Florida Medicaid
Managed Medical Assistance Waiver

1115 Research and Demonstration Waiver
#11-W-00206/4

Public Notice Document

03/09/18 – 04/07/18

Agency for Health Care Administration

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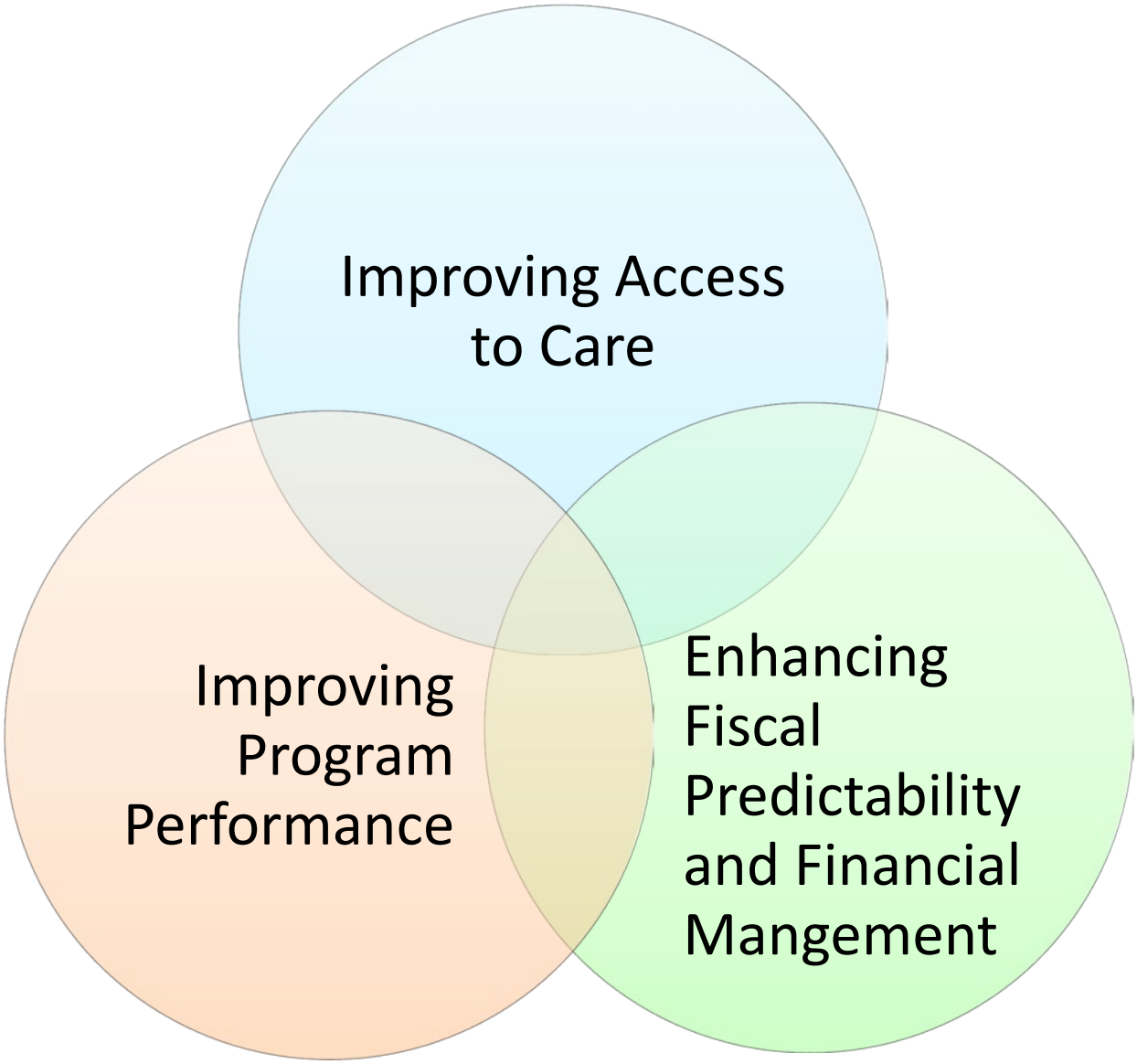
Introduction

The Managed Medical Assistance (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.



