Florida
Managed Medical Assistance Program

1115 Research and Demonstration Waiver

4th Quarter Report
April 1, 2015 – June 30, 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:

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

Quarterly Report Requirement

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

This report is the fourth quarterly report for Demonstration Year 9 (DY9) covering the period of April 1, 2015, through June 30, 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 Readiness Review and Monitoring

The Agency continues to work 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. As described in previous reports, the Agency continues to hold monthly calls in the form of an “All-Plan” call, and also holds weekly calls with each individual MMA plan. In addition to the aforementioned activities, the Agency continues to monitor the MMA plans regularly and handle issues as they arise. Staff continue to analyze complaints as they come in to the Agency, and work with each MMA plan to ensure timely resolution of these issues. In certain instances (request from Headquarters, in response to complaints, etc.), the Agency will perform ad hoc on-site visits to a managed care plan or a managed care plan’s subcontractor to ensure compliance with their contract. During Q4, the Agency’s Complaint Administration Unit escalated 3 instances of potential non-compliance by

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

d) Medical Loss Ratio

During this quarter, 12 capitated plans submitted their second-quarter MLR reports for DY9 on or before the due date, while 4 capitated plans submitted their MLR reports after the due date. The Agency submitted the capitated plans' preliminary DY9 MLR results for the 12 plans that reported on time to CMS in May 2015. None of the 12 capitated plans that submitted their second-quarter MLR reports for DY9 reported an MLR below 85%.

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

e) MMA Plan Reported Complaints, Grievances, and Appeals

MMA Plan Reported Complaints

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

Table 2 MMA Plan Reported Complaints (April 1, 2015 – June 30, 2015)	
Quarter	**Total**
April 1, 2015 – June 30, 2015	9,920

Grievances and Appeals

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

Table 3 MMA Grievances and Appeals (April 1, 2015 – June 30, 2015)		
Quarter	**Total Grievances**	**Total Appeals**
April 1, 2015 – June 30, 2015	6,300	2,731

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 (April 1, 2015 – June 30, 2015)		
Quarter	**MFHs Requested**	**MFHs Held**
April 1, 2015 – June 30, 2015	482	62

Subscriber Assistance Program

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

Table 5 MMA SAP Requests (April 1, 2015 – June 30, 2015)	
Quarter	**Total**
April 1, 2015 – June 30, 2015	6

f) 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 (April 1, 2015 – June 30, 2015)	
Quarter	**Total**
April 1, 2015 – June 30, 2015	1,817

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 (April 1, 2015 – June 30, 2015)				
	April	**May**	**June**	**Total**
Enrollments	15,199	14,494	23,301	**52,994**

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
(April 1, 2015 – June 30, 2015)

Type of Calls	April	May	June	Totals
Incoming Calls	85,266	77,959	87,287	**250,512**
Outgoing Calls	7,711	10,950	5,322	**23,983**
Totals	**92,977**	**88,909**	**92,609**	**274,495**

Mail

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

Table 9
Outbound Mail Activities
(April 1, 2015 – June 30, 2015)

Mail Activities	Totals
New-Eligible Packets*	166,088
Confirmation Letters	234,130
Open Enrollment Packets	35,025

*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
(April 1, 2015 – June 30, 2015)

Field Activities	Totals
Group Sessions	1181
Private Sessions	281
Home Visits and One-On-One Sessions	115

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
(April 1, 2015 – June 30, 2015)

	April	May	June
Self-Selected	91,057	85,910	99,799
Auto-Assignment	53,460	65,542	48,793
Total Enrollments	144,517	151,452	148,592
Self-Selected %	63.01%	56.72%	67.16%
Auto-Assignment %	36.99%	43.28%	32.84%

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 was 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 (April 30, 2015 – June 30, 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 the final update on the Enhanced Benefits Account (EBA) program activities for the call center, statistics, advisory panel, and phase-out of the EBA program.

The Enhanced Benefits Account program was terminated June 30, 2014. Recipients in counties that transitioned from Medicaid Reform to MMA continued to have access to their accrued credits under the EBA program until June 30, 2015.

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 April 1, 2015 – June 30, 2015, and contains the following enrollment reports:

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

5. Policy and Administrative Issues

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

Contract Amendments

During this quarter, the Agency finalized a general contract amendment for the MMA plans, effective April 15, 2015, which incorporated technical corrections and changes to MMA plans' contracts. A copy of the model contract may be viewed on the Agency's Web site at the following link: http://ahca.myflorida.com/SMMC. 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 five policy transmittals released to the MMA plans during this quarter.

