Florida Managed Medical Assistance Program

1115 Research and Demonstration Waiver

Year 7

Final Annual Report

(July 1, 2012 – June 30, 2013)

Agency for Health Care Administration

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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Letter from the Medicaid Director

Florida's 1115 Managed Medical Assistance Waiver is a comprehensive demonstration designed to improve the Medicaid delivery system by integrating the increased use of managed care principles with innovative approaches like customized benefit packages and health-related incentives for recipients. The demonstration continues to generate an environment that encourages recipients to actively participate in the management of their health care and incentivizes health plans to provide care centered on the person's individual needs.

The following are highlights from Demonstration Year Seven. A more in-depth review of these highlights can be found in the body of the report.[1]

Highlights of Demonstration Year Seven

- Encounter Data Compliance Reports were distributed to health plans on a monthly basis.
- Performance of the health plans continued to be above the national mean on several components of the Comprehensive Diabetes Care measure and for Well-Child Visits in the 3rd- 6th years of life, along with several other Healthcare Effectiveness Data and Information Set (HEDIS) measures. The health plans had a weighted mean that was above the national mean [as published by the National Committee for Quality Assurance (NCQA) for the Medicaid product line] for nine HEDIS measures reported in 2012. The health plans had weighted means that were within one percentage point of the national mean for five additional HEDIS measures.
- Improvements in select health plan HEDIS measure performances over time: Childhood Immunization Status increased 11.2% for Combo 2 and 15.4% for Combo 3 between 2009 and 2012 reporting. Annual Dental Visits increased 20.1% between 2008 and 2012. For Well-Child Visits in the First 15 Months of Life, six or more visits, the weighted average for the health plans increased 11.9% from 2011 to 2012 reporting.
- Online enrollment was 7% percent of the total recipient self-selected enrollments this year (processing 9,955 enrollments online).
- Executed a new three-year contract with each plan, effective September 1, 2012 through August 31, 2015, and added liquidated damages for breach of contract requirements.
- Sent various policy transmittals and "Dear Provider" letters/e-mails to the health plans to include addressing the following issues:
    - Health plan requirements to pay certain physicians who provide Florida Medicaid-covered eligible primary care services in accordance with the Affordable Care Act (ACA) and 42 CFR sections 438 and 447, for the period January 1, 2013 through December 31, 2014, and advising health plans that such requirements are being added to their contract.
    - Information regarding the ACA requirements that prohibit payments for provider-preventable conditions (PPCs); the identification and reporting of PPCs, including payments expended in facility settings for such services and encounter data requirements; and provider subcontract requirements.

[1] Prepared by the Agency for Health Care Administration in accordance with Section 409.91213(1)(b), F.S. This report covers the seventh operational year of the waiver demonstration (July 1, 2012 through June 30, 2013).

- Fewer health plan complaints were received by the Agency for Health Care Administration (the Agency) in Year Seven than the previous year with: 43 PSNs complaints received in Year Seven compared to 73 in Year Six; and 96 HMO complaints received in Year Seven compared to 186 in Year Six. The average rate of complaints reported to the Agency decreased from 6.3 per 10,000 recipients in Year Six to 3.2 per 10,000 recipients in Year Seven. (The complaints noted are reported to the Agency by recipients, advocates and other stakeholders. See pages 16-21 of the report)
- The extension of the LIP Primary Care Grant ($34 million) was continued by the 2013 Florida Legislature for the last year of the three year waiver extension (the three years were Demonstration Year Five, Six and Seven). Awards were funded to the same 38 applicants as the previous year.
- Met the Low Income Pool (LIP) deliverables as required by the STCs including collecting deliverables on the top 15 hospitals quality initiatives to implement new/enhanced programs and deliverables on the $35 Million Primary Care Award.

The Agency gratefully acknowledges the Florida Legislature, recipients, providers and other key stakeholders for their assistance in making this demonstration a success. We continue to search for future opportunities for improvement as we gain more data and experience. The Florida Medicaid community is leading the way in improving care for all Florida residents.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

I. Waiver History

Background

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

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

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

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

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

- Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;
- Ensures the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan (no more than 60 calendar days after the effective date of enrollment);
- Ensures recipient complaints, grievances and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishes Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires plans offer a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan;

- Requires Florida's External Quality Assurance Organization to validate each plan's encounter data every three years;
- Enhances consumer report cards to ensure recipients have access to understandable summaries of quality, access and timeliness regarding the performance of each participating managed care plan;
- Enhances the plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health and reducing per capita Medicaid expenditures;
- Enhances metrics on plan quality and access to care to improve plan accountability; and
- Creates a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

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

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

This report is the final annual report for Demonstration Year Seven covering the period of July 1, 2012 – June 30, 2013. For detailed information about the activities that occurred during previous periods of the demonstration, refer to the quarterly and annual reports, which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml

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

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II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

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

Health Plan Application and Expansion Requests

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

During Demonstration Year Seven, one new health plan application was received from CareAccess PSN to serve Broward County; however, the applicant withdrew the following quarter. The following four new health plans were approved in Demonstration Year Seven:

- Simply Healthcare HMO (Broward County). Note: this is an HMO that is separate and distinct from the Simply Healthcare d/b/a Clear Health Alliance specialty plan.
- Healthease HMO (all five demonstration counties)
- Magellan Complete Care (Broward County)
- Simply Healthcare d/b/a Clear Health Alliance specialty plan for individuals living with HIV or AIDS (Broward County)

The following three plans requested to increase maximum enrollment levels during Demonstration Year Seven:

- United HMO in Clay and Duval Counties.
- Children's Medical Services (PSN) in Broward County.
- Sunshine State Health Plan (HMO) in Duval County.

United HMO's request was approved in the fourth quarter of Demonstration Year Seven. The other two remain under review.

Sunshine State Health Plan's (HMO) previously submitted request to expand into Baker and Nassau Counties remains under Agency review at the close of Demonstration Year Seven.

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

Table 1
Health Plan Applicants

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

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

Table 2
Medicaid Reform Health Plan Contracts

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

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

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

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

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

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

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

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

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

Contract Amendments and Model Contracts

In Demonstration Year Seven, the Agency executed a new three-year contract with each plan, effective September 1, 2012 through August 31, 2015. The new contract included requirements addressing the regional implementation of the Statewide Managed Medical Assistance program, removed obsolete language regarding benefit maximums and comprehensive and catastrophic program components, and added liquidated damages for breach of contract requirements. Two general amendments to the health plan contracts were also completed. The main purposes of the first general amendment was to allow the use of telemedicine for dental and behavioral health, to specify the demonstration waiver required Medical Loss Ratio requirements and to include state statutory changes regarding FFS PSN reconciliation and conversion to capitation requirements. The purpose of the second general amendment was to implement rates effective September 1, 2012 through August 31, 2013, and to require health plans to pay certain physicians who provide Florida Medicaid-covered eligible primary care services as required by the Affordable Care Act and 42 CFR 438 and 447, for the period January 1, 2013 through December 31, 2014. Some plans chose to also amend their expanded benefits effective January 1, 2013.

Additionally, plans that chose to provide home health visits and primary care physician visits beyond limitations contained in Florida's State Plan signed another amendment to allow them to list the services as expanded benefits effective March 1, 2013.

Contract Conversions/Terminations

Shands Jacksonville Medical Center d/b/a First Coast Advantage submitted a request and was approved for an ownership change to become First Coast Advantage, LLC.

On March 21, 2013, Universal Health Care, Inc. (HMO) was ordered into receivership by the Second Judicial Circuit Court in Leon County, Florida. Pursuant to the Court Order, Universal moved into receivership for purposes of liquidation on April 1, 2013 resulting in the Agency's termination of the Universal Health Care, Inc. (HMO) contract. The Agency actively worked to seamlessly transition impacted recipients into new health plans.

FFS PSN Conversion Process

FFS PSNs are required to convert to capitation by the beginning of the final year of operation under the waiver extension, unless the FFS PSN opts to convert to capitation earlier as specified in s. 409.91211(3)(e), F.S. The Agency released an updated FFS PSN conversion application in April 2012 and continues to provide technical assistance to the FFS PSNs regarding conversion. Most FFS PSNs have submitted a conversion application. Table 3 provides the timeline to comply with the FFS PSN conversion-to-capitation requirement.

Table 3
PSN Conversion to Capitation Timeline

Deadline for current FFS PSNs to submit conversion applications to the Agency.	09/01/2013
Successful conversion of applicants and execution of capitated contracts for service begin date of 09/01/2014.	06/30/2014

Demonstration Year Seven at a Glance

The following summarizes this year's accomplishments regarding the health plan contracting process.

- The Agency approved four new health plan applications.
- The Agency approved United HMO's request to increase its maximum enrollment levels in Clay and Duval Counties.
- The Agency revised the model health plan contract to allow the use of telemedicine for certain services, require submission of medical loss ratio reports, and implement the primary care physician increase per the terms of the Affordable Care Act and 42 CFR 438 and 447.
- The Agency provided technical assistance to demonstration health plans over the year.

Lessons Learned

The following summarizes the lessons learned and opportunities for improvement that were identified during Demonstration Year Seven regarding the health plan contracting process. Additional information regarding lessons learned is provided in Section J of this report.

- Trouble-shooting Florida Medicaid Management Information System (FLMMIS) issues and staying up-to-date on previously identified FLMMIS issues was time intensive. Conveying appropriate information to the plans was dependent on expert communication by all parties.
- As the Agency works to refine provider network standards, reliance on manual processes to confirm accuracy and adequacy has become time consuming and cumbersome; therefore, the Agency is working to develop an automated network verification tool. This tool was in testing with a couple of health plans at the close of this demonstration year.

Looking Ahead to Demonstration Year Eight

The Agency anticipates learning best practices from the plans that have remained successful throughout the demonstration and from the plans that are performing well. In addition, the Agency will continue to look to the successes of the specialty plan for children with chronic conditions and the specialty plan for persons living with HIV/AIDS for more information on how to effectively provide care to these specialized populations.

The Agency will continue to work with the plans to define new ways to improve health plan performance, enhance fraud and abuse activities, and further augment provider access.

FLMMIS training and technical assistance to the health plans will continue during Demonstration Year Eight. The Agency will communicate with all health plans about known systems issues and the progress of requested modifications. In particular, the Agency intends to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to continue to refine their health care delivery and achieve additional efficiencies.

2. Benefit Package

Overview

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

Demonstration Year Seven at a Glance

Customized Benefit Packages

The customized benefit packages became operational on January 1, 2013 and will remain valid until December 31, 2013, effectively overlapping Year Seven and Year Eight of the demonstration. These benefit packages include 26 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

Table 4 located on the following page lists the number of co-payments for each service type by each Demonstration Year. Benefit packages approved for Year Three of the demonstration were extended until December of 2009 in order to provide adequate notification to the recipients of any changes in their current health plan's benefit package as well as to allow time for the printing and distribution of the revised choice materials for Demonstration Year Four. As such, in Tables 4 and 5, Demonstration Year Three has been divided into three columns: July 1, 2008 through December 31, 2008; January 1, 2009 through November 30, 2009; and December 2009. These different columns reflect the departure of health plans that ceased operations during Demonstration Year Three. In addition, Table 4 has been updated to reflect the customized benefit packages effective January 1, 2013 – December 31, 2013.

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

Table 5 shows the number and percentage of benefit packages that do not require any co-payments, separated by demonstration year.

Table 5 Number & Percent of Total Benefit Packages Requiring No Co-payments by Demonstration Year														
	Year One	**Year Two**	**Year Three**			**Year Four**		**Year Five**		**Year Six**		**Year Seven**		
	July 2006-June 2007	July 2007-June 2008	July-Dec 2008	Jan-Nov 2009	Dec 2009	Jan-April 2010	May-June 2010	July-Dec 2010	Jan-June 2011	July-Dec 2011	Jan-June 2012	July-Dec 2012	Jan-Mar 2013	Apr-Jun 2013
Total Number of Benefit Packages	28	30	28	24	20	20	19	19	20	20	20	22	28	26
Total Number of Benefit Packages Requiring No Co-payments	12	16	20	20	17	16	15	15	14	14	13	15	21	19
Percent of Benefit Packages Requiring No Co-payments	43%	53%	71%	83%	85%	80%	79%	79%	70%	70%	65%	68%	75%	73%

Table 6 shows the number of benefit packages for Demonstration Years Four through Seven not requiring co-payments by population and area. Table 6 shows that for each area and target population, there is at least one benefit package to choose from that does not require co-payments.

Table 6
Number of Benefit Packages Requiring No Co-payments by Target Population & Area
(Demonstration Years Four – Seven)

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

Expanded Services

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

- Over-the-counter drug benefit – $25 per household, per month;
- Adult preventive dental;
- Circumcisions for male newborns;
- Additional adult vision;
- Wellness and nutrition therapy; and
- Respite care.

Plan Evaluation Tool (PET)

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

package meets or exceeds, and maintains, a minimum threshold of 98.5% for benefits identified as sufficiency tested benefits as required by newly amended STC #31.

The PET submission procedure for Demonstration Year Seven was similar to that of the six previous years. The new PET was released by the Agency during the second quarter of Demonstration Year Seven. The health plans' Year Seven benefit packages were approved during the second quarter of Demonstration Year Seven and became effective January 1, 2013.

3. Health Plan Reported Complaints, Grievances and Appeal Process

Overview

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

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of the health plan to act within ninety (90) days from the date the health plan receives a grievance, or 45 days from the date the health plan receives an appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise his or her rights to obtain services outside the network.
- Appeal means a request for review of an action, pursuant to 42 CFR 438.400(b).
- Grievance means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

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

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

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

Demonstration Year Seven at a Glance

The Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. To better understand the issues recipients face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan

level in the quarterly reports. The Agency also uses this information internally as part of the Agency's continuous improvement efforts.

Health Plan Reported Complaints

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

Table 7 provides the number of complaints reported by plan type for Demonstration Year Seven. The health plan contract defines complaint as: any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day. The subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices or provision of services that relate to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system.

Table 7
Health Plan Reported Complaints
(July 1, 2012 – June 30, 2013)

Quarter	PSN Complaints	HMO Complaints	HMO and PSN Enrollment*
July 2012 – September 2012	311	517	342,428
October 2012 – December 2012	206	538	344,922
January 2013 – March 2013	80	623	349,232
April 2013 – June 2013	161	554	349,208
July 1, 2012 – June 30, 2013	**758**	**2,232**	**432,198**

*unduplicated enrollment count

Grievances and Appeals

Table 8 provides the number of grievances and appeals reported by health plan type for Demonstration Year Seven.

Table 8
Grievances and Appeals
(July 1, 2012 – June 30, 2013)

Quarter	PSN Grievances	PSN Appeals	HMO Grievances	HMO Appeals	HMO and PSN Enrollment*
July 2012 – September 2012	21	52	117	96	342,428
October 2012 – December 2012	21	55	222	81	344,922
January 2013 – March 2013	6	29	205	64	349,232
April 2013 – June 2013	10	55	238	81	349,208
July 1, 2012 – June 30, 2013	**58**	**191**	**782**	**322**	**432,198**

*unduplicated enrollment count

The number of plan-reported grievances and appeals fluctuated during Year Seven of the demonstration. The PSNs had fewer grievances in Demonstration Year Seven (58) than in Years Six (71), Five (143) and Four (483). The number of PSN appeals ranged from 29 to 55

per quarter. The number of HMO grievances was higher in Demonstration Year Seven (782), compared to Years Six (213), Five (245) and Four (242) although this number is still relatively low given the total enrollment in the HMOs and PSNs, which grew over Demonstration Year Seven. The number of HMO appeals decreased during Demonstration Year Seven, and the total number (322) is less than Years Six (414) and Five (406).

Medicaid Fair Hearings (MFH)

Table 9 provides the number of MFHs requested and held during Demonstration Years One through Seven. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and, as a result, health plans are not required to report the number of fair hearings requested by enrolled members; however, the Agency monitors the MFH process.

Table 9
Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held
(July 1, 2006 – June 30, 2013)

Demonstration Period		Medicaid Fair Hearings Held	Medicaid Fair Hearing Requests
Year One	Quarter 1: July 2006 – August 2006	No Plan Enrollment	
	Quarter 2: September 2006 – December 2006	1	1
	Quarter 3: January 2007 – March 2007	0	0
	Quarter 4: April 2007 – June 2007	0	0
Year Two	Quarter 1: July 2007 – September 2007	1	4
	Quarter 2: October 2007 – December 2007	0	0
	Quarter 3: January 2008 – March 2008	1	3
	Quarter 4: April 2008 – June 2008	1	3
Year Three	Quarter 1: July 2008 – September 2008	0	5
	Quarter 2: October 2008 – December 2008	1	5
	Quarter 3: January 2009 – March 2009	0	2
	Quarter 4: April 2009 – June 2009	2	6
Year Four	Quarter 1: July 2009 – September 2009	2	7
	Quarter 2: October 2009 – December 2009	0	2
	Quarter 3: January 2010 – March 2010	4	7
	Quarter 4: April 2010 – June 2010	7	14
Year Five	Quarter 1: July 2010 – September 2010	6	11
	Quarter 2: October 2010 – December 2010	9	15
	Quarter 3: January 2011 – March 2011	2	14
	Quarter 4: April 2011 – June 2011	1	8
Year Six	Quarter 1: July 2011 – September 2011	7	12
	Quarter 2: October 2011 – December 2011	3	8
	Quarter 3: January 2012 – March 2012	4	16
	Quarter 4: April 2012 – June 2012	2	7
Year Seven	Quarter 1: July 2012 – September 2012	2	22
	Quarter 2: October 2012 – December 2012	10	27
	Quarter 3: January 2013 – March 2013	5	24
	Quarter 4: April 2013 – June 2013	13	20
Total		**84**	**241**

There were a total of 93 MFHs requested during Demonstration Year Seven; 41 for PSNs and 52 for HMOs. Of the 93 MFH requests, 20 requests were related to denial of benefits/services, 15 requests were related to reduction of benefits, seven requests were related to denial of prescription medication, six were related to the inability to change plans, and 45 have not progressed to being classified. Thirty (30) MFHs were held, although, in two of the cases, the recipient did not show or abandoned the hearing. Out of the remaining 28 hearings, one was dismissed, three were withdrawn, one was rejected, one was moot and nine plan actions were confirmed as accurate and the plan having provided services appropriately. The outcome is pending in 13 cases. Of the 63 MFH requests that did not have hearings, 30 were abandoned or withdrawn by the member, two were dismissed, seven were out of jurisdiction, one was resolved and 23 were still pending at the end of the demonstration year.

Beneficiary Assistance Program

Health plans grievances and appeals are being at the plan level as only four grievances were submitted to the BAP in Demonstration Year Seven. Of the four BAP grievance issues, all were related to services not deemed medically necessary. In regards to outcomes, three issues were resolved prior to the hearing and one was resolved during the hearing. The low number of BAP requests indicates that the plans are resolving these issues internally as enrolled members are not requesting further review. Table 10 provides the number of requests to BAP for Demonstration Year Seven.

Table 10
BAP Requests
(July 1, 2012 – June 30, 2013)

Quarter	PSN	HMO	Total
July 2012 – September 2012	0	0	0
October 2012 – December 2012	1	0	1
January 2013 – March 2013	1	2	3
April 2013 – June 2013	0	0	0
Total	**2**	**2**	**4**

4. Agency-Received Complaints/Issues Resolution Process

Overview

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

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

The complaints/issues are processed by Florida Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. Medicaid staff use the Complaints/Issues Reporting and Tracking System

(CIRTS), which allows for real-time, secure access through the Agency's web portal. In addition, the Agency tracks the complaints by plan and plan type to review complaint data on individual plans on a monthly basis and reviews complaint trends on a quarterly basis at the management level.

Demonstration Year Seven at a Glance

During Demonstration Year Seven, the Agency received a total of 139 complaints/issues regarding health plans. The volume of complaints is low relative to the number of recipients enrolled in the demonstration. Table 11 provides a summary of the complaints/issues received compared to enrollment during Demonstration Years One through Seven.

Table 11
Agency-Received Health Plan Complaints/Issues
(Demonstration Years One – Seven)

Year One

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year One Total	Complaints per 10,000
PSN	0	0.00	1	0.19	18	3.28	10	1.78	29	4.28
HMO	0	0.00	6	0.99	18	1.41	37	2.65	61	3.87
TOTAL	0	0.00	7	0.62	36	1.97	47	2.40	90	3.99
Enrollment*										
PSN		488		52,620		54,925		56,194		67,836
HMO		7,116		60,701		127,606		139,408		157,745
TOTAL		7,604		113,321		182,531		195,602		225,581

Year Two

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Two Total	Complaints per 10,000
PSN	10	1.87	16	2.63	13	2.15	6	0.99	45	5.85
HMO	16	1.18	48	3.17	72	4.59	48	2.93	184	8.76
TOTAL	26	1.32	64	3.07	85	3.92	54	2.41	229	7.98
Enrollment*										
PSN		53,664		60,913		60,516		60,091		76,978
HMO		143,776		151,282		156,583		163,961		210,037
TOTAL		197,440		212,195		217,099		224,052		287,015

Year Three

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Three Total	Complaints per 10,000
PSN	7	1.12	3	0.41	5	0.59	6	0.48	21	1.48
HMO	46	2.83	67	4.34	74	4.89	59	4.82	246	14.5
TOTAL	53	2.36	70	3.09	79	3.34	65	2.63	267	8.57
Enrollment*										
PSN		62,276		72,374		85,003		124,773		141,679
HMO		162,554		154,280		151,372		122,491		169,884
TOTAL		224,830		226,654		236,375		247,264		311,563

Year Four

Plan Type	Qtr 1	Complaints per 10,000	Qtr 2	Complaints per 10,000	Qtr 3	Complaints per 10,000	Qtr 4	Complaints per 10,000	Year Four Total	Complaints per 10,000
PSN	11	1.1	8	0.8	15	1.6	7	0.6	41	2.7
HMO	81	5.0	60	3.4	57	3.1	46	2.8	244	12.0
TOTAL	92	3.5	68	2.5	72	2.6	52	1.8	285	8.1

Table 11 Agency-Received Health Plan Complaints/Issues (Demonstration Years One – Seven)									
Enrollment*									
PSN		**96,526**		**94,240**		**96,277**		**125,911**		**150,437**
HMO		**162,647**		**178,209**		**183,267**		**161,542**		**202,949**
TOTAL		**259,173**		**272,449**		**279,544**		**287,453**		**353,386**
Year Five										
Plan Type	**Qtr 1**	**Complaints per 10,000**	**Qtr 2**	**Complaints per 10,000**	**Qtr 3**	**Complaints per 10,000**	**Qtr 4**	**Complaints per 10,000**	**Year Five Total**	**Complaints per 10,000**
PSN	**19**	**1.5**	**17**	**1.3**	**25**	**1.8**	**19**	**1.3**	**80**	**4.6**
HMO	**37**	**2.2**	**44**	**2.6**	**45**	**2.7**	**38**	**2.2**	**164**	**7.7**
TOTAL	**56**	**1.9**	**61**	**2.0**	**70**	**2.3**	**57**	**1.8**	**244**	**6.3**
Enrollment*										
PSN		**127,084**		**128,225**		**140,295**		**146,150**		**175,800**
HMO		**166,653**		**171,423**		**169,695**		**172,187**		**213,936**
TOTAL		**293,737**		**299,648**		**309,990**		**318,337**		**389,736**
Year Six										
Plan Type	**Qtr 1**	**Complaints per 10,000**	**Qtr 2**	**Complaints per 10,000**	**Qtr 3**	**Complaints per 10,000**	**Qtr 4**	**Complaints per 10,000**	**Year Six Total**	**Complaints per 10,000**
PSN	**17**	**1.1**	**14**	**0.9**	**22**	**1.4**	**20**	**1.2**	**73**	**3.7**
HMO	**43**	**2.5**	**47**	**2.7**	**48**	**2.8**	**49**	**2.8**	**187**	**8.6**
TOTAL	**60**	**1.9**	**61**	**1.9**	**70**	**2.1**	**69**	**2.0**	**260**	**6.3**
Enrollment*										
PSN		**150,355**		**152,729**		**156,173**		**161,025**		**194,955**
HMO		**170,756**		**171,191**		**172,964**		**176,286**		**218,647**
TOTAL		**321,111**		**323,920**		**329,137**		**337,311**		**413,602**
Year Seven										
Plan Type	**Qtr 1**	**Complaints per 10,000**	**Qtr 2**	**Complaints per 10,000**	**Qtr 3**	**Complaints per 10,000**	**Qtr 4**	**Complaints per 10,000**	**Year Seven Total**	**Complaints per 10,000**
PSN	**11**	**0.7**	**7**	**0.4**	**16**	**1.0**	**9**	**0.5**	**43**	**2.1**
HMO	**27**	**1.5**	**23**	**1.3**	**27**	**1.5**	**19**	**1.0**	**96**	**4.0**
TOTAL	**38**	**1.1**	**30**	**0.9**	**43**	**1.2**	**28**	**0.8**	**139**	**3.2**
Enrollment*										
PSN		**163,433**		**163,614**		**163,285**		**166,740**		**202,451**
HMO		**178,995**		**181,308**		**185,947**		**182,468**		**229,747**
TOTAL		**342,428**		**344,922**		**349,232**		**349,208**		**432,198**

**Enrollment is enrollment of last month of quarter and year end.*

All complaints/issues were worked and addressed with the health plans and providers, resulting in no sanctions. Issues regarding policy were discussed with the health plans in monthly technical and operational issues conference calls, policy transmittals and by e-mail. As noted earlier, the majority of complaints/issues are related to managed care in general and not specific to the demonstration. The Agency will continue to monitor the complaints/issues received for contractual compliance, plan performance, and trends that may require policy or operational changes.

