Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

3rd Quarter Report
January 1, 2015 – March 31, 2015
Demonstration Year 9

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I. Waiver History

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

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

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

- Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;
- Ensures the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan;
- Ensures recipient complaints, grievances, and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishes Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires MMA plans offer a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan;
- Requires Florida's external quality assurance organization to validate each MMA plan's encounter data every three years;
- Enhances consumer report cards to ensure recipients have access to understandable summaries of quality, access, and timeliness regarding the performance of each participating MMA plan;
- Enhances the MMA plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health, and reducing per capita Medicaid expenditures;
- Enhances metrics on MMA plan quality and access to care to improve MMA plan accountability; and
- Creates a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

Quarterly Report Requirement

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

This report is the third quarterly report for Demonstration Year 9 (DY9) covering the period of January 1, 2015, through March 31, 2015. For detailed information about the activities that occurred during previous quarters of the demonstration, please refer to the quarterly and annual reports at: http://ahca.myflorida.com/Medicaid/statewide_mc/mma_federal_reports.shtml.

II. Operational Update

1. Health Care Delivery System

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

a) MMA Plan Contracting

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

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

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

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

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

b) Benefit Packages

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

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

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

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

c) MMA Plan Reported Complaints, Grievances, and Appeals

MMA Plan Reported Complaints

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

Table 2 **MMA Plan Reported Complaints** (January 1, 2015 – March 31, 2015)	
Quarter	**Total**
January 1, 2015 – March 31, 2015	11,511

Grievances and Appeals

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

Table 3 MMA Grievances and Appeals (January 1, 2015 – March 31, 2015)		
Quarter	**Total Grievances**	**Total Appeals**
January 1, 2015 – March 31, 2015	4,572	1,693

Medicaid Fair Hearing (MFH)

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

Table 4 MMA MFHs Requested and Held (January 1, 2015 – March 31, 2015)		
Quarter	**MFHs Requested**	**MFHs Held**
January 1, 2015 – March 31, 2015	341	56

Subscriber Assistance Program

Table 5 provides the number of requests submitted to the SAP during this quarter.

Table 5 MMA SAP Requests (January 1, 2015 – March 31, 2015)	
Quarter	**Total**
January 1, 2015 – March 31, 2015	4

d) Agency-Received Complaints/Issues

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

Table 6 Agency-Received MMA Complaints/Issues (January 1, 2015 – March 31, 2015)	
Quarter	**Total**
January 1, 2015 – March 31, 2015	1,683

e) Medical Loss Ratio

During this quarter, 11 capitated plans submitted their fourth-quarter MLR reports for DY8 and 12 capitated plans submitted their annual MLR reports for DY8 to the Agency. The Agency submitted the capitated plans' DY8 MLR results to CMS in February 2015. None of the capitated plans reported an MLR below 85% for either the fourth quarter or annual reporting period. In addition, 18 capitated plans submitted their first-quarter MLR reports for DY9. The Agency submitted the capitated plans' DY9 MLR results to CMS in February 2015. One of the 18 capitated plans reported an MLR below 85% for the first quarter of DY9.

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

f) MMA Plan Readiness Review and Monitoring

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

2. Choice Counseling Program

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

a) Online Enrollment

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

Table 7
Online Enrollment Statistics
(January 1, 2015 – March 31, 2015)

	January	February	March	Total
Enrollments	19,637	21,346	42,889	**83,872**

b) Call Center Activities

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

quarter, the call center had an average of 274 full time equivalent employees available to answer calls.

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

Table 8
Call Volume for Incoming and Outgoing Calls
(January 1, 2015 – March 31, 2015)

Type of Calls	January	February	March	Totals
Incoming Calls	91,412	80,174	86,170	**257,756**
Outgoing Calls	2,486	13,022	4,205	**19,713**
Totals	**93,898**	**93,196**	**90,375**	**277,469**

Mail

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

Table 9
Outbound Mail Activities
(January 1, 2015 – March 31, 2015)

Mail Activities	Totals
New-Eligible Packets*	197,781
Confirmation Letters	224,449
Open Enrollment Packets	19,179

*Mandatory and voluntary.

Face-to-Face/Outreach and Education

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

Table 10
Choice Counseling Outreach Activities
(January 1, 2015 – March 31, 2015)

Field Activities	Totals
Group Sessions	290
Private Sessions	69
Home Visits and One-On-One Sessions	391

Quality Improvement

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

survey to every recipient who calls to enroll in an MMA plan or to make a plan change. The Agency is currently reviewing the survey for changes and improvements, as well as to assure all questions are still valid for the MMA program.

c) Self-Selection and Auto-Assignment Rates

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

Table 11
Self-Selection and Auto-Assignment Rates
(January 1, 2015 – March 31, 2015)

	January	February	March
Self-Selected	94,413	84,144	78,461
Auto-Assignment	69,794	67,761	56,628
Total Enrollments	164,207	151,905	135,089
Self-Selected %	57.5%	55.39%	58.08%
Auto-Assignment %	42.5%	44.61%	41.92%

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

3. Healthy Behaviors Programs

Healthy Behaviors Programs

Each of the 18 MMA plans were required to submit three Healthy Behavior Programs that addressed smoking cessation, weight loss, and alcohol or substance abuse. There were a total of 89 Healthy Behavior Programs submitted by the plans that were approved for implementation.

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

Enhanced Benefits Account Program

Attachment III of this report, Enhanced Benefits Account Program, provides an update for this quarter on Enhanced Benefits Account (EBA) program activities for the call center, statistics, advisory panel, and phase-out of the EBA program. The Agency will continue to provide EBA program statistics in the quarterly report until the fourth quarter of DY9.

4. MMA Plan and Regional Enrollment Data

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

- Number of MMA plans and
- Regional MMA enrollment.

