Florida Medicaid Reform

Extension Request

1115 Research and Demonstration Waiver

Submitted on June 30, 2010

Agency for Health Care Administration

FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

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I. Executive Summary

A. Federal and State Waiver Authority

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (federal CMS) on October 19, 2005. State authority to operate the program is located in Section 409.91211, Florida Statutes (F.S.), which provides authorization for a statewide pilot program with implementation that began in Broward and Duval Counties on July 1, 2006. The program expanded to Baker, Clay and Nassau Counties on July 1, 2007.

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting a health plan option, the State has gained valuable information about the effects of allowing market-based approaches to assist the state in delivering services to Medicaid beneficiaries.

Key components of the demonstration include:

- Comprehensive Choice Counseling;
- Customized Benefit Packages;
- Enhanced Benefits for participating in healthy behaviors;
- Risk Adjusted Premiums based on enrollee health status;
- Catastrophic Component of the premium (i.e., state reinsurance to encourage development of provider service networks and health maintenance organizations in rural and underserved areas of the State); and
- Low Income Pool.

B. Legislative Direction – Seek Waiver Extension

On April 30, 2010, the Florida Legislature passed Senate Bill 1484 and Governor Crist signed the bill into law (Chapter 2010-144, Laws of Florida) on May 28, 2010. Within this bill, the Florida Legislature directed the Agency for Health Care Administration (the Agency) to seek approval of a three-year waiver extension in order to maintain and continue operation of the 1115 waiver in Baker, Broward, Clay, Duval and Nassau Counties. The Agency was directed to submit the extension request to federal CMS by no later than July 1, 2010.

C. Federal Request – Issues to be Addressed in Extension Request

In a letter dated March 15, 2010, federal CMS requested the Agency address the following issues in the requested three-year extension of the waiver.

- **Public Notice –** a description of the process used to obtain input from all interested parties (including program stakeholders, citizens, as well as Federally-recognized Indian tribes) regarding the possible continuation of the demonstration. (See Section II of this document)
- **Public Comment –** a summary of comments received during the public notice process. Provide response to any unanswered issues raised in the course of the public notice process. (See Section II of this document)
- **Program Objectives** – a list of the waiver objectives and a summary of how each objective was met as well as future goals for the demonstration. (See Section III of this document)
- **Compliance with the Budget Neutrality Cap** - financial data (as set forth in the current Special Terms and Conditions) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. In addition, the State must provide up-to-date responses to the CMS Financial Management standard questions. (See Section IV of this document)
- **Evidence of Beneficiary Satisfaction** - summaries of the results of beneficiary surveys performed during the period of the demonstration, along with the results of the baseline surveys performed prior to the implementation. (See Section V of the document)
- **Quality** - summaries of External Quality Review Organization reports, managed care organization and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration. (See Section VI of this document)
- **Draft of Evaluation Status and Findings** - a summary of the evaluation design, status including evaluation activities and findings to date, and plans for evaluation activities during the expansion period. Also, report on interim research and evaluation findings for key research questions. (See Section VII of this document)
- **Special Terms and Conditions** – a narrative documenting compliance with the Special Terms and Conditions of the waiver. (See Section VIII of this document)
- **Waiver and Expenditure Authorities** – a list along with programmatic description of the waivers and expenditure authorities that are being requested for the extension. (See Section IX of this document)

II. Public Process

This section provides a summary of public notice and input process used by the Agency as provided in the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Development of Public Process Strategy

On May 6, 2010, the Agency provided the draft public process strategy document (see Attachment A.1) to federal CMS in preparation for a call held on May 10, 2010, to discuss the legislation that directs the Agency to seek a three-year extension to the demonstration without change and the draft public process strategy. The public process strategy document was developed to solicit stakeholder input on the demonstration waiver extension request, as authorized by the Florida Legislature in Senate Bill 1484 (Chapter 2010-144, Laws of Florida).

Prior to the submission of the draft strategy and in conjunction with the 2010 Florida Legislative session, there were numerous Legislative hearings held at which the waiver extension request was discussed and there was opportunity for public input. Attachment A.2 provides a detailed list documenting the legislative and public meetings held prior to the end of the 2010 Legislative session. The attachment also includes links to the legislative and public meetings presentation materials. The Agency believes that the Legislative hearings meet the federal requirements to solicit public input on the waiver extension request. However, the Agency understands the need to solicit additional stakeholder input prior to submitting the waiver extension request to federal CMS. Therefore, the Agency hosted six (6) public input meetings and three (3) advisory group meetings to ensure individuals had an opportunity for input. Since the Legislature authorized the waiver extension request without changes, the Agency, during the public meetings, clarified the following:

- Substantive changes would need to be addressed by the Legislature; and
- The Agency's focus is to address recommendations or issues that would improve the operation of the demonstration.

A summary description of the public notice process and the public meetings are provided on pages 4 through 11 of this document.

B. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[1] located in Florida through written correspondence and conference calls, to solicit input on the waiver extension request. Attachment A.3 documents the correspondence sent on April 30, 2010, to the Seminole Tribe and Miccosukee Tribe requesting input on the waiver extension request.

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

The Agency also held conference calls[2] with representatives from the Seminole Tribe and Miccosukee Tribe to discuss establishing an agreed upon process for communicating changes to the Florida Medicaid Program that may impact their tribes. The Seminole Tribe representative and the Miccosukee representative, each stated during the conference calls that enrolled members of their tribes are not eligible for Medicaid due to income limits. Both tribes indicated the best method to consult with their tribe would be through written correspondence. The Miccosukee Tribe representative agreed to work with the Agency representative when the occasion arises that an American Indian, who is not enrolled in the tribe, needs assistance to become eligible for Medicaid.

C. Public Notice Process

The following list describes the notification process used to inform stakeholders of the public meetings to be held to solicit input on the waiver extension request.

- Published Public Meeting Notices in the Florida Administrative Weekly (FAW) in compliance with Chapter 120, F.S. (Attachment A.4).
- Emailed the meeting information to over 400 individuals and organizations from the interested parties list on May 21, and May 28, 2010 (Attachment A.5). The interested parties list was created during the development of the waiver application in 2005 and updated regularly thereafter.
- Mailed letters to members of the Florida Legislature announcing the meetings which can be viewed on the Agency's website (see link below).
- Released Agency Media Advisory announcing the meetings (Attachment A.6).
- Posted on the Agency's website the meeting schedule including dates, times, and locations. The materials can be viewed by clicking on the following link:

  http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml
- Submitted the public notice of meetings for posting on community bulletin boards.

In addition, articles were published on the internet describing the public meetings (see Attachment A.7).

D. Florida Medicaid Advisory Meetings

The Agency requested input on the extension request from the members of the three key Medicaid advisory groups listed below. The public meeting notices for the advisory groups were published in FAW on May 14, 2010. During the meetings, the Agency provided an overview of the provisions in Senate Bill 1484 that impact the waiver, a description of the extension request, and sought to obtain feedback on the materials to be used for the public input process, the public process itself and provided opportunity for comment on the waiver. Attachment A.8 provides a brief summary of the meetings

[2] Call held with Seminole Tribe on April 30, 2010; and call held with Miccosukee Tribe on May 18, 2010.

held. The agenda and presentation materials were posted on the Agency's website provided above.

- Medicaid Medical Advisory Committee meeting was held May 18, 2010.
- Low Income Pool Council meeting was held May 24, 2010.
- The Medicaid Reform Technical Advisory Panel meeting was held June 2, 2010.

A description of each advisory group is provided below.

Florida Medicaid's Medical Care Advisory Committee

The Medical Care Advisory Committee is mandated in accordance with section 431.12, Title 42, Code of Federal Regulations, based on section 1902(a)(4) of the Social Security Act. The purpose of the Medical Advisory Committee is to provide input on a variety of Medicaid materials, and to make recommendations to the Agency on Medicaid policies, rules and procedures.

The Advisory Committee is comprised of: board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income people; members of consumer groups, including Medicaid recipients; and representatives of state agencies involved with the Medicaid program, including the secretaries of the Florida Department of Children and Families, the Florida Department of Health and the Florida Department of Elder Affairs, or their designees.

Low Income Pool Council

Section 409.911(10), F.S., directs the Agency to create a Medicaid Low Income Pool Council that is comprised of 24 members, including:

- 2 members appointed by the President of the Senate,
- 2 members appointed by the Speaker of the House of Representatives,
- 3 representatives of statutory teaching hospitals,
- 3 representatives of public hospitals,
- 3 representatives of nonprofit hospitals,
- 3 representatives of for-profit hospitals,
- 2 representatives of rural hospitals,
- 2 representatives of units of local government which contribute funding,
- 1 representative of family practice teaching hospitals,
- 1 representative of federally qualified health centers,
- 1 representative from the Department of Health, and
- 1 nonvoting representative of the Agency for Health Care Administration who shall serve as chair of the council.

The LIP council was created to:

(a) Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.

(b) Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.

(c) Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.

(d) Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Technical Advisory Panel

The Technical Advisory Panel is required in s. 409.91211(7), F.S. The Panel is advisory in nature and provides the Agency with the opportunity to receive input on key aspects of the demonstration waiver, specifically, risk-adjusted-rate setting, benefit design, and choice counseling. The Panel includes representatives from the Florida Association of Health Plans, representatives from provider-sponsored networks, and a representative from the Office of Insurance Regulation.

The Technical Advisory Panel has and continues to advise the Agency concerning:

1) The risk-adjusted rate methodology used by the agency, including recommendations on mechanisms to recognize the risk of all Medicaid enrollees and for the transition to a risk adjustment system, including recommendations for phasing in risk adjustment and the use of risk corridors.
2) Implementation of an encounter data system to be used for risk-adjusted rates.
3) Administrative and implementation issues regarding the use of risk-adjusted rates, including, but not limited to, cost, simplicity, client privacy, data accuracy, and data exchange.
4) Issues of benefit design, including the actuarial equivalence and sufficiency standards to be used.
5) The implementation plan for the choice counseling system, including the information and materials to be provided to recipients, the methodologies by which recipients will be counseled regarding choice, criteria to be used to assess plan quality information, the methodology to be used to assign recipients into plans if they fail to choose a managed care plan, and the standards to be used for responsiveness to recipient inquiries.

E. Public Meeting Held in Tallahassee

The Agency published a public meeting notice in the FAW on May 14, 2010, inviting all interested parties to a public meeting to be held in Tallahassee, Florida, on May 21, 2010. Individuals unable to attend the meeting in person could participate via conference call by using the toll free number provided in the notice. During the meeting, the Agency provided an overview of the provisions in Senate Bill 1484 that impact the waiver, an overview of the existing waiver, a description of the extension request and time for public comments. This meeting was also used to obtain stakeholder input on the public process strategy to be used to solicit public input on the waiver extension

request. Attachment A.9 provides a summary of the public meeting including the number of attendees (in person and by conference call), a link to the presentation materials, and a summary of the public comments. A video recording of this public meeting was posted on the Agency's website on May 26, 2010.

F. Public Meetings held in Demonstration Counties

The Agency held a series of public meetings in accessible geographic locations where the demonstration is operational (Duval, Broward, Nassau, Baker and Clay Counties) to ensure that beneficiaries had an opportunity to provide public input. The Agency published the public meetings notice in the FAW on May 28, 2010, inviting all interested parties to the public meetings. The public meeting announcement was also posted on community bulletin boards.

During the public meetings, the Agency provided an overview of the provisions in Senate Bill 1484 that impact the waiver, an overview of the existing waiver, a description of the extension request and time for public comment. A summary of the public comments received is provided on the following page of this document. The Agenda, presentation materials, and a video recording of the meetings are posted on the Agency's website (link provided below).

G. Waiver and Supporting Documents Made Available to the Public

Since Senate Bill 1484 does not authorize changes to the waiver program, the Agency posted on its website (link below) on May 21, 2010, a copy of the approved waiver documents (1115 waiver, special terms and conditions, amended special term and condition #105 and waiver authorities) and supporting documents such as patient satisfaction reports, plan performance measures reports, and a link to the University of Florida waiver evaluation reports. Senate Bill 1484 was also posted on the Agency website.

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

H. Submission of Written Comments

The Agency's website provided the public the option of submitting written comments on the waiver extension request by mail or email (see below). In addition, the Agency provided attendees of the public meetings a comment card for the submission of written comments.

Mail comments and suggestions to:
1115 Medicaid Reform Waiver
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
You may also email your comments and suggestions to
medicaidreform@ahca.myflorida.com.

I. Summary of Public Comments

The Agency received 20 written comments and 22 individuals provided public testimony regarding the program during the public meetings held in the demonstration counties June 8 through June 11, 2010. Table 1 summarizes the public comments the Agency received in writing and during the public meetings on the waiver extension request.

The Agency received a limited number of comments on the program design. However, several did acknowledged the positive impact of the enhanced benefit account program, risk adjusting health plan rates, and the Low Income Pool Program. One speaker recommended the Low Income Pool be expanded due to the rising number of uninsured. It is important to note that a number of comments relate to managed care in general and are not specific to the demonstration. The Agency did not receive any negative comments on the Opt Out Program.

Table 1
Summary of Public Comments

Individuals with Special Health Care Needs

- Beneficiary spoke about the challenges experienced in accessing care at the time the demonstration was implemented and how not having access to needed services negatively impacted the beneficiary's health. (Broward County Meeting)
- Two advocates and one provider reported that beneficiaries had stopped complaining and that this is why there are low complaints on the demonstration. (Broward County Meeting)
- Grandmother of beneficiary spoke about the difficulties her grandchild had experienced accessing needed care and ended up being served in the school setting. (Broward County Meeting)
- One provider in Duval County recommended the Agency consider creating a specialty plan for beneficiaries with mental/behavioral health care needs.

Customized Benefit Package

- Advocate noted that the variation in the benefit package was too confusing for beneficiaries and requested that the Agency develop a standardized benefit package for the demonstration health plans. (Tallahassee meeting)
- Provider reported that there were too many choices for beneficiaries and this was difficult for beneficiaries to manage**. (**Broward County meeting**)**

Plan Prior Authorization Procedures

- Three mental health care providers (at both the Duval and Broward county meetings) and one mental health advocate (at the Tallahassee meeting) spoke about the difficulties mental health care providers are experiencing with the multiple prior authorization procedures utilized by the health plans. Two providers believe the variation in plan prior authorization procedures for mental health services have resulted in delays in the provision of care for beneficiaries. In addition, it was noted that in some instances when mental health providers have provided services without obtaining prior authorization, the

Table 1
Summary of Public Comments

providers did not receive reimbursement from the health plans.

- One provider noted that contracting with multiple plans required additional administrative resources to obtain prior authorization for mental health services and to navigate the plans claims process since plans have separate prior authorization and claims submission processes. (Duval County Meeting)
- Advocate requested the Agency host another workgroup for behavioral health care providers and health plans to discuss issues and streamline processes. (Tallahassee Meeting)
- Two advocates reported that the many rules the health plans had in place prevented access to care and that beneficiaries do not complain due to fear of retaliation. (Broward County meeting)
- OB/GYN doctor spoke about trouble receiving prior authorizations to perform necessary OB and GYN services which resulted in delays of care and therefore, pregnant women should be exempt. (Broward County meeting)
- County health department provider spoke about the large amount of paperwork for specialty services and the delay this causes for beneficiaries in receiving care. (Baker County meeting)

Post Waiver Extension Documents

- Advocate requested that the waiver extension document be posted for comments. (Tallahassee meeting)

Post Questions and Comments from the federal CMS

- Advocate requested that the questions and comments received from federal CMS be posted on the Agency website. (Tallahassee meeting)

Plan Provider Network

- Advocate reported that the health plan networks are not accurate and that many providers listed in the network files were not accepting patients. (Broward County Meeting)
- Provider reported difficulties in being able to become part of health plan networks. (Nassau County)
- Advocate at the Nassau County meeting and a provider at the Baker County meeting both noted that there were not enough providers in the rural counties in the demonstration which resulted in not enough choice for beneficiaries and delays in care.
- Former beneficiary reported being unable to receive care at Shands Hospital when enrolled in an HMO which resulted in a delay in care the beneficiary needed. (Baker County meeting)

Medication

- Two mental health care providers (at both the Duval and Broward counties meetings) spoke about confusion with the multiple drug formularies used by the health plans for mental health drugs and how frequently these formularies change.
- Advocate spoke about the complicated health plan formularies which result in lack of

Table 1
Summary of Public Comments

access to medications. (Broward County meeting)

- Father of beneficiary spoke of son's trouble getting plan approval for needed medication which resulted in negative outcomes for the beneficiary and family. (Broward County Meeting)
- County health department provider spoke about the changes in the drug formularies and the problem this causes beneficiaries. (Baker County meeting)

Plan Transitions and Continuity of Care Provided

- Advocate spoke about the confusion and disruption in care that beneficiaries have experienced as a result of the health plan transitions. (Duval County meeting)
- State Senator spoke about the need to fine or sanction health plans to prevent them from leaving the demonstration. (Broward County meeting)
- Provider requested that when a beneficiary is going to change plans that information be posted prior to change to assist providers. (Nassau County Meeting)

Transportation

- Two transportation providers, one mental health provider and one advocate (at the Duval and Clay county meetings) requested that the Agency review transportation services provided in the demonstration by the health plans. They noted the challenges experienced since transportation is no longer handled by the Transportation for Disadvantaged coordinated system.
- Beneficiary spoke about personal experiences with transportation under the demonstration and requested that transportation return to the Commission for Transportation Disadvantaged. (Clay County Meeting)

After a full review of the public comments received, the Agency separated the issues identified as follows: (a) issues that can be addressed through operational changes to the program; and (b) issues that will require additional state and/or federal authority to implement.

The following are the operational issues raised during the public process that the Agency is addressing or will address over the next year:

- Reconvening the behavioral health care workgroup that consisted of providers and health plans to address streamlining health plan prior authorization procedures and evaluating medication formularies.
- Following up with beneficiaries and providers who spoke at the meetings to address their individual issues. The Agency is investigating the individual issues to resolve any individual issues and to identify any systematic problems that may exist.
- Following up with the advocate and provider who stated that beneficiaries do not complain for fear of retaliation in an effort to obtain additional information and to

clearly communicate that retaliation is prohibited and consequences are in place for plans or providers who engage in this practice. The Agency will take action as specified in law against any health plan or provider that engages in this practice.

- Scheduling a meeting with the Healthy Start Coalition to be held in July to discuss any issues with services being provided to pregnant women enrolled in the demonstration.
- Posting all documents related to the demonstration online, including videos of the public meetings, to allow access to information on the demonstration. Many of the documents were already available on the Agency website. Others were posted following the public meeting held in Tallahassee.
- Posting the questions and comments from federal CMS related to the waiver extension request on the Agency's website when received.
- Continuing to hold public meetings to solicit input from the public on the demonstration.

The following issues would require Legislative direction to modify:

- Excluding voluntary beneficiary eligibility categories specified in Florida Statutes and the approved waiver from participation in the demonstration.
- Including a Medical Loss Ratio requirement for the demonstration health plans and/or applying the "80/20" behavioral health reporting requirement currently specified in Florida Statutes for health maintenance organizations operating in non-demonstration areas.
- Fining or sanctioning health plans that withdraw from service areas.
- Limiting the number of health plans who participate in the demonstration (in an effort to reduce beneficiary confusion and to address provider concern of administrative resources necessary to network with multiple plans).

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III. Program Objectives of the Demonstration

A. Program Objectives

As required by the letter from federal CMS dated March 15, 2010, the Agency is required to address how the program objectives were met since implementation of the demonstration. An overview of the principles, structure and fundamental elements of the demonstration are outlined on pages 3, 4 and 5 of the waiver. The six (6) key design elements tracked by the Agency to evaluate progress towards achieving its goals are listed below along with a description of how each objective was met.

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

Since the beginning of the demonstration, the Agency has received 23 health plan applications (16 HMOs, including the specialty plan for individuals living with HIV or AIDS, and 7 PSNs, including the specialty plan for children with chronic conditions) of which 22 applicants sought and received approval to provide services to the TANF and SSI population. One HMO application is still pending, but the review process is nearly complete.

As illustrated by the Tables 2 through 4, the number and types of health plans have increased in each geographical pilot area since the implementation of the demonstration. Since the health plans have the ability to create customized benefit packages to meet the needs of specific populations, Florida Medicaid beneficiaries not only have a greater number of health plans from which to choose, but also have a greater variety of benefits. This new flexibility empowers the beneficiaries to choose the health plans that best meets their needs. An exciting aspect of the demonstration is the development of specialty plans. Florida Medicaid now has, as a result of the demonstration waiver, a health plan that specializes in serving children with chronic conditions and a health plan that specializes in serving individuals living with HIV or AIDS. As each specialty plan was developed, the Agency worked closely with medical professionals and national experts to ensure the model contracts encompass the unique needs of each population.

Tables 2 through 4 show the number of health plans by plan type before implementation of the demonstration and as of May 31, 2010. Prior to the demonstration, there were no specialty plans. Now there are 2 specialty plans in Broward County and 1 in Duval County. Similarly, there was one PSN in Broward County and none in Duval County prior to the demonstration. Now there are 2 PSNs in Broward and 1 in Duval. The demonstration brought managed care to Baker, Clay, and Nassau Counties. There are now 2 HMOs serving each of these three counties.

During the last three years of the demonstration, several plans have withdrawn or been acquired by other entities. The majority of health plans that withdrew from the

demonstration reported the primary reason for withdrawing was difficulty with specialty providers and hospital contracting. It should be noted that a number of new plans were approved to operate in the demonstration during this same period of time and that the overall impact was a net increase. Broward County has seen a net increase of 2 health plans since implementation of the demonstration, as has Baker, Clay, and Nassau Counties. Duval County has seen a net increase of 3 health plans. On balance, there are now more health plan choices including 2 specialty plans in the demonstration areas.

Table 2
Comparison of Number & Type of Health Plans in Broward County
(As of May 31, 2010)

Type of Health Plan	# Pre-Demonstration	# in Demonstration
HMO	8	7
PSN	1	2
Specialty Plan	0	2
Total	**9**	**11**

Table 3
Comparison of Number & Type of Health Plans in Duval County
(As of May 31, 2010)

Type of Health Plan	# Pre-Demonstration	# in Demonstration
HMO	2	3
PSN	0	1
Specialty Plan	0	1
Total	**2**	**5**

Table 4
Comparison of Number & Type of Plans in Baker, Clay and Nassau Counties
(As of May 31, 2010)

Type of Health Plan	# Pre-Demonstration	# in Demonstration
HMO	0	2
PSN	0	0
Specialty Plan	0	0
Total	**0**	**2**

A summary of the number and type of managed care plans available prior to the demonstration is provided in Attachment B.

With the transition of beneficiaries into the demonstration, managed care and the plans are serving as an effective deterrent against fraud and abuse by moving from fee-for-services system. In addition, the Agency has increased oversight of the plans and has adapted its fraud efforts to closely monitor fraud and abuse within the managed care system. The following provides an overview of those efforts.

It should be noted that fraud and abuse in Florida Medicaid has primarily been a fee-for-service system problem. A review[3] of fraud and abuse cases between July 1, 2005 and November 30, 2009, concluded that 97% of those cases were occurring in the fee-for-service system and 3% were related to Medicaid managed care organizations. Reducing the fee-for-service marketplace through increased penetration of managed care into the marketplace, will result in cost avoidance and expenditure predictability through additional fraud and abuse prevention.

Managed care is a tool for Medicaid programs to more effectively use resources while improving outcomes. As managed care has expanded in Florida Medicaid, the Agency has implemented a series of program improvements to increase managed care plan quality and accountability.

Medicaid managed care organizations are paid a monthly capitation rate and have financial incentive to be vigilant about preventing, identifying, and combating fraud and abuse. Regardless of this fact, it is important to have stringent prevention and reporting requirements in place through statutory and contract provisions.

During the 2006-2009 contract period and for the 2009-2012 contract period, requirements regarding fraud and abuse prevention and reporting for managed care plans have been continually reviewed and strengthened. Florida Medicaid managed care plans, including the demonstration health plans, are required to:

- Develop and maintain written policies and procedures for fraud prevention;
- Have an adequately staffed Medicaid compliance office;
- Have a system for provider profiling, credentialing, and recredentialing, including a review process for claims and encounters for providers who are suspected of potential fraud and abuse activities; and
- Have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities.

The health plans are required by contract to have a written fraud and abuse prevention program, including a compliance plan, compliance committee, standards for a code of conduct, training and education, and an organizational arrangement of anti-fraud personnel with responsibilities for investigations and reporting. The health plans are also required to report all instances of suspected fraud or abuse by contracted providers to the Agency through an online form within 15 days of detection. A secure FTP site has been created to allow health plans to submit additional supplemental documentation when reporting suspected fraud and abuse. This site also allows the health plans to demonstrate their due diligence by submitting their Quarterly Fraud and Abuse Activity Reports, due 15 days after the end of each calendar quarter.

[3] Review was conducted by the Florida Bureau of Medicaid Program Integrity.

The Agency's Florida Medicaid Program Integrity (MPI) staff conduct on-site reviews of new health plans prior to contracting. In addition, MPI has conducted on-site survey visits for all existing demonstration health plans during the first contact year. The first on-site visit was conducted in November 2006. MPI's activities were focused on assessing the capabilities of the health plans (HMOs and PSNs) in the area of fraud and abuse prevention and detection. This was accomplished through on-site survey and desk reviews of the plans' Compliance Programs, of which fraud/abuse prevention and detection (program integrity) should be a key component.

During the 2009-2012 health plan contract cycle, MPI instituted a new survey tool, independent of the other tools used by the Agency. MPI staff now use this tool to review the plans' policies and procedures prior to health plan contract implementation.

For the 2009-2012 health plan contract cycle, these requirements are strengthened, in that plans must report any suspected or confirmed instances of provider or enrollee fraud and abuse within 15 calendar days of detection. New quarterly reporting requirements were implemented and the Agency established a secure file transfer site to provide a mechanism for additional documents, data, and report transmittal. The implementation of this report provides an adjunct tool in statewide surveillance for managed care fraud and abuse. The Agency is also in the process of automating the quarterly reporting so that reporting is simpler for plans, and that aggregating and analyzing data is more efficient and effective for the Agency. Also during the current contract cycle, new regulations are in place which grant civil immunity to certain persons who report suspected Medicaid fraud.

In addition, Florida Statute has now been amended to allow the Agency to impose monetary fines against plans who fail to comply with contract requirements relating to Fraud and Abuse prevention, and rulemaking authority to implement those fines. The Agency continues to move forward to strengthen contract and regulatory provisions to ensure managed care plan compliance with all state and federal laws relating to Fraud and Abuse prevention and reporting.

Please note that patient satisfaction is addressed in Objective 5.

Objective 2: To ensure that there is access to services not previously covered and improved access to specialists.

Access to Services Not Previously Covered

Since implementation of the demonstration, the health plans have recognized the value in offering services that were not previously covered under the Florida Medicaid State Plan. The health plans have worked to create customized benefit packages designed to meet the needs of the beneficiaries they serve. During the course of the demonstration, all of the capitated health plans offered expanded or additional benefits that were not previously covered under the Florida Medicaid State Plan. The health plan expanded services primarily target adults since all health plans are required to offer EPSDT services at the State Plan level to all enrolled children. The expanded services available to beneficiaries during the course of the program have included:

- **Over-the-Counter Drug Benefit** – The benefit has ranged from $10 - $25 per household, per month. Approved items can vary but usually include non-prescription drugs, first aid materials, and other health-related items.
- **Adult Preventative Dental Services** – Benefits offered in this category have varied some but usually included coverage of select restorative dental procedures as well as preventative dental services for adults age 21 and over. Often there has been no cost for annual exams, x-rays, fluoride treatment (every six months), amalgams, or simple surgical extractions.
- **Circumcisions for Male Newborns** – Some health plans have extended circumcision coverage from six weeks after birth to one year.
- **Acupuncture** – Acupuncture has been offered to beneficiaries specifically to aid with pain management and smoking cessation.
- **Adult Vision Services** – Vision services that have been offered to beneficiaries age 21 and over include unlimited exams and eyeglasses when medically necessary (in some cases, this was limited to one pair per year). In addition to State Plan covered adult vision services, some plans offered an extra $125 beyond the standard Medicaid vision benefit, which has been applied to upgrades to scratch-proof or tinted lenses, better frames, or additional pairs of glasses.
- **Hearing Aid Services** – Beneficiaries were offered one complete visit and received one hearing aid per year. This included an upgrade from a standard hearing aid to a digital canal hearing aid.
- **Nutrition Therapy** – Home-delivered meals have been offered to beneficiaries recovering from surgery as well as to families of newborns.
- **Respite Care** – Beneficiaries have received an initial home visit by a Registered Nurse as well as eight follow-up visits of four hours in length. There have been various packages including a maximum of 16 hours allowed per month and 32 hours allowed per year.

- **Adult Hospital Outpatient** – One health plan has offered an additional $3,500 per year for adult hospital outpatient services for their TANF and SSI populations above the $1,500 standard limit.

- **Copayment Reduction or Elimination** – Copayments for services rendered to non-pregnant adults have been significantly reduced over the course of the demonstration, and in many cases have been eliminated completely.

The most common expanded benefits offered by the capitated plans were over-the-counter drug, adult preventive dental, and the reduction or elimination of copayments.

The creation and implementation of the health plans' customized benefit packages is an ongoing process and the packages are revised annually. The additional and expanded services offered by the health plans have become a key component in helping beneficiaries choose a plan that best meets their needs.

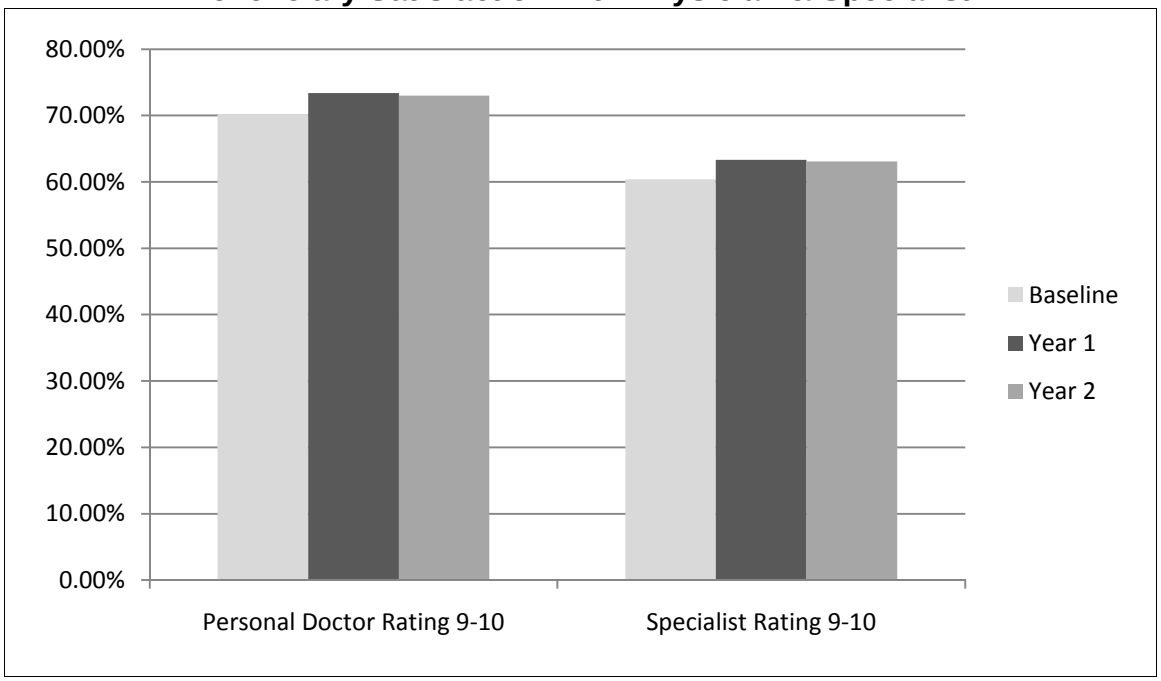
Improved Access to Specialists

The state has used a variety of methods for tracking and ensuring that beneficiaries have access to specialty care through their health plans. The primary methods used are as follows:

- The Agency assessed beneficiaries' experiences with specialists through items in the CAHPS Survey. The item regarding ease in seeing a specialist changed from the baseline to the Year One survey as did the response categories. In the 2006 CAHPS survey, the question was "In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?" and the possible responses were "Big Problem," "Small Problem," or "Not a Problem." In the baseline CAHPS survey for Broward and Duval Counties, 52.59% of beneficiaries in Broward County reported that it was not a problem to see a specialist, while 53.81% of beneficiaries in Duval County reported that it was not a problem. In the 2008 CAHPS survey, the question was "In the last 6 months, how often was it easy to get appointments with specialists?" and the possible responses were "Never," "Sometimes," "Usually," or "Always." After Year One of the demonstration, 64.58% of beneficiaries in Broward County reported that it was always or usually easy to get an appointment with specialists, while 63.48% of beneficiaries in Duval County reported that it was always or usually easy.

- Additionally, the percentage of beneficiaries in Broward and Duval Counties rating their satisfaction with their personal doctors and specialists at the highest level (9 or 10 on a scale from 1 to 10) increased from the baseline to Year 1 and remained stable in Year 2 (see Chart A). This change was statistically significant for personal doctor ratings but not for specialist ratings.

Chart A
Beneficiary Satisfaction with Physician & Specialist



- Issues and complaints received at the Agency, from providers or beneficiaries, are tracked, researched and resolved in a timely manner. In each case, Agency staff contacted the health plan immediately and health plan staff worked with the member to ensure that they received the needed appointment and/or care. The health plan contract requires plans to ensure the availability of at least 26 specialty provider types and 19 different behavioral health specialties to ensure access to contract covered services. The volume of complaints received in general is low compared to the number of recipients served (a total of 267 issues/complaints from approximately 311,000 enrollees were received between July 2008 – June 2009, fewer than 9 issues per 10,000 enrollees). Service issues/complaints (which include access, authorization and denials) are one of the types tracked and discussed internally each quarter within the Agency to determine any concerning trends. To date, the overall volume or percentage of complaints received related to service has not been significantly different. In addition, health plan contract managers review complaints/issues received on a monthly basis to ensure there are no issues of concern with a particular health plan.

- Beginning January 2010, all health plans were required to report total number of complaints received. This information is reviewed relative to grievances and appeals to ensure that the volume of complaints received are not a concern.

- In addition to monitoring plan reported complaints, grievances and appeals, the Agency also monitors the number of Medicaid Fair Hearings (MFH) requested by beneficiaries or providers on behalf of beneficiaries. Medicaid Fair Hearings are conducted by the Florida Department of Children and Families with Agency staff in

attendance. For the period September 2006 to March 2009, there were 43 requests for Medicaid Fair Hearings. Of the Hearings requested, 13 Hearings were held and 30 requests were withdrawn. Of the hearings held, 8 were decided in favor of the plan. The health plans are notified when a Fair Hearing is requested and continue to work with the beneficiary and provider to resolve the issue. The low number of Fair Hearings held demonstrates issues are being resolved at the plan level. The Agency continues to monitor the Fair Hearings on a quarterly basis to identify issues or trends of concern. Table 5 identifies the number of Medicaid Fair Hearing Requests and the number of Fair Hearings held.

Table 5
Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held
Demonstration Years One through Four

Demonstration Period		Medicaid Fair Hearing Held	Medicaid Fair Hearing Requests
Year One	July 2006 – August 2006	No Plan Enrollment	
	September 2006 – December 2006	1	1
	Quarter 3 Jan 2007-Mar 2007	0	0
	Quarter 4 April 2007-June 2007	0	0
Year Two	Quarter 1 July 2007-Sept 2007	0	4
	Quarter 2 Oct 2007-Dec 2007	0	0
	Quarter 3 Jan 2008-Mar 2008	1	3
	Quarter 4 April 2008-June 2008	1	3
Year Three	Quarter 1 July 2008-Sept 2008	0	5
	Quarter 2 Oct 2009-Dec 2009	1	5
	Quarter 3 Jan 2009-Mar 2009	0	2
	Quarter 4 April 2010-June 2010	1	6
Year Four	Quarter 1 July 2009-Sept 2009	2	7
	Quarter 2 Oct 2009- Dec 2009	1	0
	Quarter 3 Jan 2010-Mar 2010	5	7
	Quarter 4 April 2011-June 2011	N/A	N/A
Total		**13**	**43**

- From March 2008 through March 2009, the Agency headquarters staff and field office staff conducted 11 monthly plan Provider Network Validation surveys. These surveys assessed the percentage of health plan providers in the network files that are in fact contracted with the health plans. In the last six monthly surveys (September 2008 thru March 2009), the accuracy rates were consistently 99% or 100%, so the survey process was moved to a quarterly basis beginning in July 2009. Table 6 provides the survey results for the period March 2008 through March 2009.

Table 6 Results of Statewide Provider Network Validation Surveys March 2008 through March 2009			
Survey Month/Year	**Statewide Accuracy Rate**	**Geographic Medicaid Area**	**Medicaid Area Accuracy Rate**
March 2008	88%*	10	95%*
April 2008	88%*	4	84%*
May 2008	97%	11	99%
June 2008	96%	9	97%
August 2008	97%	6	100%
September 2008	99%	3	99%
October 2008	100%	5	100%
November 2008	100%	8	100%
January 2009	99%	7	100%
February 2009	99%	2	100%
March 2009	99%	1	100%

- Quarterly Provider Network Validation Surveys were conducted in July and October 2009 and January 2010. With the switch from monthly to quarterly surveys, the sample size doubled (i.e., 30 providers were sampled from each health plan rather than 15) and the survey is at the statewide level, rather than focusing on a geographic Medicaid Area each time as well. Follow up on the July and October 2009 surveys found that 95% and 98% of providers, respectively, were in fact contracted with the health plans from which they were sampled. Agency staff are currently following up on the January 2010 surveys and the May 2010 quarterly survey is being conducted.

- The Agency reviews the plan provider networks on an annual basis and at any time that the Agency receives notice of termination from a provider that appears to have a material impact on the health plan's provider network.

- The Agency reviews the plans' monthly submission of plan provider network files to ensure that the files are as accurate and complete as possible. Agency staff also review the provider networks displayed on the health plans' websites to ensure that the website directories are as up to date and accurate as possible.

Future Efforts

In addition to the ongoing monitoring and assessment of the health plan networks, the Agency has asked an outside consulting firm to analyze the Agency's provider network requirements and provider network and utilization patterns to develop a network adequacy methodology that will assist the Agency in setting improved provider network requirements.

Objective 3: *To improve enrollee outcomes as demonstrated by (a) improvement in the overall health status of enrollees for select health indicators; (b) reduction in ambulatory sensitive hospitalization; and (c) decreased utilization of emergency room care.*

(3)(a) Improvement in the overall health status of enrollees for selected health indicators

Quality is a primary focus of the demonstration. In order to appropriately monitor health care service delivery and to provide a mechanism for assessing the effectiveness of the demonstration, the state selected a wide array of performance measures that all participating health plans would be required to submit. The Agency reviewed the HEDIS® (Health Effectiveness Data and Information Set) measures and Agency-defined performance measures specified in the Reform health plan contracts to ensure the measures were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable. The Agency also reviewed the disease management performance measures used by health plans and disease management programs nationally and in Florida to determine which of those measures the plans would be required to collect and report to the Agency.

After a full review of the measures along with public input obtained through public meetings held in November 2006, the Agency identified a total of 33 proposed performance measures of which 21 Agency-defined measures were not listed in the initial 2006 health plan contract and would be applicable to the disease management enrollees. These measures were collected over a three-year period (with the third year being reported July 1, 2010). For Year One of the demonstration, the Agency collected 13 performance measures. The first set of performance measures was due to the Agency on July 1, 2008, for the measurement year beginning January 1, 2007 and ending December 31, 2007.

As the end of first measurement year approached, the Agency answered questions about specifications and submission procedures from health plans preparing their data submissions. Although a few health plans requested short extensions on the due date as a result of unforeseen problems, the majority of health plans were prepared to submit data on July 1, 2008. Seven health plans submitted data files prior to the deadline. Performance measure data can be viewed on the Agency's Quality in Managed Care website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

For Year Two, the state made several changes to the list in response to modifications to the HEDIS® by the National Committee for Quality Assurance (NCQA). Two measures that were previously selected by the state were retired by NCQA: Mental Health Utilization: Inpatient Discharges and Average Length of Stay; and Adolescent Immunization Status, although NCQA stated its intent to return Adolescent Immunization Status in 2009 with revisions. In response to these changes, the state created a new Agency-defined measure, Mental Health Readmission Rate, which tracks the rate at which persons who are hospitalized for a mental illness are rehospitalized within 30 days. The state also added two new HEDIS® measures: Follow-up Care for Children Prescribed ADHD Medication and Lead Screening in Children. Because NCQA stated its intent to return the Adolescent Immunization Status measure, the state

postponed submission of this data until Year Three, which represents calendar year 2009.

The Agency provided specifications to the health plans on the Agency-defined measures for Year Two, which represents calendar year 2008. These measures included Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy for enrollees participating in the disease management program for Congestive Heart Failure, Lipid Profile Annually for enrollees in the Hypertension disease management program, and the aforementioned Mental Health Readmission Rate. Although the state had expressed intent in the initial list of measures to create two additional Agency-defined measures for the Asthma disease management program (Use of Rescue Medication and Use of Controller Medication), it was decided that a HEDIS® measure, Use of Appropriate Medications for People with Asthma, was suitable for this purpose and more efficiently collected by the health plans.

The Agency hired a national consulting firm to assist with the development of a plan for performance improvement. A comprehensive performance improvement strategy was created and disseminated to all health plans that required health plans to complete corrective action plans for all performance measures that fell below the 50th percentile as calculated in the HEDIS® 2007 National Means and Percentiles, published by the National Committee for Quality Assurance. The corrective action plans must be designed to achieve performance at the 75th percentile in two years for measures falling below the 25th percentile and three years for measures above the 25th percentile but below the 50th percentile. The Agency selected the 75th percentile as its goal for all contracted performance measures. It should be noted that this improvement strategy applies to both Reform and Non-Reform health plans as the Agency has committed to improving quality throughout our managed care system.

To impart to the health plans the importance of the performance measures and the Agency's commitment to improvement, at the time, the Secretary for the Agency for Health Care Administration met with health plans individually to discuss their performance. Agency quality staff also held workshops with each health plan to discuss and improve their corrective action plans, culminating in the submission of final corrective action plans in late March and early April 2009. Health plans were required to report on the progress they made toward the goals in their corrective action plans quarterly. The Agency developed and distributed a quarterly reporting template, and the first reports were submitted to the Agency on August 17, 2009.

In Year Three calendar year 2010, the Agency updated the list of performance measures and completed the specifications for the final group of Agency-defined measures. Comments from health plans, the EQRO, and HEDIS® auditors were reviewed and incorporated. The revised list removed separate reporting of measures for the disease management population. This was done in response to differing methodologies within the health plans for identifying and enrolling beneficiaries into the programs and in response to a desire to reduce reporting burdens on the health plans. Instead, health plans will report measures for the disease states targeted by the disease

management programs, but the measures will be applied to the entire health plan population. To capture disease management information, the health plans will now report a measure that asks for the percentage of enrolled beneficiaries participating in each of the disease management programs. This will allow the State to identify any relationships between high performance and high disease management participation. The final list of measures is listed below in Table 7. Specifications for the Agency-Defined measures may be viewed on the following webpage: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Table 7
Plan Performance Measures

	HEDIS	Note	Benchmark Year
1	Adolescent Well Care Visits (AWC)		HEDIS 2007
2	Adults' Access to Preventive /Ambulatory Health Services (AAP)		HEDIS 2008
3	Ambulatory Care (AMB)		N/A**
4	Annual Dental Visits (ADV)		HEDIS 2007
5	Antidepressant Medication Management (AMM)		HEDIS 2008
6	BMI Assessment (ABA)		HEDIS 2009
7	Breast Cancer Screening (BCS)		HEDIS 2008
8	Cervical Cancer Screening (CCS)		HEDIS 2007
9	Childhood Immunization Status (CIS) – Combo 2 and 3		HEDIS 2008
10	Comprehensive Diabetes Care (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy		HEDIS 2007
11	Controlling High Blood Pressure (CBP)		HEDIS 2007
12	Follow-up Care for Children Prescribed ADHD Medication (ADD)		HEDIS 2009
13	Immunizations for Adolescents (IMA)	new	HEDIS 2011
14	Lead Screening in Children (LSC)		HEDIS 2008
15	Mental Health Utilization – Inpatient, Intermediate, & Ambulatory Services (MPT)		N/A*
16	Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)		HEDIS 2009
17	Prenatal and Postpartum Care – (PPC)		HEDIS 2007
18	Use of Appropriate Medications for People With Asthma (ASM)		HEDIS 2008
19	Well-Child Visits in the First 15 Months of Life (W15)		HEDIS 2007
20	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		HEDIS 2007
Agency-Defined Performance Measures			
21	Follow-Up after Hospitalization for Mental Illness (FHM)		CY 2009
22	Mental Health Readmission Rate (RER)		CY 2008
23	Lipid Profile Annually (LPA)		CY 2009
24	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy (ACE)		CY 2008
25	Prenatal Care Frequency (PCF)	new	CY 2009
26	Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)		CY 2009
27	Highly Active Anti-Retroviral Treatment (HAART)		CY 2009
28	HIV-Related Medical Visits (HIVV)		CY 2009
29	Percentage of Enrollees Participating in Disease Management Program (DM)		N/A
30	Transportation Timeliness (TRT)	new	CY 2010
31	Transportation Availability (TRA)	new	CY 2010

**AMB and MPT are utilization measures and will not be compared against a national benchmark.*

With the submission of the second year (January 2008-December 2008) of performance measures in July 2009, the Agency was finally able to assess the improvement of care provided to Reform enrollees. Compared to the performance measures submitted to the Agency for the first year of the demonstration project, statewide average performance showed improvement in all measures with the exception of one. Of particular note are gains achieved in the Annual Dental Visit, Controlling Blood Pressure, and the Follow-Up after Hospitalization for Mental Illness-30 day measures. It should be noted that these improvements occurred prior to the implementation of the Agency's performance measure improvement strategy. Table 8 lists the statewide average results for each measure that was submitted in both Year One and Year Two.

