Florida Managed Medical Assistance Program

1115 Research and Demonstration Waiver

Final Annual Report
Demonstration Year 8
July 1, 2013 – June 30, 2014

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I. Waiver History

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

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

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

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

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

On July 31, 2014, CMS granted a three-year extension of the waiver. The Low Income Pool supplemental payment authority was extended through June 30, 2015. Please refer to Section VII, Waiver Extension Request, of this report for more information on the approved waiver extension request.

Annual Report Requirement

The quarterly and annual reporting requirements for the waiver are specified in Special Terms and Conditions (STCs) #90 and #91 of the waiver. The state is required to submit quarterly and annual reports summarizing the events occurred or anticipated to occur in the near future that affect health care delivery, including, but not limited to, approval and contracting with new health plans, specifying coverage area, populations served, benefits, enrollment, and other operational issues as found in this report.

This report is the final annual report for Demonstration Year Eight (DY8) covering the period of July 1, 2013 – June 30, 2014. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and annual reports, which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/federal.shtml.

Please note, the Medicaid Reform program was phased out during the fourth quarter of DY8 as the Agency for Health Care Administration (Agency) began implementation of the MMA program in Baker, Clay, Duval, and Nassau counties (Region 4) on May 1, 2014 and Broward County (Region 10) on July 1, 2014. Therefore, this annual report concludes reporting of the Medicaid Reform program in the annual reports.

II. Operational Update

A. Managed Medical Assistance Program

1. Implementation Activities

On May 1, 2014, the Agency began implementation of the MMA program in Regions 2, 3 and 4. The Agency is coordinating with the contracted MMA plans and the Agency's choice counseling vendor to create a transition to ensure that the volume of recipients being transitioned occurs in an organized manner. The following tables provide the phased implementation schedule for the MMA program and the MMA program regions established under Part IV of Chapter 409, F.S.

MMA Implementation Schedule		
Regions	**Enrollment Date**	**Status**
2, 3 and 4	May 1, 2014	Completed
5, 6 and 8	June 1, 2014	Completed
10 and 11	July 1, 2014	On Schedule
1, 7 and 9	August 1, 2014	On Schedule

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

a) Comprehensive Outreach and Education Strategy

A detailed description of the Agency's comprehensive outreach and education strategy for the MMA program is provided in the MMA Implementation Plan, available on the Agency's website at: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_archive.shtml. The comprehensive outreach schedule and activities that occurred during DY8 can be viewed in the second, third and fourth quarter reports of DY8, available on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

b) Medicare-Medicaid Eligible Enrollees

Please note, Medicare-Medicaid eligible enrollees who are enrolled in a Medicare Advantage plan will participate in an open enrollment period that coincides with the Medicare open enrollment period (October 15 through December 7) to facilitate enrollees' choice of Medicare and Medicaid managed care plans. MMA coverage will begin on January 1, 2015 for enrollees in both Medicare and Medicaid managed care plans. The Agency continues to seek technical assistance from the CMS Medicare-Medicaid Coordination Office to promote alignment and integration with Medicare for Medicare-Medicaid eligible individuals in the MMA program.

2. Health Plan Delivery System

The following provides a summary for DY8 on health care delivery system activities for managed care plan contracting; benefit packages; plan readiness review and monitoring; health plan reported complaints, grievances and appeals; and Agency-received complaints/issues.

a) Managed Care Plan Contracting

During DY8, from January 2014 through March 2014, the Agency finalized contracts for the second phase of its Statewide Medicaid Managed Care (SMMC) program, the MMA component. MMA contracts were executed with the MMA plans on February 6, 2014. Many MMA plans signed new contracts to also provide Long-term Care (LTC) services. The Agency also identified transitional reporting requirements for the managed care plans and updated its SMMC Report Guide to include new reporting requirements.

Table 1 lists the contracted managed care organizations for the MMA program. MMA plans that began providing services during DY8 can be viewed in the fourth quarter report of DY8 on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

Table 1
MMA Plans

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

*This MMA plan is contracted to provide specialized services.
**This MMA plan is also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.
***Sunshine Health is contracted to provide specialized services and is also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.

The Agency finalized a SMMC general contract amendment, effective June 1, 2014, which incorporated corrections and changes to the SMMC contracts. The general amendment applied to the LTC plans, MMA plans and the MMA plans that are also contracted to provide LTC services. A copy of the model contract can be viewed on the Agency's website at: http://ahca.myflorida.com/SMMC.

During DY8, there were three contract interpretations, seven policy transmittals, and six "Dear Provider" letters sent to the managed care plans.

- The three contract interpretations advised managed care plans of the following topics: guidance on the enhanced standards specifically related to claims and provider payment, enrollee services, and utilization management that were negotiated as part of the MMA Invitation to Negotiate process and their applicability to the LTC program; and guidance on the development of contracts with the Florida Medical School Quality Network.

- The seven policy transmittals advised managed care plans of the following topics: changes and guidance related to performance measures and other quality management-related contract requirements; the provision of hospice and curative care; reporting for enrollees diagnosed with HIV/AIDS; performance measures for monitoring nursing facilities; the new Freedom of Choice reporting requirement related to enrollees in the Home and Community Based Services Waiver; and processes for retroactive changes to nursing home per diems.

- The six "Dear Provider" letters advised managed care plans of the following topics: expansion of the Type of Bill codes that are valid for nursing facility providers, effective February 11, 2014; the ability of providers (including hospitals) located in Georgia and Alabama (within 50 miles of the Florida state line) that regularly provide services to Florida Medicaid recipients to enroll with Florida Medicaid and contract with managed care plans as in-state providers; the state law requirement that MMA plans offer all home medical equipment and supplies providers a network contract if they meet certain criteria; a guide developed by the Agency for billing services using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model; the use of additional behavioral health codes as downward substitutions for services in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook; and information about the implementation of a Community High Risk Pool (CHRP) in the SMMC LTC program.

b) Benefit Packages

In addition to the expanded benefits available under the MMA program that are listed in Attachment I of this report, the MMA plans will provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid Coverage and Limitations Handbooks, and the Florida Medicaid fee schedules. The table below lists the 28 standard benefits that will be provided under the MMA contracts that were executed by the MMA plans:

Required MMA Services	
(1)	Advanced Registered Nurse Practitioner
(2)	Ambulatory Surgical Center Services
(3)	Assistive Care Services
(4)	Behavioral Health Services
(5)	Birth Center and Licensed Midwife Services
(6)	Clinic Services
(7)	Chiropractic Services
(8)	Dental Services
(9)	Child Health Check Up
(10)	Immunizations

Required MMA Services	
(11)	Emergency Services
(12)	Emergency Behavioral Health Services
(13)	Family Planning Services and Supplies
(14)	Healthy Start Services
(15)	Hearing Services
(16)	Home Health Services and Nursing Care
(17)	Hospice Services
(18)	Hospital Services
(19)	Laboratory and Imaging Services
(20)	Medical Supplies, Equipment, Protheses and Orthoses
(21)	Optometric and Vision Services
(22)	Physician Assistant Services
(23)	Podiatric Services
(24)	Practitioner Services
(25)	Prescribed Drug Services
(26)	Renal Dialysis Services
(27)	Therapy Services
(28)	Transportation Services

c) Plan Readiness Review and Monitoring

During DY8, the Agency selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies through a competitive procurement process to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe mental illness, and dual eligibles with chronic conditions.

In March 2014, the Agency completed the process of conducting a readiness review of MMA plans. All MMA plans were required to submit requested readiness documents in order for the Agency to complete a thorough desk review of identified key areas before the MMA plans began providing services on May 1, 2014. As of June 30, 2014, the Agency has received responses to the readiness review request for 17 of 18 MMA plans. The Agency has also completed desk reviews and on-site reviews for 17 of 18 MMA plans as shown in Table 2. The only MMA plan that has not completed the readiness process is Freedom Health, which isn't scheduled to "Go Live" until January 2015. Furthermore, the Agency holds weekly calls with all MMA plans, and continues to monitor the MMA plans on a daily basis as the SMMC program rolls out statewide.

Table 2
MMA Plan Readiness Review

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

Table 2 MMA Plan Readiness Review				
MMA Plan	**Readiness Review Request Sent**	**Readiness Review Response Received**	**Desk Review Complete**	**Onsite Review Complete**
8. **Humana**	X	X	X	X
9. **Integral**	X	X	X	X
10. **Magellan**	X	X	X	X
11. **Molina**	X	X	X	X
12. **Preferred**	X	X	X	X
13. **Prestige**	X	X	X	X
14. **SFCCN**	X	X	X	X
15. **Simply**	X	X	X	X
16. **Staywell**	X	X	X	X
17. **Sunshine**	X	X	X	X
18. **United**	X	X	X	X

d) Health Plan Reported Complaints, Grievances and Appeals

During the fourth quarter of DY8, the Agency began implementation of the MMA program in Regions 2, 3 and 4; therefore, only one quarter of MMA health plan reported complaints, grievances and appeals, Medicaid Fair Hearings (MFHs) requested and held, and requests submitted to the Beneficiary Assistance Panel (BAP) are available for DY8. This information can be viewed in the fourth quarter report for DY8, available on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

e) Agency-Received Complaints/Issues

As noted above, only one quarter of Agency-received complaints/issues is available for DY8 and can be viewed in the fourth quarter report for DY8 on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

3. Enrollment Data

As noted above, only one quarter of MMA enrollment data is available for DY8 and can be viewed in the fourth quarter report for DY8 on the Agency's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

4. Choice Counseling Program

The following provides a summary for DY8 on choice counseling program activities for the call center, self-selection rate and auto assignments.

a) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During DY8,

the call center had an average of 240.5 full time equivalent employees who can answer calls in English, Spanish and Haitian Creole.

The choice counseling call center received 620,823 calls during DY8, which remains within the anticipated call volume. Table 3 provides the call volume for DY8. Please note, first and second quarter data is not provided since recipient outreach for the MMA program began during the third quarter of DY8.

Table 3
Call Volume for Incoming and Outgoing Calls
(January 1, 2014 – June 30, 2014)

Type of Calls	3rd Quarter	4th Quarter	Total
Incoming Calls	68,839	551,984	620,823
Outgoing Calls	0	33,052	33,052

b) Self-Selection and Auto Assignment Rates

From August 2013 to June 2014, 35% of recipients enrolled in the demonstration self-selected a health plan and 65% were auto-assigned. Table 4 provides the current self-selection and auto-assignment rate for DY8. Please note, first and second quarter data is not provided since recipient choice counseling for the MMA program began during the third quarter of DY8.

Table 4
Self-Selection and Auto-Assignment Rate*
(January 1, 2014 – June 30, 2014)

	3rd Quarter	4th Quarter	Total
Self-Selected	16,576	750,797	767,373
Auto-Assignment	28,182	1,415,723	1,443,905
Total Enrollments	44,758	2,166,520	2,211,278
Self-Selected %	37%	35%	35%
Auto-Assignment %	63%	65%	65%

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

5. Quality

The following provides a summary for DY8 on quality activities for the External Quality Review Organization (EQRO) and health plan performance measure reporting.

a) EQRO

In January 2014, Health Services Advisory Group (HSAG), the state's EQRO, held an onsite quarterly meeting for the managed care plans, Agency staff, and sister agency staff. HSAG also held two quarterly webinars in March, one for the LTC plans and one for MMA plans, in which HSAG staff presented information on the Plan-Do-Study-Act cycle and how this approach

may be used to improve the managed care plans' Performance Improvement Projects (PIPs). During the webinar for MMA plans, HSAG shared the proposed methodologies for indicators for the statewide PIPs related to preventive dental care for children and prenatal care/well-child visits in the first 15 months of life.

During the third quarter of DY8, HSAG completed the Performance Measure Validation Report, and during the fourth quarter, HSAG completed the Annual Technical Report and the PIP Validation Summary Report. The Agency submitted the Technical Report to CMS on April 8, 2014.

On May 20, 2014, HSAG conducted an on-site quarterly meeting with the managed care plans, Agency staff, and sister agency staff in Tallahassee, Florida. Presentations were given by the Florida Department of Health on the following topics: Improving Asthma Outcomes, the Diabetes Prevention Change Program, and Diabetes Self-Management Education. Agency staff gave a presentation on the Event Notification Service, which offers participating managed care plans an opportunity to receive alerts when members receive services in an emergency department or are admitted to an inpatient hospital setting. HSAG's PIP coordinator provided a presentation on HSAG's redesigned PIP summary forms. On May 20th and 21st, HSAG conducted one-on-one PIP technical assistance sessions with each managed care plan that requested one.

In mid-June, HSAG submitted the first draft of the annual Encounter Data Validation Study related to the review of the Agency's and its contracted managed care plans' information systems. Agency staff reviewed the report and sent feedback to HSAG at the end of June, and this report will be finalized in the first quarter of DY9.

b) Plan Performance Measure Reporting

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

In addition to updating the performance measures for MMA plans, the Agency's February policy transmittal included some revisions to performance measures for the Child Welfare Specialty Plan and the HIV/AIDS Specialty Plans. Due to the Child Welfare Specialty Plan serving children under the age of 21 years, the MMA performance measures that are specifically for those Medicaid enrollees ages 18 and older have been removed from reporting requirements.

The Child Welfare Specialty Plan contract requires the reporting of three measures related to the use of antipsychotic medications, but these measures will not be required until the final technical specifications have been released. The National Committee for Quality Assurance

(NCQA) included two of the three measures in its proposed changes for HEDIS 2015 that were available for public comment. These two measures will be included in reporting if they are adopted for HEDIS 2015.

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

During the fourth quarter of DY8, Agency staff began updating the Performance Measure Specifications Manuals for the LTC and MMA plans. In the past the Agency's specifications manual has only included Agency-defined measures, as all other required performance measures were the National Committee for Quality Assurance's HEDIS measures. Due to the inclusion of non-HEDIS measures from the Adult and Child Core Sets of measures, as well as several Health Resources and Services Administration – HIV/AIDS Bureau measures, the Performance Measure Specifications Manuals now include a list of all the required performance measures, with links to the technical specifications for non-HEDIS, non-Agency-defined measures. The updated Performance Measure Specifications Manuals for July 1, 2015 reporting will be provided to the LTC and MMA plans during the first quarter of DY9.

c) Comprehensive Quality Strategy

During DY8, the Agency transitioned to the SMMC program from a variety of health care delivery systems, allowing the state to focus on better coordination and quality of services for all enrollees. This transition has been accompanied by a shift to a greater emphasis on quality improvement and quality measurement, and further opportunities to achieve the goals of CMS' Three-Part Aim: improving population health; improving enrollee experiences with care; and reducing per-capita costs. As part of the transition to managing and monitoring the SMMC program, the Agency is establishing a new Bureau of Medicaid Quality, which is aimed at providing data-driven, focused, and systematic feedback to managed care plan contract managers and policy staff, and recommending measurable ways to improve managed care plans' quality of service delivery and outcomes for Medicaid recipients. This bureau will also have oversight responsibility for the fee-for-service program, allowing more opportunities for a cohesive quality strategy across managed care and fee-for-service programs.

Over the past year, the state has continued to use performance measures reported by its managed care plans and as part of the state's Children's Health Insurance Program Reauthorization Act (CHIPRA) Grant to identify areas in need of improvement throughout the Florida Medicaid program. These performance measures include NCQA HEDIS measures, CHIPRA Child Core Set measures, CMS Medicaid Adult Core Set measures, and state-defined measures. In addition to performance measures previously reported by managed care plans, the state has added several of the CMS Medicaid Adult Core Set measures to the reporting requirements for MMA plans, including Annual Monitoring for Patients on Persistent Medications, Plan All-Cause Readmission, Antenatal Steroids, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. The MMA plans will submit their first performance measure report including these measures by July 1, 2015. It should be noted that specialty plans will be reporting on additional measures that are relevant to the populations they serve. For example, the Child Welfare Specialty Plan and the plan for children with chronic conditions will not be reporting on the adult-only performance measures, but will be reporting on several additional performance measures related to children's health care. Based on past performance by the health plans, the state identified and was given support by CMS to require MMA plans to conduct Performance Improvement Projects (PIPs) related to Preventive Dental Care for Children and Prenatal Care and Well-Child Visits in the First 15 Months of Life. The

MMA plans will be submitting the proposals for these PIPs to the Agency and the EQRO by August 1, 2014.

For additional details regarding the managed care plans' performance measure results, see Section II.B, Objective 3a, of this report regarding improving enrollee outcomes. More information regarding the state's progress with its Comprehensive Quality Strategy and next steps is included in the updated Comprehensive Quality Strategy that will be submitted to CMS in October 2014 of DY9.

6. Policy and Administrative Issues

The Agency continues to identify and resolve various operational issues for the managed care plans. The Agency's internal and external communication processes play a key role in managing and resolving issues effectively and efficiently. These forums provide an opportunity for discussion and feedback on proposed processes, and provide finalized policy in the form of "Dear Provider" letters and policy transmittals to the managed care plans. The following provides a summary for DY8 on these forums as the Agency continues its initiatives on process and program improvement.

a) Weekly "All Plan Call" and Individual Calls with Managed Care Plans

The Agency replaced the Technical and Operational Issues conference call with a weekly call with all managed care plans. This call takes place every Friday, and participation is required by all MMA plans. Additionally, an individual call is held with each managed care plan on a weekly basis to discuss operational issues and any other pressing issues for the week.

b) Fraud and Abuse Meetings

In an effort to reduce the amount of fraud and abuse in the Medicaid program, the Agency meets with the SIUs/Compliance Officers of each managed care plan on a quarterly basis. These meetings are held throughout the state, and attendance is mandatory for each of the health plans. During these meetings, a wide variety of topics are discussed which includes, but is not limited to, trainings, discussions about current initiatives (both by the Agency and the managed care plans), discussions about best practices, and discussions about current investigations being conducted by the plans. During DY8, the Agency held 4 meetings with an average attendance of 71 people.

B. Medicaid Reform

Please note, the Medicaid Reform program was phased out during the fourth quarter of DY8 as the Agency began implementation of the MMA program in Baker, Clay, Duval, and Nassau counties (Region 4) on May 1, 2014 and Broward County (Region 10) on July 1, 2014. Therefore, this annual report concludes reporting of the Medicaid Reform program in the annual reports.

1. Health Plan Delivery System

The following provides a summary for DY8 on activities related to the health care delivery system for health plan contracting, benefit packages, health plan reported complaints, grievances and appeals, Agency-received complaints, grievances and appeals, medical loss ratio, and on-site surveys and desk reviews.

a) Health Plan Contracting

Health Plan Applications and Expansion Requests

Since the implementation of the Reform demonstration, the Agency received 29 Reform 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. The listing of Reform health plan applicants and contracts since the implementation of the Reform demonstration can be viewed in the second quarter report of DY8 on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/quarterly.shtml.

After the first quarter of DY8, health plan application and expansion requests were not processed through the implementation of the MMA program.

Health Plan Capacity

Health plan capacity was monitored on an ongoing basis during DY8 to ensure recipients had a choice of at least two health plans in each Reform demonstration county. Please refer to Attachment II, Medicaid Reform Enrollment Report, of this report for a listing of the Reform health plans by county that operated during DY8.

b) Benefit Packages

The customized benefit packages became operational on January 1, 2013 and remained valid through the implementation of the MMA program, effectively overlapping DY7 and DY8. To view the customized benefit packages, please refer to the second quarter report of Demonstration Year Eight at the link provided above.

Expanded Services

During DY8, all of the capitated Reform health plans offered expanded or additional benefits that were not previously covered by the state under the Medicaid State Plan in order to meet the

needs of new enrollees. The following is a list of the expanded services offered by the capitated Reform health plans of which the over-the-counter drug benefits and adult preventive benefits were the most frequently offered:

- Over-the-counter drug benefit – $25 per household per month
- Adult preventive dental
- Circumcisions for male newborns
- Additional adult vision
- Nutritional counseling.

Plan Evaluation Tool

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

c) Health Plan Reported Complaints, Grievances and Appeals

Health Plan Reported Complaints

Table 5 provides the number of complaints reported by health plan type during DY8.

Table 5 **Reform Health Plan Reported Complaints** (July 1, 2013 – June 30, 2014)		
Demonstration Period	**HMO**	**PSN**
July 1, 2013 – September 30, 2013	379	157
October 1, 2013 – December 31, 2013	357	131
January 1, 2014 – March 31, 2014	1,037	173
April 1, 2014 – June 30, 2014	760	34
Total	**2,533**	**495**

Grievances and Appeals

Table 6 provides the number of grievances and appeals by health plan type for DY8.