The contract interpretation advised MMA plans of the following:

- Clarified the MMA plans' responsibility to ensure that Pre-admission Screening and Resident Review (PASRR) is completed in accordance with Rule 59G-1.040, F.A.C., prior to the enrollee's admission into a nursing facility.
- Clarified MMA plan medical/case record review requirements specific to primary care provider (PCP) sites, and clarified managed care plan responsibilities related to submission of the written strategy for conducting medical/case record reviews.
- Clarified MMA plan claim payment provisions as revised in the April 15, 2015 SMMC contract amendment, and the plans' responsibility to ensure that claims are processed in accordance with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.
- Clarified that MMA plans must submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor's final report to the Agency, along with the plan's action plan to address the results of the CAHPS survey, by October 1, 2015.

The policy transmittals advised the MMA plans of the following:

- Notified MMA plans of a new ad hoc report requirement regarding the Achieved Savings Rebate Financial Report for the period of January 1, 2014 through December 31, 2014.
- Notified MMA plans of a new ad hoc report requirement regarding the Achieved Savings Rebate Financial Report for the period January 1, 2015 through March 31, 2015.
- Notified MMA plans of a new ad hoc request for current transition of care policies and procedures as described in Attachment II, Section V.E.2. of the contract.
- Notified MMA plans of a new ad hoc report requirement regarding the CMS Critical Success Factors (CSFs) Provider Testing Results Report.
- Notified MMA plans of a change in frequency for the Emergency Room Visits for Enrollees without PCP Appointment 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 (7/1/13 – 6/30/14) LIP Special Terms and Conditions (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 *Milestone Statistics and Findings Report* for DY8 to CMS on May 1, 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 required the submission of a draft RFMD for CMS approval by September 29, 2014, incorporating a cost review protocol that employs a modified Disproportionate Share Hospital (DSH) survey tool to report additional cost for the underinsured, and includes cost documentation standards for new LIP provider types in DY9.

- On May 27, 2015 the Agency submitted the DY7 LIP Cost Limit Report to CMS.
- On June 30, 2015 the Agency submitted the revised RFMD for DY9 and is currently awaiting approval 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 that 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.

- The LIP participation requirements have been met and the qualified LIP participants have been fully funded.

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 (CDPS/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

Budget Neutrality figures included in Attachment V of this report are through the fourth quarter (April 1, 2015 –June 30, 2015) of DY9. The 1115 MMA Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget neutrality is calculated on a statewide basis. During this quarter, 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 for an update on Budget Neutrality figures through the fourth quarter (April 1, 2015 – June 30, 2015) of Demonstration Year Nine.

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.

HP Encounter Support team continues to work with the Plans to offer on-site visits, training and technical assistance. Regular meetings are scheduled with most of the Plans, they have been very appreciative of the meetings and most state they have had denial rate improvements since meeting with the Support team. HP maintains an area on the Medicaid Public Portal that provides information and support to the health plans. The documents are updated regularly to keep the plans up to date of any new changes, issues and pending implementations.

HP implemented a new encounter testing process system for the plans to utilize as needed. HP also registered health plans for an ICD-10 encounter testing session that will begin in July 2015.

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.

VII. Evaluation of the Demonstration

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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. On April 21, 2015, the Agency submitted a response to CMS' comments regarding the draft evaluation design update for the waiver period 2014-2017.

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 final version of the Low Income Pool Milestone Statistics and Findings Report to CMS for DY8 on May 1, 2015. The report identified that in FY 2013-2014, the LIP program included the following categories: primary care hospitals; rural hospitals; safety-net hospitals; hospital provider access system; hospitals that operate poison control centers; specialty pediatric hospitals; hospitals with designated trauma centers; primary care project awards; quality awards; and LIP-Other, which includes designated premium assistance programs, Federally Qualified Health Centers (FQHCs), County Health Initiatives as performed by County Health Departments (CHDs), and Rural Health Networks. The following is a summary of key findings:

