Florida
Medicaid Reform

Implementation Plan

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Executive Summary

The 2005 Florida Legislature created the Medicaid managed care pilot program in s. 409.91211, F.S. The law authorizes the Agency for Health Care Administration to seek a demonstration waiver, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. The law requires the Agency to submit an implementation plan with budgetary projections of the effect of the pilot program on the total Medicaid Budget for the 2006-2007 through 2009-2010 state fiscal years as specified in s. 409.91211(6), F.S. This implementation plan was developed pursuant to s. 409.91211, F.S., and the Florida Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services (CMS).

This document summarizes the implementation milestones and activities the Agency has undertaken and will complete to begin operation of the waiver on July 1, 2006, and, with legislative approval, expand statewide by 2011. In developing the implementation plan, the Agency has conducted outreach and education to obtain comments and share information through workshops with providers, advocacy groups, recipients, and all interested parties. Medicaid reform milestones include:

I. Pre-implementation:
   - Milestone 1: Comprehensive Outreach and Education Program
   - Milestone 2: Eligibility and Enrollment Process for Mandatory and Voluntary Populations
   - Milestone 3: Choice Counseling Program
   - Milestone 4: Managed Care Plan Contracting Process
   - Milestone 5: Payment Systems
   - Milestone 6: Medicaid Opt-Out Program
   - Milestone 7: Enhanced Benefit System
   - Milestone 8: Evaluation of Medicaid Reform
   - Milestone 9: Low Income Pool Pre-Implementation Milestones
   - Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

II. Implementation:
   - Milestone 1: Implement Medicaid Reform in Broward and Duval Counties
   - Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties
   - Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties
   - Milestone 4: Complete Year 1 Milestones Established by CMS in Special Terms and Conditions

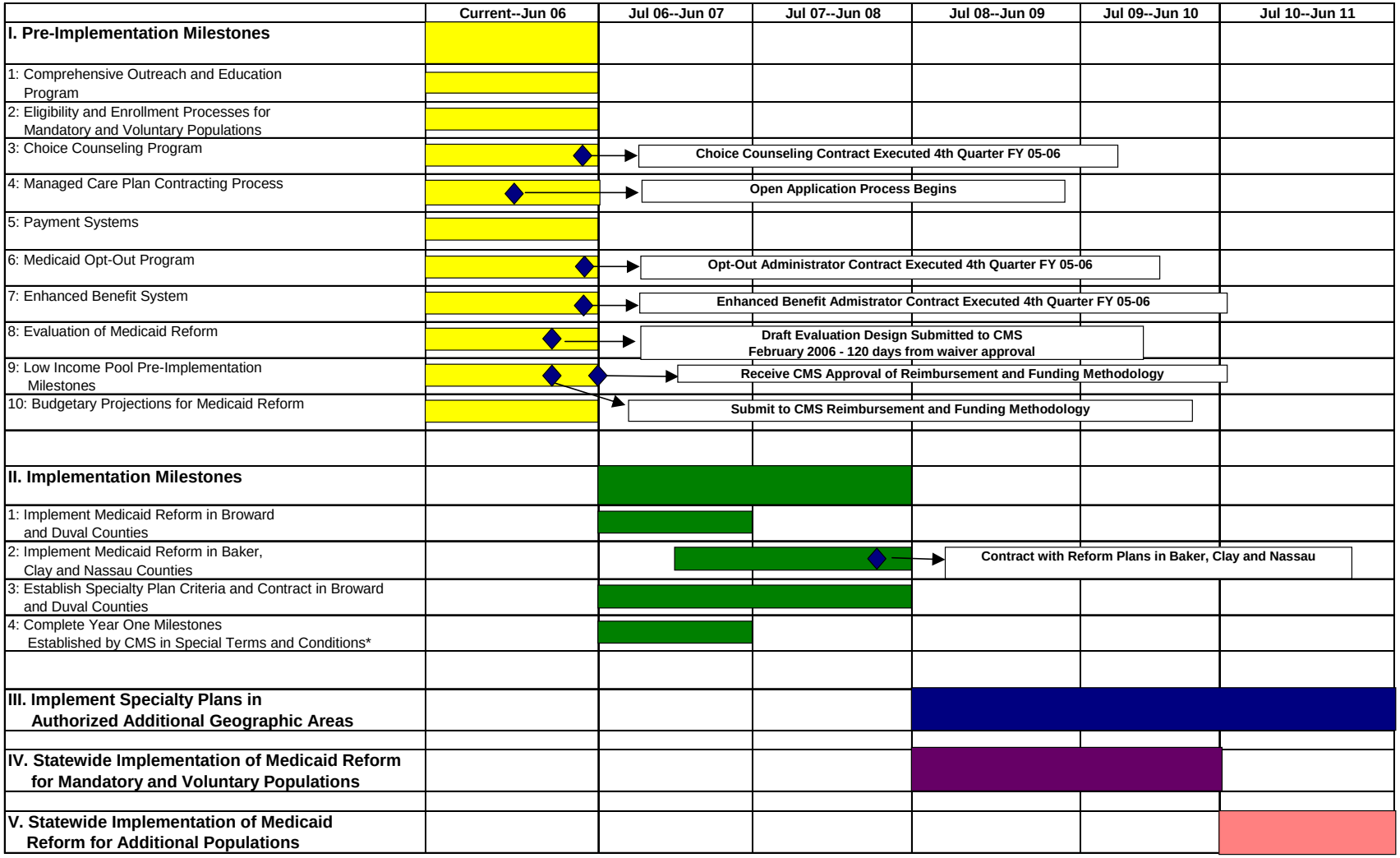
III. Implementation of specialty plans in authorized geographic areas

IV. Statewide implementation of Medicaid reform for mandatory and voluntary populations

V. Statewide implementation of Medicaid reform for additional populations

The next step is to seek legislative authority to implement the waiver in Broward and Duval Counties on July 1, 2006; and to expand the waiver to Baker, Clay and Nassau Counties within one year of becoming operational in Duval County.

Medicaid Reform Implementation Plan Schedule



* Specific Low Income Pool Milestones required throughout the term of the waiver

Medicaid Reform Implementation Plan

I. Pre-implementation Milestones and Activities for Medicaid Reform

Timeframe: Current through June 30, 2006

Upon passage in May 2005 of the legislation creating the Medicaid managed care pilot program, the Agency began to assess current programs and delivery systems, analyze operational functions, identify system gaps requiring new functions, and determine how to integrate them into the new Medicaid Reform service delivery system. This review resulted in the development of the milestones and activities contained in the implementation plan for Medicaid Reform.