Table 6 **Reform Grievances and Appeals** (July 1, 2013 – June 30, 2014)				
Demonstration Period	**HMO Grievances**	**HMO Appeals**	**PSN Grievances**	**PSN Appeals**
July 1, 2013 – September 30, 2013	264	101	17	91
October 1, 2013 – December 31, 2013	233	118	18	69
January 1, 2014 – March 31, 2014	330	194	30	75
April 1, 2014 – June 30, 2014	228	110	32	24
Total	**1,055**	**523**	**97**	**259**

Medicaid Fair Hearing (MFH)

Table 7 provides the number of MFHs requested and held during DY8. There were a total of 42 MFHs requested this demonstration year, of which 10 were for HMOs and 12 for PSNs. In regards to outcomes; four of the MFHs held received mixed results in favor of the plan and the member, six of the hearings were in favor of the plan, two of the hearings were in favor of the recipient and the other issues are pending a result.

Table 7
Reform Medicaid Fair Hearings Requested and Medicaid Fair Hearings Held
(July 1, 2013 – June 30, 2014)

Demonstration Period	MFHs Requested	MFHs Held
July 1, 2013 – September 30, 2013	5	2
October 1, 2013 – December 31, 2013	8	3
January 1, 2014 – March 31, 2014	11	5
April 1, 2014 – June 30, 2014	18	12
Total	**42**	**22**

Beneficiary Assistance Program (BAP)

Table 8 provides the number of requests submitted to the BAP during DY8. The BAP program received no Reform requests in DY8. The BAP did have one Reform PSN case that was received in DY7, but heard and closed in favor of the member in July of DY8.

Table 8
Reform BAP Requests
(July 1, 2013 – June 30, 2014)

Demonstration Period	HMO	PSN
July 1, 2013 – September 30, 2013	0	0
October 1, 2013 – December 31, 2013	0	0
January 1, 2014 – March 31, 2014	0	0
April 1, 2014 – June 30, 2014	0	0
Total	**0**	**0**

d) Agency-Received Complaints/Issues

Table 9 provides the number of complaints/issues the Agency received by type of health plan during DY8. There were no trends discovered in the Agency-received complaints for DY8.

Table 9
Agency-Received Reform Complaints/Issues
(July 1, 2013 – June 30, 2014)

Demonstration Period	HMO	PSN
July 1, 2013 – September 30, 2013	41	19
October 1, 2013 – December 31, 2013	18	8
January 1, 2014 – March 31, 2014	30	14
April 1, 2014 – June 30, 2014	4	4
Total	**93**	**45**

e) Medical Loss Ratio (MLR)

All capitated health plans submitted their MLR reports to the Agency on or before the due date during DY8. The Agency submitted the capitated health plan's MLR results to CMS according to the schedule outlined in Table 11, Health Plan Medical Loss Ratio Reporting Schedule, of the second quarter report for DY8. For the first quarter report for DY8, one of nine capitated plans reported an MLR under 85% for the reporting period October 1, 2012 through December 31, 2012. For the second quarter report for DY8, three of 11 capitated plans reported MLR below 85% for the reporting period January 1, 2013 through March 31, 2013. For the third quarter report for DY8, all 12 capitated plans reported an MLR above 85% for the reporting period April 1, 2013 through June 30, 2013. For the fourth quarter report for DY8, all twelve capitated plans reported an MLR above 85% for the reporting period July 1, 2013 through September 30, 2013.

f) On-Site Surveys and Desk Reviews

With the implementation of the MMA program, the Agency did not conduct on-site surveys of the Reform health plans during DY8. The Agency conducted desk reviews of health plan provider networks for adequacy; review financial reports; review medical, behavioral health, and fraud and abuse policies and procedures; and review and approve performance improvement projects, quality improvement plans, disease management programs, member and provider materials and handbooks.

2. Enrollment Data

Attachment II provides the annual Reform enrollment for DY8, beginning July 1, 2013 and ending June 30, 2014, and contains the following enrollment reports:

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

All Reform health plans are included in each of the reports. During DY8, there were a total of 15 Reform health plans – 11 HMOs and four FFS PSNs – prior to the implementation of the MMA program. Attachment II shows enrollment numbers decreasing for Baker, Clay, Duval, Nassau and Broward counties due to freezing of new enrollments during the transition process to the MMA program.

3. Choice Counseling Program

The following provides a summary for DY8 on choice counseling program activities for online enrollment, call center and new eligible self-selection data.

a) Online Enrollment

Table 10 located on the following page shows the number of online enrollments for DY8.

Table 10 Online Enrollment Statistics (July 1, 2013 – June 30, 2014)					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Enrollments	2,807	3,035	1,424	0	**7,266**

b) Call Center Activities

The choice counseling call center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The call center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00a.m. – 8:00p.m., and Friday 8:00a.m. – 7:00p.m. During DY8, the call center had an average of 28 full time equivalent employees who can answer calls in English, Spanish and Haitian Creole. The choice counseling call center received 19,033 calls during DY8, which is trending down as expected. Table 11 provides the call volume of incoming and outgoing calls during DY8.

Table 11 Call Volume for Incoming and Outgoing Calls (July 1, 2013 – June 30, 2014)					
Type of Calls	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Incoming Calls	44,425	37,760	31,354	19,033	**132,572**
Outgoing Calls	8,895	8,917	6,790	112	**24,714**

<u>Outbound and Inbound Mail</u>

During DY8, the choice counseling vendor mailed the following:

- New-Eligible Packets (mandatory and voluntary) 47,178
- Confirmation Letters 49,543
- Open Enrollment Packets 119,163
- Transition Packets (mandatory and voluntary) 5,809
- Plan Transfer Letters (mandatory and voluntary) 0

<u>Health Literacy</u>

During DY8, the Special Needs Unit documented and reported on the verbal reviews and referrals as shown in Table 12.

Table 12 Number of Referrals and Case Reviews Completed (July 1, 2013 – June 30, 2014)					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Case Referrals	517	433	704	419	**2,073**
Case Reviews	419	351	396	379	**1,545**

Face-to-Face/Outreach and Education

Table 13 provides the outreach activities that were performed during DY8.

Table 13 Choice Counseling Outreach Activities (July 1, 2013 – June 30, 2014)					
Field Activities	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Group Sessions	127	0	0	0	**127**
Private Sessions	0	4	0	0	**4**
Home Visits and One-On-One Sessions	26	36	8	0	**70**
No Phone List*	0	0	0	0	**0**
Outbound Phone List	31	16	0	0	**47**
Enrollments	1,307	640	97	0	**2,044**
Plan Changes	357	191	738	0	**1,286**

*Attempts made by field choice counselors to contact recipients who do not have a valid phone number in the Health Track System.

The Mental Health Unit

The Mental Health Unit completed the following activities during DY8:

- 33 private sessions for a total of 33 attendees,
- 10 recipient referral calls,
- 1 community partner visit,
- 41 community partner calls, and
- 17 partner staff trainings.

Complaints/Issues

There were no complaints received related to the choice counseling program during DY8.

Quality Improvement

Every recipient who calls the toll-free choice counseling number is provided the opportunity to complete a survey at the end of the call to rank their satisfaction with the choice counseling call center and the overall service provided by the choice counselors. The call center offers the survey to every recipient who calls to enroll in a health plan or to make a health plan change. Table 14 located on the following page shows a list of all questions that are asked during the survey and how recipients ranked their overall satisfaction (represented in percentages) with the choice counseling call center and the overall service provided by the choice counselors. Due to the implementation of the MMA program, the table below reflects survey results only for the months where statistically valid samples were available during DY8.

Table 14 Choice Counseling Caller Satisfaction Results Percentage of Satisfied Callers per Question											
July 2013	*Aug 2013*	*Sept 2013*	*Oct 2013*	*Nov 2013*	*Dec 2013*	*Jan 2014*	*Feb 2014*	*Mar 2014*	*April 2014*	*May 2014*	*June 2014*
How helpful do you find this counseling to be											
90%	92%	92%	90%	90%	92%	NA	NA	NA	NA	NA	NA
Amount of time you waited											
80%	81%	83%	80%	80%	64%	NA	NA	NA	NA	NA	NA
Ease of understanding information											
79%	78%	81%	78%	79%	76%	NA	NA	NA	NA	NA	NA
Likelihood to recommend											
96%	95%	96%	95%	97%	95%	NA	NA	NA	NA	NA	NA
Overall service provided by counselor											
97%	97%	97%	97%	97%	97%	NA	NA	NA	NA	NA	NA
Quickly understood reason											
97%	97%	98%	97%	98%	96%	NA	NA	NA	NA	NA	NA
Ability to help choose plan											
96%	96%	96%	96%	96%	95%	NA	NA	NA	NA	NA	NA
Ability to explain clearly											
95%	97%	96%	96%	96%	96%	NA	NA	NA	NA	NA	NA
Confidence in the information											
96%	97%	95%	95%	96%	95%	NA	NA	NA	NA	NA	NA
Being treated respectfully											
97%	98%	98%	97%	98%	98%	NA	NA	NA	NA	NA	NA

c) New Eligible Self-Selection Data

From July 2010 to June 2014, 66% of recipients enrolled in the demonstration self-selected a health plan and 34% were auto-assigned. Table 15 shows the current self-selection and auto-assignment rate for DY8.

Table 15 Self-Selection and Auto-Assignment Rate* (July 1, 2013 – June 30, 2014)					
	1st Quarter	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Self-Selected	29,622	25,105	13,090	754	68,571
Auto-Assignment	22,861	18,854	7,899	0	49,614
Total Enrollments	52,483	43,959	20,989	754	118,185
Self-Selected %	56%	57%	62%	100%	58%
Auto-Assignment %	44%	43%	38%	0%	42%

* 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.

4. Enhanced Benefits Account Program

The following provides a summary for DY8 on enhanced benefits account program activities for the call center, statistics, advisory panel, and phase-out of the enhanced benefits account program.

a) Call Center Activities

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

The Automated Voice Response System (AVRS) that provides recipients balance-only information handled 98,561 calls during DY8. Table 16 highlights the enhanced benefits call center and mailroom activities during DY8.

Table 16
Highlights of the Enhanced Benefits Call Center Activities
(July 1, 2013 – June 30, 2014)

Enhanced Benefits Call Center Activity	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Calls Received	16,125	12,576	11,179	9,343	49,223
Calls Answered	14,602	11,119	9,648	9,174	44,543
Average Talk Time (minutes)	4:53	5:26	5:24	4:59	5:10
Calls Handled by the AVRS	28,879	28,235	20,328	21,119	98,561
Outbound Calls	37	118	68	19	242
Enhanced Benefits Mailroom Activity					
EB Welcome Letters	35,082	34,184	16,331	459	86,056

Outreach and Education

During DY8, the call center mailed 86,056 welcome letters and the fiscal agent mailed 701,136 coupon statements. The choice counselors continue to provide up-to-date information for recipients regarding their enhanced benefits account balances.

Complaints

Table 17 located on the following page provides a summary of the complaints received and actions taken during DY8.

Table 17 Enhanced Benefits Recipient Complaints (July 1, 2013 – June 30, 2014)		
Quarter	**Recipient Complaint**	**Action Taken**
1st Quarter	**1.** A recipient called about their health plan not reporting a healthy behavior. **2.** A recipient was concerned about a product posting to their EBA account from the pharmacy.	**1.** The Agency contacted the recipient's health plan to have them report the information to the Agency. **2.** The Agency contacted the pharmacy to confirm item was not posted to the recipient account.
2nd Quarter	A recipient called about their health plan not reporting a healthy behavior.	The recipient was contacted and explained the reporting timeline. Health plans report the healthy behavior the month following the occurrence of the activity; the recipient was credited the following month for the behavior.
3rd Quarter	A recipient called about their health plan not reporting healthy behaviors on his behalf.	The Agency worked with the health plan to get the healthy behavior reported. The recipient received credits for the behaviors.
4th Quarter	A recipient called about the customer service she received at the pharmacy regarding her account.	The call center apologized to the recipient and explained the OTC list is updated monthly and products on the OTC list may not available at each pharmacy.

b) Enhanced Benefits Statistics

As of the end of DY8, 14,317 recipients lost EBA eligibility resulting in losing EBA credits, totaling $643,749.49. Table 18 provides the EBA program statistics during DY8.

Table 18 Enhanced Benefits Account Program Statistics (July 1, 2013 – June 30, 2014)					
Year Eight		**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
I.	Number of health plans submitting reports by month in each county	31	31	31	31
II.	Number of enrollees who received credit for healthy behaviors by month	169,130	136,818	114,010	79,615
III.	Total dollar amount credited to accounts by each month	$4,962,547.50	$3,851,545.00	$3,259,457.50	$2,301,360.00
IV.	Total cumulative dollar amount credited through the end each month	$73,791,036.16	$77,642,581.16	$80,902,038.66	$83,203,398.66

Table 18 Enhanced Benefits Account Program Statistics (July 1, 2013 – June 30, 2014)					
Year Eight		**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
V.	Total dollar amount of credits used each month by date of service	$2,222,406.13	$3,142,775.73	$2,367,583.60	$2,125,754.02
VI.	Total cumulative dollar amount of credits used through the month by date of service	$40,644.343.46	$43,787,119.19	$46,154,702.79	$48,280,456.81
VII.	Total unduplicated number of enrollees who used credits each month	57,729	72,865	58,783	52,167

c) Enhanced Benefits Advisory Panel

There was no EB Advisory Panel meeting held during DY8. To view information on previous panel meetings, please visit the Agency's EBA website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml.

d) Notice of EBA Program Phase Out

During DY8, 1,063,151 notices were mailed regarding the phase-out of the EBA program.

5. Demonstration Goals

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

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

During the fourth quarter of DY8, the Medicaid Reform program was phased out as the Agency began implementation of the MMA program in Baker, Clay, Duval, and Nassau counties (Region 4) on May 1, 2014 and Broward County (Region 10) on July 1, 2014. The MMA program provides a limited number of plans in the 11 geographic regions to ensure stability, but all offer significant recipient choice and further ensure coverage in rural areas of the state. Please refer to Section II.A of this report for more information on the number and different type of MMA plans available in the MMA program, and Objective 4 of this report for enrollee satisfaction.

Objective 2(a): To ensure that there is access to services not previously covered.

During DY8, all of the capitated health plans offered expanded or additional benefits that were not previously covered under Florida's Medicaid State Plan in order to meet the needs of new

enrollees. Please refer to Section II.A.2 and B.1 of this report for additional information on the capitated health plans benefit packages and expanded benefits.

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

The demonstration is designed to improve access to specialty care for recipients. Each managed care 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 Agency completed the first intensive comparative analysis of the health plans' provider network files to evaluate the effectiveness of the demonstration in improving access to specialists.

During the second quarter of DY2, 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 managed care 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 Agency as areas of potential concern regarding access to care were subject to focused reviews of provider network files and provider surveys in DY2 through DY5. Results of these reviews and surveys were provided in earlier quarterly and annual reports.

In DY6 and DY7, 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 DY6, the Agency reviewed and refined methodologies for analyzing access to care in order to establish baselines and for identifying opportunities for managed care 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.

Attachment V of this report provides charts that demonstrate improving accessibility to orthopedic, neurology and dermatology services for Medicaid recipients statewide and in the demonstration counties over time, for SFY 2010-11, SFY 2011-12 and SFY 2012-13.

Specialty care access measurements have been communicated to the health 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.

Objective 3(a): To improve enrollee outcomes as demonstrated by improvement in the overall health status of enrollees for select health indicators.

During the first quarter of DY8, the Agency received the sixth year of performance measure submissions from the health plans. Results of the sixth year of performance measures can be viewed in Attachments III and IV of this report. Attachment III is a table of the demonstration health plans' performance measure rates from 2008 through 2013. Attachment IV is a table comparing the weighted mean rates for performance measures for the demonstration and non-demonstration health plans. Highlights of the sixth year of performance measures include:

- Of the 43 Healthcare Effectiveness Data and Information Set (HEDIS) measure rates included in Attachments III and IV, the statewide average results for the demonstration health plans improved for 15 of the measures compared to the previous year.

- Demonstration health plans' rates for 14 of the measures stayed about the same, while their performance on 14 of the measures dropped.

- For 19 of the 43 measures, the statewide average results for the demonstration health plans were higher than the average results for the non-demonstration health plans. Performance measures with notable improvement include:

    - Annual Dental Visit: the statewide weighted average for demonstration health plans increased from 35.3% in 2012 (representing measurement year 2011) to 40.4% in 2013 (representing measurement year 2012).

    - Adult BMI Assessment: the statewide weighted average for demonstration plans increased from 47.9% in 2012 to 63.0% in 2013.

    - Immunizations for Adolescents – Combo 1: the statewide weighted average for demonstration health plans increased from 47.3% in 2012 to 54.6% in 2013.

    - Appropriate Testing for Children with Pharyngitis: the statewide weighted average for demonstration health plans increased from 64.0% in 2012 to 67.7% in 2013.

    - Lead Screening in Children, which had notable improvement from 2011 to 2012, improved from 59.6% in 2012 to 61.7% in 2013.

- Two other measures that had notable improvement from 2011 to 2012 saw a decline or stayed flat from 2012 to 2013, but their 2013 rates remain high above the plans' rates in 2011.

    - Well-Child Visits in the First 15 Months – 6 or more: the statewide weighted average for demonstration health plans increased from 46.5% in 2011 (representing measurement year 2010) to 58.4% in 2012 (representing measurement year 2011). In 2013, the weighted average declined to 55.6%.

    - Frequency of Prenatal Care: the statewide weighted average for demonstration health plans increased from 44% in 2011 to 54.4% in 2012, then declined to 53.7% in 2013.

In addition to looking at year to year changes in performance measure results, the Agency obtained the National Medicaid Means and Percentiles for 2013 HEDIS from the National Committee for Quality Assurance (NCQA) and compared the demonstration and non-demonstration health plans' results to the National Means and Percentiles. Attachment IV includes the 2013 National Medicaid Mean for each measure.

Demonstration health plans performed as well as or better than the National Mean on 13 measures, while non-demonstration health plans performed as well as or better on 15 measures. Both demonstration and non-demonstration health plans performed as well as or better than the National Mean on eight measures, including:

- Comprehensive Diabetes Care: LDL Screening – The demonstration health plans had a weighted mean of 80.1% and the non-demonstration health plans' mean was 79.2%, while the National Medicaid Mean was 75.4%.

- Comprehensive Diabetes Care: Medical Attention for Nephropathy – The demonstration health plans' mean was 80.2% and the non-demonstration health plans' mean was 79.8%, while the National Medicaid Mean was 78.4%.

- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life – The demonstration health plans' and non-demonstration health plans' weighted means were 75.6% and 73.2%, respectively, while the National Medicaid Mean was 71.9%.

- Childhood Immunization Combo 2 – The demonstration health plans' and non-demonstration health plans' weighted means were 77.8% and 77.5%, respectively, while the National Medicaid Mean was 75.8%.

- Follow-up Care for Children Prescribed ADHD Medication: Initiation – The demonstration health plans' and non-demonstration health plans' weighted means were 45.0% and 41.3%, respectively, while the National Medicaid Mean was 39.1%.

- Chlamydia Screening: age groups and total – The demonstration health plans' and non-demonstration health plans' weighted means were above the National Mean for the lower and upper age groups and for the total. For the total rate, the demonstration health plans' and non-demonstration health plans' weighted means were 62.9% and 61.2%, respectively, while the National Medicaid Mean was 56.9%.

- Call Answer Timeliness – The demonstration health plans' and non-demonstration health plans' weighted means were 95.4% and 93.5%, respectively, while the National Medicaid Mean was 83.9%.

During the fourth quarter of DY8, Agency staff sent letters to the health plans regarding performance measure-related liquidated damages based on their 2013 submissions, and health plans submitted lessons learned from their Performance Measure Action Plan activities over the course of the demonstration. One of the most consistent lessons learned that the health plans reported was the relative ineffectiveness of relying solely on passive interventions (e.g., sending postcards or newsletters to members) to improve performance. In the third and fourth quarters of DY8, the External Quality Review Organization has emphasized to the health plans the importance of focusing on active interventions in a few targeted areas in order to improve performance significantly.

Objective 3(b): To improve enrollee outcomes as demonstrated by 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 utilizing MedRx, per member per month utilization 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 health plan performance. During DY8, the Agency 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 3(c): To improve enrollee outcomes as demonstrated by 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 aggregate data for all health plans demonstrate that ED utilizations went down between State Fiscal Years (SFY) 2010-2011 and 2011-2012, back up in SFY 2012-2013, and then decreased during the first half of SFY 2013-2014.

The model is set up to process data, and then generates comparable results across the fee-for-service recipients and managed care enrollees. The reports include a volumetric with morbidity scoring utilizing MedRx, utilization per member per month per 1,000 recipients, and distribution by reporting ED utilization category on a statewide (FFS and managed care), reform, non-reform and per-managed care organization basis. Portions of the report are designed to produce a county comparison based on managed care eligible recipient utilization or according to health 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-ED care settings.

The Agency is assessing this model for use as a tool for measuring health plan performance. During DY8, the Agency 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 enrollee 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. 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 CMS on December 15, 2011.