5. Policy and Administrative Issues

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

Contract Amendments

During this quarter, the Agency finalized a general contract amendment for the MMA plans, effective January 15, 2015, which incorporated corrections and changes to the MMA plans’ contracts. A copy of the model contract may be viewed on the Agency’s Web site at the following link: http://ahca.myflorida.com/SMMC. In addition, on March 6, 2015, the Agency finalized a contract amendment with Freedom Health, Inc., for services to dual eligible enrollees with chronic conditions. Also during this quarter, the Agency finalized revisions to the SMMC Report Guide to include corrections and new reporting requirements and also began to gather items for the next general contract amendment.

Agency Communications to MMA Plans

There was one contract interpretation and four policy transmittals released to the MMA plans during this quarter.

The contract interpretation advised MMA plans of the following:

- Instructed MMA plans on which drugs they may reimburse in addition to those listed on the Agency’s Medicaid Preferred Drug List.

The policy transmittals advised the MMA plans of the following:

- Notified the MMA plans of an ad hoc report requirement regarding the provider network for Statewide Inpatient Psychiatric Program services.
- Notified the MMA plans of a new ad hoc report requirement regarding the Achieved Savings Rebate Financial Report.
- Notified the MMA plans of an audit regarding payments made under the Affordable Care Act Primary Care Services Rate Increase.
- Informed MMA plans of instructions for completing Child Health Check-Up (CHCUP) (Form CMS-416) and FL 80% Screening Report.

III. Low Income Pool

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

a) DY8 LIP STCs – Reporting Requirements

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

STC #84d – LIP Tier-One Milestones

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

- The Agency submitted the annual *Primary Care and Alternative Delivery Systems Report* for DY8 to CMS on February 16, 2015.
- The Agency submitted the encounter data for the completion of the annual *Milestone Statistics and Findings Report* for DY8 to the University of Florida on March 16, 2015.

b) Current (DY9) LIP STCs – Reporting Requirements

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

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

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

The Agency submitted the draft RFMD for DY9 on September 29, 2014.

- On January 9, 2015, CMS responded to the Agency's draft submission of the RFMD for DY9 with comments.
- On March 19, 2015, the Agency submitted the RFMD for DY9 and is awaiting feedback from CMS.

STC #78 – LIP Provider Participation Requirements

Provider access systems (hospitals, county health departments, and federally qualified health centers) and medical school physician practices who receive LIP funds have certain

participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds. The state may grant an exemption to a hospital of the requirement in (a)(ii) of this STC upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a specialty plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.

- On October 1, 2014, the LIP providers were required to meet the first LIP Participation Requirement Milestone in order to receive second-quarter distributions.
- On January 30, 2015, the LIP providers were required to meet the second LIP Participation Requirement Milestone in order to receive third-quarter distributions.
- On March 31, 2015, the LIP providers were required to meet the third LIP Participation Requirement Milestone in order to receive fourth-quarter distributions.

STC #79d – LIP Tier-One Milestones

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

- On September 29, 2014, the Agency submitted the anticipated timeline for the two annual reports and is awaiting feedback from CMS. There are no updates for this quarter.

IV. Demonstration Goals

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 3: To ensure that enrollee satisfaction increases.

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

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

STC #79 – Tier-One Milestones

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

Final Evaluation Plan

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

V. Monitoring Budget Neutrality

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

Updated Budget Neutrality

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

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

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

Please refer to Attachment V of this report, Budget Neutrality Update, for an update on budget neutrality figures through the third quarter (January 1, 2015 – March 31, 2015) of DY9.

VI. Encounter and Utilization Data

a) Encounter Data

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

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

The Agency and the Medicaid fiscal agent developed new outreach activities to assist the MMA plans with encounter submissions and submission issues. The HP Encounter Support team continues to work with the MMA plans to offer onsite visits, training, and technical assistance. They have regularly scheduled meetings with most of the MMA plans and meet with some of them monthly. The MMA plans have been very appreciative of the meetings and have reported reductions in their denied encounter rates since meeting with the support team.

b) Rate Setting/Risk Adjustment

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

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

VII. Evaluation of the Demonstration

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

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

Pending and Upcoming Evaluation Reports and Activities

The Agency submitted the draft Final Evaluation Summary Report to CMS on October 28, 2014. Key findings of this report were included in the DY9 Quarter 2 report.

The University of Florida evaluation team submitted the Preliminary Low Income Pool Milestone Statistics and Findings Report on February 23, 2015. Agency staff reviewed the report and provided comments to the evaluators in March. The Agency will submit the final version of the report to CMS in the fourth quarter of DY9.

The following provides an update of the pending and upcoming MMA Waiver evaluation activities as of the third quarter of DY9:

- The Agency submitted the revised MMA evaluation design (for the waiver period July 1, 2014 through June 30, 2017) to CMS on January 30, 2015. The Agency received CMS' comments on the design at the end of February, and staff began working on additional revisions and clarifications to the design. The revised evaluation design will be submitted to CMS in the fourth quarter of DY9.
- At the end of February, the Agency received proposals from Florida state universities to conduct the MMA Waiver evaluation.
- Agency staff reviewed the evaluation proposals in March and made a recommendation to management regarding with which university we will work to initiate a contract for the evaluation.

The Agency will work with the selected university to develop a contract during the fourth quarter of DY9.

VIII. Quality

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

a) EQRO

During state fiscal year (SFY) 2014 – 2015, the Agency contracted with HSAG to conduct an encounter data validation study. The goal of the study is to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate. One component of the study includes HSAG's evaluation of encounter data completeness and accuracy through the review of medical records. In February 2015, HSAG held two technical assistance conference calls with the managed care plans to provide clarification and to offer the opportunity for plans to ask questions regarding the medical record procurement process. Based on the questions received during these calls, HSAG put together and distributed a Questions and Answers document to the plans. HSAG identified a sample of medical records for each managed care plan, and the plans were directed to submit the medical records to HSAG by April 3, 2015.