In Demonstration Year Seven, the major reasons for complaints/issues were related to services (e.g., referral to a specialty provider and authorization of services) and claims processing (including payment delays). Charts A and B located on the following pages provide the total HMO and PSN complaints by complaint type (claims, customer service, services, and other) for Demonstration Year Seven.

Complaint type descriptions are as follows:

Claims	Claims complaints include, but are not limited to, timely provider payment, eligibility denial (claim denied because service was not eligible for payment or recipient was not eligible at the time of service), and issues regarding inpatient provider payment.
Customer Service	Customer Service complaints include, but are not limited to, issues regarding enrollment, disenrollment, member verification, provision of incorrect information by a customer service representative, and inability to obtain member materials.
Services	Service complaints include, but are not limited to, complaints received from providers and recipients regarding timely service authorization requests, participating provider availability, and authorization denials.
Other	Other complaints include those that don't fall into other general categories. For example: a provider called to ask for assistance in negotiating a payment rate with a health plan. The Agency maintains a neutral position regarding plan-provider negotiations.

Chart A
HMO Complaints by Type
(July 1, 2012 – June 30, 2013)

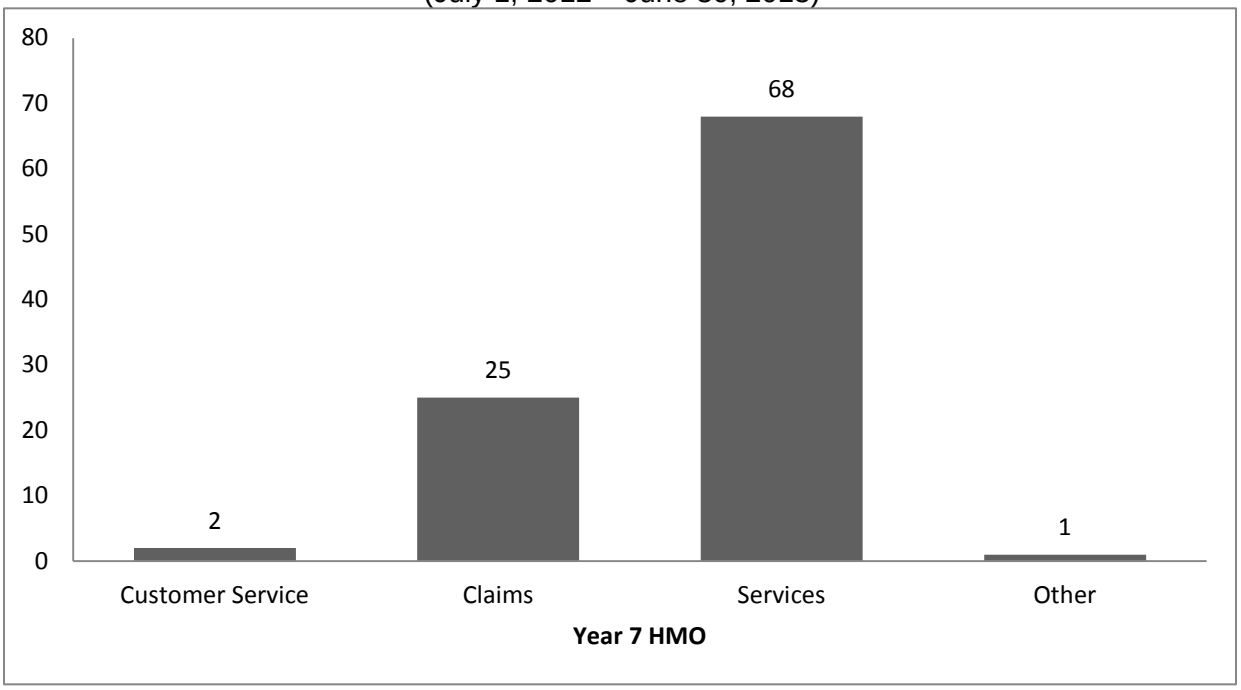
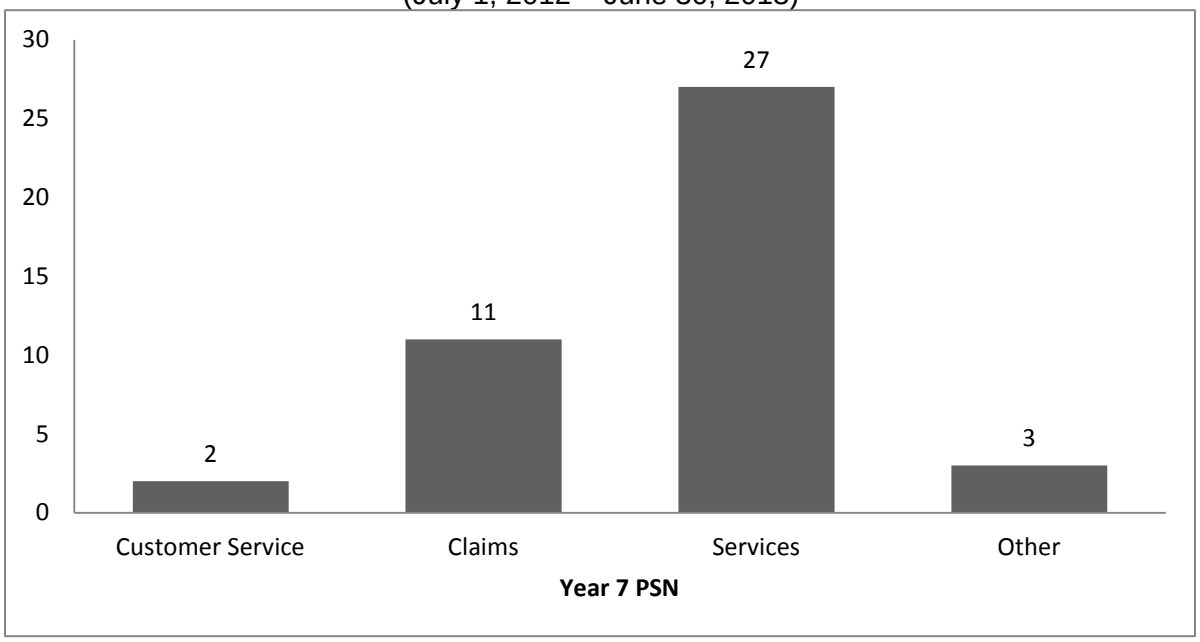


Chart B
PSN Complaints by Type
(July 1, 2012 – June 30, 2013)



Trending reports on HMO and PSN complaints in Demonstration Year Seven are provided in Charts C and D. There were fewer complaints received related to PSNs in Demonstration Year Seven (43) than in Year Six (73). The number of complaints received related to HMOs decreased in Demonstration Year Seven (96) relative to Year Six (187). The average rate of issues reported decreased from Demonstration Year Six (6.3 per 10,000 recipients) to Year Seven (3.2 per 10,000 recipients). In Demonstration Year Seven, the Agency continued reviewing complaints on a monthly basis and looking at complaints by health plan and issue type on a quarterly basis.

Chart C
HMO Overall Complaint Trends
(July 1, 2012 – June 30, 2013)

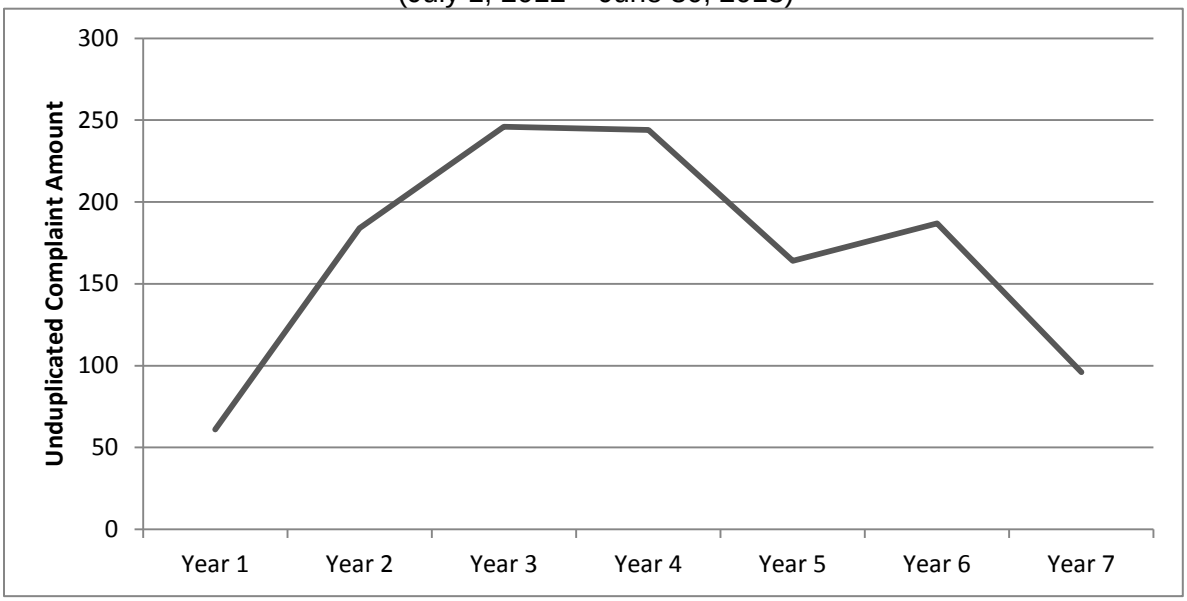
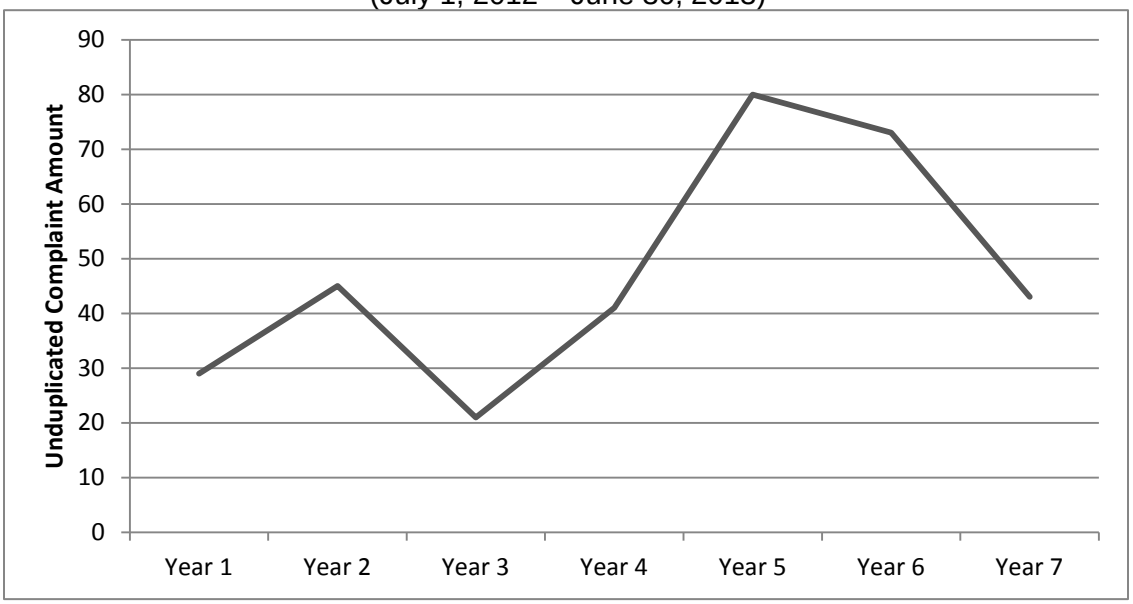


Chart D
PSN Overall Complaint Trends
(July 1, 2012 – June 30, 2013)



5. Medical Loss Ratio

Overview

On June 25, 2012 and in accordance with new amended STC #17, the Agency submitted to Federal CMS the revised MLR instructions and templates, reporting schedule and the report guide that incorporated comments from the health plans and Federal CMS. The substantive change made to this policy was to extend the reporting deadline from 45 days to seven months after the end of each quarter or year for which the health plan is reporting. This change was made based on comments received by Federal CMS on June 15, 2012 to allow for the initial claims filing and claims adjudication to conclude so that the incurred but not reported (IBNR) ratio is lower. The revised MLR reporting schedule is outlined in Table 12 located on the following page, and became effective October 1, 2012. This information is posted on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/Special_Terms_Conditions_14_03-13-2012.pdf.

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

In addition, the draft plan contract amendment language was posted on the Agency's managed care website and provided to the health plans on July 1, 2012. After reviewing comments from Federal CMS and the health plans, the Agency revised the core contract provisions that became effective September 1, 2012 to reflect the following:

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

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

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

The MLR calculation shall utilize uniform financial data collected from all capitated health plans operating in the demonstration areas and shall be computed for each plan on a statewide basis. For the purpose of calculating the MLR, "health care covered services" are defined as services provided by the health plan to Medicaid recipients in the demonstration area in accordance with

the Health Plan Medicaid Contract and as outlined in Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I (see below).

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

Demonstration Year Seven at a Glance

The first quarterly MLR report for Demonstration Year Seven was due to the Agency on April 30, 2013 in accordance with newly amended STC #17c, and all nine capitated health plans submitted their MLR reports to the Agency on or before the due date of April 30, 2013. The Agency submitted the capitated plan's MLR results to Federal CMS on May 15, 2013 as outlined in Table 12, the Health Plan Medical Loss Ratio Reporting Schedule. Two of the nine capitated plans reported an MLR below 85% for the reporting period from July 1, 2012 to September 30, 2012. As noted earlier in the report, the capitated plan's MLR data is evaluated annually to determine compliance, and quarterly reports are provided primarily for informational purposes. Seasonality and inherent claims volatility may cause MLR results to fluctuate somewhat from quarter to quarter, especially for smaller plans.

6. On-Site Surveys and Desk Reviews

Demonstration Year Seven at a Glance

During Demonstration Year Seven, the Agency completed both desk reviews and on-site surveys of all demonstration HMOs and PSNs. Demonstration Year Seven spanned two parts of the on-site survey process. On-site surveys consisted of health plan staff interviews, demonstrations of health plan processes and review of selected parts of the health plan contract. The behavioral health on-site survey consisted of a comprehensive review of the health plans' operations for compliance with the specific provisions of the contract related to behavioral health and all applicable federal and state laws and regulations.

<u>Desk Reviews</u>

The desk reviews focused on new and revised policies and procedures, including medical, fraud and abuse, and behavioral health. Provider network reviews were performed upon the health plan's request for expansion of the service areas and/or increases in enrollment in existing service areas. In addition, the desk reviews consisted of reviewing member and provider materials and a review of complaints received concerning the recipients and/or providers.

<u>On-Site Surveys</u>

The Agency continued to further refine and strengthen the health plan survey process and monitoring tools with the assistance of Florida's External Quality Review Organization, Health

Services Advisory Group, Inc. (HSAG). All monitoring tools and functions are compliant with state and federal regulations.

Table 13 provides the list of on-site survey categories that may be reviewed during an on-site visit.

Table 13 On-Site Survey Categories	
➲ Services	➲ Provider Coverage/Services
➲ Marketing/Community Outreach	➲ Provider Records/Credentialing
➲ Utilization Management	➲ Claims Process
➲ Quality of Care	➲ Grievances and Appeals
➲ Member Services	➲ Financials

Each of the health plans received an on-site survey during the 2012 calendar year, which spans two demonstration years. The on-site surveys consisted of medical and care/case management record reviews focusing on pregnancy, newborn and child health check-up; review of complaints, grievances and appeals; prior authorization denials; member services; enrollment, disenrollment and eligibility; and community outreach. During Demonstration Year Seven, only one health plan received a behavioral health on-site survey. This survey was to ensure the plan's transition to a newly subcontracted behavioral health organization was in compliance with contract standards. Desk reviews of provider networks, websites, member materials, policies and procedures, and clinical records were conducted on the other health plans.

The survey process was consistent across health plan types. The survey team consisted of a team leader and at least two team members and lasted an average of two days. The survey teams consisted of analysts and Registered Nurses from the bureaus of Health Systems Development and Managed Health Care. The behavioral health review was performed separately. The behavioral health survey teams included licensed clinical mental health professionals and consisted of a team lead and at least one team member. Health plan policies and procedures were reviewed prior to the on-site visit. Health plan staff were interviewed to make sure the plan processes were consistent with written procedures and plan staff were cognizant of the health plan responsibilities and how the various committees worked together to provide quality services to enrollees. The results of these surveys showed that all health plans are currently in good standing with the state and there were no sanctions administered as a result of desk and on-site reviews.

The Agency processed one new health plan application during this period. Medical, behavioral health and fraud and abuse staff completed a full desk review and performed an onsite survey prior to implementation. Results of the full desk review indicated that the plan was in compliance and no deficiencies were cited.

Remainder of page intentionally left blank.

B. Choice Counseling Program

Overview

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

1. Choice Selection Tools

Demonstration Year Seven at a Glance

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

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

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

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

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

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Chart E
Illustration of Choice Selection Tools in Health Track Enrollment System

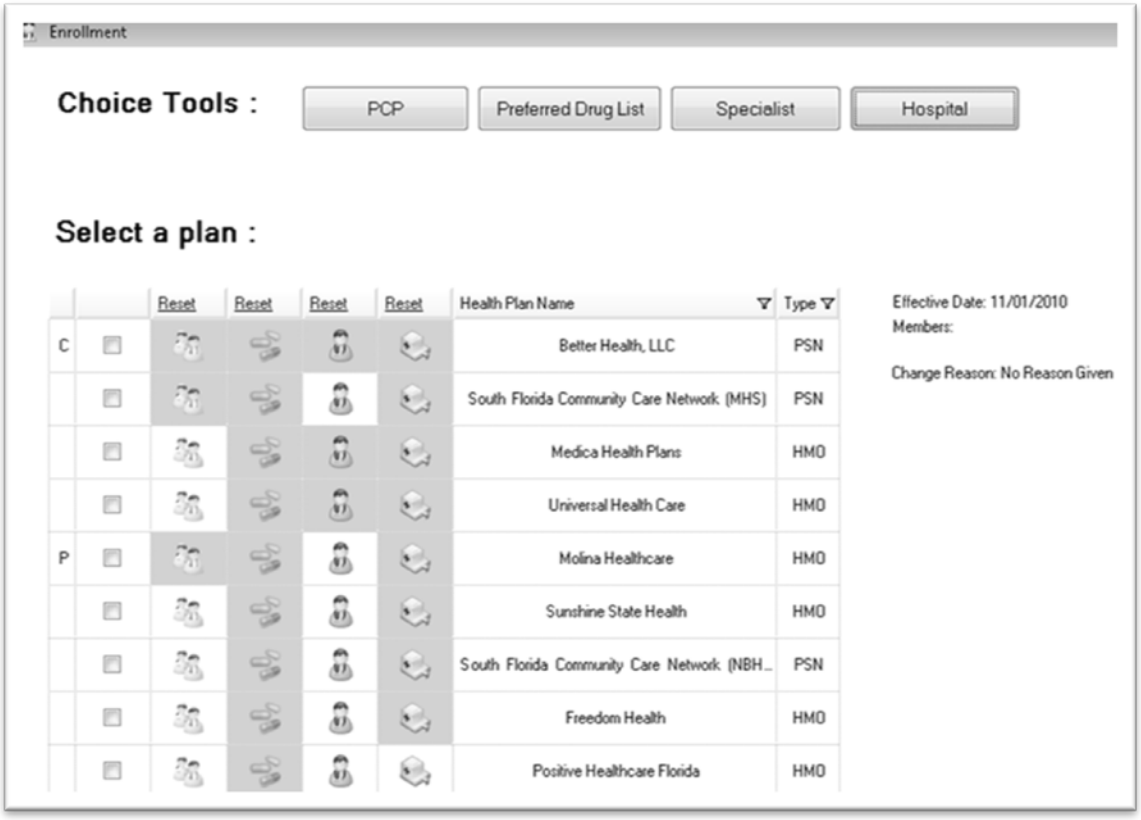
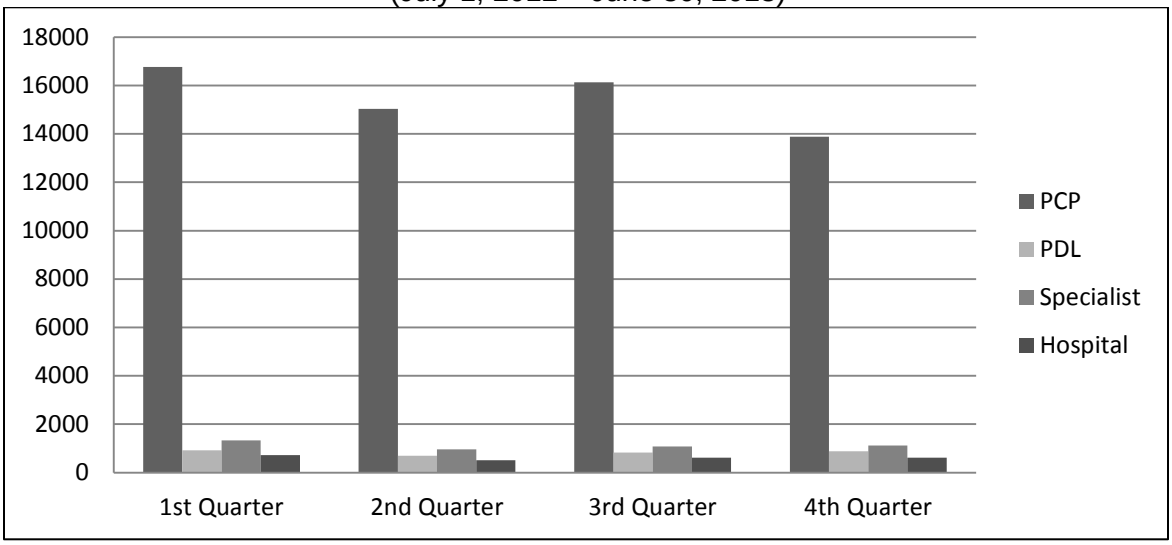


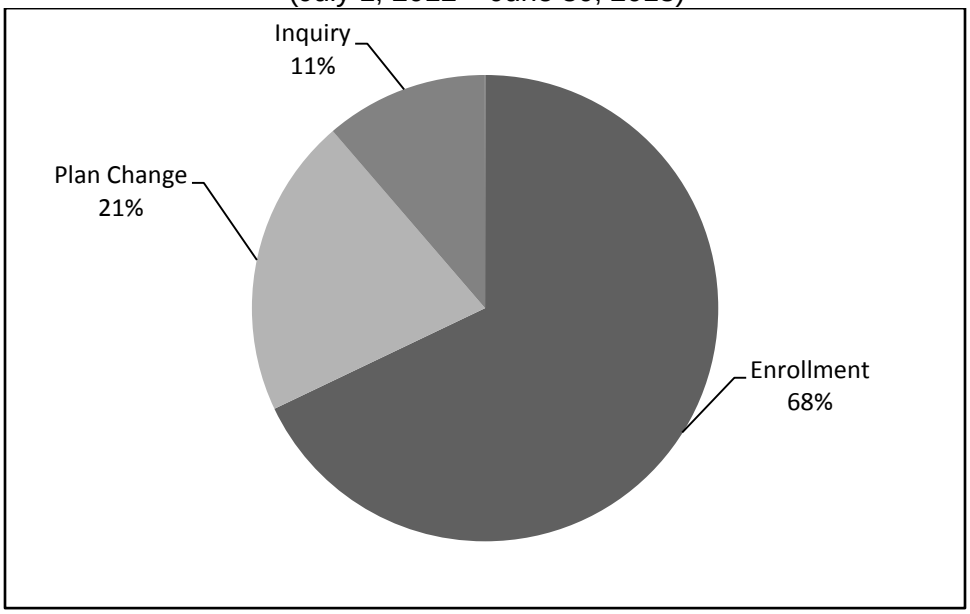
Chart F represents the number of times each choice selection tool was utilized during the enrollment or plan change process for Demonstration Year Seven. The results are broken out by choice tool type.

Chart F
Choice Tool Use by Type
(July 1, 2012 – June 30, 2013)



Choice counseling captures data to indicate whether a person is using the choice tools for an enrollment, plan change or an inquiry. Chart G shows (by percentage) what types of calls were received using this program as a choice driver during Demonstration Year Seven.

Chart G
Navigator Use by Call Type
(July 1, 2012 – June 30, 2013)



2. Online Enrollment

Demonstration Year Seven at a Glance

Table 14 shows the number of online plan selection enrollments by quarter for Demonstration Year Seven. The Agency continues to work on increasing recipient awareness of the availability of online enrollment.

