DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 11, 2014

Justin Senior
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Justin:

I am writing to memorialize the work we have accomplished together to date on Florida's request to renew its section 1115 demonstration, titled, Managed Medical Assistance, demonstration number 11-W-00206/4. We have made significant progress toward the goal of finalizing the terms of the demonstration renewal. We are eager to continue working together to grant the renewal based on the following agreements described below:

- A three-year extension of the demonstration through June 30, 2017, except for the Low Income Pool (LIP), which will be extended only for one year from July 1, 2014 through June 30, 2015.
- During the one-year extension for the LIP, expenditures would be authorized to provide stability for providers for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. The LIP would be funded only through existing state and local funding arrangements. Federal LIP funding for the year is still under review, but would not exceed $2.16 billion (total computable), or the level of previous LIP funding (in the prior year) increased by the amount of federal funding previously provided for certain supplemental payments, to the extent that those payments are discontinued by the state. Final LIP funding amounts and provider participation requirements will be specified in the terms and conditions of the demonstration approval documents.
- During this one year extension of the LIP, Florida will review Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that will ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding.
- Expenditures authorized under the LIP would be limited to uncompensated care costs of providers, the independent report discussed below, and other categories of expenditure as specified in the demonstration's current special terms and conditions. Uncompensated care costs will be verified through provider cost reports. Allowable LIP expenditures will be offset by the amount of payments that were made to providers in prior demonstration years in excess of allowable costs identified on provider cost reports.

- During the one-year LIP extension, the state will use a portion of the LIP funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. The report must recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015, to move toward Medicaid fee-for-service and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. A final report will be due no later than March 1, 2015.

We look forward to working with you further on these topics as part of our effort to reach a final agreement on the demonstration. Please feel free to call me if you have concerns or questions as we continue our discussions.

Sincerely,

/s/

Cindy Mann
Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

DEC 2 3 2013

Justin Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

Thank you to you and your staff for your work on the Implementation Plan for Florida's section 1115 demonstration, entitled "Florida Managed Medical Assistance (MMA) Program" (11-W-00206/4). We are writing to approve the state's Implementation Plan, which was submitted on October 30, 2013, in accordance with paragraph 35 of the Special Terms and Conditions (STCs). As a condition of this approval and implementation of the MMA Program, we request that the state engage key stakeholder groups on the implementation process on at least a monthly basis. We request that the state report to CMS on the collaboration efforts and feedback received during the CMS/State MMA monthly monitoring calls, beginning with the January 2014 call.

The approved Implementation Plan has been added to the STCs as Attachment B. A copy is enclosed with this letter.

We look forward to continuing to work together to ensure the successful implementation of the Managed Medical Assistance Program. If you have additional questions or concerns, please contact your assigned project officer Ms. Heather Hostetler, Division of State Demonstrations & Waivers, at (410) 786-4515, or at heather.hostetler@cms.hhs.gov.

Sincerely,

Eliot Fishman
Director

Enclosure

cc: Jackie Glaze, ARA, CMS Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

December 12, 2013

Justin Senior
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

Thank you for your recent request to extend the state's Managed Medical Assistance section 1115 demonstration (11-W-00206/4). The Centers for Medicare & Medicaid Services (CMS) received your extension request on November 27, 2013. We have completed a preliminary review of the application and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The documents will be posted on Medicaid.gov and the comment period will last 30 days, as required under 42 CFR 431.416(b). The state's extension request is available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact your assigned project officer Ms. Heather Hostetler, Division of State Demonstrations and Waivers, at (410) 786-4515, or at heather.hostetler@cms.hhs.gov.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstration and Waivers

cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Jackie Glaze, ARA, Region IV
CMS Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

July 25, 2013

Justin Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #2
Tallahassee, FL 32308

Dear Mr. Senior:

Thank you for your letter regarding Florida's section 1115 demonstration, entitled Managed Medical Assistance (MMA) (project number 11-W-00206/4). The letter requests the Centers for Medicare & Medicaid Services' (CMS) approval for a funding methodology that uses certified public expenditures (CPE) to reimburse Florida hospitals for uncompensated care costs, in addition to the money for uncompensated care distributed through the Low Income Pool (LIP) program. The state also requests CMS approval to apply this funding methodology retrospectively, to allow Jackson Health System to receive uncompensated care funding in excess of the LIP payments it received in demonstration years 4-7.

The proposal references requirements in the demonstration's Special Terms and Conditions (STCs) related to state certification of funding conditions. Paragraph 99(b) provides that if the state wishes to use CPEs as a funding mechanism for title XIX payments (or payments under section 1115 authority), a cost reimbursement methodology must be used that is approved by CMS. While CMS would support the development of a CPE funding methodology for this demonstration, there is no authority in the approved MMA demonstration for the state to receive reimbursement for uncompensated care costs in excess of the approved $1 billion annual LIP allotment. Any additional payment in excess of the approved LIP allotment, or in excess of allowable costs as defined in the LIP Reimbursement and Funding Methodology document, require an amendment to the demonstration. Finally, all claims for expenditures subject to the demonstration's budget neutrality agreement (including LIP payments) must be made within two years after the calendar quarter in which the state made the expenditures, as required in paragraph 94(i) of the STCs.

The CMS stands ready to work with Florida on a CPE methodology for the MMA demonstration. The first step is for Florida to submit a draft protocol to CMS. If you would like to initiate this process, your assigned project officer, Heather Hostetler of our Division of State Demonstrations and Waivers, can assist you. She can be reached at (410) 786-4515, or at Heather.Hostetler@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

cc: Jennifer Ryan, CMCS
Jackie Glaze, ARA, CMS Atlanta Regional Office
Heather Hostetler, CMCS

RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

July 8, 2013

Ms. Heather Hostetler
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Hostetler:

Thank you for sending the approval letter of the Managed Medical Assistance (MMA) amendment to Florida's 1115 Research and Demonstration Waiver (Project Number 11-W-00206/4) dated June 14, 2013. We accept the special terms and conditions of the waiver that are listed in the approval letter.

The waiver permits Florida Medicaid to move from a fee-for-service system to the MMA program that will increase consumer protections as well as quality of care and access for Floridians in many ways including:

- Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;
- Ensures the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan (no more than sixty calendar days after the effective date of enrollment);
- Ensures recipient complaints, grievances and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishes Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requires plans offer a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan;
- Requires Florida's External Quality Assurance Organization to validate each plan's encounter data every three years;
- Enhances consumer report cards to ensure recipient have access to understandable summary 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 expenditure;
- 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.

We appreciate your efforts in working with our staff on the amendment. Should you have any questions, please contact me at (850) 412-3603. We look forward to continuing to work with you.

Sincerely,

/s/

Elizabeth Dudek
Secretary

ED/lam
cc: Jackie L. Glaze, CMS-RO
Justin M. Senior, Deputy Secretary for Medicaid

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

February 20, 2013

Justin Senior
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Justin:

I am writing to memorialize the work we have accomplished together to date on Florida's request to amend its section 1115 demonstration, titled, Medicaid Reform, demonstration number 11-W-00206/4. We have made significant progress in agreeing upon terms of a demonstration that will ensure access to high quality health care services for Florida's Medicaid beneficiaries. We are eager to continue working together and have reached agreement in principle on granting the waiver.

Moving ahead, we look forward to developing and incorporating into the terms and conditions of the demonstration amendment:

- Assurance of a comprehensive quality strategy that reflects the health needs of Florida beneficiaries across the state's Medicaid program at large, that has specific data-driven achievable goals and strategies, and that is aligned with the broader goals of improving care, improving health and lowering cost through these improvements. We have just received additional materials from you on this topic that we are now reviewing, and we appreciate that Florida has incorporated into its competitive procurement a large number of quality measures from our core set of health quality measures for both adults and children;

- Clarification and enhancements of the monitoring and evaluation plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and

- Development of enhanced stakeholder engagement strategies to ensure that the state is able to benefit from robust community input from beneficiaries and their advocates, providers and other state stakeholders in the management of the demonstration.

As we also have discussed, we will work together to ensure that a robust independent consumer support program is in operation to help beneficiaries navigate and access long term care services and supports so that beneficiary concerns are identified and addressed. Florida has some existing capabilities that could potentially provide for this kind of function, and we should continue to discuss whether this activity should be assured in the 1115 waiver or through an amendment to the recent 1915(b)(c) approval.

We look forward to working with you further on these topics as part of our effort to reach a final agreement on the demonstration. Please feel free to call me if you have concerns or questions as we continue our discussions.

Sincerely,

/s/

Cindy Mann
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

December 15, 2011

Ms. Elizabeth Dudek
Secretary
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #1
Tallahassee, FL 32308

Dear Ms. Dudek:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to renew the Florida Medicaid Reform section 1115 Demonstration (Project No. 11-W-00206/4). This renewal is effective December 16, 2011, through June 30, 2014. The extension is granted under the authority of section 1115(a) of the Social Security Act.

This approval allows the Demonstration to continue to operate in the five counties where it is currently implemented, while adding protections for Demonstration beneficiaries receiving services in the five counties, including a Medical Loss Ratio (MLR) requirement for pre-paid plans. Managed care plans and provider service networks must also have policies in place to ensure stability among plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans. Managed care performance, initiatives, and activities will continue to be monitored as measured by HEDIS, CAHPs and other quality metrics. Encounter data requirements must also be met by the State that address the collection, reporting, and utilization of data on services furnished to Demonstration beneficiaries.

The Low Income Pool (LIP) will be maintained at $1 billion (total computable) annually for the 3-year extension of the Demonstration. Two tiers of milestones must be met during each Demonstration year for the State and providers to have access to 100 percent of LIP funds. The milestones established are intended to enhance the delivery of health care to low income populations in Florida. In addition, the State is required to submit by February 1, 2012, a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. Financial penalties apply if the State does not submit an approvable protocol.

Under the extension of the Demonstration, the State will no longer impose a maximum annual benefit level for Medicaid beneficiaries in the Reform counties. In addition to meeting an actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed a minimum threshold of 98.5 percent for benefits identified as sufficiency tested benefits. Additionally, waivers that applied to retroactive eligibility and that limited benefits available

during the time a beneficiary selected a plan, which were never implemented by the State, have not been renewed.

The State requested not to continue the Opt Out program that has allowed Demonstration enrollees to voluntarily elect to apply their Medicaid premium to employer sponsored insurance (ESI). Accordingly, the Opt Out program has been removed from the Demonstration. Beneficiaries currently participating in the Opt Out program will have the option to continue to access ESI under the State plan premium assistance program, that includes full wrap-around benefits, or return to Medicaid managed care under the Demonstration. CMS will work with the State to ensure the required cost-effectiveness determinations are implemented.

Our approval of this Demonstration project is subject to the limitations specified in the attached waiver and expenditure authorities. The State may deviate from Medicaid State plan requirements only to the extent those requirements have been specifically waived, or with respect to expenditure authorities, listed as not applicable to expenditures for Demonstration populations and other services not covered under the State plan in the expenditure authority.

The approval is conditional upon acceptance and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of Federal involvement in the Demonstration. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs and waiver and expenditure authorities within 30 days of the date of this letter.

Your acceptance and any questions regarding the Florida Reform Demonstration may be directed to your project officer, Mr. Mark Pahl. Mr. Pahl's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1584
Facsimile: (410) 786-8534
E-mail: Mark.Pahl@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Pahl and Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Thank you for your efforts to improve care for low-income Floridians. We look forward to continuing to work with you and your staff.

Sincerely,

//s//

Cindy Mann
Director

Enclosure

cc: Jackie Glaze, ARA, Region IV

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00206/4**

TITLE: **Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115(a) Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Agency for Health Care Administration (Florida) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The effective date of the Demonstration is December 16, 2011, and is approved through June 30, 2014.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Description and Objectives;
III. General Program Requirements;
IV. General Reporting Requirements;
V. Florida Reform Implementation;
VI. Eligibility;
VII. Enrollment;
VIII. Choice Counseling;
IX. Benefit Packages and Medicaid Reform Plans;
X. Enhanced Benefits Account Program;
XI. Cost Sharing;
XII. Delivery Systems;
XIII. Low Income Pool;
XIV. Low Income Pool Milestones;
XV. General Financial Requirements;
XVI. Monitoring Budget Neutrality;
XVII. Evaluation of the Demonstration; and,
XVIII. Schedule of State Deliverables.

Additionally, one attachment has been included to provide supplementary guidance.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida Medicaid Reform Demonstration was approved October 19, 2005. The State implemented the Demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007.

Under the Demonstration, most Medicaid eligibles are required to enroll in a managed care plan (either a capitated health plan or a fee-for-service Provider Service Network plan) as a condition for receiving Medicaid. Participation is mandatory for TANF related populations and the aged and disabled with some exceptions. The Demonstration allows plans to offer customized benefit packages and reduced cost-sharing, although each plan must cover all mandatory services, and all State plan services for children and pregnant women (including EPSDT). The Demonstration provides incentives for healthy behaviors by offering Enhanced Benefits Accounts and established a Low Income Pool (LIP) to ensure continued support for the provision of health care services to Medicaid, underinsured and uninsured populations.

The fundamental elements of Florida Medicaid Reform are as follows:

> Risk-Adjusted Premiums pay Medicaid Reform capitated plans monthly premiums that are adjusted to reflect the health status of plan's beneficiaries and are actuarially equivalent to all services covered under the current Florida Medicaid program.
>
> Enhanced Benefits Accounts provide incentives to Medicaid Reform enrollees for healthy behaviors. Enrollees who participate in these activities earn credits that can be used for health care related expenditures such as over-the-counter pharmaceuticals and vitamins.
>
> Low Income Pool (LIP) funds provide direct payment and distributions to safety net providers in the State for the purpose of defraying some of the uncompensated costs these providers incur in furnishing services to the uninsured and underinsured populations. The LIP is also designed to support programs that enhance the quality of care and the health of low income populations.

Under the Demonstration, Florida seeks to continue building on the following objectives:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost;
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program;
- Improve health outcomes and reduce inappropriate utilization;
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve;
- Serve as an effective deterrent against fraud and abuse by moving from a fee-for-service to a managed care delivery system;
- Maintain strict oversight of managed care plans including adapting fraud efforts to surveillance of fraud and abuse within the managed care system;
- Provide managed care plans with flexibility in creating benefit packages to meet the

needs of specific groups; and,

- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy**. The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

    a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b) If mandated changes in the Federal law, regulation, or policy requires State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit a title XIX State plan amendment for changes to any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, LIP, Federal financial participation (FFP), sources of non-Federal share of funding, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7, below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

    a) An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates by Eligibility Group the impact of the amendment;

    c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,

    d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Enhanced Benefits Account Program Phase Out.** The State shall submit a phase-out plan to CMS for approval no later than 6 months prior to any such time the State proposes to terminate the Enhanced Benefits Account Program (EBAP) provision of this Demonstration. The EBAP will be limited as follows:

    a) Enrollees will not be able to earn credits for enhanced benefits for deposit into their account during the last 3 months of the Demonstration or the termination of the EBAP Provision under the Demonstration; and

b) Individuals, who previously earned credits for enhanced benefits in their account, will continue to have access to funds for health care related expenditures in accordance with EBAP rules (see paragraph 51).

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

11. **Withdrawal of Waiver or Expenditure Authority**. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) unless they are otherwise superseded by rules promulgated by CMS. The State must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this Demonstration.

14. **Managed Care Requirements**. The State must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

    The State must provide for the following:

a) Policies to ensure an increased stability among managed care organizations (MCO) and provider service networks (PSNs) and minimize plan turnover. This could include a limit on the number of participating plans in the five Demonstration counties. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the State; and financial penalties for not completing a contract term. The State must report quarterly on the plans entering and leaving Demonstration counties, including the reasons for plans leaving. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;
b) Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The State must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to CMS on a quarterly basis. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;
c) A requirement that each MCO and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the Demonstration counties and provide documentation to the State and CMS to show ongoing compliance. The State must develop quarterly reporting of MLR during Demonstration year (DY) 6 specific to Demonstration counties. Beginning in DY 7 (July 1, 2012), plans must meet annual MLR requirements. CMS will determine the corrective action for non-compliance with this requirement;
d) Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and requests by beneficiaries to seek out of network care. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension; and,
e) Policies to ensure adequate choice when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension.

IV. GENERAL REPORTING REQUIREMENTS

15. **General Financial Requirements.** The State must comply with all general financial requirements set forth in Section XV.

16. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements set forth in Section XVI.

17. **Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438. Encounter data requirements shall include the following:

    a) Encounter Data – All managed care organizations in the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan's encounter data are timely, complete and accurate. The State will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.

    b) Encounter Data Validation Study for New MCOs - If the State contracts with new managed care organizations, the State shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.

    c) Submission of Encounter Data - The State shall submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law. The State must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the State.

18. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include but are not limited to, MCO operations (such as contract amendments, rate certifications, plans withdrawing or entering the Demonstration), health care delivery, enrollment, quality of care, access, benefit packages, the Enhanced Benefits Account Program, choice counseling activities, audits, lawsuits, financial reporting related to budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting that impact the Demonstration. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

19. **Quarterly Reports.** The State must submit progress reports, to include the items outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

    a) An updated budget neutrality monitoring spreadsheet including enrollment data, member month data, and expenditure data in the format provided by CMS;
    b) A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including but not limited to: approval and contracting with new plans; geographic expansion; benefits; enrollment and disenrollment; grievances; quality of care; access; pertinent legislative or litigation activity; and other operational issues;
    c) Action plans for addressing any policy, administrative, or budget issues identified;
    d) State efforts related to the collection and verification of encounter data, and utilization data;
    e) Medical Loss Ratio data pertaining to Medicaid plan operations in Demonstration counties;
    f) Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF and SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the State will provide a summary of voluntary and mandatory selection rates and disenrollment data;
    g) Choice of plans and capacity of plans participating in the Reform counties;
    h) Low Income Pool activities and associated expenditures;
    i) Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups;
    j) Participation rates in the Enhanced Benefits Account Program. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account;
    k) Status of managed care plan performance, initiatives and activities, as measured by HEDIS, CAHPs and other quality metrics;
    l) Progress toward the Demonstration goals; and,
    m) Evaluation activities.

20. **Annual Report.** The State must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 19 and include a section that provides qualitative and quantitative data that describes the impact the LIP has had on the rate of uninsurance in Florida since implementation of the Demonstration. The State must submit this report no later than 120 days after the close of each DY.

21. **Transition Plan.** The State is required to prepare and incrementally revise, a Transition

Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The State must submit a draft final report to CMS by July 1, 2012, with progress updates included in each quarterly report required by paragraph 19.

V. FLORIDA REFORM IMPLEMENTATION

22. **Reform Implementation.** Counties where Reform is implemented will be known as Reform Counties. The State must request an amendment to the Demonstration, as described in paragraphs 6 and 7, should the State desire to expand the Demonstration to additional Florida counties or mandate enrollment into the Demonstration for populations that are not required to be mandatorily enrolled in the Demonstration as of December 5, 2011. The following is a list of Reform Counties:

    a) Baker, Broward, Clay, Duval, and Nassau Counties (as of June 30, 2011); and,
    b) Other counties which the State may designate as Reform Counties by obtaining CMS approval of a Demonstration amendment.

VI. ELIGIBILITY

23. **Consistency with State Plan Eligibility Criteria.** There is no eligibility expansion or reduction under this Demonstration except that individuals who lose Medicaid eligibility will continue for a period of one-year to have access to benefits accrued in their name under the EBAP.

24. **Participation in the Reform Demonstration.** Reform Participants are individuals eligible under the approved State plan who reside in Reform Counties who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a MCO or PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a Demonstration MCO or PSN to receive Medicaid benefits.

    a) Mandatory Participants - Individuals who reside in Reform Counties and who belong to the categories of Medicaid eligibles listed in the following table and who are not listed as excluded from mandatory participation are required to be Reform Participants.

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population (See STC 64)
Infants under age 1	Up to 150 % of the Federal Poverty Level (FPL)	Population 7
Children 1-5	Up to 133% of the FPL	Population 7
Children 6-18	Up to 100% of the FPL	Population 7
Blind/Disabled Children	Children eligible under SSI	Population 1
TANF Pregnant women	Up to AFDC Income Level (Families whose	Population 7

	income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.	
Section 1931 adults	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.	Population 7
Aged/Disabled Adults	Persons receiving SSI whose eligibility is determined by SSA	Population 1
Optional State Plan Groups		
Infants under age 1 (Title XIX funded)	151% up to 185% of the FPL	Population 7

Note: Mandatory enrollment into the Children's Medical Services Specialty Plan is required for children residing in Broward and Duval Counties with special health care needs who meet clinical eligibility screening requirements.

b) Voluntary Participants – The following individuals are excluded from mandatory participation under subparagraph (a) but may choose to be voluntary participants in the Reform Demonstration:

i. Foster care children;
ii. Individuals with developmental disabilities;
iii. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
iv. Individuals receiving hospice services;
v. Pregnant women with incomes above the 1931 poverty level;
vi. Dual eligible individuals;
vii. Medikids under title XXI; and,
viii. Children under age 1 with family income 186% - 200% of the FPL under title XXI.

c) Excluded From Reform Participation - The following groups of Medicaid eligibles are excluded from participation in the Demonstration.

i. Individuals whose immigration status is as a refugee eligible;
ii. Individuals eligible as medically needy;
iii. Individuals residing in State mental facilities (over age 65);
iv. Family planning waiver eligibles; and,
v. Individuals eligible as women with breast or cervical cancer.

25. **Expansion Population for the Continuation of the EBAP.** Individuals who lose eligibility for Medicaid will continue to have limited eligibility under this Demonstration for a period of one year. This population retains eligibility under the Demonstration solely to access accrued funds in their individual enhanced benefits account for a period of one year, except in the instance of termination of the Demonstration or the EBAP. These individuals will receive no other benefits than those available through the EBAP. This population is limited to individuals who have accrued

funds in an individual enhanced benefit account. These individuals are identified as Demonstration Population A.

VII. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid eligible individuals living in Florida counties in which the Reform Demonstration has been implemented.

26. **New Reform Demonstration Enrollees.** At the time of eligibility determination, individuals who are mandated to participate must receive information about managed care plan choices in their area. They must be informed of their options in selecting an authorized managed care plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice. New enrollees will be required to select a plan within 30 days of eligibility determination. If the individual does not select a plan within the 30-day period, the State may auto-assign the individual into a Medicaid Reform Plan or a PSN. Once individuals have made their choice, they will be able to contact the State or the State's designated choice counselor to register their plan selection.

27. **Auto-Enrollment Criteria.** Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the choice counselor will provide information to the individuals to encourage an active selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the State will use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit. The criteria includes but is not limited to:

    a) A managed care plan has sufficient provider network capacity to meet the needs of enrollees;
    b) The managed care plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers has previously provided health care to the enrollee;
    c) The State has knowledge that the enrollee has previously expressed a preference for a particular managed care plan as indicated by Medicaid fee-for-service claims data, but has failed to make a choice; and,
    d) The managed care plan's primary care providers are geographically accessible to the recipient's residence.

    For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI beneficiary to a managed care plan, the State will determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so, the State will assign the SSI recipient to that managed care plan whenever feasible. Those SSI recipients who do not have such a provider relationship will be assigned to a managed care plan using the assignment criteria previously outlined.

28. **Lock-In/Disenrollment in a Medicaid Reform Plan.** Once a mandatory enrollee has selected or been assigned a Medicaid Reform plan the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a Medicaid Reform plan the individual must have 90 days to voluntarily disenroll from that plan without cause and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan. Voluntary enrollees may disenroll from the Reform plan at any time.

    The choice counselor will record the plan change/disenrollment reason for all recipients who request such a change. The State or the State's designee will be responsible for processing all enrollments and disenrollments.

29. **Re-enrollment.** In instances of a temporary loss of Medicaid eligibility, which the State is defining as 6 months or less, the State will re-enroll Reform enrollees in the same health plan they were enrolled in prior to the temporary loss of eligibility.

VIII. CHOICE COUNSELING

30. **Choice Counseling Defined.** The State shall contract for choice counselor services to provide full and complete information about managed care plans choices. The State will ensure a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

31. **Choice-Counseling Materials.** Through the choice counselor the State offers an extensive enrollee education and rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly.

32. **Choice Counseling Information.** The State or the State's administrator provides information on selecting a Reform plan. The State or the State's designated choice counselor provides information about each plan's coverage in accordance with Federal requirements. Information includes but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information,

performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the State may supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

33. **Delivery of Choice Counseling Materials.** Choice counseling materials will be provided in a variety of ways including the internet, print, telephone, and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY.

34. **Contacting the Choice Counselor.** Individuals contact the State or the State's designated choice counselor to obtain additional information. Choice counseling and enrollment information is available at the AHCA website or by phone. The State or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The State must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

IX. BENEFIT PACKAGES & MEDICAID REFORM PLANS

35. **Customized Benefit Packages for Medicaid Reform**. Capitated plans will have the flexibility to provide customized benefit packages for Demonstration enrollees. PSNs operating under fee-for-service must provide all benefits for all enrolled beneficiaries as are available under the State plan. The customized benefit packages must include all State plan services otherwise available under the State plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the State plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population and plans can offer additional services and benefits not available under the State plan. The plans authorized by the State shall not have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women, and emergency services. The State may also capitate all State Plan services for Demonstration enrollees.

36. **Overall Standards for Customized Benefit Packages.** All benefit packages must be prior-approved by the State and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.

37. **Plan Evaluation Tool.** The State will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for a Medicaid Reform Plan contract meets State requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, it 1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensures that the overall level (sufficiency) of certain benefits is adequate to cover the vast majority of enrollees. The State will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

38. **Plan Evaluation Tool: Actuarial Equivalency.** Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process ensures that the expected claim cost levels of all Reform plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan for the target population and its historic levels of utilization. The State uses this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the PET considers the following components of the benefit package: services covered; cost sharing; and additional benefits offered, if any. Additional services offered by the plan will be considered a component of the plan's customized benefits and not a component of the Enhanced Benefit Plan.

39. **Plan Evaluation Tool: Sufficiency**. In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent for benefits identified as sufficiency tested benefits. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target population's historic use of the applicable Medicaid State Plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the State as sufficiency tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to cover the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

X. ENHANCED BENEFITS ACCOUNT PROGRAM

40. **Enhanced Benefits Account Program Defined.** The EBAP provides incentives to Medicaid Reform enrollees for participating in State defined activities that promote healthy behaviors. An individual who participates in a State defined activity that promotes healthy behaviors earns credits that are posted to an individual's account. Earned credits may be used for health care related expenditures as approved under the EBAP and defined in Section 1905 of the Act.

41. **Administration Overview.** The State will maintain a list of activities that generate contributions to the account. A menu of benefits or programs will be provided as will the individual value of each item on the menu. The amount available to individuals from their enhanced benefit account will depend on the activities in which they participate up to a maximum amount. Once an enrollee completes an approved activity, the enrollee will be considered an active participant. The State will post earned credits into an account for use by the enrollee. Additional credits may be earned as the enrollee participates in additional activities. In no instance will the individual receive cash.

42. **Participants Earning Enhanced Benefits Accounts Defined.** All enrollees in a Reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn enhanced benefits for the duration of their enrollment. The exception to this provision is at the time of EBAP phase out as discussed in Section III, "General Program Requirements".

43. **Participant Access to Credits.** The State will provide access to an individual's earned credits in an enhanced benefit account as follows:

    a) Individuals who are enrolled in a Reform plan and who have participated in a State defined activity that promotes healthy behavior and thus have a positive balance;
    b) Individuals who no longer are enrolled in a Reform plan (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate) but who have a positive balance in their account;
    c) Regardless of the reason for the loss of eligibility to participate in the Demonstration, an individual may retain access to any earned funds for a maximum of one year, except in the instance of termination of the Demonstration or the EBAP; and,
    d) If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBAP and earn additional credits.

44. **Federal Financial Participation (FFP).** The State shall claim FFP at the time the enhanced benefits credits are utilized by an enrollee to purchase an approved product, supply, or service.

45. **Enhanced Benefits Account Program Contracts.** The State shall provide CMS a copy of any procurement document to administer the EBAP. In addition, the State will provide the CMS Regional Office a copy of the contract for approval, to administer the EBAP. At a minimum, the contract will specify the scope of work, duration of the contract, and the amount of contract.

46. **Effective and Efficient Administration.** The State will submit documentation related to EBAP eligibility activities, respective earnings for each activity, eligible health related expenditures and access to account information in the Annual Report and Quarterly Reports as discussed in Section IV.

XI. COST SHARING

47. **Premiums and Co-Payments.** The State must pre-approve all cost sharing allowed by Reform plans. Cost-sharing must be consistent with the State Plan except that Reform plans may elect to assess cost sharing that is less than what is allowed under the State plan.

XII. DELIVERY SYSTEMS

48. **Health Plans.** The MCOs and capitated PSNs must be authorized by State Statute and must adhere to 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438. The certification shall identify historical utilization of State plan services used in the rate development process. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.

    a) Managed Care Organization MCO) – An entity that meets the requirements as described in 42 CFR 438.2.
    b) Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of Florida Statutes. A PSN may be reimbursed on a fee-for-service or capitated basis as specified in State statute.

49. **Freedom of Choice.** An enrollee's Freedom of choice of providers shall be limited to and through whom individuals may seek services, including the EBAP for populations enrolled in the Florida Medicaid Reform Demonstration. The State must provide Demonstration enrollees access to the MediPass or fee-for-service delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52 and 42 CFR 42 438.56.

50. **Evaluation of Plan Benefits.** The State will review and update the PET for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the Medicaid Reform area. At a minimum, the State must conduct the review and update on an annual basis. The State will provide CMS with 60-days advance notice and a copy of any proposed changes to the PET.

XIII. LOW INCOME POOL

51. **Low Income Pool Definition.** The LIP provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP 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. Initiatives must broadly drive from the three overarching goals of CMS'

Three-Part Aim as described in paragraph 61(a). The LIP consists of a capped annual allotment of $1 billion total computable for each year of the Demonstration extension.

52. **Availability of Low Income Pool Funds.** Funds in the LIP are available to the State on an annual basis subject to any penalties that are assessed by CMS for the failure to meet milestones as discussed in Section XV "Low Income Pool Milestones". Funds available through the LIP may be reduced to recoup payments made to providers that are determined by CMS to have been made in excess of allowable costs. Any necessary recoupments will be achieved through a reduction of FFP claimed against current LIP payments. Available funds not distributed in a DY may be rolled over to the next DY. All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the State and not recoverable.

53. **LIP Reimbursement and Funding Methodology.** LIP permissible expenditures defining State authorized expenditures from and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document dated June 26, 2009. This document limits LIP payments to allowable costs incurred by providers and requires the State to reconcile LIP payments to auditable costs. CMS is currently working with the State on reconciliations for DY 1, 2, and 3. Reconciliations for DY 4 and 5 are not yet available. CMS and the State will finalize DY 1, 2, and 3 reconciliations within 60 days of the acceptance of these STCs. The State must submit the LIP reconciliations for DY 4 to CMS by May 31, 2012 and the reconciliations for DY 5 by May 31, 2013. The DY 4 and DY 5 reconciliations (required by May 31st of the respective year) may include "as filed cost report data" but will be considered the final reconciliation.

    If the reconciliations for DY 1, 2, and 3 identify LIP payments in excess of allowable cost consistent with paragraph 54 and the Reimbursement and Funding Methodology document implementing the LIP, the State must modify the Reimbursement and Funding Methodology applicable to DY 6 to ensure that payments under the LIP are consistent with the LIP goals and that providers will not receive payments that exceed their costs utilizing the cost reconciliation information to inform payment methodology modifications. CMS will also work with the State to identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied prospectively to payments and audits for DY 6. The State may claim LIP payments based on the existing Methodology during the 60 day reconciliation finalization period. Claims after that period can only be made on the modified final Reimbursement and Funding Methodology approved by March 1, 2012. Changes to the Reimbursement and Funding Methodology document requested by the State must be approved by CMS and are only approved for DY 6 LIP expenditures.

    DY 4 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 7. If the final reconciliations for DY 4 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 7 will not result

in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and Funding Methodology. Any required modifications to the DY 7 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 7 LIP payments.

DY 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 8. If the final reconciliations for DY 5 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 8 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and Funding Methodology. Any required modifications to the DY 8 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 8 LIP payments.

The State shall by February 1, 2012 and each successive February 1st of the renewal period, submit a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP as described in paragraph 51 and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. FFP is not available for LIP payments until the protocol is finalized and approved by CMS.

54. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments).

55. **Low Income Pool Expenditures - Non-Qualified Aliens.** LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

56. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services,

hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in paragraph 53.

57. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and are further defined in the Reimbursement and Funding Methodology document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

58. **Low Income Pool Permissible Non-Hospital Based Expenditures**. To ensure services are paid at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.

59. **Permissible Sources of Funding Criteria.** Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

XIV. LOW INCOME POOL MILESTONES

60. **Aggregate LIP Funding.** At the beginning of each DY, $1 billion in LIP funds will be available to the State. These amounts will be reduced by any milestone penalties that are assessed by CMS. Two tiers of milestones, as described in paragraph's 61 and 62, must be met for the State and facilities to have access to 100 percent of the annual LIP funds. Funds not distributed in a DY may be rolled over to the next DY.

61. **Tier - One Milestone.** Tier-one milestones are defined as follows:

    a) Development and implementation of a State initiative that requires Florida to allocate $50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly 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.

        Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIII, Low Income Pool. The State will utilize DY 6 to

develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DYs 7 and 8.

b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.
c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

CMS will assess penalties on an annual basis for the State's failure to meet tier-one milestones or components of tier-one milestones. Penalties of $6 million will be assessed annually for each tier-one milestone that is not met. Penalties will be determined by December 31st of each DY and assessed to the State in the following DY. LIP dollars that are lost as a result of tier-one penalties not being met, are surrendered by the State.

62. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of the Three-Part Aim as described in paragraph 61(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities 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 (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facility's annual LIP allocation. The milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 15 hospitals, do not total at least $700 million, the population of hospitals must be expanded until $700 million is reached.

    Hospitals will be required to select and participate in 3 initiatives. Depending on the breadth of health care activities undertaken by a facility, CMS may consider exceptions to the requirement that three initiatives must be implemented.

