Florida Managed Medical Assistance Program

(Project Number 11-W-00206/4)

Extension Request
Public Notice Document

1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration

Page Intentionally Left Blank

TABLE OF CONTENTS

STATEMENT OF PURPOSE

The State of Florida (State) is seeking a two-year extension of the 1115 Managed Medical Assistance (MMA) Waiver, which would extend the waiver approval period through June 30, 2024. An extension of the MMA Waiver would allow the State to continue efficiently operating and evaluating all programs and pilots authorized under the current Special Terms and Conditions for an additional two-year period. Throughout this extension request, the State will highlight many of the successes that have been achieved under the 1115 Waiver thus far. **This extension request does not include any amendments to the current waiver design or the approved Special Terms and Conditions.**

Success of first five years of waiver lays foundation for further gains. Florida Medicaid serves more than 3.8 million recipients with an annual budget of over $29 billion. With the inception of Statewide Medicaid Managed Care through an 1115 waiver in 2013-14, the program shifted its focus from basic access to care and timely payment of claims to a focus on paying for improved health outcomes. The first five years of the program laid a solid foundation for this quality improvement work, emphasizing consumer satisfaction and improved access to care as measured by CAHPS and HEDIS. Consumer satisfaction with managed care has been consistently high, and the several dozen HEDIS measures Florida tracks improved from 41% being at or above the national average in 2013 to 58% being at or above the national average in 2018. The waiver program also began to bend the cost curve. Between FY 2009-10 and FY 2017-18, Florida Medicaid's per member, per year costs grew by 9 percent. In contrast, during the same period, the Consumer Price Index grew by almost 15 percent, and the Medical Consumer Price Index grew by more than 25 percent.

Building on success. In 2018-19, Florida implemented new health plan contracts that built on the success of the first five years of the program, setting targets to improve population health through evidence-based interventions implemented in collaboration with health plans, hospitals, physicians, and other stakeholders. The State has used a population health approach, bringing significant health concerns into focus and addressing ways that resources can be allocated to overcome the problems that drive poor health outcomes. The State is measuring results through reductions in potentially preventable hospital admissions, re-admissions, and emergency department visits and through improved birth outcomes. Stakeholders are highly engaged, pilots are starting around Florida, and dashboards are published to report results and ensure transparency across the program.

In order to accomplish these quality goals, the State convened health care providers and other community partners from across Florida to identify key strategies and evidence-based interventions that will improve health outcomes and facilitate paying for value over volume. The State (through the MMA plans) plans to deploy the following key initiatives related to potentially preventable healthcare events:

1. A hospital discharge planning pilot that focuses on connecting high-risk patients with the appropriate services and resources in the community to avoid re-admissions;
2. An emergency department (ED) diversion program which will address inappropriate use of the ED for ambulatory sensitive conditions as well as super utilizers of the ED (recipients with 12 or more ED visits in a year); and
3. A provider resource toolkit that targets outreach to providers with high rates of potentially preventable admissions.

The MMA plans will also be deploying the following initiatives related to improving birth outcomes:

1. Initiating a statewide awareness campaign to increase recipient education around preventative strategies, particularly focused on reducing unnecessary C-sections;
2. Increasing access to maternal home visits for high-risk mothers;
3. Expanding access to doula services;
4. Participating in statewide initiatives through the Florida Perinatal Quality Collaborative, which focus on increasing substance use screening, referral, and treatment for pregnant women and reducing lengths of stay for babies born with neonatal abstinence syndrome.

While each of these are separate initiatives, there is considerable overlap in the health systems involved (hospitals, physician groups, etc.) and community partners needed to address social determinants of health.

Driving to value-based care. The significant success Florida has achieved in increasing access to care and improving health outcomes only underscores the reality that population health will only be achieved when incentives in the health care system align to focus on individual and population outcomes through proven approaches to care delivery and management. Florida has made a start on value-based purchasing, requiring Medicaid health plans to contract with a percentage of their primary care providers through value-based purchasing arrangements, but more needs to be done. For example, the State is exploring maternity bundled payments in conjunction with the State's major commercial payers but needs the current system of payments authorized by the waiver to remain stable for two more years while the State continues this work. The State also intends to partner with private sector employers to maximize purchasing power in order to accomplish goals.

Hospital services, whether inpatient or outpatient, not only comprise a large percentage of health care costs, but are an area where significant opportunities exist to improve quality of care and drive system-wide quality improvement. Under the Medicare program, hospitals have been incentivized (both through value-based purchasing programs and financial penalties) to implement protocols that improve quality and reduce readmissions rates. These quality-driven process improvements made by hospitals should be evidenced regardless of payer, but the data does not reflect that when it comes to Florida Medicaid.

Redesign of Florida's hospital funding structure to incentivize quality outcomes rather than volume of services has the potential for systemic impact on the Medicaid program. Goals of hospital payment redesign are: 1) Payments are consistent with efficiency, economy, and quality of care, 2) Improved adequacy of rates across providers, and 3) Fiscal integrity of the Medicaid program.

Other outcomes that the State would achieve through the redesign are:

- Aligning Incentives
  - Reward facilities that operate and provide care most efficiently
  - Increase reimbursement for difficult to treat populations
  - Create incentives to avoid performing unnecessary services
- Increasing Financial Predictability by establishing predictable rates for providers and the State
- Establishing Fair Practices

- Provide the same payment for the same service across all facilities with similar characteristics
- Align payments with the cost of care for different types of services

The State is also striving to align physician payment incentives with the Medicaid potentially preventable event and birth outcome quality goals. As the State identifies best practices and lessons learned through the quality initiatives, this information can be used to develop alternative payment arrangements with physician practices. Managed Medical Assistance plans have various incentive programs in place for physicians, but they do not all align directly with the State's initiatives. The State is driving MMA plans to engage their networks of providers in more shared risk payment arrangements. This is essential in achieving the State's triple aim and ensuring providers have shared responsibility in improving care and lowering costs.

While these more sophisticated risk-based payment models are developed, interim steps can help begin the alignment process. Plans need to equip physicians with data that helps them understand their performance in comparison to their peers and national benchmarks and to share data regarding patients with care gaps and real-time hospital encounters. Another opportunity is to create payment models that incentivize providers who are making significant strides related to electronic health information exchange within their region or those who are reserving capacity in their schedules to meet the urgent care needs that are contributing to unnecessary ED use.

In the discussions held with stakeholders, increasing the use of patient centered medical homes to serve members with complex medical and/or behavioral health needs is a growing need. Addressing this issue is a critical step in changing the trajectory related to unnecessary ED use and hospitalizations. Through the pilots, MMA plans are working collaboratively with hospital systems to identify medical homes for complex high-risk members that can provide the intense wrap around supports to meet the needs of the patient and financially incentivize these providers accordingly. While this is a step in the right direction, greater transparency is needed to ensure medical home providers are adhering to the fidelity of the model and can demonstrate success in improving health outcomes.

Recipient Engagement. The State continues to put meaningful facility-level and provider health care cost information into the hands of Florida consumers. This is critical in engaging recipients in the health care decision-making process and providing them with key information and the tools needed to make informed choices. Medicaid recipients have access to more information than ever before that will aid them in making the best health care decisions (e.g., choosing the right health plan, comparing re-admission and C-section rates of hospitals in their geographic area, etc.). There is, however, more than can be done to provide information to recipients that would assist in their selection of physicians that meet or exceed quality standards and those who routinely are rated highly for prescribing only necessary care based on clinical/evidenced based guidelines.

One area of focus in many of the quality initiatives is providing better patient education about available services and community resources and bringing greater awareness to recipients on how to advocate for themselves to achieve the best health outcome (e.g., adoption of educational campaigns such as California's "My Birth Matters"). The MMA plans are also establishing multi-sector partnerships to meet the needs of members, including addressing social determinants of health. Historically, Medicaid payment for services provided through these types of partnerships was unavailable, but the State recently launched its Behavioral Health and Supported Housing pilot

in two regions of the State. The authority for this initiative was granted through the 1115 MMA Waiver and has the potential to transform the lives of individuals contending with mental illness and/or substance use disorder.

Reason for the Extension Request. Through the MMA program, Florida has been embarking on transforming its delivery system in pursuit of the following three aims[1]: improving the recipient's experience of care, improving the overall health of the Medicaid population, and continuing to bend the Medicaid cost curve. The State will continue to deploy this triple aim approach by creating innovative payment and financing approaches, promoting patient centered medical homes, achieving greater data and performance transparency, and implementing the State's quality Medicaid goals focused on reducing unnecessary and avoidable health care events/services. Extension of the 1115 MMA Waiver affords the time to test innovative pilots that will help the State meet its goals.

The State has already made strides in increasing the providers participating in value-based payment arrangements, but there are greater opportunities to align payment sources flowing to providers participating in the MMA program around goals that promote better health outcomes, incentivize providers to engage consumers actively in their health care, and ensure access to appropriate and timely care in the least costly setting. In order to fully maximize the impact and success of the quality initiatives that the State has undertaken related to PPEs and birth outcomes, provider payment reform must be a part of the equation. In addition, by aligning financial incentives, the State will be able to continue to bend the Medicaid cost curve and lower overall costs.

The reality, however, is that these efforts take time and, in order to successfully achieve these goals, the State needs stability in the authorities that govern the operation of the MMA program and other supplemental payment programs for a longer period than is currently authorized. With the extra time afforded through an approved two-year extension, the State would have the ability to evaluate and implement enhanced provider payment strategies, extend current program authorities and funding levels for programs like the Low Income Pool, and provide the stability needed to engage in meaningful stakeholder engagement and analytic work to achieve the State's goals.

