Florida Managed Medical Assistance Program

1115 Research and Demonstration Waiver

3rd Quarter Progress Report
(January 1, 2014 – March 31, 2014)
Demonstration Year 8

Agency for Health Care Administration

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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I. Waiver History

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

On June 14, 2013, Federal CMS approved an amendment to the waiver to implement the Managed Medical Assistance (MMA) program. The previously named waiver "Medicaid Reform" was renamed to "Managed Medical Assistance." The amendment approval documents can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/fed_auth.shtml.

Federal approval of the MMA amendment permits Florida to move from a fee-for-service system to managed care under the MMA program. The key components of the program include: choice counseling, competitive procurement of managed care plans, customized benefit packages, healthy behavior programs, risk-adjusted premiums based on enrollee health status and continuation of the 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 another three-year waiver extension request to Federal CMS to extend Florida's 1115 MMA Waiver for the period July 1, 2014 to June 30, 2017. Please refer to Section VI of this report for more information on the waiver extension request.

Quarterly Report Requirement

The quarterly and annual reporting requirements for the waiver are specified in Special Terms and Conditions (STCs) #90 and #91 of the waiver. The state is required to 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 health plans, specifying coverage area, populations served, benefits, enrollment, grievances, and other operational issues as found in this report.

This report is the third quarterly report for Demonstration Year Eight covering the period of January 1, 2014 – March 31, 2014. 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/federal.shtml.

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

II. Operational Update

A. Medicaid Reform

1. Health Care Delivery System

The following provides an update for this quarter activities related to the health care delivery system for health plan contracting, benefit packages, health plan reported complaints, grievances and appeals, Agency-received complaints, grievances and appeals, medical loss ratio, and on-site surveys and desk reviews.

a) Health Plan Contracting

Health Plan Applications and Expansion Requests

Health plan application and expansion requests will not be processed through the implementation of the MMA program. Please refer to Attachment I, Medicaid Reform Enrollment Report, for a listing of the current Reform health plan contracts.

Health Plan Capacity

Health plan capacity is monitored on an ongoing basis to ensure recipients have a choice of at least two health plans in each demonstration county. Please refer to Attachment I, Medicaid Reform Enrollment Report, for a listing of the current Reform health plans operating by county.

Contract Conversions/Terminations

There were no contract conversions or terminations during this quarter.

FFS PSN Conversion Process

The FFS PSN 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.

b) 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. To view the customized benefit packages, please refer to the second quarter report of Demonstration Year Eight.

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. 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

The health plans' Year Seven benefit packages were approved during the second quarter of Demonstration Year Seven and became effective January 1, 2013. For 2014, the current health plans' Year Seven benefit packages will be extended through the implementation of the MMA program.

c) Health Plan Reported Complaints, Grievances and Appeals

Health Plan Reported Complaints

Table 1 provides the number of complaints reported by health plan type for this quarter.

Table 1
Health Plan Reported Complaints
(January 1, 2014 – March 31, 2014)

Quarter	PSN Complaints	HMO Complaints
January 1, 2014 – March 31, 2014	173	1,037

Grievances and Appeals

Table 2 provides the number of grievances and appeals by health plan type for this quarter.

Table 2
Grievances and Appeals
(January 1, 2014 – March 31, 2014)

Quarter	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals
January 1, 2014 – March 31, 2014	30	75	330	194

Medicaid Fair Hearing (MFH)

Table 3 provides the number of MFHs requested and held during this quarter. There were a total of 11 MFHs requested this quarter, two for HMOs and nine for PSNs. There were a total of five MFHs held this quarter, four of which were from the MFH requests received during this quarter. In regards to outcomes, three of the MFHs held received a result in favor of the health plan, one received a result in favor of the demonstration participant and the other issue is pending a result.

Table 3 Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held (January 1, 2014 – March 31, 2014)			
Quarter	**Plan Type**	**Medicaid Fair Hearings Held**	**Medicaid Fair Hearings Requested**
January 1, 2014 – March 31, 2014	**HMO**	2	2
	PSN	3	9
	Total	**5**	**11**

Beneficiary Assistance Program (BAP)

Table 4 provides the number of requests submitted to the BAP during this quarter. There were no requests submitted to the BAP this quarter.

Table 4 BAP Requests (January 1, 2014 – March 31, 2014)			
Quarter	**HMO**	**PSN**	**Total**
January 1, 2014 – March 31, 2014	0	0	**0**

d) Agency-Received Complaints/Issues

Table 5 provides the number of complaints/issues the Agency received by type of health plan during the quarter. There were no trends discovered in the Agency-received complaints for this quarter.

Table 5 Agency-Received Complaints/Issues (January 1, 2014 – March 31, 2014)			
Quarter	**HMO**	**PSN**	**Total**
January 1, 2014 – March 31, 2014	30	14	**44**

e) Medical Loss Ratio (MLR)

During this quarter, all 12 capitated health plans submitted their fourth quarter and Annual MLR reports for Demonstration Year Seven to the Agency on or before the due date. The Agency submitted the capitated plan's MLR results to Federal CMS by February 14, 2014, as outlined in Table 11, Health Plan Medical Loss Ratio Reporting Schedule, of the second quarter report for Demonstration Year Eight. All 12 capitated health plans reported an MLR above 85% for the reporting period. Only one of the capitated health plans reported an MLR below 85% for the annual reporting period. The first quarter MLR reports for Demonstration Year Eight are due to the Agency on April 30, 2014.

f) 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.

2. Choice Counseling Program

The following provides an update for this quarter on choice counseling program activities for online enrollment, call center and new eligible self-selection data.

a) Online Enrollment

Table 6 shows the number of online enrollments by month for this quarter.

Table 6
Online Enrollment Statistics
(January 1, 2014 – March 31, 2014)

	January	February	March
Enrollments	830	593	1

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 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 20 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls. The choice counseling call center received 31,354 calls during this quarter, which is trending down as expected. Table 7 compares the call volume of incoming and outgoing calls during the third quarter of Demonstration Years Seven and Eight.

Table 7
Comparison of Call Volume for Third Quarter
(Demonstration Years Seven and Eight – 3rd Quarter)

Type of Calls	January 2013	January 2014	February 2013	February 2014	March 2013	March 2014	Year 7 3rd Quarter Totals	Year 8 3rd Quarter Totals
Incoming Calls	16,726	14,037	13,591	8,853	13,827	8,464	**44,144**	**31,354**
Outgoing Calls	4,422	5,179	3,908	1,236	3,938	375	**12,268**	**6,790**
Totals	21,148	19,216	17,499	10,089	17,765	8,839	**56,412**	**38,144**

Outbound and Inbound Mail

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

- New-Eligible Packets (mandatory and voluntary) 4,071
- Confirmation Letters 7,201
- Open Enrollment Packets 0
- Transition Packets (mandatory and voluntary) 389
- Plan Transfer Letters (mandatory and voluntary) 0

Health Literacy

During this quarter, the Special Needs Unit documented and reported on the verbal reviews and referrals as shown in Table 8.