The pre-implementation plan milestones include the restructuring and/or creation of the following systems, programs and processes:

Milestone 1: Comprehensive Outreach and Education Program

Milestone 2: Eligibility and Enrollment Processes for Mandatory and Voluntary Populations

Milestone 3: Choice Counseling Program

Milestone 4: Managed Care Plan Contracting Process

Milestone 5: Payment Systems

Milestone 6: Medicaid Opt-Out Program

Milestone 7: Enhanced Benefit System

Milestone 8: Evaluation of Medicaid Reform

Milestone 9: Low-Income Pool Pre-Implementation Milestones

Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

Milestone 1: Comprehensive Outreach and Education Program

Description: The Agency has developed and continues to refine a comprehensive outreach and education program to facilitate a smooth transition to Medicaid reform by ensuring all affected individuals and parties are informed of changes and the potential impact. The Agency is partnering with community stakeholders, including local officials, small businesses, providers, and advocacy groups to increase awareness of Medicaid reform. The Agency is striving to ensure the workshops, public meetings, and written materials are effective in educating all interested parties about Medicaid reform.

The workshop topics include customized benefit packages, comprehensive and catastrophic financing components, actuarial equivalence and sufficiency tests, risk adjusted premiums, types of delivery systems, eligibility and enrollment, choice counseling, plan contracting process, plan readiness review, and plan standards and/or requirements (licensure, financial, credentialing, network capacity, cost sharing, marketing, grievance and appeals, encounter data, quality of care, quality improvement and assurance systems, program integrity, fraud and abuse).

Timeframes: Current through June 30, 2006

Activities:

1. Conduct meetings and workshops for providers.

2. Conduct meetings and workshops for recipients and advocacy groups.

3. Conduct focus groups with recipients.

4. Make information available on the Agency's web site, where official reform documents and updates are posted: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

5. Publish notices to announce public meetings and workshops to provide updates and obtain public input on the implementation of Medicaid Reform.

6. Partner with community based organizations to identify and educate consumers.

7. Coordinate with other state agencies to participate in outreach and education.

Milestone 2: Eligibility and Enrollment Processes for Mandatory and Voluntary Populations

Description: The Agency evaluated the eligibility and enrollment processes for mandatory and voluntary populations in the demonstration area to ensure that clear, correct, and timely information is available. Since the actual eligibility criteria for Medicaid will remain unchanged, the focus will be on ensuring that the mandatory groups and those who volunteer to participate in reform are connected with a choice counselor as soon as possible.

Timeframe: Current through June 30, 2006

Activities:

1. Work with the Department of Children and Families (DCF) to ensure that necessary changes to the current eligibility process are in place.

2. Work with DCF to provide recipients timely access to choice counseling.

3. Incorporate written materials about choice counseling and reform in DCF's new-eligible notification mailings.

4. Work with DCF to ensure that recipients receive information about their choice of plans at eligibility re-determination.

5. Develop a process to provide choice counselors with eligibility redetermination data from DCF to initiate choice counseling. Such data will provide the choice counseling vendor the necessary information to contact recipients and provide them an opportunity to choose a reform plan or opt out to employer-sponsored insurance.

Milestone 3: Choice Counseling Program

Description: The Agency is developing a choice counseling program designed to ensure eligible recipients are fully informed of their choice of plans and will increase the number of voluntary selections.

Timeframe: Current through June 30, 2006

Activities:

1. Conduct research about choice counseling to analyze how other states have designed their choice counseling programs and to determine which programs have been most successful in increasing the number of voluntary plan selection.

2. Develop materials to assist recipients in making an informed choice of managed care plans.

3. Review the media options to determine the most effective methods to educate recipients about their plan choices (face-to-face, telephone, electronic, and web-based materials).

4. Conduct local public meetings to obtain input on the design of the choice counseling program.

5. Conduct focus groups with recipients to obtain input on the design of the choice counseling program.

6. Incorporate information gathered through research, public meetings, and focus groups into the design of the choice counseling competitive procurement document.

7. Contract with a Medicaid reform choice counseling vendor.

8. Contract with a qualified vendor for an independent evaluation of the choice counseling.

Milestone 4: Managed Care Plan Contracting Process

Description: The Agency is restructuring the contracting process for reform plans including capitated managed care plans and fee-for-service provider service networks to ensure the resulting contracts meet all applicable requirements of state and federal regulations. This process includes determining plan readiness and evaluation of plan benefit package.

Timeframe: Current through June 30, 2006

Activities:

1. Review and revise the current plan application for capitated plans to incorporate reform requirements and make them available to interested parties.

2. Review and revise the current plan application for fee-for-service provider service networks to incorporate reform requirements and make them available to interested parties.

3. Review and revise the current managed care plan readiness criteria to comport with reform and in compliance with all federal and state regulations. (See Attachment I, Managed Care Plan Readiness Process.)

4. Identify potential specialty plans for which plan applications will be considered (e.g. HIV/AIDS and children with chronic conditions).

5. Finalize and publish the reform plan data book to include fee-for-service claims experience and eligibility history for each designated target population in the demonstration area to assist plans in designing their benefit packages. (See Attachment II, Designing Benefit Plan for Medicaid Reform.)

6. Finalize the benefit plan evaluation prototype to ensure actuarial equivalency and sufficiency of benefits. (See Attachment III, Benefit Plan Evaluation Prototype.)

Milestone 5: Payment Systems

Description: The Agency is designing the reform payment systems to include comprehensive and catastrophic premiums. The Agency will contract with managed care plans including health maintenance organizations, exclusive provider organizations, licensed health insurers, specialty plans, and provider service networks.

Timeframe: Current through June 30, 2006

Activities:

1. Modify the current premium calculation system as necessary to pay participating capitated reform plans in compliance with federal and state regulations.

2. Design an interim risk adjustment payment system based on pharmacy encounter data.

3. Develop a standardized process to collect full encounter data from each reform plan.

4. Develop a standard, long-term risk adjustment payment which will be based on full encounter data.

5. Provide technical assistance to managed care plans related to submission of encounter data.

6. Establish methods/systems to collect and verify that the encounter data are complete and accurate.

7. Modify information systems as necessary to pay risk adjusted premiums to the reform plans.

Milestone 6: Medicaid Opt-Out Program

Description: The Agency will design the Medicaid opt-out program to ensure all recipients who have access to employer-sponsored insurance are provided an opportunity to opt out of Medicaid and select an employer-sponsored insurance plan. (See Attachment IV, Medicaid Opt-Out Program.)

Timeframe: Current through June 30, 2006

Activities:

1. Contract with a qualified vendor to operate the Medicaid opt-out program.

2. Develop the coordination process between the choice counselor, Medicaid recipient, the opt-out vendor and the Agency to ensure timely enrollment in the employer-sponsored insurance plan and timely and accurate payment by the Agency.

3. Develop the Medicaid opt out reporting system to comply with the federal special terms and conditions.

4. Develop a system to monitor the opt-out vendor's performance.

Milestone 7: Enhanced Benefit System

Description: The Agency will design the Enhanced Benefit System to provide incentives to Medicaid reform enrollees for healthy behaviors. (See Attachment V, Recommendations for Earning Enhanced Benefit Credits.)