Table 8
2008-2009 Comparison of Plan Measures

Measure	2008 Statewide Average	2009 Statewide Average	Difference
Annual Dental Visit	15.2%	28.5%	13.3%
Adolescent Wellcare	44.2%	46.5%	2.3%
Controlling Blood Pressure	46.3%	55.9%	9.6%
Cervical Cancer Screening	48.2%	52.2%	4.0%
Diabetes – HbA1c Testing	78.9%	80.1%	1.2%
Diabetes - HbA1c Poor Control (INVERSE)	48.3%	46.8%	-1.5%
Diabetes - Eye Exam	35.7%	44.0%	8.3%
Diabetes - LDL Screening	80.0%	80.2%	0.2%
Diabetes - LDL Control	29.3%	35.9%	6.6%
Diabetes – Nephropathy	79.2%	80.3%	1.1%
Follow-Up after Mental Health Hospital – 7 day	20.6%	29.3%	8.7%
Follow-Up after Mental Health Hospital – 30 day	35.5%	46.6%	11.1%
Prenatal Care	66.6%	67.4%	0.8%
Postpartum Care	53.0%	51.5%	-1.5%
Well-Child First 15 Months – Zero Visits (INVERSE)	4.9%	1.6%	-3.3%
Well-Child First 15 Months – Six Visits	44.4%	49.3%	4.9%
Well-Child 3-6 years	71.3%	75.7%	4.4%

Seven additional performance measures (eleven with sub-measures counted separately) were submitted by health plans in 2009 as planned in the Agency's three year phase-in schedule. Of those new measures, most have statewide averages near or above the national mean (see Table 9).

Table 9 Plan Performance Measures for Year 2 Reporting Period (January 2008-December 2008)		
Plan Performance Measures	**National Mean**	**2009 Statewide Average**
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 20-44 years	76.8%	71.8%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 45-64 years	82.4%	84.7%
Adults' Access to Ambulatory/Preventive Health Services (AAP), Ages 65 years and older	78.8%	83.6%
Antidepressant Medication Management (AMM) Acute	42.8%	52.0%
Antidepressant Medication Management (AMM) Continuation	27.4%	29.8%
Use of Appropriate Medications for People with Asthma (ASM)	86.9%	83.6%
Breast Cancer Screening (BCS)	50.0%	51.4%
Childhood Immunization Status (CIS) Combo 2	72.3%	63.6%
Childhood Immunization Status (CIS) Combo 3	65.6%	53.8%
Frequency of Prenatal Care (FPC)	59.3%	52.6%
Lead Screening in Children (LCS)	61.5%	54.8%

Health plans were also required to submit performance measure data for their populations outside of the demonstration project. Again using statewide average data, the demonstration health plan outperformed Non-demonstration health plans in 20 of 27 measures (see Table 10).

Table 10 2009 Demonstration Measures Compared to Non-Demonstration Measures			
Plan Performance Measures	**2009 Non-Demo**	**2009 Demonstration**	**Difference**
Adolescent Well-Care	46.0%	46.5%	0.5%
Controlling Blood Pressure	51.6%	55.9%	4.3%
Cervical Cancer Screening	53.8%	52.2%	*
Diabetes – HbA1c Testing	75.1%	80.1%	5.0%
Diabetes - HbA1c Poor Control (INVERSE)	51.7%	46.8%	-4.9%
Diabetes - Eye Exam	41.9%	44.0%	2.1%
Diabetes - LDL Screening	76.3%	80.2%	3.9%
Diabetes - LDL Control	29.4%	35.9%	6.5%
Diabetes – Nephropathy	76.1%	80.3%	4.2%
Follow-Up after Mental Health Hospital – 7 day	37.2%	29.3%	*
Follow-Up after Mental Health Hospital – 30 day	51.7%	46.6%	*
Prenatal Care	69.1%	67.4%	*
Postpartum Care	50.1%	51.5%	1.4%
Well-Child First 15 Months – Zero Visits (INVERSE)	3.0%	1.6%	-1.4%
Well-Child First 15 Months – Six Visits	51.0%	49.3%	*
Well-Child 3-6 years	72.5%	75.7%	3.2%
Adults' Access to Preventive Care – 20-44 Years	69.3%	71.8%	2.5%
Adults' Access to Preventive Care – 45-64 Years	82.2%	84.7%	2.5%
Adults' Access to Preventive Care – 65+ Years	74.7%	83.6%	8.9%
Antidepressant Medication Mgmt – Acute	45.6%	52.0%	6.4%
Antidepressant Medication Mgmt -- Continuation	31.2%	29.8%	*
Appropriate Medications for Asthma	87.0%	83.6%	*

Table 10 2009 Demonstration Measures Compared to Non-Demonstration Measures			
Plan Performance Measures	**2009 Non-Demo**	**2009 Demonstration**	**Difference**
Breast Cancer Screening	47.5%	51.4%	3.9%
Childhood Immunization Combo 2	61.8%	63.6%	1.8%
Childhood Immunization Combo 3	52.0%	53.8%	1.8%
Frequency of Prenatal Care	51.6%	52.6%	1.0%
Lead Screening	46.0%	54.8%	8.8%

* = a difference is shown only for measures where Reform outperformed non-Reform.

As the Agency tracked the health plans' quarterly reports on improvement strategies, it was noted that most health plans reported that they were on track with their chosen interventions. A select few health plans, however, struggled with their own internal timelines due to personnel and technology resource deficits. Agency Quality staff scheduled teleconferences will all health plans to discuss their progress and to identify best practices that could be shared with all health plans.

The Agency completed the final phase of the Performance Improvement Strategy by finalizing incentive and sanctions language for the health plan contracts. Non-monetary incentives were created to acknowledge high performance. A quality designation system will be developed that highlights those health plans that have achieved the state standards for excellence. A quality award program will also be put in place that allows health plans to compete for the top rankings to foster continual improvement.

A sanctions strategy was developed to ensure that no health plan continues to operate below a floor threshold established by the state. Based on comparisons to HEDIS® national benchmarks, the sanctions will be levied if a plan fails to improve after being given the opportunity to institute corrective action. The health plans were given opportunity for input prior to finalizing the language. A staggered implementation schedule was included in response to their comments.

Because incentives with a fiscal impact are more desirable than non-monetary incentives, the Agency has formed a Value-Based Purchasing/Pay for Performance workgroup to develop additional incentives for high performance. The first task of the workgroup is to recommend a new auto-assignment methodology for recipients who do not select a health plan that disproportionately awards higher performing health plans with a greater portion of beneficiaries who do not voluntarily select a plan. The existing auto-assignments system operates primarily via a round-robin process that attempts to provide health plans with an equal number of recipients.

The second task of the workgroup will be to recommend a methodology and funding source to provide financial incentives to high performing health plans. Unlike the auto-assignment task that already has statutory authority for implementation, the financial incentive will result in a recommendation to the Florida Legislature for implementation.

(3)(b) Reduction in Ambulatory Sensitive Hospitalization

Due to delays in encounter data collection, the Agency constructed an alternative data resource to examine the effect the demonstration project had on Ambulatory Sensitive Hospitalizations (ASH). This alternative source can provide a precursor tool for measuring ASH criteria until the primary encounter data system becomes fully operational and is generating reliable information. This alternative data is constructed from merging two separate databases within the Agency. The first data source comes from the Hospital Inpatient Discharge Data from the Florida Center for Health Information and Policy Analysis (FCHIPA). FCHIPA is a division within the Agency that collects, validates and analyses an information repository covering all inpatient care provided in Florida. As required by Florida Statute, all hospitals in the state are required to routinely provide FCHIPA with an electronic data set for all their inpatient stays regardless of payer. The second data source is Medicaid claims history covering HMO capitation payments and Fee-For-Service (FFS) inpatient paid claims.

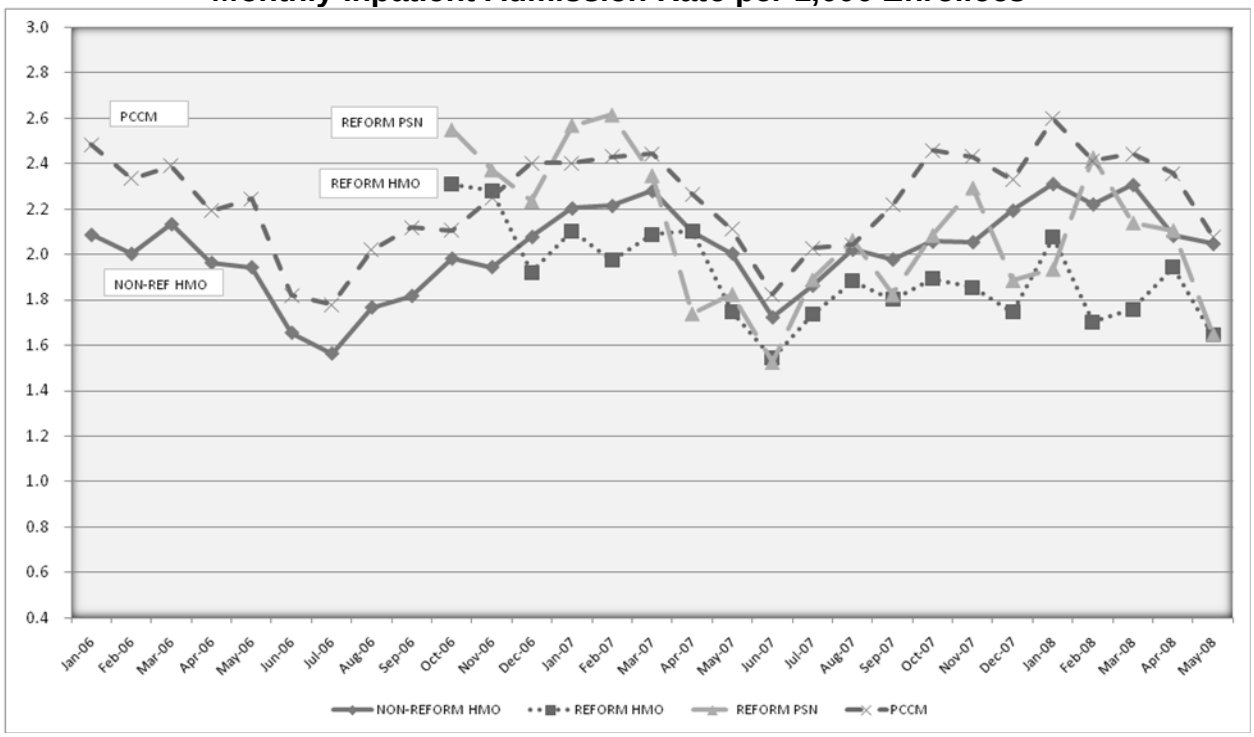
The Medicaid capitation claims identify HMO recipients by Social Security Number (SSN) and their enrollment dates. This data set is matched against the Hospital Discharge Data which contains the patient's SSN and date of admission. The successful matches (based on SSN+Date) identify those occasions of an inpatient stay that occurred in the same month that Medicaid made a capitation payment to a specific HMO to cover that recipient's care. Thus, this matched data is considered a viable precursor method for identifying HMO covered inpatient care.

A calculation was applied to this HMO matched data to compensate for missing SSN's that exist in both data resources. Approximately 2% of Medicaid capitation claims data did not have an SSN identified. Approximately 13% of the FCHIPA Hospital Discharge data lacked a valid SSN. In order to measure the rate of success for matching SSN's, an "SSN Comparison Group" was constructed from FFS inpatient claims. The premise is that all Medicaid paid inpatient admissions are contained in the Hospital Discharge data. The same SSN+Date matching exercise was performed on this SSN Comparison Group. The level of matching success achieved in this exercise was then applied to the matched HMO inpatient data in order to extrapolate the total volume of HMO inpatient admissions. This FFS comparative matching exercise was performed on 5 years of inpatient data. The average successful matching rate for this Comparison Group was 81.7%. Thus, the matched HMO inpatient data is also defined as representing 81.7% of the total inpatient care provided by the Medicaid HMO's.

The ASH indicators were then applied to this precursor HMO inpatient encounter data. A total of 24 of these indicators were individually calculated and aggregated. The ASH rates of admission were compiled monthly covering January 2006 through June 2008. The ASH rates were prepared for the Reform HMOs, Non Reform HMOs and Reform PSNs. Primary Care Case Management (PCCM) was included to provide comparative reference. For this exercise, the Children's Medical Services PSNs were excluded in order to facilitate a more uniform comparison.

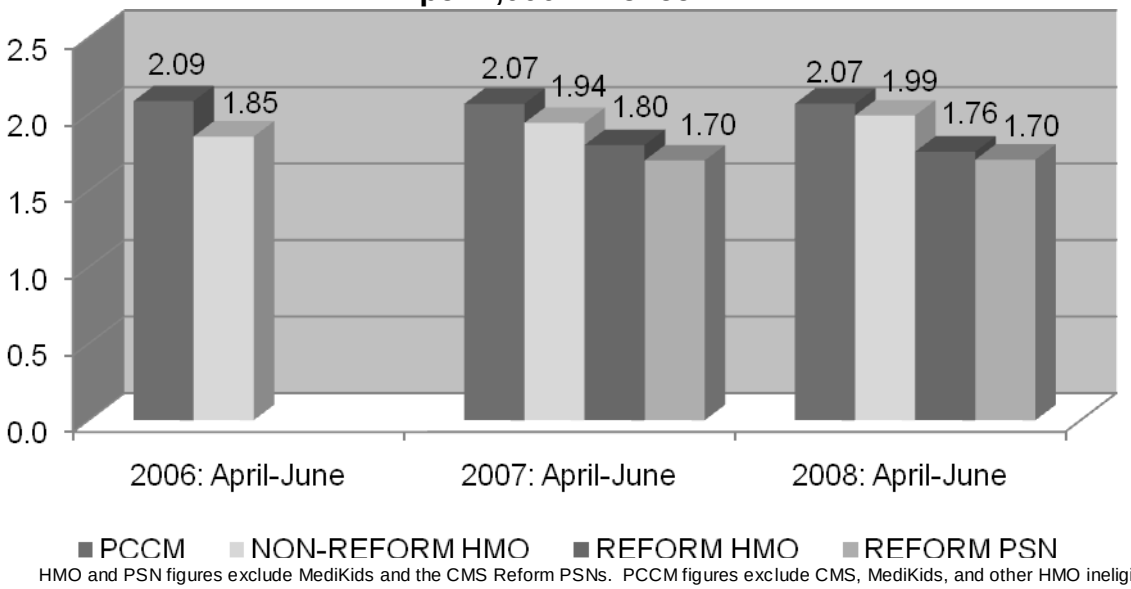
Charts B and C present the findings from this exercise. These charts demonstrate a measurably lower ASH admission rate for the Reform health plan enrollees than for the Non Reform health plan enrollees.

Chart B Ambulatory Care Sensitive Conditions
Monthly Inpatient Admission Rate per 1,000 Enrollees*



* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

Chart C Ambulatory Sensitive Hospitalizations
Comparison of Average Inpatient Admission Rates
per 1,000 Enrollee*

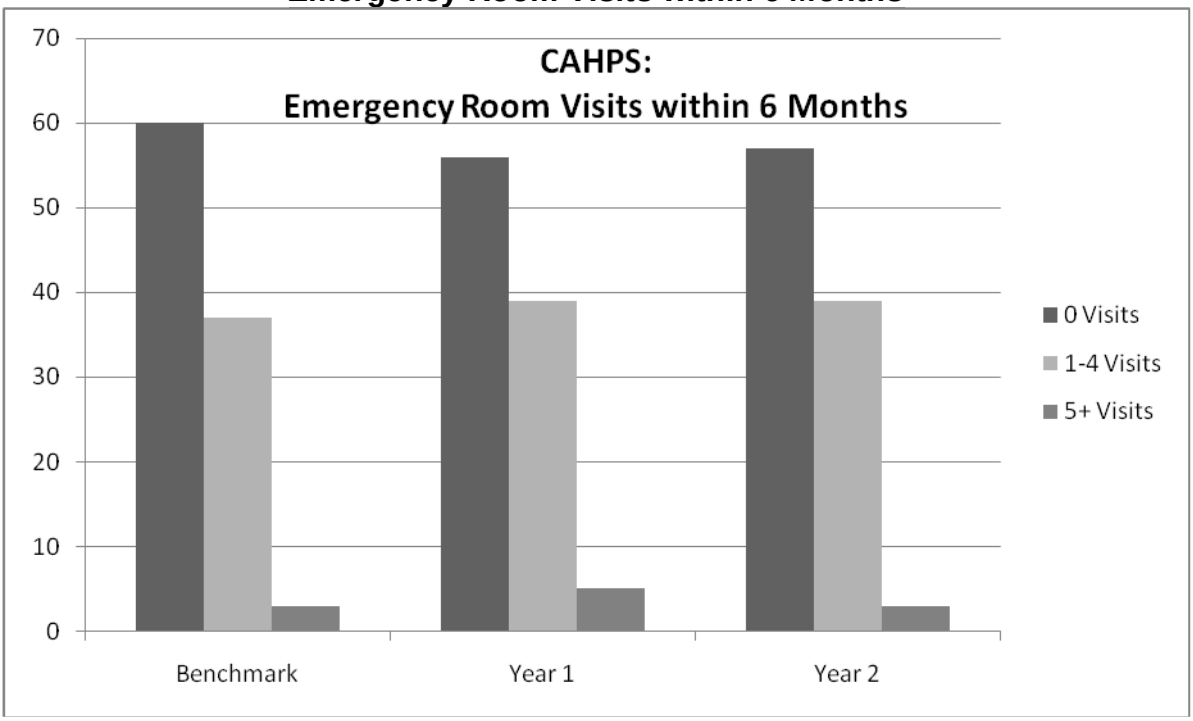


* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

(3)(c) Decreased Utilization of Emergency Room Care.

The Agency has three years of CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results for the demonstration. The first year of the survey served as the benchmark year and was administered to beneficiaries who were eligible for enrollment in the demonstration, located in Broward and Duval counties, enrolled in fee-for-service, MediPass, a provider service network or a health maintenance organization, prior to enrollment into the demonstration health plans. Two follow-up surveys were administered in Broward and Duval counties and one follow-up survey was administered in the rural counties. Included in this survey are questions regarding emergency room utilization. When comparing emergency department utilization via CAHPS across the three years, from county to county, and by plan type (HMO or PSN), there are no statistically significant differences (see Chart D).

Chart D
Emergency Room Visits within 6 Months



Additional analysis will be needed to determine where opportunities for reduction of emergency room utilization exist. Early analysis of health plan encounter data yielded some issues with the data itself that limited the Agency's ability to do a full analysis of the issue. The Agency is working to establish interventions to target the reduction of emergency department use that will be informed from deeper analysis from the encounter data when available for this analysis. A number of health plans in the demonstration already operate Emergency Room Diversion programs. This will be encouraged for health plans that do not. The Agency is in discussion with the state's External Quality Review Organization to establish a statewide collaborative project to reduce emergency room utilization.

Objective 4: *Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).*

For individuals who choose to opt out of the demonstration, the Agency through its vendor, maintains a database that captures the employer's health care premium information and whether the premium is for individual or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the vendor enters in the Opt Out Program's database the reason why an individual, who initially expressed an interest in and was provided information on the Opt Out Program from a Choice Counselor, decided not to opt out of Medicaid.

The reasons individuals have chosen to opt out of demonstration include:

(1) Primary care physician was not enrolled with a Medicaid Reform health plan and

(2) Elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.

The individuals who decided not to opt out:

(1) were not employed,

(2) did not have access to employer sponsored insurance, or

(3) after hearing about opt out decided to remain with their Medicaid Reform health plan where there were not co-pays and/or deductibles.

Opt Out Program Statistics

- 72 individuals have enrolled in the Opt Out Program beginning September 1, 2006 and ending May 31, 2010.
- 59 individuals have been disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance beginning September 1, 2006 and ending May 31, 2010.
- As of May 31, 2010, there are currently 15 individuals enrolled in the Opt Out Program.

Table 11 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending May 31, 2010.

Table 11 Opt Out Statistics September 1, 2006 –May 31, 2010						
Eligibility Category	**Effective Date of Enrollment**	**Type of Employer Sponsored Plan**	**Type of Coverage**	**Number of Beneficiaries Enrolled**	**Effective Date of Disenrollment**	**Reason for Disenrollment**
C & F	10/01/06	Large Employer	Individual	1	02/28/07	Loss of Job
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 Still Enrolled	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	09/30/09 Still Enrolled	Loss of Medicaid Eligibility Regained Eligibility on 04/01/2010
C & F	10/01/07	Large Employer	Family	2	Still Enrolled	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	Still Enrolled	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Individual	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/2010	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	09/30/09	Loss of Medicaid Eligibility
C & F	10/01/08	Large Employer	Individual	1	02/28/10	Loss of Medicaid Eligibility
C & F	12/01/08	Large Employer	Family	5	1/19/2010	Disenrolled from Commercial Insurance
C & F	12/01/08	COBRA	Family	1	11/30/09	Loss of Medicaid Eligibility
C & F	01/01/09	Large Employer	Family	2	07/31/09	Loss of Medicaid Eligibility
SSI C & F	01/01/09	Large Employer	Family	1 2	06/30/09 01/27/10	Loss of Medicaid Eligibility Disenrolled from Commercial Insurance
C & F	03/01/09	Large Employer	Family	1	12/31/09	Loss of Medicaid Eligibility
SSI	03/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	05/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	07/01/09	Small Employer	Individual	1	Still Enrolled	N/A
C & F	07/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	08/01/09	Small Employer	Family	1	09/30/2009	Loss of Medicaid Eligibility
C & F	08/01/09	Large Employer	Individual	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	1	Still Enrolled	N/A
C & F	09/01/09	Large Employer	Family	3	12/31/2009	Loss of Medicaid Eligibility
SSI	01/01/10	Large Employer	Family	1	Still Enrolled	N/A

As of May 31, 2010, the total premiums paid under the Opt Out Program is $82,971.47. The Agency would have paid Medicaid health plans approximately $158,862.31 in premiums if the individual had elected to enroll in a Medicaid plan. As identified in Table 11, the majority of individuals obtained family coverage. This was provided at a lower cost than would have been paid for enrollment in a Medicaid plan.

Objective 5: *To ensure that patient satisfaction increases.*

Section VI of this report provides key findings of the beneficiary satisfaction surveys conducted in the demonstration counties.

Objective 6: *To evaluate the impact of the low-income pool on increased access for uninsured individuals.*

Based on Census Bureau estimates, the number of uninsured in Florida has increased by almost seven percent since 2005. According to the 2005 Current Population Survey (CPS), Florida had approximately 3.38 million uninsured. The 2009 CPS shows just over 3.6 million uninsured in the state. While several factors have lead to an increase in the number of uninsured in Florida since 2005, the primary reason is the sharp rise in unemployment and a corresponding lack of availability for Employer Sponsored Insurance (ESI). There was a natural lull in the housing and construction industries following the spike in the industry due to rebuilding efforts following the abnormally active hurricane seasons in 2004 and 2005. The building industry was further hampered by the sub-prime mortgage crisis and the resulting surplus of empty housing has seriously impacted the construction industry's ability to recover. The economic downturn that accompanied the sub-prime crisis has also critically affected most of Florida's revenue sources including tourism. The vast majority of Florida's businesses are small employers with less than 50 to 100 employees in more than 4 out of 5 businesses in the state. This means the state's economy is highly susceptible to variations in economic circumstances. In addition to an increase in unemployment and the corresponding decrease in the availability of ESI, the sharp increases in insurance premium costs have also driven several employers out of the insurance market. The drop in availability of ESI, coupled with higher costs and even the unavailability of private insurance for some markets have contributed to Florida's increase in the number of uninsured as well.

Prior to the implementation of the demonstration, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The demonstration waiver created the Low Income Pool (LIP) program which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers such as County Health Department (CHDs) and Federally Qualified Health Centers (FQHCs). The inclusion of these new PAS entities allows for increased access to services for the Medicaid, underinsured, and uninsured populations.

The Florida Legislature has set a trend of increasing LIP appropriations for LIP projects outside of PAS hospital providers each demonstration year (see Table 12). It should be noted that while the majority of funding was appropriated to hospital systems, these systems also operate or contract with non-hospital providers that provide care to the underinsured and uninsured. As a result, many hospital systems use funds for non-hospital PAS entities that are reflected in Table 13.

Table 12
Low Income Pool Funding

SFY	Total UPL/ LIP Appropriation for Hospital PAS	Total LIP Appropriation for Non-Hospital PAS
2004-2005 – SFY	$631,919,923	$0
2005-2006 – SFY	$666,856,525	$0
2006-2007 – DY1	$979,352,587	$19,305,630
2007-2008 – DY2	$978,550,936	$21,449,060
2008-2009 – DY3	$975,250,000	$26,200,000
2009-2010 – DY4	$948,833,333	$51,416,666
2010-2011 – DY5	$ 922,931,940	$ 77,318,054

During Year One of the LIP program, the following PAS entities received state appropriations for LIP distributions: Hospitals, CHDs, the St. John's River Rural Health Network (SJRRHN), and FQHCs. During the first two quarters of demonstration Year One, the State approved a PAS distribution methodology and has worked with these PAS entities establishing Letters of Agreements with the local governments or health care taxing districts for the non-federal share funding.

The services realized through these PAS entities include, but are not limited to, the implementation of case management for emergency room diversion efforts and/or chronic disease management, increased hours and medical staff to allow for increased access to primary care services and pediatric services, and the inclusion of increased services for breast cancer and cervical screening services.

To monitor the impact of LIP program on increased access for uninsured individuals, the Agency collects LIP Milestone data from hospital PAS and non-hospital PAS entities. All PAS entities completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and Demonstration Year (DY) One through Three. It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. All PAS entities completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and Demonstration Year (DY) one through three. It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PAS entities with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges
- Case Mix Index
- Hospital Inpatient days
- Hospital Emergency Department Encounters (categorized by HCPC codes)
- Hospital Outpatient Ancillary Encounters (includes services such as diagnostic, surgical, therapy)
- Affiliated Services (includes services such as hospital owned clinic encounters, home health care, nursing home)
- Prescriptions filled

The non-hospital PAS LIP Milestone report data includes the following, also separated by Medicaid populations and uninsured/underinsured populations:

- Primary Care Clinic Encounters
- Obstetric/GYN Encounters
- Disease Management Encounters
- Mental Health/Substance Abuse Encounters
- Dental Service Encounters
- Prescription Drug Encounters
- Laboratory Service Encounters
- Radiology Services
- Specialty Encounters
- Care Coordination Encounters

The PAS entities input the data for the pre-LIP and DY 1-3 LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the UF LIP Evaluation team. The UF LIP Evaluation team is using the data (along with data previously submitted such as pre-LIP payments, IGTs, charge, cost, and utilization information) to perform their annual evaluations of LIP. With each new report that is received, the Agency can observe the impact of the Low Income Pool on increased access for uninsured individuals.

The University of Florida is under contract with the Agency for purposes of providing an independent evaluation of the LIP program. The scope of the contract requires reporting and analysis of milestone data which is data that is reported by the PAS entities that provides summary data of services provided to the Medicaid, Uninsured and Underinsured populations. To date, the university has completed reports for the first two years of the waiver. The reports are delayed from the end of the fiscal year to allow for end of year reporting and analysis. The milestone report for SFY 2006-07 has been completed. The report and highlights from the report can be viewed at the following links:

Evaluation of the Low-Income Pool Program Using Milestone Data: SFY 2005-06 and SFY 2006-07

Low Income Pool Highlights SFY 2007-08

In summary the highlights from the SFY 2006-07 report provides that:

- There were 206 PAS entities that received payments through the LIP program vs. 87 hospital providers that received payments through the UPL payments for the previous year (pre-demonstration period).
- The LIP program allowed for 43 non-hospital providers to participate that were not eligible for payments under the UPL.
- For all hospital PASs receiving LIP payments, it is estimated that slightly more than 1 million additional individuals were served in SFY 2006-07.
- Non-hospital PASs receiving LIP payments served approximately 660,000 Medicaid, uninsured and underinsured individuals.

In November of 2009, the Agency requested of federal CMS an amendment to the STC #105 of the waiver. This amendment allowed for the release of an additional $300 million in LIP funds to the SFY 2010-11, that could have otherwise been retained by the federal government.

The amendment resulted in revisions to STC #105 which incorporate compliance with milestones related to the Financial Management Review and the approved Reimbursement and Funding Methodology document (RFMD) that modified the way cost limits must be calculated for SFY 2009-10, SFY 2010-11, and all future years; the requirement that entities begin reporting data quarterly. The revisions also call for retroactive adjustment and reconciliation of all previous waiver Demonstration Year cost limit calculations using a regressive trend percentage. The amendment also required the Agency to report on LIP dollars currently allocated to participating providers that are within the operating budgets for SFY 2009–10, to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings by May 31, 2010.

The General Appropriations Act (GAA) approved by the legislature for the SFY 2009-10 provides funding for the LIP. The funding is allocated to both hospital and non-hospital providers. The non-hospital providers by design are not providing inpatient services and are meeting the goals and design of the LIP program as above. However, there is a large portion of the funds that are being provided to the hospital providers that in efforts to more efficiently serve the communities and residents also utilize available funding to provide care to the underinsured and uninsured population. Without the funding for alternative programs such as primary care and emergency room diversion, the uninsured and underinsured population would more often enter the health care system in more expensive settings such as the emergency room or as an inpatient stay due to delay in seeking care. Funds used by the hospitals are not specifically funded in the GAA and are not as easily identified as the non-hospital LIP participating providers. Due to the funding process, it is not clear that the hospitals that receive LIP payments in

turn utilize the funding for non-inpatient services and meeting the goal and design of the LIP.

Many of the programs and services funding by the LIP revenue for hospitals are not new programs implemented at the time of LIP implementation, but are programs that were able to be established through the UPL payment methodology that was operational in Florida prior to the implementation of the LIP. The continuation of the funding to hospitals under LIP provided a continued revenue source and allowed the hospitals to continue the services in alternative settings. In addition, there are providers that have expanded or established new programs, services or community agreements that were previously not able to be funded.

The Agency received completed templates from 81.3 percent or 135 of the 166 of the participating providers by the May 31, 2010 deadline. The level of detail provided for the program description varied by hospital. Agency staff reviewed all submissions and incorporated the programs that clearly meet the goal of the LIP program.

Participating hospitals received $1,072,510,148 in LIP funding as appropriated for SFY 2009-10. Using the information provided to the Agency from the participating providers, a total of $423,644,322 or 40% of the GAA LIP hospital funding, is currently being used by reporting hospitals to fund non-inpatient services and programs. The Agency believes that this number is understated due to reporting factors. The Agency will work to improve the reporting template and instructions and as a result anticipates that this amount will increase for future reporting periods. In addition, as the economy continues to struggle, providers seek to continue to improve efficiencies and provide services in the least costly manner when possible such as primary and preventative care environments. The funding needs for the alternative non-inpatient programs and services is likely to exceed the level of funding available through the LIP payments for many providers that serve a high level of uninsured and underinsured within communities that depend on the hospital and hospital based programs for care. The funding reported for each hospital included in this report is limited to the LIP payments the hospitals receive for the fiscal year. While these entities may have substantial additional expenditures related to the underinsured and uninsured in excess of the LIP payments, such expenditures are not included in the Table 13.

Table 13
Reporting Summary for Special Term & Condition #105 (2)(a)

Hospital Funding Programs Outside of Inpatient and Emergency Room	Total Amount
Primary Care	$209,291,941
Outreach	$ 26,798,944
Dialysis	$ 25,499,990
ER diversion programs	$ 23,648,567
Other	$138,404,880
Total	$423,644,322

In addition to the program and services summarized in the Table 13 above, the Agency was given specific authority in the GAA for SFY 2009-10 to create a new category of LIP distributions to hospital providers. The category was primary care hospital LIP; the category's focus was to expand the access to primary care to the uninsured and Medicaid populations in Florida. The Agency provided an application to all interested LIP funded hospitals. After independent scoring four awards of $750,000 each was made to the top applicants. The Agency looks forward to evaluating the successful recipients' programs to determine the number of additional individuals that were served as well as the services they received.

Summary

The Low Income Pool has provided hospital and non-hospital providers additional revenue that would not have been available to serve the Medicaid, uninsured and underinsured populations. As Florida's economy has deteriorated, the number of uninsured individuals continues to grow. In 2010, there were over 3.6 million uninsured individuals in the state, representing 19.2 percent of the population. Reauthorization of the LIP funding at current levels is a critical source of funding for care to the Medicaid, underinsured and uninsured populations in Florida. Reduction in funding would undoubtedly result in reduction and access to care for the uninsured. In addition, the Low Income Pool Council has made active recommendations to specifically allocate funding each year to expand the non-hospital inpatient programs and services for the Medicaid, uninsured and underinsured populations for the State of Florida.

B. Future Program Objectives

The 1115 Research and Demonstration Waiver established the following objectives as previously outlined in this section.

- Increase in the number of plans from which an individual may choose; an increase in the different type of plans; increased patient satisfaction.
- Access to services not previously covered by traditional Medicaid and improved access to specialists.
- Improve enrollee outcomes (overall health status of enrollees using select health indicators; reduction in ambulatory sensitive hospitalization; and decrease utilization of emergency room care).
- Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).
- Improve patient satisfaction.
- Determine the impact of the LIP program on increasing access for uninsured individuals.

A primary goal of the demonstration is to improve the Medicaid delivery system which would in turn improve health outcomes for Medicaid beneficiaries in the State of Florida.

As Florida reviews the experiences during the first five years of the demonstration and looks ahead to the three year renewal period, the Agency plans to strengthen the evaluation of access to care under the demonstration by improving health plan performance on key HEDIS® and agency-defined performance measures.

Another tool that we propose to use during the requested three year extension of the demonstration relates to access to specialty care. The Agency plans to expand the specialty care provider network review that was done in Duval County in 2007. The challenge with the initial review in Duval County was not having a unique identifier for providers enrolled in health plan provider networks. Without a unique identifier for the plan providers, it was not possible to conduct a complete account as some health plan providers were not enrolled as Medicaid providers. The requirement is that plan provider's must be eligible to be enrolled as a Medicaid provider but they are not required to be enrolled. Therefore, some provider records were not included in the analysis. With the implementation of National Provider Identification (NPI), the Agency will now be able to replicate the analysis for Duval County health plans, as well as the plans in the other demonstration counties.

As the demonstration was implemented in Florida, one major step forward was an increase in the number of performance measures the plans were required to report to the Agency. Prior to the implementation of the demonstration, the health plans were

required to report on 15 performance measures and currently the health plans are required to report on 31 measures.

In addition, to increasing the number of performance measures that plans are required to report to the Agency, the Agency has established a benchmark the plans must achieve for the HEDIS® performance measures. By 2012, each health plan must be at a minimum of the 75th percentile of the national benchmark for Medicaid health plans. This standard was established to ensure that the demonstration plans will be performing at a rate higher than 75 percent of the Medicaid plans across the nation. In conjunction with the benchmark related to performance measures, the Agency has added language to the health plan contracts which will reward the health plans who achieve the performance measure benchmark with increased auto assignments and other incentives and penalize the plans that are not performing at the established benchmarks.

IV. Budget Neutrality

A. Budget Neutrality Compliance

As required by the letter from federal CMS dated March 15, 2010, the Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested period of the extension and cumulatively over the lifetime of the demonstration. The Agency is also required to provide up-to-date responses to the federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver is budget neutral.

General Budget Neutrality Requirements

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

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

Budget Neutrality Results To Date

Table 14 provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through the third quarter of demonstration year four, expenditures have been $4.2 billion less than the authorized budget neutrality limit. As a result, the State is in substantial compliance with budget neutrality and anticipates that by the end of the demonstration the amount below the authorized budget neutrality limit will be even higher. Details for each year are provided below.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 14) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 14) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $314.31. Comparing the calculated weighted averages, the actual PCCM is 89.07% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 14) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $307.17. Comparing the calculated weighted averages, the actual PCCM is 82.51% of the target PCCM.

For the initial 3 quarters of Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 14) is $388.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $287.48. Comparing the calculated weighted averages, the actual PCCM is 74.09% of the target PCCM.

Table 14
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,863,960	$4,904,820,402	$709,960,890	$5,614,781,292	$314.31
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(689,069,663)	
% Of WOW					89.07%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	20,344,582	$5,472,479,873	$776,705,529	$6,249,185,402	$307.17
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,324,833,948)	
% Of WOW					82.51%
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,261,613	$4,317,856,359	$644,559,958	$4,962,416,317	$287.48
WOW	17,261,613			$6,697,681,708	$388.01
Difference				$(1,735,265,391)	
% Of WOW					74.09%

Florida's Demonstration Waiver

Attachment C is the required 1115 waiver templates supporting the demonstration waiver's compliance with the budget neutrality STCs. In addition, the projection of budget neutrality benchmarks for the requested three-year extension is included. The following are the key assumptions used to project the three-year extension.

The Without Waiver (WOW) trend applied to the Per Member Per Month (PMPM) expenditure projections for the first 5 years of the demonstration was eight percent for each of Medicaid Eligibility Groups (MEGs) 1 and 2. Using more recent SFY expenditure data, the Without Waiver trends calculated for the three year extension are as follows:

- MEG 1: 6.48 percent per year
- MEG 2: 6.59 percent per year

Expenditures from SFY 2002-03 through SFY 2005-06 were used to project the WOW projections. The five year history that was used to project the initial waiver period did not include SFY 2004-05 or SFY 2005-06. To project forward, the Agency updated the history to include these years, which provides the most recent expenditure and member month data prior to the implementation of the demonstration.

For MEG 1 (SSI-related), the WOW trend of 6.48 percent was calculated by averaging the annual PMPM growth factors from SFY 2003-04 through SFY 2005-06.

For MEG 2 (TANF-related), the WOW trend was based on a 2-year PMPM average using SFY 2003-04 and SFY 2005-06. This PMPM growth trend was 6.59 percent. SFY 2004-05 was an anomalous year where the caseload growth in TANF was very high (over 16%) so this year was not used in the WOW trend calculation for TANF. There were significant increases in the TANF caseload that were not understood. Outreach for KidCare and related programs may have been a factor, however, this trend did not hold, as the enrollment growth was not sustained. The following SFY began a significant decrease in the enrollment where the cause was not identified. The effect of the decrease realigned the enrollment with previous years. Therefore, the PMPM growth rate for SFY 2004-05 was not included in the calculation of the WOW trend.

The WOW trend factors described above were applied to the DY 5 PMPM identified in STC #116 b. The STC PMPM is used as this is an extension of Budget Neutrality. The trends are rebased using more recent data and expenditures that were not available at the time of the initial waiver request.

The WW trend for both MEGs 1 and 2 were based on 3 years of actual data from the demonstration (DY 1 – DY3). Since DY3 is not complete at this time due to claims processed after the last day of the year, the actual PMPMs were adjusted for the entire year. Actual data used for the projection is as of December 31, 2009. The PMPM growth rate was 4.24 percent for WW MEG 1 and 5.66 percent for WW MEG 2.

The trends used for projecting the WW and WOW for MEGs 1 and 2 provided in the column titles “Trend Rate” do not include a 3.3 percent adjustment factor to reflect increased payments for primary care services in 20113. Increasing the PMPM by 3.3% is specifically applied in the formula for “DY8 (SFY 13-14)”. Increasing the “Trend Rate” would impact the projections for all years and not specifically address the single year the change will occur. In addition, the “Trend Rate” is based on actual services, payments, and enrollment for the population subject to the waiver. The adjustment is a projected impact based on projected data. The two rates are not calculated in the same manner or using the same data. Therefore, the two should not be considered the same. The overall impact of the “Trend Rate” and the adjustment is provided on the templates as the “Annual Change” for DY8 (SFY 13-14).

The authorization of the national health care reform includes provisions that impact the reimbursement rates paid to providers under the Medicaid programs. The State has been analyzing policies and fiscal impacts of the new authorities. These analyses include projections of the Medicaid program with and without the required changes. States are required to increase reimbursement to the Medicare level beginning in 2013. Florida does not currently reimburse for services at the Medicare level. Therefore, the average cost for Medicaid enrollees will increase due to reimbursement policy changes. Since this increase is outside the demonstration, the increase in PMPM is applied to both WOW and WW projections. The PMPM for the final year of the extension request for both MEG 1 and 2 has been increased 3.3 percent. This increase is based on the projected cost of increasing the estimated cost of Medicaid services for the SFY 2013-14 to the Medicare level.

With the above rates and numbers, the total WOW expenditures for SFY 2011-12 through SFY 2013-14 are projected to be $37,714,032,742 compared to the WW expenditures of $29,462,551,955 for the same DYs. The net savings over the 3-year period would be $8,251,480,787.

MEG 3 was established in the initial waiver application as approved by CMS. The MEG is also referred to as the Low Income Pool (LIP) and is not directly linked to Medicaid eligibility. Expenditures for the Low Income Pool are authorized to provide services to the uninsured and underinsured. Distributions to qualifying providers under the LIP are determined by the type of facility and services as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the normal claims processing system but are lump sum payments made directly to the provider to offset the allowable uncompensated services. The limit for the LIP is established in the budget neutrality and is reported in accordance with the requirements of the budget neutrality special terms and conditions. However, the program requirements and monitoring are subject to specific terms and conditions for the LIP. Continuation of the $1 billion per year for the extension period not to exceed $3 billion over the three year period is provided in the budget neutrality templates. The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

B. Financial Management Standard Questions

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

   Response: Providers retain 100 percent of all payments made relating to Medicaid cost. 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.

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

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Florida Medicaid provides payments to institutional providers through per diem rates. The State's share of payments is appropriated by the Florida Legislature from the State's General Revenue. Each year we budget for the upcoming year, by applying an inflationary factor to current year payments, as well as making adjustments for estimated changes in caseload. The budget is submitted, reviewed, and ultimately approved by the Legislature.

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: No supplemental Special Medicaid Payments (SMP) are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the Low Income Pool (LIP) program, for the continuation of government support for services to Medicaid, uninsured, and underinsured populations.

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

   Response: The Upper Payment Limit (UPL) payment methodology is allowable under federal regulations 447.272 to help offset the Medicaid shortfall for Medicaid participating hospitals. The limit for UPL is based on a specific calculation (performed annually) using historical fee-for-service hospital costs and Medicaid expenditures. The UPL is broken into two categories: Public and Private. Private includes For Profit and Not for Profit entities. Each category has a separate limit for inpatient hospital services and outpatient hospital services. Florida had a UPL Payment Methodology that was in place from July 1, 2000 until June 30, 2006. Payments were made to qualifying hospitals only. The methodology provided a mechanism to supplement fee-for-service inpatient payments to Medicaid hospital providers. UPL expenditures for SFY 2005-06 were $631 million. The LIP was established July 1, 2006, to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. On June 27, 2006, Florida submitted a State Plan Amendment (SPA) # 06-006 to federal CMS to terminate the current inpatient supplemental upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. In the event of termination of the Florida Medicaid 1115 Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State has

agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration. In accordance with STC #91 of the 1115 Wavier, the LIP limit is determined by the waiver with supporting documentation. The LIP consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

Based upon a recent Request for Additional Information response specific to State Plan Amendment 08-018, County Health Department Payment methodology, the State respectfully requested clarification on the language in H.R. 1-389, Section 5003(d)(1)- that states *"… it is the sense of Congress that the Secretary of Health and Human Services should not promulgate as final regulations any proposed Medicaid regulations including cost limit for certain providers."* This regulation published on January 18, 2007 and was determined to have been "*improperly promulgated*." The State has requested clarification regarding this determination and how it applies with other cost limit measures and demonstrations for institutional providers.

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

   Response: Payments to providers would not exceed 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 federal CMS. The excess is returned to the state and the Federal share is reported on the 64 report to federal CMS.

C. Financial Data Related to Budget Neutrality

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. In addition to the budget neutrality requirement the State's independent evaluator analyzed whether or not this objective was being met. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. The report, "*An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*," can be found at: http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml.

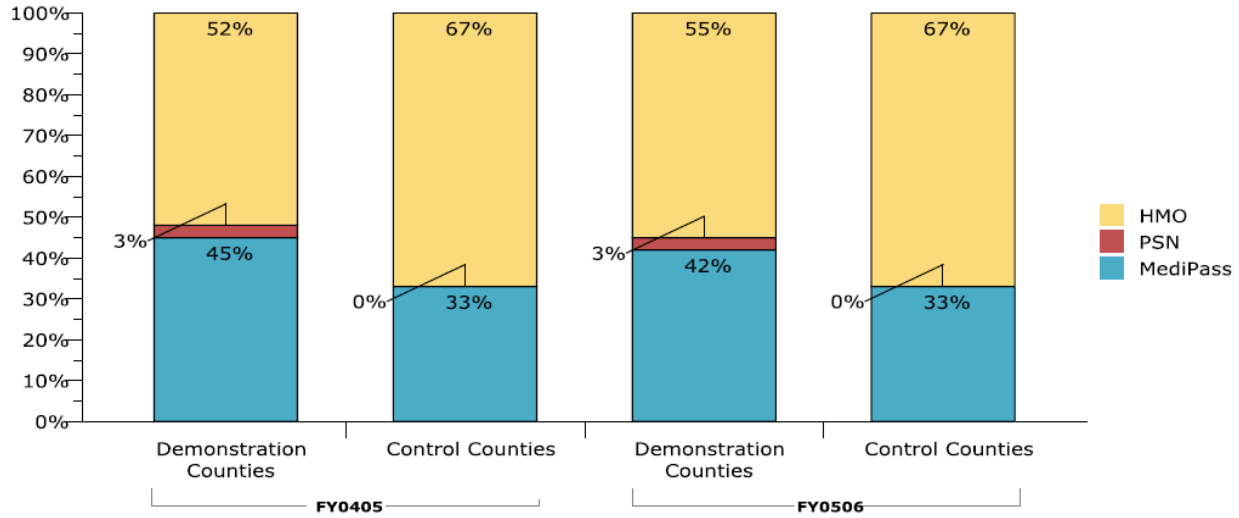
This report is the first of three fiscal analyses to be delivered to the Agency by the UF evaluation team. The multivariate methodology used for the second fiscal analysis is currently being revised by the Agency and University of Florida. The third fiscal analysis will reflect the additional data available over the life of the demonstration and will begin after the completion of the multivariate analysis. The analysis is scheduled to be completed the second quarter of Demonstration Year Five.

This fiscal analysis provided an initial indication of the 1115 demonstration waiver costs in comparison to enrollee expenditures during the pre- and post-demonstration periods. The Agency continues to work with health plans to collect and process encounter data, and once those data are comprehensive, it will be possible to determine precisely what services are purchased with expenditures on individual enrollees over time.

Study Findings: Comparison of Demonstration and Control Counties

Chart E shows HMO, PSN, and MediPass enrollments for the demonstration counties (Broward and Duval), and the control counties (Hillsborough and Orange) for SFY 2004-2005 through SFY 2005-2006. For the two years prior to the implementation of the demonstration waiver, the HMO market penetration rate for both the demonstration and control counties was over 50%, with the control counties having a slightly higher HMO presence. Compared to the control counties, the demonstration counties had a slightly higher MediPass/PSN enrollment, partly due to the lack of PSNs in the control counties. In general, the proportion of HMO and PSN/MediPass enrollees for the demonstration counties compared to the control counties was similar for both years prior to the demonstration program initiation.

Chart E
Comparison of HMO, PSN, and MediPass Enrollment in Demonstration Counties Compared to the Control Counties for SFY 2004-2005 through SFY 2007-2008*



* Demonstration counties include Broward and Duval, and the control counties include Hillsborough and Orange.

