Florida Managed Medical Assistance Program

(Project Number 11-W-00206/4)

5-Year Waiver Extension Request

Extension Period: July 1, 2017 - June 30, 2022

1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration

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Managed Medical Assistance Program

Historical Overview:

Requirement: *A historical narrative summary of the demonstration project.*

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes (F.S.), directing the Agency for Health Care Administration (Agency) to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: The Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program.

The State submitted an amendment request to the Centers for Medicare and Medicaid Services (CMS) to amend the 1115 Reform Waiver to implement the MMA program. The State received approval from CMS on June 14, 2013 to terminate the Medicaid Reform program, implement the Managed Medical Assistance (MMA) program, and rename the waiver "Managed Medical Assistance". The Medicaid Reform program was terminated on August 1, 2014. On July 31, 2014, the State received approval from CMS to extend the MMA Waiver for the period July 31, 2014 through June 30, 2017. See Attachment I for an overview of the MMA program.

Requirement: *Objectives set forth at the time the demonstration was approved.*

The State is submitting a five-year waiver extension request to CMS for Florida's 1115 MMA Waiver to continue building upon the success of the MMA program and the following program objectives:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration improves care for Florida Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The State provides oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set (HEDIS) scores), by expanding the Florida Medicaid managed care program statewide and competitively procuring plans on a regional basis the State is able to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Florida Medicaid recipients in managed care except those specifically exempt due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low- income populations in the State by targeting Low Income Pool (LIP) funding to reimburse uncompensated care costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the Healthcare Financial Management Association principles.

  Section II, Demonstration Goals, details how the State has worked towards meeting these objectives and highlights of the overall success of the MMA program.

Waiver and Expenditure Authority:

Requirement: *If changes are requested, a narrative of the changes being requested along with the objective of the change and the desired outcomes.*

The State is not proposing any substantive changes in the extension of the MMA Waiver. The State is requesting that the current waiver and expenditure authorities granted by the CMS on October 12, 2016 (and as specified in the Special Terms and Conditions (STCs)) be continued during the waiver extension period for the following programs:

- The MMA program
- The LIP program
- The Healthy Start program
- The Program for All Inclusive Care for Children
- The Comprehensive Hemophilia program

The current approved STCs can be found on the Agency's Web site at the below link:

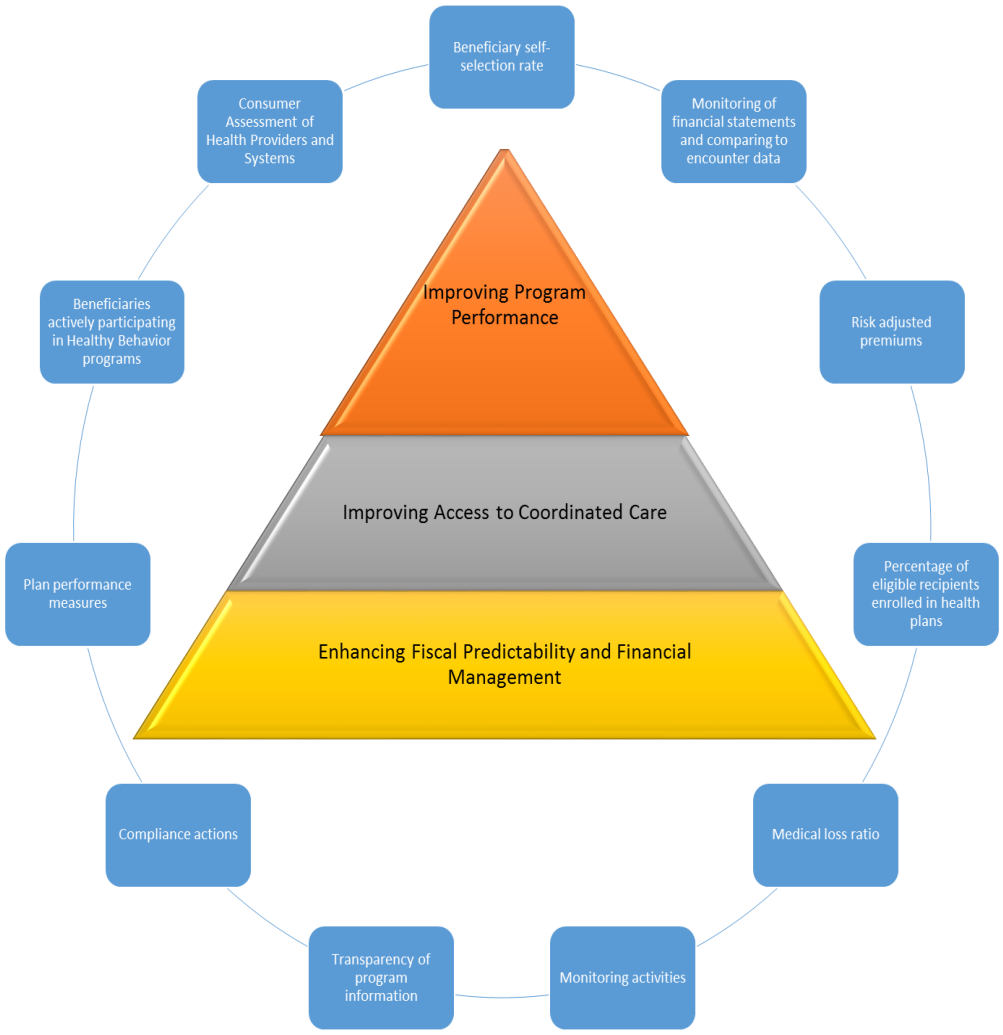
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

Note: The State received extensive comments from the public during the public comment period as outlined in Attachment IV. Consequently, the State has included the continuation of the LIP program in this extension request.

Demonstration Goals

***Requirement**: Evidence of how these objectives have or have not been met, and the future goals of the program.*

The MMA program improves health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. This is achieved through care coordination, patient engagement in their own health care, enhancing fiscal predictability and financial management, improving access to coordinated care and improving overall program performance.



Enhanced Fiscal Predictability and Financial Management

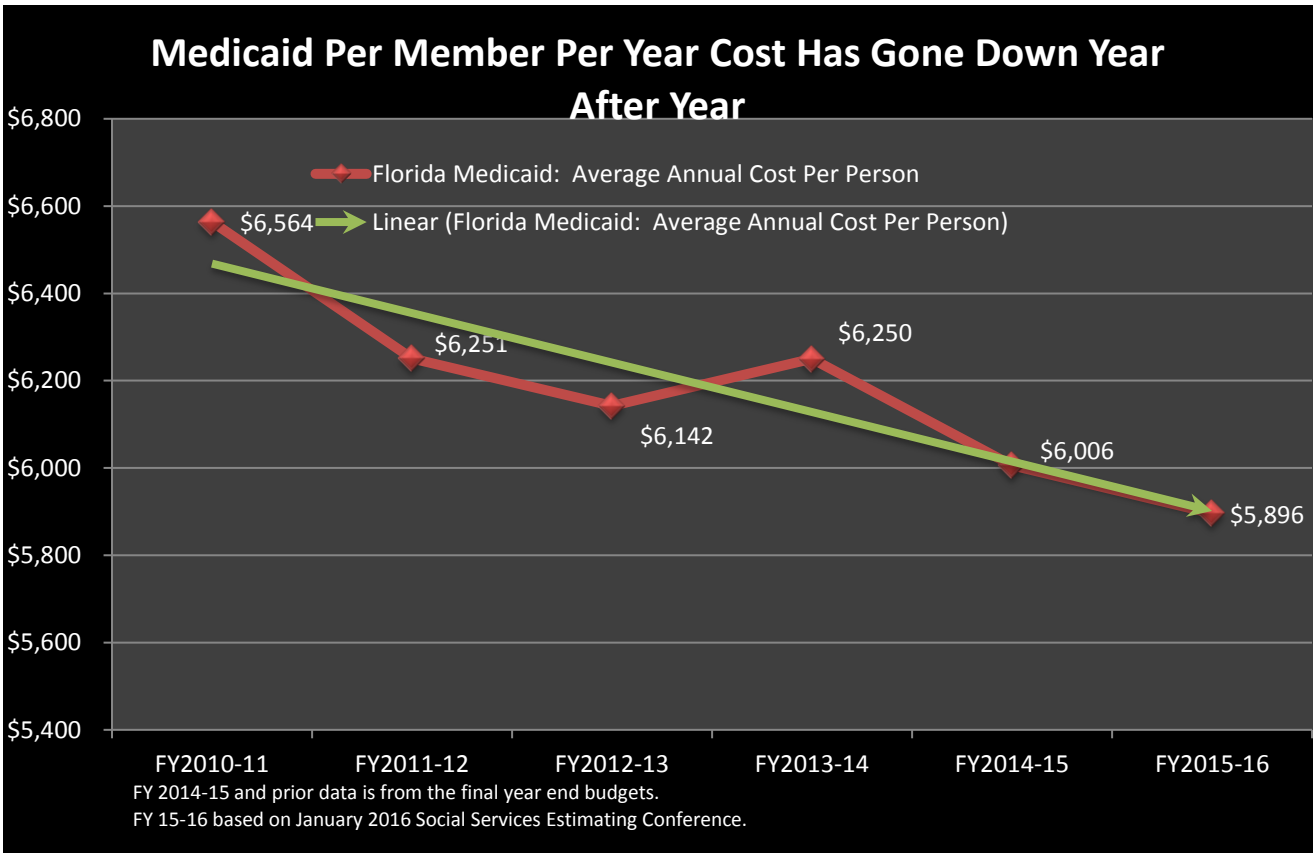
The MMA program has implemented strict financial oversight requirements for the MMA plans. These requirements have improved fiscal and program integrity along with improving customer satisfaction and allowing the State to better manage public resources.

To further enhance fiscal predictability and improve care coordination, the State submitted an amendment to CMS and received approval on October 12, 2016 for the following:

- Contracting with 1-3 vendors under the hemophilia program. This allows the State more flexibility to procure the highest-quality, most efficient and lowest cost vendor or vendors.
- Include payment for nursing facility services in MMA capitation rates for enrollees under the age of 18 years. Requiring MMA plans to pay for and provide this service for children under the age of 18 years adds a key element to the continuum of care the plans can coordinate and manage.

A. Per Member Per Year Costs

The MMA program transformed Florida Medicaid from a primarily fee-for-service payment system to a capitated, risk-adjusted, payment system. The MMA program facilitates enhanced fiscal predictably and has enabled the State to leverage the efficiencies of the managed care model to gain greater control over costs. Consequently, the per member per year cost to the State has decreased without reducing services to enrollees or quality of care.



B. Budget Neutrality

Since the start of the demonstration in 2006, expenditures have been $22.8 billion less than the authorized budget neutrality limit. As a result, the State is in substantial compliance with the waiver budget neutrality requirements and anticipates this trend will continue. See Attachment VIII for full budget neutrality.

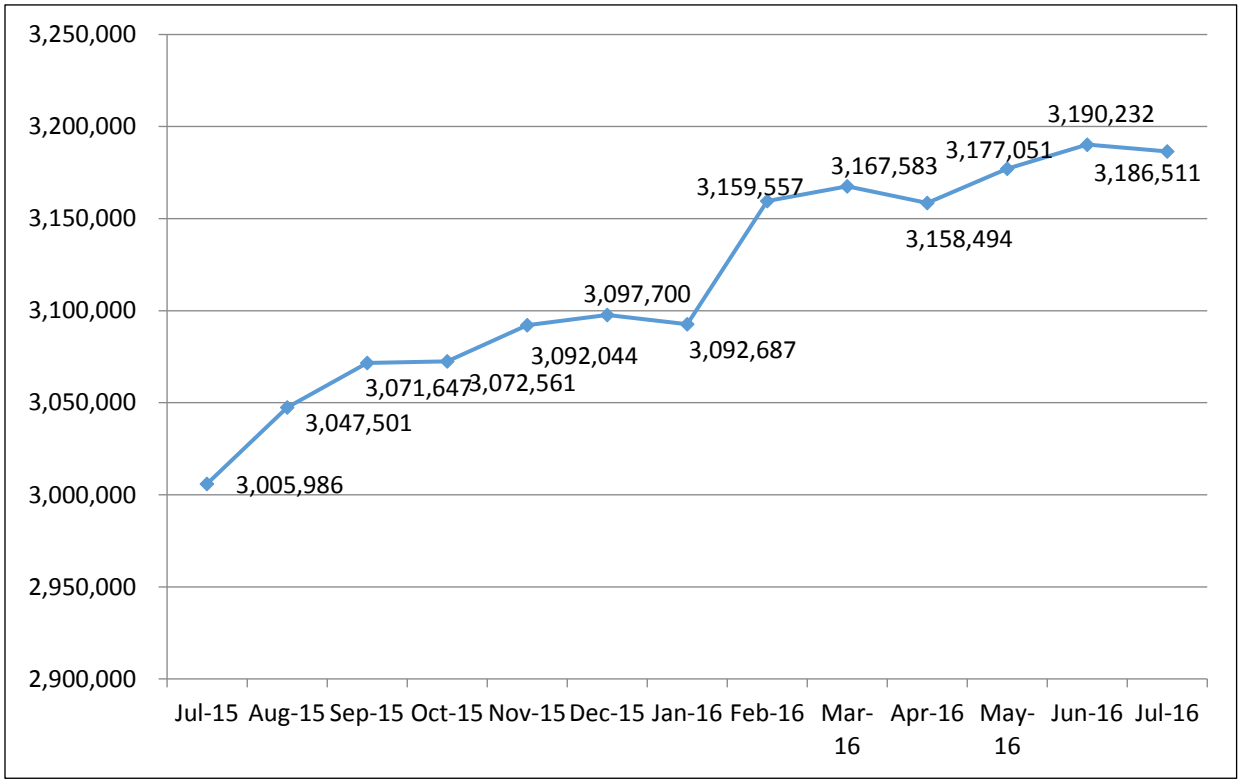
C. Financial Management Standard Questions

See Attachment IX for the State responses to the CMS standard financial management questions.