Purpose, Goals, and Objectives

Statement of Purpose

The Agency for Health Care Administration (Agency) is seeking federal authority to amend Florida Medicaid's 1115 MMA Waiver (Project Number 11-W-00206/4) to operate a Statewide Medicaid prepaid dental health program (PDHP). The State intends to operate the PDHP as an "Additional Program" under Section XIII of the Special Terms and Conditions (STCs) in order to provide Florida Medicaid State Plan dental services to recipients through dental managed care organizations (dental plans). The PDHP is expected be implemented by January 1, 2019.

The PDHP does not reduce, or otherwise impede access to, Florida Medicaid dental services for any impacted recipient. The State is not requesting any substantive changes to the 1115 MMA Waiver outside those specified in this amendment request. The State anticipates the PDHP will operate in accordance with the existing CMS-approved STCs to the extent applicable. Any areas of divergence are specified in this request.

For additional information about the current MMA program requirements, please visit the Agency's Web site at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml.

Historical Overview

The State of Florida has offered Medicaid services since 1970. The Florida Medicaid program is funded by both the state and federal governments to provide health care coverage for eligible children, seniors, disabled adults, parents of children, and pregnant women. More than 3.1 million Floridians are enrolled in Florida's Statewide Medicaid Managed Care (SMMC) program, a component of which is the MMA program.

The State previously operated a prepaid dental health program. In December 2003, the Agency received approval from the Centers for Medicare & Medicaid Services (CMS) for the Prepaid Dental Health Plan. Starting July 2004, the Agency implemented the plan, limited to Medicaid eligible children under the age of 21 in Miami-Dade County, to expand the use of dental management organizations in order to improve access, contain cost, and eliminate fraud. Through an open competitive procurement process, the Agency originally contracted with a single Prepaid Ambulatory Health Plan to implement the program in Miami-Dade County.

In 2010, Florida law authorized the Agency to implement a statewide prepaid dental health plan in 61 counties, excluding Miami-Dade County and the 1115 Medicaid Reform Waiver (now the MMA Waiver) in the following counties: Broward, Baker, Clay, Duval, and Nassau. The Agency issued a competitive procurement that resulted in the Agency contracting with two vendors to implement the statewide program. Implementation of the statewide expansion began in January 2012.

In 2013, CMS approved the Agency's request to amend Florida's 1115 Medicaid Reform Waiver and retitle it as the MMA Waiver to implement a new model of managed care in all counties in Florida. The State closed the Prepaid Dental Health Plan program in conjunction with the implementation of the SMMC program. Since 2014, the MMA Waiver has facilitated medical and acute care services, including dental services, through managed care organizations known as MMA plans. Recipients who are not enrolled in an MMA plan receive dental services through the fee-for-service delivery system.

In 2016, the Florida Legislature required the Agency to create a statewide Medicaid PDHP to provide dental services to Florida Medicaid recipients, irrespective of whether the individual is enrolled in an MMA plan or participating in the fee-for-service delivery system.

For additional information, please see Attachment I.

Goals and Objectives

The goals and objectives of this waiver amendment are to ensure the provision of Florida Medicaid dental services through an integrated system of care that improves access to services, dental health outcomes and quality metrics, and care coordination. These goals are consistent with the current MMA Waiver's goals and objectives.

Program Description

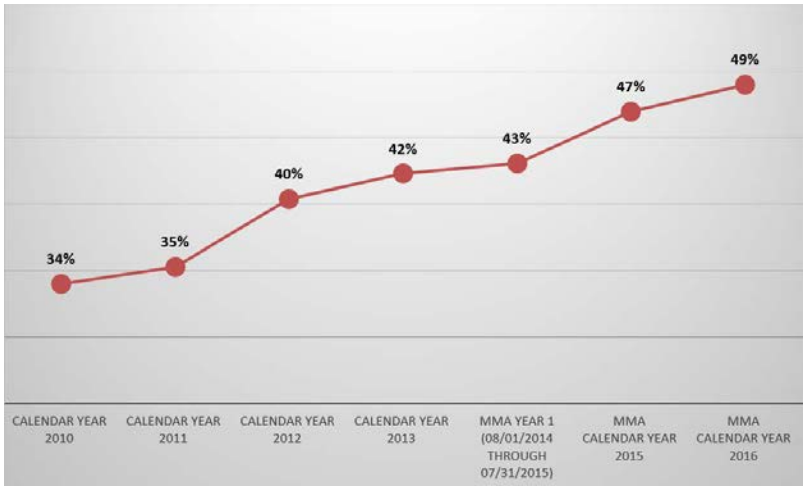
The Agency intends to implement the new PDHP to provide Florida Medicaid State Plan dental services to all Florida Medicaid recipients, except those who are identified as an excluded population. Currently, Florida Medicaid recipients receive dental services coordinated through their MMA plan, or for those who are not enrolled in the SMMC program, directly from eligible providers through the fee-for-service delivery system.