Relative to control counties, Medicaid expenditures in the demonstration counties were $6 PMPM less during the first two years of the demonstration compared to the two years prior to the demonstration.

Table 15 indicates that the average PMPM expenditures for MEG #1 enrollees was $26 lower in the first two years of the demonstration (SFY 2006-2007 through SFY 2007-2008), compared to SFY 2004-2005 through SFY 2005-2006. In the control counties, average PMPM expenditures for MEG #1 enrollees were $150 higher in SFY 2006-2007 through SFY 2007-2008, compared to SFY 2004-2005 through SFY 2005-2006. Thus, relative to the control counties, expenditures for MEG #1 enrollees in the demonstration counties were lower by $176 PMPM during the first two years of the demonstration waiver, compared to the two years immediately before implementation of the demonstration (SFY 2004-2005 through SFY 2005-2006). For MEG #2 enrollees in the demonstration counties, average PMPM expenditures were $4 higher in the first two years of the demonstration compared to the two years prior to the demonstration waiver. However, for MEG #2 enrollees in control counties, average PMPM expenditures were $10 higher in SFY 2006-2007 through SFY 2007-2008 compared to SFY 2004-2005 through SFY 2005-2006.

Table 15 Average PMPM Expenditure for All Enrollees in Dollars						
	Broward/Duval (Demonstration Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control – Demonstration)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Demo Period	809	127	683	126		
Demonstration Period	783	131	833	136		
Demonstration – Pre-Demonstration	-26	4	150	10	176	6

Pre-Demonstration Period: SFY 2004-2005 through SFY 2005-2006; Demonstration Period: SFY 2006-2007 through SFY 2007-2008

Relative to the control counties, Medicaid payments to participating HMOs on behalf of MEG #2 enrollees were greater by an average of $9 PMPM in the first two years of the demonstration waiver compared to the two years prior to the demonstration.

Table 16 shows that in the demonstration counties, the average PMPM expenditures for MEG #1 enrollees was $104 higher in the first two years of the demonstration, compared to the two years prior to the demonstration. In the control counties, average PMPM expenditures for MEG #1 enrollees were $111 higher in the first two years of the demonstration compared to two years prior to the demonstration. Therefore, relative to the control counties, the demonstration expenditures to HMOs participating in the demonstration were lower by an average of $7 PMPM in the first two years of the demonstration compared to the two years prior to the demonstration.

For MEG #2 enrollees in the demonstration counties, average PMPM expenditures were $12 greater in the first two years of the demonstration compared to the two years prior to the demonstration. In the control counties, PMPM expenditures for MEG #2 enrollees were $3 greater in the first two years of the demonstration compared to the two years prior to the demonstration.

Table 16 Average PMPM Expenditure for All Enrollees in Dollars						
	Broward/Duval (Demonstration Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control – Demonstration)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Demo Period	668	126	512	118		
Demonstration Period	772	138	623	121		
Demonstration – Pre-Demonstration	104	12	111	3	7	-9

Pre-Demonstration Period: SFY 2004-2005 through SFY 2005-2006; Demonstration Period: SFY 2006-2007 through SFY 2007-2008

Relative to the control counties, Medicaid's expenditures for MEG #2 enrollees in PSNs was on average of $34 PMPM lower in the first two years of the demonstration compared to the two years prior to the demonstration waiver.

Table 17 shows the differences in PMPM expenditures were calculated separately for MediPass enrollees and PSN enrollees. Since the PSN enrollment was extremely limited pre-demonstration in the pilot counties and not available at all in the control counties, expenditures by MediPass enrollees are used for comparison. On average, MEG #1 enrollees in PSNs in the demonstration counties had PMPM expenditures that were $95 less in the first two years of the demonstration compared to the two years prior to the demonstration waiver. MEG #1 enrollees in the control counties had $178 greater PMPM expenditures during the first two years of the demonstration compared to the two years prior to reform. Thus, relative to the control counties, Florida Medicaid expended an average of $273 PMPM less on behalf of MEG #1 enrollees in PSNs in the first two years of the demonstration compared to the two years prior to the demonstration. For MEG #2 enrollees in the demonstration counties, average PMPM expenditures in PSNs were $16 less in the first two years of the demonstration compared to the two years prior to the demonstration. For MEG #2 enrollees in the control counties, average PMPM expenditures were $18 greater in the first two years of the demonstration compared to the two years prior to the demonstration.

Table 17
Average PMPM Expenditure for MediPass/PSN Enrollees in Dollars

	Broward/Duval (Demonstration Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control – Demonstration)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Demo Period	894	128	860	139		
Demonstration Period	799	112	1038	157		
Demonstration – Pre-Demonstration	-95	-16	178	18	273	34

Pre-Demonstration Period is SFY 2004/2005 and SFY 2005/2006; Demonstration Period is SFY 2006/2007 and SFY 2007/2008

In summary, it appears that Medicaid expenditures in Broward and Duval Counties were lower on a PMPM basis during the first two years post demonstration initiation than would have been the case in the absence of the demonstration project. The observed differences are greater among MEG #1 enrollees, and the differences occurred among both HMO enrollees and PSN enrollees.

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V. Beneficiary Satisfaction

As required by the letter from federal CMS dated March 15, 2010, the Agency is required to provide summaries of the results from any beneficiary surveys performed during the period of the demonstration, along with the results of any baseline surveys performed prior to implementation. The following beneficiary satisfaction survey results are provided to address this requirement.

A. Overview of Satisfaction Surveys

The Consumer Assessment of Health Care Providers and Systems (CAHPS) satisfaction survey was conducted to track enrollees' experiences and levels of satisfaction with their health plan and health care. To date, three rounds of the CAHPS survey (Benchmark[4], Year 1 Follow-Up[5], and Year 2 Follow-Up[6]) have been completed in Broward and Duval counties and two rounds (Benchmark and Year 1 Follow-Up) have been conducted in Baker, Clay, and Nassau counties. Fieldwork is currently being conducted for the fourth round of survey in the Broward and Duval counties and the third round of survey in the Baker, Clay, and Nassau counties. A detailed methodology of each round of the survey is available on the Agency's website[7].

Several rounds of survey findings provide interesting and not entirely consistent trends. For example, upward changes in satisfaction with personal doctor, specialty care and getting needed care were observed. Many indicators of enrollee satisfaction (including emergency room visits, communication, courtesy and respect of staff) demonstrated no statistically significant change from the Benchmark Year through the first two years of the demonstration. While the above are extremely important and positive indicators, this was in contrast to a downward change observed in some ratings, specifically the indicators of overall health care satisfaction and overall health plan satisfaction.

B. Broward and Duval Counties (CAHPS Year 2 Follow-Up Survey)

Key Findings

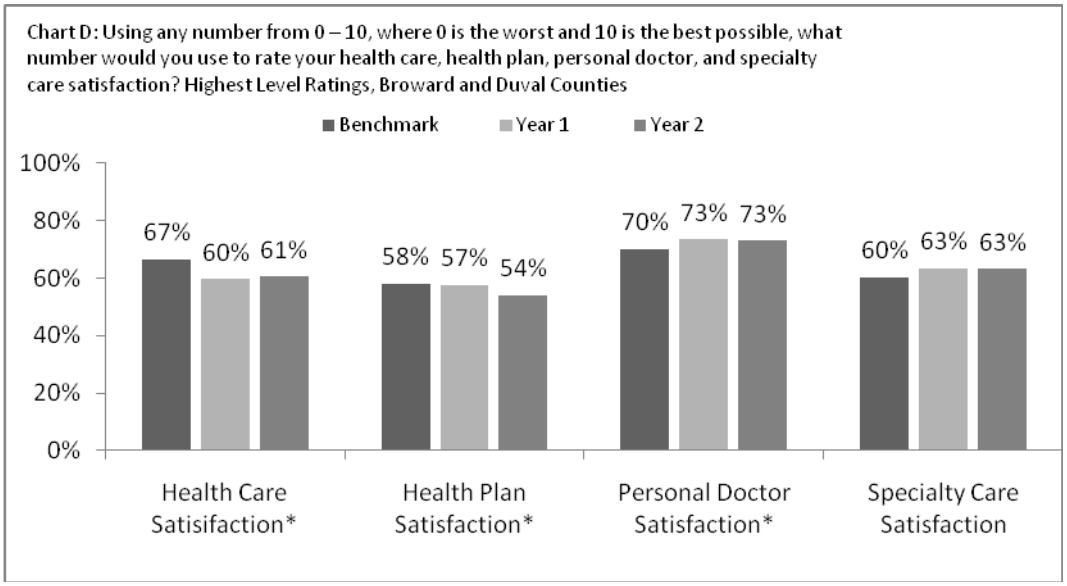
In Broward and Duval counties, more than 54% of enrollees rated their health care, health plan, personal doctor, and specialty care at the highest level (9 – 10 on a 10 point scale) [Chart F]. The decline in health care satisfaction and health plan satisfaction, over the first three years of the demonstration, may be attributable to the transition into a more managed delivery system. Conversely, personal doctor and specialty care satisfaction ratings increased (Chart F). This suggests that satisfaction is increasing *at the point of care delivery*, as evidenced by:

[4] The Benchmark survey was conducted prior to implementation of the demonstration.
[5] The Year 1 Follow up survey was conducted during the first year of the demonstration.
[6] The Year 2 Follow up survey was conducted during the second year of the demonstration.
[7] See *Medicaid Enrollee Satisfaction entries in Table 21*, Section XI

(1) the increased percentage of enrollees who reported it was not a problem getting a doctor or nurse they are happy with (75% in Benchmark Year to 86% in Demonstration Years 1 and 2), and

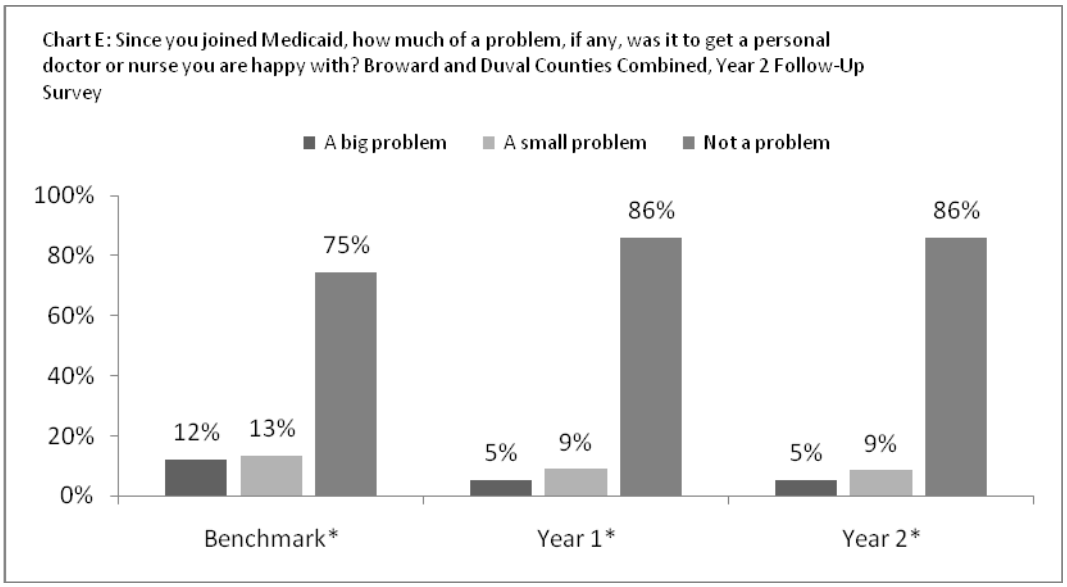
(2) the increased percentage of enrollees who said they were always able to get the help or advice needed when they called their physician's office (63% in Benchmark Year, 65% in Demonstration Year 1 and 66% in Demonstration Year 2) [Charts G and H respectively].

Chart F
Satisfaction with Health Care, Health Plan, Personal Doctor & Specialty Care (Broward & Duval Counties)



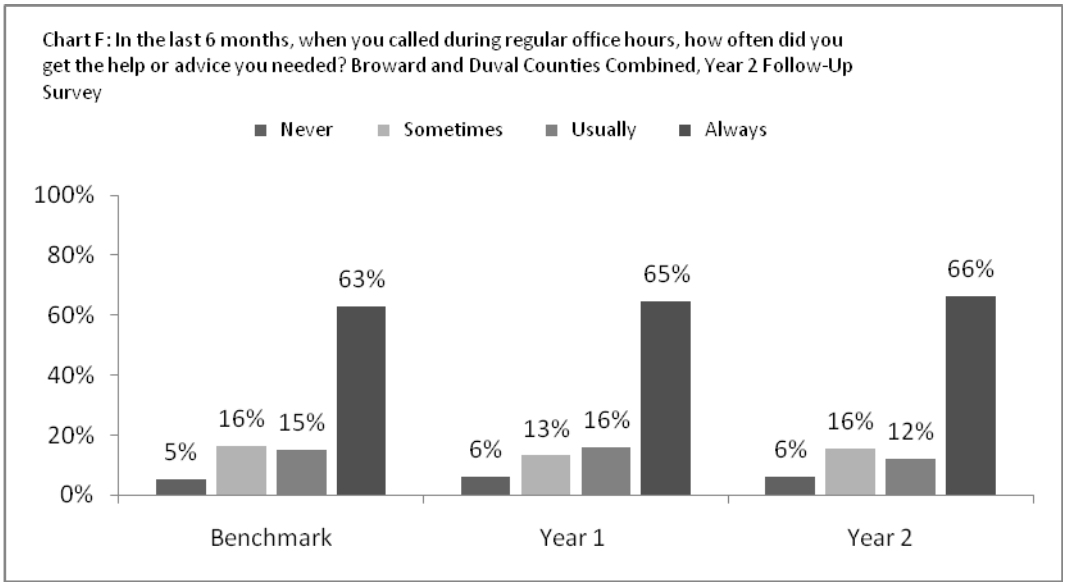
*p<.05
Note. Satisfaction ratings for each category were based on individual questions.

Chart G
Ease of Finding a Doctor or Nurse Happy With (Broward and Duval Counties)



*p < .05

Chart H
Getting Needed Help and Advice (Broward and Duval Counties)



Additional Survey Findings: Year 2 Follow-Up Broward and Duval Counties

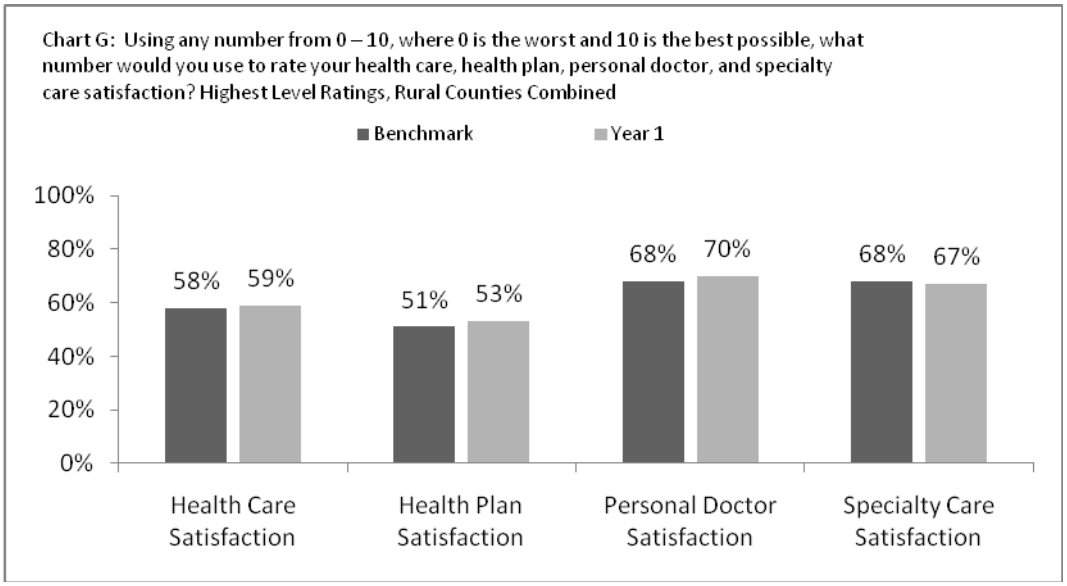
- Eighty-eight percent of enrollees in Year 1 and 87% of enrollees in Year 2 reported having a personal doctor compared to 79% in the Benchmark Year.
- The percentage of individuals who reported it was not a problem getting a doctor or nurse they are happy with increased from the Benchmark Year to Year 1 and Year 2 (75% and 86%).
- Approximately two-thirds of enrollees said they were "always" able to get the help or advice when they called their physician's office.
- Over 40% of enrollees said they were either "usually" or "always" taken to an exam room in 15 minutes.
- Eighty-four percent or enrollees in Years 1 and 2 said that their personal doctor "always" listened to them. In comparison, 78% of enrollees in the Benchmark Year said their doctor "always" listened to them.
- In Demonstration Years 1 and 2, 81% of enrollees said that their personal doctor "always" explained their health care to them in a way that was easy to understand. In comparison, during the Benchmark Year, 78% of enrollees said their doctor "always explained things in an easy way.
- The proportion of enrollees who said their doctor "always" showed them respect increased from 82% during the Benchmark Year to 87% in Year 1 and 89% in Year 2.
- Between 73% and 76% of the enrollees in both Broward and Duval Counties "never" had difficulty communicating with their providers due to language barriers.
- Between 81% and 83% of enrollees believed that their doctor's office staff "always" treated them with courtesy and respect.
- Eighty-five percent of enrollees said that their doctor's office staff was either "usually" or "always" helpful to them.

C. Baker, Clay, and Nassau Counties (Year 1 Follow-Up Survey)

Key Findings

In Baker, Clay, and Nassau Counties (rural counties), 70% of enrollees rated their personal doctor at the highest level. Specialty care was rated at the highest level by 67% of enrollees. Enrollees rated health care and health plan satisfaction at the highest level, 59% and 53%, respectively [Chart I]. Even though these increases in ratings across the Benchmark Year and Demonstration Year 1 were not statistically significant, it is still important to note an improvement.

Chart I
Satisfaction with Health Care, Health Plan,
Personal Doctor & Specialty Care (Rural Counties)



*p < .05
Note. Satisfaction ratings for each category were based on individual questions.

In Baker, Clay and Nassau Counties overall, few statistically significant differences can be observed. Exceptions include the increased percentage of enrollees who reported they "always" went to the exam room within 15 minutes (26% in Benchmark Year and 35% in Year 1) and the increased percentage of enrollees who indicated their doctor "always" showed respect (83% in Benchmark Year and 85% in year 1) [Charts J and K respectively]. Over 82% of enrollees in rural counties report having little trouble finding a doctor or nurse they were happy with. [Chart L].

Chart J
How Often Taken to Exam Room within 15 Minutes (Rural Counties)

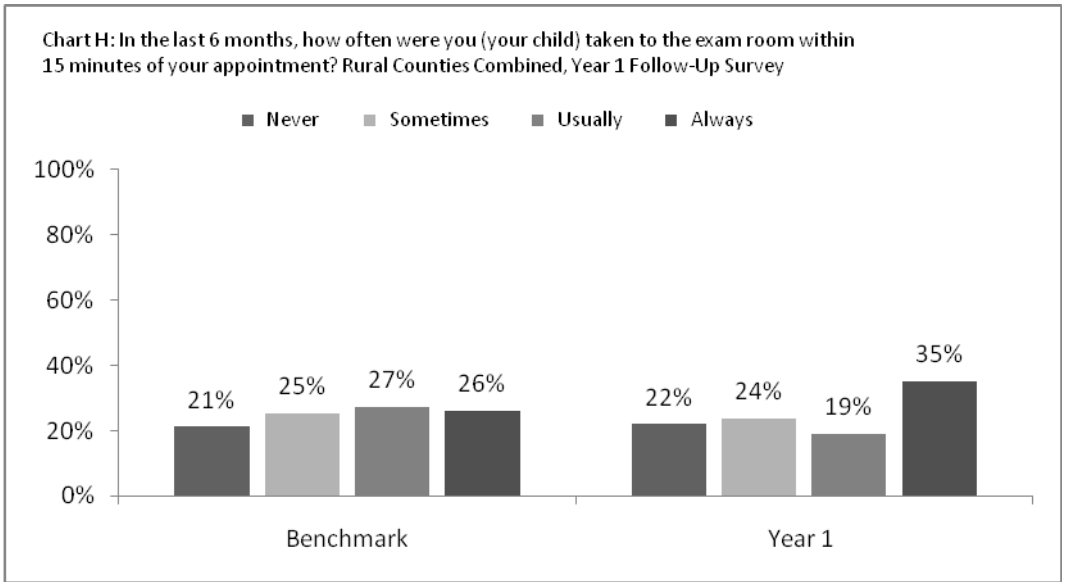


Chart K
Doctor Respect of Enrollee (Rural Counties)

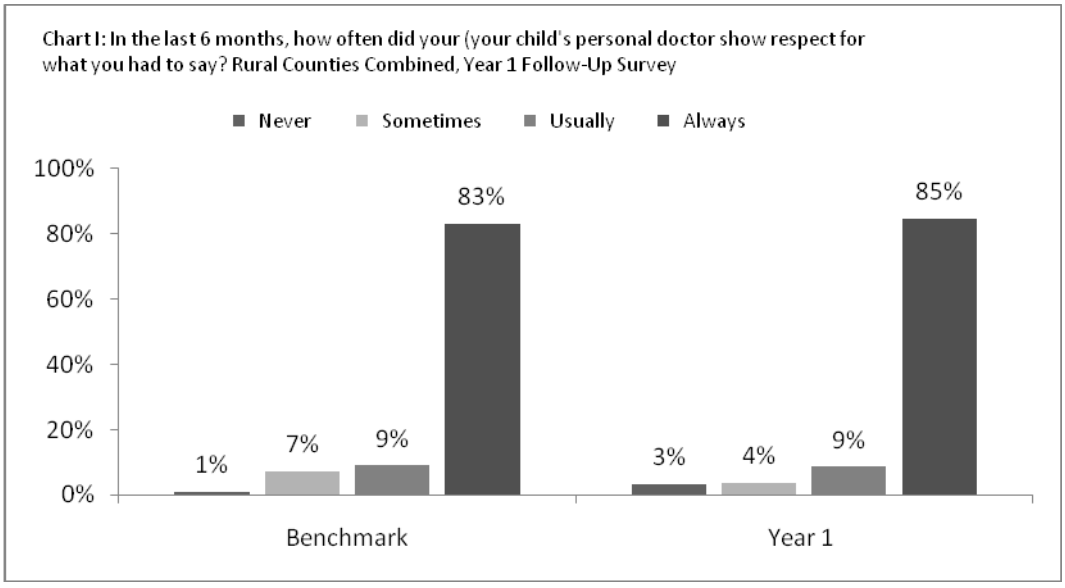
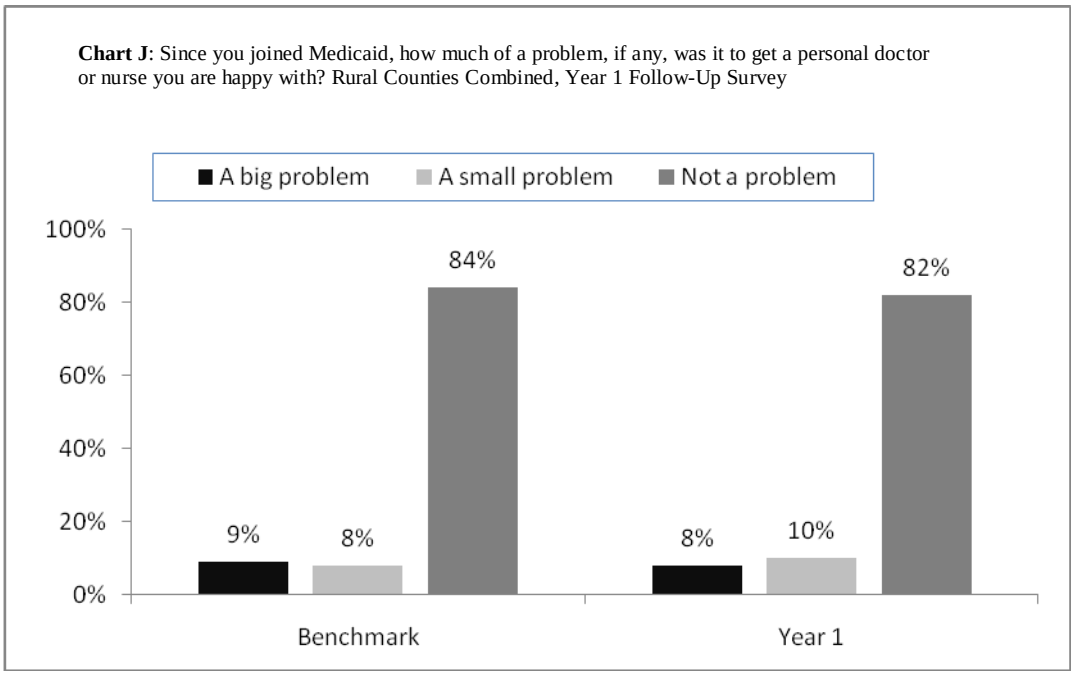


Chart L
Ease of Finding a Doctor or Nurse Happy With
(Broward and Duval Counties)



Additional Survey Findings: Year 1 Follow-Up Rural Counties

- Most enrollees (68% in Benchmark Year and 67% in Demonstration Year 1) rated their satisfaction with their specialist doctor at the highest level (9 – 10).
- Ninety percent of enrollees stated that they had a personal doctor at the time of the survey (in both Benchmark Year and Demonstration Year 1).
- Eighty-seven percent of enrollees were either “usually” or “always” able to get help they needed from their physician’s office (up from 83% in Benchmark Year).
- Over 80% of enrollees said that their personal doctor “always” explained their health care to them (80% in Benchmark Year, 82% in Demonstration Year 1).
- Most enrollees said that their personal doctor “always” showed respect to what they had to say (83% in Benchmark Year, 85% in Demonstration Year 1).
- Most enrollees believed that their doctor “always” spent enough time with them (71% in Benchmark Year, 74% in Demonstration Year 1).
- Enrollees believed that the staff at their doctor’s office “always” treated them with courtesy and respect (88% in Benchmark Year, 85% in Demonstration Year 1).
- In the Benchmark Year, over 88% of enrollees believed that their doctor’s office staff was either “usually” or “always” helpful to them (87% in Demonstration Year 1).

Future Survey Activities

Survey activities anticipated during the requested three-year waiver extension period can be summarized in two major categories. First, the existing evaluation enrollee satisfaction surveys (including the CAHPS survey) will be extended in time, allowing continued observation, further data collection, more detailed documentation and further analyses. These studies will strengthen the evaluation findings reported during the initial five-year demonstration period by providing longer observational time periods and additional data.

Beyond the considerable value of this straightforward extended time period and hence more data, the evaluation studies during the requested three-year extension period will include more use of the emerging Medicaid Encounter Data Systems information to determine in much greater detail the content of care being delivered to enrollees and assess not only enrollee satisfaction but fiscal, organizational, and other findings in context that takes medical encounter information into account.

The second major category of enrollee satisfaction evaluation activities planned for the requested three-year extension period involves initiatives that are new, or have renewed focus as a consequence of the evaluation studies accomplished since implementation of the demonstration in 2006. Specific plans in this category include more detailed analyses of the Enhanced Benefit Account program, including studies that link the Enhanced Benefit Account program participation levels to enrollee satisfaction. These studies also measure variation in the Enhanced Benefit Account program participation by enrollees in various plans and studies that begin to link the Enhanced Benefit Account program participation with health care utilization/health status.

Apart from these extended analyses of the Enhanced Benefit Account program, the UF evaluation team proposes further work and additional focus in the area of longitudinal/qualitative studies. This will include conducting series of enrollee focus groups in each of the demonstration counties (Broward, Duval, Baker, Clay and Nassau). The objective will be to capture the additional depth and richness of information that comes from detailed conversations as distinct from the kind of information that can be gleaned from surveys, claims analyses, or the like.

In addition to the Enhanced Benefit Account program analyses, in the first quarter of Demonstration Year Five, the UF evaluation team anticipates releasing the first of three volumes of CAHPS “chart books.” This first volume will provide an analysis of enrollee satisfaction data from the Year 2 Follow-Up Survey at the county level. Volumes two and three will be released early in second quarter of Demonstration Year Five and will look at enrollee satisfaction by demographics (particularly race and ethnicity) and by plan type.

D. Mental Health Enrollee Satisfaction Survey

The Experience of Care and Health Outcomes (ECHO) survey was conducted by UF to assess the experiences and levels of satisfaction of enrollees who receive mental health services. Using a stratified random sample, a total of 1,319 interviews were administered by telephone to enrollees with severe mental illness (SMI) or severe emotional disturbance (SED). The ECHO survey was fielded from May – July 2009 in the two urban demonstration counties (Broward and Duval) and a control county (Orange). Methodological details for this survey are available on the Agency's website[8].

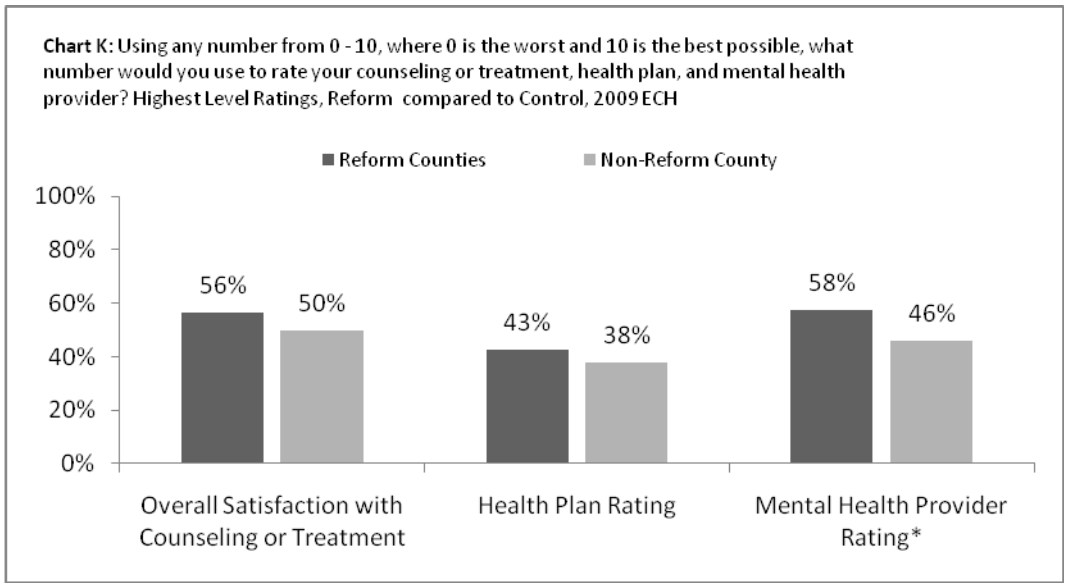
In general, enrollees in the urban demonstration counties were more satisfied than those in the urban control county,[9] although the statistical significance of these findings varied. For example, there were no statistically significant differences in the urban demonstration counties and the urban control county enrollees who rated their overall satisfaction with mental health counseling or treatment (56% in demonstration counties, 50% in non-demonstration) and overall satisfaction with their health plan (43% in demonstration compared to 38% in non- demonstration) at the highest level [Chart M]. However, enrollees in the urban demonstration counties were significantly more likely to rate their mental health provider at the highest level than those in the control county (58% in demonstration, 46% in non- demonstration) [Chart M].

In the demonstration counties, PSN enrollees tended to be more satisfied than those in the control county. For example, a higher percentage of PSN enrollees were slightly more likely to rate their overall satisfaction at the highest level for mental health counseling or treatment (59% PSN, 54% HMO). PSN enrollees in the urban demonstration counties also were slightly more likely to rate their health plan at the highest level compared to HMO enrollees (45% compared to 41%) [Chart N]. However, there was virtually no difference between PSN and HMO enrollees in rating their mental health provider at the highest level in the urban demonstration counties (58% vs. 57%) [Chart N].

[8] See http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/med027.shtml under related materials.

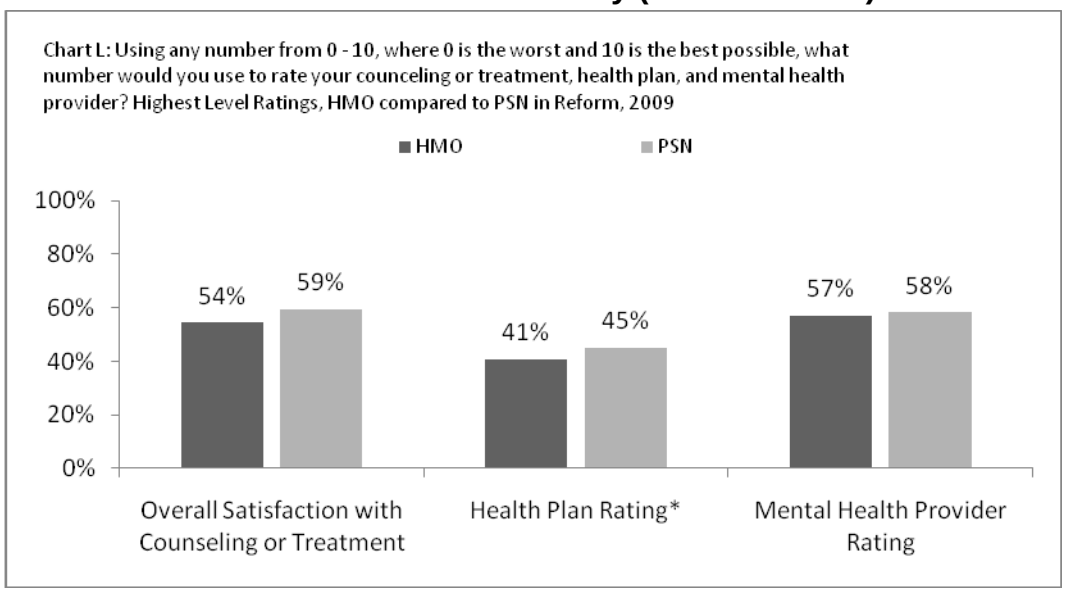
[9] It should be noted that MediPass enrollees in non-demonstration counties get their mental health services from a prepaid mental health plan (PMHP).

Chart M
Satisfaction with Overall Treatment, Health Plan & Provider – ECHO Survey (Demo and Non-Demo)



*p < .05
Note. Satisfaction ratings for each category were based on individual questions.

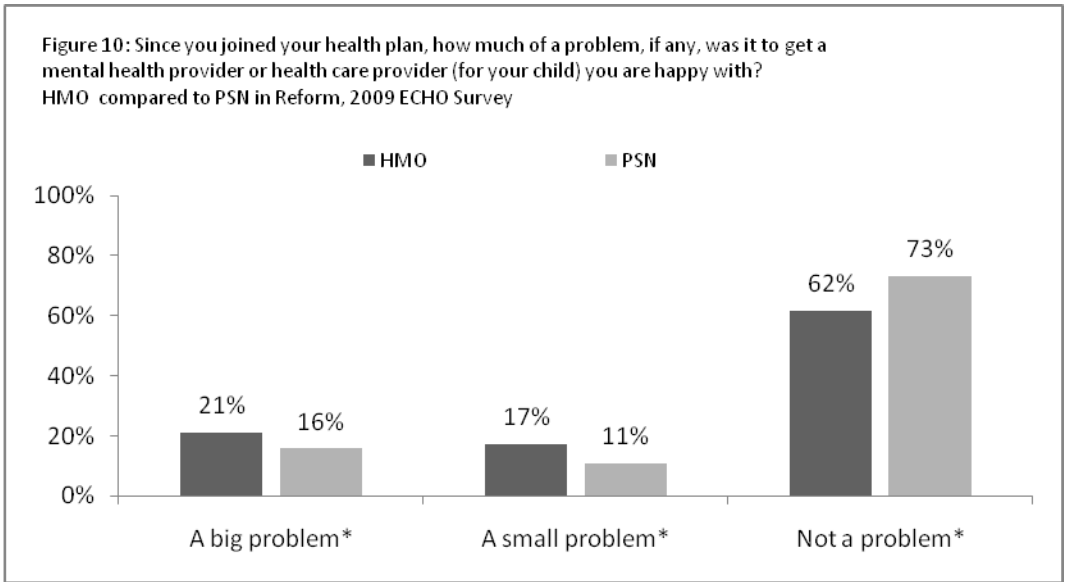
Chart N
Satisfaction with Overall Treatment, Health Plan and Provider – ECHO Survey (HMOs & PSNs)



*p < .05

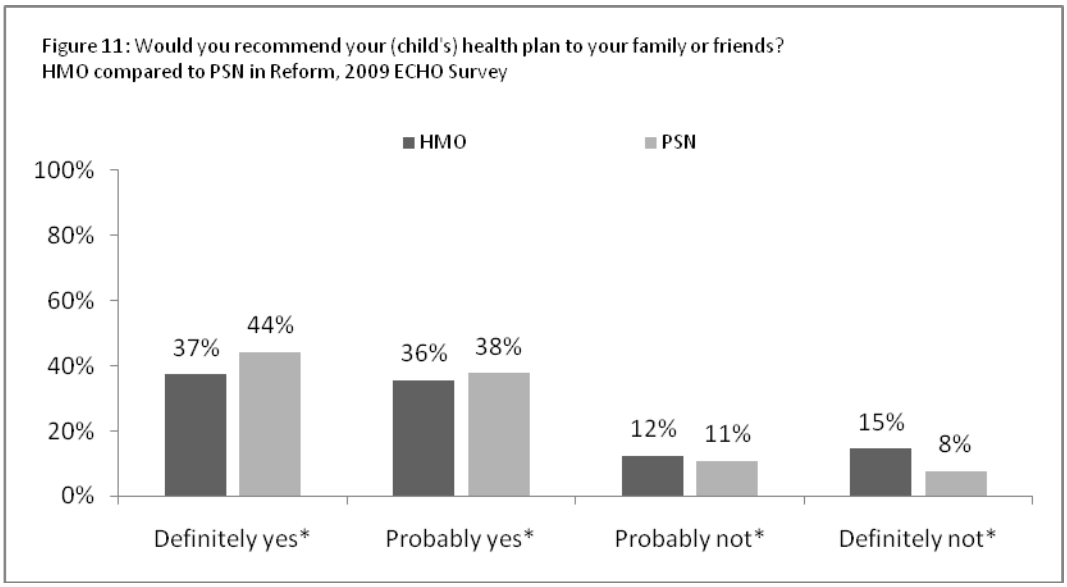
HMO enrollees were significantly more likely to indicate a problem finding a mental health care provider they were happy with (38% vs. 27%), and less likely to recommend their health plan (73% vs. 82%) than PSN enrollees in the urban demonstration counties (Charts O and P).

Chart O
Ease of Finding a Provider Happy with - ECHO Survey (HMO & PSN)



*p < .05

Chart P
Likelihood of Recommending Health Plan to Family or Friends ECHO Survey (HMO & PSN)



* p < .05

Additional Survey Findings

- With regard to access to mental health care and limitations on benefits, there were increases in enrollee satisfaction; though it should be noted that many of the differences between responses by enrollees in the demonstration and control counties were not statistically significant.
- Only 19% of enrollees in the demonstration counties indicated they had a big problem getting a mental health provider they were happy with compared to 21% in non-demonstration counties.
- Nearly 80% of respondents in both the urban demonstration counties and the urban control county reported that they "usually" or "always" got professional help when needed.
- Parents/guardians of children in HMOs were significantly more likely to report they were required to change a medication they thought worked compared to those in PSNs in the urban demonstration counties (42% vs. 21%).

E. Choice Counseling Satisfaction Survey Results

Every beneficiary that calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The survey went live in August of 2007, and since implementation 15,432 surveys have been completed, through third quarter of Year 4. Overall satisfaction with Choice Counseling averages 97.3%.

There are 7 key factors measured in beneficiary satisfaction, related to the enrollment process within the call center.

- How likely are you to recommend Choice Counseling helpline to a friend or relative?
- Satisfaction with overall service of Choice Counselor?
- How quickly the Choice Counselor understood your reason for calling?
- The Choice Counselor's ability to help you choose a plan?
- The Choice Counselor's ability to explain the information clearly?
- Confidence in the information received?
- Satisfaction with being treated respectfully?

The average satisfaction on the 7 categories measured from August 2007 through March 31, 2010, was 95%.

There are 4 key factors measured in beneficiary satisfaction, related to their interaction with the field staff and the enrollment process.

- Ability to complete enrollment/plan change at the session
- Felt the information provided by the Choice Counselor helped them make an informed decision
- The information was explained in a way that made it easy to understand
- The Choice Counselor was friendly/courteous

The average satisfaction of these 4 categories measured from October 2007 through March 31, 2010, was 98%.

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VI. Quality Initiatives

A. Plan Performance Measures and Improvement Strategies

The Agency initiated widespread, significant changes to its performance measure process in 2008 and 2009. In 2008, health plans were required to submit an expanded set of performance measures to the Agency (see Table 18). This was a new process for Provider Service Networks, who had not previously submitted performance measures. Many of the HMOs had submitted HEDIS® measures to the Agency for a number of years, but the new expanded list included a number of plan performance measures that had not been previously collected. The results were not as favorable as the Agency had hoped and a comprehensive process for overall system improvement was developed and implemented in 2009. Plan performance measure results may be viewed at the following website:

http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Table 18
Plan Performance Measures

Performance Measure	Measure Type	2008	2009
Adults' Access to Preventive/Ambulatory Health Services	HEDIS		X
Use of ACE/ARB Therapy	Agency-Defined		X
Annual Dental Visits	HEDIS	X	X
Antidepressant Medication Management	HEDIS		X
Use of Appropriate Medications for People with Asthma	HEDIS		X
Adolescent Well Care	HEDIS	X	X
Breast Cancer Screening	HEDIS		X
Controlling Blood Pressure	HEDIS	X	X
Cervical Cancer Screening	HEDIS	X	X
Comprehensive Diabetes Care	HEDIS	X	X
Childhood Immunization Status	HEDIS		X
Follow-Up after Hospitalization for Mental Illness	HEDIS	X	X
Frequency of Ongoing Prenatal Care	HEDIS		X
Lipid Profile Annually	Agency-Defined		X
Lead Screening in Children	HEDIS		X
Prenatal and Postpartum Care	HEDIS	X	X
Mental Health Readmission Rate	Agency-Defined		X
Use of Beta Agonist	Agency-Defined		X
Well-Child Visits in the First 15 Months of Life	HEDIS	X	X
Well-Child Visits in the 3-6 Years of Life	HEDIS	X	X
Ambulatory Care	HEDIS	X	X

Initial improvement efforts focused on the HEDIS® measures. All the health plans (HMOs and PSNs) were required to develop corrective action plans, referred to as Performance Measure Action Plans, for all measures that fell below the 50th percentile as listed in the National Committee on Quality Assurance's HEDIS® National Means and Percentiles. The Agency selected a goal of the 75th percentile for each HEDIS® measure and gave the health plan between one and two years to achieve the goal.

The health plans were responsive to the request for rapid improvement and presented the Agency with thoughtful, comprehensive Performance Measure Action Plans. The health plans submit quarterly reports describing their progress with details on the interventions being used. Common intervention strategies include enrollee and provider outreach and education, enhanced disease management programs, incentives for compliance with preventive and routine care, and strengthening the role of plan quality improvement staff.

B. Summary of EQRO Reports

External Quality Review Activities

As a requirement of the Balanced Budget Act of 1997 (BBA), the Agency selected Health Services Advisory Group, Inc. (HSAG) to be the Florida Medicaid managed care external quality review organization (EQRO) effective May 11, 2006. The primary purposes of the Florida EQR Program are to:

- Provide the Agency with an annual external and independent review of access to, timeliness of, and quality outcomes for the services included in the contracts between the Agency and the health plans providing health care to Florida Medicaid recipients enrolled in Medicaid managed care programs.

- Monitor each health plan's internal quality assessment and performance improvement program on a continuing basis.

Scope of External Quality Review Activities

The Florida EQR contract specifies eleven core categories of activities:

- Validation of Performance Improvement Projects (PIPs)
- Validation of Performance Measures (PMs)
- Review of Compliance with Access, Structural and Operations Standards
- Strategic Reports on Consumer-Reported Surveys
- Strategic HEDIS® (Healthcare Effectiveness Data and Information Set) Analysis Reports
- Technical Assistance on Enrollee Race/Ethnicity and Primary Household Language Information
- Value-Based Purchasing Methodologies

- Evaluation of AHCA Quality Strategy
- Focus Studies
- Dissemination and Education
- Technical Report

Attachment D lists the External Quality Review Reports by demonstration year.

Validation of Quality Initiatives

Since MCOs must have twelve consecutive months of member data available before the validation processes can take place and the demonstration health plans were considered newly enrolled Medicaid providers, they did not undergo validation of their PIPs, PMs or HEDIS® data until State Fiscal Year (SFY) 2007-2008.

1. Validation of Performance Improvement Projects

HSAG identified two performance improvement projects (PIPs) for each plans to undergo the validation process, one clinical and one nonclinical PIP per plan. One of each plan's PIPs was a collaborative PIP, which HSAG facilitated and the MCOs conducted. The collaborative PIP topic for HMOs/PSNs was: *Well-Child Visits in the First 15 Months of Life*. HSAG reviewed each PIP to ensure that the project was designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and giving confidence in the reported quality outcomes of care. Tables 19 and 20 summarize the PIP validation results for both demonstration and non-demonstration HMOs/PSNs for demonstration Years Two and Three. Results of demonstration Year Three validation activities have not been finalized as of this date.

Table 19
Performance Improvement Project Validation Results for Demonstration Year 2

	Total PIPs	Met	Partially Met	Not Met
HMOs				
Reform	19	16 (84.2%)	1 (5.3%)	2 (10.5%)
Non-Reform	27	16 (59.3%)	6 (22.2%)	5 (18.5%)
Total	46	32 (69.6%)	7 (15.2%)	7 (15.2%)
PSNs				
Reform	14	9 (64.3%)	0 (0.0%)	5 (35.7%)
Non-Reform	2	1 (50%)	0 (0.0%)	1 (50%)
Total	16	10 (62.5%)	0 (0.0%)	6 (37.5%)
Totals				
Reform	33	25 (75.8%)	1 (3.0%)	7 (21.2%)
Non-Reform	29	17 (58.6%)	6 (20.7%)	6 (20.7%)

For Demonstration Year Two, HMOs achieved a 24.9 percent higher full validation rate for their PIPs than Non-Waiver HMOs while 1115 PSN full validation rates were 14.3

percent higher. Overall, the demonstration plans achieved a 17.2 percent higher full validation rate.