On February 24, 2015, HSAG conducted an external quality review quarterly educational webinar for the Statewide Medicaid Managed Care plans, the Agency, and the Department of Elder Affairs. Presentations were given by CMS on *Developing an Effective Oral Health Performance Improvement Project*, the Agency's Policy Bureau on *Florida's State Oral Health Action Plan*, and the Florida Center for Health Information and Policy Analysis on *The Event Notification Service*. The next external quality review quarterly educational meeting is scheduled for May 12, 2015, in Tallahassee, and HSAG will be conducting training and breakout sessions on Performance Improvement Projects.

On February 24, 2015, HSAG submitted the *SFY 2013 – 2014 Annual Technical Report of External Quality Review Results* to the Agency. The Agency approved the report on March 25, 2015 and submitted it to CMS on March 30, 2015.

During SFY 2014 – 2015, the Agency contracted with HSAG to conduct a pharmacy-based encounter data validation special study in support of the Agency's prescription drug rebate program. The purpose of this study was to examine the extent to which pharmacy encounters submitted to the Agency by its contracted managed care plans are an accurate reflection of the prescription data processed, collected, and maintained within the prescription drug processing system. On February 26, 2015, HSAG submitted the *Remittance Advice Analysis Results for Retail Pharmacies* report to the Agency. This is the final deliverable for this study.

b) Plan Performance Measure Reporting

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

During the first and second quarters of DY9, Agency staff compared the MMA plans' HEDIS performance measure rates to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance for HEDIS 2013). These comparisons were used

to assign performance measure category and individual performance measure ratings to each MMA plan for the Health Plan Report Card. These comparisons are also being used to determine any liquidated damages related to performance measures. During the third quarter of DY9, the Medicaid Health Plan Report Card was posted on the Agency's Florida Health Finder Web site at the following link: http://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5. Agency staff also calculated the liquidated damages related to performance measures.

During the third quarter of DY9, Agency staff sent a policy transmittal with the revised CMS-416/Child Health Check-Up Report instructions and template to the MMA plans, based on the revisions released by CMS in November 2014. Agency staff also sent a communication to the MMA plans that clarified some performance measure reporting requirements for the report due July 1, 2015 (representing calendar year 2014). The MMA plans submitted their CHCUP reports to the Agency in late February, and Agency staff began reviewing the results and determining any applicable liquidated damages.

c) Comprehensive Quality Strategy

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

d) Assessing Enrollee Satisfaction

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

Under the MMA program, the MMA plans are required to contract with a National Committee for Quality Assurance-certified CAHPS Survey Vendor to conduct their CAHPS Surveys for Children and Adults on an annual basis. MMA plans are required to submit their survey results to the Agency by July 1 of each year, beginning with 2015. During the second quarter of DY9, Agency staff reviewed and approved the MMA plans' Enrollee Survey Proposals. During the second and third quarters of DY9, Agency staff reviewed and approved the MMA plans' survey materials.

Attachment I
Expanded Benefits under the MMA Program

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

Expanded Benefits Offered by MMA Standard Plans

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

Attachment II
Healthy Behaviors Program Enrollment

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

For this quarter (January 1, 2015 – March 31, 2015), 7 out of 18 MMA plans reported no enrollment in any of the Healthy Behaviors Programs offered and 3 of the 18 plans reported enrollees had completed at least one Healthy Behaviors Program.

Chart A
Healthy Behaviors Program
Enrollment Statistics
(January 1, 2015 – March 31, 2015)

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Amerigroup Florida							
Smoking Cessation	1	0	1	0	0	1	0
Weight Management	12	2	10	2	5	4	1
Alcohol and/or Substance Abuse	0	-	-	-	-	-	-
CDC Performance Measure Incentive	0	-	-	-	-	-	-
Performance Measure Incentives	0	-	-	-	-	-	-
Maternal Child Incentive	0	-	-	-	-	-	-
Better Health							
Smoking Cessation	1	1	0	0	0	0	1
Weight Management	4	3	1	0	0	2	2
Substance Abuse	0	-	-	-	-	-	-
Maternity	0	-	-	-	-	-	-
Well Child Visits	1	1	0	1	0	0	0
Children's Medical Services							
Tobacco Cessation	0	-	-	-	-	-	-
Overcoming Obesity	0	-	-	-	-	-	-
Changing Lives*	0	-	-	-	-	-	-
Clear Health Alliance							
Quit Smoking Healthy Behaviors Rewards	0	-	-	-	-	-	-
Weight Management Healthy Behaviors Rewards	1	0	1	0	0	1	0
Alcohol & Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	0	-	-	-	-	-	-
Well Child Visit Healthy Behaviors Rewards	0	-	-	-	-	-	-

Chart A Healthy Behaviors Program Enrollment Statistics (January 1, 2015 – March 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Coventry							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Substance Abuse	0	-	-	-	-	-	-
Baby Visions Prenatal & Postpartum Incentive	0	-	-	-	-	-	-
Freedom Health							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Humana Medical Plan							
Smoking Cessation	0	-	-	-	-	-	-
Family Fit	59	9	50	2	23	27	7
Substance Abuse	0	-	-	-	-	-	-
Mom's First Prenatal & Postpartum	2,088	0	2,088	217	1,835	36	0
First Baby Well Visit Incentive	6,016	3,106	2,910	6,016	0	0	0
Children's Nutrition Incentive	121,189	61,001	60,188	121,189	0	0	0
Lead Screening & Well-Child Visit Incentive	36,745	18,758	17,987	36,745	0	0	0
Adolescent Well-Child Visits Incentive	67,165	32,735	34,430	67,165	0	0	0
Integral Quality Care							
Smoking Cessation	0	-	-	-	-	-	-
Weight Management	0	-	-	-	-	-	-
Substance Abuse Counseling	0	-	-	-	-	-	-
Adult Health Maintenance	0	-	-	-	-	-	-
Child Health Maintenance	0	-	-	-	-	-	-
Magellan Complete Care							
Smoking & Tobacco Cessation	67	18	49	1	16	46	4
Weight Management	160	24	136	12	65	75	8
Substance Abuse	32	17	15	2	8	18	4
Molina							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Pregnancy Health	0	-	-	-	-	-	-