Timeframe: Current through June 30, 2006

Activities:

1. Establish a seven-member Enhanced Benefits Panel to oversee policy development and guidelines for the program.

2. Issue a Request for Information (RFI) to obtain input on enhanced benefit systems.

3. Develop a competitive procurement document to select a qualified vendor to administer the Enhanced Benefit System.

4. Contract with a qualified vendor to administer the Enhanced Benefit System.

Milestone 8: Evaluation of Medicaid Reform

Description: The Agency will design and submit to CMS a draft evaluation design of Medicaid reform.

Timeframe: Current through February 19, 2006

Activities:

1. Contract for the evaluation with an independent entity.
2. Design the evaluation to incorporate criteria in the waiver and special terms and conditions.
3. Submit, as required by CMS, the draft evaluation design for approval within 120 days from waiver approval.

Milestone 9: Low Income Pool Pre-Implementation Milestones

Description: The Agency will comply with the required pre-implementation milestones established by CMS in the special terms and conditions of the waiver before the first payment from the low income pool.

Timeframe: Current through June 30, 2006

Activities:

1. Develop recommendations for the reimbursement and funding methodology document through the Disproportionate Share Hospital (DSH) Council.

2. Submit to CMS by March 1, 2006 and obtain CMS approval by June 30, 2006 of a reimbursement and funding methodology document for LIP expenditures, definition of expenditures eligible for federal match under the LIP and entities eligible to receive reimbursement.

3. Submit a State Plan amendment to terminate the current inpatient supplemental payment upper payment limit (UPL).

Milestone 10: Budgetary Projections for Medicaid Reform – State Fiscal Years 2006-2007 through 2009-2010

Description: Senate Bill 838 requires the Agency to evaluate the impact of Medicaid Reform on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. (See Attachment VI, Budget Neutrality - Demonstration with Waiver and Attachment VII, Budget Neutrality - Demonstration Without Waiver.)

Timeframe: With submission of implementation plan.

II. Implementation Milestones and Activities for Medicaid Reform

Timeframe: July 1, 2006 through June 30, 2007

The Agency will establish the delivery system for Medicaid Reform in Broward and Duval Counties by July 1, 2006; and expand into Baker, Clay and Nassau Counties within one year of becoming operational in Duval County by July 1, 2007.

The implementation plan milestones include:

Milestone 1: Implement Medicaid Reform in Broward and Duval Counties.

Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties.

Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties.

Milestone 4: Complete Year 1 Milestones Established by CMS in the Special Terms and Conditions.

Milestone 1: Implement Medicaid Reform in Broward and Duval Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Continue the comprehensive outreach and education program initiated during pre-implementation period.

2. Implement all programs, systems, processes, and procedures established during the pre-implementation period.

3. Transition all interested current managed care providers to a reform plan in Broward and Duval Counties. (See Attachment VIII, Current Managed Care Programs in Broward and Duval Counties.)

4. Contract with new Agency-certified reform plans in Broward and Duval Counties.

5. Transition current Medicaid eligibles to a Medicaid reform plan. (See Attachment IX, Phase–In of Implementation.)

Milestone 2: Implement Medicaid Reform in Baker, Clay and Nassau Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Continue the comprehensive outreach and education program initiated during pre-implementation period. The Agency will refine the activities as needed to address the unique needs of these communities.

2. Open the plan contracting process to all interested applicants.

3. Implement all programs, systems, processes, and procedures established during the pre-implementation period.

4. Transition all interested current managed care providers to a reform plan in Baker, Clay and Nassau Counties.

5. Contract with new Agency-certified reform plans in Baker, Clay and Nassau Counties.

Milestone 3: Establish Specialty Plan Criteria and Contract in Broward and Duval Counties

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Identify potential specialty plan populations based on eligibility or specified diagnosis.

2. Conduct education and outreach to specialty populations.

3. Develop managed care network and quality improvement standards to ensure the developmental, emotional, and medical needs of enrollees are met in Broward and Duval Counties.

4. Contract with specialty plans, if available, that meet the criteria established by the Agency in Broward and Duval Counties.

5. Monitor the specialty plans to ensure the financial reserves and the provider networks are sufficient to deliver accessible quality care to enrollees.

6. Contract with an independent entity to evaluate and determine the impact of specialty plans on hospitalizations, lengths of stay, emergency-room visits, costs, and access to care, including specialty care and patient and family satisfaction.

Milestone 4: Complete Year 1 Milestones Established by CMS in Special Terms and Conditions

Timeframe: July 1, 2006 through June 30, 2007

Activities:

1. Submit a final document to CMS that details the payment mechanism for expenditures made from the LIP to pay for medical expenditures for the uninsured and qualified aliens, including expenditures for 10 percent of the LIP used for other purposes as defined in the special terms and conditions within six months of implementation of reform in Broward and Duval Counties.

2. Comply with all the general reporting requirements as specified by CMS in special terms and conditions. (See Attachment X, Summary of CMS General Reporting Requirements.)

III. Implement Specialty Plans in Authorized Additional Geographic Areas

Timeframe: July 1, 2008 through June 30, 2010

Activities:

1. Open the plan contracting process for specialty plans in additional geographic areas to interested applicants.

2. Contract with Agency-certified specialty plans.

IV. Statewide Implementation of Medicaid Reform for Mandatory and Voluntary Populations

Timeframe: July 1, 2008 through June 30, 2010

Activities:

1. Continue enrollment of authorized mandatory and voluntary eligibility groups into Medicaid reform.

2. Conduct meeting and workshops, in areas where reform has not been implemented, to educate the public (providers, advocacy groups, recipients, and all interested parties), obtain input on Medicaid reform, and identify communities interested in transitioning to Medicaid reform.

3. Evaluate each county's readiness to transition to Medicaid reform by opening the Medicaid reform contract application process in a county or counties.

4. With Legislative consent expand Medicaid reform into additional counties outside the geographic areas initially authorized in s. 409.91211, F.S.

V. Statewide Implementation of Medicaid Reform for Additional Populations

Timeframe: July 1, 2010 through June 30, 2011

Activities:

1. Obtain approval from CMS to expand Medicaid reform to additional recipient populations.

2. Obtain Legislative approval to expand Medicaid reform to additional recipient populations by mandating enrollment of those Medicaid population groups previously enrolled voluntarily.

3. Enroll additional recipient populations.

Attachment I:
Managed Care Plan Readiness Process

Managed Care Plan Readiness Process

The Agency shall ensure that all reform plans demonstrate readiness by successfully completing the application process which, at a minimum, will include:

(1) Organizational Review – includes, but not limited to, a review of the applicant's business plan, background checks, licenses, Certificate of Authority and Health Care Provider Certificate if required, organizational structure, governing body policies and procedures, plan staffing, financial soundness, background and experience.

For provider service network applicants that are not required to obtain a Certificate of Authority or Health Care Provider Certificate, the organizational review also includes:

- Documentation of compliance with the definition of a provider service network as specified in s. 409.912(4)(d), F.S., as follows: "A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization."
- Documentation of applicant's prior authorization and claims management system including any required licensure standards as specified in Florida statutes. For example, applicants that delegate the administration and management of this process to a third party administrator (TPA), the applicant will be required to provide documentation that the TPA is licensed to do business as a TPA in the state of Florida as specified in s. 626.88, F.S.