In the first quarter of DY8, UF submitted the final version of a trend analysis report to the Agency, which includes the CAHPS survey results for the demonstration through SFY 2011-12 (Year 4 follow-up survey). In the fourth quarter of DY8, UF submitted an evaluation report to the Agency on Domains of Focus i and ii, which included CAHPS survey results through SFY 2012-13 (Year 5 follow-up survey). A Year 6 follow-up survey was conducted during DY8, but those results are not yet available in a report.

Key findings from the CAHPS surveys from the Baseline survey through the Year 5 follow-up survey are presented in Attachment VI of this report.

The Year 6 Follow-up survey results (from surveys conducted during the third and fourth quarters of DY8) were submitted to the Agency at the end of the fourth quarter. These survey results will be included in the Reform Evaluation Draft Final Summary Report that the Agency will submit to CMS 120 days after the end of DY8.

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

STC #84 – Tier-One Milestone

As reported under this STC, both the *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report* will show the increased access to medical care for the uninsured population in Florida. Both reports can be viewed on the Agency's Low Income Pool website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/documents.shtml. Please refer to Section VI, Evaluation of the Demonstration, of this report for an update on key findings and accomplishments from both *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report*.

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 CMS' Three-Part Aim. These initiatives focus on: infrastructure development; innovation and redesign; and population focused improvement.

Please refer to Section VI, Evaluation of the Demonstration, of this report for an update on key findings from the Evaluation Report of Domains v-ix for DY7 activities related to the LIP Tier One and Tier-Two Milestone quality initiatives.

Final Evaluation Report

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 Milestone initiatives in accordance with the STCs of the waiver. On October 30, 2012, CMS approved the Agency's Final Evaluation Design. When available, the key findings of the evaluation will be reported under Section VI, Evaluation of the Demonstration, of this report.

6. Policy and Administrative Issues

The Agency's internal and external communication processes play a key role in managing and resolving issues effectively and efficiently. These forums provided an opportunity for discussion and feedback on proposed processes, and provided finalized policy in the form of "Dear Provider" letters and policy transmittals to the Reform plans. The following provides a summary for DY8.

a) Medicaid Reform Technical Advisory Panel (TAP) meetings

The Technical Advisory Panel (TAP) was created by the 2005 Florida Legislature, and appointed by the Agency with the directive of advising the Agency on various implementation issues relative to the demonstration. The TAP is scheduled to sunset effective October 1, 2014, and did not meet during DY8.

b) Health Plan Technical and Operational Issues Conference Calls

These monthly conference calls were 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. All health plans were invited to participate, whether they were currently operating in the Reform demonstration counties. Additionally, the calls were publicly noticed in the Florida Administrative Register to allow all interested parties to participate. The Agency staffed these calls with administrative experts in all areas of the demonstration and participants included 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.

During DY8, the Agency conducted four Technical and Operational Issues calls with 40 people attending in person and close to 300 phone lines in active use. These four calls took place in first and second quarters of DY8. During the second quarter of DY8, it was decided to end the Technical and Operational Issues calls so staff could focus on plan readiness activities for implementation of the MMA program. As part of the SMMC program, the Agency decided to change the format of these calls and the Agency moved to having a weekly "All Plan Call" with all health plans participating, along with weekly individual calls with each health plan.

c) PSN Systems Implementation Monthly Conference Calls

These conference calls provided a forum for discussing claims processes and enrollment file issues that are unique to the FFS PSN model. The Reform 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). PSN participants included managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs' contracted Third Party Administrators.

During DY8, the Agency conducted two calls which were attended by over 40 participants. Both calls took place in the first quarter and with the implementation of a revised electronic remittance advice file in September, no calls were needed in the second quarter. Additionally, with the implementation of the MMA program, no additional calls were necessary due to the fact that there is only one FFS PSN. The Agency continued to coordinate technical assistance between specific providers and their PSNs to assist providers in getting their claims issues addressed; however, while this function was available, it has only been needed occasionally.

d) General Amendment/Contract Overview Calls and Meetings

When new contract changes were considered or implemented, the Agency held conference calls with the Reform health plans to discuss the changes. These calls were periodic in nature, depending on the particular items that needed discussion.

During DY8, there was one general amendment to contracts with health plans participating in the Reform demonstration. In addition, the Agency hosted a conference call advising Medicaid health plans of the changes to the draft general amendment based on comments received from the health plans and stakeholders, and hosted a webinar with the health plans regarding Medicaid Program Integrity reporting requirements. Additionally, the Agency met with health plans and their managed behavioral health organizations regarding the status of current and ongoing behavioral health projects and streamlining tools.

III. Low Income Pool

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

1. LIP Council Meetings

During DY8, the Agency held one LIP Council meeting on August 8, 2013. The Council discussed DY8 LIP and the future of the LIP program. The Council meetings can be viewed on the Agency's LIP website at the following link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml.

2. LIP STCs - Reporting Requirements

The following provides a summary for DY8 on the LIP STCs that required action.

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

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

STC #84d – LIP Tier-One Milestones

This STC requires the submission of an annual *Milestones Statistics and Finding Report*, which provides a summary of LIP payments received by hospital and non-hospital providers, the number and types of services provided, the number of recipients served, and the number of service encounters, and provides information relevant to the research questions associated with domain v of the 1115 MMA Waiver. This STC also requires the submission of an annual *Primary Care and Alternative Delivery Systems Report*, which summarizes how new primary care projects or enhancements to existing primary care projects receiving LIP funds are meeting the intended goals of the program.

- On December 31, 2013, the Agency submitted to CMS the *Primary Care and Alternative Delivery Systems Expenditure Report* for DY7 to CMS.
- On April 1, 2014, the Agency submitted to CMS the annual *Milestones Statistics and Finding Report* for DY7.

Both reports can be viewed on the Agency's LIP website at the following link. http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/index.shtml. Please refer to

Section VI, Evaluation of the Demonstration, of this report for an update on key findings and accomplishments from the *Milestone Statistics and Findings Report* and the *Primary Care and Alternative Delivery Systems Report*.

STC #85 – LIP Tier-Two Milestones

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

- On October 31, 2013 and December 18, 2013, the Agency submitted the third and fourth quarter reporting for SFY 2012-13 for the 44 hospital initiatives.
- On March 11, 2014, the Agency submitted the first quarter reporting for SFY 2013-14 for the 44 hospital initiatives, on March 11, 2014
- On April 25, 2014, the Agency submitted to CMS the second quarter reporting for SFY 2013-14 for the 44 hospital initiatives.
- On June 20, 2014, the Agency submitted to CMS the third quarter reporting for SFY 2013-14 for the 44 hospital initiatives.

Please refer to Section VI, Evaluation of the Demonstration, of this report for an update on key findings from the Evaluation Report of Domains v-ix for DY7 activities related to the LIP Tier-One and Tier-Two Milestone quality initiatives.

IV. Monitoring Budget Neutrality

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

Updated Budget Neutrality

Budget Neutrality figures included in Attachment VII of this report are through June 30, 2014 of DY8. The 1115 MMA Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

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

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by STC #94, is monitored using data based on date of service. The Per Member Per Month (PMPM) and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency will track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year. The current CMS 64 reporting methodology will continue through the implementation of the MMA program.

Please refer to Attachment VII of this report for an update on Budget Neutrality figures through June 30, 2014 of DY8.

V. Encounter and Utilization Data

1. Encounter Data

During DY8, the Agency distributed monthly Encounter Data Compliance Reports to the health plans. These reports used analytical measures to gauge the completeness, accuracy and timeliness of the encounter data submissions from each health plan. The Compliance Reports were modified as needed to address any issues and to incorporate additional functionality. Additionally, dialogue with representatives from the health plans often resulted in refinements to the measures and to the narrative presented in the Compliance Reports.

Reviewing and refining the methodologies for editing, processing and extracting encounter data are ongoing processes for the Agency. During DY8, multiple system modifications and data table upgrades were implemented to improve the quality of encounter data and encounter data analytics. The Agency also developed a report for monitoring services, expenditures and utilization of the newly implemented LTC program, based on the encounter data submitted and processed.

Numerous plan outreach activities occurred during DY8. The Agency conducted bi-weekly phone calls with the health plans to discuss specific technical and policy issues related to encounter data. Through these outreach efforts, the health plans and the Agency made significant progress in resolving encounter data issues and educating the health plans on accurate completion of the encounter claims.

With the implementation of the SMMC program, the Agency implemented several changes to assist health plans with the submission of accurate, complete and timely encounter data and to focus on improving encounter data collection. These changes included:

- Enhancement of the technical support for the health plans to respond to encounter data questions or issues,
- Creation of a workgroup focused on addressing encounter data collection and policy concerns related to encounter data,
- Creation of an information technology workgroup focused on implementing functionality to support SMMC encounter data,
- Usage of financial reports in the evaluation of encounter data submissions, and
- Creation of a new methodology to identify resubmitted encounter claims.

Additionally, the Agency coordinated with its fiscal agent who assumed the responsibility for producing and distributing accuracy and timeliness reports in lieu of the previously distributed monthly compliance reports. These reports are now produced using the Medicaid Management Information System (MMIS).

The Agency has contracted with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO) vendor since 2006. Beginning on July 1, 2013, the Agency's new contract with HSAG required that the EQRO conduct an annual encounter-type focused validation, using protocol consistent with the CMS protocol, "Validation of Encounter Data Reported by the Managed Care Organization." Health Services Advisory Group (HSAG)

has worked closely with the Agency to design an encounter data validation process to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate. HSAG will compare encounter data with the managed care plan's administrative data and will also validate provider-reported encounter data against a sample of medical records. During the fourth quarter of DY8, HSAG delivered its first encounter data report which contained an analysis of encounter data field validity and completeness, a review of the Agency's and managed care plan's encounter data systems and processes, and recommendation of future improvement opportunities.

2. Rate Setting/Risk Adjustment

The rate setting process for September 2013 through August 2014 uses hospital inpatient, hospital outpatient, physician/other, pharmacy and mental health encounter data.
During DY8, the SMMC program was implemented and final rates were negotiated based on a competitive Invitation to Negotiate process, which incorporated a Data Book for respondents to view and analyze the relevant data. The current risk adjustment process in Regions 4 and 10 was phased out and replaced by a statewide case-mix adjustment for the LTC program and a statewide hybrid diagnostic/pharmacy model for the MMA program. The first quarterly report for DY9 will contain activities relating to the rate/risk adjustment process for the SMMC program.

VI. Evaluation of the Demonstration

The evaluation of the demonstration is an ongoing process to be conducted during the life of the demonstration. The Agency is required under STCs #110 – 113 to complete an evaluation design that includes a discussion of the goals, objectives and specific hypotheses that are being tested to determine the impact of the demonstration during the period of approval. To view the Final Evaluation Design for the waiver period December 16, 2011 – June 30, 2014 and to view the Final Evaluation Report that covers the initial five-year demonstration period, please visit the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/index.shtml.

For the waiver period through June 30, 2014, the Agency has a contract with the University of Florida (UF) for the evaluation of Domains i, ii, and v-ix (per the STCs). The Agency has a contract with Florida International University (FIU) for the evaluation of Domain iv.

Evaluation Design

STC 110 requires that the Agency submit to CMS for approval a Draft Evaluation Design update for the MMA program that builds and improves on the Final Evaluation Design that was approved on October 31, 2012. The Agency submitted the Draft Evaluation Design update to CMS in October 2013, received comments back from CMS in December 2013, and submitted a revised Draft Evaluation Design update to CMS in February 2014. In May 2014, CMS sent the Agency additional feedback on the updated Draft Evaluation Design (submitted by the Agency in February 2014). Agency staff reviewed the comments from CMS and began revising the updated Draft Evaluation Design. The Agency will discuss the comments and revisions with CMS in DY9.

The evaluation domains included in DY8's evaluation activities were the following:

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 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; and,

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.

Reports and Findings during DY8

Primary Care and Alternative Delivery Systems Expenditures Report for DY7 (2012-2013)

The "Primary Care and Alternative Delivery Systems Expenditures Report for DY7 (2012-2013)" was submitted to CMS on December 31, 2013. This report is required as part of the Low Income Pool (LIP) Tier-One Milestones in the STCs, and summarizes how new primary care projects or enhancements to existing primary care projects receiving LIP funds are meeting the intended goals of the program. While this report is not technically an evaluation report, it does summarize data and information to be used for answering some of the domain v-ix research questions related to the impact of the Tier-One milestone initiatives on access to care, quality of care, and the cost-effectiveness of care.

Per the STCs, Florida allocated $35 million in LIP funding in DY7 and DY8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Hospitals, county health departments, and federally qualified health centers submitted project proposals to the Agency for funding. The initiatives were required to drive from the three overarching goals of CMS' Three-Part Aim.

i. Better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
iii. Reducing per-capita costs.

This report is largely descriptive of the 31 projects that were funded. Key findings for the DY7 period include:

- Recipients served by the programs/projects included adults and children who were uninsured, underinsured, low income, Medicaid eligible, and the homeless.
- Some programs/projects focused on specific groups of recipients, including pregnant women and individuals with a particular chronic condition (such as heart failure, diabetes, or chronic obstructive pulmonary disease).
- Sixteen of the projects provided primary care medical or dental services.
- Fifteen of the projects provided obstetrical and gynecological services.
- Four of the projects were Readmission Reduction Programs, aimed at reducing the number of avoidable emergency department and inpatient visits by providing education, care coordination, and support services to patients who had recently been hospitalized for cardiovascular or pulmonary conditions.
- Four of the projects were Specialty Care Coordination Programs aimed at providing care coordination services including follow-up, transportation, home health, patient education, laboratory and/or diagnostic testing, and disease management services to individuals with chronic conditions.
- DY7 was the first year these projects operated, and the providers of the projects reported the following figures regarding numbers of recipients served and associated costs:

- Approximately 31,000 recipients were served through these projects in DY7. The maximum number of recipients served by a single project was approximately 6,800 individuals.
- The amount spent per recipient ranged from $29 to $15,680. The average amount spent by reporting projects was $2,223 per recipient.
- Several projects involved the construction of new primary care service sites in order to provide better access to patients, so these projects were unable to provide services during the first year.

Low Income Pool Milestone Statistics and Findings Report for DY7: SFY 2012-13

The "Low Income Pool Milestone Statistics and Findings Report for DY7: SFY 2012-13" was submitted to CMS on April 1, 2014. This report provides a summary of LIP payments received by hospital and non-hospital providers, the number and types of services provided, the number of recipients served, and the number of service encounters. While this report is not technically an evaluation report, it does summarize the data to be used for answering the domain v research questions, regarding how many uninsured and underinsured recipients receive services through LIP funding, what types of services are provided, and in what settings.

The DY7 accomplishments that were identified include the following:

- The LIP program included the following types of providers: primary care hospitals; rural hospitals; safety-net hospitals; hospital Provider Access Systems (PAS); hospitals that operate poison control centers; specialty pediatric hospitals; hospitals with designated trauma centers; Federally Qualified Health Centers (FQHCs); County Health Departments (CHDs); Rural Health Networks; and LIP-Other, which includes designated premium assistance programs, emergency room (ER) diversion projects, primary care projects, and quality projects.
- A total of 178 PAS in Florida received LIP payments – 106 hospitals and 72 non-hospital providers.
- Total LIP funding was approximately $1 billion.
- Reporting hospitals receiving LIP supplemental payments served approximately 3.3 million Medicaid, uninsured, and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served approximately 1.2 million Medicaid, uninsured, and underinsured individuals.
- 106 hospitals that received LIP supplemental payments reported providing approximately 14.0 million service encounters to Medicaid, uninsured, and underinsured individuals across six service categories (discharges, inpatient days, ER encounters, outpatient encounters, affiliated encounters, and prescriptions filled).
- For all categories of encounters, 62 reporting non-hospital providers receiving LIP payments provided a total of approximately 6.7 million encounters for specific services to Medicaid, uninsured, and underinsured individuals. The specific services/encounters include: primary care, OB/GYN, disease management, mental health/substance abuse, dental, prescriptions filled, lab services, radiology, specialty encounters, and care coordination.

Final Report of Domains i and ii through DY7

In June 2014, UF completed an evaluation report of Domains i and ii. This report examines research questions associated with the effect of managed care on access to care, quality and efficiency of care, and the cost of care, and research questions associated with the effect of customized benefit plans on enrollees' choice of plans, access to care, and quality of care.

Key findings of this report include:

- Overall, respondent self-reports indicate that enrollees in the Reform counties perceive services to be accessible.
- To some extent, there appear to be improvements in respondent self-report of obtaining health services. Over time, there was a significant increase in the percentage of enrollees having a personal doctor in both urban and rural Reform counties. There was also a statistically significant decrease over time in the percentage of enrollees who never saw a doctor for non-urgent care in the previous six months.
- The quality of care that enrollees receive has improved during the demonstration for 10 of 12 HEDIS chronic disease measures, while for one measure it has improved minimally.
- CAHPS survey results indicate that in the urban Reform counties, there was a significant increase over time in enrollees reporting the highest level rating for their personal doctors, their specialists, and their health plans. In rural Reform counties, there was also a significant increase in enrollees who reported the highest level rating for their health plans and the health care they received in the last 6 months. However, the proportion of enrollees who reported the highest level rating for their specialists decreased, and this result was statistically significant as well.
- In the urban Reform counties, there has been some improvement in reports of being able to access care in a timely manner. There was a statistically significant increase over time in the percentage of enrollees who were "Always" able to get urgent and non-urgent care as soon as they wanted.
- Overall, per member per month (PMPM) expenditures were greater in the Reform counties compared to the Control counties for both TANF and SSI enrollees. However, the rate of growth was lower in the Reform counties relative to the Control counties, suggesting that the Reform counties will achieve savings over time if the current trend continues in the future.
- Health plans have offered customized benefits to a minimal extent, and the scope of expanded benefit packages is small. The most commonly offered expanded benefits were over-the-counter (OTC) pharmacy benefits and adult dental benefits.
- Satisfaction ratings increased across all measures from DY6 to DY7 within plans that offered OTC expanded benefits and adult dental benefits, though these increases were not statistically significant.
- There was an increase in access to and quality of care between DY6 and DY7 for enrollees in plans with and without OTC expanded benefits and adult dental benefits, but these changes were not statistically significant.

Final Report of Domain iii through DY6

In June 2014, UF completed an evaluation report of Domain iii. This report looks at participation in the Enhanced Benefits Account (EBA) program and its effect on participant behavior or health status, using Enhanced Benefits Information System data. Medicaid claims and eligibility data, hospital discharge data, encounter data, and the Agency's quarterly and annual reports.

Key findings of this report include:

- From DY2 through DY6, $48.8 million in EBA credits were earned by enrollees and 59.4% of the earned credits were spent on eligible purchases.
- Preventive care for children and adults accounted for nearly half (48.9%) of the total credits earned.
- Cancer screening behaviors accounted for 4.3% of credit earning, while participation in disease management and diabetes management programs accounted for only 1% of all credit earnings. Participation in other healthy behaviors such as smoking cessation, alcohol and substance abuse programs, and fitness programs were reported 1,989 times from DY2 through DY6.
- While preventive services accounted for a great share of the health behaviors for which credits were earned, it is not clear that such behaviors increased in frequency during the Medicaid Reform time period.
- Between DY2 and DY6, 58% of EBA enrollees were women, 46% were black, 62% resided in Broward County, and 86% had Medicaid eligibility through Temporary Assistance for Needy Families (TANF).
- Enrollees in Medicaid Reform counties had on average more claims than Medicaid enrollees in Non-Reform counties for most services. Reform enrollees who earned more EBA credits had more claims on average than Reform enrollees who had earned fewer credits. Enrollees who did not earn any EBA credits had more claims than some EBA earners for medical, inpatient, and outpatient services.
- In Reform counties, the average number of cancer screening claims was higher among non-EBA earners compared to low earners and medium earners, but not high EBA earners.

Final Report of Domains v-ix through DY7

In June 2014, UF completed an Evaluation Report of Domains v-ix. This report provides a look at the effect of LIP funding on the provision of health care services to the uninsured and the impact of Tier-One and Tier-Two Milestone initiatives on: access to and quality of care; population health; and per capita costs and the cost-effectiveness of care. This report focuses on DY7 activities related to the Tier-One and Tier-Two Milestone quality initiatives.

Key findings of this report include:

- Overall, the number of uninsured, underinsured, and Medicaid individuals served and the types and number of outpatient services furnished by non-hospital providers has increased. For hospital providers, the number of individuals served with Medicaid has increased but the number of uninsured and underinsured individuals served has

decreased.