Florida has experienced significant improvements in its dental scores and quality metrics in recent years. For example, in its 2015/16 CMS-416 report, the State reported:

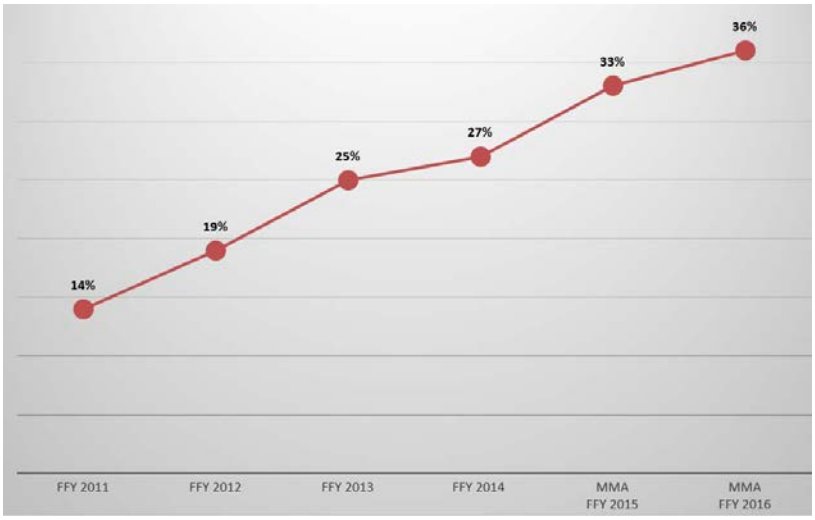
- 36% of eligible children aged one through 20 years, enrolled for 90 continuous days, received a preventive dental service, as calculated using the Child Core Set PDENT measure. This is a three-percentage point increase from the previous year and a 17-percentage point increase over the FFY 2011 – 2012 report.
- 156,291 children received a sealant on a permanent molar, an increase of more than 16,550 children (12%) compared to the previous year.
- More than 41% of eligible enrollees accessed some form of oral health care through Florida Medicaid.

In addition, dental quality scores have steadily improved, with the HEDIS Annual Dental Visit score increasing to 49% and the statewide Child Core Set Preventive Dental score rising to 36%.

Annual Dental Visit HEDIS Measure



Preventive Dental Services – Child Core Set



While the provision of dental services has improved, the PDHP is designed to aggressively help the State achieve, and exceed, a number of prescribed targets for the provision of dental services:

Description	Target Year	Target Rate
Annual Dental Visit. HEDIS Performance Measure	Contract Year 2019	48%
	Contract Year 2020	49%
	Contract Year 2021	50%
	Contract Year 2022	51%
	Contract Year 2023	52%
Preventive dental services rate for enrollees who are continuously eligible for EPSDT for 90 days. CMS-416 Report	Federal Fiscal Year 2018-19	41%
	Federal Fiscal Year 2019-20	44%
	Federal Fiscal Year 2020-21	46%
	Federal Fiscal Year 2021-22	48%
	Federal Fiscal Year 2022-23	50%
Dental treatment services rate for enrollees who are continually eligible for EPSDT for 90 days. CMS-416 Report	Federal Fiscal Year 2018-19	21%
	Federal Fiscal Year 2019-20	23%
	Federal Fiscal Year 2020-21	24%
	Federal Fiscal Year 2021-22	24%
	Federal Fiscal Year 2022-23	24%

Procurement and Contract Terms

The PDHP will engage dental plans, through a competitive procurement process, to provide high quality, coordinated, prepaid dental services. The Agency will award fixed price contracts

to a maximum of four statewide dental plans that are health maintenance organizations under Part 1 of Chapter 641, Florida Statutes, or qualified as a prepaid limited health service organization under Part I of Chapter 636, Florida Statutes. The dental plans will be paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees.