(2) Comprehensive Desk Review – includes, but not limited to, a review of the applicant's provider network policies and procedures including credentialing and recredentialing procedures, availability/accessibility of services procedures, minimum provider network standards, specialty coverage procedures; model subcontracts; service authorization procedures including prior authorization procedures and time frame for decisions; out-of-plan use of emergency and non-emergency facilities; disease management procedures; staffing standards and procedures related to quality improvement/quality assurance, continuous quality improvement, independent peer review, quality indicators, utilization management; emergency care, case management and continuity of care, individuals with special health care needs, medical records, marketing,

enrollment and enrollment reporting procedures, enrollee information requirements; enrollment notices, new-enrollee materials, provider directory, handbooks, health risk assessment, disenrollment, grievances and appeals, fraud and abuse, Medicaid encounter data reporting, and systems to include running test reports with the Agency.

The comprehensive review also involves a fiscal analysis to determine plan solvency. Licensed entities must meet the licensing agency's solvency standards, and provider service networks must comply with the solvency standards specified in the Centers for Medicare and Medicaid-approved reform waiver.

(3) Benefit Package Review – includes a review of the applicant's proposed benefit package. The Agency will use an evaluation prototype to evaluate each benefit package using a two-pronged test: (a) actuarial equivalency and (b) sufficiency of benefits.

The Medicaid Reform flexible benefit designs will have to meet two distinct standards: actuarial equivalence to current Medicaid services and benefit sufficiency standards. Actuarial equivalence refers to the assurance that the proposed benefit plan offers as much total value as the current set of Medicaid benefits. Sufficiency tests check to see whether the proposed benefit plan offers enough of each of the services which the Agency has determined are most critical. Both of these tests are evaluated for the specific population targeted by the proposed benefit plan -- a benefit package that may be very appropriate for one population may be insufficient for another because of the populations' different medical needs, so it is important to take those diverse needs into account in the plan evaluation.

The Agency will use specially-designed plan evaluation software (the "Plan Evaluation Model") to test proposed plan designs for both actuarial equivalence and sufficiency of health care services. This model will include historical claims summaries for each target population for which health plans may design customized benefit packages. The model user will enter the proposed benefit specifications into the model's input screens, which will include information about amount, scope, and duration variation and copayment levels (if any). The model will then pull from its database the historical service utilization detail for the target population. Based on the target population's medical needs as illustrated in that claims history, the model will calculate the actuarial value of the proposed plan and compare it to the actuarial value of the standard package of Medicaid benefits. If the proposed benefit plan has at least as much value in aggregate, it meets the actuarial equivalence test.

Sufficiency tests are performed at the same time by the same tool, again using service-specific utilization detail for the specified target population. For instance, if the proposed plan places an annual dollar limit on a benefit such as pharmacy, the model will use the historical detail to determine the proportion of the target population that exceeds that benefit. If that proportion is higher than the pre-set standard for pharmacy, then the proposed plan would fail on the pharmacy sufficiency test. A similar test is performed for each of the services the state has

determined are critical enough to require sufficiency standards and testing. The Plan Evaluation Model will produce reports showing the proposed plan's performance on each of these tests. If the plan is determined actuarially equivalent and meets all sufficiency standards, it is approved as a Reform benefit plan for the specified population. (See Attachment II, Benefit Plan Evaluation Prototype.)

(4) On Site Review – includes an on-site visit by an Agency team and subsequent desk review of the findings. The Agency will be satisfied that network requirements are sufficient to serve enrollee needs.

Attachment II:
Designing Benefit Plans for Medicaid Reform

Designing Benefit Plans for Medicaid Reform

One of the key features of Florida's Medicaid Reform is the ability of health plans to vary the amount, scope and duration of current State Plan covered services to best meet the needs of the Medicaid recipients they enroll. This document will provide highlights of how health plans might design a benefit package to participate in Reform.

Plans should note that the state will make a standard risk-adjusted premium available to Medicaid Reform plans for the recipients they enroll. The state will provide base premium levels and a description of the methodology for risk adjustment development and application that plans can use to assess the expected financial results of the plan of benefits they develop. The state expects health plans to perform careful financial and actuarial modeling during the benefits design process, in order to assure the sufficiency of the level of services to be offered and the ongoing financial viability of the benefits they propose.

Generally, there are nine major steps that health plans will perform as part of the benefit package design process. Those steps are listed below, and then each is discussed in more detail. It is important to note that the same steps are followed, regardless of whether the health plan has elected to receive both the comprehensive and catastrophic premiums or has chosen to accept just the comprehensive premium.

Benefit Package Design Steps

1. Select the target population(s) to be served;
2. Assess the needs of the target population(s);
3. Consider any sufficiency standards and/or policy standards in effect for the population(s);
4. Determine which services will be covered under the Reform plan;
5. Develop cost estimates for services not covered under the current State Plan;
6. Develop cost sharing requirements for covered services;
7. Determine which, if any, services will vary in amount, scope, and duration versus current State Plan coverage;
8. Test resulting benefit packages for actuarial equivalence; and
9. Model expected plan revenue and costs to ensure ongoing financial viability.

Step 1: Select Target Population. Prior to designing the benefit package of a Reform plan, the health plan must identify the population(s) to be served by the plan. For each contract year, the state will designate "target populations" for which health plans can design plans. For the initial year of operation, the state expects to seek application for the following populations: TANF; SSI; TANF and SSI; Individuals diagnosed with HIV/AIDs and Children with Special Needs. A health plan can choose to develop benefit plans for any or all of the state-identified target populations. It is expected that

health plans will develop separate benefit packages for each target population to be served. However, a health plan could choose to develop one benefit package that would be available to all target populations.

Step 2: Assess the Population's Needs. Once the health plan has identified a target population, it should assess the target population's needs for medical care, including pharmaceuticals and behavioral health services. This assessment is essential in order for health plans to have the necessary information to design an effective plan of benefits. Assessments may include, but are not limited to: surveys of current enrollees, surveys of providers, review of claims history provided by the state, and reliance on other sources of knowledge about the Medicaid marketplace and the target population. Current Medicaid HMOs should have sufficient data on their enrollees to develop a benefit plan under reform. In addition, the state will provide all plans with a databook which will provide claims history of individuals enrolled in the fee-for-service program to ensure that the plan has the information needed to conduct an assessment.

Step 3: Consider Reform Standards. In order to be approved by the state, Reform benefit packages must meet prescribed standards. All plans will be required to provide all mandatory services and needed optional services for the target population. Certain services will have to meet "sufficiency standards" – these standards apply to key services, to ensure that the benefit package provides enough of those services to meet the needs of the members of the target population. For example, a sufficiency standard may be expressed as "pharmacy benefits must be sufficient to meet the needs of x% of the target population." In addition, for certain populations, the state will establish "policy standards" that all benefit packages must meet. Policy standards will apply to particular types of services and for select groups of individuals. For example, the state did not request a waiver for EPSDT therefore, plans must provide all medically necessary services for enrolled children. Sufficiency standards and policy standards may vary by target population and will be updated on an annual basis.