Chart A Healthy Behaviors Program Enrollment Statistics (January 1, 2015 – March 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Management							
Pediatric Preventative Care	0	-	-	-	-	-	-
Positive Health Care							
Quit for Life Tobacco Cessation	0	-	-	-	-	-	-
Weight Management	0	-	-	-	-	-	-
Alcohol Abuse	0	-	-	-	-	-	-
Preferred							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Cervical Cancer Screening	0	-	-	-	-	-	-
CHCUP Preventive & Wellness Care	3	2	1	3	0	0	0
Mammogram	0	-	-	-	-	-	-
Pre-Natal/Preferred Kids Safety & Postpartum	8	0	8	0	8	0	0
Prestige Health Choice							
Smoking Cessation	70	15	55	0	15	46	9
Weight Loss	109	14	95	12	27	55	15
Alcohol & Substance Abuse – “Changing Lives Program”	4	1	3	0	2	2	0
Simply							
Quit Smoking Healthy Behaviors Rewards	1	1	0	0	0	1	0
Weight Management Healthy Behaviors Rewards	0	-	-	-	-	-	-
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	0	-	-	-	-	-	-
Well Child Visit Healthy Behaviors Rewards	0	-	-	-	-	-	-
South Florida Community Care Network							
Tobacco Cessation	0	-	-	-	-	-	-
Obesity Management	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Staywell							
Smoking Cessation	163	61	102	3	41	104	15
Weight Management	762	213	549	151	190	333	88

Chart A Healthy Behaviors Program Enrollment Statistics (January 1, 2015 – March 31, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Substance Abuse	1	1	0	0	0	1	0
Healthy Diabetes Behaviors	0	-	-	-	-	-	-
New Member Healthy Behavior Engagement	0	-	-	-	-	-	-
Well Woman Healthy Behavior	0	-	-	-	-	-	-
Children's Healthy Behavior Engagement	0	-	-	-	-	-	-
Sunshine Health							
Tobacco Cessation Healthy Rewards	40	14	26	0	6	26	8
Weight Loss Healthy Rewards	63	8	55	2	20	33	8
Substance Abuse Healthy Rewards	7	2	5	2	4	1	0
Preventive Adult Primary Care Visits	0	-	-	-	-	-	-
Preventative Well Child Primary Care Visits	0	-	-	-	-	-	-
Start Smarts for your Baby (perinatal management)	0	-	-	-	-	-	-
Post Behavioral Health Discharge Visit in 7 Days	0	-	-	-	-	-	-
Preventive Dental Visits for Children	0	-	-	-	-	-	-
Diabetic Healthy Rewards	0	-	-	-	-	-	-
Female Cancer Screening	0	-	-	-	-	-	-
UnitedHealthcare							
Tobacco Cessation – text2quit	1	0	1	0	0	0	1
Florida Population Health/Health Coaching for Weight Loss	4	1	3	0	3	1	0
Substance Abuse Incentive	0	-	-	-	-	-	-
Baby Blocks	307	0	307	45	256	6	0

*Alcohol and/or substance abuse program.

Chart B Healthy Behavior Programs Completion Statistics (January 1, 2015 – March 31, 2015)							
Program	**Total Completed**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Prestige Health Choice							
Smoking Cessation	1	0	1	0	0	1	0
Weight Loss	10	0	10	1	3	5	1
Alcohol & Substance Abuse – “Changing Lives Program”	1	0	1	0	1	0	0
Staywell							
Smoking Cessation	53	21	32	1	12	35	5
Weight Management	205	62	143	45	56	79	25
Sunshine Health							
Tobacco Cessation Healthy Rewards	3	2	1	0	0	2	1
Weight Loss Healthy Rewards	3	0	3	0	0	2	1

Attachment III
Enhanced Benefits Account Program

The following provides an update for this quarter on the EBA program activities for the call center, statistics, advisory panel, and phase-out of the EBA program. The Agency will continue to provide EBA program statistics in the quarterly report until the fourth quarter of DY9.

Call Center Activities

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

The Automated Voice Response System (AVRS), which provides recipients balance-only information, handled 4,458 calls during this quarter. Chart A of Attachment III highlights the enhanced benefits call center and mailroom activities during this quarter.

Chart A
Highlights of the Enhanced Benefits Call Center Activities
(January 1, 2015 – March 31, 2015)

Enhanced Benefits Call Center Activity	January	February	March
Calls Received	2,036	2,584	2,364
Calls Answered	2,029	2,582	2,359
Average Talk Time (minutes)	4:45	4:15	4:39
Calls Handled by the AVRS	1,939	1,364	1,155
Outbound Calls	5	2	1
Enhanced Benefits Mailroom Activity			
Enhanced Benefits Welcome Letters	0	0	0

Outreach and Education

During this quarter, the call center did not mail any welcome letters. There were 10,152 coupon statements mailed during this quarter. The choice counselors continue to provide up-to-date information for recipients regarding their EBA balances.

Complaints

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

Chart B Enhanced Benefits Recipient Complaints (January 1, 2015 – March 31, 2015)	
Recipient Complaint	**Action Taken**
There were no complaints reported by the enhanced benefits call center this quarter.	N/A

Enhanced Benefits Statistics

As of the end of this quarter, 14,408 recipients lost EBA eligibility resulting in losing EBA credits, totaling $646,895.06. Chart C of Attachment III provides the EBA program statistics during this quarter.