The anticipated term of the contracts will be from the date of contract execution through September 30, 2023. The first contract year will begin on the date of contract execution through September 30, 2019. Subsequent contract years will run from October 1 through September 30 of the contract year.

The MMA plans currently contract with dental benefit managers to provide dental services to their enrollees. These dental benefit managers are therefore familiar with the Florida Medicaid population, and many have engaged in the procurement process for the PDHP.

Eligible and Excluded Populations

All recipients who are mandatory or voluntary for enrollment in an MMA plan will be mandatory for enrollment in the PDHP and will receive dental services through a dental plan in accordance with section 409.973(5)(b), Florida Statutes unless specifically excluded. Approximately 3.4 million Florida Medicaid recipients will receive dental services through the PDHP post transition. Recipients excluded from enrollment in the PDHP are individuals who have limited Medicaid eligibility and are therefore not eligible to receive State Plan dental services or who receive dental services through the institution in which they reside or through the program in which they are enrolled:

- Individuals eligible for emergency services only due to immigration status
- Family Planning Waiver eligibles
- Presumptively eligible pregnant women
- Individuals residing in one of the following institutional settings:
    - State mental health hospital if under the age of 65 years
    - Residential treatment facility
- Program of All-Inclusive Care for the Elderly enrollees
- Partial dual eligibles

Enrollment and Disenrollment

The Agency encourages all enrollees to make an active plan choice, and will ensure timely access to dental services by automatically enrolling individuals who do not make an affirmative choice into a dental plan in accordance with the existing MMA Waiver enrollment procedures.

Choice counseling will also be available to help individuals select a dental plan that best meets their needs.

Current MMA procedures will also apply to disenrollment from dental plans. Enrollees may disenroll from their chosen or assigned dental plan at any time during the initial 120-days of enrollment, or for good cause for the remainder of the year until the next open enrollment period in accordance with Rule 59G-8.600, Florida Administrative Code.

Access to Care

The PDHP will include robust provider network requirements for dental plans that align with current MMA plan requirements. In addition, PDHPs will be required to ensure adequate access to specialist dental services and access to providers who treat individuals with special needs:

Prepaid Dental Health Plan Provider Network Standards Table					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Providers per Enrollee
Primary Dental Providers					
General Dentist	50	35	75	60	1:1,500
Specialists					
Pediatric Dentist	50	35	75	60	1:3,000
Endodontist	80	60	90	75	1:5,000
Orthodontist	100	75	110	90	1:35,500
Oral Surgeon	100	75	110	90	1:20,600

These requirements maintain current MMA dental service access standards and establish requirements for recipients who currently participate in the fee-for service delivery system.

Coverage, Expanded Benefits, and Care Coordination

The PDHP will continue to provide all current Florida Medicaid State Plan dental services to individuals enrolled in the dental plan in accordance with the applicable Florida Medicaid coverage policies and approved billing codes specified in Rule Chapter 59G-4, F.A.C listed below. This transition does not affect the provision of any other benefit or program operated

under the MMA Waiver, including transportation services that will continue to be provided by the MMA plan or state transportation vendor:

Applicable Florida Medicaid Policies	
Rule Number	**Policy Name**
59G-4.002	Dental General Fee Schedule Practitioner Fee Schedule Prescribed Drugs (Not Reviewed by the Pharmaceutical and Therapeutics Committee) Fee Schedule Prescribed Drug Fee Schedule Federally Qualified Health Center Billing Codes County Health Department Billing Codes
59G-4.055	County Health Department Clinic Services
59G-4.060	Dental Services Coverage Policy
59G-4.100	Federally Qualified Health Care Services
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook

Dental plans will be subject to the Early and Periodic Screening Diagnosis and Treatment requirements specified in Title 42, United States Code, subsection 1396d(r)(5). Dental plans will also be responsible for post-stabilization dental care services in accordance with Title 42, Code of Federal Regulation (CFR), section 438.114and section 1932(b)(2)(A)(ii) of the Social Security Act, including ensuring a follow up appointment is scheduled within 7 days of discharge.