Improved Access to Coordinated Care

An increasing number of recipients are enrolled in the MMA program:

MMA Monthly Enrollment
July 2015 – July 2016



To help facilitate enrollment into MMA plans sooner and access to the benefits of the managed care delivery system, the State submitted an amendment to CMS and received approval on October 15, 2015 for the following:

- Allow recipients under the age of 21 years who are receiving Prescribed Pediatric Extended Care services and recipients residing in group home facilities licensed under section 393.067, Florida Statutes (F.S.) to voluntarily enroll in an MMA plan.

- Enroll newly Florida Medicaid eligible recipients into a managed care plan immediately upon eligibility determination, and make changes to the auto-assignment criteria.

A. Plan Contracting

The State conducted a competitive procurement in 2012 to contract with qualified managed care plans to provide MMA services. The State currently holds contracts with 15 MMA plans:

Standard Plans	Comprehensive Plans	Specialty Plans
Covers Managed Medical Assistance services only.	Covers all Long-term Care and Managed Medical Assistance services	Provides Managed Medical Assistance services only. Serves Florida Medicaid recipients who meet specified criteria based on either: • Age • Condition • Diagnosis

At this time, no MMA plan has terminated its contract with the State. The current contract period runs from January 1, 2014 through December 31, 2018.

B. Health Plan Report Card

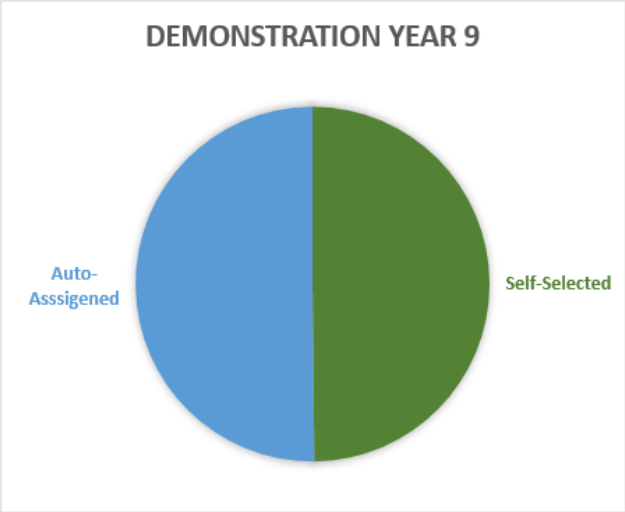
The State has designed a health plan report guide using HEDIS measures to help recipients make an informed choice of MMA plans. The MMA plans are rated on a 5-star rating system based on categories of measures such as:

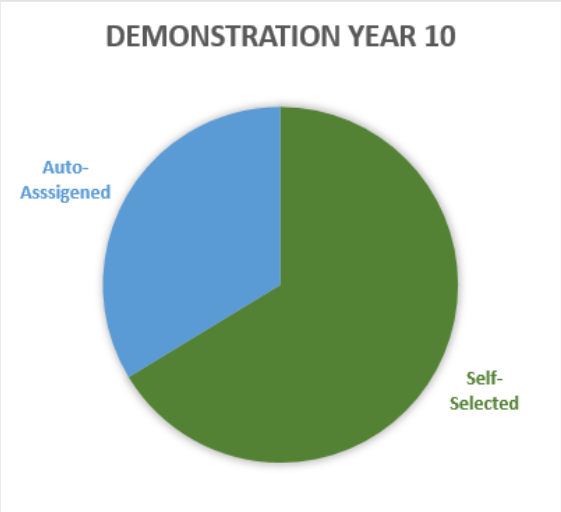
- Pregnancy Related Care
- Children's Dental Care
- Keeping Kids Healthy

The Health Plan Report Card is available at http://www.floridahealthfinder.gov

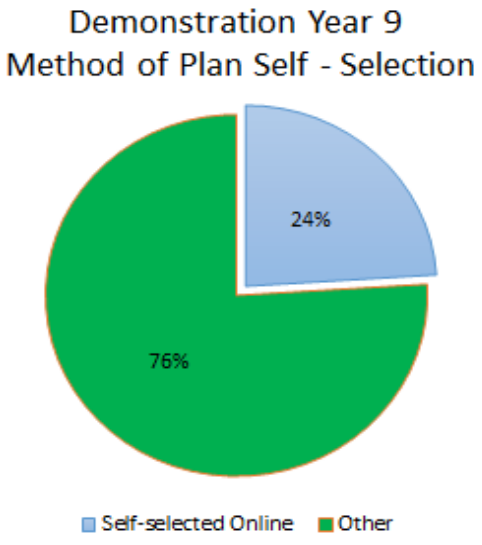
C. Choice Data

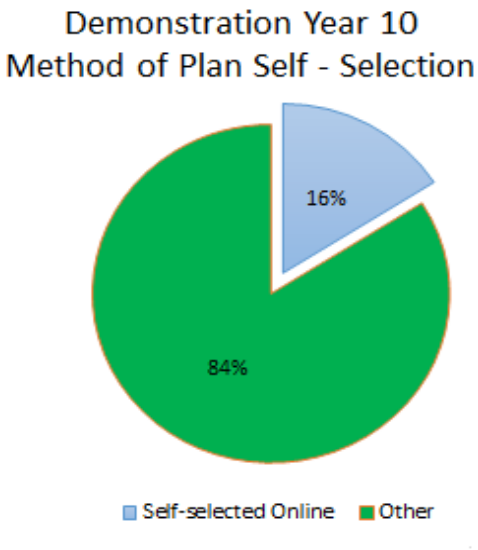
The State encourages recipients to engage in choosing an MMA plan, and its choice counseling program is successfully helping recipients exercise this choice. Since implementing the MMA program, the State has seen increasing rates of self-selection with 66.32% of recipients choosing their MMA plan in Demonstration Year (DY) 10, versus 50.16% in DY 9. See Attachment I for more information on the enrollment and auto-assignment process.



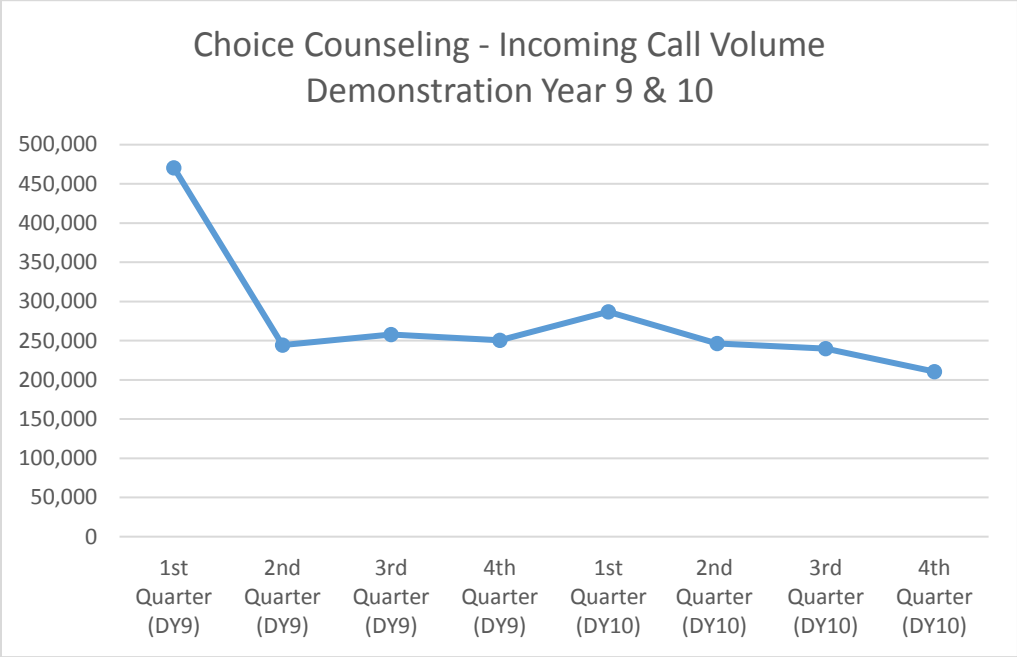


With the increasing rate of self-selection, the percentage of online self-selections is trending down from demonstration year 9 and 10. More recipients are choosing other available options when making a plan selection such as, calling the choice counseling vendor, or meeting with a choice counselor face-to-face. One inference that can be made from this downward trend is that recipients are taking advantage of the ability to speak with a live person over the phone or in person when making a plan selection.





Call volume for the choice counseling vendor has remained consistent from demonstration year 9 and 10.



D. Covered Services and Expanded Benefits

The MMA program covers a wide range of medical and acute care services. In addition, the MMA plans provide additional services that would not otherwise be available to recipients without the MMA program. See Attachment I for required covered services.

Expanded benefits are services the MMA plans offer to all enrollees in specific population groups for which the plans receive no direct payment from the State. Expanded benefits include services that the MMA plans are not required to cover or that are in excess of the amount, duration, and scope specified in the State Plan. Expanded benefits provide a substantial benefit to the State and enrollees who are able to access services from the MMA plans they would not otherwise be able to receive through Florida Medicaid.

The MMA plans also have the ability to provide “in lieu of” services with Agency approval. These services are voluntary for enrollees and are used as a substitute service.

MMA plans currently offer the following expanded benefits as approved by the Agency:

Expanded Benefits																	
	Standard Plans											Specialty Plans					
Expanded Benefits	**Amerigroup**	**Better Health**	**Coventry**	**Humana**	**Molina**	**Prestige**	**Community Care Network**	**Simply**	**Staywell**	**Sunshine**	**United**	**CMS**	**Magellan**	**Freedom**	**Sunshine**	**Clear Health Alliance**	**Positive Health**
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Adult hearing services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	Y
Adult vision services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Art therapy	Y			Y	Y				Y	Y					Y		
Equine therapy									Y								Y
Home health care for non-pregnant adults pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Medically related lodging & food		Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y	Y
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Nutritional counseling	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y	
Outpatient hospital services(Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		Y		Y	Y	Y
Pet therapy				Y	Y				Y								
Physician home visits	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	Y	
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y		Y	Y	
Prenatal/perinatal visits (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Primary care visits for non- pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Waived co-payments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y
Specialty Plans Only																	
Home and community-based services													Y			Y	
Intensive outpatient therapy													Y			Y	

E. Access to Care

The Agency requires MMA plans to conduct performance improvement projects (PIPs) in areas of specific interest or importance to the State. Currently, the MMA plans are required to conduct PIPs on:

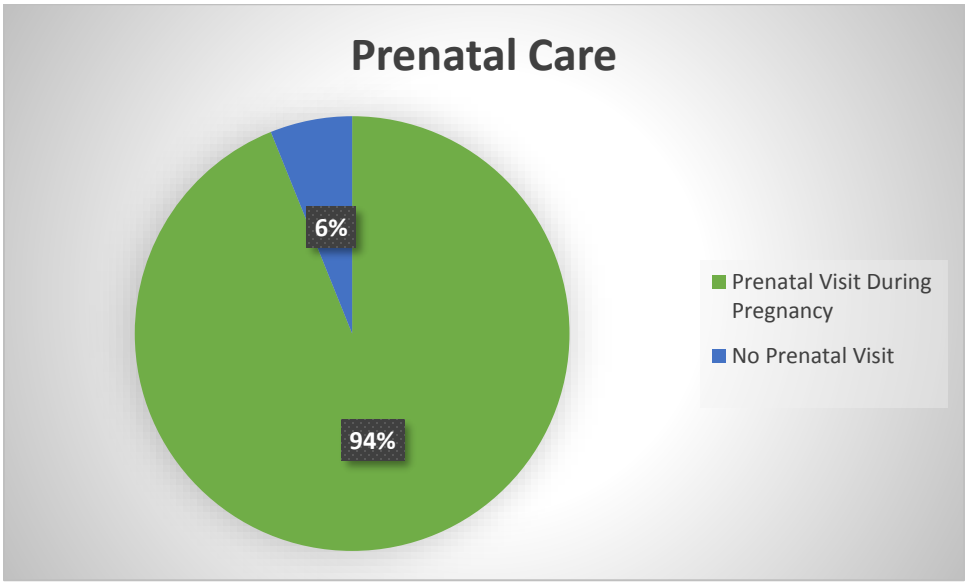
- Prenatal/postpartum care
- Well-child visits within the first 15 months of life
- Child preventive dental visits

The MMA plans are in the process of conducting the PIPs; the outcomes are not available at this time, except to the extent that outcomes of these projects are reflected in plan HEDIS and other performance scores for the areas of focus.