    Once a facility is identified as a top 15 hospital, it must continue to achieve milestones to receive future DY LIP funding regardless of whether it drops out of the top 15 category. Exceptions to this requirement may be considered by CMS. Hospitals

entering the top 15 category in future DYs will be subject to timelines similar to program planning/success and execution timelines.

A top 15 hospital cannot select quality improvement initiatives under which it is currently receiving or may be eligible to receive other Federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the State will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for the implementation and monitoring of tier-two milestones and evaluation of the impact of these initiatives. The specific metrics chosen should support the measurements required in paragraph 80 (a)(vii-ix). CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by March 31, 2012, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

Hospital initiatives that can be implemented under tier-two milestones, which are tied to the Three-Part Aim, include the following and are drawn from recent demonstration experiences:

a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives are:
   i. Increase in Primary Care capacity including residency programs and externships;
   ii. Introduction of Telemedicine;
   iii. Enhanced Interpretation Services and Culturally Competent Care; and,
   iv. Enhanced Performance Improvement Capacity;
b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
   i. Expansion of Medical Homes;
   ii. Primary Care Redesign; and,
   iii. Redesign for Efficiencies (e.g. Program Integrity).
c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
   i. Improved Diabetes Care Management and Outcomes;
   ii. Improved Chronic Care Management and Outcomes;
   iii. Reduction of Readmissions;
   iv. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems);
   v. Emergency Department Utilization and Diversion;
   vi. Reductions in Elective Preterm Births; and,
   vii. PICU and NICU Quality and Safety (e.g. pediatric catheter associated blood

stream infection rates).

Between January 1 2012 and March 31, 2012, the tier-two milestone facility's receiving funds in SFY 2011-2012 must submit a plan/program including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone. Subsequent year LIP funds allocated to these hospitals will be made available based upon the successful execution of the facilities targeted health care initiatives.

The State must assess a penalty of 3.5 percent of a facility's annual LIP allocation for failing to meet tier-two milestones or components of tier-two milestones. Penalties, if applicable, will be determined by December 31st of each DY (with the exception of DY 6, which will be determined by March 31, 2012) and assessed to the facility in the remaining 6 months of the same DY. LIP dollars that are not paid out as a result of tier-two milestones not being met, are surrendered by the facility and State.

XV. GENERAL FINANCIAL REQUIREMENTS

63. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XVI.

64. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants and categories, as described in section (d), are subject to the budget neutrality agreement. The following describes the reporting of expenditures subject to the budget agreement:

    a) Tracking Expenditures. In order to track expenditures, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00206/4) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were paid.

    b) Cost Settlements. For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 and 10C. For any cost settlement not attributable to this Demonstration,

the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c) Pharmacy Rebates. The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

d) Use of Waiver Forms. For each DY, a waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter, using the waiver names listed below. The waiver names designate the waiver forms in the MBES/CBES system to report title XIX expenditures associated with the Demonstration.

i. **Demonstration Population 1 (MEG 1)** – (Aged/Disabled): Aged and disabled Demonstration enrollees.
ii. **Demonstration Population 2 (MEG 1)** – (FMR-SSI+DsEldw/oMcare): Aged and disabled individuals without Medicare in non-Reform counties who would be required to enroll in the Demonstration.
iii. **Demonstration Population 3 (MEG 2)** – (FMR-TANF): Individuals qualifying under TANF in non-Reform counties who would be required to enroll in the Demonstration.
iv. **Demonstration Population 4 (MEG 2**) – (FMR-SOBRA/FC): Individuals qualifying under SOBRA or Foster Care in non-Reform counties who would be required to enroll in the Demonstration.
v. **Demonstration Population 5 (MEG 1)** – (FMR->65): Individuals 65 and older in non-Reform counties who would be required to enroll in the Demonstration.
vi. **Demonstration Population 6 (MEG 3)** – (Low Income Pool): Demonstration expenditures allowed under the Low Income Pool.
vii. **Demonstration Population 7 (MEG 2)** – (TANF & related grp): TANF Demonstration enrollees.

Note: See paragraph 76 for a description of MEGs 1, 2, and 3.

e) Excluded Services. All expenditures for health care services for Demonstration participants and categories, as described in paragraph 64(d), are subject to the budget neutrality agreement, with the exception of the following excluded services:

i. AIDS Waiver (Waiver Services);
ii. DD Waiver (Waiver Services);
iii. Home Safe Net (Behavioral Services);
iv. Behavioral Health Overlays Services (Services Only);
v. ICF/DD Institutional Services;
vi. Family & Supported Living Waiver Services;
vii. Katie Beckett Model Waiver Services;
viii. Brain & Spinal Cord Waiver Services;
ix. School Based Admin Claiming; and
x. Healthy Start Waiver Services.

f) Cost-Sharing Adjustments. Applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by DY on Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

g) Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

h) Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

65. **Reporting Member Months.** The following describes the reporting of member months for Demonstration Populations.

a) For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the Quarterly Report required under paragraph 19, the actual number of eligible member months for the three MEGs described in paragraph 76. The State must provide CMS, upon

request, eligible member months by Population as defined in paragraph 64(d). The State must submit a statement accompanying the Quarterly Report which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.

b) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

66. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year (FFY) on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

67. **Extent of FFP.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section XVI:

    a) Administrative costs associated with the administration of the Demonstration;
    b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration;
    c) Net expenditures and prior period adjustments for Medicaid Reform Plan premiums paid to managed care entities and fee for service coverage options;
    d) Net Expenditures associated with the LIP, as described in Section XIII; and,
    e) Net Expenditures associated with the EBAP.

68. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.
c) The State assures that all health care related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

69. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of the Demonstration expenditures are met:

a) Units of government, including governmentally-operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration;
b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures;
c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match;
d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments; and,
e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

70. **MSIS Data Submission.** The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards.

71. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

72. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

XVI. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the Demonstration period. Paragraphs 73 and 74 specify the two independent financial caps on the amount of Federal title XIX funding that the State may receive on expenditures subject to the budget neutrality limit as defined in paragraph 64. Federal financial payments for the Medicaid Reform aspects of the Demonstration are limited by a Per Member Per Month (PMPM) method cap and the payments for the LIP aspects are limited by an aggregate cap.

73. **Budget Neutrality Limit for the LIP.** The LIP amount is capped at $1 billion total computable for each DY. Funds not distributed in a DY may be rolled over to the next DY. The Federal share of the annual $1 billion total computable is the maximum amount of FFP that the State may receive during the extension period for the types of Medicaid expenditures for the LIP. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

74. **Limit on PMPM Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on the Medicaid and Demonstration expenditures identified in paragraph 64 during the approval period of the Demonstration. The limit is determined using a PMPM method. The budget neutrality targets are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire Demonstration. All data supplied by the State to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the State's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

75. **Risk.** The State shall be at risk for the per capita cost of Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees. By providing FFP for all Demonstration enrollees, the State will not be at risk for changing economic conditions which impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

76. **Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration. Demonstration expenditures are defined under the following Medicaid Eligibility Groups (MEGs) as referenced in paragraph 64(d):

    a) MEG 1: SSI
    b) MEG 2: TANF
    c) MEG 3 : Low Income Pool

    For the purpose of calculating the overall PMPM expenditure limit for the Demonstration, separate budget estimates will be calculated for each year on a Demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire Demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the extension period for the types of Medicaid expenditures for the SSI and TANF MEGs. Budget neutrality calculations for both with and without waiver expenditures are applied on a statewide basis. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year. For the purpose of monitoring budget neutrality, the $1 billion in annual LIP expenditures is considered as both with and without waiver expenditures.

    a) Projecting Service Expenditures - Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs in sub-paragraph (b) below. The annual budget estimate for each MEG will be the product of the projected PMPM cost for the MEG, times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in paragraph 65.

    b) Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate
DY 1 (SFY 2006-2007)	$ 948.79	8.0%	$ 199.48	8.0%
DY 2 (SFY 2007-2008)	$ 1,024.69	8.0%	$ 215.44	8.0%
DY 3 (SFY 2008-2009)	$ 1,106.67	8.0%	$ 232.68	8.0%
DY 4 (SFY 2009-2010)	$ 1,195.20	8.0%	$ 251.29	8.0%
DY 5 (SFY 2010-2011)	$ 1,290.82	8.0%	$ 271.39	8.0%
DY 6 (SFY 2011-2012)	$ 1,356.65	5.1%	$ 285.77	5.3%
DY 7 (SFY 2012-2013)	$ 1,425.84	5.1%	$ 300.92	5.3%
DY 8 (SFY 2013-2014)	$1,498.56	5.1%	$316.87	5.3%

77. **How the Limit will be Applied**. The limits as defined in paragraphs 73 through 76 will apply to the actual expenditures for the Demonstration, as reported by the State under Section XVI. If at the end of the Demonstration period the budget neutrality

provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed.

78. **Impermissible DSH, Taxes or Donations**. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through State Medicaid Director letters, other memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

79. **PMPM Expenditure Review.** CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, no later than 6 months after the end of each Demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in paragraph 19. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 6	Years 1 through 6 combined budget neutrality cap plus	1 percent
Year 7	Years 1 through 7 combined budget neutrality cap plus	0.5 percent
Year 8	Years 1 through 8 combined budget neutrality cap plus	0 percent

XVII. EVALUATION OF THE DEMONSTRATION

80. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the Demonstration.

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

i. The effect of managed care on access to care, quality and efficiency of

care, and the cost of care;

ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
iii. Participation in the Enhanced Benefits Account Program 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.

b) Evaluation Design – The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

81. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS' comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the current Demonstration period. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

82. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XVIII. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Progress Reports	Section IV, STC 19
120 days following the end of the Demonstration year	Annual Report	Section IV, STC 20
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVI, STC 63
90 days following the award of the Demonstration	Managed Care Policies	Section III, STC 14(a), (b), (d), and (e)
Reporting to begin during DY6	Quarterly Medical Loss Ratio Reporting for Demonstration Counties	Section III, STC 14 (c)
30 days following award of the Demonstration	Premium Assistance Transition Plan	Section IV, STC 21
July 1, 2012	ACA Transition Plan	Section IV, STC 21
60 days following acceptance of the STCs	LIP Reconciliations for DYs 1, 2, and 3	Section XIV, STC 53
30 days following acceptance of the STCs	LIP Reconciliation Schedule for DYs 6, 7, and 8	Section XV, STC 61(b)
60 days following acceptance of the STCs	Templates for Milestone and Expenditure Reports	Section XV, STC 61(d)
120 days following the award of the Demonstration	Draft Evaluation Design	Section XVIII, STC 80
Various	Milestone Deliverables	Section XV, STCs 61 and 62

ATTACHMENT A

Under paragraph 19, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – Florida Medicaid Reform

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (7/1/2011 – 6/30/2012)
Federal Fiscal Quarter: 4/2011 (7/1/2011 – 9/30/2011)

Introduction

Please provide information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0". Enrollment counts should be person counts.

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 - Aged/Disabled			
Population 2 - FMR-SSI+DsEldw/oMcare			

Population 3 - FMR-TANF			
Population 4 - FMR-SOBRA/FC			
Population 5 - FMR->65			
Population 7 - TANF & related grp			

Outreach/Innovative Activities
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

WAIVERS AND AUTHORITIES FOR FLORIDA'S
MEDICAID REFORM SECTION 1115 DEMONSTRATION

NUMBER: **11-W-00206/4**

TITLE: **Florida Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the State to implement the Florida Medicaid Reform section 1115 Demonstration consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning December 16, 2011, through June 30, 2014.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable Florida to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. Also this waiver is to permit Florida to offer different benefits to Demonstration Population A than to the categorically needy group.

3. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility.

4. Freedom of Choice **Section 1902(a)(23)(A)**

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers.

EXPENDITURE AUTHORITY
FOR FLORIDA'S MEDICAID REFORM
SECTION 1115 DEMONSTRATION

NUMBER: **11-W-00206/4**

TITLE: **Florida Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this Demonstration December 16, 2011, through June 30, 2014, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Medicaid Reform section 1115 Demonstration.

1. **Demonstration Population A.** Expenditures for health care related costs under enhanced benefit accounts for individuals who lose eligibility for Medicaid or Demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the Demonstration or the enhanced benefits account provision under the Demonstration.

2. Expenditures for costs incurred as a result of the automatic re-enrollment, in the last plan of enrollment, for enrollees who have regained eligibility within six months, and which would not otherwise be eligible for automatic re-enrollment under Section 1903(m)(2)(H) of the Act.

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

4. Expenditures for benefits under the enhanced benefits account program.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

In order to permit the Demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the Expenditure Authorities:

1. Provision of Medical Assistance **Section 1902(a)(10)(A)**

To enable Florida to limit the medical assistance for Demonstration Population A to the types of assistance described in these expenditure authorities.

2. Amount, Duration, Scope and Comparability of Benefits Section 1902(a)(10)(B)

To enable Florida to vary the amount, duration, and scope of benefits offered to Demonstration Population A from that offered to other beneficiaries under the plan, and to enable benefits for Population A to be non-comparable to those offered to the categorically needy group.

3. Provider Agreements Section 1902(a)(27)

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits under the enhanced benefits account program.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

February 20, 2013

Justin Senior
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Justin:

I am writing to memorialize the work we have accomplished together to date on Florida's request to amend its section 1115 demonstration, titled, Medicaid Reform, demonstration number 11-W-00206/4. We have made significant progress in agreeing upon terms of a demonstration that will ensure access to high quality health care services for Florida's Medicaid beneficiaries. We are eager to continue working together and have reached agreement in principle on granting the waiver.

Moving ahead, we look forward to developing and incorporating into the terms and conditions of the demonstration amendment:

- Assurance of a comprehensive quality strategy that reflects the health needs of Florida beneficiaries across the state's Medicaid program at large, that has specific data-driven achievable goals and strategies, and that is aligned with the broader goals of improving care, improving health and lowering cost through these improvements. We have just received additional materials from you on this topic that we are now reviewing, and we appreciate that Florida has incorporated into its competitive procurement a large number of quality measures from our core set of health quality measures for both adults and children;

- Clarification and enhancements of the monitoring and evaluation plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and

- Development of enhanced stakeholder engagement strategies to ensure that the state is able to benefit from robust community input from beneficiaries and their advocates, providers and other state stakeholders in the management of the demonstration.

As we also have discussed, we will work together to ensure that a robust independent consumer support program is in operation to help beneficiaries navigate and access long term care services and supports so that beneficiary concerns are identified and addressed. Florida has some existing capabilities that could potentially provide for this kind of function, and we should continue to discuss whether this activity should be assured in the 1115 waiver or through an amendment to the recent 1915(b) (c) approval.

We look forward to working with you further on these topics as part of our effort to reach a final agreement on the demonstration. Please feel free to call me if you have concerns or questions as we continue our discussions.

Sincerely,

/s/

Cindy Mann
Director

Attachment I
Amendment Request #1
Overview

Attachment I
Amendment Request #1

Purpose: The State is requesting an amendment to the Florida Medicaid Reform 1115 demonstration (Project # 11-W-00206/4) to implement certain programmatic aspects of the statewide managed medical assistance program. It is important to note that the State is seeking an amendment to the current 1115 Research and Demonstration Waiver as many of the federal authorities required to implement the program have been granted to the State. However, the new program improves upon the current reform program and upon implementation the reform program will sunset.

2011 Legislation

The Agency for Health Care Administration (the Agency) is designated as the single state agency responsible for the administration of the Florida Medicaid Program. The Agency delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Elder Affairs and the Agency for Persons with Disabilities. The Florida Medicaid program currently serves more than 3 million Medicaid recipients and has a total appropriation for state fiscal year 2011-12 of $21.2 billion.

During the 2011 Florida Legislative session, the Florida Legislature passed and Governor Scott signed legislation to expand managed care in the Florida Medicaid program. This legislation included CS/HB 7107 (Chapter 2011-134, Laws of Florida). CS/HB 7107, in part, creates a statewide managed medical assistance program which will provide primary and acute medical assistance and related services using a managed care model. The legislation reads as follows:

- Section 409.964, Florida Statutes, provides for the Managed care program; state plan; waivers. “The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.”

The newly enacted legislation requires that the Agency submit any state plan amendments or waivers requests by August 1, 2011 (see provision above) to the Centers for Medicare and Medicaid Services (CMS). The legislation also provides that implementation of this program begin by January 1, 2013, with full implementation required by October 1, 2014.

As a result, the Agency is seeking an amendment to the current 1115 research and demonstration waiver to implement the program. The following changes are requested:

- Request to expand geographic operation statewide.
- Request to include previously voluntary groups as mandatory (Medicare dual eligibles, children with chronic conditions, children in foster care and adoption subsidy).
- Update programmatic operations and safeguards.

Summary of the Statewide Managed Medical Assistance Program

The following is a summary of the key components of the statewide managed medical assistance program as provided for in CS/HB 7107.

Statewide Managed Medical Assistance Program Regions

The new legislation establishes 11 regions throughout the state of Florida, and outlines the number of plans authorized to provide services in each region. Table 1 on the following page provides a list of the counties by the 11 regions.

Table 1		
Region	**Counties**	**Anticipated Implementation Date**
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton	TBD June 2013- October 2014
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	
Region 5:	Pasco and Pinellas	
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk	
Region 7:	Brevard, Orange, Osceola and Seminole	
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	
Region 10:	Broward	
Region 11:	Miami-Dade and Monroe	

Procurement Methods of Managed Care Plans

The Agency will competitively procure health plans (managed care organizations and fee-for-service provider service networks) to provide services in each of the 11 regions. The Agency will begin implementation of the statewide managed medical assistance program beginning January 1, 2013, with full program implementation by October 1, 2014. Once the Agency has issued the procurement and awarded the contracts, the Agency will provide a detailed transition plan based on plan readiness and capacity.

The legislation establishes criteria for preference in reviewing ITN respondents, including accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. The Agency is directed to enter into five-year health plan contracts with selected vendors. The Agency may not renew the contracts, and may extend the term of the contact only in order to cover any delays in transitioning to a new plan, but the contract may not be renewed.

Number of Plans Per Region

The Agency will procure a specified number of managed medical assistance plans per region. A minimum and maximum number of plans is specified, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a provider service network if any provider service networks submit a responsive bid. Issuance of the procurement will provide for a choice of plans, as well as, market stability as the Agency will seek to enter into five year contracts. As noted in Table 2 and the map on the following page, there will be a minimum of two plans choices in each of the 11 regions. To the extent that there are fewer than two plan choices in an area, the Agency will issue a procurement to obtain a second plan and meet the federal requirements regarding choice until two plans are available.

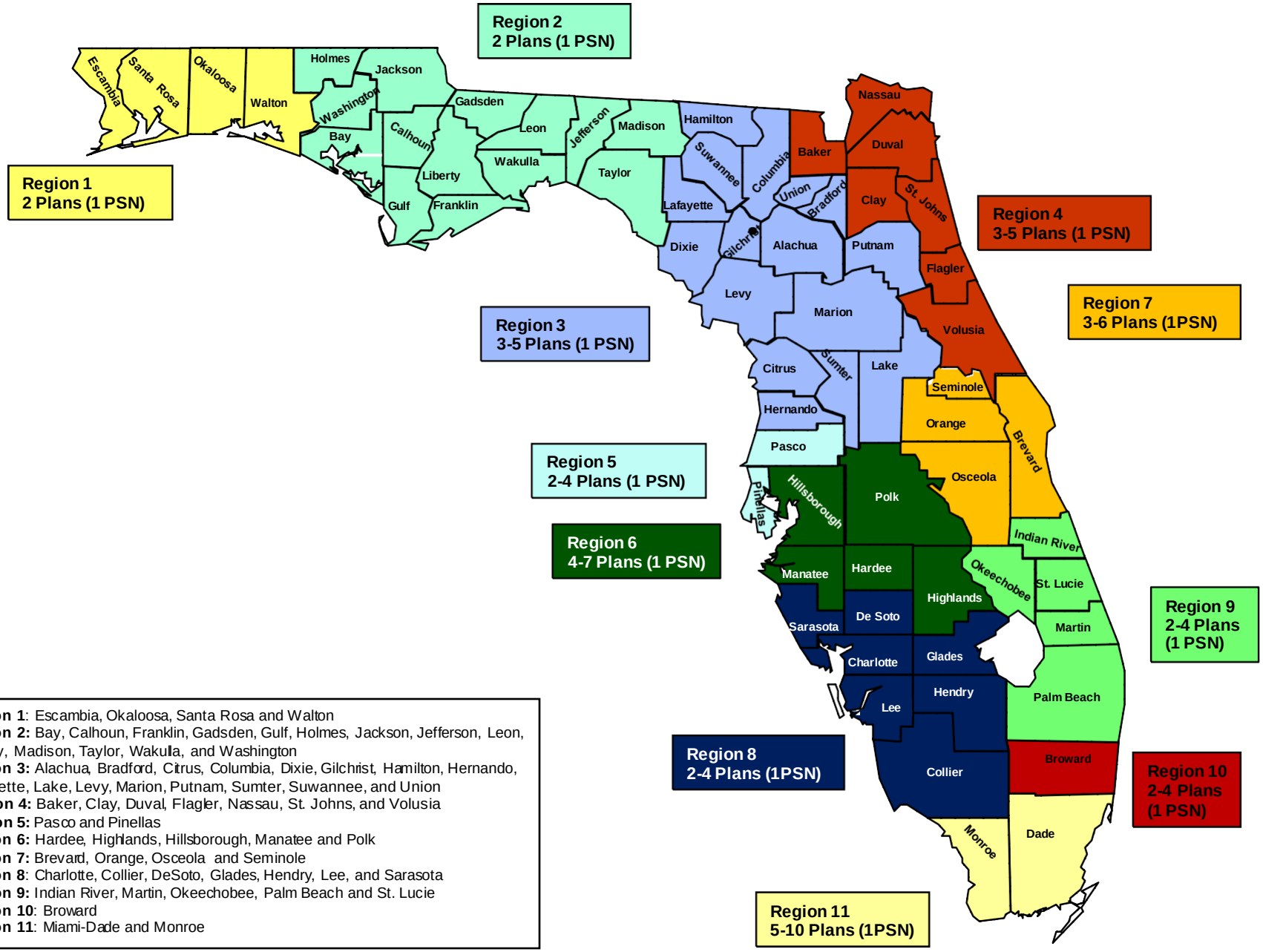
Table 2

Managed Medical Assistance: Plans Per Region

	Min # of Plans	Max # of Plans	# of PSNs	Children's Medical Services Network
Region 1	2	2	1	The CMS Network will operate statewide
Region 2	2	2	1	
Region 3	3	5	1	
Region 4	3	5	1	
Region 5	2	4	1	
Region 6	4	7	1	
Region 7	3	6	1	
Region 8	2	4	1	
Region 9	2	4	1	
Region 10	2	4	1	
Region 11	5	10	1	

Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits.

Attachment I
Amendment Request #1



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

A managed care plan is defined as an eligible plan under contract with the Agency to provide services in the Medicaid program and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to Florida Statutes, in the state that is paid a prospective per-member, per-month payment by the Agency.

An "eligible plan:" is defined as a health insurer authorized under chapter 627, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under state law or an accountable care organization authorized under federal law. For purposes of the statewide managed medical assistance program, the term also includes the Children's Medical Services Network authorized under state law.

In addition, the Agency will also seek to contract with specialty plans and participation of specialty plans will be part of the procurement requirements as well as the regional plan number limits. However, the Agency may enter into contracts with a specialty plan whose target population includes no more than 10 percent of the enrollees of that region and is not subject to the regional plan number limits in order to better serve individuals.

As part of the ITN process, the Agency will establish preference criteria for reviewing ITN respondents as previously described. Such criteria will include, but not limited to, the Agency's evaluation of whether plans' have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied will be promptly paid under state law; are organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

Excluded and Voluntary Populations - Statewide Managed Medical Assistance Program

Exempted Populations

Florida Medicaid recipients are required to become enrolled in the statewide managed medical assistance program for their primary and acute medical services unless exempt. Exempt recipients include:

- Women who are eligible only for family planning services.
- Women who are eligible only through the breast and cervical cancer services program.
- Persons who are eligible for emergency Medicaid for aliens.
- Children receiving services in a prescribed pediatric extended care facility.

Voluntary Populations

Additional provisions of the law establish that certain individuals who are exempt may voluntarily choose to participate in the statewide managed medical assistance program. Additional exempt recipients who may voluntarily enroll include:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare.

- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities, as defined in state law.
- Persons eligible for refugee assistance.
- Medicaid recipients who are residents of a developmental disabilities center.
- Medicaid recipients with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.

The new legislation provides that persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program.

Covered and Excluded Services - Statewide Managed Medical Assistance Program

The managed care plans will be required to cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner.
(b) Ambulatory surgical treatment center.
(c) Birthing center.
(d) Chiropractic.
(e) Dental.
(f) Early periodic screening diagnosis and treatment services for recipients under age 21.
(g) Emergency.
(h) Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the Agency of that election when submitting a reply to an invitation to negotiate.
(i) Healthy Start services, except as provided in s. 409.975(4).
(j) Hearing.
(k) Home health agency.
(l) Hospice.
(m) Hospital inpatient.
(n) Hospital outpatient.
(o) Laboratory and imaging.
(p) Medical supplies, equipment, prostheses, and orthotics.
(q) Mental health.
(r) Nursing care.
(s) Optical services and supplies.
(t) Optometrist.
(u) Physical, occupational, respiratory, and speech therapy.
(v) Physician services, including physician assistant.
(w) Podiatric.
(x) Prescription drugs.
(y) Renal dialysis.
(z) Respiratory equipment and supplies.
(aa) Rural health clinic.
(bb) Substance abuse treatment.
(cc) Transportation to access covered services.

In addition, plans are authorized to customize their benefit packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services. The Agency is

required to evaluate the proposed benefit package to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

Certain services are excluded from the plan benefit packages, and are "carved out" to remain under the fee-for-service system. Those services include services provided in a prescribed pediatric extended care facility, and the provision of anti-hemophilic factor replacement products to recipients diagnosed with hemophilia through the Agency's hemophilia disease management program.

Provider Network Requirements and Plan Accountability

Provider Network Requirements

In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks. The Agency will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. In addition, plans will be 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 and 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 so long as network adequacy standards are meet but must include providers classified by the Agency as "essential," which shall include at a minimum:

- Federally qualified health centers,
- Statutory teaching hospitals as defined in state law,
- Hospitals that are trauma centers as defined in state law, and
- Hospitals located at least 25 miles from any other hospital with similar services.

In addition, the Agency will identify statewide essential providers. These providers are to include:

- Faculty plans of Florida medical schools,
- Regional perinatal intensive care centers as defined in state law,
- Hospitals licensed as specialty children's hospitals as defined in state law, and
- Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

As previously noted, plans are required to negotiate in good faith with essential providers for one year and reimbursement for these essential providers is outlined.

In addition to the essential providers and statewide essential providers, plans will be required to offer a network contract to each home medical equipment and supplies provider that meets quality and fraud and abuse prevention and detection standards established by the plan.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as an option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate the pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

Plan Accountability and Performance Standards

The Agency will transition monitoring activities to provide enhanced plan accountability and clear performance standards. These requirements include, but are not limited to: posting of formulary or preferred drug list on a plan's website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan's website; accreditation within 1 year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification of the Agency of the impending birth of a child to an enrollee.

Plans will be required to comply with the Agency's reporting requirements for the Medicaid Encounter Data System. In addition, the Agency will fine plans $5,000 per day for each day of noncompliance beginning on the 31st day. The Agency is required to notify the plan on the 31st day that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance.

Additionally, program integrity requirements for plans will include but not be limited to:

- Plans must have an effective prepayment and postpayment review process including data analysis, system editing and auditing of network providers
- Plans must have in place procedures for reporting instances of fraud and abuse pursuant to Chapter 641.
- Plans must have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse.

Achieved Savings Rebate

To promote fiscal accountability, the Agency will establish an achieved savings rebate program. Under the program, the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.
2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state.

Incentives are included for plans that exceed Agency defined quality measures. Plans that exceed such measures during a reporting period may retain an additional 1 percent of revenue.

Penalties and Sanctions

To ensure stability, the Agency will impose new penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25 percent of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 days notice to the Agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the Agency is required to terminate all contracts with that plan in other regions.

If a plan that is awarded an “additional contract” to ensure managed care plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 1, 2011

Mr. Richard Jensen, Director
Division of State Demonstrations & Waivers
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Jensen:

Enclosed for your review is a request to amend Florida Medicaid Reform 1115 demonstration (Project # 11-W-00206/4) to expand geographic operation of the program and to transition the following populations: Medicare dual eligibles, children with chronic conditions, children in foster care and adoption subsidy to mandated participation in the statewide managed medical assistance program.

The newly enacted legislation provides for managed care plans (managed care organizations or fee-for-service provider service networks) that will be competitively procured by the Agency to participate in the statewide managed medical assistance program. CS/HB 7107 substantially improves the State's current managed care program and includes key safeguards to ensure plan accountability.

Attachment I is an overview of the State's amendment request to implement key provisions of the newly created Statewide Managed Medical Assistance program. Attachment II is the waiver amendment replacement packet. Attachment III is the required statewide implementation plan. Attachment IV summarizes the Agency compliance with Special Term and Condition #7 of the waiver, and Attachment V provides the required budget neutrality.

We appreciate your consideration of this request and your efforts in working with our staff on the 1115 Florida Medicaid Demonstration Waiver. Should you have any questions, please contact me at (850) 412-4007. We look forward to continuing to work with you.

Sincerely,

[redacted]

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosures
cc: Mark Pahl, CMS-CO
Jackie L. Glaze, CMS-RO
Etta Hawkins, CMS-RO

Attachment II
Replacement Packet

Statewide Managed Medical Assistance Program

1115 Research and Demonstration Waiver

FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

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Table of Contents

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I. Statement of Purpose

The Florida Medicaid program was created in 1970, and currently covers approximately 3 million Floridians. Although initially crafted as a medical care extension for persons who received federally funded cash assistance, during the 40 years the program has operated the State has exercised options as they became available under federal law to expand Medicaid coverage to categorically related groups in addition to mandatory categorically needy eligibility groups. Further, the State also receives federal matching funds to provide certain optional services, and has sought and received federal waivers to provide services through home and community based programs for individuals who might otherwise be institutionalized.

Florida currently has received federal approval for waiver authority under various sections of the Social Security Act to conduct regional and statewide demonstrations designed to cover uninsured populations and to implement new delivery systems without increasing costs. The State has used such authority to implement managed care programs to enhance access to quality care in a cost-effective manner. With the implementation of the Statewide Medicaid Managed Care Program, the State is seeking to streamline the State's various managed care programs into a more comprehensive and integrated program available throughout the State of Florida. Upon implementation, the vast majority of programs will sunset and individuals will receive services through the Statewide Medicaid Managed Care Program.

As in all other States, Florida (and the federal government) has experienced very rapid growth in Medicaid expenditures. Drivers of such costs include population growth, expansions due to federal mandates, and economic recessions; expanded coverage and utilization of services; growth of the aged and disabled population; technological advances in treatment resulting in more costly care; increased cost of long-term care; and increased drug costs. To illustrate the impact to Florida:

- From SFY 2006-07 to 2011-12, Medicaid expenditure growth for Florida has averaged 6.5% per year, and Medicaid average monthly caseload growth has averaged 7.4% per year. In State Fiscal Year (SFY) 2011-12, the average monthly Medicaid caseload will be close to 3.2 million individuals, and total Medicaid expenditures will exceed $21 billion dollars.[1] Medicaid will represent approximately 33% of the entire State budget in SFY 2011-12. If these trends continue, it is anticipated that by SFY 2014-15 Medicaid will represent 41% of the State's total budget with expenditures over $27 billion.

- Florida covers over 47 different services on a fee-for-service (FFS) basis and through contracted managed care entities not included in this demonstration waiver. Individuals can receive care through 19 contracted managed care organizations (MCOs); the statewide primary care case management (PCCM) system; MediPass; or a FFS Provider Service Network (PSN) outside the demonstration counties. In addition, the State maintains several carve-out programs for mental health services, dental care, and transportation outside the demonstration counties. These multiple delivery systems generate more than 140 million individual claims annually, from more than 110,000 service providers of all types.

[1] February 2011 Florida Social Service Estimating Conference Report

As a result, Medicaid expenditures are growing faster than other components of State budgets, and State Legislatures are seeking solutions to make the program sustainable over the long term. Care delivery to recipients in the fee-for service setting described above is often fragmented and episodic. No incentive exists for service providers to deliver efficient or coordinated health care. Rather than engage in preventive routine care, recipients often do not seek care until they become ill, and such utilization of the health care system does not leverage the dollars spent to improve the health status of the Medicaid population. A managed care system would create incentives for MCOs to identify recipients with chronic health conditions and provide preventive therapies and health maintenance, rather than wait until conditions become so severe that intensive and expensive treatment is required.

To that end, in recent years Florida has exercised options available from the federal government to improve the coordination and quality of services to recipients, while ensuring the efficiency and effectiveness of the program. In late 2010, in preparation for the 2011 Legislative session, Florida's elected leaders passed a Memorial that provided a framework for policy changes to be considered in the 2011 session.[2]

In the 2011 legislative session, both the Florida House of Representatives and the Florida Senate held numerous committee meetings to consider options for an effective and sustainable Medicaid program. Significant time was given by both houses and relevant committees of the legislature to receive public testimony from all facets of the stakeholder community. The result of this wide-ranging input was the conclusion that policy change was imperative to ensure the quality and coordination of care for Medicaid recipients, maintain access to physicians and other providers of service, and to improve the financial integrity and predictability of the need for funding of the program by Florida's taxpayers.

Two major pieces of Medicaid legislation were passed and signed into law.[3] This document is specific to CS/HB 7107, which provides for significant changes to build greater stability and accountability in Florida Medicaid managed care. The enclosed waiver amendment request seeks federal authority to implement these changes. Central to this legislation is the creation of the Statewide Managed Medical Assistance program which would provide primary and acute medical care for specified populations through competitively selected MCOs in 11 geographic regions of the State.

Objectives for moving populations from a fee-for-service system to managed care include:

- Providing incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting.
- Providing individuals a meaningful choice of plans and benefits.
- Reducing fraud, abuse and waste through managed utilization of health care services.