The State recently received approval for two new components of the 1115 Waiver – a waiver of retroactive eligibility and the Behavioral Health and Supportive Housing Assistance pilot. The State is confident that both initiatives will achieve their intended purpose; however, this extension request will allow the State to fully demonstrate its efficacy in encouraging program enrollment for eligible recipients in order to reach the maximum number of Florida consumers in need of housing assistance.

Finally, it is critical to reflect on the impact of the 2019 novel coronavirus on the health care system and on the daily lives of the people Medicaid serves. At this time, we do not know the extent or duration of the changes this pandemic will cause to the overall health of the Medicaid population, the size and composition of the Medicaid rolls, the way that people access healthcare, and the impacts to Medicaid providers. Also unknown are the impacts to the state and federal economies and how Medicaid programs may have to adapt in response to any economic downturn. The state's Medicaid program and the people we serve would benefit from stability in this program while we navigate the

immediate crisis period, restore normal operations in the aftermath, and strategically assess any change in the waiver for the future.

1115 MANAGED MEDICAL ASSISTANCE WAIVER OVERVIEW

In 2011, the Florida Legislature directed the Agency for Health Care Administration (Agency) to create the SMMC program. At that time, the SMMC program had two key components: The MMA program and the Long-term Care program.

The State submitted an amendment request to CMS to amend the 1115 Reform Waiver to implement the MMA program. The State received approval from CMS on June 14, 2013 to terminate the Medicaid Reform program, implement the MMA program, and rename the waiver "Managed Medical Assistance." The Medicaid Reform program was terminated on August 1, 2014. On July 31, 2014, the State received approval from CMS to extend the MMA Waiver for the period July 31, 2014 through June 30, 2017. Subsequently, CMS re-authorized the MMA Waiver through another extension; the approval period began July 1, 2017 and is set to continue through June 30, 2022.

Florida's current 1115 MMA demonstration waiver allows the State to provide an array of health care services to Florida Medicaid recipients. The demonstration authorizes:

1. The delivery of medical and behavioral health services through a comprehensive managed care delivery system.
    - Medicaid recipients, who are mandatory for enrollment in the MMA program, are given the opportunity to select a health plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are automatically assigned into a health plan upon an affirmative eligibility determination and are subsequently provided with information about their choice of plan along with the automatically assigned plan.
    - Voluntary populations may choose to enroll with a health plan but are not automatically assigned to plans.

Health plans are able to provide customized benefits to their members that differ from, but are not less than, the Florida Medicaid State Plan benefits—and participating Medicaid-eligibles have access to Healthy Behaviors Programs that provide incentives for healthy behaviors.

2. The delivery of MMA dental services through the Prepaid Dental Health Program:
    - The majority of Medicaid recipients are required to receive their dental services (preventive, diagnostic, restorative care, etc.) through an MMA dental plan. Dental plans are required to cover the mandatory dental benefits approved in the Florida Medicaid State Plan, but they also offer their adult enrollees expanded benefit packages.
3. A Low-Income Pool that ensures continuing support for safety net providers who furnish charity care to the Medicaid, uninsured, and underinsured populations.
4. A pilot program that provides additional behavioral health services and supportive housing assistance services to persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability.
5. A waiver of retroactive eligibility, which encourages Medicaid recipients to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (if eligibility depends on a finding of disability or a certain

diagnosis). Other programs that have been vital in ensuring vulnerable populations, or those with complex medical needs, receive specialized care and services. These programs include:

- The Healthy Start program which provides outreach and case management services for eligible pregnant women and children.
- The MEDS AD program that provides Medicaid coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level.
- The Program for All-Inclusive Care for Children program that provides pediatric palliative care support services to children enrolled in the Children's Medical Services plan who have been diagnosed with potentially life-limiting conditions and were referred by their primary care provider.
- The Medicaid Comprehensive Hemophilia Management program, which operates statewide and provides pharmaceutical services and products for recipients who have a diagnosis of hemophilia or von Willebrand disease.
- The AIDS program, which provides additional services for recipients diagnosed with AIDS who are enrolled in a specialty health plan.

Through this demonstration, the State has aimed to achieve the following objectives:

1. **Improve health outcomes** through care coordination, patient engagement in their own health care, and maintaining **fiscal responsibility**. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefit packages, top quality scores, and high rate of customer satisfaction. The State will provide oversight focused on improving access and increasing quality of care.
2. **Improve program performance**, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
3. **Improve access** to coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner, except those specifically exempt.
4. Increase access to, stabilize, and strengthen providers that serve uninsured, low-income populations in Florida by targeting Low-Income Pool (LIP) funding to **reimburse charity care costs** for services provided to low-income uninsured patients in hospitals, federally qualified health care centers, and rural health clinics that are furnished through charity care programs that adhere to the Healthcare Financial Management Association principles.
5. Improve **continuity of coverage** and care by encouraging the uptake of preventive services and/or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable; as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.
6. Improve the **integration of all services**, increase care coordination effectiveness, increase individual involvement in their care, improve health outcomes, and **reduce unnecessary or inefficient use of health care**.

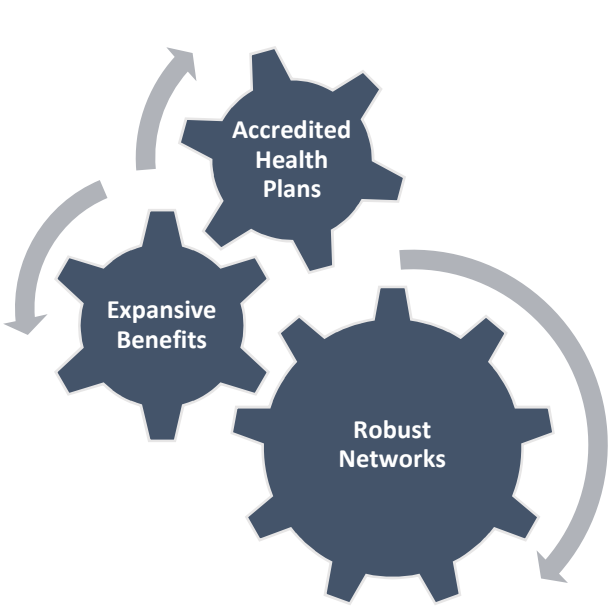
Florida has made substantial progress towards achieving these objectives and requests this waiver extension to build upon the work accomplished thus far and to further demonstrate program outcomes. The following section demonstrates how the State is meeting these objectives.

STATEWIDE MEDICAID MANAGED CARE PROGRAM

The strength of the program design along with the implementation of the Managed Medical Assistance and Prepaid Dental Health components of the Statewide Medicaid Managed Care program have been essential to the State's success in achieving the objectives of the demonstration.

IMPROVED HEALTH OUTCOMES

The foundation of the MMA health and dental programs are rooted in procuring contracts with high quality plans that offer expansive services with robust networks and who meet or exceed national performance benchmarks.



Nationally Accredited Plans

The State re-procured the health and dental plans in 2018, which resulted in MMA contracts being awarded to the following plan types:

- **7 Comprehensive Plans** – This plan type provides both MMA services and Long-Term Care (LTC) services.
- **1 Long-Term Care Plus Plan** – This plan type provides MMA services and LTC services. (Recipients who only qualify for MMA services cannot enroll in this plan type.)

- **4 MMA-Only Plans** – This plan type provides MMA services. (LTC recipients are not eligible for this plan.)
- **5 Specialty Plans** – This plan type provides MMA services to recipients who qualify under a specialty population.
- **3 Dental Plans** - This plan type provides preventive and therapeutic dental services to all MMA recipients and all fully eligible fee-for-service individuals.

Through the re-procurement process, the State negotiated terms and conditions with selected plans that will provide greater consumer protections and managed care plan accountability, including but not limited to enhanced network standards, prior authorization requirements, expanded benefits, and advancements in value-based purchasing.

Robust Provider Networks

The State requires that the health plan enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness. The State has established specific standards for the number, type, and regional distribution of providers in health plan networks. The health plans must maintain:

- A panel of preventive and specialty care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population.
- A provider network sufficient to serve a percentage of recipients in the region.
- Regional provider ratios based upon 120% of the health plan's actual monthly enrollment measured at the first of each month, by region, for all regions.

Table 1 illustrates examples of network adequacy requirements that are established for certain types of physicians. The State routinely reviews the standards to determine if changes are needed to facilitate timely access to care or to address a gap. As an example, there has been a heavy focus on addressing the opioid epidemic. In response, the State established minimum standards for medication assisted treatment. Additionally, in response to stakeholder feedback requesting more stringent standards to ensure children have access to therapy services, the State added requirements for pediatric therapists.

TABLE 1: Example of MMA Network Requirements					
Required Providers	Urban County		Rural County		Regional Provider Ratios
	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	
Primary Care Providers	30	20	30	20	1:750 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees

Provider Network Verification

The State requires plans to submit their provider network files through the Provider Network Verification (PNV) system weekly to provide current information for Medicaid recipients when selecting a health plan. The State also uses this system to determine plan compliance with several provider network contractual requirements, in addition to ensuring that all network providers are appropriately licensed, have received a background screening, and are known to Florida Medicaid. Ensuring providers are properly licensed and have been through the background screening process is vital to ensuring access to qualified providers for all Florida Medicaid enrollees.

