Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

2nd Quarter Report
October 1, 2014 – December 31, 2014
Demonstration Year 9

This page intentionally left blank.

Table of Contents

I. Waiver History **1**

II. Operational Update **3**

1. *Health Care Delivery System* *3*
2. *Choice Counseling Program* *6*
3. *Healthy Behaviors Programs* *8*
4. *MMA Plan and Regional Enrollment Data* *8*
5. *Policy and Administrative Issues* *9*

III. Low Income Pool **10**

IV. Demonstration Goals **12**

V. Monitoring Budget Neutrality **14**

VI. Encounter and Utilization Data **15**

VII. Evaluation of the Demonstration **16**

VIII. Quality **18**

Attachment I Summary of Comments of the Annual Post Award Forum **20**

Attachment II Expanded Benefits under the MMA Program **22**

Attachment III Enhanced Benefits Account Program **23**

Attachment IV MMA Enrollment Report **25**

Attachment V Budget Neutrality Update **30**

List of Tables

Table 1 MMA Plans **3**

Table 2 MMA Plan Reported Complaints **4**

Table 3 MMA Grievances and Appeals **5**

Table 4 MMA MFHs Requested and Held **5**

Table 5 MMA SAP Requests **5**

Table 6 Agency-Received MMA Complaints/Issues **5**

Table 7 Online Enrollment Statistics **6**

Table 8 Call Volume for Incoming and Outgoing Calls **7**

Table 9 Outbound Mail Activities **7**

Table 10 Choice Counseling Outreach Activities **7**

Table 11 Self-Selection and Auto-Assignment Rates **8**

This page intentionally left blank.

I. Waiver History

On July 31, 2014, the Centers for Medicare and Medicaid Services (CMS) approved a three-year extension of the Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver (MMA Waiver). The approved waiver extension documents can be viewed on the Agency for Health Care Administration's (Agency's) Web site at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml. The approval of the extension continues the improvements established in the June 2013 amendment provided below and authorized a one-year extension of the Low Income Pool (LIP) until June 30, 2015.

On June 14, 2013, CMS approved an amendment to the waiver to implement the Managed Medical Assistance (MMA) program. The approved waiver amendment documents can be viewed on the Agency's Web site at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_approved.shtml.

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

- Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;
- Ensures the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan;
- Ensures recipient complaints, grievances, and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishes Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires MMA 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 MMA plan's encounter data every three years;
- Enhances consumer report cards to ensure recipients have access to understandable summaries of quality, access, and timeliness regarding the performance of each participating MMA plan;
- Enhances the MMA plan's performance improvement projects (PIPs) 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 MMA plan quality and access to care to improve MMA 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.

In accordance with STC # 17, Attachment I provides a summary of the Post Award Forum, which was held on September 23, 2014.

Quarterly Report Requirement

The state is required to submit a quarterly report summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery.

This report is the second quarterly report for Demonstration Year 9 (DY9) covering the period of October 1, 2014, through December 31, 2014. For detailed information about the activities that occurred during previous quarters of the demonstration, please refer to the quarterly and annual reports at: http://ahca.myflorida.com/Medicaid/statewide_mc/mma_federal_reports.shtml.

II. Operational Update

1. Health Care Delivery System

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

a) MMA Plan Contracting

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

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

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

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

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

b) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment II of this report, Expanded Benefits Under the MMA Program, the MMA plans provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid coverage and limitations handbooks, and, where applicable, the Florida Medicaid fee schedules.

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

Required MMA Services	
(1)	Advanced Registered Nurse Practitioner Services
(2)	Ambulatory Surgical Center Services
(3)	Assistive Care Services
(4)	Behavioral Health Services
(5)	Birth Center and Licensed Midwife Services
(6)	Clinic Services
(7)	Chiropractic Services
(8)	Dental Services
(9)	Child Health Check-Up
(10)	Immunizations
(11)	Emergency Services
(12)	Emergency Behavioral Health Services
(13)	Family Planning Services and Supplies
(14)	Healthy Start Services
(15)	Hearing Services
(16)	Home Health Services and Nursing Care
(17)	Hospice Services
(18)	Hospital Services
(19)	Laboratory and Imaging Services
(20)	Medical Supplies, Equipment, Prostheses and Orthoses
(21)	Optometric and Vision Services
(22)	Physician Assistant Services
(23)	Podiatric Services
(24)	Practitioner Services
(25)	Prescribed Drug Services
(26)	Renal Dialysis Services
(27)	Therapy Services
(28)	Transportation Services

The MMA plans are required to cover most Florida Medicaid State Plan services and to provide access to additional services covered under early and periodic screening, diagnosis and treatment through a special services request process. Services specialized for children in foster care include: specialized therapeutic foster care, comprehensive behavioral health assessment, behavioral health overlay services for children in child welfare settings, and medical foster care.

c) MMA Plan Reported Complaints, Grievances, and Appeals

MMA Plan Reported Complaints

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

Table 2
MMA Plan Reported Complaints
(October 1, 2014 – December 31, 2014)

Quarter	Total
October 1, 2014 – December 31, 2014	12,373

Grievances and Appeals

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

Table 3 MMA Grievances and Appeals (October 1, 2014 – December 31, 2014)		
Quarter	**Total Grievances**	**Total Appeals**
October 1, 2014 – December 31, 2014	3,715	2,304

Medicaid Fair Hearing (MFH)

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

Table 4 MMA MFHs Requested and Held (October 1, 2014 – December 31, 2014)		
Quarter	**MFHs Requested**	**MFHs Held**
October 1, 2014 – December 31, 2014	267	53

Subscriber Assistance Program

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

Table 5 MMA SAP Requests (October 1, 2014 – December 31, 2014)	
Quarter	**Total**
October 1, 2014 – December 31, 2014	6

d) Agency-Received Complaints/Issues

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

Table 6 Agency-Received MMA Complaints/Issues (October 1, 2014 – December 31, 2014)	
Quarter	**Total**
October 1, 2014 – December 31, 2014	1,443

e) Medical Loss Ratio

During this quarter, eleven capitated plans submitted their third-quarter MLR reports for DY8 to the Agency. The Agency submitted the capitated plans' MLR results to CMS in November 2014. One of the eleven capitated plans reported an MLR below 85% for the reporting period. The capitated plans' MLR data are evaluated annually to determine compliance, and quarterly reports are provided for informational purposes. Seasonality and inherent claims volatility may cause MLR results to fluctuate somewhat from quarter to quarter, especially for smaller plans.

f) MMA Plan Readiness Review and Monitoring

Now that the Agency has completed implementation of the SMMC program, Agency staff is preparing operationally for the ongoing monitoring of the MMA plans. The Agency is working with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO), to develop tools that will be used to centrally record the results of monitoring of the MMA plans. The Agency continues to hold monthly calls in the form of an "All-Plan" call, and also holds weekly calls with each individual MMA plan. The Agency continues to monitor the MMA plans regularly and handle issues as they arise. Staff continues to analyze complaints as they come into the Agency and works with each MMA plan to ensure timely resolution of these issues. Further, the Agency has created two field-based plan management offices to allow for a staff presence in the areas where most of the MMA plans' offices are located and allow for quicker access to MMA plans should issues arise.