Each year the state will provide population-specific service utilization data for each type of benefit to which sufficiency standards apply. This data may be used by health plans to ensure their proposed benefit designs will meet sufficiency standards.

Step 4: Determine Covered Services. Based on the results of Steps 2 and 3, the health plan will decide what services will be covered in the benefit package. Plans must include all mandatory services, and optional services required to satisfy sufficiency standards. The needs assessment conducted by the plan may also identify other optional services or new services that should be included because they are important to the target population. As under the current system, the health plan may determine that for some types of services, it is appropriate to provide the services to children, but not to adults. An example of a service currently provided only to children is basic dental care.

Step 5: Determine Costs of New Services. As a result of the needs assessment, the health plan may determine that the target population would benefit from services not covered under the current State Plan. For each additional service proposed, the health

plan will be required to submit the estimated cost of providing the service to the target population, along with a supporting actuarial rationale. The rationale should include an estimate of the level of utilization expected, the average cost per service, and the resulting average per member per month (PMPM) value of the service.

Step 6: Develop Member Cost Sharing Requirements. Once covered services have been determined, the health plan should consider what cost-sharing, if any, should be applied to plan benefits. Any cost sharing imposed cannot exceed the currently approved nominal levels in the current State Plan. Certain individuals, such as children through age 18, pregnant women, and institutionalized individuals, are exempt by federal regulation from cost sharing. Federal regulations also prohibit the application of cost sharing to certain services, such as emergency services and family planning.

In making decisions about cost sharing levels, the health plan should consider how cost sharing can be used to encourage desirable behavior and not produce counter-productive results. For instance, if there is a copayment on physician office visits, but not on Emergency Room services, will patients choose to go to the ER when a physician visit would suffice?

Step 7: Determine variation in amount, scope and duration of covered services. In their assessment of the target population's needs, health plans may identify areas where varying the amount, scope, and duration of covered services may be appropriate. In some cases, services may need to be extended beyond what is currently allowed under the State Plan. For other types of services, the current State Plan may offer more services than are needed by the target population. In this step, the health plans will make these plan design decisions, subject to the assessment of the target population's needs in step 2 and the state standards as described in step 3.

Step 8: Test for Actuarial Equivalence. After proceeding through steps 1-7, health plans should have a draft benefit package constructed. At this point, the health plan should test to see whether the package is likely to meet the state's actuarial equivalence requirement. As has been discussed elsewhere, the state requires each benefit package to be actuarially equivalent in the aggregate to the current State Plan benefit package; this ensures that the overall level of services provided is appropriate for the premium received. The benefit package must be separately tested for actuarial equivalence to the State Plan package *for each target population* to which it will be offered.

The state's actuarial equivalence test will take into consideration all plan design elements discussed above. It will not consider variation in reimbursement levels between the health plan's benefit package and the State Plan, nor will it consider potential utilization increases or decreases due to increased utilization management or the behavioral impact of cost sharing.

Each year the state will provide utilization and cost data by type of service that health plans can use to evaluate actuarial equivalence for each potential target population.

Step 9: Model actual plan revenue and costs. Finally, the health plan should model the potential revenue and expenditures of the benefit package to ensure the offering fits within its business plan and will be financially viable.

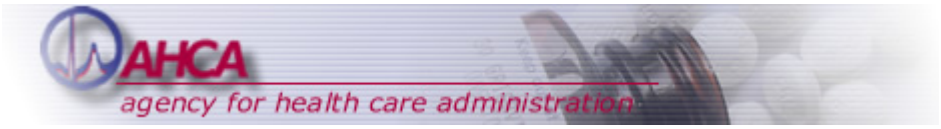
First, the health plan would model expected enrollment and project revenue associated with that enrollment, given the state's premium levels, risk adjustment methodology, and whether the health plan intends to accept the catastrophic premium and bear the associated risk. Premiums will be funded from the State's existing Medicaid budget; plans must ensure that both the medical and administrative expenses they incur on behalf of the target population can be funded at that premium level. Each year the state will provide base premium levels and risk adjustment information that can be used by plans in this revenue modeling.

Second, the plan would model expected medical and administrative costs associated with offering the benefit package to the individuals expected to enroll. In addition to the plan design characteristics outlined above, medical cost estimates would include the impact of utilization management on the number and mix of services used by the enrollees. These estimates would also reflect actual reimbursement arrangements the health plan has made or expects to make with providers. Administrative cost estimates will include the expected costs of administering the plan, including claims processing, enrollment processing, network management, overhead, and taxes.

Once the above steps are complete, the plan should have developed a customized benefit package that meets the state's requirement.

Attachment III:
Benefit Plan Evaluation Prototype

State of Florida Medicaid Reform Program - Plan Evaluation Model Prototype



Prototype Commentary: This User Input worksheet gathers information about the proposed plan: its targeted population, the geographic area in which it will be offered, and the benefit design.

A great deal of flexibility in benefit design will be accommodated in the final model, as shown in the benefit design input grid. The prototype provides examples of how annual benefit limits are evaluated for Total Inpatient Care, Total Prescription Drugs, and Outpatient Behavioral Health. It also provides examples of how co-pay differences can be evaluated, although the prototype does not value co-pays applied on a different basis than historical Medicaid (e.g., per day versus per admit). The prototype evaluates prescription drug limits on an annual basis against an unlimited benefit, whereas the current Florida Medicaid program has a monthly limit on brand name prescriptions.

Additional benefits (not historically covered by Medicaid) will be valued by the proposing entity and PMPM values input by AHCA into the model. The proposing entity will be required to submit supporting documentation to AHCA.

Step 1:

Enter Carrier Name	Florida Health Systems, Inc.
Enter Plan Name	Health Connections

Step 2: **Contract Period**

Enter Contract Period	
Begin Date (MM/DD/YY)	07/01/05
End Date (MM/DD/YY)	06/30/06

Step 3: **Population Target**

Select Target Population(s)	
Children and Families (Yes/No)	Yes
Aged and Disabled (Yes/No)	Yes

Step 4:

Select Target Region	
Target Region	11
Pensacola Area	**1**
Tallahassee and Panama City Area	**2**
Gainesville and Ocala Area	**3**
Jacksonville and Daytona Beach Area	**4**
Clearwater/St. Petersburg Area	**5**
Tampa Area	**6**
Orlando Area	**7**
Ft. Myers Area	**8**
West Palm Beach Area	**9**
Ft. Lauderdale Area	**10**
Miami and Florida Keys	**11**

Step 5:

Enter Benefit Design Limits

PROTOTYPE IS RESTRICTED TO UNIT OR DOLLAR LIMITS (if both are input for same service dollar limit will be evaluated)
GRAY AREAS ARE NOT ENABLED IN PROTOTYPE