The PVN system produces reports that the State uses to analyze plan provider network files. The reports generated by the system contain plan contractual metrics, including:

- Each provider that is accepting new Medicaid patients,
- Each provider that offers after-hours care,
- The number of providers for each provider type/specialty compared with the plan membership (provider to member ratio reports), and
- Drive time and distance from each provider type/specialty specific to the location of the residence of plan members.
- For behavioral health, the requirement includes licensed mental health counselors for both child and adult psychiatrists.

The PNV system is also valuable when the Agency conducts network research. The system enables the Agency to run various queries to assist them in their research.

Through the State's efforts to ensure continuous quality improvement it has identified future improvements related to provider network oversight activities. For example, currently there is not a formal, systematic mechanism in place to interact with the State's behavioral health authority, the Department of Children and Families, and its behavioral health network to collect feedback on their experiences serving the Medicaid population. This can result in issues such as waitlist information not being reported to the Agency for review to ensure the plans' networks truly have enough providers to appropriately serve their Medicaid members.

The Agency monitors the PNV data weekly to ensure that each of the plans are meeting provider network ratios, time, and distance standards. The Agency issues compliance actions when deficiencies are identified. Most commonly, these compliance actions are monetary liquidated damages, but they can also include more significant actions including monetary sanctions and freezing enrollment. The State also deploys secret shopper techniques that validate the information provided through the PNV and to ensure enrollees have timely access to services.

Expansive Benefits

In addition to the standard benefit package that all MMA health and dental plans must provide, they also provide expanded benefits for their enrollees. Expanded benefits are services covered by the plans beyond the mandatory services contained in the Medicaid State Plan or that are in excess of the amount, duration, and scope specified in the State Plan. See **Attachment I** for required State Plan covered services. The State negotiated these additional benefits during the 2018 procurement cycle. Once a plan commits to the benefits, it must continue them for the life of the contract. The health and dental plans pay for the expanded benefits at no additional cost to the State.

Attachment I provides a comprehensive list of all the expanded benefit services health and dental plans may choose to cover. Plans are not required to offer all expanded benefits contained in **Attachment I**; each plan has covered expanded benefit service options, which are codified in their contract. Information about expanded benefits by plan is provided to recipients as part of the plan selection and choice counseling process, and plans distribute this information to their enrollees via an Enrollee Handbook.

The expanded benefits offerings have improved the array of services available to Medicaid recipients and enhanced recipient access to care. All health plans participating in the MMA program are offering the most robust expanded benefit packages since the inception of the program. Plans are offering over 50 services that exceed State Plan coverage for adults.

Many of the expanded benefits offered by the plans support the Agency's quality goals. Examples include:

- **Potentially Preventable Events:**
  - Primary care provider expanded after hours care and telemedicine services
  - Vaccines for adults
  - Alternative pain management, including acupuncture and massage services

  - Additional behavioral health assessment, day treatment, medication management, and psychosocial rehabilitation services
  - Behavioral health services for caregivers
- **Birth Outcomes:**
  - Doula services
  - Additional dental cleanings for pregnant women
  - Additional prenatal services

Under the new SMMC contracts, the State focused on fully integrating health care, and as such, health plans became responsible for providing services previously only available through the fee-for-service delivery system. These services include:

- Early Intervention Services
- Medical Foster Care
- Short-Term Nursing Facility Services
- Child Health Services Targeted Case Management

Continuity of care is always paramount when transitioning new services into managed care. The State enacted consumer protections codified in the SMMC contracts to ensure there was no disruption in care or need to change providers because of the transition. As a result, there were no gaps in the delivery of care and 100% of recipients continued to receive services.

Enhanced Quality and Health Outcomes

During the 2018 health plan re-procurement process, each of the health plans awarded a contract for the 2018-2023 contract term committed to higher performance standards, specifically in areas that would further the State's goals. The health plans committed to reducing potentially preventable events (PPE) such as hospital admissions, re-admissions, and emergency department visits as well as reducing primary Caesarean-section rates, pre-term deliveries, and the number of babies born with neonatal abstinence syndrome. Similarly, the dental plans committed to decreasing the dental emergency department visit rate, while increasing annual dental visit and preventive dental care visit rates.

Table 2 located on the following page details the MMA health and dental plans' commitments for the new five-year contract period.

TABLE 2: MMA Health and Dental Plan Commitments			
Health Plans		**Dental Plans**	
Avg. Reduction	**Quality Outcome**	**Avg. Yearly Increase**	**Service Type**
22%	Preventable Admissions	3%	Annual Dental Visits-Above the Annual ITN Target
21%	Preventable Re-admissions	1%	Preventive Dental Care-Above the annual ITN Target
14%	Preventable Emergency Department Visits	**Reduction**	**Potentially Preventable Event**
12%	Primary C-section Rate	5%	Dental related emergency department visits within the first year
10%	Pre-term Deliveries	9%	Emergency Department Visits within the 5-year contract
15%	Babies Born with Neonatal Abstinence Syndrome		

The Agency has engaged in extensive work with stakeholders to develop initiatives that will aid in achieving these targets, such as emergency department diversion program pilots, discharge planning pilots, a C-section statewide educational campaign, intensive case management programs, and more. Stakeholders that have partnered with the State on these initiatives include the health and dental plans, the Florida Hospital Association, Safety Net Hospital Alliance of Florida, individual Florida hospitals in pilot regions, the Florida Association of Community Health Centers, the Florida Chapter of Emergency Physicians, the Florida Academy of Family Physicians, the Florida Perinatal Quality Collaborative, Florida Healthy Start Coalitions, the Florida Department of Health, the Florida Department of Children and Families, behavioral health providers, and more.

IMPROVED PROGRAM PERFORMANCE

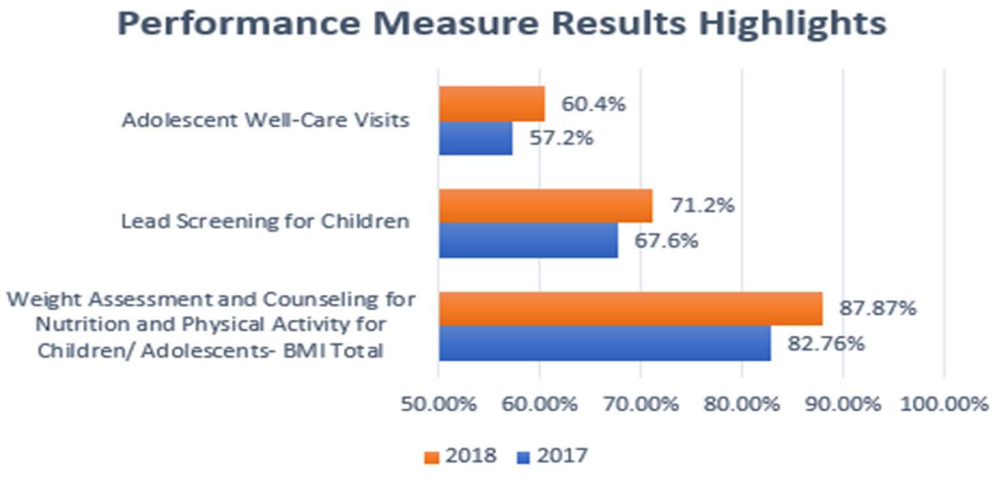
The SMMC contracts include a robust array of performance measures and standards to evaluate health plan performance and consumer satisfaction.

Performance Measures

The SMMC contracts include over 40 performance measures on which the plans report. The Health Effectiveness and Data Information System (HEDIS) is a set of nationally recognized and widely used performance measures designed to allow customers to compare health plan performance, both regionally and nationally. HEDIS was developed and is maintained by the National Committee for Quality Assurance. The Agency compares the HEDIS National Medicaid Means and Percentiles to the performance measures submitted by Florida's health plans. The State has continued to see a significant improvement in its Medicaid quality scores since the inception of the MMA program. The Agency posts detailed health plan scores on its website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.

The plan performance measure statewide average results for calendar years 2017 and 2018 demonstrate an upward trend for many of the performance measures. There are several measures during the calendar year 2018 where the statewide average results surpassed the 75th percentile of Medicaid plans nationally, and three that surpassed the 90th percentile. For calendar year 2018, 28 of the 48 statewide weighted means were at, or better than, the national mean and, of the 2018 statewide weighted means that were lower than the national mean, seven showed improvement from 2017.

The graph below illustrates notable performance measure improvements from 2017 to 2018, which are the most recent years for which the State has data available.



Prior to the June 2013 approval of the MMA program, which is structured substantially similarly to its current form, the State's HEDIS performance measures had remained stagnant and had significant room for improvement.

Comparing calendar year 2018 to calendar year 2013, the last full measurement year prior to MMA implementation, there were 36 HEDIS performance measures reported in both years. The statewide weighted means improved in calendar year 2018 for 30 of the 36 measures, while three measurers were maintained at the same rate. Measures with notable improvements from 2013 to 2018 include:

- Adolescent Well-Care Visits: increased from 50% to 60%.
- Adults' Access to Preventive Care (65+ Years group): increased from 73% to 90%.
- Adult BMI Assessment: increased from 82% to 89%.
- Annual Dental Visit: increased from 40% to 50%.
- Hemoglobin A1c Testing for people with Diabetes: increased from 80% to 86%.
- Eye Exams for People with Diabetes: increased from 49% to 56%.
- Medical Attention for Nephropathy for People with Diabetes: increased from 80% to 92%.
- Follow-up after Hospitalization for Mental Illness within 30 Days: increased from 45% to 51%.
- Immunizations for Adolescents – Combo 1: increased from 63% to 74%.
- Lead Screening in Children: increased from 60% to 71%.
- Timeliness of Prenatal Care: increased from 71% to 83%.
- Postpartum Care: increased from 51% to 63%.
- Well-Child Visits in the First 15 Months – 6 or more: increased from 54% to 70%.