Chart C EBA Program Statistics (January 1, 2015 – March 31, 2015)				
Activities		**January**	**February**	**March**
I.	Number of plans submitting reports by month in each county	*	*	*
II.	Number of enrollees who received credit for healthy behaviors by month	*	*	*
III.	Total dollar amount credited to accounts by each month	*	*	*
IV.	Total cumulative dollar amount credited through the end each month	*	*	*
V.	Total dollar amount of credits used each month by date of service	$213,599.51	$213,829.74	$250,026.34
VI.	Total cumulative dollar amount of credits used through the month by date of service	$50,275,131.09	$50,488,960.83	$50,738,987.17
VII.	Total unduplicated number of enrollees who used credits each month	7,390	6,809	7,341

* Reform health plans are no longer required to submit the Enhanced Benefits Report. Ending balance of total credits earned remains at $83,533,013.66.

Enhanced Benefits Advisory Panel

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

Notice of EBA Program Phase-Out

During this quarter, 323,669 notices were mailed to recipients in Broward County regarding the phase-out of the EBA program.

Attachment IV
MMA Enrollment Report

Number of MMA Plans in Regions Report

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

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

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

Chart A **Number of MMA Plans by Region** (January 1, 2015 – March 31, 2015)		
Region	**General**	**Specialty**
1	2	3
2	2	4
3	4	4
4	4	3
5	4	5
6	7	5
7	6	5
8	4	4
9	4	5
10	4	6
11	10	6
Unduplicated Totals	**14**	**6**

MMA Enrollment

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

Chart B
MMA Enrollment by Plan and Type Report Descriptions

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

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

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

Chart C
MMA Enrollment by Plan and Type*
(January 1, 2015 – March 31, 2015)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	General	296,038	31,243	55	15,044	**342,380**	11.1%	**330,323**	3.65%
Better Health	General	81,846	9,108	25	4,042	**95,021**	3.1%	**92,954**	2.22%
Coventry Health Care of Florida	General	40,471	4,304	34	3,301	**48,110**	1.6%	**45,331**	6.13%
First Coast Advantage	General	-	-	-	-	**0**	0%	**65,878**	-100%
Humana Medical Plan	General	247,816	35,285	163	26,973	**310,237**	10.1%	**290,700**	6.72%
Integral Quality Care	General	81,580	7,975	5	5,273	**94,833**	3.1%	**92,239**	2.81%
Molina Healthcare of Florida	General	144,902	16,186	18	8,308	**169,414**	5.5%	**100,799**	68.07%
Preferred Medical Plan	General	23,442	3,649	21	2,717	**29,829**	1.0%	**29,674**	0.52%
Prestige Health Choice	General	263,986	31,509	34	19,478	**315,007**	10.2%	**305,088**	3.25%
South Florida Community Care Network	General	39,099	3,635	9	1,761	**44,504**	1.4%	**44,244**	0.59%
Simply Healthcare	General	63,032	12,831	150	10,618	**86,631**	2.8%	**82,414**	5.12%
Staywell Health Plan	General	598,332	67,717	51	28,596	**694,696**	22.6%	**669,850**	3.71%
Sunshine State Health Plan	General	349,026	37,091	55	43,160	**429,332**	14.0%	**410,724**	4.53%
United Healthcare of Florida	General	222,323	28,496	54	29,664	**280,537**	9.1%	**267,593**	4.84%
Standard Plans Total		**2,451,893**	**289,029**	**674**	**198,935**	**2,940,531**	**95.7%**	**2,827,811**	**3.99%**
Positive Health Plan	Specialty	197	912	0	788	**1,897**	0.1%	**1,749**	8.46%
Magellan Complete Care	Specialty	16,813	17,996	9	236	**35,054**	1.1%	**38,798**	-9.65%
Freedom Health	Specialty	0	0	0	97	**97**	0.003%	**0**	N/A
Clear Health Alliance	Specialty	1,238	4,881	1	3,239	**9,359**	0.3%	**9,142**	2.37%
Sunshine State Health Plan	Specialty	19,745	1,812	0	2	**21,559**	0.7%	**23,175**	-6.97%
Children's Medical Services Network	Specialty	38,709	26,558	0	123	**65,390**	2.1%	**66,425**	-1.56%
Specialty Plans Total		**76,702**	**52,159**	**10**	**4,485**	**133,356**	**4.3%**	**139,289**	**-4.26%**
MMA TOTAL		**2,528,595**	**341,188**	**684**	**203,420**	**3,073,887**	**100%**	**2,967,100**	**3.60%**

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

Chart D
MMA Enrollment by Region and Type
(January 1, 2015 – March 31, 2015)

