women above the TANF eligibility may voluntarily enroll in a Medicaid Reform health plan. All voluntary enrollment member months and expenditures subject to the waiver are included in the reporting and monitoring of budget neutrality of the waiver.

Medicaid Reform - Excluded Eligibles:

- Refugee Eligibles
- Dual Eligibles
- Medically Needy
- Pregnant Women above the TANF eligibility (>27% FPL, SOBRA)
- ICF/DD Eligibles
- Unborn Children
- State Mental Facilities (Over Age 65)
- Family Planning Eligibles
- Women with breast or cervical cancer
- MediKids

All expenditures for the flagged eligibles are subject to the budget neutrality of the waiver unless the expenditure is identified as one of the following excluded services. These services are specifically excluded from the waiver and the budget neutrality calculation.

Medicaid Reform - Excluded Services:

- AIDS Waiver Services
- DD Waiver Services
- Home Safe Net (Behavioral Services)
- Behavioral Health Overlay Services (BHOS)
- ICF/DD Institutional Services
- Family and Supported Living Waiver Services
- Katie Beckett Model Waiver Services
- Brain and Spinal Cord Waiver Services
- School Based Administrative Claiming
- Healthy Start Waiver Services

Expenditure Reporting:

The 1115 demonstration waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to capture the expenditures by service type paid during the quarter that are subject to the monitoring of the budget neutrality. There are three MEGs within the waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of the waiver, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the Medicaid Reform program, but eligible for the waiver and enrolled in Florida's 1915(b) Managed Care Waiver, are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 demonstration waiver. To identify these eligibles, an additional five templates [one for each of the 1915(b) Managed Care Waiver (MCW) MEGs] have been added to the waiver templates for monitoring purposes.

When preparing for the quarterly CMS 64 report, the following method is applied to extract the appropriate expenditures for MEGs 1 and 2:

I. Eligibles and enrollee member months are identified;

II. Claims data for included services are identified using the list created through 'I' above;

III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:

a. MEG #1 SSI – Related
b. MEG #2 Children and Families
c. Reform – Managed Care Waiver SSI – no Medicare
d. Reform – Managed Care Waiver TANF
e. Reform – Managed Care Waiver SOBRA and Foster Children
f. Reform – Managed Care Waiver Age 65 and Older;

IV. Using the paid claims data extracted, the expenditures are identified by service type within each of the groupings in 'III' above and inserted on the appropriate line on the CMS 64 waiver templates;

V. Expenditures that are also identified as Home and Community Based (HCBS) Waiver services are identified and the corresponding HCBS waiver template expenditures are adjusted to reflect the hierarchy of the demonstration waiver reporting.

All queries and work papers related to the quarterly reporting of waiver expenditures on the CMS 64 report are maintained by the Agency. In addition, all identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated and provided to the Agency's Finance and Accounting Unit, which certifies and submits the CMS 64 report. This check sum process allows the state to verify that no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

Statistics tables below show the current status of the program's Per Capita Cost per Month (PCCM) in comparison to the negotiated PCCM as detailed in newly amended STC #106.

Definitions:

- **PCCM** - Calculated per capita cost per month, which is the total spend divided by the case months.
- **WOW PCCM** - Is the without waiver (WOW) PCCM. This is the target that the state cannot exceed in order to maintain budget neutrality.
- **Case months** - The months of eligibility for the populations subject to the waiver as defined as included populations in the waiver. In addition, months of eligibility for voluntary enrollees during the period of enrollment within a Medicaid Reform health plan are also included in the case month count.
- **MCW Reform Spend** - Expenditures subject to the Reform Budget Neutrality for those not enrolled in a Reform Health Plan but subject to the Reform Waiver [currently all non-dual-eligibles receiving services through the 1915(b) Managed Care Waiver].
- **Reform Enrolled & Non-MCW Spend** - Expenditures for those enrolled in a Reform Health Plan.
- **Total Spend** - Total of MCW Medicaid Reform Spend and Medicaid Reform Enrolled Spend.

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. Without the adjustment of drug rebates, the quarterly expenditure reform totals match the expenditures reported on the CMS 64 report, which is the amount that will be used in the monitoring process by Federal CMS.

Current Activities

Budget Neutrality figures included in this report are through the second quarter (October 1, 2013 – December 31, 2013) of Demonstration Year Eight. The 1115 demonstration waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For counties where Medicaid Reform is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where Medicaid Reform is not operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive 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 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 #94, 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.

In the following tables (Tables 29 through 34), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Tables 30 through 33 in accordance with STC #95(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 FMMIS fiscal agent: HP Enterprise, Inc.) has been assigned the task of designing and development of the new CMS64 waiver software application. In preparation of this task, APS staff has been operating the current software system for the past two CMS64 reporting quarters. APS's understanding of the current operation will facilitate its development and design of the new application. Agency staff will be working with APS during the next quarter to address application requirements and general design concepts. The new reporting operation will become effective on January 1, 2015.

Table 29 located on the following page shows the PCCM Targets established in the 1115 demonstration waiver as specified in STC #76. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 29 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

Tables 29 through 34 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending December 31, 2013. Case months provided in Tables 30 and 31 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.

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Table 30 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
October 2013	333,834	$416,763,833	$99,507,989	$516,271,821	$1,546.49
November 2013	329,927	$183,905,627	$58,732,842	$242,638,469	$735.43
December 2013	327,542	$293,375,301	$72,453,594	$365,828,895	$1,116.89
Q30 Total	991,303	$894,044,760	$230,694,425	$1,124,739,185	$1,116.89
MEG 1 Total	25,577,843	22,787,749,567	4,263,543,125	27,051,292,692	$1,134.61

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

Table 31 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
October 2013	2,084,154	$551,423,510	$75,589,844	$627,013,354	$300.85
November 2013	2,074,065	$171,934,136	$23,274,841	$195,208,977	$94.12
December 2013	2,079,491	$347,354,539	$45,890,409	$393,244,949	$189.11
Q30 Total	6,237,710	$1,070,712,185	$144,755,094	$1,215,467,279	$194.86
MEG 2 Total	148,529,795	22,639,280,444	2,667,437,811	25,306,718,255	170.38

* 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 Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 32), compared to WOW of $948.79 (Table 29), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 32), compared to WOW of $199.48 (Table 29), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 (Table 32), compared to WOW of $1,024.69 (Table 29), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 32), compared to WOW of $215.44 (Table 29), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.86 (Table 32), compared to WOW of $1,106.67 (Table 29), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 32), compared to WOW of $232.68 (Table 29), which is 71.76% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1077.30 (Table 32), compared to WOW of $1,195.20 (Table 29), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 32), compared to WOW of $251.29 (Table 29), which is 66.42% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,096.59 (Table 32), compared to WOW of $1,290.82 (Table 29, which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 (Table 32), compared to WOW of $271.39 (Table 29), which is 61.58% of the target PCCM for MEG 2.

For Demonstration Year Six, MEG 1 has a PCCM of $1,104.25 (Table 32), compared to WOW of $1,356.65 (Table 29), which is 81.40% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.09 (Table 32), compared to WOW of $285.77 (Table 29), which is 61.62% of the target PCCM for MEG 2.

For Demonstration Year Seven, MEG 1 has a PCCM of $1,093.21 (Table 32), compared to WOW of $1,425.84 (Table 29), which is 76.67% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.22 (Table 32), compared to WOW of $300.92 (Table 29, which is 59.56% of the target PCCM for MEG 2.

For Demonstration Year Eight, MEG 1 has a PCCM of $982.61 (Table 32), compared to WOW of $1,498.56 (Table 29), which is 65.57% of the target PCCM for MEG 1. MEG 2 has a PCCM of $171.55 (Table 32), compared to WOW of $316.87 (Table 29), which is 54.14% of the target PCCM for MEG 2.

Tables 33 and 33 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 Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $309.27. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $297.57. Comparing the calculated weighted averages, the actual PCCM is 76.94% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $296.27. Comparing the calculated weighted averages, the actual PCCM is 71.73% of the target PCCM.

For Demonstration Year Six, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $303.54. Comparing the calculated weighted averages, the actual PCCM is 70.13% of the target PCCM.

For Demonstration Year Seven, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $453.85. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $303.47. Comparing the calculated weighted averages, the actual PCCM is 66.87% of the target PCCM.

For Demonstration Year Eight, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $478.96. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $282.80. Comparing the calculated weighted averages, the actual PCCM is 59.04% of the target PCCM.

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Table 32 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	3,357,141	$3,066,429,103	$550,235,443	$3,616,664,546	$1,077.30

Table 32 MEG 1 and 2 Annual Statistics					
Total					
WOW DY4 Total	**3,357,141**			**$4,012,454,923**	**$1,195.20**
Difference				**$(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**	**$3,543,276,676**	**$499,177,170**	**$4,042,453,846**	**$176.09**
WOW DY6 Total	**22,956,197**			**$6,560,192,417**	**$285.77**
Difference				**$(2,517,738,571)**	
% of WOW PCCM MEG 2					**61.62%**
DY07 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY07 Total	**3,830,936**	**$3,317,906,458**	**$870,109,394**	**$4,188,015,852**	**$1,093.21**
WOW DY7 Total	**3,830,936**			**$5,462,301,786**	**$1,425.84**

Table 32 MEG 1 and 2 Annual Statistics					
Difference				**$(1,274,285,934)**	
% of WOW PCCM MEG 1					**76.67%**
DY07– MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY07 Total	**24,348,400**	**$3,880,910,322**	**$482,704,820**	**$4,363,615,142**	**$179.22**
WOW DY7 Total	**24,348,400**			**$7,326,920,528**	**$300.92**
Difference				**$(2,963,305,386)**	
% of WOW PCCM MEG 2					**59.56%**
DY08 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY08 Total	**1,974,015**	**$1,545,910,175**	**$393,770,238**	**$1,939,680,413**	**$982.61**
WOW DY8 Total	**1,974,015**			**$2,958,179,918**	**$1,498.56**
Difference				**$(1,018,499,506)**	
% of WOW PCCM MEG 1					**65.57%**
DY08– MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY08 Total	**12,417,507**	**$1,877,332,949**	**$252,882,585**	**$2,130,215,534**	**$171.55**
WOW DY8 Total	**12,417,507**			**$3,934,735,443**	**$316.87**
Difference				**$(1,804,519,909)**	
% of WOW PCCM MEG 2					**54.14%**

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Table 33 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	$6,929,006,360	$1,148,242,942	$8,077,249,302	$303.54
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,961,780)	
% Of WOW					70.13%
DY 07	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$7,198,816,780	$1,352,814,214	$8,551,630,994	$303.47
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,237,591,320)	
% Of WOW					66.87%

Table 33 MEG 1 and 2 Cumulative Statistics					
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	14,391,522	$3,423,243,124	$646,652,823	$4,069,895,947	$282.80
WOW	14,391,522			$6,892,915,361	$478.96
Difference				$(2,823,019,415)	
% Of WOW					59.04%

Table 34 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
Total Paid	$7,302,925,735

Table 35 shows that the expenditures for the 30 quarters for MEG 3, Low Income Pool (LIP), were $7,302,925,735 (91.29% of the $8 billion cap).