Table 14
Online Plan Selection Enrollment Statistics
(Demonstration Year Seven)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Online Plan Section Enrollments	2,587	2,324	2,598	2,446

3. Call Center

Demonstration Year Seven at a Glance

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During Demonstration Year Seven, the call center had an average of 28.5 full time equivalent employees who speak English, Spanish and Haitian Creole to answer calls. Saturday hours were discontinued during the fourth quarter of Demonstration Year Seven to maximize staffing hours during the week.

The choice counseling call center received 185,849 calls during Demonstration Year 7, which remains within the normal call volume.

Table 15 provides the choice counseling call center statistics for Demonstration Year Seven.

Table 15
Choice Counseling Call Center Statistics
(Demonstration Year Seven)

Type of Calls	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Inbound Calls Received	47,866	44,197	44,144	49,642	185,849
Average Speed of Answer (seconds)	:22	:27	:13	:125	:47
Abandoned Calls	983	1,222	595	5,269	8,069
Abandonment Rate[2]	2.1%	2.8%	1.3%	10.6%	4.3%
Calls Answered	46,883	42,975	43,549	44,373	177,780
Calls Answered in <180 seconds	95%	96%	98%	47%	84%
Outbound Calls	13,400	13,591	12,268	9,321	48,580

Outbound and Inbound Mail

Table 16 highlights the volume for the largest mailings completed during the demonstration. Mailings are grouped by family or case. This means if there are two children in one case, only one mailing will be sent to the household instead of two; therefore, the number of individuals is higher than the number of mailings.

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

Table 16
Mail Room Statistics Per Demonstration Year

Type	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
New Eligible Packets	66,832	84,696	95,178	87,702	93,547	87,005	91,030
Transition Packets	119,002	17,730	3,221	2,045	5,543	8,206	10,487
Auto-Assignment Reminder Letters	49,390	48,147	129,456	84,384	64,846	56,097	64,347
Confirmation Letters	49,029	57,537	106,634	84,489	94,700	93,121	95,028
Open Enrollment Packets	2,641	74,412	166,227	137,648	172,684	220,096	220,696

During Demonstration Year Seven, enrollments completed through the mail consistently remained around 1% each month. Mail-in enrollments remain significantly lower than the enrollments completed through the choice counseling call center, by the field choice counselors or online.

[2] The call abandonment rate is calculated by dividing the total number of calls abandoned by the total number of calls received.

During Demonstration Year Seven, the choice counseling vendor mailed 24,394 annual reminder notices to those who are exempt from open enrollment. The reminders are to inform recipients, who are exempt from open enrollment, that they may change their health plan at any time.

During Demonstration Year Seven, the choice counseling vendor processed 2,669 enrollments and 164 plan changes through inbound mail.

Health Literacy

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

Summary of Cases Taken by the Special Needs Unit

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

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

During Demonstration Year Seven, there were 1,748 new case referrals and 1,418 case reviews received and processed by the Special Needs Unit.

The Special Needs Unit staff scope of work includes:

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

Face-to-Face/Outreach and Education

Looking back over the results of the outreach efforts through Demonstration Year Seven, there are important points that should be considered:

- The field choice counseling team has increased the number of community partners from approximately 205 to over 300.
- Outbound call enrollment efforts continue to be a key activity, urging recipients to take an active role in their health care decisions.

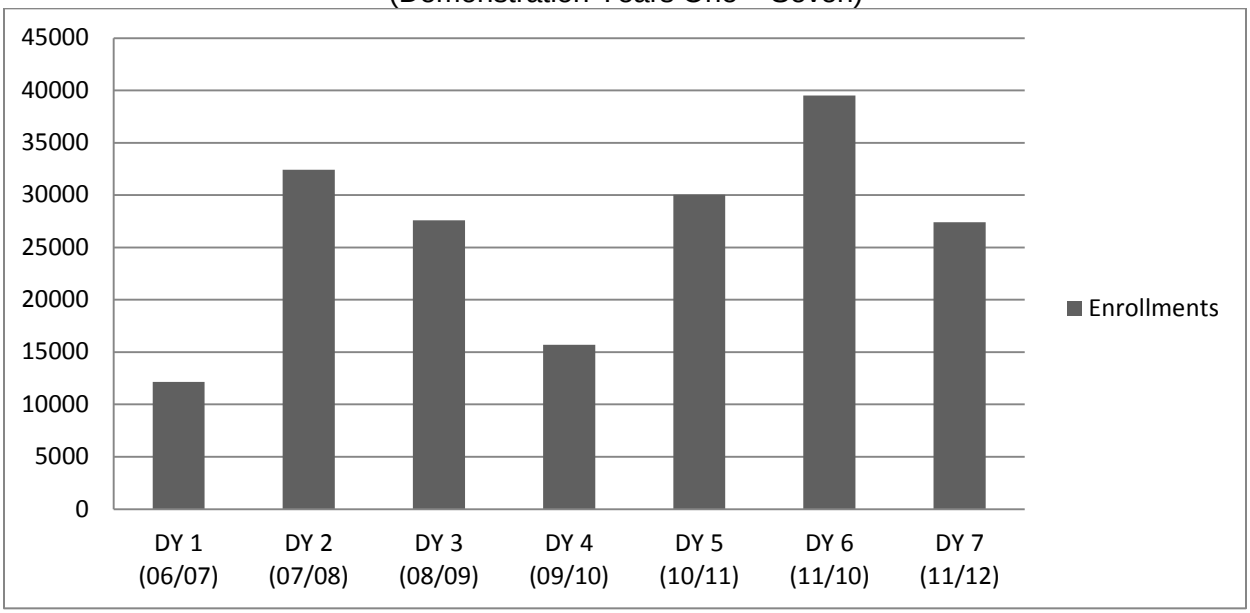
The Outreach Team conducts group sessions and makes choice counselors available after the session to assist recipients in plan choices and, if needed, provides the option for face-to-face

choice counseling at the recipient's convenience. Table 17 lists the type and volume of outreach/field choice counselor activities during Demonstration Year Seven, and Chart H shows the number of enrollments over the seven years of the demonstration.

Table 17
Choice Counseling Outreach Activities
(Demonstration Year Seven)

Field Activities	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Public Sessions	406	396	295	236	1,333
Private Sessions	41	31	17	22	111
Home/No-Phone Visits	758	698	672	263	2,391
Outbound List Calls	8,425	7,969	7,469	2,190	26,053
Outreach Enrollments	9,047	8,479	6,861	3,018	27,405

Chart H
Choice Counseling Outreach Enrollments
(Demonstration Years One – Seven)



The Mental Health Unit

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

- Susan B. Anthony Recovery Center in Broward County,
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County,
- Mental Health Resource Center and River Region Human Services in Duval County,
- Wolfson's Children's Hospital/Community Health in Duval County,
- Clay County Behavioral Health,
- Broward Addition Recovery, and
- Vocational Rehabilitation with the Florida Department of Education.

Complaints/Issues

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

Quality Improvement

Recipient Customer Survey

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rank their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the survey to every recipient who calls to enroll in a plan or to make a plan change. During Demonstration Year Seven, a total of 4,492 recipients completed the automated survey.

Table 18 located on the following page shows a list of all questions that are asked during the survey and how recipients ranked their satisfaction (represented in percentages) with the choice counseling call center and the overall service provided by the choice counselors for Demonstration Year Seven (by month).

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Table 18 Choice Counseling Caller Satisfaction Results Percentage of Satisfied Callers Per Question (July 1, 2012 – June 30, 2013)											
Jul	***Aug***	***Sept***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mar***	***Apr***	***May***	***Jun***
How helpful do you find this counseling to be											
87%	87%	89%	87%	89%	90%	89%	90%	85%	90%	88%	89%
Satisfaction with the amount of time you waited to speak with a counselor											
82%	82%	86%	87%	84%	86%	84%	91%	87%	77%	65%	73%
How easy it was to understand the information											
81%	81%	79%	78%	78%	76%	80%	78%	79%	75%	73%	77%
How likely are you to recommend Choice Counseling helpline to friend or relative											
93%	93%	93%	95%	94%	96%	95%	96%	94%	93%	94%	95%
Overall service provided by Counselor											
94%	94%	95%	94%	96%	96%	95%	97%	96%	95%	95%	94%
How quickly the Counselor understood why you called today											
95%	95%	96%	94%	97%	96%	95%	98%	95%	96%	95%	97%
The Counselor's ability to help you choose your health plan											
94%	94%	94%	94%	94%	94%	95%	97%	93%	94%	92%	95%
The Counselor's ability to explain things clearly											
95%	95%	96%	93%	95%	95%	95%	97%	94%	95%	92%	96%
The confidence you have in the information given to you by the counselor											
94%	94%	94%	95%	96%	96%	94%	96%	95%	94%	94%	96%
Satisfaction with being treated respectfully											
97%	97%	98%	97%	98%	98%	97%	98%	97%	96%	96%	96%

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

During Demonstration Year Seven, the survey results reporting the recipients' satisfaction with the overall service provided by the choice counselors indicate that more than 96% are satisfied with the choice counseling experience. The Agency continues to focus on improving communication between choice counselors and recipients, as well as evaluating comments left by recipients to improve customer service.

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

4. New Eligible Self-Selection Data[3]

Demonstration Year Seven at a Glance

From July 2010 to June 2013, 68% of recipients enrolled in the demonstration self-selected a health plan and 32% were auto-assigned. Table 19 shows the current self-selection and auto-assignment rate for Demonstration Year Seven.

Table 19
Self-Selection and Auto-Assignment Rate
(July 1, 2012 – June 30, 2013)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Self-Selected	35,374	34,939	32,318	33,056
Auto-Assignment	15,243	15,608	15,400	30,941
Total Enrollments	50,617	50,547	47,718	63,997
Self-Selected %	70%	69%	68%	52%
Auto-Assignment %	30%	31%	32%	48%

Lessons Learned and Looking Ahead to Demonstration Year Seven

During Demonstration Year Seven, the Choice Counseling program identified and implemented several improvements. The following provides a description of the lessons learned and steps to be taken during the upcoming Demonstration Year Eight.

<u>System Enhancements</u>

The Agency will continue to evaluate the enrollment system, Health Track, to make all possible improvements in efficiency and effectiveness for recipient use in plan selection. During Demonstration Year Seven, the following improvements were made:

- Improved reporting to allow better tracking of key performance factors;
- Improved systems issue tracking mechanisms; and
- Improved data transfer process between the choice counseling vendor and the Agency's Medicaid Fiscal Agent, allowing quicker resolution of any enrollment or disenrollment errors.

<u>Public Feedback</u>

The Agency will continue public interaction to provide opportunities for feedback in Demonstration Year Eight, as it is vital for the success and continued development of the Choice Counseling program.

[3] The Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate,"* the data is referred to as *"New Eligible Self-Selection Rate."* The term *"self-selection"* is now used to refer to recipients who choose their own plan and the term *"assigned"* is now used for recipients who do not choose their own plan.

C. Enrollment Data

Demonstration Year Seven at a Glance

Enrollment Reports

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

The following is a summary of the annual enrollment for Demonstration Year Seven, beginning July 1, 2012 and ending June 30, 2013. This section contains the following enrollment reports:

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

All health plans located in the five demonstration counties are included in each of the reports. During Demonstration Year Seven, there were a total of 17 health plans – 13 HMOs and four FFS PSNs.

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

1. Medicaid Reform Enrollment by Plan Report

Table 20 located on the following page contains the quarterly enrollment for each health plan during Year Seven of the demonstration, and shows how enrollment in the demonstration increased over this time period. In addition, the quarterly enrollment for each of the HMOs is displayed in Chart I and the quarterly enrollment for each of the PSNs is displayed in Chart J located on the following pages.

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Table 20 Quarterly Medicaid Reform Enrollment by Plan (July 1, 2012 – June 30, 2013)					
Plan Name	Plan Type	Number of Enrollees by Quarter – Year 7			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Care Florida	HMO	3,904	3,925	3,946	4,066
Clear Health Alliance	HMO	-	-	1	31
Freedom Health	HMO	4,696	4,624	4,618	4,658
Humana Family	HMO	8,088	10,107	11,626	12,837
Magellan	HMO	-	-	-	5
Medica Health Plans of Florida, Inc.	HMO	4,348	4,317	4,272	5,356
Molina Healthcare of Florida, Inc.	HMO	31,050	30,932	31,305	32,223
Positive Healthcare Florida	HMO	201	207	224	249
Simply	HMO	14	662	1,395	2,021
Staywell	HMO	-	-	4,448	16,781
Sunshine State Health Plan	HMO	94,972	95,126	95,253	94,967
United Healthcare	HMO	9,430	9,396	9,209	9,274
Universal Health Care	HMO	22,292	22,012	19,650	-
HMO Totals		**178,995**	**181,308**	**185,947**	**182,468**
Better Health, LLC	PSN	40,077	40,129	39,897	44,255
CMS	PSN	9,198	9,407	9,464	9,451
First Coast Advantage	PSN	73,661	74,209	74,432	73,610
SFCCN	PSN	40,497	39,869	39,492	39,424
PSN Totals		**163,433**	**163,614**	**163,285**	**166,740**
Medicaid Reform Totals		**342,428**	**344,922**	**349,232**	**349,208**

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Chart I
Quarterly Medicaid Reform Enrollment for HMOs
(July 1, 2012 – June 30, 2013)

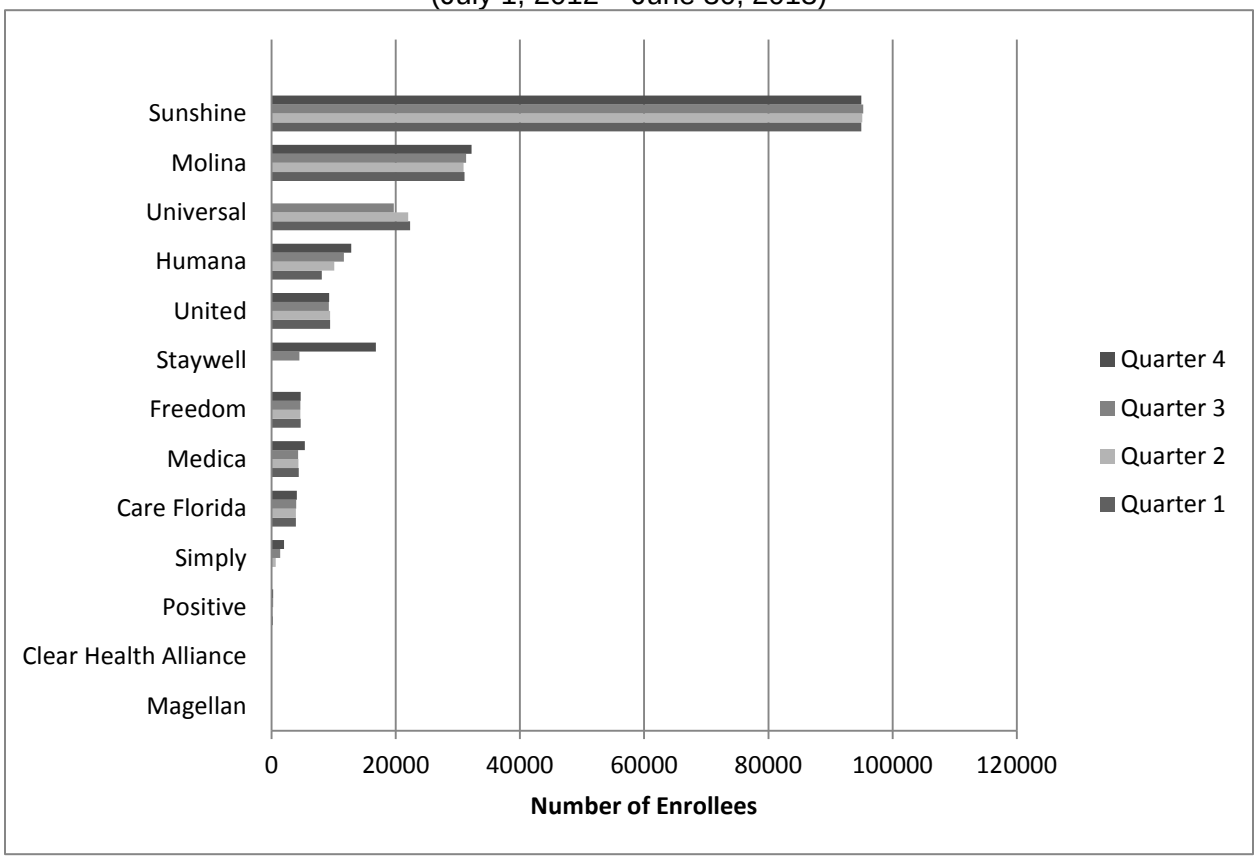
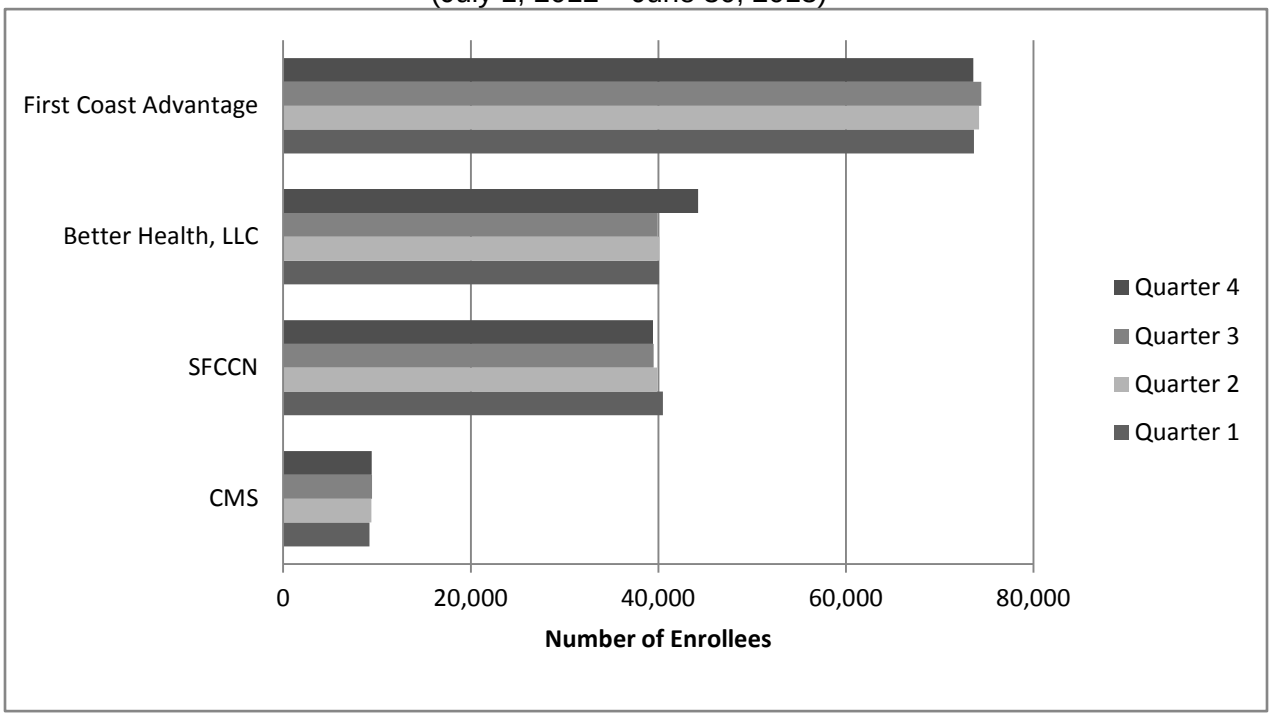


Chart J
Quarterly Medicaid Reform Enrollment for PSNs
(July 1, 2012 – June 30, 2013)



2. Medicaid Reform Enrollment Report

The annual Medicaid Reform Enrollment Report is a complete look at the entire enrollment (unduplicated count) for the demonstration program for the year being reported. Table 21 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 21
Medicaid Reform Enrollment Report Column Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled – No Medicare	The number of SSI recipients who are enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled – Medicare Part B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Part B coverage
Number of SSI Enrolled – Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's recipient pool accounts for
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year

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The information provided in this report is an unduplicated count of the recipients enrolled in each demonstration health plan at any time during Demonstration Year Seven. Please refer to Table 22 for the annual Medicaid Reform Enrollment report for Year Seven of the demonstration.

Table 22
Medicaid Reform Enrollment Report
(July 1, 2012 – June 30, 2013)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for Reform	Enrolled in Previous Year	Percent Change from Previous Year
			No Medicare	Medicare Part B	Medicare Parts A & B				
Care Florida	HMO	4,612	855	0	157	**5,624**	**1.30%**	4,855	15.84%
Clear Health Alliance	HMO	6	25	0	0	**31**	**0.01%**	-	-
Freedom Health	HMO	5,265	725	1	136	**6,127**	**1.42%**	6,117	0.16%
Humana	HMO	12,441	2,209	5	476	**15,131**	**3.50%**	6,071	149.23%
Magellan	HMO	5	0	0	0	**5**	**0.01%**	-	-
Medica	HMO	5,111	1,156	5	230	**6,502**	**1.50%**	5,517	17.85%
Molina	HMO	35,538	4,316	25	867	**40,746**	**9.43%**	39,367	3.50%
Positive Healthcare	HMO	26	238	0	19	**283**	**0.07%**	224	26.34%
Simply	HMO	1,874	298	1	47	**2,220**	**0.51%**	-	-
Staywell	HMO	14,868	1,553	2	96	**16,519**	**3.82%**	-	-
Sunshine	HMO	105,824	9,989	16	1,390	**117,219**	**27.12%**	116,531	0.59%
United Healthcare	HMO	10,013	1,380	1	170	**11,564**	**2.68%**	11,639	-0.64%
Universal Health Care	HMO	6,742	575	4	455	**7,776**	**1.80%**	28,326	-72.55%
HMO Total	**HMO**	**202,325**	**23,319**	**60**	**4,043**	**229,747**	**53.16%**	**218,647**	**5.08%**
Better Health, LLC	PSN	47,256	5,193	3	855	**53,307**	**12.33%**	47,393	12.48%
CMS	PSN	6,574	4,356	0	34	**10,964**	**2.54%**	10,325	6.19%
First Coast Advantage	PSN	77,424	10,402	5	1,781	**89,612**	**20.73%**	87,819	2.04%
SFCCN	PSN	42,542	5,165	7	854	**48,568**	**11.24%**	49,418	-1.72%
PSN Total	**PSN**	**173,796**	**25,116**	**15**	**3,524**	**202,451**	**46.84%**	**194,955**	**3.84%**
Reform Enrollment Totals		**376,121**	**48,435**	**75**	**7,567**	**432,198**	**100.00%**	**413,602**	**4.50%**

The demonstration market share percentage for each plan is calculated once all recipients have been counted and the total number of recipients enrolled is known.

The enrollment figures for Demonstration Year Seven reflect those recipients who self-selected a health plan, as well as those who were auto-assigned. In addition, some Medicaid recipients transferred from non-demonstration health plans to the demonstration health plans. There were a total of 432,198 unique recipients enrolled in the demonstration during Year Seven. There were 17 demonstration health plans active during Demonstration Year Seven with market shares ranging from 0.01% to 27.12%.

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3. Medicaid Reform Enrollment by County Report

During Demonstration Year Seven, the demonstration remained operational in the five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties is listed in Table 23.

Table 23
Number of Reform Health Plans in Demonstration Counties
(July 1, 2012 – June 30, 2013)

County Name	Number of Reform HMOs	Number of Reform PSNs
Baker	**2**	**1**
Broward	**12**	**5**
Clay	**3**	**1**
Duval	**4**	**2**
Nassau	**2**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 24 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 24
Medicaid Reform Enrollment by County Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval or Nassau)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan in the county listed
Number of SSI Enrolled - No Medicare	The number of SSI recipients who are enrolled with the plan in the county listed and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients who are enrolled with the plan in the county listed and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients enrolled with the plan in the county listed; TANF and SSI combined
Market Share for Reform by County	The percentage of the demonstration population in the county listed that the plan's recipient pool accounts for
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year (in the county listed)

Table 25 located on the following page lists, by plan and county, for this year and compared to last year, the total number of TANF and SSI individuals enrolled and the market share for each county. In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report.