Currently, approximately 43% of all Florida Medicaid recipients are served through a managed care delivery system; the remaining 57% of the population is served through the traditional fee-for-service program. Florida Medicaid is recognized as a leader in the battle against fraud and abuse and has put in place many automated and manual safeguards to detect and prevent

[2] Link to Memorial to Congress http://www.flsenate.gov/Session/Bill/2010A/0004/BillText/er/PDF.
[3] Links to CS/HB 7107 http://www.flsenate.gov/Session/Bill/2011/7107/BillText/er/PDF, and 7109 http://www.flsenate.gov/Session/Bill/2011/7109/BillText/er/PDF.

inappropriate payments, but the scale of the program and $21 billion taxpayer expenditure required the closest possible oversight to prevent inappropriate utilization and potential overbilling.

The provisions of the recently enacted legislation that established the managed care program included specific requirements to further enhance program integrity. The selection criteria for the competitive procurement of managed care plans include documentation of policies and procedures for preventing fraud and abuse. Potential contractors face strict requirements to disclose business relationships to guard against conflicts of interest or prior involvement in health care fraud. The legislation includes accountability provisions that include provider credentialing and monitoring, effective prepayment and post-payment review processes, enhanced plan financial and data reporting, and a mandatory compliance plan designed to prevent fraud and abuse. It is not feasible to conduct this level of review for over 110,000 current fee-for-service providers.

The challenges facing states to improve their Medicaid programs' design to produce optimum health outcomes and efficiently manage costs require significant changes in order to sustain this benefit for individuals with low incomes and resources. The amendment request seeks to use the current authorities already granted to implement Florida law which is designed to address these challenges.

The State believes that the Florida Medicaid Managed Medical Assistance Program provides the framework for evolution to a sustainable benefit without eliminating services or access for eligible individuals. Given the requested authority to implement this program, Florida Medicaid could transform relationships, improve accountability, and provide incentives for improved health outcomes.

II. Statewide Managed Medical Assistance Program

Florida's Statewide Managed Medical Assistance program will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The State's role has changed so that it is largely a purchaser of care, providing oversight focused on improving access and increasing quality of care. This program emphasizes personal responsibility and rewarding healthy behaviors.

The framework for the Statewide Managed Medical Assistance program was established in legislation passed by the legislature and signed by the Governor through a Memorial in a special legislative session in late 2010 and in legislation passed in the regular 2011 session.

1. The principles established for the Statewide Managed Medical Assistance program included:

   - Improved program performance by expanding key components of the Medicaid managed care program Statewide, while strengthening accountability for improved patient outcomes and preserving meaningful choices for participants. A key objective of improved program performance is to increase patient satisfaction.
   - Improved access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care). A key objective of improved access to coordinated care is to ensure access to services not previously covered and to improve access to specialists. This program includes requirements for MCOs to schedule appointments with a primary care physician within 30 days for new enrollees.
   - Enhanced fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems and shared savings model. Strict financial oversight requirements are established for MCOs to improve fiscal integrity.
   - Use of the expertise of MCOs, including health maintenance organizations (HMOs), PSNs, and other types of managed care entities to provide all coverage and services for medical assistance. A key objective of the program is to provide a choice of managed care plans throughout the state and to provide for enhanced individual choice.
   - Stabilization of plan participation by competitively procuring plans on a regional basis, extending plan contract period to five years, and imposing penalties for plan withdrawals which are designed to enhance continuity of care.
   - Protection of participants' choices and dignity by expanding the use of the opt-out provisions of the Statewide Managed Medical Assistance program and allowing funds to be used for private coverage. A key objective of the program is to increase the comparability of benefits between Medicaid and health insurance benefits received by Floridians not on Medicaid.
   - Phased implementation of the Statewide Managed Medical Assistance program, allowing for adequate development of Medicaid managed care across the State.

These principles will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government.

2. Under the Statewide Managed Medical Assistance program, there are four fundamental elements:

   - Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The risk-adjusted premium will minimize the phenomenon of "adverse selection," and in fact, provides an incentive for plans to take all necessary steps to identify Medicaid enrollees who have undiagnosed chronic conditions. Once a Medicaid enrollee has chosen a plan, the plan may receive a higher premium only if the enrollee has been diagnosed with a condition that merits the additional premium. Of course, once a plan has identified someone with a chronic condition, it is then to the plan's financial benefit to properly manage the enrollee's condition so as to avoid higher cost services typical of untreated chronic conditions.
   - Enhanced Benefits/ Healthy Behaviors will be provided through the managed care plans. The Enhanced Benefit Panel will be operational until the implementation of the Statewide Managed Medical Assistance program. The procurement process will require managed care plans to establish a program to encourage and reward healthy behaviors. The State will monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan.
   - Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace. Individuals eligible for Medicaid will be able to direct their premiums for use as a subsidy for the employee share of ESI, or as premium payment into a private plan if the individual is self- employed. If the ESI share or self-employed insured premium is greater than the Medicaid premium, the enrollee will be responsible to pay the additional amount.
   - Low-Income Pool (LIP) will be maintained by the State to provide direct payment and distributions to safety net providers in the State for the purpose of providing coverage to Medicaid, the uninsured, and underinsured populations. Funds will be distributed to safety net providers that meet certain state and federal requirements.

The Statewide Managed Medical Assistance program will introduce more individual choice, increase access, and improve quality, efficiency and fiscal integrity while stabilizing cost. The State believes more integrated models that expand the medical home concept to manage all care will provide additional opportunity to better manage care. Therefore, the State will continue to increase the number of individuals enrolled in managed care plans that are capable of managing all of an individual's care. In addition, the State will allow flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are sufficient and actuarially equivalent to meet the needs of the population.

As further described in this document, the managed care plans will be procured through a competitive, negotiated selection of qualified managed care plans that meet strict selection criteria. The program will provide for a limited number of plans in 11 geographic regions to ensure stability but allow for significant patient choice and further ensure coverage in rural areas of the state. The State will initiate procurement of the plans no later than January 1, 2013, and fully implement the program by October 1, 2014.

To effectively implement the program, the State is requesting an amendment to Florida's section 1115 Research and Demonstration waiver in order to waive statutory provisions under Section

1902 of the Social Security Act and obtain expenditure authority that permits the State to provide maximum flexibility in administering Florida's Medicaid program while the program will change substantially for the current demonstration program as there are key improvements. Specifically, the State requests waivers of statutory provisions to provide for:

- Approval and federal financial participation (FFP) for Statewide Managed Medical Assistance program benefits with cost-sharing for all Medicaid eligibility categories participating in the waiver.
- Approval and FFP for the ESI option with cost-sharing, if applicable.
- Approval and FFP for the Enhanced Benefit/ Healthy Behaviors Plan to enable managed care plans to administer programs to encourage and reward healthy behaviors.
- Approval and FFP for funds disbursed through the Low-Income Pool to eligible providers.

While the federal authorities needed to implement the program remain consistent with the current authorities granted in the 5 pilot counties. It is important to note that the program includes substantial changes to improve upon the current program.

III. Eligibility and Enrollment

A. Eligibility for Medicaid

The Department of Children and Families (DCF) is the administering agency responsible for processing Medicaid applications and determining Medicaid eligibility. The State will continue to use the same application and eligibility processes for all individuals, including participants in the Statewide Managed Medical Assistance program. Current income and asset limits will apply under the program, as will current residency and citizenship standards. There will be no limit on the number of individuals eligible for Medicaid as specified in the State Plan. The State assures that all applications will be processed in a timely manner.

B. Eligibility for the Statewide Managed Medical Assistance Program

Participation in the Statewide Managed Medical Assistance program will be mandatory for the following eligibility groups currently covered by Florida Medicaid:

1. Mandatory Population:

    a. TANF and TANF-Related Group - 1931 Eligibles:

        - Families whose income is below the TANF limit (23% of the FPL or $303 per month for a family of 3) with assets less than $2,000.
        - Pregnant women with incomes above the 1931 poverty level.
        - Poverty-related children whose family income exceeds the TANF limit as follows:
            - up to age one, family income up to 200% FPL.
            - up to age 6, family income up to 133% of FPL.
            - up to age 21, family income up to 100% FPL.

    b. Aged and Disabled Group:

        - The aged and disabled, comprising persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL; asset limit for an individual is $2,000).

    c. Children eligible under SSI.

    d. Children with chronic conditions who participate in Children's Medical Services Network.

    e. Children in foster care and who receive adoption subsidy.

    f. Individuals eligible under a hospice-related eligibility group.

    g. Individuals eligible for both Medicare and Medicaid will be required to participate in this program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals Medicare Benefits. However, to facilitate enrollment, the State will automatically enroll individuals in a Medicare Special Needs Plan (SNP), if the individual has elected the plan under Medicare.

The above groups are mandatory eligibles, with the exception of poverty level children up to age one with family income above 185% of FPL but below 200% of FPL.

2. Voluntary Populations:

Medicaid recipients who may voluntarily choose to participate in this program include:

- Individuals who have other creditable health care coverage, excluding Medicare.
- Individuals residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities, as defined in state law.
- Persons eligible for refugee assistance.
- Individuals who are residents of a developmental disabilities center.
- Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.

3. Exempt Population:

The following individuals are exempt from this program:

- Women who are eligible only for family planning services.
- Women who are eligible through the breast and cervical cancer program.
- Persons who are eligible for emergency Medicaid for aliens.
- Children receiving services in a prescribed pediatric extended care facility.

4. Expansion Population:

Individuals with incomes of less than 200% FPL, regardless of assets, who lose eligibility for Medicaid, will continue to have limited eligibility under Medicaid demonstration. This expansion population retains Medicaid eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

Once the State implements the Statewide Managed Medical Assistance program and the plans offer a healthy behavior program, the State will sunset the current enhanced benefits program. However, the individuals with unused earned credits will continue to have access to those credits for a specified period of time.

C. Enrollment and Disenrollment

Upon implementation of the program, the State anticipates developing a staggered transition plan in each region to transition individuals into the managed care plans once selected as part of the procurement process.

1. New Medicaid Enrollees:

At the time of eligibility determination, individuals in mandatory populations will receive information about the managed care plan choices in their area. They will be informed of their option to select an authorized plan or opt out of Medicaid. If they opt out, the individual can use their premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility. If

the individual does not select a plan or opt out within the 30-day period, the State will auto-assign the individual to a managed care plan. Once individuals have made their choice, they will be able to contact the State or the State's designated Choice Counselor to register their plan selection or complete enrollment through the online process.

2. Current Medicaid Enrollees:

For current Medicaid enrollees in a mandatory population, the State will develop a staggered transition plan for enrollment in the Statewide Managed Medical Assistance Program. Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program, will be required to enroll in a contracted plan, selected through competitive procurement process, at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner. The State may create an open enrollment process for all enrollees.

The State will carefully plan the transition of the affected recipients into the program to preserve continuity of care. The State will follow a multi-layered approach in the design of the transition plan by:

- Assessing the capacity of the contracted plans.
- Coordinating with the contracted plans to identify primary care providers and supply service information to ensure continuity of care and minimize disruption to the recipients.
- Coordinating with the new contracted plans to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new plan.
- Coordinating with the contracted plans and the State's designated contractor to create a staggered transition to ensure that the volume of beneficiaries being transitioned occurred in an organized manner.
- Coordinating with the new contracted plans, the State's designated contractor, local area staff, and advocacy groups in ensuring appropriate and timely notice to enrollees, including developing and releasing flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.

Additional details regarding the transition of care are provided in Appendix D.

Medicaid recipients in the demonstration areas, who are not currently enrolled in a contracted plan upon implementation, will have the opportunity to enroll in a plan at the time of open enrollment or annual eligibility redetermination. The individual may choose to contact the toll free help line to talk about their managed care plan options. If the individual does not make a selection, the State will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

3. Auto-Assignment

Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the State or State's designate will provide information to the individual to encourage an active plan selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a plan in their region. At a minimum, the State will

use the parameters listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit.

The State will use the following parameters when assigning a recipient to a plan:

- If an applicable specialty plan is available, the recipient should be assigned to the specialty plan;
- If, in the first year of the first contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.
- Newborns of eligible mothers enrolled in a plan at the time of the child's birth shall be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

In addition, when automatically enrolling a recipient into a plan, the State will consider:

- Whether the plan has sufficient network capacity to meet the needs of the recipients.
- Whether the recipient has previously received services from one of the plan's primary care providers.
- Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

The State will seek to preserve an existing provider-recipient relationship by considering whether the recipient has received services from one of the primary care providers in the plan's provider network in the past.

4. Lock-In/Disenrollment

Once a mandatory enrollee has selected or been assigned to a managed care plan, the enrollee will have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, the enrollee will be locked-in for the remainder of the 12 month period, and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan. Voluntary enrollees may disenroll from the managed care plan at any time.

The State or State's designee will record the plan change/disenrollment reason for all recipients who request such a change. The State or State's designee will be responsible for processing all enrollments and disenrollments.

The State assures CMS that it complies with Section 1932(a)(4) and 42 CFR 438.56, insofar as the provisions are applicable.

5. Opt-Out: Employer-Sponsored Insurance

Enrollees will be able to opt out of Medicaid at any time to enroll in an employer- sponsored insurance program. The State will provide an enrollee who chooses to opt out of Medicaid and enroll in an ESI plan with a 90- day change period. However, an enrollee who chooses to opt out of Medicaid and enrolls in an ESI plan may switch plans or opt back into a Medicaid contracted plan at anytime.

6. Re-enrollment

In instances of a temporary loss of Medicaid eligibility, which the State is defining as six months or less, the State will re-enroll enrollees in the same health plan they were enrolled in prior to the temporary loss of eligibility. The State believes that such re-enrollment will promote increased preventive services, maximize continuity of care, and foster continued provider relationships.

D. Information and Choice

1. Enrollee Choice

Potential enrollees in the demonstration regions will initially have the choice of enrolling in a managed care plan or to opt out of Medicaid. Potential enrollees will have a choice of two or more managed care plans in each region. Plans may include:

- HMOs,
- PSNs (FFS or capitated),
- Accountable Care Organizations (defined in federal law),
- EPOs, or
- CMS Network.

The State assures CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two options will be available in all demonstration regions. Recognizing the unique attributes of Florida's rural communities, the State will issue regional bids in an effort to provide individuals with two or more options.

2. Enrollee Information

The State or the State's designee will ensure that enrollees are provided with full and complete information about managed care plan choices and the ability to opt out of Medicaid consistent with current process. The State anticipates contracting for these services. The State or State's designee will provide information regarding an individual's choice to select a managed care plan or opt-out of Medicaid.

Through the contractor, the State will develop enrollee education so individuals will fully understand their choices and will be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly. Specifically, the State or State's designee will provide information on either selecting a managed care plan or opting out of Medicaid.

The State or State's designee will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the

administrator. The State or State's designee will assist the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice. Individuals interested in opt-out will be encouraged to contact their employer and the State's contract administrator for the opt-out program for additional information. The State or State's designee will collect information on whether the individual has access to health insurance. At a minimum, the State or State's designee will encourage the individual to determine available health insurance; when the individual can enroll; review of cost-sharing requirements of the plan; information about preexisting conditions clauses; and whether individual or family coverage is available. The State or State's designee will then refer the individual to the State's administrator, which will assist the individual in the opt-out process. Specifically, the administrator will contact the employer and verify available health insurance. To ensure enrollees understand this option, the administrator may periodically contact individuals regarding the opt-out option. This outreach process will enhance awareness of the program and help ensure coordination with the employer's time frame for open enrollment and qualifying events.

As it does now, the State or the State's designated contractor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, prescription drug formulary, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. Individuals will be assured of equal value among plans since all plans will be actuarially equivalent. In addition, the State will supplement coverage information by providing performance information on each plan. Information provided may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data. To ensure the information is as helpful as possible, the State may synthesize information into a coherent rating system. Such a system will better convey the performance of the managed care plans in an easy-to-understand format.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5% of the county speaks a language other than English. The State or State's designee will also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the State or the State's designated contractor to obtain additional information. The State or State's designed contractor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

The State assures the Centers for Medicare and Medicaid Services that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, Information Requirements.

The State or the State's designed contractor will retain responsibility for all enrollment and disenrollment activities into managed care plans.

E. Marketing

Approved managed care plans will not be allowed to market for enrollment to any potential members. Plans will be allowed to engage in brand-awareness activities, including the display

of plan or product logos. With State approval, the plans will be allowed to conduct community outreach. Community outreach includes, but is not limited to, the provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. In addition, the State will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities.

All materials provided by the plans will meet the requirements at 42 CFR 438.10, Informing Requirements, including being written at a fourth-grade reading level. The State will require translation of all enrollment and marketing materials in areas where a specific language is spoken by 5% or more of the population. In addition, the State or State's designed contractor and plans will provide oral translation services to all individuals, regardless of the language spoken. Plans will be required to have TTY/TDD service available for enrollees with hearing and speech impairments.

In addition, the State will maintain strict oversight of community activities and will monitor for marketing violations. The State will continue to apply and enforce federal and State marketing restrictions that currently apply to plans. In addition to the federal requirements, Florida law prohibits plans from offering gifts or other incentives to potential enrollees and managed care plans from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans.

IV. Benefits

The Statewide Managed Medical Assistance program will provide individuals with health care options that will allow them to better manage their health care. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit "silos" that exist today, there are statewide limits and caps on various services that have varying impact on local populations.

The Statewide Managed Medical Assistance program will provide health plans with the flexibility to develop customized benefit packages that better fit and are more appropriate for Medicaid enrollees. Since these plans will be defined locally and will likely take advantage of varying strengths of the providers in that community, they will be more appropriate to the needs of that particular population. Such packages will more closely resemble private plans, yet will be actuarially equivalent to the current Medicaid benefit package. As part of the competitive procurement process, each plan will face the competitive pressure of offering the most innovative package within the limits of the premium offered by the State. At all times, the State will ensure the benefit packages are available at an actuarially appropriate level. The State seeks to ensure that needed services are covered and provided. With increased choices, individuals will be able to use their premium to select benefit plans that best meet their needs.

Each health care plan will submit its proposed benefit package to the State for prior approval. The State will evaluate the proposed benefit package using a two-pronged test: (1) actuarial equivalency and (2) sufficiency of benefits.

In addition, as part of the competitive bid process each plan will be required to create an enhanced benefit program. The purpose of the plan's enhanced benefit program is to offer incentives to enrollees to participate in wellness activities. These activities will be designed to improve and/or maintain the enrollee's health by providing individuals with a comprehensive benefit package.

A. Customized Benefit Packages

A major element of the Statewide Managed Medical Assistance program is the ability of health plans to develop customized benefit packages targeted to specific populations. These customized benefit packages will foster enrollee choice and will enable enrollees to access the health care services they need. Additionally, it is expected that these customized benefit plans will resemble private insurance plans, further bridging public and private coverage.

The benefit packages may look different from traditional Medicaid in several ways. In order to provide additional or special services to the targeted population, these tailored benefit packages may vary the amount, duration and scope of some services and may contain service-specific coverage limits, such as the number of visits or dollar cost. All packages must cover mandatory Medicaid services, including medically necessary services for pregnant women and EPSDT services for children under age 21, as the State is not seeking to waive EPSDT requirements for children enrolled in a Medicaid managed care plan. It is also expected that managed care plans will develop benefit packages to cover most optional services. In addition, managed care plans may also cover services not currently offered under the State Plan, such as adult dental care. Services not included in an approved benefit package, or that exceed those in an approved benefit package, will be considered non-covered services.

All benefit packages must be prior-approved by the State and must be at least actuarially

equivalent to the services provided to the target population under the current State Plan benefit package. In addition to being actuarially equivalent to the value of traditional Medicaid services, each managed care plan's customized benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population (e.g., TANF, aged and disabled, etc.). See below for more detail.

While one of the major principles of the State is to encourage innovation by allowing for the variation of amount, duration and scope, plans are not required to change benefit packages and may choose to offer a benefit package that mirrors current coverage levels. Actual benefit packages will depend on market innovation and the population the plan seeks to serve and will be reviewed annually by the State.

1. Actuarial Equivalency

The State will evaluate each proposed customized benefit plan for actuarial equivalence to the current Medicaid State Plan. To do this, the State will use a Benefit Plan Evaluation Model that: 1) compares the value of the level of benefits in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensures that the overall level of benefits is appropriate.

Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that, given a specified Medicaid target population and its historical utilization, the expected claim cost levels of all managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan. The State will use this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits.

2. Sufficiency

In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet State-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. In this evaluation the State will identify specific services (e.g., inpatient hospital, outpatient physician care, behavioral health, and prescription drugs) and will evaluate each proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for target population that is expected to exceed the plan's proposed benefit level.

Thus, in order for a health plan to obtain State prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. Recipients will have the option to choose a managed care plan with a benefit package that best fits their needs. For example, one plan's benefit package may offer fewer chiropractic visits and more vision benefits than another plan's benefit package. If the recipient does not need a chiropractor but wears glasses, he/she may wish to choose a plan with a benefit package that offers more vision benefits. The State believes that

the flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for plan enrollees.

The State will evaluate service utilization on an annual basis and use this information to update the benefit comparison package to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

3. Cost Sharing

Under the Statewide Managed Medical Assistance program, the contracted plans may impose cost-sharing requirements consistent with the currently approved nominal levels in the State Plan. Current cost-sharing, including co-payments and co-insurances, are:

Services	Co-payment / Co-insurance
Birthing Center	$2 per day per provider
Chiropractic	$1 per day per provider
Community Mental Health	$2 per day per provider
Dental – Adult	5% co-insurance per procedure
FQHC	$3 per day per provider
Home Health Agency	$2 per day per provider
Hospital Inpatient	$3 per admission
Hospital Outpatient	$3 per visit
Independent Laboratory	$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner	$2 per day per provider
Optometrist	$2 per day per provider
Pharmacy	2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant	$2 per day per provider
Podiatrist	$2 per day per provider
Portable X-Ray	$1 per day per provider
Rural Health Clinic	$3 per day per provider
Transportation	$1 per trip

All individuals not exempt by federal regulation will be responsible for cost- sharing for services. The State will review and approve cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b) cost-sharing will not be required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by the Centers for Medicare and Medicaid Services. The State will also encourage managed care plans to reduce or waive cost-sharing requirements for preventive services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, vaccinations, pap smears, and certain prescribed medication. The State believes that, due to the transparency of outcomes built into the Statewide Managed Medical Assistance program – particularly with each plan's ability to maximize the number of people who receive preventive services - plans will be incentivized to remove all barriers to preventive services, – including waiving cost sharing for those services. When a co-payment or co-insurance is required as part

of the plan benefit structure, the provider will be responsible for collecting payments from individuals.

4. Enhanced Benefit /Healthy Behaviors Plan

The State will directly manage the development of policies and procedures that govern the Enhanced Benefit plan by establishing the Enhanced Benefit Panel until the implementation of the Statewide Managed Medical Assistance program. As part of the procurement process in 2013, each selected plan shall be required to establish a program to encourage and reward healthy behaviors. At that time, the State will monitor the plans programs. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse program. These programs maybe modified by the Legislature.

The State will continue operation of the panel to guide in the development and evaluation of the healthy behavior program offered by the plans. Panel composition will be determined by the Secretary of the Agency for Health Care Administration. The purpose of the panel will include, but not be limited to, the following duties:

- Designate activities that may be beneficial to individuals;
- Informing recipients of a proposed activity to enrollees;
- Establish appropriate incentivizes for participation;
- Evaluate participation levels;
- Evaluating outcomes;
- Discussing operational issues; and
- Develop recommendations for administration.

V. Opt-Out: Employer Sponsored Insurance

Two key principles of the Statewide Managed Medical Assistance program are patient choice and bridging public and private coverage. A primary mechanism to incorporate these principles into Medicaid is the ability of individuals to choose to opt out of Medicaid and obtain coverage through their employer-sponsored insurance (ESI) plan. Families that take advantage of ESI coverage are more likely to have the entire family covered under the same insurer, which increases the likelihood of continued coverage and the preventive behaviors that foster better health. Additionally, participating in coverage obtained through the workplace strengthens the tie to the workplace, further contributing to the goals of self-sufficiency and empowerment.

A. The ESI Environment in Florida

The State has permitted individuals to direct their premiums for use as a subsidy for the employee share of ESI, or as premium payment into a private plan when the individual is self-employed. As a result, some individuals have chosen this option. The State has provided outreach and education through the Choice Counselor and the Opt Out Contractor to increase awareness and understanding of the opt-out program.

According to information from the Kaiser Family Foundation, in 2010, 31.2% of Florida firms with fewer than 50 employees offered health insurance to their employees, and 97.6% of Florida firms with 50 or more employees offered health insurance to their employees[4]. In addition, in 2009, 50% of non-elderly Florida Medicaid households have at least one full-time worker, and 12% have at least one part-time worker[5].

These figures indicate that many Florida Medicaid enrollees have access to private insurance. The opt-out program has provided enrollees with one more choice and has increased Medicaid beneficiaries' participation in the private insurance market. While participation in the program has been much more modest than originally estimated, the State will undertake improvements to the program to make it more attractive to enrollees. Specifically, the State will provide wraparound benefits to children and adults that would otherwise be eligible. In addition, the State will cover cost sharing in excess of 5% of the individuals income.

The State of Florida has legislation addressing minimum standards of coverage for the following insurance products:

- Individual Health Policies
- Group Health Policies and Small Group Plans
- HMO Contracts and Small Group Plans
- Out-of-State Group
- Standard and Basic (HMO and Insurance).

The specific mandated benefits vary according to insurance product. While coverage by ESI programs may be more limited than Medicaid coverage, the State has offered individuals the option of alternative coverage. Regardless of differences in coverage, certain individuals have selected private coverage when available.

[4] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org: Florida: Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size, 2010.

[5] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org: Florida: Distribution of the Nonelderly with Medicaid by Family Work Status, states (2008-2009), U.S. (2009).

B. Enrollment and Disenrollment

All individuals eligible for the Statewide Managed Medical Assistance program may voluntarily opt out. Coverage includes individuals who have access to a qualified ESI health plan and, COBRA coverage. Enrollment in the ESI option occurs in the same manner as enrollment in managed care plans under the Statewide Managed Medical Assistance program, with enrollees receiving plan and opt-out information at eligibility determination or redetermination, or at their annual open enrollment. For new eligibles, enrollees are informed of the program at the time of eligibility determination and how to contact the Opt Out contractor for additional information.

The State's or State's designated Opt Out contractor assists the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice. Individuals interested in opt-out are encouraged to contact their employer for additional information. The State's or State's designated Opt Out contractor will collect information on whether the individual has access to health insurance. At a minimum, the State's or State's designated Opt Out contractor will encourage the individual to seek information on the available health insurance at work; when the individual can enroll; review of cost-sharing by the plan; information about preexisting condition clauses; and whether individual or family coverage is available. The State's or State's designated Opt Out contractor will assist the individual in the opt-out process. Specifically, the State's or State's designated Opt Out contractor will contact the employer and verify available health insurance.

Individuals are informed of their premium share to be used as a subsidy to pay the employee share of the ESI plan. Unlike the managed care option, however, enrollees may choose to opt-out of Medicaid at any time, even after the 90-day change window when they are otherwise locked in to a managed care plan under the Statewide Managed Medical Assistance program. To increase awareness, the State or State's designee may develop outreach process to enhance awareness of the program and help ensure coordination with the employer's time frame for open enrollment and qualifying events. This exception to the lock-in is made because individuals may be eligible for ESI at different points throughout the year.

An enrollee who chooses to opt out of Medicaid and enrolls in an ESI may select a Medicaid contracted plan at anytime.

C. Payment of Premium Share

Individuals choosing to participate in the ESI option register with the Opt Out Contractor and provide all pertinent employer information, including the amount of the employee contribution for the ESI plan. The Opt Out is responsible for contacting the employer to verify coverage information. Premium payments are reimbursed directly to the insurer of record.

Maximum payment will be the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage.

To ensure cost effectiveness, the total amount of all premiums, including any supplemental benefits or payment of cost sharing, is limited to the Medicaid authorized premium.

D. Benefits and Cost Sharing

The benefit package under ESI must meet minimum State licensure standards. The State will provide Medicaid covered benefits not covered by the ESI plan (e.g. wrap-around services) to ensure that the resulting coverage includes all State Plan benefits for children under 21 (including all EPSDT services) and all coverage otherwise available under the State Plan for pregnant women and non-pregnant adults that are covered under the State Plan.

Cost sharing that is assessed to enrollees through ESI cannot exceed 5% of a family's gross income. Cost sharing above 5% will be reimbursed by the State and cost sharing associated with the delivery of wrap-around benefits cannot exceed State Plan cost sharing limits. Participation in the Opt Out Program may be conditional upon cost-effectiveness as determined by the State.

VI. Delivery Systems

1. Procurement Method

The State will competitively procure managed care plans to provide services. The State will initiate separate but simultaneous procurements in each of the 11 regions. The State will begin implementation of the Statewide Managed Medical Assistance program no later than January 1, 2013, with full program implementation by October 1, 2014. Once the State has issued the procurement and awarded the contracts, the State will prepare a detailed transition plan based on plan readiness and capacity.

The criteria for preference in reviewing ITN respondents, including accreditation by nationally recognized accrediting bodies; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. The State will enter into five-year health plan contracts with selected contractors. The table below provides a high level overview of the draft timeframe for procurement and implementation.

Managed Medical Assistance Program Draft Timeline

Phase	Begin	End
Geographic Expansion Implementation Criteria	9/2011	10/2011
Continuity of Care Planning	3/2012	5/2012
Systems Analysis and Recommendations	12/2011	5/2012
Develop Solicitation	3/2012	12/2012
ITN Release	No Later Than 1/2013	
Databook Release	10/1/2012	
Contracts and Awards	4/2013	9/2013
Provider and Recipient Outreach and Education	Ongoing	
Readiness Reviews	12/2013	9/2014
Enrollee Plan Selection Process and Materials Development	10/2013	3/2014
Enrollee Notification and Enrollment	4/2014	9/2014

2. Managed Care Plans Defined

A managed care plan is defined as an eligible plan under contract with the State to provide services in the Medicaid program and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity in the State, or qualified pursuant to Florida Statutes, that is paid a prospective per-member, per-month payment by the Agency.

An “eligible plan” is defined as a health insurer authorized under Chapter 627, an EPO authorized under Chapter 627, a HMO authorized under Chapter 641, a PSN authorized under state law, an ACO authorized under federal law, or the Children's Medical Services Network authorized under state law.

3. Number of Plans per Region

The State will procure a specified number of plans per region. A minimum and maximum number of plans is specified by region, with a minimum of two plans choices in each of the 11 regions. Of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid. Issuance and award of the procurements will provide for a choice of plans, as well as market stability as the State will seek to enter into five-year contracts and penalize plans for early withdrawal from a region(s) prior to the end of the contract term or reduction in contracted enrollment levels.

To the extent that there are fewer than two plan choices in a region, the State will issue another procurement to obtain a second plan and meet the federal requirements regarding choice until two plans are available. Additionally, participation by the Children's Medical Services Network shall be pursuant to a single, Statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits but requires adherence to general plan network and quality requirements.

In addition, the State will also seek to contract with specialty plans and participation of specialty plans will be part of the procurement requirements as well as the regional plan number limits. However, the State may enter into contracts with a specialty plan whose target population includes no more than 10% of the enrollees of that region. Such specialty plans are not subject to the regional plan number.

4. Plan Selection Criteria

As part of the ITN process, the State will establish preference criteria for reviewing respondents as previously described. Such criteria will include, but not limited to, the State's evaluation of whether plans have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied will be promptly paid under state law; are organizations that are based in and perform operational functions in this State, in-house or through contractual arrangements, by staff located in this State; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Types of Contracted Plans

The types of contracted plans the State will contract with include: HMOs, PSNs, ACOs authorized under federal law, EPOs, and the State's Children's Medical Services Network operated by the Florida Department of Health. Refer to Appendix C for additional information on the Children's Medical Services Network. The State will reimburse most contracted plans on a capitated basis; however, fee-for-service payments may be used for PSN providers for a time limited period as authorized in state law.

As described in Section IV., Benefits, capitated plans may create customized benefit packages that vary in amount, duration, and scope from State Plan services. Those PSN plans that continue to be paid on a FFS basis will not be permitted to vary the amount, duration, or scope

of services from that set out in historical Medicaid.

Below is a description of the provider types.

A. Entities Regulated under Florida Insurance Statutes

The Office of Insurance Regulation (OIR) in the Department of Financial Services regulates many of the contracted plans that will be paid on a capitated basis. Regulatory oversight includes monitoring the solvency of life and health insurers and managed care entities that are authorized to operate in the State of Florida. OIR reviews all new entities wishing to enter the Florida marketplace as well as any material changes in ownership of insurers domiciled in Florida. When an insurer violates solvency standards, OIR initiates a plan of action with the company to address the regulatory issue.

The contracted plans that are required to be licensed, full risk-bearing entities. In accordance with 42 CFR 438.2, comprehensive risk is defined as a managed care plan that is at-risk for inpatient hospital services and three or more mandatory State Plan services in section 1905(a). Entity assuming risk consistent with federal requirements and receiving capitation payment will be considered a comprehensive risk- bearing and be required to meet state fiscal and solvency standards.

1. HMOs: Health Maintenance Organizations

An HMO is an organization authorized under Chapter 641, Florida Statutes, that provides health care coverage on a prepaid per capita basis.

2. Licensed Insurers

The State may also contract with health insurers to enroll as Medicaid managed care plans and provide coverage to individuals. These providers will be required to meet State financial and solvency standards for insurers. The financial standards are specified in Florida Statutes and are generally greater than the standards required for HMOs. Health insurers may serve enrollees in Statewide Managed Medical Assistance program with products such as:

- EPO: Exclusive Provider Organization – A provider of health care or a group of providers that has entered into a written agreement to provide benefits under a health insurance policy. EPOs are not directly regulated as to solvency by the Office of Insurance Regulation but typically contract through another entity that is so regulated, such as an HMO or an Insurance Company.

The Agency will work with the Office of Insurance Regulation to determine appropriate solvency provisions for any EPOs it contracts with as part of the Statewide Managed Medical Assistance program.