2. Choice Counseling Program

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

a) Online Enrollment

Table 7 shows the number of online enrollments by month for this quarter.

Table 7
Online Enrollment Statistics
(October 1, 2014 – December 31, 2014)

	October	November	December	Total
Enrollments	24,947	16,107	14,894	**55,948**

b) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00 a.m. – 8:00 p.m., and Friday 8:00 a.m. – 7:00 p.m. During this quarter, the call center had an average of 274 full time equivalent employees available to answer calls.

Table 8 provides the call center statistics for this quarter. The choice counseling calls remain within the anticipated call volume for the quarter.

Table 8 Call Volume for Incoming and Outgoing Calls (October 1, 2014 – December 31, 2014)				
Type of Calls	**October**	**November**	**December**	**Totals**
Incoming Calls	100,550	66,889	77,135	**244,574**
Outgoing Calls	4,099	1,804	2,340	**8,243**
Totals	**104,649**	**68,693**	**79,475**	**252,817**

Mail

Table 9 provides the choice counseling mail activities for this quarter.

Table 9 Outbound Mail Activities (October 1, 2014 – December 31, 2014)	
Mail Activities	**Totals**
New-Eligible Packets*	247,384
Confirmation Letters	244,688
Open Enrollment Packets	7,964

*Mandatory and voluntary.

Face-to-Face/Outreach and Education

Table 10 provides the choice counseling outreach activities for this quarter.

Table 10 Choice Counseling Outreach Activities (October 1, 2014 – December 31, 2014)	
Field Activities	**Totals**
Group Sessions	326
Private Sessions	78
Home Visits and One-On-One Sessions	255

Quality Improvement

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rate their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the survey to every recipient who calls to enroll in an MMA plan or to make a plan change. The Agency is currently reviewing the survey for changes and improvements, as well as to assure all questions are still valid for the MMA program.

c) Self-Selection and Auto-Assignment Rates

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

Table 11
Self-Selection and Auto-Assignment Rates
(October 1, 2014 – December 31, 2014)

	October	November	December
Self-Selected	95,280	95,398	100,483
Auto-Assignment	65,335	121,724	68,787
Total Enrollments	160,615	217,122	169,270
Self-Selected %	59.32%	43.94%	59.36%
Auto-Assignment %	40.68%	56.06%	40.64%

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

3. Healthy Behaviors Programs

Healthy Behaviors Programs

The MMA plan's Healthy Behaviors programs were approved for an October 1, 2014, implementation with the exception of one specialty health plan, which was not required to submit its program until January 2015.

Enhanced Benefits Account Program

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

4. MMA Plan and Regional Enrollment Data

Attachment IV of this report, MMA Enrollment Report, provides an update of MMA plan and regional enrollment for the period October 1, 2014, through December 31, 2014, and contains the following enrollment reports:

- Number of MMA plans and
- Regional MMA enrollment.

5. Policy and Administrative Issues

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

Contract Amendments

During this quarter, the Agency finalized a general contract amendment for the MMA plans, effective October 1, 2014, which incorporated corrections and changes to the MMA plans' contracts. A copy of the model contract may be viewed on the Agency's Web site at the following link: http://ahca.myflorida.com/SMMC. In addition, the Agency finalized a contract amendment, transitioning First Coast Advantage's (FCA's) enrollment to Molina as a result of Molina's acquisition of FCA, effective December 1, 2014. Also during this quarter, the Agency finalized revisions to the Statewide Medicaid Managed Care (SMMC) Report Guide to include corrections and new reporting requirements, and also began to gather items for the next general contract amendment.

Agency Communications to MMA Plans

There were three contract interpretations and six policy transmittals released to the MMA plans during this quarter.

The contract interpretations advised MMA plans of the following:

- Provided guidance related to the primary payer of expanded benefits when the benefit is offered by both the long-term care (LTC) plan and the MMA plan.
- Provided guidance on the provision of newborn hearing screening services and the newborn screening services covered under the MMA contract.
- Notified MMA plans of an exception regarding the use of authorization forms specified in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

The policy transmittals advised the MMA plans of the following:

- Notified the MMA plans of a new ad hoc report requirement regarding the Achieved Savings Financial Report.
- Notified MMA plans of the requirement to begin submitting a monthly ad hoc report of their performance on enrollee helpline standards and provider helpline standards contained in the contract.
- Instructed MMA plans on the reporting of procedure codes used to reimburse for tobacco cessation counseling for pregnant women in accordance with the Affordable Care Act and the Florida Medicaid State Plan.
- Provided MMA plans with the Agency-prescribed Notice of Action template and instructions for implementation of the template.
- Informed MMA plans of an ad hoc request for financial reporting policies and procedures.

III. Low Income Pool

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

a) LIP Council Meetings

Pursuant to Section 409.911, F.S., the sunset of the LIP Council was last quarter. Therefore, the Agency did not hold any LIP Council meetings during this quarter and this section of the report will end.

b) DY8 LIP STCs – Reporting Requirements

The following provides an update of the DY8 LIP STCs that required action during this quarter.

STC #84d – LIP Tier-One Milestones

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

- The Agency anticipates submitting the data to the University of Florida for the completion of the annual *Milestone Statistics and Findings Report* for DY8 in the third quarter of DY9.
- The Agency anticipates submitting data to the University of Florida for the completion of the annual *Primary Care and Alternative Delivery Systems Report* for DY8 in the third quarter of DY9.

STC #85 – LIP Tier-Two Milestones

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

- On October 6, 2014, the Agency submitted the fourth-quarter reporting for state fiscal year 2013-14 for the 44 hospital initiatives.

c) Current (DY9) LIP STCs – Reporting Requirements

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

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

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

- On September 29, 2014, the Agency submitted the draft RFMD for DY9 and is awaiting feedback from CMS.

STC #79d – LIP Tier-One Milestones

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

- On September 29, 2014, the Agency submitted the anticipated timeline for the two annual reports and is awaiting feedback from CMS.