Table 25
Medicaid Reform Enrollment by County Report
(July 1, 2012 – June 30, 2013)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for Reform by County	Enrolled in Previous Year	Percent Change from Previous Year
			No Medicare	Medicare Part B	Medicare Parts A and B				
Baker County									
First Coast Advantage	PSN	3,292	340	0	28	**3,660**	**80.42%**	3,425	6.86%
Staywell	HMO	35	7	0	1	**43**	**0.94%**	0	-
United Healthcare	HMO	737	97	0	14	**848**	**18.63%**	1,091	-22.27%
Baker		**4,064**	**444**	**0**	**43**	**4,551**	**100.00%**	**4,516**	**0.78%**
Broward County									
Better Health, LLC	PSN	47,256	5,193	3	855	**53,307**	**21.76%**	47,393	12.48%
Care Florida	HMO	4,612	855	0	157	**5,624**	**2.30%**	4,855	15.84%
Clear Health Alliance	HMO	6	25	0	0	**31**	**0.01%**	0	0.00%
CMS	PSN	4,207	3,125	0	27	**7,359**	**3.00%**	6,894	6.74%
Freedom Health Plan	HMO	5,265	725	1	136	**6,127**	**2.50%**	6,117	0.16%
Humana	HMO	12,441	2,209	5	476	**15,131**	**6.18%**	6,071	149.23%
Magellan	HMO	5	0	0	0		**0.00%**	0	0.00%
Medica	HMO	5,111	1,156	5	230	**6,502**	**2.65%**	5,517	17.85%
Molina Healthcare	HMO	35,538	4,316	25	867	**40,746**	**16.63%**	39,367	3.50%
Positive Healthcare	HMO	26	238	0	19	**283**	**0.12%**	224	26.34%
SFCCN	PSN	42,542	5,165	7	854	**48,568**	**19.82%**	49,418	-1.72%
Simply	HMO	1,874	298	1	47	**2,220**	**0.91%**	-	-
Staywell	HMO	2,716	222	0	24	**2,962**	**1.21%**	0	-
Sunshine	HMO	47,280	4,097	13	564	**51,954**	**21.20%**	50,429	3.02%
Universal Health Care	HMO	3,601	317	3	286	**4,207**	**1.72%**	15,920	-73.57%
Broward		**212,480**	**27,941**	**63**	**4,542**	**245,026**	**100.00%**	**232,205**	**5.52%**
Clay County									
First Coast Advantage	PSN	6,237	536	0	56	**6,829**	**30.44%**	6,060	12.69%
Staywell	HMO	279	35	0	4	**318**	**1.42%**	0	-
Sunshine	HMO	9,801	772	0	89	**10,662**	**47.52%**	12,210	-12.68%
United Healthcare	HMO	4,153	431	0	42	**4,626**	**20.62%**	3,412	35.58%
Clay		**20,470**	**1,774**	**0**	**191**	**22,435**	**100.00%**	**21,682**	**3.47%**
Duval County									
CMS	PSN	2,367	1,231	0	7	**3,605**	**2.38%**	3,431	5.07%
First Coast Advantage	PSN	62,029	9,002	4	1,643	**72,678**	**47.99%**	72,182	0.69%
Staywell	HMO	11,709	1,277	2	67	**13,055**	**8.62%**	0	-
Sunshine	HMO	48,743	5,120	3	737	**54,603**	**36.06%**	53,892	1.32%
United Healthcare	HMO	3,223	632	1	74	**3,930**	**2.60%**	4,862	-19.17%
Universal Health Care	HMO	3,141	258	1	169	**3,569**	**2.36%**	12,406	-71.23%
Duval		**131,212**	**17,520**	**11**	**2,697**	**151,440**	**100.00%**	**146,773**	**3.18%**
Nassau County									
First Coast Advantage	PSN	5,866	524	1	54	**6,445**	**73.69%**	6,152	4.76%
Staywell	HMO	129	12	0	0	**141**	**1.61%**	0	-
United Healthcare	HMO	1,900	220	0	40	**2,160**	**24.70%**	2,274	-5.01%
Nassau		**7,895**	**756**	**1**	**94**	**8,746**	**100.00%**	**8,426**	**3.80%**
Reform Enrollment Totals		**376,121**	**48,435**	**75**	**7,567**	**432,198**		**413,602**	**4.50%**

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

4. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 25 and 26 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing recipients in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those recipients who were not part of Medicaid Reform for at least six months prior to the start of the quarter. Table 26 provides a description of each column in this report.

Table 26
Medicaid Reform Voluntary Population Enrollment Report Descriptions

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

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Table 27 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 27
Medicaid Reform Voluntary Population Enrollment Report
(July 1, 2012 – June 30, 2013)

Plan Name	Plan Type	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
			Foster, Adoption Subsidy, and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
HMO's			New	Existing	New	Existing	New	Existing	Number	Percentage	
Care Florida	HMO	Broward	111	16	3	0	129	28	**287**	**5.10%**	5,624
Clear Health Alliance	HMO	Broward	0	0	0	0	0	0	**0**	**0.00%**	31
Freedom	HMO	Broward	106	21	4	6	46	91	**274**	**4.47%**	6,127
Humana	HMO	Broward	457	49	3	24	207	274	**1,014**	**6.70%**	15,131
Magellan	HMO	Broward	0	0	0	0	0	0	**0**	**0.00%**	5
Medica	HMO	Broward	117	19	6	4	119	116	**381**	**5.86%**	6,502
Molina Healthcare	HMO	Broward	832	181	10	31	327	565	**1,946**	**4.78%**	40,746
Positive Healthcare	HMO	Broward	0	0	0	0	3	16	**19**	**6.71%**	283
Simply	HMO	Broward	47	1	3	2	44	4	**101**	**4.55%**	2,220
Staywell	HMO	Baker	2	0	0	0	1	0	**3**	**6.98%**	43
Staywell	HMO	Broward	130	2	4	2	20	4	**162**	**5.47%**	2,962
Staywell	HMO	Clay	3	0	0	0	4	0	**7**	**2.20%**	318
Staywell	HMO	Duval	186	18	2	0	49	20	**275**	**2.11%**	13,055
Staywell	HMO	Nassau	6	0	0	0	0	0	**6**	**4.26%**	141
Sunshine	HMO	Broward	803	306	18	32	220	357	**1,736**	**3.34%**	51,954
Sunshine	HMO	Clay	112	86	3	5	21	68	**295**	**2.77%**	10,662
Sunshine	HMO	Duval	581	507	14	48	167	573	**1,890**	**3.46%**	54,603
United Healthcare	HMO	Baker	4	7	1	1	3	11	**27**	**3.18%**	848
United Healthcare	HMO	Clay	71	31	2	3	11	31	**149**	**3.22%**	4,626
United Healthcare	HMO	Duval	56	54	3	13	26	49	**201**	**5.11%**	3,930
United Healthcare	HMO	Nassau	27	19	1	6	24	16	**93**	**4.31%**	2,160
Universal Health Care	HMO	Broward	90	57	2	9	76	213	**447**	**10.63%**	4,207
Universal Health Care	HMO	Duval	84	65	4	4	67	103	**327**	**9.16%**	3,569
HMO Total	**HMO**		**3,825**	**1,439**	**83**	**190**	**1,564**	**2,539**	**9,640**	**4.20%**	**229,747**
PSN's											
Better Health, LLC.	PSN	Broward	960	277	25	65	168	690	**2,185**	**4.10%**	53,307
CMS	PSN	Duval	279	449	11	115	2	5	**861**	**23.88%**	3,605
CMS NORTH	PSN	Broward	54	45	32	155	3	18	**307**	**6.04%**	5,079
CMS SOUTH	PSN	Broward	16	21	9	42	4	2	**94**	**4.12%**	2,280
First Coast Advantage	PSN	Baker	41	26	3	2	15	13	**100**	**2.73%**	3,660
First Coast Advantage	PSN	Clay	122	53	1	5	24	32	**237**	**3.47%**	6,829
First Coast Advantage	PSN	Duval	805	732	30	128	299	1,348	**3,342**	**4.60%**	72,678
First Coast Advantage	PSN	Nassau	73	24	2	3	25	30	**157**	**2.44%**	6,445
SFCCN	PSN	Broward	996	502	14	67	187	674	**2,440**	**5.02%**	48,568
PSN Total	**PSN**		**3,346**	**2,129**	**127**	**582**	**727**	**2,812**	**9,723**	**4.80%**	**202,451**
Reform Totals			**7,171**	**3,568**	**210**	**772**	**2,291**	**5,351**	**19,363**	**4.48%**	**432,198**

D. Enhanced Benefits Account Program

Overview

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

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

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

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

Demonstration Year Seven at a Glance

Demonstration Year Seven accomplishments for the EBA program include:

- Continued increased use of the Automated Voice Response System (AVRS) at the enhanced benefits call center and highest amount of credits used by recipients.
    - Total number of calls to the AVRS were 93,782, and 57,742 calls were handled by an agent.
    - Highest usage of earned credits by recipients since implementation of the program (over 9-million dollars).

Participation Rates and Assessment of Expenditures

Table 28 located on the following page compares the credits earned each month by date of service for earned credits, purchases each month by date of service, and the number of recipients actively participating. Mailing of the monthly insert, which focuses on health related products and outbound calls to recipients who have not used their credits, continues to be very successful in increasing the spending of earned credits at the pharmacy and creation of opportunities to educate recipients about the program.

Table 28 Enhanced Benefits Information System Summary (July 1, 2012 – June 30, 2013)					
Month of Claims	**Number Credited*** **	**Earned by Date of Service***	**Amount of Credits Earned Each Month****	**Purchases by Date of Service**	**Recipients Actively Participating by Month**
July 2012	55,453	$1,762,472.50	$1,276,395.00	$664,796.33	22,967
August 2012	89,150	$1,814,392.50	$1,313,070.00	$625,872.39	22,109
September 2012	57,617	$1,341,205.00	$1,099,390.00	$780,592.96	26,496
October 2012	62,997	$1,368,287.50	$1,043,655.00	$1,074,011.64	33,767
November 2012	57,326	$1,076,820.00	$890,100.00	$855,452.53	28,465
December 2012	44,311	$919,930.00	$850,472.50	$921,073.46	29,548
January 2013	48,274	$1,235,822.50	$993,592.50	$897,900.20	29,855
February 2013	46,153	$968,342.50	$916,112.50	$622,248.94	21,603
March 2013	43,891	$962,335.00	$977,852.50	$671,854.00	22,710
April 2013	45,134	$987,202.50	$884,147.50	$708,803.00	24,327
May 2013	46,552	$724,995.00	$869,660.00	$708,379.01	24,128
June 2013	37,488	$439,190.00	$414,917.50	$743,863.46	24,243
Year 7 Totals	**291,896**	**$13,600,995.00**	**$11,529,365.00**	**$9,274,847.92**	**310,218**

* Health Plans may submit healthy behaviors up to one year after the date of service.
** This is the amount of credits earned when the EB reports are due by the 10th of each month.
*** This is the number of recipients who were credited (unduplicated).

1. Call Center Activities

Demonstration Year Seven at a Glance

The enhanced benefits call center, managed by the choice counseling vendor [Automated Health Systems (AHS)], located in Tallahassee, Florida, operates a toll-free number and a toll-free number for hearing impaired callers. The call center answers all inbound calls relating to program questions, provides enhanced benefits account updates on credits earned/used, and assists recipients with utilizing the web-based over-the-counter product list. The call center is staffed with employees who speak English, Spanish and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The hours of operation are Monday – Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. Saturday hours were discontinued during the fourth quarter of Demonstration Year Seven to maximize staffing hours during the week. During Demonstration Year Seven, the number of inbound calls handled by an agent in the call center was 57,742 compared to the reported 64,866 inbound calls in Year Six.

The Automated Voice Response System (AVRS), implemented in June 2010, provides recipients only balance information. The AVRS continues to be a success as there were 93,782 calls handled in Demonstration Year Seven compared to 91,239 in Year Six. The call center continues to perform outbound calls to recipients who have not spent any of their enhanced benefits account credits.

Table 29 highlights the enhanced benefits call center activities during Demonstration Year Seven.

Table 29
Highlights of the Enhanced Benefits Call Center Activities
(July 1, 2012 – June 30, 2013)

Enhanced Benefits Call Center Activity	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Total
Calls Received	16,558	16,800	14,189	13,370	**60,917**
Calls Answered	15,950	16,171	13,772	11,849	**57,742**
Abandonment Rate	3.67%	3.74%	2.87%	11.98%	**5.2%**
Average Talk Time (minutes)	4:00	4:05	3:45	4:20	**4:02**
Calls Handled by the AVRS	24,286	24,903	20,342	24,251	**93,782**
Outbound Calls	21	326	87	51	**485**
Enhanced Benefits Mailroom Activity					
EB Welcome Letters	32,840	37,672	33,825	39,617	**143,954**

Continued recipient usage of the AVRS demonstrates this is an effective method of assisting recipients. In Demonstration Year Seven, the call center has primarily handled calls related to recipient EBA balances. The Agency continues to evaluate call center activities to determine if additional improvements for the EBA program are needed.

Healthy Behavior Reports

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

Outreach and Education for Recipients

During Demonstration Year Seven, the call center mailed 143,954 welcome letters. The choice counselors continue to provide information for recipients regarding their enhanced benefits account balances and the opportunity to earn healthy behavior credits. The choice counseling vendor made 485 outbound calls to recipients who have not utilized their enhanced benefits account credits. The out bound calls are conducted to encourage recipients to use their earned credits, explain some of the nuances at the pharmacy when using their earned credits, and how they can earn additional credits by participation in a healthy behavior.

Outreach and Education for Pharmacies

The pharmacy benefits manager, Magellan, continued to provide ongoing technical assistance to pharmacies as needed related to all billing aspects of the EBA program during Demonstration Year Seven. Continued updates of the over-the-counter product list posted onto the EB website are planned for Demonstration Year Eight until implementation of the Managed Medical Assistance program. Training efforts for pharmacy personnel will continue, when applicable.

Complaints

During Demonstration Year Seven, the EBA program received eight recipient complaints. The low number of complaints is attributed to improved call center staff training and direct problem resolution through the EB call center lead and the Agency EB staff person. Table 30 provides a summary of the complaints received and actions taken to address the complaints.

Table 30
Enhanced Benefits Recipient Complaints
(July 1, 2012 – June 30, 2013)

Recipient Complaint	Action Taken
1. Three recipients called to complain they were unhappy with the services provided at the pharmacy.	➲ The recipients were referred to another pharmacy.
2. Five recipients called about their health plan not reporting a healthy behavior.	➲ The Agency reached out to the health plans regarding submitting the healthy behaviors.

2. Enhanced Benefits Statistics

Demonstration Year Seven at a Glance

Table 31 provides the EBA program statistics for Demonstration Year Seven.

Table 31
Enhanced Benefits Account Program Statistics
(July 1, 2012 – June 30, 2013)

	Year Seven Activities	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
I.	Average number of plans submitting reports by quarter.	26	26	32	31
II.	Number of enrollees who received credit for healthy behaviors by quarter (not unduplicated by date of service as of July 2013).	170,595	164,634	138,318	129,174
III.	Total dollar amount credited to accounts by each quarter (as of July 2013, by date of service).	$3,688,855.00	$3,913,242.50	$3,162,387.50	$3,163,605.00
IV.	Total cumulative dollar amount credited through each quarter (not based on date of service).	$58,589,253.66	$62,502,496.16	$65,664,883.66	68,828,488.66
V.	Total dollar amount of credits spent each quarter by date of service.	$2,071,909.68	$2,851,121.26	$2,191,984.91	$2,163,686.85
VI.	Total cumulative dollar amount of credits used through the quarter by date of service.	$30,579,441.66	$33,430.003.21	$35,621,433.26	$37,785,086.32
VII.	Total cumulative number of enrollees who used credits through the quarter (duplicated – by date of service through July 2013).	71,565	91,768	74,141	72,690

Through Demonstration Year Seven, 13,956 recipients lost EBA eligibility for a total of $626,127.84 and they no longer have access to those credits. Programming is in process to address the recent FLMMIS EBA customer service request fix that should increase the three-year EBA expiration counts. As of June 30, 2013, there are 224,725 individuals who continue to retain access to funds ($16,730,045.00) in an account, but have never made a purchase with their earned credits.

Table 32 lists the dollar amount and count of recipients during Demonstration Year Seven who have lost EBA eligibility and credits because they have not been Medicaid eligible for three consecutive years. There is a decreased number during Demonstration Year Seven.

Table 32
Count of Recipients Who Lost EBA Eligibility and Credits
(July 1, 2012 – June 30, 2013)

Month	Recipient Count	Total Dollar Amount
July 2012	25	$654.46
August 2012	16	$451.73
September 2012	25	$1,008.68
October 2012	28	$720.30
November 2012	28	$908.75
December 2012	13	$503.29
January 2013	18	$310.52
February 2013	9	$276.48
March 2013	10	$344.93
April 2013	19	$611.06
May 2013	13	$170.79
June 2013	9	$255.14
Total	**213**	**$6,216.13**

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Table 33 provides a cumulative count of healthy behaviors and the sum of granted credit amounts for the demonstration. Since implementation of the program in September 2006 until June 30, 2013, a total of 566,839 recipients have earned $68,828,488.66 in EBA credits; as of June 30, 2013, there are 311,674 recipients who have spent $38,212,406.15 in earned credits.

Table 33
Healthy Behavior Counts and Credit Amounts
(September 2006 – June 30, 2013)

Healthy Behavior	Count of Procedure Code	Sum of Granted Credit Amount
Childhood Preventive Care	1,269,550	$31,559,247.50
Office Visit-Adult/Child	1,319,632	$14,997,705.00
Dental Preventive Services-Adult/Child	349,399	$8,679,465.00
Compliance with prescribed maintenance drugs	589,753	$4,385,315.00
Vision Exam-Adult/Child	147,093	$3,659,460.00
Pap Smear	92,377	$2,303,225.00
Child and Adult Preventive Care	72,742	$1,320,277.50
Diabetes Management	43,897	$656,520.00
Mammography	14,358	$354,415.00
Adult Preventive Care	23,545	$351,590.00
Prostate Specific Antigen (PSA)	10,197	$152,385.00
Colorectal Screening	5,548	$137,325.00
Healthy Start Screen - 1st Trimester	5,309	$79,622.50
Adult BMI Assessment	2,783	$69,225.00
Hypertension Disease Management Program	1,731	$42,102.50
Diabetes Disease Management Program	1,157	$28,015.00
Asthma Disease Management Program	861	$21,240.00
HIV/AIDS Disease Management Program	505	$12,572.50
Smoking Cessation Program	298	$7,327.50
Other Disease Management Program	247	$6,120.00
Congestive Heart Failure Disease Management Program	162	$3,930.00
Flu Shot	14	$350.00
Dental Preventive Services-Adult/Child	19	$312.50
Exercise Program	10	$250.00
Administrative Credit	10	$151.16
Weight Management	4	$100.00
Weight Management 6 month Success	5	$75.00
Exercise Program 6 Months Success	4	$60.00
Alcoholics Anonymous Program	2	$50.00
Smoking Cess. 6 months Success	2	$30.00
Narcotics Anonymous Program	1	$25.00

Table 34 compares credits earned and used (by date of service) since implementation of the program in September 2006 through June 30, 2013.

Table 34 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2013)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Demonstration Year 1		
Sep-06	$40,202.50	0
Oct-06	$249,542.50	0
Nov-06	$366,097.50	$203.87
Dec-06	$487,102.50	$840.55
Jan-07	$631,890.00	$3,424.90
Feb-07	$621,636.16	$8,716.25
Mar-07	$722,477.50	$17,574.09
Apr-07	$647,160.00	$13,992.22
May-07	$653,342.50	$28,306.64
Jun-07	$585,930.00	$40,113.83
Year 1 Totals	**$5,005,381.16**	**$113,172.35**
Demonstration Year 2		
Jul-07	$943,790.00	$44,384.70
Aug-07	$982,095.00	$70,911.44
Sep-07	$872,717.50	$62,306.52
Oct-07	$1,113,220.00	$80,152.87
Nov-07	$897,445.00	$50,090.15
Dec-07	$834,907.50	$96,201.45
Jan-08	$996,050.00	$192,651.11
Feb-08	$922,135.00	$201,522.48
Mar-08	$892,452.50	$309,345.83
Apr-08	$850,625.00	$353,031.31
May-08	$721,262.50	$471,499.13
Jun-08	$692,177.50	$500,632.17
Year 2 Totals	**$10,718,877.50**	**$2,432,729.16**
Demonstration Year 3		
Jul-08	$836,270.00	$388,174.48
Aug-08	$691,197.50	$550,109.57
Sep-08	$649,355.00	$399,778.90
Oct-08	$610,170.00	$447,146.30
Nov-08	$510,127.50	$621,714.31
Dec-08	$497,597.50	$687,201.89

Table 34 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2013)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Jan-09	$575,282.50	$756,472.24
Feb-09	$369,185.00	$537,540.62
Mar-09	$621,027.50	$490,833.88
Apr-09	$616,705.00	$496,206.27
May-09	$572,660.00	$517,902.37
Jun-09	$630,025.00	$491,310.10
Year 3 Totals	**$7,179,602.50**	**$6,384,390.93**
Demonstration Year 4		
Jul-09	$920,607.50	$440,639.00
Aug-09	$942,385.00	$382,316.85
Sep-09	$702,145.00	$574,232.19
Oct-09	$678,590.00	$705,808.07
Nov-09	$574,665.00	$646,379.87
Dec-09	$546,220.00	$606,652.34
Jan-10	$550,725.00	$467,090.95
Feb-10	$519,765.00	$344,644.76
Mar-10	$731,987.50	$437,492.81
Apr-10	$711,135.00	$505,832.73
May-10	$646,965.00	$437,806.85
Jun-10	$792,142.50	$410,001.97
Year 4 Totals	**$8,317,332.50**	**$5,958,898.39**
Demonstration Year 5		
Jul-10	$1,193,995.00	$403,007.99
Aug-10	$1,289,937.50	$487,111.13
Sep-10	$951,010.00	$586,819.33
Oct-10	$828,962.50	$638,763.82
Nov-10	$761,742.50	$581,962.80
Dec-10	$768,330.00	$707,653.68
Jan-11	$878,912.50	$375,649.41
Feb-11	$807,900.00	$374,798.66
Mar-11	$984,875.00	$464,282.12
Apr-11	$862,497.50	$444,919.99
May-11	$855,545.00	$527,643.72
Jun-11	$876,670.00	$516,529.20
Year 5 Totals	**$11,060,377.50**	**$6,109,141.85**

Table 34 Comparison of Credits Earned by Credits Expended (September 2006 – June 30, 2013)		
Month of Claims	**Earned by Date of Service**	**Purchases by Date of Service**
Demonstration Year 6		
Jul-11	$1,276,395.00	$569,518.78
Aug-11	$1,316,197.50	$495,013.93
Sep-11	$1,104,562.50	$636,576.88
Oct-11	$1,051,572.50	$772,908.21
Nov-11	$900,177.50	$734,708.26
Dec-11	$888,860.00	$674,429.18
Jan-12	$1,073,617.50	$759,980.44
Feb-12	$994,780.00	$492,712.98
Mar-12	$1,110,847.50	$511,504.82
Apr-12	$1,062,492.50	$609,725.63
May-12	$1,120,917.50	$625,702.66
Jun-12	$1,045,502.50	$626,332.60
Year 6 Totals	**$12,945,922.50**	**$7,509,114.37**
Demonstration Year 7		
Jul-12	$1,762,472.50	$664,796.33
Aug-12	$1,814,392.50	$625,872.39
Sep-12	$1,341,205.00	$780,592.96
Oct-12	$1,368,287.50	1,074,011.64
Nov-12	$1,076,820.00	$855,452.53
Dec-12	$919,930.00	$921,073.46
Jan-13	$1,235,822.50	$897,900.20
Feb-13	$968,342.50	$622,248.94
Mar-13	$962,335.00	$671,854.00
Apr-13	$987,202.50	$708,803.00
May-13	$724,995.00	$708,379.01
Jun-13	$439,190.00	$743,863.46
Year 7 Totals	**$13,600,995.00**	**$9,274,847.92**
Cumulative Total	**$68,828,488.66**	**$37,782,294.97**

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Table 35 highlights the Demonstration Year Seven amount of credits submitted by each health plan for recipients as of June 30, 2013 (date of service).

Table 35 Amount of Credits Submitted by Health Plan (July 1, 2012 – June, 30, 2013)		
County	**Health Plan Company Name**	**Granted Credit Amount**
Baker	Sunshine State Health Plan, Inc.-Baker	$102,095.00
Baker	Staywell-Baker	$345.00
Baker	Access Health Solutions	$159,697.50
Baker	First Coast Advantage - Baker	$239,055.00
Baker	United Healthcare of Florida, Inc.	$174,107.50
Broward	Molina	$4,224,882.50
Broward	Sunshine State Health Plan, Inc.-Broward	$5,320,285.00
Broward	Medica Health Plans of Florida, Inc.	$355,062.50
Broward	CareFlorida	$251,635.00
Broward	Simply Healthcare Plans, Inc.	$28,572.50
Broward	Staywell-Broward	$22,985.00
Broward	Clear Health Alliance	$202.50
Broward	Preferred Medical Plan, Inc.	$156,912.50
Broward	Access Health Solutions	$648,542.50
Broward	Total Health Choice, Inc	$1,071,057.50
Broward	Staywell	$2,951,117.50
Broward	HealthEase	$1,468,065.00
Broward	Vista Healthplan, Inc. (Buena Vista)	$753,525.00
Broward	Vista Healthplan of South Florida, Inc.	$575,345.00
Broward	Freedom Health Plan	$464,787.50
Broward	CMS Network Broward North	$1,226,007.50
Broward	CMS Network Broward South	$393,260.00
Broward	Humana Inc.	$2,479,295.00
Broward	United Healthcare of Florida, Inc.	$753,315.00
Broward	AMERIGROUP Florida, Inc.	$1,928,780.00
Broward	South Florida Community Care Network	$3,981,563.66
Broward	South Florida Community Care Network	$3,843,120.00
Broward	Pediatric Associates PSN, LLC	$1,069,322.50
Broward	Universal Health Care Broward	$1,231,175.00
Broward	Better Health	$5,503,980.00
Broward	Positive Healthcare Florida	$26,057.50
Broward	Florida NetPass, LLC	$763,020.00
Clay	Sunshine State Health Plan, Inc. - Clay	$995,575.00
Clay	Staywell-Clay	$1,345.00
Clay	Access Health Solutions	$407,962.50
Clay	First Coast Advantage - Clay	$358,017.50
Clay	United Healthcare of Florida, Inc.	$768,630.00

Table 35 Amount of Credits Submitted by Health Plan (July 1, 2012 – June, 30, 2013)		
County	**Health Plan Company Name**	**Granted Credit Amount**
Duval	Sunshine State Health Plan, Inc. -Duval	$4,567,067.50
Duval	Staywell-Duval	$44,480.00
Duval	Access Health Solutions	$1,040,637.50
Duval	Staywell	$259,832.50
Duval	HealthEase	$3,404,717.50
Duval	First Coast Advantage - Duval	$11,015,447.50
Duval	CMS Duval/Ped-I-Care	$636,712.50
Duval	United Healthcare of Florida, Inc.	$1,537,912.50
Duval	Universal Health Care Duval	$669,672.50
Nassau	Sunshine State Health Plan, Inc.-Nassau	$147,260.00
Nassau	Staywell-Nassau	$585.00
Nassau	Access Health Solutions	$135,357.50
Nassau	First Coast Advantage - Nassau	$337,932.50
Nassau	United Healthcare of Florida, Inc.	$332,170.00

Table 36 provides the top 25 purchases in terms of dollar amount, made by recipients, during Demonstration Year Seven.