Table 8
Number of Referrals and Case Reviews Completed
(January 1, 2014 – March 31, 2014)

	January	February	March
Case Referrals	118	187	399
Case Reviews	93	125	178

Face-to-Face/Outreach and Education

Table 9 provides the outreach activities that were performed this quarter.

Table 9
Choice Counseling Outreach Activities
(October 1, 2013 – December 31, 2013)

Field Activities	3rd Quarter – Year 8
Group Sessions	0
Private Sessions	0
Home Visits and One-On-One Sessions	8
No Phone List*	0
Outbound Phone List	0
Enrollments	97
Plan Changes	738

*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

During this quarter, the Mental Health Unit completed five recipient referral calls.

Complaints/Issues

There were no complaints received related to the Choice Counseling program during this quarter.

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 health plan or to make a health plan change. Due to the implementation of Statewide Medicaid Managed Care, there were not enough surveys available for a statistically valid sample.

c) New Eligible Self-Selection Data

From July 2010 to March 2014, 66% of recipients enrolled in the demonstration self-selected a health plan and 34% were auto-assigned. Table 10 shows the current self-selection and auto-assignment rate for this quarter.

Table 10
Self-Selection and Auto-Assignment Rate*
(January 1, 2014 – March 31, 2014)

	January	February	March
Self-Selected	5,819	6,836	435
Auto-Assignment	3,929	3,970	0
Total Enrollments	9,748	10,806	435
Self-Selected %	59.69%	63.26%	100%
Auto-Assignment %	40.31%	36.74%	0%

* 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.

3. Enrollment Data

Attachment I provides an update of the monthly enrollment for this quarter, beginning January 1, 2014 and ending March 31, 2014, and contains the following enrollment reports:

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

All Reform health plans are included in each of the reports. During this quarter, there were a total of 15 Reform health plans – 11 HMOs and four FFS PSNs. Attachment I shows enrollment numbers decreasing for Baker, Clay, Nassau and Duval counties due to freezing of new enrollments during the transition process to Managed Medical Assistance program.

4. Enhanced Benefits Account Program

The following provides an update for this quarter on enhanced benefits account program activities for the call center, statistics, advisory panel, and phase-out of the enhanced benefits account program.

a) Call Center Activities

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

The Automated Voice Response System (AVRS) that provides recipients balance-only information handled 23,625 calls during this quarter. Table 11 highlights the enhanced benefits call center and mailroom activities during this quarter.

Table 11
Highlights of the Enhanced Benefits Call Center Activities
(January 1, 2014 – March 31, 2014)

Enhanced Benefits Call Center Activity	January	February	March
Calls Received	3,977	3,973	3,265
Calls Answered	2,618	3,833	3,197
Average Talk Time (minutes)	5:26	5:44	4:56
Calls Handled by the AVRS	9,842	7,221	6,562
Outbound Calls	38	14	16
Enhanced Benefits Mailroom Activity			
EB Welcome Letters	3,447	6,355	6,529

Outreach and Education

During this quarter, the call center mailed 16,331 welcome letters and 168,224 coupon statements. A flyer or pharmacy billing instructions are 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.

Complaints

Table 12 located on the following page provides a summary of the complaints received and actions taken during this quarter.

Table 12
Enhanced Benefits Recipient Complaints
(January 1, 2014 – March 31, 2014)

Recipient Complaint	Action Taken
1. A recipient called about their health plan not reporting healthy behaviors on his behalf.	➲ The Agency worked with the health plan to get the healthy behavior reported. The recipient received credits for the behaviors.

b) Enhanced Benefits Statistics

As of the end of this quarter, 14,194 recipients lost EBA eligibility resulting in losing EBA credits, totaling $636,758.71. Table 13 provides the EBA program statistics during this quarter.

Table 13
Enhanced Benefits Account Program Statistics
(January 1, 2014 – March 31, 2014)

Third Quarter Activities – Year Eight		January	February	March
I.	Number of health plans submitting reports by month in each county	31	31	31
II.	Number of enrollees who received credit for healthy behaviors by month	49,890	45,613	42,046
III.	Total dollar amount credited to accounts by each month	$1,188,010.00	$1,077,557.50	$993,890.00
IV.	Total cumulative dollar amount credited through the end each month	$78,830,591.16	$79,908,148.66	$80,902,038.66
V.	Total dollar amount of credits used each month by date of service	$849,001.77	$727,540.70	$791,219.76
VI.	Total cumulative dollar amount of credits used through the month by date of service	$44,632,355.36	$45,359,896.06	$46,151,118.18
VII.	Total unduplicated number of enrollees who used credits each month	26,428	22,430	23,643

c) 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.

d) Notice of EBA Program Phase Out

During this quarter, 315,439 recipients in Broward County received a second notification letter regarding the phase-out of the EBA program.

5. Demonstration Goals

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

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

Table 14 located on the following page provides the number and types of health plans the Agency currently has under contract in Broward and Duval Counties.

Table 14 Number and Type of Plans in Broward and Duval Counties (January 1, 2014 – March 31, 2014)		
County	**Type of Plan**	**Number of Plans**
Broward	HMOs	10
	PSNs	3
	Total	**13**
Duval	HMOs	3
	PSNs	2
	Total	**5**

Currently, the Agency contracts with three HMOs and one PSN, for a total of four health plans in Baker, Clay and/or Nassau Counties. Please refer to Section II.A.1 of this report for additional information on health plan applications and expansion requests, and Objective 4 of this report for enrollee satisfaction.

Objective 2(a): To ensure that there is 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. Please refer to Section II.A.1 of this report for additional information on the capitated health plans benefit packages and expanded benefits.

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

The Annual Reports will demonstrate access to specialists. The latest analysis on access to specialists can be found in the Final Annual Report for Demonstration Year Seven at the Agency's following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/annual.shtml.

(3)(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 Demonstration Year Eight. During this quarter, the Agency finished 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 completed calculating the performance measure-related liquidated damages for the health plans based on their 2013 submission. Agency staff sent the health plans lists of their performance measures that compared them to Agency benchmarks and identified plan-level trends on the measures.

During the next quarter, the health plans will submit Lessons Learned from their Performance Measure Action Plan activities, and the Agency will send out the liquidated damages letters to the health plans. The Performance Measure Report covering calendar year 2013 is due to the Agency by July 1, 2014.

Performance measures for the MMA program are discussed in Section II.B.4. of this report.

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

The Agency runs 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. Using this model, the Agency can 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 enables a comparison by county or by health 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 health plans and the non-Reform health plans. The model has been updated to support the latest version (4.4) provided by Agency for Healthcare Research and Quality. The aggregate data for all health plans demonstrate ACSC hospitalizations have trended down over the past three state fiscal years.