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	MMA	**83,697**	11,332	2	6,393	**101,424**	3.3%	**98,015**	3.48%
02	MMA	**91,228**	14,662	16	8,711	**114,617**	3.7%	**111,789**	2.53%
03	MMA	**213,788**	29,833	21	16,236	**259,878**	8.5%	**252,007**	3.12%
04	MMA	**256,280**	31,234	13	17,526	**305,053**	9.9%	**296,305**	2.95%
05	MMA	**150,469**	21,891	12	14,425	**186,797**	6.1%	**180,916**	3.25%
06	MMA	**354,979**	47,357	39	20,683	**423,058**	13.8%	**407,282**	3.87%
07	MMA	**338,725**	45,113	31	18,353	**402,222**	13.1%	**386,714**	4.01%
08	MMA	**183,653**	18,620	20	13,281	**215,574**	7.0%	**207,925**	3.68%
09	MMA	**222,767**	24,568	24	14,844	**262,203**	8.5%	**251,823**	4.12%
10	MMA	**217,211**	26,831	68	15,506	**259,616**	8.4%	**250,160**	3.78%
11	MMA	**415,798**	69,747	438	57,462	**543,445**	17.7%	**524,164**	3.68%
MMA Total		**2,528,595**	**341,188**	**684**	**203,420**	**3,073,887**	**100%**	**2,967,100**	**3.60%**
01	General	**81,938**	10,373	2	6,318	**98,631**	3.4%	**94,926**	3.90%
02	General	**86,236**	11,837	16	8,607	**106,696**	3.6%	**103,410**	3.18%
03	General	**207,539**	26,921	21	15,997	**250,478**	8.5%	**242,755**	3.18%
04	General	**247,655**	26,699	13	17,495	**291,862**	9.9%	**281,935**	3.52%
05	General	**144,532**	18,211	11	13,842	**176,596**	6.0%	**170,143**	3.79%
06	General	**344,371**	39,887	39	20,347	**404,644**	13.8%	**388,051**	4.28%
07	General	**327,875**	37,126	29	17,886	**382,916**	13.0%	**365,650**	4.72%
08	General	**179,047**	16,482	20	13,051	**208,600**	7.1%	**200,502**	4.04%
09	General	**215,202**	19,709	23	14,357	**249,291**	8.5%	**238,304**	4.61%
10	General	**209,421**	20,998	68	14,901	**245,388**	8.3%	**235,813**	4.06%
11	General	**408,077**	60,786	432	56,134	**525,429**	17.9%	**506,322**	3.77%
General Total		**2,451,893**	**289,029**	**674**	**198,935**	**2,940,531**	**100.0%**	**2,827,811**	**3.99%**

Chart D
MMA Enrollment by Region and Type
(January 1, 2015 – March 31, 2015)

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	Specialty	**1,759**	959		75	**2,793**	2.1%	**3,089**	-9.58%
02	Specialty	**4,992**	2,825		104	**7,921**	5.9%	**8,379**	-5.47%
03	Specialty	**6,249**	2,912		239	**9,400**	7.0%	**9,252**	1.60%
04	Specialty	**8,625**	4,535		31	**13,191**	9.9%	**14,370**	-8.20%
05	Specialty	**5,937**	3,680	1	583	**10,201**	7.6%	**10,773**	-5.31%
06	Specialty	**10,608**	7,470		336	**18,414**	13.8%	**19,231**	-4.25%
07	Specialty	**10,850**	7,987	2	467	**19,306**	14.5%	**21,064**	-8.35%
08	Specialty	**4,606**	2,138		230	**6,974**	5.2%	**7,423**	-6.05%
09	Specialty	**7,565**	4,859	1	487	**12,912**	9.7%	**13,519**	-4.49%
10	Specialty	**7,790**	5,833		605	**14,228**	10.7%	**14,347**	-0.83%
11	Specialty	**7,721**	8,961	6	1,328	**18,016**	13.5%	**17,842**	0.98%
Specialty Total		**76,702**	**52,159**	**10**	**4,485**	**133,356**	**100.0%**	**139,289**	**-4.26%**

Attachment V
Budget Neutrality Update

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

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

In accordance with STC #88(d)(ii), the Agency initiated the development of the new CMS-64 reporting operation that will be required to support the MMA Waiver. The new reporting operation was effective October 2014 (Q34 - date of payment), which is the first complete quarter under the MMA program.

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

Chart A
PCCM Targets

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

*Without waiver.

**Medicaid eligibility group.

Charts B through H of Attachment V contain the statistics for MEGs 1, 2, and 3 for date of payment beginning with the period January 1, 2015 and ending March 31, 2015. Case months provided in Charts B and C for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Chart B MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case Months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	737,829	$534,465,763	$13,022,287	$547,488,050	$742.03
Q2 Total	741,024	$656,999,737	$40,270,607	$697,270,344	$940.96
Q3 Total	746,739	$627,627,027	$74,363,882	$701,990,909	$940.08
Q4 Total	752,823	$627,040,703	$98,024,915	$725,065,618	$963.13
Q5 Total	755,417	$630,937,251	$101,516,732	$732,453,983	$969.60
Q6 Total	755,837	$648,757,106	$106,374,845	$755,131,951	$999.07
Q7 Total	758,014	$651,490,311	$111,968,931	$763,459,242	$1,007.18
Q8 Total	764,701	$661,690,100	$115,206,649	$776,896,750	$1,015.95
Q9 Total	818,560	$708,946,109	$116,393,637	$825,339,746	$1,008.28
Q10 Total	791,043	$738,232,869	$128,914,992	$867,147,861	$1,096.21
Q11 Total	810,753	$783,046,121	$125,741,442	$908,787,564	$1,120.92
Q12 Total	829,386	$676,381,576	$120,999,077	$797,380,652	$961.41
Q13 Total	826,842	$846,747,351	$153,763,674	$1,000,511,025	$1,210.04
Q14 Total	830,530	$769,968,776	$137,267,631	$907,236,407	$1,092.36
Q15 Total	847,324	$781,783,604	$141,815,963	$923,599,567	$1,090.02
Q16 Total	852,445	$732,226,661	$129,489,247	$861,715,907	$1,010.88
Q17 Total	868,873	$880,557,949	$163,583,238	$1,044,141,187	$1,201.72
Q18 Total	876,564	$823,362,358	$147,720,232	$971,082,591	$1,107.83
Q19 Total	851,488	$793,116,969	$137,115,775	$930,232,743	$1,092.48
Q20 Total	902,833	$730,735,500	$137,409,896	$868,145,395	$961.58
Q21 Total	933,661	$897,184,808	$165,500,587	$1,062,685,395	$1,138.19
Q22 Total	916,713	$780,812,437	$149,928,159	$930,740,596	$1,015.30
Q23 Total	871,050	$806,728,589	$161,201,346	$967,929,935	$1,111.22
Q24 Total	932,443	$878,147,146	$168,609,996	$1,046,757,142	$1,122.60
Q25 Total	939,670	$876,968,622	$168,972,615	$1,045,941,236	$1,113.09
Q26Total	953,518	$865,669,039	$218,704,121	$1,084,373,159	$1,137.24
Q27 Total	964,650	$749,820,061	$229,337,800	$979,157,860	$1,015.04
Q28 Total	973,098	$855,023,277	$235,487,639	$1,090,510,916	$1,120.66
Q29 Total	982,712	$879,236,988	$234,142,785	$1,113,379,773	$1,132.97
Q30 Total	991,303	$894,044,760	$230,694,425	$1,124,739,185	$1,116.89
Q31 Total	1,007,552	$841,069,140	$201,039,197	$1,042,108,337	$1,034.30
Q32 Total	1,018,823	$882,045,900	$175,884,772	$1,057,930,671	$1,038.39
Q33 Total	1,025,818	$890,525,436	$136,560,571	$1,027,086,007	$1,001.24
Q34 Total	1,500,372			$1,307,504,932	$871.45
January 2015	408,646			$213,316,912	$522.01
February 2015	531,282			$385,253,606	$725.14
March 2015	522,429			$535,785,514	$1,025.57
Q35 Total	**1,462,357**			**$1,134,356,032**	**$775.70**
MEG 1 Total	**31,592,765**	**$25,401,390,043**	**$4,777,027,664**	**$32,620,278,671**	**$1,032.52**