Table 35
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	$480,652,434	$1,000,000,000	48.07%
Total MEG 3	$7,302,925,735	$8,000,000,000	91.29%

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

During Demonstration Year Three, the Florida Legislature directed the Agency to carry forward approximately $123 million dollars from the Demonstration Year Three LIP appropriation until an amendment of the STC #105 could be negotiated. Upon approval of the amendment, approximately $123 million dollars in carry forward funding was provided to the Agency through appropriations for Demonstration Year Four. The appropriations for Demonstration Year Four totaled $1,001,250,000 plus the $123,577,163 of carry forward LIP funds for a grand total of $1,124,827,163. Due to the payment process and the reporting period, payments made after June 30, 2010, were not captured in the Fourth Quarter report of Year Four or the Year Four Annual Report. The report for the first quarter of Demonstration Year Five included the final LIP payment totals for Demonstration Year Four.

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G. Encounter and Utilization Data

Overview

The Agency is required to capture medical services encounter data for all Medicaid covered services in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, F.S. In addition, s. 409.91211(3)(p), F.S., requires a risk-adjusted methodology be a component of the rate setting process for capitated payments to the demonstration health plans. Risk adjustment was phased in over a period of three years, using the Medicaid Rx (MedRx) model.

Current Activities

Encounter Data

During this quarter, monthly Encounter Data Compliance Reports were distributed to the health plans. These reports use analytical measures to gauge the completeness, accuracy and timeliness of the encounter data submissions from each plan. The Compliance Reports for encounters processed in July 2013, August 2013, September 2013 and October 2013 were distributed on October 2, 2013, October 31, 2013, November 27, 2013 and December 23, 2013, respectively. The analytical processes used to generate the Compliance Reports undergo iterative reviews and validation checks each month. The Compliance Reports are modified as needed to address any issues and to incorporate additional functionality.

The Agency is currently researching new methods to validate encounter data completeness in the Compliance Reports, before the implementation of the MMA program. One methodology under consideration compares a health plan's per member per month (PMPM) estimated volume to the forecasted volume calculated by the Agency using the CDPS/Med RX risk model, and to actual volumes submitted and processed. Further analysis is also being conducted on monthly and annual levels of recipients served and recipient utilization to determine and compare trends among similar health plan types/contracts, to confirm that recipients are receiving appropriate care, and to ensure that health plans are submitting their encounter data. Additionally, ongoing dialogue with representatives from the health plans continues to result in refinements to the measures and to the narrative presented in the Compliance Reports.

In the previous quarter, the Agency initiated bi-weekly phone calls with the health plans to discuss specific technical and policy issues related to encounter data. The first of these phone calls took place on September 6, 2013, and resulted in the development of a new approach to the identification of resubmitted encounter data. The Agency subsequently developed and submitted a change order to modify the system. Work to implement the change order is underway.

During this quarter there were four phone calls with the plans that focused on two areas important to the quality of encounter data: understanding and resolving encounter data issues using X12 277 and 835 transactions, and accurate registration and identification of providers. The Agency has made significant progress in resolving provider identification issues and educating the plans on completion of the provider fields.

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 managed care plan's administrative data and will also validate provider-reported encounter data against a sample of medical records. Throughout the term of their contract, HSAG will provide technical assistance and training to the managed care plans in data submission, analysis and quality improvement.

Rate Setting/Risk Adjustment

The rate setting process for September 2013 through August 2014 currently uses hospital inpatient, hospital outpatient, physician/other, pharmacy and mental health encounter data.

During this quarter, National Council for Prescription Drug Program (NCPDP) pharmacy encounter claims with dates of service within the April 1, 2012 – March 31, 2013 measurement period (paid through June 30, 2013) were provided to the Agency's actuary for use in the MedRx model to generate risk scores for December 2013, and for January - February 2014.

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H. Demonstration Goals

Objective 1: *To ensure there is an increase in the number of plans from which an individual may choose, an increase in the different type of plans, and increased patient satisfaction.*

Broward and Duval Counties

Tables 36 and 37 provide the number and types of health plans the Agency contracted with prior to the implementation of the Reform demonstration.

Table 36
Broward County
Number and Type of Plans
(Pre-Demonstration 2006)

Type of Plan	Number of Plans
HMOs	8
PSNs	1
Total	**9**

Table 37
Duval County
Number and Type of Plans
(Pre-Demonstration 2006)

Type of Plan	Number of Plans
HMOs	2
PSNs	0
Total	**2**

The Agency also contracted with a Pediatric Emergency Room (ER) Diversion program and two Minority Physician Networks (MPNs) that operated as prepaid ambulatory health plans offering enhanced medical management services to recipients enrolled in MediPass, Florida's primary care case management program. One MPN operated in Duval County, and both MPNs operated in Broward County. The Pediatric ER Diversion program operated only in Broward County.

Tables 38 and 39 provide the number and types of health plans the Agency currently has under contract in Broward and Duval Counties.

Table 38
Broward County
Number and Type of Plans
(October 1, 2013 – December 31, 2013)

Type of Plan	Number of Plans
HMOs	10
PSNs	3
Total	**13**

Table 39
Duval County
Number and Type of Plans
(October 1, 2013 – December 31, 2013)

Type of Plan	Number of Plans
HMOs	3
PSNs	2
Total	**5**

Baker, Clay and Nassau Counties

Prior to expansion of the Reform demonstration into Baker, Clay and Nassau Counties on July 1, 2007, the Agency contracted with one MPN that operated in all three counties as a prepaid ambulatory health plan.

Currently, the Agency contracts with three HMOs and one PSN, for a total of four health plans in Baker, Clay and/or Nassau Counties.

Health Plan Applications and Expansion Requests

The Agency will have no new contracts with health plans in Reform counties through the implementation of the MMA program. See Section A.1 of this report for additional information on health plan applications and expansion requests.

Please note that patient satisfaction is addressed in Objective 4.

Objective 2(a): *To ensure that there is access to services not previously covered.*

Access to Services Not Previously Covered

In Year Eight of the Reform demonstration, all of the capitated health plans continue to offer expanded or additional benefits that were not previously covered under Florida's Medicaid State Plan in order to meet the needs of new enrollees. The customized benefit packages and expanded benefits became operational on January 1, 2013 and will remain valid through the implementation of the MMA program, effectively overlapping Demonstration Years Seven and Eight. These benefit packages include 26 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

The following list identifies the expanded benefits currently offered by the capitated health plans. Over-the-counter drug benefits and adult preventive dental benefits are the most frequently offered.

- Over-the-counter drug benefit – $25 per household per month
- Adult preventive dental
- Circumcisions for male newborns
- Additional adult vision
- Nutritional counseling.

Objective 2(b): *To ensure that there is improved access to specialists*

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for recipients. Through the contracting process, each health plan is required to provide documentation to the Agency of a network of providers (including specialists) that will guarantee access to care for recipients. As Demonstration Year One ended, the Agency began the first intensive review of the health plan provider network files to evaluate the effectiveness of the demonstration in improving access to specialists. The analysis included the following steps:

1. Identifying the number of unduplicated providers that participate in the demonstration,
2. Identifying providers that were not fee-for-service providers, but now serve recipients as a part of the demonstration,
3. Comparison of plan networks that were operational prior to the demonstration with the demonstration health plan networks at the end of Year One of the waiver, and
4. Comparison of demonstration provider networks to the active FFS providers.

During the third quarter of Demonstration Year Two, the Agency began additional provider network analysis of the Medicaid health plans. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on recipient access to providers (e.g., if the provider accepts only current patients, or if they treat only children and women, etc.).

Specialties identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care were subject to focused reviews of provider network files and provider surveys in Demonstration Year Two through Year Five. Results of these reviews and surveys are provided in earlier quarterly and annual reports.

In Demonstration Year Six, the Agency began developing additional ways to analyze health plan encounter data to assess health care access. The most recent analyses focused on three types of specialty care: orthopedics, neurology and dermatology. The analyses used encounter data to target the number of recipients receiving these specialty services in demonstration counties. This measure calculates the recipient utilization per 1,000 eligible recipients. During the first quarter of Demonstration Year Seven, the Agency reviewed and documented methodologies for analyses begun in the last quarter of Year Six, intended for future analytics of access to care and a basis for identifying opportunities for MCO performance improvements. Encounter data improvements intended to enhance the analyses are ongoing. Health plans are encouraged to educate and retrain providers to complete provider detail in the appropriate fields on encounter transactions. The accurate completion of specialty fields pertaining to the providers will provide necessary detail and enhance the analyses.

The Annual Reports will demonstrate access to specialists using the refined measures. These enhancements show improvements to the measures due to two factors: (1) Increase in volume of encounter data in the database; and (2) Improvement in filtering and stratifying data to target reform health plan enrollees.

The latest analysis on access to specialists can be found in the Draft Annual Report for Demonstration Year Seven, at the Agency's following link: http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_MMA_YR_7_Draft_Annual_Report_07-01-2012_06-30-2013.pdf.

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

During the first quarter of Demonstration Year Eight, the Agency received the sixth year of performance measure submissions from the health plans. Results of the sixth year of performance measures can be viewed in Attachments III and IV of this report. Attachment III is a table of the demonstration plans' performance measure rates from 2008 through 2013. Attachment IV is a table comparing the weighted mean rates for performance measures for the demonstration and non-demonstration plans.

During this quarter, Agency staff found through additional calculations that there was an error in the initial weighted mean rate calculations and corrected them. The initial weighted means included the rates of plans with unreportable rates due to having fewer than 30 eligible members for a measure, while the calculations for previous years have all excluded those rates. The corrected weighted means have been included in Attachments III and IV.

Highlights of the sixth year of performance measures include:

- Of the 43 Healthcare Effectiveness Data and Information Set (HEDIS) measure rates included in Attachments III and IV, the statewide average results for the demonstration plans improved for 15 of the measures compared to the previous year.
- Demonstration plans' rates for 14 of the measures stayed about the same, while their performance on 14 of the measures dropped.
- For 19 of the 43 measures, the statewide average results for the demonstration plans were higher than the average results for the non-demonstration plans. Performance measures with notable improvement include:
  - Annual Dental Visit: the statewide weighted average for demonstration plans increased from 35.3% in 2012 (representing measurement year 2011) to 40.4% in 2013 (representing measurement year 2012).
  - Adult BMI Assessment: the statewide weighted average for demonstration plans increased from 47.9% in 2012 to 63.0% in 2013.
  - Immunizations for Adolescents – Combo 1: the statewide weighted average for demonstration plans increased from 47.3% in 2012 to 54.6% in 2013.
  - Appropriate Testing for Children with Pharyngitis: the statewide weighted average for demonstration plans increased from 64.0% in 2012 to 67.7% in 2013.
  - Lead Screening in Children, which had notable improvement from 2011 to 2012, improved from 59.6% in 2012 to 61.7% in 2013.

Two other measures that had notable improvement from 2011 to 2012 saw a decline or stayed flat from 2012 to 2013, but their 2013 rates remain high above the plans' rates in 2011.