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. The aggregate data for all health plans demonstrate the Emergency Department utilizations went down between State Fiscal Years (SFY) 2010-11 and 2011-12 and back up in SFY 2012-13.

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 health plan groups. Portions of the report are designed to show county comparisons based on utilization by managed care eligible recipients, or according to health 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 enrollee satisfaction increases.

During this quarter, the Agency's evaluation vendor began administering the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan 5.0 Survey. The surveys will be completed during the fourth quarter of Demonstration Year Eight.

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

STC #84 – Tier-One Milestone

As reported under this STC, both the *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report* will show the increased access to medical care for the uninsured population in Florida. Please refer to Section III, Low Income Pool, of this report for an update on STC #84.

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. These initiatives focus on: infrastructure development; innovation and redesign; and population focused improvement. Please refer to Section III, Low Income Pool, of this report for an update on STC #85.

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 VI, Evaluation of the Demonstration, of this report.

6. Policy and Administrative Issues

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. The following provides an update for this quarter on these forums as the Agency continues its initiatives on process and program improvement.

a) 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.

b) 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 March 13, 2014 for all health plans. The training was located in Sunrise, Florida. The fraud and abuse meeting included the following:

- Presentation by the U.S. Department of Health and Human Services Office of the Inspector General regarding fraud and abuse issues that are being seen at the federal level;
- 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, and other training needs);
- Health plan best practices; and
- Health plans sharing concerns or needs about more effectively addressing fraud.

Seventy-four persons attended the training, with representation from all but three Medicaid health plans.

B. Managed Medical Assistance Program

1. Implementation Activities

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

2. Health Plan Delivery System

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

a) Managed Care Plan Contracting

During this quarter, the Agency finalized contracts for the second phase of its Statewide Medicaid Managed Care (SMMC) program, the MMA component. The Agency executed 17 contracts for the MMA program between January 31, 2014 and February 3, 2014. In addition to the managed care plans that will be providing only MMA services, the six health plans that were providing Long-term Care (LTC) services under LTC contracts signed new "Comprehensive LTC" contracts that incorporated MMA services in addition to the LTC services. A copy of the model contract may be viewed on the Agency's website at http://ahca.myflorida.com/SMMC. Select the Managed Medical Assistance link, then MMA Plans, then Managed Medical Assistance Model Contract. Contracted vendors are:

Contract #	Managed Care Plan Name	Managed Care Plan Type
FP 021	Amerigroup Florida	Comprehensive Long-term Care Plan
FP 013	Better Health	Managed Medical Assistance Plan
FP 030	Clear Health Alliance HIV/AIDS Specialty Plan	Specialty Plan (HIV/AIDS)
FP 022	Coventry	Comprehensive Long-term Care Plan
FP 014	First Coast Advantage	Managed Medical Assistance Plan
FP 023	Humana Medical Plan	Comprehensive Long-term Care Plan
FP 015	Integral Quality Care	Managed Medical Assistance Plan
FP 024	Molina	Comprehensive Long-term Care Plan
FP 027	Positive Health Care	Specialty Plan (HIV/AIDS)
FP 016	Preferred	Managed Medical Assistance Plan
FP 017	Prestige Health Choice	Managed Medical Assistance Plan
FP 018	Simply	Managed Medical Assistance Plan
FP 019	South Florida Community Care Network	Managed Medical Assistance Plan
FP 020	Staywell	Managed Medical Assistance Plan
FP 026	Sunshine Health	Comprehensive Long-term Care Plan, Specialty Plan (Child Welfare)
FP 025	United Healthcare	Comprehensive Long-term Care Plan
FP 028	Magellan Complete Care	Specialty Plan (Serious Mental Illness)

There were two contract interpretations, one policy transmittal and two “Dear Provider” letters released to the health plans during this quarter.

The two contract interpretations advised managed care plans of the following:

- For Comprehensive Long-term Care plans, provided guidance on the enhanced standards specifically related to claims and provider payment, enrollee services, and utilization management that were negotiated as part of the Managed Medical Assistance Invitation to Negotiate process and their applicability to the Long-term Care program.
- For Comprehensive Long-term Care plans and Managed Medical Assistance plans, provided guidance on the development of contracts with the Florida Medical School Quality Network in accordance with s. 409.975(2), F.S.

The one policy transmittal advised managed care plans of the following:

- Provided changes and guidance related to performance measures and other quality management-related contract requirements.

The three “Dear Provider” letters advised health plans of the following:

- Medicaid expanded the Type of Bill codes that are valid for nursing facility providers, effective February 11, 2014.
- Provided a reminder that providers (including hospitals) located in Georgia and Alabama (within 50 miles of the Florida state line) that regularly provide services to Florida Medicaid recipients may enroll with Florida Medicaid and contract with managed care plans as in-state providers.
- State law requires that Medicaid Managed Medical Assistance plans offer all home medical equipment and supplies providers a network contract if they meet certain criteria.

Also during this quarter, the Agency began identifying transitional reporting requirements for the managed care plans that will be transitioning to the MMA program beginning May 1, 2014. This process continues to the present, as the Agency is in the process of updating its SMMC Report Guide to include new reporting requirements, and is also beginning to gather items for the next MMA contract amendment.

b) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment III of this report, the managed care plans will provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid Coverage and Limitations Handbooks, and the Florida Medicaid fee schedules. The table below lists the standard benefits that will be provided under the MMA contracts that were executed by the managed care plans this quarter:

Required MMA Services	
(1)	Advanced Registered Nurse Practitioner
(2)	Ambulatory Surgical Center Services
(3)	Assistive Care Services
(4)	Behavioral Health Services

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

c) Plan Readiness Review and Monitoring

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

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 health plans are required to respond to in order for the Agency to complete a thorough desk review of identified key areas. As of March 31, 2014, the Agency sent and received responses to the readiness review request for 17 of 18 health plans. The Agency has completed desk reviews and on-site reviews for 17 of 18 health plans as shown in Table 15.