Table 20
Performance Improvement Project Validation Results for Demonstration Year 3

	Total PIPs	Met	Partially Met	Not Met
HMOs				
Reform	33	22 (66.7%)	9 (27.3%)	2 (6.0%)
Non-Reform	27	13 (48.1%)	10 (37.1%)	4 (14.8%)
Total	50	25 (50.0%)	19 (38.0%)	6 (12.0%)
PSNs				
Reform	14	6 (42.9%)	2 (14.2%)	6 (42.9%)
Non-Reform	2	0 (0.0%)	0 (0.0%)	2 (100.0%)
Total	16	6 (37.5%)	2 (12.5%)	8 (50.0%)
Totals				
Reform	47	28 (59.6%)	11 (23.4%)	8 (17.0%)
Non-Reform	29	13 (44.8%)	10 (34.5%)	6 (20.7%)

For Demonstration Year Three, the HMOs achieved an 18.6 percent higher full validation rate for their PIPs than Non-Waiver HMOs while 1115 PSN full validation rates were 42.9 percent higher. Overall, demonstration plans achieved a 14.8 percent higher full validation rate.

2. Validation of Performance Measures

HSAG determined that the data collected and reported for the measures selected by AHCA followed NCQA HEDIS® methodology. Therefore, any rates and audit designations are determined to be valid, reliable, and accurate.

3. Strategic HEDIS® Analysis Reports

HSAG has examined the measures along four different dimensions of care: (1) Pediatric Care, (2) Women's Care, (3) Living With Illness, and (4) Use of Services.

Florida Medicaid HEDIS® results were analyzed in three ways:

- A weighted average comparison presents the Florida Medicaid 2009 results relative to the 2008 Florida Medicaid weighted averages and the national HEDIS® 2008 Medicaid 50th percentiles.

- A performance profile analysis discusses the overall Florida Medicaid 2009 results and presents a summary of HMO and PSN performance relative to the Florida Medicaid performance levels.

- An HMO/PSN ranking analysis for each dimension of care (Sections 3 to 7) provides a more detailed comparison, presenting results relative to the Florida Medicaid performance levels and the national HEDIS® 2008 Medicaid percentiles.

During Demonstration Year Three, of the 18 weighted averages calculated for the demonstration health plans that were comparable to national standards, three (or 16.7 percent) fell below the national Medicaid 10th percentile (namely *Annual Dental Visits*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*), seven (or 38.9 percent) fell between the national Medicaid 10th and 25th percentiles, three (or 16.7 percent) fell between the 25th and 50th percentiles, four (or 22.2 percent) fell between the 50th and 75th percentiles, and one (or 5.6 percent) fell between the 75th and 90th percentiles. The weighted average that exceeded the 75th percentile was for the *Comprehensive Diabetes Care—LDL-C Screening* measure.

During Demonstration Year Four, of the 38 weighted averages calculated for the 1115 Waiver plans that were comparable to national standards, 1 (or 2.6 percent) fell below the national Medicaid 10th percentile, 13 (or 34.2 percent) fell between the national Medicaid 10th and 25th percentiles, and 11 (or 28.9 percent) fell between the 25th and 50th percentiles. Nine (or 23.7 percent) fell between the 50th and 75th percentiles, 2 (or 5.3 percent) fell between the 75th and 90th percentiles, and the remaining 2 (or 5.3 percent) exceeded the 90th percentile.

A more detailed description of Florida Medicaid HEDIS® results may be found in Attachment E.

C. State Quality Assurance Monitoring

On-Site Surveys

Prior to contract execution and each operational year thereafter, the Agency performs an on-site survey of each health plan to gauge compliance with contract standards. The survey process is consistent across health plan types (HMO and PSN). Each survey team consists of a team leader and at least two team members. Each survey lasted an average of three days. Since implementation of the pilot, the results of these on-site surveys show that all health plans are in good standing with the state and no related sanctions have been imposed.

Often, health plan policies and procedures are reviewed prior to an on-site visit to allow the on-site team to focus on health plan operations. Typical categories reviewed on a general on-site survey include the following:

- Services
- Outreach and Marketing
- Utilization Management
- Quality of Care
- Provider Networks
- Provider Selection
- Provider Coverage
- Provider Records
- Claims Processing
- Grievances & Appeals
- Financials

On-site surveys may also be focused on a particular aspect of the contract, such as review of the following types of records:

- Medical Records
- Disease Management
- Case Management
- Provider Credentialing

Over the past few years, the Agency has worked with Florida's External Quality Review Organization, Health Services Advisory Group, Inc. (HSAG), to refine and strengthen the health plan survey process and monitoring tools. As a result, the Agency recently implemented an Access database that will improve the on-site survey process by standardizing the monitoring tools, automatically scoring results, and improving the model interview questions. The 2010 on-site surveys of existing plans will focus on care management/care coordination, utilization management, quality improvement, grievance/appeals, administration/management, medical record reviews, and claims reviews. Other major sections of the contract will be reviewed on-site in the next two years.

Ongoing Desk Reviews

Several aspects of health plan compliance are reviewed on an ongoing basis through desk reviews, such as the following:

- Provider Network Adequacy
- Medical and Behavioral Health Policies and Procedures
- Cultural Competency Plans
- Member Materials
- Outreach Requests
- Reporting

The Access database and tools developed in conjunction with HSAG are now also being used in desk reviews.

Annual Document Review

Health plans are required to submit documentation/reports of certain requirements prior to contract execution and then on an annual basis and must obtain Agency approval.

For example, health plans must submit a Quality Improvement Plan within 30 days of their initial contract execution and annually by April 1 of each contract year. The health plan's Quality Improvement Plans are reviewed against the required components in the contract, both medical and behavioral health. The Agency reviews the Quality Improvement Plans within 30 days of receipt, providing technical assistance as necessary to ensure each Quality Improvement Plan meets the contract requirements. The annual Quality Improvement Plan submissions are reviewed for action items such as problem identification and interventions developed as a result. In Demonstration Year Four, all Quality Improvement Plans were submitted timely and all approval letters were sent out within 45 days. Each health plan's Quality Improvement Program and Quality Improvement Plan are reviewed again during the annual on-site survey visit. The on-site survey team evaluates policies and procedures, reviews member and provider records, and interviews health plan staff.

Disease management is another example. Each health plan is required by contract to offer disease management programs for at least five conditions: HIV/AIDS, asthma, diabetes, congestive heart failure, and hypertension. The specialty plan for beneficiaries living with HIV/AIDS must also offer disease management for tuberculosis and hepatitis B and C. All initial health plan applicants complied with these requirements in 2006, and submitted their programs as a part of their initial reviews. All plans have been submitting them annually by April 1. The health plans have taken varied methods to comply with these requirements. Some of plans have in-house disease managers and very structured programs for each of the referenced diseases. Other plans have chosen to have an over-arching disease management algorithm that narrows the focus for the individual member as the evaluation is done. The health plan disease managers monitor their plan's disease management programs through the individualized treatment plans that are tailored to meet the needs of the beneficiary. Still other health plans have chosen to outsource to disease management companies. When the programs are outsourced, the Agency evaluates the health plan's incorporation of oversight into their Quality Improvement Program. The only exception is the specialty plan for children with chronic conditions. This specialty plan's entire program is geared toward disease management of children and is very individualized. Members are not eligible for this program unless they meet pre-determined clinical screening criteria. Once a child is enrolled, he or she is assigned to a nurse care coordinator who works with him or her throughout his or her enrollment to ensure individualized and highly specialized disease and case management.

D. Additional Quality Activities

Continuous Improvement Activities

Throughout the demonstration, the Agency has actively pursued input from beneficiaries, providers, advocates and all stakeholders in many areas of the program. Program areas have included health plan contract development and amendment, choice counseling, enhanced benefits, health plan and provider technical assistance, complaint tracking, and transition of health plan membership when plans leave the demonstration areas. The Agency has also developed internal feedback loops to collect recommendations from staff on many ongoing operational processes.

The Agency has taken many improvements made in the demonstration and applied those to the entire state so that all Medicaid beneficiaries and providers can benefit from these accomplishments. In general, changes have been made only when there has been regulatory authority or when funding has been available. Table 21 provides a detailed list of the more notable quality improvement activities that the Agency has been involved with that stems from the demonstration and lessons learned through public input, workshops, team efforts and forums.

Table 21
Continuous Quality Improvement Activities

Health Plan Communication Activities

- Technical and operational calls with all Medicaid health plans on a regular basis, at least biweekly
- Technical assistance calls with fee-for-service (FFS) PSNs and their third party administrators regarding Medicaid fiscal agent processes, including claims, file submission and reports, at least monthly
- Technical assistance calls with new health plans to assist in implementation of the contract and beneficiary enrollment and to ensure communication is made to all affected Agency parties regarding the new plan
- Focus group with plan applicants and new contractors to request input on what worked and was cumbersome in the health plan application process in order to streamline the application process and better serve potential contractor needs
- Technical assistance calls with health plans and plan applicants to collect input on revisions to the model health plan contract for 2009-2012 contract period
- Technical assistance calls with health plans and plan applicants to collect input on the development and implementation of the electronic Report Guide companion to the model health plan contract for 2009-2012 contract period
- Continuous improvement meetings with the health plans to collect input into various processes related to implementation of the demonstration, including outreach, systems, claims processing, etc.
- Technical assistance and review calls with health plans regarding their provider network accuracy
- Technical assistance calls with affected health plans when plans leave a county or transition

Table 21 Continuous Quality Improvement Activities
populations due to acquisition or assignment • Technical assistance calls with health plans related to collection of Medicaid encounter data • Technical assistance calls and meetings with health plans related to fraud and abuse initiatives • Technical assistance calls and meetings with health plans and the External Quality Review Organization (EQRO) vendor relative to performance improvement plans, at least quarterly • Technical assistance calls with health plans regarding the development of and implementation of performance measures, required performance measure objectives, related corrective action process, sanctions and incentives • Technical assistance calls relative to implementation of enhanced benefits program and enhancements in various aspects of the program • Technical assistance calls relative to development and implementation of choice counseling program and particularly, the pharmacy benefits navigator program • Technical assistance calls relative to data used for capitation rate development • Included affected providers on technical and operational calls with the health plans to discuss implementation issues. Such providers included prescribed pediatric extended care (PPEC) providers and the Department of Health • Technical assistance calls between FFS PSNs and particular network providers that were having problems navigating the FFS PSN claims process.
Health Plan Application and Contract Revisions • Streamlined the multiple application processes for both PSNs and HMOs into one application process • Streamlined the process for health plan expansion into Baker, Clay and Nassau counties to eliminate the need to submit information on contract items where there are no changes from existing operations • Streamlined the health plan contract to eliminate duplicative contract requirements and reporting and incorporating an electronic Report Guide that provides health plans and applicants with the detailed information necessary to develop and submit contract required reports • Added additional plan performance measure reporting, implementing performance measure objectives, corrective action plan and sanction requirements, and incentives for high performance • Added claims processing, submission, provider notification and reporting requirements for FFS PSNs • Added Medicaid encounter data submission and accuracy requirements and sanctions for poor performance • Deleted duplicative medical record reviews if health plans were credentialed by a national accrediting organization • Revised behavioral health reporting requirements to streamline audits for ongoing health plans in good status • Added requirements to improve enhanced benefit reporting • Added requirements for disease management programs, annual submission of a quality improvement plan and quality improvement committee. • Added requirements relative to fraud and abuse detection, reporting and policies and

Table 21 Continuous Quality Improvement Activities
procedures in order to ensure appropriate plan activities and oversight • Added marketing and community outreach requirements and eliminated direct marketing • Added an optional ability for health plans to notice enrollees on upcoming Medicaid eligibility redetermination dates • Added requirements for 120-day notice and enrollee transition plan requirements when a health plan leaves a county • Added additional Agency monitoring relative to health plan websites, provider networks and directories, fraud and abuse and quality initiatives, such as performance measures • Contracted with EQRO for development of an automated on-site health plan survey tool to ensure consistency of reviews and standardized scoring • Implemented monthly contract oversight review meetings between various Agency plan analysts responsible for oversight of some aspect of the health plan contract, including changes in plan management, on-site and desk reviews regarding behavioral health, fraud and abuse and general medical health care, and reporting • Provided contract revisions to statewide advocacy groups such as Florida Legal Services and Florida CHAIN, and sister agencies, Florida Department of Health and Florida Department of Children and Families, to collect input on the 2009-2012 health plan contact
Consolidated Complaint Database • Conducted workgroup meetings and conference calls with Agency headquarters and local agency staff relative to development of a standardized database for health plan complaint reporting and tracking • Implemented a consolidated complaint database for the collection of complaints received about health plans by the Agency either at a headquarters location or local area office location and automated referrals to the appropriate Agency Office responsible for resolution • Developed a standard complaint definition, reporting process and training manual for staff to handle, disseminate, resolve and track complaints received about health plans using the consumer issues report system database • Developed quarterly trend reports and conducted meetings to review such trends to ensure attention to any atypical results.
Choice Counseling Public Meetings • Revisions in Choice Counseling Materials to make such materials more user-friendly and understandable. • Creation of a Special Needs Unit and a Mental Health Unit to provide beneficiaries who have complex needs with the information necessary to better assist them make their enrollment choices. • Implementation of a Pharmacy Navigator system that allows choice counselors to provide callers with information on the drug formularies offered by health plans so that beneficiaries can make informed enrollment decisions. • Development of an on-line health plan enrollment application to be implemented by the new choice counseling vendor during 2010.
Enhanced Benefit Panel Meetings • Revised the Enhanced Benefit program title, materials and ongoing operations in order to increase public awareness and use of credits earned.

Table 21 Continuous Quality Improvement Activities
• Revised type of behaviors allowed for Enhanced Benefit credit earning to better reward active healthy behaviors • Provision of education and outreach to pharmacies
Legislatively Mandated Advisory Panels • LIP Council – LIP Council meetings, several per year, to advise the Agency, the Governor and the Florida Legislature on financing and distributions of the LIP. • Technical Advisory Panel - Technical Advisory Panel meetings, at least quarterly, to advise the Agency on various aspects of the demonstration, including choice counseling, enhanced benefit program, opt-out program, risk-adjusted capitation rates, and encounter data • Medical Care Advisory Committee – The Medical Advisory Committee meets at least annually to provide advice on various aspects of the demonstration. • Health plan rate setting workgroup – required by Florida legislature in 2008, provides input into the health plan rate setting process and met several times in 2008 and 2009 to discuss process.
Quality Workshop & Related Activities • Performance Measures Workshops • Collaborative Performance Improvement Projects with the external quality review coordinator • Quality Team review of quality requirements specified in health plan contracts • Quality Team review of state quality monitoring and improvement processes • Technical assistance calls with health plans on Medicaid encounter data • Series of public meetings held in Leon, Broward and Duval counties in 2007 and 2008 to obtain input on key elements of the demonstration. Such input was used to affect many of the revisions indicated in the above sections.

Florida Medicaid Encounter Data

The Agency has collected fee-for-service (FFS) claims data for more than 30 years; encounter claims are a new data source and required changes to the existing processes. Since July 2009, the Agency has collected and validated more than 51 million historical and current encounter claims. This achievement emphasizes the Agency's ability to effectively coordinate both internally (i.e., multiple bureau utilization) and externally (i.e., health plans, fiscal agents, third party contractors, and related state agencies).

Encounter data collection in the Florida Medicaid Management Information System (FMMIS) is operational and health plans are making regular monthly submissions. Current day encounter claims are routinely processing in the claims systems, and move to claims history (Decision Support System/DSS) as they are processed. The Agency also continues to reconcile monthly data submissions to the encounter data certifications provided by the health plans. The Agency has processed in excess of 51 million encounter claims (medical services and pharmacy). Encounter claim volume

reflects the number of unduplicated encounter claims processed and not the number of services provided. Many claims contain information on multiple services. The Agency's efforts to work with the health plans to help make their encounter data submissions successful included:

- Participation in bi-weekly Agency coordinated Technical and Operations calls with the health plans to respond to questions and technical issues.
- Continued updates to the encounter data Companion Guides and other documents on the Agency's Medicaid Encounter Data System (MEDS) website (http://ahca.myflorida.com/Medicaid/meds/index.shtml).
- Provided technical assistance to health plans regarding data submission and address their issues. This effort included an encounter data Technical Assistance Workshop for all health plans in Tallahassee on September 2-3, 2009.
- Performed Data assessment activities to support encounter data collection and processing in HP FMMIS. These activities included an initial review of production health plan medical services and pharmacy files to verify the accuracy of the data submitted.
- Automated and produced encounter error rate reports, which inform health plans of claim errors and the failure percentage.
- Completed improvements in reporting processes to communicate to health plans their encounters failing FMMIS edits and assist them in remediating the identified encounters.
- Conducted a Medicaid Encounter Data Collection Survey of the health plans in June 2009 to assist the Agency in identifying possible causes of under-reported, incomplete, and /or inaccurate encounter data for each health plan.

Now that the Agency has transitioned to operational collection of encounter data, opportunities for its use are beginning to emerge. Data validation is essential to identifying statistical anomalies and evaluating data integrity and reasonableness.

The data is partially validated and, the Agency is currently augmenting the system validation by performing analytic procedures on the encounter data, which dates back to 2007. The analytics will help determine the encounter data's reliability by pinpointing possible gaps or other deficiencies that should be corrected. These procedures are designed to instill confidence in the data's ability to accurately describe the services provided by health plans. The Agency will be working directly with health plans as results are obtained from the analytic validation.

Analytic validation will be performed for all encounter data received to date and for all future submissions by plan by month. For each set of analytic procedures, a feedback loop allows the Agency to communicate results from the procedures to the health plans using a series of standard reports, including a dashboard. These reports are currently

under development. Analytic procedure results may require the plans to respond formally to questions from the Agency and/or to perform corrective action, such as when the variance between forecast and actual submissions for a particular claim type and month is more than 2 standard deviations (a 95% confidence interval).

In addition to the analytic validation procedures performed within the Agency, three external vendors, Mercer, Milliman, Inc., and Health Services Advisory Group (HSAG) will assist the Agency. Mercer and Milliman are the Agency's actuaries and HSAG is the Agency's External Quality Review Organization (EQRO). Mercer and Milliman will perform validation procedures to help determine the encounter data completeness and accuracy and to what extent (percentage) encounter data will be used as part of the base data for setting the health plan capitation rates effective September 2010. The Agency is in discussions with HSAG about their role in validating encounter data.

As part of a larger project, Mercer has developed data intake processes and sets of general validation reports that summarize the quality and completeness of the various data sources. It should be noted that Mercer is also an EQRO entity and will conduct validation activities include, but are not limited to, the following:

- Using eligibility and encounter claims to determine the percentage of recipients that used services within the period. A lower than normal user percentage could indicate underreporting by the plans.

- Analyzing the dollars paid by month of service and month of payment to determine if there are any missing encounter data.

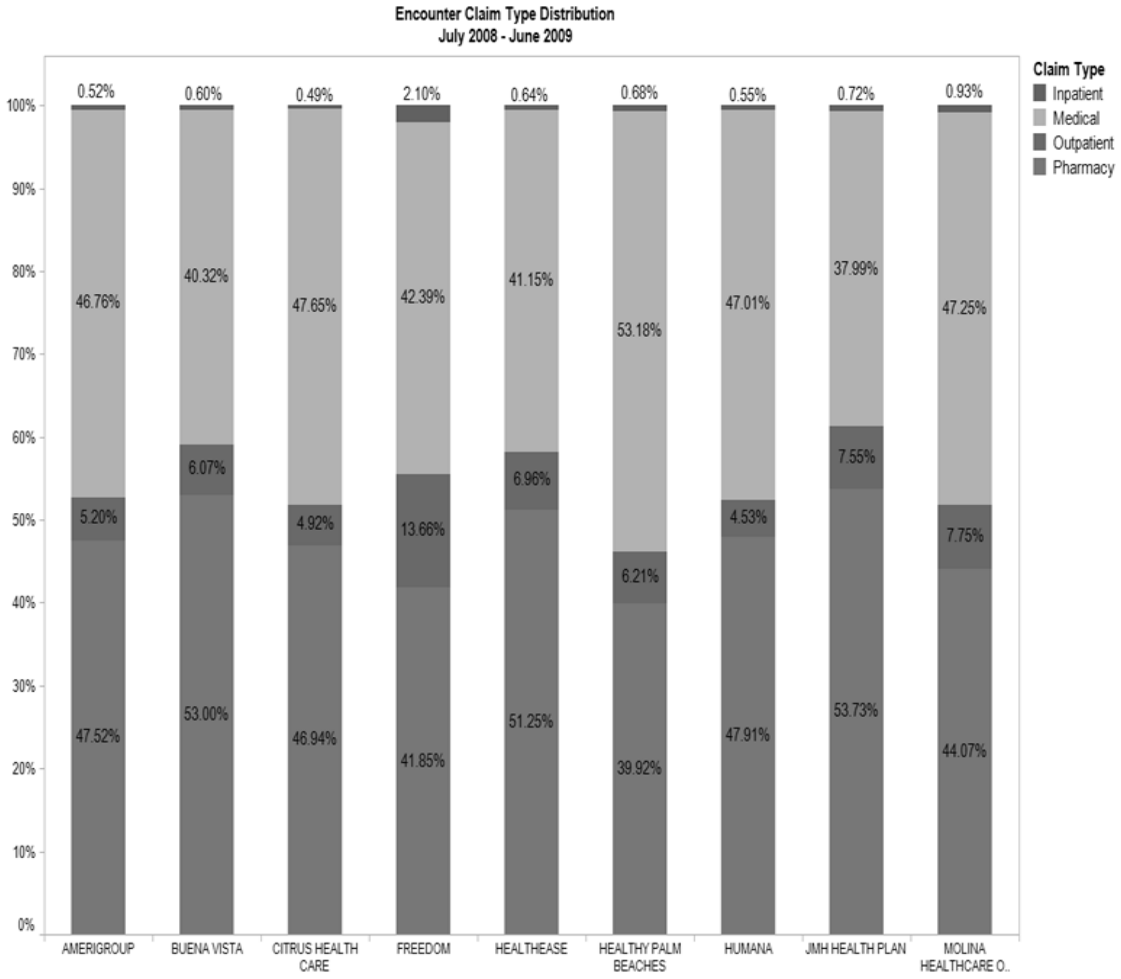
- Analyzing the percentage of diagnosis codes populated by position (Dx1, Dx2, etc.) on the encounter claims, as well as the average number of diagnoses populated per encounter across the health plans.

- Analyzing the missing values in encounter claims and the percentage of total encounter claims this represents to determine the completeness of the encounter data.

Once the Agency determines that the data are sufficiently reliable, analysis will begin to ascertain the quality of services provided. A comparison will be possible across health plans and to a statewide average profile. Best practices can be established.

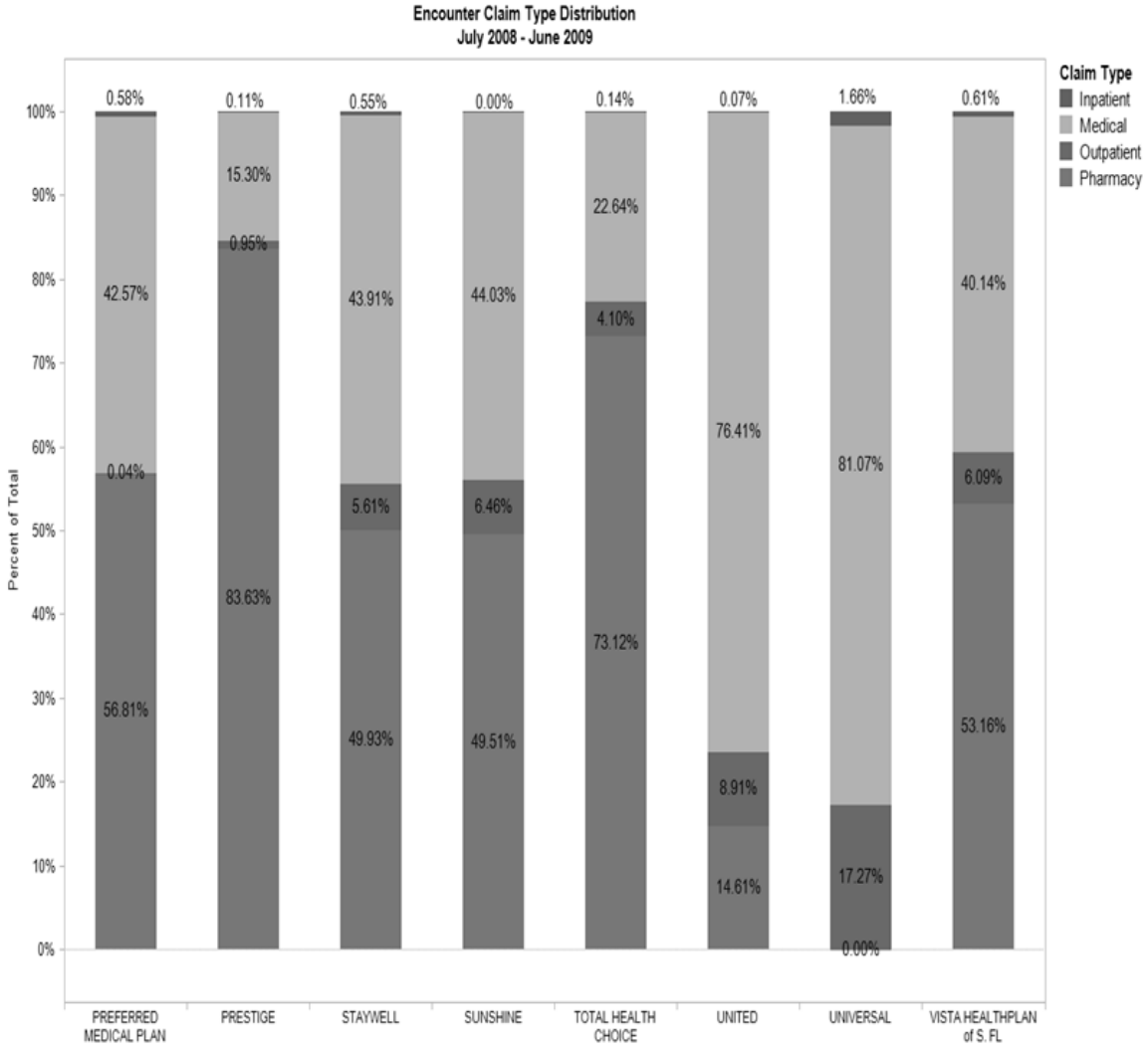
Charts Q through T show the results of volume analysis for all capitated health plans by claim type for state fiscal year 2008-2009 at two different points in time. Chart Q and Chart R show the SFY 2008-2009 pre-validation volume analysis by claim type as of February 2010 (plan payment dates November 2009). Chart S and Chart T show the SFY 2008-2009 volume by claim type as of April 2010 (plan payment date January 2010). The volume is beginning to normalize across the plans and claim types.

Chart Q – Results of Volume Analysis for Capitated Health Plans



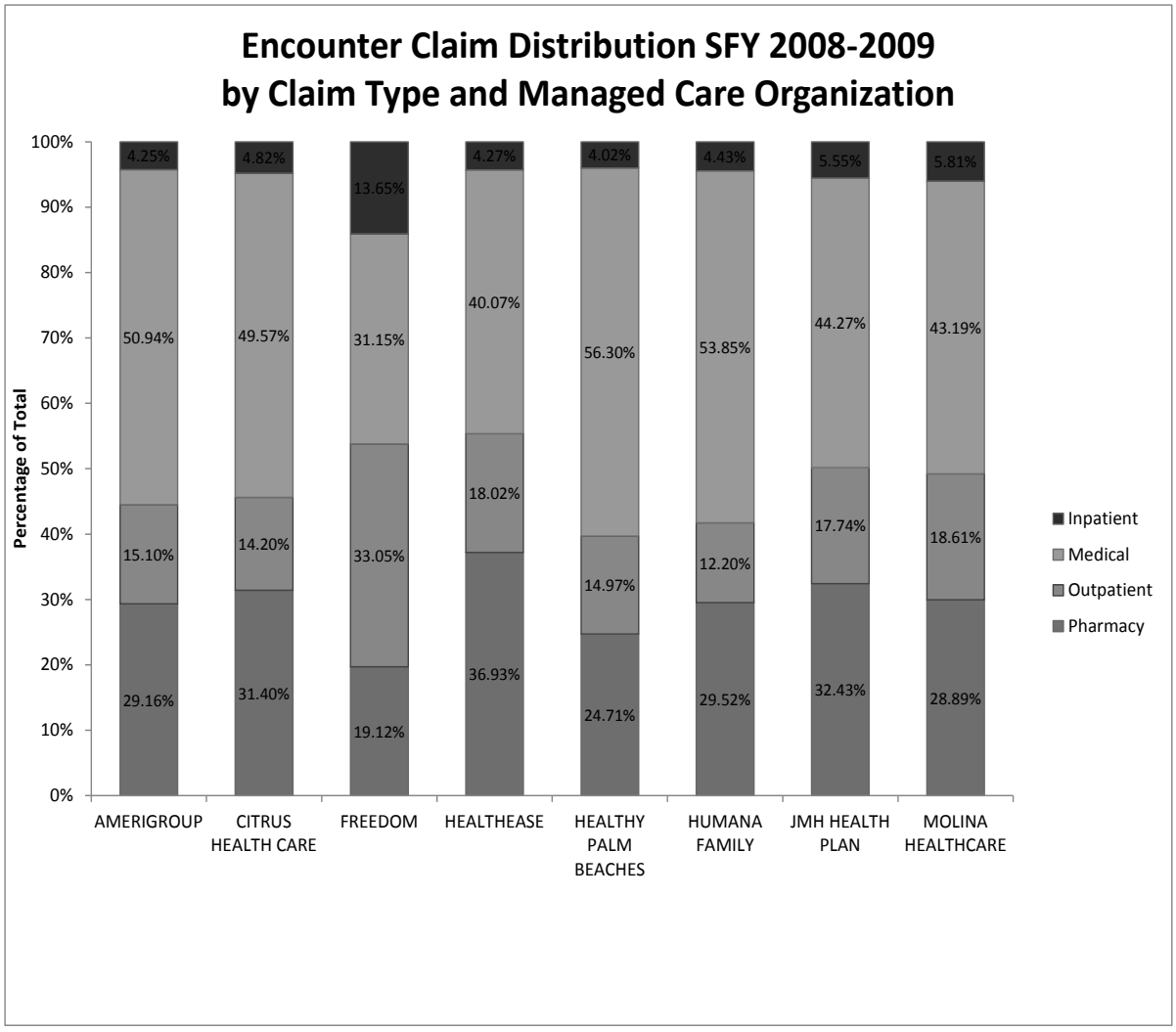
* February 2010 Analysis (Health plan payment date November 2009)

Chart R – Results of Volume Analysis for Capitated Health Plans



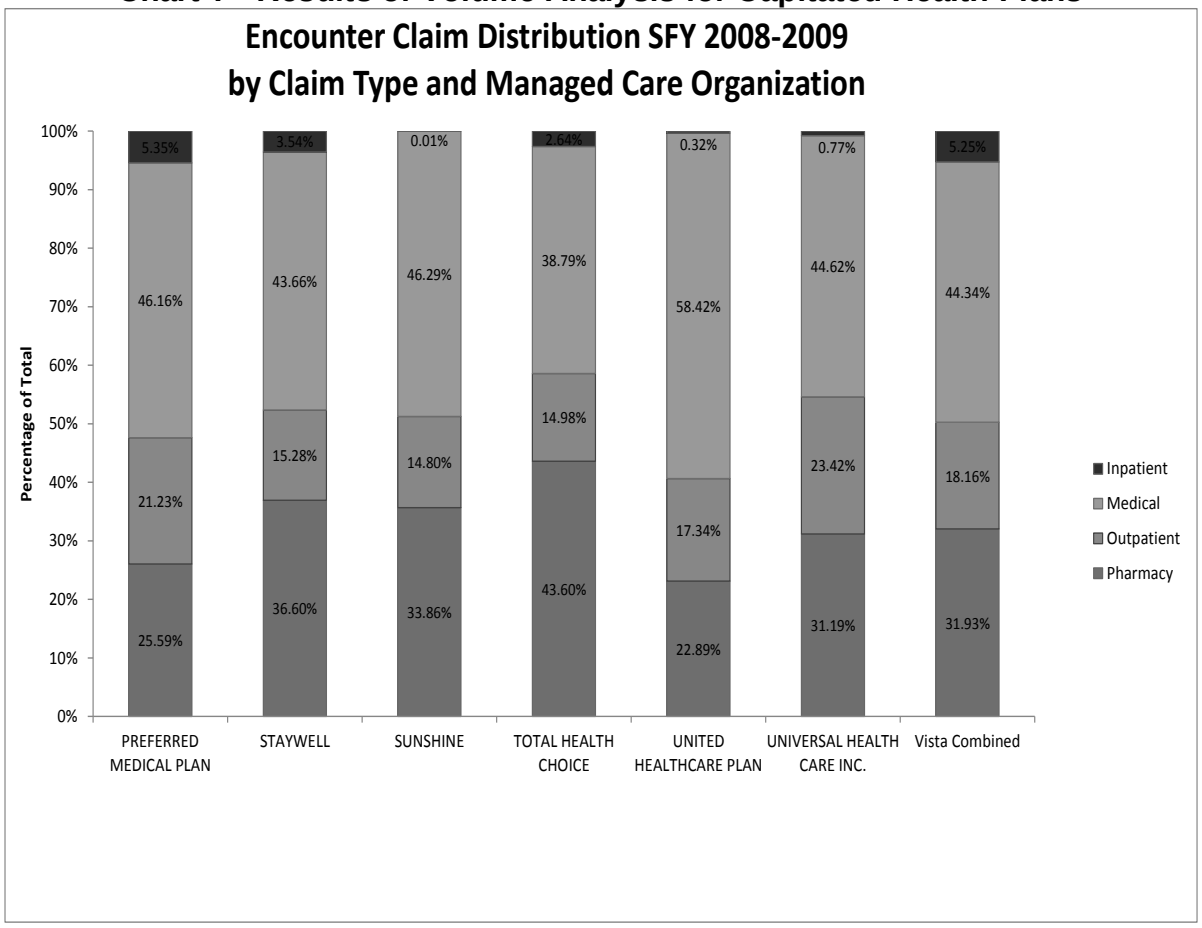
* February 2010 Analysis (Health plan payment date November 2009)

Chart S - Results of Volume Analysis for Capitated Health Plans



* April 2010 Analysis (Health plan payment date January 2010)

Chart T - Results of Volume Analysis for Capitated Health Plans



* April 2010 Analysis (Health plan payment dates January 2010)

During the February-March 2010 timeframe, the Agency received a legislative request for a data analysis comparing the performance of Medicaid managed care plans (which includes both traditional HMOs and Provider Service Networks) to the MediPass program. The request included comparisons of four specified service delivery models, MCO-Non Reform, MCO-Reform, MediPass and PSN. The results of the analysis are available on the Agency's website through the following link:

http://ahca.myflorida.com/Medicaid/meds/pdf/managed_care_data_comparison_06-23-2010.pdf.

Encounter data will allow the Agency to bring efficiencies into its monitoring process. Data analysis can be used to determine if contractually required health care is being provided, and health plan networks can be compared to encounter data to determine if providers, particularly specialists, are available to enrollees. Both of these examples can be, and are, monitored now, but the need for paper records and samples is time consuming and limiting. Valid encounter data will allow the state to view the entire system and only delve into the paper records when the data analysis indicates a problem may exist.

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VII. Evaluation Status and Findings

A. Overview of Independent Evaluation

The Agency contracted with a health services research team at the University of Florida (UF) to conduct an independent evaluation of Florida's Section 1115 Research and Demonstration. The UF research team has examined the evolution of the demonstration, including the earliest expressions of interest, the initial legislation, the waiver application process, the subsequent legislation, the program design, the initial implementation in Broward and Duval Counties, the subsequent expansion in Baker, Clay, and Nassau Counties, and ongoing operations to date.

As part of development of 1115 waiver, the Agency prepared a series of evaluation questions designed to capture relevant information regarding the hypotheses to be tested with, and anticipated results to be obtained from, the demonstration activities. After contracting with the University of Florida as the independent evaluator, the state submitted a draft evaluation design to federal CMS as required by STC #88. Federal CMS approved the Evaluation with very minor modifications on June 13, 2006. As the UF Evaluation Team began their evaluation process, they recognized the need to modify and refine some of the questions to better fit with the academic evaluation approach. These modifications were reflected in the questions provided in the demonstration evaluation plan approved by federal CMS. As the independent evaluator of the demonstration, the University of Florida continues to refine the evaluation questions, which is to be anticipated with a project of this scope, magnitude and duration.

The UF research team conducted its analysis through inquiry in five major project areas:

(1) Organizational analyses,
(2) Enrollee experiences analyses,
(3) Fiscal analyses,
(4) Low Income Pool program analyses, and
(5) Mental health services analyses.

The organizational analyses focused on the demonstration implementation process, the health plans, the Agency's activities, and the Choice Counseling process. The enrollee experiences analyses measured the changes in enrollee experiences, primarily their satisfaction with their health care. The fiscal analyses assessed pre- and post-demonstration Medicaid expenditures for both the demonstration and non-demonstration health plans. The Low Income Pool Program analysis examined the impact of the new financing mechanism that provides reimbursement for the provision of services to the Medicaid, uninsured, and underinsured populations. The mental health analyses examined the impact of the demonstration on mental health services and experiences. Each of the five major project areas was led by a UF faculty member with substantial experience in the area of interest.

Table 22 lists the evaluation reports completed as of June 29, 2010, and provides a link to each report which is posted on the Agency's website. A list of the pending evaluation reports is provided in Table 23.

Table 22
Final Evaluation Reports

Title	Link to Report
Evaluating Medicaid Reform in Florida: MED027 A Comprehensive Five-Year Work Plan	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_i_detailed_work_plan_final.pdf NOTE: This is a comprehensive plan for the five-year evaluation and was developed by UF. It serves as a detailed description of the various evaluation activities to be conducted in accord with the CMS-approved evaluation plan requirements.
Plan for Evaluation of the Low Income Pool	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/plan_for_evaluating_lip_final_02-2007.pdf
Evaluation of the Low Income Pool Using Milestone Data: 2005-2006	http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/milestone_report_2008.pdf
Data Needs Matrix	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ivb_data_needs_matrix_final.pdf
Medicaid Reform Health Plans and Networks	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_iiib_medicaid_reform_health_plans_and_networks_final.pdf
Progress Report on Key Aspects of the Evaluation, Phase 1 Interim Report: January – March 2006	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ii_a_final.pdf
Progress Report on Key Aspects of the Evaluation, Phase 1: January – June 2006	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_iii_a_de-id.pdf
Progress Report on Key Aspects of the Evaluation, Phase 2: July – December 2006	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_iv_a_progres_report_de-id.pdf
Progress Report on Key Aspects of the Evaluation, Phase 3: January – July 2007	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_v_a_progress_report_11-05-07.pdf
Progress Report on Key Aspects of the Evaluation, Phase 4: January – July 2007	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_vi_a_progress_report_08-20-09.pdf
Progress Report on Key Aspects of the Evaluation, Phase 5: January – July 2007	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_vii_a_progress_report_binder.pdf
Progress Report on Key Aspects of the Evaluation, Phase 6: January – July 2007	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ix_progress_report_07-15-09_final_04-28-10.pdf
Progress Report on Key Aspects of the Evaluation, Phase7: January – July 2007	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ix_progress_report_07-15-09_final_04-28-10.pdf
Progress Report on Key Aspects of the Evaluation, Phase 8: January – July 2007	http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/deliverable_x-a_progress_report_final_06-17-2010.pdf
Qualitative Studies Summary Report	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_x_c_qualitative_studies_summary_report_final_06-08-2010.pdf
Medicaid Reform in Florida: Key Events and Activities in 2006	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ivd_medicaid_reform_annual_report_2006_final.pdf
Summary Report on the Medicaid Reform Section 1115 Waiver Process	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_iib_summary_report_on_the_waiver_process_final.pdf
Medicaid Reform Enrollee Satisfaction: Baseline CAHPS Survey in Broward and Duval Counties	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_v-e_baseline_cahps_survey_10-05-07.pdf

Table 22 Final Evaluation Reports	
Title	**Link to Report**
Medicaid Reform Enrollee Satisfaction: Year One Follow-Up Survey	http://ahca.myflorida.com/medicaid/quality_management/pdf/cahps_report_final_03-12-09.pdf
Medicaid Reform Organizational Analyses	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_v-b_org_analyses_report_10-05-07.pdf
Medicaid Reform Preliminary Baseline Findings from Longitudinal Study	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_v-c_longitudinal_study_report_10-05-07.pdf
An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_viii_d_fisca_analysis_report_07-10-09.pdf
Academic Presentations (Phase 2)	http://ahca.myflorida.com/medicaid/quality_management/mrp/contracts/med027/deliverable_ivc_academic_presentations_final.pdf

Table 23 Pending Evaluation Reports		
Subproject Area	**Description**	**Iteration/Revision Process**
Low Income Pool	Evaluation of Low-Income Pool Program Using FHURS Data: SFY 2006-07	Agency is reviewing the final report.
Mental Health	Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 1: Enrollee Experiences with Mental Health and Substance Abuse Treatment and Counseling Services	Agency is reviewing the final report.
Mental Health	Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 2: The Effect of Medicaid Reform on Baker Act and Criminal Justice Encounters	Newly available data allow extension of longitudes and as a result more robust analyses. Due to Agency end of summer 2010.
Mental Health	Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 3: The Effect of Medicaid Reform on Pharmacotherapy for Individuals with Severe Mental Illness	Newly available data allow extension of longitudes and as a result more robust analyses. Due to Agency end of summer 2010.
Organizational Analyses	Medicaid Reform Organizational Analyses: April 2007 – March 2008	Agency is reviewing the final report.
Organizational Analyses	Medicaid Reform Organizational Analyses: April 2008 – March 2009	Agency is reviewing the final report.
Organizational Analyses	Review of 2008 Performance Indicators for Florida Medicaid Reform Health Plans	Under Agency review.
Enrollee Experiences	The Enhanced Benefits Reward$ Program: Extended Evaluation Proposal	Revision #3 with UF for additional edits to methodology.
Enrollee Experiences	Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey Volume 1: Demonstration County Estimates; Volume 2: Plan Type Estimates; Volume 3: Estimates by Enrollee Characteristics.	Agency finalizing Volume 1. Volumes 2 and 3 are being revised by UF.
Low Income Pool	Evaluation of the Low-Income Pool Using Milestone Data: SFY 2007-08	Agency is reviewing the final report.
Low Income Pool	Evaluation of the Low-Income Pool Using Milestone Data: SFY 2008-09	Agency is reviewing the final report.
Fiscal Analysis	Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analysis	Adjusting methodology, final report expected end of summer 2010.

The future evaluation reports to be completed during Demonstration Year Five are provided below.

Enrollee Experience

- Enrollee Satisfaction Year Two Follow-Up Survey Volume 2: Plan Type Estimates - due first quarter, Demonstration Year Five.
- Enrollee Satisfaction Year Two Follow-Up Survey Volume 3: Select Enrollee Characteristics Estimates - due first quarter, Demonstration Year Five.
- Enrollee Satisfaction Year Three Follow-Up Survey Report (Volumes 1-3) - due first quarter, Demonstration Year Five.
- Enhanced Benefit Rewards Analyses Report - due first quarter, Demonstration Year Five.

Fiscal Analyses

- Fiscal Analyses – due second quarter, Demonstration Year Five

Low Income Pool

- Evaluation of Low-Income Pool Program Using FHURS Data: SFY 2007-08 - due first quarter, Demonstration Year Five.
- Evaluation of Low-Income Pool Program Using Milestone Data: SFY 2008-09 - due first quarter, Demonstration Year Five.
- Evaluation of Low-Income Pool Program Using Milestone Data: SFY 2009-10 - due fourth quarter, Demonstration Year Five.

Mental Health

- Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 3: The Effect of Medicaid Reform on Pharmacotherapy for Individuals with Severe Mental Illness – due first quarter, Demonstration Year Five..

Organizational Analyses

- Medicaid Reform Organizational Analyses: April 2009 – March 2010 – due first quarter, Demonstration Year Five.

Final Overall Evaluation

- Summary Report of Overall Evaluation Findings – Due second quarter, Demonstration Year Five.

B. Research Questions and Findings

In this section, the key research questions are noted (Tables 24-28) and major findings are summarized. For clarity of presentation, the research questions are summarized in accord with the five major project areas, although it is acknowledged that several of the research questions might reasonably be considered part of two or more project areas. Greater specificity regarding the findings, summarized briefly in this document as well as extensive methodological detail, can be found in numerous reports (as previously noted, all available reports are posted on the Agency's website).

Table 24 Organizational Analyses: Key Research Questions
1. **Plan Participation**: Will the number, types, and distribution of health plans participating in Medicaid increase? Does the comprehensive/catastrophic financing mechanism attract new health plans to Medicaid? Do risk-adjusted premiums influence health plans' decisions to participate in Medicaid?
2. **Plan Benefit Packages**: When provided the opportunity, do plans provide additional services not previously covered by Medicaid? Will enrollees select health plans offering customized benefit plans and specialty care networks over traditional benefit plans and networks?
3. **Health Disparities**: Do plans that focus on specific populations (e.g., chronic conditions or minority populations) offer additional services not covered under Medicaid in an effort to reduce any associated health disparity?

Key Findings – Organizational Analyses[10]

- Twenty health plans (15 HMOs and 5 PSNs) participated in the demonstration during the first four years. The health plan environment was dynamic, with multiple plans entering and leaving the demonstration over time. Mergers and acquisitions occurred. While changes have occurred, there is no question that a significant number of both existing and new plans chose to and continue to participate in the demonstration.

- Currently two specialty plans have emerged in the demonstration, serving disabled children and beneficiaries with HIV/AIDS, offering special services to address the unique health care needs of their populations.

- Despite an overall economic downturn which limited health plan's flexibility and ability to target the needs of unique populations, most plans continued to offer additional services not previously offered (under the Florida Medicaid State Plan).

[10] Medicaid reform organizational analyses: April 2008 - March 2009. University of Florida.

- Several health plans continue to offer additional services, though the overall number of additional services declined between 2007 and 2008. In October 2007, 28 health plans offered a total of 84 additional services, or about 3 per plan on average. As of October 2008, 24 health plans offered an additional 59 services, or just fewer than 2.5 additional services per plan.

- Even with the additional services offered by most health plans, to date, enrollees have reported selecting plans based more on their physicians' participation than on variation in benefit packages.

- The Agency designed and implemented a payment process based on risk-adjusted premiums. Risk adjustment was not identified as the reason any health plan chose to withdraw from the demonstration counties.

- Participating health plans remain aware of and closely attuned to the risk adjustment process.

- Despite extremely ambitious time lines, the Agency was clearly successful in designing and initiating a program that reflected the intentions of the waiver in a timely fashion.

- Key elements of the demonstration implementation were accomplished as intended.