The performance measures with a ten-percentage point increase or more had dedicated performance improvement projects under the MMA program:

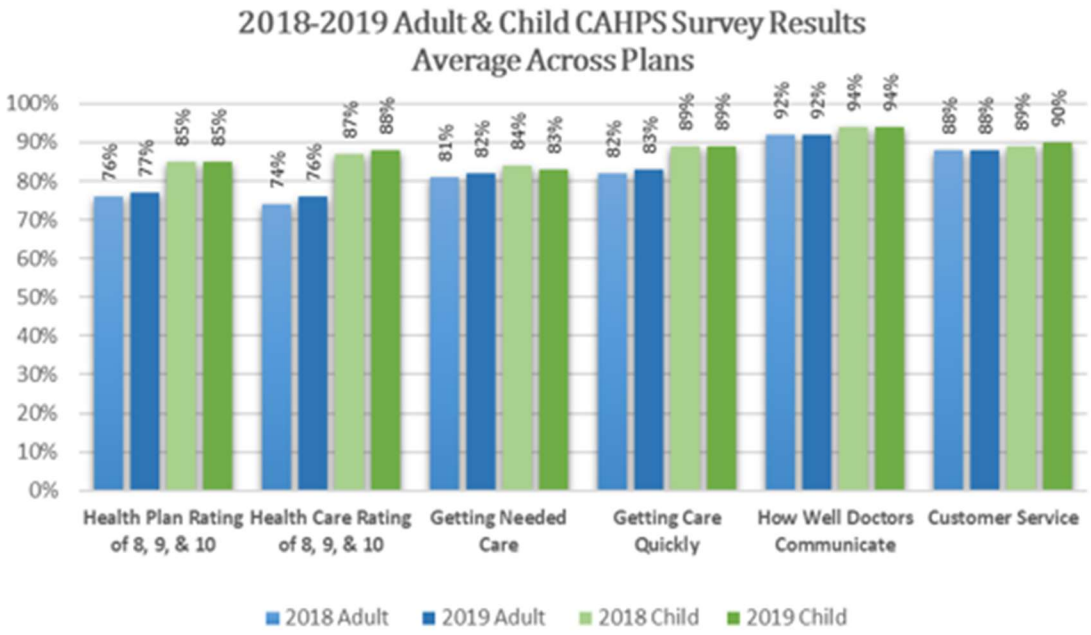
- Focus on preventive dental services for children led to overall performance improvement in dental visits.
- Focus on prenatal care and well-child visits in the first 15 months resulted in performance improvements in the prenatal care and postpartum care measures and the well-child visits measure.

Enrollee Satisfaction Surveys Results

The health plans are required to contract with a certified survey vendor to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey each year. The surveys must be conducted according to the National Committee for Quality Assurance's (NCQA) mixed mode protocols, and health plans must conduct both adult and child surveys. The health plans are required to report their certified results to both the Agency and NCQA annually; NCQA includes the results in the national Medicaid means and percentiles.

Overall, the MMA CAHPS survey results for 2018 and 2019 showed health plans consistently having high enrollee satisfaction rates. Health plan enrollees reported having positive experiences with getting care quickly, getting needed care, customer service, and communicating with their providers.

In 2018, 76% of adult members and 85% of parents of child enrollees rated their health plans an 8, 9, or 10. In 2019, 77% of adult members and 85% of parents of child enrollees rated their health plans an 8, 9, or 10. Please see the chart below for additional detail.



The above chart contains the 2018 and 2019 Adult and Child CAHPS survey results, showing the average across health plans.

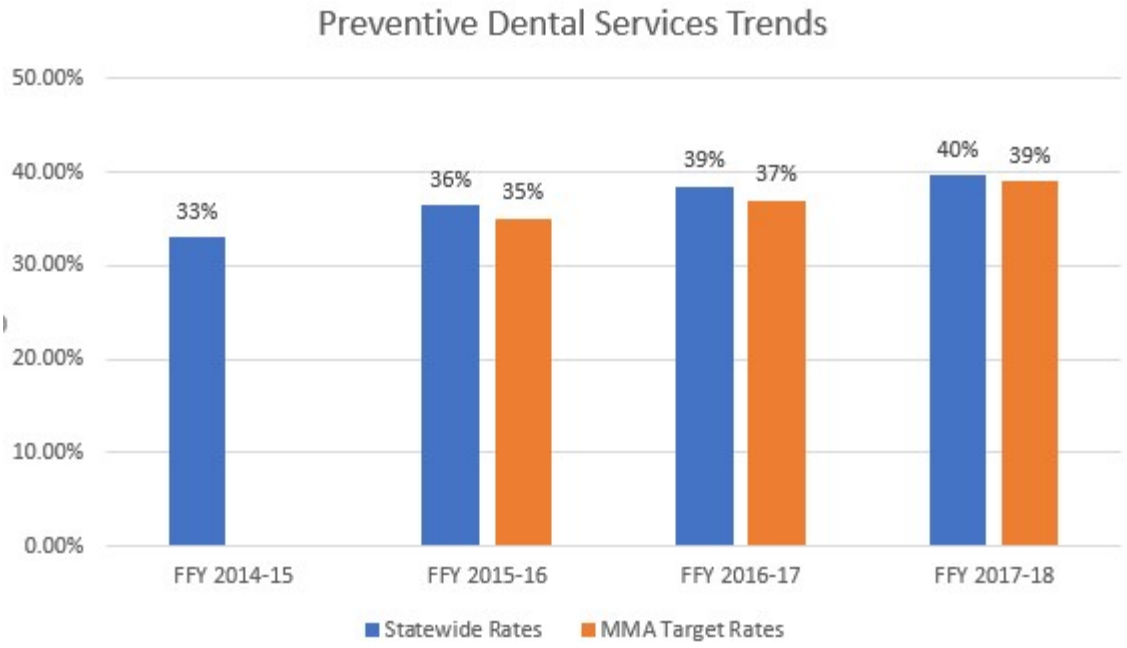
Rates in the above chart indicate the percentage of survey respondents giving an 8, 9, or 10 rating; a usually or always rating; or a very good or excellent rating.

CMS-416 Results

The MMA program has allowed the State to set incremental target measures to improve the rate at which children access services. The measures are reported annually within the CMS-416 Well-Child Visit Report that is submitted to CMS for the Federal Fiscal Year (FFY). The health plans may be assessed liquidated damages if they do not achieve the set target measures on this, as well as on the dental preventive and treatment services rates. Health plans must achieve at least 80% for those enrollees who are continuously enrolled in the health plan for at least eight months for the Florida Screening Ratio measure. The plans far exceeded this for FFY 2017-2018, achieving a Screening Ratio across the health plans of 93.7%.

In FFY 2017-2018, nine health plans met or exceeded the 39% target rate for preventive dental services. Preventive dental has been the subject of a targeted, mandatory performance improvement project. The 39% target was Florida Medicaid's highest performance rate set to date for preventive dental services and represents a 25-percentage point increase over the State's FFY 2011 rate of 14%. Since the inception of MMA in FFY 2014-2015, the health plans have been trending above the contractual targets for this measure. Failure to meet preventive dental services rates may result in the State requiring plans to implement corrective action plans, in addition to imposing liquidated damages.

The statewide rates for each FFY, and corresponding target rates, are outlined in the following chart. The Agency did not have target rates for FFY 2014-2015 as this was within the MMA and SMMC transition period.



Medicaid Health Plan Report Card

The Agency, in its efforts to promote transparency, publishes a Medicaid Health Plan Report Card, which highlights key performance measures in a consumer-friendly format. The Report Card is updated annually and illustrates HEDIS scores utilizing a five-star rating system, grouping HEDIS measures into related and understandable categories, such as Keeping Kids Healthy and Pregnancy-Related Care. The Medicaid Health Plan Report Cards are available online at the Agency's award-winning Consumer Health Care Transparency website, www.FloridaHealthFinder.gov.

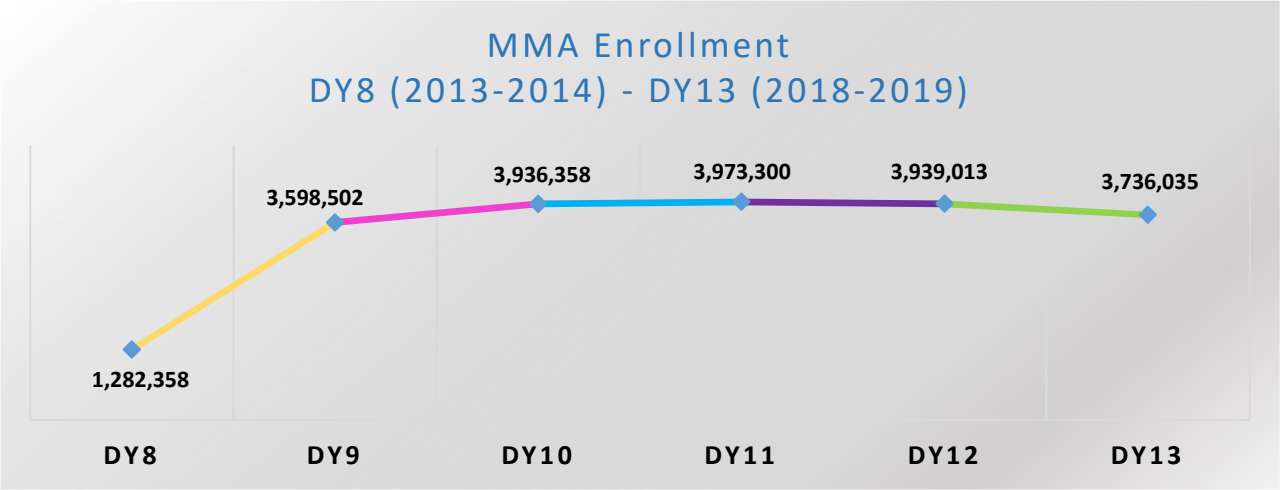
The State is developing other transparency tools to assist in driving improvements in health care outcomes. This includes more frequently updated dashboards that will allow the State, the plans, and its stakeholder partners to measure the impact of the interventions being implemented to drive to the quality improvement goals. Six dashboards displaying data about potential preventable hospitalizations, re-admissions, and emergency department visits and for neonatal abstinence syndrome, preterm births, and C-sections are live and being used by the quality improvement workgroups. For the potentially preventable hospital events, the dashboards are interactive, and users can display data by year, region, health plan, and recipient gender, race/ethnicity, and age group. The dashboards are on the Agency's Quality Initiatives Dashboard website, available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityandPerformanceMeasuresDashboardSeries-20190923/SwitchboardMain?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no

IMPROVED ACCESS TO COORDINATED CARE

The MMA program promotes coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner.