Table 15
MMA Plan Readiness Review

MMA Plan	Readiness Review Request Sent	Readiness Review Response Received	Desk Review Complete	Onsite Review Complete
1. **AHF/Positive**	**X**	**X**	**X**	**X**
2. **Amerigroup**	**X**	**X**	**X**	**X**
3. **Better**	**X**	**X**	**X**	**X**
4. **Clear Health**	**X**	**X**	**X**	**X**
5. **Coventry**	**X**	**X**	**X**	**X**
6. **FCA**	**X**	**X**	**X**	**X**
7. **Freedom**				
8. **Humana**	**X**	**X**	**X**	**X**

Table 15 MMA Plan Readiness Review				
MMA Plan	**Readiness Review Request Sent**	**Readiness Review Response Received**	**Desk Review Complete**	**Onsite Review Complete**
9. **Integral**	**X**	**X**	**X**	**X**
10. **Magellan**	**X**	**X**	**X**	**X**
11. **Molina**	**X**	**X**	**X**	**X**
12. **Preferred**	**X**	**X**	**X**	**X**
13. **Prestige**	**X**	**X**	**X**	**X**
14. **SFCCN**	**X**	**X**	**X**	**X**
15. **Simply**	**X**	**X**	**X**	**X**
16. **Staywell**	**X**	**X**	**X**	**X**
17. **Sunshine**	**X**	**X**	**X**	**X**
18. **United**	**X**	**X**	**X**	**X**

3. Choice Counseling Program

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

a) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During this quarter, the call center had an average of 166 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls.

The choice counseling call center received 68,839 calls during this quarter, which remains within the normal call volume.

Table 16 Call Volume for Third Quarter (January 1, 2014 – March 31, 2014)				
Type of Calls	**January 2014**	**February 2014**	**March 2014**	**Year 8 3rd Quarter Totals**
Incoming Calls	8,959	10,757	49,123	**68,839**
Outgoing Calls	0	0	0	**0**
Totals	**8,959**	**10,757**	**49,123**	**68,839**

b) Self-Selection and Auto Assignment Rates

From August 2013 to March 2014, 48% of recipients enrolled in the demonstration self-selected a health plan and 52% were auto-assigned.

Table 17 Self-Selection and Auto-Assignment Rate[1] (January 1, 2014 – March 31, 2014)			
	January	**February**	**March**
Self-Selected	8,987	5,593	1,996
Auto-Assignment	13,027	13,497	1,658
Total Enrollments	22,014	19,090	3,654
Self-Selected %	41%	71%	55%
Auto-Assignment %	59%	29%	45%

4. Quality

The following provides an update on quality activities for the External Quality Review Organization (EQRO) and health plan performance measure reporting.

a) EQRO

In January 2014, Health Services Advisory Group (HSAG), the state's EQRO, held an onsite quarterly meeting for the managed care plans, Agency staff and sister agency staff. HSAG also held two quarterly webinars in March, one for Long-term Care plans and one for MMA plans, in which HSAG staff presented information on the Plan-Do-Study-Act cycle and how this approach may be used to improve the health plans' Performance Improvement Projects (PIPs). During the webinar for MMA plans, HSAG shared the proposed methodologies for indicators the statewide PIPs related to preventive dental care for children and prenatal care/well-child visits in the first 15 months of life. During this quarter, HSAG completed the Performance Measure Validation Report and submitted a portion of the plan-specific PIP Validation reports to the Agency and the managed care plans for review. The draft Technical Report was submitted to the Agency during this quarter.

b) Plan Performance Measure Reporting

In February 2014, the Agency sent a policy transmittal regarding quality management activities to the MMA plans. This policy transmittal updated the list of performance measures that health plans are required to collect and report to the Agency on an annual basis. The MMA plans' first Performance Measure Report is due to the Agency no later than July 1, 2015, covering the measurement period of calendar year 2014. In the policy transmittal, the Agency specified that for this first report, measures should be collected based on the technical specifications for the measures, across the Statewide Medicaid Managed Care contract and the previous Managed Care Plan contract (2012-2015) as applicable. For example, if someone has been in XYZ Managed Care Plan for six months under the SMMC contract and for six months under the previous managed care contract, the person would meet the 12 months of continuous enrollment required for many performance measures. The Performance Measure Report covering calendar year 2015 is due to the Agency no later than July 1, 2016, and this will be the first report covering a full year of SMMC contract operations for MMA plans.

In addition to updating the performance measures for MMA plans, the Agency's February policy transmittal included some revisions to performance measures for the Child Welfare Specialty

[1] As of February 17, 2014, the self-selection and auto-assignment rate includes the Long-term Care and Managed Medical Assistance populations.

Plan and the HIV/AIDS Specialty Plans. Due to the Child Welfare Specialty Plan serving children under the age of 21 years, the MMA Performance measures that are specifically for those Medicaid enrollees ages 18 and older have been removed from reporting requirements.

The NCINQ measures will not be required until these measures have been finalized and the technical specifications have been released. The National Committee for Quality Assurance included two of the three NCINQ measures (HRDPSY and CONPSY) in its proposed changes for HEDIS 2015 that were available for public comment, so these two measures will be included in reporting if they are adopted for HEDIS 2015.

HIV/AIDS Specialty Plans will report all the MMA performance measures and four additional measures.

III. Low Income Pool

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

1. LIP Council Meetings

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

2. LIP STCs - Reporting Requirements

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

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

Finalize Modifications to the 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 23, 2014, Federal CMS approved the RFMD for DY7.
- On January 30, 2014, the Agency submitted a revised RFMD for DY8 to Federal CMS.

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 March 11, 2014, the Agency submitted the first quarter reporting for SFY 2013-14 for the 44 hospital initiatives.

IV. Monitoring Budget Neutrality

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

1. Updated Budget Neutrality

Budget Neutrality figures included in Attachment IV of this report are through the third quarter (January 1, 2014 – March 31, 2014) of Demonstration Year Eight. The 1115 MMA Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For 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 Services Waivers.

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by STC #94, is monitored using data based on date of service. The Per Member Per Month (PMPM) and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency will track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year.

Please refer to Attachment IV of this report for an update on Budget Neutrality figures through the third quarter (January 1, 2014 – March 31, 2014) of Demonstration Year Eight.

V. Encounter and Utilization Data

1. Encounter Data

During this quarter, several monthly Encounter Data Compliance Reports were distributed to the health plans. The Compliance Reports for encounters processed in November 2013, December 2013 and January 2014 were distributed on January 31, 2014, February 24, 2014 and March 28, 2014, respectively. These reports focused on analytical measures to gauge the accuracy and timeliness of the encounter data submissions from each health plan. 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.

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

The Agency has contracted with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO) vendor since 2006. Beginning on July 1, 2013, the Agency's new contract with HSAG required that the EQRO conduct an annual encounter-type focused validation, using protocol consistent with the CMS protocol, "Validation of Encounter Data Reported by the Managed Care Organization." HSAG has worked closely with the Agency to design an encounter data validation process to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate. HSAG will compare encounter data with the managed care plan's administrative data and will also validate provider-reported encounter data against a sample of medical records. During this quarter, the Agency worked with HSAG to identify cases for a medical record review, which will begin next quarter.

2. 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 July 1, 2012 – June 30, 2013 measurement period (paid through September 30, 2013) were provided to the Agency's actuary for use in the MedRx model to generate risk scores for March – May 2014.