B. Provider Service Networks

PSNs are networks established or organized and operated by a health care provider, or group of affiliated health care providers, which provide a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. They may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the

financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN.

In accordance with Florida Statutes, the State may reimburse a PSN on either a fee-for-service or prepaid basis. Once capitated, all PSNs will be required to assume responsibility for comprehensive coverage and meet established solvency standards. Capitated PSNs are exempt from many of the regulatory provisions that apply to HMOs under parts I and III of Chapter 641, Florida Statutes, unless they serve other populations, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the State. Once a PSN accepts capitation, it must meet the same surplus and solvency requirements as HMOs, consistent with licensed HMOs in Chapter 641, Florida Statutes, and s. 409.912, Florida Statutes. Chapter 641 requires that an entity shall at all times maintain a minimum surplus in an amount that is greater of $1,500,000, or 10% of total liabilities, or 2% of total contract amount. The State may also consider the following:

- If the organization is a public entity, the Agency may take under advisement a Statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;
- The State guarantees the solvency of the organization; or
- The entity meets the financial standards for federally approved provider- sponsored organizations as defined in 42 C.F.R. s. 422.350, subpart H, or ss. 422.380-422.390.

In addition to the fee-for-service specialty plan operated by the Florida Department of Health for children with chronic conditions, currently, the State contracts with six PSNs that, cumulatively, provide services in 34 counties.

C. Specialty Plans

The contracted plans will be encouraged to develop and offer specialty plans to serve individuals with specific conditions or select eligibility groups.

A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the State as a specialty plan. Specialty plans are designed for a specific population and currently include plans that primarily serve children with chronic conditions or recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS). A health plan must be licensed under Chapter 641, F.S., to offer a specialty plan for recipients living with HIV/AIDS. Participation of specialty plans will be part of the procurement requirements as well as the regional plan number limits. However, if the State enters into a contract with a specialty plan whose target population includes no more than 10% of the enrollees of that region, the specialty plan does not count toward regional plan number limits.

The State will identify specialty plans as part of the procurement process and may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the existence of clinical programs or special expertise and/or providers to serve that target population. The State will not approve plans that discriminate against sicker

members of a target population.

The State may also contract with Medicare Advantage Plans, designated as Special Needs Plans, to serve dual eligible enrollees, authorized by the Centers for Medicare and Medicaid Services.

In addition to meeting general financial reserve requirements and network sufficiency requirements, the State will develop enhanced standards for specialty plans that may include but are not limited to:

- Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should be an integrated network of primary care physicians (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
- Network with sufficient capacity of board-certified specialists in the care and management of the disease for plans that seek to focus services for enrollees with a particular disease state. In addition, it is recognized that individuals have multiple diagnoses, and, therefore, the plan should have sufficient capacity of additional specialists to manage the different diagnoses.
- Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).
- Availability of specialty pharmacies, where appropriate.
- Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
- Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.
- Use of evidence-based clinical guidelines in the management of the disorder.
- Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.
- Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

D. Employer-Sponsored Insurance (ESI)

Individuals who choose to opt out of Medicaid will be eligible to receive care from an employer-sponsored insurer. Coverage will include individuals who have access to a qualified ESI health plan and COBRA coverage. A qualified ESI plan will include the following:

- Large employer groups – Health insurance coverage provided by Florida- licensed insurers to businesses with more than 50 employees.

- Small employer groups – Health insurance coverage provided by Florida- licensed insurers to businesses with one to 50 employees.
- Employee Retirement Income Security Act (ERISA) plans – Employers establish these plans to provide health insurance. The employer may contract with an insurance carrier to insure the plan or may opt for self-insurance. These plans are not regulated or licensed by the State.

E. Reimbursement

Capitation rates will be developed in accordance with 42 CFR 438.6. The State will develop actuarially sound, risk-adjusted premiums. The premiums will be based on historical Medicaid expenditures including the use of encounter data, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures.

The State will reimburse some PSNs on a fee-for-service basis with a shared savings arrangement and all other managed care plans on the basis of the risk-adjusted capitation premiums. Risk adjustment will be used to reflect differences in health status of enrollee and the overall risk profiles between the FFS and capitated populations and between the populations served by each managed care entity. This will help ensure budget neutrality and properly budget the proportion of expenditures that are anticipated to be attributable to the different payment methods and plans.

1. Risk-Adjusted Capitation Premiums

As noted above, the State will develop risk-adjusted premium rates to pay the managed care entities.

Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender can do. The purpose of health-based risk adjustment is to provide a risk score for each individual to reflect predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan.

The State currently utilizes a health-based risk adjustment model to adjust rates for capitated plans in five Reform counties. The purpose of health-based risk adjustment is to provide a risk score for each individual receiving services through Medicaid which reflects their predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan. The State will work with its contracted actuary to update and enhance risk adjustment methodologies to reflect nationally recognized models best suited for this program.

For certain events that may not be predicted in advance, such as pregnancy, the birth of a newborn, or high-cost cases for which there is a significant variance in historical expenditure (e.g. hemophilia), the State may develop special "kick payments" and/or high-cost claim pooling mechanisms.

The State assures CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary.

The Centers for Medicare and Medicaid Services Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

2. Fee-for-Service Reimbursement

The State may pay some or all PSNs on a fee-for-service (FFS) basis as authorized by Legislation, using historical Medicaid covered services with no variation of benefit package. The State will not reimburse a FFS-based PSN for services not authorized under the State Plan. PSNs may provide and directly pay for additional services through any savings earned at no cost the State.

The State will work with the actuary to develop guidelines for phasing in financial risk for PSNs. Any phase-in shall be converted to a risk-adjusted capitated premium as specified in state law.

VII. Accountability and Monitoring

The Agency will follow standard State contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all state and federal requirements. The Agency will specify monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted plans to enrollees. The overarching goal is to promote the health and well being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes, and promoting quality and cost-effective delivery of services. Other tenets of the Statewide Managed Medical Assistance program are as follows:

- Comprehensive transition requirements for implementing the program
- Increased stability among health plans
- Comprehensive transition requirements when plan changes are necessary
- Limits on the number of participating plans in the eleven regions
- Plan selection criteria
- Network adequacy
- Plan solvency
- Penalties for not completing a contract term
- Penalties for failure to comply with encounter data reporting requirements

A. Contracting Assurances

Provider Network Requirements

The State will require that all managed care plans ensure availability of services consistent with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206, that is, managed care plans will be required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected utilization of service.

In evaluating adequacy of networks for managed care plans, the State will consider the demographics of a community and availability of services locally. In geographic areas where there are a large number of Medicaid recipients, the State will require contracted plans to demonstrate access to an adequate network of health care providers serving that community.

In order to ensure access to necessary Medicaid services, the State is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks. The State will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the plans must maintain a panel of preventive and specialty care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population. Plans will be required to have providers available within reasonable travel and distance standards comparable to standards established by the State.

In addition, plans will be 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 State deems necessary. The provider database must be available online to both the Agency and the public and 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, if network adequacy standards are met, but must include providers classified by the Agency as "essential," which shall include at a minimum:

- Federally qualified health centers,
- Statutory teaching hospitals as defined in state law,
- Hospitals that are trauma centers as defined in state law, and
- Hospitals located at least 25 miles from any other hospital with similar services.

The Agency will also identify statewide essential providers. These providers are to include:

- Faculty plans of Florida medical schools,
- Regional perinatal intensive care centers as defined in state law,
- Hospitals licensed as specialty children's hospitals as defined in state law, and
- Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Plans are required to negotiate in good faith with essential providers for one year and reimbursement rates for these essential providers are specified.

In addition to the essential providers and statewide essential providers, plans will be required to offer a network contract to each home medical equipment and supplies provider that meets quality and fraud and abuse prevention and detection standards established by the plan.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as a pharmacy option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate each plan's pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians the network and the establishment of partnership with community providers that provide community based services.

B. Plan Accountability and Performance Standards

The Agency will transition monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of formulary or preferred drug list on the plan's website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan website; accreditation within 1 year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification of the Agency of the impending birth of a child to an enrollee. The Agency will conduct periodic contract oversight and

monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

Grievance and Appeals

The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.

- Maintains a State-level panel to hear appeals of grievances not resolved at the plan level.

- Preserves the Medicaid fair hearing process that requires each Medicaid managed care plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:

  - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
  - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinStatement of services if the State takes action without the advance notice and as required in accordance with State policy consistent with Fair Hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated, and
  - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

C. Program Integrity

The State assures the Medicaid program integrity system will require each Medicaid MCO to comply with Section 1932(d)(1) of the Social Security Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State will prohibit any of the Medicaid MCOs from knowingly having a relationship with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the Medicaid MCO,
2. A person with beneficial ownership of 5% or more of the Medicaid MCO's equity,
3. A person with an employment, consulting or other arrangement with Medicaid MCO for the provision of items and services that are significant and material to the

Medicaid MCO's obligations under its contract with the State.

The Agency's Medicaid program integrity system will oversee the activities of Medicaid MCO enrollees, health care providers, MCO networks, and their representatives in order to prevent fraud or abuse, over-utilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of enrollees and to recover overpayments as appropriate. The State will refer incidents of suspected fraud, abuse, over utilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency, including the licensing agency and the Medicaid Fraud Control Unit of the Attorney General's office.

The program integrity system will require each Medicaid MCO to comply with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable.

The payments to each Medicaid MCO will be based on data submitted by the MCO and will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

D. Achieved Savings Rebate

To promote fiscal accountability, the Agency will establish an achieved savings rebate program. Under the program, the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5% of revenue shall be retained by the plan.
2. Fifty percent of income above 5% and up to 10% shall be retained by the plan, and the other 50% refunded to the State.
3. One hundred percent of income above 10% of revenue shall be refunded to the State.

Incentives are included for plans that exceed Agency defined quality measures. Plans that exceed such measures during a reporting period may retain an additional 1% of revenue.

E. Penalties and Sanctions

To ensure stability, the Agency will impose new penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25% of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 days notice to the Agency before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the agency is required to terminate all contracts with that plan in other regions.

If a plan that is awarded an "additional contract" to ensure plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

If the Agency terminates a contract with a plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medication needs, and existing provider or care relationships.

The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes the Agency will assess a daily fine for each day of non-compliance beginning on the 31st day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

F. Quality Initiatives

Improved quality and performance has been a key component of the State's managed care strategy will continue to be a primary focus of the Statewide Managed Medical Assistance program.

Quality and performance measurement will play a primary role in the selection of managed care plans during the procurement process in the Statewide Medicaid Managed Care program. Accreditation by a nationally recognized accrediting body, the organization's record in achieving specific quality standards, and the organization's documented commitment to quality improvement will be among the criteria for selection.

Once contracts are finalized, quality oversight will exist on two levels: at the Agency and at individual managed care plans. The Agency has a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans to their enrollees. This strategy targets overall system improvement and specifies the steps the Agency will take to hold plans accountable for on-going quality:

- Coverage and authorization of services
- Systems performance
- Clinical outcome measures
- Enrollee satisfaction
- Provider satisfaction
- Provider access and timeliness of care
- Network adequacy
- Performance improvement projects
- Quality improvement indicators
- Care coordination and continuity of care
- Timeliness of handling complaints and grievances
- External quality review
- Evaluation of disease management programs

Reporting requirements by the contracted plans as a component of the quality strategy including, but are not limited to:

- Enrollment and disenrollment
- Enrollee information
- Provider network
- Encounter data
- Grievances and appeals
- Financial reporting
- Child health check-up (a.k.a. EPSDT)

The Agency assures CMS that it complies with Section 1932(c) of the Act and 42 CFR 438.200, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions.

The managed care plans are currently required to develop and document a Quality Improvement Plan (QIP) that guides the efforts that will be taken at the managed care plan level to improve quality in both clinical and non-clinical areas of operation. As part of the Statewide Medicaid Managed Care program plan, the QIP will be required to include enrollee satisfaction and disenrollment surveys. The Agency reviews and approves the managed care plans' QIPs.

Managed care plans are currently required to report annual audited performance measures that include both HEDIS (Healthcare Effectiveness Data and Information Set) and HEDIS-like, or Agency-defined, measures, and this reporting will continue under the Statewide Medicaid Managed Care program.

A key component is continuous improvement. Below highlights select measures which demonstrate recipient improvements. These measures target both preventive and illness-based care and include measures for special populations such as recipients of behavioral health care services and enrollees with HIV/AIDS. The Agency re-assesses the list of required measures annually to comply with any changes to HEDIS made by the National Committee for Quality Assurance (NCQA) and to ensure that the list optimally targets key priorities for managed care in Florida.

All Florida Medicaid managed care plans have been required to report an array of HEDIS and HEDIS-like performance measures, beginning in 2008 (reporting year 2007). The performance for the demonstration plans and the non-demonstration plans has steadily improved overall with demonstration plans outperforming non-demonstration plans on most measures. In 2009, all demonstration plan performance measures improved with the exception of one plan and the demonstration plans out-performed non- demonstration plans in 20 of 27 reported measures.

In 2010, notable results included an 18.3% increase in Annual Dental Visits over the course of the demonstration. Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3. Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.

The Agency will develop or adopt additional performance measures in response to features of the Statewide Medicaid Managed Care Program to promote quality of care. When possible, established measures with available benchmark data, such as HEDIS, will be preferentially selected. Public input will be sought on the selection, adoption, and development of new and

on-going measures. Managed care plans will be required to publish their results on their plan websites. The existing list of performance measures required for Florida health plans can be viewed on the following webpage: http://ahca.myflorida.com/medicaid/quality_mc/index.shtml. Managed care plan performance measure results are available for public viewing on the Agency's website, http://www.floridahealthfinder.gov/. In turn, managed care plans will be required to set performance standards for their network providers and determine continued network participation based on achievement with those standards. See Appendix A for additional information on performance measures.

In an effort to improve quality of care, the Agency adopted high standards, as defined by the NCQA National Means and Percentiles, as the performance target for each of the HEDIS measures that health plans are required to report. The strategies adopted by the Agency aim to bring the statewide level of performance in line with that performance target. To accomplish this goal, the Agency will require the development of a strategy that requires managed care plans to develop corrective action plans to address deficient scores. Failure to comply with the terms of their internally developed corrective action plans or failure to improve scores to minimal levels as set by the Agency will result in monetary sanctions. The Agency will also develop an incentive program to reward higher performing health plans. Such incentives may include additional auto-assignments each month and a financial incentive payment to encourage continual improvement.

Under the existing managed care program, plans are required to conduct Performance Improvement Projects (PIPs) in four content areas, as specified in contract: 1) clinical behavioral health; 2) cultural competence or health disparities; 3) a statewide collaborative PIP facilitated by the External Quality Review Organization (EQRO); and 4) an area of deficiency selected by the health plan. PIPs must be conducted in compliance with the Centers for Medicare and Medicaid Services protocol for conducting performance improvement projects. Under the Statewide Medicaid Managed Care program, PIPs will continue to be required, although the specific content areas may change, particularly to accommodate the addition of PIPs.

Managed care plans must participate in the activities of the EQRO, which include validation of performance measures, validation of performance improvement projects, and reviews of compliance with standards. The current EQRO contract will expire on June 30, 2012. The new contract will be selected through competitive procurement and will contain provisions related to the Statewide Medicaid Managed Care Program.

All capitated health plans, as well as fee-for-service PSNs that are capitated for transportation, must submit encounter data to the Agency that reports services provided to enrollees under the contract. Data must be reported in a HIPAA-compliant X12 format and must meet minimum quality standards for processing through the state's Medicaid Management Information System. Non-compliant health plans can be assessed a penalty for failure to submit data accurately and timely.

The Agency will utilize encounter data to conduct quality of care studies and evaluations of services provided to recipients in the Statewide Medicaid Managed Care program. As the program is developed, the Agency will work with stakeholders to identify areas of particular interest for studies, but will include, at a minimum, studies regarding access to care, appropriateness of care, and fraud and abuse.

G. Employer-Sponsored Insurance

Individuals opting out of Medicaid will receive services directly from an employer- sponsored plan or private insurer. These entities will not have a contract directly with Medicaid. Therefore, the State will rely on monitoring efforts conducted by the Florida Office of Insurance Regulation.

Appendix A
Performance Measures and Outcomes

The following is an overview of select measures regarding the impact of the demonstration.

Performance Measures

Medicaid Reform health plans are required to submit an extensive list of quality indicators (HEDIS and HEDIS-like) that measure plan performance on both preventive and illness care. Select successes from the 2010 submission include:

- Annual Dental Visit, a measure that is particularly challenging for most health plans, achieved an 18.2% increase over the course of the demonstration with a 4.9% increase over the past year.
- Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3.
- Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.
- Strong performance continued for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.

In addition to requiring the calculation and submission of the performance measures, the Agency requires that health plans operate continuous quality improvement programs. The measures submitted this year are subject to new contract terms that require formal interventions for all measures scoring below the 50th national percentile. If the interventions fail to improve the measures, sanctions may be assessed in response to the 2011 performance measure submission.

Satisfaction

The key findings of the patient satisfaction survey results are highlighted below.

Key Findings

- Enrollee satisfaction for most indicators remained stable or increased slightly (including specialty care ratings, emergency room visits, communication, courtesy and respect of staff) and showed little if any change from benchmark measures taken prior to demonstration through the first three years of implementation.
- In some areas, statistically significant changes were observed. There was an upward change in satisfaction with recipient's personal doctor and with getting needed care.
- This upswing indicates an increase in satisfaction at the point of care.

Appendix B
Florida Medicaid Program

1. The Florida Medicaid Program

In 1965, the federal Social Security Act was amended to establish two major national health care programs: Title XVIII (Medicare) and Title XIX (Medicaid). If a State chooses to participate in the Medicaid program, the State is then obligated to provide services to all individuals who are eligible for the program. Federal Medicaid laws and regulations mandate certain benefits for certain populations and States must administer their programs in accordance with federal regulations and laws.

The State operates the program under a State plan approved by the federal Centers for Medicare and Medicaid Services, which can be thought of as a contract. To participate, States are required to cover certain mandatory populations and services, while federal matching funds are available if a State chooses to cover other optional populations and services. A State cannot limit the number of people its Medicaid program will serve, and cannot limit provision of medically necessary covered services to enrollees based on budgetary constraints.
The Florida Medicaid program currently serves more than 3.1 million recipients and total appropriation for the program for State fiscal year 2011-2012 is $21.2 billion. Medicaid covers low-income pregnant women, children and disabled adults.

2. Florida Medicaid Delivery Systems and Program Enrollment

Since its inception, the Florida Medicaid program has evolved into a complex model with a collection of programs, waivers, and delivery systems through which recipients receive care. These delivery systems for covered medical services include FFS, primary care case management (offered in Florida through the MediPass program), or managed care under a capitated HMO or a FFS or capitated PSN.

The Florida program was established as a FFS program in 1970, and the first Medicaid managed care plan was established in 1984. MediPass, the primary care case management (PCCM) program, was established in 1991 and several other changes have also been implemented in care management and delivery in the last two decades.

The implementation of the Statewide Managed Care System will serve to streamline these varied systems into a more comprehensive program and is anticipated to create an integrated delivery system available throughout the State.

Fee-For-Service

The FFS system is operated under the federally approved State plan. The FFS system serves those Medicaid recipients who are not eligible for or enrolled in a managed care program. As a result of the passage of HB 7107, the vast majority of enrollees will have to select a plan. As of June 1, 2011, there were over 939,000 recipients receiving services through the FFS system. These recipients include those who are eligible for limited or diagnosis specific services such as services related to pregnancy, or a diagnosis of breast or cervical cancer, the dual eligible population (those who are eligible for both Medicare and Medicaid), the Medically Needy populations, individuals in institutional settings, and those who are newly eligible for Medicaid but who have not yet enrolled in a health plan. While most individuals will enroll in a contracted

plan under the Statewide Managed Medical Assistance program, the State will continue to maintain a FFS program to provide services to excluded individuals and to recipients newly eligible for Medicaid who are in their choice period that occurs before enrolling into a contracted plan.

MediPass is the Florida Medicaid primary care case management program. The State established the MediPass program in 1991 and expanded the program Statewide in 1996. MediPass is operational in 62 counties outside of the demonstration counties (Medicaid Reform). MediPass providers (physicians, ARNPs, and physician assistants) are paid a $2.00 monthly case management fee. Medicaid pays for services provided to MediPass members on a FFS basis. As of June 1, 2011, there were 611,864 recipients receiving services through the MediPass program. Under the Statewide Managed Medical Assistance program, individuals currently enrolled in MediPass will be required to select and enroll in a plan.

Managed Care

The managed care delivery systems, including capitated plans and FFS PSNs, are currently operated under two waivers: (1) The 1915(b) Managed Care Waiver or (2) the 1115 Medicaid Managed Care Pilot (Reform) Waiver. The Reform waiver is operational in five counties, including Baker, Broward, Clay, Nassau and Duval counties.

A PSN is defined in section 409.912 (4)(d), Florida Statutes, as an integrated health care delivery system owned and operated by a health care provider, or group of affiliated health care providers which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers. PSNs are reimbursed on a FFS basis, with shared savings, or prepaid (capitated) basis. As of June 1, 2011, there were six PSNs serving 221,853 recipients in both Reform and non-Reform counties. Under the Statewide Managed Care program, PSNs will be eligible plans to participate in both the Long Term Care Managed Care program and the Managed Medical Assistance Program. Specifically, the State is required to contract with at least one PSN, in each region, for both program components, if a qualified PSN submits a response to the invitation to negotiate in the region. As a result, PSN contracting and contract monitoring will increase with the potential of more than 22 PSN contracts.

A HMO is an entity licensed under Chapter 641, Florida Statutes. The State contracts with HMOs on a prepaid fixed monthly rate per member (e.g., capitation rate) for which the HMOs assume all risk for providing covered services to their enrollees. As of June 1, 2011, there were 19 HMOs serving 1,135,892 recipients in both Reform and non-Reform counties. Under the Statewide Medicaid Managed Care program, HMOs will be eligible plans to participate in both the Long Term Care Managed Care program and the Statewide Managed Medical Assistance program. HMO contracting and contract monitoring is expected to increase significantly, with the potential for 30-53 contracts for Statewide Managed Medical Assistance program and an additional 30-53 contracts for the Long Term Care program.

a) Demographics of Enrollment – By Delivery System

In general, most children and adults who are fully eligible for Medicaid are currently required to enroll in some form of managed care to receive medical services. For those in counties operating under Florida's 1915(b) Managed Care Waiver, this means they must enroll in an available managed care program which currently includes either a capitated HMO, a PSN, or the MediPass program. For those in counties operating under the 1115 Research and

Demonstration Waiver (Baker, Broward, Clay, Duval, and Nassau), this means they must be enrolled in either an HMO or a PSN. MediPass is not an option for demonstration enrollees.

The following Medicaid recipients are currently excluded from enrolling in a managed care program: Medically Needy recipients, aliens receiving emergency assistance, recipients enrolled through the breast and cervical cancer program, recipients enrolled in the family planning waiver, recipients in institutional settings, recipients receiving hospice services, and recipients residing in facilities operated by the Department of Juvenile Justice and the Department of Children and Families (including the Family Safety and preservation program and substance abuse and mental health residential treatment programs).

Elderly recipients who reside in a nursing home are not currently required to enroll in managed care to receive medical services.

b) Demographics of Enrollment-By Eligibility Type

In general, Medicaid enrollment can be broadly categorized as being made up of three main groups:

- The TANF population (Temporary Assistance for Needy Families), which generally includes low income children and their families,
- The SSI population (Supplemental Security Income), which generally includes the disabled, and
- The dually eligible population, which includes the disabled elderly and the poor elderly who also receive Medicare benefits who are also eligible for Medicaid.

The TANF population is most impacted by the economy, and TANF enrollment makes up a majority of program enrollment and thus follows general enrollment trends. Overall, Medicaid enrollment in Florida is estimated to have increased by more than 44% from the 2005-2006 fiscal year through the 2011-2012 fiscal year. TANF enrollment will have increased, during that same period, by 37%; SSI enrollment by 23% and Dual enrollment by 37%. Table 1 provides an overview of Medicaid eligibility for these groups during this period.

Table 1: Average Monthly Florida Medicaid Enrollment – By Eligibility Group

Average Monthly Florida Medicaid Enrollment - Breakout of SSI and TANF				
Fiscal Year	TANF Enrollment	SSI Enrollment	Dual Eligibles	Total Enrollment
FY 2005-06	1,256,264	502,395	482,624	2,204,481
FY 2006-07	1,165,000	519,000	486,962	2,112,000
FY 2007-08	1,131,574	531,433	498,870	2,148,705
FY 2008-09	1,272,284	551,405	531,246	2,398,613
FY 2009-10	1,500,811	574,345	569,631	2,718,524
FY 2010-11	1,633,066	598,381	616,355	2,937,573
FY 2011-12	1,726,785	621,300	664,057	3,191,710

TANF Source: Medicaid Services Eligibility Subsystem Reports. Caseload includes TANF and SOBRA Children

SSI and Total Enrollment Source: Medicaid Services Eligibility Subsystem Reports.

c) Florida Medicaid Managed Care Penetration

Currently, approximately 43% of the total Medicaid population is enrolled in either a HMO or a PSN. It should be noted that the "total Medicaid population" includes individuals currently ineligible for enrollment into managed care. Table 2 on the following page provides Florida Medicaid enrollment by managed care delivery model as of June 1, 2011.

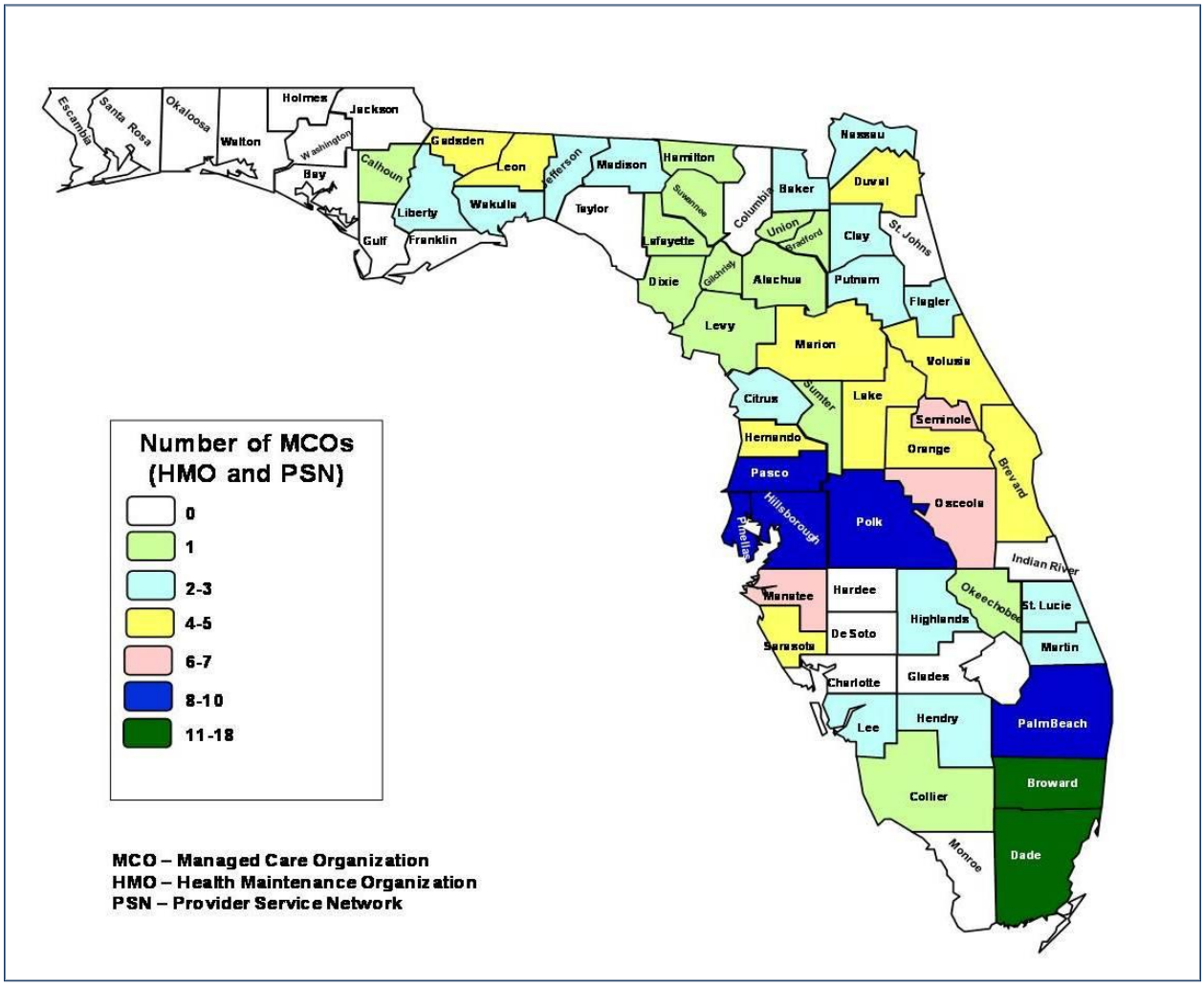
Table 2: Florida Counties with Managed Care Health Plans – June 1, 2011

Florida Counties with Managed Care Plans – By Plan Type – June 1, 2011		
Plan Type	**Number of Florida Counties**	***Total Enrollment***
Capitated PSN	29	79,271
Capitated Non-Reform HMO	35	981,159
FFS PSN	6	142,583
Capitated Reform HMO	5	154,733
	Total unduplicated Counties: 48	***Total plan enrollment: 1,357,746***

Florida Counties with Managed Care Plans (HMO and PSN) – June 1, 2011	
Total Unduplicated Counties with Health Plans Currently In Operation	48 Counties
Total Unduplicated Counties with No Health Plans Currently in Operation	19 Counties

Figure 3 on the following page illustrates the distribution of health plans by Florida County. Note: Although PACE plans are not included for the purposes of this figure, they are in operation in Lee, Miami-Dade, Pinellas, and Charlotte counties.

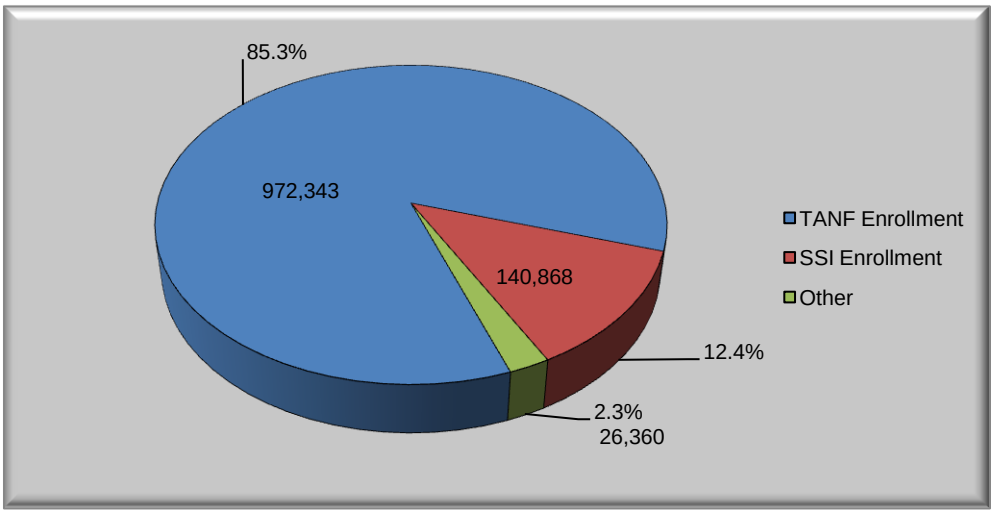
Figure 3: Managed Care in Florida Medicaid By County as of June 1, 2011



With full implementation of the Statewide Medicaid Managed Care program, it is anticipated that nearly 85% of the total Medicaid population will be enrolled in the Statewide Managed Medical Assistance program.

Under the current Medicaid program, the majority of HMO and PSN enrollees are TANF eligibles, with a smaller percentage being SSI eligible. Currently, 87% of managed care eligibles are TANF and 13% are SSI. Figure 4 on the following page reflects to distribution of TANF and SSI eligibles within HMOs and PSNs for June 1, 2011.

Figure 4: June 1, 2011 Medicaid Managed Care Enrollment – By Eligibility Type



It is anticipated that the number and proportion of SSI enrollees in managed care will increase once the Statewide Medicaid Managed Care program is fully implemented. The TANF population will look very similar to the recent trend with a majority enrolled in managed care. With the addition of SSI populations and the dually eligible population to managed care, a greater proportion of the overall managed care population will consist of SSI and dual eligibles in the future.

Appendix C
Children's Medical Services Network

The Children's Medical Services (CMS) Network

Purpose of the CMS Network

The CMS Network is Florida's Title V Program for children with special health care needs. It is a State program located in the Department of Health and operates under Chapter 391, Florida Statutes. Its purpose is to develop and procure a comprehensive and coordinated Statewide system of medical and health-related services for children with special health care needs. The eligible children are defined as those children under age 21 whose serious or chronic physical, developmental, behavioral or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children, Section 391.02 FS.

Structure of the CMS Network

The State program is comprised of a central office and 22 local offices organized in eight regions. The functions of the central office are:

- Contract management
- Pharmacy Benefit Management (Title XXI only)
- Policy development
- Quality assurance and development of program standards
- Selection of regional and Statewide programs and provider networks
- Centralized and automated credentialing
- Centralized claims processing
- Financial management
- Data analysis
- Maintenance of technology systems
- Enrollment file management
- Training and technical assistance
- Statewide clinical review and recommendation teams
    - Physician peer review
    - Drug utilization review
    - Medical procedures and equipment
- HEDIS reporting and evaluation

The functions of the local offices are:

- Clinical eligibility determination (financial eligibility determination is conducted through Florida's systems for Medicaid and CHIP eligibility)
- Recruitment and retention of providers (over 11,000 providers, 110 facilities, home health agencies, etc.)
- Utilization management
- Care coordination (nurses and social workers)
- Transition planning
- Staffing specialty satellite or telemedicine clinics
- Member services and enrollment assistance (selection of primary care provider)

- Outreach and activities to encourage continued participation in the program
- Family to family support

Clinical and Financial Eligibility

Children are screened clinically using a tool that addresses a combination of diagnoses, functional status and health care needs, and utilization. The child must have a medical, behavioral, or developmental health condition that has lasted or is expected to last at least 12 months, or be in foster care. CMS Network is also the lead agency for Part C of the Individuals with Disabilities Education Act. Any infant and toddler under the age of 3 who meets the developmental criteria for this program are clinically eligible for the CMS Network.