- Well-Child Visits in the First 15 Months – 6 or more: the statewide weighted average for demonstration plans increased from 46.5% in 2011 (representing measurement year 2010) to 58.4% in 2012 (representing measurement year 2011). In 2013, the weighted average declined to 55.6%.
- 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.

During this quarter, the Agency began reviewing the performance measure results to identify plan-level trends in performance and areas that should be focused on through Performance Measure Action Plans and other quality activities. Agency staff began determining the performance measure-related sanctions for the health plans based on their 2013 submission as well. The Agency obtained the National Medicaid Means and Percentiles for 2013 HEDIS from the National Committee for Quality Assurance (NCQA) and compared the demonstration and non-demonstration plans' results to the National Means and Percentiles. Attachment IV has been updated to include the 2013 National Medicaid Mean for each measure.

Demonstration plans performed as well as or better than the National Mean on 13 measures, while non-demonstration plans performed as well as or better on 15 measures. Both demonstration and non-demonstration plans performed as well as or better than the National Mean on eight measures, including:

- Comprehensive Diabetes Care: LDL Screening – The demonstration plans had a weighted mean of 80.1% and the non-demonstration plans' mean was 79.2%, while the National Medicaid Mean was 75.4%.
- Comprehensive Diabetes Care: Medical Attention for Nephropathy – The demonstration plans' mean was 80.2% and the non-demonstration plans' mean was 79.8%, while the National Medicaid Mean was 78.4%.
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life – The demonstration plans' and non-demonstration plans' weighted means were 75.6% and 73.2%, respectively, while the National Medicaid Mean was 71.9%.
- Childhood Immunization Combo 2 – The demonstration plans' and non-demonstration plans' weighted means were 77.8% and 77.5%, respectively, while the National Medicaid Mean was 75.8%.
- Follow-up Care for Children Prescribed ADHD Medication: Initiation – The demonstration plans' and non-demonstration plans' weighted means were 45.0% and 41.3%, respectively, while the National Medicaid Mean was 39.1%.
- Chlamydia Screening: age groups and total – The demonstration plans' and non-demonstration plans' weighted means were above the National Mean for the lower and upper age groups and for the total. For the total rate, the demonstration plans' and non-demonstration plans' weighted means were 62.9% and 61.2%, respectively, while the National Medicaid Mean was 56.9%.
- Call Answer Timeliness – The demonstration plans' and non-demonstration plans' weighted means were 95.4% and 93.5%, respectively, while the National Medicaid Mean was 83.9%.

During the third quarter of Demonstration Year Eight, Agency staff will complete their determinations regarding performance measure-related sanctions and will finish reviewing the plan-level trends on performance measures.

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

The Agency continues to run its model to analyze the utilization of Ambulatory Care Sensitive Conditions (ACSCs) using quality indicators (QI) from the Agency for Healthcare Research and Quality (AHRQ). Using this model, the Agency can analyze the prevalence of ACSCs that lead to possibly preventable hospitalizations. Aggregation of utilization data across multiple fee-for-service and managed care delivery systems enables a comparison by county or by plan. The reports generated include morbidity scoring for risk adjustment (MedRx), 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 organization and for the reform plans and the non-reform plans. The model has been updated to support the latest version (4.4) provided by AHRQ.

Reports can be generated for designated Florida counties possessing similar Standard Metropolitan Statistical Areas (SMSA) characteristics – classified as small rural, medium rural, medium urban and large urban areas. Reports are also generated for plan-to-plan comparisons.

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

The Agency uses a model based on the New York University ED (emergency departments) algorithm to analyze the utilization of emergency departments. This model is set up to process and compare results between fee-for-service recipients and managed care enrollees. These reports also include a volumetric with morbidity scoring (MedRx), 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 reform and non-reform plan groups. Portions of the report are designed to show county comparisons based on utilization by managed care eligible recipients, or according to plan member utilization. The model has been updated to support the latest version (2.0) provided by New York University.

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

Objective 4: *To ensure that patient satisfaction increases.*

The Agency continues to contract with the University of Florida (UF) to conduct patient satisfaction surveys of recipients enrolled in the demonstration. The survey instrument used by UF is based on the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) *Survey*. The CAHPS Survey is one of a family of standardized instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care. UF has adapted the CAHPS telephone survey component by adding questions specific to the demonstration.

During the second quarter of Demonstration Year Seven, UF submitted a comprehensive draft report on CAHPS Survey results to the Agency based on the SFY 2011-12 surveys. This draft report included survey results for both the demonstration and non-demonstration health plans. During the third and fourth quarters of Demonstration Year Seven, the Agency provided feedback to UF on the report and UF made the final revisions. During the fourth quarter of Demonstration Year Seven, UF submitted a draft trend analysis report on CAHPS Survey results. In the first quarter of Demonstration Year Eight, the Agency provided feedback to UF and UF revised the trend analysis report. The trend analysis report includes baseline survey data (prior to Reform, state fiscal year 2006-2007) through a Year 4 follow-up survey that was conducted in state fiscal year 2011-12. A Year 5 follow-up survey was conducted in state fiscal year 2012-13, but these survey results are not yet available in a report. Key findings from the CAHPS surveys from the Baseline survey through the Year 4 follow-up survey can be viewed in the first quarterly report for Demonstration Year Eight at the Agency's following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

During this quarter, Agency staff sent the enrollee eligibility, plan enrollment and demographic files to UF so they could pull the samples for the Year 6 follow-up survey. UF staff will begin administering the survey in the third quarter of Demonstration Year Eight.

Objective 5: *To evaluate the impact of the low income pool (LIP) on increased access for uninsured individuals.*

Prior to the implementation of the demonstration, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The demonstration created the LIP program, which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of the new PAS providers allows for increased access to services for the Medicaid, underinsured and uninsured populations. For information on activities that occurred prior to this quarter, please see the previous quarterly and annual reports posted on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Current Activities

Newly Amended STC #84 – Tier-One Milestone

Two reports correspond to this STC:

- The *Milestone Statistics and Findings Report* covering SFY 2011-12. The Agency collected milestone data for this report from the PAS providers. The final deadline for the PAS providers to submit their milestone data to the Agency was on October 31, 2012. During the fourth quarter of Demonstration Year Seven, the Agency submitted to Federal CMS the final annual *Milestone Statistics and Findings Report* on April 1, 2013.
- The *Milestone Statistics and Findings Report* covering SFY 2012-13 will be submitted on April 1, 2014 as required by STC #84.
- The *Primary Care and Alternative Delivery Systems Expenditure Report*. There are many different primary care and alternative delivery systems operating with LIP funds. Programs range from: Recipients Outreach; Emergency Room Diversion; Insurance Products; Primary Care Extensions; and Disease Management Initiatives. Although each program contains certain measures and reporting that are similar (i.e., Number of recipients served, Number of services provided, Program expenditures), there are also measures that will be unique for each program. These programs were required to submit reporting to the Agency on August 31, 2013. During this quarter, the Agency continued to review all of the reporting received and incorporating them into the report. The Agency submitted the *Primary Care and Alternative Delivery Systems Expenditure Report* with the data to Federal CMS on December 31, 2013.

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 this population in Florida.

Newly Amended STC #85 – Tier-Two Milestone

This STC requires that the top 15 LIP hospitals, which are allocated the largest annual amounts in LIP funding, participate in initiatives that broadly drive from the three overarching goals of Federal CMS' Three-Part Aim:

a) Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

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

c) Reducing per-capita costs.

These initiatives focus on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities have implemented new, or enhanced existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100% of allocated LIP funding.

Tier-Two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5% of each of these facilities' annual LIP allocation. The milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 15 hospitals do not total at least $700 million, then the population of hospitals must be expanded until $700 million is reached.

The top 15 hospitals were required to select and participate in three initiatives. Federal CMS exempted one facility from providing three initiatives, and required only two initiatives bringing the total number of initiatives required for the top 15 to 44 initiatives or programs. All 44 initiatives were submitted to Federal CMS on April 10, 2012, and the Agency received Federal CMS approval for the 44 initiatives on June 29, 2012. On October 15, 2012, the Agency received the first quarter reporting for the 44 hospital initiatives and submitted the reports to Federal CMS on November 20, 2012. On December 31, 2012, Federal CMS approved the first quarter reporting for the 44 hospital initiatives.

During this quarter, the Agency submitted the third and fourth quarter reporting for the 44 hospital initiatives on October 31, 2013 and on December 18, 2013.

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, Federal CMS approved the Agency's final evaluation design. When available, the results of the evaluation will be reported under Section I, Evaluation of the Demonstration, of this report.

I. Evaluation of the Demonstration

Overview

The evaluation of the demonstration is an ongoing process to be conducted during the life of the demonstration. The Agency is required 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.

In 2005, the Agency contracted for the initial demonstration evaluation for the period July 1, 2006-June 30, 2011, with an independent entity, the University of Florida (UF). This initial evaluation was a five-year "over-arching" study that presented its major findings in the Final Evaluation Report that was submitted to Federal CMS on December 15, 2011. The report can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/FL_1115_Final_UF_Eval_Report_12-15-11.pdf.

With the renewal of the demonstration on December 15, 2011, the Agency is required to conduct an evaluation of the demonstration during the renewal period, December 16, 2011 – June 30, 2014. STC #80 (effective December 15, 2011 until June 14, 2013) required the Agency to submit a draft evaluation design to Federal CMS 120 days (April 14, 2012) after receiving approval to renew the demonstration. STC #81 (effective December 15, 2011 until June 14, 2013) required Federal CMS to provide comments within 60 days (June 20, 2012) of receiving the draft evaluation design and for the Agency to submit the final evaluation plan to Federal CMS within 60 days (August 11, 2012) of receiving comments from Federal CMS. The Agency submitted the final evaluation design to Federal CMS on August 9, 2012. Federal CMS approved the Agency's final evaluation design on October 30, 2012. Following approval, the final evaluation design was posted on the Agency's website. The final evaluation design included a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the demonstration.

The Agency's contract with UF for the evaluation of Domains i, ii, iii, and v-ix (per the STCs) was executed at the end of October 2012. Due to the contract being executed later than was initially anticipated, Agency staff worked with UF to establish new due dates for several deliverables in SFY 2012-13.

During the third quarter of Demonstration Year (DY) Seven, the Agency executed a contract with Florida International University (FIU) for the evaluation of Domain iv (per the STCs). Researchers from FIU came to the Agency and met with staff to discuss the evaluation of the impact of the demonstration as a deterrent to fraud and abuse.

On June 14, 2013, Federal CMS added new STC #110 that the Agency submit for approval, within 120 days of approval of the MMA amendment, a draft evaluation design update that builds and improves on the evaluation design approved October 31, 2012. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in new STC #112. The updated design should accommodate and reflect the staggered implementation of the MMA program to produce more reliable estimates of program impacts. The design, including the budget and adequacy of

approach, to assure the evaluation meets the requirements of STC #112(a), is subject to CMS approval.