VI. Evaluation of the Demonstration

The evaluation of the demonstration is an ongoing process to be conducted during the life of the demonstration. The Agency is required under STCs #110 – 113 to complete an evaluation design that includes a discussion of the goals, objectives and specific hypotheses that are being tested to determine the impact of the demonstration during the period of approval.

To view the Final Evaluation Design for the current waiver period December 16, 2011 – June 30, 2014 and to view the Final Evaluation Report that covers the initial five-year demonstration period, please visit the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/index.shtml. For information on evaluation activities, reports and findings that occurred prior to this quarter, please refer to previous quarterly and annual reports posted on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

1. Pending and Upcoming Evaluation Reports and Activities

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

- The University of Florida (UF) submitted and revised, based on Agency feedback, the Low Income Pool *Milestone Statistics and Findings Report* for Demonstration Year Seven. This report will be submitted to Federal CMS during the next quarter. At the end of the last quarter, the UF research team submitted the draft final report for Domains i and ii, and during this quarter, UF submitted the draft final report for Domain iii. The Agency provided feedback to UF on both of these reports, and UF is revising these reports. Both reports will be resubmitted during the next quarter.
- Florida International University (FIU) conducted a round of 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 submitted a preliminary report on their analysis of the managed care plans' anti-fraud plans, and the Agency provided feedback to the research team. The final report on the evaluation of Domain iv will be done in the spring of 2014.
- Agency staff revised the updated draft evaluation design for the MMA program based on feedback received from Federal CMS and resubmitted it to Federal CMS in February 2014.

VII. 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 to 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/fed_auth.shtml.

1. 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 posted 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
Medicaid Reform Enrollment Report

Medicaid Reform Enrollment Report

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. The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the demonstration program for the quarter being reported. Table 1 provides a description of each column in Medicaid Reform Enrollment Report.

Table 1
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 2 provides an unduplicated count of the recipients enrolled in each Reform health plan at any time during this quarter. There were a total of 333,644 recipients enrolled in the Reform demonstration during this quarter. There were 15 Reform health plans active during this quarter with market shares ranging from 0.08% to 25.7%.

Table 2
Medicaid Reform Enrollment
(January 1, 2014 – March 31, 2014)

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	3,023	643	1	125	**3,792**	**1.14%**	3,918	-3.22%
Clear Health	HMO	12	53	-	2	**67**	**0.02%**	52	28.85%
Freedom	HMO	3,623	580	1	103	**4,307**	**1.29%**	4,408	-2.29%
Humana	HMO	11,754	2,165	9	379	**14,307**	**4.29%**	13,847	3.32%
Magellan	HMO	635	114	1	14	**764**	**0.23%**	556	37.41%
Medica	HMO	3,616	850	3	153	**4,622**	**1.39%**	4,772	-3.14%
Molina	HMO	27,634	3,400	7	535	**31,576**	**9.46%**	32,089	-1.60%
Positive	HMO	21	246	-	12	**279**	**0.08%**	274	1.82%
Staywell	HMO	17,270	1,744	3	156	**19,173**	**5.75%**	21,008	-8.73%
Sunshine	HMO	76,341	8,322	2	1,089	**85,754**	**25.70%**	92,134	-6.92%
United	HMO	7,905	1,300	2	186	**9,393**	**2.82%**	10,772	-12.80%
HMO Total	**HMO**	**151,834**	**19,417**	**29**	**2,754**	**174,034**	**52.16%**	**183,830**	-5.33%
Better Health	PSN	40,457	5,009	8	645	**46,119**	**13.82%**	45,740	0.83%
CMS	PSN	5,369	4,147	-	25	**9,541**	**2.86%**	9,580	-0.41%
FCA	PSN	55,109	8,659	2	1,604	**65,374**	**19.59%**	73,978	-11.63%
SFCCN	PSN	33,644	4,299	1	632	**38,576**	**11.56%**	38,569	0.02%
PSN Total	**PSN**	**134,579**	**22,114**	**11**	**2,906**	**159,610**	**47.84%**	**167,867**	-4.92%
Reform Enrollment Totals		**286,413**	**41,531**	**40**	**5,660**	**333,644**	**100.00%**	**351,697**	-5.13%

The market share percentage for each Reform health 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-Reform health plans to Reform health plans.

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 3.

Table 3
Number of Reform Health Plans in Demonstration Counties
(January 1, 2014 – March 31, 2014)

County Name	Number of Reform HMOs	Number of Reform PSNs
Baker	**2**	**1**
Broward	**11**	**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 4 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 4
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 5 located on the following page lists, by health 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 5
Medicaid Reform Enrollment by County Report
(January 1, 2014 – March 31, 2014)

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	576	82	-	11	669	20.99%	791	-15.42%
Staywell	HMO	Baker	77	8	-	1	86	2.70%	107	-19.63%
FCA	PSN	Baker	2,153	258	-	21	2,432	76.31%	2,811	-13.48%
Baker			**2,806**	**348**	**0**	**33**	**3,187**	**100.00%**	**3,709**	**-14.07%**
Clear Health	HMO	Broward	12	53	-	2	67	0.03%	52	28.85%
Freedom	HMO	Broward	3,623	580	1	103	4,307	2.17%	4,408	-2.29%
Humana	HMO	Broward	11,754	2,165	9	379	14,307	7.20%	13,847	3.32%
Magellan	HMO	Broward	635	114	1	14	764		556	37.41%
Medica	HMO	Broward	3,616	850	3	153	4,622	2.33%	4,772	-3.14%
Molina	HMO	Broward	27,634	3,400	7	535	31,576	15.89%	32,089	-1.60%
Positive	HMO	Broward	21	246	-	12	279	0.14%	274	1.82%
Care Florida	HMO	Broward	3,023	643	1	125	3,792	1.91%	3,918	-3.22%
Simply	HMO	Broward	-	-	-	-	-	0.00%	-	NA
Staywell	HMO	Broward	6,282	464	1	51	6,798	3.42%	6,133	10.84%
Sunshine	HMO	Broward	37,047	3,655	1	418	41,121	20.69%	41,220	-0.24%
Better Health	PSN	Broward	40,457	5,009	8	645	46,119	23.21%	45,740	0.83%
CMS	PSN	Broward	3,377	2,995	-	16	6,388	3.21%	6,497	-1.68%
SFCCN	PSN	Broward	33,644	4,299	1	632	38,576	19.41%	38,569	0.02%
Broward			**171,125**	**24,473**	**33**	**3,085**	**198,716**	**99.62%**	**198,075**	**0.32%**
Sunshine	HMO	Clay	6,049	581	-	65	6,695	44.88%	7,848	-14.69%
Staywell	HMO	Clay	673	73	-	7	753	5.05%	896	-15.96%
United	HMO	Clay	2,783	351	-	45	3,179	21.31%	3,681	-13.64%
FCA	PSN	Clay	3,845	396	-	48	4,289	28.75%	5,059	-15.22%
Clay			**13,350**	**1,401**	**0**	**165**	**14,916**	**100.00%**	**17,484**	**-14.69%**
Staywell	HMO	Duval	9,917	1,178	2	95	11,192	10.08%	13,449	-16.78%
Sunshine	HMO	Duval	33,245	4,086	1	606	37,938	34.18%	43,066	-11.91%
United	HMO	Duval	3,368	690	-	95	4,153	3.74%	4,713	-11.88%
CMS	PSN	Duval	1,992	1,152	-	9	3,153	2.84%	3,083	2.27%
FCA	PSN	Duval	45,486	7,596	2	1,489	54,573	49.16%	61,271	-10.93%
Duval			**94,008**	**14,702**	**5**	**2,294**	**111,009**	**100.00%**	**125,582**	**-11.60%**
Staywell	HMO	Nassau	321	21	-	2	344	5.91%	423	-18.68%
United	HMO	Nassau	1,178	177	2	35	1,392	23.93%	1,587	-12.29%
FCA	PSN	Nassau	3,625	409	-	46	4,080	70.15%	4,837	-15.65%
Nassau					**5,124**	**607**	**2**	**83**	**5,816**	**100.00%**
Reform Enrollment Totals			**286,413**	**41,531**	**40**	**5,660**	**333,644**		**351,697**	**-5.13%**