Table 25 **Enrollee Experiences Analyses: Key Research Questions**
1. **Enrollee Satisfaction and Access to Care**: Will enrollee satisfaction with the quality of care improve? Do customized benefit packages and specialty networks increase enrollee access to care? Will health disparities be reduced among select minority enrollees under the demonstration for specific health indicators and conditions?
2. **Choice Counseling**: Will the Choice Counselor enhance individuals' exposure to, search for, obtaining and use of, health information? Will such enhancement result in increased health literacy of Medicaid enrollees, thus increasing patient demand for appropriate services?
3. **Health Behaviors**: Will the availability of Enhanced Benefit Accounts foster increased patient participation for select preventive health care services and healthy behaviors? How many enrollees establish Enhanced Benefit Accounts? What are the characteristics of enrollees who participate in the EBR program? Will health status and outcomes of the demonstration enrollees improve? Will customized benefit packages and specialty networks result in health status improvement for the target populations?

Key Findings – Enrollee Satisfaction[11]

- Enrollee satisfaction for most indicators remained stable or increased slightly (including specialty care ratings, emergency room visits, communication, courtesy and respect of staff) and showed little if any change from benchmark measures taken prior to demonstration through the first three years of implementation.

[11] Medicaid reform enrollee satisfaction year two follow-up survery volume 1: County estimates.University of Florida.

- In some areas, statistically significant changes were observed. There was an upward change in satisfaction with recipient's personal doctor and with getting needed care. In the urban counties, a higher percentage of enrollees reported they had a regular doctor in the years following implementation than in the year prior to the demonstration.
- This upswing indicates an increase in satisfaction at the point of care.
- The indicators of overall health care satisfaction and overall health plan satisfaction have shown a slight decline over the three year period.
- A Choice Counseling program was designed and implemented by means of contracted services.
- Approximately 80 percent of all new enrollees choose their own health plan, indicating an increased level of participation over traditional Medicaid.
- Enrollee participation in the Enhanced Benefits Rewards continues to climb and substantial participation in the program has been observed.
- A more in-depth analysis of health status, utilization, and recipient characteristics is on the near horizon.[12]

Table 26 **Fiscal Analyses: Key Research Questions**
1. **Cost Control**: For enrollees in the demonstration health plans (HMOs and PSNs) how do utilization of and expenditures for services differ before and after implementation of the demonstration? What is the difference in PMPM total expenditures between enrollees in the demonstration and comparable enrollees in non-demonstration Medicaid?
2. **Risk Adjustment**: How appropriate are the risk adjustment methods used for calculating monthly capitated premiums for plans and PSNs participating in the demonstration? Will implementation of risk-adjusted premiums more appropriately pay managed care providers? Do the financial safeguards developed for the management of the catastrophic component provide proper incentive to manage care and reduce potential cost shifting?

Key Findings – Fiscal Analyses[13]

- Analyses indicate that the demonstration is reducing PMPM expenditures relative to what would have been absent of the demonstration.
- Summed over the first 24 months of the demonstration, preliminary analyses of gross expenditures indicated that Florida Medicaid's expenditures in the two urban demonstration counties were lower than would have been expected for those enrollees in those counties absent the demonstration.

[12] See entries for *Enrollee Experiences* in Table 25.

[13] An analysis of Medicaid expenditures before and after implementation of Florida's Medicaid reform pilot demonstration: Multivariate analysis. University of Florida.

- Thorough analyses regarding the rate of change of expenditures during the demonstration (compared to non-demonstration settings during the same time period in Florida) cannot be accomplished until three years of data are available. This analysis will be one of the next steps for the evaluation as the demonstration continues.[14]

- As yet, the source of the changes in expenditures has not been identified. The exact nature of changes in utilization patterns is a focus of current and future analyses to be accomplished now that the Medical Encounter Data System is operational. This analysis will be one of the next steps for the evaluation as the demonstration continues.[15]

Table 27 **Low Income Pool Program Analyses: Key Research Questions**
1. **Access to Care**: To evaluate the impact of the low income pool on increased access for uninsured individuals.
2. **Cost-Effectiveness**: The State will conduct a study to evaluate the cost-effectiveness of various provider access systems.

Key Findings – Low Income Pool Program Analyses[16]

- Total funding and number of hospitals receiving Low Income Pool funding increased compared to the Special Medicaid Payments (SMP) program that were operational prior to initiation of the demonstration.

- Non-hospital providers began receiving funding under the Low Income Pool program in SFY0607.

- Hospitals receiving Low Income Pool payments served an estimated 3.6 – 3.7 million Medicaid, underinsured, and uninsured (MUU) individuals in each of the first three years of the demonstration.

- Non-hospitals receiving Low Income Pool payments served an estimated 700,000 – 800,000 MUU individuals in each of the first three years of the demonstration.

- For hospitals, average payments for MUU individuals declined over the first three years of the demonstration.

- For non-hospital providers, average payments for MUU individuals declined over the first two years of the demonstration.

NOTE: Because data are not available to compare program outcomes with and without the LIP program, it is difficult to perform a true comprehensive cost-effectiveness analysis. The LIP provides *supplemental* support for existing services, therefore it is not possible to compare program outcomes literally with and without the LIP. However, the

[14] See entry for *Fiscal Analysis* in Table 26

[15] See entries for *Organizational Analysis* in Table 24

[16] Evaluation of low-income pool program using milestone data: SFY 2007- 2008. University of Florida.

LIP analyses do provide strong evidence supporting cost-effective health care access for MUU individuals.[17]

- More Provider Access Systems received LIP payments; 206 Provider Access Systems compared to 87 providers under SMP.
- More hospital Provider Access Systems received LIP payments; 163 hospital Provider Access Systems compared to 87 under SMP.
- Because non-hospital providers also began receiving payments, 43 non-hospital Provider Access Systems received LIP payments.
- Total LIP payments to Provider Access Systems were $998,658,215 compared to $666,858,300 under SMP.
- For all hospital Provider Access Systems receiving LIP payments, slightly more than 3 million MUU individuals were served compared to slightly less than 2 million for all hospitals receiving SMP.
- Non-hospital Provider Access Systems receiving LIP payments served approximately 660,000 MUU individuals.
- LIP payments also supported a variety of non-hospital Provider Access System projects, including five county health initiatives, one rural health network, and enhanced capacity at Florida Federally Qualified Health Centers.

Table 28 **Mental Health Analyses: Key Research Questions**
1. **Enrollee Experience**: What are enrollee experiences with various aspects of mental health and substance abuse treatment and counseling services?
2. **Baker Act & Criminal Justice Encounters**: What are the rates of Baker Act evaluations and arrests among adults diagnosed with severe mental illnesses (SMI) and children diagnosed with serious emotional disturbances (SED)?
3. **Pharmacotherapy**: What is the impact of the demonstration on pharmacotherapy provided to Medicaid enrollees with severe mental illness?

[17] Please see http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/highlights_year_one.pdf.

Key Findings – Mental Health: Enrollee Experience[18], Baker Act & Criminal Justice Encounters[19] and Pharmacotherapy[20]

- Baker Act rates showed greater variability in the non-demonstration counties, but overall there were few substantial differences observed between the demonstration to non-demonstration counties for Baker Act rates, arrest rates, and juvenile justice recidivism.

- Measures of enrollee satisfaction with mental health services indicate that enrollees in the demonstration counties were more satisfied than those in the control counties.

- In the demonstration counties, enrollees in PSNs tended to be more satisfied than those in HMOs. More analysis on the underlying causes is warranted.

- Analyses of pharmacy claims data revealed a few small differences in pharmacotherapy in the demonstration counties compared to a control county, but more analysis is needed. Further analysis will be undertaken as part of the continuation of the evaluation utilizing a larger array of available data.

C. Proposed Evaluation Activities

Evaluation activities anticipated during the requested three year waiver extension period can be summarized in two major categories. First, the existing five fundamental evaluation projects will each be extended in time, allowing continued observation, further data collection, more detailed documentation and further analyses. These studies will strengthen the evaluation findings reported during the initial five-year period of the demonstration by providing longer observational time periods and additional data.

Beyond the considerable value of this straightforward three-year extension in time and hence more data, the evaluation studies during the requested three-year waiver extension period will include more use of the emerging Medicaid Encounter Data System information to determine in much greater detail the content of health care being delivered to enrollees and assess the fiscal, satisfaction, organizational, and other findings in a context that takes medical encounter information into account.

The second major category of evaluation activities planned for the requested three year waiver extension period involve initiatives that are new, or have renewed focus as a consequence of the evaluation studies accomplished during the initial five-year period. Specific plans in this category include more detailed analyses of the Enhanced Benefit Account program, including studies that link the Enhanced Benefit Account participation levels to enrollee satisfaction, studies to measure variation in EBR participation by

[18] Evaluating the impact of Florida Medicaid reform on recipients of mental health services subproject 1: Enrollee experiences with mental health and substance abuse treatment. University of Florida.
[19] Evaluating the impact of Florida Medicaid reform on recipients of mental health services subproject 2: The effect of Medicaid reform on baker act and criminal justice encounters. University of Florida.
[20] Evaluating the impact of Florida medicaid reform on recipients of mental health services subproject 3: The effect of Medicaid reform on pharmacotherapy for individuals with severe mental illness. University of Florida.

enrollees in various plans and studies that begin to link the Enhanced Benefit Account participation with health care utilization/health status. Apart from these extended analyses of the Enhanced Benefit Account program, the evaluation team proposes further work and additional focus in the area of longitudinal/qualitative studies. This will include conducting a series of enrollee focus groups in each of the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). The objective will be to capture the additional depth and richness of information that comes from detailed conversations as distinct from the kind of information that can be gleaned from surveys, claims analyses, or the like.

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VIII. Special Terms and Conditions of Waiver

As required by the letter from federal CMS dated March 15, 2010, the Agency is required to document compliance with the 120 special terms and conditions of the demonstration waiver

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00206/4

TITLE: Medicaid Reform Section 1115 Demonstration

AWARDEE: Agency for Health Care Administration

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115 demonstration (hereinafter "demonstration"). The parties to this agreement are the Agency for Health Care Administration (Florida) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the Demonstration. This demonstration is approved for a 5-year period, from July 1, 2006, through June 30, 2011.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; Low Income Pool Definitions; Low Income Pool Milestones; General Financial Requirements under title XIX; and Monitoring Budget Neutrality.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Florida Medicaid Reform section 1115 demonstration, the State's role will change so that it is largely a purchaser of care, and oversight will focus on improving access and increasing quality of care. Medicaid consumers will have a choice in the marketplace and will be able to choose plans and the methods of accessing services. The State proposes to transform Medicaid by integrating key principles of reform in the structure and daily operation of the Medicaid program as follows:

> *Patient Responsibility and Empowerment* – With the support of choice counselors, individuals will then be expected to take an active role in their health care. They will have the flexibility to choose from a variety of benefit packages and be able to choose the package that best meets their needs. Additionally,

they will be rewarded for demonstrating healthy practices and personal responsibility.

Marketplace Decisions – The State will reshape its role in health care from that of a centralized decision maker that creates and manages health care services to a purchaser of health care services responsible for ensuring the systems of care delivery meet the higher standards and follow the rules for ensuring delivery of quality services. Managed care plans will have the ability to create customized packages to meet the needs of specific Medicaid groups.

Bridging Public and Private Coverage – Individuals with access to employer sponsored insurance (ESI) coverage will be offered the choice to "opt out" of Medicaid. This choice will help bridge the gap to independence by providing individuals with a subsidy to move to private health insurance coverage.

Sustainable Growth Rate – Medicaid will move to a premium-based system and Medicaid expenditures will become more predictable.

The four fundamental elements of Florida Medicaid Reform are as follows:

Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

Enhanced Benefits Accounts will be established to provide incentives to Medicaid Reform enrollees for healthy behaviors. As enrollees earn access to these incentives, funds will be deposited into individual Enhanced Benefits Accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins etc.

Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace.

Low-Income Pool (LIP) will be established and maintained by the state to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

Under this demonstration Florida expects to achieve the following objectives.

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost.
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program.
- Improve health outcomes and reduce inappropriate utilization.

- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve.
- Serve as an effective deterrent against fraud and abuse by moving from fee-for-services.
- Maintain strict oversight of managed care plans and will adapt its fraud efforts to surveillance of fraud and abuse within the managed care system.
- Provide managed care plans with additional flexibility in creating benefit packages to meet the needs of specific groups.
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

III. GENERAL PROGRAM REQUIREMENTS

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

The State has complied with federal non-discrimination statutes including, but are not limited to, the American Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

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

The State has complied with Medicaid Law, Regulation, and Policy including all requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the demonstration award letter of which these terms and conditions apply.

3. **Changes in Law**. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid Program that occur after the approval date of this Demonstration.

Since the implementation of the demonstration, the state has worked closely with CMS's Central and Regional Offices to ensure compliance with any changes in Federal law.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

The state is in compliance with Federal law, regulation and policy statements.

5. **State Plan Amendments.** The State shall not be required to submit Title XIX State Plan amendments for changes to any populations covered solely through the demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required, except otherwise noted in the terms and conditions. Reimbursement of providers by the MCO will not be limited to those described in the State Plan.

The state is in compliance with this term and condition of the waiver.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to eligibility, enrollment, auto-enrollment benefits, cost sharing, employer sponsored insurance, implementation changes, Low Income Pool, Federal financial participation (FFP), sources of the non-Federal share, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. The State agrees it will submit an amendment to the demonstration prior to adding dual eligible individuals; hospice and hospice-related groups, and individuals eligible, as Medically Needy. The State shall not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7, below.

The state has not made any changes to the demonstration related to eligibility, enrollment, auto-enrollment benefits, cost sharing, employer sponsored insurance, implementation changes, Federal financial participation (FFP), sources of the non-Federal share or budget neutrality. At the time of submitting the extension request, the State has not added the following groups to the demonstration: dual eligible individuals; hospice and hospice-related groups, and individuals eligible, as Medically Needy. The State is not seeking to amend the waiver as part of the extension request and is in compliance with this term and condition of the waiver.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests shall be reviewed by the Federal review team and must include but are not limited to the following:

a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;

b) A current assessment, including necessary expenditure data, of the impact the requested amendment shall have on budget neutrality;

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

d) A description of how the evaluation design shall be modified to incorporate the amendment provisions.

The state has submitted waiver amendments to the demonstration in compliance with this term and condition of the waiver.

8. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted herein Section 1115(a) of the Social Security Act (the Act), the State is then responsible for reviewing, complying and adhering to the timeframes and reporting requirements as stated in Section 1115(a), 1115(e) or 1115(f) of the Act as applicable.

The state has reviewed, complied, and adhered to the timeframes and reporting requirements as stated in Section 1115 of the Social Security Act and is in compliance with the requirements under 1115(e) authority to extend the waiver.

9. **Demonstration Phase-Out.** The State may suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State shall submit a phaseout plan to CMS, for approval, at least 6 months prior to initiating phase out activities. Nothing herein shall be construed as preventing the State

from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal close out costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

The state is seeking an extension of the waiver. If the Agency is directed in Florida Law to suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration, the state will promptly notify the Centers for Medicare and Medicaid Services in writing of the reason(s) for the suspension or termination, at least 6 months prior to initiating phase out activities.

10. **Enhanced Benefit Accounts Program Phase Out.** The State shall submit a phase-out plan to CMS for approval no later than 6 months prior to any such time the State proposes to terminate the enhanced benefit account (EBA) provision of this demonstration. The Enhanced Benefit Accounts Program will be limited as follows:

- Enrollees will not be able to earn enhanced benefits for deposit into their account during the last 3 months of the demonstration or the termination of the EBA Provision under the demonstration; and
- Individuals, who previously earned funds in their EBA, will continue to have access to funds for health care related expenditures in accordance with EBA rules. All funds must be expended within a 2-year period from the expiration date of the demonstration.
- The Federal share of any unspent funds shall be returned to CMS no later than the end of the first quarter after, which ends the 2-year period above.

The state is seeking an extension of the waiver. If directed in Florida Law, the state will submit a phase-out plan to the Centers for Medicare and Medicaid Services for approval no later than 6 months prior to any proposed termination of the Enhanced Benefit Account provision of the demonstration. The Enhanced Benefit Account Program is limited to those provisions specified in this term and condition of the waiver.

11. **Enrollment Limitation.** During the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the demonstration is extended by CMS.

N/A as the state is seeking an extension of waiver.

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

The state is in substantial compliance with the terms and conditions of the waiver and that the state has not been notified of any material deficiencies.

13. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS's finding that the State materially failed to comply.

The state has not informed or notified of any finding of non-compliance by CMS.

14. **Withdrawal of Waiver or Expenditure Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. If a waiver or expenditure authority is withdrawn, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

The State acknowledges this term and condition of the waiver which specifies that CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. The state believes it is eligible for an extension under 1115(e) authority and requests that CMS process the extension request under this authority.

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

The State has and continues to ensure the availability of adequate resources for implementation and monitoring of the demonstration as specified in this term and condition of the waiver.

16. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration are proposed by the State.

The State has complied with this term and condition of the waiver regarding public notice and consultation with interested parties when any program changes to the demonstration are proposed by the State.

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

The State has complied with this term and condition of the waiver regarding managed care requirements published in 42 CFR 438 and the capitation rates have been developed and certified as actuarially sound in accordance with 42 CFR 438.6 and other terms of the waiver.

IV. GENERAL REPORTING REQUIREMENTS

18. **General Financial Reporting Requirements.** The State shall comply with all general financial reporting requirements set forth in Section XVIII, "General Reporting Requirements under Title XIX."

The State has complied with the general financial reporting requirements specified in this term and condition of the waiver.

19. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XIX, "Monitoring Budget Neutrality."

The State has complied with the term and condition of the waiver regarding the reporting requirements for monitoring budget neutrality set forth in Section XIX of this document.

20. **Managed Care Data Requirements.** All managed care organizations, prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.

The State has complied with this term and condition of the waiver regarding managed care data requirements as set forth in 42 CFR 438.

21. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO 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 that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

The State has complied with this term and condition of the waiver regarding monthly calls with CMS to discuss significant developments affecting the demonstration.

22. **Quarterly Reports.** The State shall submit progress reports no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of various operational areas. Quarterly reports shall include but are not limited to the following:

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 State 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 State shall include data that will identify enrollee characteristics as follows: 1) eligibility category; 2) type of employer-sponsored insurance (e.g., small employer, large employer, ERISA); 3) type of coverage – single or family coverage. The State will develop and maintain disenrollment reports specifying the reason for disenrolling in an ESI program. The State shall also track and report on those enrollees who elect the option to reenroll in the Medicaid Reform demonstration.

j) Progress toward the demonstration goals.

k) Evaluation activities.

The State has complied with the quarterly reporting requirements specified in this term and condition of the waiver.

23. **Annual Report.** The State shall submit 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 Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted to CMS.

Beginning with the annual report for demonstration year 2, the State must include a section on the administration of Enhanced Benefit Accounts, participation rates, an assessment of expenditures, and potential cost savings.

Beginning with the annual report for demonstration year four, the State must include 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 demonstration.

The State has complied with the annual reporting requirements specified in this term and condition of the waiver.

V. FLORIDA MEDICAID REFORM DEMONSTRATION IMPLEMENTATION

24. **Florida Legislation SB 838.** The State will implement the Medicaid Reform demonstration in three phases. The State shall notify CMS 90 days prior to any geographic expansion prior to submission of a statewide implementation plan as required in item 100. The State will submit any required amendments in accordance with paragraphs six and seven in Section III, "General Program Requirements."

The State has complied with this term and condition of the waiver.

25. Implementation of Phase I. The State will initially implement the Medicaid Reform demonstration in two counties Broward and Duval. Reform shall become operational in the first quarter of state fiscal year (SFY) 2007, which is July through September 2006.

Within a year of implementation in Duval County, the State shall expand the demonstration to include three contiguous counties to Duval County: Baker, Clay and Nassau Counties. The State expects this to be operational by July 2007.

Further implementation of Phase II and Phase III will be only as authorized by the Florida State Legislature.

The State has complied with this term and condition regarding Phase I implementation and will comply with Phase II and Phase III implementation as authorized by the Florida Legislature.

26. **Implementation of Phase II.** The State will begin preliminary assessments on availability of plans, variation of plans, voluntary selection rates, consumer satisfaction and perform on-site reviews of the plans authorized in Phase I. The preliminary fact-finding and evaluation of Phase I rollout will occur during the second year of operation, and will be complete by June 2008. This information will be available to the Legislature, and, once the Agency receives approval, it will initiate implementation in additional geographic areas of the State.

The State complied with this term and condition with the submission on June 30, 2008 of the preliminary fact-finding and evaluation of Phase I rollout during the second year of operation. This information was provided to the Florida Legislature.

27. **Implementation of Phase III.** Implementation of Phase III will occur over the course of the following 2 State fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis.

The fourth and final phase of Medicaid Reform implementation will occur once the geographic implementation is complete. This phase consists of expanding Reform to additional populations, specifically by mandating the enrollment of those population groups previously enrolled voluntarily. The area-by-area roll out of each population may be different for different population groups, depending upon the availability of fully developed networks. Enrollment may be limited to those areas that were fully implemented by the end of Phase II, thus enabling those with the most experience under Reform principles to be the initial sites for population expansion. The transition of these populations will also be on a staggered basis.

In addition, by Phase III the State expects that the special care networks for children with chronic conditions will be fully developed beyond the Broward and Duval areas, either on a limited or statewide basis. Enrollment of these children will become mandatory in those areas with such networks.

The state has not expanded to additional geographic areas to date. The state will comply with this term and condition regarding implementation of Phase III as authorized by the Florida Legislature and noted in term and condition #26.

VI. ELIGIBILITY

28. **Consistency with State Plan Eligibility Criteria.** The State assures CMS that the eligibility criteria under this demonstration shall be consistent with the criteria in the State Plan.

The State has complied with this term and condition and assures CMS that the eligibility criteria under the demonstration is consistent with the criteria in the State Plan.

29. **Enrollment Process.** The State agrees to notify participants within 30-days of their entry into this demonstration.

The State has complied with this term and condition of the waiver to notify participants within 30-days of their entry into the demonstration.

30. **Eligibility for Medicaid Reform Demonstration.** During the initial phase, participation in Medicaid Reform will be mandatory for two eligibility groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, herein referred to as the TANF and TANF-related eligibility group. The second is the Aged and Disabled group.

Mandatory Participant Populations

Aged and Disabled Group (MEG 1):

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

TANF and TANF-Related Group - 1931 Eligibles (MEG 2):

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

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

The State has complied with this term and condition of the waiver regarding eligibility of enrollment in the demonstration.

31. **Initial Demonstration Voluntary Participation Populations.** During the initial phase, individuals as listed below, may voluntarily participate in the demonstration. The State anticipates that during subsequent phases, individuals identified as voluntary in the groups below, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in demonstration. Specifically, children with chronic conditions participating in Children's Medical Services, foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified by the State Legislature.

The following individuals eligible under the TANF and SSI groups listed below will be excluded from mandatory participation during the initial phase:

a. Foster care children will be a mandatory population no later than the end of demonstration year 3.

b. Individuals with developmental disabilities will be a mandatory population no later than the end of demonstration year 3.

c. Children with special health care needs will be a mandatory population no later than the end of demonstration year 3.

d. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD.

e. Individuals eligible under a hospice-related eligibility group (by year 5).

f. Pregnant women with incomes above the 1931 poverty level (by year 5).

g. Dual eligible individuals.

The State has complied with this term and condition of the waiver.

32. The State shall provide notification to CMS no later than 90 days prior to transitioning voluntary participants to a group mandated to participate in the Medicaid Reform demonstration. In accordance with item six in Section III "General Program Requirements," the State shall submit an amendment for identified groups prior to transitions.

The State has complied with this term and condition of the waiver.

33. **Enhanced Benefit Accounts Program Expansion Populations.** Individuals with incomes of less than 200 percent FPL, regardless of assets, who lose eligibility for Medicaid or subsidized employer sponsored insurance coverage, will continue to have limited eligibility under this demonstration. This expansion population retains Medicaid eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

The State has complied with this term and condition of the waiver regarding Enhanced Benefit Account program expansion population.

34. **Voluntary and Expansion Eligibility Groups Expenditure.** The State is not obligated under this demonstration to extend eligibility to population groups listed above as voluntary populations, but may do so. The State must seek approval to modify program eligibility via the waiver amendment process as described in number six and seven of Section III "General Program Requirements." Regardless of any extension of eligibility, the State will be limited to Federal funding reflected in the budget neutrality requirements set forth in these STCs.

The State acknowledges this term and condition of the waiver and is in compliance as the state has not modified program eligibility.

VII. ENROLLMENT

This section describes enrollment provisions and is subject to Section V, "Florida Medicaid Reform Demonstration Implementation."

35. **Staggered Enrollment.** Within each geographic demonstration area the State will stagger the transition for enrollment of mandatory participants into the Medicaid Reform demonstration.

The State has complied with this term and condition of the waiver regarding staggering the transition for enrollment of mandatory participants into the demonstration.

36. **New Medicaid Reform Demonstration Enrollees.** At the time of eligibility determination, individuals who are mandated to participate will receive information about managed care plan choices in their area. They will be informed of their option to select an authorized managed care plan or opt out of Medicaid. Individuals will be given the opportunity to meet with a choice counselor (either State-employed or State-designated) to obtain additional information in making a choice. If they opt out, they can use their Medicaid established premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility determination. If the individual does not select a plan or opt out within the 30-day period, the State will autoassign the individual into a Medicaid Reform Plan.

Once individuals have made their choice, they will be able to contact the State or the State's designated choice counselor to register their plan selection. The eligibility process will be considered complete once the individual has selected a managed care plan or has chosen to opt out of Medicaid. Until the individual makes a choice, or the individual is auto-assigned, the individual is only eligible for emergency services, nursing home care, and ICF/DD care. The State shall assure that appropriate mechanisms are in place to ensure that only claims for emergency services, nursing home level of care and ICF/DD are submitted to CMS for individuals who have not selected a plan within 30 days.

The State has complied with this term and condition. Furthermore, the state has not implemented authority to limit the services available until a plan choice is made.

37. **Current Medicaid State Plan Enrollees.** Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program will be required to enroll in a

reform plan at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner.

During the transition period, current enrollees will be able to remain with their current managed care plan if it continues to provide the currently contracted package, either under the current contract or as a reform plan with the same benefit package. The State will create an open enrollment process for all enrollees in a plan if the plan no longer has a contract with the State or develops a plan that is different from the current managed care plan without maintaining the current benefit package. In this instance, since the plan is different, the State will allow all enrollees in the plan to remain enrolled in the plan or select a new reform plan.

Once an individual is redetermined eligible for Medicaid, enrollees will have 30 days to make a choice of a reform plan. If the individual does not make a selection, the state will auto-assign the individual to a reform plan to ensure that services will continue uninterrupted.

Medicaid recipients in the demonstration areas who are not currently enrolled in a capitated managed care plan upon implementation of Reform will have the opportunity to enroll in a managed care plan at the time of annual eligibility redetermination. An information and redetermination packet will be sent to the enrollee at least 45 days prior to the redetermination date. This packet will include information on the managed care plan choices in the area information on the opt-out option. The individual may choose to meet with a choice counselor to discuss the options. If the individual does not make a selection, the State will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

All current enrollees may voluntarily elect to enroll in a reform plan prior to their redetermination period. The State will treat the request to disenroll from the current plan as a good cause disenrollment request and allow the individual to enroll in the reform plan. In addition, all current Medicaid enrollees, regardless of the delivery system in which they are enrolled prior to Reform, may opt out of Medicaid at any time after the demonstration implementation date in their area.

The State has complied with this term and condition of the waiver.

38. **Auto-Enrollment Criteria.** Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the State or State's designated choice counselor will provide information to the individuals to encourage an active selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the State will use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit. The criteria are:

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

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

The State has complied with this term and condition of the waiver.

39. **Lock-In/Disenrollment in a Medicaid Reform Plan.** Once a mandatory enrollee has selected a Medicaid Reform Plan the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a Medicaid Reform Plan the individual will have 90 days to voluntarily disenroll from that plan and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan. Voluntary enrollees may disenroll from the reform plan at any time.

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

The State has complied with this term and condition of the waiver regarding lock-in and disenrollment in the demonstration.

40. **Opt-Out: Employer Sponsored Insurance.** Enrollees will be able to opt out of Medicaid at any time to enroll in an employer-sponsored insurance program (ESI). The decision to opt out of Medicaid and elect ESI is completely voluntary. The State will provide an enrollee who chooses to opt out of Medicaid and enroll in an ESI plan with a 90-day change period. The 90-day change period may be limited by the employer in order to comport with the employer's open enrollment period. After 90 days, no further changes may be made until the next employer-sponsored open enrollment period which includes qualifying events, or unless the enrollee no longer has access to employer-sponsored coverage.

The State has complied with this term and condition of the waiver regarding Opt Out Employer Sponsored Insurance.

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

The State has complied with this term and condition of the waiver regarding temporary loss of Medicaid eligibility and re-enrolling demonstration enrollees in the same heath plan.

42. **Enrollment Cap Parameters.** The State of Florida shall not place enrollment caps on current State Plan eligible individuals. The State of Florida may impose an enrollment cap on non-State Plan demonstration eligibles that receive services funded through the Low Income Pool as described in Section XV, "Low Income Pool."

The State has complied with this term and condition of the waiver regarding enrollment cap parameters.

VIII. CHOICE COUNSELING

43. **Choice Counseling Defined.** The State shall contract with an independent choice counselor to provide full and complete information about managed care plans choices and the ability to opt out of Medicaid. As directed by the State Legislature, the State will develop a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

The State has complied with this term and condition regarding contracting with an independent choice counseling entity and developed a choice counseling system.

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

The State has complied with this term and condition of the waiver regarding choice counseling materials.

45. **Choice Counseling Information to be Provided.** Specifically, the choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. The choice counselor will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the administrator. The choice counselor will assist the individual in making an informed choice about optout by highlighting information the individual will need to consider in order to make a fully informed choice. As it does now, the State or the State's designated choice counselor will provide information about each plan's coverage in accordance with Federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the State will supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

The State has complied with the choice counseling information to be provided to enrollees as specified in this term and condition.

46. **Choice Counseling for Opt-Out Provision.** Individuals interested in opt-out will be encouraged to contact their employer and the State's contract administrator for the opt-out program for additional information. The choice counselor will collect information on whether the individual has access to health insurance. At a minimum, the choice counselor will encourage the individual to determine available health insurance; when the individual can enroll; review of cost-sharing requirements of the plan; information about preexisting conditions clauses; and whether individual or family coverage is available. The choice counselor will then refer the individual to the State's administrator,

which will assist the individual in the opt-out process. The administrator will contact the employer and verify available health insurance. To ensure enrollees understand this option, the administrator may periodically contact individuals regarding the opt-out option.

The State has complied with this term and condition.

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

The State has complied with this term and condition regarding choice counseling materials being provided in a variety of ways including print, telephone, and face-to-face. All materials are provided in fourth-grade reading level and available in languages other than English when 5 percent of the county speaks a language other than English. The choice counseling vendor has also provided oral interpretation services, regardless of the language, and other services for impaired beneficiaries.

48. **Contacting the Choice Counselor.** Individuals will be able to contact the State or the State's designated choice counselor to obtain additional information. The State or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

The State has complied with this term and condition to allow individuals to be able to contact the State and the State's designated choice counselor to obtain additional information. The choice counseling vendor operates a toll-free number that individuals eligible for the demonstration can use to ask questions and obtain assistance on health plan options. The call center is operated during business days and has been staffed by certified choice counselors to address the needs of the enrollees and potential enrollees.

IX. BENEFIT PACKAGES & MEDICAID REFORM PLANS

49. **Customized Benefit Packages for Medicaid Reform**. Medicaid Reform Plans will have the flexibility to provide customized benefit packages for Medicaid Reform enrollees. The customized benefit packages must cover all mandatory services specified in the State Plan including medically necessary services for pregnant women

and EPSDT services for children under age 21. In addition, the plans will cover needed optional services as indicated by historical data. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans authorized by the State shall not have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women, and emergency services. The State may also capitate all State Plan services in a demonstration area.

The State has complied with this term and condition.

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

The State has complied with this term and condition of the waiver and has prior approved all benefit packages. All benefit packages are at a minimum least actuarially equivalent to services provided to the target population under the State Plan benefit package.

51. **Risk Adjusted Premium Development for Customized Benefit Packages.** The State will separate the Medicaid premium into two components – comprehensive care and catastrophic care. The distinction between comprehensive and catastrophic coverage is with respect to the development of the premium and related only to the risk level the Medicaid Reform Plan will retain. The aggregate premium will be based on historical utilization of currently covered mandatory and optional services. Based on this aggregate premium, the State will develop a premium for each component.

The State has complied with this term and condition by separating the Medicaid premium into two components (comprehensive and catastrophic coverage). The aggregate premium has been based on historical utilization of currently covered mandatory and optional services. To date no plan has elected this option.

52. **Comprehensive Care Premium Development.** The comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees will need and is expected to represent approximately 90 percent of historical medical expenditures. Initially, comprehensive care premiums may be based on eligibility groups, age, and gender for a specified geographic area and then risk adjusted for health status. All health plans will be at risk for the comprehensive care premium and will provide all services outlined in their customized benefit packages approved by the State.

The State has complied with this term and condition of the waiver regarding comprehensive care premium development.

53. **Catastrophic Care Premium Development.** The catastrophic care component is designed to meet the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. For each target population served, the State will establish criteria to allow plans to choose whether or not to assume the catastrophic risk.

The State has complied with this term and condition of the waiver regarding catastrophic care premium development.

54. **State Benefit Plan Evaluation Model.** The State will develop a Benefit Plan Evaluation Prototype to determine if a plan that is applying for a Medicaid Reform Plan contract meets State requirements. The evaluation tool will measure for actuarial equivalency and sufficiency. Specifically, it will 1) compare the value of the level of benefits in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensure that the overall level of benefits is appropriate. The State will evaluate service utilization on an annual basis and use this information to update the prototype to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

The State has complied with this term and condition of the waiver regarding the development of the benefit plan evaluation model.

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

The State has complied with this term and condition of the waiver regarding the state benefit plan evaluation model assessing and ensuring the proposed benefit package meets actuarial equivalent as specified.

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

The State has complied with this term and condition regarding the state benefit plan evaluation model assessing and ensuring the proposed customized benefit package meets the state established standards of benefit sufficiency.

57. **Comprehensive Component Limits for Reform Plans**. The comprehensive component will cover 100 percent of the cost of an enrollee's care, less any required enrollee cost sharing, until that care reaches an established threshold. At that time the expenses for care, less any required plan co-insurance, become subject to the

catastrophic component. Through a plan cost sharing mechanism, a small portion of the expenses over the threshold will be retained within the comprehensive component of the premium to ensure that plans not bearing catastrophic risk have financial motivation to continue to manage care efficiently. The actual proportion of the total premium dedicated to the comprehensive component will depend upon the threshold level and the post-threshold plan co-insurance established for the catastrophic component. The proportion may vary among target populations.

The State has complied with this term and condition of the waiver regarding comprehensive component limits of the demonstration health plans as specified in this term and condition. To date no plan has elected this option.

58. **Catastrophic Component**. The catastrophic premium component covers the bulk of an individual's medical expenses, less any required plan cost sharing, after those expenses exceed a pre-established catastrophic threshold. Health plans cannot choose to accept catastrophic risk on an individual recipient basis, nor can they change the decision for a target population during a plan year. If a plan chooses not to cover the catastrophic component, the State will assume the financial risk for catastrophic services furnished by the plan.

The State expects that less than 10 percent of the aggregate premium will need to be allocated to the catastrophic care component. However, the actual portion of premium dedicated to the catastrophic component will depend on the established threshold level and plan cost sharing.

The State has complied with this term and condition of the waiver regarding catastrophic premium component as specified in this term and condition. To date no plan has elected this option.

59. **Mechanics of an Individual Catastrophic Threshold.** An individual's medical expenses become subject to catastrophic component funding when one of two defined thresholds is reached: 1) dollar threshold or 2) inpatient day threshold. The established thresholds may vary across populations (e.g., TANF vs. aged and disabled) and across health plans as part of negotiations to bring in new managed care entities.

The State has complied with this term and condition regarding individual catastrophic threshold. To date no plan has elected this option.

60. **Dollar Threshold for Triggering Catastrophic Threshold.** All health care expenditures for each individual will be accumulated throughout the plan year and

compared to a pre-established dollar threshold. The dollar threshold is derived from the historical utilization analysis used to develop the comprehensive and catastrophic premiums. The methodology for deriving the dollar threshold will be based on high-cost claims analysis, the desired amount of the high-cost claims to be retained in the comprehensive premium component (i.e., plan cost sharing), and the desired percentage of medical expenses covered by the catastrophic component. If an individual's expenses exceed that threshold, the remainder of the expenses, excluding any required plan cost sharing, for that individual are provided through the catastrophic premium component, up to a maximum per year benefit limit.

The State has complied with this term and condition regarding dollar threshold for triggering catastrophic threshold. To date no plan has elected this option.

61. **Inpatient Day for Triggering Catastrophic Threshold.** The current Medicaid State Plan limits Medicaid coverage of inpatient hospital days to 45 days per state fiscal year for individuals over age 21. It is possible that a customized benefit plan may include fewer covered inpatient hospital days, yet still meet the sufficiency test for certain target populations. However, the State will provide up to 45 days of inpatient coverage regardless of the nominal limit established by the health plan and those excess days will be funded through the catastrophic premium component. The State will establish a separate inpatient day threshold that will trigger payment through the catastrophic premium component for inpatient care that occurs after covered days are used and prior to the dollar threshold being met.

The State has complied with this term and condition of the waiver regarding inpatient day for triggering catastrophic threshold. To date no plan has elected this option.

62. **Overall Annual Aggregate Maximum.** The State will also establish an overall annual maximum benefit level in conjunction with the development of the premium components. The maximum benefit limit will be applied to all reform recipients with the exception of children under age 21 and pregnant women. The annual aggregate maximum limit provides a safeguard to enrollees, as the annual limit will renew each year to cover additional services.

The State has complied with this term and condition and established an overall annual maximum benefit level in conjunction with the premium components. To date no plan has reached the annual limit.

63. **Medicaid Reform Plans Responsibilities.** All health plans will be responsible for providing and coordinating all recipient benefits, regardless of whether those benefits

are being funded through the comprehensive or catastrophic premium component and regardless of whether the plan has chosen to bear financial risk for catastrophic care. For those plans that do not accept financial risk, the State becomes the re-insurer, and the health care plan remits claims to the State for services rendered under this component. The move from comprehensive to catastrophic is seamless for the enrollee, and the enrollee does not know which health plans are at risk for the catastrophic component.

The State has complied with this term and condition of the waiver. However, to date no plan has elected this option.

64. **Safeguards to Minimize Cost-Shifting & Maximize Enrollee Care**. To minimize financial cost shifting and to maximize enrollee care the State will require the following:

State notification - Health plans must notify the State when they have paid claims reaching a specific amount, such as 50 percent of the catastrophic dollar threshold. This puts the State on notice that an individual may reach the dollar or inpatient day threshold during the fiscal year. This will also provide the State the opportunity to intervene, through utilization review or peer review, if appropriate, in the management of the delivery of care. The State may implement penalties if a health plan fails to properly notify the state.

Fee-for-service pricing - Each health care plan will have the flexibility to reimburse its providers by the method of its choosing, and in the amounts of its choosing. This creates an opportunity for a health plan to pay providers considerably more than market rates, yet still be protected from further financial loss because the catastrophic care component would step in at a defined amount.

To prevent this opportunity for cost shifting, each health plan will be required to maintain a shadow claims process whereby all claims are repriced at the Medicaid fee schedule. An enrollee will reach the dollar threshold only when claims priced at the Medicaid fee schedule reach the threshold, regardless of the actual rates paid to network providers. Reinsurance to the plan will be based only on the Medicaid fee schedule.

Health care plan co-insurance - For those health plans that choose not to accept risk for the catastrophic component, once an individual becomes eligible for the catastrophic component, the State will act as the re-insurer and will pay the catastrophic claims submitted by the health plan. The health plan will continue to manage and coordinate care for the Medicaid enrollee. To ensure that there is adequate incentive for the plans to appropriately manage care once an individual gets close to the dollar or inpatient day threshold, the health care plan will be required to pay a coinsurance amount for each catastrophic claim and their on-going cost. Once the threshold is crossed, the State will pay the bulk of (e.g. 90 to 95 percent) the catastrophic claim based on the Medicaid fee schedule, and the health plan will pay the co-insurance (e.g. 5 to 10 percent) of the catastrophic claim along with any amount greater than the Medicaid fee schedule and

its own provider reimbursement arrangement. The value of the plan coinsurance will be incorporated into the comprehensive premium component. Plans will have financial incentive to manage the enrollee, as the plans will keep the value of the coinsurance for individuals who do not enter into the catastrophic component.

The State has complied with this term and condition of the waiver to ensure safeguards to minimize cost-shifting and maximize enrollee care. To date no plan has elected this option.

65. **Marketing**. Approved managed care plans will be allowed to market to individuals within the parameters defined by law to prevent inappropriate or unfair marketing. With prior approval from the State, direct marketing will be permitted and may include direct mailings, health fairs, and other activities. The State will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities. In addition to the Federal requirements, Florida law prohibits plans from offering gifts or other incentives to potential enrollees and managed care plans from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans.

The State has complied with the terms and conditions regarding health plan marketing to individuals within the parameters defined by law and assures CMS that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing Activities. In addition, the State assures the health plans are in compliance with state laws and regulations regarding marketing activities.

X. EMPLOYER SPONSORED INSURANCE

66. **Employer Sponsored Insurance Populations.** Mandatory and voluntary Medicaid Reform enrollees may voluntarily opt-out of Medicaid Reform plans into an employer sponsored insurance (ESI) plan or a private insurance plan when available.

The State has complied with this term and condition of the waiver to allow mandatory and voluntary demonstration enrollees to voluntarily opt-out of the demonstration health plans and enroll in an employer sponsored insurance plan or private insurance plan when available.

67. **90-Day Opt-Out Provision.** An enrollee who chooses to opt-out of the Medicaid reform plan shall have 90-days to opt back into a Medicaid Reform Plan. The 90-day change period may be limited by the employer in order to comport with the employer's open enrollment period. After 90 days, no further changes may be made until the next employer-sponsored open enrollment period which includes qualifying events, or unless the enrollee no longer has access to the employer-sponsored coverage.

The State has complied with this term and condition regarding 90 day opt out provision and allows opt out enrollees to disenroll from the Opt Out program at anytime.

68. **Payment of Premium Share.** Individuals choosing to participate in the ESI option will register with the State's contractor and will provide all pertinent employer information, including the amount of the employee contribution for the ESI plan. The State's contracted administrator will be responsible for contacting the employer to verify coverage information and establish payment of the employee's share of the premium.

The State has complied with this term and condition regarding payment of premium share. The State's contracted administrator is responsible for contacting the employer to verify coverage information and establish payment of the employee's share of the premium.

69. **Portion of the Premium Share to be Paid.** The State shall provide the employee share but no more than the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, then the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage or purchase supplemental health insurance coverage offered by the employer. The State may limit payment for supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage. Payment will be made directly to the employer of record whenever possible. In the case of an enrollee that is self-insured and has private coverage, payment will be made directly to the insurer of record.

The State has complied with this term and condition of the waiver regarding the portion of the premium share to be paid.

70. **Benefits and Cost Sharing Employer Sponsored Insurance.** The benefit package under the ESI plan must meet minimum state licensure standards, but may be more restrictive than Medicaid coverage. The State will not provide wrap-around benefits with the exception of any funds accrued in the individual Enhanced Benefits Account. Enrollees electing to opt-out will be responsible for paying the cost sharing requirements of the ESI plan, including deductibles, co-insurance and co-payments. Medicaid does not contract directly with these entities and does not have the ability to limit cost sharing. ESI cost sharing requirements may be higher than the cost sharing requirements under Medicaid. Since the enrollee has voluntarily chosen to participate in the ESI option, the State will not provide cost sharing or wrap around services.

The State has complied with this term and condition regarding benefits and cost sharing for employer sponsored insurance.

71. **Statewide Subscriber Assistance Panel**. Individuals electing to opt-out into an ESI plan that is a licensed HMO, Exclusive Provider Organization (EPO) or a prepaid health plan authorized under Section. 409.912, Florida Statute will be able to appeal grievances not resolved through the required internal grievance process to the Statewide Subscriber Assistance Panel. The State level panel will review grievances within the following timeframes:

- 45 day – General grievances;
- 120 days – Grievances that the agency determines poses an immediate and serious threat to a subscriber's health.
- 24 hours – Grievances that the agency determines relate to imminent and emergent jeopardy to the life of the subscriber.

The State has complied with this term and condition of the waiver. Individuals electing to opt out into an employer sponsored insurance plan that is licensed as a HMO, EPO or prepaid health plan as authorized under Section 409.912, Florida Statutes, are able to appeal grievances not resolved through the internal grievance process to the Statewide Subscriber Assistance Panel.

72. **Opt-Out Guidelines**. The State will provide CMS with a document that details the administration of the opt-out program at least 30-days prior to implementation. The document will include the safeguards used to verify employer-sponsored coverage, the employee's share of premiums and any respective cost-savings.

The State has complied with this term and condition of the waiver. On March 31, 2006, the State provided CMS with documentation that detailed the proposed administration of the opt-out program 30 days before implementation. The State entered into a contract with the Opt Out Vendor July 1, 2006.

XI. ENHANCED BENEFIT ACCOUNTS PROGRAM

73. **Enhanced Benefit Accounts Program Defined.** Enhanced Benefits Accounts (EBA) will be established to provide incentives to Medicaid reform enrollees for participating in State defined activities that promote healthy behaviors. An individual who participates in a State defined activity that promotes healthy behavior shall have

funds deposited into the individual EBA. These funds shall be used for health care related expenditures as defined in Section 1905 of the Act. The State will directly manage the development of policies and procedures that govern the Enhanced benefit plan by establishing the Enhanced Benefit Panel.

The State has complied with this term and condition. The State directly managed the development of policies and procedures that govern the program by establishing an Enhanced Benefit Panel.

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

The State has complied with this term and condition of the waiver regarding the administration of the Enhanced Benefit Account Program as specified.

75. **Participants Earning Enhanced Benefits Accounts Defined.** All enrollees in a Medicaid reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn Enhanced Benefits for the duration of their enrollment. The State shall exclude Medicaid individuals who choose to opt-out of Medicaid reform plans. The exception to this provision is at the time of EBA Program phase out as discussed in Section III, “General Program Requirements,”

The State has complied with this term and condition of the waiver regarding participants earning enhanced benefit credits for the duration of their enrollment. The State assures CMS Medicaid individuals who choose to opt out of the demonstration health plans are excluded from earning enhanced benefit credits as specified.

76. **Participant Access to Funds.** The State will provide access to an individuals earned funds in an Enhanced Benefit Account as follows:

- Individuals who are enrolled in a reform plan and who have participated in a State defined activity that promotes healthy behavior and thus have a positive balance.