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

Chart C MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	3,944,437	$491,214,740	$1,723,494	$492,938,235	$124.97
Q2 Total	3,837,172	$590,933,703	$21,021,285	$611,954,988	$159.48
Q3 Total	3,728,063	$559,579,323	$44,697,737	$604,277,060	$162.09
Q4 Total	3,653,147	$524,161,918	$57,096,383	$581,258,301	$159.11
Q5 Total	3,588,363	$520,316,242	$57,360,334	$577,676,576	$160.99
Q6 Total	3,648,832	$553,763,665	$63,871,154	$617,634,819	$169.27
Q7 Total	3,736,212	$570,477,394	$69,992,290	$640,469,684	$171.42
Q8 Total	3,856,584	$564,601,990	$70,899,271	$635,501,261	$164.78
Q9 Total	4,080,307	$586,455,736	$70,031,931	$656,487,667	$160.89
Q10 Total	4,174,698	$659,100,473	$71,936,704	$731,037,178	$175.11
Q11 Total	4,298,379	$708,620,481	$73,835,227	$782,455,708	$182.04
Q12 Total	4,541,456	$581,030,798	$60,822,514	$641,853,312	$141.33
Q13 Total	4,772,864	$824,013,811	$98,637,714	$922,651,526	$193.31
Q14 Total	4,959,454	$768,385,369	$89,723,473	$858,108,842	$173.02
Q15 Total	5,098,381	$773,609,163	$93,647,855	$867,257,018	$170.10
Q16 Total	5,203,143	$793,529,141	$90,471,922	$884,001,063	$169.90
Q17 Total	5,356,742	$766,604,001	$91,544,719	$858,148,720	$160.20
Q18 Total	5,470,396	$848,694,828	$99,937,769	$948,632,597	$173.41
Q19 Total	5,247,390	$787,922,115	$91,638,763	$879,560,878	$167.62
Q20 Total	5,611,671	$673,700,632	$90,712,877	$764,413,510	$136.22
Q21 Total	5,695,156	$965,461,910	$121,274,250	$1,086,736,159	$190.82
Q22 Total	5,773,020	$778,633,250	$99,802,883	$878,436,134	$152.16
Q23 Total	5,592,756	$860,576,398	$115,331,882	$975,908,280	$174.50
Q24 Total	5,895,265	$922,979,983	$122,296,078	$1,045,276,061	$177.31
Q25 Total	6,013,128	$884,131,387	$121,673,666	$1,005,805,053	$167.27
Q26 Total	6,092,265	$1,016,884,642	$131,066,964	$1,147,951,606	$188.43
Q27 Total	6,117,120	$915,201,600	$133,635,131	$1,048,836,732	$171.46
Q28 Total	6,125,887	$1,018,851,885	$133,876,042	$1,152,727,927	$188.17
Q29 Total	6,179,797	$1,059,131,680	$75,589,844	$1,193,254,080	$193.09
Q30 Total	6,237,710	$1,070,712,185	$144,755,094	$1,215,467,279	$194.86
Q31 Total	6,198,060	$901,166,406	$122,286,818	$1,023,453,224	$165.12
Q32 Total	6,251,742	$901,370,619	$134,058,091	$1,035,428,710	$165.62
Q33 Total	6,536,925	$1,005,038,684	$131,032,178	$1,136,070,862	$173.79
Q34 Total	6,858,360			$1,997,982,421	$291.32
January 2015	2,293,805			$313,542,190	$136.69
February 2015	2,487,261			$580,734,739	$233.48
March 2015	2,513,081			$826,263,254	$328.78
Q35 Total	**7,294,147**			**$1,720,540,183**	**$235.88**
MEG 2 Total	**181,669,029**	**$25,446,856,153**	**$3,054,814,898**	**$32,220,193,655**	**$177.36**