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 health plans operate.

Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 6 and 7 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 6 provides a description of each column in this report.

Table 6
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

Table 7 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 7
Medicaid Reform Voluntary Population Enrollment Report
(January 1, 2014 – March 31, 2014)

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**
Care Florida	Broward	-	56	-	1	-	126	**183**	**4.83%**	**3,792**
Clear Health	Broward	-	-	-	-	-	2	**2**	**2.99%**	**67**
Freedom	Broward	-	49	-	-	-	104	**153**	**3.55%**	**4,307**
Humana	Broward	-	150	-	-	-	388	**538**	**3.76%**	**14,307**
Magellan	Broward	-	6	-	-	-	15	**21**	**0.00%**	**764**
Medica	Broward	-	31	-	-	-	156	**187**	**4.05%**	**4,622**
Molina	Broward	-	377	-	1	-	542	**920**	**2.91%**	**31,576**
Positive	Broward	-	-	-	-	-	12	**12**	**4.30%**	**279**
Simply	Broward	-	-	-	-	-	-	**-**	**0.00%**	**-**
Staywell	Broward	-	47	-	-	-	52	**99**	**1.46%**	**6,798**
Staywell	Baker	-	-	-	-	-	1	**1**	**1.16%**	**86**
Staywell	Clay	-	12	-	-	-	7	**19**	**2.52%**	**753**
Staywell	Duval	-	95	-	-	-	97	**192**	**1.72%**	**11,192**
Staywell	Nassau	-	2	-	-	-	2	**4**	**1.16%**	**344**
Sunshine	Broward	-	475	-	2	-	419	**896**	**2.18%**	**41,121**
Sunshine	Clay	-	74	-	-	-	65	**139**	**2.08%**	**6,695**
Sunshine	Duval	-	601	-	-	-	607	**1,208**	**3.18%**	**37,938**
United	Baker	-	14	-	-	-	11	**25**	**3.74%**	**669**
United	Clay	-	41	-	-	-	45	**86**	**2.71%**	**3,179**
United	Duval	-	95	-	-	-	95	**190**	**4.58%**	**4,153**
United	Nassau	-	26	-	-	-	37	**63**	**4.53%**	**1,392**
HMO Total	**-**	**2,151**	**-**	**4**	**-**	**2,783**	**4,938**	**2.84%**	**174,034**	**45,740**
Better Health	Broward	-	515	-	1	-	653	**1,169**	**2.53%**	**46,119**
CMS	Broward	-	95	-	3	-	16	**114**	**1.78%**	**6,388**
CMS	Duval	-	640	-	2	-	9	**651**	**20.65%**	**3,153**
FCA	Baker	-	32	-	-	-	21	**53**	**2.18%**	**2,432**
FCA	Clay	-	70	-	-	-	48	**118**	**2.75%**	**4,289**
FCA	Duval	-	867	-	2	-	1,491	**2,360**	**4.32%**	**54,573**
FCA	Nassau	-	43	-	-	-	46	**89**	**2.18%**	**4,080**
SFCCN	Broward	-	600	-	1	-	633	**1,234**	**3.20%**	**38,576**
PSN Total		**-**	**2,862**	**-**	**9**	**-**	**2,917**	**5,788**	**3.63%**	**159,610**
Reform Totals		**0**	**5,013**	**0**	**13**	**0**	**5,700**	**10,726**	**3.21%**	**333,644**

Attachment II
Comprehensive MMA Outreach Schedule

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 1/1/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Standard Populations	Choice Counseling	Letter	Pre-Welcome Letters mailed
	Legislature	External Affairs	Letter	Letters provided to Legislators in Regions 2, 3 and 4 notifying of implementation of of the SMMC Managed Medical Assistance (MMA) Program within their districts effective May 1, 2014.
	General Public / Media	Agency / Communications Office	Press Release	Press Release announcing Agency's proposed implementation schedule for MMA Program receives final approval from Federal CMS.
Week of 1/13/2014				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101
	MMA Network Providers	AHCA Staff	In Person	Meeting with Independent Pharmacy Owners to discuss the SMMC Program.
Week of 1/20/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
	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; and Individuals with Intellectual Disabilities
Week of 1/27/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Stakeholders	Bureau of Managed Health Care	In Person	Presentation on SIPP at Quarterly Behavioral Health Meeting.
Week of 2/3/2014				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101; and Individuals with Intellectual Disabilities
	Stakeholders	Executive Management	In Person	Meetings with Florida Medical Directors Association Industry Advisory Board and Florida Developmental Disability Council Managed Care Workgroup to discuss MMA Implementation.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Plans	Agency	In Person	MMA Contract signing event at the Agency.
	Legislature	External Affairs	Letter	Letters provided to Legislators in Regions 5, 6, and 8 notifying of implementation of the SMMC Managed Medical Assistance (MMA) Program within their districts effective June 1, 2014.
	General Public / Media	Communications Office	Press Release	Inform recipients of Welcome Letters coming

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
	General Public / Media	Communications Office	Press Release	Announcing AHCA to host public contract celebration for the MMA plans
	General Public / Media	Communications Office	Press Release	Announcing Agency is ready to move forward with the MMA program.
	General Public	Communications Office	Facebook	Inform recipients of Welcome Letters coming and any upcoming webinars.
	General Public	Communications Office	Twitter	Inform recipients of Welcome Letters coming and any upcoming webinars.
	Beneficiaries	Choice Counseling	Letter	Pre-Welcome Letters mailed.
Week of 2/10/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101; and Individuals with Intellectual Disabilities
	Standard Populations	Choice Counseling	Letter	Welcome Letters mailed
Week of 2/17/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101; and Choice Counseling and Continuity of Care
Week of 2/24/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101; and Individuals with Intellectual Disabilities
	AHCA Staff	Executive Management	In Person	AHCA Staff update on SMMC.