Reports and Findings during the Renewal Period

Low Income Pool Milestone Statistics and Findings Report for DY6: SFY 2011-12

The "Low Income Pool Milestone Statistics and Findings Report for DY6: SFY 2011-12" was completed by UF at the end of March 2013, and was submitted to CMS on April 1, 2013. This report 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. While this report is not technically an evaluation report, it does summarize the data to be used for answering the Domain v. research questions, regarding how many uninsured and underinsured recipients receive services through LIP funding, what types of services are provided, and in what settings.

The DY6 accomplishments that were identified include the following:

- The LIP program included the following types of providers: safety-net hospitals; hospitals that operate poison control centers; specialty pediatric hospitals; rural hospitals; hospitals with designated trauma centers; primary care hospitals; hospital Provider Access Systems (PAS), LIP-other (which includes designated premium assistance programs, emergency room (ER) diversion projects, primary care projects, and Federally Qualified Health Centers (FQHCs); County Health Initiatives as performed by County Health Departments (CHDs); and Rural Health Networks.
- A total of 146 PAS in Florida received LIP payments – 74 hospitals and 72 non-hospital providers.
- Total LIP funding was approximately $1 billion.
- Reporting hospitals receiving supplemental payments or rate enhancements served a total of approximately 3.7 million Medicaid, uninsured, and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served a total of approximately 1.2 million Medicaid, uninsured, and underinsured individuals.
- 126 hospitals that received supplemental payments or rate enhancements reported providing approximately 14.5 million service encounters to Medicaid, uninsured, and underinsured individuals across six service categories (discharges, inpatient days, ER encounters, outpatient encounters, affiliated encounters, and prescriptions filled).
- For all categories of encounters, 63 reporting non-hospital providers receiving LIP payments provided a total of approximately 6.5 million encounters for specific services to Medicaid, uninsured, and underinsured individuals. The specific services/encounters include: primary care, OB/GYN, disease management, mental health/substance abuse, dental, prescriptions filled, lab services, radiology, specialty encounters, and care coordination.

Final Report of Domains v-ix: through DY6

In the summer of 2013, UF completed an Evaluation Report of Domains v-ix. This report provides a preliminary look at the effect of LIP funding on the provision of health care services to the uninsured and the impact of Tier-One and Tier-Two Milestone initiatives on: access to

and quality of care; population health; and per capita costs and the cost-effectiveness of care. Tier-One and Tier-Two Milestone initiatives are described in STCs #84 and #85, respectively.

- STC #84 (a) Tier-One Milestone requires Florida to allocate $50 million in total LIP funding in DY7 and DY8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. These initiatives are required to be driven from the overarching goals of CMS' Three-Part Aim: better care for individuals; better health for populations; and reducing per-capita costs.
- STC #85, Tier-Two Milestones, requires that the 15 hospitals that are allocated the largest annual amounts of LIP funding develop and conduct initiatives that are driven by the Three-Part Aim and focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. The participating facilities are required to 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 (including low income populations).

This report focuses on DY6 and the beginning of DY7 activities related to the Tier-One and Tier-Two Milestone quality initiatives. This timeframe included planning, development, and implementation of the initiatives, so outcomes and the successes/challenges of the initiatives could not yet be assessed. General findings of this report for domains v-ix include:

- Overall, the number of uninsured, underinsured, and Medicaid individuals served and the types and number of outpatient services furnished by non-hospital providers has increased. For hospital providers, the number of individuals with Medicaid served has increased but the number of uninsured and underinsured individuals served has decreased. The types of services provided by reporting hospital providers have not changed.
- In general, the Tier-One and Tier-Two initiatives intend to reduce healthcare disparities for similar demographic, socioeconomic, and condition-specific populations. Examples of targeted populations include: individuals with chronic obstructive pulmonary disease (COPD), behavioral health disorders, the homeless, pregnant women, and other groups.
- Regarding access to care and quality of care, the various Tier-One and Tier-Two initiatives are focused on :
    - Providing better care coordination;
    - Reducing inpatient readmissions and avoidable ER visits;
    - Expanding infrastructure to increase access to primary care services;
    - Providing integrated, comprehensive care to uninsured and underinsured individuals; and
    - Improving the health of vulnerable populations.
- Regarding population health, Tier-One and Tier-Two initiatives are aimed at affecting population health by:
    - Increasing access to primary care services;
    - Targeting chronic conditions such as diabetes, hypertension, and cardiovascular disease; and

- Focusing on specific population groups including, but not limited to, women, children, and the homeless.

The activities being conducted to achieve these goals include readmission reduction and ER diversion programs, expanding primary care residency programs, and the addition of mental health care and dental services in rural outpatient clinics.

- Tier-One initiatives aimed at lowering per-capita costs and improving the cost-effectiveness of care include focusing on providing comprehensive and coordinated acute, chronic and preventive primary care services (including medical, dental, and behavioral health) with the goal of reducing the number of avoidable ER and inpatient visits.
- Tier-Two initiatives aimed at lowering per-capita costs include implementing ER diversion and readmission reduction programs, establishing condition-specific outpatient clinics, and testing the use of mobile health technology to monitor heart failure patients at home.

Preliminary Analysis and Final Report for 2012-13, Evaluation of the Florida Medicaid Reform Demonstration's Impact on Deterring Fraud and Abuse

A Preliminary Analysis Report and a Final Report regarding the demonstration's impact as a deterrent against Medicaid fraud and abuse were completed by the Florida International University (FIU) in May and June of 2013. In these first reports regarding Domain iv, FIU research team describes the results of their preliminary content analysis of four Medicaid managed care plans' anti-fraud plans. The researchers' review of the plans' anti-fraud plans identified five major themes, although they note that the level of detail regarding each of these themes varies by plan. These five major themes reflect statutory requirements regarding anti-fraud plans and are:

1) Detection tools, including descriptions of: plan staff and their qualifications and responsibilities; strategies and various tools used to identify areas of risk for fraud and abuse (e.g., utilization review, data mining/analysis, auditing, and monitoring); hotlines for reporting suspected fraud or abuse; and notifications to plan members.
2) Education and training, including descriptions of: activities geared toward plan employees, members, providers, vendors/suppliers, and contractors; health care fraud and abuse training and business ethics training; and trainings specific to particular risk areas.
3) Internal and external reporting, including descriptions of: methods to handle reports of fraud and abuse through internal committees and higher plan administration; procedures for reporting suspected or confirmed fraud and abuse to the appropriate regulatory or law enforcement agencies; and the Annual and Quarterly Fraud and Abuse Activity Reports that are required to be submitted to the Agency.
4) Internal and external investigations, including descriptions of: the staff responsible for conducting investigations; the steps involved in internal investigations; and the possible use of outside vendors for external investigations, as well as if and when external entities will be notified as a result of internal investigative actions.
5) Corrective actions, including descriptions of: disciplinary steps or termination of employees and/or providers in confirmed cases of fraud and abuse; recovery of losses through repayments; termination or amendment of contracts; and claims suspension or denial.

Pending and Upcoming Evaluation Reports and Activities

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

- UF submitted and revised, based on Agency feedback, the Primary Care and Alternative Delivery Systems Expenditure Report for DY7. This report was submitted to Federal CMS on December 31, 2013. At the end of this quarter, the UF research team submitted the draft final report for Domains i and ii. During next quarter, the Agency will provide feedback to UF on this report, and UF will submit the LIP Milestone Statistics and Findings Report for DY7 to the Agency.
- FIU conducted a round of pilot interviews with compliance staff for several managed care plans and continued conducting content analysis of managed care plans' anti-fraud plans and fraud and abuse activity reports. FIU's reports on the evaluation of domain iv will be done in the spring of 2014.
- On October 11, 2013, the Agency submitted its updated draft evaluation design for the MMA program to Federal CMS. Agency staff received CMS' comments on the draft evaluation design at the end of the quarter, and will be responding to the feedback with a revised evaluation design during next quarter.
- The Agency is updating its website to include the completed evaluation reports. The website should be updated by the end of next quarter.

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J. Policy and Administrative Issues

Current Activities

The Agency continues to identify and resolve various operational issues for capitated health plans and FFS PSNs. The Agency's internal and external communication processes play a key role in managing and resolving issues effectively and efficiently. These forums provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of our "Dear Provider" letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement. In conference call forums, the focus during this quarter has been on operational updates and information exchange.

Medicaid Reform Technical Advisory Panel (TAP)

The Technical Advisory Panel (TAP) was created by the 2005 Florida Legislature, and appointed by the Agency with the directive of advising the Agency on various implementation issues relative to the demonstration. It is scheduled to sunset effective October 1, 2014. The seven-member TAP did not meet this quarter.

Technical and Operational Issues Conference Calls

The Technical and Operational Issues conference calls are used to communicate the Agency's response to issues addressed at a higher level in the TAP meetings and to respond to plan questions posed through e-mail, telephone inquiries and previous technical calls. Previously, these calls occurred biweekly, but with the demonstration being fully operational, the need for biweekly calls has significantly lessened. Unless a particular need arises for calls to occur more often, the Technical and Operational Issues conference calls are now quarterly.

During this quarter, the Agency conducted one Technical and Operational Issues conference call with health plans as Agency Medicaid staff focused on plan readiness activities for implementation of the Managed Medical Assistance component of Statewide Medicaid Managed Care. Approximately 20 participants attended the October call with 128 phone lines in active use. The agenda items discussed on this quarter's call were as follows:

- Update on the pilot of a new service offered by the Florida Health Information Exchange (HITECH grantee) to Florida hospitals and health plans. The service's main objective is to promote care coordination.
- Update on X12 834 file and companion guide changes required in order to provide health plans with information when their enrollees are also enrolled in other health plans (such as long-term care plans).
- Update on the implementation of the ACA primary care physician fee increase.

PSN Systems Implementation conference calls provide a forum for discussing claims processes and enrollment file issues that are unique to the FFS PSN model.

With the implementation of a revised electronic remittance advice file in September, there were no calls held during this quarter. The Agency continued to coordinate technical assistance between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, it has been needed only occasionally.

Policy Transmittals and "Dear Provider" Letters

Policy transmittals and "Dear Provider" letters and e-mails are used to send key policy and operational information to health plans. During this quarter, there were three policy transmittals and four "Dear Provider" letters released to the health plans.

The three policy transmittals advised health plans regarding the following:

- Updated self-attestation information for the 2014 calendar year relative to the two-year payment increases to certain providers for primary care services as specified in the Affordable Care Act (ACA) and 42 CFR sections 438 and 447.
- Provided an extension to the health plan ad hoc reporting requirements related to the ACA primary care physician services fee increase.
- Specified primary care services provided to MediKids are not eligible for the ACA physician fee increase.

The four "Dear Provider" letters advised health plans of the following:

- Additional advisement regarding a change in s. 119.0701, F.S., that affects how health plans under contract with the Agency must comply with public records requests.
- Clarification regarding health plan coverage of ancillary services provided in a hospital setting.
- Information regarding quarterly changes to the electronic Report Guide for the contract covering the period September 1, 2012 through August 31, 2015.
- Responses to additional questions received from health plans and interested parties regarding the ACA primary care services two-year fee increase (two "Dear Provider" letters).