IV. Demonstration Goals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 3: To ensure that enrollee satisfaction increases.

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

Objective 4: To evaluate the impact of the LIP on increased access for uninsured individuals.

STC #79 – Tier-One Milestones

As reported under this STC, both the *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report* will show the increased access to medical care for the uninsured population in Florida. Both reports can be viewed on the Agency's Web site at the following link:
http://www.ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml. Please refer to Section III of this report, Low Income Pool, for an update (if available) on both Tier-One Milestone reports.

Final Evaluation Plan

The required demonstration evaluation will include specific studies regarding access to care and quality of care as affected by the Tier-One and Tier-Two initiatives in accordance with the STCs of the waiver. On December 31, 2014, CMS approved the Agency's Final Evaluation Design. When available, the results of the evaluation will be reported under Section VII of this report, Evaluation of the Demonstration.

V. Monitoring Budget Neutrality

In accordance with the requirements of the approved MMA Waiver, the state must monitor the status of the program on a fiscal basis. To comply with this requirement, the state will submit waiver templates on the quarterly CMS-64 reports. The submission of the CMS-64 reports will include administrative and service expenditures. For purposes of monitoring the budget neutrality of the program, only service expenditures are compared to the projected without-waiver expenditures approved through the waiver.

Updated Budget Neutrality

The MMA Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 Waiver, the budget neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. During this quarter, MMA program was operational in all regions of the State. The case months and expenditures reported are for enrolled mandatory and voluntary

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the budget neutrality, as required by STC #88, is monitored using data based on date of service. The PMPM and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency will track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year.

Please refer to Attachment V of this report, Budget Neutrality Update, for an update on budget neutrality figures through the second quarter (October 1, 2014 – December 31, 2014) of DY9.

VI. Encounter and Utilization Data

a) Encounter Data

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

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

The Agency and the Medicaid fiscal agent developed new outreach activities to assist the MMA plans with encounter submissions and submission issues. The outreach efforts include creation of an encounter support e-mail box and onsite and teleconference meetings with the MMA plans.

b) Rate Setting/Risk Adjustment

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

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

VII. Evaluation of the Demonstration

The evaluation of the demonstration is an ongoing process to be conducted during the life of the demonstration. The Agency is required under STCs #104 – 107 to complete an evaluation design that includes a discussion of the goals, objectives and specific hypotheses that are being tested to determine the impact of the demonstration during the period of approval. During the first quarter of DY9, the Agency made revisions to the updated evaluation design for the MMA program, based on comments received from CMS at the end of May 2014. Agency staff held calls with CMS in July and August to obtain clarification on some of the written comments, and finished revising the evaluation design. The revised design was submitted to CMS at the end of October 2014, and CMS approved the updated evaluation design on December 31, 2014.

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

Pending and Upcoming Evaluation Reports and Activities

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

- The Agency submitted the draft Final Evaluation Summary Report to CMS on October 28, 2014. Key findings of this report include:
  - Overall, respondent self-reports indicate that enrollees in the Reform counties perceive services to be accessible. There were increases across several access measures in both Reform and Non-Reform counties between DY6 and DY8. In general, changes were not statistically significant.
  - To some extent, there appear to be improvements in respondent self-report of obtaining health services. Over time, there was a significant increase in the percentage of enrollees having a personal doctor in urban Reform counties. There was a statistically significant increase over time in the percentage of enrollees who saw a doctor for non-urgent care one to three times in the previous six months, and a decrease in the percentage of enrollees with four or more non-urgent visits.
  - The quality of care that enrollees receive improved during the demonstration for 10 of 12 Healthcare Effectiveness Data & Information Set (HEDIS) chronic disease measures. The measures that declined had minimal average annual decreases.
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) results indicate that in the urban Reform counties, there was a significant increase over time in enrollees reporting the highest level rating for their health plans. Increases in other measures were not statistically significant.
  - In the urban Reform counties, there was a statistically significant increase over time in the percentage of enrollees who were "Always" able to get urgent and non-urgent care as soon as they wanted. From DY6 to DY8 in Reform counties, there was a significant increase in the percentage of enrollees who reported

"Always" getting urgent care right away and getting an appointment as soon as they needed.

- Overall, PMPM expenditures were greater in the Reform counties compared to the Control counties for Supplemental Security Income (SSI) enrollees. However, for SSI enrollees, the rate of growth was lower in the Reform counties relative to the Control counties, suggesting that the Reform counties will achieve savings over time if the current trend continues in the future.
- From DY2 through DY7, enrollees earned $63,820,095 in EBA credits, and 60% of the earned credits were spent on eligible purchases.

- The Agency will solicit proposals from Florida state universities to conduct the MMA Waiver evaluation during the third quarter of DY9.

VIII. Quality

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

a) EQRO

During the second quarter of DY9, HSAG submitted the Performance Measure Validation Findings Report (covering calendar year 2013 data) to the Agency for review. The report was approved in December, and the findings will be included in the Technical Report, which is due in the third quarter of DY9.

HSAG submitted a deemed compliance crosswalk proposal in October. This project will involve HSAG reviewing the Medicaid MMA plans' accreditation standards and completing a crosswalk to indicate which standards could potentially be deemed, along with providing recommendations for non-duplication deeming. The Agency provided HSAG with some feedback on the proposal and HSAG submitted a revised version to the Agency in December.

In November, HSAG submitted the draft PIP Validation Reports to the Agency, and they were forwarded to the MMA plans for review in December.

On November 18, 2014, HSAG conducted a face-to-face external quality review quarterly meeting for the MMA plans. The Agency solicited presentations in a variety of areas, with an emphasis on making the MMA plans aware of available resources and strategies for improving health and health care for their members. The presentations included:

- "What is Infant and Early Childhood Mental Health?"
- "School-based Dental Sealant Programs"
- "Increasing Prenatal, Postpartum, and Well Child Visits within the Medicaid Managed Care System"
- "Successes in Asthma Management: Case Studies from Boston and North Carolina"
- "A Patient Care Business: Communications that Make a Difference"
- "Health Plan Report Card – Opportunity for Plans to Provide Feedback"

There were 49 attendees from the MMA plans, the Agency, the Department of Elder Affairs, the Department of Health, Florida State University, and the University of Florida.

During the second quarter of DY9, HSAG submitted encounter data requests to the MMA plans and the Agency for EDV activities. In December, HSAG held a call with the MMA plans and the MMA plans submitted their data to HSAG. For the Pharmacy EDV project, HSAG submitted two interim reports on Comparative Analysis and Remittance Advice Analysis findings to the Agency for review.

b) Plan Performance Measure Reporting

During the first quarter of DY9, the Agency received the seventh year of performance measure submissions from the managed care plans prior to MMA implementation. Results and highlights of the seventh year of performance measures (representing calendar year 2013) were included in the first quarter report for DY9.