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
	Stakeholders	Agency Staff	In Person	Healthy Start Coalition meeting in Volusia County to discuss MMA
Week of 3/3/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: Hospice
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Legislature	External Affairs	Letter	Letters provided to Legislators in Regions 10 and 11 notifying of implementation of of the SMMC Managed Medical Assistance (MMA) Program within their districts effective July 1, 2014.
	AHCA Staff	Executive Management	Phone	Area Office Update call provided 2 months prior to Go Live
	General Public / Media	Communications Office	Press Release	Inform recipients of Welcome Letters coming
	General Public	Communications Office	Facebook	Inform recipients of Welcome Letters coming
	General Public	Communications Office	Twitter	Inform recipients of Welcome Letters coming
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: MMA 101
	Providers	Outreach Team	Phone	General SMMC / MMA Update
	AHCA Staff	Outreach Team	Webinar	General SMMC / MMA Update
	Standard Populations	Choice Counseling	Letter	Pre-Welcome Letters mailed
Week of 3/10/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: Hospice Transitioning to MMA - Selecting a plan and Continuing your services
	Recipients	Outreach Team	In Person	SMMC / MMA Update and Enrollment

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Plans	Outreach Team	In Person	General SMMC / MMA Update
	AHCA Staff	Outreach Team	In Person	MMA Update / SMMC Policy Brown Bag Lunch
	Providers / Recipients	Outreach Team	In Person	SMMC Update / MTC and MMA
Week of 3/17/2014				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Provider Associations	Medicaid Services Staff	Phone	DCF regional managing entity call for Suncoast Regions (areas 5, 6 & 8) to answer behavioral health services for children
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 3/24/2014				
	Provider Associations	Outreach Team	In Person	SMMC Update for the Florida Assisted Living Facility Association
	AHCA Staff	Outreach Team	Webinar	SMMC / MMA Update for Medicaid Staff in Regions 5 ,6, 7,8, 10, 11, 1 ,9
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs: Hospice Transitioning to MMA - Selecting a plan and Continuing your services
	Network Associations	Outreach Team	In Person	SMMC Update / LTC and MMA for Foundation for LTC Solutions
	Network Associations	Outreach Team	In Person	SMMC Update / LTC and MMA for Pharmacy and Therapeutics Committee
	Network Associations	Outreach Team	In Person	SMMC Update / LTC and MMA for DUR Board
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/Special Populations/General Public	Outreach Team	Webinar	LTC & MMA: Putting the Pieces Together
	Beneficiaries	Choice Counseling	Letter	Welcome Letters mailed
	Beneficiaries	Choice Counseling	Letter	Reminder Letters mailed

Attachment III
Expanded Benefits under the MMA program

Expanded benefits are those services or benefits not otherwise covered in the Statewide Medicaid Managed Care (SMMC) program's list of required services, or that exceed limits outlined in the in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules. The managed care plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA Managed Care Plans and Comprehensive LTC Plans, and the LTC Exhibit for Comprehensive LTC Managed Care Plans and LTC Managed Care Plans, upon approval by the Agency. The managed care plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the Agency. The chart below lists the expanded benefits approved by the Agency that are being offered by the SMMC health plans in 2014.

Expanded Benefits

List of Expanded Benefits	Amerigroup	Better	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	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		Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Medically related lodging & food		Y			Y		Y		Y		Y	Y	Y	
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	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		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		Y		Y	Y	Y	Y
Waived co-payments	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

NOTE: Details regarding scope of covered benefit may vary by managed care plan.

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Attachment IV
Budget Neutrality Update

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

The Agency certifies the accuracy of the member months identified in Tables 2 through 5 in accordance with STC #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 the FMMIS fiscal agent: HP Enterprise, Inc.) has been assigned the task of designing and constructing the new CMS64 waiver software application. In preparation for this task, APS is operating the current CMS64 software system. APS's understanding of the current operation will facilitate its development and design of the new application. Agency staff is working with APS to address application requirements and general design concepts. The new reporting operation will become effective in January, 2015.

Table 1 shows the Primary Care Case Management (PCCM) Targets established in the waiver as specified in STC #76. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 1
PCCM Targets

WOW PCCM	MEG 1	MEG 2
DY01	$948.79	$199.48
DY02	$1,024.69	$215.44
DY03	$1,106.67	$232.68
DY04	$1,195.20	$251.29
DY05	$1,290.82	$271.39
DY06	$1,356.65	$285.77
DY07	$1,425.84	$300.92
DY08	$1,498.56	$316.87

Tables 1 through 8 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending March 31, 2014. 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.

Table 2 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
January 2014	335,444	$406,154,119	$95,754,688	$501,908,807	$1,496.25
February 2014	335,837	$272,744,863	$64,939,737	$337,684,601	$1,005.50
March 2014	336,271	$162,170,158	$40,344,772	$202,514,929	$602.24
Q31 Total	1,007,552	$841,069,140	$201,039,197	$1,042,108,337	$1,034.30
MEG 1 Total	26,585,395	23,628,818,707	4,464,582,322	28,093,401,028 92	1,056.72

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

Table 3 MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
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
January 2014	2,058,035	$481,915,539	$62,296,533	$544,212,072	$264.43
February 2014	2,068,819	$286,629,453	$38,948,927	$325,578,380	$157.37
March 2014	2,071,206	$132,621,415	$21,041,358	$153,662,773	$74.19
Q31 Total	6,198,060	$901,166,406	$122,286,818	$1,023,453,224	$165.12
MEG 2 Total	154,727,855	23,540,446,851	2,789,724,629	26,330,171,479	170.17

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

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

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

For Demonstration Year Four, MEG 1 has a PCCM of 1077.30 (Table 4), compared to WOW of $1,195.20 (Table 1), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 4), compared to WOW of $251.1 (Table 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 4), compared to WOW of $1,290.82 (Table 1, which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 (Table 4), compared to WOW of $271.39 (Table 1), which is 61.58% of the target PCCM for MEG 2.

For Demonstration Year Six, MEG 1 has a PCCM of $1,104.25 (Table 4), compared to WOW of $1,356.65 (Table 1), which is 81.40% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.11 (Table 4), compared to WOW of $285.77 (Table 1), which is 61.63% of the target PCCM for MEG 2.