There were also several "Dear Provider" e-mails sent to provide updated information on the Medicaid program. Issues addressed in the "Dear Provider" e-mails included the following:

- Notice of and information regarding the 2013 contract general rate amendment for the Medicaid Health Plan Contracts and related rate-setting meetings. Such notice included that no benefit changes would be included in the 2013-2014 rate amendments.
- Clarifications regarding ACA primary care services physician fee increase ad hoc reporting dates, data submission information, and ACA report card for the first and second quarters of calendar year 2013.
- Updated information regarding unborn activation and newborn enrollment processing.

Contract Amendments and Model Contracts

During this quarter, there was one general amendment to contracts with health plan participants in the Reform demonstration covering the following major items:

- Implementation of the 2013-2014 actuarially certified rate changes.
- Added requirements for how inpatient days are counted under Diagnosis-Related Group (DRG) implementation.

- Specified the exclusion of primary care services provided to MediKids recipients from the services allowed for the Affordable Care Act (ACA) primary care physician services payment increase.
- Updated the performance improvement project (PIP) requirements to specify that the health plans must transfer ongoing PIPs to new, updated external quality review organization PIP summary forms in its annual progress submission to the Agency.
- Deleted obsolete inpatient discharge report from the reporting requirements.
- Added a designated address for health plans to use when submitting disputes and appeals to the Agency.
- Added requirement that terminated health plans must continue to submit encounter data according to contract provisions.
- Updated the ad hoc request requirements to allow for a less than 30-day timeframe for completion if required by the Agency.
- Added and revised liquidated damages.
- Added provider requirements to reflect requirements specified in Medicaid prepaid dental health plan contracts.
- Added specifications regarding the payment methodology the Agency is using for the ACA primary care physician services payment increase.

General Amendment/Contract Overview/Training Calls and Meetings

When new contract changes are being considered or are implemented, the Agency holds conference calls with the health plans to discuss the changes. These calls are periodic in nature, depending on the particular items needing discussion.

During this quarter, the Agency held the following training calls regarding the 2012 – 2015 Medicaid Health Plan Contract:

- Webinar held with health plans on October 30, 2013, regarding Medicaid Program Integrity reporting requirements.
- Meeting held with health plans and their managed behavioral health organizations on October 23, 2013, regarding the status of current and ongoing behavioral health projects and streamlining tools.
- Quarterly fraud and abuse meeting as discussed below.

Fraud and Abuse Meetings

As an effort to enhance the program integrity function required by contract, the Agency typically holds quarterly meetings with the health plans and other state agencies involved with health care fraud and abuse in order to discuss fraud and abuse initiatives and current health plan processes.

During this quarter, the Agency held a fraud and abuse meeting on December 5, 2013 for all health plans. The training was located in Miramar, Florida, at one of the health plan sites. The fraud and abuse meeting included the following:

- Government agencies sharing about processes that are integral to the health plans' anti-fraud efforts;
- Discussion about operational issues (Agency site visits, provision of information regarding terminated providers, provider registration processes, investigation updates, Medicaid Program Integrity's report training and other training needs);
- Health plan best practices; and
- Health plans sharing concerns or needs about more effectively addressing fraud.

Eighty-one persons attended the training, with representation from most Medicaid health plans.

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III. Status of the Managed Medical Assistance Program

A. Managed Medical Assistance Program

1. Implementation Plan

On December 23, 2013, the Agency received a letter from Federal CMS approving the implementation plan for the MMA program in accordance with STC #35 of the 1115 MMA Waiver. As a condition of this approval and the implementation of the MMA program, Federal CMS requested the Agency engage key stakeholder groups on a monthly basis on the implementation of the program. The MMA Implementation Plan can be viewed on the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA

A detailed description of the Agency's comprehensive outreach and education strategy for the MMA program is provided in the MMA Implementation Plan on pages 7-10. The Agency designated a dedicated senior staff person, the Director of Community Relations, to lead and to better coordinate outreach activities. The Agency conducted several meetings and presentations with key stakeholder groups during this quarter as outlined in Table 40 below and in the comprehensive outreach schedule provided in Attachment V of this report.

Table 40
Key Stakeholder Engagement
(August 2013 – December 2013)

Topic	Audience	Date
MMA Extension Request	LIP Council Meeting	08/08/2013
MMA Overview	Florida House Health and Human Services	09/25/2013
MMA Overview	Florida Senate Health and Human Services Appropriations Committee	09/25/2013
MMA Extension Request	Public Meeting	10/08/2013
MMA Extension Request	Public Meeting	10/09/2013
MMA Extension Request	Public Meeting	10/11/2013
MMA Extension Request	Medical Care Advisory Committee	10/15/2013
Statewide Medicaid Managed Care	ARC of Florida	10/17/2013
MMA Overview	AIDS Insurance Continuation Program Statewide Technical Advisory Committee	10/15/2013
Statewide Medicaid Managed Care	Developmental Disabilities Council Task Force Meeting	10/29/2013
MMA Overview	Florida HIV/AIDS Network Patient Care Planning Group	11/07/2013
Reviewed Draft MMA pre-welcome letter to recipient	HIV/AIDS Advocacy Network	11/08/2013
MMA Overview	Early Steps Coalition	11/13 and 11/14/2013
Reviewed Draft MMA pre-welcome letter to recipient	Florida Legal Services	11/14/2013
MMA Overview	Florida Dental Steering Committee	11/15/2013
MMA Overview	KidCare Coordinating Council	12/06/2013
MMA Overview	Florida Senate Health Policy	12/08/2013

Table 40 Key Stakeholder Engagement (August 2013 – December 2013)		
MMA Overview	Florida House Health Care Appropriations	12/09/2013
MMA Overview	Agency Webinar for Providers and Advocates	12/10/2013
MMA Overview	PHARMA Task Force	12/10/2013
MMA Overview	Commission for the Transportation Disadvantaged	12/11/2013
MMA Overview	Northeast Florida AIDS Network	12/12/2013
MMA Overview	Medicaid Cure Summit	12/14/2013
MMA Overview for Long-term Care enrollees	Past, Current and Incoming chairs of the Elder Law Section of the Florida Bar	12/17/2013
MMA Overview and Initial Implementation Discussion	Florida Legal Services	12/30/2013
MMA Overview for Long-term Care enrollees	Foundation for Long Term Care Solutions, Inc.	12/30/2013

2. Plan Readiness Activities

MMA Plan Readiness

In October 2013, the Agency began the process of conducting a readiness review of MMA plans. The Agency developed a readiness review request that all plans are required to respond to in order for the Agency to complete a thorough desk review of identified key areas. As of December 31, 2013 the Agency sent and received responses to the readiness review request for 17 of 18 plans. The Agency completed desk reviews for 12 of 18 plans. In the month of December, the Agency performed two onsite readiness reviews as noted in Table 41. Table 41 provides an overview of the MMA plan readiness review process for the month of December.

Table 41 MMA Plan Readiness Review – December 2013				
MMA Plan	**Readiness Review Request Sent**	**Readiness Review Response Received**	**Desk Review Complete**	**Onsite Review Complete**
1. **AHF / Positive**	**X**	**X**		
2. **Amerigroup**	**X**	**X**	**X**	
3. **Better**	**X**	**X**	**X**	
4. **Clear Health**	**X**	**X**	**X**	
5. **Coventry**	**X**	**X**		
6. **FCA**	**X**	**X**	**X**	
7. **Freedom**				
8. **Humana**	**X**	**X**	**X**	
9. **Integral**	**X**	**X**		
10. **Magellan**	**X**	**X**		
11. **Molina**	**X**	**X**		
12. **Preferred**	**X**	**X**		
13. **Prestige**	**X**	**X**	**X**	
14. **SFCCN**	**X**	**X**		
15. **Simply**	**X**	**X**	**X**	
16. **Staywell**	**X**	**X**	**X**	
17. **Sunshine**	**X**	**X**	**X**	**X**
18. **United**	**X**	**X**	**X**	**X**

B. MMA Plan Selection

The Agency has selected the MMA plans through a competitive procurement with strict selection criteria. The program will provide for a limited number of plans in 11 geographic regions to ensure stability, but allow for significant recipient choice and further ensure coverage in rural areas of the state. The Agency initiated the procurement of the plans on December 28, 2012 and Notices of Intent of Award were published on September 23, 2013, October 10, 2013, October 21, 2013 and October 24, 2013. A listing of the plans selected for each region and relevant information about the procurement can be found via the Florida Department of Management Services' Vendor Bid System at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu.

The Agency selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe and persistent mental illness, and dual eligbiles with chronic conditions.

IV. Waiver Extension Request

A. Submission of Waiver Extension Request

On November 27, 2013, the Agency submitted a three-year waiver extension request to Federal CMS to extend Florida's 1115 MMA Waiver for the period July 1, 2014 – June 30, 2017. The waiver extension request document can be viewed by visiting the Agency's website at the following link and under the heading named, "Request for Extension of the 1115 MMA Waiver and Public Input."
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA

B. Public Input Process

In preparing the waiver extension request document, the Agency held a series of public meetings to solicit public input on the extension of Florida's 1115 MMA Waiver. The agenda items for the public meetings included: the future of Florida's 1115 MMA Waiver, legislation creating the MMA program passed during the 2011 Florida Legislative Session, overview of the existing waiver and description of the draft waiver extension request. There was an opportunity for public input during the meetings.

The location, date and time of the public meetings held are provided below. In addition, the Agency accepted written comments on the waiver extension request via mail and e-mail. A complete summary of the public notice and public process used in the development of the extension request is included in the final document and posted on the Agency's website at the link provided above.

Schedule of Public Meetings		
Location	**Date**	**Time**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00 p.m. – 3:30 p.m.
Miami Florida International University Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00 p.m. – 3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00 p.m. – 3:30 p.m.

Florida Medicaid Advisory Meetings and "Post Award Forum"

In addition, to the public meetings listed on the above, the Agency requested input on the extension request from the Low Income Pool Council and the Medical Care Advisory Committee (MCAC). The following is a brief summary of the advisory committee meetings held on the waiver extension request, including the Post Award Forum held during the MCAC, in accordance with STC #18 of the waiver.

Low Income Pool Council

The Agency held a public meeting on the waiver extension request with the LIP Council on August 8, 2013. During the meeting, the Agency provided an overview of the three-year waiver extension and solicited input on the future of the LIP program. The Agency also provided an overview of other state's quality incentive programs and solicited input on the approaches available under the waiver extension period. The LIP Council recommended the Agency pursue additional funding to implement quality incentive programs.

Medical Care Advisory Committee and "Post Award Forum"

The Agency held a public meeting and Post Award Forum with the Medical Care Advisory Committee on October 15, 2013. During the meeting, the Agency provided a detailed overview of the waiver extension request, the implementation of certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 related to Title XXI Children's Health Insurance Program in 2014 and the intent to seek additional funding for the Low Income Pool program to establish quality incentive programs.

The public meeting and Post Award Forum held on October 15, 2013, provided the Medical Care Advisory Committee members and the public an opportunity to provide meaningful comments on the progress of the 1115 MMA Waiver. The comments and recommendations from the committee and public were incorporated in the summary of public comments provided in Section III.H of the waiver extension request for the 1115 MMA Waiver, which can also be viewed in Attachment VI of this quarterly report.