Prenatal Care: Almost 60% of births in Florida are paid for by Florida Medicaid. Adequate prenatal care is shown to be beneficial for both the mother and unborn baby. The State focuses not only on proper prenatal care but also in preventing unintended pregnancies. The MMA plans cover pregnancy tests, nursing assessments, care coordination, and any necessary referrals and follow-ups as components of prenatal care coverage.

The Florida Medicaid Maternal and Child Health Status Indicators report compares the interpregnancy rate of less than 18 months between Florida Medicaid and the national average. On this measure, Florida Medicaid performs better than the national rate in 2013 and 2014. In 2014, the Florida Medicaid interpregnancy rate was 24.9%, and the national rate was 33.1%. In 2014, the Florida Medicaid interpregnancy rate was 25.2%, and the national rate was 33.1%.

Encounter data information from October 2013 – September 2015 demonstrated 93.9% of pregnant women enrolled in an MMA plan received prenatal care prior to delivery[1]. The State expects this percentage of women receiving prenatal care to increase as the MMA plans complete the PIPs.



Well-child visits: The State has worked to improve the rates at which children receive routine care. Regular well-child visits with a primary care physician (PCP) helps to ensure children receive proper preventive care and also allows the PCPs to track growth and

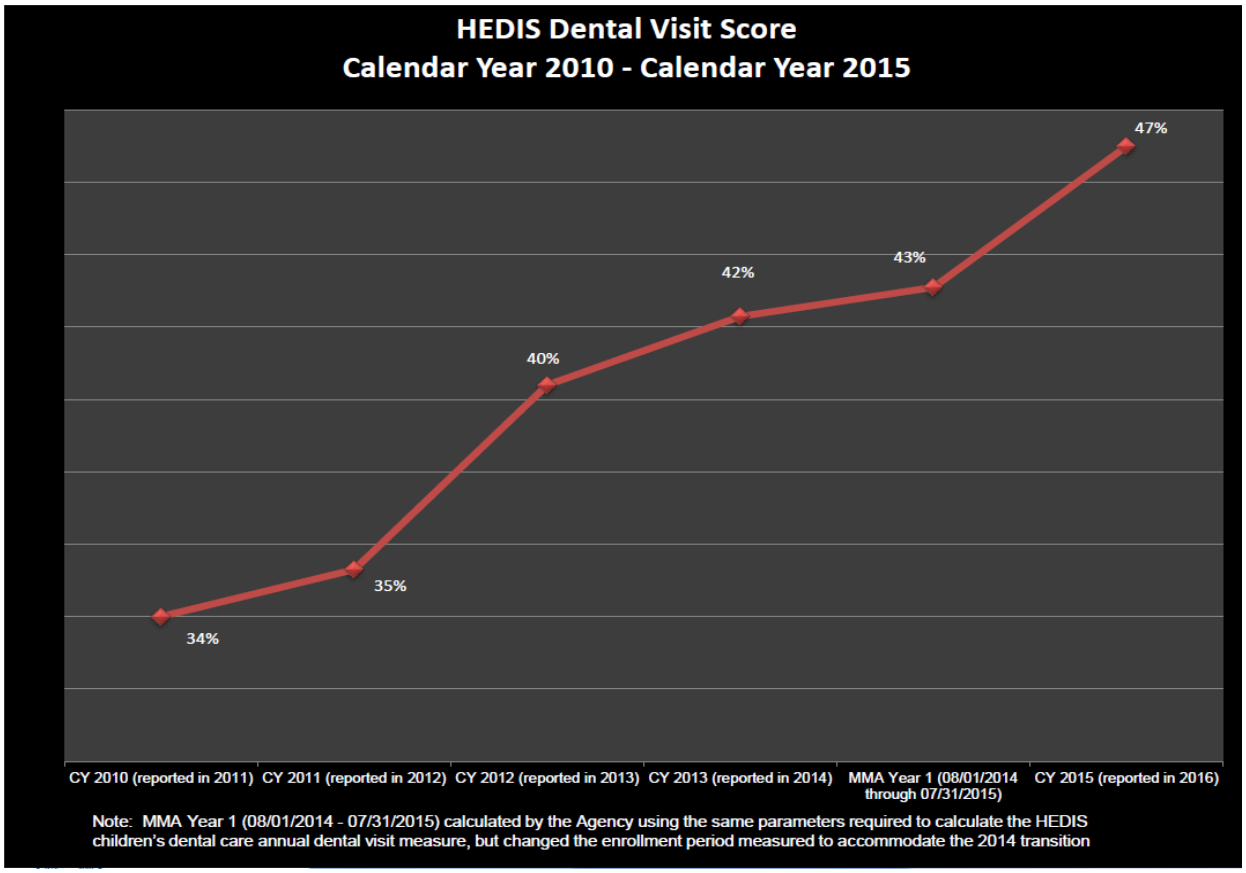
[1] Florida Medicaid Managed Information System (FLMMIS) Eligibility, Encounter, and Claims Information, October 2013 – September 2015.

development. Well-child visits also provide an opportunity for the parent or legal guardian to raise any health or development concerns they might have.

The MMA program has improved the rates of well child visits:

- Only 3% of enrollees under the age of 15 months did not receive a well-child visit in calendar year 2014. This reduced to 2% in calendar year 2015.
- 55% of enrollees under the age of 15 months received more than six well care visits in calendar year 2014. This increased to 58% in calendar year 2015.
- 75% of enrollees aged three to six years received child well care visits in calendar years 2014 and 2015.

Child dental visits: Early dental checkups help to prevent cavities and tooth decay, which can lead to pain and other medical issues. The State has seen a consistent upward trend in the HEDIS Dental Visit Score and continues to work with MMA plans and providers to increase preventive dental visits for children.



F. Network Adequacy Requirements

The Agency has established specific standards for the number, type, and regional distribution of providers in MMA plan networks. The MMA 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.

- Are required to maintain a provider network sufficient to serve a percentage of recipients in the region, as established by the Agency, such that if any one MMA plan leaves a region, the remaining MMA plans have immediate capacity in the provider network (primary care and specialists) to serve all recipients in that region. For example, the contract requires:
  - Plans in Regions 3 through 11 have a network sufficient to meet 120% of actual monthly enrollment.
  - Plans in Regions 1 and 2 to have a network sufficient to meet 200% of actual monthly enrollment.
- Are required to have providers available within time and distance standards established by the Agency.

The Agency continues to look at ways to improve the network standards and increase access to services. Recent contract amendments that have directly impacted the network are:

- Amended contract provider network requirements to reinforce that each medically necessary covered service is provided to the enrollee with reasonable promptness and that any medically necessary covered service is provided including, if necessary, by utilizing out-of-network providers.
- Amended MMA provider network requirements to add endodontist, pediatric dentist, and other specialty dental provider requirements.
- Amended MMA provider network requirements to allow Board Certified or Board Eligible Adult or Child Psychiatrist ratios to be increased by 750 enrollees for each FTE advanced registered nurse practitioner with a certificate of psychiatric nursing through the American Nurses Credentialing Center or physician's assistant with a Certificate of Added Qualifications in psychiatry through the National Commission on Certification of Physician Assistants, affiliated with a board certified or board eligible psychiatrist.

Below is an example of the MMA plan network requirements. A full list of the of the MMA plan provider network standards can be found in the SMMC contract on the Agency's Web site:

http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf#page=76

Example of MMA Network Requirements

Required Providers	Urban County		Rural County		Regional Provider Ratios
	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	

Primary Care Providers	30	20	30	20	1:1,500 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees

G. Provider Network Verification System

The State uses a Provider Network Verification (PNV) system to assure all network providers are appropriately licensed, background screened, and are known to Florida Medicaid. Ensuring providers are properly licensed and have been through background screening is vital to ensuring access to qualified providers for enrollees. The PNV system can also provide the Agency with network related reports and queries for network research. The MMA plans must update the networks in the PNV system weekly.

H. Validating Network Adequacy

In 2015, the External Quality Review Organization (EQRO) conducted a targeted network adequacy review of hospitals in the MMA program. This was completed in two phases:

- Phase 1: compared network data from the MMA plans to the Agency licensure data and identified discrepancies in MMA plans' network data.
- Phase 2: compared calendar year 2016 Medicare advantage health services delivery reference file standards to the Agency's urban/rural network standards and identified the differences in the two sets of standards.

The EQRO reviews concluded the MMA plans were in compliance with the acute care hospital bed ratio, and the Agency's minimum performance standards for travel time and distance are generally more stringent than the performance standards for travel time and distance required for Medicare managed care plans.

The Agency monitors the PNV data weekly and issues compliance actions when deficiencies are found.

I. Validating Encounter Data

The Agency selected targeted service areas to be examined, and the EQRO reviewed the encounter data along with the associated medical records.

- During State Fiscal Year 2013-2014, the EQRO conducted an assessment of the MMA plans' and the Agency's information systems.
- During State Fiscal Year 2014-2015, the EQRO conducted a review of encounter data for dates of services from January 1, 2013 through March 31, 2014, for professional, dental, and institutional encounters.
- During State Fiscal Year 2015-2016, the EQRO conducted a review of encounter data for dates of services from January 1, 2015 through June 30, 2015, for dental and therapy encounters.

The EQRO is in the process of finalizing the State Fiscal Year 2015-2016 report. Preliminary findings indicate the encounters submitted by the MMA plans were generally supported by the medical records.

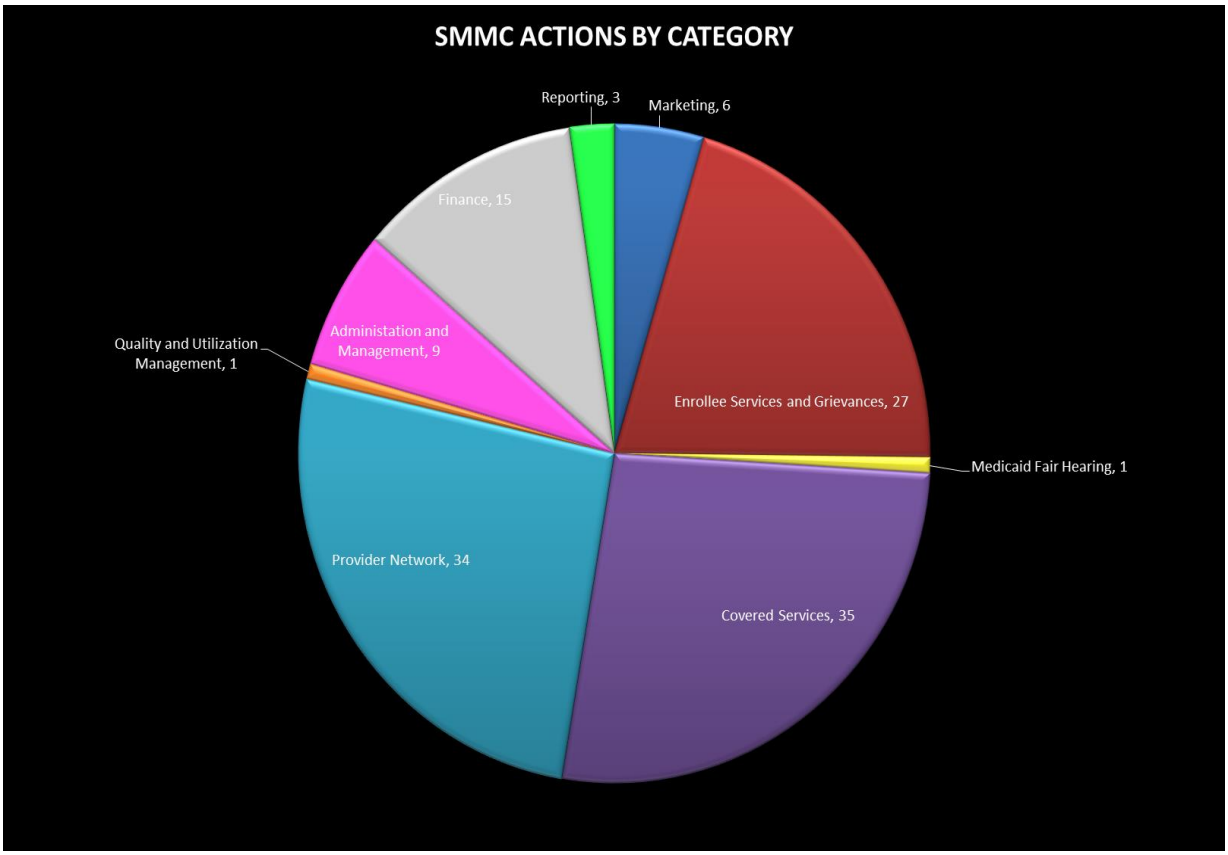
The Agency is in the process of improving the encounter data system to reduce the number of rejected encounters. This includes allowing encounters for enhanced benefits to be submitted to the system.