- For all providers, total LIP payments were approximately $991.0 million, a decrease of $5.0 million from DY7: SFY 2012–13.
- Reporting hospitals receiving LIP supplemental payments served approximately 3.7 million Medicaid, uninsured, and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served approximately 1.3 million Medicaid, uninsured, and underinsured individuals.
- Reporting hospitals provided approximately 617,000 inpatient services and approximately 3.1 million outpatient services to Medicaid, uninsured, and underinsured individuals.
- 108 hospitals that received LIP supplemental payments reported providing approximately 13.7 million service encounters to Medicaid, uninsured, and underinsured individuals across six service categories.
- For all categories of encounters, 68 reporting non-hospital providers receiving LIP payments provided approximately 7.6 million encounters for specific services to Medicaid, uninsured, and underinsured individuals.
- The Tier-Two Top 15 Hospitals provided inpatient and outpatient services to approximately 161,400 Medicaid recipients and to 838,700 to uninsured or underinsured individuals.

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

- The university selected as the evaluator submitted revised project proposals to the Agency to address the Agency's questions.
- Agency staff created a draft scope of services for the evaluation contract.
- Agency staff responded to CMS' inquiry regarding the timing of inclusion of changes to the Adult and Child Core Sets into the MMA contract reporting requirements.

The Agency will work with the selected university to finalize a contract during the first quarter of DY10.

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 a Focused Study on Cultural Competencies with the goal of assisting the Agency and its managed care plans in identifying areas and strategies for improvement. HSAG completed a review and analysis of each plan's cultural competency plan and each plan's evaluation of its cultural competency plan. The primary objective of this review was to provide information to the Agency regarding each plan's state and federal compliance, and consistency with National Culturally and Linguistically Appropriate Services (CLAS) standards in the area of cultural competency. On April 10, 2015, HSAG submitted their Cultural Competency Focused Study Report to the Agency. In addition, HSAG worked with the Agency to assist in the selection of Cultural Competency-Related Supplemental Items for possible inclusion in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Medicaid Health Plan Surveys to be administered by the plans. Based on this project, the Agency identified four supplemental items for possible inclusion in the plans' CAHPS® surveys, beginning July 2016.

On May 12, 2015, HSAG conducted an external quality review quarterly educational meeting in Tallahassee for the SMMC, the Agency, and the Department of Elder Affairs. Presentations were provided by the Florida Renal Administrators Association on *The Benefits of Home Dialysis*; the Department of Health presented on their *Asthma Learning and Action Network Opportunity*; and Health Services Advisory Group's Performance Improvement Project (PIP) experts presented on *Intervention Determination Using Process Mapping and Failure Modes Effect Analysis*, followed by breakout sessions for the plans to work on *Process Mapping and Failure Modes Effect Analysis* for each plan's Dental PIP. In addition, HSAG offered one-on-one technical assistance sessions with the plans related to their PIPs. The next external quality review quarterly educational meeting will be a webinar, which will be held on August 25, 2015.

On May 26, 2015, HSAG submitted their Annual Performance Improvement Project Validation Summary Report. The purpose of this report was to present the status and results for the performance improvement projects submitted for validation by the Agency's managed care plans. Since the SMMC Program was phased in during 2013 and 2014, all PIPs validated by HSAG for SFY 2014 – 2015 had progressed through the Design Stage (Activities I-VI) only.

During SFY 2014 – 2015, the Agency contracted with HSAG for a Deemed Compliance Crosswalk Project. The Agency directed HSAG to review the managed care plans' accreditation results and complete a deemed compliance crosswalk indicating which federal managed care standards could potentially be deemed. In addition, HSAG was asked to provide the Agency with recommendations for non-duplication deeming. The crosswalk and recommendations document was submitted to the Agency on June 8, 2015.

Beginning in SFY 2013 – 2014, the Agency contracted with HSAG to conduct an annual encounter data validation study. The goal of this annual study is to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate. SFY 2014 - 2015 was the second year of a five year contract with HSAG that included the completion of an encounter data validation study. The State Fiscal Year 2014 –

2015 Encounter Data Validation Study Aggregate Report was submitted to the Agency on June 12, 2015.

b) Plan Performance Measure Reporting

During the fourth quarter of DY9, Agency staff completed reviewing the MMA plans' CMS-416/ Child Health Check-Up (CHCUP) Reports that were submitted in February and determined which plans had liquidated damages for not meeting target rates for the participation and screening ratios. The Agency submitted the statewide Medicaid CHCUP Report to federal CMS during this quarter as well.