C. Status of Federal Approval

On December 12, 2013, Federal CMS notified the Agency they had finished their preliminary review of the state's extension request and determined the state's request has met the requirements of a complete extension request as specified under Section 42 CFR 431.412(c). Federal CMS will post the documents for public comments on their website for 30 days at the following link:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

Attachment I
PSN Complaints/Issues

PSN Complaints/Issues (October 1, 2013 – December 31, 2013)	
PSN Informal Issue	**Action Taken**
1. A PSN enrollee complained that they were unable to obtain a new pair of replacement glasses after losing their current pair.	The PSN clarified that the enrollee had already exceeded their allowed benefit for the year but will assist the enrollee in obtaining a new pair when eligible.
2. A PSN enrollee needed assistance in obtaining an appointment with a specialist.	The PSN assisted the enrollee in making an appointment with the specialist.
3. The parent of a PSN enrollee was unable to obtain authorization for an appointment with a specialist.	The PSN assisted the parent with making an appointment with the child's Primary Care Physician (PCP) who would be able to provide a referral for the needed specialist.
4. The parent of a PSN enrollee complained about hospital charges incurred by the enrollee during out-of-state travel.	The PSN stated that the services were not considered emergency and no prior authorization was requested. The PSN denied the claims.
5. The parent of a PSN enrollee needed assistance in obtaining authorization for an out-of-network PCP.	The PSN assisted the parent in finding an adequate in-network provider.
6. A provider complained that a PSN had not paid a large amount of claims.	Since the provider did not resubmit the claims in a timely manner, the PSN properly denied the claims.
7. The parent of a PSN enrollee complained about sub-par dental services.	The PSN provided the parent with an alternate provider.
8. A PSN enrollee needed assistance in obtaining a timely medical appointment.	The PSN assisted the enrollee in scheduling an appointment.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues (October 1, 2013 – December 31, 2013)	
HMO Informal Issue	**Action Taken**
1. The parent of an HMO enrollee expressed concerns about being solicited to by an unknown health-related company and about the security of the enrollee's health information.	The HMO informed the parent that the company that contacted them is contracted to provide disease management services with the plan and that there are no concerns with the security of the enrollee's health information.
2. The parent of an HMO enrollee complained that they have not received necessary medical supplies.	The HMO made arrangements for immediate delivery of supplies.
3. An HMO enrollee was unable to obtain authorization for necessary medical testing.	The HMO authorized the testing.
4. An HMO enrollee experienced difficulty in locating in-network providers.	The HMO assisted the enrollee in obtaining medical appointments with in-network providers and provided a full new member orientation.
5. An HMO enrollee complained about inadequate medical treatment by an in-network specialist.	The HMO authorized the use of an out-of-network specialist.
6. An HMO enrollee requested authorization for medication.	The HMO denied the use of the medication because it was not determined to be medically necessary.
7. An HMO enrollee was denied authorization for a necessary medication.	The HMO contacted the enrollee and explained that the authorization would not be approved until the enrollee completed the necessary testing for the medication.
8. An HMO enrollee was billed for dental services.	The HMO contacted the enrollee and explained that they were ineligible for coverage the date the service was rendered.
9. An HMO enrollee needed assistance in obtaining necessary medical equipment.	The HMO authorized the equipment.
10. The parent of an HMO complained about being billed for orthodontic services.	The HMO paid the claims.
11. An HMO enrollee needed assistance in obtaining an appointment with a specialist.	The HMO assisted the enrollee in scheduling appointments.
12. A provider complained that a large amount of claims had not been paid.	The HMO paid the claims.
13. An HMO enrollee was unable to obtain an appointment for surgery.	The HMO assisted the enrollee in scheduling an appointment.

HMO Complaints/Issues (October 1, 2013 – December 31, 2013)	
HMO Informal Issue	**Action Taken**
14. An HMO enrollee complained that they were denied authorization for a medication.	The HMO authorized the medication.
15. An HMO enrollee complained about a sub-par in-network medical provider.	The HMO authorized the use of an out-of-network provider.
16. An HMO enrollee needed assistance in obtaining a timely appointment with a specialist.	The HMO contacted the specialist and made a timely appointment.
17. An HMO enrollee needed assistance in gaining approval for a non-generic medication.	The HMO assisted the enrollee in scheduling a necessary appointment with the provider prior to approving the medication.
18. An HMO enrollee complained that their PCP was not providing adequate service.	The HMO assisted the enrollee in finding a new PCP.

Attachment III
2008 – 2013 Managed Care Performance Measures
Reform Plans

	Reform Plans*						
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**Trend**
Annual Dental Visit	15.2%	28.5%	33.4%	34.0%	35.3%	40.4%	improve
Adolescent Well-Care	44.2%	46.5%	46.3%	46.2%	47.6%	48.5%	flat
Controlling Blood Pressure	46.3%	55.9%	53.4%	46.3%	52.9%	45.4%	decline
Cervical Cancer Screening	48.2%	52.2%	50.8%	53.2%	56.8%	58.2%	improve
Diabetes - HbA1c Testing	78.9%	80.1%	82.8%	81.9%	82.2%	79.5%	decline
Diabetes - HbA1c Poor Control (INVERSE)	48.3%	46.8%	44.9%	48.6%	43.6%	48.9%	decline
Diabetes - HbA1c Good Control	32.2%	48.0%	47.5%	43.7%	47.9%	43.6%	decline
Diabetes - Eye Exam	35.7%	44.0%	45.4%	49.3%	50.2%	48.7%	decline
Diabetes - LDL Screening	80.0%	80.2%	83.5%	81.8%	81.9%	80.1%	decline
Diabetes - LDL Control	29.3%	35.5%	36.1%	36.9%	37.8%	32.1%	decline
Diabetes - Nephropathy	79.2%	80.3%	81.9%	83.1%	82.3%	80.2%	decline
Follow-up after Hospitalization for Mental Illness - 7 day	20.6%	29.3%	25.4%	23.1%	22.7%	23.5%	flat
Follow-up after Hospitalization for Mental Illness - 30 day	35.5%	46.6%	41.3%	44.3%	41.2%	40.8%	flat
Prenatal Care	66.6%	67.4%	75.2%	68.4%	72.1%	67.2%	decline
Postpartum Care	53.0%	51.5%	52.1%	49.3%	52.9%	51.4%	decline
Well-Child First 15 Mos. - 0 Visits (INVERSE)	4.9%	1.6%	6.0%	3.0%	2.1%	1.6%	improve
Well-Child First 15 Mos. - 6(+) Visits	44.4%	49.3%	35.4%	46.5%	58.4%	55.6%	decline
Well-Child 3-6 Years	71.3%	75.7%	72.7%	75.0%	75.5%	75.6%	flat
Adults' Access to Preventive Care - 20-44 Yrs	n/a	71.8%	71.2%	71.2%	69.8%	69.2%	flat
Adults' Access to Preventive Care - 45-64 Yrs	n/a	84.7%	84.9%	85.5%	84.9%	85.0%	flat
Adults' Access to Preventive Care - 65+ Yrs	n/a	83.6%	83.7%	84.2%	73.9%	76.2%	improve
Adults' Access to Preventive Care - total	n/a	77.2%	77.6%	77.0%	75.0%	74.7%	flat
Antidepressant Medication Mgmt - Acute**	n/a	52.0%	56.3%	56.3%	57.4%	55.1%	decline
Antidepressant Medication Mgmt - Continuation**	n/a	29.8%	43.8%	44.0%	43.1%	41.7%	decline

	Reform Plans*						
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**Trend**
Appropriate Medications for Asthma***	n/a	83.6%	87.6%	86.0%	81.1%	79.3%	decline
Breast Cancer Screening	n/a	51.4%	56.9%	59.2%	52.3%	52.7%	flat
Childhood Immunization Combo 2	n/a	63.6%	70.0%	74.0%	74.8%	77.8%	improve
Childhood Immunization Combo 3	n/a	53.8%	62.7%	66.9%	69.2%	71.6%	improve
Frequency of Prenatal Care	n/a	52.6%	46.9%	44.0%	54.4%	53.7%	flat
Lead Screening in Children	n/a	54.8%	52.0%	54.1%	59.6%	61.7%	improve
Adult BMI Assessment	n/a	n/a	41.9%	52.7%	47.9%	63.0%	improve
Follow-up Care for Children Prescribed ADHD Medication - Initiation****	n/a	n/a	43.6%	44.5%	44.4%	45.0%	flat
Immunizations for Adolescents Combo 1	n/a	n/a	44.1%	43.6%	47.3%	54.6%	improve
Chlamydia Screening - 16-20 years	n/a	n/a	n/a	56.2%	56.4%	58.6%	improve
Chlamydia Screening - 21-24 years	n/a	n/a	n/a	67.8%	68.2%	70.9%	improve
Chlamydia Screening - total	n/a	n/a	n/a	60.2%	60.6%	62.9%	Improve
Appropriate Testing for Children with Pharyngitis	n/a	n/a	n/a	65.0%	64.0%	67.7%	improve
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	n/a	n/a	n/a	n/a	94.8%	94.5%	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%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	n/a	n/a	n/a	n/a	85.0%	86.2%	improve
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	n/a	n/a	n/a	n/a	81.2%	82.3%	improve
Call Abandonment (INVERSE)	n/a	n/a	n/a	n/a	3.2%	3.4%	flat
Call Answer Timeliness	n/a	n/a	n/a	n/a	94.9%	95.4%	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 is the weighted mean across Reform health plans, weighted by the number of eligible members each plan has per measure. Each year listed is the year in which data were reported for the previous calendar year. E.g., rates reported in 2013 are for calendar year 2012.

** Antidepressant Medication Management - Acute and Continuation: only 6 of the 13 Reform plans had sufficient eligible members to report on these measures.

*** 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 13 Reform plans had sufficient eligible members to report this measure.