For Demonstration Year Seven, MEG 1 has a PCCM of $1,096.18 (Table 4), compared to WOW of $1,425.84 (Table 1), which is 76.88% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.54 (Table 4), compared to WOW of $300.92 (Table 1, which is 59.66% of the target PCCM for MEG 2.

For Demonstration Year Eight, MEG 1 has a PCCM of $996.26 (Table 4), compared to WOW of $1,498.56 (Table 1), which is 66.48% of the target PCCM for MEG 1. MEG 2 has a PCCM of $168.97 (Table 4), compared to WOW of $316.87 (Table 1), which 53.32% of the target PCCM for MEG 2.

Tables 4 and 5 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 5) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For 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 5) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 3 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 5) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $309.27. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

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

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

For 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 5) is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $303.56. Comparing the calculated weighted averages, the actual PCCM is 70.14% 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 5) is $453.85. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $304.15. Comparing the calculated weighted averages, the actual PCCM is 67.02% 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 5) is $480.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 5 is $283.18. Comparing the calculated weighted averages, the actual PCCM is 58.99% of the target PCCM.

Table 4 MEG 1 and 2 Annual Statistics					
DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 Total	3,033,969	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,937,427,184	$500,344,974	$3,437,772,158	$1,057.86
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(158,619,822)	
% of WOW PCCM MEG 1					95.59%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,572,390,668	$281,844,467	$2,854,235,134	$166.96
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,123,392,237)	
% of WOW PCCM MEG 2					71.76%
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	3,357,141	$3,066,429,103	$550,235,443	$3,616,664,546	$1,077.30
WOW DY4 Total	3,357,141			$4,012,454,923	$1,195.20

Table 4 MEG 1 and 2 Annual Statistics					
Difference				**$(395,790,377)**	
% of WOW PCCM MEG 1					**90.14%**
DY04 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY04 Total	**20,033,842**	**$2,992,091,000**	**$351,770,759**	**$3,343,861,760**	**$166.91**
WOW DY4 Total	**20,033,842**			**$5,034,304,156**	**$251.29**
Difference				**$(1,690,442,397)**	
% of WOW PCCM MEG 2					**66.42%**
DY05 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY05 Total	**3,499,758**	**$3,247,599,951**	**$590,194,459**	**$3,837,794,411**	**$1,096.59**
WOW DY5 Total	**3,499,758**			**$4,517,557,622**	**$1,290.82**
Difference				**$(679,763,211)**	
% of WOW PCCM MEG 1					**84.95%**
DY05 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY05 Total	**21,686,199**	**$3,225,551,490**	**$398,406,833**	**$3,623,958,323**	**$167.11**
WOW DY5 Total	**21,686,199**			**$5,885,417,547**	**$271.39**
Difference				**$(2,261,459,223)**	
% of WOW PCCM MEG 2					**61.58%**
DY06 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY06 Total	**3,653,867**	**$3,385,729,683**	**$649,065,772**	**$4,034,795,456**	**$1,104.25**
WOW DY6 Total	**3,653,867**			**$4,957,018,666**	**$1,356.65**
Difference				**$(922,223,210)**	
% of WOW PCCM MEG 1					**81.40%**
DY06 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY06 Total	**22,956,197**	**$3,543,357,275**	**$499,558,259**	**$4,042,915,534**	**$176.11**
WOW DY6 Total	**22,956,197**			**$6,560,192,417**	**$285.77**
Difference				**$(2,517,276,882)**	
% of WOW PCCM MEG 2					**61.63%**
DY07 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY07 Total	**3,830,936**	**$3,327,639,269**	**$871,744,476**	**$4,199,383,745**	**$1,096.18**
WOW DY7 Total	**3,830,936**			**$5,462,301,786**	**$1,425.84**
Difference				**$(1,262,918,041)**	
% of WOW PCCM MEG 1					**76.88%**

Table 4 MEG 1 and 2 Annual Statistics					
DY07– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY07 Total	24,348,400	$3,887,828,826	$483,565,868	$4,371,394,694	$179.54
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,955,525,834)	
% of WOW PCCM MEG 2					59.66%
DY08 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY08 Total	2,981,567	$2,377,246,504	$593,174,353	$2,970,420,857	$996.26
WOW DY8 Total	2,981,567			$4,468,057,044	$1,498.56
Difference				$(1,497,636,187)	
% of WOW PCCM MEG 1					66.48%
DY08– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY08 Total	18,615,567	$2,771,500,253	$373,927,266	$3,145,427,518	$168.97
WOW DY8 Total	18,615,567			$5,898,714,715	$316.87
Difference				$(2,753,287,197)	
% of WOW PCCM MEG 2					53.32%

Table 5 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.27
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	

Table 5 MEG 1 and 2 Cumulative Statistics					
% 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	$6,929,086,958	$1,148,624,032	$8,077,710,990	$303.56
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,500,092)	
% Of WOW					70.14%
DY 07	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$7,215,468,095	$1,355,310,344	$8,570,778,439	$304.15
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,218,443,875)	
% Of WOW					67.02%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	21,597,134	$5,148,746,756	$967,101,619	$6,115,848,375	$283.18
WOW	21,597,134			$10,366,771,759	$480.01
Difference				$(4,250,923,384)	
% Of WOW					58.99%

Commencing with the January-March 2014 quarter, the Healthy Start Program and the Program for All-inclusive Care for Children (PACC) are authorized as Cost Not Otherwise Matchable (CNOM) services under the 1115 MMA Waiver. Table 6 identifies the DY08 costs for these two programs. For budget neutrality purposes, these CNOM costs are deducted from the savings resulting from the difference between the With Waiver costs and the With-Out Waiver costs identified for DY08 in Table 5 above.

Table 6 WW/WOW Difference Less CNOM Costs	
DY08 Difference July 2013 - March 014:	($4,250,923,384)
CNOM Costs Jan 2014 - Mar 2014:	
Healthy Start	$2,517,326
PACC	$109,028
DY08 Net Difference:	($4,248,297,031)

Table 7 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Q19	**$180,732,289**
Q20	**$353,499,776**
Q21	**$57,414,775**
Q22	**$346,827,872**
Q23	**$175,598,167**
Q24	**$227,391,753**
Q25	**$189,334,002**
Q26	**$243,596,958**
Q27	**$277,637,763**
Q28	**$308,722,821**
Q29	**$163,925,949**
Q30	**$316,726,485**
Q31	**$374,225,087**
Total Paid	**$7,677,150,822**

Table 8 shows that the expenditures for the 31 quarters for MEG 3, Low Income Pool (LIP), were $7,677,150,822 (95.96% of the $8 billion cap).

Table 8 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$807,232,567	$1,000,000,000	80.72%
DY07	$1,019,291,544	$1,000,000,000	101.93%
DY08	$854,877,521	$1,000,000,000	85.49%
Total MEG 3	$7,677,150,822	$8,000,000,000	95.96%

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

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