Agency staff made revisions to the Performance Measure Report template and made it available to the plans in May. Agency staff also responded to inquiries from the MMA plans and their National Committee for Quality Assurance - certified HEDIS auditors during this quarter. The Performance Measure Report covering calendar/measurement year 2014 is due to the Agency by July 1, 2015.

c) Comprehensive Quality Strategy

There is no update to this section for the fourth quarter of DY9.

d) Assessing Enrollee Satisfaction

During the fourth quarter of DY9, the MMA plans' contracted with the National Committee for Quality Assurance - certified survey vendors completed the CAHPS Health Plan 5.0 Survey for the plans. The results of these surveys are due to the Agency by July 1, 2015.

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 (April 1, 2015 – June 30, 2015), 4 out of 18 MMA plans reported no enrollment in any of the Healthy Behaviors Programs offered and 9 of the 18 plans reported enrollees had completed at least one Healthy Behaviors Program.

Chart A
Healthy Behaviors Program
Enrollment Statistics
(April 1, 2015 – June 30, 2015)

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Amerigroup Florida							
Smoking Cessation	11	2	9	0	1	8	2
Weight Management	49	7	42	0	11	31	7
Alcohol and/or Substance Abuse	1	1	0	0	0	0	1
CDC Performance Measure Incentive	0	-	-	-	-	-	-
Performance Measure Incentives	0	-	-	-	-	-	-
Maternal Child Incentive	0	-	-	-	-	-	-
Better Health							
Smoking Cessation	5	2	3	0	1	2	2
Weight Management	24	6	18	0	6	14	4
Substance Abuse	0	-	-	-	-	-	-
Maternity	0	-	-	-	-	-	-
Well Child Visits	10	8	2	10	0	0	0
Children's Medical Services							
Tobacco Cessation	0	-	-	-	-	-	-
Overcoming Obesity	0	-	-	-	-	-	-
Changing Lives*	0	-	-	-	-	-	-
Clear Health Alliance							
Quit Smoking Healthy Behaviors Rewards	7	2	5	0	0	7	0
Weight Management Healthy Behaviors Rewards	6	0	6	0	0	6	0
Alcohol & Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	0	-	-	-	-	-	-
Well Child Visit Healthy Behaviors Rewards	0	-	-	-	-	-	-

Chart A Healthy Behaviors Program Enrollment Statistics (April 1, 2015 – June 30, 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	1	1	0	0	0	0	1
Weight Loss	1	0	1	0	0	0	1
Alcohol or Substance Abuse	1	0	1	0	0	0	1
Humana Medical Plan							
Smoking Cessation	0	-	-	-	-	-	-
Family Fit	98	13	85	2	38	44	14
Substance Abuse	0	-	-	-	-	-	-
Mom's First Prenatal & Postpartum	3,093	0	3,093	317	2,722	54	0
First Baby Well Visit Incentive	5,912	3,007	2,905	5912	0	0	0
Children's Nutrition Incentive	131,741	66,391	65,350	131,741	0	0	0
Lead Screening & Well-Child Visit Incentive	51,375	26,232	25,143	51,375	0	0	0
Adolescent Well-Child Visits Incentive	67,947	33,033	34,914	67,947	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	214	64	150	5	79	115	15
Weight Management	303	56	247	17	140	129	17
Substance Abuse	44	21	23	2	16	22	4
Molina							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Pregnancy Health	0	-	-	-	-	-	-

Chart A Healthy Behaviors Program Enrollment Statistics (April 1, 2015 – June 30, 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	31	17	14	0	8	20	3
Alcohol Abuse	0	-	-	-	-	-	-
Preferred							
Smoking Cessation	0	-	-	-	-	-	-
Weight Loss	0	-	-	-	-	-	-
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Cervical Cancer Screening	0	-	-	-	-	-	-
CHCUP Preventive & Wellness Care	171	83	88	171	0	0	0
Mammogram	0	-	-	-	-	-	-
Pre-Natal/Preferred Kids Safety & Postpartum	34	0	34	2	32	0	0
Prestige Health Choice							
Smoking Cessation	42	6	36	0	10	25	7
Weight Loss	56	8	48	3	15	24	14
Alcohol & Substance Abuse – "Changing Lives Program"	3	1	2	0	1	2	0
Simply							
Quit Smoking Healthy Behaviors Rewards	9	7	2	0	0	4	5
Weight Management Healthy Behaviors Rewards	5	1	4	3	1	0	1
Alcohol and Substance Abuse	0	-	-	-	-	-	-
Maternity Healthy Behaviors Rewards	1	0	1	0	1	0	0
Well Child Visit Healthy Behaviors Rewards	13	9	4	13	0	0	0
South Florida Community Care Network							
Tobacco Cessation	1	1	0	0	0	1	0
Obesity Management	0	-	-	-	-	-	-
Alcohol or Substance Abuse	0	-	-	-	-	-	-
Staywell							
Smoking Cessation	335	137	198	7	93	200	35
Weight Management	17,050	6,502	10,548	6,146	5,544	4,466	894