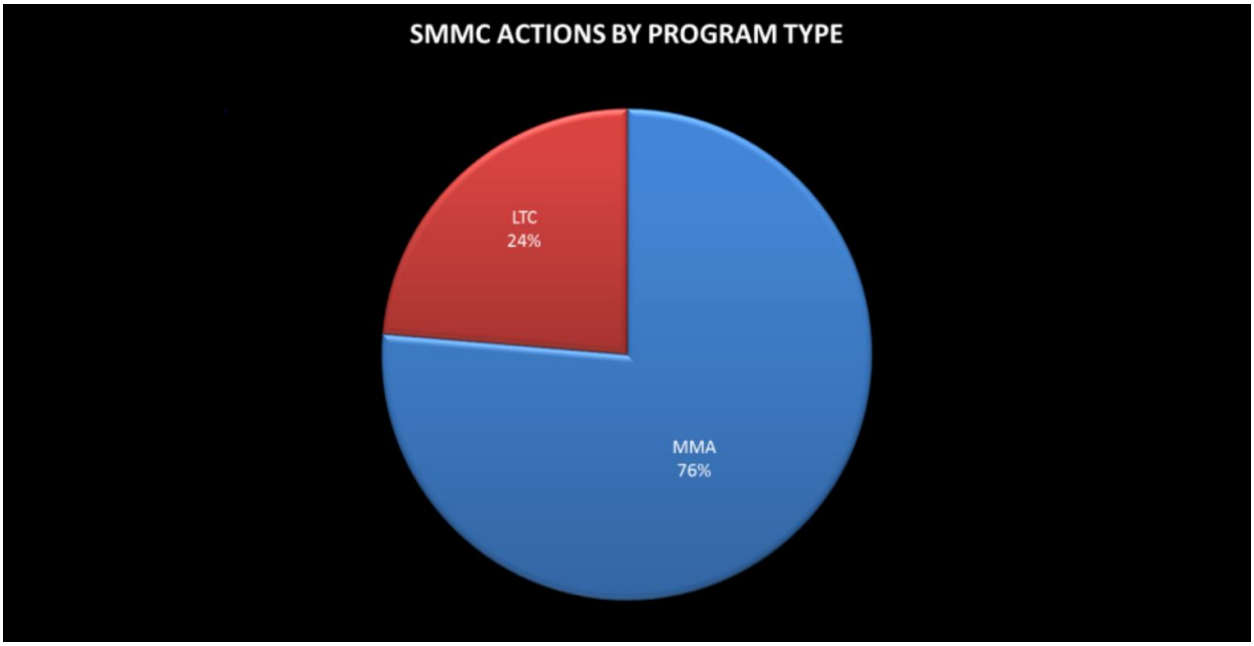
J. Monitoring and Compliance Outcomes

The Agency oversees the MMA program utilizing a multi-prong monitoring approach that incorporates subject matter experts across the Agency to ensure MMA plans are in compliance with the contract. Monitoring efforts occur weekly, monthly, quarterly, yearly, and on an ad-hoc basis. The approaches used include on-site visits to the MMA plans and reviews of monitoring reports and other program data and documents.

The State's compliance framework ensures MMA plans are held accountable when an action (or lack thereof) does not meet contractual requirements. The State requires corrective action plans and/or levies liquidated damages and sanctions when an MMA plan is out of compliance with its contract. The liquidated damages range from $250 per occurrence (failure to certify reports correctly) to $25,000 per occurrence (imposition of arbitrary utilization guidelines). These types of compliance actions have shown to be effective in ensuring MMA plans comply with contract requirements.

The Agency levied a total of $994,250 is sanctions and liquidated damages during the reporting period. Note: Data includes actions for the LTC program.


SMMC ACTIONS BY CATEGORY
Reporting, 3
Marketing, 6
Finance, 15
Administation and Management, 9
Quality and Utilization Management, 1
Enrollee Services and Grievances, 27
Medicaid Fair Hearing, 1
Provider Network, 34
Covered Services, 35


SMMC ACTIONS BY PROGRAM TYPE
LTC
24%
MMA
76%

Improved Program Performance

Requirement: *Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.*

Improved program performance and quality is a top priority to the State. The State also strives to continually improve the quality of the MMA program and to ensure quality initiatives are meaningful and reflective of the varying needs of the population it serves. To this end, the State recognized a need to improve the application of PIPs to specialty plans to ensure the plans are conducting PIPs that are meaningful to their enrollees. The Agency submitted an amendment to CMS to enable specialty plans to conduct PIPs on other topics that have more impact on their enrollees, with Agency approval. The Agency received approval from CMS for this amendment on October 12, 2016.

A. Validating Performance Improvement Projects

The MMA plans are required to submit the PIP designs to the State and the EQRO each year. The EQRO evaluates the implementation of the PIPs to determine how well the MMA plan has improved trend rates on the targeted performance measures. The EQRO reviewed the PIP designs in the fall/winter of 2014-2015 and the baseline reporting in the fall of 2015. The MMA plans used their calendar year 2014 performance measure results as the baseline data reported in 2015, see Attachment II for the 2014 performance measure results. The first re-measurement reporting was reviewed in the fall of 2016. Preliminary findings show some plans have achieved statistically significant improvements over 2014 results.

B. Improving Performance Measures

The Agency continues to review the performance measures reported by the MMA plans and consider changes. As national, standardized measures are developed that can replace Agency-defined measures, the Agency will adopt those measures in order to collect data that can be compared to other states and national benchmarks. As measures are added and removed from the child and adult core sets, and as technical specifications for these measures become available, the Agency will work on including these measures in required reporting.

Over the past two years, the Agency has made several changes to the required performance measures. These changes were due to modifications to HEDIS by the National Committee for Quality Assurance and changes to CMS's child core set and corresponding adult core set. The Agency has selected standardized national measures as much as possible, but has retained several Agency-defined measures when there were no comparable national measures for key areas of health outcomes.

The Agency has also added several of the CMS Medicaid adult core set measures to the reporting requirements for the MMA plans (e.g., annual monitoring for patients on persistent medications, hospital readmissions, and initiation and engagement of alcohol and other drug dependence treatment). See Attachment II for the 2015 performance measures.

C. Validating Performance Measures

The MMA plans must report on a specific set of Agency-defined performance measures. The EQRO determines that the data collected and reported by the MMA plans for the performance measures selected by the Agency followed the appropriate methodology. The EQRO then reviews and validates the audit findings from each MMA plan's final audit report produced by the licensed auditing organization. Therefore, any rates and audit designations were determined to be valid, reliable, and accurate. The EQRO has conducted performance measure validation activities for calendar year 2015. See Attachment II for a complete list of the 2015 performance measures. The Agency has received the draft validation report and is in the process of reviewing and finalizing the validation findings.

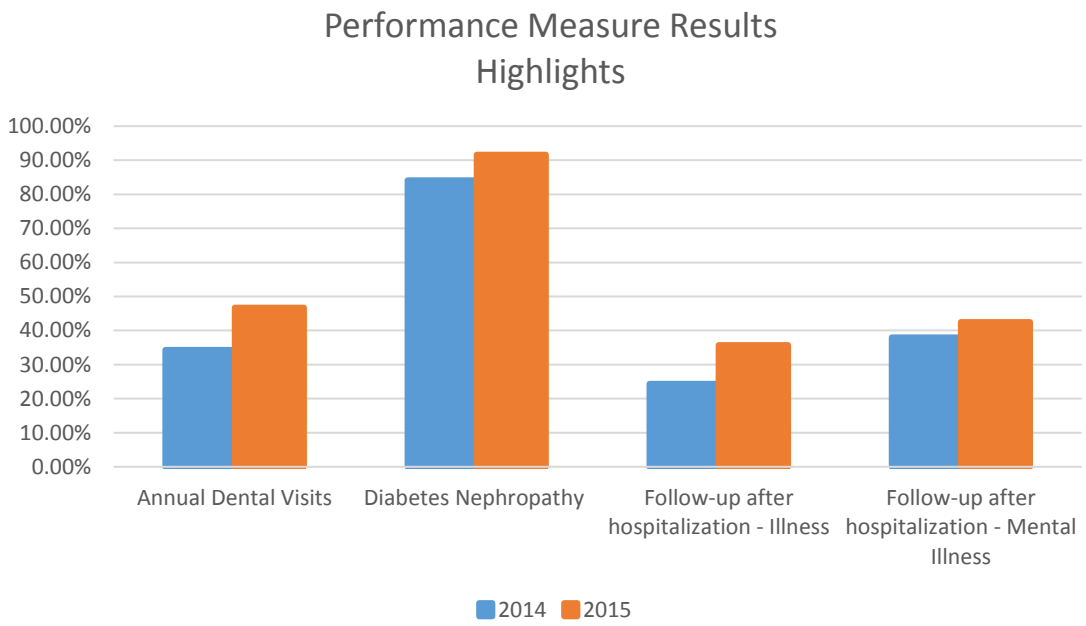
D. Plan Performance Measure Results

The MMA plan performance measure statewide average results for calendar years 2014 and 2015 demonstrates an upward trend for many of the performance measures. There are several measures where the calendar year 2015 statewide average results surpassed the 75th percentile of Medicaid plans nationally, and three that surpassed the 90th percentile.

- Calendar year 2014: 33 of the 51 statewide weighted means were at, or better than, the national mean.
- Calendar year 2015: 25 of the 49 statewide weighted means were at, or better than, the national mean.

Of the 2015 statewide weighted means that were lower than the national mean, seven of them showed improvement from 2014.

Performance measures with notable improvement include:



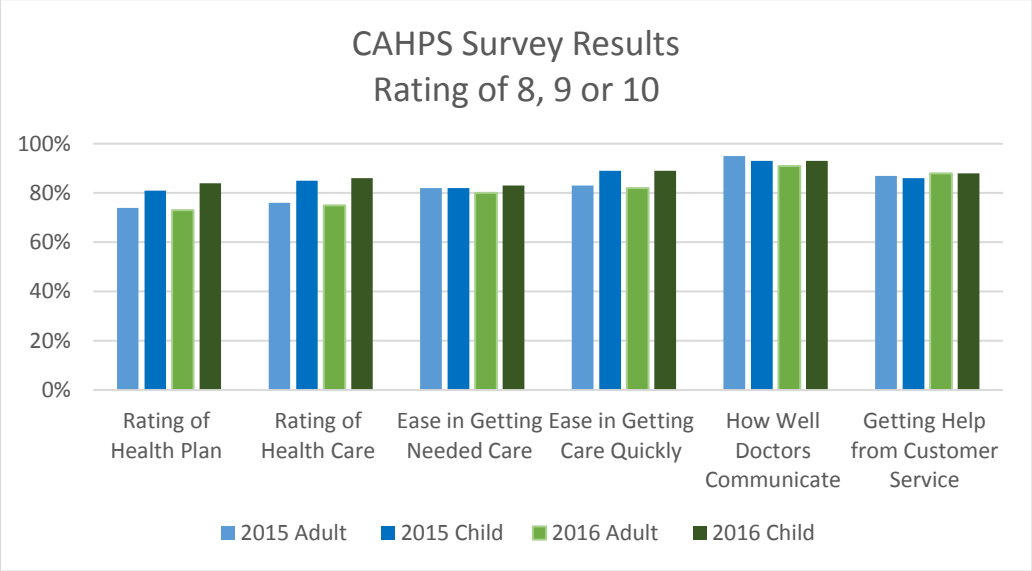
See Attachment II for a complete list of the statewide average results for performance measures for calendar years 2014 and 2015 compared to the respective national means.

E. Enrollee Satisfaction Surveys Results

The MMA plans are required to contract with a certified survey vendor to conduct the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey each year. The surveys must be conducted according to the National Committee on Quality Assurance's (NCQA) mixed mode protocols, and MMA plans must conduct both an adult survey and a child survey. The MMA plans are required to report the certified results to the Agency annually. Beginning with the 2016 survey, MMA plans are also required to report the results to NCQA to be included in the national Medicaid means and percentiles

The MMA program has high enrollee satisfaction rates. The MMA program Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were conducted in the spring of 2015 and 2016.

Enrollees were more satisfied with their MMA plans than commercial Preferred Provider Organization (PPO) and commercial Health Maintenance Organization (HMO) members were with their plans. In the 2015 CAHPS survey, 57% of commercial PPO members and 67% of commercial HMO members rated their plans an 8, 9, or 10 out of 10. By contrast, 74% of Medicaid MMA members rated their plans an 8, 9, or 10.



The results of these surveys are used to assess quality of, and experiences with, care provided by the MMA plans. These results are posted on the Agency's Florida Health Finder Web site so that recipients may use the survey results to compare plans when making enrollment decisions.

F. CMS - 416 Results

The MMA program has allowed the State to set and achieve incremental targets to improve the rate at which child-related services for enrollees are accessed. The MMA plans are exceeding State targets as reported on the CMS-416 report annually.

Plans must achieve a child health checkup screening rate of at least 80% for those enrollees who are continuously enrolled in the MMA plan for at least eight months. The MMA plans

achieved a screening rate of 88.54%. In addition, The MMA plans may be assessed liquidated damages if the child health check-up screening rate falls below the 80% goal.