- In general, the Tier-One and Tier-Two initiatives decreased disparities in the provision of healthcare services in both urban and rural geographic locations and for multiple demographic, socioeconomic, and disease-specific population groups. Examples include individuals with chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, sickle cell disease, the uninsured, and low income individuals.
- Access to care was the focus of approximately 60% of the Tier-One initiatives and approximately 40% of the Tier-One initiatives focused on quality of care. Among the Tier-Two initiatives, 70% or more impacted both quality of care and access to care. Overall, the Tier-One and Tier-Two initiatives provided better care coordination and increased access to primary care and disease management services.
- Tier-One and Tier-Two Milestone initiatives affected population health by increasing access to primary care services; improving management of chronic illnesses such as diabetes, hypertension, and cardiovascular disease; and focusing on population groups including but not limited to women, children, and the homeless. Specific activities included implementation of Specialty Care Coordination Programs for cardiovascular and pulmonary conditions; implementation of protocols to reduce infections in neonates; and the development and use of a depression screening tool to help primary care providers identify low income patients with depression.
- Tier-One and Tier-Two initiatives impacted per-capita costs and the cost-effectiveness of care by providing coordinated acute, disease management, and preventive primary care, medical, dental, and behavioral health services with the goal of reducing the numbers of avoidable emergency department and inpatient visits. Initiatives included implementing Emergency Department Diversion programs, Readmission Reduction Programs, and establishing condition-specific outpatient clinics as well as others.

VII. Waiver Extension Request Approved July 31, 2014

On November 27, 2013, the Agency submitted a three-year waiver extension request to CMS to extend Florida's 1115 MMA Waiver for the period July 1, 2014 to June 30, 2017. On July 31, 2014, CMS granted the three-year extension of the waiver. The Low Income Pool supplemental payment authority was extended through June 30, 2015. The waiver extension request document can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_extension.shtml

a) Public Input Process

In preparing the waiver extension request document, the Agency held a series of public meetings to solicit public input on the extension of Florida's 1115 MMA Waiver. The agenda items for the public meetings included: the future of Florida's 1115 MMA Waiver, legislation creating the MMA program passed during the 2011 Florida Legislative Session, overview of the existing waiver and description of the draft waiver extension request. There was an opportunity for public input during the meetings.

The location, date and time of the public meetings held are provided below. In addition, the Agency accepted written comments on the waiver extension request via mail and e-mail. A complete summary of the public notice and public process used in the development of the extension request is included in the final document and posted on the Agency's website at the link provided above.

Schedule of Public Meetings		
Location	**Date**	**Time**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00 p.m. – 3:30 p.m.
Miami Florida International University Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00 p.m. – 3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00 p.m. – 3:30 p.m.

In addition, to the public meetings listed on the above, the Agency requested input on the extension request from the Low Income Pool Council and the Medical Care Advisory Committee (MCAC). The following is a brief summary of the advisory committee meetings held on the waiver extension request, including the Post Award Forum held during the MCAC, in accordance with STC #18 of the waiver.

Low Income Pool Council

The Agency held a public meeting on the waiver extension request with the LIP Council on August 8, 2013. During the meeting, the Agency provided an overview of the three-year waiver extension and solicited input on the future of the LIP program. The Agency also provided an overview of other state's quality incentive programs and solicited input on the approaches available under the waiver extension period. The LIP Council recommended the Agency pursue additional funding to implement quality incentive programs.

Medical Care Advisory Committee and "Post Award Forum"

The Agency held a public meeting and Post Award Forum with the Medical Care Advisory Committee on October 15, 2013. During the meeting, the Agency provided a detailed overview of the waiver extension request, the implementation of certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 related to Title XXI Children's Health Insurance Program in 2014 and the intent to seek additional funding for the Low Income Pool program to establish quality incentive programs.

The public meeting and Post Award Forum held on October 15, 2013, provided the Medical Care Advisory Committee members and the public an opportunity to provide meaningful comments on the progress of the 1115 MMA Waiver. The comments and recommendations from the committee and public were incorporated in the summary of public comments provided in Section III.H of the waiver extension request for the 1115 MMA Waiver, which can also be viewed in Attachment VIII of this report.

b) Status of Federal Approval

- On December 12, 2013, CMS notified the Agency they had finished their preliminary review of the state's extension request and determined the state's request has met the requirements of a complete extension request as specified under Section 42 CFR 431.412(c). CMS posted the documents for public comments on their website for 30 days at the following link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

- On June 30, 2014, the Agency received a letter from CMS granting a 31-day temporary extension of the 1115 MMA Waiver until July 31, 2014. The temporary extension ensured continued service delivery to Medicaid recipients and provided additional time to finalize the waiver authorities, expenditure authority and STCs of the waiver.

- On July 31, 2014, CMS granted the three-year extension of the waiver. The Low Income Pool supplemental payment authority was extended through June 30, 2015.

Attachment I
Expanded Benefits under the MMA program

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

Expanded Benefits Offered by MMA Standard Plans

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

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

Attachment II
Medicaid Reform Enrollment Report

Medicaid Reform Enrollment Report

There are two categories of Medicaid recipients who are enrolled in the health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the recipients' eligibility for Medicare. Each enrollment report and the process used to calculate the data it contains are described on the following pages. The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the demonstration program for the DY being reported. Table 1 provides a description of each column in Medicaid Reform Enrollment Report.

Table 1
Medicaid Reform Enrollment Report Column Descriptions

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

Table 2 provides an unduplicated count of the recipients enrolled in each Reform health plan at any time during DY8. There were a total of 401,457 recipients enrolled in the Reform demonstration during DY8. There were 17 Reform health plans active during DY8 with market shares ranging from 0.03% to 48.86%.

Table 2
Medicaid Reform Enrollment
(July 1, 2013 – June 30, 2014)

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 and B				
Clear Health	HMO	15	55	0	2	**72**	**0.03%**	**31**	**132.26%**
Freedom	HMO	4,389	647	2	135	**5,173**	**2.44%**	**6,127**	**-15.57%**
Humana	HMO	14,233	2,383	10	532	**17,158**	**8.10%**	**15,131**	**13.40%**
Magellan	HMO	708	127	1	24	**860**	**0.41%**	**5**	**17100.00%**
Medica	HMO	4,517	982	7	227	**5,733**	**2.71%**	**6,502**	**-11.83%**
Molina	HMO	33,150	3,809	23	747	**37,729**	**17.81%**	**40,746**	**-7.40%**
Positive	HMO	32	273	0	18	**323**	**0.15%**	**283**	**14.13%**
Preferred	HMO	4,029	757	3	174	**4,963**	**2.34%**	**5,624**	**-11.75%**
Simply	HMO	73	12	0	22	**107**	**0.05%**	**2,220**	**-95.18%**
StayWell	HMO	22,154	2,128	2	237	**24,521**	**11.57%**	**16,519**	**48.44%**
Sunshine	HMO	92,839	9,317	19	1,349	**103,524**	**48.86%**	**117,219**	**-11.68%**
United	HMO	10,035	1,471	2	225	**11,733**	**5.54%**	**11,564**	**1.46%**
Universal	HMO	0	0	0	0	**0**	**0.00%**	**7,776**	**-100.00%**
HMO Total	**HMO**	**186,174**	**21,961**	**69**	**3,692**	**211,896**	**57.43%**	**229,747**	**-7.77%**
Better Health	PSN	47,275	5,503	14	877	**53,669**	**28.31%**	**53,307**	**0.68%**
CMS	PSN	6,282	4,460	0	37	**10,779**	**5.69%**	**10,964**	**-1.69%**
FCA	PSN	68,975	9,636	9	1,795	**80,415**	**42.42%**	**89,612**	**-10.26%**
SFCCN	PSN	39,118	4,768	12	800	**44,698**	**23.58%**	**48,568**	**-7.97%**
PSN Total	**PSN**	**161,650**	**24,367**	**35**	**3,509**	**189,561**	**42.57%**	**202,451**	**-6.37%**
Reform Enrollment Totals		**347,824**	**46,328**	**104**	**7,201**	**401,457**	**100.00%**	**432,198**	**-7.11%**

Medicaid Reform Enrollment by County Report

The numbers of HMOs and PSNs in each of the Reform demonstration counties, prior to implementation of the MMA program in those counties, are listed in Table 3.

Table 3
Number of Reform Health Plans in Demonstration Counties
(July 1, 2013 – June 30, 2014)

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

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The Reform demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 4 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 4
Medicaid Reform Enrollment by County Report Descriptions

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

Table 5 located on the following page lists, by health 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 5
Medicaid Reform Enrollment Report by County
(July 1, 2013 – June 30, 2014)

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 & B				
FCA	PSN	2,772	291	0	23	**3,086**	**75.94%**	3,660	-15.68%
Staywell	HMO	99	19	0	3	**121**	**2.98%**	43	181.40%
United	HMO	745	99	0	13	**857**	**21.09%**	848	1.06%
Baker		**3,616**	**409**	**0**	**39**	**4,064**	**100.00%**	**4,551**	**-10.70%**
Better Health	PSN	47,275	5,503	14	877	**53,669**	**22.99%**	53,307	0.68%
Care Florida	HMO	4,029	757	3	174	**4,963**	**2.13%**	5,624	-11.75%
Clear Health	HMO	15	55	0	2	**72**	**0.03%**	31	0.00%
CMS	PSN	3,901	3,228	0	25	**7,154**	**3.06%**	7,359	-2.79%
Freedom	HMO	4,389	647	2	135	**5,173**	**2.22%**	6,127	-15.57%
Humana	HMO	14,233	2,383	10	532	**17,158**	**7.35%**	15,131	13.40%
Magellan	HMO	708	127	1	24	**860**	**0.37%**	0	N/A
Medica	HMO	4,517	982	7	227	**5,733**	**2.46%**	6,502	-11.83%
Molina	HMO	33,150	3,809	23	747	**37,729**	**16.16%**	40,746	-7.40%
Positive	HMO	32	273	0	18	**323**	**0.14%**	283	14.13%
SFCCN	PSN	39,118	4,768	12	800	**44,698**	**19.14%**	48,568	-7.97%
Simply	HMO	73	12	0	22	**107**	**0.05%**	2,220	-95.18%
Staywell	HMO	7,222	521	2	72	**7,817**	**3.35%**	2,962	163.91%
Sunshine	HMO	43,472	3,985	15	561	**48,033**	**20.57%**	51,954	-7.55%
Universal	HMO	0	0	0	0	**0**	**0.00%**	4,207	-100.00%
Broward		**202,134**	**27,050**	**89**	**4,216**	**233,489**	**100.00%**	**245,026**	**-4.71%**
FCA	PSN	5,196	472	1	55	**5,724**	**29.52%**	6,829	-16.18%
Staywell	HMO	872	93	0	8	**973**	**5.02%**	318	205.97%
Sunshine	HMO	7,835	691	0	80	**8,606**	**44.39%**	10,662	-19.28%
United	HMO	3,626	403	0	55	**4,084**	**21.07%**	4,626	-11.72%
Clay		**17,529**	**1,659**	**1**	**198**	**19,387**	**100.00%**	**22,435**	**-13.59%**
CMS	PSN	2,381	1,232	0	12	**3,625**	**2.65%**	3,605	0.55%
FCA	PSN	56,167	8,408	7	1,664	**66,246**	**48.38%**	72,678	-8.85%
Staywell	HMO	13,531	1,468	0	152	**15,151**	**11.06%**	13,055	16.06%
Sunshine	HMO	41,532	4,641	4	708	**46,885**	**34.24%**	54,603	-14.13%
United	HMO	4,141	774	0	114	**5,029**	**3.67%**	3,930	27.96%
Universal	HMO	0	0	0	0	**0**	**0.00%**	3,569	-100.00%
Duval		**117,752**	**16,523**	**11**	**2,650**	**136,936**	**100.00%**	**151,440**	**-9.58%**
FCA	PSN	4,840	465	1	53	**5,359**	**70.69%**	6,445	-16.85%
Staywell	HMO	430	27	0	2	**459**	**6.05%**	141	225.53%
United	HMO	1,523	195	2	43	**1,763**	**23.26%**	2,160	-18.38%
Nassau		**6,793**	**687**	**3**	**98**	**7,581**	**100.00%**	**8,746**	**-13.32%**
Reform Enrollment Totals		**347,824**	**46,328**	**104**	**7,201**	**401,457**		**432,198**	**-7.11%**

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

Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 6 and 7 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing recipients in each of these categories who chose to enroll in a Medicaid Reform health plan. "New" enrollees are defined as those recipients who were not part of Medicaid Reform for at least six months prior to the start of the year. Table 6 provides a description of each column in this report.

Table 6
Medicaid Reform Voluntary Population Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval or Nassau)
Foster, SOBRA and Refugee	The number of unique Foster Care, SOBRA, or Refugee recipients who voluntarily enrolled in a plan during the current reporting 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

Table 7 lists the number of individuals in the voluntary populations who chose to enroll in the Reform demonstration, as well as the percentage of the Medicaid Reform population they represent.

Table 7 Medicaid Reform Voluntary Population (July 1, 2013 – June 30, 2014)											
Plan Name	Plan Type	Plan County	Reform Voluntary Population								Medicaid Reform Enrollment
			Foster, Adoption Subsidy, and SOBRA		Developmental Disabilities		Dual-Eligibles		Total Voluntary		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Care Florida	HMO	Broward	21	150	0	4	35	142	**352**	**7.09%**	4,963
Clear Health	HMO	Broward	0	0	0	0	0	2	**2**	**2.78%**	72
Freedom	HMO	Broward	19	137	1	7	15	122	**301**	**5.82%**	5,173
Humana	HMO	Broward	59	558	4	33	102	442	**1,198**	**6.98%**	17,158
Magellan	HMO	Broward	3	58	0	0	7	18	**86**	**10.00%**	860
Medica	HMO	Broward	13	123	2	7	51	184	**380**	**6.63%**	5,733
Molina	HMO	Broward	130	1,204	3	47	141	631	**2,156**	**5.71%**	37,729
Positive	HMO	Broward	1	0	0	0	7	11	**19**	**5.88%**	323
Simply	HMO	Broward	5	0	3	0	22	0	**30**	**28.04%**	107
Staywell	HMO	Baker	1	2	0	0	2	1	**6**	**4.96%**	121
Staywell	HMO	Broward	39	462	0	6	13	62	**582**	**7.45%**	7,817
Staywell	HMO	Clay	4	24	0	0	1	8	**37**	**3.80%**	973
Staywell	HMO	Duval	91	320	0	7	45	107	**570**	**3.76%**	15,151
Staywell	HMO	Nassau	3	11	0	0	0	2	**16**	**3.49%**	459
Sunshine	HMO	Broward	127	1,258	1	60	95	485	**2,026**	**4.22%**	48,033
Sunshine	HMO	Clay	38	147	4	5	9	71	**274**	**3.18%**	8,606
Sunshine	HMO	Duval	170	978	10	56	62	653	**1,929**	**4.11%**	46,885
United	HMO	Baker	4	21	0	1	1	12	**39**	**4.55%**	857
United	HMO	Clay	13	81	2	5	3	52	**156**	**3.82%**	4,084
United	HMO	Duval	27	164	1	22	11	104	**329**	**6.54%**	5,029
United	HMO	Nassau	4	47	0	5	4	42	**102**	**5.79%**	1,763
HMO Total	**HMO**		**772**	**5,745**	**31**	**265**	**626**	**3,151**	**10,590**	**5.00%**	**211,896**
Better Health	PSN	Broward	133	1,558	9	84	151	746	**2,681**	**5.00%**	53,669
CMS	PSN	Duval	85	700	4	119	2	10	**920**	**25.38%**	3,625
CMS (North)	PSN	Broward	5	121	19	185	6	11	**347**	**7.02%**	4,941
CMS (South)	PSN	Broward	4	35	9	59	1	7	**115**	**5.20%**	2,213
FCA	PSN	Baker	13	56	0	4	3	21	**97**	**3.14%**	3,086
FCA	PSN	Clay	38	138	0	5	6	50	**237**	**4.14%**	5,724
FCA	PSN	Duval	248	1,475	7	155	124	1,568	**3,577**	**5.40%**	66,246
FCA	PSN	Nassau	30	93	0	7	5	49	**184**	**3.43%**	5,359
SFCCN	PSN	Broward	148	1,424	6	75	111	706	**2,470**	**5.53%**	44,698
PSN Total	**PSN**		**704**	**5,600**	**54**	**693**	**409**	**3,168**	**10,628**	**5.61%**	**189,561**
Reform Enrollment Totals			**1,476**	**11,345**	**85**	**958**	**1,035**	**6,319**	**21,218**	**5.29%**	**401,457**

Attachment III
2008 – 2013 Managed Care Performance Measures for Reform Health Plans

	Reform Plans*						
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**Trend**
Annual Dental Visit	15.2%	28.5%	33.4%	34.0%	35.3%	40.4%	improve
Adolescent Well-Care	44.2%	46.5%	46.3%	46.2%	47.6%	48.5%	flat
Controlling Blood Pressure	46.3%	55.9%	53.4%	46.3%	52.9%	45.4%	decline
Cervical Cancer Screening	48.2%	52.2%	50.8%	53.2%	56.8%	58.2%	improve
Diabetes - HbA1c Testing	78.9%	80.1%	82.8%	81.9%	82.2%	79.5%	decline
Diabetes - HbA1c Poor Control (INVERSE)	48.3%	46.8%	44.9%	48.6%	43.6%	48.9%	decline
Diabetes - HbA1c Good Control	32.2%	48.0%	47.5%	43.7%	47.9%	43.6%	decline
Diabetes - Eye Exam	35.7%	44.0%	45.4%	49.3%	50.2%	48.7%	decline
Diabetes - LDL Screening	80.0%	80.2%	83.5%	81.8%	81.9%	80.1%	decline
Diabetes - LDL Control	29.3%	35.5%	36.1%	36.9%	37.8%	32.1%	decline
Diabetes - Nephropathy	79.2%	80.3%	81.9%	83.1%	82.3%	80.2%	decline
Follow-up after Hospitalization for Mental Illness - 7 day	20.6%	29.3%	25.4%	23.1%	22.7%	23.5%	flat
Follow-up after Hospitalization for Mental Illness - 30 day	35.5%	46.6%	41.3%	44.3%	41.2%	40.8%	flat
Prenatal Care	66.6%	67.4%	75.2%	68.4%	72.1%	67.2%	decline
Postpartum Care	53.0%	51.5%	52.1%	49.3%	52.9%	51.4%	decline
Well-Child First 15 Mos. - 0 Visits (INVERSE)	4.9%	1.6%	6.0%	3.0%	2.1%	1.6%	improve
Well-Child First 15 Mos. - 6(+) Visits	44.4%	49.3%	35.4%	46.5%	58.4%	55.6%	decline
Well-Child 3-6 Years	71.3%	75.7%	72.7%	75.0%	75.5%	75.6%	flat
Adults' Access to Preventive Care - 20-44 Yrs	n/a	71.8%	71.2%	71.2%	69.8%	69.2%	flat
Adults' Access to Preventive Care - 45-64 Yrs	n/a	84.7%	84.9%	85.5%	84.9%	85.0%	flat
Adults' Access to Preventive Care - 65+ Yrs	n/a	83.6%	83.7%	84.2%	73.9%	76.2%	improve
Adults' Access to Preventive Care - total	n/a	77.2%	77.6%	77.0%	75.0%	74.7%	flat
Antidepressant Medication Mgmt - Acute**	n/a	52.0%	56.3%	56.3%	57.4%	55.1%	decline
Antidepressant Medication Mgmt - Continuation**	n/a	29.8%	43.8%	44.0%	43.1%	41.7%	decline
Appropriate Medications for Asthma***	n/a	83.6%	87.6%	86.0%	81.1%	79.3%	decline

	Reform Plans*						
Measure	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**Trend**
Breast Cancer Screening	n/a	51.4%	56.9%	59.2%	52.3%	52.7%	flat
Childhood Immunization Combo 2	n/a	63.6%	70.0%	74.0%	74.8%	77.8%	improve
Childhood Immunization Combo 3	n/a	53.8%	62.7%	66.9%	69.2%	71.6%	improve
Frequency of Prenatal Care	n/a	52.6%	46.9%	44.0%	54.4%	53.7%	flat
Lead Screening in Children	n/a	54.8%	52.0%	54.1%	59.6%	61.7%	improve
Adult BMI Assessment	n/a	n/a	41.9%	52.7%	47.9%	63.0%	improve
Follow-up Care for Children Prescribed ADHD Medication - Initiation****	n/a	n/a	43.6%	44.5%	44.4%	45.0%	flat
Immunizations for Adolescents Combo 1	n/a	n/a	44.1%	43.6%	47.3%	54.6%	improve
Chlamydia Screening - 16-20 years	n/a	n/a	n/a	56.2%	56.4%	58.6%	improve
Chlamydia Screening - 21-24 years	n/a	n/a	n/a	67.8%	68.2%	70.9%	improve
Chlamydia Screening - total	n/a	n/a	n/a	60.2%	60.6%	62.9%	Improve
Appropriate Testing for Children with Pharyngitis	n/a	n/a	n/a	65.0%	64.0%	67.7%	improve
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	n/a	n/a	n/a	n/a	94.8%	94.5%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	n/a	n/a	n/a	n/a	88.4%	88.3%	flat
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	n/a	n/a	n/a	n/a	85.0%	86.2%	improve
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	n/a	n/a	n/a	n/a	81.2%	82.3%	improve
Call Abandonment (INVERSE)	n/a	n/a	n/a	n/a	3.2%	3.4%	flat
Call Answer Timeliness	n/a	n/a	n/a	n/a	94.9%	95.4%	flat

* 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 is the weighted mean across Reform health plans, weighted by the number of eligible members each plan has per measure. Each year listed is the year in which data were reported for the previous calendar year. E.g., rates reported in 2013 are for calendar year 2012.