In addition to State Plan dental benefits, the dental plans may offer prescribed Agency-approved expanded benefits to enrollees. Expanded benefits are services that are in excess of the amount, duration, and scope of those services required by Florida Medicaid, for example, more comprehensive dental services for recipients aged 21 years and older. Potential expanded benefit offerings under the PDHP would be in addition to any MMA plan expanded benefits.

The dental plans will coordinate enrollee dental services, and provide case management support. The plans will also coordinate with an enrollee's MMA plan as appropriate. The MMA plans remain responsible for coordinating all other services for their enrollees, including services that may be tangential or necessary to complete a dental service, for example an inpatient hospital stay or home and community-based dental services.

Continuity of Care

The PDHP maintains the continuity of care provisions of the MMA program as they relate to dental services. Dental plans will be required to continue previously authorized services at the

authorized levels, and through the existing provider, for up to the first sixty days of enrollment. Continuity of care requirements will apply to orthodontia services until the care is completed.

Effect on Recipients

Managed Medical Assistance plan enrollees currently receive dental services in a managed care environment, so these recipients will experience minimal differences in how they receive services. Many of these individuals will already be familiar with some of the dental plans and their providers if existing MMA dental benefit managers are chosen to participate as dental plans. These individuals may also benefit from additional expanded benefits not available through their MMA plan.

Recipients who currently receive dental services through the fee-for-service delivery system will benefit from coordinated dental services, greater choice of providers, and access to dental expanded benefits through their dental plan. Furthermore, the State anticipates the PDHP will improve access to dental services, especially to those with intellectual and developmental disabilities who represent a significant portion of the state's fee-for-service population.

The State expects all recipients to benefit from a targeted, integrated system of care, that focuses on dental services to improve dental health outcomes overall. Recipients will still have access to the same State Plan dental services available to them currently in addition to expanded benefits. Recipients will not experience a loss or gap in services resulting from implementing the PDHP due to safeguards the State has put in place, particularly the continuity of care requirements that apply during transition and whenever a recipient enrolls in a new plan.

Communications and Outreach

The Agency will conduct a robust outreach campaign to ensure recipients and providers impacted by this transition are aware of the PDHP, the impending transition into the program, and the choices available to them, through multiple mediums. For example:

- Written correspondence
- Educational materials and webinars
- Choice counseling and enrollment materials
- Web-based information
- Provider alerts

Transition-Specific Activities

The PDHP will largely operate in accordance with existing MMA Waiver procedures once fully implemented. However, during the transition period, the following elements will apply:

Plan Readiness

The Agency will conduct a readiness review of all dental plans selected to participate in the PDHP. Dental plans that do not demonstrate the ability to provide services to enrollees, including having an adequate network of providers, will not receive any recipient enrollment.

Auto Enrollment Assignment Process

The Agency will auto-assign individuals who do not make an active plan choice into their existing dental plan that was subcontracted as a dental benefits manager for their current MMA plan. If an individual's existing plan is not a participating dental plan under the PDHP, or if the recipient does not have an existing plan, the Agency will auto-assign based on the following criteria:

- Whether the plan has sufficient network capacity to meet the needs of the recipients.
- Whether the recipient has previously received services from one of the plan's primary dental providers.
- Whether primary dental providers in one plan are more geographically accessible to the recipient's residence than those in other plans.
- A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the Prepaid Dental Health Plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing Florida Medicaid services to the newborn. The mother may choose another plan for the newborn within 90 days after the child's birth.

Effect on the MMA Waiver

The State proposes the PDHP operate as an additional program authorized under the MMA Waiver. While many of the STCs that pertain to the MMA Waiver apply, there are some notable points of difference:

- Dental plans will be the sole providers of State Plan dental services. MMA plans will no longer provide State Plan dental services.
- There will not be dental specialty plans.
- Dental plans will provide services statewide.

- Dental plans may opt to provide Agency-approved healthy behavior programs related to dental services.
- Dental plans will be responsible for any required dental-related performance improvement projects.

Evaluation

The Agency proposes adding the following component to the MMA Waiver evaluation to examine the effect of providing dental health services to Florida Medicaid recipients through the PDHP:

Component 8- The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services.