Chart A Healthy Behaviors Program Enrollment Statistics (April 1, 2015 – June 30, 2015)							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Substance Abuse	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	34	16	18	0	4	26	4
Weight Loss Healthy Rewards	51	11	40	13	18	15	5
Substance Abuse Healthy Rewards	9	4	5	1	3	5	0
Preventive Adult Primary Care Visits	0	-	-	-	-	-	-
Preventative Well Child Primary Care Visits	0	-	-	-	-	-	-
Start Smart for your Baby (perinatal management)	0	-	-	-	-	-	-
Post Behavioral Health Discharge Visit in 7 Days	0	-	-	-	-	-	-
Preventive Dental Visits for Children	0	-	-	-	-	-	-
Diabetic Healthy Rewards	0	-	-	-	-	-	-
Female Cancer Screening	0	-	-	-	-	-	-
UnitedHealthcare							
Tobacco Cessation – text2quit	4	0	4	0	0	3	1
Florida Population Health/Health Coaching for Weight Loss	14	1	13	1	5	7	1
Substance Abuse Incentive	0	-	-	-	-	-	-
Baby Blocks	706	0	706	90	602	14	0

*Alcohol and/or substance abuse program.

Chart B Healthy Behavior Programs Completion Statistics (April 1, 2015 – June 30, 2015)							
Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Amerigroup							
Smoking Cessation	29	9	20	0	10	17	2
Weight Loss	104	13	91	3	37	51	13
Alcohol & Substance Abuse – “Changing Lives Program”	1	1	0	0	0	0	1
Freedom							
Alcohol or Substance Abuse	1	0	1	0	0	0	1
Humana							
Family Fit	12	2	10	1	7	2	2
Mom’s First Prenatal & Postpartum	32	0	32	3	29	0	0
First Baby Well Visit Incentive	2788	1441	1347	2788	0	0	0
Children’s Nutrition Incentive	6949	3509	3440	6949	0	0	0
Lead Screening & Well-Child Visit Incentive	2733	1414	1319	2733	0	0	0
Adolescent Well-Child Visits Incentive	6515	3015	3500	6515	0	0	0
Magellan Complete Care							
Alcohol & Substance Abuse – “Changing Lives Program”	2	1	1	0	1	1	0
Preferred							
CHCUP Preventive & Wellness Care	171	83	88	171	0	0	0
Pre-Natal/Preferred Kids Safety & Postpartum	34	0	34	2	32	0	0
Prestige Health Choice							
Smoking Cessation	4	0	4	0	1	2	1
Weight Loss	62	5	57	5	13	36	8
Alcohol & Substance Abuse – “Changing Lives Program”	1	0	1	0	1	0	0
Simply							
Well Child Visit Healthy Behaviors Rewards	1	1	0	1	0	0	0
Staywell							
Smoking Cessation	155	56	99	4	43	91	17
Weight Management	633	195	438	153	182	232	66
Sunshine Health							
Tobacco Cessation Healthy Rewards	5	1	4	0	1	4	0

Weight Loss Healthy Rewards	2	0	2	0	0	2	0
Substance Abuse Healthy Rewards	2	2	0	0	0	2	0

Attachment III
Enhanced Benefits Account Program

The following provides the final update on the EBA program activities for the call center, statistics, advisory panel, and phase-out of the EBA program. The EBA program was terminated June 30, 2014. Recipients in counties that transitioned from Medicaid Reform to MMA continued to have access to their accrued credits under the EBA program until June 30, 2015.

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 3,684 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
(April 1, 2015 – June 30, 2015)

Enhanced Benefits Call Center Activity	April	May	June
Calls Received	1,318	970	1,121
Calls Answered	1,316	970	1,120
Average Talk Time (minutes)	5:01	5:05	4:53
Calls Handled by the AVRS	1,282	971	1,431
Outbound Calls	3	3	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 5,236 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 (April 1, 2015 – June 30, 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, 556,833 recipients lost EBA eligibility resulting in losing EBA credits, totaling $32,270,568.93. Chart C of Attachment III provides the EBA program statistics during this quarter.