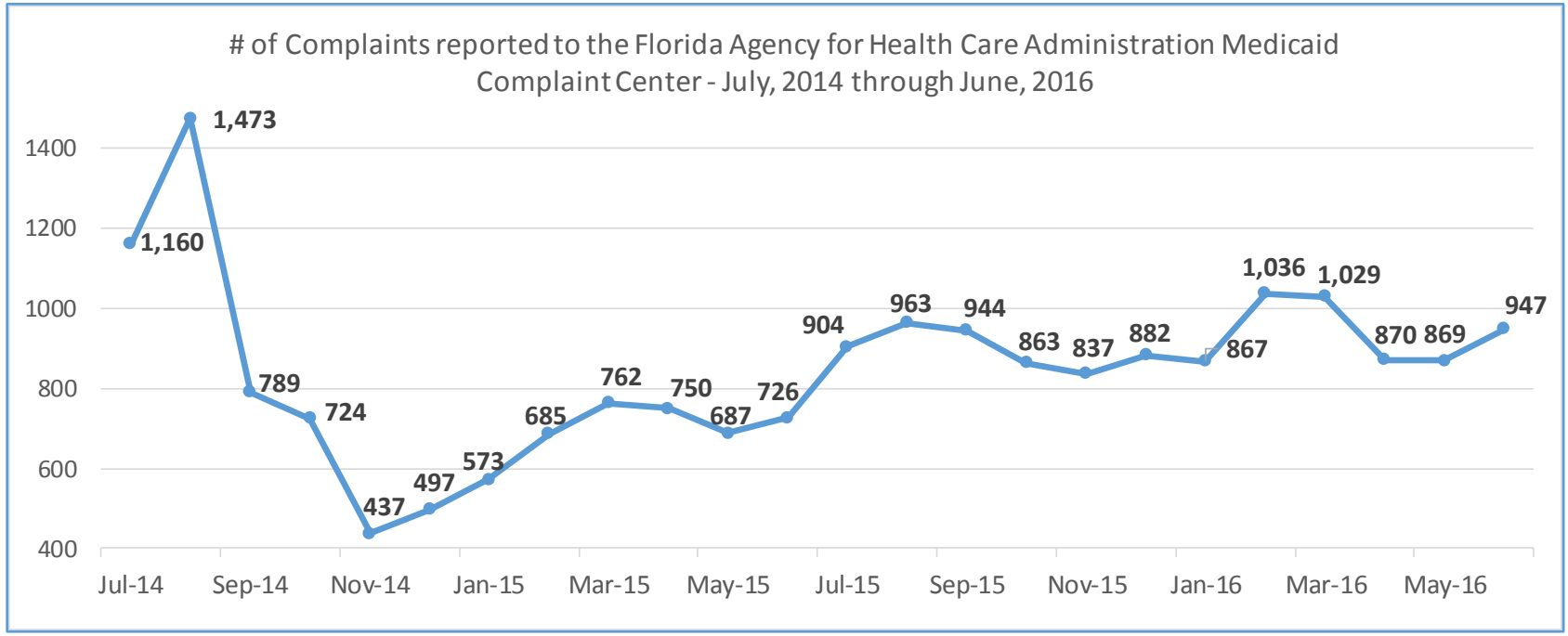
The Agency also added a child preventive dental services rate requirement of at least 28% to the MMA plan contract, with possible liquidated damages if an MMA plan did not meet the requirement in federal fiscal year 2014-15. The MMA plans exceeded the rate requirement by achieving an overall rate of 33% for this service. Beginning with federal fiscal year 2015 - 2016 reporting, the Agency has added new targets for each preventive dental services and dental treatment services, with possible liquidated damages if an MMA plan does not meet each year's target rates.

G. Complaint Data

To enhance transparency, promote efficiency, and improve tracking, trending, and response times, the Agency established a centralized recipient and provider assistance operations center to receive and manage all complaints. Recipients and providers may report a complaint online at http://ahca.myflorida.com/Medicaid or by phone at 1-877-254-1055. The monthly complaint reports are available on the Agency's web site at: http://ahca.myflorida.com/medicaid/statewide_mc/program_issues.shtml

The number of complaints has decreased by approximately one- third since the inception of the MMA program and represents less than 3% of total enrollees.

Reported Complaints[2]
July 1, 2014 through June 30, 2016



SMMC Enrollment:	2,187,515	2,808,135	2,858,539	2,953,484	3,038,586	3,089,246	3,137,972	3,172,113	3,197,781	3,239,013	3,256,080	3,281,932
# Issues per 1,000 Enrollees:	0.530	0.281	0.153	0.194	0.251	0.222	0.288	0.298	0.262	0.268	0.316	0.265

[2] Includes both Long-term Care and Managed Medical Assistance

Evaluation Status and Findings

Requirement: An evaluation report of the demonstration, inclusive of: evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

Overview of Independent Evaluation

The independent evaluation covers the period July 1, 2014 through June 30, 2017. The current evaluation design builds, and improves upon, the previous evaluation design. The evaluation design includes a discussion of the goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on recipients, providers, plans, market areas and public expenditures. The design accommodates and reflects the staggered implementation of the MMA program to produce more reliable estimates of program impacts. The evaluation contract was executed on December 7, 2016.

Research Questions and Findings

The Agency intends to continue to use the approved evaluation questions, hypothesis, and analyses to study the domains. At this time, no evaluation reports have been completed, and therefore there are no findings to report.

Proposed Evaluation Activities

The Agency intends to continue with the existing evaluation activities.

Public Notice Process

Requirement: Documentation of the State's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

Public Notice Process

The Agency conducted a public comment period from October 11, 2016 through November 10, 2016. See Attachment IV for the summary of comments received.

The Agency notified stakeholders of the public comment period to solicit input on the waiver extension request using the following methods:

- Published public notice on October 6, 2016 in the Florida Administrative Register in compliance with Chapter 120, F.S
- Emailed information to individuals and organizations on its interested stakeholders list.
- Posted a prominent link on the Agency's Web site to obtain the public notice materials posted at:

  http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[3] located in Florida through written correspondence to solicit input on the waiver extension request. The tribes did not provide any comments or feedback related to the extension request. See Attachment V for a copy of the letters.

Public Meetings

Individuals who were unable to attend the meetings in person could participate via conference call by using the toll free number provided. During the meetings, the Agency provided an overview of the MMA program, a brief history of the MMA Waiver, a description of the extension request, and allowed time for public comment.

Pursuant to the provisions of the Americans with Disabilities Act, any person that required special accommodations to participate in the workshop/meeting was asked to advise the Agency at least seven days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034, or by email at Heather.Morrison@ahca.myflorida.com.

Individuals who are hearing or speech impaired, were able to contact the Agency using the Florida Relay Service, 1 (800) 955-8771 (TDD) or 1 (800) 955-8770 (Voice).

[3] The State of Florida has two federally recognized tribes, the Seminole Tribe and Miccosukee Tribe, and does not have any Urban Indian Organizations.

Table 1 Schedule of Public Meetings		
Location	**Date**	**Time**
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Line: 1 888 419 5570 Participant Code: 492 773 91	October 18, 2016	2:00 p.m. – 4:00 p.m.
Tampa Agency for Health Care Administration 6800 North Dale Mabry Highway Main Training Room Tampa, FL 33614 Conference Line: 1 888 419 5570 Participant Code: 498 282 50	October 20, 2016	11:30 a.m. – 1:00 p.m.
Miami Agency for Health Care Administration 8333 NW 53rd St, Suite 200 Doral, FL 33166 Conference Line: 1 888 419 5570 Participant Code:474 080 47	October 21, 2016	10:00 a.m. – 11:30 a.m.

Submitting Written Comments

Written comments on the waiver extension could be submitted to the Agency during the public comment period as follows:

Mail: 1115 MMA Waiver Extension Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Email: FLMedicaidWaivers@ahca.myflorida.com

Public Comments

The Agency carefully considered all comments received on the waiver extension. While the Agency is not recommending changes to the STCs for all of these comments, the Agency takes all comments seriously and may be undertaking efforts related to these comments outside of the STCs.

Waiver and Expenditure Authorities

Requirement: *A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.*

To effectively maintain the MMA program, the State is seeking a five-year extension of Florida's 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.

The federal waiver and expenditure authorities requested for the program remain consistent with the current authorities granted by CMS on October 12, 2016. See Attachment III for a copy of the current approved Waiver and Expenditure Authorities.

Attachment I
Managed Medical Assistance Program Overview

MMA Plan Contracting

A. Eligible Plans

Services provided through the MMA program must be provided by eligible managed care plans. Eligible plans include:

- A health insurer authorized under Chapter 624, F.S.
- An exclusive provider organization authorized under Chapter 627 F.S.
- A health maintenance organization authorized under Chapter 641, F.S.
- A provider service network authorized under section 409.912(2), F.S. or an accountable care organization authorized under federal law. For purposes of the MMA program, the term also includes:
  - The Children's Medical Services plan authorized under Chapter 391, F.S.
  - Entities qualified under 42 CFR 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

B. Competitive Procurement

Florida law requires the Agency to contract with MMA plans through a competitive procurement process using, at a minimum, the following criteria in the selection process:

- Accreditation by a 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
- Documentation of policies for preventing fraud and abuse

C. Plans Per Region

The table below provides the current number of MMA plans that may provide services in each region.

MMA Plans Per Region			
	Min # of Plans	**Max # of Plans**	**Min # of PSNs[4]**
Region 1	2	2	1
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

The Agency imposes penalties for MMA plans that leave a region before the end of the contract term or without giving the Agency at least 180 days' notice. Specifically, MMA plans are required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the MMA plan action. If a contracted MMA plan leaves a region before the end of the contract term, the Agency is required by law to terminate all contracts with that MMA plan in other regions.

D. Re-procurement

During the summer of 2017, the Agency will release an Invitation to Negotiate to solicit managed care plans that are qualified to provide required services under the MMA program.

The Agency will conduct readiness reviews of the newly procured plans to ensure those selected are qualified and able to comply with the MMA plan contract.

[4] The PSN counts toward the minimum number of plans per region.

Benefit Packages

A. Standard Benefit Packages

Managed Medical Assistance plans must ensure the provision of services in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished.

Managed Medical Assistance plans must use the Agency's definition of medical necessity (as defined in Rule 59G-1.010, Florida Administrative Code) when authorizing covered services.

Managed Medical Assistance plans must comply with federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements of 42 U.S.C. § 1396d(r)(5). As such, MMA plans must, for enrollees under the age of 21 years, pay for any "other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan." MMA plans may not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for enrollees under the age of 21 years.

Managed Medical Assistance plans are required to provide the following services:

Standard Benefit Package
Advanced Registered Nurse Practitioner Services
Ambulatory Surgical Center Services
Assistive Care Services
Behavioral Health Services
Birth Center and Licensed Midwife Services
Clinic Services
Chiropractic Services
Dental Services
Child Health Check-Up
Immunizations
Emergency Services
Emergency Behavioral Health Services
Family Planning Services and Supplies
Healthy Start Services
Hearing Services
Home Health Services and Nursing Care
Hospice Services
Hospital Services
Laboratory and Imaging Services
Medical Supplies, Equipment, Prostheses and Orthoses
Nursing Facility Services (for enrollees under the age of 18 years)
Optometric and Vision Services
Physician Assistant Services

Podiatric Services
Practitioner Services
Prescribed Drug Services
Renal Dialysis Services
Therapy Services
Transportation Services

B. Customized Benefit Packages

Managed Medical Assistance plans have the flexibility to provide customized benefit packages for non-pregnant adult enrollees. Customized benefit packages must include all mandatory State Plan services. Managed Medical Assistance plans may vary the amount, duration and scope of optional State Plan services to reflect the needs of the MMA plan's target population, and may offer additional services and benefits not available under the State Plan.

Customized benefit packages must be at least actuarially equivalent to the services provided to the target population under the current State Plan, meet a sufficiency test to ensure it meets the medical needs of the target population, and be prior-approved by the Agency and CMS.

Managed Medical Assistance plans are not currently offering customized benefit packages.

C. Cost Sharing

The Agency must pre-approve all cost-sharing (premiums and copayments) required by MMA plans from enrollees. Managed Medical Assistance plans may not exceed the cost-sharing amounts specified in the State Plan for covered services. Most MMA plans, as part of their expanded benefit package, have eliminated cost-sharing requirements.

Reimbursement

Capitation rates for the MMA plans are developed in accordance with 42 CFR 438.6. The Agency develops actuarially sound, risk-adjusted premiums by assessing historical Florida Medicaid expenditures and encounter data.

Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. 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 recipients enrolled in each MMA plan determine the collective risk score and the resulting premiums for that MMA plan.

The Centers for Medicare and Medicaid Services reviews and approves all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

Provider Network and Access Requirements

The Agency requires MMA plans to ensure availability of services in accordance with section 1932(c)(1)(A)(i) of the SSA and 42 CFR 438.206. Managed Medical Assistance plans are required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected service utilization. The MMA plans may limit the providers

in their network if network adequacy standards are met, but must include statewide essential providers in accordance with section 409.975, F.S.

The Agency may authorize MMA plans to include providers located outside of the contracted region, if appropriate, to meet time and distance or other network adequacy requirements standards.

MMA plans are required to establish and maintain an accurate and complete electronic database of contracted providers that is accessible to the public and allows comparison of the availability of providers to network adequacy standards. The plans must also report to the Agency weekly their updated network.

Grievance and Appeals

The Agency requires each MMA plan to have an approved internal grievance system that is consistent with federal law and allows a recipient, or a provider on behalf of a recipient, to challenge the denial of coverage of, or payment for, services as required by section 1932(b)(4) of the SSA and 42 CFR 438 Subpart H and Subpart F, Grievance System, insofar as these regulations are applicable. The Agency is in the process of making changes to the MMA plan contract to ensure compliance with the new CMS rule, CMS-2390-F, published on May 6, 2016.