Children who qualify for Title XIX or XXI are financially eligible for the CMS Network. Financial eligibility is determined through the Florida KidCare application or Medicaid financial determination processes. The KidCare application and Medicaid Choice Counseling have screening questions that trigger referral to CMS Network for clinical screening. If special health care needs are identified or suspected the family is provided with the necessary information to contact CMS Network for further information and clinical eligibility screening. There is no requirement that the family must contact CMS Network and there is no mandatory assignment for children with special health care needs. Once eligibility is determined the family must select CMS Network and enroll through the Agency for Health Care Administration Choice Counseling system.

Benefits

A multidisciplinary approach to the provision of services is important and required to meet the needs of both the child and the family.

The continuum of care includes prevention and early intervention programs, primary care, medical and therapeutic specialty care, and long term care for medically complex or fragile children and high-risk pregnant women. Long term care services include medical day care, medical foster care, nursing home care and in-home care.

Children in the CMS Network receive, at a minimum, the Medicaid benefit package and care coordination. Care coordination is provided by a CMS Network Nurse Care Coordinator whose role is that of integrating all of the elements of each child's life related to his/her special health care needs, in coordination with the primary care physician and the family. The Care Coordinator is a critical link in obtaining the appropriate clinical care and services, social and emotional development of the child within the context of their family, school and community, and is integral for the development of a true medical home environment for the child and family.

State law authorizes CMS Network to offer additional benefits for early intervention services, respite services, genetic testing, genetic and nutritional counseling and parent support services, if such services are determined to be medically necessary and are subject to the availability of funds. These services are not covered by the Florida Medicaid program, but are covered through funds available in the CMS Network (general revenue, maternal and child health block grant funds, etc.).

Provider Requirements and Structure

CMS Network uses NCQA criteria as its baseline for its credentialing activities. An on-line application process is available to providers who are interested in participating in the CMS

Network. Physician providers must be licensed in Florida and board-certified.

CMS Network focuses on the medical home in the child's community. In 12 areas of the State CMS Network contracts with non-profit corporations to recruit primary care providers and offer EPSDT case management. CMS Network also recruits available specialties and supports in the communities, including dental care, mental and behavioral health care, pediatric palliative care and transition from pediatrics to adult care. However, CMS Network selects and approves regional programs based on national or state standards. These include centers focusing on hematology/oncology, diabetes/endocrine issues, craniofacial/cleft lip and cleft palate, cardiac, pulmonary, Children's Comprehensive Kidney Failure Center, sickle cell, brain and spinal cord injury, medical foster care, pediatric HIV-AIDS, genetics, transplantation, regional perinatal intensive care centers, etc.

Services are offered in hospitals, outpatient settings and community based settings, including a child's home based on the nature of the service. Services are prior authorized by nurses and, as appropriate, by the CMS Network Medical Director.

If a child needs a service that is not available in the community, the Statewide network of providers is available to the child. In addition, children are evaluated for out-of-state services when such services may not be available in Florida.

CMS Network and Medicaid Reform

Under Medicaid reform, CMS Network has been designated as a specialty plan for children with special health care needs. In the Medicaid reform counties, the CMS Network central office contracts with local Integrated Care Systems (ICS) who work in partnership with the local CMS Network offices to provide for the needs of enrolled children. The responsibilities of each entity are delineated in a formal care coordination plan.

The local CMS Network office is responsible for clinical eligibility determination and annual redetermination, care plan development, care coordination with the Care Coordinator serving as the primary liaison at the local level between the CMS Network program, the ICS, the family and the child's service providers, health education, social work services and counseling, family support and transition support. Specialty clinics and the use of telemedicine are utilized as necessary to meet the multi-disciplinary and multi-specialty needs of enrolled children.

The lCS is responsible for physician recruitment, network management, credentialing and/or contracting, provider services, authorization for services, claims payment, utilization review, quality management, complaint and grievance resolution, behavioral health services and transportation in addition to the other Medicaid State Plan services.

Additionally, the local CMS Network offices and the ICSs have a multi-disciplinary review process to ensure that the child is receiving the most appropriate, medically necessary services based upon their individual needs.

The program operates through a shared savings arrangement. CMS Network has consistently demonstrated savings through its reform arrangements and meets or exceeds HEDIS measures and patient satisfaction measures.

In areas where there is not a current ICS relationship, the CMS Network local office is responsible for all program components.

Evaluation

CMS Network consistently meets or exceeds HEDIS child health measures used by Medicaid for this population. In addition, CMS Network has used CAHPS since 1998 to evaluate family satisfaction and other measures. There is a high degree of satisfaction with the CMS Network and, as mentioned above, CMS Network has continued to demonstrate savings.

Appendix D
Plan Transition Process

The State's mission is to ensure quality care is provided to Florida's residents. The primary goal of the transition to the new contracted plan will be to ensure continuity of care for all affected enrollees. The following is a summary of the processes and requirements established in state law that will enable the State to reach this goal.

DETAILED PLAN TRANSITION PROCESSES

The State will carefully plan the transition of the affected enrollees into other plan. To ensure continuity of care of affected enrollees upon enrollment in a new plan and to assist them through the choice process, the State follows a multi-layered approach:

- Assessing the capacity of the new contracted plans to ensure all impacted enrollees have access to quality care.
- Requiring the existing health plan to provide a listing of members' primary care providers (PCPs) to facilitate the transition into a new contracted plan that also includes the PCP.
- Requiring the existing health plan to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new contracted plan.
- Working with the new contracted plans and the State's or State's designated contractor to create staggered transition dates will ensure that the number of recipients being transitioned occurred in an organized manner.
- Working with the new contracted plans, the State or the State's designated contractor, local area staff, and advocacy groups will ensure appropriate and timely notice to enrollees, including the development and release of flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.
- Working with the new contracted plans to supply PCP and service information will ensure continuity of care and minimize disruption to the recipients, including reviewing the existing plan's provider network to determine which PCPs are available in the new contracted plans.
- Assisting PCPs unique to the existing plan through the Medicaid provider enrollment process to facilitate the PCPs enrollment in new contracted plan networks.
- Conducting weekly calls with the Florida Medicaid Area Offices, Medicaid Contract Management, and the State's or State's designated contractor will ensure all issues are resolved in a timely manner.

The State's or State's designated will station choice counselors in the Medicaid Area Offices to assist enrollees in their choice of a new contracted plan. These choice counselors may conduct special face-to-face choice counseling sessions specifically geared to transition enrollees.

ENROLLEE NOTIFICATIONS

For the transition to the new contract plans and if a contracted plan leaves a region early, enrollees will be given written notification of the change and an opportunity to select a new contracted plan. The member notices will include the date on which the existing health plan will no longer participate in the State's Medicaid program and instructions on contacting the State's or State's designated contractor's toll free help line to obtain information on enrollment options and to request a change to a new contracted plan.

If an affected enrollee selects a new contracted plan 30 days prior to transition date, the State will send a letter confirming the effective date of enrollment into the new contracted plan.

If the affected enrollee doesn't select a new contracted plan 30 days prior to transition date, the State will send a letter to the enrollee with information on the new plan enrollment and how to contact the State's or State's designated contractor's toll free help line to request a change to another contracted plan prior to the enrollment effective date.

All impacted beneficiaries will be given 90 days after enrollment in the new contracted plan to select another contracted plan without cause.

OVERVIEW OF CONTRACTED PLAN TRANSITION REQUIREMENTS

When a contracted plan decides to withdraw from a demonstration county, the plan will be required to provide written notice to the State at least 180 days prior to the anticipated effective date and must cease community outreach activities. The contracted plan will be required to work with the State to ensure a smooth transition for enrollees. The State's model contract will allow the State to extend the termination date depending on the number of plan enrollees affected. In addition, 60 days prior to the withdrawal date, the State will halt enrollment of new members into the plan.

By contract, to ensure continuity of care, health plans will be contractually required to honor prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first. Prearranged covered services may include provider appointments, surgeries, and prescriptions. For covered behavioral health services, this policy will be extended for up to three months.

To ensure stability, the State will impose new penalties for the contracted plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the State for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks will be required to pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another contracted plan, whichever occurs first. In addition to payment of costs, all other plans will be required to pay a penalty of 25% of the minimum surplus requirement pursuant to state law. The contracted plans will be required to provide at least 180 days notice to the State before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the State will be required to terminate all contracts with that plan in other regions.

For plans that are awarded an “additional contract”, to ensure plan participation in Regions 1 and 2, the plan will be subject to penalties pursuant to state law for activities in Region 1 or Region 2, The additional contract will automatically be terminated 180 days after the imposition of the penalties. The plan will be required to reimburse the State for the cost of enrollment changes and other transition activities.

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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Mission Statement
Better Healthcare for All Floridians.

Attachment III
Statewide
Implementation Plan

Statewide Implementation Plan
Statewide Managed Medical Assistance Program

As required in the letter dated April 28, 2011, from the Centers for Medicare and Medicaid Services (CMS), Attachment II of this amendment request addresses the following areas: quality, stability, transparency and accountability, and evaluation. In addition, the following items are addressed to ensure recipient protections, readiness, transparency and accountability.

A detailed implementation schedule for the geographic expansion and the inclusion of populations beyond the TANF-related and aged, blind and disabled (ABD) populations currently required to be covered under the Reform Demonstration.

Managed Medical Assistance Program Draft Timeline

Phase	Begin	End
Geographic Expansion Implementation Criteria	9/2011	10/2011
Continuity of Care Planning	3/2012	5/2012
Systems Analysis and Recommendations	12/2011	5/2012
Develop Solicitation	3/2012	12/2012
ITN Release	No Later Than 1/2013	
Databook Release	10/1/2012	
Contracts and Awards	4/2013	9/2013
Provider and Recipient Outreach and Education	Ongoing	
Readiness Reviews	12/2013	9/2014
Enrollee Plan Selection Process and Materials Development	10/2013	3/2014
Enrollee Notification and Enrollment	4/2014	9/2014

A description of procedures for transitioning individuals currently enrolled under the State's 1915(b) waiver program and MediPass (the State's primary care case management (PCCM) program) to the new system without loss of ongoing services.

Transition Procedures:

The statewide transition plan is designed to stagger the enrollment of recipients who are enrolled in various managed care programs and the fee-for-service system into the procured plans that will operate in the Statewide Managed Medical Assistance Program.

The Agency will carefully plan the transition of the affected recipients into contracted plans. To ensure continuity of care to affected enrollees as they enroll in the new contracted plans and to assist them through the choice process, the Agency will follow a multi-layered approach as outlined in Appendix D of Attachment II Replacement Packet.

In the development of the statewide transition plan schedule, consideration will be given as to the readiness of:

- The contracted plans to receive enrollment through the State's onsite review to confirm the plan's operations is sufficient to provide services to enrolled member.
- The State's Florida Medicaid Management Information Systems and the Choice Counseling call center capacity to ensure impacted recipients will have access to information that will allow them to make an informed choice and the system capacity to honor the recipient choice.

Beginning in the first quarter of statewide operation, enrollment in a contracted plan will include enrollment of newly mandated populations. Each enrollee will be provided written notification of:

- The 30 day choice period.
- The contracted plan options.
- Plan assignment if they do not select a plan within 30 day choice period.
- Right to disenroll without cause up to 90 days after enrollment in the plan.

Plan selection policies to ensure stability among managed care organizations (MCOs) and Provider Services Network (PSNs), and minimize plan turnover. This would include:

- **A limit on the number of participating plans**
- **Solvency**
- **History of performance in Florida and elsewhere in the country**
- **Conflict of interest policies**

Regions: The Statewide Managed Medical Assistance program includes the following regions.

Region	Counties	Anticipated Implementation Date
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton	TBD June 2013-October 2014
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	
Region 5:	Pasco and Pinellas	
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk	
Region 7:	Brevard, Orange, Osceola and Seminole	
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	
Region 10:	Broward	
Region 11:	Miami-Dade and Monroe	

Number of plans: The Agency will competitively procure a limited number of eligible plans to participate in the Statewide Managed Medical Assistance program as provided below.

Statewide Managed Medical Assistance: Plans Per Region				
	Min # of Plans	**Max # of Plans**	**# of PSNs**	**CMS Network**
Region 1	2	2	1	The CMS Network will operate statewide
Region 2	2	2	1	
Region 3	3	5	1	
Region 4	3	5	1	
Region 5	2	4	1	
Region 6	4	7	1	
Region 7	3	6	1	
Region 8	2	4	1	
Region 9	2	4	1	
Region 10	2	4	1	
Region 11	5	10	1	

See Section VI of Attachment II Replacement Packet.

Assurances that the State will follow standard State contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all Federal requirements, including:

- **Coverage of the full benefit package**
- **Enrollment process including ensuring choice of plans and disenrollment policies**
- **Grievance and appeals system**
- **Actuarially sound capitation rates**

See Section III, IV, and VII of Attachment II Replacement Packet. Details will be included in the procurement document and contracts.

Network adequacy and access requirements supported by evidence based research and data, as well as a thorough and consistent oversight review for determining plan compliance with those requirements.

See Section VII of Attachment II Replacement Packet. Details will be included in the procurement document and contracts.

A requirement that each MCO and PSN maintain a Medical Loss Ratio at a designated percent (to be determined) and provide documentation to the State and CMS to show ongoing compliance.

See Section VII of Attachment II Replacement Packet.

Assurances that the Agency for Health Care Administration and the contracted plans are complying with all State laws.

See Attachment II Replacement Packet. Relevant state laws will be specified in the plan contract, and the State will monitor the plans to ensure compliance with contract provisions.

An updated quality strategy incorporating initiatives and activities pertinent to the Reform expansion:

- **Health care system outcome goals**
- **HEDIS and CAHPS measures**
- **Quality Improvement Plan for each of the plans, some of which may be regional or statewide**
- **External Quality Review**

See Section VII of Attachment II Replacement Packet.

Implementation of a standardized encounter data validation process for all contracted plans.

See Section VII of Attachment II Replacement Packet. Details will be included in the procurement document and contracts.

Use of all encounter data to monitor access and quality, and establish capitation rates.

See Section VII of Attachment II Replacement Packet. Details will be included in the procurement document and contracts.

Managed care contracts that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, maintaining existing care relationships).

See Section VII of Attachment II Replacement Packet.

Assurances of adequate choice when there are fewer than two plans in any urban county, including contracting on a regional basis where appropriate

See Section III of Attachment II Replacement Packet.

An updated consumer choice and education program.

See Section III of Attachment II Replacement Packet.

A readiness review protocol in each county/region before enrollment. The review would ensure that the health plans are ready to begin operations as specified by the contracts. Review would include:

- **Ability to enroll members in the plan and assign them to an appropriate primary care provider**
- **Communications with providers and members capabilities, including education of members**
- **Provider contracts to assess network adequacy and amount of risk placed on individual providers**
- **Ability to process claims, and forward enrollment and encounter data to the State – Case management capabilities**
- **Ongoing and substantive consultation/involvement of community groups and advocacy organizations**

See Section VII of Attachment II Replacement Packet. The readiness review will be part of the the procurement process and specified in the contracts.

Attachment IV
Compliance with Special Term and Condition #7

Attachment IV
Compliance with Special Term and Condition #7

For reference purposes, find below Special Term and Condition (STC) #7 that outlines the process for requesting amendments to the waiver.

STC # 7. Amendment Process**.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

a) An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates by Eligibility Group the impact of the amendment; this paragraph will not apply to an amendment request for a geographic expansion since budget neutrality is statewide.

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,

d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

The Agency is submitting this amendment request 120 days prior to the date of implementation of mandating the specified populations to managed care. The Agency understands approval from the Centers for Medicare and Medicaid Services must be granted before the amendment can be implemented. Find below the requirements specified in STC #7 and a description of how the state has complied with each requirement.

(a) An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment:

Public Process: The Agency provided public notice[1] in the Florida Administrative Weekly on June 3, 2011, regarding a series of 3 hour public workshops to be held across the state regarding the new legislation. The 3 hour public workshops were held in the 11 Medicaid regions (see below) beginning on June 10 and ending June 17, 2011. The workshops occurred as outlined in Table A on the following page:

[1] Link to public notice: https://www.flrules.org/gateway/View_Notice.asp?id=9980444

Attachment IV
Compliance with Special Term and Condition #7

Table A		
Region	**Counties**	**Date, Time, Location**
Region 1	Escambia, Okaloosa, Santa Rosa, Walton	June 13, 2011 1-4 p.m. Pensacola
Region 2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	June 10, 2011 1-4 p.m. Tallahassee
Region 3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union	June 14, 2011 2:30-5:30 p.m. Alachua
Region 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	June 14, 2011 9 a.m.-noon Jacksonville
Region 5	Pasco, Pinellas	June 15, 2011 9 a.m.-noon Largo
Region 6	Hardee, Highlands, Hillsborough, Manatee, Polk	June 16, 2011 9 a.m.-noon Tampa
Region 7	Brevard, Orange, Osceola, Seminole	June 16, 2011 2-5 p.m. Orlando
Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	June 17, 2011 2-5 p.m. Fort Myers
Region 9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	June 14, 2011 9 a.m.-noon West Palm Beach
Region 10	Broward	June 16, 2011 9 a.m.-noon Ft. Lauderdale
Region 11	Miami-Dade, Monroe	June 16, 2011 2-5 p.m. Miami Gardens

The public workshops included an overview of the new legislation and included information on:

- What happens before implementation
- Medicaid vs. Medicare
- Evolution of Florida Medicaid delivery systems
- Key points of 2011 legislation
- Why changes are needed
- What statewide Medicaid managed care does not include
- When changes will happen
- Where the program will be implemented
- Who will participate
- Who may volunteer to participate
- Who will not participate
- What kinds of health plans can participate
- What to expect
- Timeline of recipient plan choice
- Public input and program improvements
- How to get more information
- How to submit comment

Supplemental information was also made available during the workshops on:

- The federal Medicaid program
- The Florida Medicaid program
- Mandatory services
- Optional services
- Medicaid waivers
- Florida Medicaid enrollment
- Statewide managed care:
  - Timelines
  - Procurement process
  - Plans per area
  - Eligibility, benefits
- Other program components

Summary of Comments

The following is a summary of the public comments received regarding the new legislation. A total of 1,785 attended the workshops and total of 348 provided verbal comments during the workshops. The opportunity for public comment will continue past the initial submission deadline of July 17, 2011. Table B below provides an overview of the number of attendees at each meeting and the number of attendees that provided public comments.

Table B
Final Number of Attendees and Speakers

Location	# of attendees	# of speakers
Tallahassee	178	28
Largo	154	28
Gainesville	80	19
West Palm Beach	170	29
Jacksonville	127	24
Pensacola	148	40
Broward	155	30
Tampa	180	39
Miami	266	37
Orlando	186	43
Ft Myers	141	31
Total Workshops	**1,785**	**348**

The Agency has received a total of 586 written comments as of July 29, 2011. This includes comments given at the public workshops described above, e-mails received through the Statewide Medicaid Managed Care program website, comments mailed directly to the Agency, and comments forwarded to the Agency from the Centers for Medicare and Medicaid Services.

Attachment IV
Compliance with Special Term and Condition #7

Below is a summary of verbal and written comments provided during the public workshops. The comments are grouped by topic.

Summary of Issues Raised

- Health Plan Quality: Several comments expressed concern regarding quality of care under health plans participating in the program. Comments included concerns regarding access to specialty services and providers and prescription drugs, particularly for recipients with disabilities, chronic conditions or special health care needs. CS/HB 7107 outlines plan contract requirements relating to plan accountability and performance standards. These requirements include:

  - Posting of formulary or preferred drug list on plan website and ensuring the list is updated within 24 hours of any change;
  - Acceptance of electronic prior authorization requests;
  - Establishments of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers;
  - Requirement that all plans establish a primary care initiative to encourage enrollees to establish a relationship with the primary care provider and requiring enrollees see their primary care provider within 30 days of plan enrollment;
  - Collection and reporting of Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan website;
  - Accreditation during the first year of contract execution;
  - Establishment of programs and procedures to improve pregnancy outcomes and infant health, and notification of the Agency of the impending birth of a child to an enrollee;
  - Establishment of enhanced fraud and abuse or program integrity requirements; and
  - Establishment of Agency approved internal process for reviewing and responding to grievances from enrollees. Plans are required to report on a quarterly basis regarding the number, description, and outcome of grievances filed by enrollees.

Requirements for compliance with the quality of care and other requirements listed above will be integral in the procurement documents, evaluation of procurement responses, contracting and monitoring of contract compliance.

- Confusion regarding participation: Several comments have indicated that individuals are unclear whether or not they will participate once the plans become available. In general, all individuals eligible for Medicaid will receive coverage through a plan once fully implemented. Comments made by specific groups are as follows:

  - Developmental disabilities population has expressed concerns about changes to their program, specifically the requirement that a sliding scale premium be imposed on families of children enrolled in the DD waivers. Those enrolled in the developmental disabilities waivers are not required to enroll in managed care, although they have the option to do so voluntarily.

- Dual eligibles: Comments expressed concerns regarding the program requirement that dual eligibles, as a unique population with extensive needs, enroll in managed care plans. Pursuant to HB 7107, duals are required to enroll in either a Managed Medical Assistance plan or a Long Term Care managed care plan.

As program implementation moves forward, additional information regarding enrollment requirements will be made available through the Agency's website and other publications. Once the Agency has selected plans and they are ready to provide services, then the Agency will send individuals information regarding changes and their plan choices.

- Network Adequacy- Several comments were provided regarding concerns and recommendations regarding network requirements. Comments included concerns regarding access to specialty or community providers, and a desire that health plans be required to enroll "any willing provider". Specific comments have been provided as follows:

  - The community pharmacy population has expressed concerns relating to potential shift to mail order or out of state pharmacy under managed care expansion. This concern is likely combined with general concerns about the Medicaid program implementing statutory language authorizing expanded mail order provision of pharmacy products. It should be noted that under the Statewide Medicaid Managed Care program, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards.

  - The Advanced Registered Nurse Practitioner community has expressed concern that they will not be included as eligible Primary Care Providers (in plan networks) under the Statewide Medicaid Managed Care program. However, the current managed care contract definition includes advanced registered nurse practitioners (ARNPs) as primary care providers (PCP) – and the language outlining the Statewide Medicaid Managed Care program does not preclude the use of ARNPs as primary care providers.

- CS/HB 7107 Provisions regarding Network Adequacy: In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks.

  - Plans are required to maintain a network of providers in sufficient numbers to meet the needs of the recipients.

  - 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, 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 specific providers that are classified by Agency as "essential."

  - The Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and

specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

As part of a competitive process, the Agency will establish plan participation criteria including network requirements. The Agency is currently evaluating enhancements to provider network monitoring activities.

- Appropriate Level of Care Long Term Care Managed Care Program: The Elder Law community has expressed concerns about "granny dumping" under the Long Term Care Managed Care program, and has specifically referenced concern with what they see as "bonus payments" for moving enrollees out of nursing homes.

  - Placement in facilities or home and community based settings will be closely monitored by the Agency to ensure that enrollees are receiving the appropriate level of care and "patient dumping" will not be tolerated.
  - The Statewide Medicaid Managed Care program includes incentives for plans to move enrollees from an institutional setting (such as a nursing home) to a home and community based setting as appropriate. Specifically, the Agency is directed to adjust the payment in order to provide an incentive for reducing institutional placements over time and increasing the utilization of home and community-based services.
  - The move to more home and community based setting is in line with recent nursing home transition and other efforts.

There appears to be a misunderstanding regarding components in CS/HB 7107 as the adjustment to payments will be applied at the plan level to encourage plans to serve more individuals in the community and most integrated setting over time. Granny dumping will not be tolerated. The Agency will continue to educate individuals about plan requirements regarding appropriate levels of care and transition to home and community based settings.

- Cost Sharing Requirements: Several comments were provided regarding concerns about the impact of the cost sharing requirements included in HB 7107 and HB 7109. Comments included concerns regarding cost sharing as a barrier to enrollment or to seeking needed medical care. Specifically:

  - Concern was expressed that the requirement of a monthly premium of $10 as a condition of eligibility will keep Floridians from enrolling or maintaining enrollment in the Medicaid program.
  - Concern was expressed that the requirement for a $100 co-payment for non-emergency treatment in an emergency room setting would create an access barrier to services.
  - As previously noted, concern was expressed regarding the requirement that a sliding scale premium be imposed on families of children enrolled in the DD waivers.

  The Agency will seek required federal authority to implement the provisions in law and will work with CMS to ensure appropriate safeguards while facilitating the objectives of more appropriate use of care and individual contribution.

- Timeline for Implementation: Many comments indicate that there is confusion regarding the timeline for implementation of the program. Comments indicated that many people believed implementation of program changes would be immediate. During the public workshops, the Agency provided the following detail regarding the timeline.

  - CS/HB 7107 requires that before seeking a waiver, the Agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application.
  - The Agency is required to hold one public meeting in each of the regions described in s. 409.966(2), F.S., and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.
  - The Agency is required to submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the Statewide Medicaid Managed Care program by August 1, 2011.
  - The Agency is directed to begin implementation of the Long Term Care Managed Care program by July 1, 2012, with full program implementation by October 13, 2013.
  - The Agency is required to begin implementation of the Managed Medical Assistance program by January 1, 2013, with full program implementation by October 1, 2014.

The Agency anticipates providing regular updates on the Agency's website. The Agency will also evaluate the best methods to provide ongoing information on updated timelines for recipients, providers, and stakeholders.

- Participation by Aging Networks: The Florida Association of Area Agencies on Aging, and other constituents, have expressed their desire to continue their role in assisting elderly Medicaid recipients with program choice, enrollment, etc. The Aging Resources Centers expressed support for their inclusion in the role outlined for them in CS/HB 7109.

- Concern about covered services: Several areas of concern regarding specific covered services were raised at numerous meetings. These included:

  - Concern relating to the impact of the Statewide Medicaid Managed Care Program on Behavioral Health Overlay Services, or BHOS. Providers have expressed concern that BHOS services will be included in managed care. However, BHOS is not listed as a covered service under the Statewide Medicaid Managed Care program.
  - Concern about the impact of the Statewide Medicaid Managed Care Program on non-emergency transportation (NET) services. Several expressed the desire to carve out this service and allow the Commission for the Transportation Disadvantaged continues to be the contracted provider for NET services to Florida Medicaid recipients.

- Support for Nursing Home Diversion Program: Many comments were received regarding gratitude for care received through the Nursing Home Diversion program. Comments included:

  - Appreciation for the care Nursing Home Diversion plans provided in regard to the quality and speed services were provided.

- Appreciation for the coordination of care and assistance provided by plan case managers was consistent throughout the comments received.

- Hospital Systems: In addition, several hospital systems have submitted letters which urge the state to consider elements included in the April 28, 2011 letter from CMS, regarding the state's 1115 Medicaid Reform waiver, when developing the Statewide Medicaid Managed Care program waiver and amendment requests. Key elements mentioned include:

  - Medical Loss Ratio
  - Financial Reporting by Plans
  - Encounter Data
  - Low Income Pool Funding
  - Recipients ability to participate in cost sharing

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

  - Request that Hillsborough be considered its own Region under the Statewide Medicaid Managed Care program.
  - Request for limits on flexibility of benefits packages.
  - Request for clarification on choice counseling/ enrollment broker services under Statewide Medicaid Managed Care program.
  - Consideration of Medical Home concept with drafting waiver/ amendment submissions.

The Agency has established a dedicated email box to receive comments regarding the program and is receiving comments via that mailbox and regular mail. Comments received as of July 29, 2011, fall into the groupings discussed above.

Consultation with Federally Recognized Tribes: The Agency consulted with the Indian Health Programs[2] located in Florida through written correspondence, to solicit input on the new legislation creating the Statewide Medicaid Managed Care program. The correspondence was sent to the Seminole Tribe and Miccosukee Tribe requesting input on the new Statewide Medicaid Managed Care program on June 1, 2011. The Seminole Tribe and Miccosukee Tribe did not provide input on the new legislation. A copy of the State's written notification to the Florida Federally Recognized Tribes and the State's reassurances of compliance with the American Recovery and Reinvestment Act (ARRA) requirements are provided on pages 10-12 of this Attachment.

(b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current Budget Neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates by Eligibility Group the impact of the amendment**.**

[2] The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Organizations.

Attachment IV
Compliance with Special Term and Condition #7

A data analysis and Budget Neutrality: The Agency believes this amendment request does not impact the budget neutrality as the voluntary populations are included budget neutrality. Attachment V is the Budget Neutrality provided to the Centers for Medicare and Medicaid Services updated in June 2011 as part of the renewal package.

(c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation.

Impact on Beneficiaries: See Attachments I and II for a summary description of the Statewide Managed Medical Assistance program.

(d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions

Evaluation Design: Approval of this amendment request will not require the Agency to modify to the evaluation design.

Attachment IV
Compliance with Special Term and Condition #7

Written Notification to the Seminole Tribe of Florida

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

June 1, 2011

Ms. Connie Whidden, MSW
Health Director
Seminole Tribe of Florida
3006 Josie Billie Avenue
Hollywood, FL 33024

Dear Ms. Whidden:

The State of Florida, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

[redacted]

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Visit AHCA online at
AHCA.MyFlorida.com

Attachment I
Notice of Public Meetings

The notice of public meeting/workshop/hearing was submitted to the Florida Administrative Weekly (FAW) and will be published in the FAW's June 3rd publication related to the public meetings to be held on the Statewide Medicaid Managed Care Program. This information will also be posted on the Agency for Health Care Administration (Agency) website www.ahca.myflorida.com.

The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

Notice of Meeting/Workshop/Hearing

The Agency announces a series of public meetings to which all persons are invited.

DATE AND TIME: June 10, 2011 from 1:00pm - 4:00pm
PLACE: Agency for Health Care Administration, Building 3, Conference Room A, 2727 Mahan Drive, Tallahassee, FL, 32308

DATE AND TIME: June 13, 2011 from 1:00pm - 4:00pmCT
PLACE: City Hall, Hagler/Mason Auditorium 2nd floor, 222 W. Main St., Pensacola, FL 32502

DATE AND TIME: June 14, 2011 from 9:00am – 12:00pm
PLACE: Department of Children and Families, 5920 Arlington Expressway, Jacksonville, FL 32211, Main Auditorium

DATE AND TIME: June 14, 2011 from 9:00am -12:00pm
PLACE: Hilton Palm Beach Airport, 150 Australian Avenue, West Palm Beach, FL 33406

DATE AND TIME: June 14, 2011 from 2:30pm – 5:30pm
PLACE: Alachua Regional Service Center, 14107 US Highway 441, Conf Rm 190-A, Alachua, FL 32615

DATE AND TIME: June 15, 2011 from 9:00am -12:00pm
PLACE: Mary Grizzle Building, Rooms 136 & 137, 11351 Ulmerton Road, Largo, FL 33778-1629

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Florida Department of Transportation, Auditorium, 11201 N. McKinley Dr., Tampa, FL 33612

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: El Palacio, 21485 NW – 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D – 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm – 5:00pm
PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

Attachment IV
Compliance with Special Term and Condition #7

Written Notification to the Miccosukee Tribe of Florida

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

June 1, 2011

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola:

The State of Florida, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Miccosukee Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

[redacted]

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

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The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

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PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: El Palacio, 21485 NW – 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D – 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm – 5:00pm
PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

Attachment IV
Compliance with Special Term and Condition #7

State's Reassurances of Compliance with the ARRA

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

MEMORANDUM

TO: Mary Kay Justis, Acting Associate Regional Administrator
Centers for Medicare and Medicaid Services

FROM: Roberta K. Bradford, Deputy Secretary for Medicaid

DATE: January 6, 2010

RE: American Recovery and Reinvestment Act (ARRA)
Stimulus Funding Compliance Reassurances – Standard Responses

The state provides the following reassurances of compliance with the ARRA requirements on all State Plan amendments, waivers and waiver amendments, contract and contract amendments as specified below:

1. Maintenance of Effort - The Florida Legislature continued funding for the following programs to meet the Maintenance of Effort requirements: MEDS-AD Waiver and the Medically Needy program.

2. Local Match – The Florida Legislature did not impose any additional local funding requirements for the state share of the Florida Medicaid program.

3. Prompt Pay – Mechanisms are in place to assure Florida Medicaid's conformity with prompt pay requirements, and we do not anticipate any issues meeting these requirements.

4. Rainy Day Funds – ARRA funds as appropriated by the Florida Legislature allowed for decreased demand for state revenue. Those "freed up" state funds were then used to fund other priority items in the state budget as approved by the Florida Legislature and Governor. None of the ARRA funds were used as rainy day funds or other reserve funds.

5. Eligible Expenditures (e.g. no DSH or other enhanced match payments) – Via Finance and Accounting systems, only eligible expenditures are being captured for ARRA funding purposes, and non-eligible expenditures are specifically excluded from ARRA expenditures as part of this Finance and Accounting process.