Chart C EBA Program Statistics (April 1, 2015 – June 30, 2015)				
Activities		**April**	**May**	**June**
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	$208,850.94	$125,903.59	$212,560.60
VI.	Total cumulative dollar amount of credits used through the month by date of service	$50,947,838.11	$51,073,741.70	$51,286,302.30
VII.	Total unduplicated number of enrollees who used credits each month	5,537	3,224	3,912

* 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

There were no phase-out notices mailed during this quarter.

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

Table 1 provides the number of general and specialty MMA plans in each region.

Table 1 Number of MMA Plans by Region (April 1, 2015 – June 30, 2015)		
Region	General	Specialty
01	2	3
02	2	4
03	4	4
04	4	3
05	4	5
06	7	5
07	6	5
08	4	4
09	4	5
10	4	6
11	10	6
Unduplicated Totals	13	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 the recipients' eligibility for Medicare. The MMA Enrollment reports are a complete look at the entire enrollment for the MMA program for the quarter being reported. Table 2 provides a description of each column in the MMA Enrollment reports that are located on the following pages in Tables 3A and 3B.

Table 2
MMA Enrollment by Plan and Type Report Descriptions

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

Table 3A located on the following page lists, by health plan and type, for this quarter and compared to last quarter, the total number of TANF and SSI individuals enrolled, and the corresponding market share. In addition, the total MMA enrollment counts are included at the bottom of the report.

Table 3B lists enrollment by region and plan type, for this quarter and compared to last quarter, the total number of TANF and SSI individuals enrolled and the corresponding market share. In addition, the total MMA enrollment counts are included at the bottom of the report.

Table 3 A
MMA Enrollment by Plan and Type[1]
(April 1, 2015 – June 30, 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	301,332	31,226	56	15,133	347,747	11.0%	**342,380**	1.57%
Better Health	GENERAL	83,772	8,990	26	4,144	96,932	3.1%	**95,021**	2.01%
Coventry Health Care Of Florida	GENERAL	42,357	4,312	23	3,297	49,989	1.6%	**48,110**	3.91%
Humana Medical Plan	GENERAL	259,424	36,066	232	27,772	323,494	10.3%	**310,237**	4.27%
Integral Quality Care	GENERAL	83,422	7,943	14	5,312	96,691	3.1%	**94,833**	1.96%
Molina Healthcare Of Florida	GENERAL	148,125	15,849	42	8,565	172,581	5.5%	**169,414**	1.87%
Preferred Medical Plan	GENERAL	22,680	3,579	23	2,756	29,038	0.9%	**29,829**	-2.65%
Prestige Health Choice	GENERAL	272,348	31,750	35	19,743	323,876	10.3%	**315,007**	2.82%
South Florida Community Care Network	GENERAL	39,606	3,546	18	1,767	44,937	1.4%	**44,504**	0.97%
Simply Healthcare	GENERAL	65,601	13,040	156	10,959	89,756	2.9%	**86,631**	3.61%
Staywell Health Plan	GENERAL	606,945	68,042	76	29,154	704,217	22.4%	**694,696**	1.37%
Sunshine State Health Plan	GENERAL	359,667	37,249	86	43,458	440,460	14.0%	**429,332**	2.59%
United Healthcare Of Florida	GENERAL	229,771	28,193	79	29,627	287,670	9.1%	**280,537**	2.54%
General Plans Total		**2,515,050**	**289,785**	**866**	**201,687**	**3,007,388**	**95.5%**	**2,940,531**	**2.27%**
Positive Health Plan	SPECIALTY	206	915	0	787	1,908	0.1%	**1,897**	0.58%
Magellan Complete Care	SPECIALTY	21,440	20,257	13	220	41,930	1.3%	**35,054**	19.62%
Freedom Health	SPECIALTY	0	0	0	79	79	0.003%	**97**	-18.56%
Clear Health Alliance	SPECIALTY	1,312	5,041	1	3,247	9,601	0.3%	**9,359**	2.59%
Sunshine State Health Plan	SPECIALTY	20,178	1,818	0	3	21,999	0.7%	**21,559**	2.04%
Children's Medical Services Network	SPECIALTY	38,442	26,842	0	140	65,424	2.1%	**65,390**	0.05%
Specialty Plans Total		**81,578**	**54,873**	**14**	**4,476**	**140,941**	**4.5%**	**133,356**	**5.69%**
MMA TOTAL	**MMA**	**2,596,628**	**344,658**	**880**	**206,163**	**3,148,329**	**100%**	**3,073,887**	**2.42%**