Benefit Design (Unit and Dollar Limits as Applied to Non-Pregnant Adults)

COVERED SERVICE CATEGORY	Covered for Adults	Covered for Children	Day/Visit Limit	Limit Period (Annual/Monthly)	Dollar Limit	Limit Period (Annual/Monthly)	Copay Amount	Copay Application
Inpatient Hospital	Y	Y	45	Annual		Annual		admit
Non-maternity Physical Health	Y	Y						
Maternity Care	Y	Y						
Behavioral Health	Y	Y						
Substance Abuse	Y	Y						
Skilled Nursing Facility	Y	Y						
Hospice	Y	Y						visit
Outpatient Hospital	Y	Y						visit
Physician Services	Y	Y						visit
Primary Care Physician	Y	Y						
Specialty Physician	Y	Y						
Physician Extender Services	Y	Y						visit
Pharmacy	Y	Y		Annual		Annual		script
Brand Pharmacy	Y	Y						
Generic Pharmacy	Y	Y						
Outpatient Therapy (PT/OT/ST)	Y	Y						visit
Outpatient Behavioral Health	Y	Y		Annual		Annual		visit
Outpatient Substance Abuse	Y	Y						visit
Home Health Services	Y	Y						visit
Lab Services	Y	Y						visit
Radiology	Y	Y						visit
Dental Services	Y	Y						visit
Vision Services	Y	Y						visit
Hearing Services	Y	Y						visit
Family Planning	Y	Y						
Durable Medical Equipment	Y	Y						
Transportation	Y	Y						trip

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Aged & Disabled Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

The proposed plan is assumed to pass the actuarial equivalence test if it scores at least 100% of the actuarial value of the current State Plan benefits.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Aged and Disabled
Effective Date	7/1/2005

AHCA Plan Approval Decision	**PASS**	
Actuarial Equivalence Results	**PASS**	101% of value of current State Plan benefits included in proposed plan
Benefit Sufficiency Results	**PASS**	All Sufficiency Thresholds Met

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Children and Families Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

The proposed plan is assumed to pass the actuarial equivalence test if it scores at least 100% of the actuarial value of the current State Plan benefits.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Children & Families
Effective Date	7/1/2005

AHCA Plan Approval Decision	***PASS***	
Actuarial Equivalence Results	***PASS***	***100% of value of historical Medicaid benefits***
Benefit Sufficiency Results	***PASS***	***All Sufficiency Thresholds Met***

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Children and Families Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

In this prototype, the proposed plan is assumed to pass the actuarial equivalence test if it falls within 3 percent of the value of the historical Medicaid plan. The ultimate level of tolerance that will be used in plan evaluation is still not determined, but is expected to be small.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections
Target Region:	Area 11
Target Population:	Children & Families
Effective Date	7/1/2005

AHCA Plan Approval Decision	***PASS***	
Actuarial Equivalence Results	***PASS***	***100% of value of historical Medicaid benefits***
Benefit Sufficiency Results	***PASS***	***All Sufficiency Thresholds Met***

Attachment IV:
Medicaid Opt-Out Program

SUMMARY

Through comprehensive choice counseling, participants will be provided the opportunity to opt out of Medicaid into employer-sponsored plans. Consumers may use premiums to opt out of Medicaid to purchase insurance through the workplace. Consumers may also direct premiums into a private plan if the consumer is self-employed. The opt-out program will be a voluntary program.

A participant will be required to select a managed care plan or opt out within 30 days of eligibility. A participant who chooses to opt out and enroll in an Employer Sponsored Insurance (ESI) plan will be provided with a 90-day change period. The change period may be limited by the employer's open enrollment period. During this change period, the participant may opt back into Medicaid and select a managed care plan. After the change period, no further changes may be made until the consumer's open enrollment period, the next employer-sponsored open enrollment period, certain qualifying events or unless the enrollee no longer has access to ESI.

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

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

If the ESI share or self-employed insurance premium is greater than the Medicaid premium, the consumer will be responsible to pay the additional amount.

PROCESS

- The choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. They will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the state's contracted vendor. The choice counselor will also assist the individual in making an informed choice about opt out by highlighting information the individual will need to consider in order to make a fully informed choice.

- The choice counselor will collect information on whether the individual has access to health insurance.
- Individuals interested in opt out will be encouraged to contact their employer and the state's ESI contracted vendor for the opt out program for additional information.
- The choice counselor will notify the ESI contracted vendor of individuals who have access to insurance.
- The ESI contracted vendor will contact the individual's employer to verify the insurance available.
- The ESI contracted vendor will contact the individual and explain the insurance available through their employer and also advise of any costs the individual may have to accrue (e.g. if the ESI share or self-employed insurance premium is greater than the Medicaid premium, the individual will be responsible to pay the additional amount).
- If the enrollee chooses the opt out provision, the enrollee's information will be added to a database to be maintained by the ESI contracted vendor.
- The contracted vendor will follow-up with employers on a quarterly basis to verify continued employment.

EVALUATION

The following items will be evaluated in relation to the opt-out program.

1. Determine the basis of an individual's selection to opt out and whether the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g. family health coverage).

   During the enrollment process, the contracted vendor will enter in their database information as to what reason(s) the individual chose the opt out provision.

2. What is the participation in employer-sponsored insurance by Medicaid enrollees with access to ESI when compared to participation levels in similar Medicaid programs in other states?

   The contracted vendor will compare the enrollment in ESI plans in Florida with those in other states. The contracted vendor will submit questionnaires to other states in order to obtain this information.

3. What are the characteristics of individuals who choose to opt out?

   The contracted vendor will maintain demographic information on each individual enrolled in the opt-out program.

4. The number of enrollees under Medicaid Reform who are insured though private health coverage (ESI or other private coverage) in the year after losing Medicaid will increase as demonstrated by the difference in reenrollment in Medicaid.

The contracted vendor will maintain information in their database on the enrollment and disenrollment date from the opt-out program. The contracted vendor will also contact individuals on a regular basis to answer any questions regarding the -out program.

5. Evaluate the hypothesis that the rate of disenrollment for opt out during the 90-day disenrollment period for individuals who have opted-out will be less than the rate of disenrollment for Medicaid plans.

   The contracted vendor will maintain information in their database on the disenrollment date from the opt-out program. The contracted vendor will also contact individuals on a regular basis to answer any questions regarding the opt-out program.

6. Will the opt out option reduce Medicaid expenditures associated with the participating population?

   The contracted vendor will maintain data on the premium amount for each individual enrolled in the opt-out program.

7. Premiums paid on behalf of individuals who opt out will provide the state with per member per month savings when compared to the premium that would have otherwise been paid to a Medicaid reform plan.

   The contracted vendor will maintain data on the premium amount for each individual enrolled in the opt-out program.

REPORTS

The ESI contracted vendor will provide the following reports to the state.