The Agency requires each MMA plan to provide recipients with access to the Florida Medicaid fair hearing process as required under 42 CFR 431 Subpart E.

Program Integrity

The Agency requires each MMA plan to comply with section 1932(d)(1) of the SSA and 42 CFR 438.610, Prohibited Affiliations with Individuals Barred by Federal Agencies.

Managed Medical Assistance plans must comply with 42 CFR 438.608, Program Integrity Requirements, insofar as these regulations are applicable. The Agency exercises administrative authority over the MMA program to prevent:

- Fraud or abuse
- Over-utilization/underutilization or duplicative utilization
- Inappropriate denial of services
- Enrollee abuse, neglect, or exploitation

The Agency refers suspected incidents to the appropriate regulatory agency, including the licensing authority and the Medicaid Fraud Control Unit in the Attorney General's office.

Eligibility

A. Florida Medicaid Eligibility

In order to receive services under the MMA program, an individual must first be determined eligible for Florida Medicaid benefits as set forth in the Title XIX Florida Medicaid State Plan. The Agency is not requesting authority under this demonstration to expand Florida Medicaid eligibility to populations beyond what is currently authorized through its State Plan. All

Florida Medicaid eligibility applications are processed in accordance with the approved State Plan.

B. Eligibility for the MMA Program

The following individuals are eligible for the MMA program. Mandatory recipients are required to enroll in an MMA plan in order to receive covered Florida Medicaid services. Voluntary recipients are exempt from mandatory enrollment, but may elect to enroll in an MMA plan to receive covered Florida Medicaid services.

Mandatory Recipients: The following individuals are required to enroll in an MMA plan:

Mandatory Recipients			
Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
Infants under the age of 1 year. Population 2	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & Related Grp
Children ages 1 through 5 years old. Population 2	No more than 140% of the FPL.	Title XIX	TANF & Related Grp
Children ages 6 through 18 years old. Population 2	No more than 133% of the FPL.	Title XIX	TANF & Related Grp
Blind/Disabled Children. Population 1	Children eligible under Supplemental Security Income (SSI), or deemed to be receiving SSI.	Title XIX	Aged/Disabled
IV-E Foster Care and Adoption Subsidy. Population 2	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & Related Grp
Pregnant women. Population 2	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Grp
Section 1931 parents or other caretaker relatives. Population 2	No more than Aid to Families with Dependent Children (AFDC) Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.)	Title XIX	TANF & Related Grp
Aged/Disabled Adults. Population 1	Individuals receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
Former foster care children under the age of 26 years.	Individuals who are under the age of 26 years and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & Related Grp
Optional State Plan Groups			

Mandatory Recipients			
Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
State-funded Foster Care or Adoption assistance under the age of 18 years. Population 2	Individuals who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & Related Grp
Individuals eligible under a hospice-related eligibility group. Population 1	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified in 42 CFR 435.236. Population 1	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community-based waiver group specified in 42 CFR 435.217. Population 1	This group includes institutionalized individuals eligible under this special Home and Community Based Services waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category.	Title XIX	Aged/Disabled

Medicare-Medicaid Eligible Recipients: Individuals fully eligible for both Medicare and Florida Medicaid (dually eligible recipients) are required to enroll in an MMA plan to receive Florida Medicaid covered services. These individuals continue to have their choice of Medicare providers as the MMA program does not impact individuals' Medicare benefits.

Voluntary Recipients: The following individuals are excluded from mandatory enrollment but may choose to enroll in an MMA plan voluntarily:

- Florida Medicaid recipients who have other creditable health care coverage, excluding Medicare.
- Persons eligible for refugee assistance.
- Florida Medicaid recipients who are residents of an intermediate care facility for individuals with intellectual disabilities, including Sunland Center in Marianna and Tacachale in Gainesville.
- Florida Medicaid recipients enrolled in the Developmental Disabilities Individual Budgeting (iBudget) home and community-based services waiver pursuant to Chapter 393, F.S., and Florida Medicaid recipients waiting for iBudget waiver services.
- Florida Medicaid recipients residing in a group home facility licensed under Chapter 393, F.S.
- Children receiving services in a Prescribed Pediatric Extended Care center.

Excluded from MMA Program Participation: The following individuals are excluded from enrollment in an MMA plan under the demonstration:

- Individuals who are eligible for emergency Medicaid for aliens.
- Women who are eligible only for family planning services
- Women who are eligible through the breast and cervical cancer services program.
- Individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in State law. (These individuals are inmates who are not eligible for covered services under the State Plan but may be covered as inpatients in a medical institution).
- Individuals who are eligible for the Medically Needy program.

Enrollment and Disenrollment

A. Recipient Information and Enrollee Materials

The Agency provides information in accordance with section 1932(a)(5) of the SSA and 42 CFR 438.10, Information Requirements.

The MMA plans are required to provide enrollee information in accordance with 42 CFR 438.10, including:

- All enrollee communications, including written materials, spoken scripts and websites are at, or near, the fourth grade comprehension level.
- Written materials are available in English, Spanish, and all other appropriate foreign languages.
- Written materials are available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency.

The MMA plans are required to make available (in print and online) a member handbook that provides information about the enrollees' rights and responsibilities, the role of primary care physicians, how to obtain care, what to do in an emergency or urgent medical situation, how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing, how to report suspected fraud and abuse, how to report abuse, neglect and exploitation, and all other requirements and benefits of the plan.

B. Recipient Choice

Recipients have a choice of two or more MMA plans in each region. The Agency assures it complies with section 1932(a)(3) of the SSA and 42 CFR 438.52, relating to choice.

C. Choice Counseling

The Agency contracts with a vendor to process all managed care enrollment and disenrollment requests, and to provide recipients with meaningful information to enable them to make an informed selection among the available plans providing services in their region.

Individuals applying for Florida Medicaid benefits receive information about the MMA plan choices in their region at the time of their application for Florida Medicaid if they meet the criteria for mandatory enrollment in the MMA program.

Individuals are provided with information to encourage an active plan selection electronically (online) or in print, and are given the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice. The Agency's choice counseling vendor provides information about each MMA plan's coverage in accordance with federal requirements. Additional MMA plan information includes, but is not limited to: benefits and benefit limitations, cost-sharing requirements, provider network information, and contact information. The Agency posts performance information including recipient satisfaction survey results and performance measure data (as data is available) on its Web site.

The choice counseling vendor provides recipients who have been auto-assigned into a plan with written information about their MMA plan assignment and information about the choice of MMA plans in their region (in the event the recipient wishes to change plans).

Once the enrollment is effective, the choice counseling vendor mails a welcome letter, a packet of information about the MMA plans available in the enrollee's region, accessing choice counseling services, and their right to change MMA plans.

D. General Enrollment Criteria

Mandatory recipients are enrolled in an MMA plan once their Medicaid enrollment determination is complete. Mandatory recipients are afforded the opportunity to choose an MMA plan. However, if the recipient does not select an MMA plan, the recipient will be auto-assigned to an MMA plan.

Voluntary recipients are enrolled in an MMA plan upon making a plan selection.

E. Auto-Assignment/Enrollment Criteria

General Provisions: At a minimum, the Agency uses the following criteria when auto-assigning a recipient to an MMA plan:

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

Special Populations: The Agency uses the following parameters when auto-assigning the following special populations to an MMA plan:

- <u>Recipients Enrolled in a Medicare Advantage Plan:</u>

  To promote alignment between Florida Medicaid and Medicare, each recipient who is enrolled in a Medicare Advantage Plan is assigned to any MMA plan in the recipient's region that is operated by the same parent organization as the recipient's Medicare Advantage Plan.

- Newborns:

  Newborns of mothers who are enrolled in a plan at the time of the child's birth are automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 120-days after enrollment. If the mother is enrolled in a specialty plan, the newborn must also meet the specialty plan eligibility criteria before being assigned into the specialty plan.

- Children in Foster Care:

  Children in foster care are assigned/re-assigned to the same primary care physician to which the child was most recently assigned in the last 12 months, if applicable.

- Recipients Meeting the Criteria for Enrollment in a Specialty Plan:

  Recipients who meet the eligibility criteria for a specialty plan in their region are assigned to the specialty plan.

F. Re-enrollment

In instances of a temporary (six month or less) loss of Florida Medicaid eligibility, the Agency re-enrolls recipients in the same MMA plan they were enrolled in prior to the loss of eligibility unless enrollment into the MMA plan has been suspended.

G. Lock-in Disenrollment

Enrollees maintain their enrollment in their selected, or assigned, MMA plan for a total of 12 months until the next open enrollment period, unless:

- The enrollee is determined ineligible for Florida Medicaid.
- The enrollee requests to be voluntarily dis-enrolled from the MMA plan (without cause) during the 120 days following the date of the enrollee's initial enrollment in the plan. Mandatory enrollees are required to choose another MMA plan in their region.
- The enrollee submits a request for dis-enrollment (for cause). Good cause reasons for disenrollment from an MMA plan are specified in Rule 59G-8.600, Florida Administrative Code.
- Voluntary enrollees may dis-enroll from their MMA plan at any time.

Additional Programs

A. Healthy Start Program

The Healthy Start program is available statewide for eligible Medicaid recipients. 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 dis-enroll 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, and Medicaid coverage for the infant and the need to select a primary care physician.

The Healthy Start Coordinated System of Care includes outreach and case management services for eligible pregnant women 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 three 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.

B. Program for All Inclusive Care for Children (PACC)

Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the Children's Medical Services plan who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider:

- Support Counseling
- Expressive Therapies
- Respite Support
- Hospice Nursing Services
- Personal Care
- Pain and Symptom Management

C. Comprehensive Hemophilia Disease Management Program

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby all Florida Medicaid 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 the vendors contracted with the Agency. In addition to product distribution, the program provides for the following additional services at no cost to the State:

- Pharmacy benefit management
- Direct beneficiary contact
- Personalized education
- Enhanced monitoring
- Direct support of beneficiaries in the event of hospitalization

D. Low Income Pool program

The LIP program provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. The State assures LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200% of the federal poverty level. The total computable dollar limit for LIP expenditures in DY 11 is $607,825,452 million. The State understands that the CMS has a methodology for determining the size of the total computable dollar limit for the LIP program. The state reserves the right to request an expenditure limit that is larger than the current limit set for demonstration year 11.

Attachment II
Performance Measures and Results

The Agency has specific performance measures for which the MMA plans are required to submit data. These performance measures are in place to monitor health care service delivery and to provide a mechanism for assessing the effectiveness of the program. The Agency reviewed the following quality performance measure sets to ensure the Agency required measures in the MMA contract were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable:

- Health Plan Effectiveness Data and Information Set (HEDIS) measures
- CMS core set of children's health care quality measures for Medicaid and Children's Health Insurance Program (child core set)
- CMS core set of adult health care quality measures for Medicaid (adult core set)

The MMA plans were required to report on the following measures to the Agency on July 1, 2016, for calendar year 2015.

Plan Performance Measures for Calendar Year 2015		
HEDIS		**Children's and/or Adult Core Set Measure**
1	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Yes
2	Adolescent Well Care Visits (AWC)	Yes
3	Adults' Access to Preventive /Ambulatory Health Services (AAP)	
4	Ambulatory Care (AMB)	Yes
5	Annual Dental Visit (ADV)	
6	Annual Monitoring for Patients on Persistent Medications (MPM)	Yes
7	Antidepressant Medication Management (AMM)	Yes
8	Adult Body Mass Index (BMI) Assessment (ABA)	Yes
9	Breast Cancer Screening (BCS)	Yes
10	Call Answer Timeliness (CAT)	
11	Cervical Cancer Screening (CCS)	Yes
12	Childhood Immunization Status (CIS) – Combo 2 and 3	Yes
13	Children and Adolescents' Access to Primary Care Practitioners (CAP)	Yes
14	Chlamydia Screening in Women (CHL)	Yes
15	Comprehensive Diabetes Care (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • Medical attention for nephropathy	Yes
16	Controlling High Blood Pressure (CBP)	Yes
17	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Yes
18	Frequency of Ongoing Prenatal Care (FPC)	Yes
19	Immunizations for Adolescents (IMA)	Yes
20	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Yes
21	Lead Screening in Children (LSC)	

Plan Performance Measures for Calendar Year 2015		
HEDIS		**Children's and/or Adult Core Set Measure**
22	Medication Management for People with Asthma (MMA)	Yes
23	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
24	Prenatal and Postpartum Care (PPC)	Yes
25	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	Yes
26	Well-Child Visits in the First 15 Months of Life (W15)	Yes
27	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Yes
Agency-defined Performance Measures		
28	Follow-Up after Hospitalization for Mental Illness (FHM)	Yes
29	Highly Active Anti-Retroviral Treatment (HAART)	
30	HIV-Related Medical Visits (HIVV)	
31	Mental Health Readmission Rate (RER)	
32	Transportation Timeliness (TRT)	
33	Transportation Availability (TRA)	
Child Health Check-Up Report (CMS-416)		
34	Dental Treatment Services (TDENT)	
35	Sealants (SEA)	
Child Core Set		
36	Preventive Dental Services (PDENT)	Yes
37	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL)	Yes
38	HPV Vaccine for Female Adolescents (HPV)	Yes
39	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC)	Yes
Adult Core Set		
40	Antenatal Steroids (ANT)	Yes
41	Plan All-Cause Readmissions (PCR)	Yes
42	HIV Viral Load Suppression (VLS)	Yes
43	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	Yes