Enrollment

Since the statewide rollout of the MMA program in DY9, the average yearly enrollment figure has been 3,836,642. The MMA program's enrollment has remained consistent with minor fluctuations from year to year. The trend since DY9 indicates that the MMA program has matured and stabilized, operating smoothly and efficiently. The decline in enrollment is DY13 is consistent with an overall decline in Medicaid enrollment.



Auto-Assignment and Self-Selection

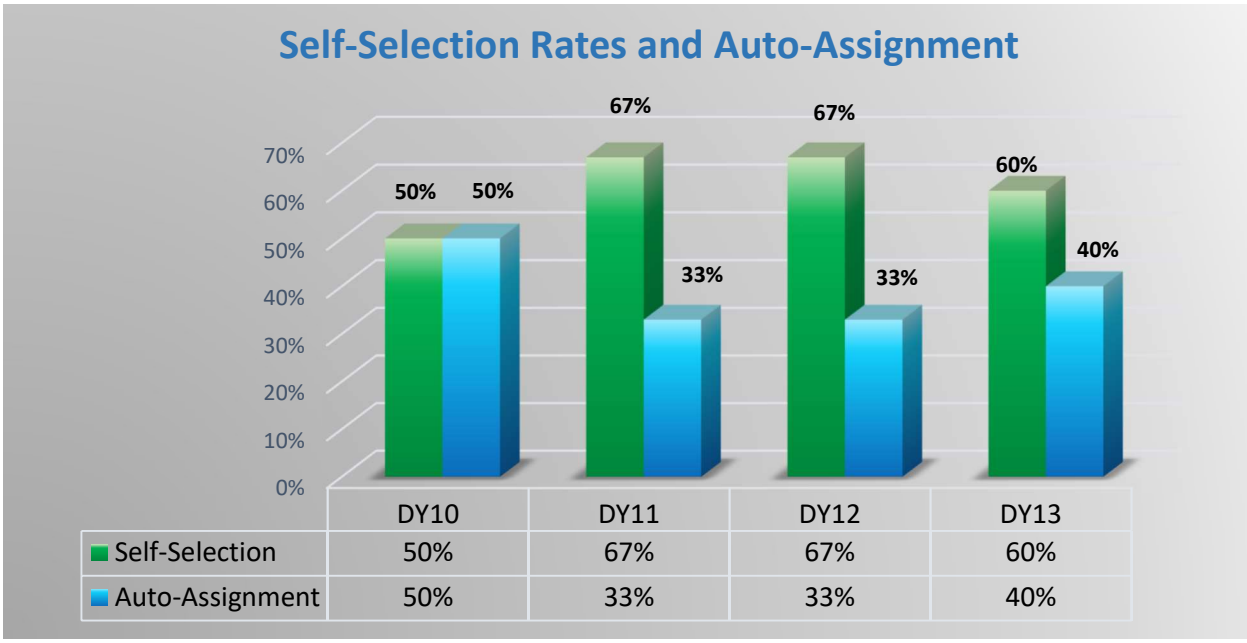
To facilitate early enrollment and earlier access to the benefits of the managed care delivery system for Medicaid eligible recipients, the State has been:

- Automatically enrolling new Florida Medicaid eligible recipients into a managed care plan immediately upon eligibility determination since 2015.
  - Florida encourages individuals to take an active role in the health plan selection process prior to or upon their eligibility determination. Information regarding the health plan enrollment process, as well as plan availability in their area, is provided upon submission of their Florida Medicaid eligibility application.
  - If the individual does not select a health plan prior to becoming Medicaid eligible, the State utilizes an algorithm to select a health plan that best fits their needs, and immediately assigns them to that plan. This assignment process ensures there is no lag time between an individual's eligibility determination and health plan enrollment, which grants recipients immediate access to care. All individuals enrolled have an open

enrollment window of 120-days during which they are permitted to change their health plan.

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

The State's efforts to engage individuals by providing extensive information upon their application for Florida Medicaid, which encourages them to take an active role in their health care by selecting a health plan prior to their eligibility determination or during the 120-day post enrollment change period, have been successful. As the following chart illustrates, the percentage of recipients selecting their health plan was increased and stabilized prior to DY13, indicating that the State's efforts have been successful.

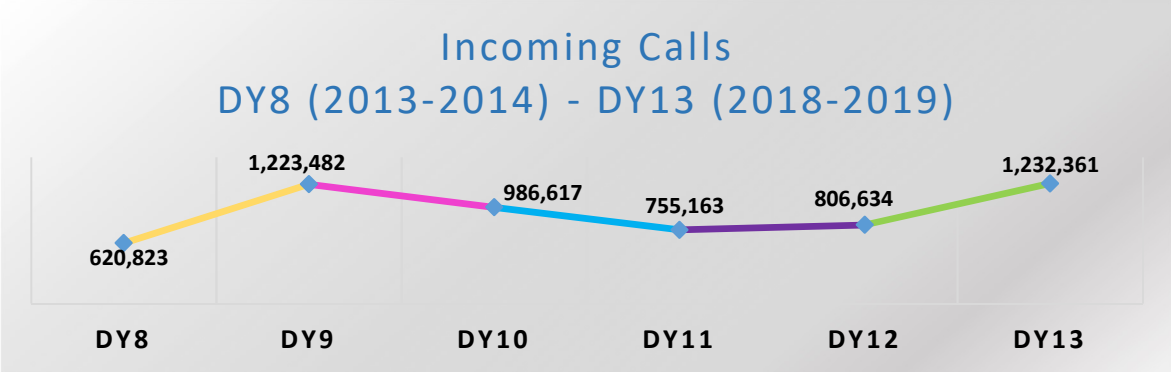


There was a 7-percentage point decrease in the self-selection rate from DY12 to DY13. This was due to the health plan procurement process. Individuals whose health plans were no longer going to be contracted with the State or were no longer going to be covering the individual's Medicaid region after the end of the 2014-2018 contract period received a health plan auto-assignment followed by an open choice period upon the expiration of the contract.

Choice Counseling Activities

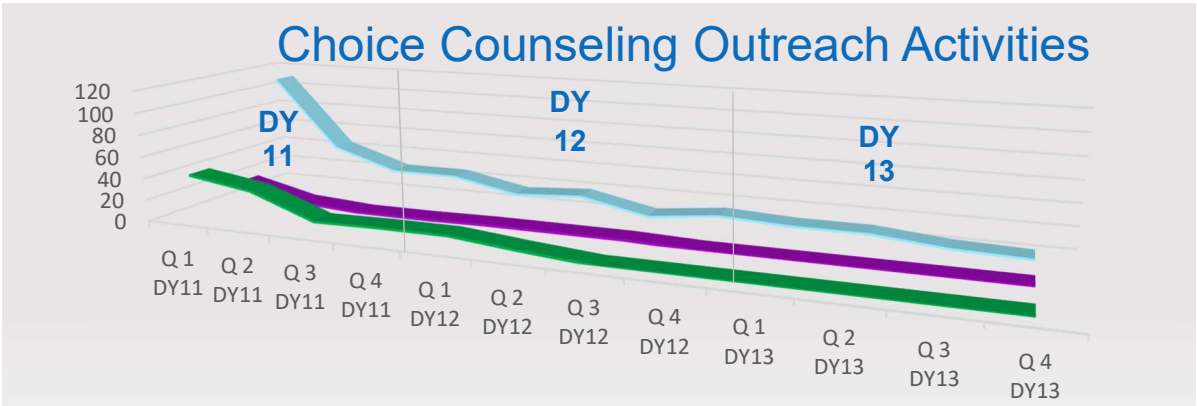
The Agency contracts with an enrollment broker/choice counseling vendor to manage Florida Medicaid recipients' enrollment in, and disenrollment from, managed care plans. This also includes the operation of the call center and other outreach activities such as mailings.

The chart below details the choice counseling center's call volume from DY8 to DY13.