During the second quarter of DY9, Agency staff prepared a communication to the MMA plans that clarified some performance measure reporting requirements for the report due July 1, 2015 (representing calendar year 2014). This communication will go out to the MMA plans at the beginning of the third quarter. Agency staff also revised the SMMC Report Guide instructions for the CMS-416/Child Health Check-Up Report to mirror the revisions released by CMS in November. A policy transmittal with the revised instructions will be sent to the MMA plans in January. The reports are due to the Agency by February 20, 2015.

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

c) Comprehensive Quality Strategy

During the second quarter of DY9, Agency staff compiled and reviewed all the feedback and comments that were received regarding the Comprehensive Quality Strategy. The Agency submitted the draft updated Comprehensive Quality Strategy to CMS at the end of October 2014.

d) Assessing Enrollee Satisfaction

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

Under the MMA program, the MMA plans are required to contract with a National Committee for Quality Assurance-certified CAHPS Survey Vendor to conduct their CAHPS Surveys for Children and Adults on an annual basis. MMA plans are required to submit their survey results to the Agency by July 1 of each year, beginning with 2015. During this quarter, Agency staff reviewed and approved the MMA plans' Enrollee Survey Proposals and began reviewing the MMA plans' survey materials.

Attachment I
Summary of Comments of the Annual Post Award Forum

The Agency for Health Care Administration (Agency) held its annual Post Award Forum, which afforded the public an opportunity to provide meaningful comment on the progress of the Managed Medical Assistance (MMA) Program, on September 23, 2014, in compliance with the Special Terms and Condition #17 of Florida's 1115 MMA Waiver. The State published a public notice, which contained the date, time, and location of the planned public forum, on August 22, 2014, in a prominent location on the Agency's Web site and in the Florida Administrative Register. Florida utilized its Medical Care Advisory Committee to conduct the public forum. The following summarizes the public comments, grouped by topic, received during the forum.

<u>Choice Counseling</u>
Concerns were expressed related to communication with the counselors related to children, specifically foster children.

<u>Recipient Enrollment</u>
Clarification was requested as to whether dual eligibles have the opportunity to enroll in Medicaid and Medicare Advantage and concerns were expressed regarding communication with the Agency on enrollment issues.

<u>Provider Enrollment</u>
Request was received for an update on plan enrollment and concerns were expressed regarding the unwillingness of providers to join plans, provider qualifications, and the length of time it is taking certain MMA plans to credential providers.

<u>Network Adequacy Standards</u>
Concerns were expressed regarding provider network adequacy related to children with special health care needs and those in foster care and whether the MMA plans' provider networks were adequate to serve their enrollees.

<u>Access to Services</u>
Concerns were expressed relating to the Early Steps Program and the Children's Medical Services Network; behavioral health treatment during pregnancy; dental care for children with special health care needs and those in foster care; therapy, durable medical equipment, transportation, and specialty services; specialists, in- and out-of-state, the medical practice borders between Florida and Georgia; and accessing client files and exchange from the Agency.

Comments were received regarding the continuity of care provisions, the transitional protections the Agency has in place, and some recipients experiencing gaps in services when changing from fee-for-service to MMA.

A recommendation was made for additional guidance and to engage an ombudsman.

<u>Service Authorization</u>
Concerns were expressed regarding authorization for medications, mail-order pharmacies and therapy services.

Reimbursement
Concerns were expressed related to provider claim payments for children with special health care needs and those in foster care, inconsistencies in the MMA plans' reimbursement amounts for dental services, and communication with the Agency on reimbursement issues.

Managed Care Plan Name
Clarification was requested as to whether Wellcare Plan was now being called StayWell.

General
A request was made for an update on what would happen after 2017.

Attachment II
Expanded Benefits under the MMA Program

Expanded benefits are those services or benefits not otherwise covered in the MMA program's list of required services, or that exceed limits outlined in the Florida Medicaid State Plan and the Florida Medicaid coverage and limitations handbooks and fee schedules. The MMA plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA plans, upon approval by the Agency. The MMA plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the Agency. The chart below lists the expanded benefits approved by the Agency that are being offered by the MMA standard plans in 2014.

Expanded Benefits Offered by MMA Standard Plans

List of Expanded Benefits	MMA Standard Plans													
	Amerigroup	Better Health	Coventry	First Coast	Humana	Integral	Molina	Preferred	Prestige	SFCCN	Simply	Staywell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y			Y	Y (Region 1 only)	Y	Y	Y		Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y				Y		Y					Y	Y	
Equine therapy												Y		
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y (Region 1 only)	Y		Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Medically related lodging & food		Y			Y	Y (Region 1 only)	Y		Y		Y	Y	Y	
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y			Y	Y		Y	Y		Y	Y	Y	
Outpatient hospital services (Expanded)	Y	Y			Y	Y (Region 1 only)	Y	Y	Y		Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y
Pet therapy					Y		Y					Y		
Physician home visits	Y	Y			Y	Y (Region 1 only)	Y		Y		Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y
Post-discharge meals	Y	Y			Y	Y	Y	Y			Y	Y	Y	Y
Prenatal/perinatal visits (Expanded)	Y	Y			Y	Y	Y	Y	Y		Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y (Region 1 only)	Y		Y		Y	Y	Y	Y
Waived co-payments	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Note: Details regarding scope of covered benefit may vary by MMA plan. FCA enrollment was transitioned to Molina as of December 1, 2014.

Attachment III
Enhanced Benefits Account Program

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

Call Center Activities

The enhanced benefits call center, managed by the choice counseling vendor (Automated Health Systems), located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for hearing-impaired callers. The call center answers all inbound calls relating to program questions, provides EBA 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 8:00 a.m. – 8:00 p.m., and Friday 8:00 a.m. – 7:00 p.m.

The Automated Voice Response System (AVRS), which provides recipients balance-only information, handled 7,664 calls during this quarter. Chart A of Attachment III highlights the enhanced benefits call center and mailroom activities during this quarter.