** Antidepressant Medication Management - Acute and Continuation: only 6 of the 13 Reform plans had sufficient eligible members to report on these measures.

*** The specifications for the Appropriate Medications for People with Asthma measure changed for 2012 reporting, so it may not be appropriate to compare results reported in 2012 and subsequent years to prior years.

**** Follow-up Care for Children Prescribed ADHD Medication - Continuation: the rate is not displayed, as only 4 of the 13 Reform plans had sufficient eligible members to report this measure.

Attachment IV
2013 Managed Care Plan Performance Measures
Comparison of Reform and Non-Reform

Measure	Non-Reform Plans*	Reform Plans*	2013 National Medicaid Mean****
Annual Dental Visit**	31.6%	40.4%	49.1%
Adolescent Well-Care	50.1%	48.5%	49.6%
Controlling Blood Pressure	52.9%	45.4%	56.1%
Cervical Cancer Screening	56.5%	58.2%	64.1%
Diabetes - HbA1c Testing	79.6%	79.5%	82.9%
Diabetes - HbA1c Poor Control (INVERSE)	44.0%	48.9%	44.8%
Diabetes - HbA1c Good Control	47.5%	43.6%	46.5%
Diabetes - Eye Exam	46.1%	48.7%	53.2%
Diabetes - LDL Screening	79.2%	80.1%	75.4%
Diabetes - LDL Control	35.0%	32.1%	33.9%
Diabetes - Nephropathy	79.8%	80.2%	78.4%
Follow-up after Hospitalization for Mental Illness - 7 day	36.3%	23.5%	43.3%
Follow-up after Hospitalization for Mental Illness - 30 day	53.5%	40.8%	63.1%
Prenatal Care	73.3%	67.2%	82.9%
Postpartum Care	52.1%	51.4%	63.1%
Well-Child First 15 Mos. - 0 Visits (INVERSE)	2.7%	1.6%	1.8%
Well-Child First 15 Mos. - 6(+) Visits	56.3%	55.6%	63.6%
Well-Child 3-6 Years	73.2%	75.6%	71.9%
Adults' Access to Preventive Care - 20-44 Yrs	66.3%	69.2%	80.2%
Adults' Access to Preventive Care - 45-64 Yrs	81.5%	85.0%	86.5%
Adults' Access to Preventive Care - 65+ Yrs	69.8%	76.2%	84.2%
Adults' Access to Preventive Care - total	70.9%	74.7%	82.5%
Antidepressant Medication Mgmt - Acute	51.8%	55.1%	52.9%
Antidepressant Medication Mgmt - Continuation	36.5%	41.7%	36.9%
Appropriate Medications for Asthma	81.0%	79.3%	83.8%

Measure	Non-Reform Plans*	Reform Plans*	2013 National Medicaid Mean****
Breast Cancer Screening	50.0%	52.7%	51.7%
Childhood Immunization Combo 2	77.5%	77.8%	75.8%
Childhood Immunization Combo 3	71.9%	71.6%	72.1%
Frequency of Prenatal Care	62.8%	53.7%	60.5%
Lead Screening in Children	57.4%	61.7%	67.4%
Adult BMI Assessment	73.8%	63.0%	67.6%
Follow-up Care for Children Prescribed ADHD Medication - Initiation***	41.3%	45.0%	39.1%
Immunizations for Adolescents Combo 1	57.3%	54.6%	67.2%
Chlamydia Screening - 16-20 years	56.5%	58.6%	53.4%
Chlamydia Screening - 21-24 years	69.1%	70.9%	63.4%
Chlamydia Screening - total	61.2%	62.9%	56.9%
Appropriate Testing for Children with Pharyngitis	61.6%	67.7%	68.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95.3%	94.5%	96.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	87.4%	88.3%	88.3%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	85.7%	86.2%	89.8%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	82.8%	82.3%	88.3%
Call Abandonment (INVERSE)	3.3%	3.4%	N/A
Call Answer Timeliness	93.5%	95.4%	83.9%

* 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.

** Annual Dental Visits - only 8 of 23 Non-Reform plans cover dental services. Only 4 of the plans had sufficient denominators to report on this measure in 2013.

*** Follow-up Care for Children Prescribed ADHD Medication - Continuation is not displayed as less than half of the Non-Reform (6 of 23) and Reform (4 of 13) plans had sufficient eligible members to report this measure.

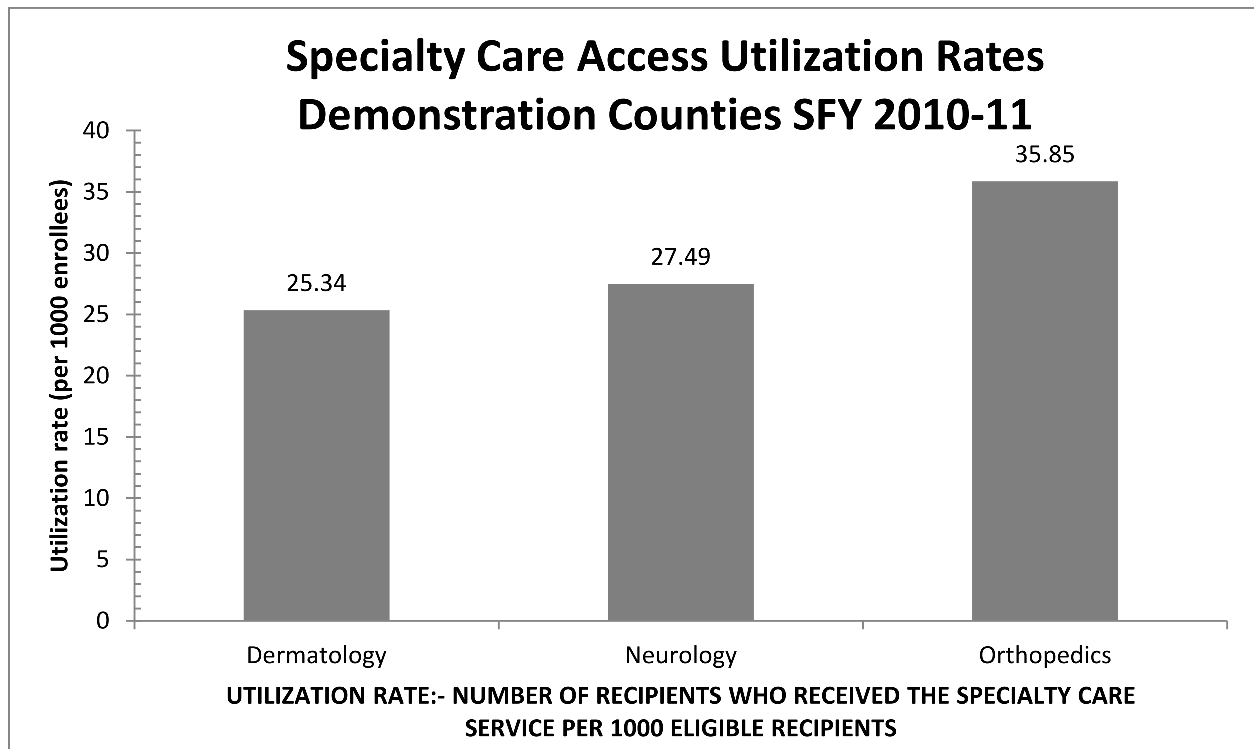
**** National Mean as published by NCQA, Medicaid product line. The National Mean that is presented is the HEDIS 2013 National Mean, for calendar/measurement year 2012. There is no longer a national mean for the Call Abandonment measure, as NCQA retired this measure. The state is continuing to have health plans report this measure, per the last NCQA specifications for the measure.

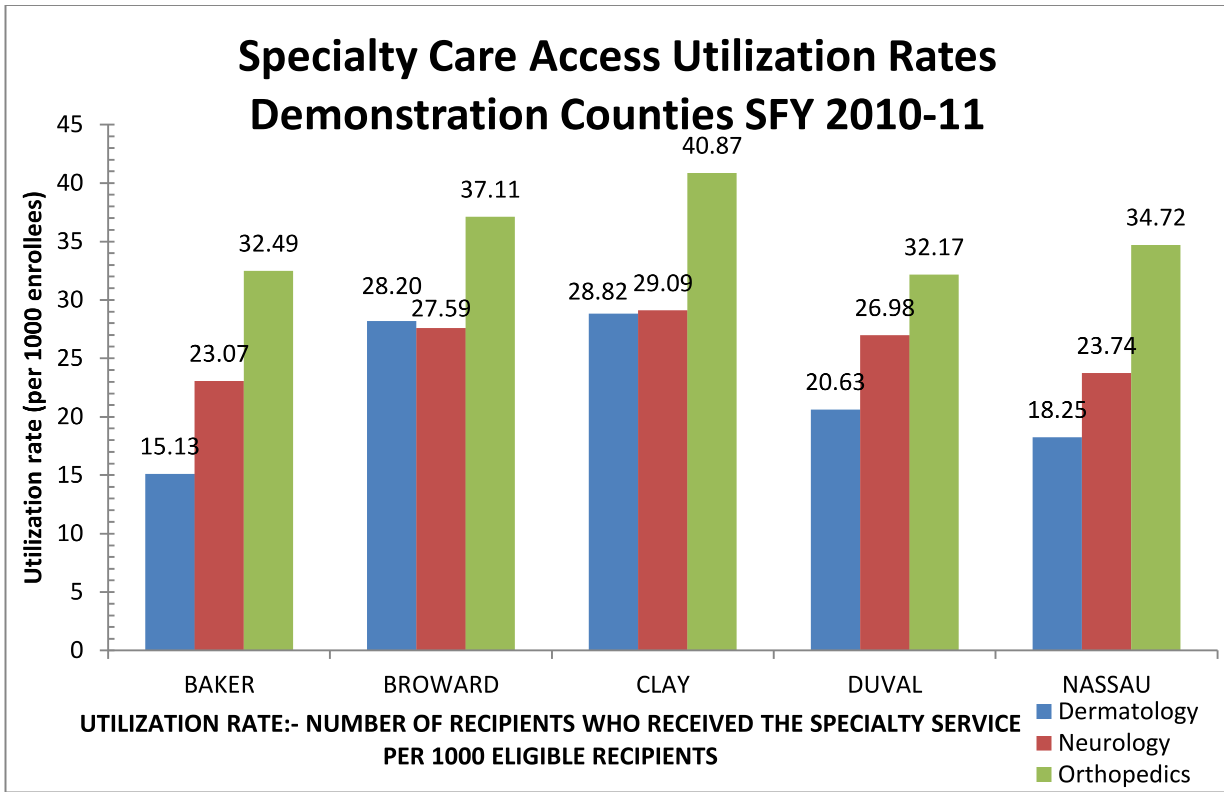
Highlighted cells indicate that the weighted means are the same as or better than the National Medicaid Mean.

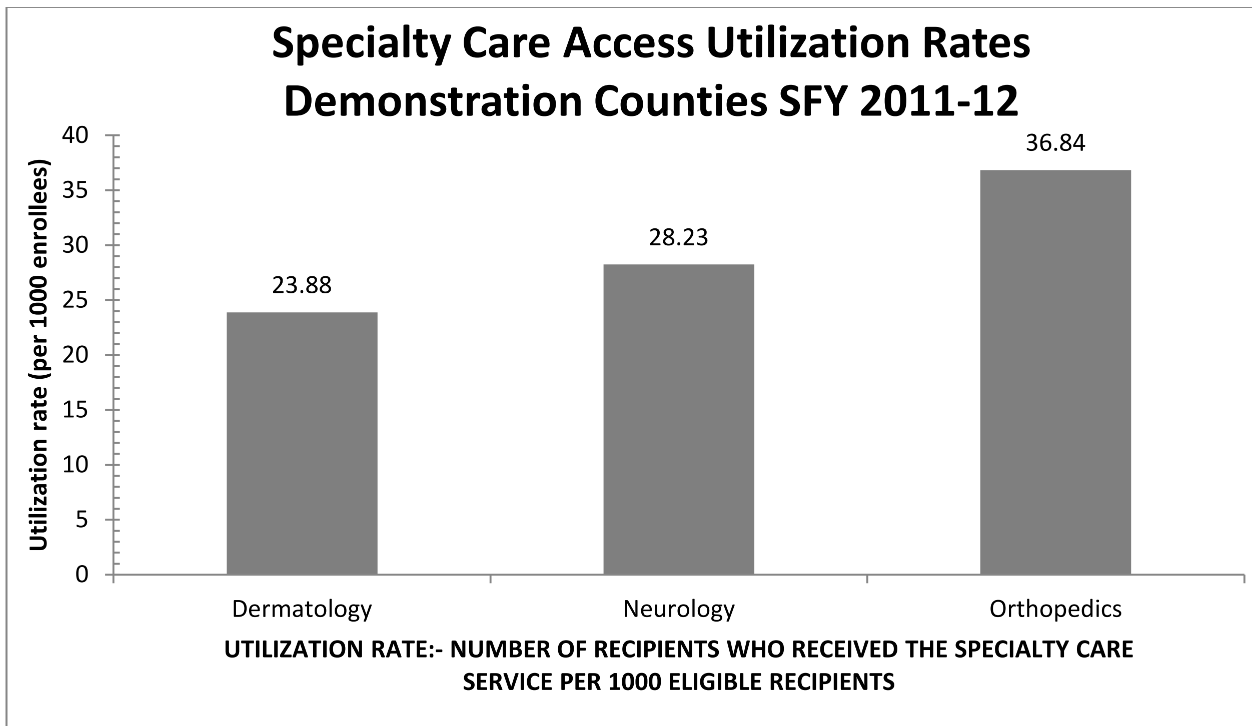
Attachment V
Objective 2(b) Improved Access to Specialists

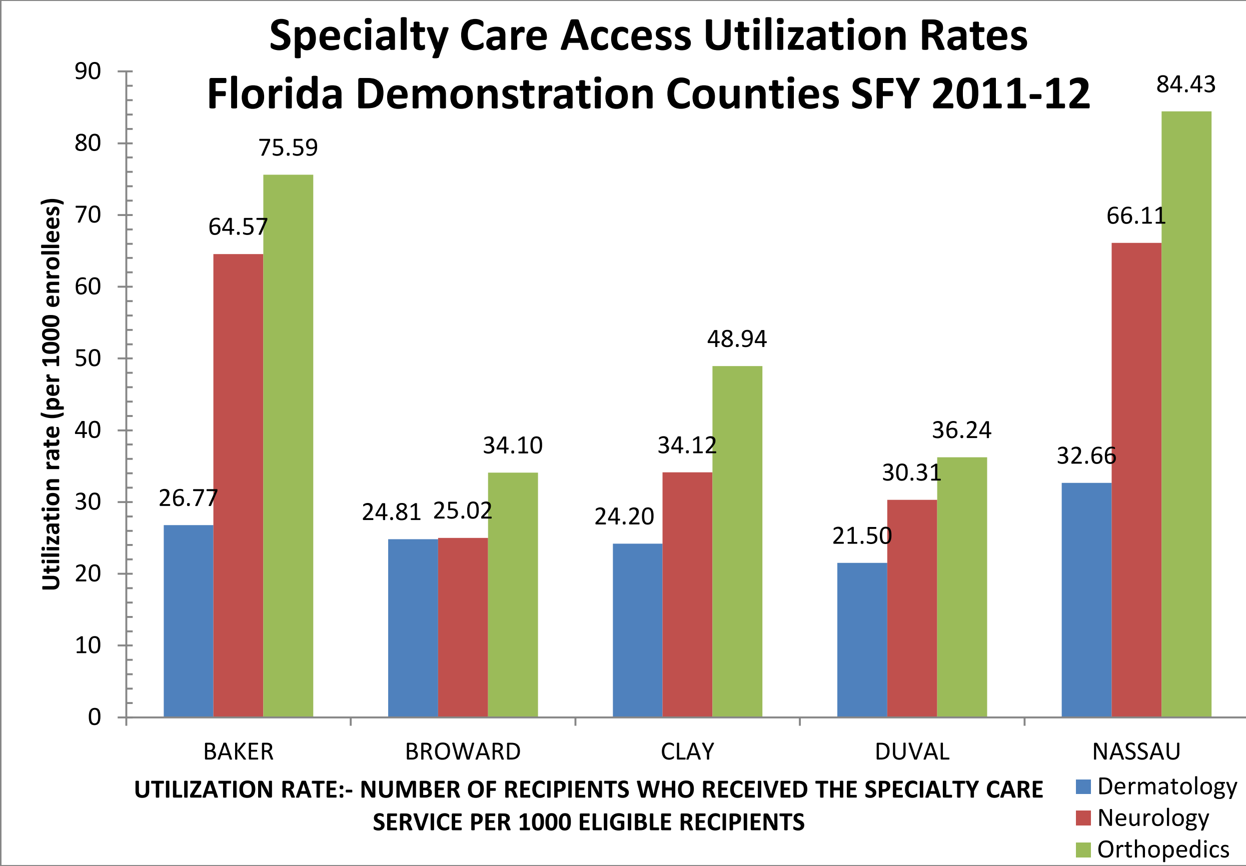
Objective 2(b): To ensure that there is improved access to specialists.

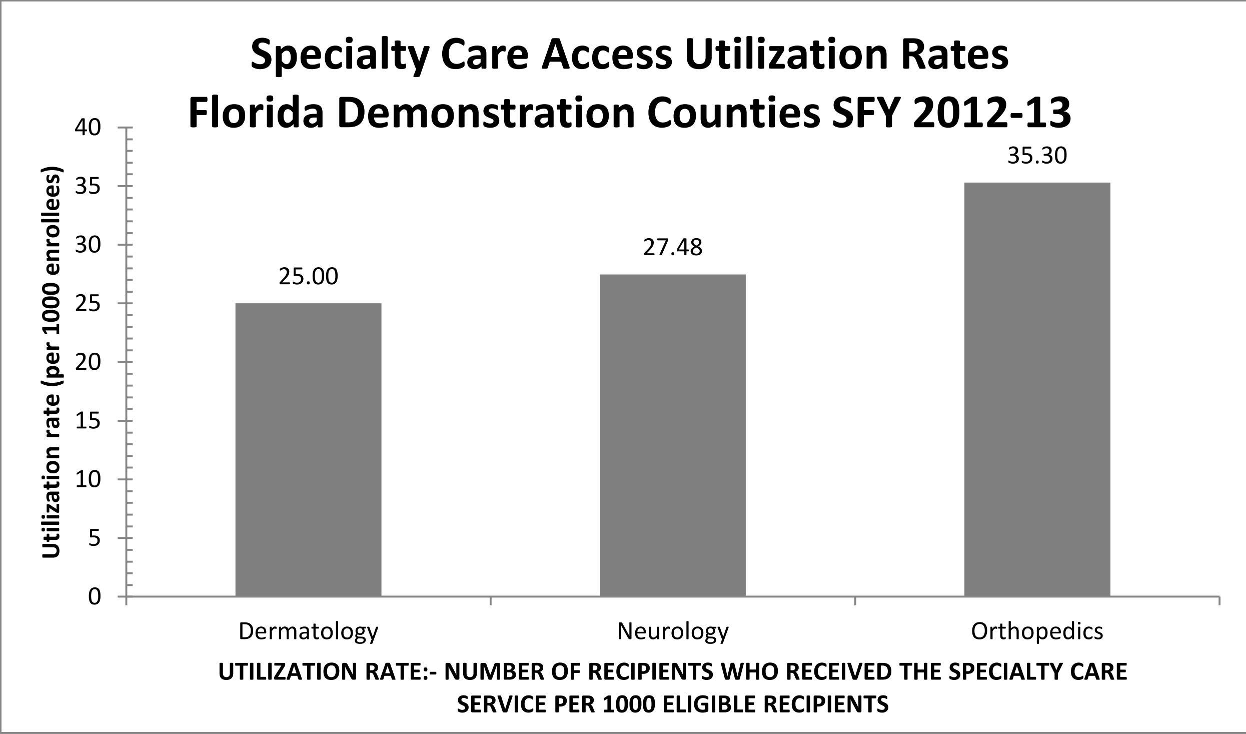
The following charts demonstrate improving accessibility to orthopedic, neurology and dermatology services for Medicaid recipients statewide and in the demonstration counties over time, for SFY 2010-11, SFY 2011-12 and SFY 2012-13.