As illustrated above, DY9 and DY13 had the highest incoming call rates. This is due to the MMA program expanding statewide in DY9 and the health plan re-procurement in DY13. There was also an increase in call volume during DY12. This was due to the consolidation of the 1915(c) Project AIDS Care Waiver, Adults with Cystic Fibrosis Waiver, and Traumatic Brain and Spinal Cord Injury Waiver into the SMMC program. During this time, individuals affected by the consolidation were permitted to change their health plans. The level of call volume indicates individuals actively engaging in selecting their health plan.

Choice counseling outreach activities include group counseling sessions, private counseling sessions, and home visits, which also entail one-on-one counseling sessions and are available to all Medicaid recipients. However, as online resources have been expanded, through the development of the online portal, and the availability of the call center increased, the overall demand for home visits and one-on-one choice counseling sessions continues to decrease; as illustrated below. This downward trend is not surprising as the MMA program has matured and recipients have become more comfortable and familiar with the program.



	Q 1 DY11	Q 2 DY11	Q 3 DY11	Q 4 DY11	Q 1 DY12	Q 2 DY12	Q 3 DY12	Q 4 DY12	Q 1 DY13	Q 2 DY13	Q 3 DY13	Q 4 DY13
Group Sessions	41	32	10	11	11	5	0	0	0	0	0	0
Private Sessions	19	5	1	1	2	2	2	0	0	0	0	0
Home Visits & One-On-One Sessions	110	45	26	26	14	18	5	12	9	9	3	1

LOW INCOME POOL

The objective of LIP is to increase access to, stabilize, and strengthen Florida providers who serve Medicaid, uninsured, and underinsured low-income populations. This is achieved by targeting LIP funding to reimburse charity care costs for services provided to these populations. Eligible providers are hospitals, medical school faculty physician practices, behavioral health providers, federally qualified health care centers, and rural health clinics that furnish care through charity care programs that adhere to the Healthcare Financial Management Association principles. The LIP program operates as a charity care pool used to compensate participating providers for their charity care cost, as long as each of the providers meet the participation requirements in STC 71.

Charity care is health care provided at reduced or no cost to low-income patients, and the LIP program reimburses providers for these services up to cost as long as the services are within the definition of "medical assistance" provided in Section 1905(a) of the Social Security Act. The annual allotment for the LIP program, which may not be exceeded and cannot roll over into the next demonstration year, is $1,508,385,773. Permissible expenditures for the program are expressed in STC 66 through 68 of the MMA Waiver as well as in the Reimbursement and Funding Methodology Document. In DY13, the State paid $857.6 million to qualified providers. **Table 3** details the amount paid in DY13 to each of the provider groups.

TABLE 3: DY13 Paid Amounts to Provider Groups

Provider Group	Behavioral Health Providers	FQHCs	Medical School Physicians	Hospitals
DY13 Reported Charity Care Costs	$9,968,026	$278,576,830	$101,302,245	$9,833,833,094
LIP Payments	$7,489,752	$40,546,416	$101,302,245	$708,268,904
Percentage of Charity Care Costs Covered by LIP Payments	75%	15%	100%	7%

The evaluation will include a review of both claims-based reimbursement (through the Diagnosis Related Groups and Enhanced Ambulatory Patient Groups methodologies) and supplemental payments.

RETROACTIVE ELIGIBILITY

The waiver of retroactive eligibility eliminates retroactive Medicaid coverage for non-pregnant adults only, meaning payments for Medicaid-covered services begin the first day of the month in which an application was submitted, rather than up to three-months prior to the month in which an application was submitted. Eligible pregnant women and children under the age of 21 are not affected by this waiver and are still eligible for retroactive Medicaid coverage for up to 90 days prior to the month in which their application was submitted.

The retroactive eligibility policy change, implemented by the State in February 2019, enhances fiscal predictability for the State, promotes continuity of care for recipients, and encourages individuals to engage the health care system by applying for Florida Medicaid as soon as they become eligible. This allows individuals to be placed in a health plan and receive care coordination immediately upon approval of their Medicaid application. By promoting personal responsibility, individuals are encouraged to participate in their own health care by securing and keeping health coverage; individuals should apply for Medicaid without hesitation to encourage continuity of eligibility and enrollment. The waiver of retroactive eligibility will continue to operate under the current STCs for the requested two-year extension period.

The two-year extension would permit the State to continue operating with the waiver of retroactive eligibility while providing the essential time to fully evaluate the policy change's progress towards the goals of fiscal predictability, continuity of care, and personal responsibility as well as the impact to individuals and providers.

BEHAVIORAL HEALTH AND SUPPORTIVE HOUSING

The State initiated a pilot program for Medicaid recipients in Medicaid regions 5 and 7 (Pinellas, Pasco, Seminole, Orange, Osceola, and Brevard counties). There were kickoff events for the Behavioral Health and Supportive Housing Assistance pilot, hosted by the State, on November 20, 2019 and November 21, 2019 in Medicaid regions 5 and 7, respectively. The events were for program providers, the health plans, and interested stakeholders. Secretary Mary C. Mayhew presented and publicly announced the four health plans selected to participate in the pilot program. The event highlighted that the new pilot will be a collaborative effort, between the State and the four health plans; the pilot program officially began on December 1, 2019.

The overall goal of the Behavioral Health and Supportive Housing Assistance pilot is to facilitate housing stability and improve health outcomes for participants. The intent is to serve approximately 4,000 Medicaid recipients annually. This pilot provides additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD), or SMI with co-occurring SUD, and who are homeless or at risk of homelessness due to their disability. This program will provide enrollees with additional tools necessary to improve health outcomes and achieve stable tenancy and is projected to have the effect of reducing state costs related to unnecessary beneficiary service utilization.

Supportive services offered through the pilot program are designed to promote autonomy and aid in effectively helping recipients engage and remain in their community. These services consist of:

- Transitional housing services - designed to prepare and support the transition into permanent housing
- Tenancy sustaining services - supports the individual in being a successful tenant
- Mobile crisis management - established to provide immediate, on-site de-escalation of issues when crises occur
- Self-help/peer support - designed to allow individuals to work with peer support specialists to help manage SUD or SMI symptoms and promote community living skills
- One-time incidental payment– assists with moving expenses or other housing related needs

Through this program, the State is evaluating the effectiveness of services by assessing the:

- Percentage of participants who achieved housing permanency
- Percentage of participants whose days of homelessness were reduced (when applicable)
- Percentage of participants diagnosed with a SUD receiving medication assisted treatment
- Percentage of participants diagnosed with an SMI who are compliant with medication management requirements
- Percentage of reduced emergency department and inpatient hospital use among participants

The demonstration objective is to improve the integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

To date, the State has enrolled over 279 participants. While it is too early to provide outcome data, evidence-based studies demonstrate that addressing an individual's social determinants of health is critical to achieving optimal health outcomes. Many of Florida's health plans have programs that focus on addressing such social determinants; however, the need for housing assistance continually comes up as a barrier in need of resolution to address high emergency department use or re-admission rates among recipients diagnosed with an SMI or SUD. The State hopes to capitalize on the successes of this pilot to expand statewide.

Extending the current waiver affords the State the time to achieve optimal enrollment in the program and to bring the program's goals into fruition. Under the extension, the State would have time to collect data on the program's operations and to conduct a deeper evaluation on the effectiveness of the program. The program's effectiveness is evaluated based on the extent to which the provision of these services results in increased care coordination, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care services.

FINANCIAL ACCOUNTABILITY

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

BUDGET NEUTRALITY

Since the start of the demonstration in 2006, expenditures have been well below the authorized budget neutrality limit. As a result, the State continues to be in substantial compliance with the waiver budget neutrality requirements and anticipates that this trend will continue. See **Attachment IX** for the full budget neutrality.

FINANCIAL MANAGEMENT STANDARD QUESTIONS

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

SUMMARY OF PROGRAM MONITORING

This section provides summaries of the External Quality Review Organization (EQRO) reports, health plan information, State quality assurance monitoring, and other documentation pertaining to quality and access to care provided under the demonstration. The health plans submit performance improvement project results annually and, in DY12, all of the State-mandated performance improvement projects experienced statistically significant improvement. This was the highest percentage increase to date across all of the State-mandated performance improvement topics. The accomplishments achieved, and the upward trend in meeting or exceeding performance improvement project goals, illustrate the continued effectiveness of the program, which will continue to improve through collaborative efforts such as those highlighted in previous sections regarding the health and dental plan quality improvement targets. More detailed information on the mandated performance improvement projects is contained in the following sections.

EXTERNAL QUALITY REVIEW REQUIREMENTS

The Agency contracts with the Health Services Advisory Group (HSAG) as its External Quality Review Organization vendor. The Agency is responsible for contracting with an EQRO and conducting other quality improvement activities, including but not limited to audits of:

- Enrollee records,
- Enrollee plans of care,
- Provider credentialing records,
- Service provider reimbursement records,
- Contractor personnel records, and
- Other documents and files as required under the Contract and its Exhibits.

Contained below is a summary of activities performed by the Florida EQRO and their key findings.

VALIDATING PERFORMANCE IMPROVEMENT PROJECTS

The health plan Performance Improvement Projects (PIP) are showing significant improvements. For the SFY 2017–2018 (DY12) PIP validation cycle, the plans progressed to reporting their performance indicator results after having implemented their interventions for the first re-measurement, after year one, and the second re-measurement after year two. Across the three state-mandated topics (Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits, Preventive Dental Services for Children, and Medication Review), 73% of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. Every one of the 14 Preventive Dental Services for Children PIPs achieved statistically significant improvement over baseline for the PIP's one study indicator.