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

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

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

Chart D MEGs 1 and 2 Annual Statistics					
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY4 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY4 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY5 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY5 Total	3,499,758	$3,247,599,951	$590,194,459	$3,837,794,411	$1,096.59
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(679,763,211)	
% of WOW PCCM MEG 1					84.95%
DY5 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY5 Total	21,686,199	$3,225,551,490	$398,406,833	$3,623,958,323	$167.11
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,261,459,223)	
% of WOW PCCM MEG 2					61.58%
DY6 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY6 Total	3,653,867	$3,385,729,683	$649,065,772	$4,034,795,456	$1,104.25
WOW DY6 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(922,223,210)	
% of WOW PCCM MEG 1					81.40%
DY6 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY6 Total	22,956,197	$3,543,588,406	$499,575,622	$4,043,164,027	$176.13
WOW DY6 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,517,028,389)	
% of WOW PCCM MEG 2					61.63%
DY7 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY7 Total	3,830,936	$3,331,762,672	$910,186,295	$4,241,948,967	$1,107.29
WOW DY7 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,220,352,819)	
% of WOW PCCM MEG 1					77.66%
DY7 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY7 Total	24,348,400	$3,892,512,229	$488,692,125	$4,381,204,354	$179.94
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,945,716,174)	

Chart D MEGs 1 and 2 Annual Statistics					
% of WOW PCCM MEG 2					59.80%
DY8 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY8 Total	4,000,390	$3,414,538,645	$918,876,580	$4,333,415,225	$1,083.25
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,661,409,213)	
% of WOW PCCM MEG 1					72.29%
DY8 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY8 Total	24,867,309	$3,783,670,392	$619,099,455	$4,402,769,846	$177.05
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,476,934,357)	
% of WOW PCCM MEG 2					55.87%
DY9 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY9 Total	3,988,547			$3,121,318,052	$782.57
WOW DY9 Total	3,988,547			$3,137,789,925	$786.70
Difference				$(16,471,873)	
% of WOW PCCM MEG 1					101.46%
DY9 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY9 Total	20,689,432			$4,622,621,695	$223.43
WOW DY9 Total	20,689,432			$6,706,065,594	$324.13
Difference				$(2,083,443,900)	
% of WOW PCCM MEG 2					68.93%

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

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

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

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

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

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

For DY7, MEG 1 has a PCCM of $1,107.29 (Chart D), compared to WOW of $1,425.84 (Chart A), which is 77.66% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.94 (Chart D), compared to WOW of $300.92 (Chart A), which is 59.80% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1,083.25 (Chart D), compared to WOW of $1,498.56 (Chart A), which is 72.20% of the target PCCM for MEG 1. MEG 2 has a PCCM of $177.05 (Chart D), compared to WOW of $316.87 (Chart A), which is 55.87% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $782.57 (Chart D), compared to WOW of $786.70 (Chart A), which is 99.48% of the target PCCM for MEG 1. MEG 2 has a PCCM of $223.43 (Chart D), compared to WOW of $324.13 (Chart A), which is 68.93% of the target PCCM for MEG 2.

Chart E
MEGs 1 and 2 Cumulative Statistics

DY1	Actual CM	MEGs 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
MEGs 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% of WOW					91.02%
DY2	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% of WOW					89.15%
DY3	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.27
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% of WOW					83.07%
DY4	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% of WOW					76.94%
DY5	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27

Chart E MEGs 1 and 2 Cumulative Statistics					
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% of WOW					71.73%
DY6	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% of WOW					70.14%
DY7	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	28,179,336	$7,224,274,901	$1,398,878,420	$8,623,153,321	$306.01
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,166,068,993)	
% of WOW					67.43%
DY8	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	28,867,699	$7,198,209,036	$1,537,976,035	$8,736,185,071	$302.63
WOW	28,867,699			$13,874,528,641	$480.62
Difference				$(5,138,343,570)	
% of WOW					62.97%
DY9	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	24,677,979			$7,743,939,747	$313.80
WOW	24,677,979			$9,843,855,519	$398.89
Difference				$(2,099,915,772)	
% of WOW					78.67%

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

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

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

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

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

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

For DY7, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart F) is $453.85. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table F is $306.01. Comparing the calculated weighted averages, the actual PCCM is 67.43% of the target PCCM.

For DY8, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Chart F) is $480.62. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table F is $302.63. Comparing the calculated weighted averages, the actual PCCM is 62.97% of the target PCCM.

For DY9, the weighted target PCCM for the reporting period using the actual case months and the MMA specific targets in the STCs (Chart G) is $398.89. The actual PCCM weighted for the reporting period using the actual case months and the MMA specific actual PCCM as provided in Table F is $313.80. Comparing the calculated weighted averages, the actual PCCM is 78.67% of the target PCCM.

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

Chart F WW/WOW Difference Less CNOM Costs	
DY9 Difference July 2014 – March 2015	$(2,099,915,772)
CNOM Costs July 2014 – December 2014	
Healthy Start	$1,456,462
PACC	$420,001
DY9 Net Difference	**(2,098,039,309)**

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

Chart G MEG 3 Statistics: LIP	
MEG 3 LIP	**Paid Amount**
Q30	$316,726,485
Q31	$374,225,087
Q32	$301,519,921
Q34	$690,421,416
Q35	$556,474,290
Total Paid	**$9,225,566,449**

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

Chart H MEG 3 Total Expenditures: LIP			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY1	$998,806,049	$1,000,000,000	99.88%
DY2	$999,632,926	$1,000,000,000	99.96%
DY3	$877,493,058	$1,000,000,000	87.75%
DY4	$1,122,122,816	$1,000,000,000	112.21%
DY5	$997,694,341	$1,000,000,000	99.77%
DY6	$807,232,567	$1,000,000,000	80.72%
DY7	$1,019,291,544	$1,000,000,000	101.93%
DY8	$1,156,397,442	$1,000,000,000	115.64%
DY9	$1,246,895,706	$2,167,718,341	57.52%
Total MEG 3	**$9,225,566,449**	**$10,167,718,341**	**90.73%**

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

State of Florida
Rick Scott, Governor

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Mission Statement
Better Healthcare for All Floridians.