2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

Visit AHCA online at
http://ahca.myflorida.com

Attachment V
Budget Neutrality

Attachment V
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F
1						
2	**States would enter information in the shaded cells. The rest of the sheet will be calculated.**					
3	HISTORIC DATA: SFY 0910 and 7 PRIOR YEARS FOR MANDATORY POPULATIONS					
4	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:**					
5	**Pre-Demonstration Waiver Periods**	**SFY 02-03**	**SFY 03-04**	**SFY 04-05**	**SFY 05-06**	**WOW AVERAGES**
6	**TOTAL EXPENDITURES**					**AHCA:** Trends not used in June 2011 updated WOW projection - President's trend used instead.
7	MEG 1 - SSI RELATED	$ 2,047,157,566	$ 2,203,085,933	$ 2,413,865,641	$ 2,514,883,881	
8	**ELIGIBLE MEMBER MONTHS**	2,890,214	2,925,038	2,992,401	2,941,374	
9	**COST PER ELIGIBLE**	$ 708.31	$ 753.18	$ 806.67	$ 855.00	
10						
11	**TREND RATES**		**ANNUAL CHANGE**			**3-YEAR AVERAGE**
12	TOTAL EXPENDITURE		7.62%	9.57%	4.18%	5.90%
13	ELIGIBLE MEMBER MONTHS		1.20%	2.30%	-1.71%	0.59%
14	COST PER ELIGIBLE		6.34%	7.10%	5.99%	***6.48%***
15						
16	**TOTAL EXPENDITURES**					**AHCA:** Trends not used in June 2011 updated WOW projection - President's trend used instead.
17	MEG 2 - CHILD & FAM	$ 2,204,501,439	$ 2,473,745,468	$ 2,955,249,433	$ 2,908,107,720	
18	**ELIGIBLE MEMBER MONTHS**	14,908,204	15,621,916	18,153,023	16,836,229	
19	**COST PER ELIGIBLE**	$ 147.87	$ 158.35	$ 162.80	$ 172.73	
20						
21	**TREND RATES**		**ANNUAL CHANGE**			**2-YEAR AVERAGE**
22	TOTAL EXPENDITURE		12.21%	19.46%	-1.60%	5.31%
23	ELIGIBLE MEMBER MONTHS		4.79%	16.20%	-7.25%	4.14%
24	COST PER ELIGIBLE		7.09%	2.81%	6.10%	***6.59%***
25	NOTE: Children between 150-185% FPL are included in above MEGS. Although this is technically an optional category, the					
26	nature of this waiver allows for their inclusion in the mandatory MEGS. No other optional eligibility groups are included.					
27						

Attachment V
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F
28	**Pre-Demonstration Waiver Periods**	**SFY 02-03**	**SFY 03-04**	**SFY 04-05**	**SFY 05-06**	
29	**TOTAL EXPENDITURES**					
30	COMBINED ALL MEGS		$ 4,676,831,402	$ 5,369,115,075	$ 5,422,991,601	
31	**ELIGIBLE MEMBER MONTHS**		18,546,954	21,145,425	19,777,604	
32	**COST PER ELIGIBLE**		$ 252.16	$ 253.91	$ 274.20	
33						
34	**TREND RATES**					
35	TOTAL EXPENDITURE		10.00%	14.80%	1.00%	
36	ELIGIBLE MEMBER MONTHS		4.21%	14.01%	-6.47%	
37	COST PER ELIGIBLE		5.56%	0.69%	7.99%	
38						
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Attachment V
Revised Budget Neutrality - 6/10/2011

Demonstration Waiver Periods	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10 *	DY5 SFY 10-11	WW 4-YEARS
TOTAL EXPENDITURES						
MEG 1 - SSI RELATED	$ 2,895,417,932	$ 3,101,151,925	$ 3,437,614,582	$ 3,596,647,161	$ 3,912,500,869	**$ 13,030,831,601**
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,352,695	3,409,260	
COST PER ELIGIBLE	$ 972.13	$ 1,022.14	$ 1,057.81	$ 1,072.76	$ 1,147.61	
TREND RATES		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		7.11%	10.85%	4.63%	8.78%	7.50%
ELIGIBLE MEMBER MONTHS		1.87%	7.11%	3.17%	1.69%	4.02%
COST PER ELIGIBLE		5.14%	3.49%	1.41%	6.98%	3.34%
TOTAL EXPENDITURES						
MEG 2 - CHILD & FAM	$ 2,429,520,901	$ 2,518,857,614	$ 2,853,852,002	$ 3,325,471,871	$ 4,321,206,430	**$ 11,127,702,388**
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	19,964,506	22,460,415	
COST PER ELIGIBLE	$ 160.23	$ 169.85	$ 166.94	$ 166.57	$ 192.39	
TREND RATES		**ANNUAL CHANGE**				**3-YEAR PMPM AVERAGE**
TOTAL EXPENDITURE		3.68%	13.30%	16.53%	29.94%	11.03%
ELIGIBLE MEMBER MONTHS		-2.20%	15.27%	16.79%	12.50%	9.60%
COST PER ELIGIBLE		6.00%	-1.71%	-0.22%	15.50%	2.07%

Attachment V
Revised Budget Neutrality - 6/10/2011

	H	I	J	K	L	M	N
28	**Demonstration Waiver Periods**	**DY1 SFY 06-07**	**DY2 SFY 07-08**	**DY3 SFY 08-09**	**DY4 SFY 09-10**	**DY5 SFY 10-11 ***	**WW 5-YEARS**
29	**LIP Allocated**	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
30	**LIP Actual Expenditures ***	$ 998,806,049	$ 999,632,926	$ 877,493,058	$ 1,122,122,816	$ 463,462,276	$ 4,461,517,125
31	**ELIGIBLE MEMBER MONTHS**	N/A	N/A	N/A	N/A	N/A	N/A
32	**COST PER ELIGIBLE**	N/A	N/A	N/A	N/A	N/A	N/A
33							
34	**TREND RATES**		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
35			0.08%	-12.22%	27.88%	-58.70%	3.96%
36		N/A	N/A	N/A	N/A	N/A	N/A
37		N/A	N/A	N/A	N/A	N/A	N/A
38							
39							
40	**TOTAL EXPENDITURES**	**DY1 SFY 06-07**	**DY2 SFY 07-08**	**DY3 SFY 08-09**	**DY4 SFY 09-10 ***	**DY5 SFY 10-11**	
41	COMBINED ALL MEGS ***WITHOUT*** LOW INCOME SUBSIDY POOL	$ 5,324,938,833	$ 5,620,009,540	$ 6,291,466,584	$ 6,922,119,032	$ 8,233,707,298	$ 24,158,533,989
42	**ELIGIBLE MEMBER MONTHS**	18,141,234	17,863,960	20,344,582	23,317,201	25,869,675	
43	**COST PER ELIGIBLE**	$ 293.53	$ 314.60	$ 309.25	$ 296.87	$ 318.28	
44							
45	**TREND RATES**		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
46	TOTAL EXPENDITURE		5.54%	11.95%	10.02%	18.95%	9.14%
47	ELIGIBLE MEMBER MONTHS		-1.53%	13.89%	14.61%	10.95%	8.73%
48	COST PER ELIGIBLE		7.18%	-1.70%	-4.00%	7.21%	0.38%
49							
50	*Actual Demonstration Values as of December 31, 2010 payments. SFY 10-11 are partial year payments for LIP; the full allotment is anticipated to be spent.						

Attachment V
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F	G
1							
2	**EXTENSION OF REFORM 1115 DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**						
3							
4	**MANDATORY POPULATIONS**						
5	**ELIGIBILITY**	**DEMONSTRATION**	**MONTHS**	**RENEWAL DEMONSTRATION YEARS (DY)**			**TOTAL**
6	**GROUP**	**TREND RATE**	**OF AGING**	**DY6 (SFY 11-12)**	**DY7 (SFY 12-13)**	**DY8 (SFY 13-14)**	**WOW**
7	**MEG 1 - SSI RELATED**						
8	Eligible Member Months	N/A	12	3,627,670	3,773,502	3,925,197	
9	Total Cost Per Eligible	5.10%	12	$ 1,357	$ 1,426	$ 1,548	
10	Total Expenditure			$ 4,921,484,792	$ 5,380,414,233	$ 6,076,249,521	$ 16,378,148,547
11							
12	**MEG 2 - CHILD & FAM**						
13	Eligible Member Months	N/A	12	23,981,684	26,283,926	28,807,183	
14	Total Cost Per Eligible	5.30%	12	$ 286	$ 301	$ 327	
15	Total Expenditure			$ 6,853,333,861	$ 7,909,350,369	$ 9,429,313,198	$ 24,191,997,427
16							
17	**TOTAL EXPENDITURES WOW D6-D8**						
18	**COMBINED MEGS 1 and 2**			$ 11,774,818,653	$ 13,289,764,602	$ 15,505,562,719	$ 40,570,145,974
19	**ELIGIBLE MEMBER MONTHS**			27,609,354	30,057,428	32,732,379	
20	**COST PER ELIGIBLE**			$ 426.48	$ 442.15	$ 473.71	
21							
22	**TREND RATES**						**3-YEAR**
23						**ANNUAL CHANGE**	**AVERAGE**
24	TOTAL EXPENDITURE				12.87%	16.67%	14.75%
25	ELIGIBLE MEMBER MONTHS				8.87%	8.90%	8.88%
26	COST PER ELIGIBLE				3.67%	7.14%	5.39%

AHCA: President's trend.

AHCA: President's trend.

AHCA: 12 months represents inflation from DY5 PCCM (per STC) to midpoint of DY6.

Attachment V
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F	G
1							
2	**EXTENSION OF REFORM 1115 DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**						
3					n		
4	**MANDATORY POPULATIONS**						
5	**ELIGIBILITY**	**DEMONSTRATION**	**MONTHS**	**RENEWAL DEMONSTRATION YEARS (DY)**			**TOTAL**
6	**GROUP**	**TREND RATE**	**OF AGING**	**DY6 (SFY 11-12)**	**DY7 (SFY 12-13)**	**DY8 (SFY 13-14)**	**WW**
7	**MEG 1 - SSI RELATED**						
8	Eligible Member Months	4.02%	24	3,627,670	3,773,502	3,925,197	
9	Total Cost Per Eligible	3.34%	24	$ 1,145.62	$ 1,183.88	$ 1,263.80	
10	Total Expenditure			$ 4,155,932,144	$ 4,467,388,837	$ 4,960,659,098	$ 13,583,980,079
11							
12	**MEG 2 - CHILD & FAM**						
13	Eligible Member Months	9.60%	24	23,981,684	26,283,926	28,807,183	
14	Total Cost Per Eligible	2.07%	24	$ 173.54	$ 177.13	$ 186.76	
15	Total Expenditure			$ 4,161,698,524	$ 4,655,638,869	$ 5,380,074,330	$ 14,197,411,722
16		**AHCA:**					
17	**LOW INCOME SUBSIDY POOL**	24 months represents inflation from midpoint of 0910 (last base year) to midpoint of DY6.					
18	Eligible Member Months			N/A	N/A	N/A	
19	Total Cost Per Eligible			N/A	N/A	N/A	
20	Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 3,000,000,000
21							
22	**TOTAL EXPENDITURES WW D6-D8**						
23	**COMBINED MEGS 1 and 2**			$ 8,317,630,668	$ 9,123,027,706	$ 10,340,733,427	$ 27,781,391,801
24	**ELIGIBLE MEMBER MONTHS**			27,609,354	30,057,428	32,732,379	
25	**COST PER ELIGIBLE**			$ 301.26	$ 303.52	$ 315.92	
26							
27	**TREND RATES**						**3-YEAR**
28						**ANNUAL CHANGE**	**AVERAGE**
29	TOTAL EXPENDITURE				9.68%	13.35%	11.50%
30	ELIGIBLE MEMBER MONTHS				8.87%	8.90%	8.88%
31	COST PER ELIGIBLE				0.75%	4.08%	2.40%
32							
33	(WOW-WW)						
34	$ 12,788,754,173						

Replacement Waiver

Statewide Managed Medical Assistance Program

1115 Research and Demonstration Waiver

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Table of Contents

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I. Statement of Purpose

The Florida Medicaid program was created in 1970, and currently covers approximately 3 million Floridians. Although initially crafted as a medical care extension for persons who received federally funded cash assistance, during the 40 years the program has operated the State has exercised options as they became available under federal law to expand Medicaid coverage to categorically related groups in addition to mandatory categorically needy eligibility groups. Further, the State also receives federal matching funds to provide certain optional services, and has sought and received federal waivers to provide services through home and community based programs for individuals who might otherwise be institutionalized.

Florida currently has received federal approval for waiver authority under various sections of the Social Security Act to conduct regional and statewide demonstrations designed to cover uninsured populations and to implement new delivery systems without increasing costs. The State has used such authority to implement managed care programs to enhance access to quality care in a cost-effective manner. With the implementation of the Statewide Medicaid Managed Care Program, the State is seeking to streamline the State's various managed care programs into a more comprehensive and integrated program available throughout the State of Florida. Upon implementation, the vast majority of programs will sunset and individuals will receive services through the Statewide Medicaid Managed Care Program.

As in all other States, Florida (and the federal government) has experienced very rapid growth in Medicaid expenditures. Drivers of such costs include population growth, expansions due to federal mandates, and economic recessions; expanded coverage and utilization of services; growth of the aged and disabled population; technological advances in treatment resulting in more costly care; increased cost of long-term care; and increased drug costs. To illustrate the impact to Florida:

- From SFY 2006-07 to 2011-12, Medicaid expenditure growth for Florida has averaged 6.5% per year, and Medicaid average monthly caseload growth has averaged 7.4% per year. In State Fiscal Year (SFY) 2011-12, the average monthly Medicaid caseload will be close to 3.2 million individuals, and total Medicaid expenditures will exceed $21 billion dollars.[1] Medicaid will represent approximately 33% of the entire State budget in SFY 2011-12. If these trends continue, it is anticipated that by SFY 2014-15 Medicaid will represent 41% of the State's total budget with expenditures over $27 billion.

- Florida covers over 47 different services on a fee-for-service (FFS) basis and through contracted managed care entities not included in this demonstration waiver. Individuals can receive care through 19 contracted managed care organizations (MCOs); the statewide primary care case management (PCCM) system; MediPass; or a FFS Provider Service Network (PSN) outside the demonstration counties. In addition, the State maintains several carve-out programs for mental health services, dental care, and transportation outside the demonstration counties. These multiple delivery systems generate more than 140 million individual claims annually, from more than 110,000 service providers of all types.

[1] February 2011 Florida Social Service Estimating Conference Report

As a result, Medicaid expenditures are growing faster than other components of State budgets, and State Legislatures are seeking solutions to make the program sustainable over the long term. Care delivery to recipients in the fee-for service setting described above is often fragmented and episodic. No incentive exists for service providers to deliver efficient or coordinated health care. Rather than engage in preventive routine care, recipients often do not seek care until they become ill, and such utilization of the health care system does not leverage the dollars spent to improve the health status of the Medicaid population. A managed care system would create incentives for MCOs to identify recipients with chronic health conditions and provide preventive therapies and health maintenance, rather than wait until conditions become so severe that intensive and expensive treatment is required.

To that end, in recent years Florida has exercised options available from the federal government to improve the coordination and quality of services to recipients, while ensuring the efficiency and effectiveness of the program. In late 2010, in preparation for the 2011 Legislative session, Florida's elected leaders passed a Memorial that provided a framework for policy changes to be considered in the 2011 session.[2]

In the 2011 legislative session, both the Florida House of Representatives and the Florida Senate held numerous committee meetings to consider options for an effective and sustainable Medicaid program. Significant time was given by both houses and relevant committees of the legislature to receive public testimony from all facets of the stakeholder community. The result of this wide-ranging input was the conclusion that policy change was imperative to ensure the quality and coordination of care for Medicaid recipients, maintain access to physicians and other providers of service, and to improve the financial integrity and predictability of the need for funding of the program by Florida's taxpayers.

Two major pieces of Medicaid legislation were passed and signed into law.[3] This document is specific to CS/HB 7107, which provides for significant changes to build greater stability and accountability in Florida Medicaid managed care. The enclosed waiver amendment request seeks federal authority to implement these changes. Central to this legislation is the creation of the Statewide Managed Medical Assistance program which would provide primary and acute medical care for specified populations through competitively selected MCOs in 11 geographic regions of the State.

Objectives for moving populations from a fee-for-service system to managed care include:

- Providing incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting.
- Providing individuals a meaningful choice of plans and benefits.
- Reducing fraud, abuse and waste through managed utilization of health care services.

Currently, approximately 43% of all Florida Medicaid recipients are served through a managed care delivery system; the remaining 57% of the population is served through the traditional fee-for-service program. Florida Medicaid is recognized as a leader in the battle against fraud and abuse and has put in place many automated and manual safeguards to detect and prevent

[2] Link to Memorial to Congress http://www.flsenate.gov/Session/Bill/2010A/0004/BillText/er/PDF.
[3] Links to CS/HB 7107 http://www.flsenate.gov/Session/Bill/2011/7107/BillText/er/PDF, and 7109 http://www.flsenate.gov/Session/Bill/2011/7109/BillText/er/PDF.

inappropriate payments, but the scale of the program and $21 billion taxpayer expenditure required the closest possible oversight to prevent inappropriate utilization and potential overbilling.

The provisions of the recently enacted legislation that established the managed care program included specific requirements to further enhance program integrity. The selection criteria for the competitive procurement of managed care plans include documentation of policies and procedures for preventing fraud and abuse. Potential contractors face strict requirements to disclose business relationships to guard against conflicts of interest or prior involvement in health care fraud. The legislation includes accountability provisions that include provider credentialing and monitoring, effective prepayment and post-payment review processes, enhanced plan financial and data reporting, and a mandatory compliance plan designed to prevent fraud and abuse. It is not feasible to conduct this level of review for over 110,000 current fee-for-service providers.

The challenges facing states to improve their Medicaid programs' design to produce optimum health outcomes and efficiently manage costs require significant changes in order to sustain this benefit for individuals with low incomes and resources. The amendment request seeks to use the current authorities already granted to implement Florida law which is designed to address these challenges.

The State believes that the Florida Medicaid Managed Medical Assistance Program provides the framework for evolution to a sustainable benefit without eliminating services or access for eligible individuals. Given the requested authority to implement this program, Florida Medicaid could transform relationships, improve accountability, and provide incentives for improved health outcomes.

II. Statewide Managed Medical Assistance Program

Florida's Statewide Managed Medical Assistance program will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The State's role has changed so that it is largely a purchaser of care, providing oversight focused on improving access and increasing quality of care. This program emphasizes personal responsibility and rewarding healthy behaviors.

The framework for the Statewide Managed Medical Assistance program was established in legislation passed by the legislature and signed by the Governor through a Memorial in a special legislative session in late 2010 and in legislation passed in the regular 2011 session.

1. The principles established for the Statewide Managed Medical Assistance program included:

   - Improved program performance by expanding key components of the Medicaid managed care program Statewide, while strengthening accountability for improved patient outcomes and preserving meaningful choices for participants. A key objective of improved program performance is to increase patient satisfaction.
   - Improved access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care). A key objective of improved access to coordinated care is to ensure access to services not previously covered and to improve access to specialists. This program includes requirements for MCOs to schedule appointments with a primary care physician within 30 days for new enrollees.
   - Enhanced fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems and shared savings model. Strict financial oversight requirements are established for MCOs to improve fiscal integrity.
   - Use of the expertise of MCOs, including health maintenance organizations (HMOs), PSNs, and other types of managed care entities, to provide all coverage and services for medical assistance. A key objective of the program is to provide a choice of managed care plans throughout the state and to provide for enhanced individual choice.
   - Stabilization of plan participation by competitively procuring plans on a regional basis, extending plan contract period to five years, and imposing penalties for plan withdrawals which are designed to enhance continuity of care.
   - Phased implementation of the Statewide Managed Medical Assistance program, allowing for adequate development of Medicaid managed care across the State.

These principles will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government.

2. Under the Statewide Managed Medical Assistance program, there are three fundamental elements:

   - Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The risk-adjusted premium will minimize the phenomenon of "adverse selection,"

and in fact, provides an incentive for plans to take all necessary steps to identify Medicaid enrollees who have undiagnosed chronic conditions. Once a Medicaid enrollee has chosen a plan, the plan may receive a higher premium only if the enrollee has been diagnosed with a condition that merits the additional premium. Of course, once a plan has identified someone with a chronic condition, it is then to the plan's financial benefit to properly manage the enrollee's condition so as to avoid higher cost services typical of untreated chronic conditions.

- Enhanced Benefits/ Healthy Behaviors will be provided through the managed care plans. The Enhanced Benefit Panel will be operational until the implementation of the Statewide Managed Medical Assistance program. The procurement process will require managed care plans to establish a program to encourage and reward healthy behaviors. The State will monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan.
- Low-Income Pool (LIP) will be maintained by the State to provide direct payment and distributions to safety net providers in the State for the purpose of providing coverage to Medicaid, the uninsured, and underinsured populations. Funds will be distributed to safety net providers that meet certain state and federal requirements.

The Statewide Managed Medical Assistance program will introduce more individual choice, increase access, and improve quality, efficiency and fiscal integrity while stabilizing cost. The State believes more integrated models that expand the medical home concept to manage all care will provide additional opportunity to better manage care. Therefore, the State will continue to increase the number of individuals enrolled in managed care plans that are capable of managing all of an individual's care. In addition, the State will allow flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are sufficient and actuarially equivalent to meet the needs of the population.

As further described in this document, the managed care plans will be procured through a competitive, negotiated selection of qualified managed care plans that meet strict selection criteria. The program will provide for a limited number of plans in 11 geographic regions to ensure stability but allow for significant patient choice and further ensure coverage in rural areas of the state. The State will initiate procurement of the plans no later than January 1, 2013, and fully implement the program by October 1, 2014.

To effectively implement the program, the State is requesting an amendment to Florida's section 1115 Research and Demonstration waiver in order to waive statutory provisions under Section 1902 of the Social Security Act and obtain expenditure authority that permits the State to provide maximum flexibility in administering Florida's Medicaid program while the program will change substantially for the current demonstration program as there are key improvements. Specifically, the State requests waivers of statutory provisions to provide for:

- Approval and federal financial participation (FFP) for Statewide Managed Medical Assistance program benefits with cost-sharing for all Medicaid eligibility categories participating in the waiver.
- Approval and FFP for the Enhanced Benefit/ Healthy Behaviors Plan to enable managed care plans to administer programs to encourage and reward healthy behaviors.
- Approval and FFP for costs not otherwise matchable for Program for All Inclusive Care

for Children services and the Healthy Start program.

- Approval and FFP for funds disbursed through the Low-Income Pool to eligible providers.

While the federal authorities needed to implement the program remain consistent with the current authorities granted in the 5 pilot counties, it is important to note that the program includes substantial changes to improve upon the current program.

III. Eligibility and Enrollment

A. Eligibility for Medicaid

The Department of Children and Families (DCF) is the administering agency responsible for processing Medicaid applications and determining Medicaid eligibility. The State will continue to use the same application and eligibility processes for all individuals, including participants in the Statewide Managed Medical Assistance program. Current income and asset limits will apply under the program, as will current residency and citizenship standards. There will be no limit on the number of individuals eligible for Medicaid as specified in the State Plan. The State assures that all applications will be processed in a timely manner.

B. Eligibility for the Statewide Managed Medical Assistance Program

Participation in the Statewide Managed Medical Assistance program will be mandatory for the following eligibility groups currently covered by Florida Medicaid:

1. Mandatory Population:
   a. TANF and TANF-Related Group - 1931 Eligibles:
      - Families whose income is below the TANF limit (23% of the FPL or $303 per month for a family of 3) with assets less than $2,000.
      - Pregnant women with incomes above the 1931 poverty level.
      - Poverty-related children whose family income exceeds the TANF limit as follows:
        - up to age one, family income up to 200% FPL.
        - up to age 6, family income up to 133% of FPL.
        - up to age 21, family income up to 100% FPL.

   b. Aged and Disabled Group:
      - The aged and disabled, comprising persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL; asset limit for an individual is $2,000).

   c. Children eligible under SSI.

   d. Children with chronic conditions who participate in Children's Medical Services Network.

   e. Children in foster care and who receive adoption subsidy.

   f. Individuals eligible under a hospice-related eligibility group.

   g. Individuals eligible for both Medicare and Medicaid will be required to participate in this program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. However, to facilitate enrollment, the State will automatically enroll individuals in a Medicare Special Needs Plan (SNP), if the individual has elected the plan under Medicare.

The above groups are mandatory eligibles, with the exception of poverty level children up to age one with family income above 185% of FPL but below 200% of FPL.

2. Voluntary Populations:

Medicaid recipients who may voluntarily choose to participate in this program include:

- Individuals who have other creditable health care coverage, excluding Medicare.
- Individuals residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities, as defined in state law.
- Persons eligible for refugee assistance.
- Individuals who are residents of a developmental disabilities center.
- Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.
- Poverty level children up to age one with family income above 185% of FPL but below 200% of FPL.

3. Exempt Population:

The following individuals are exempt from this program:

- Women who are eligible only for family planning services.
- Women who are eligible through the breast and cervical cancer program.
- Persons who are eligible for emergency Medicaid for aliens.
- Children receiving services in a prescribed pediatric extended care facility.

4. Expansion Population:

Individuals who lose eligibility for Medicaid, regardless of assets, will continue to have limited eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

Once the State implements the Statewide Managed Medical Assistance program and the plans offer a healthy behavior program, the State will sunset the current Enhanced Benefits program. However, the individuals with unused earned credits will continue to have access to those credits for a specified period of time.

C. Enrollment and Disenrollment

Upon implementation of the program, the State anticipates developing a staggered transition plan in each region to transition individuals into the managed care plans once selected as part of the procurement process.

1. New Medicaid Enrollees:

At the time of eligibility determination, individuals in mandatory populations will receive information about the managed care plan choices in their area. They will be informed of their option to select an authorized plan within 30 days of eligibility. If the individual does not select a plan within the 30-day period, the State will auto-assign the individual to a managed care plan. Once individuals have made their choice, they will be able to contact the State or the State's designated Choice Counselor to register their plan selection or complete enrollment through the online process.

2. Current Medicaid Enrollees:

For current Medicaid enrollees in a mandatory population, the State will develop a staggered transition plan for enrollment in the Statewide Managed Medical Assistance Program. Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program, will be required to enroll in a contracted plan, selected through competitive procurement process, at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner. The State may create an open enrollment process for all enrollees.

The State will carefully plan the transition of the affected recipients into the program to preserve continuity of care. The State will follow a multi-layered approach in the design of the transition plan by:

- Assessing the capacity of the contracted plans.
- Coordinating with the contracted plans to identify primary care providers and supply service information to ensure continuity of care and minimize disruption to the recipients.
- Coordinating with the new contracted plans to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new plan.
- Coordinating with the contracted plans and the State's designated contractor to create a staggered transition to ensure that the volume of beneficiaries being transitioned occurred in an organized manner.
- Coordinating with the new contracted plans, the State's designated contractor, local area staff, and advocacy groups in ensuring appropriate and timely notice to enrollees, including developing and releasing flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.

Additional details regarding the transition of care are provided in Appendix D.

Medicaid recipients in the demonstration areas, who are not currently enrolled in a contracted plan upon implementation, will have the opportunity to enroll in a plan at the time of open enrollment or annual eligibility redetermination. The individual may choose to contact the toll free help line to talk about their managed care plan options. If the individual does not make a selection, the State will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

3. Auto-Assignment

Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the State or State's designate will provide information to the individual to encourage an active plan selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a plan in their region. At a minimum, the State will use the parameters listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit.

The State will use the following parameters when assigning a recipient to a plan:

- If an applicable specialty plan is available, the recipient should be assigned to the specialty plan;
- If, in the first year of the first contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.
- Newborns of eligible mothers enrolled in a plan at the time of the child's birth shall be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

In addition, when automatically enrolling a recipient into a plan, the State will consider:

- Whether the plan has sufficient network capacity to meet the needs of the recipients.
- Whether the recipient has previously received services from one of the plan's primary care providers.
- Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

The State will seek to preserve an existing provider-recipient relationship by considering whether the recipient has received services from one of the primary care providers in the plan's provider network in the past.

4. Lock-In/Disenrollment

Once a mandatory enrollee has selected or been assigned to a managed care plan, the enrollee will have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, the enrollee will be locked-in for the remainder of the 12 month period, and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan. Voluntary enrollees may disenroll from the managed care plan at any time.

The State or State's designee will record the plan change/disenrollment reason for all recipients who request such a change. The State or State's designee will be responsible for processing all enrollments and disenrollments.

The State assures CMS that it complies with Section 1932(a)(4) and 42 CFR 438.56, insofar as the provisions are applicable.

5. Re-enrollment

In instances of a temporary loss of Medicaid eligibility, which the State is defining as six months or less, the State will re-enroll enrollees in the same health plan they were enrolled in prior to the temporary loss of eligibility. The State believes that such re-enrollment will promote increased preventive services, maximize continuity of care, and foster continued provider relationships.

D. Information and Choice

1. Enrollee Choice

Potential enrollees in the demonstration regions will initially have the choice of enrolling in a managed care plan. Potential enrollees will have a choice of two or more managed care plans in each region. Plans may include:

- HMOs,
- PSNs (FFS or capitated),
- Accountable Care Organizations (defined in federal law),
- EPOs, or
- CMS Network.

The State assures CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two options will be available in all demonstration regions. Recognizing the unique attributes of Florida's rural communities, the State will issue regional bids in an effort to provide individuals with two or more options.

2. Enrollee Information

The State or the State's designee will ensure that enrollees are provided with full and complete information about their managed care plan options. The State anticipates contracting for these services. The State or State's designee will provide information regarding an individual's choice to select a managed care plan.

Through the contractor, the State will develop enrollee education so individuals will fully understand their choices and will be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly. Specifically, the State or State's designee will provide information on selecting a managed care plan.

As it does now, the State or the State's designated contractor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, prescription drug formulary, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. Individuals will be assured of equal value among plans since all plans will be actuarially equivalent. In addition, the State will supplement coverage information by providing performance information on each plan. Information provided may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance

data. To ensure the information is as helpful as possible, the State may synthesize information into a coherent rating system. Such a system will better convey the performance of the managed care plans in an easy-to-understand format.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5% of the county speaks a language other than English. The State or State's designee will also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the State or the State's designated contractor to obtain additional information. The State or State's designated contractor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

The State assures the Centers for Medicare and Medicaid Services that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, Information Requirements.

The State or the State's designated contractor will retain responsibility for all enrollment and disenrollment activities into managed care plans.

E. Marketing

Approved managed care plans will not be allowed to market for enrollment to any potential members. Plans will be allowed to engage in brand-awareness activities, including the display of plan or product logos. With State approval, the plans will be allowed to conduct community outreach. Community outreach includes, but is not limited to, the provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. In addition, the State will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities.

All materials provided by the plans will meet the requirements at 42 CFR 438.10, Informing Requirements, including being written at a fourth-grade reading level. The State will require translation of all enrollment and marketing materials in areas where a specific language is spoken by 5% or more of the population. In addition, the State or State's designated contractor and plans will provide oral translation services to all individuals, regardless of the language spoken. Plans will be required to have TTY/TDD service available for enrollees with hearing and speech impairments.

In addition, the State will maintain strict oversight of community activities and will monitor for marketing violations. The State will continue to apply and enforce federal and State marketing restrictions that currently apply to plans. In addition to the federal requirements, Florida law prohibits plans from offering gifts or other incentives to potential enrollees and managed care plans from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans.

IV. Benefits

The Statewide Managed Medical Assistance program will provide individuals with health care options that will allow them to better manage their health care. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit "silos" that exist today, there are statewide limits and caps on various services that have varying impact on local populations.

The Statewide Managed Medical Assistance program will provide health plans with the flexibility to develop customized benefit packages that better fit and are more appropriate for Medicaid enrollees. Since these plans will be defined locally and will likely take advantage of varying strengths of the providers in that community, they will be more appropriate to the needs of that particular population. Such packages will more closely resemble private plans, yet will be actuarially equivalent to the current Medicaid benefit package. As part of the competitive procurement process, each plan will face the competitive pressure of offering the most innovative package within the limits of the premium offered by the State. At all times, the State will ensure the benefit packages are available at an actuarially appropriate level. The State seeks to ensure that needed services are covered and provided. With increased choices, individuals will be able to use their premium to select benefit plans that best meet their needs.

Each health care plan will submit its proposed benefit package to the State for prior approval. The State will evaluate the proposed benefit package using a two-pronged test: (1) actuarial equivalency and (2) sufficiency of benefits.

In addition, as part of the competitive bid process each plan will be required to create an enhanced benefit program. The purpose of the plan's enhanced benefit program is to offer incentives to enrollees to participate in wellness activities. These activities will be designed to improve and/or maintain the enrollee's health by providing individuals with a comprehensive benefit package.

A. Customized Benefit Packages

A major element of the Statewide Managed Medical Assistance program is the ability of health plans to develop customized benefit packages targeted to specific populations. These customized benefit packages will foster enrollee choice and will enable enrollees to access the health care services they need. Additionally, it is expected that these customized benefit plans will resemble private insurance plans, further bridging public and private coverage.

The benefit packages may look different from traditional Medicaid in several ways. In order to provide additional or special services to the targeted population, these tailored benefit packages may vary the amount, duration and scope of some services and may contain service-specific coverage limits, such as the number of visits or dollar cost. All packages must cover mandatory Medicaid services, including medically necessary services for pregnant women and EPSDT services for children under age 21, as the State is not seeking to waive EPSDT requirements for children enrolled in a Medicaid managed care plan. It is also expected that managed care plans will develop benefit packages to cover most optional services. In addition, managed care plans may also cover services not currently offered under the State Plan, such as adult dental care. Services not included in an approved benefit package, or that exceed those in an approved benefit package, will be considered non-covered services.

All benefit packages must be prior-approved by the State and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition to being actuarially equivalent to the value of traditional Medicaid services, each managed care plan's customized benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population (e.g., TANF, aged and disabled, etc.). See below for more detail.

While one of the major principles of the State is to encourage innovation by allowing for the variation of amount, duration and scope, plans are not required to change benefit packages and may choose to offer a benefit package that mirrors current coverage levels. Actual benefit packages will depend on market innovation and the population the plan seeks to serve and will be reviewed annually by the State.

1. Actuarial Equivalency

The State will evaluate each proposed customized benefit plan for actuarial equivalence to the current Medicaid State Plan. To do this, the State will use a Benefit Plan Evaluation Model that: 1) compares the value of the level of benefits in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensures that the overall level of benefits is appropriate.

Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that, given a specified Medicaid target population and its historical utilization, the expected claim cost levels of all managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan. The State will use this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits.

2. Sufficiency

In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet State-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. In this evaluation, the State will identify specific services (e.g., inpatient hospital, outpatient physician care, behavioral health, and prescription drugs) and will evaluate each proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

Thus, in order for a health plan to obtain State prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. Recipients will have the option to choose a managed care plan with a benefit package that best fits their needs. For example, one plan's benefit package may offer fewer chiropractic visits and more vision benefits than another plan's benefit package. If the recipient does not need a chiropractor but wears glasses, he/she may wish to

choose a plan with a benefit package that offers more vision benefits. The State believes that the flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for plan enrollees.