Attachment IV
2013 Managed Care Performance Measures
Comparison of Reform and Non-Reform Plans

Measure	Non-Reform Plans*	Reform Plans*	2013 National Medicaid Mean****
Annual Dental Visit**	31.6%	40.4%	49.1%
Adolescent Well-Care	50.1%	48.5%	49.6%
Controlling Blood Pressure	52.9%	45.4%	56.1%
Cervical Cancer Screening	56.5%	58.2%	64.1%
Diabetes - HbA1c Testing	79.6%	79.5%	82.9%
Diabetes - HbA1c Poor Control (INVERSE)	44.0%	48.9%	44.8%
Diabetes - HbA1c Good Control	47.5%	43.6%	46.5%
Diabetes - Eye Exam	46.1%	48.7%	53.2%
Diabetes - LDL Screening	79.2%	80.1%	75.4%
Diabetes - LDL Control	35.0%	32.1%	33.9%
Diabetes - Nephropathy	79.8%	80.2%	78.4%
Follow-up after Hospitalization for Mental Illness - 7 day	36.3%	23.5%	43.3%
Follow-up after Hospitalization for Mental Illness - 30 day	53.5%	40.8%	63.1%
Prenatal Care	73.3%	67.2%	82.9%
Postpartum Care	52.1%	51.4%	63.1%
Well-Child First 15 Mos. - 0 Visits (INVERSE)	2.7%	1.6%	1.8%
Well-Child First 15 Mos. - 6(+) Visits	56.3%	55.6%	63.6%
Well-Child 3-6 Years	73.2%	75.6%	71.9%
Adults' Access to Preventive Care - 20-44 Yrs	66.3%	69.2%	80.2%
Adults' Access to Preventive Care - 45-64 Yrs	81.5%	85.0%	86.5%
Adults' Access to Preventive Care - 65+ Yrs	69.8%	76.2%	84.2%
Adults' Access to Preventive Care - total	70.9%	74.7%	82.5%
Antidepressant Medication Mgmt - Acute	51.8%	55.1%	52.9%
Antidepressant Medication Mgmt - Continuation	36.5%	41.7%	36.9%
Appropriate Medications for Asthma	81.0%	79.3%	83.8%

Measure	Non-Reform Plans*	Reform Plans*	2013 National Medicaid Mean****
Breast Cancer Screening	50.0%	52.7%	51.7%
Childhood Immunization Combo 2	77.5%	77.8%	75.8%
Childhood Immunization Combo 3	71.9%	71.6%	72.1%
Frequency of Prenatal Care	62.8%	53.7%	60.5%
Lead Screening in Children	57.4%	61.7%	67.4%
Adult BMI Assessment	73.8%	63.0%	67.6%
Follow-up Care for Children Prescribed ADHD Medication - Initiation***	41.3%	45.0%	39.1%
Immunizations for Adolescents Combo 1	57.3%	54.6%	67.2%
Chlamydia Screening - 16-20 years	56.5%	58.6%	53.4%
Chlamydia Screening - 21-24 years	69.1%	70.9%	63.4%
Chlamydia Screening - total	61.2%	62.9%	56.9%
Appropriate Testing for Children with Pharyngitis	61.6%	67.7%	68.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95.3%	94.5%	96.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	87.4%	88.3%	88.3%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	85.7%	86.2%	89.8%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	82.8%	82.3%	88.3%
Call Abandonment (INVERSE)	3.3%	3.4%	N/A
Call Answer Timeliness	93.5%	95.4%	83.9%

* 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) health plans, weighted by the number of eligible members each plan has per measure.

** Annual Dental Visits - only 8 of 23 Non-Reform plans cover dental services. Only 4 of the plans had sufficient denominators to report on this measure in 2013.

*** Follow-up Care for Children Prescribed ADHD Medication - Continuation is not displayed as less than half of the Non-Reform (6 of 23) and Reform (4 of 13) plans had sufficient eligible members to report this measure.

**** National Mean as published by NCQA, Medicaid product line. The National Mean that is presented is the HEDIS 2013 National Mean, for calendar/measurement year 2012. There is no longer a national mean for the Call Abandonment measure, as NCQA retired this measure. The state is continuing to have managed care plans report this measure, per the last NCQA specifications for the measure.

Highlighted cells indicate that the weighted means are the same as or better than the National Medicaid Mean.

Attachment V
Comprehensive MMA Outreach Schedule

October 2013

Date Weekly:	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 10/7/2013				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	General Public	Agency / Communications Office	Press Release	Press Release announcing Agency Welcomes Public Comment at Meetings about Managed Medical Assistance Waiver.
	General Public	Agency / Communications Office	In Person	Public meetings regarding MMA extension request.
	General Public	Agency / Communications Office	Twitter	Tweet regarding the Managed Medical Assistance Program.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/14/2013				
	Stakeholders	Agency / Communications Office	In Person	Meeting with Medical Care Advisory Committee regarding MMA extension request; meeting with AIDS Insurance Continuation Program Statewide Technical Advisory Committee regarding MMA overview; and meeting with ARC of Florida regarding the Statewide Medicaid Managed Care Program.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/21/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/28/2013				
	General Public	Agency / Communications Office	Facebook	Facebook post to announce Agency YouTube channel update and webinar references.
	Stakeholders	Agency / Communications Office	In Person	Meeting with Developmental Disabilities Council Task Force regarding the Statewide Medicaid Managed Care Program.
	General Public	Agency / Communications Office	Twitter	Tweet regarding the Managed Medical Assistance Program.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.

November 2013

Date Weekly:	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 11/1/2013				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Legislature	Agency / Communications Office	Letter	Legislative correspondence regarding MMA sent to area offices 5 & 6 and delegations.
	Stakeholders	Agency / Communications Office	In Person	Meeting with Florida HIV/AIDS Network Patient Care Planning Group regarding MMA overview; and meeting with HIV/AIDS Advocacy Network to review draft MMA pre-welcome letter to recipients.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Technical Assistance Calls with the Plans.
Week of 11/11/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	General Public	Agency / Communications Office	Twitter	Tweet regarding the Managed Medical Assistance Program.
	Stakeholders	Agency / Communications Office	In Person	Meeting with Early Steps Coalition regarding MMA overview; meeting with Florida Legal Services to review draft MMA pre-welcome letter to recipients; and meeting with Florida Dental Steering Committee regarding MMA overview.
	Plans	Readiness Team	Phone	Technical Assistance Calls with the Plans.
Week of 11/18/2013				
	AHCA Staff	Executive Management	In Person	Monthly AHCA Staff update on SMMC.
	Legislature	External Affairs	In Person	Meet in person with House and Senate staff to discuss developments in the Statewide Medicaid Managed Care Program.
	General Public	Agency / Communications Office	Twitter	Tweet regarding the Managed Medical Assistance Program.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Monthly AHCA Staff update on SMMC.
Week of 11/25/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Technical Assistance Calls with the Plans.

December 2013

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 12/2/2013				
	AHCA Staff	Executive Management	In Person	Monthly AHCA Staff update on SMMC.
	Stakeholders	Agency / Communications Office	In Person	Meeting with KidCare Coordinating Council regarding MMA overview; and meeting with Florida Senate Health Policy regarding MMA overview.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Technical Assistance Calls with the Plans.
Week of 12/9/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Stakeholders	Agency / Communications Office	In Person	Meetings with Florida House Health Care Appropriations, PHARMA Task Force, Commission for the Transportation Disadvantaged, Northeast Florida AIDS Network, and Medicaid Cure Summit regarding MMA overview.
	Legislature	External Affairs	In Person	Meet in person with House and Senate staff to discuss developments in the Statewide Medicaid Managed Care Program.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101
Week of 12/16/2013				
	General Public	Agency / Communications Office	Facebook	Facebook post to announce 100,000 views on Slide Share post and Hospice webinar.
	General Public	Agency / Communications Office	Twitter	Tweets regarding the Managed Medical Assistance Program.
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Stakeholders	Agency / Communications Office	In Person	Meeting with past, current, and incoming chairs of the Elder Law Section of the Florida Bar regarding MMA overview for Long-Term Care enrollees.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 12/23/2013				
	General Public	Agency / Communications Office	Press Release	Press Release announcing
	Stakeholders	Agency / Communications Office	In Person	Meeting with Florida Legal Services regarding MMA overview and initial implementation discussion; and meeting with Foundation for Long Term Care Solutions, Inc. regarding MMA overview for Long-term Care enrollees.
	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.

Attachment VI
Summary of Public Comments

(Section III.H of the 1115 MMA Waiver Extension Request)

The following summarizes the public comments received during the 30-day comment period for the waiver extension request that began October 1, 2013 and ended October 30, 2013. A total of 219 individuals attended the public meetings and 78 comments or questions were received during the public comment period. Table 4 provides the total number of participants for each of the public meetings.

Table 4
Total Number of Participants by Public Meeting

Date	Type of Meeting	Location	Number of Participants
August 8, 2013	LIP Council	Tallahassee	13
October 8, 2013	Public Meeting	Tampa	56
October 9, 2013	Public Meeting	Miami	65
October 11, 2013	Public Meeting	Tallahassee	63
October 15, 2013	Medical Care Advisory Committee[1]	Tallahassee	22
Total			**219**

Summary of Comments

The comments received are grouped by topic with an explanation ***(bolded and italicized)*** describing how issues raised are addressed in the plan contract, competitive procurement process, state law or rule.

Pharmacy Services

- Concerns were expressed about a potential shift in utilization to mail order or out of state pharmacies under the expansion of managed care. A related general concern was expressed related to the Florida Medicaid program implementing statutory provisions which allow expanded mail order of pharmacy products.

  Specific requirements in the MMA program were established to ensure recipients receive medically necessary pharmacy services in a timely manner. Managed Care Plans must ensure that regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of the contract. Some of the contract requirements, specific to pharmacy services are outlined below:

  - ***There must be at least one pharmacy for every 2,500 enrollees in a region.***
  - ***In urban areas, a pharmacy must be available to an enrollee within a 30 minute drive or 20 mile distance.***

[1] Due to technical difficulties with the conference call, the two council members who attended by conference call were unable to participate during the first part of the meeting held on October 15, 2013 from 1pm to 4pm.

- ***In rural areas, a pharmacy must be available within a 60 minute drive or 45 mile distance.***

MMA plans may choose to utilize mail order pharmacies to provide various services, including expanded benefits, but may not require enrolled recipients to utilize mail order pharmacies exclusively as a pharmacy services provider. In addition, mail order pharmacies cannot be used to meet the network adequacy requirements that are established in the contract.

- Concerns were expressed related to manufacturer rebates.

In 2010, the federal law changed to require states to collect manufacturer rebates for claims reimbursed by Medicaid managed care plans. Currently, managed care plans (or their pharmacy benefit managers) may negotiate with manufacturers for supplemental rebates. The new MMA contracts will prohibit plans from negotiating rebates directly with manufacturers, and all federal and supplemental rebates paid for claims reimbursed by Medicaid plans will be paid directly to the state.

ARNP Participation

- Concerns were expressed that Advanced Registered Nurse Practitioners will not be included as eligible primary care providers under the MMA program.

The current managed care contract and the MMA contract provide a definition of primary care provider to include Advanced Registered Nurse Practitioners (ARNP). Neither the statutory nor the plan contract language for the MMA program preclude the use of ARNPs as primary care providers.

Subcontractor Concerns

- Questions were received from durable medical equipment providers regarding the subcontracting process and how it will work under Managed Medical Assistance program. For example, will the MMA plans be allowed to contract with network managers who contracts with durable medical equipment providers?

Managed care plans may delegate some of their functions or responsibilities for providing services (e.g., credentialing) under the MMA program. However, if a managed care plan chooses to delegate some of its functions related to network management, the plan must still comply with network adequacy standards outlined in the contract. This includes regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties.

Provider Grievance Process

- Concerns were expressed by providers that a strong provider grievance process will need to be established for the MMA program. Providers stated concerns about being locked into a contract with a poor performing MMA plan.

Providers may appeal claim disputes through the plan or through the state's independent dispute resolution organization. A description of the independent dispute resolution process is provided at the following link: *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/SPHPClaimDRP/claimsdisputeprogramsummary.pdf.* ***No provider is required to contract with any managed care plan, and there is no state requirement that locks providers into contracts with managed***

care plans, and contracts without a cancellation clause are rare. Providers that are concerned about being locked in, however, should ensure that they only sign contracts that have a termination clause.