1. The contracted vendor will provide to the state a quarterly report of enrollment data on ESI that documents the number of individuals selecting to opt out when ESI is available. The report shall include data that will identify enrollee characteristics as follows:

   a. Eligibility category
   b. Type of employer-sponsored insurance (e.g., small employer, large employer, ERISA)
   c. Type of coverage – single or family coverage

2. The contracted vendor will develop and maintain disenrollment reports specifying the reason for disenrolling in an ESI program.

3. The contracted vendor will track and report on those enrollees who elect the option to reenroll in the Medicaid Reform demonstration.

4. The contracted vendor will submit to the state the premium amounts that must be paid each month.

5. The contracted vendor will submit to the state a monthly invoice of all participants enrolled in the opt-out program. The contracted vendor will be paid a fee per individual enrolled in the program.

6. The contracted vendor must develop and maintain a database that contains at a minimum the following elements:

    - Enrollee Demographic Information
    - Employer Information
    - Reason(s) Enrollee Chose Opt Out Provision
    - Premium Amount
    - Premium Due Date
    - Employer Contact Dates
    - Enrollee Contact Dates
    - Disenrollment of Opt Out Provision Date
    - Reason(s) for Disenrollment

7. The contracted vendor will provide the state access to the database.

8. The contracted vendor will provide any additional reports as requested by the state.

MONITORING

The state will monitor the performance of the contracted vendor by conducting at a minimum the following activities:

1. Review of monthly invoice to determine all individuals included are enrolled in the opt-out program. This will include reviewing the database maintained by the contracted vendor; contacting a random sample of employers to verify the individual is still employed then contacting the insurance companies to verify the individual still has active coverage.

2. In addition to review of the invoice, the state will conduct the following monitoring activities on at least a quarterly basis:

    a. Contact a random sample of employers and insurance companies to verify the individual is employed and has active coverage.
    b. Submit questionnaires to a random sample of enrollees to provide their opinion on the service of the contracted vendor.

c. Submit questionnaires to a random sample of individuals who did not choose the opt out provision to determine their reason for not choosing this option as well as their opinion on the service of the contracted vendor.
d. Submit questionnaires to a random sample of individuals who have disenrolled from the opt-out program to determine their reason for disenrolling as their opinion on the service of the contracted vendor.

Attachment V:
Recommendations for Earning Enhanced Benefit Credits

Potential Healthy Behaviors / Practices

General Adult & Child	Participation (if eligible)	Additional Practices
Makes and keeps all primary care appointments	Disease management participation	Prescription drug regimen compliance
Adult age-sex appropriate preventive practices (mammograms, pap smears, colorectal screenings)	Alcohol and/or drug treatment program participation	Flu shot when recommended by physician
Childhood wellness visit	Smoking cessation program participation	Living will or advance directive completion
Childhood prevention care (age-appropriate screenings and immunizations)	Weight loss program	Age-appropriate documented exercise program
Childhood vision exam		
Childhood annual dental exam		

Attachment V.
Recommendations for Earnings Enhanced Benefit Credits

Sample List of Medical Service Covered by Enhanced Benefit Account

• Adult Routine Dental	• OTC or Brand-name Drugs
• Alcohol and Drug Treatments	• Stop-smoking Programs
• Bandages	• Telephone services for Hearing Impaired
• Contact Lenses	• Weight-loss Programs
• Dental Treatment	
• Eyeglasses	
• Hearing Aids	

Attachment VI:
Budget Neutrality – Demonstration with Waiver

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION								
AS SUBMITTED IN ORIGINAL WAIVER								
MANDATORY POPULATIONS								
ELIGIBILITY	**DEMONSTRATION**	**MONTHS**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
GROUP	**TREND RATE**	**OF AGING**	**DY 01 7/1/06-6/30/07**	**DY 02 7/1/07-6/30/08**	**DY 03 7/1/08-6/30/09**	**DY 04 7/1/09-6/30/10**	**DY 05 7/1/10-6/30/11**	**WW**
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	7.03%	26	$ 936	$ 1,002	$ 1,073	$ 1,150	$ 1,233	
Total Expenditure			$ 2,948,516,733	$ 3,242,956,545	$ 3,569,663,911	$ 3,932,622,123	$ 4,336,375,468	$ 18,030,134,780
MEG 2 - CHILD & FAM								
Eligible Member Months	9.67%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	6.23%	26	$ 192	$ 204	$ 217	$ 231	$ 246	
Total Expenditure			$ 3,866,100,441	$ 4,504,092,763	$ 5,253,744,917	$ 6,135,051,187	$ 7,171,616,475	$ 26,930,605,782

Attachment VI:
Budget Neutrality – Demonstration with Waiver

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION								
AS SUBMITTED IN ORIGINAL WAIVER								
LOW INCOME SUBSIDY POOL								
Eligible Member Months	0.00%		-	-	-	-	-	
Total Cost Per Eligible	0.00%		$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
TOTAL EXPENDITURES WW D1-D5								
COMBINED ALL MEGS PLUS LOW INCOME								
SUBSIDY POOL			$ 7,814,617,174	$ 8,747,049,308	$ 9,823,408,828	$11,067,673,309	$ 12,507,991,943	$ 49,960,740,562
ELIGIBLE MEMBER MONTHS			23,282,449	25,317,177	27,544,621	29,983,473	32,654,250	
COST PER ELIGIBLE			$ 335.64	$ 345.50	$ 356.64	$ 369.13	$ 383.04	
TREND RATES								**5-YEAR**
					ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE				11.93%	12.31%	12.67%	13.01%	12.48%
ELIGIBLE MEMBER MONTHS				8.74%	8.80%	8.85%	8.91%	8.82%
COST PER ELIGIBLE				2.94%	3.22%	3.50%	3.77%	3.36%

Attachment VII:
Budget Neutrality – Demonstration without Waiver

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION								
USING NEGOTIATED PMPM RATES PER FINAL SPECIAL TERMS AND CONDITIONS								
MANDATORY POPULATIONS								
ELIGIBILITY	**TREND**	**MONTHS**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
GROUP	**RATE**	**OF AGING**	**DY 01 7/1/06-6/30/07**	**DY 02 7/1/07-6/30/08**	**DY 03 7/1/08-6/30/09**	**DY 04 7/1/09-6/30/10**	**DY 05 7/1/10-6/30/11**	**WOW**
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	8.00%	33	948.79	1,024.69	1,106.67	1,195.20	1,290.82	
Total Expenditure			$ 2,989,539,607	$ 3,317,923,683	$ 3,682,822,048	$ 4,088,363,572	$ 4,539,154,597	$ 18,617,803,507
MEG 2 - CHILD & FAM								
Eligible Member Months	9.80%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	8.00%	33	199.48	215.44	232.67	251.29	271.39	
Total Expenditure			$ 4,015,842,012	$ 4,756,709,480	$ 5,634,601,332	$ 6,674,902,406	$ 7,907,705,387	$ 28,989,760,616