Table 36 Top 25 Recipient Purchases (July 1, 2012 – June, 30, 2013)				
	Description*	**Count**	**Sum**	**Average**
1	HUGGIES	175558	$1,649,208.74	-$9.39
2	HUGGIES BABY WIPES	114393	$553,747.18	-$4.84
3	HUGGIES PULL-UPS	47441	$473,692.29	-$9.98
4	PREMIUM BABY DIAPER	43367	$353,568.47	-$8.15
5	LISTERINE ANTISEPTIC	48925	$238,276.8	-$4.87
6	DIAPERS	33451	$226,965.95	-$6.79
7	PAMPERS BABY-DRY	19398	$194,314.86	-$10.02
8	BABY WIPES	60193	$154,042.26	-$2.56
9	CETAPHIL	21065	$131,722.21	-$6.25
10	SENSODYNE	24265	$129,186.18	-$5.32
11	CHILDREN'S IBUPROFEN	21851	$118,384.19	-$5.42
12	KOTEX	20196	$106,978.38	-$5.3
13	FLINTSTONES MULTI-VIT GUMMIES	12002	$101,049.08	-$8.42
14	AVEENO	11219	$92,050.09	-$8.2
15	IBUPROFEN	15507	$82,211.43	-$5.3
16	BABY SHAMPOO	21644	$81,783.42	-$3.78
17	TRAINING PANTS	11260	$80,594.70	-$7.16
18	PREMIUM BABY WIPES	23055	$68,268.55	-$2.96
19	BLOOD PRESSURE MONITOR	2712	$67,706.96	-$24.97

Table 36 Top 25 Recipient Purchases (July 1, 2012 – June, 30, 2013)				
	Description*	**Count**	**Sum**	**Average**
20	PREMIUM TRAINING PANTS	8634	$65,661.38	-$7.6
21	KIDPANT	9150	$63,539.91	-$6.94
22	ISOPROPYL ALCOHOL	24207	$58,662.07	-$2.42
23	GOODNITES	5513	$58,224.53	-$10.56
24	CHILDREN'S PAIN RELIEF	11308	$58,107.24	-$5.14
25	LUBRIDERM DAILY MOISTURE	7806	$54,235.34	-$6.95

*Includes purchase/return combinations

3. Enhanced Benefits Advisory Panel

Demonstration Year Seven at a Glance

During Demonstration Year Seven, the EB Advisory Panel met once on January 31, 2013; there were no changes or additional healthy behaviors suggested by the Panel. To view information on previous panel meetings, please visit the Agency's EBA website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

4. Notice of EBA Program Phase Out

On June 28, 2013, the Agency submitted to Federal CMS the EBA program phase out timeline and sample letters to provide health plans and enrollees with accrued credits notice of the program ending. This information was provided to Federal CMS in accordance with STC #8 of the waiver.

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E. Low Income Pool

Overview

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

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

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

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

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

1. LIP Council Meetings

Demonstration Year Seven at a Glance

The LIP Council held eight meetings during Demonstration Year Seven to prepare recommendations for Demonstration Year Eight. The LIP Council met on the following dates:

- August 30, 2012
- September 19, 2012
- November 14, 2012
- December 4, 2012
- December 20, 2012
- January 9, 2013
- January 16, 2013
- January 22, 2013

The LIP Council meetings can be viewed on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml

The LIP Council anticipates beginning meetings regarding State Fiscal Year (SFY) 2014-15 (Demonstration Year Eight) in the first quarter of Demonstration Year Eight.

LIP Council Recommendations for SFY 2013-14

The LIP Council recommends continued full utilization of the federally authorized funding level of $1 billion for SFY 2013-14. Detailed schedules, which show the distributions and calculations by Provider Access Systems (PAS), are included in Attachment C of the *LIP Council Report for SFY 2012-13 with Recommendations for SFY 2013-14*. For the programs related to LIP, the LIP Council recommended: maximize funding through the Disproportionate Share Hospital (DSH) program at $245.8 million; continue the Exemptions Program at a level of $676.4 million (which includes $9.9 million for liver transplants); and provide the "buy-back" program with a funding level of $130.5 million. In order to accomplish this level of funding, an appropriation of $18.6 million in state General Revenue (GR) is continued and a decrease of $17.6 million of local Intergovernmental Transfers (IGTs) is proposed. A detailed description of each LIP component is presented in the following pages of this report.

Table 37 located on the following page provides a brief financial summary by component (in millions) of the LIP Council's recommendations for SFY 2013-14 compared to SFY 2012-13 appropriations:

Table 37 Comparison Summary of LIP Council Recommendations for SFY 2012-13 and SFY 2013-14 Appropriations			
	Appropriation SFY 2012-13	**LIP Council Recommendations SFY 2013-14**	**Appropriations SFY 2013-14**
Low Income Pool:			
LIP Hospital	$771.50	$766.90	$766.90
Special LIP	113.40	118.00	116.00
LIP Non-Hospital	115.30	115.30	117.30
Total LIP	**$1,000.30**	**$1,000.20**	**$1,000.20**
Related Programs:			
Disproportionate Share Hospital	$246.60	$245.80	$239.40
Exemptions	638.60	666.50	666.50
Medicaid "Buy-Back" Program	130.60	130.50	130.50
Total LIP Related	**$1015.80**	**$1,042.80**	**$1,036.40**
Total LIP and Related Programs	**$2016.10**	**$2,043.00**	**$2,036.60**

The LIP Council reviewed several options and approaches for consideration of LIP funding at each LIP Council meeting. Models which utilized no additional state funds and maximized the use of local IGTs were considered. A summary of every model considered by the LIP Council is included in the *LIP Council Report for SFY 2012-13 with Recommendations for SFY 2013-14*. Major LIP Council recommendations include a comprehensive proposal which:

- Fully allocates the $1 billion of the federally-approved LIP allocation authorized by the Florida 1115 Managed Medical Assistance Waiver;
- Requests $18.6 million in continued state GR funding;
- Partially funds, via a tiered approach, the Exemption Program (including global liver fee) using SFY 2012-13 policy guidelines at a level of $676.4 million;
- Uses a 10% Medicaid, charity, and bad debt threshold for general distributions; an 8.5% allocation factor; and a $2.4 million charity distribution pool for rural hospitals;
- Fully distributes available federally allotted DSH funding of $240 million;
- Continues the currently authorized self-exemption policy for public hospitals, which can provide qualified IGTs and continues the same self-exemption policy to allow for the buy-back of the cost margin between the current exempt rate and 100 percent of Medicaid allowable costs for public hospitals;
- Hospitals with pediatric facilities are designated $19,866,022 of the total exemption funds.
- Authorizes maximizing exemption and buy-back authority for all qualifying hospital providers with access to qualified IGT matching funds; and
- Allocates $50 million to fulfill the LIP Tier-One Milestone requirement as specified in STC #84. Of the $50 million:

- $15 million of these funds are distributed to hospitals based on the hospital meeting specific Quality Measures collected by the Agency and Core Measures collected by Federal CMS. A detailed description of these measures is provided in Attachment E of the *LIP Council Report for SFY 2012-13 with Recommendations for SFY 2013-14*.
- The remaining $35 million will be distributed via an open, competitive process to be administered by the Agency.

Additional information regarding the LIP Council Recommendations including detailed recommendations by program and distribution tables can be found under the title, "LIP Council Recommendations to Governor and Legislature for SFY 2013-14" on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml

On April 29, 2013, the Governor signed the SFY 2013-14 General Appropriations Act that included $1,000.20 million in LIP distributions and funding. The SFY 2013-14 LIP distributions and funding recommended by the Florida Legislature and signed by the Governor are similar to the LIP Council recommendations.

2. LIP STCs - Reporting Requirements

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

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

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

- **DY1 – DY3 LIP Reconciliations Finalized –** Federal CMS has determined that payments made to providers are in excess of the allowable costs; therefore, the state is required to return the federal portion of $104,351,578 total computable expenditures claimed in excess of allowable cost and/or in excess of applicable cost limits. This will be achieved through a reduction of the amount available to be claimed under the pool by $104 million the first year of the state's intended renewal period in the event the demonstration is renewed or, by issuing a disallowance to the state.

- **DY4 LIP Reconciliations –** The Agency submitted the LIP reconciliations for DY4 to Federal CMS on May 30, 2012. Federal CMS did not provide the Agency any feedback or request additional information regarding DY4 LIP reconciliations during DY7.

- **DY5 LIP Reconciliations –** During this quarter, the Agency submitted the LIP reconciliations for DY5 to Federal CMS on May 31, 2013. Federal CMS did not provide the Agency any feedback or request additional information regarding DY5 LIP reconciliations during DY7.

- **Finalize Modifications to RFMD –** By February 1 of each Demonstration Year, the Agency must submit an RFMD that ensures the payment methodologies for distributing LIP funds to providers supports the goals of the LIP program.

- On January 31, 2012, the Agency submitted the revised RFMD for DY6 to Federal CMS, which only included updated references since the results of Federal CMS's review of DY1-DY3 LIP reconciliations were not available prior to the February 1st submission due date specified in the STCs.
- On May 5, 2012 and June 6, 2012, the Agency submitted a revised RFMD for DY6 to Federal CMS. The revisions to the document were made based on comments from Federal CMS.
- On August 7, 2012, the Agency submitted a revised RFMD for DY6 to Federal CMS. This version included additional changes requested by Federal CMS.
- On September 27, 2012, Federal CMS indicated that the final version of the RFMD for DY6 was routing for final approval.
- On October 16, 2012, Federal CMS gave written approval of the RFMD for DY6.
- On January 29, 2013, the Agency submitted a revised RFMD for DY7 to Federal CMS.

- **Claiming LIP Payments –** The Agency may claim LIP payments based on the existing methodology during the 60-day reconciliation finalization period. Claims after that period can only be made on the final RFMD for DY6 as approved by Federal CMS. Changes to the RFMD for DY6 requested by the Agency must be approved by Federal CMS and are only applicable for DY6 LIP expenditures.
    - On October 16, 2012, Federal CMS gave written approval of the RFMD for DY6. The Agency then begun the distribution of DY7 LIP payments.

- **RFMD Protocol –** By February 1, 2012, and each successive February 1st of the waiver renewal period, the state must submit an RFMD protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP.
    - As noted earlier, on October 16, 2012, Federal CMS gave written approval of the RFMD for DY6.

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

Newly Amended STC #84 – LIP Tier-One Milestone

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

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

The remaining $15 million (Quality Measures) of the $50 million falls under the Special LIP for Hospital Provider Access System category listed in the GAA. This $15 million, or Quality

Measures, category is broken down into three smaller amounts. Of the total, $400,000 is provided for the specialty children's hospitals to be distributed based on an allocation methodology incorporating quality measures that shall be developed by the Agency. The second amount is $7,300,000 and shall be allocated using the core measures as determined by Federal CMS. The remaining amount of $7,300,000 shall be distributed equally using the following six outcome measures:

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

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

- On June 29, 2012, the Agency posted the LIP Primary Care Application for the $35 million (SFY 2012-13) up for bid on the Agency's LIP website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml
- During the first quarter of DY7, the Agency received 50 applications for the $35 million LIP Primary Care Award and reviewed the proposals.
- During the third quarter of Demonstration Year Seven, the Agency awarded the $35 million LIP Primary Care Award and began the contracting for state share and distributions of the new and enhanced provider projects. For new projects, the Agency awarded seven hospitals, three Federally Qualified Health Centers (FQHCs) and three County Health Departments (CHDs). For enhanced projects, the Agency awarded seven hospitals, five FQHCs and six CHDs.

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

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

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

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

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

- On February 9, 2012, the Agency sent the draft templates to Federal CMS.
- On March 13, 2012, the Agency submitted the final templates to Federal CMS.
- On March 14, 2012, the Agency was notified that Federal CMS had no comments and the final templates were posted on the Agency's LIP website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml.
- The PAS providers are required to submit individual Milestone Reports to the Agency on October 31, 2012. The Agency received all the Milestone Reports. The data was reviewed, compiled and given to University of Florida (UF) for data analysis.
- On April 1, 2013, the Agency sent the final annual Milestone Statistics and Findings Report to Federal CMS.
- The Primary Care and Alternative Delivery Systems Expenditure Report requires that the providers submit data to the Agency by August 31, 2013. The Agency will provide this final annual report to Federal CMS by January 1, 2014.

Newly Amended STC #85 – LIP Tier-Two Milestones – This STC requires the top 15 hospitals receiving LIP funds to choose three initiatives that follow the guidelines of the Three-Part Aim. These hospitals must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served. The three initiatives should focus on: infrastructure development; innovation and redesign; and population-focused improvement.

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

Demonstration Year Seven at a Glance

Throughout Demonstration Year Seven, the Agency has collected information from hospitals

related to encounter data, budgeted uninsured and medical items outside of inpatient care. The Agency provided the SFY 2006-07 through SFY 2011-12 Milestone data for further research and evaluation with the LIP evaluation team at the University of Florida. The Agency has received and reviewed the results from UF during SFY 2012-13, and continues to work with UF on completion of the report.

During Demonstration Year Seven, $992,590,912 in Low Income Pool funding was released to the participating providers.

On April 29, 2013, the Governor signed into law the *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2013-2014 Conference Committee Report on SB 1500*, a supplemental document accompanying the General Appropriations Act for SFY 2013-14. This document provides instructions for the funding and distribution of SFY 2013-14 Low Income Pool funds.

Additional information regarding the *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2013-2014 Conference Committee Report on SB 1500*, including detailed recommendations by program and distribution tables, can be found under the title *Medicaid Supplemental Hospital Funding Programs Fiscal Year 2013-2014 Conference Committee Report on SB 1500* on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml

F. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved Florida MMA Waiver (previously called the Medicaid Reform Waiver as noted earlier in the report), the state must monitor the status of the program on a fiscal basis. To comply with this requirement, the state will submit waiver templates on the quarterly CMS 64 reports. The submission of the CMS 64 reports will include administrative and service expenditures. For purposes of monitoring the Budget Neutrality of the program, only service expenditures are compared to the projected without-waiver expenditures approved through the waiver.

MEGS

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

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

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

Explanation of Budget Neutrality

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

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

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

Medicaid Reform - Excluded Eligibles:

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

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

Medicaid Reform - Excluded Services:

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

Expenditure Reporting:

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

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

I. Eligibles and enrollee member months are identified;

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

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

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

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

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

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

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

Definitions:

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

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

Demonstration Years One through Seven at a Glance

Budget Neutrality figures included in this report are through the fourth quarter (April 1, 2013 – June 30, 2013) of Demonstration Year Seven. The 1115 demonstration waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For counties where Medicaid Reform is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where Medicaid Reform is not operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive their services through the Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and/or providers of 1915(c) Home and Community Based Waivers.

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

In following tables (Tables 37 through 41), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Tables 38 through 41 in accordance with the June 14, 2013 newly amended STC #95a.

Table 38 shows the PCCM Targets established in the 1115 demonstration waiver as specified in STC #106. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 38
PCCM Targets

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

Tables 39 through 43 provide the statistics for MEGs 1, 2 and 3 for the period beginning July 1, 2006 and ending June 30, 2013. Case months provided in the tables for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 39
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	246,803	$115,206,670	$909,045	$116,115,714	$470.48
August 2006	243,722	$279,827,952	$6,513,291	$286,341,243	$1,174.87
September 2006	247,304	$139,431,141	$5,599,951	$145,031,093	$586.45
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
October 2006	247,102	$212,114,488	$10,499,950	$222,614,438	$900.90
November 2006	246,731	$295,079,823	$18,063,945	$313,143,768	$1,269.17
December 2006	247,191	$149,805,426	$11,706,712	$161,512,138	$653.39
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
January 2007	248,051	$289,253,764	$30,144,893	$319,398,657	$1,287.63
February 2007	248,980	$199,868,304	$23,329,519	$223,197,824	$896.45
March 2007	249,708	$138,504,959	$20,889,470	$159,394,429	$638.32
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
April 2007	250,807	$204,909,087	$32,432,588	$237,341,675	$946.31
May 2007	250,866	$283,310,716	$43,277,952	$326,588,667	$1,301.85
June 2007	251,150	$138,820,900	$22,314,375	$161,135,275	$641.59
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
July 2007	251,568	$194,519,903	$31,707,197	$226,227,100	$899.27
August 2007	252,185	$293,494,559	$47,527,547	$341,022,105	$1,352.27
September 2007	251,664	$142,922,789	$22,281,988	$165,204,777	$656.45
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
October 2007	252,364	$301,165,314	$48,429,002	$349,594,316	$1,385.28
November 2007	251,614	$200,847,517	$33,089,608	$233,937,124	$929.75
December 2007	251,859	$146,744,275	$24,856,235	$171,600,510	$681.34
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
January 2008	252,534	$292,515,280	$50,864,554	$343,379,834	$1,359.74
February 2008	252,261	$208,197,150	$36,231,781	$244,428,931	$968.95
March 2008	253,219	$150,777,881	$24,872,596	$175,650,476	$693.67
Q7 Total	**758,014**	**$651,490,311**	**$111,968,931**	**$763,459,242**	**$1,007.18**
April 2008	254,500	$307,160,089	$52,986,151	$360,146,240	$1,415.11
May 2008	255,239	$151,280,053	$26,304,457	$177,584,510	$695.76
June 2008	254,962	$203,249,958	$35,916,041	$239,165,998	$938.05
Q8 Total	**764,701**	**$661,690,100**	**$115,206,649**	**$776,896,750**	**$1,015.95**
July 2008	277,846	$192,176,160	$31,991,699	$224,167,859	$806.81
August 2008	270,681	$158,778,526	$21,165,601	$179,944,126	$664.78
September 2008	270,033	$357,991,424	$63,236,337	$421,227,761	$1,559.91
Q9 Total	**818,560**	**$708,946,109**	**$116,393,637**	**$825,339,746**	**$1,008.28**

Table 39 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
October 2008	266,157	$232,318,022	$41,440,930	$273,758,952	$1,028.56
November 2008	263,789	$166,522,672	$28,803,376	$195,326,048	$740.46
December 2008	261,097	$339,392,175	$58,670,686	$398,062,860	$1,524.58
Q10 Total	**791,043**	**$738,232,869**	**$128,914,992**	**$867,147,861**	**$1,096.21**
January 2009	272,167	$158,151,954	$26,709,588	$184,861,542	$679.22
February 2009	270,390	$249,476,784	$40,934,581	$290,411,365	$1,074.05
March 2009	268,196	$375,417,383	$58,097,273	$433,514,656	$1,616.41
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
July 2009	277,093	$319,718,390	$52,941,079	$372,659,469	$1,344.89
August 2009	274,819	$168,336,551	$33,437,914	$201,774,466	$734.21
September 2009	274,930	$358,692,409	$67,384,681	$426,077,090	$1,549.77
Q13 Total	**826,842**	**$846,747,351**	**$153,763,674**	**$1,000,511,025**	**$1,210.04**
October 2009	275,733	$169,233,974	$30,153,422	$199,387,395	$723.12
November 2009	277,577	$252,330,497	$45,182,664	$297,513,161	$1,071.82
December 2009	277,220	$348,404,305	$61,931,546	$410,335,851	$1,480.18
Q14 Total	**830,530**	**$769,968,776**	**$137,267,631**	**$907,236,407**	**$1,092.36**
January 2010	282,575	$159,062,482	$29,470,651	$188,533,134	$667.20
February 2010	283,235	$249,307,944	$44,581,877	$293,889,821	$1,037.62
March 2010	281,514	$373,413,178	$67,763,434	$441,176,612	$1,567.16
Q15 Total	**847,324**	**$781,783,604**	**$141,815,963**	**$923,599,567**	**$1,090.02**
April 2010	280,909	$253,666,997	$48,259,799	$301,926,796	$1,074.82
May 2010	283,942	$174,652,397	$31,571,736	$206,224,133	$726.29
June 2010	287,594	$303,907,266	$49,657,712	$353,564,978	$1,229.39
Q16 Total	**852,445**	**$732,226,661**	**$129,489,247**	**$861,715,907**	**$1,010.88**
July 2010	289,450	$245,111,199	$45,804,917	$290,916,116	$1,005.07
August 2010	288,959	$257,400,660	$50,362,126	$307,762,786	$1,065.07
September 2010	290,464	$378,046,090	$67,416,195	$445,462,285	$1,056.69
Q17 Total	**868,873**	**$880,557,949**	**$163,583,238**	**$1,044,141,187**	**$1,201.72**
October 2010	290,791	$178,740,566	$32,056,390	$210,796,956	$725.42
November 2010	292,081	$259,494,453	$49,145,534	$308,639,987	$1,054.89
December 2010	293,692	$385,127,339	$66,518,308	$451,645,646	$1,537.82
Q18 Total	**876,564**	**$823,362,358**	**$147,720,232**	**$971,082,591**	**$1,107.83**

Table 39 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
January 2011	286,758	$169,087,404	$30,705,047	$199,792,451	$696.73
February 2011	283,891	$254,801,466	$45,756,956	$300,558,423	$1,058.71
March 2011	280,839	$369,228,098	$60,653,771	$429,881,870	$1,530.71
Q19 Total	**851,488**	**$793,116,969**	**$137,115,775**	**$930,232,743**	**$1,092.48**
April 2011	302,990	$172,927,438	$34,444,241	$207,371,679	$684.42
May 2011	301,388	$262,943,250	$48,035,560	$310,978,811	$1,031.82
June 2011	298,455	$294,864,812	$54,930,094	$349,794,906	$1,172.03
Q20 Total	**902,833**	**$730,735,500**	**$137,409,896**	**$868,145,395**	**$961.58**
July 2011	312,416	$259,712,742	$48,660,712	$308,373,454	$987.06
August 2011	311,787	$394,898,931	$68,931,416	$463,830,347	$1,487.65
September 2011	309,458	$242,573,135	$47,908,459	$290,481,594	$938.68
Q21 Total	**933,661**	**$897,184,808**	**$165,500,587**	**$1,062,685,395**	**$1,138.19**
October 2011	307,662	$185,681,455	$37,250,558	$222,932,013	$724.60
November 2011	305,786	$405,816,970	$77,239,455	$483,056,425	$1,579.72
December 2011	303,265	$189,314,012	$35,438,146	$224,752,158	$741.11
Q22 Total	**916,713**	**$780,812,437**	**$149,928,159**	**$930,740,596**	**$1,015.30**
January 2012	290,381	$239,317,133	$49,116,158	$288,433,291	$993.29
February 2012	290,339	$389,776,652	$76,272,631	$466,049,284	$1,605.19
March 2012	290,330	$177,634,805	$35,812,556	$213,447,361	$735.19
Q23 Total	**871,050**	**$806,728,589**	**$161,201,346**	**$967,929,935**	**$1,111.22**
April 2012	312,916	$275,686,028	$54,220,241	$329,906,270	$1,054.30
May 2012	311,290	$416,163,778	$78,399,857	$494,563,635	$1,588.76
June 2012	308,237	$186,297,339	$35,989,898	$222,287,237	$721.16
Q24 Total	**932,443**	**$878,147,146**	**$168,609,996**	**$1,046,757,142**	**$1,122.60**
July 2012	**315,498**	**$280,532,187**	**$53,658,168**	**$334,190,356**	**$1,059.25**
August 2012	**313,545**	**$410,042,922**	**$78,756,160**	**$488,799,082**	**$1,558.94**
September 2012	**310,627**	**$186,393,513**	**$36,558,286**	**$222,951,799**	**$717.75**
Q25 Total	**939,670**	**$876,968,622**	**$168,972,615**	**$1,045,941,236**	**$1,113.09**
October 2012	**319,808**	**$417,728,365**	**$81,517,587**	**$499,245,952**	**$1,561.11**
November 2012	**318,070**	**$256,347,435**	**$71,981,598**	**$328,329,034**	**$1,032.25**
December 2012	**315,640**	**$191,593,238**	**$65,204,935**	**$256,798,173**	**$813.58**
Q26Total	**953,518**	**$865,669,039**	**$218,704,121**	**$1,084,373,159**	**$1,137.24**
January 2013	**323,474**	**$323,122,183**	**$99,191,870**	**$422,314,054**	**$1,305.56**
February 2013	**321,784**	**$259,288,289**	**$74,996,618**	**$334,284,906**	**$1,038.85**
March 2013	**319,392**	**$167,409,589**	**$55,149,312**	**$222,558,900**	**$696.82**
Q27Total	**964,650**	**$749,820,061**	**$229,337,800**	**$979,157,860**	**$1,015.04**

Table 39 MEG 1 Statistics: SSI Related					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
April 2013	326,137	$269,942,718	$74,397,891	$344,340,609	$1,055.82
May 2013	324,747	$421,765,664	$103,646,815	$525,412,478	$1,617.91
June 2013	322,214	$163,314,895	$57,442,933	$220,757,828	$685.13
Q28 Total	973,098	$855,023,277	$235,487,639	$1,090,510,916	$1,120.66
MEG 1 Total	23,603,828	$21,014,467,819	$3,798,705,914	$24,813,173,734	$1,051.24

*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.