Chart A
Highlights of the Enhanced Benefits Call Center Activities
(October 1, 2014 – December 31, 2014)

Enhanced Benefits Call Center Activity	October	November	December
Calls Received	1,553	892	1,456
Calls Answered	1,549	891	1,452
Average Talk Time (minutes)	4:21	4:35	4:30
Calls Handled by the AVRS	3,138	2,096	2,430
Outbound Calls	1	3	4
Enhanced Benefits Mailroom Activity			
Enhanced Benefits Welcome Letters	0	0	0

Outreach and Education

During this quarter, the call center did not mail any welcome letters. There were 5,887 coupon statements mailed during this quarter. The choice counselors continue to provide up-to-date information for recipients regarding their EBA balances.

Complaints

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

Chart B **Enhanced Benefits Recipient Complaints** (October 1, 2014 – December 31, 2014)	
Recipient Complaint	**Action Taken**
There were no complaints reported by the enhanced benefits call center this quarter.	N/A

Enhanced Benefits Statistics

As of the end of this quarter, 14,383 recipients lost EBA eligibility resulting in losing EBA credits, totaling $645,625.66. Chart C of Attachment III provides the EBA program statistics during this quarter.

Chart C **EBA Program Statistics** (October 1, 2014 – December 31, 2014)				
Activities		**October**	**November**	**December**
I.	Number of plans submitting reports by month in each county	23*	**	**
II.	Number of enrollees who received credit for healthy behaviors by month	1,030*	**	**
III.	Total dollar amount credited to accounts by each month	$25,730.00*	**	**
IV.	Total cumulative dollar amount credited through the end each month	$83,533,013.66	**	**
V.	Total dollar amount of credits used each month by date of service	$203,775.20	$141,140.79	$152,670.00
VI.	Total cumulative dollar amount of credits used through the month by date of service	$49,767,910.13	$49,767,910.13	$50,061,720.92
VII.	Total unduplicated number of enrollees who used credits each month	7,610	5,454	5,565

* October reporting is reflective of month the Enhanced Benefits Report is due by Reform health plans (no longer reflective of dates of service).

** Reform health plans are no longer required to submit the Enhanced Benefits Report.

Enhanced Benefits Advisory Panel

There was no Enhanced Benefits Advisory Panel meeting held during this quarter.

Notice of EBA Program Phase-Out

During this quarter, 232,687 notices were mailed to recipients in Duval, Baker, Clay, and Nassau counties regarding the phase-out of the EBA program; Broward county recipients will be mailed notices in January 2015.

Attachment IV
MMA Enrollment Report

Number of MMA Plans in Regions Report

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

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

Chart A of Attachment IV provides the number of general and specialty MMA plans in each region.

Chart A Number of MMA Plans by Region (October 1, 2014 – December 31, 2014)		
Region	**General**	**Specialty**
1	2	3
2	2	4
3	4	3
4	4	3
5	4	4
6	7	4
7	6	4
8	4	3
9	4	4
10	4	5
11	10	5
Unduplicated Totals	**14**	**5**

MMA Enrollment

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

Chart B MMA Enrollment by Plan and Type Report Descriptions	
Column Name	**Column Description**
Plan Name	Name of the MMA plan
Plan Type	MMA plan type (General or Specialty)
Number of TANF Enrolled	Number of TANF recipients enrolled with the MMA plan
Number of SSI Enrolled - No Medicare	Number of SSI recipients enrolled with the MMA plan and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	Number of SSI recipients enrolled with the MMA plan and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	Number of SSI recipients enrolled with the MMA plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	Total number of enrollees with the MMA plan; TANF and SSI combined
Market Share for MMA	Percentage of the MMA population compared to the entire enrollment for the quarter being reported
Enrolled in Previous Quarter	Total number of recipients (TANF and SSI) who were enrolled in an MMA plan during the previous reporting quarter
Percent Change from Previous Quarter	Change in percentage of the MMA plan's enrollment from the previous reporting quarter to the current reporting quarter

Chart C of Attachment IV lists, by MMA plan and type, for this quarter and compared to last quarter, the total number of TANF and SSI individuals enrolled, and the corresponding market share. In addition, the total MMA enrollment counts are included at the bottom of the chart.

Chard D of Attachment IV lists enrollment by region and MMA plan type, for this quarter and compared to last quarter, the total number of TANF and SSI individuals enrolled and the corresponding market share. In addition, the total MMA enrollment counts are included at the bottom of the chart.

Chart C
MMA Enrollment by Plan and Type*
(October 1, 2014 – December 31, 2014)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	General	284,776	30,223	66	15,208	**330,323**	11.1%	**318,212**	**3.81%**
Better Health	General	79,850	9,041	12	4,051	**92,954**	3.1%	**91,711**	**1.36%**
Coventry Health Care of Florida	General	37,745	4,185	26	3,375	**45,331**	1.5%	**45,076**	**0.57%**
First Coast Advantage	General	56,588	7,512	2	1,776	**65,878**	2.2%	**67,712**	**-2.71%**
Humana Medical Plan	General	233,200	33,813	143	23,544	**290,700**	9.8%	**272,236**	**6.78%**
Integral Quality Care	General	78,972	7,954	9	5,304	**92,239**	3.1%	**91,647**	**0.65%**
Molina Healthcare of Florida	General	85,619	8,490	28	6,662	**100,799**	3.4%	**95,828**	**5.19%**
Preferred Medical Plan	General	23,234	3,690	28	2,722	**29,674**	1.0%	**30,108**	**-1.44%**
Prestige Health Choice	General	254,526	31,206	38	19,318	**305,088**	10.3%	**297,136**	**2.68%**
South Florida Community Care Network	General	38,778	3,686	5	1,775	**44,244**	1.5%	**44,399**	**-0.35%**
Simply Healthcare	General	59,449	12,387	124	10,454	**82,414**	2.8%	**80,499**	**2.38%**
Staywell Health Plan	General	576,252	65,936	63	27,599	**669,850**	22.6%	**649,332**	**3.16%**
Sunshine State Health Plan	General	331,835	36,079	72	42,738	**410,724**	13.8%	**400,080**	**2.66%**
United Healthcare of Florida	General	211,447	28,304	73	27,769	**267,593**	9.0%	**254,864**	**4.99%**
Standard Plans Total		**2,352,271**	**282,556**	**689**	**192,295**	**2,827,811**	**95.3%**	**2,738,840**	**3.25%**
Positive Health Plan	Specialty	204	963	2	580	**1,749**	0.1%	**1,884**	**-7.17%**
Magellan Complete Care	Specialty	18,350	20,162	12	274	**38,798**	1.3%	**44,350**	**-12.52%**
Clear Health Alliance	Specialty	1,168	4,759	2	3,213	**9,142**	0.3%	**9,265**	**-1.33%**
Sunshine State Health Plan	Specialty	21,212	1,960	0	3	**23,175**	0.8%	**22,577**	**2.65%**
Children's Medical Services Network	Specialty	40,150	26,158	0	117	**66,425**	2.2%	**62,983**	**5.46%**
Specialty Plans Total		**81,084**	**54,002**	**16**	**4,187**	**139,289**	**4.7%**	**141,059**	**-1.25%**
MMA TOTAL		**2,433,355**	**336,558**	**705**	**196,482**	**2,967,100**	**100%**	**2,879,899**	**3.03%**