The State will evaluate service utilization on an annual basis and use this information to update the benefit comparison package to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

3. Cost Sharing

Under the Statewide Managed Medical Assistance program, the contracted plans may impose cost-sharing requirements consistent with the currently approved nominal levels in the State Plan. Current cost-sharing, including co-payments and co-insurances, are:

Services	Co-payment / Co-insurance
Birthing Center	$2 per day per provider
Chiropractic	$1 per day per provider
Community Mental Health	$2 per day per provider
Dental – Adult	5% co-insurance per procedure
FQHC	$3 per day per provider
Home Health Agency	$2 per day per provider
Hospital Inpatient	$3 per admission
Hospital Outpatient	$3 per visit
Independent Laboratory	$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner	$2 per day per provider
Optometrist	$2 per day per provider
Pharmacy	2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant	$2 per day per provider
Podiatrist	$2 per day per provider
Portable X-Ray	$1 per day per provider
Rural Health Clinic	$3 per day per provider
Transportation	$1 per trip

All individuals not exempt by federal regulation will be responsible for cost-sharing for services. The State will review and approve cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing will not be required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by the Centers for Medicare and Medicaid Services. The State will also encourage managed care plans to reduce or waive cost-sharing requirements for preventive services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, vaccinations, pap smears, and certain prescribed medication. The State believes that, due to the transparency of outcomes built into the Statewide Managed Medical Assistance program – particularly with each plan's ability to maximize the number of people who receive preventive services - plans will be incentivized to remove all barriers to preventive services, including

waiving cost sharing for those services. When a co-payment or co-insurance is required as part of the plan benefit structure, the provider will be responsible for collecting payments from individuals.

4. Enhanced Benefit /Healthy Behaviors Plan

The State will directly manage the development of policies and procedures that govern the Enhanced Benefit plan by maintaining the Enhanced Benefit Panel until the implementation of the Statewide Managed Medical Assistance program. As part of the procurement process in 2013, each selected plan shall be required to establish a program to encourage and reward healthy behaviors. At that time, the State will monitor the plans programs. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse program. These programs maybe modified by the Legislature.

The State will continue operation of the panel to guide in the development and evaluation of the healthy behavior program offered by the plans. Panel composition will be determined by the Secretary of the Agency for Health Care Administration. The purpose of the panel will include, but not be limited to, the following duties:

- Designating activities that may be beneficial to individuals;
- Informing recipients of a proposed activity to enrollees;
- Establishing appropriate incentivizes for participation;
- Evaluating participation levels;
- Evaluating outcomes;
- Discussing operational issues; and
- Developing recommendations for administration.

V. Delivery Systems

1. Procurement Method

The State will competitively procure managed care plans to provide services. The State will initiate separate but simultaneous procurements in each of the 11 regions. The State will begin implementation of the Statewide Managed Medical Assistance program no later than January 1, 2013, with full program implementation by October 1, 2014. Once the State has issued the procurement and awarded the contracts, the State will prepare a detailed transition plan based on plan readiness and capacity.

The criteria for preference in reviewing ITN respondents include: accreditation by nationally recognized accrediting bodies; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. The State will enter into five-year health plan contracts with selected contractors. The table below provides a high level overview of the draft timeframe for procurement and implementation.

Managed Medical Assistance Program Draft Timeline

Phase	Begin	End
Geographic Expansion Implementation Criteria	9/2011	10/2011
Continuity of Care Planning	3/2012	5/2012
Systems Analysis and Recommendations	12/2011	5/2012
Develop Solicitation	3/2012	12/2012
ITN Release	No Later Than 1/2013	No Later Than 1/2013
Databook Release	10/1/2012	10/1/2012
Contracts and Awards	4/2013	9/2013
Provider and Recipient Outreach and Education	Ongoing	Ongoing
Readiness Reviews	12/2013	9/2014
Enrollee Plan Selection Process and Materials Development	10/2013	3/2014
Enrollee Notification and Enrollment	4/2014	9/2014

2. Managed Care Plans Defined

A managed care plan is defined as an eligible plan under contract with the State to provide services in the Medicaid program and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity in the State, or qualified pursuant to Florida Statutes, that is paid a prospective per-member, per-month payment by the Agency.

An “eligible plan” is defined as a health insurer authorized under Chapter 627, an EPO authorized under Chapter 627, a HMO authorized under Chapter 641, a PSN authorized under

state law, an ACO authorized under federal law, or the Children's Medical Services Network authorized under state law.

3. Number of Plans per Region

The State will procure a specified number of plans per region. A minimum and maximum number of plans is specified by region, with a minimum of two plans choices in each of the 11 regions. Of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid. Issuance and award of the procurements will provide for a choice of plans, as well as market stability as the State will seek to enter into five-year contracts and penalize plans for early withdrawal from a region(s) prior to the end of the contract term or reduction in contracted enrollment levels.

To the extent that there are fewer than two plan choices in a region, the State will issue another procurement to obtain a second plan and meet the federal requirements regarding choice until two plans are available. Additionally, participation by the Children's Medical Services Network shall be pursuant to a single, Statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits but requires adherence to general plan network and quality requirements.

In addition, the State will also seek to contract with specialty plans and participation of specialty plans will be part of the procurement requirements as well as the regional plan number limits. However, the State may enter into contracts with a specialty plan whose target population includes no more than 10% of the enrollees of that region. Such specialty plans are not subject to the regional plan number.

4. Plan Selection Criteria

As part of the ITN process, the State will establish preference criteria for reviewing respondents as previously described. Such criteria will include, but not limited to, the State’s evaluation of whether plans have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied will be promptly paid under state law; are organizations that are based in and perform operational functions in this State, in-house or through contractual arrangements, by staff located in this State; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Types of Contracted Plans

The types of contracted plans the State will contract with include: HMOs, PSNs, ACOs authorized under federal law, EPOs, and the State’s Children’s Medical Services Network operated by the Florida Department of Health. Refer to Appendix C for additional information on the Children’s Medical Services Network. The State will reimburse most contracted plans on a capitated basis; however, fee-for-service payments may be used for PSN providers for a time limited period as authorized in state law.

As described in Section IV., Benefits, capitated plans may create customized benefit packages

that vary in amount, duration, and scope from State Plan services. Those PSN plans that continue to be paid on a FFS basis will not be permitted to vary the amount, duration, or scope of services from that set out in historical Medicaid.
Below is a description of the provider types.

A. Entities Regulated under Florida Insurance Statutes

The Office of Insurance Regulation (OIR) in the Department of Financial Services regulates many of the contracted plans that will be paid on a capitated basis. Regulatory oversight includes monitoring the solvency of life and health insurers and managed care entities that are authorized to operate in the State of Florida. OIR reviews all new entities wishing to enter the Florida marketplace as well as any material changes in ownership of insurers domiciled in Florida. When an insurer violates solvency standards, OIR initiates a plan of action with the company to address the regulatory issue.

The contracted plans are required to be licensed, full risk-bearing entities. In accordance with 42 CFR 438.2, comprehensive risk is defined as a managed care plan that is at-risk for inpatient hospital services and three or more mandatory State Plan services in section 1905(a). Entities assuming risk consistent with federal requirements and receiving capitation payment will be considered a comprehensive risk- bearing entity and be required to meet state fiscal and solvency standards.

1. HMOs: Health Maintenance Organizations

An HMO is an organization authorized under Chapter 641, Florida Statutes, that provides health care coverage on a prepaid per capita basis.

2. Licensed Insurers

The State may also contract with health insurers to enroll as Medicaid managed care plans and provide coverage to individuals. These providers will be required to meet State financial and solvency standards for insurers. The financial standards are specified in Florida Statutes and are generally greater than the standards required for HMOs. Health insurers may serve enrollees in the Statewide Managed Medical Assistance program with products such as:

- EPO: Exclusive Provider Organization – A provider of health care or a group of providers that has entered into a written agreement to provide benefits under a health insurance policy. EPOs are not directly regulated as to solvency by the Office of Insurance Regulation but typically contract through another entity that is so regulated, such as an HMO or an Insurance Company.

The Agency will work with the Office of Insurance Regulation to determine appropriate solvency provisions for any EPOs with which the State contracts with as part of the Statewide Managed Medical Assistance program.

B. Provider Service Networks

PSNs are networks established or organized and operated by a health care provider, or group of affiliated health care providers, which provide a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. They may make arrangements with physicians or other health care professionals, health care

institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN.

In accordance with Florida Statutes, the State may reimburse a PSN on either a fee-for-service or prepaid basis. Once capitated, all PSNs will be required to assume responsibility for comprehensive coverage and meet established solvency standards. Capitated PSNs are exempt from many of the regulatory provisions that apply to HMOs under parts I and III of Chapter 641, Florida Statutes, unless they serve other populations, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the State. Once a PSN accepts capitation, it must meet the same surplus and solvency requirements as HMOs, consistent with licensed HMOs in Chapter 641, Florida Statutes, and s. 409.912, Florida Statutes. Chapter 641 requires that an entity shall at all times maintain a minimum surplus in an amount that is the greater of $1,500,000, or 10% of total liabilities, or 2% of total contract amount. The State may also consider the following:

- If the organization is a public entity, the Agency may take under advisement a Statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;
- The State guarantees the solvency of the organization; or
- The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 C.F.R. s. 422.350, subpart H, or ss. 422.380-422.390.

In addition to the fee-for-service specialty plan operated by the Florida Department of Health for children with chronic conditions, currently, the State contracts with six PSNs that, cumulatively, provide services in 34 counties.

C. Specialty Plans

The contracted plans will be encouraged to develop and offer specialty plans to serve individuals with specific conditions or select eligibility groups.

A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the State as a specialty plan. Specialty plans are designed for a specific population and currently include plans that primarily serve children with chronic conditions or recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS). A health plan must be licensed under Chapter 641, F.S., to offer a specialty plan for recipients living with HIV/AIDS. Participation of specialty plans will be part of the procurement requirements and the aggregate enrollment of all specialty plans in a region may not exceed 10% of the enrollees of that region. .

The State will identify specialty plans as part of the procurement process and may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the existence of clinical programs or special expertise and/or providers to serve that target population. The State will not approve plans that discriminate against sicker members of a target population.

The State may also contract with Medicare Advantage Plans, designated as Special Needs Plans, to serve dual eligible enrollees, authorized by the Centers for Medicare and Medicaid Services.

In addition to meeting general financial reserve requirements and network sufficiency requirements, the State will develop enhanced standards for specialty plans that may include but are not limited to:

- Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should be an integrated network of primary care physicians (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
- Network with sufficient capacity of board-certified specialists in the care and management of the disease for plans that seek to focus services for enrollees with a particular disease state. In addition, it is recognized that individuals have multiple diagnoses, and, therefore, the plan should have sufficient capacity of additional specialists to manage the different diagnoses.
- Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).
- Availability of specialty pharmacies, where appropriate.
- Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
- Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.
- Use of evidence-based clinical guidelines in the management of the disorder.
- Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.
- Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

D. Reimbursement

Capitation rates will be developed in accordance with 42 CFR 438.6. The State will develop actuarially sound, risk-adjusted premiums. The premiums will be based on historical Medicaid expenditures including the use of encounter data, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures.

The State will reimburse some PSNs on a fee-for-service basis with a shared savings arrangement and all other managed care plans on the basis of the risk-adjusted capitation premiums. Risk adjustment will be used to reflect differences in health status of enrollee and

the overall risk profiles between the FFS and capitated populations and between the populations served by each managed care entity. This will help ensure budget neutrality and properly budget the proportion of expenditures that are anticipated to be attributable to the different payment methods and plans.

1. Risk-Adjusted Capitation Premiums

As noted above, the State will develop risk-adjusted premium rates to pay the managed care entities.

Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender can do. The purpose of health-based risk adjustment is to provide a risk score for each individual to reflect predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan.

The State currently utilizes a health-based risk adjustment model to adjust rates for capitated plans in five Reform counties. The purpose of health-based risk adjustment is to provide a risk score for each individual receiving services through Medicaid which reflects their predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan. The State will work with its contracted actuary to update and enhance risk adjustment methodologies to reflect nationally recognized models best suited for this program.

For certain events that may not be predicted in advance, such as pregnancy, the birth of a newborn, or high-cost cases for which there is a significant variance in historical expenditure (e.g. hemophilia), the State may develop special "kick payments" and/or high-cost claim pooling mechanisms.

The State assures CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary.

The Centers for Medicare and Medicaid Services Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

2. Fee-for-Service Reimbursement

The State may pay some or all PSNs on a fee-for-service (FFS) basis as authorized by legislation, using historical Medicaid covered services with no variation of benefit package. The State will not reimburse a FFS-based PSN for services not authorized under the State Plan. PSNs may provide and directly pay for additional services through any savings earned at no cost the State.

The State will work with the actuary to develop guidelines for phasing in financial risk for PSNs. Any phase-in shall be converted to a risk-adjusted capitated premium as specified in state law.

VI. Accountability and Monitoring

The Agency will follow standard State contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all state and federal requirements. The Agency will specify monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted plans to enrollees. The overarching goal is to promote the health and well being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes, and promoting quality and cost-effective delivery of services. Other tenets of the Statewide Managed Medical Assistance program are as follows:

- Comprehensive transition requirements for implementing the program
- Increased stability among health plans
- Comprehensive transition requirements when plan changes are necessary
- Limits on the number of participating plans in the eleven regions
- Plan selection criteria
- Network adequacy
- Plan solvency
- Penalties for not completing a contract term
- Penalties for failure to comply with encounter data reporting requirements

A. Contracting Assurances

Provider Network Requirements

The State will require that all managed care plans ensure availability of services consistent with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206, that is, managed care plans will be required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected utilization of service.

In evaluating adequacy of networks for managed care plans, the State will consider the demographics of a community and availability of services locally. In geographic areas where there are a large number of Medicaid recipients, the State will require contracted plans to demonstrate access to an adequate network of health care providers serving that community.

In order to ensure access to necessary Medicaid services, the State is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks. The State will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the plans must maintain a panel of preventive and specialty care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population. Plans will be required to have providers available within reasonable travel and distance standards comparable to standards established by the State.

In addition, plans will be 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 State deems necessary. The provider database must be available online to both the Agency and the public and 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, if network adequacy standards are met, but must include providers classified by the Agency as “essential,” which shall include at a minimum:

- Federally qualified health centers,
- Statutory teaching hospitals as defined in state law,
- Hospitals that are trauma centers as defined in state law, and
- Hospitals located at least 25 miles from any other hospital with similar services.

The Agency will also identify statewide essential providers. These providers are to include:

- Faculty plans of Florida medical schools,
- Regional perinatal intensive care centers as defined in state law,
- Hospitals licensed as specialty children's hospitals as defined in state law, and
- Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Plans are required to negotiate in good faith with essential providers for one year and reimbursement rates for these essential providers are specified.

In addition to the essential providers and statewide essential providers, plans will be required to offer a network contract to each home medical equipment and supplies provider that meets quality and fraud and abuse prevention and detection standards established by the plan.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as a pharmacy option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate each plan’s pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

B. Plan Accountability and Performance Standards

The Agency will transition monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of formulary or preferred drug list on the plan’s website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures with results published on each plan website; accreditation within 1 year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification of the Agency of the impending

birth of a child to an enrollee. The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

Grievance and Appeals

The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.

- Maintains a State-level panel to hear appeals of grievances not resolved at the plan level.

- Preserves the Medicaid fair hearing process that requires each Medicaid managed care plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:

  - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
  - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the State takes action without the advance notice and as required in accordance with State policy consistent with Fair Hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated, and
  - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

C. Program Integrity

The State assures the Medicaid program integrity system will require each Medicaid MCO to comply with Section 1932(d)(1) of the Social Security Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State will prohibit any of the Medicaid MCOs from knowingly having a relationship with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the Medicaid MCO,
2. A person with beneficial ownership of 5% or more of the Medicaid MCO's equity,
3. A person with an employment, consulting or other arrangement with Medicaid MCO

for the provision of items and services that are significant and material to the Medicaid MCO's obligations under its contract with the State.

The Agency's Medicaid program integrity system will oversee the activities of Medicaid MCO enrollees, health care providers, MCO networks, and their representatives in order to prevent fraud or abuse, over-utilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of enrollees and to recover overpayments as appropriate. The State will refer incidents of suspected fraud, abuse, over utilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency, including the licensing agency and the Medicaid Fraud Control Unit of the Attorney General's office.

The program integrity system will require each Medicaid MCO to comply with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable.

The payments to each Medicaid MCO will be based on data submitted by the MCO and will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

D. Achieved Savings Rebate

To promote fiscal accountability, the Agency will establish an achieved savings rebate program. Under the program, the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5% of revenue shall be retained by the plan.
2. Fifty percent of income above 5% and up to 10% shall be retained by the plan, and the other 50% refunded to the State.
3. One hundred percent of income above 10% of revenue shall be refunded to the State.

Incentives are included for plans that exceed Agency defined quality measures. Plans that exceed such measures during a reporting period may retain an additional 1% of revenue.

E. Penalties and Sanctions

To ensure stability, the Agency will impose new penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25% of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 days notice to the Agency before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the agency is required to terminate all contracts with that plan in other regions.

If a plan that is awarded an "additional contract" to ensure plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

If the Agency terminates a contract with a plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medication needs, and existing provider or care relationships.

The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes, the Agency will assess a daily fine for each day of non-compliance beginning on the 31st day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

F. Quality Initiatives

Improved quality and performance has been a key component of the State's managed care strategy, and will continue to be a primary focus of the Statewide Managed Medical Assistance program.

Quality and performance measurement will play a primary role in the selection of managed care plans during the procurement process in the Statewide Medicaid Managed Care program. Accreditation by a nationally recognized accrediting body, the organization's record in achieving specific quality standards, and the organization's documented commitment to quality improvement will be among the criteria for selection.

Once contracts are finalized, quality oversight will exist on two levels: at the Agency and at individual managed care plans. The Agency has a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans to their enrollees. This strategy targets overall system improvement and specifies the steps the Agency will take to hold plans accountable for on-going quality:

- Coverage and authorization of services
- Systems performance
- Clinical outcome measures
- Enrollee satisfaction
- Provider satisfaction
- Provider access and timeliness of care
- Network adequacy
- Performance improvement projects
- Quality improvement indicators
- Care coordination and continuity of care
- Timeliness of handling complaints and grievances
- External quality review
- Evaluation of disease management programs

Reporting requirements by the contracted plans as a component of the quality strategy including, but are not limited to:

- Enrollment and disenrollment
- Enrollee information
- Provider network
- Encounter data
- Grievances and appeals
- Financial reporting
- Child health check-up (a.k.a. EPSDT)

The Agency assures CMS that it complies with Section 1932(c) of the Act and 42 CFR 438.200, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions.

The managed care plans are currently required to develop and document a Quality Improvement Plan (QIP) that guides the efforts that will be taken at the managed care plan level to improve quality in both clinical and non-clinical areas of operation. As part of the Statewide Medicaid Managed Care program plan, the QIP will be required to include enrollee satisfaction and disenrollment surveys. The Agency reviews and approves the managed care plans' QIPs.

Managed care plans are currently required to report annual audited performance measures that include both HEDIS (Healthcare Effectiveness Data and Information Set) and HEDIS-like, or Agency-defined, measures, and this reporting will continue under the Statewide Medicaid Managed Care program.

A key component is continuous improvement. Below highlights select measures which demonstrate recipient improvements. These measures target both preventive and illness-based care and include measures for special populations such as recipients of behavioral health care services and enrollees with HIV/AIDS. The Agency re-assesses the list of required measures annually to comply with any changes to HEDIS made by the National Committee for Quality Assurance (NCQA) and to ensure that the list optimally targets key priorities for managed care in Florida.

All Florida Medicaid managed care plans have been required to report an array of HEDIS and HEDIS-like performance measures, beginning in 2008 (reporting year 2007). The performance for the demonstration plans and the non-demonstration plans has steadily improved overall with demonstration plans outperforming non-demonstration plans on most measures. In 2009, all demonstration plan performance measures improved with the exception of one plan and the demonstration plans out-performed non- demonstration plans in 20 of 27 reported measures.

In 2010, notable results included an 18.3% increase in Annual Dental Visits over the course of the demonstration. Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3. Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.

The Agency will develop or adopt additional performance measures in response to features of the Statewide Medicaid Managed Care Program to promote quality of care. When possible, established measures with available benchmark data, such as HEDIS, will be preferentially selected. Public input will be sought on the selection, adoption, and development of new and on-going measures. Managed care plans will be required to publish their results on their plan

websites. The existing list of performance measures required for Florida health plans can be viewed on the following webpage: http://ahca.myflorida.com/medicaid/quality_mc/index.shtml. Managed care plan performance measure results are available for public viewing on the Agency's website, http://www.floridahealthfinder.gov/. In turn, managed care plans will be required to set performance standards for their network providers and determine continued network participation based on achievement with those standards. See Appendix A for additional information on performance measures.

In an effort to improve quality of care, the Agency adopted high standards, as defined by the NCQA National Means and Percentiles, as the performance target for each of the HEDIS measures that health plans are required to report. The strategies adopted by the Agency aim to bring the statewide level of performance in line with that performance target. To accomplish this goal, the Agency will require the development of a strategy that requires managed care plans to develop corrective action plans to address deficient scores. Failure to comply with the terms of their internally developed corrective action plans or failure to improve scores to minimal levels as set by the Agency will result in monetary sanctions. The Agency will also develop an incentive program to reward higher performing health plans. Such incentives may include additional auto-assignments each month and a financial incentive payment to encourage continual improvement.

Under the existing managed care program, plans are required to conduct Performance Improvement Projects (PIPs) in four content areas, as specified in contract: 1) clinical behavioral health; 2) cultural competence or health disparities; 3) a statewide collaborative PIP facilitated by the External Quality Review Organization (EQRO); and 4) an area of deficiency selected by the health plan. PIPs must be conducted in compliance with the Centers for Medicare and Medicaid Services protocol for conducting performance improvement projects. Under the Statewide Medicaid Managed Care program, PIPs will continue to be required, although the specific content areas may change, particularly to accommodate the addition of PIPs.

Managed care plans must participate in the activities of the EQRO, which include validation of performance measures, validation of performance improvement projects, and reviews of compliance with standards. The current EQRO contract will expire on December 31, 2012. The new contract will be selected through competitive procurement and will contain provisions related to the Statewide Medicaid Managed Care Program.

All capitated health plans, as well as fee-for-service PSNs that are capitated for transportation, must submit encounter data to the Agency that reports services provided to enrollees under the contract. Data must be reported in a HIPAA-compliant X12 format and must meet minimum quality standards for processing through the state's Medicaid Management Information System. Non-compliant health plans can be assessed a penalty for failure to submit data accurately and timely.

The Agency will utilize encounter data to conduct quality of care studies and evaluations of services provided to recipients in the Statewide Medicaid Managed Care program. As the program is developed, the Agency will work with stakeholders to identify areas of particular interest for studies, but will include, at a minimum, studies regarding access to care, appropriateness of care, and fraud and abuse.

VII. Additional Programs

With the implementation of the Statewide Managed Medical Assistance program, the 1915(b) Manage Care Waiver will be terminated and the following programs, currently authorized under the 1915(b) Managed Care Waiver, will be transitioned to this waiver.

A. The Healthy Start Program
B. The Program for All Inclusive Care for Children
C. The Comprehensive Hemophilia Program

The transitioning of these programs to this waiver will ensure the continuation of services to the eligible recipients. A description of each program follows.

A. Healthy Start Program

Background

In 1991, the Florida Legislature passed the Healthy Start Initiative and created sections 383.14 and 383.016, F.S., which provided funding for a defined set of services targeted to reduce infant mortality and morbidity. The state-only funded Healthy Start program began operations in April 1992 with the goals of reducing infant mortality, reducing the number of low birth weight infants, and improving health and developmental outcomes.

In 2001, the Agency, in collaboration with the local Healthy Start Community Coalitions and the Florida Department of Health (DOH), developed a program to increase the number and intensity of services available to women receiving Medicaid. The Healthy Start program was amended into Florida's 1915(b) Medicaid Managed Care Waiver in June 2001. The program continues to operate under Florida's 1915(b) Managed Care Waiver that was recently renewed for the period February 1, 2012 through January 31, 2014. The Agency executed a memorandum of agreement with DOH, approved by the Centers for Medicare and Medicaid Services, to administer this program. DOH subcontracts with the Healthy Start Coalitions and specified County Health Departments for the provision of the program services. The Florida Healthy Start Coalitions were established in s. 383.016, F.S., which provides for the required membership, including consumers.

In 2011, Florida legislation was passed creating s. 409.975(4), F.S., under the Statewide Managed Medical Assistance program to require the Agency to contract with an administrative services organization (ASO) representing all Healthy Start Coalitions providing care coordination services in accordance with a federal waiver and Florida law. As the program transitions under this waiver, the Agency will contract with the ASO representing all Healthy Start Coalitions for the provision of services as described below and in accordance with this waiver.

Program Description

The Healthy Start program is comprised of the following two components:

- **MomCare**: includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is mandatory for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care,

Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, Medicaid coverage for the infant and the need to select a primary care physician for the infant.

- **Healthy Start Coordinated System of Care**: includes outreach and case management services for eligible pregnant woman and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to the age of 3 who are identified to be at risk for a poor birth outcome, poor health and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling. The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

The numbers of recipients served for State Fiscal Year 2010-2011 are as follows:

- 38,316 pregnant women,
- 9,604 infants birth to 1 year,
- 1,593 infants age 1 to 3 years, and
- MomCare through SOBRA Medicaid served 196,587.

The Healthy Start Coalitions operate under the direct oversight of Florida's Title V grantee (DOH). DOH monitor's the coalitions and specified county health departments to ensure compliance with all federal and state managed care regulations.

The Healthy Start program is available statewide for eligible Medicaid recipients. The following is a list of entities with which DOH contracts with for the provision of services as of January 2012.

Healthy Start Program List of Contracted Entities	
County	**Contracting Entity**
Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Putnam, Suwannee, Union	Healthy Start of North Central Florida, Inc.
Baker, Clay, Duval, Nassau, St. Johns	Northeast Florida Healthy Start Coalition, Inc.
Bay, Franklin, Gulf	Bay, Franklin, Gulf Healthy Start Coalition, Inc.
Brevard	Healthy Start Coalition of Brevard County, Inc.
Broward	Broward Healthy Start Coalition, Inc.
Calhoun, Holmes, Jackson, Liberty, Washington,	Chipola Healthy Start
Charlotte	Charlotte County Healthy Start Coalition, Inc.
Collier, Glades, Hendry, Lee	Healthy Start Coalition of Southwest Florida, Inc.
Citrus, Hernando, Lake, Sumter	Central Healthy Start, Inc.
Miami-Dade	Healthy Start Coalition of Miami-Dade, Inc.
Desoto	Desoto County Health Department
Escambia	Escambia County Healthy Start Coalition, Inc.
Flagler, Volusia	The Healthy Start Coalition of Flagler and Volusia

Healthy Start Program List of Contracted Entities	
County	**Contracting Entity**
	Counties, Inc.
Gadsden	Gadsden County-Healthy Start Coalition, Inc.
Hardee, Highlands, Polk	Healthy Start Coalition of Hardee / Highlands / Polk Counties, Inc.
Hillsborough	Healthy Start Coalition of Hillsborough County, Inc.
Indian River	Indian River County Healthy Start Coalition, Inc.
Jefferson, Madison, Taylor	Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc.
Leon, Wakulla	Capital Area Healthy Start Coalition, Inc.
Manatee	Healthy Start Coalition of Manatee County, Inc.
Martin	Martin County Healthy Start Coalition, Inc.
Monroe	Florida Keys Healthy Start Coalition, Inc.
Okaloosa, Walton	Healthy Start Community Coalition of Okaloosa and Walton Counties, Inc.
Okeechobee	Okeechobee County Family Health / Healthy Start Coalition, Inc.
Orange	Orange County Healthy Start Coalition, Inc.
Osceola	The Healthy Start Coalition of Osceola County, Inc.
Palm Beach	Healthy Start Coalition of Palm Beach County, Inc.
Pasco	Healthy Start Coalition of Pasco County, Inc.
Pinellas	Healthy Start Coalition of Pinellas County, Inc.
Santa Rosa	Healthy Start Coalition of Santa Rosa County, Inc.
Sarasota	Healthy Start Coalition of Sarasota County, Inc.
Seminole	Seminole County Health Department
St. Lucie	Healthy Start Coalition of St. Lucie County, Inc.

B. Program for All Inclusive Care for Children

Background

In October 2000, Florida was one of five states identified in federal proviso and selected by the Centers for Medicare and Medicaid Services and Children's Hospice International (CHI) to participate in developing a Program for All-Inclusive Care for Children (PACC). The intent of the PACC model is to provide pediatric palliative support services to children with life-threatening conditions from the time of diagnosis throughout the treatment phase of their illness.

In 2005, the PACC was amended into Florida's 1915(b) Managed Care Waiver as a component of the Children's Medical Services (CMS) Network with the Florida Department of Health. Section 1915(b)(3) expenditures are authorized to provide pediatric palliative care services to children who are enrolled in the CMS Network and diagnosed with potentially life-limiting conditions. The pediatric palliative care services are provided in areas of Florida where the local licensed hospice provider has a pediatric palliative care program that meets current Children's Hospice International PACC Standards and Guidelines.

Program Description

The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP). Participation in the program is voluntary.

- Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.
- Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.
- Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.
- Hospice Nursing Services – Assessment, pain and symptom management, and in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.
- Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.
- Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

Bereavement and volunteer services are provided but are not reimbursable services.

A total of 1,315 children have received PACC services since the program began operating in 2005. The number of children receiving services as of April 2012 was 485. Enrollment in the program is capped at 940 children and services are provided on a fee-for-service basis to eligible participating hospice providers.

PACC services are currently available in 48 counties of the state. CMS Network is working with local hospice programs in the additional 19 counties to develop viable pediatric palliative care programs in those counties.

CMS Network - Program for All Inclusive Care for Children	
Regions	**Entity**
Region 1 – Escambia, Okaloosa, Santa Rosa, Walton	Florida Department of Health
Region 2 – Bay, Franklin, Gulf, Holmes, Jackson, Washington, Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla	Florida Department of Health
Region 3 – Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Levy, Lafayette, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, Sumter	Florida Department of Health
Region 4 – Baker, Clay, Duval, Nassau, St. Johns, Flagler, Volusia	Florida Department of Health
Region 5 – Pasco, Pinellas.	Florida Department of Health

CMS Network - Program for All Inclusive Care for Children	
Regions	**Entity**
Region 6 – Hardee, Highlands, Hillsborough, Manatee, Polk	Florida Department of Health
Region 7 – Orange, Osceola, Seminole (Brevard expansion Oct 2012)	Florida Department of Health
Region 8 – Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	Florida Department of Health
Region 9 – Indian River, Martin, St. Lucie, Okeechobee, Palm Beach	Florida Department of Health
Region 10 – Broward	Florida Department of Health
Region 11 – Dade, Monroe	Florida Department of Health

C. Comprehensive Hemophilia Disease Management Program

Background

In 2002, Florida legislation mandated the implementation of the hemophilia disease management program. The Centers for Medicare and Medicaid Services approved the inclusion of this program initiative under Florida's 1915(b) Managed Care Waiver in May 2003 for eligible recipients who were enrolled in the FFS system or a Medicaid managed care program, excluding HMOs. The program was geographically expanded statewide on April 1, 2008, for the specified populations, and on July 12, 2012, the program was expanded to include recipients enrolled in HMOs. The program provides a specialized service whereby eligible recipients who have a diagnosis of hemophilia or von Willebrand disease are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the two contracted vendors. In addition to product distribution, the contracted vendors provide a comprehensive disease management program to recipient enrolled in the program. The primary intent of the program is to allow for pharmaceutical management for Florida hemophiliacs, resulting in cost savings to the state.

Program Description

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the fee-for-service (FFS) system, the MediPass program, FFS provider service network (PSN), capitated PSN or an HMO, are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the two contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual

and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs from the therapeutic MOF Factor IX, and MOE-Antihemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand; are in the FFS system, MediPass program, FFS PSN, HMO or capitated PSN. Medicaid and Medicare dual eligible individuals may voluntarily enroll in the program.

As of July 2012**,** there were 209 recipients enrolled in the statewide program.

VIII. Budget Neutrality

Budget Neutrality Overview

The revised Budget Neutrality for Florida's pending Managed Medical Assistance (MMA) amendment to the 1115 Medicaid Reform Waiver is based on the expansion of specific recipient groups who are not currently eligible for enrollment in the waiver. These new populations have been assigned into two of the three established Medicaid Eligibility Groups (MEG) defined for the current 1115 Medicaid Reform Waiver:

MEG #1 – SSI Related
MEG #2 – Children and Families

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

With the MMA amendment populations' MEG assignments, the budget neutrality historical trends were updated to reflect the expanded case months and costs resulting in new projected PMPMs. The MMA amendment's historical trend covers Demonstration Year (DY) 3 – DY6 (SFY 2008-09 through SFY 2011-12). The MMA amendment's projected years cover DY9-DY11 (SFY 2014-15 through SFY 2016-17).

Transition of 1915(b) Managed Care Programs:

As noted under Section VII, the Healthy Start program, PACC and the Comprehensive Hemophilia Management program that currently operate under Florida's 1915(b) Managed Care Waiver will transition to this waiver. The Healthy Start and PACC program cost are defined as costs not otherwise matchable (CNOM) and these service costs will be funded from the MMA amendment's budget neutrality cost savings. For the Comprehensive Hemophilia Management program, the projected drug cost savings have been factored into the MMA amendment budget neutrality calculations.

Historic Trends Methodology

The first task towards updating Budget Neutrality for the MMA amendment was to identify the new eligible case months to be covered in the amendment. Florida law provides the Medicaid recipient populations who are eligible for the MMA program. This listing identifies those recipient eligibility and claim history factors that define a recipient's enrollment status under the MMA program as mandatory, voluntary or excluded. Refer to Section III of this document for the eligible and excluded populations for the MMA program.