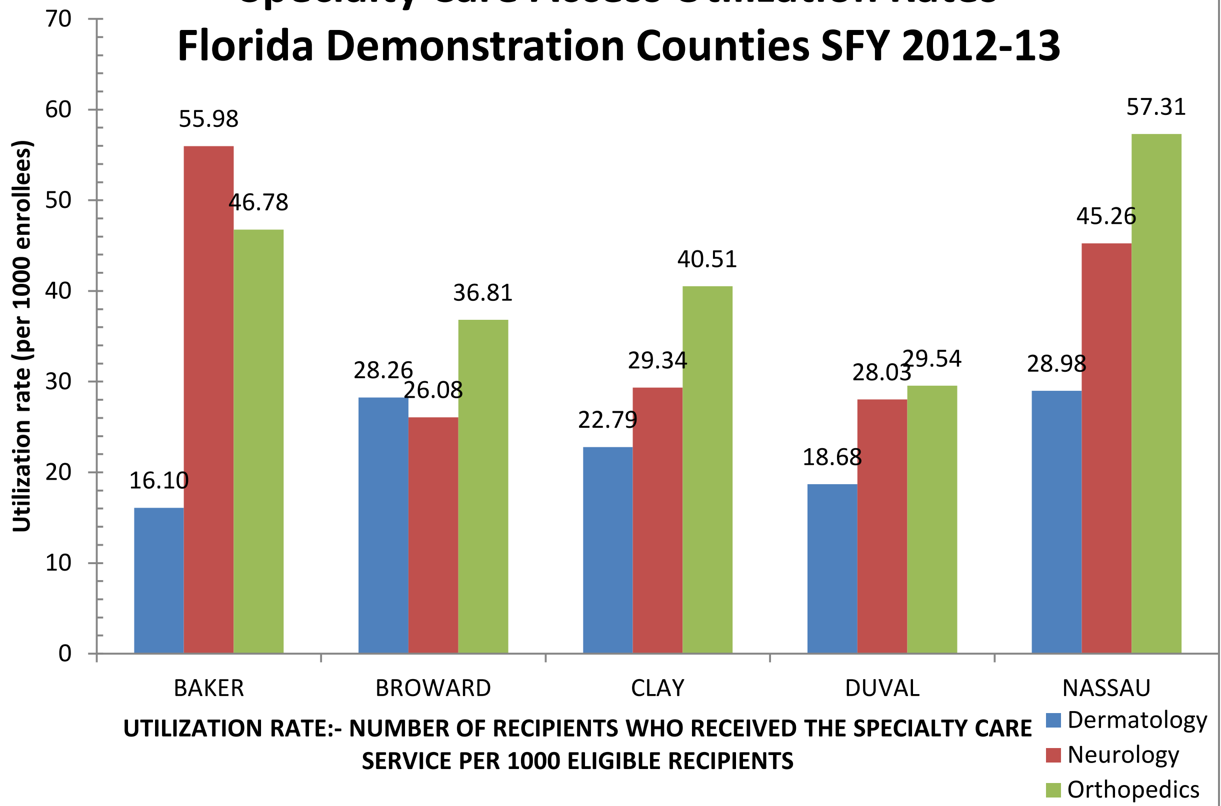



Specialty Care Access Utilization Rates
Demonstration Counties SFY 2010-11
Utilization rate (per 1000 enrollees)
45
40
35
30
25
20
15
10
5
0
15.13
23.07
32.49
28.20
27.59
37.11
28.82
29.09
40.87
20.63
26.98
32.17
18.25
23.74
34.72
BAKER
BROWARD
CLAY
DUVAL
NASSAU
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY SERVICE PER 1000 ELIGIBLE RECIPIENTS
Dermatology
Neurology
Orthopedics


Specialty Care Access Utilization Rates
Demonstration Counties SFY 2011-12
Utilization rate (per 1000 enrollees)
40
35
30
25
20
15
10
5
0
23.88
28.23
36.84
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2011-12
Utilization rate (per 1000 enrollees)
90
80
70
60
50
40
30
20
10
0
26.77
64.57
75.59
24.81
25.02
34.10
24.20
34.12
48.94
21.50
30.31
36.24
32.66
66.11
84.43
BAKER
BROWARD
CLAY
DUVAL
NASSAU
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS
Dermatology
Neurology
Orthopedics


Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2012-13
Utilization rate (per 1000 enrollees)
40
35
30
25
20
15
10
5
0
25.00
27.48
35.30
Dermatology
Neurology
Orthopedics
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS

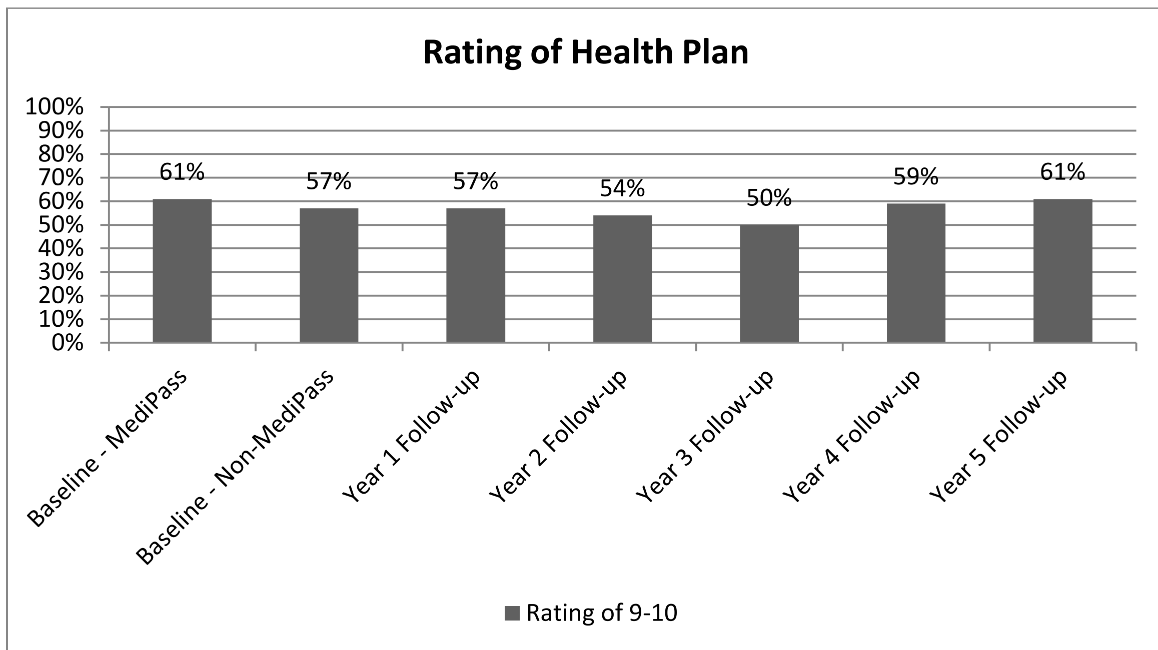

Specialty Care Access Utilization Rates
Florida Demonstration Counties SFY 2012-13
Utilization rate (per 1000 enrollees)
70
60
50
40
30
20
10
0
55.98
46.78
16.10
28.26
26.08
36.81
22.79
29.34
40.51
18.68
28.03
29.54
28.98
45.26
57.31
BAKER
BROWARD
CLAY
DUVAL
NASSAU
UTILIZATION RATE:- NUMBER OF RECIPIENTS WHO RECEIVED THE SPECIALTY CARE SERVICE PER 1000 ELIGIBLE RECIPIENTS
Dermatology
Neurology
Orthopedics

Attachment VI
Objective 4 CAHPS Survey Results

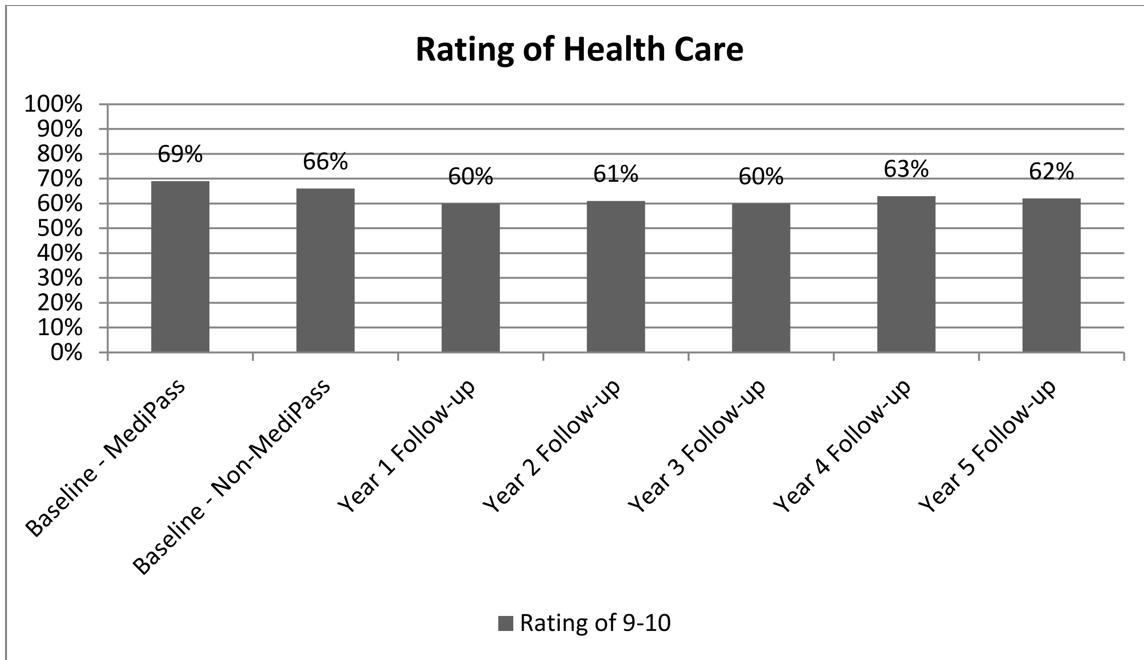
Objective 4: To ensure that enrollee satisfaction increases.

Ratings of Health Plan, Health Care, Personal Doctor, and Specialist

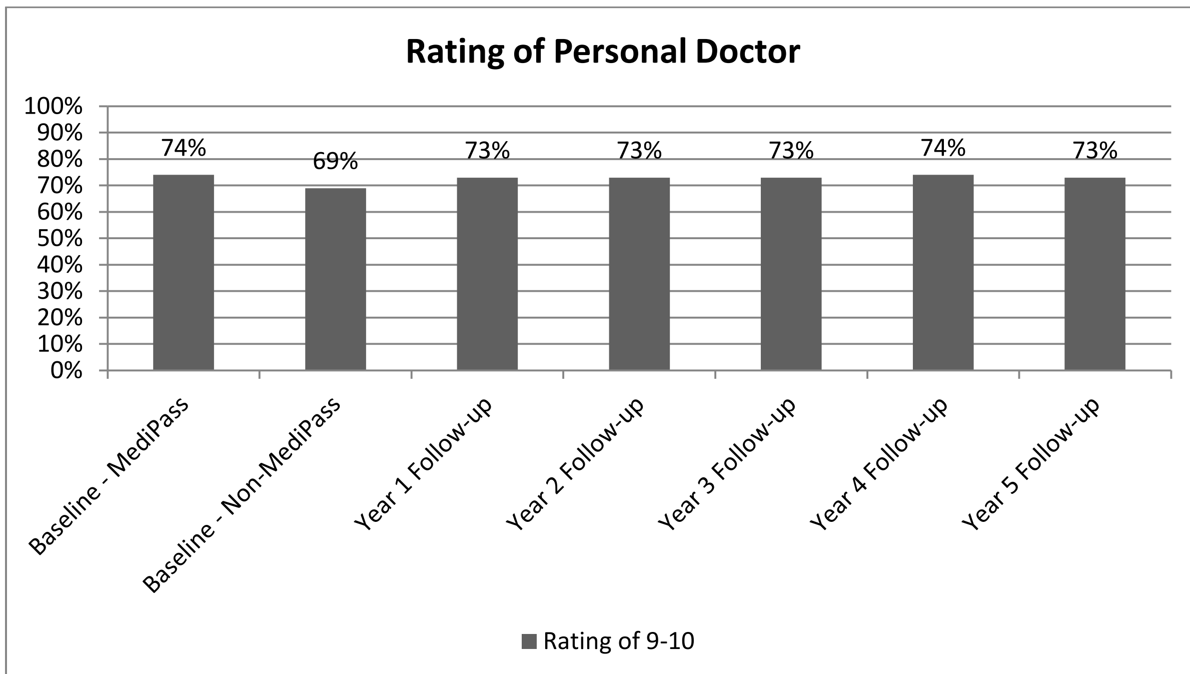
The CAHPS survey asks enrollees to rate their health plan on a scale from 0 to 10, with 0 being the worst health plan possible and 10 being the best health plan possible. At baseline, 61% of MediPass enrollees and 57% of Non-MediPass enrollees rated their health plan a 9 or a 10. The percentage of demonstration enrollees rating their plan a 9 or a 10 dropped in the Year 1 through 3 follow-up surveys, but jumped back up to 61%, approximately its Baseline level, in the Year 5 follow-up survey.



CAHPS survey respondents are asked to rate their health care on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best health care possible. At Baseline, 69% of MediPass enrollees and 66% of Non-MediPass enrollees rated their health care a 9 or 10. The percentage of demonstration enrollees rating their health care a 9 or 10 dropped in the follow-up surveys, but increased from 60% in the Year 3 follow-up survey to 63% in the Year 4 follow-up survey. In the Year 5 follow-up survey, there was an insignificant drop to 62% of enrollees rating their health care a 9 or 10.

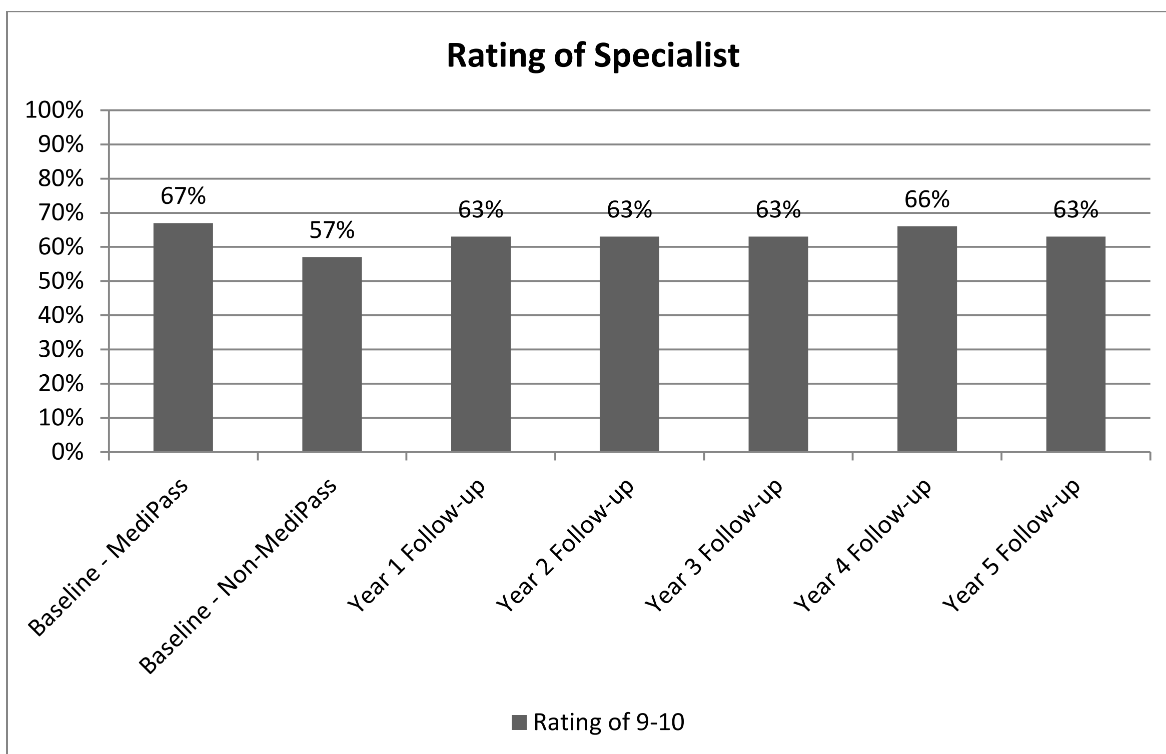


Enrollees are asked to rate their personal doctor on a scale of 0 to 10, with 0 being the worst and 10 being the best possible personal doctor. At Baseline, 74% of MediPass enrollees and 69% of Non-MediPass enrollees rated their personal doctor a 9 or a 10. The percentage of demonstration enrollees rating their personal doctor a 9 or a 10 remained high, at 73% and 74% in the Year 1 through Year 5 follow-up surveys.



The CAHPS survey also has enrollees who have seen a specialist rate their specialist on a scale from 0 to 10, with 0 being the worst possible specialist and 10 being the best possible specialist. At Baseline, 67% of MediPass enrollees and 57% of Non-MediPass enrollees rated

their specialist a 9 or 10. In the Year 1, 2, and 3 follow-up surveys, 63% of demonstration enrollees rated their specialist a 9 or 10. In the Year 4 follow-up survey, 66% of demonstration enrollees rated their specialist a 9 or 10, and this dropped back to 63% in the Year 5 follow-up survey.



Ease of Getting Care: Specialists and Care, Tests, or Treatment (Charts K and L)

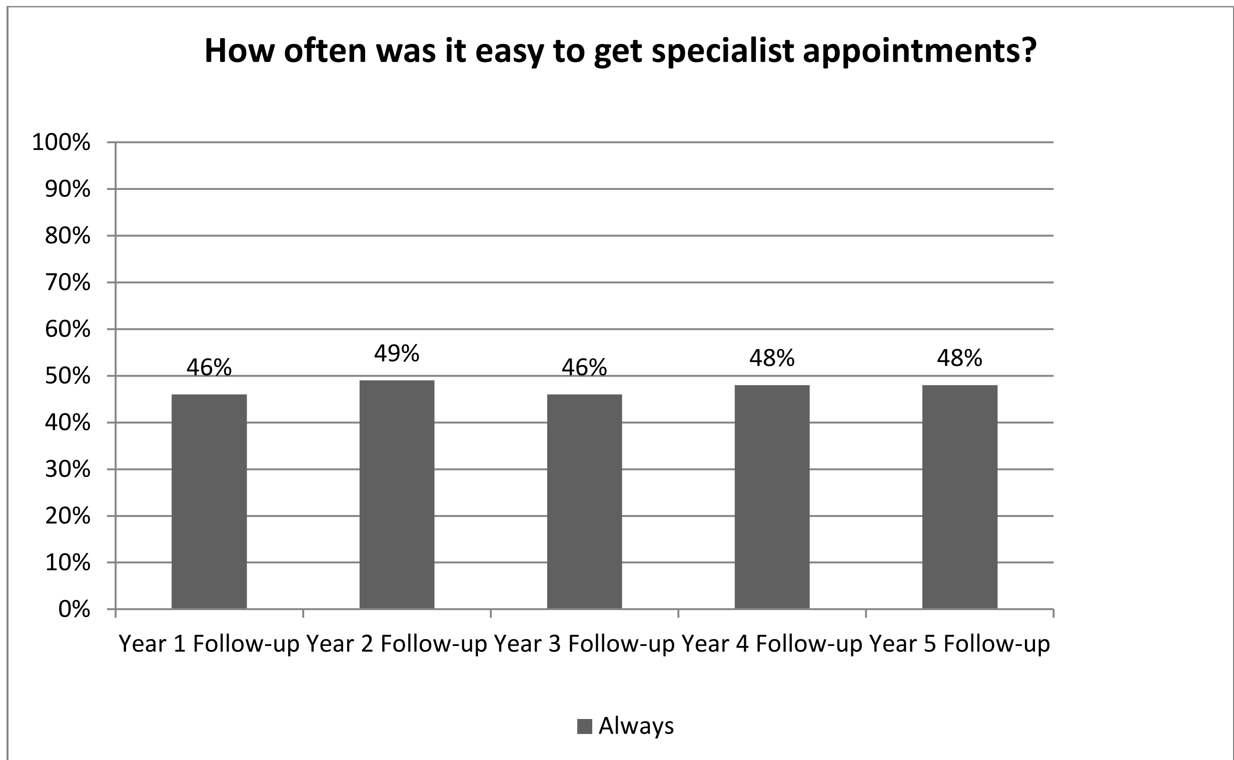
In the Baseline and Year 1 through 5 follow-up surveys, enrollees were asked about ease of getting specialist appointments and getting care, tests, or treatment needed through the respondent's health plan. The wording and orientation of these survey items changed from the Baseline to the follow-up surveys, as the Agency for Healthcare Research and Quality (AHRQ) changed from the CAHPS 3.0 version to CAHPS 4.0. In the 3.0 survey, the question was "In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?" There were only three answer categories: "a big problem," "a small problem," and "not a problem." The 3.0 survey question regarding care, tests, and treatment asked "In the last 6 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?" This question had the same three answer categories as the question regarding specialists.