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

Chart D MMA Enrollment by Region and Type (October 1, 2014 – December 31, 2014)									
Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	MMA	**80,438**	11,289	2	6,286	**98,015**	3.3%	**92,307**	6.2%
02	MMA	**88,619**	14,596	10	8,564	**111,789**	3.8%	**109,915**	1.7%
03	MMA	**206,497**	29,467	19	16,024	**252,007**	8.5%	**246,419**	2.3%
04	MMA	**248,296**	30,855	17	17,137	**296,305**	10.0%	**291,275**	1.7%
05	MMA	**145,317**	21,622	15	13,962	**180,916**	6.1%	**176,658**	2.4%
06	MMA	**340,684**	46,513	35	20,050	**407,282**	13.7%	**401,384**	1.5%
07	MMA	**324,367**	44,342	48	17,957	**386,714**	13.0%	**361,936**	6.8%
08	MMA	**176,649**	18,339	20	12,917	**207,925**	7.0%	**202,785**	2.5%
09	MMA	**213,396**	24,234	29	14,164	**251,823**	8.5%	**237,524**	6.0%
10	MMA	**209,114**	26,528	68	14,450	**250,160**	8.4%	**243,154**	2.9%
11	MMA	**399,978**	68,773	442	54,971	**524,164**	17.7%	**516,542**	1.5%
MMA Total		**2,433,355**	**11,289**	**2**	**6,286**	**98,015**	**100.0%**	**2,879,899**	**3.0%**
01	General	**78,442**	10,279	2	6,203	**94,926**	3.4%	**89,327**	6.3%
02	General	**83,331**	11,602	9	8,468	**103,410**	3.7%	**101,191**	2.2%
03	General	**200,340**	26,580	19	15,816	**242,755**	8.6%	**237,298**	2.3%
04	General	**238,891**	25,932	15	17,097	**281,935**	10.0%	**275,538**	2.3%
05	General	**138,998**	17,717	14	13,414	**170,143**	6.0%	**165,271**	2.9%
06	General	**329,603**	38,675	32	19,741	**388,051**	13.7%	**380,926**	1.9%
07	General	**312,272**	35,860	47	17,471	**365,650**	12.9%	**342,206**	6.9%
08	General	**171,585**	16,199	20	12,698	**200,502**	7.1%	**195,397**	2.6%
09	General	**205,342**	19,273	27	13,662	**238,304**	8.4%	**224,851**	6.0%
10	General	**201,213**	20,600	67	13,933	**235,813**	8.3%	**228,751**	3.1%
11	General	**392,254**	59,839	437	53,792	**506,322**	17.9%	**498,084**	1.7%
General Total		**2,352,271**	**282,556**	**689**	**192,295**	**2,827,811**	**100.0%**	**2,738,840**	**3.2%**

Chart D
MMA Enrollment by Region and Type
(October 1, 2014 – December 31, 2014)

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	Specialty	**1,996**	1,010	-	83	**3,089**	2.2%	**2,980**	**3.7%**
02	Specialty	**5,288**	2,994	1	96	**8,379**	6.0%	**8,724**	**-4.0%**
03	Specialty	**6,157**	2,887	-	208	**9,252**	6.6%	**9,121**	**1.4%**
04	Specialty	**9,405**	4,923	2	40	**14,370**	10.3%	**15,737**	**-8.7%**
05	Specialty	**6,319**	3,905	1	548	**10,773**	7.7%	**11,387**	**-5.4%**
06	Specialty	**11,081**	7,838	3	309	**19,231**	13.8%	**20,458**	**-6.0%**
07	Specialty	**12,095**	8,482	1	486	**21,064**	15.1%	**19,730**	**6.8%**
08	Specialty	**5,064**	2,140	-	219	**7,423**	5.3%	**7,388**	**0.5%**
09	Specialty	**8,054**	4,961	2	502	**13,519**	9.7%	**12,673**	**6.7%**
10	Specialty	**7,901**	5,928	1	517	**14,347**	10.3%	**14,403**	**-0.4%**
11	Specialty	**7,724**	8,934	5	1,179	**17,842**	12.8%	**18,458**	**-3.3%**
Specialty Total		**81,084**	**53,003**	**5**	**4,230**	**139,289**	**100.0%**	**141,059**	**-1.3%**

Attachment V
Budget Neutrality Update

In Charts A through H of Attachment V, both date of service and date of payment data are presented. Charts that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Charts that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Charts B through H of Attachment V in accordance with STC #88.

In accordance with STC #88(d)(ii), the Agency has initiated the development of the new CMS-64 reporting operation that will be required to support the MMA Waiver. The new reporting operation was effective for the October 2014 – December 2014 reporting period.

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

Chart A PCCM Targets		
WOW* PCCM	**MEG** 1**	**MEG 2**
DY1	$948.79	$199.48
DY2	$1,024.69	$215.44
DY3	$1,106.67	$232.68
DY4	$1,195.20	$251.29
DY5	$1,290.82	$271.39
DY6	$1,356.65	$285.77
DY7	$1,425.84	$300.92
DY8	$1,498.56	$316.87
DY9	$786.70	$324.13
DY10	$818.95	$339.04
DY11	$852.53	$354.64

*Without waiver.

**Medicaid eligibility group.

The quarter beginning October 2014 (Q34 - date of payment) is the first complete quarter under the MMA program.