This component will be evaluated beginning Demonstration Year 14 (State Fiscal Year 2019-20).

In keeping with the Agency's goals to improve dental health outcomes for enrollees, analyses for this component will include the following:

- Description of enrollee demographics (age, race/ethnicity, gender), including geographic information
- Quantitative analyses focusing on what changes occur in dental health service utilization, quality, and cost with the implementation of the PDHP
- Examining barriers that enrollees encounter when accessing dental health services utilizing Agency complaint data and information
- Quantitative analyses focusing on the impact of enrollees' utilization of dental health services, including enrollees' use of expanded benefits provided by the dental health plans, on dental-related hospital events, to the extent possible
- Examining and describing the number and types of expanded benefits offered by the dental health plans and which ones are most commonly used
- Qualitative and quantitative analyses focusing on how enrollees rate their experiences and satisfaction, including timeliness of dental health care services, with the implementation of the PDHP. Enrollees' experiences and satisfaction with dental expanded benefits will also be examined

Expenditure Authority

See Attachment III for the State's current approved Waiver and Expenditure Authorities. The State is seeking waiver and expenditure authority to operate a Statewide Medicaid Prepaid Dental Health Program as an "Additional Program" under MMA, as referenced in Section XIII of the STCs.

Budget Neutrality Compliance

The State is required to provide an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its amendment request.

The current budget neutrality accounts for member months and expenditures for dental expenses in the MMA Waiver program. The Agency will revise the With Waiver (WW) and With Out Waiver (WOW) calculations for the MMA Medicaid Eligibility Groups in accordance with this amendment request. The WW and WOW calculate the anticipated changes to the budget, including the PDHP, and project what the budgetary impact would be if the State continued the demonstration in its current form.

The State will update the budget neutrality to include the fee-for-service population that will be part of the PDHP. The State anticipates the PDHP will not impact budget neutrality and that the MMA Waiver will continue to be budget neutral for the life of the extension.

Public Notice Process

Public Notice Process

The State will conduct a 30-day public comment period from March 9, 2018 to April 7, 2018 to solicit input on the waiver amendment request.

The State notified stakeholders of the public comment period using the following methods:

- Published public notice on March 9, 2018 in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes
- Emailed individuals and organizations on the interested stakeholders list
- Posted a provider alert on the Agency's Web site

Public Notice Materials

The State posted the dates, times, and locations of two public meetings, and a link to this public notice document on the Agency's Web site at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The State provided this link in the FAR notice and email to interested stakeholders.

Consultation with Indian Health Programs

The State sent written correspondence to the Indian Health Programs located in Florida to solicit input on the waiver amendment request (Attachment II). The State of Florida does not have any Urban Indian Organizations, but has two federally recognized tribes: the Seminole Tribe and Miccosukee Tribe.

Public Meetings

The State will hold two public meetings during the public comment period. Individuals unable to attend the meetings in person may participate via conference call by using the toll-free number provided. During the meetings, the State will provide a brief overview of the 1115 MMA Waiver amendment request and allow time for public comment.

MMA Amendment Public Meetings		
Location	**Date**	**Time**
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3 Tallahassee, FL 32308 Conference Line: 1 (888) 419-5570 Participant Code: 157-551-90	March 20, 2018	2:00 – 4:00 pm
Tampa Agency for Health Care Administration 6800 N. Dale Mabry Highway, Suite 220 Tampa, FL 33614 Conference Line: 1 (888) 419-5570 Participant Code: 571-178-31	March 28, 2018	3:30 – 5:00 pm

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 Kimberly Quinn at (850) 412-4284 or by email at Kimberly.Quinn@ahca.myflorida.com.

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

Submitting Written Comments

Written comments on the waiver amendment can be submitted via mail or email with the subject "1115 MMA Amendment – Dental Carve Out" during the public comment period.

Mail: Agency for Health Care Administration
Bureau of Medicaid Policy
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

Email: FLMedicaidWaivers@ahca.myflorida.com

Attachment I -
Federal and State Waiver Authority, Historical Description

Initial 5-Year Period (2006-2011):

On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by CMS. The program was implemented in Broward and Duval counties on July 1, 2006, and expanded to Baker, Clay, and Nassau counties on July 1, 2007.