Provider Access to Risk Adjustment Data

- Requests received to access to data the Agency used to establish risk adjusted rates.

  The Agency will respond to public requests for data within constraints related to protecting personal health information as required by both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by 42 CFR 431.300-306.

Access to Certain Services

- Concerns were expressed regarding the provision of inpatient psychiatric services to children through the MMA program.

  The state's current Section 1915(b) Statewide Inpatient Psychiatric Program waiver will continue to operate until that federal authority expires on 12/31/2013. After that time and until the MMA program is implemented, inpatient psychiatric services for children will continue to be offered under the authority of Florida's Medicaid State Plan. During this period, inpatient psychiatric services for children will continue to be reimbursed on a fee-for-service arrangement. Upon implementation of the MMA program, inpatient psychiatric services for children will be provided by the MMA plans in accordance with the plan contract. The MMA plans and service providers will be required to comply with the state's rules and coverage and limitations policies.

- Concerns were raised regarding the State's implementation of recent statutory changes that allow foster care children to continue to receive services up to age 21.

  The Agency is in the process of updating its coverage and limitations handbooks to reflect this statutory change and has also submitted a state plan amendment to modify Medicaid eligibility requirements. Managed Medical Assistance plans will be required to continue to provide services to this population up to the age of 21.

- A recommendation was received that smoking cessation medications be included as a covered service and alcohol and drug screenings become more thorough for Medicaid recipients.

  Smoking cessation prescription products are already covered services under the Florida Medicaid program. Approved drug categories related to smoking cessation are listed on the Medicaid preferred drug list (PDL). In order to promote an effective transition of recipients during implementation of the MMA program, the Agency will require that plans use the Medicaid PDL during the first year of operation. Therefore, MMA plans must provide smoking cessation medications consistent with the Agency PDL to enrollees who want to quit smoking. After the first year of operation MMA plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.

  In addition, the MMA plans are required to offer healthy behavior programs that encourage and reward behaviors designed to improve the enrollee's overall health. More specifically, the plans are required to implement a medically approved smoking cessation program. Plans may choose to utilize different therapeutic approaches to

aid an enrollee who wishes to quit smoking, which may include the use of prescription medications.

The MMA plans are also required to implement a medically approved alcohol or substance abuse recovery healthy behavior program. Under this program, MMA plans must offer annual alcohol or substance abuse screening training to their providers. In addition, primary care providers must screen managed care enrollees for signs of alcohol or substance abuse as part of the evaluation at the following times:

- ***Initial contact with a new enrollee***
- ***Routine physical examinations***
- ***Initial prenatal contact***
- ***When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services***
- ***When documentation of emergency room visits suggests the need.***

- Concerns were expressed about potential delays with obtaining prior authorization for hospice services since recipients often cannot wait 24 to 48 hours for approval.

  Managed Medical Assistance plans are not required to prior authorize every covered service. Therefore, some managed care plans may choose to not prior authorize hospice service. However, if authorization is required, MMA plans must process the request and make a decision as expeditiously as the enrollee's health condition requires.

- Concerns were expressed about the participation of limited mental health assisted living facilities in the MMA program.

  The Agency is involved in discussions with owners/operators of assisted living facilities with limited mental health licenses and managed care plans to address the special needs of these recipients as we expand managed care across the state. One of the goals of these discussions is to build bridges between the assisted living facilities, managed care plans, and providers of behavioral health care treatment to ensure that recipients have a stable living environment and access to the care they need to maintain residency in a community setting of their choice.

<u>Plan Accountability and Monitoring</u>

- Recommendation was received that the Agency monitor the plan's financial data reported closely to ensure the accuracy of the plan's medical loss ratio reports and prevent fraud.

  The Agency is establishing new financial reporting requirements that will support additional plan financial monitoring, medical loss ratio justification, and calculation of the achieved savings rebate outlined in s. 409.967(3), F.S.

- Recommendation was received to use "secret shoppers" and other methods to ensure provider availability.

  The Agency will utilize multiple monitoring and evaluation tools to ensure managed care plans are compliant with network adequacy standards.

Program Participation

- Comments received indicated that some individuals were unclear about whether or not certain groups (family members, dually eligible recipients, and individuals with developmental disabilities) will be required to participate in the program.

  In general, all individuals eligible for Medicaid will receive coverage through an MMA plan upon full implementation except for groups specified in state law and the terms and conditions of the waiver. Prior to implementation of the program in a region, information regarding enrollment in the program will be made available to impacted recipients through the Agency's website and other publications. In addition, the Agency has developed a comprehensive education and outreach program that is outlined in the MMA Implementation Plan posted on the Agency's website at the following link:
  http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf

  Individuals eligible for Medicare and Medicaid services are required to enroll in a MMA plan in accordance with state law and the terms and conditions of the waiver.

  Individuals enrolled in the developmental disabilities (iBudget) waiver may voluntarily choose to enroll in an MMA plan in accordance with state law and the special terms and conditions of the waiver.

Provider Network Adequacy

- Concerns were expressed regarding the MMA plans provider network standards.

  In order to ensure access to necessary Medicaid services, the Agency established specific standards for the number, type, and regional distribution of providers in plan networks.

  The MMA plans are required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the Agency deems necessary. The provider database must be available online to both the Agency and the public. It must allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

  Plans may limit the providers in their networks but must include certain provider types and also certain providers that are specified in Part IV of Chapter 409, F.S., as "statewide essential."

- Concerns were expressed regarding network adequacy that out-patient dialysis facilities also be listed on the Provider Network Standards list.

  Managed Medical Assistance plans must develop and maintain a provider network that meets the needs of enrollees, including contracting with a sufficient number of credentialed providers to furnish all covered services. MMA plans must ensure that each covered service is provided promptly and is reasonably accessible. Recipients will be able to select an MMA plan in their region that has the service providers that are important to them. To assist in their decision making, enrollees with have access to a list of available dialysis centers in each plan's network. Recipients can select the

plan whose network includes the dialysis center best meeting their needs in terms of convenience of location and enrollee experience or preference.

Cost Sharing Requirements

- Concerns were expressed related to the recipient cost sharing requirements not complying with federal regulations and creating a barrier for recipients seeking needed medical care.

  Cost-sharing must be consistent with the Medicaid State Plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan and federal regulations. MMA plans are allowed to assess nominal cost sharing in accordance with federal regulations. A description of the nominal cost-sharing, including co-payments and co-insurances, for the MMA plans in accordance with federal regulations is provided in Section II.F of this document. The Agency will pre-approve all cost sharing arrangements proposed by the MMA plans.

Timeline for Implementation

- Comments were received asking for the timeline for implementing the program.

  The Agency submitted the required implementation plan to Federal CMS for approval on October 30, 2013. The implementation plan includes the proposed implementation schedule of the program, which is subject to approval by Federal CMS. The document is posted on the Agency's website at the following link: *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf .*

Plan Assignment Process

- Questions were received asking how the enrollment and plan assignment process will work under the MMA program.

  The Agency will follow the enrollment and disenrollment process outlined in this document in Section II.C, and as provided in the special terms and conditions of the waiver as approved on June 14, 2013.

Low Income Pool Program

- A recommendation was received urging the state to seek increased funding for the Low Income Pool program.

  As part of the waiver extension request, the Agency is seeking an increase in funding for the Low Income Pool program (Refer to Section V.B of this document for a description of this request).

- A recommendation was received urging the state to develop protocols for LIP providers to coordinate with enrollment activities under the Affordable Care Act.

  The Agency will work with CMS and LIP providers to establish activities and programs to be funded through the LIP.

Other issues included in written comments received through the mail or email included:

- Comments were received in support of the state's goals to decrease the administrative burden related to prior authorizations and the ability for providers to process prior authorizations electronically under the MMA program.

  The Agency appreciates the feedback that it has received from the public on the enhanced standards that will be included in the MMA program.

- Concerns were expressed regarding the reimbursement rate for dental care services for vulnerable populations receiving life maintenance procedures.

  Managed Medical Assistance plans will have greater flexibility in reimbursing providers at a rate higher than what is published on the Medicaid fee schedules, if that is needed to assist an enrollee in accessing services.

- Concerns were expressed regarding limited access to the Mom Care program of prenatal care for all women presumptively eligible for Medicaid under SOBRA.

  Under the MMA program, women who are eligible for Medicaid under SOBRA will be enrolled in an MMA plan and have their prenatal care coordinated through the managed care plan. The MMA plans will be responsible for ensuring these women have access to the full array of prenatal care necessary to promote a healthy birth – comparable to what they received through the MomCare program.

- Comments and suggestions were received regarding continuity of quality care for persons with disabilities, which included:

  - Increasing consumer protections that require plans to separately measure referrals to specialists,
  - Participation in disability awareness training by managed care providers, and
  - Increasing access to specialty care.

  The provider network standards developed for the MMA program are more comprehensive than any prior network standards established by the Agency. The MMA plans must enter into provider contracts with a sufficient number of specialists to ensure enrollees of all ages have access to the services needed. The MMA plans must maintain written care coordination/case management and continuity of care protocols that include a mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs. Further, the MMA plans are required to submit a provider network file of all participating providers on a weekly basis. This report can be used to monitor the plan's compliance with network adequacy requirements and access to care standards.

  The MMA plans are also required to offer training to all providers and their staff regarding the special needs of enrollees.

  The Agency has also adopted specific quality performance measures under the MMA program that focus on improving the health outcomes for individuals with special health care needs.

- Comments were received on the state's Comprehensive Quality Strategy regarding quality initiatives, Medicaid Fair Hearing reporting, and the grievance and appeal process for beneficiaries.

The Agency considered all comments received in the development of the draft Comprehensive Quality Strategy submitted to Federal CMS on October 10, 2013. The Agency will work with Federal CMS to finalize the strategy in accordance with the terms and conditions of the waiver.

- Concerns were expressed with the existing Medicaid Reform program prior to implementation of the MMA program to include:
    - Urging Federal CMS to not grant additional waiver authority until roll out of the MMA program has completed and is thoroughly evaluated.
    - Concerns with utilization rates being used as a basis for reporting care received.
    - Urging the Agency take additional measures to ensure the expansion of Medicaid.
    - Building in additional opportunities to receive and meaningfully use public input from all stakeholders.

Section III of the document describes the public input process the state utilized to solicit feedback on the three-year extension request for the 1115 MMA waiver. All comments received were considered in the development of this waiver extension request. Section VI of this document provides the quality initiatives, including plan performance that occurred during the current waiver period and outlines the quality initiatives that will be undertaken during the proposed extension period.

The Agency will continue to solicit feedback from the public (public meetings, web based training sessions, etc.) as we implement the new program.

Please note that comments received as of November 21, 2013 after the end of the 30-day public comment period, fall into the groupings discussed above. The Agency took all comments received under consideration in the development of this waiver extension request.

The Agency established a dedicated email box (FLMedicaidWaivers@ahca.myflorida.com) to receive comments on an ongoing basis regarding the MMA program.

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