- Individuals who no longer are enrolled in a reform plan (either due to loss of eligibility, change of eligibility to an eligibility group not authorized to participate, or opting out of Medicaid), but who have a positive balance in their account.
- Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual may retain access to any earned funds for a maximum of 3 years, so long as, the individual's income is below 200 percent of the FPL.
- If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBA Program and earn additional funds.

The State has complied with this term and condition of the waiver regarding demonstration participant access to funds as specified.

77. **Federal Financial Participation.** The State shall claim Federal financial participation (FFP) at the time funds are deposited into an account. For purposes of FFP, the deposit of funds into an account will be considered an eligible expenditure at the time the funds are deposited.

The State has complied with this term and condition.

78. **Deposit of Earned Funds for the Enhanced Benefit Accounts Program.** The State agrees that all funds earned for the EBA program by individuals eligible under the demonstration shall be deposited into an escrow type account. These funds shall not be commingled with other State funds or accessible by the State for any other purpose other than the EBA program. Applicable amounts will be withdrawn from this account as individuals make a transaction for authorized expenditures under the EBA program.

The State has complied with this term and condition and assures CMS that all funds earned for the Enhanced Benefit Account program by individuals eligible under the demonstration shall be deposited into an escrow type account.

79. **Dormant Account Reconciliation.** The State will establish a process to review dormant accounts at the end of the 3-year period. The State will recoup any unspent funds and then return the Federal portion to CMS in a timely manner.

The State has complied with this term and condition by establishing a process to review dormant accounts at the end of the 3-year period. The State will recoup any unspent funds and then return the Federal portion to CMS in a timely manner.

80. **Enhanced Benefits Accounts Milestones.** The State shall provide CMS a copy of any procurement document issued to obtain a contractor to administer the Enhanced Benefit Program. In addition, the State will provide the CMS Regional Office a copy of the contract for approval to administer the Enhanced Benefit Program. At a minimum, the contract will specify the scope of work, duration of the contract, and the amount of contract.

The State has complied with this term and condition regarding procurement documents and contractors.

81. **Effective and Efficient Administration.** The State will submit documentation on an annual basis related to EBA eligibility activities, respective earnings for each activity, eligible health related expenditures, access to account information, and accounting requirements. The State will include this information in the Annual Report and Quarterly Reports as discussed in Section III, "General Reporting Requirements." The State will assure effective and efficient administration of the program.

The State has complied with this term and condition by providing documentation in the quarterly and annual reports to CMS related to Enhanced Benefit eligibility activities, respective earnings for each activity, eligible health related expenditures, access to account information, and accounting requirements.

XII. COST SHARING

82. **Premiums and Co-Payments.** The State must exempt enrollees from cost sharing for those services and populations identified in 42 CFR 447.53-54. The state must pre-approve all cost sharing allowed by plans. In no instance shall cost sharing exceed the nominal levels identified in 42 CFR 447.53-54 as specified in the State Plan, as of June 2005 and the following chart.

Services Co-payment / Co-insurance
Birthing Center $2 per day per provider
Chiropractic $1 per day per provider
Community Mental Health $2 per day per provider
Dental – Adult 5% co-insurance per procedure
FQHC $3 per day per provider

Home Health Agency $2 per day per provider
Hospital Inpatient $3 per admission
Hospital Outpatient $3 per visit
Independent Laboratory $1 per day per provider
Hospital Emergency Room 5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner $2 per day per provider
Optometrist $2 per day per provider
Pharmacy 2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant $2 per day per provider
Podiatrist $2 per day per provider
Portable X-Ray $1 per day per provider
Rural Health Clinic $3 per day per provider
Transportation $1 per trip

Any changes to cost sharing must be submitted as an amendment to the demonstration or the State Plan for CMS approval.

The State has complied with this term and condition regarding cost sharing (premiums and copayments) as specified.

83. **Employer Sponsored Insurance Cost Sharing.** For individuals who voluntarily choose to opt-out into ESI plan, cost sharing will be consistent with the requirements under the enrollee's specific ESI program. In accordance with State and Federal insurance laws cost sharing imposed by ESI plans may exceed Medicaid limits. Since the enrollee has voluntarily chosen to participate in the ESI option, the State will not provide additional funds for cost sharing or wrap around services.

The State has complied with this term and condition regarding employer sponsored insurance cost sharing.

XIII. DELIVERY SYSTEMS

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

The State has complied with this term and condition of the waiver. The State assures CMS that the demonstration health plans adhere to 42 CFR 438 capitation rates. The health plans are selected through an open application process that meets all state and federal regulations.

85. **Freedom of Choice.** An enrollee's Freedom of choice of providers shall be limited to and through whom individuals may seek services, including the enhanced benefits accounts program for populations enrolled in the Florida Medicaid Reform demonstration.

The State has complied with this term and condition of the waiver. Enrollee's Freedom of Choice of providers are limited to and through whom individuals may seek services, including the enhanced benefits accounts program for populations enrolled in the demonstration.

86. **Contracting with Federally Qualified Health Centers (FQHCs).** Prior to the start date of the demonstration, the State will review health plan and physician capacity to ensure that it is adequate to serve the expected enrollment as part of the ongoing monitoring of the demonstration. The State will require plans, to make a good faith effort to include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and County Health Departments (CHDs) in their network. If a plan can demonstrate to the State and CMS that both adequate capacity and an appropriate range of services for vulnerable population exists to serve the expected enrollment in all service areas without contracting with FQHCs, RHCs, or CHDs, the plan can be relieved of this requirement. The State shall evaluate the number of FQHCs/RHCs and CHDs that contract with plans and make this information available to CMS upon request.

The State has complied with this term and condition regarding contracting with Federally Qualified Health Centers, Rural Health Clinics and County Health Departments.

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

The State has complied with this term and condition regarding evaluation of the plan benefits.

XIV. EVALUATION

88. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population and capitated revenue expenditures for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

The State has complied with this term and condition regarding the evaluation of the demonstration. The State submitted the draft evaluation plan February 15, 2006, to CMS for review and approval.

89. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and as stated in section III, "General Reporting Requirements," submit its progress in the quarterly reports. The State shall submit to CMS a draft of the evaluation report 120 days after the expiration of the current demonstration period (March 31, 2011). CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final evaluation report for this demonstration period by August 31, 2011.

The State has complied with this term and condition regarding the final evaluation design and implementation. The final evaluation was approved by CMS on June 13, 2006. The State will submit the final report to CMS no later than 120 days after the expiration of the demonstration (October 28, 2011).

90. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

The State has complied with this term and condition regarding cooperation with Federal evaluators. The State held a conference call with Federal evaluators on March 23, 2006, to discuss the draft evaluation. A second conference call with Federal evaluators was held with the State and the University of Florida (the State's independent contractor) to further discuss the evaluation plan. On June 13, 2006, CMS sent the State written approval.

XV. LOW INCOME POOL

91. **Low Income Pool Definition.** A Low Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

The State has complied with this term and condition regarding Low Income Pool definition. The State implemented a Low Income Pool (LIP) program effective July 1, 2006 as provided in the approved 1115 waiver application. The Florida Legislature provided and continues to provide necessary budget authority and direction to utilize the $1 billion per year cap not to exceed the $5 billion total for the 5 year period.

92. **Availability of Low Income Pool Funds.** Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones."

The State has complied with this term and condition regarding availability of Low Income Pool Funds. The State implemented the LIP program on July 1, 2006 meeting the date specified in STC #92. AHCA received a letter from CMS granting approval to make expenditures through the LIP program in accordance with the STCs on June 30, 2006.

93. **Reimbursement and Funding Methodology Document.** In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low Income Pool Milestones." Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

In compliance with STC #93, the State formally submitted to CMS for review and approval the Reimbursement and Funding Methodology document on May 26,' 2006. The Agency worked closely with CMS to obtain approval of the document. CMS granted informal approval of the document via email on January 26, 2007. At a later date CMS provided additional clarification and requirements of the document. The state in turn submitted multiple versions of the document. The State's final submission of the revised document was submitted to CMS on June 26, 2009. Final approval from CMS in the form of an approval letter was received December 2, 2010.

94. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS

The State has complied with this term and condition regarding Low Income Pool permissible expenditures. The Florida Legislature authorized the Low Income Pool Council which is responsible for making a formal recommendation to the Legislature for the distribution and requirements of the funds and qualifying entities for the LIP each year. As of demonstration year 4, there were payments made for each of the provider and program types provided in STC 94. Additional information providing the funding amount or providers and programs is available in the quarterly and annual reports as required by CMS regarding the demonstration. Additional information is available for resubmission to CMS if needed. All reports and recommendations of the LIP Council or Agency have been provided to the CMS staff at the point of completion and submission to the required recipients of the reports.

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

The State has complied with this term and condition regarding Low Income Pool expenditures related to non-qualified aliens. The State does not use LIP funds for cost associated with the provisions of health care for non qualified aliens. Allowable cost for LIP funds are defined in the June 26, 2009 Reimbursement and Funding Methodology document.

96. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services

to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in item 91 of this section and Section XVI, "Low Income Pool Milestones."

To date, the state has not executed the policies provided in STC #96. The State reserves the right to use this authority as appropriate and permitted under STC #96.

97. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost and this requirement is further clarified with the submission of a corresponding State Plan Amendment, as outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones."

The State has complied with this term and condition regarding Low Income Pool permissible hospital expenditures. The State requires all hospital LIP participating providers to complete a LIP cost limit to ensure that providers do not receive LIP payments in excess of the cost of providing health care to the Medicaid, uninsured and underinsured populations. The requirements and calculation of the cost limit are defined and detailed in the Reimbursement and Funding Methodology document approved by CMS and required in STC#93.

98. **Low Income Pool Permissible Non-Hospital Based Expenditures**. To ensure services are paid at cost, CMS and the State will agree upon cost reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.

The State has complied with this term and condition regarding Low Income Pool permissible non-hospital based expenditures. The State requires all non-hospital LIP participating providers to complete a LIP cost limit to ensure that providers do not receive LIP payments in excess of the cost of providing health care to the Medicaid, uninsured and underinsured populations. The requirements and calculation of the cost limit are defined and detailed in the Reimbursement and Funding Methodology document approved by CMS and required in STC#93.

99. **Permissible Sources of Funding Criteria.** At least, 120 days prior to the demonstration implementation the State must submit for CMS approval the source of non-Federal share used to access the LIP, as outlined in the pre-implementation milestones. The State shall not have access to these funds until the source of non-Federal share has been approved by CMS. CMS assures the State that it will review the sources of non-Federal share in a timely manner. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

The State has complied with this term and condition regarding Low Income Pool permissible sources of funding criteria. February 3, 2006, the State submitted for CMS approval a document providing details of all sources of non-Federal share funding to be used to for the LIP program. On March 16, 2006, CMS requested additional information of these sources and the Agency submitted a revised document of source of non-Federal share funding April 7, 2006. The State received approval from CMS May 8, 2006.

XVI. LOW INCOME POOL MILESTONES

100. Pre-Implementation Milestones. The availability of funds for the LIP in the amount of $1 billion is contingent upon the following items prior to implementation:

a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement.

b. Florida's submission and CMS approval of a State Plan Amendment (SPA) that will terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Nothing herein precludes the State from submitting a State Plan Amendment reinstituting inpatient hospital supplemental payments upon termination of this demonstration. The State agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

c. The State shall submit a State Plan Amendment for CMS approval limiting the inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96.

d. The State shall submit for CMS approval of all sources of non-Federal share funding to be used to access the LIP. The sources of the non-Federal share must be compliant with all Federal statutes and regulations.

e. The State's ability to access the restricted portion of funds at the time of implementation and for the duration of the demonstration shall be contingent upon the State's capacity to meet the following milestones outlined in this Section.

The State has complied with this term and condition regarding Low Income Pool Pre-Implementation Milestones. The State has completed the following:

a. *1st Submission of Reimbursement & Funding Methodology Document (RFMD) on May 26, 2006; 2nd Submission of RFMD on June 26, 2006. Informal approval via email was provided January 26, 2007. Formal approval letter was received on December 2, 2009.*

b. *A State Plan Amendment was submitted (4.19-A) to remove the UPL from Florida's State Plan in August of 2006, the State received approval of the State Plan Amendment from CMS March 21, 2007. No new inpatient or outpatient UPL programs have been considered or implemented since the implementation of the LIP program.*

c. *On June 27, 2006, Florida submitted a State Plan Amendment (SPA) #06-006 to CMS to terminate the current inpatient supplemental payment program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. On March 21, 2007, the SPA was approved by CMS.*

d. *The State submitted to CMS the Source of Funds to be used with the Low Income Pool for SFY 2006-2007 and received approval from CMS May 8, 2006.*

e. *The State received a letter June 30, 2006 from CMS stating that the State was granted authority to make expenditures from the Low Income Pool in accordance with the Special Terms and Conditions.*

101. **Demonstration Year 1 Milestones.** The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91). The final document shall detail 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 paragraph 94.

This document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include *a projection of these amounts for each current year of operation*, and final reporting of historical demonstration periods. Providers with access to the LIP and services funded from the LIP shall be known as the provider access system. Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, “General Program Requirements.”

The State has complied with this term and condition regarding Demonstration Year 1 Milestones. The State has completed the following:

- *Submission of Final Reimbursement and Funding Methodology document (RFMD) on November 22, 2006, with Agency responses to CMS questions.*
- *Resubmission on March 16, 2007 responses to January 26, 2007 CMS questions.*
- *Resubmission of Final RFMD to CMS on May 29, 2007*
- *Resubmission of Final RFMD on March 20, 2008, and Florida's responses to CMS questions*
- *Resubmission of Final RFMD on December 17, 2008*
- *Resubmission of Final RFMD on May 13, 2009*
- *Resubmission of Final RFMD on June 26, 2009*

December 2, 2009, the State received a letter from CMS approving the Reimbursement and Funding Methodology document submitted June 26, 2009. The letter also confirmed the States compliance with STCs 93, 97, 98,100a and 101.

102. **Demonstration Year 2 Milestones.** At the beginning of demonstration year 2, $700 million will be available. An additional *$300 million will be available at the completion of milestones as specified in demonstration year one* for a total of $1 billion.

The State will conduct a study to evaluate the cost-effectiveness of various provider access systems. The results of this study shall be disseminated to the provider access systems for the continuous improvement in the structure, scope and access to such systems.

During demonstration year 2, using the results of the study as a guideline, the State and CMS will define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the low-income pool for demonstration years 3 through 5.

By the end of demonstration year 2, the State will develop a plan for the continuous improvement of provider access systems and evaluation of the impact of these systems on the uninsured to be implemented in demonstration year 3.

By the end of demonstration year 2, the State will develop a plan for the statewide implementation of the demonstration by the end of waiver year 5.

The State has complied with this term and condition regarding Demonstration Year 2 Milestones. The Agency submitted to CMS the "Evaluation of the Low Income Pool Program using Milestone Data: SFY 2005-06 and SFY 2006-07" and also submitted a highlight document June 30, 2008. The Agency posted the "Evaluation of the Low Income Pool Program using Milestone Data: SFY 2005-06 and SFY 2006-07" on the Low Income Pool web site for access by all providers as well as disseminating to all providers via email. The scale of the provider access systems and the indicators were discussed in the June 30, 2008 letter from the State to CMS. The Plan for continuous improvement of provider access systems and evaluation was explained in the June 30, 2008 letter to CMS. The June 30, 2008 letter to CMS addresses the statewide expansion.

103. **Demonstration Year 3 Funding.** At the beginning of demonstration year 3, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 2 for a total of $1 billion.

Demonstration Year 3 Milestone. The State shall implement the indicators established under the plan for continuous improvement of provider access systems for the uninsured as indicated in demonstration year 2.

The State has complied with this term and condition regarding Demonstration Year 3 Milestones. The State collected the indicator data information on the milestone report from all LIP provider access system (PAS) entities in Demonstration Year (DY) 3. Expansion of the use of LIP funds occurred through "continuous improvement of PAS for the uninsured" as authorized by the Florida Legislature.

104. **Demonstration Year 4.** At the beginning of demonstration year four $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 3 for a total of $1 billion.

Demonstration Year 4 Milestone. The State shall identify the qualitative impact on the implemented indicators in demonstration year 3 on uninsured individuals. This analysis may require the State to adjust the indicators as necessary.

The state has complied with this term and condition. The state collected the milestone data from all PAS entities in Demonstration Year (DY) 3. This information was provided to the University of Florida evaluation team, and Agency has received the report. The Agency anticipates using the report to assist with the "qualitative impact on the implemented indicators in DY3" and sharing it with CMS and all PAS entities.

Original STC #105

105. Demonstration Year 5. At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

During the 2009 Legislative Session, the Florida Legislature directed the Agency to work with federal CMS to obtain in writing or through an amendment to the waiver confirmation that the $1 billion dollars in LIP funds would be available to the State if the demonstration is not operating on a statewide basis by demonstration year 5.

As directed by the Florida Legislature, the Agency held a conference call with federal CMS on July 15, 2009, regarding the legislative directive. Federal CMS asked the State to send a letter regarding the legislative directive.

On September 2, 2009, the State sent a letter to federal CMS requesting clarification on STC 105. On October 30, 2009, federal CMS informally notified the State it would have to submit an amendment to STC #105 of the waiver.

On November, 4, 2009, the State notified the Florida Legislature (see Attachment F) that the Agency would have to submit an amendment to STC #105.

On November 28, 2009, the State submitted an amendment to federal CMS to amend STC #105.

On January 29, 2010, federal CMS sent a letter approving the amendment to STC #105. To view the approval letter, click on the link below:
http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/pdf/fl_medicaid_reform_section_1115_stc_105.pdf.

Amended STC #105 is provided below.

Amended STC #105 as approved by federal CMS 1/29/10.

Amended 105. At the beginning of demonstration year 5, $700 million will be available. At the beginning of demonstration year 5, an additional $150 million will be available at the completion of milestones due on or before demonstration year 4 ending June 30, 2010. An additional $150 million will be available at the completion of milestones due on or before October 31, 2010.

1) The Florida Agency for Health Care Administration will:

   (a) Develop a draft reconciliation review tool and instructions, in consultation with CMS, to be used for the reconciliation of LIP expenditures by April 30, 2010. CMS will have 30 days to review the draft reconciliation tool, request additional information or approve the tool. The 'tool' will implement the following recommendations provided to the State in the Financial Management Review (FMR).

i. Written procedures to calculate the Medicaid Shortfall Amount will be provided to participating providers to ensure correct calculations.
ii. Written instructions and definitions and review procedures regarding allowable costs will be provided to participating providers to ensure that only allowable costs are being included.
iii. Written procedures will be provided to participating providers to ensure that the LIP cost limit forms are consistently completed.

(b) Provide CMS a schedule for the completion of provider reconciliations statewide for demonstration years 1, 2, 3, and 4 by June 30, 2010.

(c) Provide completed reconciliations, by demonstration year and by provider, for all providers for demonstration years 1 and 2 by October 31, 2010. Demonstration year 1 LIP expenditure reconciliations must use the DSH audit reports for verification of reconciliation results and method.

(d) Provide completed reconciliations for all providers for demonstration year 3 by March 31, 2011.

(e) Provide reconciliations for providers for demonstration year 4 by March 31, 2011.

For LIP hospitals that receive DSH funding, DSH audit results and a supplemental LIP report for primary care and ancillary provider distributions and STC #96, may be used as part of the LIP reconciliation. The results of the reconciliations must be reported to CMS with summary by provider and in aggregate for the LIP with sufficient details included or made available upon request for validation.

2) The Florida Agency for Health Care Administration will provide:

(a) A report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for State fiscal year 2009 – 2010 (SFY) to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings by May 31, 2010. The report will provide a baseline assessment of current administrative capabilities and develop a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventative care settings.

(b) An update with SFY 2010-11 projections for LIP dollars allocated (as described in 2 a) to participating providers by June 30, 2010. This update will include descriptions of increases to allocations and changes to current allocations.

For those milestones with a completion to date prior to the submission of this extension request, the state is in full compliance. For those milestones with a completion date after the submission of the extension request, the state is confident that it will be in compliance with the future requirements. It is the state's position that it cannot be out of compliance with future events that have not yet occurred.

STC # 105 (1)(a) *– On April 30, 2010, the state submitted the "Reconciliation Draft Review Tool and Written Procedures for Reconciliation of LIP Expenditures to Allowable Provider Costs". Revisions to the document were submitted to federal CMS on June 14, 2010. CMS emailed informal approval of this submission on June 17, 2010. The state is in compliance with this milestone.*

STC # 105 (1)(b) *– On June 29, 2010, the state will submitted a schedule for the completion of provider reconciliations statewide for demonstration years 1, 2, 3, and 4. The state is in compliance with this milestone.*

STC # 105 (1)(c) *– By October 31, 2010, the state will submit completed reconciliations, by demonstration Year and by provider, for all providers for demonstration years 1 and 2. Demonstration Year 1 LIP expenditure reconciliations will use the DSH audit reports for verification of reconciliation results and method. The state is confident it will meet this deadline and be fully compliant.*

STC # 105 (1)(d) *– By March 31, 2011, the state will submit completed reconciliations for all providers for demonstration year 3. The state is confident it will meet this deadline and be fully compliant. The state is confident it will meet this deadline and be fully compliant.*

STC # 105 (1)(e) *– By March 31, 2011 the state will submit reconciliations for providers for demonstration year 4. The state is confident it will meet this deadline and be fully compliant.*

STC # 105 (2)(a) *– On May 31, 2010, the State submitted "State Fiscal Year 2009-10 Low Income Pool funding of Funding Alternative Delivery Systems". The state is in compliance with this milestone.*

STC # 105 (2)(b) *– On June 29, 2010, the State submitted an update with SFY 2010-11 projections for LIP dollars allocated [as described in 2(a)] to participating providers. This update will include descriptions of increases to allocations and changes to current allocations. The state is fully compliant with this milestone.*

All documents submitted to federal CMS are posted on the Agency's website at this link: http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/lip.shtml.

XVII. OTHER DEMONSTRATION MILESTONES

106**. Other Demonstration Milestones.** The State agrees it must adhere to all of the timeframes and deliverables specified in the sections outlined below in order to be considered compliant with Section XVI, "Low Income Milestones:"

1. Section IV. General Reporting Requirements
    a. Quarterly Reports
    b. Annual Reports
2. Section V. Florida Medicaid Reform Demonstration Implementation
3. Section VIII. Choice Counseling
    a. Developing Choice Counseling Materials
4. Section X. Employer Sponsored Insurance
    a. Opt-Out Guidelines
5. Section XI. Enhanced Benefit Accounts Program
    a. Enhanced Benefit Accounts Milestones
6. Section XIV. Evaluation
    a. Submission of Draft Evaluation Design
    b. Final Evaluation Design and Implementation
7. Section XVI. Low Income Pool Milestones

The State has and continues to comply with term and condition #106 of the waiver.

XVIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

107. Quarterly Expenditure Reports. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIX (Monitoring Budget Neutrality for the Demonstration).

The State has and continues to comply with this term and condition of the waiver regarding quarterly expenditure reports. The State submits quarterly expenditure reports using the Form CMS 64 to report total expenditures for the Medicaid program, including expenditures provided through the Demonstration under Section 1115 authority. The expenditures for the Demonstration under Section 1115 authority do not exceed the pre-defined limits on the costs incurred under the Demonstration as specified in Section XIX. Therefore, the state complies with STC #107.

108. Reporting Expenditures Subject to the Budget Neutrality Cap. The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Florida shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which service was provided or for which capitation payments were made – incurred/accrual basis). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 108.c.

b) For each demonstration year at least three separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports must be submitted reporting expenditures subject to the budget neutrality cap – more than three forms will be needed when there is more than one date of service year. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported on waiver forms. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 108.c.). The Florida Medicaid Reform eligibility groups (MEGs), for reporting purposes, include the following names and definitions:

MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For purposes of this section, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 106.b.of this section) and who are receiving the services subject to the budget neutrality cap, with the exception of the excluded services identified at the end of this paragraph. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver. The excluded services are the following:

<u>Excluded Services</u>
AIDS Waiver (Waiver Services)
DD Waiver (Waiver Services)
Home Safe Net (Behavioral Services)
BHOS (Services Only)
ICF/DD Institutional Services
Family & Supported Living (W.S.)
Katie Beckett Model Waiver Services

Brain & Spinal Cord Waiver Services
School Based Admin Claiming
Healthy Start Waiver Services

d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64. In order to assure that the Demonstration is properly credited with premium collections, all premium collections from demonstration participants must be separated from other collections in the State's Medicaid program and reported in the narrative portion of the CMS-64 report as well as reported on line 9.D of the CMS-64 Summary Sheet.

e) Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

The State reports expenditures subject to the budget neutrality cap in accordance with the provisions of term and condition 108. Expenditures subject to the budget neutrality cap include all Medicaid expenditures on behalf of demonstration eligibles, except expenditures for services excluded as listed in STC 108(c).

Demonstration expenditures and administrative costs are reported through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, additional Medicaid Eligibility Groups (MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

Expenditures for the Demonstration are reported on the Form CMS 64 under Waiver Number 11W00206/4 using a separate template for each Florida Medicaid Reform eligibility group (MEG) for each demonstration year. The MEGs included on the Form CMS 64 and the Waiver Name used on the Form CMS 64.9 Waiver and Form CMS 64.9P Waiver are as follows:

MEG	*Waiver Name on MBES/CBES*
SSI	*Aged/Disabled*

TANF	*TANF & related groups*
Low Income Pool	*Low-Income Pool*
Managed Care Waiver SSI – No Medicare	*FMR-SSI+DsEldw/oMcare*
Managed Care Waiver TANF	*FMR-TANF*
Managed Care Waiver SOBRA and Foster Children	*FMR-SOBRA/FC*
Managed Care Waiver Age 65 and Older	*FMR->65*
Administrative Cost	*ADM*

109. Reporting Member Months. The following describes the reporting of member months subject to the budget neutrality cap:

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

b) The term “Demonstration eligibles” excludes unqualified aliens and generally refers to the following categories of enrollees, pursuant to the waiver specifications and expenditures included in budget neutrality, with the exceptions noted in paragraph 106.d:

MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For the purpose of monitoring the budget neutrality expenditure cap described in Section XIX, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined above. This information must be provided to CMS in conjunction with the quarterly progress report referred to in number 22 of Section IV. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.)

d) The excluded eligibles are the following:

Excluded Eligibles
Refugee Eligibles
Dual Eligibles
Medically Needy
PW above TANF Eligible (>27% FPL, SOBRA)
ICF/DD Eligibles
Unborn Children
State Mental Facilities (Over Age 65)
Family Planning Waiver Eligibles

Women w/ breast or cervical cancer
MediKids

The State reports member months subject to the budget neutrality cap in accordance with the provisions of term and condition 109. The State provides the actual number of eligible member months for the demonstration eligibles as defined in term and condition 109(b), and excludes eligibles listed in term and condition 109(d). The member months are provided to CMS on a quarterly basis in conjunction with the Florida Medicaid Reform Quarterly Progress Report and on an annual basis with the Florida Medicaid Reform Annual Report.

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

The State complies with term and condition 110 by estimating the matchable Medicaid expenditures on the quarterly Form CMS 37, and the state submits Form CMS 64 quarterly Medicaid expenditure report for each quarter of the Demonstration.

111. Non-Federal Share of Funding Conditions and Availability of Federal financial payments (FFP). Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section XIX:

1. Administrative costs associated with the direct administration of Florida Medicaid Reform at the appropriate FFP rate authorized under Medicaid.

2. Net expenditures and prior period adjustments of the Medicaid and Florida Medicaid Reform programs, which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service and during the operation of the 1115 waiver.

3. The employee subsidy portion of the ESI, as subsidized by the State of Florida, provided that the employer or self-employed person contributes. In no instance shall the subsidy exceed the premium, which would be paid to a Medicaid capitated plan in the

absence of the individual not opting out of Medicaid. The program is limited to enrollees eligible for Medicaid, as authorized under the current state plan.

4. Health insurance (individual, two-person, or family) purchased by a self-employed person on his/her own behalf, will be treated as employer-sponsored insurance, and will be eligible for employer subsidies and employee subsidies which, are for FFP purposes, subject to the same limits

5. Net Expenditures associated with the Low Income Pool, as described in Section XV.

6. Net Expenditures associated with the Enhanced Benefits Accounts Program.

The State provides CMS with copies of the State's General Appropriations Act for each State fiscal year to show the source of the non-Federal share of expenditures. The State, through Form CMS 37, Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the Florida Medicaid Reform Annual Report, provides the net expenditures matchable for Federal financial participation. The State complies with CMS provisions relating to the reporting of the expenditures listed in term and condition #111.

112. State Certification of Funding. The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

The State complies with term and condition 112 relating to the use of State/local monies as certified matching funds.

113. MSIS Data Submission. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

The State complies with term and condition 113. MSIS data is submitted electronically to CMS in accordance with CMS requirements and timeliness standards.

XI. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Special Terms and Conditions specify the two independent financial caps on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 106.c. of Section X of this document. Federal financial payments for the Medicaid Reform aspects of the demonstration are limited by a per member per month method cap and the payments for the Low Income Pool aspects are limited by an aggregate cap.

The State complies with the monitoring of budget neutrality through quarterly extracts of Demonstration expenditures and member months.

Demonstration eligibles, enrollee member months, and related claims data for included services are identified using a query of SQL tables built from claims and eligibility data extracted from the Florida Medicaid Management Information System.

The claims data and member months are separated into appropriate categories or Medicaid Eligibility Groups (MEGs) to report on the waiver forms of the Form CMS 64. Please see response to term and condition 108 for details of the MEGs used.

Using the paid claims data extracted, the included expenditures for each MEG are identified by service type and reported on the appropriate line on the Form CMS 64.9 Waiver or Form CMS 64.9P Waiver.

Included expenditures that are also identified as Home and Community-Based Waiver Services (HCBS) are identified and the corresponding HCBS waiver template on the Form CMS 64 is adjusted to reflect the hierarchy of the 1115 waiver reporting.

All identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated by the FMMIS and provided to the Agency's Finance and Accounting unit which certifies and submits the Form CMS 64 report.

114. Budget Neutrality Limit for the Low Income Pool. Florida will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Low Income Pool amount will be capped at $1 billion total computable for each year of the demonstration for a total of $5 billion. In each year, use of a specific amount of the Pool is restricted by the provisions of Paragraphs 100 through 105 of the terms and conditions. Unexpended funds from the restricted amount may not be used for purposes other than these provisions and may not be carried over to other years. For the balance of the Pool

amount each year, any unexpended portion may be expended for Pool purposes in subsequent demonstration years subject to clause 94. The Federal share of the annual $1 billion total computable is the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the Low Income Pool MEG, subject to the previous conditions on what portions may be carried over from year to year. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

The State complies with the budget neutrality limit and spending provisions for the Low Income Pool, and expenditures do not exceed the $5 billion total computable limit.

115. Budget Neutrality Limit under the Per Capita Cost Per Month Method.

The limit is determined by using a per capita cost per month (PCCM) method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration. In this way, Florida will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing Florida at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

The State complies with the budget neutrality limit under the Per Capita Cost Per Month Method as of the Quarter Ended March 31, 2010.

The following is a summary of the annual actual PCCM by MEG compared to the targeted PCCM under the terms and conditions for budget neutrality:

For Demonstration Year One, MEG 1 has a PCCM of $972.13, compared to WOW of $948.79, which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23, compared to WOW of $199.48, which is 80.32% of the target PCCM for MEG 2

For Demonstration Year Two, MEG 1 has a PCCM of $1,020.78, compared to WOW of $1,024.69, which is 99.62% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.78, compared to WOW of $215.44, which is 78.80% of the target PCCM for MEG 2

For Demonstration Year Three, MEG 1 has a PCCM of $1,049.23, compared to WOW of $1,106.67, which is 94.81% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.10, compared to WOW of $232.68, which is 71.39% of the target PCCM for MEG 2

For the initial 3 quarters of Demonstration Year Four, MEG 1 has a PCCM of $1,010.94, compared to WOW of $1,195.20, which is 84.58% of the target PCCM for MEG 1. MEG 2 has a PCCM of $164.94, compared to WOW of $251.29, which is 65.64% of the target PCCM for MEG 2

The combined annual PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the terms and conditions are also weighted using the actual case months. The following is the combined annual PCCM compared to the PCCM targets:

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the terms and conditions is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the terms and conditions is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $314.31. Comparing the calculated weighted averages, the actual PCCM is 89.07% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the terms and conditions is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $307.17. Comparing the calculated weighted averages, the actual PCCM is 82.51% of the target PCCM.

For the initial 3 quarters of Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the terms and conditions is $388.01. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $287.48. Comparing the calculated weighted averages, the actual PCCM is 74.09% of the target PCCM

116. Calculating the Per Capita Cost Per Month. For the purpose of calculating the overall PCCM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the SSI and TANF MEGs. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

a) **Projecting Service Expenditures.** Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs defined below. The annual budget estimate for each MEG will be the product of the projected per capita cost per month (PCCM) cost for the MEG, times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in section X.

b) **Projected PCCM Cost.** Projected PCCM for each MEG has been calculated by using a pre-determined trend rates to convert the base year per capita costs into annual

projected per capita costs for each year of the demonstration. Rates of 8 and 8 percent apply to the SSI and TANF MEGs respectively. The monthly equivalent growth rates are: .643403 and .643403 percent for each MEG and have been used to convert Base Year/State fiscal year (FFY) PCCM cost estimates to Demonstration Year (DY) estimates. The agreement to use these trend rates is based on analysis of State and National data.

The base year and projected DY PCCM amounts are the following (using July 1, 2006 as start date for the demonstration):

Time Period SSI MEG TANF MEG
Base Year $753.18 $158.35
DY 01 (SFY 2006-2007) $948.79 $199.48
DY 02 (SFY 2007-2008) $ 1,024.69 $215.44
DY 03 (SFY 2008-2009) $ 1,106.67 $232.68
DY 04 (SFY 2009-2010) $ 1,195.20 $251.29
DY 05 (SFY 2010-2011) $ 1,290.82 $271.39

c) Converting PCCM to an Alternative Start Date. Because the beginning demonstration may deviate from the expected start date, the following methodology may be used to produce revised DY estimates of PCCM amounts. Using the monthly equivalent growth rate, the appropriate number of monthly trend rates would be used to convert base year PCCM costs to PCCM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations

First Demonstration Year:
As an example, assume that a base year (SFY 2000) per capita cost for the enrolled population is $1,000, and the first year of the demonstration (DY 2001) is January 1, 2001, and ends December 31, 2001. DY 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward DY to 2001. Assume a trend rate of 5.2% and the associated monthly trend of .42336%. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PCCM cost of $1079. ($1079 = $1000 x 1.00423336^{18})

Second and Subsequent Demonstration Years:
Since DY 2002 is 12 months beyond DY 2001, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PCCM cost of $1079 gives a DY 2002 PCCM cost of $1135.

The State complies with term and condition 116. The state is within the projected PCCM cap and does not exceed budget neutrality. Please see the response to term and condition 115 and the following Tables 29 and 30.

Table 29 MEGs 1 & 2 Annual Statistics					
DY01 – MEG 1	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 1 - DY01 Total	*2,978,415*	*$2,631,566,388*	*$263,851,544*	*$2,895,417,932*	*$972.13*
WOW DY01 Total	*2,978,415*			*$2,825,890,368*	*$948.79*
Difference				*$69,527,564*	
% of WOW PCCM MEG 1					*102.46%*
DY01 – MEG 2	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 2 - DY01 Total	*15,162,819*	*$2,293,656,191*	*$135,864,711*	*$2,429,520,901*	*$160.23*
WOW DY01 Total	*15,162,819*			*$3,024,679,134*	*$199.48*
Difference				*$(595,158,233)*	
% of WOW PCCM MEG 2					*80.32%*
DY02 – MEG 1	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 1 - DY02 Total	*3,033,969*	*$2,651,751,857*	*$445,267,012*	*$3,097,018,869*	*$1,020.78*
WOW DY02 Total	*3,033,969*			*$3,108,877,695*	*$1,024.69*
Difference				*$(11,858,825)*	
% of WOW PCCM MEG 1					*99.62%*
DY02 – MEG 2	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 2 - DY02 Total	*14,829,991*	*$2,253,068,544*	*$264,693,878*	*$2,517,762,423*	*$169.78*
WOW DY02 Total	*14,829,991*			*$3,194,973,261*	*$215.44*
Difference				*$(677,210,838)*	
% of WOW PCCM MEG 2					*78.80%*
DY03 – MEG 1	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 1 - DY03 Total	*3,249,742*	*$2,913,812,534*	*$495,906,978*	*$3,409,719,511*	*$1,049.23*
WOW DY03 Total	*3,249,742*			*$3,596,391,979*	*$1,106.67*
Difference				*$(186,672,468)*	
% of WOW PCCM MEG 1					*94.81%*

Table 29 MEGs 1 & 2 Annual Statistics					
DY03 – MEG 2	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 2 - DY03 Total	*17,094,840*	*$2,558,667,339*	*$280,798,552*	*$2,839,465,891*	*$166.10*
WOW DY03 Total	*17,094,840*			*$3,977,627,371*	*$232.68*
Difference				*$(1,138,161,480)*	
% of WOW PCCM MEG 2					*71.39%*
DY04 – MEG 1	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 1 - DY04 Total	*2,500,250*	*$2,146,983,626*	*$380,619,731*	*$2,527,603,356*	*$1,010.94*
WOW DY04 Total	*2,500,250*			*$2,988,298,800*	*$1,195.20*
Difference				*$(460,695,444)*	
% of WOW PCCM MEG 1					*84.58%*
DY04 – MEG 2	*Actual CM*	*Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
MEG 2 - DY04 Total	*14,761,363*	*$2,170,872,733*	*$263,940,228*	*$2,434,812,961*	*$164.94*
WOW DY04 Total	*14,761,363*			*$3,709,382,908*	*$251.29*
Difference				*$(1,274,569,947)*	
% of WOW PCCM MEG 2					*65.64%*

Table 30 Combined MEG 1 & 2 Cumulative Statistics					
DY 01	*Actual CM*	*MEG 1 & 2 Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
Meg 1 & 2	*18,141,234*	*$4,925,222,579*	*$399,716,255*	*$5,324,938,833*	*$293.53*
WOW	*18,141,234*			*$5,850,569,502*	*$322.50*
Difference				*$(525,630,669)*	
% Of WOW					*91.02%*
DY 02	*Actual CM*	*MEG 1 & 2 Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
Meg 1 & 2	*17,863,960*	*$4,904,820,402*	*$709,960,890*	*$5,614,781,292*	*$314.31*
WOW	*17,863,960*			*$6,303,850,956*	*$352.88*
Difference				*$(689,069,663)*	
% Of WOW					*89.07%*
DY 03	*Actual CM*	*MEG 1 & 2 Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
Meg 1 & 2	*20,344,582*	*$5,472,479,873*	*$776,705,529*	*$6,249,185,402*	*$307.17*
WOW	*20,344,582*			*$7,574,019,350*	*$372.29*
Difference				*$(1,324,833,948)*	
% Of WOW					*82.51%*
DY 04	*Actual CM*	*MEG 1 & 2 Actual Spend MCW & Reform Enrolled*		*Total*	*PCCM*
Meg 1 & 2	*17,261,613*	*$4,317,856,359*	*$644,559,958*	*$4,962,416,317*	*$287.48*
WOW	*17,261,613*			*$6,697,681,708*	*$388.01*
Difference				*$(1,735,265,391)*	
% Of WOW					*74.09%*

117. How the Limit will be Applied. The limits as defined in paragraphs 93 and 94 will apply to actual expenditures for demonstration, as reported by the State under Section XVIII. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

The State complies with term and condition 117. The State monitors the PCCM through quarterly data extracts to monitor budget neutrality. The resulting PCCMs based on actual expenditures and member months are reported through the Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the Florida Medicaid Reform Annual Report.

118. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations

implemented through SMD letters, other memoranda on or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donations and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

The State complies with term and condition 118. The State does not have any impermissible provider payments or health care related taxes.

119. Expenditure Review CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in term and condition #22. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year Cumulative target definition
Percentage
Year 1 Year 1 budget neutrality cap plus 8 percent

Year 2 Years 1 and 2 combined budget neutrality cap plus 3 percent

Year 3 Years 1 through 3 combined budget neutrality cap plus 1 percent

Year 4 Years 1 through 4 combined budget neutrality cap plus 0.5 percent

Year 5 Years 1 through 5 combined budget neutrality cap plus 0 Percent

The State complies with term and condition 119. Over the course of the Demonstration, the State has not exceeded the cumulative target PCCM. The State calculates an annual expenditure target for each completed year and reports it to CMS as part of the Florida Medicaid Reform Quarterly Progress Report and the Florida Medicaid Reform Annual Report. Please see the responses to term and condition 115 and term and condition 116 for additional information.

120. **Expenditure Review.** Expenditure through the low-income pool may not exceed the amounts determined by term and condition #93 – the annual contingent amount of

$300 million must not be exceeded during applicable demonstration years of 02-05. The non-contingent amount during demonstration years 02-05 may not exceed $700 million, except as permitted by rollover amounts as guided by the following:

Year Non-Contingent Low Income Pool Expenditures Cumulative
Amount

Year 1 $1 billion, providing implementation requirements are met $1 billion

Year 2 $700 million $1.7 billion

Year 3 $700 million $2.4 billion

Year 4 $700 million $3.1 billion

Year 5 $700 million $3.8 billion

The State complies with term and condition 120. Please see response to term and condition 93 for details. Low Income Pool expenditures are reported on Form CMS 37, Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the Florida Medicaid Reform Annual Report. Below is a summary of Low Income Pool expenditures through March 31, 2010.

Low Income Pool Expenditures by Demonstration Year as of March 31, 2010

DY	*Total Paid*	*DY Limit*	*% of DY Limit*
DY01	*$998,806,049*	*$1,000,000,000*	*99.88%*
DY02	*$999,632,926*	*$1,000,000,000*	*99.96%*
DY03	*$877,493,058*	*$1,000,000,000*	*87.75%*
DY04	*$417,805,306*	*$1,000,000,000*	*41.78%*
Total MEG 3	*$3,293,737,339*	*$5,000,000,000*	*65.87%*

IX. Waiver and Expenditure Authorities

As required in the letter from federal CMS dated March 15, 2010, the Agency is providing a list along with a programmatic description of the waivers and expenditure authorities that are being requested for this extension. As previously noted, the Florida Legislature directed the Agency to seek a three-year extension to the demonstration waiver without changes. Therefore, the Agency is requesting the same waiver and expenditure authorities specified in the approval letter by federal CMS on October 19, 2005 (Attachment G). The Agency acknowledges and understands that federal CMS may want to revise the waiver and expenditure authorities to conform to recent changes in law and/or regulations as noted in STC #2, #3, and #4 and respectfully requests written communications regarding changes to authority to comport with new statutory and regulatory provisions. The Agency will provide this information to the Florida Legislature as part of monthly reporting requirements so that there is transparency regarding any required changes and all parties understand the statutory and regulatory basis for such changes.

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Attachments

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Attachment A.1
Draft Public Process Strategy

Extension Request for Florida's 1115 Research and Demonstration Waiver

The State of Florida will provide stakeholders with the opportunity to provide input on the 1115 Research and Demonstration Waiver (Medicaid Reform) extension request, as authorized by the Florida Legislature in Senate Bill 1484. We believe that much of the input obtained during the Legislative session meets the requirements for input but understand the need to solicit additional stakeholder opinion prior to submitting any waiver renewal authorized by the Legislature. The State will:

- **Record the legislative activities and public meetings** held prior to and during the 2010 Florida Legislative session at which the waiver extension request was discussed and, to the extent provided, the opportunity for public input.

- **Work with the Indian Health Programs and Urban Organizations** through written correspondence, conference calls and/or meetings to obtain input on the future of the demonstration and the waiver extension request. The Agency will also invite the tribes to participate as a member of the Medicaid Medical Care Advisory Committee.

- **Publish a public meeting notice** on May 14, 2010, in the Florida Administrative Weekly, to hold a meeting with stakeholders on May 21, 2010, from 1:00 pm to 3:30 pm to discuss the future of Florida's 1115 Research and Demonstration Waiver including any legislation passed during the 2010 Florida Legislative Session which impacts the waiver. This public meeting will also be used to obtain stakeholders' input on the public process outlined below to be used to solicit additional public input on the waiver extension request.

  - **Hold one or more public hearings/meetings** tentatively scheduled for the first week of June. During the meetings, the draft extension request will be described and time will be provided for public comment. The notice for the public meetings will be published in the Florida Administrative Weekly and posted on the Agency's website. The meetings will be held in accessible geographic areas where the demonstration currently operates.

  - **Hold one or more advisory committee meetings** at which the draft extension request will be discussed and time will be provided for public comment. The advisory committee meetings will be open to the public, noticed in the Florida Administrative Weekly and posted on the Agency's website. Examples of the advisory committees include the Technical Advisory Panel, Low Income Pool Council and the Medical Care Advisory Committee.

  - **Post the Legislation authorizing the extension request on the Agency website for comment**. The Agency will post the draft extension request on the Agency's website (http://ahca.myflorida.com/) and will include a link to the Legislation that authorizes the State to seek the extension of the waiver.

  - **Provide for formal notice and comment**. The State will provide formal notice of the extension request in the Florida Administrative Weekly. The notice will provide instructions on how obtain a copy of the draft extension request and submit written comments.