Three-Year Extension Period (2011-2014):

On December 15, 2011, the Agency received approval from CMS to extend Florida's 1115 Medicaid Reform Waiver for the period July 1, 2011 through June 30, 2014.

MMA Waiver Amendment (2014):

On June 14, 2013, the Agency received CMS approval to amend the waiver to terminate the Medicaid Reform program, implement the MMA program, and rename the waiver, "Managed Medical Assistance". The Reform program was terminated on August 1, 2014 with the implementation of the MMA program.

Three-Year Waiver Extension (2014-2017):

On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver for an additional three years (July 31, 2014 - June 30, 2017). The Agency received approval for the three-year extension from CMS on July 31, 2014. The effective dates of the current waiver period are July 31, 2014 through June 30, 2017.

MMA Waiver Amendment (2015):

On October 15, 2015, the Agency received approval to:

1. 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, to voluntarily enroll in an MMA plan.
2. Enroll newly Medicaid eligible recipients into a managed care plan immediately after their eligibility determination, and to make changes to the auto-assignment criteria.
3. Extend the LIP program through the remainder of the demonstration period ending June 30, 2017.

MMA Waiver Amendment (2016):

On October 12, 2016, the Agency received approval to:

1. Allow the Agency flexibility to contract with one to three vendors under the hemophilia program.
2. Include payments for nursing facility services in the MMA capitation rates for MMA enrollees under the age of 18 years.
3. Allow flexibility for specialty plans to conduct Performance Improvement Projects on topics that have more specific impacts to their enrollees, with Agency approval.

MMA Waiver Extension (2016):

On December 31, 2016, the Agency submitted a request to extend authority for the 1115 MMA Waiver for an additional five years (June 30, 2017 - June 30, 2022). The extension request did not include any substantive programmatic or authority changes.

The Agency received temporary extensions to operate the MMA program from July 1, 2017 through August 4, 2017.

Five-Year Extension (2017-2022):

On August 3, 2017, the Agency received approval to extend authority for the 1115 MMA Waiver for the period of August 3, 2017 through June 30, 2022.

MMA Waiver Amendment (2017):

On December 20, 2017, the Agency received approval to:

- Transition the federal authority to serve individuals enrolled in the 1115 MEDS-AD to the MMA Waiver.
- Establish financial and non-financial eligibility criteria for individuals diagnosed with Acquired Immune Deficiency Syndrome to obtain and maintain coverage for Medicaid benefits without the need for enrollment in the 1915(c) Project AIDS Care (PAC) waiver.

Attachment II – Tribal Notification

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

March 8, 2018

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

Dear Ms. Osceola:

The purpose of this letter is to inform you that the Agency for Health Care Administration (Agency) is seeking federal authority to amend Florida Medicaid's 1115 Managed Medical Assistance Waiver (Project Number 11-W-00206/4) to operate a Statewide Medicaid prepaid dental health program (PDHP). The Agency intends to operate the PDHP as an "Additional Program" under Section XIII of the Special Terms and Conditions in order to provide Florida Medicaid State Plan dental services to recipients through dental managed care organizations. The PDHP is expected be implemented by January 1, 2019.

The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendments. The meetings will be held in:

- Tallahassee, Florida on March 20, 2018 from 2:00 – 4:00 pm at the Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Tallahassee, FL 32308. To participate by phone, please call: 1 (888) 419-5570 and enter the participant passcode: 157-551-90.

- Tampa, Florida on March 28, 2018 from 3:30 – 5:00 pm at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Tampa, FL 33614. To participate by phone, please call: 1 (888) 419-5570 and enter the participant passcode: 571-178-31.

If you would like to make any comments or need additional information, please contact Kimberly Quinn of my staff by phone at (850) 412-4284 or by email at Kimberly.Quinn@ahca.myflorida.com.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

March 8, 2018

Dr. Paul Isaacs
Executive Director, Health and Human Services
Seminole Tribe of Florida
6365 Taft Street, Suite 2004
Hollywood, FL 33024

Dear Dr. Isaacs:

The purpose of this letter is to inform you that the Agency for Health Care Administration (Agency) is seeking federal authority to amend Florida Medicaid's 1115 Managed Medical Assistance Waiver (Project Number 11-W-00206/4) to operate a Statewide Medicaid prepaid dental health program (PDHP). The Agency intends to operate the PDHP as an "Additional Program" under Section XIII of the Special Terms and Conditions in order to provide Florida Medicaid State Plan dental services to recipients through dental managed care organizations. The PDHP is expected be implemented by January 1, 2019.