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

Table 3 B
MMA Enrollment by Region and Type
(April 1, 2015 – June 30, 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	85,789	11,467	0	6,477	103,733	3.3%	101,424	2.28%
02	MMA	93,101	14,737	4	8,759	116,601	3.7%	114,617	1.73%
03	MMA	219,232	30,201	18	16,417	265,868	8.4%	259,878	2.30%
04	MMA	262,934	31,529	28	17,717	312,208	9.9%	305,053	2.35%
05	MMA	153,501	22,149	29	14,566	190,245	6.0%	186,797	1.85%
06	MMA	363,088	47,807	63	21,217	432,175	13.7%	423,058	2.16%
07	MMA	350,876	45,951	48	18,819	415,694	13.2%	402,222	3.35%
08	MMA	187,945	18,729	34	13,488	220,196	7.0%	215,574	2.14%
09	MMA	231,019	24,926	44	15,083	271,072	8.6%	262,203	3.38%
10	MMA	224,050	27,087	99	15,804	267,040	8.5%	259,616	2.86%
11	MMA	425,093	70,075	513	57,816	553,497	17.6%	543,445	1.85%
MMA TOTAL		2,596,628	344,658	880	206,163	3,148,329	100%	3,073,887	2.42%

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous Quarter	Percent Change from Previous Quarter
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	GENERAL	84,144	10,514	0	6,404	101,062	3.4%	98,631	2.46%
02	GENERAL	87,966	11,836	2	8,659	108,463	3.6%	106,696	1.66%
03	GENERAL	212,777	27,221	18	16,185	256,201	8.5%	250,478	2.28%
04	GENERAL	253,072	26,320	27	17,679	297,098	9.9%	291,862	1.79%
05	GENERAL	147,140	18,321	28	14,016	179,505	6.0%	176,596	1.65%
06	GENERAL	351,882	40,003	62	20,881	412,828	13.7%	404,644	2.02%
07	GENERAL	339,015	37,640	47	18,354	395,056	13.1%	382,916	3.17%
08	GENERAL	183,653	16,629	34	13,259	213,575	7.1%	208,600	2.38%
09	GENERAL	223,072	19,905	41	14,596	257,614	8.6%	249,291	3.34%
10	GENERAL	215,704	20,877	98	15,194	251,873	8.4%	245,388	2.64%
11	GENERAL	416,625	60,519	509	56,460	534,113	17.8%	525,429	1.65%

GENERAL TOTAL		2,515,050	289,785	866	201,687	3,007,388	100.0%	2,940,531	2.27%
01	SPECIALTY	1,645	953	0	73	2,671	1.9%	2,793	-4.37%
02	SPECIALTY	5,135	2,901	2	100	8,138	5.8%	7,921	2.74%
03	SPECIALTY	6,455	2,980	0	232	9,667	6.9%	9,400	2.84%
04	SPECIALTY	9,862	5,209	1	38	15,110	10.7%	13,191	14.55%
05	SPECIALTY	6,361	3,828	1	550	10,740	7.6%	10,201	5.28%
06	SPECIALTY	11,206	7,804	1	336	19,347	13.7%	18,414	5.07%
07	SPECIALTY	11,861	8,311	1	465	20,638	14.6%	19,306	6.90%
08	SPECIALTY	4,292	2,100	0	229	6,621	4.7%	6,974	-5.06%
09	SPECIALTY	7,947	5,021	3	487	13,458	9.5%	12,912	4.23%
10	SPECIALTY	8,346	6,210	1	610	15,167	10.8%	14,228	6.60%
11	SPECIALTY	8,468	9,556	4	1,356	19,384	13.8%	18,016	7.59%
SPECIALTY TOTAL		81,578	54,873	14	4,476	140,941	100.0%	133,356	5.69%