Attachment.2
Legislative Activities and Public Meetings

Legislative Activities and Public Meetings 1115 Research and Demonstration Waiver Extension Request August 1, 2009 – April 30, 2010					
Date	**Location**	**Target Audience**	**Type of Meeting**	**Subject**	**Presentation Link**
Legislative Meetings					
12/08/09	Tallahassee	Senate Health Regulation Committee	Florida Medicaid Reform	• Low Income Pool *(Presented by Assistant Deputy Secretary of Medicaid Finance, Phil Williams)*	Florida Medicaid Low Income Pool
01/21/10	Tallahassee	Senate Health and Human Services Appropriations Committee	Florida Medicaid Reform	• Cost Efficiencies in Florida Medicaid Program *(Presented by Secretary Arnold)*	Cost Efficiencies in the Florida Medicaid Program
02/03/10	Tallahassee	Senate Health Regulation Committee	Florida Medicaid Reform	• Outreach Efforts • Choice Counseling • Delivery System • New Options/Choice • Financing • LIP *(Presented by Deputy Secretary for Medicaid, Roberta Bradford)*	Florida Medicaid Reform February 3, 2010
02/09/10	Tallahassee	Senate Health and Human Services Appropriations Committee	Florida Medicaid Reform	• LIP vs. UPL *(Presented by Deputy Secretary for Medicaid, Roberta Bradford)*	Low Income Pool (LIP) vs. Upper Payment Limit (UPL): A Comparison
02/17/10	Tallahassee	Senate Ways and Means Committee	Florida Medicaid Reform	• Managed Care in Florida Medicaid *(Presented by Secretary Arnold)*	Managed Care in Florida Medicaid
02/18/10	Tallahassee	House Health Care Appropriations Committee	Florida Medicaid Reform	• LIP vs. UPL: A Comparison • Implementation of UPL • Impact of UPL • Continuation of LIP *(Presented by Deputy Secretary for Medicaid, Roberta Bradford)*	UPL vs. LIP: A Comparison

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
03/05/10	Tallahassee	House Select Council on Strategic and Economic Planning	Florida Medicaid Reform	• Outreach Efforts • Choice Counseling • Delivery System • New Options/Choice • Financing • LIP *(Presented by Deputy Secretary for Medicaid, Roberta Bradford)*	Florida Medicaid Reform March 5, 2010
03/08/10	Tallahassee	Joint Legislative Committee on Inter governmental Regulations	Florida Medicaid Reform Waiver	• Low Income Pool Reauthorization • Key Elements of Reform • UPL and LIP Comparison *(Presented by Deputy Secretary for Medicaid, Roberta Bradford)*	Florida Medicaid Reform Waiver and Low Income Pool
Nassau County Meeting					
01/07/10	Nassau County	Nassau County Board of County Commissioners	Florida Medicaid	National Healthcare Reform Proposals *(Presented by Secretary Arnold)*	Florida Medicaid: National Healthcare Reform Proposals
Low Income Pool Council Meetings					
10/29/09	Tallahassee	LIP Council	Low Income Pool Program	• Legislative Update • Introduction of LIP Council • Discussion of Sunshine Laws • Overview of Medicaid, 1115 Demonstration Waiver and LIP • Updates • Overview of Tables	• Final Agenda • Approved Meeting Summary • Legislative Update • Introduction of LIP Council • Sunshine Laws • Florida Medicaid Program: An Overview • 1115 Demonstration Waiver and Low Income Pool • Special Terms and Conditions • Reimbursement and Funding Methodology Document • SFY 2008-09 Final distributions • SFY 2009-10 Appropriated distributions

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
12/02/09	Tallahassee	LIP Council	Low Income Pool Program	• Federal Update • Presentations by LIP funded entities • Updates • Overview of Tables	• Final Agenda • Federal update • County Health Departments (CHDs) Emergency Room Alternative Projects • Federally Qualified Health Centers (FQHCs) • Policy Decisions / Considerations List • Chapter 409.911 Disproportionate Share Program with subsections • Letters of Agreement • Base Model • Model 1 • Model 2 • Model 3 • Model 4 • Model 5 • Model 6 • Model 7 • Model 8
12/17/09	Tallahassee	LIP Council	Low Income Pool Program	• Federal Update • Presentations by LIP funded entities • Updates • Overview of Tables • Member Comments	• FAW Notice • Final Agenda • CMS Approval Letter • Miami-Dade County Premium Assistance Program (PAP) in conjunction with Miami-Dade Blue • Attachment 1– Flow Chart • Attachment 2 – Application • Attachment 3 – Miami-Dade Blue Benefits Summary • Policy Decisions / Considerations • Safety Net History - Safety Net Summary • Buyback – GAA and current hospital • Model 9 Model 10 Model 11 Model 12 • Model 13

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
01/08/10	Orlando, FL	LIP Council	Low Income Pool Program	• Federal Update • Presentations by LIP funded entities • Palm Beach County's Healthcare Delivery in Public Schools Proposal • Updates • Overview of Tables • Member Comments	• FAW Notice • Final Agenda • Orlando Health Downtown Orlando Campus Map • Downtown Orlando Directions • Meeting Logistics • Sarasota County Health Department Presentation • Duval County Health Department Presentation • Data Analysis: Duval CHD Hospital Emergency Room Alternatives Program • Palm Beach County 's Premium Assistance Demonstration Project • Palm Beach County's Healthcare Delivery in Public Schools Proposal • Update – Mike Marks • Financial Background • LIP/Hospital Cost Limits North Highland • Model 14 • Model 15 • Model 16 • Model 17
01/22/10	Tallahassee	LIP Council	Low Income Pool Program	• Federal Update • January 2010 rates updates • Summary of new LIP funding requests • Council Model discussions • Member first round voting • Member discussion on remaining Models • Final Vote	• FAW Notice • Agenda • Exemption updated with January 2010 Rates • Buy-backs updated with January 2010 Rates • Model 1A • Model 11A • Model 12A • Model 14A • Model 14B • Model 15A • Model 16A • Model 17A • Model 18
Technical Advisory Panel Meetings					
08/10/09	Tallahassee	Panel	Operational Issues of Reform	• UF Evaluation Update – Drs. Paul Duncan & Jeff Harman • Rates Discussion • MEDS Update	• FAW Notice • Meeting Agenda • Evaluating Medicaid Reform: Fiscal Analyses Update • An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration - Release Date: June 2009

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
10/16/09	Tallahassee	Panel	Operational Issues of Reform	• Choice Counseling and Enhanced Benefits Update • MEDS and Risk Adjustment Update • Reimbursement Workgroup Updates	• Meeting Agenda • Florida's Medicaid Reform Choice Counseling • Florida's Medicaid Reform Enhanced Benefits Program • Medicaid Encounter Data System (MEDS) • Risk Adjusted Rates • Summary of Reimbursement Workgroups 2009
01/15/10	Tallahassee	Panel	Operational Issues of Reform	• MEDS and Risk Adjustment Update • Medicaid Reform Evaluation Update • Presentation of the Future of FL Medicaid Reform • Choice Counseling • Enhanced Benefits • Financial Update	• Meeting Agenda • Meeting Summary Final • Medicaid Encounter Data System (MEDS) • Risk Adjustment • Medicaid Reform Evaluation Update • Future of Florida Medicaid Reform • Florida's Medicaid Reform Choice Counseling • Florida's Medicaid Reform Enhanced Benefits Program
03/12/10	Tallahassee	Panel	Operational Issues of Reform	• MEDS and Risk Adjustment Update • Reform Evaluation • Rate Setting-Timeline & Process • EB Impact on Rates • Choice Counseling • Enhanced Benefits • Legislative Update • Discussion of Present to Senate Ways/Means • Update on National Healthcare Reform	• Meeting Agenda • Final Meeting Summary • Medicaid Encounter Data (MEDS) and Risk Adjustment Update • Rate Setting-Timeline and Process • Choice Counseling • Enhanced Benefits Presentation • Enhanced Benefits Rewards Brochure • Discussion of the Agency's Presentation to Senate Ways and Means • National Healthcare Reform Presentation • Federal Health Reform Revenue Provisions
Medical Care Advisory Committee					

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
08/19/09	Tallahassee	Low Income Population Groups	Updates on Health and Medical Care Services	• Creation of Bylaws • Medicaid Reform Update • Community Health Centers • Legislative Proposal Process • Legislative Budget Process	• Meeting Agenda • The 2009 Florida Statute, Title XIV, Chapter 216, 216-011 Definitions • The 2009 Florida Statute, Title XIV, Chapter 216, 216-023 Legislative budget requests to be furnished to Legislature by agencies • Agency Legislative Budget Request • FY 2010-2011 Legislative Budget Request and Proposed Legislation Timelines • Florida Fiscal Portal • The Agency's Legislative Proposal Process • Florida Medicaid Reform • Medical Care Advisory Committee Proposed Bylaws, May 2009 • Medical Care Advisory Committee Proposed Bylaws, May 2009 • Section 19. State Budgeting, Planning and Appropriations Processes
11/17/09	Tallahassee	Low Income Population Groups	Updates on Health and Medical Care Services	• Creation of Bylaws • Legislative Proposal Process • Legislative Budget Process • Medicaid Health Information Technology • Medical Home Task Force Discussion • Presentation on Medicaid Reform "Findings, Concerns and Questions" by the Fact-finding Subcommittee, FL Legal Services, Inc.	• Meeting Agenda • The 2009 Florida Statute, Title XIV, Chapter 216, 216-011 Definitions • The 2009 Florida Statute, Title XIV, Chapter 216, 216-023 Legislative budget requests to be furnished to Legislature by agencies • Agency Legislative Budget Request • FY 2010-2011 Legislative Budget Request and Proposed Legislation Timelines • Florida Fiscal Portal • The Agency's Legislative Proposal Process • Medical Care Advisory Committee Proposed Bylaws, November 2009 • Medical Care Advisory Committee Proposed Bylaws, November 2009 • Schedule VIIIA - Priority Listing Of Agency Budget Issues Required Expenditures over Base Operations Budget • Fact-finding Subcommittee on Medicaid Reform - Findings, concerns, and questions • Section 19. State Budgeting, Planning and Appropriations Processes

Legislative Activities and Public Meetings

1115 Research and Demonstration Waiver Extension Request

August 1, 2009 – April 30, 2010

Date	Location	Target Audience	Type of Meeting	Subject	Presentation Link
02/23/10	Tallahassee	Low Income Population Groups	Updates on Health and Medical Care Services	• Medical Home Update • Telemedicine • EPO • Recipient Correspondence • Medicaid Health Information Technology Update • Encounter Data • Performance Measures	• Meeting Agenda • Minutes of the November 17, 2009 Meeting • 2009 Managed Care Performance Measures • Medicaid Encounter Data • Recipient Correspondence Project Packet • Medical Advisory Committee, TELEMEDICINE, February 17, 2010 • Medicaid Managed Care Performance Measures • Medicaid Health Information Technology Planning – Advance Planning Document, February 1, 2010 • Survey - Summary of Responses - Medicaid Recipient Correspondence

Attachment A.3
Letters to the Miccosukee Tribe and the Seminole Tribe

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

April 30, 2010

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

Dear Ms. Osceola:

The State of Florida anticipates submitting to the Centers for Medicare and Medicaid Services (CMS) a three-year extension request for Florida's 1115 Research and Demonstration Waiver (Medicaid Reform) by June 30, 2010. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the waiver extension request.

The 1115 Research and Demonstration Waiver was originally authorized by CMS for a five year period, July 1, 2006, to June 30, 2011. The waiver is operational in Broward, Duval, Baker, Clay and Nassau Counties.

The 1115 waiver authority enables the State to enroll the majority of Medicaid recipients into approved managed care health plans. Managed care eligible recipients located in the demonstration counties may choose to participate in an available Medicaid health maintenance organization or a Medicaid reform provider service network. Unless found to be ineligible for enrollment in the demonstration waiver, newly eligible Medicaid recipients receive information to assist them in choosing one of the approved health plans. The information includes materials about the available health plan options, timetable for making a choice, and a telephone number for choice counseling and enrollment. If a Medicaid eligible recipient does not select a health plan within the given timeframe, the recipient will be assigned, as appropriate, to a health plan.

Medicaid recipients who are members of federally-recognized Indian tribes are allowed to enroll in managed care programs if they are determined to be managed care eligible. However, they are not automatically enrolled or locked in to any managed care program and are permitted to change health plans and/or primary care providers at any time.

If you would like additional information or have any questions about the State's 1115 Research and Demonstration waiver or the three year waiver extension request, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam

2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

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

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

April 30, 2010

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

Dear Ms. Whidden:

The State of Florida anticipates submitting to the Centers for Medicare and Medicaid Services (CMS) a three-year extension request for Florida's 1115 Research and Demonstration Waiver (Medicaid Reform) by June 30, 2010. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the waiver extension request.

The 1115 Research and Demonstration Waiver was originally authorized by CMS for a five year period, July 1, 2006, to June 30, 2011. The waiver is operational in Broward, Duval, Baker, Clay and Nassau Counties.

The 1115 waiver authority enables the State to enroll the majority of Medicaid recipients into approved managed care health plans. Managed care eligible recipients located in the demonstration counties may choose to participate in an available Medicaid health maintenance organization or a Medicaid reform provider service network. Unless found to be ineligible for enrollment in the demonstration waiver, newly eligible Medicaid recipients receive information to assist them in choosing one of the approved health plans. The information includes materials about the available health plan options, timetable for making a choice, and a telephone number for choice counseling and enrollment. If a Medicaid eligible recipient does not select a health plan within the given timeframe, the recipient will be assigned, as appropriate, to a health plan.

Medicaid recipients who are members of federally-recognized Indian tribes are allowed to enroll in managed care programs if they are determined to be managed care eligible. However, they are not automatically enrolled or locked in to any managed care program and are permitted to change health plans and/or primary care providers at any time.

If you would like additional information or have any questions about the State's 1115 Research and Demonstration waiver or the three year waiver extension request, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam

2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

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

Attachment A.4
Public Meeting Notices Published in FAW

Tallahassee: May 21, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The **Agency for Health Care Administration** announces a meeting to which all individuals are invited.

DATE AND TIME: May 21, 2010, 1:00 p.m. – 3:30 p.m.

PLACE: Agency for Health Care Administration, Conference Room A, 2727 Mahan Drive, Building 3, Tallahassee, FL 32308

Those not able to attend in person may participate via conference phone by calling 1(888)808-6959 and entering Conference Code 9227320.

GENERAL SUBJECT MATTER TO BE CONSIDERED: This public meeting is being held to provide stakeholders with the opportunity to provide input on the future of Florida's 1115 Research and Demonstration Waiver. The following items will be discussed: overview of the existing waiver, any legislation passed during the 2010 Florida Legislative Session which impacts the waiver, and description of the draft extension request. There will be an opportunity for public comment at the meeting.

CONTACT: Ms. Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan, Drive, Mail Stop #50, Tallahassee, FL 32308, Office Phone: (850)412-4031, Email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting Linda Macdonald, at the address and phone number written above. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact Linda Macdonald, at the address and phone number written above.

Duval County: June 8, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The **Agency for Health Care Administration** announces a public meeting to which all persons are invited.

DATE AND TIME: June 8, 2010, 1:00 p.m. – 3:00 p.m.

PLACE: The Arc Jacksonville, 1050 North Davis Street, Jacksonville, Florida 32209

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to provide stakeholders and all interested parties with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. During the meetings, the following items will be discussed: legislation passed during the 2010 Florida Legislative Session which impacts the waiver, overview of the existing waiver and description of the draft extension request. There will be an opportunity for public comment at the meetings.

A copy of the agenda may be obtained by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Broward County: June 9, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration announces a public meeting to which all persons are invited.

DATE AND TIME: June 9, 2010, 10:00 a.m. – 12:00 Noon

PLACE: Broward County Health Department, Main Auditorium, 780 S. W. 24 Street, Fort Lauderdale, FL 33315

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to provide stakeholders and all interested parties with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. During the meetings, the following items will be discussed: legislation passed during the 2010 Florida Legislative Session which impacts the waiver, overview of the existing waiver and description of the draft extension request. There will be an opportunity for public comment at the meetings.

A copy of the agenda may be obtained by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, Please

Nassau County: June 10, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration, Medicaid announces a public meeting to which all persons are invited.

DATE AND TIME: June 10, 2010, 2:00 p.m. – 4:00 p.m.

PLACE: Nassau County Children and Family Education Center, 86207 (479) Felmor Road, Yulee, FL 32097

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to provide stakeholders and all interested parties with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. During the meetings, the following items will be discussed: legislation passed during the 2010 Florida Legislative Session which impacts the waiver, overview of the existing waiver and description of the draft extension request. There will be an opportunity for public comment at the meetings.

A copy of the agenda may be obtained by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Clay County: June 10, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration, Medicaid announces a public meeting to which all persons are invited.

DATE AND TIME: June 11, 2010, 10:00 a.m. – 12:00 Noon

PLACE: Clay County Agricultural Center, 2463 SR 16 W. Green Cove Springs, FL 32043

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to provide stakeholders and all interested parties with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. During the meetings, the following items will be discussed: legislation passed during the 2010 Florida Legislative Session which impacts the waiver, overview of the existing waiver and description of the draft extension request. There will be an opportunity for public comment at the meetings.

A copy of the agenda may be obtained by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Baker County: June 11, 2010

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration, Medicaid announces a public meeting to which all persons are invited.

DATE AND TIME: June 11, 2010, 2:00 p.m. – 4:00 p.m.

PLACE: Baker County Health Department, 480 W. Lowder Street, McClenny, FL 32063

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to provide stakeholders and all interested parties with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. During the meetings, the following items will be discussed: legislation passed during the 2010 Florida Legislative Session which impacts the waiver, overview of the existing waiver and description of the draft extension request. There will be an opportunity for public comment at the meetings.

A copy of the agenda may be obtained by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan Drive, MS #50, Tallahassee, FL 32308, (850)412-4031, email: Linda.Macdonald@ahca.myflorida.com.

Attachment A.5
Emails to Interested Parties Announcing Public Meetings

May 17, 2010

Medicaid Reform

From: Medicaid Reform
Sent: Monday, May 17, 2010 4:34 PM
Subject: Medicaid Public Meeting Announcement

Dear Interested Parties,

The Agency for Health Care Administration announces a meeting to which all individuals are invited.

DATE AND TIME: May 21, 2010 from 1:00p.m. – 3:30p.m.

PLACE: Agency for Health Care Administration
Conference Room C and D
2727 Mahan Drive, Building 3
Tallahassee, FL 32308

Those not able to attend in person may participate via conference phone by calling 1(888) 808-6959 and entering Conference Code 9227320.

GENERAL SUBJECT MATTER TO BE CONSIDERED:
This public meeting is being held to provide stakeholders with the opportunity to provide input on the extension request for Florida's 1115 Research and Demonstration Waiver. The following items will be discussed: overview of the existing waiver, the legislation passed during the 2010 Florida Legislative Session which impacts the waiver, and description of the draft extension request. There will be an opportunity for public comment at the meeting.

CONTACT: Ms. Linda Macdonald
Bureau of Health Systems Development
2727 Mahan Drive, Mail Stop #50
Tallahassee, FL 32308
Office Phone: (850) 412-4031
Email: Linda.Macdonald@ahca.myflorida.com

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting Linda Macdonald, at the address and phone number written above. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice). For more information, you may contact Linda Macdonald, at the address and phone number written above.

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May 21, 2010

Medicaid Reform

From: Medicaid Reform
Sent: Friday, May 21, 2010 3:59 PM
Subject: PUBLIC MEETINGS ANNOUNCEMENT: FL 1115 Research & Demonstration Waiver

Dear Interested Parties,

On April 30, 2010, the Florida Legislature passed Senate Bill 1484. Within this bill, the Florida Legislature directed the Agency to seek approval of a 3 year waiver extension in order to continue operation of the 1115 waiver in Baker, Broward, Clay, Duval and Nassau Counties. The Agency was directed to submit the extension request by no later than July 1, 2010.

Although the Governor has not yet signed this bill into law (and has until May 28th to take final action), the Agency has moved forward as quickly as possible to schedule public meetings regarding the required extension application.

The Agency will hold a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver (Medicaid Reform) as authorized by the Florida Legislature. The agenda items for the public meetings will include: an overview of the existing waiver, legislation passed during the 2010 Florida Legislative Session which impacts the waiver, and description of the draft extension request. There will be an opportunity for public comment during the meetings. The location, date and time for upcoming public meetings are listed below. In addition, the Agency will be accepting written comments on the draft extension request. Comments may be submitted to the Agency via mail or email (see below).

Schedule of Public Meetings

Location	Date	Time
The Arc Jacksonville 1050 North Davis Street Jacksonville , FL 32209	June 8, 2010	1:00 p.m. - 3:00 p.m.
Broward County Health Department Main Auditorium 780 SW 24 Street Fort Lauderdale, FL 33315	June 9, 2010	10:00 a.m. - 12:00 p.m.
Nassau County Children and Family Education Center 86207 (479) Felmor Road Yulee, FL 32097	June 10, 2010	2:00 p.m. - 4:00 p.m.
Clay County Agricultural Center 2463 SR 16 W	June 11, 2010	10:00 a.m. - 12:00 p.m.

1

Green Cove Springs, FL 32043

Baker County Health Department June 11, 2010 2:00 p.m. - 4:00 p.m.
480 W. Lowder Street
McClenny, FL 32063

Schedule of Agency (Public) Meetings

Meeting	Location	Date	Time
Low Income Pool Council	Tallahassee, FL (AHCA)	Monday, May 24, 2010	1:00 p.m. - 3:00 p.m.
Technical Advisory Panel	Tallahassee, FL (AHCA)	Wednesday, June 2, 2010	10:00 a.m. - 12:00 p.m.

More information is available at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Please mail comments and suggestions to:
1115 Medicaid Reform Waiver
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
You may also email your comments and suggestions to:
medicaidreform@ahca.myflorida.com

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting Linda Macdonald, at the address and phone number written below. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information CONTACT: Ms. Linda Macdonald, Bureau of Health Systems Development, 2727 Mahan, Drive, Mail Stop #50, Tallahassee, FL 32308, Office Phone: (850)412-4031, Email: Linda.Macdonald@ahca.myflorida.com

Attachment A.6
Agency Media Advisory

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

THOMAS W. ARNOLD
SECRETARY

MEDIA ADVISORY

FOR IMMEDIATE RELEASE
May 17, 2010

Contact: Tiffany Vause, Press Secretary
Tiffany.Vause@ahca.myflorida.com, 850-412-3623

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION TO HOLD PUBLIC MEETINGS ON MEDICAID MANAGED CARE PILOT PROGRAM

~Florida Medicaid will take input from stakeholders on Florida's Managed Care Pilot Program~

TALLAHASSEE – The Florida Agency for Health Care Administration (Agency) will hold a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver (Managed Care Pilot). The Florida Managed Care Pilot is a program in Baker, Broward, Clay, Duval and Nassau Counties that seeks to improve the services provided to Medicaid recipients through mandatory participation in managed care plans for specific populations. The program began in 2005, and as of May 1, 2010, 260,394 Floridians are enrolled in the Florida Managed Care Pilot.

During the recent legislative session, the Florida Legislature passed language that authorized the Agency to submit an extension request to the federal Centers for Medicare and Medicaid Services (CMS) for the Managed Care Pilot. The extension request will ask CMS to allow Florida to continue the Waiver program until 2014. Currently, the program is set to expire on June 30, 2011.

"It is important that everyone has the opportunity to understand what our agency has been asked to do," said Secretary Thomas W. Arnold. "We encourage stakeholders to attend, learn more and offer input about the Managed Care Pilot and its next steps."

The agenda for each public meeting will include a presentation of legislation passed during the 2010 Florida Legislative Session impacting Florida's Managed Care Pilot, an overview of the program as it currently exists and a description of the proposed extension request. The Agency will then take public comment.

The Florida Managed Care Pilot Extension Request meetings will take place:

Friday, May 21, 2010
1:00 p.m.
Agency for Health Care Administration Headquarters
2727 Mahan Drive, Building 3, Conference Room A
Tallahassee

Tuesday, June 8, 2010
1:00 p.m.
Duval County

2727 Mahan Drive, MS#1
Tallahassee, Florida 32308

Visit AHCA online at
AHCA.MyFlorida.com

Wednesday, June 9, 2010
10:00 a.m.
Broward County

Dates, times and locations for meetings in Baker, Broward, Clay, Duval and Nassau Counties will be posted on the Agency's Web site, AHCA.MyFlorida.com, under Public Meeting Notices and in the Florida Administrative Weekly as soon as they are available.

The Agency will also add the Florida Managed Care Pilot Extension Request to the agendas of the Medicaid Medical Care Advisory Committee meeting on May 18, 2010, the Low Income Pool Council meeting on May 24, 2010, and the Medicaid Technical Advisory Panel meeting on June 2, 2010. If Floridians would like to submit comments, but cannot attend one of the meetings, they may submit them to the Agency via email at MedicaidReform@ahca.myflorida.com.

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The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 41,000 health care facilities and 43 health maintenance organizations, and publishes health care data and statistics on FloridaHealthFinder.gov. For more information, please visit AHCA.MyFlorida.com.

Attachment A.7
Published Articles

Capital Soup Article Posted May 17, 2010

Florida Agency For Health Care Administration To Hold Public Meetings On Medicaid Managed Care Pilot Program

May 17, 2010 Government 1 Comment

~Florida Medicaid will take input from stakeholders on Florida's Managed Care Pilot Program~

TALLAHASSEE – The Florida Agency for Health Care Administration (Agency) will hold a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver (Managed Care Pilot). The Florida Managed Care Pilot is a program in Baker, Broward, Clay, Duval and Nassau Counties that seeks to improve the services provided to Medicaid recipients through mandatory participation in managed care plans for specific populations. The program began in 2005, and as of May 1, 2010, 260,394 Floridians are enrolled in the Florida Managed Care Pilot.

During the recent legislative session, the Florida Legislature passed language that authorized the Agency to submit an extension request to the federal Centers for Medicare and Medicaid Services (CMS) for the Managed Care Pilot. The extension request will ask CMS to allow Florida to continue the Waiver program until 2014. Currently, the program is set to expire on June 30, 2011.

"It is important that everyone has the opportunity to understand what our agency has been asked to do," said Secretary Thomas W. Arnold. "We encourage stakeholders to attend, learn more and offer input about the Managed Care Pilot and its next steps."

The agenda for each public meeting will include a presentation of legislation passed during the 2010 Florida Legislative Session impacting Florida's Managed Care Pilot, an overview of the program as it currently exists and a description of the proposed extension request. The Agency will then take public comment.

The Florida Managed Care Pilot Extension Request meetings will take place:

Friday, May 21, 2010
1:00 p.m.
Agency for Health Care Administration Headquarters
2727 Mahan Drive, Building 3, Conference Room A
Tallahassee

Tuesday, June 8, 2010
1:00 p.m.
Duval County

Wednesday, June 9, 2010
10:00 a.m.
Broward County

Dates, times and locations for meetings in Baker, Broward, Clay, Duval and Nassau Counties will be posted on the Agency's Web site, AHCA.MyFlorida.com, under Public Meeting Notices and in the Florida Administrative Weekly as soon as they are available.

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Contact: Tiffany Vause, Press Secretary
Tiffany.Vause@ahca.myflorida.com, 850-412-3623

WCTV Article_Posted May 17, 2010

Florida Agency for Health Care Administration To Hold Public Meetings On Medicaid Managed Care Pilot Program
Florida Medicaid will take input from stakeholders on Florida's Managed Care Pilot Program.
Posted: 2:52 PM May 17, 2010
Reporter: Press Release
Email Address: **news@wctv.tv**

Florida Agency for Health Care Administration Press Release:

TALLAHASSEE –

The Florida Agency for Health Care Administration (Agency) will hold a series of public meetings to solicit public input on the extension of Florida's 1115 Research and Demonstration Waiver (Managed Care Pilot). The Florida Managed Care Pilot is a program in Baker, Broward, Clay, Duval and Nassau Counties that seeks to improve the services provided to Medicaid recipients through mandatory participation in managed care plans for specific populations. The program began in 2005, and as of May 1, 2010, 260,394 Floridians are enrolled in the Florida Managed Care Pilot.

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Christine Jordan Sexton Article May 19, 2010

Have something to say about Medicaid Reform?

Christine Jordan Sexton, 05/19/2010 - 11:54 AM

Agency for Health Care Administration Secretary Tom Arnold knows people have a lot to say about Medicaid Reform; and he is looking for input.

The state has established an email address -- MedicaidReform@ahca.myflorida.com -- so people can submit comments on Florida's Medicaid Reform experiment in five Florida counties. The announcement was made at a Medical Care Advisory Committee meeting in Tallahassee on Tuesday.

The committee is required by federal law and it meets several times throughout the year. This week's meeting provided Arnold and **Deputy Secretary for Medicaid Roberta Bradford**, to have a soft debut of presentations they will be making on Friday at a two and a half hour public meeting on Florida's Medicaid 1115 waiver.

Bradford's 52 page powerpoint will also be used at the upcoming meeting on Friday. A dedicated webpage also has been established where the state has listed all its information on the Medicaid Reform experiment, from the waiver itself to quarterly reports to the Low Income Pool.

The Agency for Health Care Administration was authorized to seek an extension of its Medicaid 1115 waiver during the 2010 session. AHCA wasn't empowered to amend the waiver or alter the program. Arnold said at Tuesday's meeting, though, that the state could make "operational changes" to improve the program which wouldn't require federal approval. Operational changes would be accomplished at the state level

In addition to collecting written comment the state has scheduled a series of public meetings in Tallahassee and in the counties that participate in the Medicaid Reform pilot--Nassau, Baker, Clay, Duval, Broward, for The state is seeking public input on Medicaid Reform, a requirement it must meet to have the waiver extended.

Other requirements that must be included in Florida's request for a waiver extension include It is a requirement that the state must meet before submitting its request to extend its Medicaid 1115 waiver. AHCA also must include in its request documentation of several items including how it met the objectives of the initial demonstration project and the satisfaction of beneficiaries.

Health News Fla Jim Saunders Article Posted May 20, 2010

Medicaid pilot hearings begin

By Jim Saunders
5/20/2010 © Health News Florida

A massive overhaul of Florida's Medicaid system is on the shelf --- at least for now. But get ready for three more years of debates over the pilot managed-care program that former Gov. Jeb Bush left behind, with hearings starting Friday.

The state Agency for Health Care Administration will hold the hearings as a prelude to filing a request with the federal government to continue the controversial program. It currently requires about 260,000 Medicaid recipients in five counties to get care through HMOs or provider-service networks.

AHCA Secretary Tom Arnold said the state won't seek to make changes in the program's original outline, created through a waiver of federal Medicaid rules. But he said he hopes the hearings will offer information on how the program is working.

"I think it's important to get out and ask the people directly, 'What can we do better?' " Arnold said this week.

But critics of the pilot, such as Greg Mellowe of the advocacy group Florida CHAIN, aren't sure the process of extending the waiver will be so benign. Mellowe said he doesn't rule out the possibility that AHCA will try to make substantive changes in the program.

As federal and state officials discuss an extension in the coming months, he said, it will be important for the federal government to consider issues and viewpoints beyond those of AHCA.

If not, he said, "then nothing that stakeholders say, at these hearings or otherwise, will matter.

"And based on AHCA`s track record, these hearings are nothing more than an attempt to say that they heard from the public, in the hopes that the feds will simply check off some 'public participation' box on the review checklist," Mellowe said in an e-mail Wednesday.

State lawmakers spent much of this spring's legislative session debating possible ways to overhaul the Medicaid system, primarily by moving more beneficiaries into managed-care plans. But the House and Senate did not agree on a plan and, in the end, passed a bill directing AHCA to start the process of seeking an extension of the pilot program. It now operates in Broward, Duval, Baker, Clay and Nassau counties.

AHCA faces a July 1 deadline for submitting an application to the federal government. The original waiver for the program, which was a top priority of Bush, expires June 30, 2011.

Even if the details of the waiver do not change, the extension process has high stakes. Arnold said, for example, the waiver already allows an expansion of the pilot program to other counties --- which could bolster efforts by future legislative leaders to increase the use of managed care in the Medicaid system.

Also, a waiver extension is critical to many hospitals because it includes the "Low Income Pool," about $1 billion a year in extra funds to care for the uninsured patients.

Tony Carvalho, president of the Safety Net Hospital Alliance of Florida, said it would be "devastating" if the Low Income Pool funding ended. While hospitals likely would be able to tap into another program, known as the Upper Payment Limit, Carvalho said it is widely believed they would end up with less money than they receive through the Low Income Pool.

"Is it (the Low Income Pool) important? Yeah. It's a billion dollars for the state,'' Carvalho said.

But the extension --- and any future requirements that more Medicaid beneficiaries enroll in managed-care plans --- will run into criticism. Some advocacy groups have long feared that patients tend to suffer in a managed-care system because HMOs will squeeze benefits to save money.

Also, they argue that beneficiaries in Broward and Duval faced upheaval when HMOs pulled out of the pilot program, forcing people to look for other health plans.

"Our biggest concern is that AHCA will continue to act as if the multitude of problems with the current pilot don`t even exist, let alone have been resolved,'' said Mellowe, the policy director for Florida CHAIN. "We believe that there are reasons to consider extending the waiver, but to do so without fixing the problems is far too risky, especially since expansion would bring those same unresolved problems to the rest of the state.'' But supporters of requiring Medicaid patients to enroll in managed care contend that it helps hold down costs in the $19 billion program. Also, they say it helps combat fraud, which is particularly rampant in South Florida.

The waiver extension would allow the pilot program to continue running until 2014. If necessary, the state could ask for another three-year extension after that, continuing the program until 2017.

The first public hearing will be at 1 p.m. Friday at AHCA headquarters in Tallahassee. That will be followed by a hearing at 1 p.m. June 8 in Duval County and at 10 a.m. June 9 in Broward County.

The locations of the Duval and Broward hearings, along with details of hearings in Baker, Clay and Nassau counties, were not available this week.

As of last month, about 170,000 people in the five counties were enrolled in HMOs as part of the pilot program. An additional 90,000 were enrolled in provider-service networks.

--Capital Bureau Chief Jim Saunders can be reached at 850-228-0963 or by e-mail at jim.saunders@healthnewsflorida.org.

Alliance for Pediatric Therapies Article June 2, 2010

State agency holds Medicaid Reform hearings
The state Agency for Health Care Administration (AHCA) is holding several hearings across the state about the future of the five-county Medicaid Reform pilot program.

The first hearing was held in Tallahassee on May 14 (read about it here). The next one is scheduled for June 8 in Jacksonville. Click here to see the full schedule.

The Medicaid Reform pilot program has been underway since 2006 in Broward, Duval, Baker, Clay and Nassau counties. It was an initiative of former Gov. Jeb Bush and was approved by the federal Centers for Medicare and Medicaid Services (CMS) under the administration of his brother, President George Bush.

CMS gave Florida permission, in the form of a federal "waiver," to move forward with its Medicaid Reform experiment through June 30, 2011.

Under the waiver, Florida must tell CMS by June 30 what it plans to do with the pilot program.

The Florida Legislature voted, in SB 1484, to ask the federal government to extend the waiver beyond 2011. In preparation, AHCA is seeking public comment on how the program has worked.

Results have been inconclusive as to whether it has saved money. Studies have certainly shown that the program has not improved access to health care.

Medicaid Reform is different than the traditional Medicaid program. It allows HMOs and provider service networks to enroll Medicaid-eligible Floridians and offer their own package of benefits. That means that the Reform health plans do not have to abide by state Medicaid guidelines in terms of the amount, duration and scope of services, including pediatric therapies.

The Florida Current June 7, 2010

THE WEEK AHEAD
JUNE 7-JUNE 11, 2010

FIGURING OUT THE DAMAGE…Gov. Charlie Crist has finished up most of the work from the 2010 session so the focus this week will likely be on the ongoing oil spill and the damage it is causing on Florida beaches. Crist starts out Monday in Pinellas County where he will tour the beach and visit businesses there. The only other question is whether there will be additional fallout this week from the arrest of former Republican Party of Florida chairman Jim Greer.

Monday, June 7

INVESTMENT ADVISORY COUNCIL…The quarterly meeting of the board that reviews investments of the state pension plan will be held Monday at 10 a.m. in the Hermitage Centre, 1801 Hermitage Blvd. in Tallahassee.

OIL SPILL ROUNDTABLE…Gov. Charlie Crist will participate in a roundtable with local hospitality and business leaders at 11 a.m. at the Tradewinds Resort in St. Petersburg Beach. Crist will tour the beach following the roundtable.

Tuesday, June 8

CABINET... Gov. Charlie Crist and members of the Cabinet will meet at 9 a.m. in the Capitol and will take up several items, including rule proposals for several agencies and a request to pay nearly $1.66 million for a conservation easement on 343 acres located in St. Johns County. The Cabinet will also be given a briefing on the Deepwater Horizon oil spill.

STATE BOARD OF ADMINISTRATION….The trustees of the board that oversees Florida's pension plan – Gov. Charlie Crist, Chief Financial Officer Alex Sink and Attorney General Bill McCollum – will hold their quarterly meeting at 1 p.m. in the Capitol for their quarterly meeting to go over investment performance reports, reports about other SBA functions including the Florida Hurricane Catastrophe Fund and a review of the pension fund business plan.

MEDICAID PILOT MEETING…The Agency for Health Care Administration will hold a public hearing in Jacksonville from 1 p.m. to 3 p.m. to take testimony on Florida's Medicaid reform pilot which the state wants to continue. The state must hold public hearings before it can request an extension from the federal government. The Jacksonville hearing will be held at The ARC Jacksonville, 1050 North Davis Street.

Wednesday, June 9

MEDICAID PILOT MEETING…The Agency for Health Care Administration will hold a public hearing in Fort Lauderdale from 10 a.m. to 12 p.m. to take testimony on Florida's Medicaid reform pilot which the state wants to continue. The state must hold public hearings before it can request an extension from the federal government. The Fort Lauderdale hearing will be held at the main auditorium of the Broward County Health Department, 780 SW 24 St. in Fort Lauderdale.

Thursday, June 10

PUBLIC SERVICE COMMISSION NOMINATING COUNCIL…The legislative panel responsible for nominating replacements for ousted PSC members David Klement and Ben "Steve" Stevens will meet at 9 a.m. at the Orlando International Airport in Orlando.

The council is scheduled to conduct interviews from 28 finalists previously selected and nominate 3 people for each vacancy.

CONFLICT COUNSEL…The Florida Supreme Court will hold oral arguments at 9 a.m. in the case where 26 counties and the Florida Association of Counties sued over the creation of the Offices of Criminal Conflict and Civil Regional counsel because state lawmakers made the counties responsible for certain costs including the cost to build or lease offices for the conflict counsels. Lower courts have ruled in that it was unconstitutional for the Legislature to impose those costs on counties.

SUPREME COURT…The Florida Supreme Court releases its weekly rulings on Thursday at 11 a.m.

MEDICAID PILOT MEETING…The Agency for Health Care Administration will hold a public hearing in Yulee from 2 p.m. to 4 p.m. to take testimony on Florida's Medicaid reform pilot which the state wants to continue. The state must hold public hearings before it can request an extension from the federal government. The Yulee hearing will be held at the Nassau County Children and Family Education Center 86207 Felmor Road.

Friday, June 11

MEDICAID PILOT MEETING…The Agency for Health Care Administration will hold a public hearing in Green Cove Springs from 10 a.m. 12 p.m. to take testimony on Florida's Medicaid reform pilot which the state wants to continue. The state must hold public hearings before it can request an extension from the federal government. The Green Cove Springs hearing will be held at the Clay County Agricultural Center, 2643 SR 16 W.

MEDICAID PILOT MEETING…The Agency for Health Care Administration will hold a public hearing in Macclenny from 2 p.m. to 4 p.m. to take testimony on Florida's Medicaid reform pilot which the state wants to continue. The state must hold public hearings before it can request an extension from the federal government. The Macclenny hearing will be held at the Baker County Health Department, 480 W. Lowder Street.

The Florida Times-Union Jacksonvile.com Article Posted June 8, 2010

Medicaid reform panel hears clashing opinions
Some think the pilot program works, others see erratic service.
Posted: June 8, 2010 - 5:27pm
Public input
Medicaid reform public input meetings.
When: 2-4 p.m. Thursday
Where: Nassau County Children and Family Education Center, 86207 Felmor Road, Yulee
When: 10 a.m.-noon Friday
Where: Clay County Agricultural Center, 2463 Florida 16 West, Green Cove Springs
When: 2-4 p.m. Friday
Where: Baker County Health Department, 480 West Lowder St., Macclenny
By Jeremy Cox
Two disparate depictions of Northeast Florida's Medicaid reform experiment emerged Tuesday at a public meeting in Jacksonville.

Officials with the Florida Agency for Health Care Administration described the program as a promising work-in-progress. They said it gives consumers a chance to pick a plan that suits them best, shows signs of saving the state money and scores highly in recipient surveys.

Two of the three people who spoke publicly at Tuesday's meeting offered a more critical assessment. They said the program has helped make profits for managed-care companies while limiting services to vulnerable children and poor adults.

The allegations suggested that although state lawmakers are seeking to extend Medicaid reform's life on the First Coast, the pilot continues to rankle many physicians and patient advocates.

"Before you expand to other areas, let's fix some of the challenges we have in the five current counties," said Veronica Valentine, CEO of the Child Guidance Center, a mental-health clinic with several Jacksonville-area locations.

Facing a $3 billion budget shortfall, lawmakers last session considered two proposals to expand the 4-year-old reform experiment beyond Baker, Broward, Clay, Duval and Nassau counties. Unable to reconcile the bills, they settled on asking the federal government to extend the current program until 2014.

Medicaid reform essentially privatizes the state and federal insurance program for the poor. It places recipients into private managed-care plans of their choice and offers them credits for healthy behaviors that can be cashed in for certain health products at drug stores.

"The objective was to mirror more the commercial sector," said Roberta Bradford, the state's deputy secretary for Medicaid.

The state must turn in an application by June 30 or risk losing $1 billion in federal funding to help finance health-care for the poor. In the meantime, AHCA officials are traveling the state seeking public input on the program.

Tuesday's meeting in Jacksonville was their first stop in a reform county.

Greg Mellowe of the patients' advocacy group Florida CHAIN criticized Medicaid reform for allowing insurers to drop in and out of the program as they please, creating confusion among recipients. Bradford said the state has responded by extending the amount of notice they must give the state from 90 to 120 days.

Valentine said the experiment has been a headache. Because children may belong to one of 11 plans, her staff often scrambles to make sure they are following each policy's specific guidelines.

What's more, she said, carriers in the pilot program counties don't have to adhere to a Medicaid rule that requires the state to spend at least 80 percent of the premiums they collect on medical and mental health services. As a result, they deny needed services and pocket the savings, Valentine said.

Bradford said AHCA is implementing the program as the Legislature intended, and the statute behind Medicaid reform doesn't set any medical-loss ratios, as the medical reimbursement requirement is known.

She added that the state doesn't expect Medicaid reform to be affected by the new federal reform law, which requires private insurers to have ratios no lower than 80 percent in small and individual groups and 85 percent in large groups.

Unless the Department of Health and Human Services expands the definition of the types of impacted plans, those percentages won't apply to Medicaid programs, Bradford said.

jeremy.cox@jacksonville.com, (904) 359-4083

The Florida Times-Union Jacksonville.com Jeremy Cox June 8, 2010

Health Caring: State wants feedback on First Coast's Medicaid reform experiment
Submitted by Jeremy Cox on June 8, 2010 - 11:13am Health Caring
A short-on-time Florida Legislature didn't expand Northeast Florida's Medicaid reform pilot statewide, but lawmakers did manage to keep the program alive.

They did so by passing a bill directing the Florida Agency for Health Care Administration to ask the federal government to grant the experiment a three-year extension.

Federal approval ensures that Medicaid recipients in Baker, Clay, Duval and Nassau counties maintain their privately run plans. Those in South Florida's Broward County, which also is in the program, would stay put as well.

The extension would also keep in play the $1 billion the state gets every year to subsidize hospital care for the poor.

But first, state officials want to hear what you have to say. To that end, a handful of public meetings are scheduled on the matter, starting today.

Here are the details:

- When: Today, 1-3 p.m.
- Where: The Arc Jacksonville
- 1050 North Davis St., Jacksonville

- When: Thursday, 2-4 p.m.
- Where: Nassau County Children and Family Education Center
- 86207 Felmor Road, Yulee

- When: Friday, 10 a.m.-noon
- Where: Clay County Agricultural Center
- 2463 Florida 16 West, Green Cove Springs

- When: Friday, 2-4 p.m.
- Where: Baker County Health Department

480 West Lowder St., Macclenny

Attachment A.8
Summary of the Advisory Committee Meetings

Medical Care Advisory Committee Meeting Summary

Meeting Date: May 18, 2010

Meeting Location: The Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida

AHCA Presenters
Roberta K. Bradford, Deputy Secretary of Florida Medicaid
Chris Osterlund, Assistant Deputy Secretary of Medicaid Operations
Damon Rich, AHC, Administrator, Medicaid Contract Management

Committee Members Present:
Marcy Hajdukiewicz, representing, E. Douglas Beach, Ph.D.,
Dr. Joseph Chiaro, representing Dr. Ana Viamonte Ros, M.D.,
Ms. Jennifer Lange, representing Mr. George Sheldon,
Dr. Robert Payne, DDS,
Dr. Richard R. Thacker, D.O.,
Dr. Catherine Moffitt, M.D., F.A.A.P.,
Mr. Paul Belcher (by phone),
Ms. Amy Guinan,
Ms. Martha Pierce

Presentation Materials
The agenda and presentation materials can be viewed by clicking on the following link:

http://ahca.myflorida.com/Medicaid/mcac/index.shtml

Committee Member Comments on Public Process and Extension Request
The members offered no specific suggestions on the public process the Agency described during the presentation regarding the extension request. The Agency asked the members to send any comments on the public process and/or the extension request to the following Agency mailbox.

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Low Income Pool (LIP) Meeting Summary

Meeting Date: May 24, 2010

Type of Meeting: Conference Call with some members attending in person

Meeting Location: The Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida

LIP Members On Call
Alicia Watson for Dee Schaeffer
William Robinson
Steve Short
Bill Little
Stephen Purves
Lewis Seifert
Michael Gingras
Kevin Kearns
Clark Scott
Charlotte Mather
Gwendolyn MacKenzie
Dr. Joseph J. Tepas, III
Dave Ross
Mike Hutchins
Steve Harr
Dwight Chenette
Mike Marks

LIP Members Present
Phil Williams, LIP Chairman
John Benz

AHCA Staff and Presenters
Tom Arnold
Michele Hudson
Lecia Behenna
Bill Perry
Ryan Perry
Tiffany Vause

Members Absent
Dr. Eneida Roldan
Charles Colvert
Steve Mason
Hugh Greene
Dr. Mark Mckenney

Presentation Materials
The agenda and presentation materials can be viewed by clicking on the following link:

http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/upcoming_meetings.shtml

Summary of Member Comments on Pubic Process:
The Council offered no specific suggestions on the public process described during the presentation. The Council did express concern that the Agency request additional Low Income Pool funding in the waiver extension request. The Agency asked that Council members send any comments on the public process and/or the extension request to the following Agency mailbox.