Charts B through H of Attachment V contain the statistics for MEGs 1, 2, and 3 for date of payment beginning with the period October 1, 2014, and ending December 31, 2014. Case months provided in Charts B and C for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Chart B MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case Months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	737,829	$534,465,763	$13,022,287	$547,488,050	$742.03
Q2 Total	741,024	$656,999,737	$40,270,607	$697,270,344	$940.96
Q3 Total	746,739	$627,627,027	$74,363,882	$701,990,909	$940.08
Q4 Total	752,823	$627,040,703	$98,024,915	$725,065,618	$963.13
Q5 Total	755,417	$630,937,251	$101,516,732	$732,453,983	$969.60
Q6 Total	755,837	$648,757,106	$106,374,845	$755,131,951	$999.07
Q7 Total	758,014	$651,490,311	$111,968,931	$763,459,242	$1,007.18
Q8 Total	764,701	$661,690,100	$115,206,649	$776,896,750	$1,015.95
Q9 Total	818,560	$708,946,109	$116,393,637	$825,339,746	$1,008.28
Q10 Total	791,043	$738,232,869	$128,914,992	$867,147,861	$1,096.21
Q11 Total	810,753	$783,046,121	$125,741,442	$908,787,564	$1,120.92
Q12 Total	829,386	$676,381,576	$120,999,077	$797,380,652	$961.41
Q13 Total	826,842	$846,747,351	$153,763,674	$1,000,511,025	$1,210.04
Q14 Total	830,530	$769,968,776	$137,267,631	$907,236,407	$1,092.36
Q15 Total	847,324	$781,783,604	$141,815,963	$923,599,567	$1,090.02
Q16 Total	852,445	$732,226,661	$129,489,247	$861,715,907	$1,010.88
Q17 Total	868,873	$880,557,949	$163,583,238	$1,044,141,187	$1,201.72
Q18 Total	876,564	$823,362,358	$147,720,232	$971,082,591	$1,107.83
Q19 Total	851,488	$793,116,969	$137,115,775	$930,232,743	$1,092.48
Q20 Total	902,833	$730,735,500	$137,409,896	$868,145,395	$961.58
Q21 Total	933,661	$897,184,808	$165,500,587	$1,062,685,395	$1,138.19
Q22 Total	916,713	$780,812,437	$149,928,159	$930,740,596	$1,015.30
Q23 Total	871,050	$806,728,589	$161,201,346	$967,929,935	$1,111.22
Q24 Total	932,443	$878,147,146	$168,609,996	$1,046,757,142	$1,122.60
Q25 Total	939,670	$876,968,622	$168,972,615	$1,045,941,236	$1,113.09
Q26Total	953,518	$865,669,039	$218,704,121	$1,084,373,159	$1,137.24
Q27 Total	964,650	$749,820,061	$229,337,800	$979,157,860	$1,015.04
Q28 Total	973,098	$855,023,277	$235,487,639	$1,090,510,916	$1,120.66
Q29 Total	982,712	$879,236,988	$234,142,785	$1,113,379,773	$1,132.97
Q30 Total	991,303	$894,044,760	$230,694,425	$1,124,739,185	$1,116.89
Q31 Total	1,007,552	$841,069,140	$201,039,197	$1,042,108,337	$1,034.30
Q32 Total	1,018,823	$882,045,900	$175,884,772	$1,057,930,671	$1,038.39
Q33 Total	1,025,818	$890,525,436	$136,560,571	$1,027,086,007	$1,001.24
October 2014	502,757			$555,474,500	$1,104.86
November 2014	501,310			$196,181,190	$391.34
December 2014	496,305			$555,849,242	$1,119.98
Q34 Total	**1,500,372**			**$1,307,504,932**	**$871.45**
MEG 1 Total	**30,130,408**	**25,401,390,043**	**4,777,027,664**	**$31,485,922,639**	**$1,044.99**

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

Chart C MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	3,944,437	$491,214,740	$1,723,494	$492,938,235	$124.97
Q2 Total	3,837,172	$590,933,703	$21,021,285	$611,954,988	$159.48
Q3 Total	3,728,063	$559,579,323	$44,697,737	$604,277,060	$162.09
Q4 Total	3,653,147	$524,161,918	$57,096,383	$581,258,301	$159.11
Q5 Total	3,588,363	$520,316,242	$57,360,334	$577,676,576	$160.99
Q6 Total	3,648,832	$553,763,665	$63,871,154	$617,634,819	$169.27
Q7 Total	3,736,212	$570,477,394	$69,992,290	$640,469,684	$171.42
Q8 Total	3,856,584	$564,601,990	$70,899,271	$635,501,261	$164.78
Q9 Total	4,080,307	$586,455,736	$70,031,931	$656,487,667	$160.89
Q10 Total	4,174,698	$659,100,473	$71,936,704	$731,037,178	$175.11
Q11 Total	4,298,379	$708,620,481	$73,835,227	$782,455,708	$182.04
Q12 Total	4,541,456	$581,030,798	$60,822,514	$641,853,312	$141.33
Q13 Total	4,772,864	$824,013,811	$98,637,714	$922,651,526	$193.31
Q14 Total	4,959,454	$768,385,369	$89,723,473	$858,108,842	$173.02
Q15 Total	5,098,381	$773,609,163	$93,647,855	$867,257,018	$170.10
Q16 Total	5,203,143	$793,529,141	$90,471,922	$884,001,063	$169.90
Q17 Total	5,356,742	$766,604,001	$91,544,719	$858,148,720	$160.20
Q18 Total	5,470,396	$848,694,828	$99,937,769	$948,632,597	$173.41
Q19 Total	5,247,390	$787,922,115	$91,638,763	$879,560,878	$167.62
Q20 Total	5,611,671	$673,700,632	$90,712,877	$764,413,510	$136.22
Q21 Total	5,695,156	$965,461,910	$121,274,250	$1,086,736,159	$190.82
Q22 Total	5,773,020	$778,633,250	$99,802,883	$878,436,134	$152.16
Q23 Total	5,592,756	$860,576,398	$115,331,882	$975,908,280	$174.50
Q24 Total	5,895,265	$922,979,983	$122,296,078	$1,045,276,061	$177.31
Q25 Total	6,013,128	$884,131,387	$121,673,666	$1,005,805,053	$167.27
Q26 Total	6,092,265	$1,016,884,642	$131,066,964	$1,147,951,606	$188.43
Q27 Total	6,117,120	$915,201,600	$133,635,131	$1,048,836,732	$171.46
Q28 Total	6,125,887	$1,018,851,885	$133,876,042	$1,152,727,927	$188.17
Q29 Total	6,179,797	$1,059,131,680	$75,589,844	$1,193,254,080	$193.09
Q30 Total	6,237,710	$1,070,712,185	$144,755,094	$1,215,467,279	$194.86
Q31 Total	6,198,060	$901,166,406	$122,286,818	$1,023,453,224	$165.12
Q32 Total	6,251,742	$901,370,619	$134,058,091	$1,035,428,710	$165.62
Q33 Total	6,536,925	$1,005,038,684	$131,032,178	$1,136,070,862	$173.79
October 2014	2,238,870			$862,195,930	$385.10
November 2014	2,290,489			$327,068,249	$142.79
December 2014	2,329,001			$808,718,242	$347.24
Q34 Total	**6,858,360**			**$1,997,982,421**	**$291.32**
MEG 2 Total	**174,374,882**	**25,446,856,153**	**3,054,814,898**	**$30,499,653,472**	**$174.91**

* 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.