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 April 1, 2015 and ending June 30, 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		Managed Care Waiver (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
Q35 Total	1,462,357			$1,134,356,032	$775.70
April 2015	293,244			$379,195,669	$1,293.11
May 2015	527,900			$228,855,224	$433.52
June 2015	516,482			$391,120,951	$757.28
Q36 Total	**1,337,626**			**$999,171,844**	**$746.97**
MEG 1 Total	**32,930,391**	**$25,401,390,043**	**$4,777,027,664**	**$33,619,450,515**	**$1,020.92**

* 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 Actual MEG 2	Case months	MCW Reform Spend*	Reform Enrolled 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
Q35 Total	7,294,147			$1,720,540,183	$235.88
April 2015	1,391,829			$543,984,163	$390.84
May 2015	2,552,622			$298,395,017	$116.90
June 2015	2,535,461			$619,370,033	$244.28
Q36 Total	**6,479,912**			**$2,507,829,674**	**$387.02**
MEG 2 Total	**188,148,941**	**$25,446,856,153**	**$3,054,814,898**	**$34,728,023,328**	**$184.58**

* 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 DY. 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	$916,168,033	$4,247,930,705	$1,108.85
WOW DY7 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,214,371,081)	
% of WOW PCCM MEG 1					77.77%
DY7 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY7 Total	24,348,400	$3,892,512,229	$490,792,975	$4,383,305,204	$180.02
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,943,615,324)	

Chart D MEGs 1 and 2 Annual Statistics					
% of WOW PCCM MEG 2					59.82%
DY8 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY8 Total	4,000,390	$3,414,538,645	$937,066,111	$4,351,604,756	$1,087.80
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,643,219,682)	
% of WOW PCCM MEG 1					72.59%
DY8 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY8 Total	24,867,309	$3,783,670,392	$627,829,104	$4,411,499,496	$177.40
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,468,204,707)	
% of WOW PCCM MEG 2					55.99%
DY9 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY9 Total	5,326,173			$4,096,318,627	$769.09
WOW DY9 Total	5,326,173			$4,190,100,299	$786.70
Difference				$(93,781,673)	
% of WOW PCCM MEG 1					97.76%
DY9 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY9 Total	27,169,344			$6,073,540,409	$223.54
WOW DY9 Total	27,169,344			$8,806,399,471	$324.13
Difference				$(2,732,859,062)	
% of WOW PCCM MEG 2					68.97%

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 $1,108.85 (Chart D), compared to WOW of $1,425.84 (Chart A), which is 77.77% of the target PCCM for MEG 1. MEG 2 has a PCCM of $180.02 (Chart D), compared to WOW of $300.92 (Chart A), which is 59.82% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1,087.80 (Chart D), compared to WOW of $1,498.56 (Chart A), which is 72.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $177.40 (Chart D), compared to WOW of $316.87 (Chart A), which is 55.99% of the target PCCM for MEG 2.

For DY9, MEG 1 has a PCCM of $769.09 (Chart D), compared to WOW of $786.70 (Chart A), which is 97.76% of the target PCCM for MEG 1. MEG 2 has a PCCM of $223.54 (Chart D), compared to WOW of $324.13 (Chart A), which is 68.97% 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	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% of WOW					67.49%
DY8	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	28,867,699	$7,198,209,036	$1,564,895,215	$8,763,104,252	$303.56
WOW	28,867,699			$13,874,528,641	$480.62
Difference				$(5,111,424,389)	
% of WOW					63.16%
DY9	**Actual CM**	**MEGs 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEGs 1 & 2	32,495,517			$10,169,859,035	$312.96
WOW	32,495,517			$12,996,499,770	$399.95
Difference				$(2,826,640,735)	
% of WOW					78.25%

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 E) 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 $306.30. Comparing the calculated weighted averages, the actual PCCM is 67.49% 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 E) 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 $303.56. Comparing the calculated weighted averages, the actual PCCM is 63.16% 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 E) is $399.95. 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 $312.96. Comparing the calculated weighted averages, the actual PCCM is 78.25% 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 – June 2015	$(2,826,640,735)
CNOM Costs July 2014 – June 2015	
Healthy Start	$31,628,984
PACC	$622,731
DY9 Net Difference	**($2,794,389,020)**

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
Q36	$830,244,034
Total Paid	**$10,055,810,483**

Chart H of Attachment V shows that the expenditures for DY9 MEG 3, LIP, were $2,077,139,740 (95.82% of the $2,167,718,341 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	$2,077,139,740	$2,167,718,341	95.82%
Total MEG 3	**$10,055,810,483**	**$10,167,718,341**	**98.90%**

*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.