IMPROVING PERFORMANCE MEASURES

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

Over the past few years, the Agency has made several changes to the required performance measures. These changes were due to modifications to the HEDIS measures by the National Committee for Quality Assurance and changes to CMS' Child and Adult Core set. The Agency has selected standardized national measures as much as possible but has retained several Agency-defined measures when there were no comparable national measures for key areas of health outcomes. The Agency has also added several of the CMS Medicaid Adult Core set measures to the reporting requirements for the health plans.

VALIDATING PERFORMANCE MEASURES

As discussed in the Program Performance Improvement section, the health plans must report on a specific set of performance measures selected by the Agency. The EQRO determines that the data collected and reported by the health plans for the performance measures selected by the Agency followed the appropriate methodology. The EQRO then reviews and validates the audit findings from each health plan's final audit report produced by the licensed auditing organization. Therefore, any rates and audit designations are determined to be valid, reliable, and accurate. The EQRO conducted performance measure validation activities for calendar year 2017 and 2018 measures. The Agency has reviewed the draft validation report for calendar year 2018 and the EQRO is in the process of finalizing the report. The initial findings show that the performance measures were calculated accurately.

VALIDATING ENCOUNTER DATA

The Agency, in its continuing efforts to improve encounter data, developed the Health Plan Portal. This portal grants health plans access to view encounter data within the Florida Medicaid Management Information System. It contains monitoring tools, such as dashboards and reports on timeliness and accuracy, to assist the health plans in monitoring and tracking encounter accuracy, and it permits plans to submit online attestations, conduct encounter look-ups, view accuracy and timeliness trend data, and submit enhanced benefit data. The Health Plan Portal was implemented in January 2019, and the Agency has hosted meetings with the plans, both online and in-person, to provide a platform for health plans to provide comments and feedback regarding the Health Plan Portal and the encounter validation process.

The improved Encounter Accuracy Report was implemented in April 2019, and provides detailed information regarding every rejected encounter, including the denial reason. The dissemination of these reports has provided the health plans with valuable information, and the easy-to-use platform

has assisted the plans in determining where encounter submission improvements need to be implemented.

These targeted efforts to improve the completeness and accuracy of encounter data have matured to the point that hospital and pharmacy encounter data, which account for approximately 53% of costs, will be used for rate year 2020-2021 capitation rate setting. Previously, the State has used supplemental data sources for rate-setting. By rate year 2021-2022, the State will rely solely on encounter data for capitation rate setting. During State Fiscal Year 2016-2017 (DY11), the EQRO conducted a review of encounter data for dates of services from January 1, 2016 through June 30, 2016, as a follow-up to the study of dental encounters conducted in SFY 2015-2016 (DY10). The review showed that the encounter data had achieved a high level of accuracy, including the following validation findings:

- The overall accuracy rate for procedure codes associated with validated dates of service from the encounter data that were correctly coded on the enrollees' medical records showed a high overall accuracy rate of 94% (7,372 of the 7,849 code pairs found to have equivalent values).
- Dental procedure code validity was high for both plans' and the Agency's submitted encounters with at least 99% valid values.
- The procedure code accuracy rates showed minimal variation across plans, with rates ranging from 87% to 98%.

During SFY 2019-2020 (DY14), the Agency contracted with the EQRO to conduct a review of encounter data for dates of services from January 1, 2018 through November 30, 2018, for MMA physician (professional) encounters. The Agency anticipates the study being completed by June 2020.

AGENCY MONITORING AND COMPLIANCE OUTCOMES

The Agency oversees the program utilizing a multi-prong monitoring approach that incorporates subject matter experts across the Agency to ensure health and dental plans are in compliance with their contracts. The Agency monitors plans' performance through a variety of mechanisms including, but not limited to, plan reports and submissions, desk and on-site compliance reviews, and reviews of complaints and grievances. Monitoring efforts occur weekly, monthly, quarterly, yearly, and on an ad-hoc basis.

This compliance framework ensures plans are held accountable when an action, or lack thereof, does not meet contractual requirements. The most prevalent areas of non-compliance over the past four demonstration years, which resulted in a compliance action being taken, have been plan administration and management as well as covered services; demonstrated in the chart on the following the page and in **Table 4**.

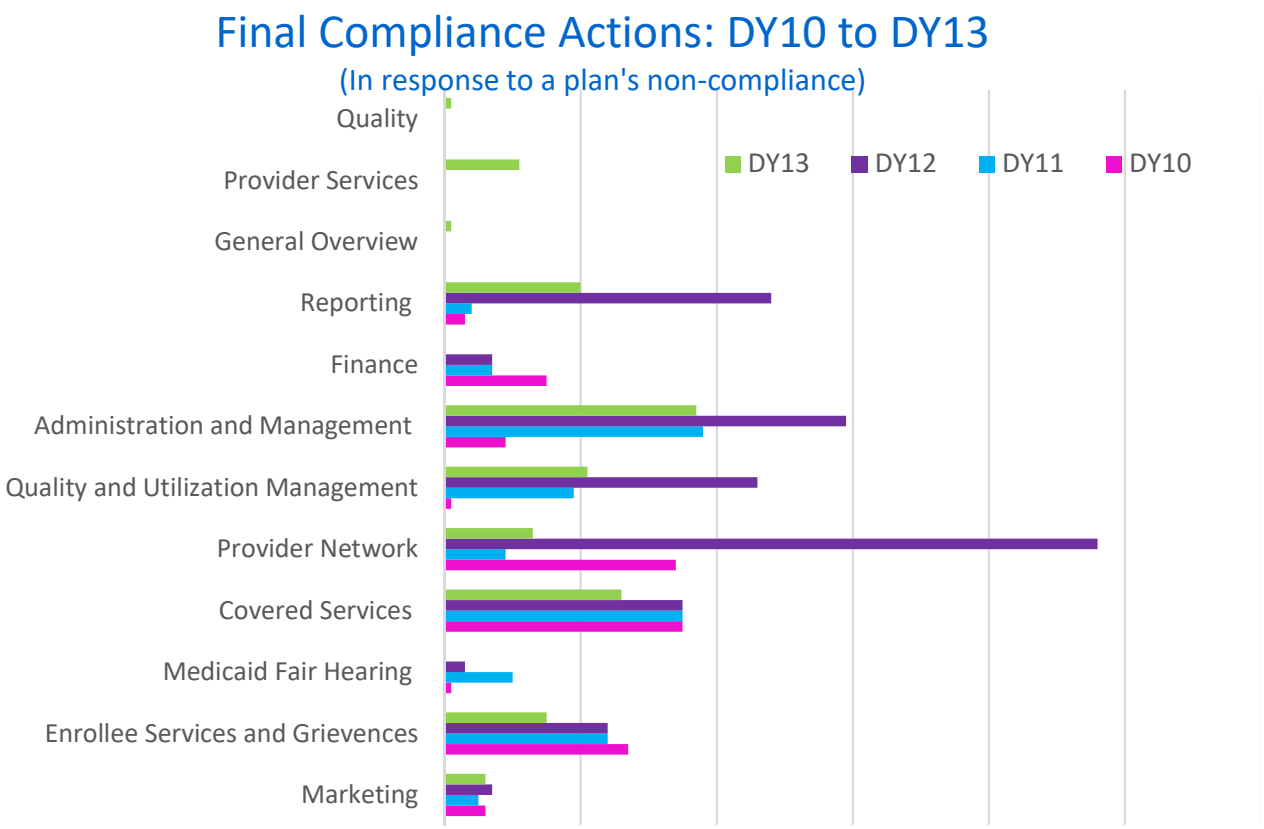


TABLE 4: Itemized Compliance Actions				
Area of Non-Compliance (contract violation)	DY10	DY11	DY12	DY13
Marketing	6	5	7	6
Enrollee Services and Grievances	27	24	24	15
Medicaid Fair Hearing	1	10	3	0
Covered Services	35	35	35	26
Provider Network	34	9	96	13
Quality and Utilization Management	1	19	46	21
Administration and Management	9	38	59	37
Finance	15	7	7	0
Reporting	3	4	48	20
General Overview	0	0	0	1
Provider Services	0	0	0	11
Quality	0	0	0	1
Totals	**131**	**151**	**325**	**151**

COMPLAINT DATA

To enhance transparency, promote efficiency, and improve tracking, trending, and response times, the Agency established a centralized recipient and provider assistance operations center to receive and manage all complaints. Recipients, providers, or any other stakeholder may report complaints to the Agency:

Online: http://ahca.myflorida.com/Medicaid

By phone: 1-877-254-1055

Recipients and providers may also report complaints directly to the plan. The following graph and corresponding table contain health and dental complaint data, reported both to the plans and the Agency, for DY11 through DY13. Please note that the total complaint data may contain duplicative information as recipients and/or providers may have filed the same complaint with both the plan and the Agency.