In the CAHPS 4.0 survey, the wording of these two items changed to "In the last 6 months, how often was it easy to get appointments with specialists?" and "In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you (your child) needed through your health plan?" Instead of three answer categories, the 4.0 survey included four answer categories: "Never," "Sometimes," "Usually," and "Always."

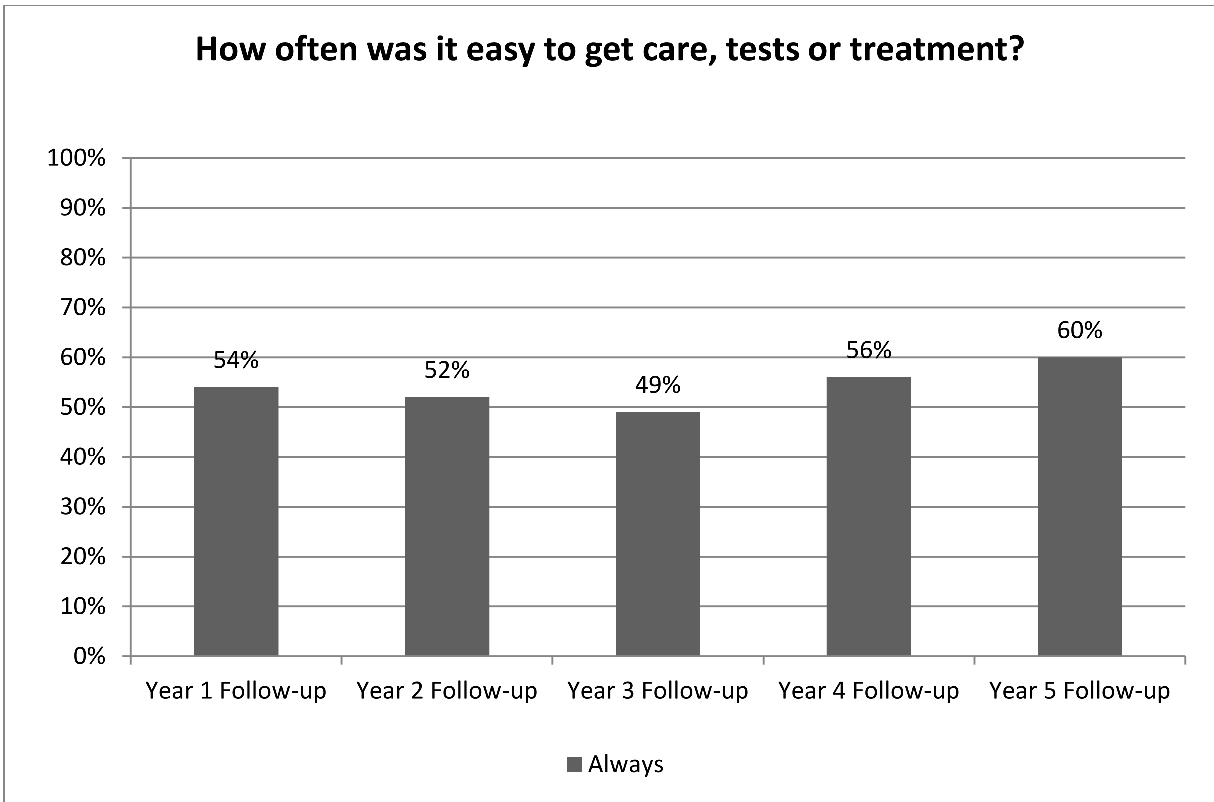
Due to the change in response categories between the Baseline survey and follow-up surveys, a comparison of the Baseline and follow-up survey results is given in the text, while the charts

below shows the percentage of respondents answering “Always” in the Year 1 through Year 5 follow-up surveys.

At Baseline, 56% of MediPass enrollees and 54% of Non-MediPass enrollees stated it was “not a problem” to see a specialist they needed to see. In the Year 1 through Year 5 follow-up surveys, the percentage of demonstration enrollees reporting it was “always” easy to get appointments with specialists ranged from 46% to 49%.

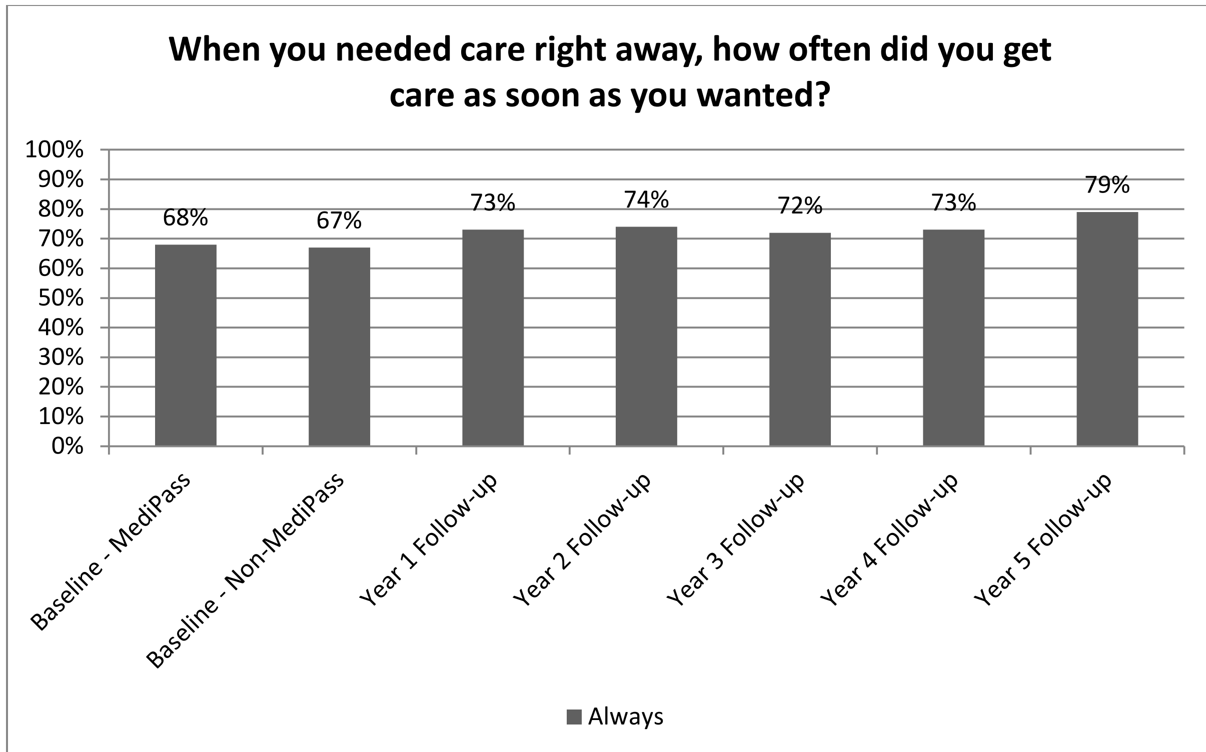


At Baseline, 72% of MediPass enrollees and 69% of Non-MediPass enrollees said it was “not a problem” to get the care, tests or treatment they or a doctor believed necessary. In the Year 1 through Year 5 follow-up surveys, the percentage of demonstration enrollees reporting it was “always” easy to get the care, tests, or treatment they thought they needed ranged from 49% to 60%.

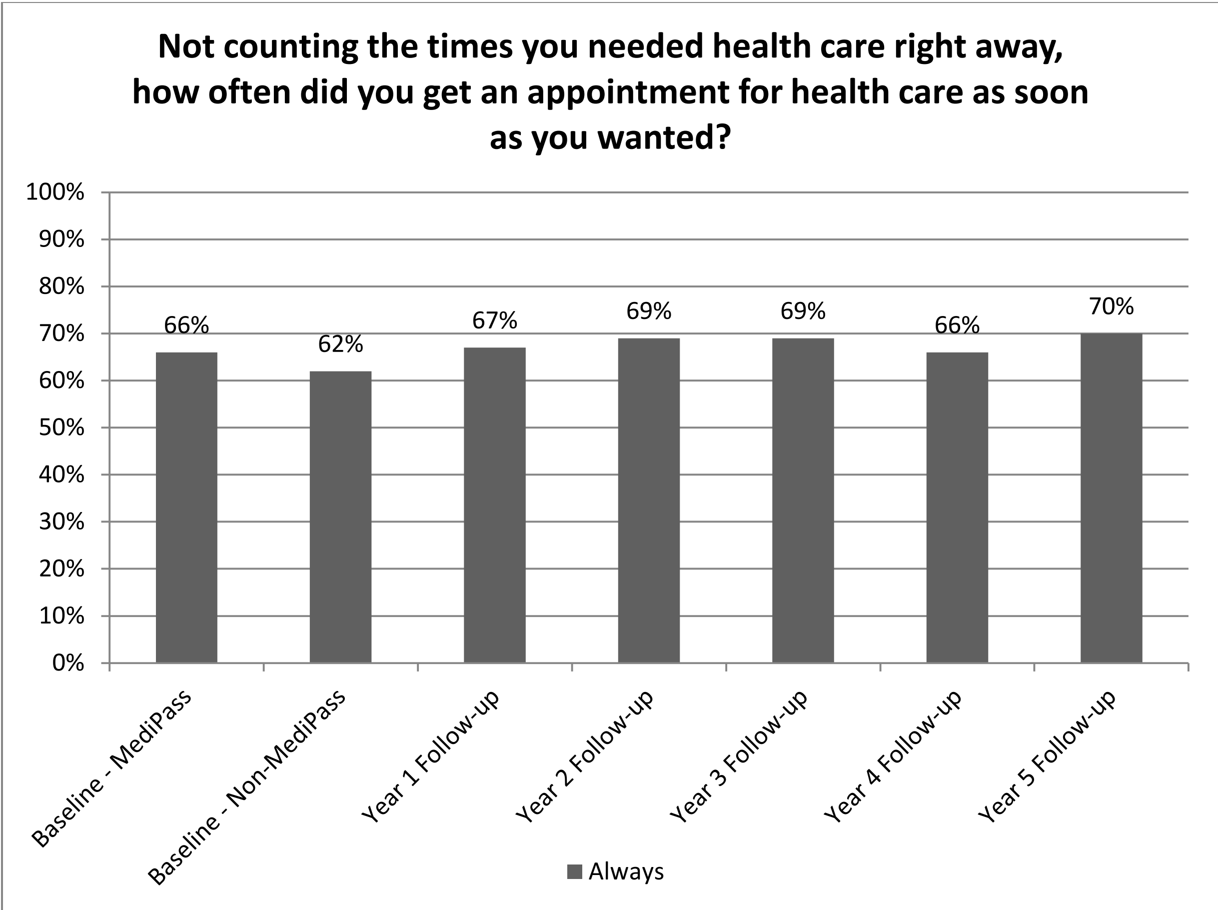


Getting Care when Needed: Urgent Care and Non-Urgent Care

Survey respondents were asked how often they got care as soon as they wanted when they needed care right away for an illness, injury, or condition. At the Baseline, 68% of MediPass and 67% of Non-MediPass respondents reported that they "always" got care as soon as they wanted when they needed care right away. In the Year 1 through Year 5 follow-up surveys, the percentage of demonstration enrollees reporting that they "always" got care as soon as they wanted it ranged from 72% to 74% in Years 1 through 4, and increased to 79% in the Year 5 follow-up survey.

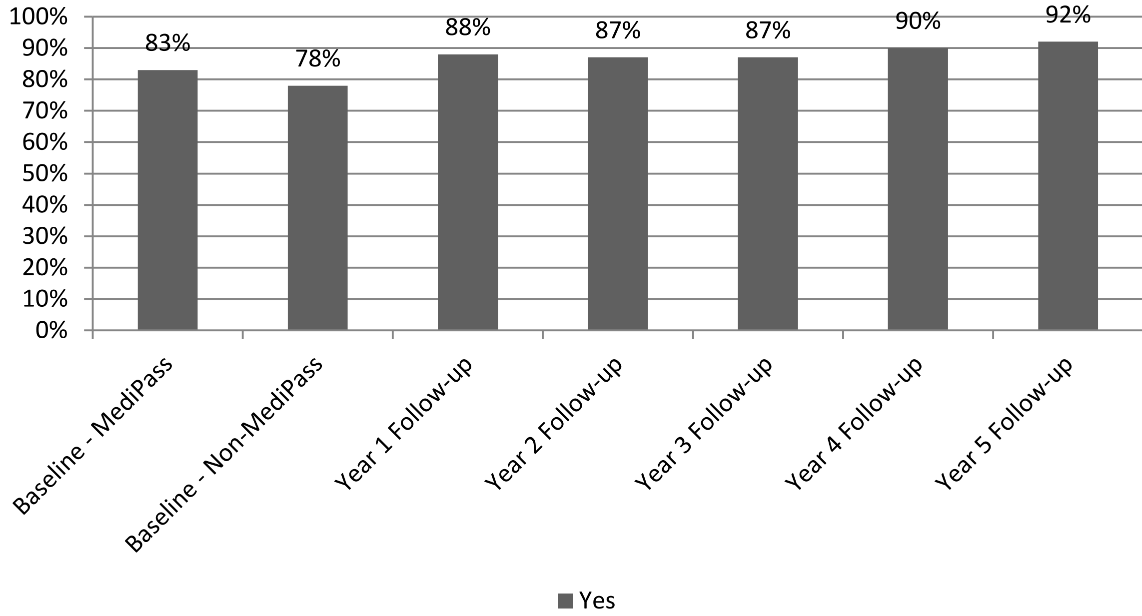


Survey respondents were also asked how often they got appointments for health care as soon as they wanted, not counting the times they needed health care right away. At Baseline, 66% of MediPass enrollees and 62% of Non-MediPass enrollees reported that they “always” got an appointment as soon as they wanted. In the Year 1 through Year 5 follow-up surveys, the percentage of demonstration enrollees reporting that they “always” got an appointment as soon as they wanted ranged from 66% to 70%.



Having a Personal Doctor

The CAHPS survey asks respondents whether they have a personal doctor, which is described as the doctor that someone would see if he or she needed a checkup, wanted advice about a health problem, or got sick or hurt. At Baseline, 83% of MediPass enrollees and 78% of Non-MediPass enrollees reported having a personal doctor. In the Year 1 through Year 5 follow-up surveys, the percentage of demonstration enrollees reporting that they have a personal doctor ranged from 87% to 92%.


Do you (or your child) have a personal doctor?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83%
78%
88%
87%
87%
90%
92%
Baseline - MediPass
Baseline - Non-MediPass
Year 1 Follow-up
Year 2 Follow-up
Year 3 Follow-up
Year 4 Follow-up
Year 5 Follow-up
Yes

Attachment VII
Budget Neutrality Update

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

The Agency certifies the accuracy of the member months identified in Tables 2 through 5 in accordance with STC #95(a).

In accordance with STC #94(d)(iv), the Agency has initiated the development of the new CMS64 reporting operation that will be required to support the 1115 MMA Waiver. The APS Healthcare company (a subcontractor under the FMMIS fiscal agent: HP Enterprise, Inc.) has been assigned the task of designing and constructing the new CMS64 waiver software application. In preparation for this task, APS is operating the current CMS64 software system. APS's understanding of the current operation will facilitate its development and design of the new application. Agency staff is working with APS to address application requirements and general design concepts. The new reporting operation will become effective in January 2015.

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

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

Tables 2 through 8 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2014. Case months provided in Tables 4 and 5 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 2 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
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**
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

Table 2 MEG 1 Statistics: SSI Related					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
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**
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**

Table 2 MEG 1 Statistics: SSI Related					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
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**
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**
July 2013	329,320	$269,942,718	$74,397,891	$344,340,609	$1,045.61
August 2013	327,794	$421,765,664	$103,646,815	$525,412,478	$1,602.87
September 2013	325,598	$163,314,895	$57,442,933	$220,757,828	$678.01
Q29 Total	**982,712**	**$879,236,988**	**$234,142,785**	**$1,113,379,773**	**$1,132.97**
October 2013	333,834	$416,763,833	$99,507,989	$516,271,821	$1,546.49
November 2013	329,927	$183,905,627	$58,732,842	$242,638,469	$735.43

Table 2 MEG 1 Statistics: SSI Related					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	Case months	Spend*	Spend*	Total Spend*	PCCM
December 2013	327,542	$293,375,301	$72,453,594	$365,828,895	$1,116.89
Q30 Total	**991,303**	**$894,044,760**	**$230,694,425**	**$1,124,739,185**	**$1,116.89**
January 2014	335,444	$406,154,119	$95,754,688	$501,908,807	$1,496.25
February 2014	335,837	$272,744,863	$64,939,737	$337,684,601	$1,005.50
March 2014	336,271	$162,170,158	$40,344,772	$202,514,929	$602.24
Q31 Total	**1,007,552**	**$841,069,140**	**$201,039,197**	**$1,042,108,337**	**$1,034.30**
April 2014	339,717	$439,021,196	$88,913,591	$527,934,787	$1,554.04
May 2014	339,557	$158,552,323	$32,054,482	$190,606,805	$561.34
June 2014	339,549	$284,472,380	$54,916,699	$339,389,079	$999.53
Q32 Total	**1,018,823**	**$882,045,900**	**$175,884,772**	**$1,057,930,671**	**$1,038.39**
MEG 1 Total	**27,604,218**	**24,510,864,606**	**4,640,467,093**	**29,151,331,699**	**1,056.05**

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

Table 3 MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
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

Table 3 MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
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
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

Table 3 MEG 2 Statistics: Children and Families					
Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	Case months	Spend*	Spend*	Total Spend*	PCCM
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
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

Table 3 MEG 2 Statistics: Children and Families					
Quarter		**MCW Reform**	**Reform Enrolled**		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
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**
July 2013	2,058,208	$557,312,597	$73,872,340	$631,184,938	$306.67
August 2013	2,067,890	$165,413,504	$18,308,331	$183,721,835	$88.85
September 2013	2,053,699	$336,405,579	$41,941,729	$378,347,308	$184.23
Q29 Total	**6,179,797**	**$1,059,131,680**	**$134,122,400**	**$1,193,254,080**	**$193.09**
October 2013	2,084,154	$551,423,510	$75,589,844	$627,013,354	$300.85
November 2013	2,074,065	$171,934,136	$23,274,841	$195,208,977	$94.12
December 2013	2,079,491	$347,354,539	$45,890,409	$393,244,949	$189.11
Q30 Total	**6,237,710**	**$1,070,712,185**	**$144,755,094**	**$1,215,467,279**	**$194.86**
January 2014	2,058,035	$481,915,539	$62,296,533	$544,212,072	$264.43
February 2014	2,068,819	$286,629,453	$38,948,927	$325,578,380	$157.37
March 2014	2,071,206	$132,621,415	$21,041,358	$153,662,773	$74.19
Q31 Total	**6,198,060**	**$901,166,406**	**$122,286,818**	**$1,023,453,224**	**$165.12**
April 2014	2,073,461	$485,506,218	$74,562,670	$560,068,887	$270.11
May 2014	2,075,518	$113,845,160	$16,741,937	$130,587,098	$62.92
June 2014	2,102,763	$302,019,241	$42,753,483	$344,772,725	$163.96
Q32 Total	**6,251,742**	**$901,370,619**	**$134,058,091**	**$1,035,428,710**	**$165.62**
MEG 2 Total	**160,979,597**	**24,441,817,470**	**2,923,782,719**	**27,365,600,189**	**169.99**

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

For DY1, MEG 1 has a PCCM of $972.13 (Table 4), compared to WOW of $948.79 (Table 1), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 4), compared to WOW of $199.48 (Table 1), which is 80.32% of the target PCCM for MEG 2.

For DY2, MEG 1 has a PCCM of $1,022.14 (4), compared to WOW of $1,024.69 (Table 1), which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 (Table 4), compared to WOW of $215.44 (Table 1), which is 78.84% of the target PCCM for MEG 2.

For DY3, MEG 1 has a PCCM of $1,057.86 (Table 4), compared to WOW of $1,106.67 (Table 1), which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 (Table 4), compared to WOW of $232.68 (Table 1), which is 71.76% of the target PCCM for MEG 2.

For DY4, MEG 1 has a PCCM of 1077.30 (Table 4), compared to WOW of $1,195.20 (Table 1), which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 (Table 4), compared to WOW of $251.1 (Table 29), which is 66.42% of the target PCCM for MEG 2.

For DY5, MEG 1 has a PCCM of $1,096.59 (Table 4), compared to WOW of $1,290.82 (Table 1, which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 (Table 4), compared to WOW of $271.39 (Table 1), which is 61.58% of the target PCCM for MEG 2.