Calendar Years 2014 and 2015 Florida MMA Performance Measures Results					
	CY 2014		**CY 2015**		
Measure	**CY 2014 Weighted Mean[1]**	**CY 2014 Comparison to National Mean**	**CY 2015 Weighted Mean**	**CY 2015 Comparison to National Mean**	**CY 2015 Comparison to CY 2014 Weighted Mean**
Adolescent Well-Care	53%	Higher	53%	Higher	Same
Adults' Access to Preventive Care - 20-44 Yrs	68%	Lower	69%	Lower	Higher
Adults' Access to Preventive Care - 45-64 Yrs	85%	Lower	85%	Lower	Same
Adults' Access to Preventive Care - 65+ Yrs	80%	Lower	77%	Lower	Lower

Calendar Years 2014 and 2015 Florida MMA Performance Measures Results					
	CY 2014		CY 2015		
Measure	CY 2014 Weighted Mean[1]	CY 2014 Comparison to National Mean	CY 2015 Weighted Mean	CY 2015 Comparison to National Mean	CY 2015 Comparison to CY 2014 Weighted Mean
Adults' Access to Preventive Care - total	74%	Lower	75%	Lower	Higher
Adult BMI Assessment	86%	Higher	86%	Higher	Same
Annual Dental Visit - total	34%	Lower	47%	Lower	Higher
Annual Monitoring for Patients on Persistent Medications - ACEs/ARBs	92%	Higher	91%	Higher	Lower
Annual Monitoring for Patients on Persistent Medications - Digoxin	46%	Lower	55%	Higher	Higher
Annual Monitoring for Patients on Persistent Medications - Diuretics	92%	Higher	91%	Higher	Lower
Annual Monitoring for Patients on Persistent Medications - total	92%	Higher	91%	Higher	Lower
Antidepressant Medication Mgmt – Acute	52%	Higher	52%	At the mean	Same
Use of Appropriate Medications for People with Asthma	84%	At the mean	N/A	N/A	N/A
Breast Cancer Screening	59%	Higher	61%	Higher	Higher
Call Answer Timeliness	87%	Higher	84%	Higher	Lower
Cervical Cancer Screening	55%	N/A	51%	Lower	Lower
Controlling Blood Pressure	57%	Higher	50%	Lower	Lower
Childhood Immunization Status - Combo 2	75%	Higher	77%	Higher	Higher
Childhood Immunization Status - Combo 3	71%	At the mean	72%	Higher	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	96%	At the mean	95%	At the mean	Lower
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	89%	Higher	89%	Higher	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	89%	Lower	89%	Lower	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	86%	Lower	86%	Lower	Same
Chlamydia Screening - 16-20 years	57%	Higher	59%	Higher	Higher

Calendar Years 2014 and 2015 Florida MMA Performance Measures Results					
	CY 2014		CY 2015		
Measure	CY 2014 Weighted Mean[1]	CY 2014 Comparison to National Mean	CY 2015 Weighted Mean	CY 2015 Comparison to National Mean	CY 2015 Comparison to CY 2014 Weighted Mean
Chlamydia Screening - 21-24 years	70%	Higher	69%	Higher	Lower
Chlamydia Screening - total	60%	Higher	62%	Higher	Higher
Diabetes - HbA1c Testing	85%	Higher	81%	Lower	Lower
Diabetes - HbA1c Poor Control (INVERSE)	42%	Lower (Better)	48%	Higher (Worse)	Higher (Worse)
Diabetes - HbA1c Good Control	48%	Higher	43%	Lower	Lower
Diabetes - Eye Exam	51%	Lower	51%	Lower	Same
Diabetes - LDL Screening	82%	Higher	N/A	N/A	N/A
Diabetes - LDL Control	34%	At the mean	N/A	N/A	N/A
Diabetes - Nephropathy	84%	Higher	92%	Higher	Higher
Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years of age	13%	Lower	10%	Lower	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years of age	6%	Lower	5%	Lower	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - total	7%	Lower	6%	Lower	Lower
Follow-up after Hospitalization for Mental Illness - 7 day	24%	Lower	36%	Lower	Higher
Follow-up after Hospitalization for Mental Illness - 30 day	38%	Lower	43%	Lower	Higher
Follow-up Care for Children Prescribed ADHD Medication - Initiation	50%	Higher	50%	Higher	Same
Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance	61%	Higher	63%	Higher	Higher
Frequency of Prenatal Care - ≥ 81% of expected visits	65%	Higher	67%	Higher	Higher
Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years of age	46%	Higher	38%	Lower	Lower
Initiation of Alcohol and Other Drug Dependence	43%	Higher	40%	Higher	Lower

Calendar Years 2014 and 2015 Florida MMA Performance Measures Results					
	CY 2014		CY 2015		
Measure	CY 2014 Weighted Mean[1]	CY 2014 Comparison to National Mean	CY 2015 Weighted Mean	CY 2015 Comparison to National Mean	CY 2015 Comparison to CY 2014 Weighted Mean
Treatment - 18+ years of age					
Initiation of Alcohol and Other Drug Dependence Treatment - total	44%	Higher	40%	Higher	Lower
Immunizations for Adolescents - Combo 1	65%	Lower	67%	Lower	Higher
Lead Screening in Children	62%	Lower	61%	Lower	Lower
Prenatal Care	84%	Higher	83%	Higher	Lower
Postpartum Care	60%	Lower	59%	Lower	Lower
Well-Child First 15 Mos. - 0 Visits (INVERSE)	3%	At the mean	2%	At the mean	Lower (Better)
Well-Child First 15 Mos. – 6+ Visits	55%	Lower	58%	Lower	Higher
Well-Child 3-6 Years	75%	Higher	75%	Higher	Same

Attachment III
Waiver and Expenditure Authority

WAIVERS FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

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

TITLE: **Managed Medical Assistance Program**

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 Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STC). The state has acknowledged that it has not asked for, nor has it received, a waiver to Section 1902(a)(2).

These waivers are effective beginning July 31, 2014, through June 30, 2017.

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) and 1902(a)(17)**

   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.

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

   To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers. This does not authorize restricting freedom of choice of family planning providers.

EXPENDITURE AUTHORITIES FOR
FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION

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

TITLE: **Managed Medical Assistance Program**

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 from July
31, 2014, through June 30, 2017, be regarded as expenditures under the state's Title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration (formerly titled Medicaid Reform). The authorities also promote the objectives of title XIX in the following ways:

- Expenditure Authorities 1 and 3 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state; and
- Expenditure Authority 2 promotes the objectives of title XIX by increasing access to, stabilizing, and strengthening providers to serve uninsured, low-income populations in the state

1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.

2. For demonstration year 10, through June 30, 2016—and demonstration year 11, July 1, 2016 through June 30, 2017—expenditures made by Florida for uncompensated care costs incurred by providers for health care services for the uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 64 and 65.

Attachment IV
Summary of Comments

The Agency carefully considered all comments received on the waiver extension. While the Agency is not recommending changes to the Special Terms and Conditions for all of these comments, the Agency takes all comments seriously and may be undertaking efforts related to these comments outside of the STCs.

Subject	Comment	Actioned (Y/N)	Notes
Extension Length	• The Agency received questions on why the State was only requesting a 3-year waiver extension instead of a 5-year waiver extension.	Y	The State is requesting a 5-year extension of the MMA program.
Low Income Pool program	• CMS incorrectly cast LIP as an "uncompensated care pool." This is not, and has not been the purpose of LIP. • LIP payments promote services that support uninsured and underinsured patients (primary care, trauma care) or facilities that provide safety net services to this population (teaching hospitals). • The LIP funding for DY11 is less than half of the cost of services for uninsured and underinsured patients. • LIP funding is critical to helping children's hospitals offset the costs of providing quality care to Florida's sickest, most vulnerable children. • LIP is the only program through which hospitals may receive assistance for providing charity care to Florida's poor and uninsured. • Texas and California both have large LIP-like federal funding programs. Florida should fight for its fair share of federal Medicaid funding and demand that LIP be maintained. • Without the LIP program, Florida's hospitals that are treating large numbers of poor, uninsured patients will be forced to shift those unreimbursed costs to paying patients. • Continuation of the LIP program ensures continuous and sustainable funding pool to help offset some of the expense that hospitals bear.		The State has taken these comments into consideration and will be requesting an extension of the LIP program in the extension request to be submitted to CMS on December 31, 2016.

Subject	Comment	Actioned (Y/N)	Notes
	• The LIP ensured that the Medicaid funds would go to those providers that disproportionately met the demand for Medicaid services within our State. • There remains an unmet level of uncompensated care of at least $608 million even if Florida were to expand Medicaid. Other States such as Texas and California have received large uncompensated care pools similar to LIP. • Ensuring continued supplemental funding, be it through an extended Low Income Pool program or a new methodology, is vital to the continued financial health of the state's Medicaid system. • Florida has a large number of residents who are not eligible for Medicaid expansion, and some uncompensated care pool necessary. • Current STCs related to LIP program provide significant improvement in terms of ensuring that funds are used only for the costs of treating the uninsured. • Current the tiering structure injects unnecessary complexity into the program and provides a disincentive to counties whose LIP recipient hospitals are in Tiers 2-4, from submitting Inter-Governmental Transfers (IGTs). It may be difficult (or impossible) for hospitals that are not in Tier 1 to receive the hospital's potential LIP allotment, and it appears that several of these hospitals are critical to their community's safety net. • AHCA should aggressively seek continuation of a LIP type program similar to the more recent CMS-approved methodology and should seek additional charity care replacement funding from CMS to make up for the recent reductions to the LIP pool.		
Access to Pharmacy Services	• Recipients are restricted from freedom of choice in pharmacy services. • Recipients are forced into narrow networks and away from pharmacies that they choose to use. • Small business owners are now being left out of participation in Medicaid networks. • Limited access to pharmacies for both acute care prescriptions and maintenance prescriptions for chronic conditions. • Florida community pharmacies should be allowed to qualify and participate in MMA health plan pharmacy networks based on their individual credentials.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.

Subject	Comment	Actioned (Y/N)	Notes
	• The Agency should review the current pharmacy networks, particularly those in rural areas, to ensure that the intent of 409.912(8)(a)4 is achieved and that SMMC recipients living in rural areas are able to access pharmacy providers without traveling unreasonably, lengthy distances. • Mail service pharmacies are unable to provide adequate services to Medicaid recipients lacking a stable phone service or home address.		
Pharmacy Services	• Require insurance plans to use Florida's Medicaid State Plan Preferred Drug List and prohibit the use of additional utilization management tools beyond those already used by the State. • Include HIV quality measures in the annual MMA Health Plan Report Card. • Waiver should include an amendment to the state plan to modify the list of covered outpatient prescription drugs to include anti-obesity drugs as permitted by section 1927(d)(2) of the Social Security Act. • Waiver STCs should require the Agency to work with CMS and other national experts to design and implement an adult vaccination program as a mandatory covered service.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.
Network Adequacy and Access to Services	• The plans' urgent care policies and protocols should support the contract one-day urgent care standard. • Health plan contracts should be modified to increase the plans' responsibility to educate their members about the timely access and network provider protections, and to ensure their customer service staff are properly trained. • The Agency should work with CMS to "pilot" a new quality rating system for Florida plans which are tailored to measure access and care quality relevant to the unique needs of Medicaid consumers. • The Agency should develop and pursue an outreach campaign on Medicaid managed care consumer protections, including educating families about Early and Periodic Screening Diagnosis and Treatment benefits, and how to access them.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.

Subject	Comment	Actioned (Y/N)	Notes
Plan Enrollment and Access	• Recipients are having difficulty in: - Obtaining referrals to specialists or finding a specialist who is accepting new patients in their health plans - Obtaining consumable medical supplies - Locating a provider for their consumable medical supplies • The DCF website lacks an express enrollment option. • Recipients are auto-enrolled into specialty plans with no prior notice. • Choice counseling process should be revised to ensure that enrollment in both MMA and LTC programs are accomplished together, and not delayed by a second enrollment process.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.
Improving Quality of Care	• Enhanced payment fee schedule available to the MMAs caring for average Medicaid children to boost payments to those physicians seeing Children's Medical Services children. • Payment should be aligned with quality outcomes. • Instead of penalizing providers for an excess number of readmissions and emergency visits, the State should provide incentives for hospitals and plans to coordinate care and reduce hospital readmissions. • Place protections to ensure that the plans that have absorbed Medicaid-eligible children with complex medical needs have the provider networks necessary to treat those kids. • Recommend a single streamlined process for obtaining authorizations and standard criteria to determine utilization management, in order to reduce length of stay, improve the transition to home, and limit readmissions for our patients. • Many providers have difficulty becoming contracted with MMA plans. • Therapy services are often approved at levels that are not sufficient to achieve the goals established in the Plan of Care, or in a timely manner. • The State Waiver should prohibit plans from denying level of care for Inpatient Care and Continuous Home Care to ensure terminally-ill beneficiaries in crisis receive the high acuity pain control and symptom management they need.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.