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If you would like to make any comments or need additional information, please contact Kimberly Quinn of my staff by phone at (850) 412-4284 or by email at Kimberly.Quinn@ahca.myflorida.com.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
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Attachment III – Waiver Expenditure Authority

MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION
WAIVER AUTHORITIES

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—and not expressly waived in the Title XIX Waivers list below—shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act ("the Act") to enable the state to continue its Florida Managed Medical Assistance Program section 1115 demonstration 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 of Section 1902(a)(2).

These waivers are effective beginning August 1 through June 30, 2022.

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 service 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.

MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION
EXPENDITURE AUTHORITIES

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 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 August 1, 2017, through June 30, 2022, 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.

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. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured and/or underinsured.

3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.

4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 19.

5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 20.

Attachment IV –
Standard Financial Management Questions

1. The following questions are being asked and should be answered in relation to all payments made to all providers under the section 1115 demonstration under review. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

a. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?

Response: Providers retain 100 percent of all payments made relating to this program.

b. If providers are required to return any portion of any payment, 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: 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 Federal CMS by making adjustments on the quarterly CMS 64 report.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

Response: The state share of payments for this program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund (HCTF), and the Provider Medical Assistance Trust Fund (PMATF).

b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to

provide the NFS. Note that, if the appropriation is not to the 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 also indicate if any managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.

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

c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Response: The state share of payments for this program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund (HCTF), and the Provider Medical Assistance Trust Fund (PMATF).

d. If any of the NFS 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.

Response: There are no intergovernmental transfers or certified public expenditures directly related to the payments for this program.

e. 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 is in accordance with 42 CFR 433.51(b).

Response: There are no certified public expenditures directly related to the payments for this program.

f. 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 this program.

3. 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 this program.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated).

Response: The UPL demonstration reflecting SFY 2015-16 will be submitted electronically.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

a. If payments exceed the cost of services (as defined above), does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

Response: Payments to providers relating to this program would 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.

6. In the case of risk-based MCOs, PIHPs, and PAHPs:

a. Are there any payments to MCOs, PIHPs, PAHPs, or providers that are outside of the actuarial sound capitation rates in 42 CFR 438.4?

Response: Yes, besides the capitation payments made to MCOs, Florida Medicaid also pays MCOs supplemental (kick) amounts for maternity costs and for certain Medicaid covered transplants, and a separate annual amount for the ACA Health Insurance Providers Fee (HIPF). The kick payments are developed by our actuaries and the HIPF methodology and amounts are reviewed by our actuaries.

b. Are there any actual or potential payments which would be subject to 42 CFR 438.6(b), 438.6(c), 438.6(d), 438.60, or 438.74? (These payments could be for such things as managed care plan incentive arrangements, risk sharing mechanisms such as stop-loss

limits, risk corridors, medical loss ratios with a remittance, or contractual requirements that direct the managed care plans on how to pay providers, or direct payments from the State to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Response: Yes, Florida Medicaid pays DSH hospitals, certain hospitals for Graduate Medical Education (GME), Medical School Faculty payments, and wrap payments to FQHCs.

c. If so, how do the arrangements in Item (b) comply with the requirements on payments in §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74 of the managed care regulations?

Response: All payments are in compliance with the requirements on payments of the managed care regulations.

d. In situations, where MCOs, PIHPs, or PAHPs are not permitted to retain some or all of the recoveries of overpayments under the policies required in 42 CFR 438.608(d), does the state return the federal share of the recovery to CMS on the quarterly expenditure report?

Response: No, Florida Medicaid does not require MCOs to refund to the State any recoveries of overpayments to their network providers.

7. In the case of non-risk-based PIHPs, and PAHPs:

a. How do the arrangements comply with the upper payment limits specified in §447.362 limits on payments?

Response: Payments are limited to the Medicaid fee-for-service rate on the applicable Medicaid fee-for-service schedule.

b. If payments exceed the cost of services, does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

Response: Payments to providers relating to this program would 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.