Attachment VII:
Budget Neutrality – Demonstration without Waiver

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION								
USING NEGOTIATED PMPM RATES PER FINAL SPECIAL TERMS AND CONDITIONS								
HOSPITAL INPATIENT SUPPLEMENTAL PAYMENTS								
Eligible Member Months	0.00%	33	-	-	-	-	-	
Total Cost Per Eligible	20.33%	33	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
TOTAL EXPENDITURES WOW D1-D5								
COMBINED ALL MEGS WHICH								
INCLUDE TOTAL HOSPITAL UPL			$ 8,005,381,618	$ 9,074,633,163	$ 10,317,423,381	$11,763,265,977	$ 13,446,859,984	$ 52,607,564,123
ELIGIBLE MEMBER MONTHS			23,282,449	25,317,177	27,544,621	29,983,473	32,654,250	
COST PER ELIGIBLE			343.84	358.44	374.57	392.32	411.80	
TREND RATES								**5-YEAR**
					ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE				13.36%	13.70%	14.01%	14.31%	13.84%
ELIGIBLE MEMBER MONTHS				8.74%	8.80%	8.85%	8.91%	8.82%
COST PER ELIGIBLE				4.25%	4.50%	4.74%	4.96%	4.61%

Attachment VIII:
Current Managed Care Programs in Broward and Duval Counties

Current Delivery Systems	Broward	Duval
Health Maintenance Organization – HMO	7	1
Provider Service Network – PSN	1	-
Minority Physician Network – MPN	2	1
Emergency Room Diversion Program	1	-
Total	***11***	***2***

As of November 2005, there were 11 managed care entities in Broward County and 2 managed care entities in Duval. The state anticipates that all HMOs and PSNs that currently contract will continue to provide services under reform. The Minority Physician Networks and ER Diversion Program are expected to create a PSN to provide services under reform.

In addition to the current contractors, the state has received several inquiries from new plans that have expressed an interest in participating in reform. With the entry of new managed care plans, individual choice will be increased in the reform sites, when compared to the period prior to implementation.

Attachment IX:
Phase-In of Implementation

Roll Out Reform Plan in Duval and Broward Counties

The tables below indicate Reform will start in Broward and Duval Counties and provide an overview of the transition. The model assumes that during the transition period, there will be 134,065 individuals in Broward County and 78,124 in Duval County enrolled in a managed care plan under Reform. Both models exclude children enrolled in Children's Medical Services in the initial roll-out. These figures are the current managed care enrollment levels as of June 2005 and do not include unassigned individuals. No increase in new eligibles or total enrollment is assumed. Below is a summary of the transition in the first year.

Broward County

As of June 2005, the state contracts with one PSN, two MPNs and one ER diversion program with a total enrollment of 34,881. The state also contracts with seven HMOs with a total enrollment of 74,121. The current managed care plans will have to apply as a reform plan to participate. The Agency assumes that there will be at least two managed care reform plans. If all plans continue as reform plans, there will be at least 11 managed care choices. Individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. The model assumes that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in a PSN, MPN, or ER diversion program will also be given the opportunity to change plans at the time of redetermination. However, should the plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is estimated to increase by 12,531, which represents half of the total MediPass enrollment at implementation.

Broward County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MPN-ER Diversion (4)	34,881	-
HMO (7)	74,121	-
MediPass	25,063	-
PSNs Reform	-	47,413
HMOs Reform	-	86,653
Total Enrollment in Reform		**134,065**

Duval County

As of June 2005, the state contracted with one MPN with a total enrollment of 3,826 and one HMO with a total enrollment of 41,418. The Agency assumes that if both plans continue as reform plans, there will be at least two managed care choices. Therefore, individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. It is assumed that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in the MPN or HMO will also be given the opportunity to change plans at the time of redetermination. Should a plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is assumed to increase by 16,440, which represents half of the total MediPass enrollment at implementation.

Duval County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MPN	3,826	-
HMO	41,418	-
MediPass	32,880	-
PSN Reform	-	20,266
HMO Reform	-	57,858
Total Enrollment in Reform		**78,124**

Assumptions:

- Enrollment levels as of June 2005 are assumed to remain the same at the time of implementation
- Enrollment choice will be made at redetermination of Medicaid eligibility.
- The total managed care eligible population will go through redetermination within 12 months
- Enrollment choices are estimated to be made by 1/12 of the total population each month in each county
- In Broward County there will be 2,088 choosers from MediPass each month, 6,177 choosers from the HMO each month, and 2,656 choosers from the PSN-MSN each month.
- In Duval county there will be 2,740 choosers from MediPass each month, 3,451 choosers from the HMO each month, 319 choosers from the MPN
- The split between the new reform plans will be 50%-50% for MediPass enrollees
- People currently enrolled in a PSN, MPN or HMO are assigned to the reform choice of the current choice (100% of PSN goes to PSN reform, 100% of HMO goes to HMO reform)

Actual experience may deviate from the estimates.

Attachment X:
Summary of CMS General Reporting Requirements

Summary of CMS General Reporting Requirements

1. General financial reporting requirements include submission of quarterly expenditure reports on total expenditures for services provided as specified in Section XVIII of the Special Terms and Conditions.

2. Budget neutrality reporting requirements for monitoring budget neutrality as specified in the waiver.

3. Managed care data requirements include requiring by contract that all managed care organizations maintain an information system that collects, analyzes, integrates and reports data pursuant to 42 CFR 438.

4. Monthly calls to discuss any significant developments affecting the Medicaid Reform waiver including, but not limited to, managed care organization operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, enhanced benefit accounts program, choice counseling activities, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or State Plan amendments the state is considering submitting.

5. Quarterly reports will be submitted to the Centers for Medicare and Medicaid Services no later than 60 days following the end of each quarter to present the Agency's analysis and the status of various operational areas. The reports will include, but shall not be limited to:

    a. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits; enrollment; grievances; and other operational issues.

    b. Action plans for addressing any policy and administrative issues.

    c. State efforts related to the collection and verification of encounter data, and utilization data.

    d. Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF or SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the Agency will provide a summary of voluntary and mandatory selection rates and disenrollment data.

e. For purposes of monitoring budget neutrality the quarterly reports shall include enrollment data, member month data, and expenditures in the budget neutrality-monitoring format provided by CMS.

f. Low Income Pool activities and associated expenditures.

g. Activities related to the implementation of choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups.

h. Participation rates in the Enhanced Benefit Accounts Program. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account.

i. Enrollment data on employer-sponsored insurance (ESI) that documents the number of individuals selecting to opt out when ESI is available. The Agency will include data that will identify enrollee characteristics as specified.

j. Progress toward the demonstration goals.

k. Evaluation activities.

6. The annual report includes the submission of a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the reform waiver no later than 120 days after the end of each operational year. The final report shall be submitted within 30 days of the draft annual report. The Agency will include, beginning with the second annual report, a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings. The Agency will include, beginning with the fourth annual report, a section that provides qualitative and quantitative data that describes the impact the Low Income Pool had on the rate of uninsurance in Florida starting with the implementation of the waiver.