A data algorithm was then constructed utilizing both Medicaid recipient eligibility and claims history. This algorithm was applied to all Medicaid recipient case months for the historical Demonstration Years (DY3-DY6). Each case month was designated as either mandatory, voluntary or excluded. For the MMA amendment Budget Neutrality calculations, only the mandatory population is included. Within this mandatory group, Medically Needy and Title XXI MediKid recipients are excluded from the calculations. The state is utilizing a "what if" model by applying the new MMA mandatory populations' eligibility criteria to the historical case months to identify what recipient months would have been enrolled if the MMA amendment had existed during those years. This provides a basis for generating the historic trend rates necessary to complete the Federal CMS Budget Neutrality template projections.

The resulting eligibility database is then cross-referenced with the current 1115 Medicaid Reform Waiver caseload for these same demonstration years. For CMS 64 reporting purposes, the state maintains an eligibility file that identifies the recipient case months that are eligible on a statewide basis for the current 1115 Medicaid Reform Waiver. These case month figures are identified in the Florida 1115 Medicaid Reform Waiver quarterly and annual progress reports. The resulting cross-referenced database can identify those specific historical case months that were not eligible under the current 1115 Medicaid Reform Waiver, but would have been eligible under the MMA amendment. With the MMA amendment case months identified, these recipient identification numbers (IDs) and eligible months are processed through Medicaid claim history to identify and aggregate their costs. The remaining task is to assign the MMA amendment case months and the costs into MEG 1 or MEG 2. This is done by recipient eligibility codes following the same principle of MEG 1 being SSI related and MEG 2 being children and families.

Table A: Amendment Impact on Trends

Table A provides the results from the above database exercise. Table A objective is to quantify the overall case month trends that will result from the inclusion of the MMA expansion and to quantify what the MMA amendment impact will be on case month mix and costs. Table A has three segments:

- The first segment identifies the caseload for the current 1115 Medicaid Reform Waiver. These annual case month figures are found in the 1115 Medicaid Reform Fourth Quarter Report for DY6 (see Table 31 on pages 50-51). The PMPMs are the PCCM Targets utilized for the current 1115 Medicaid Reform Waiver WOW calculations.
- The second segment identifies the annual MMA new population case months that would be covered under the MMA amendment along with their WOW costs.
- The third segment is an aggregate of both the current 1115 Medicaid Reform Waiver and the MMA new population figures. The resulting aggregate totals are then inserted into the Budget Neutrality Historic Data template for DY3-DY6 (Table B).

The core services to be covered under the state's 1915(b)(c) Managed Care Long-Term-Care (LTC) waiver are excluded from both the current 1115 Medicaid Reform Waiver and the MMA amendment Table A cost figures. These core services are nursing home care and home and community based services (Aged/Disabled Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver and Channeling Waiver). These home and community based services (HCBS) costs are excluded from this MMA amendment's Budget Neutrality. In addition, the excluded services from the 1115 Medicaid Reform Waiver are also removed from the new MMA population costs. This allows for a more consistent cost base when comparing these two populations.

MEG 1 Expanded Population Impact

The 1115 Medicaid Reform Waiver MEG 1 population will be significantly increased by the new MMA populations. As shown in Table A, the addition of the new MEG 1 eligibles doubles the size of the current 11115 Medicaid Reform MEG 1 case months. In addition, the MMA amendment MEG 1 population has a substantially lower PMPM cost (approximately 22% of the current MEG 1 PCCM targets). Under the 1115 Medicaid Reform Waiver, dual eligible (Medicaid/Medicare) recipients are not mandatorily enrolled in managed care plans, but can voluntarily enroll. With the MMA amendment, dual eligibles will be mandatorily enrolled in

managed care plans. These LTC service costs (nursing home care and HCBS waivers) represent approximately 88% of all the dual eligibles' Medicaid costs, with nursing home costs alone being 76%.

MEG 2 Expanded Population Impact

The current 1115 Medicaid Reform Waiver MEG 2 population will be impacted primarily by the new MMA population to include adoption subsidy and foster care children and SOBRA pregnant women. These recipient populations represent 64% of the new expanded MEG 2 case months, with SOBRA pregnant women being 44% and adoption/foster care children being 20%. The PMPM for these new populations are significantly higher than the current MEG 2 PCCM targets. The overall new MEG 2 PMPMs are identified in Table A and are approximately twice as much as the current PCCM targets. In particular, the SOBRA pregnant women population has a SFY 2010-11 PMPM of $777.60 compared to the current 1115 Medicaid Reform Waiver MEG 2 PCCM target of $271.39.

Table B: Historic Data Trends

This Federal CMS template utilizes the case month and expenditures identified in Table A. These figures calculate the case month trend rate for both the Without Waiver (WOW) and With Waiver (WW) projections. The template also calculates the costs per eligible trend rate for the WOW projection.

Table C: Without Waiver Projection

Based on the historic trend rates and Months of Aging, the WOW case months, expenditures and costs per eligible are projected for DY9-DY11. The 36 Months of Aging reflects the mid-point of DY6 through the mid-point of DY9.

Table D: With Waiver Projection

Both the WW and WOW utilize the same case month projection. The first step for calculating the WW PMPM is a continuation of the projection from the previous Budget Neutrality submitted in the MMA amendment on August 1, 2011. This previous projection covered DY6-DY8. The same August 1, 2011 projection equation is now extended to cover DY9-DY11. Table E is included to show the extension of the previously submitted August 1, 2011 WW projection. Table E projected PMPMs are identified in Table D in the row labeled: Total Cost Per Eligible (Continuation of August 1, 2011 Projections).

The second component for calculating the WW PMPM is a weighted adjustment factor to account for the new case month mix resulting from the MMA amendment. At the bottom of Table A, there are a set of MEG 1-MEG 2 annual figures that are a ratio of the combined programs' PMPMs to the current 1115 Medicaid Reform Waiver PMPMs. These ratios are averaged over the four years. This weighted PMPM adjustment factor is identified as 55.18% for MEG 1 and 109.55% for MEG 2. These weighted ratios provide a method for adjusting the current 1115 Medicaid Reform Waiver WW projected PMPMs to account for the impact of the new MMA populations. These adjustment factors are applied to the WW projections in Table D.

An adjustment is also added to Table D to identify projected cost savings that will occur in the WW projected years (DY9-DY11). This cost savings will result from the operation of the Comprehensive Hemophilia Management program vendor contracts that went into effect July 1,

2012 of DY7. The Table D cost savings figures identify the 25% drug price discount for the specified hemophilia related drugs covered in these vendors' contracts. These are cost savings that will not be realized in the WOW projections. Table F identifies the historic trends and projected the saving calculations of the Comprehensive Hemophilia Management program.

Table G and H: Summary of CNOM Impact

Tables G and H are provided to demonstrate how the two CNOM programs' projected expenditures for DY9-DY11 were calculated. The Budget Neutrality summary identifies that the MMA amendment savings will be adequate to sustain these CNOM programs.

Budget Neutrality Summary

An overall Budget Neutrality summary is provided at the bottom of Table D. A specific table reference is provided to identify where each of the individual figures is calculated. The table calculations presented herein result in a determination that the MMA amendment will be Budget Neutral.

Appendix A
Performance Measures and Outcomes

The following is an overview of select measures regarding the impact of the

demonstration. Performance Measures

Medicaid Reform health plans are required to submit an extensive list of quality indicators (HEDIS and HEDIS-like) that measure plan performance on both preventive and illness care. Select successes from the 2010 submission include:

- Annual Dental Visit, a measure that is particularly challenging for most health plans, achieved an 18.2% increase over the course of the demonstration with a 4.9% increase over the past year.

- Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3.

- Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.

- Strong performance continued for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.

In addition to requiring the calculation and submission of the performance measures, the Agency requires that health plans operate continuous quality improvement programs. The measures submitted this year are subject to new contract terms that require formal interventions for all measures scoring below the 50th national percentile. If the interventions fail to improve the measures, sanctions may be assessed in response to the 2011 performance measure submission.

Satisfaction

The key findings of the patient satisfaction survey results are highlighted below.

Key Findings

- Enrollee satisfaction for most indicators remained stable or increased slightly (including specialty care ratings, emergency room visits, communication, courtesy and respect of staff) and showed little if any change from benchmark measures taken prior to demonstration through the first three years of implementation.

- In some areas, statistically significant changes were observed. There was an upward change in satisfaction with recipient's personal doctor and with getting needed care.

- This upswing indicates an increase in satisfaction at the point of care.

Appendix B
Florida Medicaid Program

1. The Florida Medicaid Program

In 1965, the federal Social Security Act was amended to establish two major national health care programs: Title XVIII (Medicare) and Title XIX (Medicaid). If a State chooses to participate in the Medicaid program, the State is then obligated to provide services to all individuals who are eligible for the program. Federal Medicaid laws and regulations mandate certain benefits for certain populations and States must administer their programs in accordance with federal regulations and laws.

The State operates the program under a State plan approved by the federal Centers for Medicare and Medicaid Services, which can be thought of as a contract. To participate, States are required to cover certain mandatory populations and services, while federal matching funds are available if a State chooses to cover other optional populations and services. A State cannot limit the number of people its Medicaid program will serve, and cannot limit provision of medically necessary covered services to enrollees based on budgetary constraints.
The Florida Medicaid program currently serves more than 3.1 million recipients and total appropriation for the program for State fiscal year 2011-2012 is $21.2 billion. Medicaid covers low-income pregnant women, children and disabled adults.

2. Florida Medicaid Delivery Systems and Program Enrollment

Since its inception, the Florida Medicaid program has evolved into a complex model with a collection of programs, waivers, and delivery systems through which recipients receive care. These delivery systems for covered medical services include FFS, primary care case management (offered in Florida through the MediPass program), or managed care under a capitated HMO or a FFS or capitated PSN.

The Florida program was established as a FFS program in 1970, and the first Medicaid managed care plan was established in 1984. MediPass, the primary care case management (PCCM) program, was established in 1991 and several other changes have also been implemented in care management and delivery in the last two decades.

The implementation of the Statewide Medicaid Managed Care System will serve to streamline these varied systems into a more comprehensive program and is anticipated to create an integrated delivery system available throughout the State.

Fee-For-Service

The FFS system is operated under the federally approved State plan. The FFS system serves those Medicaid recipients who are not eligible for or enrolled in a managed care program. As a result of the passage of HB 7107, the vast majority of enrollees will have to select a plan. As of June 1, 2011, there were over 939,000 recipients receiving services through the FFS system. These recipients include those who are eligible for limited or diagnosis specific services such as services related to pregnancy, or a diagnosis of breast or cervical cancer, the dual eligible population (those who are eligible for both Medicare and Medicaid), the Medically Needy populations, individuals in institutional settings, and those who are newly eligible for Medicaid but who have not yet enrolled in a health plan. While most individuals will enroll in a contracted

plan under the Statewide Managed Medical Assistance program, the State will continue to maintain a FFS program to provide services to excluded individuals and to recipients newly eligible for Medicaid who are in their choice period that occurs before enrolling into a contracted plan.

MediPass is the Florida Medicaid primary care case management program. The State established the MediPass program in 1991 and expanded the program Statewide in 1996. MediPass is operational in 62 counties outside of the demonstration counties (Medicaid Reform). MediPass providers (physicians, ARNPs, and physician assistants) are paid a $2.00 monthly case management fee. Medicaid pays for services provided to MediPass members on a FFS basis. As of June 1, 2011, there were 611,864 recipients receiving services through the MediPass program. Under the Statewide Managed Medical Assistance program, individuals currently enrolled in MediPass will be required to select and enroll in a plan.

Managed Care

The managed care delivery systems, including capitated plans and FFS PSNs, are currently operated under two waivers: (1) The 1915(b) Managed Care Waiver or (2) the 1115 Medicaid Managed Care Pilot (Reform) Waiver. The Reform waiver is operational in five counties, including Baker, Broward, Clay, Nassau and Duval counties.

A PSN is defined in section 409.912 (4)(d), Florida Statutes, as an integrated health care delivery system owned and operated by a health care provider, or group of affiliated health care providers which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers. PSNs are reimbursed on a FFS basis, with shared savings, or prepaid (capitated) basis. As of June 1, 2011, there were six PSNs serving 221,853 recipients in both Reform and non-Reform counties. Under the Statewide Managed Care program, PSNs will be eligible plans to participate in both the Long Term Care Managed Care program and the Managed Medical Assistance Program. Specifically, the State is required to contract with at least one PSN, in each region, for both program components, if a qualified PSN submits a response to the invitation to negotiate in the region. As a result, PSN contracting and contract monitoring will increase with the potential of more than 22 PSN contracts.

A HMO is an entity licensed under Chapter 641, Florida Statutes. The State contracts with HMOs on a prepaid fixed monthly rate per member (e.g., capitation rate) for which the HMOs assume all risk for providing covered services to their enrollees. As of June 1, 2011, there were 19 HMOs serving 1,135,892 recipients in both Reform and non-Reform counties. Under the Statewide Medicaid Managed Care program, HMOs will be eligible plans to participate in both the Long Term Care Managed Care program and the Statewide Managed Medical Assistance program. HMO contracting and contract monitoring is expected to increase significantly, with the potential for 30-53 contracts for Statewide Managed Medical Assistance program and an additional 30-53 contracts for the Long Term Care program.

a) Demographics of Enrollment – By Delivery System

In general, most children and adults who are fully eligible for Medicaid are currently required to enroll in some form of managed care to receive medical services. For those in counties operating under Florida's 1915(b) Managed Care Waiver, this means they must enroll in an available managed care program which currently includes either a capitated HMO, a PSN, or the MediPass program. For those in counties operating under the 1115 Research and

Demonstration Waiver (Baker, Broward, Clay, Duval, and Nassau), this means they must be enrolled in either an HMO or a PSN. MediPass is not an option for demonstration enrollees.

The following Medicaid recipients are currently excluded from enrolling in a managed care program: Medically Needy recipients, aliens receiving emergency assistance, recipients enrolled through the breast and cervical cancer program, recipients enrolled in the family planning waiver, recipients in institutional settings, recipients receiving hospice services, and recipients residing in facilities operated by the Department of Juvenile Justice and the Department of Children and Families (including the Family Safety and preservation program and substance abuse and mental health residential treatment programs).

Elderly recipients who reside in a nursing home are not currently required to enroll in managed care to receive medical services.

b) Demographics of Enrollment-By Eligibility Type

In general, Medicaid enrollment can be broadly categorized as being made up of three main groups:

- The TANF population (Temporary Assistance for Needy Families), which generally includes low income children and their families,
- The SSI population (Supplemental Security Income), which generally includes the disabled, and
- The dually eligible population, which includes the disabled elderly and the poor elderly who also receive Medicare benefits who are also eligible for Medicaid.

The TANF population is most impacted by the economy, and TANF enrollment makes up a majority of program enrollment and thus follows general enrollment trends. Overall, Medicaid enrollment in Florida is estimated to have increased by more than 44% from the 2005-2006 fiscal year through the 2011-2012 fiscal year. TANF enrollment will have increased, during that same period, by 37%; SSI enrollment by 23% and Dual enrollment by 37%. Table 1 provides an overview of Medicaid eligibility for these groups during this period.

Table 1: Average Monthly Florida Medicaid Enrollment – By Eligibility Group

Average Monthly Florida Medicaid Enrollment - Breakout of SSI and TANF				
Fiscal Year	TANF Enrollment	SSI Enrollment	Dual Eligibles	Total Enrollment
FY 2005-06	1,256,264	502,395	482,624	2,204,481
FY 2006-07	1,165,000	519,000	486,962	2,112,000
FY 2007-08	1,131,574	531,433	498,870	2,148,705
FY 2008-09	1,272,284	551,405	531,246	2,398,613
FY 2009-10	1,500,811	574,345	569,631	2,718,524
FY 2010-11	1,633,066	598,381	616,355	2,937,573
FY 2011-12	1,726,785	621,300	664,057	3,191,710

TANF Source: Medicaid Services Eligibility Subsystem Reports. Caseload includes TANF and SOBRA Children

SSI and Total Enrollment Source: Medicaid Services Eligibility Subsystem Reports.

c) Florida Medicaid Managed Care Penetration

Currently, approximately 43% of the total Medicaid population is enrolled in either a HMO or a PSN. It should be noted that the "total Medicaid population" includes individuals currently ineligible for enrollment into managed care. Table 2 on the following page provides Florida Medicaid enrollment by managed care delivery model as of June 1, 2011.

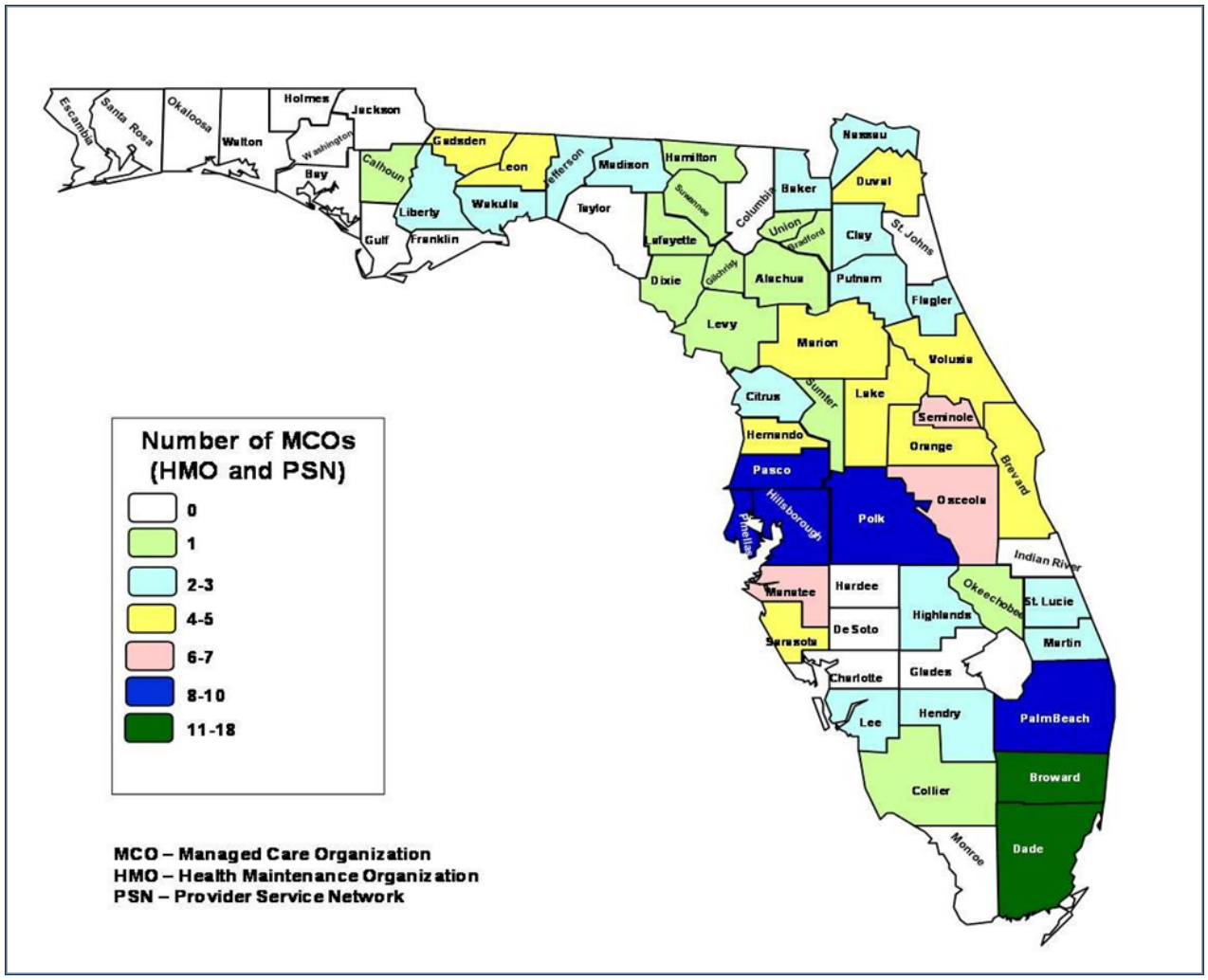
Table 2: Florida Counties with Managed Care Health Plans – June 1, 2011

Florida Counties with Managed Care Plans – By Plan Type – June 1, 2011		
Plan Type	**Number of Florida Counties**	***Total Enrollment***
Capitated PSN	29	79,271
Capitated Non-Reform HMO	35	981,159
FFS PSN	6	142,583
Capitated Reform HMO	5	154,733
	Total unduplicated Counties: 48	***Total plan enrollment: 1,357,746***

Florida Counties with Managed Care Plans (HMO and PSN) – June 1, 2011	
Total Unduplicated Counties with Health Plans Currently In Operation	48 Counties
Total Unduplicated Counties with No Health Plans Currently in Operation	19 Counties

Figure 3 on the following page illustrates the distribution of health plans by Florida County. Note: Although PACE plans are not included for the purposes of this figure, they are in operation in Lee, Miami-Dade, Pinellas, and Charlotte counties.

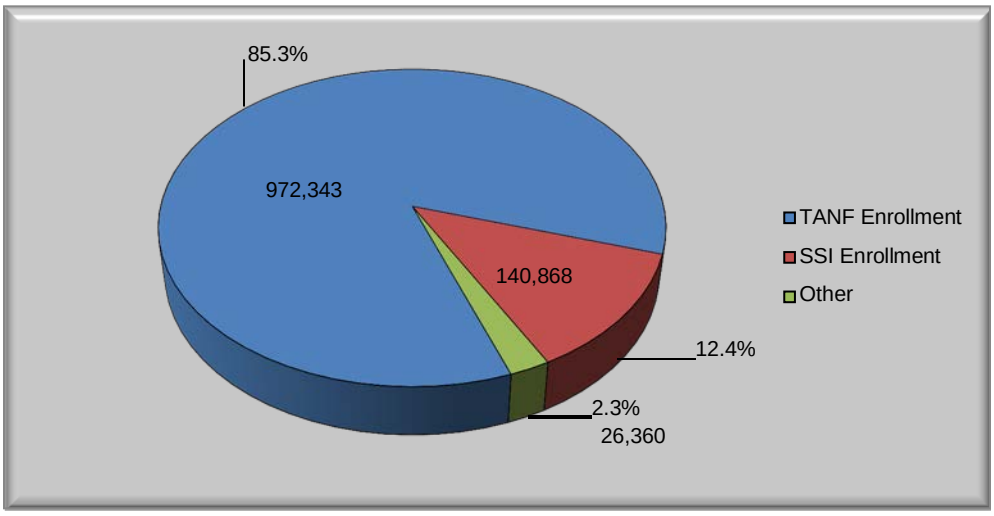
Figure 3: Managed Care in Florida Medicaid By County as of June 1, 2011



With full implementation of the Statewide Medicaid Managed Care program, it is anticipated that nearly 85% of the total Medicaid population will be enrolled in the Statewide Managed Medical Assistance program.

Under the current Medicaid program, the majority of HMO and PSN enrollees are TANF eligibles, with a smaller percentage being SSI eligible. Currently, 87% of managed care eligibles are TANF and 13% are SSI. Figure 4 on the following page reflects the distribution of TANF and SSI eligibles within HMOs and PSNs for June 1, 2011.

Figure 4: June 1, 2011 Medicaid Managed Care Enrollment – By Eligibility Type



It is anticipated that the number and proportion of SSI enrollees in managed care will increase once the Statewide Medicaid Managed Care program is fully implemented. The TANF population will look very similar to the recent trend with a majority enrolled in managed care. With the addition of SSI populations and the dually eligible population to managed care, a greater proportion of the overall managed care population will consist of SSI and dual eligibles in the future.

Appendix C
Children's Medical Services Network

The Children's Medical Services (CMS) Network

Purpose of the CMS Network

The CMS Network is Florida's Title V Program for children with special health care needs. It is a State program located in the Department of Health and operates under Chapter 391, Florida Statutes. Its purpose is to develop and procure a comprehensive and coordinated Statewide system of medical and health-related services for children with special health care needs. The eligible children are defined as those children under age 21 whose serious or chronic physical, developmental, behavioral or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children, Section 391.02 FS.

Structure of the CMS Network

The State program is comprised of a central office and 22 local offices organized in eight regions. The functions of the central office are:

- Contract management
- Pharmacy Benefit Management (Title XXI only)
- Policy development
- Quality assurance and development of program standards
- Selection of regional and Statewide programs and provider networks
- Centralized and automated credentialing
- Centralized claims processing
- Financial management
- Data analysis
- Maintenance of technology systems
- Enrollment file management
- Training and technical assistance
- Statewide clinical review and recommendation teams
    - Physician peer review
    - Drug utilization review
    - Medical procedures and equipment
- HEDIS reporting and evaluation

The functions of the local offices are:

- Clinical eligibility determination (financial eligibility determination is conducted through Florida's systems for Medicaid and CHIP eligibility)
- Recruitment and retention of providers (over 11,000 providers, 110 facilities, home health agencies, etc.)
- Utilization management
- Care coordination (nurses and social workers)
- Transition planning
- Staffing specialty satellite or telemedicine clinics
- Member services and enrollment assistance (selection of primary care provider)

- Outreach and activities to encourage continued participation in the program
- Family to family support

Clinical and Financial Eligibility

Children are screened clinically using a tool that addresses a combination of diagnoses, functional status and health care needs, and utilization. The child must have a medical, behavioral, or developmental health condition that has lasted or is expected to last at least 12 months, or be in foster care. CMS Network is also the lead agency for Part C of the Individuals with Disabilities Education Act. Any infant and toddler under the age of 3 who meets the developmental criteria for this program are clinically eligible for the CMS Network.

Children who qualify for Title XIX or XXI are financially eligible for the CMS Network. Financial eligibility is determined through the Florida KidCare application or Medicaid financial determination processes. The KidCare application and Medicaid Choice Counseling have screening questions that trigger referral to CMS Network for clinical screening. If special health care needs are identified or suspected the family is provided with the necessary information to contact CMS Network for further information and clinical eligibility screening. There is no requirement that the family must contact CMS Network and there is no mandatory assignment for children with special health care needs. Once eligibility is determined the family must select CMS Network and enroll through the Agency for Health Care Administration Choice Counseling system.

Benefits

A multidisciplinary approach to the provision of services is important and required to meet the needs of both the child and the family.

The continuum of care includes prevention and early intervention programs, primary care, medical and therapeutic specialty care, and long term care for medically complex or fragile children and high-risk pregnant women. Long term care services include medical day care, medical foster care, nursing home care and in-home care.

Children in the CMS Network receive, at a minimum, the Medicaid benefit package and care coordination. Care coordination is provided by a CMS Network Nurse Care Coordinator whose role is that of integrating all of the elements of each child's life related to his/her special health care needs, in coordination with the primary care physician and the family. The Care Coordinator is a critical link in obtaining the appropriate clinical care and services, social and emotional development of the child within the context of their family, school and community, and is integral for the development of a true medical home environment for the child and family.

State law authorizes CMS Network to offer additional benefits for early intervention services, respite services, genetic testing, genetic and nutritional counseling and parent support services, if such services are determined to be medically necessary and are subject to the availability of funds. These services are not covered by the Florida Medicaid program, but are covered through funds available in the CMS Network (general revenue, maternal and child health block grant funds, etc.).

Provider Requirements and Structure

CMS Network uses NCQA criteria as its baseline for its credentialing activities. An on-line application process is available to providers who are interested in participating in the CMS

Network. Physician providers must be licensed in Florida and board-certified.

CMS Network focuses on the medical home in the child's community. In 12 areas of the State CMS Network contracts with non-profit corporations to recruit primary care providers and offer EPSDT case management. CMS Network also recruits available specialties and supports in the communities, including dental care, mental and behavioral health care, pediatric palliative care and transition from pediatrics to adult care. However, CMS Network selects and approves regional programs based on national or state standards. These include centers focusing on hematology/oncology, diabetes/endocrine issues, craniofacial/cleft lip and cleft palate, cardiac, pulmonary, Children's Comprehensive Kidney Failure Center, sickle cell, brain and spinal cord injury, medical foster care, pediatric HIV-AIDS, genetics, transplantation, regional perinatal intensive care centers, etc.

Services are offered in hospitals, outpatient settings and community based settings, including a child's home based on the nature of the service. Services are prior authorized by nurses and, as appropriate, by the CMS Network Medical Director.

If a child needs a service that is not available in the community, the Statewide network of providers is available to the child. In addition, children are evaluated for out-of-state services when such services may not be available in Florida.

CMS Network and Medicaid Reform

Under Medicaid reform, CMS Network has been designated as a specialty plan for children with special health care needs. In the Medicaid reform counties, the CMS Network central office contracts with local Integrated Care Systems (ICS) who work in partnership with the local CMS Network offices to provide for the needs of enrolled children. The responsibilities of each entity are delineated in a formal care coordination plan.

The local CMS Network office is responsible for clinical eligibility determination and annual redetermination, care plan development, care coordination with the Care Coordinator serving as the primary liaison at the local level between the CMS Network program, the ICS, the family and the child's service providers, health education, social work services and counseling, family support and transition support. Specialty clinics and the use of telemedicine are utilized as necessary to meet the multi-disciplinary and multi-specialty needs of enrolled children.

The lCS is responsible for physician recruitment, network management, credentialing and/or contracting, provider services, authorization for services, claims payment, utilization review, quality management, complaint and grievance resolution, behavioral health services and transportation in addition to the other Medicaid State Plan services.

Additionally, the local CMS Network offices and the ICSs have a multi-disciplinary review process to ensure that the child is receiving the most appropriate, medically necessary services based upon their individual needs.

The program operates through a shared savings arrangement. CMS Network has consistently demonstrated savings through its reform arrangements and meets or exceeds HEDIS measures and patient satisfaction measures.

In areas where there is not a current ICS relationship, the CMS Network local office is responsible for all program components.

Evaluation

CMS Network consistently meets or exceeds HEDIS child health measures used by Medicaid for this population. In addition, CMS Network has used CAHPS since 1998 to evaluate family satisfaction and other measures. There is a high degree of satisfaction with the CMS Network and, as mentioned above, CMS Network has continued to demonstrate savings.

Appendix D
Plan Transition Process

The State's mission is to ensure quality care is provided to Florida's residents. The primary goal of the transition to the new contracted plan will be to ensure continuity of care for all affected enrollees. The following is a summary of the processes and requirements established in state law that will enable the State to reach this goal.

DETAILED PLAN TRANSITION PROCESSES

The State will carefully plan the transition of the affected enrollees into other plan. To ensure continuity of care of affected enrollees upon enrollment in a new plan and to assist them through the choice process, the State follows a multi-layered approach:

- Assessing the capacity of the new contracted plans to ensure all impacted enrollees have access to quality care.
- Requiring the existing health plan to provide a listing of members' primary care providers (PCPs) to facilitate the transition into a new contracted plan that also includes the PCP.
- Requiring the existing health plan to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new contracted plan.
- Working with the new contracted plans and the State's or State's designated contractor to create staggered transition dates will ensure that the number of recipients being transitioned occurred in an organized manner.
- Working with the new contracted plans, the State or the State's designated contractor, local area staff, and advocacy groups will ensure appropriate and timely notice to enrollees, including the development and release of flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.
- Working with the new contracted plans to supply PCP and service information will ensure continuity of care and minimize disruption to the recipients, including reviewing the existing plan's provider network to determine which PCPs are available in the new contracted plans.
- Assisting PCPs unique to the existing plan through the Medicaid provider enrollment process to facilitate the PCPs enrollment in new contracted plan networks.
- Conducting weekly calls with the Florida Medicaid Area Offices, Medicaid Contract Management, and the State's or State's designated contractor will ensure all issues are resolved in a timely manner.

The State's or State's designated will station choice counselors in the Medicaid Area Offices to assist enrollees in their choice of a new contracted plan. These choice counselors may conduct special face-to-face choice counseling sessions specifically geared to transition enrollees.

ENROLLEE NOTIFICATIONS

For the transition to the new contract plans and if a contracted plan leaves a region early, enrollees will be given written notification of the change and an opportunity to select a new contracted plan. The member notices will include the date on which the existing health plan will no longer participate in the State's Medicaid program and instructions on contacting the State's or State's designated contractor's toll free help line to obtain information on enrollment options and to request a change to a new contracted plan.

If an affected enrollee selects a new contracted plan 30 days prior to transition date, the State will send a letter confirming the effective date of enrollment into the new contracted plan.

If the affected enrollee doesn't select a new contracted plan 30 days prior to transition date, the State will send a letter to the enrollee with information on the new plan enrollment and how to contact the State's or State's designated contractor's toll free help line to request a change to another contracted plan prior to the enrollment effective date.

All impacted beneficiaries will be given 90 days after enrollment in the new contracted plan to select another contracted plan without cause.

OVERVIEW OF CONTRACTED PLAN TRANSITION REQUIREMENTS

When a contracted plan decides to withdraw from a demonstration county, the plan will be required to provide written notice to the State at least 180 days prior to the anticipated effective date and must cease community outreach activities. The contracted plan will be required to work with the State to ensure a smooth transition for enrollees. The State's model contract will allow the State to extend the termination date depending on the number of plan enrollees affected. In addition, 60 days prior to the withdrawal date, the State will halt enrollment of new members into the plan.

By contract, to ensure continuity of care, health plans will be contractually required to honor prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first. Prearranged covered services may include provider appointments, surgeries, and prescriptions. For covered behavioral health services, this policy will be extended for up to three months.

To ensure stability, the State will impose new penalties for the contracted plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the State for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks will be required to pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another contracted plan, whichever occurs first. In addition to payment of costs, all other plans will be required to pay a penalty of 25% of the minimum surplus requirement pursuant to state law. The contracted plans will be required to provide at least 180 days notice to the State before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the State will be required to terminate all contracts with that plan in other regions.

For plans that are awarded an “additional contract”, to ensure plan participation in Regions 1 and 2, the plan will be subject to penalties pursuant to state law for activities in Region 1 or Region 2, The additional contract will automatically be terminated 180 days after the imposition of the penalties. The plan will be required to reimburse the State for the cost of enrollment changes and other transition activities.

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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Mission Statement
Better Healthcare for All Floridians.