Subject	Comment	Actioned (Y/N)	Notes
	• The Agency should identify funding for, and engage in regular ongoing secret shopper surveys to ensure that plans are in compliance with the provider network standards set out in the model contract. • CMS and AHCA should include monitoring and evaluation of the Medicaid Fair Hearing process as the process is redesigned.		
Payment	• Implement a pass-through payment mechanism to enable plans to improve payments to providers as directed by AHCA. • AHCA should include some description of the "actuarially sound premiums" as being based on historical expenditures that are not necessarily limited to Medicaid fee-for-service payment rates. • CMS and AHCA should include evaluation of actual payments to providers and not solely capitation payments paid to MMA plans, as well as MMA plan rates for contracted providers for the services included in the MMA program. • Recommend extending the inclusion of payments for nursing facility in the MMA capitation rates for all MMA enrollees, not just those under age 18.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.
Dental Services	• Florida's dental managed care program and dental care should be independent and excluded from the scope of services of the MMA. • The Agency should mandate liquidated damages for all plans that fail to reach target rates.	N	The State has taken these comments into consideration, and at this time the State is not requesting changes to Special Terms and Conditions based on these comments.

Attachment V
Letters to the Miccosukee and Seminole Tribe

October 11, 2016

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

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from October 11, 2016 through November 10, 2016. The Agency has scheduled three public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held in:

- Tallahassee, Florida: October 18, 2016, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1 888 419 5570, and enter the participant passcode: 492 773 91#.
- Tampa, Florida: October 20, 2016, 11:30 a.m. – 1:00 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 498 282 50#.
- Miami, Florida: October 21, 2016, 10:00 a.m. – 11:30 a.m. at the Agency for Health Care Administration, 8333 NW 53rd St, Suite 200, Doral, FL 33166. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 474 080 47#.

If you have any questions about this amendment or would like to hold a call, please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Beth Kidder
Interim Deputy Secretary for Medicaid

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

Dear Ms. Osceola:

This letter is being sent to notify the Seminole Tribe of Florida the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from October 11, 2016 through November 10, 2016. The Agency has scheduled three public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held in:

- Tallahassee, Florida: October 18, 2016, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1 888 419 5570, and enter the participant passcode: 492 773 91#.
- Tampa, Florida: October 20, 2016, 11:30 a.m. – 1:00 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 498 282 50#.
- Miami, Florida: October 21, 2016, 10:00 a.m. – 11:30 a.m. at the Agency for Health Care Administration, 8333 NW 53rd St, Suite 200, Doral, FL 33166. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 474 080 47#.

If you have any questions about this amendment or would like to hold a call, please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Beth Kidder
Interim Deputy Secretary for Medicaid

Attachment VI
FAR Notice

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration (Agency) announces public meetings to which all persons are invited.

DATES AND TIMES: October 18, 2016, 2:00 p.m. – 4:00 p.m.; October 20, 2016, 11:30 a.m. – 1:00 p.m.: October 21, 2016, 10:00 a.m. – 11:30 a.m.

PLACES: October 18, 2016, 2:00 p.m. – 4:00 p.m.: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL 32308; to participate by phone, please call: 1 888 419 5570, and enter the participant passcode: 492 773 91#.

October 20, 2016, 11:30 a.m. – 1:00 p.m.: The Agency for Health Care Administration, 6800 North Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 498 282 50#.

October 21, 2016, 10:00 a.m. – 11:30 a.m.: The Agency for Health Care Administration, 8333 NW 53rd St, Suite 200, Doral, FL 33166: To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 474 080 47#.

GENERAL SUBJECT MATTER TO BE CONSIDERED: Three-year extension request for Florida Medicaid's1115 Managed Medical Assistance (MMA) Waiver

SUMMARY DESCRIPTION OF EXTENSION REQUEST: The State is seeking federal authority to extend Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 through June 30, 2020. The MMA program operates statewide and provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including higher quality of care and stronger protections for Florida Medicaid recipients.

Starting October 11, 2016, a full description of the extension request, the public notice document, will be published on the Agency's website at the following link:

http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

PUBLIC NOTICE AND PUBLIC COMMENT PERIOD: The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The Agency will consider all public comments received regarding the proposed extension request. The 30-day public notice and public comment period is from October 11, 2016 through November 10, 2016. This public notice and public comment period is being held to solicit public input from recipients, providers and all stakeholders and interested parties on the proposed extension request for Florida's 1115 MMA Waiver.

To submit comments by postal service or Internet email, please follow the directions outlined below. When providing comments regarding the extension request for the 1115 MMA Waiver, please put '1115 MMA Waiver Extension' in the subject line. Mail comments and suggestions to: 1115 MMA Waiver Extension, Office of the

Deputy Secretary for Medicaid, Agency for Health Care Administration, 2727 Mahan Drive, MS 8, Tallahassee, Florida 32308. Email your comments and suggestions to FLMedicaidWaivers@ahca.myflorida.com.

A copy of the agenda may be obtained by contacting Heather Morrison at (850)412-4034 or by email, Heather.Morrison@ahca.myflorida.com

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Heather Morrison at (850)412-4034 or by email, Heather.Morrison@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

Attachment VII
Provider Alert

The State is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. The MMA program operates statewide and provides primary and acute medical care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including, stronger protections for Florida Medicaid recipients.

For more information on the public meetings, information on submitting comments, and to view a comprehensive description of the waiver amendment request. *Please visit:*

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

During the meetings, the Agency for Health Care Administration will provide a description of the MMA program; and allow time for public comments. The public meetings for the MMA Waiver extension request will take place:

Tuesday, October 18, 2016 from 2:00 p.m. – 4:00 p.m.

Agency for Health Care Administration

2727 Mahan Drive
Building 3

Conference Room A

Tallahassee, FL 32308

Conference Line: 1 888 419 5570

Participant Code: 492 773 91

Thursday, October 20, 2016 from 11:30 a.m. – 1:00 p.m.

Agency for Health Care Administration

6800 North Dale Mabry Highway

Main Training Room

Tampa, FL 33614

Conference Line: 1 888 419 5570

Participant Code: 498 282 50

Friday, October 21, 2016 from 10:00 a.m. – 11:30 a.m.

Agency for Health Care Administration

8333 NW 53rd St, Suite 200

Doral, FL 33166

Conference Line: 1 888 419 5570

Participant Code:474 080 47

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least seven days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034 or by email at Heather.Morrison@ahca.myflorida.com

If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

In addition to at the public meetings, comments can be submitted via mail or email. Comments will be accepted from October 11 – November 10, 2016.

Mail comments and suggestions to:

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver Extension Request" referenced in the subject line.

Additional information about the SMMC program can be accessed by visiting www.ahca.myflorida.com/SMMC

Attachment VIII
Budget Neutrality Spreadsheets

Requirement: *Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.*

Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested waiver extension period (July 1, 2017 to June 30, 2022) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the CMS financial management standard questions, see Attachment IX. The following addresses the items specified above and documents that the waiver is budget neutral.

A. General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs of the waiver, as agreed upon by the State and CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality "test", as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida's MMA Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

B. Budget Neutrality Results to Date

The table located on the following page, provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Capita Cost per Month (PCCM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PCCM targets, as provided in the STCs, are also weighted using the actual case months. Since inception of the demonstration through DY9, expenditures have been $22.8 billion less than the authorized budget neutrality limit. As a result, the State is in substantial compliance with budget neutrality and anticipates that by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 6	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					70.14%
DY 7	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$7,224,274,901	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% Of WOW					67.49%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,867,69	$7,198,209,036	$1,579,606,142	$8,777,815,179	$304.07
WOW	28,867,69			$13,874,528,641	$480.62
Difference				$(5,096,713,462)	
% Of WOW					63.27%

DY 09	Actual CM	Total	PCCM
Meg 1 & 2	32,495,517	$10,405,223,930	$320.20
WOW	32,495,517	$12,996,499,770	$399.95
Difference		$(2,591,275,840)	
% Of WOW			80.06%
DY 10	**Actual CM**	**Total**	**PCCM**
Meg 1 & 2	36,177,671	$12,612,837,488	$348.64
WOW	36,177,671	$15,453,675,472	$427.16
Difference		$(2,840,837,984)	
% Of WOW			81.62%

C. Florida's 1115 Research and Demonstration Waiver

The projection of budget neutrality benchmarks for the requested five-year waiver extension (July 1, 2017-June 30, 2022) is included. The following are the basic concepts and assumptions used to project the five-years (DY12-DY16).

The without waiver (WOW) trend applied to the member month projections are based on the waiver's historic population trends experienced during DY1 to DY8. For the MMA population, the waiver was amended commencing with DY8, and a separate trend calculation was constructed for SFY10/11 to SFY13/14 (DY5-DY9). This is same trend methodology utilized for the waiver amendment approved October 12, 2016. The trend calculation has subsequently been updated to include the most current data available. The same "president's trend" rates as defined in the latest amendment were utilized for the WOW PCCM projections. For the historic waiver populations, the DY8 PCCM as defined in STC#116b was applied to DY8, and the president's trend rates were applied to DY12-DY16. For the MMA populations, a separate trend calculation was utilized as defined in budget neutrality spreadsheets.

The with waiver (WW) projections follow the same concept as the WOW calculations. There are no president's trends utilized in the WW projections. All the WW trend rates were derived from the historical population trends and the separate MMA trend calculations.

The WOW and WW months of aging are defined as the 48 months from the mid-point of DY8 through the mid-point DY12.

Regarding historic trend data for DY9, expenditures are complete through June 30, 2016. Since the demonstration years are defined as dates-of-service, there will be additional claim submissions still forthcoming for this year.

With the above calculated PMPMs and member months, the total WOW expenditures for the five extension years are projected to be $146,650,536,432 compared to the WW expenditures of $105,580,097,021 for the same extension years. This would result in a savings over the five-year period of $41,070,439,411. Separate calculations are identified for the two programs covered under this waiver extension as costs not otherwise matchable (CNOM).–These are the Healthy Start program and the Program of All Inclusive Care for Children.

MEG 3 was established in the initial waiver application as approved by CMS. The MEG is also referred to as the LIP and is not directly linked to Florida Medicaid eligibility. Expenditures for the LIP program are authorized for the costs of uncompensated charity care for low-income

individuals that are uninsured. The uncompensated care must be furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level but may not include uncompensated care for insured individuals, “bad debt,” or Florida Medicaid and CHIP shortfall. Distributions to qualifying hospitals under the LIP program are determined by their percentage of charity care cost to commercial charges. Payments to hospitals are not paid through the claims processing system but are lump sum payments made directly to the hospital to offset the allowable uncompensated care. The limit for the LIP program is established in the budget neutrality and is reported in accordance with the requirements of the STCs of the waiver specific to budget neutrality. However, the program requirements and monitoring are subject to STCs of the waiver established for the LIP program. The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

Attachment IX
Standard Financial Questions

1. **Question**: Section 1903(a) (1) of the SSA, provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan. Do providers receive and retain the total Florida Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   Response: Providers retain 100 percent of all payments made relating to the MMA program. If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS by making adjustments on the quarterly CMS 64 report.

2. **Question:** Section 1902(a) (2) of the SSA, provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Florida Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature to the Florida Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Note that, if the appropriation is not to the Florida Medicaid agency, the source of the State share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;

   (ii) the operational nature of the entity (State, county, city, other);

   (iii) the total amounts transferred or certified by each entity;

   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,

   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: There are no intergovernmental transfers or certified public expenditures directly related to the payments for the MMA program. The State share of payments for the MMA program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, and the Provider Medical Assistance Trust Fund.

3. **Question:** Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   Response: There are no supplemental or enhanced payments being made for the MMA program.

4. **Question**: Please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated and privately owned or operated). Please provide a current (i.e. applicable to current rate year) UPL demonstration.

   Response: On March 18, 2013, Federal CMS issued a State Medicaid Director's Letter (SMDL #13-003) describing the mutual federal and state obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program. Among the obligations included: ongoing consistency with the applicable federal upper payment limit (UPL) requirements described in regulation for certain services. The regulations implement, in part, section 1902(a)(30)(A) of the Social Security Act which requires that Medicaid rates are consistent with efficiency, economy and quality of care. Starting in 2013, states are required to submit UPL demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Beginning in 2013, states must submit UPL demonstrations for inpatient hospital services, outpatient hospital services and nursing facilities.

   For Florida State Fiscal Year (SFY) 2015-16, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

   Comparisons of Medicaid payments to estimated Medicare payments (the UPLs) are made separately for hospital inpatient and outpatient services. Also, the comparisons are made for three categories of providers: (1) state owned (2) non-state government owned; and (3) privately owned hospitals.

   A UPL analysis has been completed to accompany both the SFY 2015-16 inpatient and outpatient reimbursement state plan amendments.

   Estimated Medicare payments which determine the UPL were calculated using a detailed costing method. For each hospital, information extracted from Medicare cost reports were

used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories: state-owned, non-state government owned, and privately owned (all others).

The UPL for each of the three UPL categories was calculated using the detailed costing demonstration method. For each hospital, information extracted from Medicare cost reports was used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. Standard cost centers as defined by CMS were used. In addition, a mapping was created to assign revenue codes to cost centers. This allowed each claim detail line item to be assigned a cost center. Hospital costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Hospital costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. The hospital cost amounts on all the claim lines for a hospital were summed to get the total cost for the hospital, and total hospital cost was used as the upper payment limit.

5. **Question:** Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to Federal CMS on the quarterly expenditure report?

   Response: Payments to providers relating to this program will not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the State and the federal share is reported on the 64 report to CMS.