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Technical Advisory Panel (TAP) Meeting Summary

Meeting Date: June 2, 2010

Meeting Location: The Agency for Health Care Administration, 2727 Mahan, Tallahassee, Florida

AHCA Presenters
Roberta K. Bradford, Deputy Secretary of Florida Medicaid
Chris Osterlund, Assistant Deputy Secretary of Medicaid Operations
Phil Williams, Assistant Deputy Secretary of Medicaid Finance
Michele Hudson, Bureau Chief of Medicaid Program Analysis
Susan Whitmire, Bureau Chief of Medicaid Quality Management
Damon Rich, AHC, Administrator, Medicaid Contract Management
Peggy Claborn, AHC Administrator, Medicaid Bureau Quality Management
Dr. Paul Duncan, Director of the University of Florida's Department of Health Services Research, Management and Policy

TAP Members Present:
Joe Rogers, North Broward Hospital District, TAP Chairman
John Kaelin, Vice President of Americhoice Corporation
David Pollack, President of Molina Healthcare of Florida
Richard Tan, Representative of Florida Office of Insurance Regulation
Michael Lawton, Representative of Provider Service Networks
John Benz, Representative of Provider Service Networks

Presentation Materials
The agenda and presentation materials can be viewed by clicking on the following link:

http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/meetings.shtml

Member Comments on Public Process and Extension Request
The members offered no specific suggestions on the public process the Agency described during the presentation or the extension request. The Agency asked TAP members to send any comments on the public process and/or the extension request to the following Agency mailbox.

http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

Attachment A.9
May 21 Public Meeting Summary

AHCA Presenters

Roberta K. Bradford, Deputy Secretary of Florida Medicaid
Chris Osterlund, Assistance Deputy Secretary of Medicaid Operations
Damon Rich, AHC, Administrator of Choice Counseling Program

Sign Language Interpreters: Carol Ross and Valeria Bradley

Number of Attendees at Meeting: 60
Number of Conference Call Attendees: 44
Number of Speakers for Public Input: 6

Meeting Highlights

Presenter*: Roberta Bradford, Deputy Secretary for Florida Medicaid*

- Welcomed individuals attending the public meeting in person and by conference call. Explained to attendees participating by conference call that today's presentation could be accessed by visiting the Agency for Health Care Administration's website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml. Attendees were also informed that the website includes the following information:
    - A schedule of the upcoming public meetings to be held in Duval, Broward, Baker, Clay and Nassau counties.
    - The email and mailing address to submit written comments on the extension request. Attendees were also encouraged to fill out the comment form provided to them as they entered the meeting room.
- Provided an overview of the 2010 Legislation impacting the waiver and a description of the waiver extension request. Key items included:
    - Florida Legislature directed the Agency in SB 1484 to request an extension of the 1115 waiver. The Governor has not yet signed the bill into law (and has until May 28, 2010 to take final action).
    - The Agency was not authorized to amend the waiver.
    - An extension would maintain the program in the current geographic areas of operation (Baker, Clay, Nassau, Duval, and Broward Counties).
    - An expansion into new geographic areas or any other substantial change would require Legislative authority.
    - Experience to date shows that operational changes can be made within the framework of the approved waiver in response to public input.
    - These public forums will continue that dialog with the public and provide new opportunities to improve the program.

- The Agency does not have authority to act on public comments received that require legislative direction or statutory authority.
- The federal requirements specify that Florida is responsible for reviewing, complying and adhering to all timeframes and reporting requirements specified in Section 1115(e) of Social Security Act. In addition, Florida must submit documentation of: How the program objectives were met; compliance with special terms and conditions of the waiver, summary of beneficiary satisfaction and quality, compliance with budget neutrality cap, and pubic process used to obtain stakeholder input.
- The extension request is scheduled to be submitted to the federal Centers for Medicare and Medicaid Services (federal CMS) by June 30, 2010.
- The extension request does not change the Low Income Pool (LIP). The Agency will request that the federal CMS authorize the current LIP funding level of $1 billion a year.

Presenters: *Chris Osterlund, Assistance Deputy Secretary of Medicaid Operations and Damon Rich, AHC, Administrator of Choice Counseling Program*

- Provided an overview of the existing 1115 waiver. Key items included:
  - Review of key elements of the waiver such as LIP, Outreach efforts, Delivery Systems, new choice options (number and type of health plans and customized benefit packages), financing, and choice counseling.
  - Review of Medicaid Reform goals: increased access to health care services, increased choice of plans and services, opportunity for beneficiaries to take a more active role in health care decisions, reduce the administrative complexities of managing the Florida Medicaid Program, and slow the rate of Medicaid expenditures.
  - Review of the LIP program: implemented July 1, 2006; LIP funded primarily through intergovernmental transfers of $1 billion a year for a total not to exceed $5 billion in five years, LIP payments made to qualifying provider access systems (hospitals, federally qualified health centers and county health departments), with the goal to ensure support for the provision of health care services to Medicaid, underinsured and uninsured populations.
  - LIP program is only available through the 1115 Reform Waiver. If LIP is not continued, non-hospital based providers would not be eligible for payments.
  - The Agency will request that federal CMS continue the current level of funding of $1 billion a year in LIP funds. However federal CMS may adjust the funding level.
  - Review of marketplace changes, plan benefit design, enhanced benefit account program, risk adjusted health plan rates, health plan encounter data, the opt out program, choice counseling program, evaluation of waiver and performance.

Public Input

Speakers:

Ms. Anne Swerlick, Florida Legal Services, Inc.
Ms. Karen A. Koch, Florida Council for Community Mental Health, Inc.
Mr. Aaron Nagle, waiverprovider.com
Ms. Margaret J. Hooper, Florida Developmental Disabilities Council
Ms. Suzanne Sewell, Florida Association of Rehabilitation Facilities
Mr. Paul Belcher, Florida Hospital Association

Summary of Public Comments

Florida Legal Services:

- Requested the waiver extension documents be posted on the Agency's website.
- Requested documents and reports on the current status of the waiver including the external quality review organization be posted on the Agency's website.
- Recommended the questions and comments received from the Centers for Medicare and Medicaid Services regarding the extension request be posted on the Agency's website on the same page as the schedule of public meetings.
- Expressed appreciation that in the presentation the Agency commented on having limited authority to make changes to the program and that changes would be more operational.
- Noted that feedback received from beneficiaries regarding problems with network of providers, and prior authorization of prescription drugs. Beneficiaries have expressed the need to be able to stay with their provider and maintain the treatment regiment and prescription drugs. These concerns are practically important for people with severe disabilities and illnesses.
- Plan prior authorization procedures, plan network insufficiency, instability of the network, and plan churning are disrupted to continuity of care and continue to be of concern. Appreciated the steps the agency has taken to address these issues but noted there is room for improvement. Stated she would be happy to further talk with Agency officials about these issues.
- Flexible benefit packages are confusing and overwhelming to our clients. Recommended a uniform benefit package that is developed at the state level but acknowledge this may be not be possible in the extension.
- Concern about health plans being given continued flexibility around the benefit package and amount duration in its scope. And wanted to know if the sufficiency levels and annual benefit cap be changed? Urged the use of a public process around flexible benefit packages and some way to alert beneficiaries of changes to benefits.
- Strongly felt the Centers for Medicare and Medicaid Services may note the GAO study concerns with the opt out provision and the provision that beneficiaries only have access to emergency services until they choice a plan. Acknowledged that this

provision has never been implemented by the Agency. Strongly supports this provision not being implemented and to take it out of the extension request.

- Expressed interest in continuing a dialog with the Agency about the waiver and figuring out how the program can be more responsive to beneficiary needs.

Florida Council for Community Mental Health, Inc.:

- Noted that comments provided today by the Florida Council relate to persons with severe mental illness and the safety net providers that provide care and may not be unique across all the other providers in reform.
- Stated the demonstration created a logistical nightmare for persons with severe mental illness and for the providers of that care due to the number of providers and plans in the area.
- Stated safety net providers need to enroll in all the plans to properly serve your population. This creates a nightmare in terms of trying to figure out who is serving who, when, who to bill, and whether to get a new authorization when a person changes a plan.
- Stated there was a lack of coordination of behavioral health care since almost all the plans carve out their behavior health care. Providers are having difficulty getting paid due to plan transitions combined with the 90 day disenrollment without cause provision.
- Prior authorization requirements and plan changes to formularies is still an ongoing problem. Acknowledged the Agency has tried to address but plans still change formularies and authorization requirements before it gets on the Choice Counseling navigation system.
- Recommended implementing the 80/20 behavioral health provision. The Council believes this provision could be implemented without statutory authority. The Council believes not having the 80/20 provision in the demonstration has decreased care by anywhere from 40 to 50 percent.
- Suggested one prior authorization form and streamlining the forms. The decision of what is medically necessary for psychosocial rehabilitation services changes over plans, limitation change over plans. Some plans authorize 60 days some authorize 30 day and some don't have any as long as you stay under a certain percentage.

Mr. Aaron Nagle, waiverprovider.com:

- Concerned about making sure individuals with disabilities are taken care of.
- Noted 30 thousand plus individuals that get services through the Agency for Persons with Disabilities. Medicaid beneficiaries such as the developmentally disabled waiver consumers have less choice in selecting their providers; their case workers, support coordinators, and other providers.
- Expressed concern that providers will be eliminated since HMOs will have their own case managers and decide which new cheaper providers they can use. This will result in the quality and quantity of services decreasing because managed care providers have vested interest in cutting services to maximize their profits.

- HMOs and PPOs are based on medical models, not on special needs of the DD consumers. Over 15 thousand persons with disabilities will remain on the wait list.
- There will also be thousands of people that will likely lose their jobs once implemented since HMOs and PPNs would employ their own people disregarding many of the current providers.
- Felt the current system needs to be fixed and HMOs should not be coming in, cause my experience with HMOs is people who are very healthy like HMOs cause they can get things over the counter like twenty five dollars and over the counter medications. But people like chronically ill decide to switch back to Medipass so they get more choices of providers and they have more access to complete treatment. The HMO plan is not going to be a good thing for thousands of people in Florida, and I do hope they do away with that.

Florida Developmental Disabilities Council:

- The council wants to work with the Agency on the development of a specialty health plan that would serve person with developmental disabilities.
- Noted the original legislation did not include the developmental disabled until a plan was developed that would meet their needs.
- The Council has a project on managed care and the information may be helpful.
- The Council thinks it's a good idea to start developing the health plan based on outcomes and satisfaction. Then, we would be prepared in case legislation passed to include persons with developmental disabilities in the future.

Florida Association of Rehabilitation Facilities:

- The Association represents over 60 provider agencies across the state. The association is fully supportive of the reform pilot for traditional Medicaid services.
- Pleased that the Agency is keeping current operation and populations served.
- Recommended the intermediate care facility for the developmentally disabled program not be included in the pilot.
- The Association is concerned about moving from a home and community based service model to a medical model.
- Recommended the intermediate care facilities for developmental disabled continue under the Florida Agency for Persons with Disabilities.

Florida Hospital Association:

- The Association represents 160 members and supports the three-year extension of the waiver. Hospitals have benefited from the Low Income Pool Program.
- Noted the waiver had assisted hospitals in meeting the increased charity care burden as well as the Medicaid shortfall that occurs.
- Glad to see from in the PowerPoint presentation that the Federal CMS may consider changing the level of the Low Income Pool Program.
- Noted hearing that one state is considering requesting a growth factor in their program. Therefore, the Association requested the opportunity to discuss this issue

with the Agency further. Acknowledged budget neutrality issues may be have an effect on it.

- The Association really feels that the current economic conditions in Florida, the recession has had a significant impact on hospitals' ability to continue to provide services and that the original growth that was embedded in the program, has essentially been exhausted.

Attachment B
Number & Type of Plans Available Prior to Demonstration

Number and Type of Plans Available Prior to Demonstration

Prior to the implementation of Medicaid Reform, the Agency contracted with various managed care programs including: 8 HMOs, 1 PSN, 1 Pediatric Emergency Room Diversion Program, and 2 Minority Physician Networks (MPNs), for a total of 12 managed care programs in Broward County; and 2 HMOs and 1 MPN, for a total of 3 managed care programs in Duval County. The Pediatric Emergency Room Diversion Program and MPNs that operated in Broward and Duval Counties prior to implementation of the demonstration operated as prepaid ambulatory health plans offering enhanced medical case management services to beneficiaries enrolled in MediPass, Florida's primary care case management program. There were no health plans serving Baker, Clay, and Nassau populations prior to implementation of demonstration; there was one MPN serving those counties. There were no specialty plans serving children with chronic conditions or individuals living with HIV or AIDS prior to the demonstration.

Florida implemented Medicaid managed care in 1982, when the Palm Beach County Public Health Unit began operating Florida's first Medicaid managed care plan. In 1984, Florida was selected as one of five states to receive a grant from what is now the Centers for Medicare and Medicaid Services, formerly named the Health Care Financing Administration (HCFA), to implement a demonstration program. Between 1984 and 1990, eligible Medicaid recipients were provided the opportunity to enroll in Medicaid health maintenance organizations (HMO). Since Medicaid HMOs were not available statewide, many areas of the state were initially left uncovered. In response, Florida developed a primary care case management (PCCM) program known as MediPass as an alternative strategy to expand managed care throughout the state and to provide Medicaid recipients with another managed care option.

After the implementation of MediPass in 1990, Medicaid managed care evolved into a variety of programs, including managed care organizations (MCO), primary care case management programs, prepaid inpatient health plans (PIHP), and prepaid ambulatory health plans (PAHP). The chart below lists the programs by delivery system.

Delivery System	Program Name
MCO	Health Maintenance Organization (HMO)
	Frail / Elderly Program
	Exclusive Provider Organization (EPO)
PCCM	MediPass
	Children's Medical Services Network
PIHP	Provider Service Network (PSN)
	Prepaid Mental Health Plan (PMHP)
PAHP	Prepaid Dental Health Plan (PDHP)
	Minority Physicians Network (MPN)
	Pediatric Emergency Room Diversion Program

Prior to implementation of the demonstration, of the 2.2 million individuals eligible for Medicaid, 1.5 million were enrolled in one of the managed care programs. Of this number, over 700,000 individuals were enrolled in primary care case management (PCCM) programs paid on a fee-for-service basis. In an effort to better manage their care, individuals enrolled in MediPass may also be enrolled in other managed care programs. For example, an individual in MediPass may also be enrolled in the prepaid mental health program and the prepaid dental program. One goal of the demonstration waiver was to eliminate the fragmented system of carve outs by requiring all comprehensive health plans to cover all State Plan services.

Attachment C Budget Neutrality Templates

FY 1115 Budget Neutrality Templates

States would enter information in the shaded cells. The rest of the sheet will be calculated.

Historic Data: SFY 0809 and 6 Prior Years for Mandatory Populations

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	SFY 02-03	SFY 03-04	SFY 04-05	SFY 05-06	WOW AVERAGES
TOTAL EXPENDITURES					
MEG 1 - SSI RELATED	$2,047,157,566	$2,203,085,933	$2,413,865,641	$2,514,883,881	
ELIGIBLE MEMBER MONTHS	2,890,214	2,925,038	2,992,401	2,941,374	
COST PER ELIGIBLE	$ 708.31	$ 753.18	$ 806.67	$ 855.00	
TREND RATES		**ANNUAL CHANGE**			**3-YEAR AVERAGE**
TOTAL EXPENDITURE		7.62%	9.57%	4.18%	5.90%
ELIGIBLE MEMBER MONTHS		1.20%	2.30%	-1.71%	-0.25%
COST PER ELIGIBLE		6.34%	7.10%	5.99%	***6.48%***
TOTAL EXPENDITURES					
MEG 2 - CHILD & FAM	$2,204,501,439	$2,473,745,468	$2,955,249,433	$2,908,107,720	
ELIGIBLE MEMBER MONTHS	14,908,204	15,621,916	18,153,023	16,836,229	
COST PER ELIGIBLE	$ 147.87	$ 158.35	$ 162.80	$ 172.73	

	SFY 02-03	SFY 03-04	SFY 04-05	SFY 05-06	WOW AVERAGES
TREND RATES			**ANNUAL CHANGE**		**2-YEAR AVERAGE**
TOTAL EXPENDITURE		12.21%	19.46%	-1.60%	5.31%
ELIGIBLE MEMBER MONTHS		4.79%	16.20%	-7.25%	-1.23%
COST PER ELIGIBLE		7.09%	2.81%	6.10%	***6.59%***

NOTE: Children between 150-185% FPL are included in above MEGS. Although this is technically an optional category, the nature of this waiver allows for their inclusion in the mandatory MEGS. No other optional eligibility groups are included in the waiver.

TOTAL EXPENDITURES					
LOW INCOME SUBSIDY POOL					Allocated Actual *
ELIGIBLE MEMBER MONTHS		N/A	N/A	N/A	N/A
COST PER ELIGIBLE		N/A	N/A	N/A	N/A
TREND RATES					
TOTAL EXPENDITURE		N/A	N/A	N/A	N/A
ELIGIBLE MEMBER MONTHS		N/A	N/A	N/A	N/A
COST PER ELIGIBLE		N/A	N/A	N/A	N/A

TOTAL EXPENDITURES				
COMBINED ALL MEGS ***WITHOUT*** LOW INCOME SUBSIDY POOL	$4,676,831,402	$5,369,115,075	$5,422,991,601	
ELIGIBLE MEMBER MONTHS	18,546,954	21,145,425	19,777,604	
COST PER ELIGIBLE	252.16	253.91	274.20	

	SFY 02-03	SFY 03-04	SFY 04-05	SFY 05-06	WOW AVERAGES
TREND RATES					
TOTAL EXPENDITURE		10.00%	14.80%	1.00%	
ELIGIBLE MEMBER MONTHS		4.21%	14.01%	-6.47%	
COST PER ELIGIBLE		5.56%	0.69%	7.99%	

	DY1 SFY06/07	DY2 SFY0708	CNOM proj DY3 SFY0809 *	CNOM proj (not used) DY4 SFY0910	DY5 SFY1011	WW 3-YEARS
TOTAL EXPENDITURES						
MEG 1 - SSI RELATED	$2,895,417,932	$ 3,094,117,975	$ 3,432,474,993	$3,650,125,111	$3,912,500,869	**$9,422,010,900**
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,315,372	3,409,260	
COST PER ELIGIBLE	972.13	$ 1,019.83	$ 1,056.23	$ 1,100.97	1147.61	
TREND RATES	**ANNUAL CHANGE**			**3-YEAR AVERAGE**		
TOTAL EXPENDITURE	15.13%	6.86%	10.94%	6.34%	7.19%	8.88%
ELIGIBLE MEMBER MONTHS	1.26%	1.87%	7.11%	2.02%	2.83%	4.46%
COST PER ELIGIBLE	13.70%	4.91%	3.57%	4.24%	4.24%	4.24%
TOTAL EXPENDITURES						
MEG 2 - CHILD & FAM	$2,429,520,901	$ 2,517,446,487	$3,058,095,928	$3,635,230,939	$4,321,206,430	**$8,005,063,316**
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	19,231,991	21,636,323	
COST PER ELIGIBLE	160.23	169.75	178.89	189.02	199.72	
TREND RATES	**ANNUAL CHANGE**			**3-YEAR AVERAGE**		
TOTAL EXPENDITURE	-16.46%	3.62%	21.48%	18.87%	18.87%	12.19%
ELIGIBLE MEMBER MONTHS	-9.94%	-2.20%	15.27%	12.50%	12.50%	6.18%
COST PER ELIGIBLE	-7.24%	5.94%	5.38%	5.66%	5.66%	5.66%

	DY1 SFY06/07	DY2 SFY0708	CNOM proj DY3 SFY0809 *	CNOM proj (not used) DY4 SFY0910	DY5 SFY1011	WW 3-YEARS
TOTAL EXPENDITURES	$ 998,806,049	$999,632,926	$877,493,058	$1,122,506,942	$1,001,561,025	$5,000,000,000
LOW INCOME SUBSIDY POOL	$ 998,806,049	$ 999,632,926	$ 877,493,058	$ 245,982,795		$ 3,121,914,828
ELIGIBLE MEMBER MONTHS	N/A	N/A	N/A	N/A	N/A	N/A
COST PER ELIGIBLE	N/A	N/A	N/A	N/A	N/A	N/A
TREND RATES		**ANNUAL CHANGE**				**3-YEAR AVERAGE**
TOTAL EXPENDITURE		0.08%	-12.22%			-6.27%
ELIGIBLE MEMBER MONTHS	N/A	N/A	N/A	N/A	N/A	N/A
COST PER ELIGIBLE	N/A	N/A	N/A	N/A	N/A	N/A

TOTAL EXPENDITURES						
COMBINED ALL MEGS ***WITHOUT*** LOW INCOME SUBSIDY POOL	$5,324,938,833	$5,611,564,462	$6,490,570,920	$7,285,356,050	$8,233,707,298	$32,946,137,563
ELIGIBLE MEMBER MONTHS	18,141,234	17,863,960	20,344,582	22,547,363	25,045,583	
COST PER ELIGIBLE	293.53	314.13	319.03	323.11	328.75	
TREND RATES		**ANNUAL CHANGE**				**3-YEAR AVERAGE**
TOTAL EXPENDITURE		5.38%	15.66%	12.25%	13.02%	10.40%
ELIGIBLE MEMBER MONTHS		-1.53%	13.89%	10.83%	11.08%	5.90%
COST PER ELIGIBLE		7.02%	1.56%	1.28%	1.74%	4.25%

Extension of Reform 1115 Demonstration without Waiver (WOW) Budget Projection

MANDATORY POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY6 (SFY 11-12)	DY7 (SFY 12-13)	DY8 (SFY 13-14)	TOTAL WOW
MEG 1 - SSI RELATED						
Eligible Member Months	N/A	12	3,704,239	3,869,448	4,042,025	
Total Cost Per Eligible	6.48%	12	$ 1,374	$ 1,463	$ 1,610	
Total Expenditure			$ 5,091,169,164	$ 5,662,659,437	$ 6,506,144,133	$ 17,259,972,735
MEG 2 - CHILD & FAM						
Eligible Member Months	N/A	12	20,464,126	21,728,809	23,071,650	
Total Cost Per Eligible	6.59%	12	$289	$308	$ 340	
Total Expenditure			$5,919,973,383	$6,700,314,449	$ 7,833,772,175	$20,454,060,007
TOTAL EXPENDITURES WOW D6-D8						
COMBINED MEGS 1 and 2			$ 1,011,142,548	$12,362,973,886	$14,339,916,308	$37,714,032,742
ELIGIBLE MEMBER MONTHS			24,168,365	25,598,257	27,113,674	
COST PER ELIGIBLE			455.60	482.96	528.88	

TREND RATES	ANNUAL CHANGE	3-YEAR AVERAGE
TOTAL EXPENDITURE	12.28%	15.99%	14.12%
ELIGIBLE MEMBER MONTHS	5.92%	5.92%	5.92%
COST PER ELIGIBLE	6.01%	9.51%	7.74%

STC #116 b. PCCM WOW initial waiver	PCCM MEG 1	MEG 2
Base Year	$ 753.18	$ 158.35
DY 1	$ 948.79	$199.48
DY 2	$1,024.69	$ 215.44
DY 3	$ 1,106.67	$232.68
DY 4	$1,195.20	$ 251.29
DY 5	$ 1,290.82	$271.39

Extension of Reform 1115 Demonstration with Waiver (WW) Budget Projection

MANDATORY POPULATIONS

ELIGIBILITY GROUP	DEMONSTRATION TREND RATE	Months of Aging	RENEWAL DEMONSTRATION YEARS (DY) DY6 (SFY 11-12)	DY7 (SFY 12-13)	DY8 (SFY 13-14)	TOTAL WW
MEG 1 - SSI RELATED						
Eligible Member Months	4.46%	36	3,704,239	3,869,448	4,042,025	
Total Cost Per Eligible	4.24%	36	1,196	1,247	1,343	
Total Expenditure			$4,431,601,028	$4,825,530,653	$5,427,874,835	$14,685,006,516
MEG 2 - CHILD & FAM						
Eligible Member Months	6.18%	36	20,464,126	21,728,809	23,071,650	
Total Cost Per Eligible	5.66%	36	211	223	243	
Total Expenditure			$4,318,282,860	$4,844,672,386	$5,614,590,193	$ 14,777,545,439
LOW INCOME SUBSIDY POOL						
Eligible Member Months	N/A		N/A	N/A	N/A	
Total Cost Per Eligible	N/A		N/A	N/A	N/A	
Total Expenditure			$1,000,000,000	$1,000,000,000	$1,000,000,000	$ 3,000,000,000
TOTAL EXPENDITURES WW D6-D8						
COMBINED MEGS 1 and 2			$8,749,883,888	$9,670,203,039	$11,042,465,027	$29,462,551,955
ELIGIBLE MEMBER MONTHS			24,168,365	25,598,257	27,113,674	
COST PER ELIGIBLE			362.04	$377.77	$ 407.27	

TREND RATES	ANNUAL CHANGE		3-YEAR AVERAGE
TOTAL EXPENDITURE	10.52%	14.19%	12.34%
ELIGIBLE MEMBER MONTHS	5.92%	5.92%	5.92%
COST PER ELIGIBLE	4.34%	7.81%	6.06%

(wow-ww)

$8,251,480,787

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Attachment D
External Quality Review Reports

External Quality Review Reports Submitted by Demonstration Year

Demonstration Year 1 - July 1, 2006 through June 30, 2007

External Quality Review Organization (EQRO) Introduction, May 10, 2006

Annual EQR Communication Plan

Annual Performance Improvement Projects (PIP) Technical Assistance Plan

*Annual PIP Validation Summary Report (Statewide Aggregate)

*Annual PIP Managed Care Organization (MCO) Specific Validation Reports

*Annual PIP Strategic Report

*Annual Statewide Collaborative Methodology Report for PIPs

*Quarterly PIP Technical Assistance Reports

*Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report

*MCO-Specific Strategic HEDIS Analysis Reports

*Since twelve continuous months of data are required to validate these activities, HSAG reviewed the data-collecting capabilities of the plans and offered technical assistance in preparation for validation activities to begin in Demonstration Year Two.

†Annual Validation of Performance Measures Statewide Report

†Annual Validation of Performance Measures MCO-Specific Reports

†Validation activities began in Demonstration Year Three using Calendar Year 2007 data. HSAG reviewed plan processes and offered technical assistance in preparation for validation activities to begin in Demonstration Year Three.

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures

Review of Compliance with Access, Structural, and Operations Standards Report,

HMO Consumer Satisfaction Surveys (CAHPS) Alternate Scoring Methods Report with Recommendations to Improve HMO Scoring Algorithm, FY 2006-2007

Approaches for Improving CAHPS and other MCO Consumer Satisfaction Surveys, 2006-2007

Technical Assistance Report on Enrollee Race/Ethnicity and Primary Household Language

Report on Value-Based Purchasing Methodologies (Approaches for Defining and Evaluating Superior Performance), FY 2006-2007

Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided

Annual Report on Evaluation of AHCA's Quality Strategies

Statewide Focused Study Report on Identification of Individuals with Special Health Care Needs, FY 2006-2007

Statewide Focused Study Report on Adolescent Well-Care, FY 2006-2007

Managed Care Organization Specific Reports on Adolescent Well-Care Focused Study, FY 2006-2007

HSAG Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activity

Annual Florida Medicaid Managed Care External Quality Review Technical Report

Demonstration Year 2 - July 1, 2007 through June 30, 2008

Annual EQR Communication Plan

Annual Performance Improvement Projects (PIP) Technical Assistance Plan

Annual PIP Validation Summary Report (Statewide Aggregate)

Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs

Annual PIP Strategic Report

Annual Statewide Collaborative Methodology Report for PIPs

Annual PIP Strategic and Collaboration Methodology Report

Quarterly PIP Technical Assistance Reports

†Annual Validation of Performance Measures Statewide Report

†Annual Validation of Performance Measures MCO-Specific Reports

> †Validation activities began in Demonstration Year Three using Calendar Year 2007 data. HSAG reviewed plan processes and offered technical assistance in preparation for validation activities to begin in Demonstration Year Three.

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures

Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report

MCO-Specific Strategic HEDIS Analysis Reports, FY 2006-2007

Review of Compliance with Access, Structural, and Operations Standards Report,

Report of Technical Assistance Provided for Improving Consumer Satisfaction Surveys,

Technical Assistance Report on Enrollee Race/Ethnicity and Primary Household Language

Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided

Annual Report on Evaluation of AHCA's Quality Strategies

HSAG Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activity

Annual Florida Medicaid Managed Care External Quality Review Technical Report

Demonstration Year 3 - July 1, 2008 through June 30, 2009

Annual EQR Communication Plan

Annual Performance Improvement Projects (PIP) Technical Assistance Plan

Annual PIP Validation Summary Report (Statewide Aggregate)

Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs

Annual PIP Strategic Report

Annual Statewide Collaborative Methodology Report for PIPs

Annual PIP Strategic and Collaboration Methodology Report

Quarterly PIP Technical Assistance Reports

Annual Validation of Performance Measures Statewide Report

Annual Validation of Performance Measures MCO-Specific Reports

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures

Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report

Review of Compliance with Access, Structural, and Operations Standards Report,

Report of Technical Assistance Provided for Improving Consumer Satisfaction Surveys,

Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided

Technical Assistance Provided on AHCA's Quality Strategies

HSAG Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activity

Annual Florida Medicaid Managed Care External Quality Review Technical Report

Technical Assistance on Network Adequacy, FY 2008-2009

Demonstration Year 4 - July 1, 2009 through June 30, 2010

Annual EQR Communication Plan

Annual Performance Improvement Projects (PIP) Technical Assistance Plan

Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs

Quarterly PIP Technical Assistance Reports, through 3rd Quarter

Annual Validation of Performance Measures Statewide Report

Annual Validation of Performance Measures MCO-Specific Reports

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures

Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report

HMO Consumer Satisfaction Surveys (CAHPS) Alternate Scoring Methods Report with Recommendations to Improve HMO Scoring Algorithm, FY 2006-2007, June 2007

HSAG Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activity, through April 2010)

Development and Onsite Testing of Standards Compliance Monitoring Tools for HMOs and PSNs

Attachment E
Strategic HEDS Analysis Report

Strategic HEDIS® Analysis Reports

Strategic HEDIS® Analysis Reports – HEDIS® is a standard tool used to measure performance on important dimensions of care and service. This makes it possible to compare the performance of health plans. The plans also use HEDIS® results themselves to see where they need to focus their improvement efforts, such as PIPs. HEDIS® Compliance Audits indicate whether managed care organization s have adequate and sound capabilities for processing medical, member and provider information as a foundation for accurate and automated performance measurement.

July 1, 2007 through June 30, 2008
An examination of Waiver plan HEDIS® results was not performed in Waiver Year Two because twelve consecutive months of member data are required to validate performance measures and the CMS protocol specifies the measurement period to be a calendar year. Thus, the first measurement period was Calendar Year 2007. The first validation of HEDIS® results occurred during Waiver Year Three (SFY 2008-2009).
July 1, 2008 through June 30, 2009

HSAG established performance levels for all of the reported HEDIS® measures. The performance levels were set at specific, attainable rates and were based on NCQA national means and percentiles. This standardization allowed for comparison to the performance levels. HMOs meeting the high performance level (HPL) exhibited rates among the top in the nation and performed at or above the national HEDIS® Medicaid 90th percentile. The low performance level (LPL) was set to identify HMOs/PSNs in the greatest need for improvement. The LPL represents rates at or below the national HEDIS® Medicaid 25th percentile.

HSAG has examined the measures along four different dimensions of care: (1) **Pediatric Care**, (2) **Women's Care**, (3) **Living With Illness**, and (4) **Use of Services**. This approach to the analysis was designed to encourage consideration of the key measures as a whole rather than in isolation and to think about the strategic and tactical changes required to improve overall performance. The data presented in this report (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2008 HEDIS® data, which was collected by the HMO/PSN in calendar year 2007, but reported in 2008.

HSAG analyzed the Florida Medicaid HEDIS results in three ways:

- A weighted average comparison presents the Florida Medicaid 2009 results relative to the 2008 Florida Medicaid weighted averages and the national HEDIS® 2008 Medicaid 50th percentiles.
- A performance profile analysis discusses the overall Florida Medicaid 2009 results and presents a summary of HMO and PSN performance relative to the Florida Medicaid performance levels.

- An HMO/PSN ranking analysis for each dimension of care (Sections 3 to 7) provides a more detailed comparison, presenting results relative to the Florida Medicaid performance levels and the national HEDIS® 2008 Medicaid percentiles.

Of the 18 weighted averages calculated for 1115 Waiver health plans that were comparable to national standards, three (or 16.7 percent) fell below the national Medicaid 10th percentile (namely *Annual Dental Visits*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*), seven (or 38.9 percent) fell between the national Medicaid 10th and 25th percentiles, three (or 16.7 percent) fell between the 25th and 50th percentiles, four (or 22.2 percent) fell between the 50th and 75th percentiles, and one (or 5.6 percent) fell between the 75th and 90th percentiles. The weighted average that exceeded the 75th percentile was for the *Comprehensive Diabetes Care—LDL-C Screening* measure.

Pediatric Care

Performance for 1115 Waiver HMOs and PSNs within the Pediatric Care dimension ranged from below average to average, except for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, which had one health plan that performed above the HPL.

For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measures, 7 of the 16 Waiver plans were not able to report rates due to insufficient sample sizes (with a denominator of less than 30). Six of the remaining 9 plans that reported rates ranked below the LPL for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure, and 4 health plans reported rates below the LPL for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure.

For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures, 1 of the 16 1115 Waiver plans was not able to report a rate because the denominators were less than 30. Most plans performed above the national HEDIS 2007 Medicaid 50th percentile, and 1 of those plans exceeded the HPL.

For the *Annual Dental Visits* measure, two 1115 Waiver health plans had an audit designation of *Not Report* (NR) because the rates were materially biased. The remaining plans all reported rates below the LPL.

Women's Care

Overall performance for the Women's Care dimension for the 1115 Waiver HMOs and PSNs ranged from below average to average. One HMO was unable to report a rate for the *Cervical Cancer Screening* measure, and six health plans were unable to report rates for the *Timeliness of Prenatal Care* and *Postpartum Care* measures due to insufficient sample sizes (with denominators of less than 30).

All of the 1115 Waiver HMOs and PSNs with reported rates performed below the LPL for *Cervical Cancer Screening*. All 10 Waiver health plans with rates other than NA

performed below the LPL for *Timeliness of Prenatal Care*. Six out of 10 health plans with rates other than NA performed below the LPL for *Postpartum Care*.

Living With Illness

Performance for measures in the Living With Illness dimension ranged from below average to above average. All of the measures had at least one 1115 Waiver HMO or PSN that was unable to report rates due to insufficient sample sizes (with denominators of less than 30), designated as NA in the tables.

Performance on the *Comprehensive Diabetes Care* measures ranged from below average to above average. For the *Comprehensive Diabetes Care—HbA1c Testing*, four of the 1115 Waiver plans performed below the LPL. The *Comprehensive Diabetes Care—Poor HbA1c Control* and *Comprehensive Diabetes Care—Good HbA1c Control* measures had only one and two health plans performing below the LPL, respectively, indicating that for those members who had HbA1c testing, the rate of members who had their HbA1c under control ranged between the LPL and the HPL. For the *Comprehensive Diabetes Care—LDL-C Screening* measure, six of the HMOs and PSNs performed above the HPL and six performed between the LPL the HPL. The *Comprehensive Diabetes Care—LDL-C Level <100* measure for all of the 1115 Waiver plans with reported rates ranked between the LPL and HPL, indicating that for those members who had an LDL-C screening, the percentage of members with an LDL-C level <100 mm/dL was average. Performance for the *Comprehensive Diabetes Care—Eye Exam* indicator ranged from below average to average, with eight plans ranking below the LPL. The majority of the health plans ranked between the LPL and HPL for the *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* measure, with one health plan ranking below the LPL.

For *Controlling High Blood Pressure*, three of the 1115 Waiver HMOs and PSNs reported an NA due to an insufficient sample, five health plans had rates below the LPL, six health plans had rates between the LPL and HPL, and one health plan had a rate above the HPL. One PSN was not required to report the *Controlling High Blood Pressure* measure since the population it served did not meet eligibility requirements.

Performance on the *Follow-Up After Hospitalization for a Mental Illness* measures ranged from below average to average. Five of the 1115 Waiver plans reported an NA due to an insufficient sample size. The majority of plans ranked below the LPL for both the *30 Day and 7 Day* measures.

Use of Services

The HMOs and PSNs began collecting and reporting Use of Services data in FY 2008. All plans reported valid rates for the *Ambulatory Care* measure. Use of Services data are descriptive in nature and are used to monitor patterns of utilization over time. Because the measures do not lend themselves to measuring the quality of care, HSAG did not compare plan performance on these measures.

July 1, 2009 through June 30, 2010

Eleven HMOs and six PSNs were reviewed. The data presented (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2008 HEDIS data, which was collected by the HMO/PSN in calendar year 2008, but reported in 2009.

Of the 38 weighted averages calculated for the 1115 Waiver plans that were comparable to national standards, 1 (or 2.6 percent) fell below the national Medicaid 10th percentile, 13 (or 34.2 percent) fell between the national Medicaid 10th and 25th percentiles, and 11 (or 28.9 percent) fell between the 25th and 50th percentiles. Nine (or 23.7 percent) fell between the 50th and 75th percentiles, 2 (or 5.3 percent) fell between the 75th and 90th percentiles, and the remaining 2 (or 5.3 percent) exceeded the 90th percentile.

Pediatric Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to above average for the Pediatric Care dimension measures. For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measures, 6 Waiver plans performed between the LPL and HPL, while 1 plan performed above the HPL. Five plans reported that the rates for the measures were NA because of small sample sizes. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, 10 plans reported rates between the LPL and HPL, while 3 plans reported rates that exceeded the HPL. For the *Adolescent Well-Care Visits* measure, 12 plans reported rates between the LPL and HPL, while 1 plan reported a rate higher than the HPL. Four plans reported that rates for both of these measures were NA because of small sample sizes.

While all of the 1115 Waiver plans offered dental benefits, only two reported rates between the LPL and HPL. Thirteen plans reported rates lower than the LPL, while two of the plans had sample sizes too small to report rates.

Of all the *Childhood Immunization Status* measures, diphtheria, tetanus, and acellular pertussis (DTaP) and HiB were the only measures that had two and three plans, respectively, that performed higher than the HPL. The inactivated polio vaccine (IPV) and pneumococcal conjugate vaccine (PCV) measures both had nine 1115 waiver plans that performed below the LPL and five plans that performed between the LPL and HPL. For the measles, mumps, and rubella (MMR), HiB, and varicella zoster virus (VZV) measures, three plans performed below the LPL. Eleven plans performed between the LPL and HPL for the MMR and VZV measures, while eight plans performed between the LPL and HPL for the HiB measure. For the Hepatitis B measure, eight plans performed below the LPL, while six plans performed between the LPL and HPL. Seven plans performed below the LPL and seven other plans performed between the LPL and HPL for the Combination 3 measure, while six plans performed below the LPL

and eight plans performed between the LPL and HPL for the Combination 2 measure. For all of the *Childhood Immunization Status* measures, three plans reported that the rates were NA.

Four of the 1115 Waiver plans performed below the LPL for the *Lead Screening in Children* measure, while 10 plans performed between the LPL and HPL. Three plans reported that rates for the measures were NA.

Women's Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to average for the Women's Care dimension measures. Two plans were not required to report rates for the *Cervical Cancer* and *Breast Cancer Screening* measures because they serve a younger population and would not have eligible populations for these measures. For the *Cervical Cancer Screening* measure, 10 plans performed below average, while 2 plans performed between the LPL and HPL for the measure. Three plans reported that their rate was NA because of a small sample size.

For the *Breast Cancer Screening* measure, two 1115 Waiver plans performed below average, while eight plans performed between the 25th and 90th percentiles, or between the LPL and HPL. Five plans reported that the rate was NA. Almost all of the plans that could report the *Timeliness of Prenatal Care* measure performed below average. One plan performed between the LPL and HPL, while seven plans reported that the rate was NA. For *Postpartum Care*, five plans performed below average, while five plans performed between the LPL and HPL. Seven plans reported that the rate was NA.

Living With Illness

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to above average for the Living With Illness dimension measures. For the *Comprehensive Diabetes Care* measure, there was mixed performance. Five plans reported that all of their *Comprehensive Diabetes Care* measure rates were NA because of small sample sizes. The plans performed best on the *Good HbA1c Control* measure. Eight plans performed above the HPL, two plans performed between the LPL and HPL, and only one plan performed below the LPL. Another measure with good performance was *LDL-C Screening*. Four plans performed above the HPL, and the remaining seven plans performed between the LPL and HPL. The plans also performed nearly as well on the *Nephropathy* and *LDL-C Screening < 100* measures. For both measures, three plans performed better than the HPL, seven plans performed between the LPL and HPL, and one plan performed below the LPL. For the remaining *Comprehensive Diabetes Care* measures—*HbA1c Testing*, *Poor HbA1c Control*, and *Eye Exam*—none of the plans performed above average. For the *HbA1c Testing* measure, all of the plans performed between the LPL and HPL. For the *Poor*

HbA1c Control measure, eight plans performed average, while three plans performed below average. For the *Eye Exam* measure, six plans performed average, while five plans performed below average.

For the *Controlling High Blood Pressure* measure, 10 of the 1115 Waiver plans performed between the 25th and 90th percentiles, or between the LPL and HPL, and one plan performed above average. Four plans reported the measure's rate as NA.

For both of the *Antidepressant Medication Management* measures, 10 plans reported that the rate was NA. Four plans performed above the HPL for the *Effective Acute Phase Treatment* measure, while two plans reported above the HPL for the *Effective Continuation Phase Treatment* measure. For the *Effective Acute Phase Treatment* measure, one plan performed between the LPL and HPL. For the *Effective Continuation Phase Treatment* measure, three plans performed between the LPL and HPL. For both measures, only one plan performed below average.

For both of the *Follow-Up After Hospitalization for Mental Illness* measures, five plans reported that the rates were NA. For the *30-Day* measure, six plans performed below average and six plans performed between the LPL and HPL. For the *Seven-Day* measure, three plans performed below average and nine plans performed between the LPL and HPL. None of the plans performed above average for either of the measures.

None of the 1115 Waiver plans performed above average for any of the *Use of Appropriate Medications for People With Asthma* measures. For the *5–9* age group, 5 plans performed below average, 2 plans performed between the LPL and HPL, and the remaining 10 plans reported that the rate was NA. For the *10–17* age group, 5 plans also performed below average, 1 plan performed between the LPL and HPL, and the remaining 11 plans reported that the rate was NA. For the *18–56* age group, 3 plans performed below average, 3 plans performed between the LPL and HPL, and 11 plans reported that the rate was NA. For the *Total* age group, 7 plans performed below average, 4 plans performed between the LPL and HPL, and the remaining 6 plans reported that the rate was NA.

Access to Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to average for the Access to Care dimension measures. PAR did not report the Access to Care dimension measures because they were not appropriate for the populations PAR serves. Eight of the plans performed below average, while 5 plans performed between the LPL and HPL for the *Adults' Access to Preventive Ambulatory Health Services for 20–44 Years*. Three plans reported that the measure was NA. For the same measure for *45–64 Years*, only 1 plan performed below average, 10 plans performed between the LPL and HPL,

and 5 plans reported that the rate was NA. For *65+ Years*, 1 plan performed below average, 9 plans performed between the LPL and HPL, and 6 plans reported that the rate was NA. For the *Total* measure, data were not presented because there were no Medicaid benchmarks for that measure.

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Attachment F
Notification to Florida Legislature

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

November 4, 2009

The Honorable Larry Cretul
Speaker, Florida House of Representatives
420 The Capitol
402 South Monroe Street
Tallahassee, FL 32399-1300

Dear Speaker Cretul:

Section 409.91211(6), Florida Statutes, directs the Agency to provide written notification 15 days prior to seeking approval by the federal government of any modifications to the special terms and conditions to the 1115 Medicaid Reform Wavier. Therefore, the Agency is notifying you that the Agency is submitting an amendment to Special Term and Condition (STC) #105 of waiver to obtain approval from the federal government to spend a total of $1 billion of Low Income Pool (LIP) funds in year 5 of the demonstration. The amendment is submitted in accordance with proviso language which follows Specific Appropriation 190 of the General Appropriations Act for state fiscal year 2009-2010 and reads as follows:

> "The distribution of funds under this section of proviso are contingent on the Agency for Health Care Administration obtaining an amendment to the Special Terms and Conditions for the Florida Medicaid Reform section 1115 demonstration that allows for the distribution of $1 billion under the Low Income Pool program in the fifth year of the demonstration. If the amendment to the demonstration is not approved by January 31, 2010, then the funds in this section of proviso shall be used in Fiscal Year 2010-2011 for the Low Income Pool program as appropriated in the Fiscal Year 2010-2011 General Appropriations Act."

In July 2009, the Agency held a call with the Centers for Medicare and Medicaid Services (CMS) to discuss the above Legislative directive to amend the STCs of the waiver. The call focused on STC #105, which reads as follows:

> "Demonstration Year 5. At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion."

As a follow-up to this call, the Agency submitted a letter to CMS dated September 2, 2009, requesting approval to spend a total of $1 billion of LIP funds in year 5 of the demonstration.

2727 Mahan Drive, MS#1
Tallahassee, Florida 32308

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

As of the date of this letter, the Agency has not received a formal response to the September 2 letter. Based on recent informal feedback from federal CMS, the Agency is submitting an amendment to STC #105 of the waiver requesting approval to spend a total of $1 billion of LIP funds in year 5 of the demonstration.

Should you have any questions or require additional information, please contact me at 488-3560

Sincerely,

Phil E. Williams
Interim Deputy Secretary for Medicaid

PEW/lam
cc: Thomas W. Arnold, Secretary

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

November 4, 2008

The Honorable Jeff Atwater
President, Florida Senate
409 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear President Atwater:

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Should you have any questions or require additional information, please contact me at 488-3560

Sincerely,

Phil E. Williams
Interim Deputy Secretary for Medicaid

PEW/lam
cc: Thomas W. Arnold, Secretary

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Attachment G
Waiver and Expenditure Authorities

Waiver Authorities for Florida's Medicaid Reform Section 1115 Demonstration

NUMBER: **ll-W-OO206/4**
TITLE: **Florida Medicaid Reform Section 1115 Demonstration**
AWARDEE: **Agency for Health Care Administration**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning July 1, 2006, through June 30, 2011.

The following waivers shall enable the State to implement the approved Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115 Demonstration

Title XIX Waivers

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

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

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

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements and to permit Florida to offer different benefits to demonstration populations one and two than to the categorically needy group.

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

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility. Beneficiaries will also be permitted to accumulate financial resources in a separate account for special approved services.

4. Cost Sharing **Section 1902(a)(14) insofar as it incorporates Section 1916**

To enable Florida to authorize coverage of employer-based or private plans that have cost sharing requirements for participants covered under the demonstration in excess of statutory limits.

5. Freedom of Choice **Section 1902(a)(23)**

To enable Florida to restrict the freedom of choice of providers.

6. Provider Agreements **Section 1902(a)(27)**

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

7. Retroactive Eligibility **Section 1902(a)(34)**

To enable Florida to waive the requirement o provide medical assistance for up to 3 months prior to the date that the application for assistance is made.

8. Eligibility Section 1902(a)(I0)(A)

To allow the State to provide only emergency medical services and nursing home level of care for up to 30 days from the time the applicant is determined eligible until the newly eligible beneficiary selects a managed care plan or is automatically enrolled into a managed care plan.

To allow the State to not provide Medicaid covered State plan services for individuals who voluntarily elect to opt out of Medicaid into an employer sponsored insurance program or private health plan for the duration of the individual's voluntary enrollment into the plans covered outside the parameters of the demonstration.

9. Payment Review **1902(a)(37)(B)**

To the extent that prepayment review may not be available for disbursements by individual beneficiaries to their providers.