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Table 40 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
July 2006	1,343,704	$122,231,743	$122,430	$122,354,173	$91.06
August 2006	1,292,330	$272,615,188	$1,255,306	$273,870,494	$211.92
September 2006	1,308,403	$96,367,809	$345,759	$96,713,568	$73.92
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
October 2006	1,293,922	$193,175,740	$5,068,653	$198,244,393	$153.21
November 2006	1,277,102	$287,043,912	$13,069,579	$300,113,491	$235.00
December 2006	1,266,148	$110,714,051	$2,883,053	$113,597,104	$89.72
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
January 2007	1,252,859	$277,959,312	$23,489,568	$301,448,880	$240.61
February 2007	1,240,860	$176,632,680	$13,010,558	$189,643,238	$152.83
March 2007	1,234,344	$104,987,331	$8,197,611	$113,184,942	$91.70
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
April 2007	1,230,451	$177,538,314	$17,859,854	$195,398,168	$158.80
May 2007	1,218,171	$252,644,634	$32,885,813	$285,530,447	$234.39
June 2007	1,204,525	$93,978,970	$6,350,716	$100,329,686	$83.29
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
July 2007	1,198,205	$165,939,175	$18,185,330	$184,124,505	$153.67
August 2007	1,195,369	$257,178,317	$34,274,917	$291,453,235	$243.82
September 2007	1,194,789	$97,198,750	$4,900,087	$102,098,837	$85.45
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
October 2007	1,211,534	$274,566,880	$37,109,258	$311,676,138	$257.26
November 2007	1,215,472	$172,270,731	$20,848,427	$193,119,158	$158.88
December 2007	1,221,826	$106,926,054	$5,913,469	$112,839,523	$92.35
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
January 2008	1,231,168	$279,664,231	$39,614,594	$319,278,825	$259.33
February 2008	1,244,515	$182,593,894	$22,899,968	$205,493,862	$165.12
March 2008	1,260,529	$108,219,269	$7,477,728	$115,696,997	$91.78
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
April 2008	1,276,861	$291,385,556	$41,006,725	$332,392,281	$260.32
May 2008	1,293,377	$106,077,385	$7,461,623	$113,539,008	$87.78
June 2008	1,286,346	$167,139,049	$22,430,923	$189,569,972	$147.37
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$164.78**
July 2008	1,343,457	$167,028,012	$23,630,815	$190,658,827	$141.89
August 2008	1,358,765	$104,719,507	$5,873,974	$110,593,481	$81.39
September 2008	1,378,085	$314,708,216	$40,527,142	$355,235,358	$257.77
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
October 2008	1,393,235	$204,320,959	$24,116,899	$228,437,858	$163.96
November 2008	1,397,296	$130,108,959	$7,934,545	$138,043,504	$98.79
December 2008	1,384,167	$324,670,555	$39,885,260	$364,555,815	$263.38
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
January 2009	1,425,771	$119,386,179	$8,007,586	$127,393,766	$89.35

Table 40 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
February 2009	1,440,339	$228,220,385	$24,038,667	$252,259,052	$175.14
March 2009	1,432,269	$361,013,917	$41,788,973	$402,802,890	$281.23
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
July 2009	1,650,790	$333,483,694	$34,533,935	$368,017,629	$222.93
August 2009	1,583,503	$119,609,810	$13,057,173	$132,666,984	$83.78
September 2009	1,538,571	$370,920,307	$51,046,606	$421,966,913	$274.26
Q13 Total	**4,772,864**	**$824,013,811**	**$98,637,714**	**$922,651,526**	**$193.31**
October 2009	1,634,683	$134,315,902	$10,464,027	$144,779,929	$88.57
November 2009	1,657,122	$250,553,059	$29,249,216	$279,802,275	$168.85
December 2009	1,667,649	$383,516,409	$50,010,230	$433,526,639	$259.96
Q14 Total	**4,959,454**	**$768,385,369**	**$89,723,473**	**$858,108,842**	**$173.02**
January 2010	1,682,493	$116,073,248	$9,104,061	$125,177,309	$74.40
February 2010	1,700,550	$248,374,376	$29,806,739	$278,181,115	$163.58
March 2010	1,715,338	$409,161,539	$54,737,055	$463,898,594	$270.44
Q15 Total	**5,098,381**	**$773,609,163**	**$93,647,855**	**$867,257,018**	**$170.10**
April 2010	1,720,938	$369,963,534	$30,906,075	$400,869,609	$232.94
May 2010	1,737,239	$137,689,965	$11,390,819	$149,080,785	$85.81
June 2010	1,744,966	$285,875,642	$48,175,029	$334,050,671	$191.49
Q16 Total	**5,203,143**	**$793,529,141**	**$90,471,922**	**$884,001,063**	**$169.90**
July 2010	1,760,314	$119,876,307	$11,136,093	$131,012,400	$74.43
August 2010	1,785,641	$242,522,154	$29,130,986	$271,653,141	$152.13
September 2010	1,810,787	$404,205,540	$51,277,639	$455,483,179	$251.54
Q17 Total	**5,356,742**	**$766,604,001**	**$91,544,719**	**$858,148,719**	**$160.20**
October 2010	1,821,814	$136,151,894	$13,761,006	$149,912,900	$82.02
November 2010	1,823,878	$269,927,226	$32,202,089	$302,129,316	$165.65
December 2010	1,824,704	$442,615,707	$53,974,674	$496,590,381	$272.15
Q18 Total	**5,470,396**	**$848,694,828**	**$99,937,769**	**$948,632,597**	**$173.41**
January 2011	1,765,702	$136,138,730	$11,522,305	$147,661,035	$83.63
February 2011	1,741,315	$257,027,907	$30,781,930	$287,809,837	$165.28
March 2011	1,740,373	$394,755,478	$49,334,529	$444,090,007	$255.17
Q19 Total	**5,247,390**	**$787,922,115**	**$91,638,763**	**$879,560,878**	**$167.62**
April 2011	1,873,928	$126,334,678	$16,832,953	$143,167,631	$76.40
May 2011	1,877,042	$255,956,821	$33,906,598	$289,863,419	$154.43
June 2011	1,860,701	$291,409,133	$39,973,326	$331,382,459	$178.10

Table 40 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q20 Total	**5,611,671**	**$673,700,632**	**$90,712,877**	**$764,413,510**	**$136.22**
July 2011	1,894,919	$259,656,357	$32,638,562	$292,294,919	$154.25
August 2011	1,908,952	$435,988,483	$55,271,229	$491,259,713	$257.35
September 2011	1,891,285	$269,817,069	$33,364,459	$303,181,528	$160.30
Q21 Total	**5,695,156**	**$965,461,910**	**$121,274,250**	**$1,086,736,159**	**$190.82**
October 2011	1,927,438	$152,385,612	$17,583,568	$169,969,180	$88.18
November 2011	1,928,774	$468,337,497	$66,128,240	$534,465,738	$277.10
December 2011	1,916,808	$157,910,141	$16,091,075	$174,001,216	$90.78
Q22 Total	**5,773,020**	**$778,633,250**	**$99,802,883**	**$878,436,134**	**$152.16**
January 2012	1,974,661	$252,551,795	$33,783,082	$286,334,877	$145.00
February 2012	1,811,968	$457,595,125	$63,262,036	$520,857,161	$287.45
March 2012	1,806,127	$150,429,478	$18,286,764	$168,716,242	$93.41
Q23 Total	**5,592,756**	**$860,576,398**	**$115,331,882**	**$975,908,280**	**$174.50**
April 2012	1,966,756	$292,598,685	$38,771,593	$331,370,279	$168.49
May 2012	1,970,680	$481,066,431	$66,493,796	$547,560,228	$277.85
June 2012	1,957,829	$149,314,866	$17,030,689	$166,345,554	$84.96
Q24 Total	**5,895,265**	**$922,979,983**	**$122,296,078**	**$1,045,276,061**	**$177.31**
July 2012	**2,005,046**	**$285,197,648**	**$38,426,279**	**$323,623,927**	**$161.40**
August 2012	**2,012,553**	**$463,745,803**	**$66,342,696**	**$530,088,499**	**$263.39**
September 2012	**1,995,529**	**$135,187,936**	**$16,904,691**	**$152,092,627**	**$76.22**
Q25 Total	**6,013,128**	**$884,131,387**	**$121,673,666**	**$1,005,805,053**	**$167.27**
October 2012	**2,038,168**	**$495,559,037**	**$67,296,676**	**$562,855,713**	**$276.16**
November 2012	**2,034,764**	**$342,640,459**	**$40,926,904**	**$383,567,363**	**$188.51**
December 2012	**2,019,333**	**$178,685,146**	**$22,843,384**	**$201,528,530**	**$99.80**
Q26Total	**6,092,265**	**$1,016,884,642**	**$131,066,964**	**$1,147,951,606**	**$188.43**
January 2013	**2,043,580**	**$446,870,543**	**$72,582,993**	**$519,453,536**	**$254.19**
February 2013	**2,041,439**	**$318,241,573**	**$43,134,442**	**$361,376,015**	**$177.02**
March 2013	**2,032,101**	**$150,089,484**	**$17,917,697**	**$168,007,181**	**$82.68**
Q27Total	**6,117,120**	**$915,201,600**	**$133,635,131**	**$1,048,836,732**	**$171.46**
April 2013	**2,048,478**	**$319,987,180**	**$41,439,325**	**$361,426,505**	**$176.44**
May 2013	**2,045,418**	**$545,847,163**	**$74,045,032**	**$619,892,195**	**$303.06**
June 2013	**2,031,991**	**$153,017,542**	**$18,391,686**	**$171,409,228**	**$84.36**
Q28 Total	**6,125,887**	**$1,018,851,885**	**$133,876,042**	**$1,152,727,927**	**$188.17**
MEG 2 Total	**136,112,288**	**20,509,436,579**	**2,388,560,316**	**22,897,996,896**	**168.23**

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

Table 41 MEG 1 and 2 Annual Statistics					
DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY02 Total	3,033,969	$2,655,180,625	$445,971,300	$3,101,151,925	$1,022.14
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(7,725,769)	
% of WOW PCCM MEG 1					99.75%
DY02 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY02 Total	14,829,991	$2,254,071,149	$264,786,465	$2,518,857,614	$169.85
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(676,115,647)	
% of WOW PCCM MEG 2					78.84%
DY03 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY03 Total	3,249,742	$2,937,427,184	$500,344,974	$3,437,772,158	$1,057.86
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(158,619,822)	
% of WOW PCCM MEG 1					95.59%
DY03 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY03 Total	17,094,840	$2,572,390,668	$281,844,467	$2,854,235,134	$166.96
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,123,392,237)	
% of WOW PCCM MEG 2					71.76%

Table 41 MEG 1 and 2 Annual Statistics					
DY04 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY04 Total	3,357,141	$3,066,429,103	$550,235,443	$3,616,664,546	$1,077.30
WOW DY4 Total	3,357,141			$4,012,454,923	$1,195.20
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY05 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY05 Total	3,499,758	$3,247,599,951	$590,194,459	$3,837,794,411	$1,096.59
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(679,763,211)	
% of WOW PCCM MEG 1					84.95%
DY05 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY05 Total	21,686,199	$3,225,551,490	$398,406,833	$3,623,958,323	$167.11
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,261,459,223)	
% of WOW PCCM MEG 2					61.58%
DY06 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY06 Total	3,653,867	$3,383,148,738	$649,023,510	$4,032,172,248	$1,103.54
WOW DY5 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(924,846,417)	
% of WOW PCCM MEG 1					81.34%
DY06 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY06 Total	22,956,197	$3,539,069,082	$498,749,513	$4,037,818,595	$175.89
WOW DY5 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,522,373,822)	
% of WOW PCCM MEG 2					61.55%

Table 41 MEG 1 and 2 Annual Statistics					
DY07– MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY07 Total	3,830,936	$3,093,115,831	$799,084,683	$3,892,200,514	$1,015.99
WOW DY4 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,570,101,272)	
% of WOW PCCM MEG 1					71.26%
DY07 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY07 Total	24,348,400	$3,632,607,000	$457,137,568	$4,089,744,568	$167.97
WOW DY4 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(3,237,175,960)	
% of WOW PCCM MEG 2					55.82%

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Table 42 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 6	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,922,217,820	$1,147,773,023	$8,069,990,843	$303.27
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,447,220,239)	
% Of WOW					70.07%
DY 7	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$6,725,722,831	$1,256,222,251	$7,981,945,082	$283.26
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,807,277,232)	
% Of WOW					62.41%

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 41), compared to WOW of $948.79 (Table 38), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 41), compared to WOW of $199.48 (Table 38), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 (Table 41), compared to WOW of $1,024.69 (Table 38), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 41), compared to WOW of $215.44 (Table 38), which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.86 (Table 41), compared to WOW of $1,106.67 (Table 38), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 41), compared to WOW of $232.68 (Table 38), which is 71.76% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of $1,077.30 (Table 41), compared to WOW of $1,195.20 (Table 38), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 41), compared to WOW of $251.29 (Table 38), which is 66.42% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,096.59 (Table 34), compared to WOW of $1,290.82 (Table 31), which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 (Table 34), compared to WOW of $271.39 (Table 31), which is 61.58% of the target PCCM for MEG 2

For Demonstration Year Six, MEG 1 has a PCCM of $1,103.54 (Table 34), compared to WOW of $1,356.65 (Table 31), which is 81.34% of the target PCCM for MEG 1. MEG 2 has a PCCM of $175.89 (Table 34), compared to WOW of $285.77 (Table 31), which is 61.55% of the target PCCM for MEG 2.

For Demonstration Year Seven, MEG 1 has a PCCM of $1,015.99 (Table 34), compared to WOW of $1,425.84 (Table 31), which is 71.26% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.97 (Table 34), compared to WOW of $300.92 (Table 31), which is 55.82% of the target PCCM for MEG 2.

Tables 41 and 42 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 42) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 42 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 42) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 42 is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 42) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 42 is $309.25. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 42) is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 42 is $297.57. Comparing the calculated weighted averages, the actual PCCM is 76.94% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 35) is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 35 is $296.27. Comparing the calculated weighted averages, the actual PCCM is 71.73% of the target PCCM.

For Demonstration Year Six, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 35) is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 35 is $303.27. Comparing the calculated weighted averages, the actual PCCM is 70.07% of the target PCCM.

For Demonstration Year Seven, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 35) 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 35 is $283.26. Comparing the calculated weighted averages, the actual PCCM is 62.41% of the target PCCM.

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Table 43 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Q19	**$180,732,289**
Q20	**$353,499,776**
Q21	**$57,414,775**
Q22	**$346,827,872**
Q23	**$175,598,167**
Q24	**$227,391,753**
Q25	**$189,334,002**
Q26	**$243,596,958**
Q27	**$277,637,763**
Q28	**$308,722,821**
Total Paid	**$6,822,273,301**

Table 44 shows that the expenditures for the first 28 quarters for MEG 3, Low Income Pool (LIP), were $6,822,273,301 (85.28% of the $8 billion cap).

Table 44 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**Percent of DY Limit**
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$807,232,567	$1,000,000,000	80.72%
DY07	$1,019,291,544	$1,000,000,000	101.93%
Total MEG 3	$6,822,273,301	$8,000,000,000	85.28%

*DY totals are calculated using date of service data as required in STC #94.

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

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G. Encounter and Utilization Data

Overview

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

Demonstration Year Seven at a Glance

During Demonstration Year Seven, the Agency continued its analysis and validation of encounter data by focusing on developing and honing the Encounter Data Compliance Report. These reports use analytical measures to report the completeness, accuracy and timeliness of encounter data submissions by plan by month. The processes for analysis undergo iterative reviews and validation checks. Additionally, dialogue with the managed care stakeholders each month often results in refinements that are then applied to the measures and to the narrative. In this way, the Encounter Data Compliance Reports have been modified and improved over the year to address any issues and incorporate additional functionality. The first Encounter Data Compliance Reports were distributed to managed care organizations in November 2012. These reports were for encounters processed in July 2012 and August 2012. Encounter Data Compliance Reports continue to be distributed on monthly basis.

The Agency designed and constructed an encounter data lexicon which uses an arithmetical approach to the elements present in the encounter data fields. This lexicon is used to help distinguish encounter data resubmissions from original submissions, in order to help the Agency enforce compliance with encounter data timeliness. Encounter data analyses with the lexicon in the Second, Third and Fourth Quarters of Demonstration Year Seven showed a very low number of resubmissions, so this process is being re-evaluated. Isolating resubmitted claims from original claims continues to be a topic in brainstorming sessions with Agency staff, the Medicaid Fiscal Agent, health plan stakeholders, and Medicaid offices in other states. On March 15, 2013, the Agency held a workshop with representatives from 17 health plans, to focus on resubmission of denied encounters. Staff from several Agency bureaus addressed challenges related to successful submission of encounter transactions.

On April 16, 2013, another workshop was held for the health plans, to focus on provider errors. Staff from the bureaus of Medicaid Program Analysis and Medicaid Contract Management addressed challenges relative to successful submission of encounter transactions. Topics reviewed included the mass registration process for managed care providers (introduced last year) and the provider National Provider Identifier crosswalk, used by plans to determine if a provider is already in the Florida Medicaid system. The Agency and plan representatives review and vetted a new attestation form for encounter data submissions, designed to capture more accurate data for the encounter files being uploaded and to speed up the system front-end process.

During Demonstration Year Seven, the Agency also adapted for use in its Encounter Data Compliance Reports, the Chronic Disability and Illness Payment System (CDPS) model. The Medicaid CDPS + Rx v5.3 model, developed and distributed by the University of California, San Diego and customized for the state of Florida, provides guidelines for medical service utilization among individuals having common chronic illnesses, grouped by age, gender, and aid

categories. Diseases are identified through diagnosis codes and National Drug Codes (NDC) existing in medical and pharmacy claims and encounter transactions. Based on the encounter data reported by the health plans for a month-over-month period, the CDPS model calculates an encounter volumetric that predicts Medicaid recipient encounter volume, which can then be compared to the encounter data actually submitted by a health plan to help determine encounter submission completeness. The CDPS model, together with an Auto Regressive Integrated Moving Average (ARIMA), a multivariate statistical analysis model, tracks and trends actual health plan submissions to predict encounter volume. The volumetric results of the two methods are being cross-validated. Additionally, computations of CDPS risk scores can be validated against the risk scores produced by the Agency's actuaries using pharmacy encounter claims data and the MedRx model. The CDPS methodology was validated for fit and predictability using multiple statistical methods and was first implemented in preparation of the March 2013 Encounter Data Compliance Reports.

Inpatient, pharmacy and mental health encounter data are being utilized for capitation rate setting, with the addition of outpatient encounter data for the September 2012 through August 2013 rate setting process. NCPDP pharmacy encounter claims are provided to the Agency's actuary for use in the MedRx model to generate risk scores for plans in the demonstration counties. The Agency is still considering transitioning to a CDPS-type model for calculating these risk scores.

Looking Ahead to Demonstration Year Eight

In Demonstration Year Eight, the Agency will continue to analyze encounter data submissions to determine their accuracy, timeliness and completeness. For the last demonstration year, the Agency has evaluated encounter data and distributed the results to the demonstration plans in a monthly Encounter Data Compliance Report, with the goal of improving submitted data. Distribution of these reports will continue for Demonstration Year Eight. The Agency will also enhance its efforts to obtain quality data by dedicating staff to assist demonstration plans with correcting data submission issues.

In Demonstration Year Seven, the Agency incorporated the Chronic Illness and Disability Payment System (CDPS) model into the methodology used for determining encounter data completeness. In Demonstration Year Eight, the Agency will continue to refine the use of this model while exploring other methodologies for evaluating completeness.

The Agency will intensify its efforts to improve the quality of the data it is receiving from plans, and develop new methodologies to analyze the plans' service delivery model.

Beginning in July 2013, the Agency will contract with an External Quality Review Organization (EQRO) to validate encounter data submissions. Agency staff will work with the EQRO to evaluate the plans' encounter data systems, to evaluate the Agency's encounter data system and data warehouse, and to validate the accuracy of the data as compared to the medical record. As issues are identified, the EQRO will provide recommendations for improvements and technical assistance to the plans and the Agency.

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H. Demonstration Goals

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

Broward and Duval Counties

Tables 45 and 46 provide the number and types of health plans the Agency contracted with prior to the implementation of the demonstration.

Table 45
Broward County
Number and Type of Plans
(Pre-Demonstration 2006)

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

Table 46
Duval County
Number and Type of Plans
(Pre-Demonstration 2006)

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

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

Tables 47 and 48 provide the number and types of health plans the Agency currently has under contract in Broward and Duval Counties.

Table 47
Broward County
Number and Type of Plans
(July 1, 2012 – June 30, 2013)

Type of Plan	Number of Plans
HMOs	11
PSNs	3
Total	**14**

Table 48
Duval County
Number and Type of Plans
(July 1, 2012 – June 30, 2013)

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

Baker, Clay and Nassau Counties

Prior to expansion of the demonstration into Baker, Clay and Nassau Counties on July 1, 2007, the Agency contracted with one MPN that operated in all three counties as a prepaid ambulatory health plan. The Agency had no contracts with HMOs, PSNs or the Pediatric ER Diversion program in these counties.

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

Health Plan Applications and Expansion Requests

The following four new health plans were approved in Demonstration Year Seven:

- Simply Healthcare HMO (Broward County). Note: this is an HMO that is separate and distinct from the Simply Healthcare d/b/a Clear Health Alliance specialty plan.
- Healthease HMO (all five demonstration counties)
- Magellan Complete Care (Broward County)
- Simply Healthcare d/b/a Clear Health Alliance specialty plan for individuals living with HIV or AIDS (Broward County)

Sunshine State Health Plan's (HMO) previously submitted request to expand into Baker and Nassau Counties remained under Agency review at the close of Demonstration Year Seven.

See Section A.1 of this report for additional information on health plan applications and expansion requests. Please note that patient satisfaction is addressed in Objective 4.

Please note that under the Medical Managed Assistance program to be implemented no later than October 1, 2014, this objective will no longer be applicable as health plans will be competitively procured.

Objective 2: *To ensure that there is access to services not previously covered and improved access to specialists.*

Access to Services Not Previously Covered

In Year Seven of the demonstration, all of the capitated health plans continue to offer expanded or additional benefits that were not previously covered under Florida's Medicaid State Plan in order to meet the needs of new enrollees. The customized benefit packages and expanded benefits became operational on January 1, 2013 and will remain valid until December 31, 2013, effectively overlapping Years Seven and Eight of the demonstration. These benefit packages include 26 customized benefit packages for the HMOs and 10 benefit packages for the FFS PSNs.

The following is a list of the expanded benefits currently offered by the capitated health plans of which the over-the-counter drug benefits and adult preventive benefits are the most frequently offered:

- Over-the-counter drug benefit – $25 per household, per month;
- Adult preventive dental;
- Circumcisions for male newborns;
- Additional adult vision;
- Wellness and nutrition therapy; and
- Respite care.

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for recipients. Each health plan is required to provide documentation to the Agency to demonstrate contractual arrangements for a network of providers (including specialists) that will guarantee access to

care for recipients. As Year One of the demonstration ended, the first intensive comparative analysis Agency of the health plans' provider network files to evaluate the effectiveness of the demonstration in improving access to specialists.

During the second quarter of Demonstration Year Two, the Agency began additional analysis of provider networks among the Medicaid health plans, including each demonstration health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories, and to certify the provider network files submitted to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files were required to note any restrictions to recipient access (e.g., if the provider accepts only current patients, if they treat only children/women, etc.).

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

In Demonstration Year Six and Seven, the Agency began developing additional ways to analyze health plan encounter data in order to assess health care access. The most recent analyses focused on three types of specialty care: orthopedics, neurology and dermatology. These analyses use encounter data to target the number of recipients receiving these specialty services in demonstration counties (measured as recipient utilization per 1,000 eligible recipients).

Initiated in Year Six, the Agency reviewed and refined methodologies for analyzing access to care in order to establish baselines and for identifying opportunities for health plans performance improvements. Encounter data improvements intended to enhance these analyses are ongoing, but recent improvements can be attributed to two factors: (1) Increase in volume of encounter data in the database; and (2) Improvement in filtering and stratifying data to target demonstration health plan enrollees. Charts K through P located on the following three pages demonstrate improving accessibility to neurology, dermatology and orthopedic services for Medicaid recipients statewide and in the demonstration counties over time, for SFY 2009-10, SFY 2010-11 and SFY 2011-12.