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

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

Chart D MEGs 1 and 2 Annual Statistics					
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY4 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY4 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY5 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY5 Total	3,499,758	$3,247,599,951	$590,194,459	$3,837,794,411	$1,096.59
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(679,763,211)	
% of WOW PCCM MEG 1					84.95%
DY5 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY5 Total	21,686,199	$3,225,551,490	$398,406,833	$3,623,958,323	$167.11
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,261,459,223)	
% of WOW PCCM MEG 2					61.58%
DY6 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY6 Total	3,653,867	$3,385,729,683	$649,065,772	$4,034,795,456	$1,104.25
WOW DY6 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(922,223,210)	
% of WOW PCCM MEG 1					81.40%
DY6 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY6 Total	22,956,197	$3,543,588,406	$499,575,622	$4,043,164,027	$176.13
WOW DY6 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,517,028,389)	
% of WOW PCCM MEG 2					61.63%
DY7 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY7 Total	3,830,936	$3,331,762,672	$902,730,218	$4,234,492,890	$1,105.34
WOW DY7 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,227,808,896)	
% of WOW PCCM MEG 1					77.52%
DY7 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY7 Total	24,348,400	$3,892,512,229	$485,469,403	$4,377,981,632	$179.81
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,948,938,896)	

Chart D MEGs 1 and 2 Annual Statistics					
% of WOW PCCM MEG 2					59.75%
DY8 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY8 Total	4,000,390	$3,414,538,645	$896,924,719	$4,311,463,364	$1,077.76
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,683,361,074)	
% of WOW PCCM MEG 1					71.92%
DY8 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY8 Total	24,867,309	$3,783,670,392	$600,658,615	$4,384,329,006	$176.31
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,495,375,196)	
% of WOW PCCM MEG 2					55.64%
DY9 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY9 Total	2,526,190			$2,016,369,958	798.19
WOW DY9 Total	2,526,190			$1,987,353,673	$786.70
Difference				$29,016,285	
% of WOW PCCM MEG 1					101.46%
DY9 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY9 Total	13,395,285		$2,923,745,073		$218.27
WOW DY9 Total	13,395,285		$4,341,813,727		$324.13
Difference			$(1,418,068,654)		
% of WOW PCCM MEG 2					67.34%

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

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

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

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

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

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

For DY7, MEG 1 has a PCCM of $1,105.34 (Chart D), compared to WOW of $1,425.84 (Chart A), which is 77.52% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.81 (Chart D), compared to WOW of $300.92 (Chart A), which is 59.75% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1,077.76 (Chart D), compared to WOW of $1,498.56 (Chart A), which is 71.92% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.31 (Chart D), compared to WOW of $316.87 (Chart A), which is 55.64% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $798.19 (Chart D), compared to WOW of $786.70 (Chart A), which is 101.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $218.27 (Chart D), compared to WOW of $324.13 (Chart A), which is 67.34% of the target PCCM for MEG 2.

Chart E MEGs 1 and 2 Cumulative Statistics					
DY1	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 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%
DY2	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 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%
DY3	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 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%
DY4	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 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%
DY5	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27

Chart E MEGs 1 and 2 Cumulative Statistics					
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% of WOW					71.73%
DY6	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% of WOW					70.14%
DY7	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	28,179,336	$7,224,274,901	$1,388,199,621	$8,612,474,522	$305.63
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,176,747,792)	
% of WOW					67.34%
DY8	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	28,867,699	$7,198,209,036	$1,497,583,334	$8,695,792,371	$301.23
WOW	28,867,699			$13,874,528,641	$480.62
Difference				$(5,178,736,271)	
% of WOW					62.67%
DY9	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	15,921,475			$4,940,115,031	$310.28
WOW	15,921,475			$6,329,167,400	$397.52
Difference				$(1,389,052,369)	
% of WOW					78.05%

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

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

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

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

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

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

For DY7, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart F) 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 F is $305.63. Comparing the calculated weighted averages, the actual PCCM is 67.34% of the target PCCM.

For DY8, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart F) is $480.62. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table F is $301.23. Comparing the calculated weighted averages, the actual PCCM is 62.67% of the target PCCM.

For DY9, the weighted target PCCM for the reporting period using the actual case months and the MMA specific targets in the STCs (Chart G) is $397.52. The actual PCCM weighted for the reporting period using the actual case months and the MMA specific actual PCCM as provided in Table F is $310.28. Comparing the calculated weighted averages, the actual PCCM is 78.05% of the target PCCM.

The Healthy Start program and the Program for All-inclusive Care for Children (PACC) are authorized as cost not otherwise matchable (CNOM) services under the MMA Waiver. Chart F identifies the DY9 costs for these two programs. For budget neutrality purposes, these CNOM costs are deducted from the savings resulting from the difference between the WW (with waiver) costs and the WOW costs identified for DY9 in Chart E.

Chart F WW/WOW Difference Less CNOM Costs	
DY9 Difference July 2014 – December 2014	$(1,389,052,369)
CNOM Costs July 2014 – December 2014	
Healthy Start	$1,036,352
PACC	$259,416
DY9 Net Difference	**(1,387,756,601)**

Chart G MEG 3 Statistics: LIP	
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

Chart G MEG 3 Statistics: LIP	
MEG 3 LIP	**Paid Amount**
Q30	$316,726,485
Q31	$374,225,087
Q32	$301,519,921
Q34	$690,421,416
Total Paid	**$8,669,092,159**

Chart H of Attachment V shows that the expenditures for DY9 MEG 3, LIP, were $690,421,416 (31.85%) of the $2,167,698,340 cap.

Chart H MEG 3 Total Expenditures: LIP			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY1	$998,806,049	$1,000,000,000	99.88%
DY2	$999,632,926	$1,000,000,000	99.96%
DY3	$877,493,058	$1,000,000,000	87.75%
DY4	$1,122,122,816	$1,000,000,000	112.21%
DY5	$997,694,341	$1,000,000,000	99.77%
DY6	$807,232,567	$1,000,000,000	80.72%
DY7	$1,019,291,544	$1,000,000,000	101.93%
DY8	$1,156,397,442	$1,000,000,000	115.64%
DY9	$690,421,416	$2,167,968,340	31.85%
Total MEG 3	**$8,669,092,159**	**$10,167,968,340**	**85.26%**

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

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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

Mission Statement
Better Healthcare for All Floridians.