For DY6, MEG 1 has a PCCM of $1,104.25 (Table 4), compared to WOW of $1,356.65 (Table 1), which is 81.40% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.13 (Table 4), compared to WOW of $285.77 (Table 1), which is 61.63% of the target PCCM for MEG 2.

For DY7, MEG 1 has a PCCM of $1,097.22 (Table 4), compared to WOW of $1,425.84 (Table 1), which is 76.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $179.68 (Table 4), compared to WOW of $300.92 (Table 1, which is 59.71% of the target PCCM for MEG 2.

For DY8, MEG 1 has a PCCM of $1006.00 (Table 4), compared to WOW of $1,498.56 (Table 1), which is 67.13% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.98 (Table 4), compared to WOW of $316.87 (Table 1), which is 53.01% of the target PCCM for MEG 2.

Table 4
MEG 1 and 2 Annual Statistics

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

Table 4 MEG 1 and 2 Annual Statistics					
Difference				$(395,790,377)	
% of WOW PCCM MEG 1					90.14%
DY04 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY04 Total	20,033,842	$2,992,091,000	$351,770,759	$3,343,861,760	$166.91
WOW DY4 Total	20,033,842			$5,034,304,156	$251.29
Difference				$(1,690,442,397)	
% of WOW PCCM MEG 2					66.42%
DY05 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY05 Total	3,499,758	$3,247,599,951	$590,194,459	$3,837,794,411	$1,096.59
WOW DY5 Total	3,499,758			$4,517,557,622	$1,290.82
Difference				$(679,763,211)	
% of WOW PCCM MEG 1					84.95%
DY05 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY05 Total	21,686,199	$3,225,551,490	$398,406,833	$3,623,958,323	$167.11
WOW DY5 Total	21,686,199			$5,885,417,547	$271.39
Difference				$(2,261,459,223)	
% of WOW PCCM MEG 2					61.58%
DY06 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY06 Total	3,653,867	$3,385,729,683	$649,065,772	$4,034,795,456	$1,104.25
WOW DY6 Total	3,653,867			$4,957,018,666	$1,356.65
Difference				$(922,223,210)	
% of WOW PCCM MEG 1					81.40%
DY06 – MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY06 Total	22,956,197	$3,543,588,406	$499,575,622	$4,043,164,027	$176.13
WOW DY6 Total	22,956,197			$6,560,192,417	$285.77
Difference				$(2,517,028,389)	
% of WOW PCCM MEG 2					61.63%
DY07 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY07 Total	3,830,936	$3,330,902,447	$872,460,169	$4,203,362,616	$1,097.22
WOW DY7 Total	3,830,936			$5,462,301,786	$1,425.84
Difference				$(1,258,939,170)	
% of WOW PCCM MEG 1					76.95%

Table 4 MEG 1 and 2 Annual Statistics					
DY07– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY07 Total	24,348,400	$3,890,893,353	$483,915,369	$4,374,808,722	$179.68
WOW DY7 Total	24,348,400			$7,326,920,528	$300.92
Difference				$(2,952,111,806)	
% of WOW PCCM MEG 2					59.71%
DY08 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY08 Total	4,000,390	$3,256,029,225	$768,343,431	$4,024,372,657	$1,006.00
WOW DY8 Total	4,000,390			$5,994,824,438	$1,498.56
Difference				$(1,970,451,782)	
% of WOW PCCM MEG 1					67.13%
DY08– MEG 2	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 2 - DY08 Total	24,867,309	$3,669,575,214	$507,618,494	$4,177,193,707	$167.98
WOW DY8 Total	24,867,309			$7,879,704,203	$316.87
Difference				$(3,702,510,495)	
% of WOW PCCM MEG 2					53.01%

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

Table 5 MEG 1 and 2 Cumulative Statistics					
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 06	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					70.14%
DY 07	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$7,221,795,800	$1,356,375,538	$8,578,171,338	$304.41
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,211,050,976)	
% Of WOW					67.07%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,867,699	$6,925,604,439	$1,275,961,925	$8,201,566,364	$284.11
WOW	28,867,699			$13,874,528,641	$480.62
Difference				$(5,672,962,277)	
% Of WOW					59.11%

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

Table 6 WW/WOW Difference Less CNOM Costs	
DY08 Difference July 2013 - June 2014:	($5,672,962,277)
CNOM Costs January 2014 - June 2014:	
Healthy Start	$9,944,595
PACC	$295,361
DY08 Net Difference:	($5,662,722,321)

Table 7 MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
Q1	**$1,645,533**
Q2	**$299,648,658**
Q3	**$284,838,612**
Q4	**$380,828,736**
Q5	**$114,252,478**
Q6	**$191,429,386**
Q7	**$319,005,892**
Q8	**$329,734,446**
Q9	**$165,186,640**
Q10	**$226,555,016**
Q11	**$248,152,977**
Q12	**$178,992,988**
Q13	**$209,118,811**
Q14	**$172,524,655**
Q15	**$171,822,511**
Q16	**$455,671,026**
Q17	**$324,573,642**
Q18	**$387,535,118**
Q19	**$180,732,289**
Q20	**$353,499,776**
Q21	**$57,414,775**
Q22	**$346,827,872**
Q23	**$175,598,167**
Q24	**$227,391,753**
Q25	**$189,334,002**
Q26	**$243,596,958**
Q27	**$277,637,763**
Q28	**$308,722,821**
Q29	**$163,925,949**
Q30	**$316,726,485**
Q31	**$374,225,087**
Q32	**$301,519,921**
Total Paid	**$7,978,670,743**

Table 8 shows that the expenditures for the 32 quarters for MEG 3, Low Income Pool (LIP), were $7,978,670,743 (99.73% of the $8 billion cap).

Table 8 MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$877,493,058	$1,000,000,000	87.75%
DY04	$1,122,122,816	$1,000,000,000	112.21%
DY05	$997,694,341	$1,000,000,000	99.77%
DY06	$807,232,567	$1,000,000,000	80.72%
DY07	$1,019,291,544	$1,000,000,000	101.93%
DY08	$1,156,397,442	$1,000,000,000	115.64%
Total MEG 3	$7,978,670,743	$8,000,000,000	99.73%

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

Attachment VIII
Summary of Public Comments

(Section III.H of the 1115 MMA Waiver Extension Request)

The following summarizes the public comments received during the 30-day comment period for the waiver extension request that began October 1, 2013 and ended October 30, 2013. A total of 219 individuals attended the public meetings and 78 comments or questions were received during the public comment period. Table 4 provides the total number of participants for each of the public meetings.

Table 4
Total Number of Participants by Public Meeting

Date	Type of Meeting	Location	Number of Participants
August 8, 2013	LIP Council	Tallahassee	13
October 8, 2013	Public Meeting	Tampa	56
October 9, 2013	Public Meeting	Miami	65
October 11, 2013	Public Meeting	Tallahassee	63
October 15, 2013	Medical Care Advisory Committee[1]	Tallahassee	22
Total			**219**

Summary of Comments

The comments received are grouped by topic with an explanation ***(bolded and italicized)*** describing how issues raised are addressed in the plan contract, competitive procurement process, state law or rule.

Pharmacy Services

- Concerns were expressed about a potential shift in utilization to mail order or out of state pharmacies under the expansion of managed care. A related general concern was expressed related to the Florida Medicaid program implementing statutory provisions which allow expanded mail order of pharmacy products.

  Specific requirements in the MMA program were established to ensure recipients receive medically necessary pharmacy services in a timely manner. Managed Care Plans must ensure that regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of the contract. Some of the contract requirements, specific to pharmacy services are outlined below:

  - ***There must be at least one pharmacy for every 2,500 enrollees in a region.***
  - ***In urban areas, a pharmacy must be available to an enrollee within a 30 minute drive or 20 mile distance.***

[1] Due to technical difficulties with the conference call, the two council members who attended by conference call were unable to participate during the first part of the meeting held on October 15, 2013 from 1pm to 4pm.

- ***In rural areas, a pharmacy must be available within a 60 minute drive or 45 mile distance.***

MMA plans may choose to utilize mail order pharmacies to provide various services, including expanded benefits, but may not require enrolled recipients to utilize mail order pharmacies exclusively as a pharmacy services provider. In addition, mail order pharmacies cannot be used to meet the network adequacy requirements that are established in the contract.

- Concerns were expressed related to manufacturer rebates.

In 2010, the federal law changed to require states to collect manufacturer rebates for claims reimbursed by Medicaid managed care plans. Currently, managed care plans (or their pharmacy benefit managers) may negotiate with manufacturers for supplemental rebates. The new MMA contracts will prohibit plans from negotiating rebates directly with manufacturers, and all federal and supplemental rebates paid for claims reimbursed by Medicaid plans will be paid directly to the state.

ARNP Participation

- Concerns were expressed that Advanced Registered Nurse Practitioners will not be included as eligible primary care providers under the MMA program.

The current managed care contract and the MMA contract provide a definition of primary care provider to include Advanced Registered Nurse Practitioners (ARNP). Neither the statutory nor the plan contract language for the MMA program preclude the use of ARNPs as primary care providers.

Subcontractor Concerns

- Questions were received from durable medical equipment providers regarding the subcontracting process and how it will work under Managed Medical Assistance program. For example, will the MMA plans be allowed to contract with network managers who contracts with durable medical equipment providers?

Managed care plans may delegate some of their functions or responsibilities for providing services (e.g., credentialing) under the MMA program. However, if a managed care plan chooses to delegate some of its functions related to network management, the plan must still comply with network adequacy standards outlined in the contract. This includes regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties.

Provider Grievance Process

- Concerns were expressed by providers that a strong provider grievance process will need to be established for the MMA program. Providers stated concerns about being locked into a contract with a poor performing MMA plan.

Providers may appeal claim disputes through the plan or through the state's independent dispute resolution organization. A description of the independent dispute resolution process is provided at the following link: *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/SPHPClaimDRP/claimsdisputeprogramsummary.pdf.* ***No provider is required to contract with any managed care plan, and there is no state requirement that locks providers into contracts with managed***

care plans, and contracts without a cancellation clause are rare. Providers that are concerned about being locked in, however, should ensure that they only sign contracts that have a termination clause.

Provider Access to Risk Adjustment Data

- Requests received to access to data the Agency used to establish risk adjusted rates.

  The Agency will respond to public requests for data within constraints related to protecting personal health information as required by both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by 42 CFR 431.300-306.

Access to Certain Services

- Concerns were expressed regarding the provision of inpatient psychiatric services to children through the MMA program.

  The state's current Section 1915(b) Statewide Inpatient Psychiatric Program waiver will continue to operate until that federal authority expires on 12/31/2013. After that time and until the MMA program is implemented, inpatient psychiatric services for children will continue to be offered under the authority of Florida's Medicaid State Plan. During this period, inpatient psychiatric services for children will continue to be reimbursed on a fee-for-service arrangement. Upon implementation of the MMA program, inpatient psychiatric services for children will be provided by the MMA plans in accordance with the plan contract. The MMA plans and service providers will be required to comply with the state's rules and coverage and limitations policies.

- Concerns were raised regarding the State's implementation of recent statutory changes that allow foster care children to continue to receive services up to age 21.

  The Agency is in the process of updating its coverage and limitations handbooks to reflect this statutory change and has also submitted a state plan amendment to modify Medicaid eligibility requirements. Managed Medical Assistance plans will be required to continue to provide services to this population up to the age of 21.

- A recommendation was received that smoking cessation medications be included as a covered service and alcohol and drug screenings become more thorough for Medicaid recipients.

  Smoking cessation prescription products are already covered services under the Florida Medicaid program. Approved drug categories related to smoking cessation are listed on the Medicaid preferred drug list (PDL). In order to promote an effective transition of recipients during implementation of the MMA program, the Agency will require that plans use the Medicaid PDL during the first year of operation. Therefore, MMA plans must provide smoking cessation medications consistent with the Agency PDL to enrollees who want to quit smoking. After the first year of operation MMA plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.

  In addition, the MMA plans are required to offer healthy behavior programs that encourage and reward behaviors designed to improve the enrollee's overall health. More specifically, the plans are required to implement a medically approved smoking cessation program. Plans may choose to utilize different therapeutic approaches to

aid an enrollee who wishes to quit smoking, which may include the use of prescription medications.

The MMA plans are also required to implement a medically approved alcohol or substance abuse recovery healthy behavior program. Under this program, MMA plans must offer annual alcohol or substance abuse screening training to their providers. In addition, primary care providers must screen managed care enrollees for signs of alcohol or substance abuse as part of the evaluation at the following times:

- ***Initial contact with a new enrollee***
- ***Routine physical examinations***
- ***Initial prenatal contact***
- ***When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services***
- ***When documentation of emergency room visits suggests the need.***

- Concerns were expressed about potential delays with obtaining prior authorization for hospice services since recipients often cannot wait 24 to 48 hours for approval.

  Managed Medical Assistance plans are not required to prior authorize every covered service. Therefore, some managed care plans may choose to not prior authorize hospice service. However, if authorization is required, MMA plans must process the request and make a decision as expeditiously as the enrollee's health condition requires.

- Concerns were expressed about the participation of limited mental health assisted living facilities in the MMA program.

  The Agency is involved in discussions with owners/operators of assisted living facilities with limited mental health licenses and managed care plans to address the special needs of these recipients as we expand managed care across the state. One of the goals of these discussions is to build bridges between the assisted living facilities, managed care plans, and providers of behavioral health care treatment to ensure that recipients have a stable living environment and access to the care they need to maintain residency in a community setting of their choice.

Plan Accountability and Monitoring

- Recommendation was received that the Agency monitor the plan's financial data reported closely to ensure the accuracy of the plan's medical loss ratio reports and prevent fraud.

  The Agency is establishing new financial reporting requirements that will support additional plan financial monitoring, medical loss ratio justification, and calculation of the achieved savings rebate outlined in s. 409.967(3), F.S.

- Recommendation was received to use "secret shoppers" and other methods to ensure provider availability.

  The Agency will utilize multiple monitoring and evaluation tools to ensure managed care plans are compliant with network adequacy standards.

Program Participation

- Comments received indicated that some individuals were unclear about whether or not certain groups (family members, dually eligible recipients, and individuals with developmental disabilities) will be required to participate in the program.

  In general, all individuals eligible for Medicaid will receive coverage through an MMA plan upon full implementation except for groups specified in state law and the terms and conditions of the waiver. Prior to implementation of the program in a region, information regarding enrollment in the program will be made available to impacted recipients through the Agency's website and other publications. In addition, the Agency has developed a comprehensive education and outreach program that is outlined in the MMA Implementation Plan posted on the Agency's website at the following link:
  http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf

  Individuals eligible for Medicare and Medicaid services are required to enroll in a MMA plan in accordance with state law and the terms and conditions of the waiver.

  Individuals enrolled in the developmental disabilities (iBudget) waiver may voluntarily choose to enroll in an MMA plan in accordance with state law and the special terms and conditions of the waiver.

Provider Network Adequacy

- Concerns were expressed regarding the MMA plans provider network standards.

  In order to ensure access to necessary Medicaid services, the Agency established specific standards for the number, type, and regional distribution of providers in plan networks.

  The MMA plans are required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the Agency deems necessary. The provider database must be available online to both the Agency and the public. It must allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

  Plans may limit the providers in their networks but must include certain provider types and also certain providers that are specified in Part IV of Chapter 409, F.S., as "statewide essential."

- Concerns were expressed regarding network adequacy that out-patient dialysis facilities also be listed on the Provider Network Standards list.

  Managed Medical Assistance plans must develop and maintain a provider network that meets the needs of enrollees, including contracting with a sufficient number of credentialed providers to furnish all covered services. MMA plans must ensure that each covered service is provided promptly and is reasonably accessible. Recipients will be able to select an MMA plan in their region that has the service providers that are important to them. To assist in their decision making, enrollees with have access to a list of available dialysis centers in each plan's network. Recipients can select the

plan whose network includes the dialysis center best meeting their needs in terms of convenience of location and enrollee experience or preference.

Cost Sharing Requirements

- Concerns were expressed related to the recipient cost sharing requirements not complying with federal regulations and creating a barrier for recipients seeking needed medical care.

  Cost-sharing must be consistent with the Medicaid State Plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan and federal regulations. MMA plans are allowed to assess nominal cost sharing in accordance with federal regulations. A description of the nominal cost-sharing, including co-payments and co-insurances, for the MMA plans in accordance with federal regulations is provided in Section II.F of this document. The Agency will pre-approve all cost sharing arrangements proposed by the MMA plans.

Timeline for Implementation

- Comments were received asking for the timeline for implementing the program.

  The Agency submitted the required implementation plan to CMS for approval on October 30, 2013. The implementation plan includes the proposed implementation schedule of the program, which is subject to approval by CMS. The document is posted on the Agency's website at the following link: *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf* .

Plan Assignment Process

- Questions were received asking how the enrollment and plan assignment process will work under the MMA program.

  The Agency will follow the enrollment and disenrollment process outlined in this document in Section II.C, and as provided in the special terms and conditions of the waiver as approved on June 14, 2013.

Low Income Pool Program

- A recommendation was received urging the state to seek increased funding for the Low Income Pool program.

  As part of the waiver extension request, the Agency is seeking an increase in funding for the Low Income Pool program (Refer to Section V.B of this document for a description of this request).

- A recommendation was received urging the state to develop protocols for LIP providers to coordinate with enrollment activities under the Affordable Care Act.

  The Agency will work with CMS and LIP providers to establish activities and programs to be funded through the LIP.

Other issues included in written comments received through the mail or email included:

- Comments were received in support of the state's goals to decrease the administrative burden related to prior authorizations and the ability for providers to process prior authorizations electronically under the MMA program.

The Agency appreciates the feedback that it has received from the public on the enhanced standards that will be included in the MMA program.

- Concerns were expressed regarding the reimbursement rate for dental care services for vulnerable populations receiving life maintenance procedures.

  Managed Medical Assistance plans will have greater flexibility in reimbursing providers at a rate higher than what is published on the Medicaid fee schedules, if that is needed to assist an enrollee in accessing services.

- Concerns were expressed regarding limited access to the Mom Care program of prenatal care for all women presumptively eligible for Medicaid under SOBRA.

  Under the MMA program, women who are eligible for Medicaid under SOBRA will be enrolled in an MMA plan and have their prenatal care coordinated through the managed care plan. The MMA plans will be responsible for ensuring these women have access to the full array of prenatal care necessary to promote a healthy birth – comparable to what they received through the MomCare program.

- Comments and suggestions were received regarding continuity of quality care for persons with disabilities, which included:

  - Increasing consumer protections that require plans to separately measure referrals to specialists,
  - Participation in disability awareness training by managed care providers, and
  - Increasing access to specialty care.

  The provider network standards developed for the MMA program are more comprehensive than any prior network standards established by the Agency. The MMA plans must enter into provider contracts with a sufficient number of specialists to ensure enrollees of all ages have access to the services needed. The MMA plans must maintain written care coordination/case management and continuity of care protocols that include a mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs. Further, the MMA plans are required to submit a provider network file of all participating providers on a weekly basis. This report can be used to monitor the plan's compliance with network adequacy requirements and access to care standards.

  The MMA plans are also required to offer training to all providers and their staff regarding the special needs of enrollees.

  The Agency has also adopted specific quality performance measures under the MMA program that focus on improving the health outcomes for individuals with special health care needs.

- Comments were received on the state's Comprehensive Quality Strategy regarding quality initiatives, Medicaid Fair Hearing reporting, and the grievance and appeal process for beneficiaries.

  The Agency considered all comments received in the development of the draft Comprehensive Quality Strategy submitted to CMS on October 10, 2013. The Agency

will work with CMS to finalize the strategy in accordance with the terms and conditions of the waiver.

- Concerns were expressed with the existing Medicaid Reform program prior to implementation of the MMA program to include:
  - Urging CMS to not grant additional waiver authority until roll out of the MMA program has completed and is thoroughly evaluated.
  - Concerns with utilization rates being used as a basis for reporting care received.
  - Urging the Agency take additional measures to ensure the expansion of Medicaid.
  - Building in additional opportunities to receive and meaningfully use public input from all stakeholders.

Section III of the document describes the public input process the state utilized to solicit feedback on the three-year extension request for the 1115 MMA waiver. All comments received were considered in the development of this waiver extension request. Section VI of this document provides the quality initiatives, including plan performance that occurred during the current waiver period and outlines the quality initiatives that will be undertaken during the proposed extension period.

The Agency will continue to solicit feedback from the public (public meetings, web based training sessions, etc.) as we implement the new program.

Please note that comments received as of November 21, 2013 after the end of the 30-day public comment period, fall into the groupings discussed above. The Agency took all comments received under consideration in the development of this waiver extension request.

The Agency established a dedicated email box (FLMedicaidWaivers@ahca.myflorida.com) to receive comments on an ongoing basis regarding the MMA program.

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