Specialty care access measurements have been communicated to the plans in their monthly Compliance Reports since March 2013. The Agency has reached out to the health plans to identify specific errors in their provider identification on encounter transactions and encouraged to educate and retrain providers. The accurate completion of specialty fields pertaining to these providers will provide necessary detail and enhance the ongoing analyses.

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Chart K
Specialty Care – Demonstration Counties SFY 2009-10

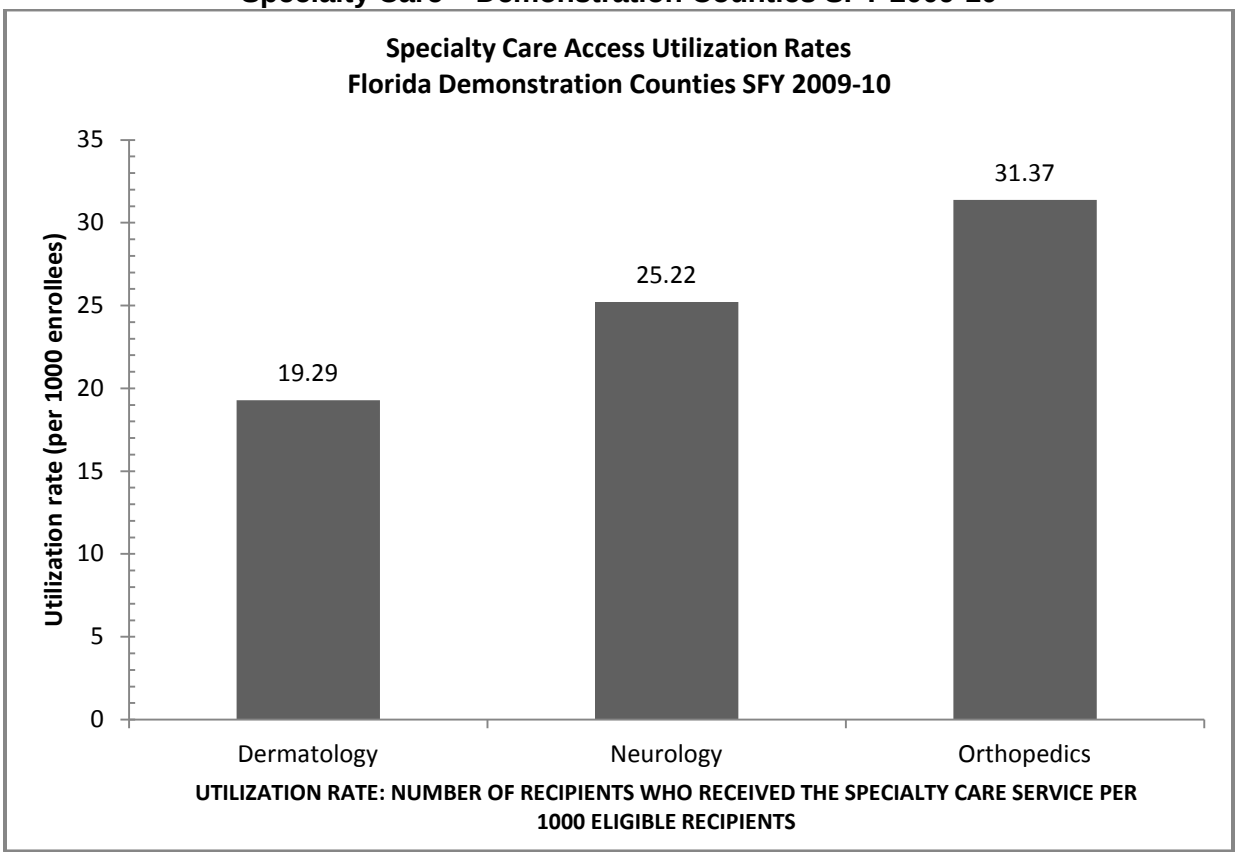


Chart L
Specialty Care – Demonstration Counties SFY 2009-10

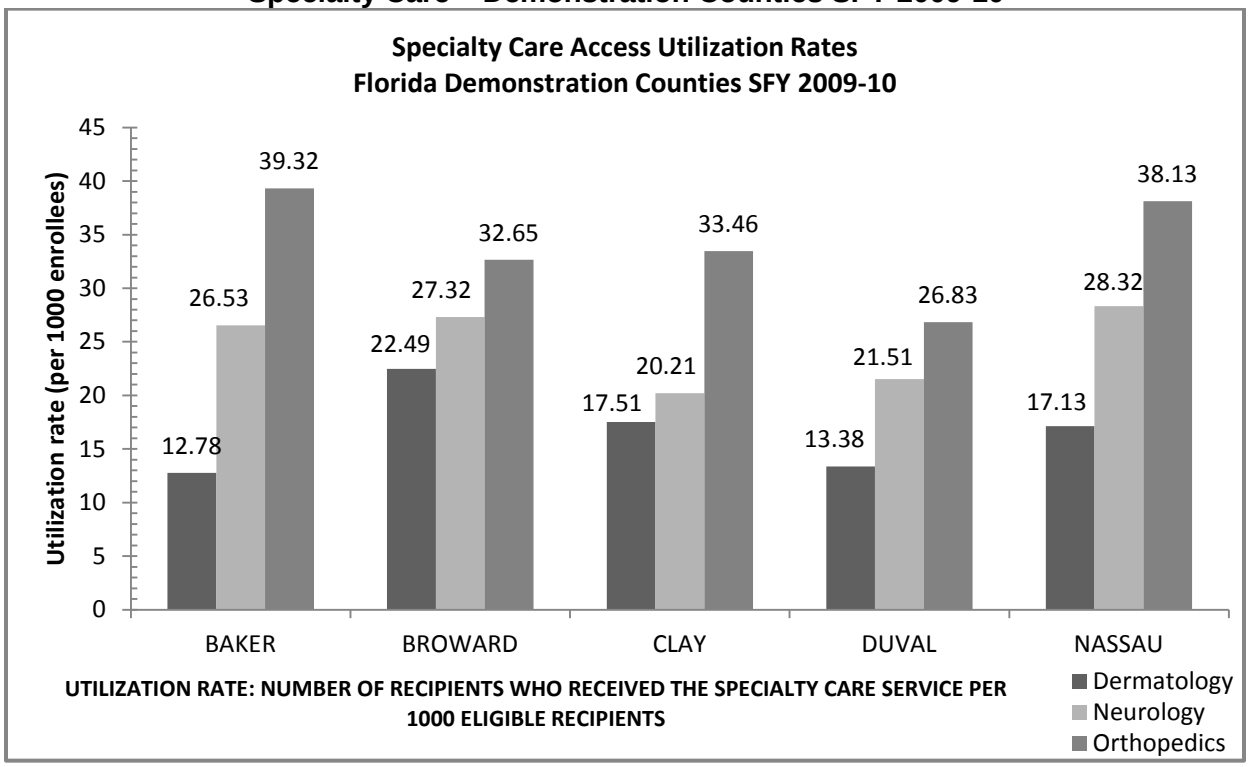


Chart M
Specialty Care – Demonstration Counties SFY 2010-11

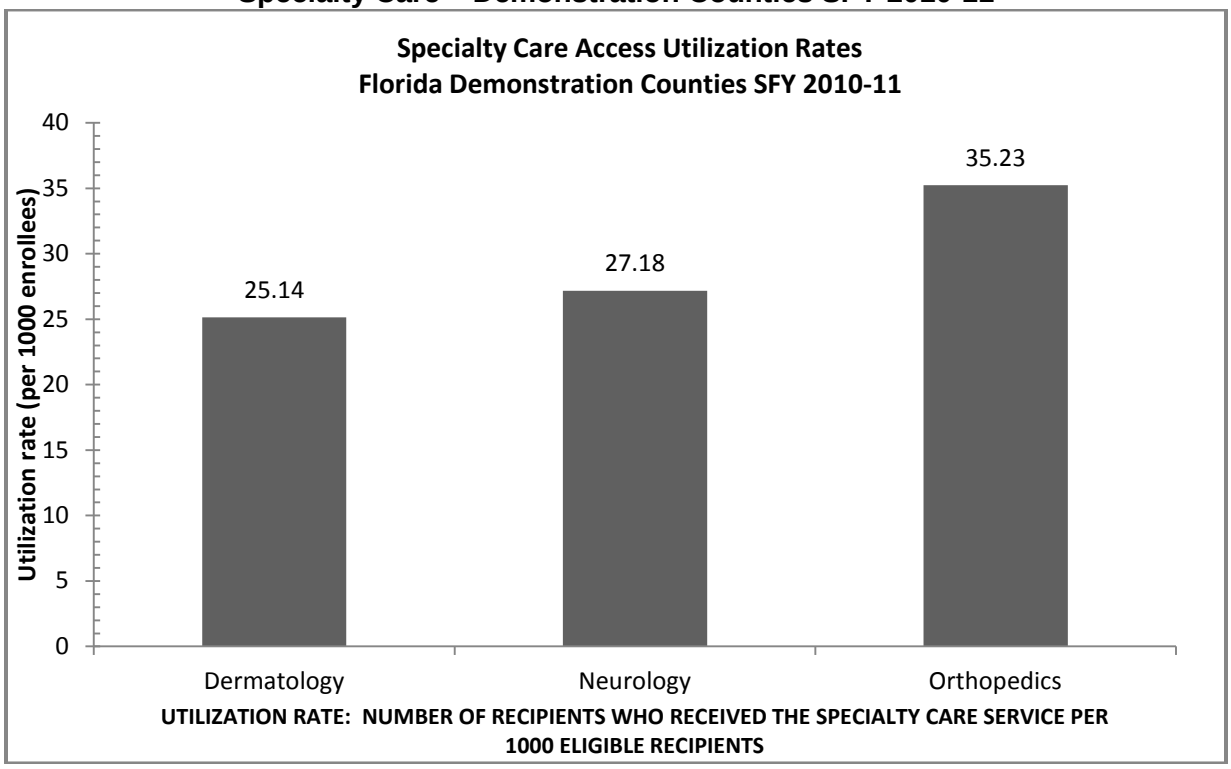


Chart N
Specialty Care – Demonstration Counties SFY 2010-11

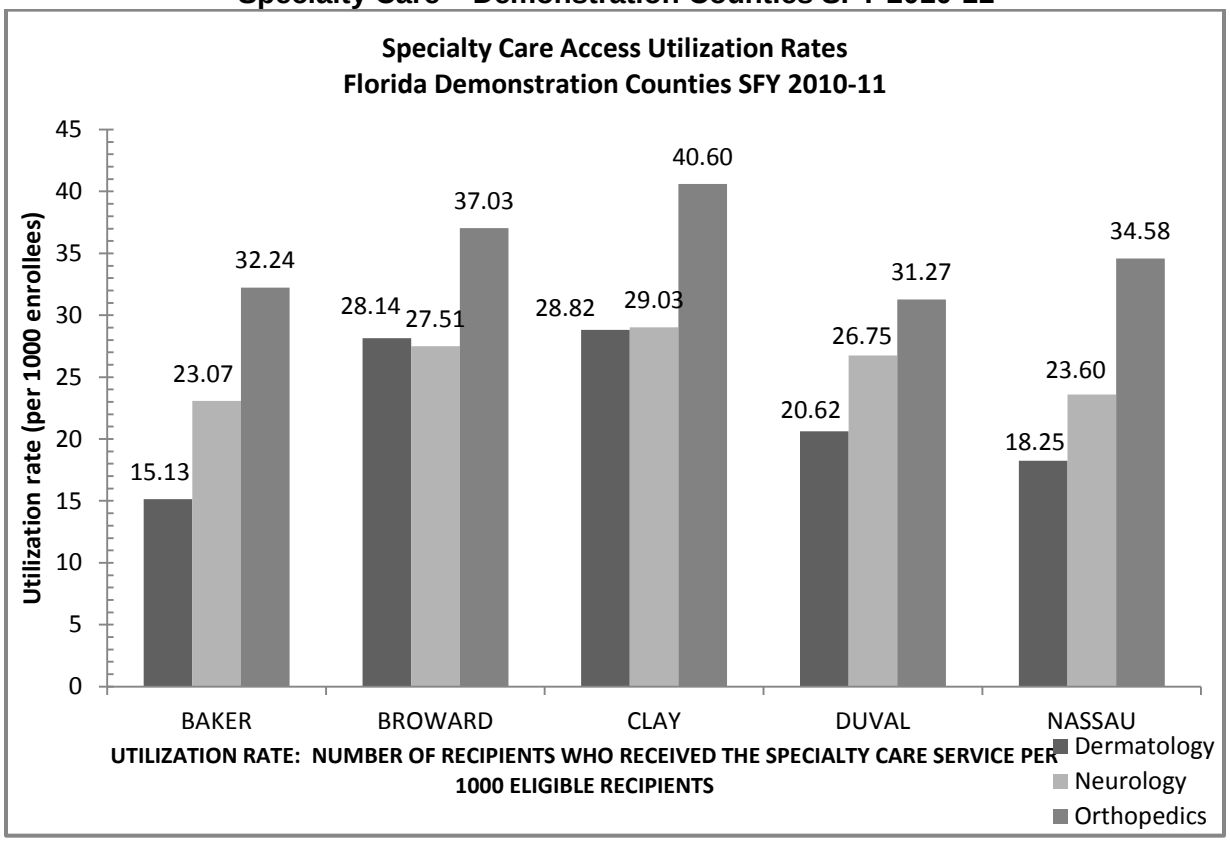


Chart O
Specialty Care – Demonstration Counties SFY 2011-12

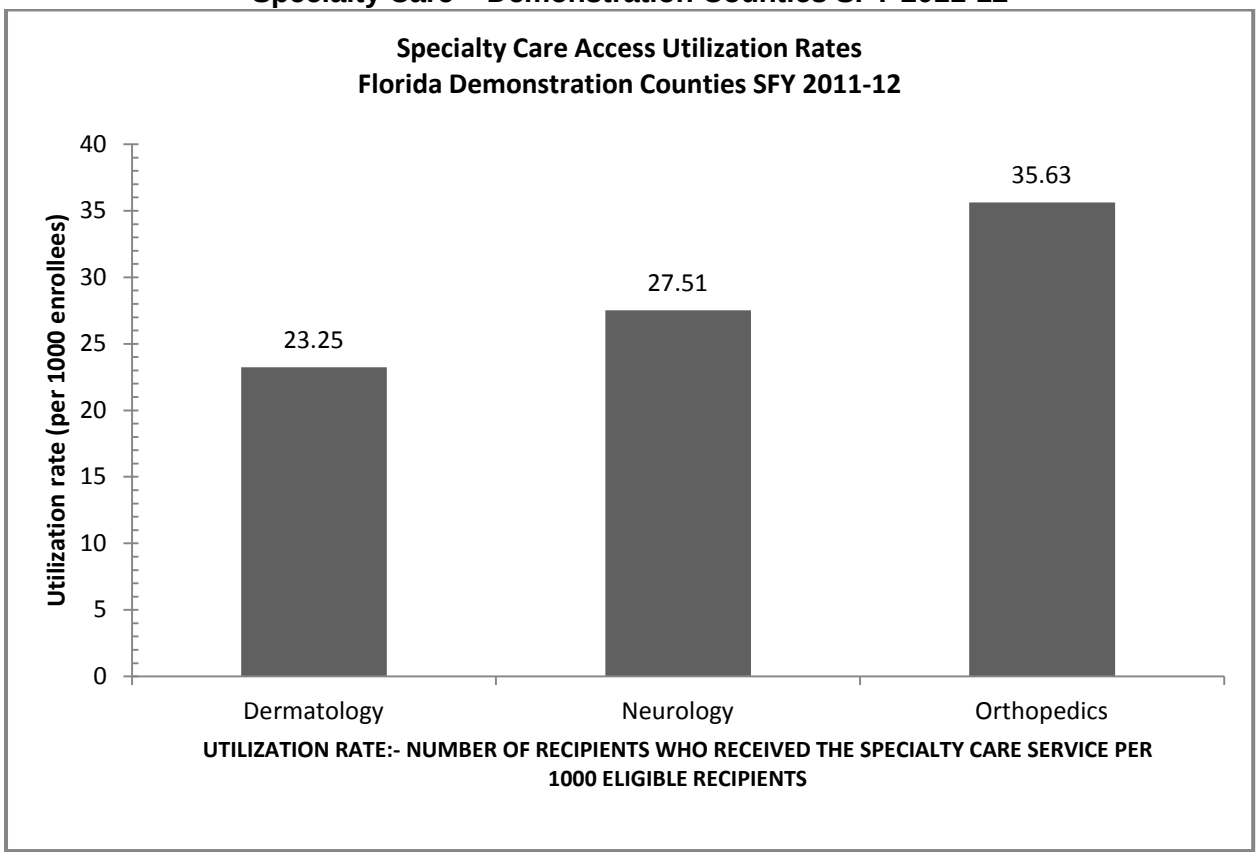
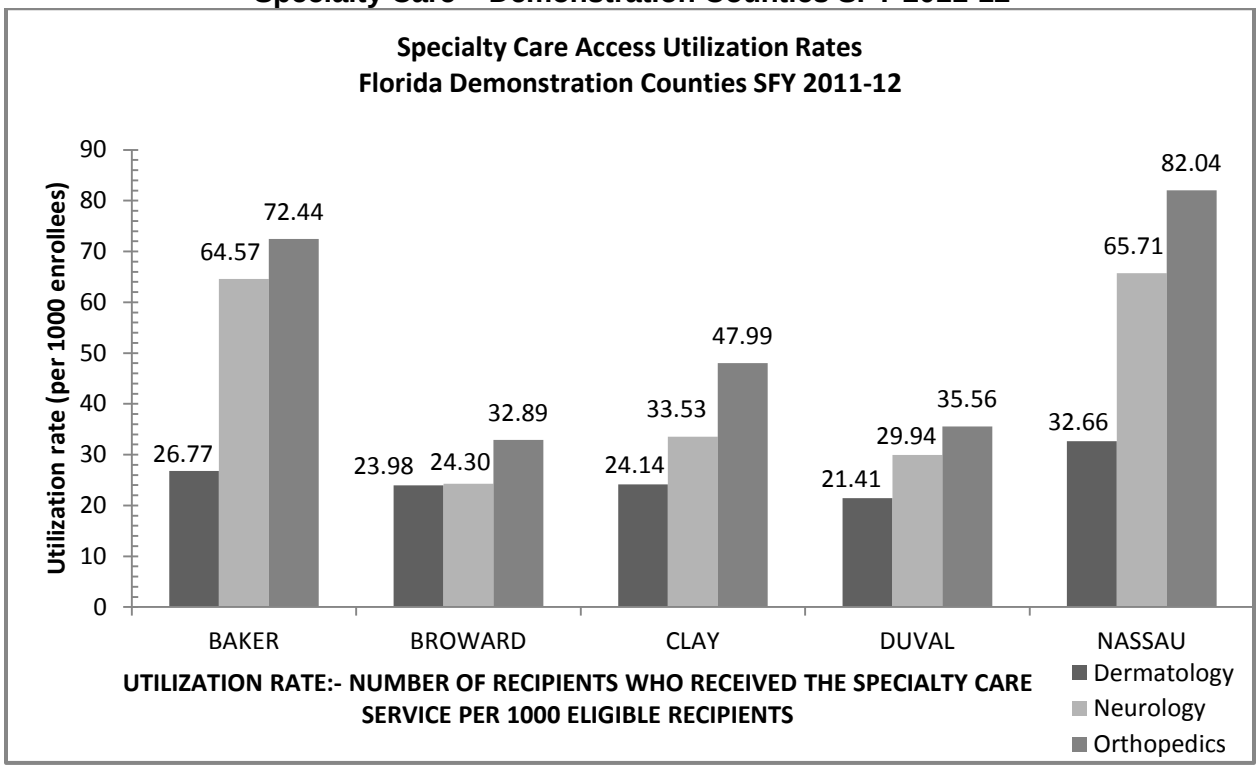


Chart P
Specialty Care – Demonstration Counties SFY 2011-12



Objective 3: *To improve enrollee outcomes as demonstrated by: a) improvement in the overall health status of enrollees for select health indicators; b) reduction in ambulatory sensitive hospitalizations; and c) decreased utilization of emergency room care.*

(3)(a) Improvement in the overall health status of enrollees for selected health indicators.

The Agency received the fifth year of performance measure submissions from the health plans during the first quarter of Demonstration Year Seven. Results of the fifth year of performance measures can be viewed in Attachment I of this report and the following provides highlights of the fifth year of performance measures:

- Of the 34 HEDIS measures for which plans may need to do Performance Measure Action Plans (PMAPs), the statewide average results for the demonstration plans improved for 15 of the measures compared to the previous year. A statewide weighted average for one measure was not calculated for the demonstration plans as only three of the 13 plans had sufficient eligible members to report the measure. Thus, only 33 of the measures have statewide averages for the demonstration plans.
- Demonstration plans' rates for 11 of the measures stayed about the same, while their performance on seven of the measures dropped.
- For 22 of the 33 measures, the statewide average results for the demonstration plans were higher than the average results for the non-demonstration plans. Performance measures with notable improvement include:
  - Well-Child Visits in the First 15 Months – 6 or more: the statewide weighted average for demonstration plans increased from 46.5% in 2011 (representing measurement year 2010) to 58.4% in 2012 (representing measurement year 2011).
  - Controlling Blood Pressure: the statewide weighted average for demonstration plans increased from 46.3% in 2011 to 52.9% in 2012.
  - Frequency of Prenatal Care: the statewide weighted average for demonstration plans increased from 44% in 2011 to 54.4% in 2012.
  - Diabetes – HbA1c Poor Control: the statewide weighted average for demonstration plans dropped from 48.6% in 2011 to 43.6% in 2012. Please note that this is an inverse measure, meaning that a lower rate is more desirable.
  - Lead Screening in Children: the statewide weighted average for demonstration plans increased from 54.1% in 2011 to 59.6% in 2012.

During the second quarter of Demonstration Year Seven, the Agency sent lists of measures requiring PMAPs to the health plans. The PMAPs are required for all measures that scored below the 50th percentile as identified in the National Committee for Quality Assurance's (NCQA) National Means and Percentiles for Medicaid plans. The health plans submitted their PMAPs to the Agency in December 2012 and Agency staff reviewed them.

During the third quarter of Year Seven, the Agency obtained the most recent National Means and Percentiles from NCQA in order to compare the Florida Medicaid health plans' performance measure rates to the 2012 Means and Percentiles. On average, the demonstration plans performed better than the national mean for a number of measures.

- For three of the Comprehensive Diabetes Care measure components, the statewide weighted average for demonstration plans was higher than the national mean.

  - LDL Screening: the national mean was 74.9% while the weighted average for demonstration plans was 81.9%.
  - LDL Control: the national mean was 35.2% while the weighted average for demonstration plans was 37.8%.
  - Medical Attention for Nephropathy: the national mean was 77.8% while the weighted average for demonstration plans was 82.3%.
- For the measure Well Child Visits in the 3rd-6th years of life, the weighted average for demonstration plans was 75.5%, which exceeds the national mean of 71.9%.
- For both of the Antidepressant Medication Management rates (acute and continuation), the demonstration plans' weighted averages (57.4% and 43.1%, respectively) exceeded the national means of 51.1% and 34.4%, respectively.
- For the Breast Cancer Screening measure, the demonstration plans' weighted average was 52.3%, while the national mean was 50.4%.
- For the Follow-up Care for Children Prescribed ADHD Medication – Initiation measure, the demonstration plans' weighted average was 44.4% while the national mean was 38.8%.

During the second quarter of Demonstration Year Seven, the Agency sent lists of measures requiring PMAPs to the health plans, and the plans submitted their PMAPs to the Agency. Progress reports were submitted in April 2013.

Performance measure reports for calendar year 2012 are due to the Agency during the first quarter of Demonstration Year Eight. Results will be provided in the first quarterly report.

(3)(b) Reduction in ambulatory sensitive hospitalizations

The Agency continues to run its model to analyze the utilization of Ambulatory Care Sensitive Conditions (ACSC) using the Agency for Healthcare Research and Quality (AHRQ) quality indicators (QI). The model enables the Agency to analyze the prevalence of ACSCs that lead to preventable hospitalizations. Aggregation of utilization data across multiple fee-for-service and managed care delivery systems enables a comparison by county or by plan. The reports include morbidity scoring (MedRx), utilization by per member per month normalized to report per 1,000 recipients, and a distribution by category of the QI's for statewide (FFS & managed care), reform, non-reform, and per-MCO basis. The model has been updated to support the latest version (4.4) provided by AHRQ.

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

The Agency is assessing this model for use as a tool for measuring plan performance. The Agency has shared the report results with the state's health plan professional association, the Florida Association of Health Plans. Through this collaboration, the Agency has refined the model and is moving forward with the changes.

(3)(c) Decreased utilization of emergency room care.

The Agency uses a model to analyze the utilization of emergency departments (ED) based on the New York University ED algorithm. The model is set up to process data, generating comparable results across the fee-for-service recipients and managed care enrollees. The reports include a volumetric with morbidity scoring (MedRx), utilization per member per month per 1,000 recipients, and distribution by reporting ED utilization category on a statewide (FFS & managed care), reform, non-reform and per-MCO basis. Portions of the report are designed to produce a county comparison based on managed care eligible recipient utilization or according to plan member utilization. The model is being updated to support the latest version 2.0 provided by New York University.

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

The Agency is assessing this model for use as a tool for measuring plan performance. The Agency has shared the report results with the state's health plan professional association, the Florida Association of Health Plans. Through this collaboration, the Agency has refined the model and is moving forward with the changes.

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

The Agency contracted with the University of Florida (UF) to conduct patient satisfaction surveys throughout the initial five-year demonstration period and the three-year extension period as well. The survey instrument used by UF is based on the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) *Survey*. The CAHPS Survey is one of a family of standardized instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care. The UF has adapted the CAHPS telephone survey component by adding questions specific to the demonstration.

Findings from the CAHPS survey for a baseline year and three follow-up surveys were included in the Final Evaluation Report for the initial five-year demonstration period, which the Agency submitted to Federal CMS on December 15, 2011.

During the fourth quarter of Demonstration Year Seven, UF submitted a draft trend analysis report to the Agency, which includes the CAHPS survey results for the demonstration through SFY 2011-12. Agency staff reviewed the report and provided feedback to UF. During the first quarter of Year Eight, UF will complete revisions to the report and the Agency will complete its review. These results will also be included in the evaluation report regarding Domains of Focus i and ii. Beginning with the first quarterly report for Demonstration Year Eight, information regarding this objective will be included in Section II. I, Evaluation of Demonstration. The results of past reports and all other evaluation reports conducted by UF can be viewed at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml

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

Prior to the implementation of the demonstration, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The demonstration created the LIP program, which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of the new PAS providers allows for increased access to

services for the Medicaid, underinsured and uninsured populations. For information on activities that occurred prior to this quarter, please see the previous quarterly and annual reports posted on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Newly Amended STC #84 – Tier-One Milestone

Two reports correspond to this STC:

1. The Milestone Statistics and Findings Report. The Agency collected milestone data for this report from the PAS providers covering SFY 2011-12. The final deadline for the PAS providers to submit their milestone data to the Agency was on October 31, 2012. On April 1, 2013, the Agency submitted to Federal CMS the final annual Milestone Statistics and Findings Report.

   The Milestone data tracks the number of individuals and types of services provided through LIP. The following is some of the key data included in the results:

   - A total of 146 PAS in Florida received LIP payments – 74 hospitals and 72 non-hospital providers.
   - Total LIP funding was approximately $1 billion.
   - Reporting hospitals receiving supplemental payments of rate enhancements served a total of approximately 3.7 million Medicaid, uninsured and underinsured individuals.
   - Reporting non-hospital providers receiving LIP payments served a total of approximately 1.2 million Medicaid, uninsured and underinsured individuals.
   - 126 hospitals that received supplemental payments of rate enhancements reported providing approximately 14.5 million service encounters to Medicaid, uninsured individuals across six service categories.
   - For all categories of encounters, 63 reporting non-hospital providers receiving LIP payments provided a total of approximately 6.5 million encounters for specific services to Medicaid, uninsured and underinsured individuals.

   One of the objectives of the Milestone Statistics and Findings Report is to determine the number of uninsured and underinsured recipients who receive services through LIP funding and determining what types of services are being provided in what setting. The following section summarizes and reports on the number of Medicaid, Uninsured, and Underinsured individuals served, the type of services provided, and the setting in which the services were awarded by reporting providers receiving supplemental payments or rate enhancements.

   a. Number of Uninsured and Underinsured individuals served

      Hospital Providers

      - Between DY1: SFY 2006-07 and DY6: SFY 2011-12, approximately 1.8 million uninsured and underinsured individuals were treated on an inpatient basis, and approximately 10.8 million uninsured and underinsured individuals were served on an outpatient basis by reporting hospital providers.
      - Over six years. The average number of uninsured and underinsured individuals served that received inpatient services was approximately 10,700 per reporting

hospital. For outpatient services, the average number of uninsured and underinsured individuals served per reporting hospital was approximately 63,400.

- From DY1: SFY 2006-07 to DY6: SFY 2011-12, the number of reporting hospital providers decreased by 32 from 158 in DY1: SFY 2006-07 to 126 in DY6: SFY 2011-12. The number of Medicaid individuals served by hospital providers in inpatient and outpatient settings increased by 17,000 and 239,000 respectively. The number of uninsured and underinsured individuals served on an inpatient basis and an outpatient basis by reporting hospital providers decreased.

Non- Hospital Providers

- Overall for non-hospital providers, between DY1: SFY 2006-07 and DY6: SFY 2011-12, there were 70 reporting non-hospital providers that furnished outpatient services to a total of approximately 2.1 million Medicaid and 3.4 million uninsured and underinsured individuals.
- The Number of uninsured and underinsured individuals served increased by approximately 255,500, from 438,800 in DY1: SFY 2006-07 to 694,300 in DY6: SFY 2011-12 with a parallel increase in the number of reporting providers, 38 to 64.
- Overall, based on 70 reporting non-hospital providers, from DY1: SFY 2006-07 to DY6: SFY 2011-12, the average total number of uninsured and underinsured individuals served per reporting non-hospital providers was approximately 48,700. The average annual number of uninsured and underinsured individuals served per non-hospital provider decreased from 11,550 in DY1: SFY 2006-07 to approximately 10,800 per reporting non-hospital provider in DY6: SFY 2011-12. In DY3: SFY 2008-09 and DY4: SFY 2009-10, the average number of uninsured and underinsured individuals served per reporting non-hospital providers were approximately 11,500 and 14,500 respectively.

2. The Primary Care and Alternative Delivery Systems Expenditure Report. There are many different primary care and alternative delivery systems operating with LIP funds. Programs range from: Recipients Outreach; Emergency Room Diversion; Insurance Products; Primary Care Extensions; and Disease Management Initiatives. Although each program contains certain measures and reporting that are similar (i.e., Number of recipients served, Number of services provided, Program expenditures), there are also measures that will be unique for each program. These programs are required to submit reporting to the Agency on August 31, 2013. The Agency will submit the data to Federal CMS on January 1, 2014.

The Milestone Statistics and Findings Report and the Primary Care Report and Alternative Delivery Systems Report will show increased access to medical care for this population in Florida.

Newly Amended STC #85 – Tier-Two Milestone

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

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

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

c) Reducing per-capita costs.

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

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

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

The Agency will submit second, third and fourth quarter reporting to Federal CMS on September 30, 2013 for the 44 hospital initiatives.

Final Evaluation Plan

The required demonstration evaluation will include specific studies regarding access to care and quality of care as affected by the Tier-One and Tier-Two initiatives in accordance with the STCs of the waiver. On October 30, 2012, Federal CMS approved the Agency's final evaluation design. When available, the results of the evaluation will be reported under Section I, Evaluation of the Demonstration, of this report.

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I. Evaluation of the Demonstration

Overview

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

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

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

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

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

Demonstration Year Seven at a Glance

During Demonstration Year Seven, the Agency executed contracts with two public state universities for the evaluation. A research team at Florida International University (FIU) is conducting the evaluation of domain iv, and a research team at UF is conducting the evaluation of the other eight domains. FIU analyzed the fraud and abuse plans for a sample of four demonstration plans during Year Seven, and submitted preliminary and final reports to the Agency. UF completed an annual Milestone Statistics and Findings Report, which the Agency submitted to Federal CMS in the Spring of 2013. UF also completed preliminary analyses related to the Low Income Pool (domains v-ix). UF submitted draft reports related to domains i and ii, and domain iii to the Agency in June 2013.

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

The following are the requirements added in new STC #112 effective June 14, 2013:

a) Domains of Focus – The Agency must propose as least one research question that it will investigate within each of the domains listed in the following items i-xiii. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs. With respect to domains vii, viii, and ix, the state must propose two research questions under each domain (one each from Tier-One and Tier-Two milestones).

i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
iii. Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status;
iv. The impact of the demonstration as a deterrent against Medicaid fraud and abuse;
v. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
vi. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
vii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
viii. The impact of Tier-One and Tier-Two milestone initiatives on population health;
ix. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care;
x. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
xi. The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
xii. The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs; and,
xiii. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals.

b) Measures – The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);

ii. The measure steward;

iii. The baseline value for each measure;

iv. The sampling methodology for assessing these outcomes; and

v. The methods of data collection.

c) Sources of Measures – Federal CMS recommends use of measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d) The Evaluation Design – The draft design is required to also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

The following requirements were added in new STC #113 effective June 14, 2013 regarding the Final Evaluation Design and Implementation**.**

Federal CMS will provide comments on the draft design and the draft MMA evaluation strategy within 60 days of receipt, and the Agency is required to submit a final design within 60 days of receipt of Federal CMS' comments. The Agency must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The Agency must submit to Federal CMS a draft of the evaluation final report by October 31, 2014. The Agency is to submit the final report within 60 days after receipt of Federal CMS' comments.

The Agency is required to submit to Federal CMS a draft of the evaluation final report by October 31, 2014. The final report must include the following:

a. An executive summary;
b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
f. Successes, challenges, and lessons learned.

Looking Ahead to Demonstration Year Eight

In the first quarter of Demonstration Year Eight, the Agency will prepare the Draft Evaluation Design Update to address the new evaluation Domains of Focus and the new evaluation requirements in STC #110. The update will be submitted to Federal CMS by October 11, 2013, as required by STC #110. The Agency will be working with UF to complete reports related to domains i and ii and domain iii. FIU will begin preparing to interview health plan compliance staff regarding their fraud and abuse policies and activities.

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J. Policy and Administrative Issues

Overview

During Demonstration Year Seven, the Agency continued to address policy, administrative and operational issues with health plans through the following main processes:

- Technical Advisory Panel regular meetings,
- Policy transmittals and "Dear Provider" letters and e-mails,
- Health Plan Technical and Operational Issues conference calls,
- PSN Systems Implementation monthly conference calls,
- General amendment/contract overview calls and meetings, and
- Fraud and abuse meetings.

Overall, these forums provided excellent opportunity for discussion and collecting feedback on proposed processes, implementation issues, and communicating finalized policy in documented products. The quarterly progress reports provide detail of issues covered during Demonstration Year Seven. This section of the annual report provides the highlights of key issues addressed during Demonstration Year Seven.

Demonstration Year Seven at a Glance

Medicaid Reform Technical Advisory Panel

The TAP was created by the 2005 Florida Legislature, and appointed by the Agency with the directive of advising the Agency on various implementation issues relative to the demonstration. During Demonstration Year Seven, the Medicaid Reform Technical Advisory Panel (TAP) held two meetings on the following dates:

- November 19, 2012
- January 30, 2013

This year the meetings centered on rate development, encounter data, Medicaid Reform evaluation and on the MMA program enacted into law by the 2011 Florida Legislature (including updates on waiver amendment and approval).

The TAP continued to be helpful through its provider and plan insight – ensuring Agency processes and procedures were well thought out and properly vetted.

Policy Transmittals and "Dear Provider" Letters

Policy transmittals and "Dear Provider" letters and e-mails are used to send key policy and operational information to health plans.

During Demonstration Year Seven, the Agency released six policy transmittals and several "Dear Provider" letters/emails to the health plans. The policy transmittals were operational in nature as processes have become stabilized in the demonstration counties. The major issues addressed in the various policy transmittals and "Dear Provider" letters/emails are summarized below:

- Health plan requirements to pay certain physicians who provide Florida Medicaid-covered eligible primary care services in accordance with the Affordable Care Act (ACA) and 42 CFR sections 438 and 447, for the period January 1, 2013 through December 31, 2014, and advising health plans that such requirements are being added to their contract.
- Information on 2012 Florida-legislated limits being implemented on home health visits and general office visits, and information regarding how health plans could expand their benefits beyond these state limits.
- Ad hoc encounter data request related to child health check-up program services.
- Changes in submittal and processing requirements for certain inpatient hospital claims and outpatient hospital claims.
- Information regarding the ACA requirements that prohibit payments for provider-preventable conditions (PPCs); the identification and reporting of PPCs, including payments expended in facility settings for such services and encounter data requirements; and provider subcontract requirements.
- Provision of performance measures due to the Agency, specifications for such measures and HEDIS national means and percentiles that will be used as the performance benchmark for each measure.
- Health Plan Report Guide quarterly changes for the September 1, 2012 through August 31, 2013 contract year.
- Updated Plan Evaluation Tool (PET) and/or benefit request submission deadlines/extensions and capitation rate development information for the September 1, 2012 through August 31, 2013 contract period and the September 1, 2013 through August 31, 2014 contract period, respectively.
- General information regarding the 5010 X12 companion guide postings, provider mass registration and encounter data updates.
- Technical information to FFS health plans regarding paper claims processing.
- Notices regarding the final draft 2012-2015 Medicaid Health Plan Model Contract.

Health Plan Technical and Operational Issues Conference Calls

These conference calls are used to communicate the Agency's response to issues addressed at a higher level in the TAP meetings and to respond to plan questions posed through e-mail, telephone inquiries and previous technical calls. Previously, these calls occurred biweekly, but with the demonstration being fully operational, the need for biweekly calls has significantly lessened. As discussed with the health plans in June 2010, a decision was made to change to monthly calls beginning in July 2010. Unless a particular need arises for calls to occur more often, the Technical and Operational Issues conference calls are now monthly.

All health plans are invited to participate, whether they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Register to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of the demonstration and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers, and health plan subcontractors.

The Agency conducted 10 Technical and Operational Issues Conference Calls with health plans and health plan applicants between July 1, 2012 and June 30, 2013. Demonstration Year Seven saw an increase in call participation. Approximately 20 participants attended in person

and the popularity of these calls was shown by over 150 phone lines in active use on the calls during the last quarter. Agenda topics that have appeared on most calls include updates on Medicaid encounter data submissions, fraud and abuse, review of policy transmittals and "Dear Provider" letters (see Policy Transmittals and "Dear Provider" Letters above).

Other agenda items included:

- Updates on the Medicaid electronic health record incentive program and direct secure messaging;
- Updates on registering providers in Medicaid;
- Update on Universal Health Care, Inc., transition of enrollment;
- State legislative updates; and
- Contract updates, including September 2012 and 2013 rate and benefit amendment timelines, databook, fine-tuning amendment timelines, and quarterly updates in the Health Plan Report Guide.

Feedback from call participants indicates that the calls are well-received, a good forum for discussion of technical and operational issues, and an avenue for quick discussion and feedback on identified operational issues.

PSN Systems Implementation Monthly Conference Calls

As a result of the newness of the PSNs and their third party administrators in processing claims through the Medicaid Fiscal Agent claims process, the Agency determined that additional resources were needed to assist the PSNs with systems issues, and implemented special, biweekly, technical assistance calls for the PSNs. While these calls started out as biweekly in Demonstration Year One, they became monthly in Demonstration Year Two and continued to occur in several months in Demonstration Year Seven. The purpose of these calls was to provide a forum to discuss claims processes and enrollment file issues that were unique to the FFS PSN model.

During these conference calls, the Agency and the PSNs discussed and, as appropriate, resolved claims processing and enrollment file transmittal questions and issues. The PSNs were encouraged to submit questions and/or issues in advance in order for systems research to occur internally at the Agency (or between the Agency and the Agency's Medicaid Fiscal Agent). Agency participants included management and technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Contract Management Bureau, Medicaid Area Office staff and Bureau of Managed Health Care staff responsible for monitoring the health plans. PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions as well as key staff at the PSNs-contracted TPAs.

Of over 150 issues brought up through these system issues calls, during Demonstration Year Seven, there were no new issues opened. By the end of Demonstration Year Seven, only four issues remained as unresolved. Those unresolved are waiting for prioritization in order for those systems changes to occur. Where available, manual workarounds were implemented to address these issues.

A summary of key items addressed during Demonstration Year Seven included the following:

- Revisions to the PSNs' electronic remittance voucher to ensure inclusion of final claims adjustments and additional supplemental files provided until remittance voucher changes can be made.
- Correcting dental claim processing issues related to non-Reform systems programming.

In addition to these calls, the Agency continued to coordinate technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, it has been needed only with a few providers.

General Amendment/Contract Overview/Training Calls/Webinars and Meetings

During Demonstration Year Seven, several conference calls/meetings were held with health plans regarding the following:

- Behavioral health issues, including national outcome measures, assisted living facility issues, court-ordered inpatient admissions, emergency admissions and transition of service authorizations.
- Provider preventable conditions and how these are treated under Florida FFS Medicaid.
- Health plan contract requirements for fraud and abuse prevention and training on the critical need for health plan involvement in the fight against fraud, waste and abuse in Medicaid.
- Managed care implementation of the ACA primary care services fee increase.

These calls provided the Agency with an opportunity to provide overviews of upcoming amendments, contract changes and current processes and provided forums for health plans to provide feedback on the topics being discussed.

Fraud and Abuse Meetings

During Demonstration Year Six, the Agency began holding quarterly meetings on fraud and abuse initiatives; these meetings were well attended. In Demonstration Year Seven, these quarterly meetings continued and almost all plans continually attended. Attendance increased during Demonstration Year Seven with over 60 persons attending each meeting. To help ensure health plan attendance, the meetings were held either in Tallahassee or at south/central Florida locations. The fraud and abuse meetings included the following:

- Government agencies sharing about processes that are integral to the health plans' anti-fraud efforts,
- Presentations by the Agency on current program integrity projects, Medicaid Health Plan Contract provisions and reporting requirements;
- Health plans sharing concerns or needs about more effectively addressing fraud, and
- Health plan best practices regarding fraud schemes seen or anticipated, and discussion on how best to address them (prevention, detection, investigation, enforcement, and prosecution).

Attachment I
2008 – 2012 Managed Care Performance Measures

	Non-Reform Plans*						Reform Plans*						
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**Trend**	**2008**	**2009**	**2010**	**2011**	**2012**	**Trend**	**National Mean****
Annual Dental Visit***	n/a	n/a	n/a	16.1%	17.6%	increase	15.2%	28.5%	33.4%	34.0%	35.3%	increase	45.8%
Adolescent Well-Care	41.9%	46.0%	45.7%	49.2%	48.2%	drop	44.2%	46.5%	46.3%	46.2%	47.6%	increase	49.7%
Controlling Blood Pressure	52.7%	51.6%	53.0%	54.3%	51.5%	flat	46.3%	55.9%	53.4%	46.3%	52.9%	increase	56.8%
Cervical Cancer Screening	56.6%	53.8%	55.3%	55.6%	55.0%	flat	48.2%	52.2%	50.8%	53.2%	56.8%	increase	66.6%
Diabetes - HbA1c Testing	74.7%	75.1%	76.4%	79.6%	77.3%	drop	78.9%	80.1%	82.8%	81.9%	82.2%	flat	82.4%
Diabetes - HbA1c Poor Control (INVERSE)	48.5%	51.7%	46.4%	42.5%	46.6%	drop	48.3%	46.8%	44.9%	48.6%	43.6%	increase	43.2%
Diabetes - HbA1c Good Control	31.7%	41.4%	44.6%	49.6%	45.5%	drop	32.2%	48.0%	47.5%	43.7%	47.9%	increase	48.0%
Diabetes - Eye Exam	36.3%	41.9%	48.3%	52.1%	45.2%	drop	35.7%	44.0%	45.4%	49.3%	50.2%	flat	53.2%
Diabetes - LDL Screening	75.6%	76.3%	77.9%	80.0%	77.4%	drop	80.0%	80.2%	83.5%	81.8%	81.9%	flat	74.9%
Diabetes - LDL Control	29.5%	29.4%	33.8%	32.8%	34.2%	increase	29.3%	35.5%	36.1%	36.9%	37.8%	flat	35.2%
Diabetes - Nephropathy	77.1%	76.1%	77.1%	79.0%	77.7%	drop	79.2%	80.3%	81.9%	83.1%	82.3%	flat	77.8%
Follow-up after Hospitalization for Mental Illness - 7 day	30.5%	37.0%	24.2%	28.4%	37.5%	increase	20.6%	29.3%	25.4%	23.1%	22.7%	flat	46.5%
Follow-up after Hospitalization for Mental Illness - 30 day	47.0%	51.9%	41.4%	47.9%	56.5%	increase	35.5%	46.6%	41.3%	44.3%	41.2%	drop	65.0%
Prenatal Care	71.7%	69.1%	69.5%	71.7%	73.1%	increase	66.6%	67.4%	75.2%	68.4%	72.1%	increase	82.7%
Postpartum Care	58.5%	50.1%	52.7%	54.6%	51.8%	drop	53.0%	51.5%	52.1%	49.3%	52.9%	increase	64.1%
Well-Child First 15 Months. - 0 Visits (INVERSE)	2.8%	3.0%	4.2%	3.3%	3.2%	flat	4.9%	1.6%	6.0%	3.0%	2.1%	increase	2.0%
Well-Child First 15 Mos. - 6(+) Visits	44.0%	51.0%	46.1%	51.2%	56.2%	increase	44.4%	49.3%	35.4%	46.5%	58.4%	increase	61.7%
Well-Child 3-6 Years	71.1%	72.5%	74.9%	74.8%	75.6%	flat	71.3%	75.7%	72.7%	75.0%	75.5%	flat	71.9%
Adults' Access to Preventive Care - 20-44 Years	n/a	69.1%	67.9%	68.1%	66.2%	drop	n/a	71.8%	71.2%	71.2%	69.8%	drop	79.9%
Adults' Access to Preventive Care - 45-64 Years	n/a	82.2%	81.2%	81.5%	80.5%	drop	n/a	84.7%	84.9%	85.5%	84.9%	flat	85.9%
Adults' Access to Preventive Care - 65+ Years	n/a	74.7%	66.9%	69.9%	64.1%	drop	n/a	83.6%	83.7%	84.2%	73.9%	drop	83.3%

Measure	Non-Reform Plans*						Reform Plans*						National Mean**
	2008	2009	2010	2011	2012	Trend	2008	2009	2010	2011	2012	Trend	
Adults' Access to Preventive Care - total	n/a	73.7%	71.5%	71.9%	69.9%	drop	n/a	77.2%	77.6%	77.0%	75.0%	drop	81.8%
Antidepressant Medication Mgmt - Acute	n/a	45.6%	46.8%	47.0%	50.4%	increase	n/a	52.0%	56.3%	56.3%	57.4%	increase	51.1%
Antidepressant Medication Mgmt - Continuation	n/a	31.2%	29.2%	31.4%	33.6%	increase	n/a	29.8%	43.8%	44.0%	43.1%	flat	34.4%
Appropriate Medications for Asthma****	n/a	87.0%	87.0%	86.6%	82.1%	drop	n/a	83.6%	87.6%	86.0%	81.1%	drop	85.0%
Breast Cancer Screening	n/a	47.5%	50.1%	50.9%	50.1%	flat	n/a	51.4%	56.9%	59.2%	52.3%	drop	50.4%
Childhood Immunization Combo 2	n/a	61.8%	71.4%	73.8%	79.1%	increase	n/a	63.6%	70.0%	74.0%	74.8%	flat	74.5%
Childhood Immunization Combo 3	n/a	52.0%	63.7%	67.6%	72.8%	increase	n/a	53.8%	62.7%	66.9%	69.2%	increase	70.7%
Frequency of Prenatal Care	n/a	51.6%	54.3%	60.6%	60.2%	flat	n/a	52.6%	46.9%	44.0%	54.4%	increase	60.9%
Lead Screening in Children	n/a	46.0%	53.1%	53.5%	59.5%	increase	n/a	54.8%	52.0%	54.1%	59.6%	increase	67.7%
Adult BMI Assessment	n/a	n/a	31.2%	48.3%	58.6%	increase	n/a	n/a	41.9%	52.7%	47.9%	drop	52.6%
Follow-up Care for Children Prescribed ADHD Medication - Initiation	n/a	n/a	37.8%	37.1%	40.8%	increase	n/a	n/a	43.6%	44.5%	44.4%	flat	38.8%
Follow-up Care for Children Prescribed ADHD Medication - Continuation*****	n/a	n/a	46.6%	46.7%	54.8%	increase	n/a	n/a	n/a	n/a	n/a	N/A	45.9%
Immunizations for Adolescents Combo 1	n/a	n/a	43.9%	50.2%	56.1%	increase	n/a	n/a	44.1%	43.6%	47.3%	increase	60.4%

* Data are submitted to the Agency by HMOs and PSNs and are audited by NCQA-certified HEDIS auditors. Data do not include Medicaid FFS or MediPass. Each rate presented for Non-Reform (and for Reform) is the weighted mean across Non-Reform (and Reform) health plans, weighted by the number of eligible members each plan has per measure.

** National Mean as published by NCQA, Medicaid product line. The National Mean that is presented is the National Mean for 2012.

*** Annual Dental Visits - only seven of 21 Non-Reform plans cover dental services. Only six of the plans had sufficient denominators to report on this measure in 2012.

**** The specifications for the Appropriate Medications for People with Asthma measure changed this year; therefore, it may not be appropriate to compare results reported in 2012 to prior years.

*****Follow-up Care for Children Prescribed ADHD Medication - Continuation: only three of the 13 Reform plans had sufficient eligible members to report this measure; therefore, no weighted mean has been calculated.

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