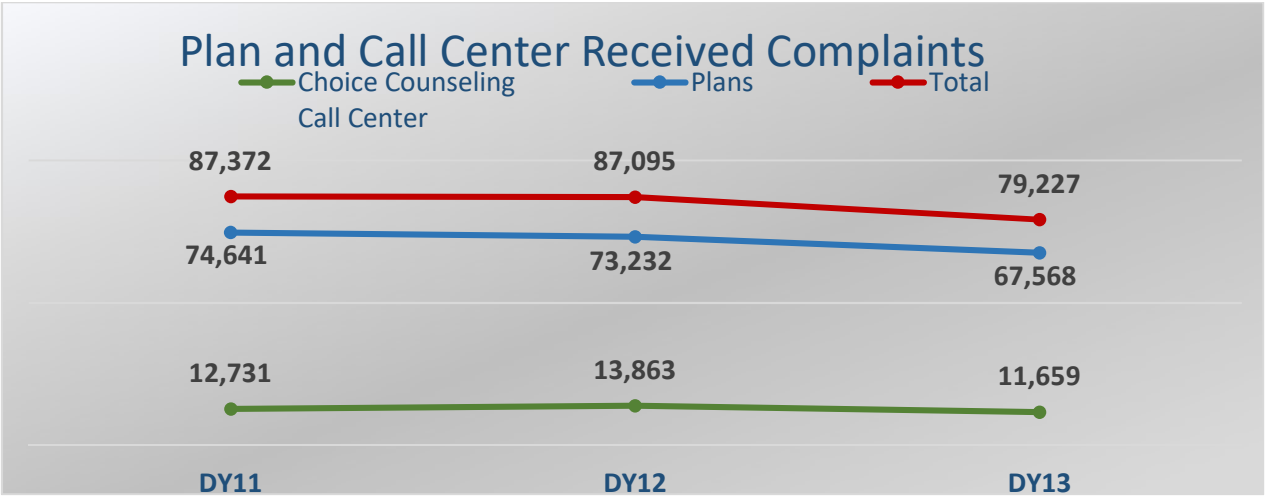


TABLE 5: Health and Dental Complaint Data

Complaint Source	DY11	DY12	DY13
Choice Counseling Call Center	12,731	13,863	11,659
MMA Plan	74,641	73,232	67,568
Total	**87,372**	**87,095**	**79,227**

	DY11	DY12	DY13
Enrollment	3,973,300	3,939,013	3,736,035
Plan and Call Center Complaints*	87,372	87,095	79,227
Complaints per 1,000 Enrollees	**22**	**22**	**21**

EVALUATION STATUS AND FINDINGS

This section provides a summary of the interim evaluation report of the demonstration, including evaluation activities and findings to date and plans for evaluation activities during the extension period.

EVALUATION OF THE DEMONSTRATION

The evaluation of the demonstration is an ongoing process conducted during the life of the demonstration. The purpose of evaluating demonstration components is to ensure that all of the programs authorized under the demonstration are operating successfully and to identify areas for improvement. Evaluation reports are required under the Code of Federal Regulations as well as the Special Terms and Conditions of the waiver.

For a demonstration extension request, 42 CFR 431.412(c)(vi) requires an evaluation report to be submitted alongside the demonstration extension application. The State is requesting that CMS waive this requirement for this early extension application under the flexibilities available in 42 CFR 431.412(3), which specifies that a state may propose application modifications. The State's request to waive the evaluation report with this application would not constitute a substantial change to the original demonstration as the Agency has been operating under the approved STCs and evaluation design timeline. The currently approved evaluation design timeline states that the Draft Interim Evaluation Report, for the completed years of the demonstration, DY9 through DY14, is due to CMS on January 1, 2022 and the Agency anticipates meeting that deadline.

EVALUATION DESIGN

The evaluation design includes a discussion of the goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on recipients, providers, plans, market areas, and public expenditures. Agency staff work with the independent evaluators at the University of Florida on an ongoing basis to update and revise the evaluation design to align with the amended STCs as needed. The Agency submitted the following amendment requests to CMS, which included subsequent updates to the evaluation design:

- An amendment to operate a statewide Medicaid Prepaid Dental Health Program was approved November 2018.
- An amendment to waive retroactive eligibility for certain populations was approved November 2018, and evaluation guidance regarding this component was received in March 2019.
- An amendment to operate a Behavioral Health and Supportive Housing Assistance pilot was approved March 2019. Under this amendment, the State is authorized to implement a pilot program providing behavioral health services and supportive housing assistance services to beneficiaries who have a serious mental illness (SMI), substance abuse disorder (SUD), or co-occurring SMI/SUD diagnoses.

- The Agency submitted the finalized evaluation design incorporating the retroactive eligibility and Behavioral Health and Supportive Housing Assistance programs on March 2, 2020.

DY11 MMA WAIVER EVALUATION FINDINGS

Notable findings for the evaluation of DY11 (SFY 2016-17) for Projects 1 through 4 are included below.

PROJECT 1: ACCESS TO CARE, QUALITY OF CARE, AND COST OF CARE

- Performance on HEDIS measures related to access to care remained relatively stable between CY 2016 and 2017, although two measures noticeably improved: Adult's Access to Preventive/Ambulatory Services for enrollees over the age of 65 (80% in CY 2016 to 90% in CY2017) and Well Child Visits in the First 15 Months of Life (63% in CY 2016 to 70% in CY2017).
- Performance on CAHPS measures related to access to care were stable between DY10 (SFY2015-16) and DY11 (SFY2016-17) for both adults and children.
- Improvements in performance indicators associated with certain Performance Improvement Projects have occurred between 2017 and 2018. Key factors associated with the success of specific initiatives include aggressive outreach and engagement with enrollees.
- Improvements in the quality of care shown in DY9 (SFY2014-15) and DY10 (SFY2015-16) have been sustained with relatively little year-to-year change.
- Medicaid costs per member per month are lower in the MMA period (SFY 2014-15 through SFY 2016-17) compared to the pre-MMA period (SFY 2011-12 through SFY 2013-14) while quality of care remained stable.

PROJECT 2: HEALTHY BEHAVIORS PROGRAMS

- Of the mandatory programs required of all plans in DY11, the medically-directed weight loss program reported the highest number of current enrollees (31,273), as well as the highest number of enrollees who completed the program (658).
- Out of all healthy behavior programs in DY11, the well-child visits program had the highest number of enrollees who completed the program (124,608), followed by the dental program (58,273).

PROJECT 3: LOW INCOME POOL (LIP)

- In DY11, 157 hospitals received a total of approximately $577 million in LIP supplemental payments for providing charity care services to individuals.

- Hospitals that received LIP funding and reported milestone data in DY11 reported providing approximately 7.5 million total service encounters for charity care to patients across six service categories.

PROJECT 4: DUAL-ELIGIBLE ENROLLEES

- For behavioral health services in DY11, dual-eligible enrollees have lower dollars per user compared to non-dual-eligible enrollees ($389.65 vs. $1,563.86, respectively).
- For behavioral health services in DY11, both dollars per encounter and encounters per user are lower for dual-eligibles compared to non-dual-eligibles ($81.80 vs. $144.51 and 4.76 vs. 10.82, respectively).
- In DY11, dual-eligible enrollees are using more transportation services, but those services have lower costs per use compared to non-dual-eligible enrollees.

DY12 MMA WAIVER PRELIMINARY EVALUATION FINDINGS

The DY 12 (SFY 2017-18) evaluation has been completed by the evaluator and is undergoing State review, though the findings typically do not change as part of this review. Preliminary notable findings for Projects 1 through 4 are included below.

PROJECT 1: ACCESS TO CARE, QUALITY OF CARE, AND COST OF CARE

- Significant improvements were noted for Controlling High Blood Pressure (55 % to 64%) and Mental Health Re-Admission Rate (41% to 26%) from DY11 to DY12.
- 92% (22 measures) of the 24 service accessibility measures showed improvement and two measures remained stable between the pre-MMA and MMA periods.
- Average per member per month expenditures continue to be lower for all eligibility groups during the MMA period compared to the pre-MMA period, while performance on quality metrics has improved.

PROJECT 2: HEALTHY BEHAVIORS PROGRAMS

- Of the healthy behavior programs required of all plans in DY12, the medically-directed weight loss program reported the highest number of current enrollees (1,026), as well as the highest number of enrollees who completed the program (124).
- Out of all healthy behavior programs in DY12, the well-child visits program had the highest number of enrollees who completed the program (36,126), followed by pregnancy/ maternity programs (3,209).

PROJECT 3: LOW INCOME POOL (LIP)

- In DY12, 172 hospitals received a total of approximately $745 million in LIP payments.
- There were 7.9 million encounters across six service categories (discharges, inpatient days, emergency department visits, outpatient visits, affiliated encounters, and filled prescriptions) for charity care patients in DY12.

PROJECT 4: DUAL-ELIGIBLE ENROLLEES

- For behavioral health services in DY12, dual-eligibles had lower dollars per user compared to non-dual-eligibles ($253.68 vs. $1030.82, respectively).
- For behavioral health services in DY12, both dollars per encounter and encounters per user were lower for dual-eligibles compared to non-dual-eligibles ($53.67 vs. $110.94 and 4.73 vs. 9.28, respectively).
- For behavioral health services in DY12, both dollars per encounter and encounters per user contributed to the lower dollars per user for dual-eligibles.

PUBLIC NOTICES

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

PUBLIC NOTICE PROCESS

The Agency will conduct a public comment period from June 1, 2020 through June 30, 2020.

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

- Publish public notice on June 1, 2020 in the Florida Administrative Register in compliance with Chapter 120, Florida Statutes.
- Email information to individuals and organizations on its interested stakeholders list.
- Post a prominent link on the Agency's website to obtain the public notice materials:

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

CONSULTATION WITH INDIAN HEALTH PROGRAMS

The Agency will consult with the Indian Health Programs[2] located in Florida through written correspondence to solicit input on the waiver extension request. See **Attachment VI** for a copy of the letters.

PUBLIC MEETINGS

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

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in the workshop/meeting advise the Agency within at least seven days before the workshop/meeting by contacting Karen Williams-Rockwell by email at Karen.Williams-Rockwell@ahca.myflorida.com.

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

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

Schedule of Public Meetings		
Location	**Date**	**Time**
Webinar **GoToMeeting:** **https://attendee.gotowebinar.com/register/5097900362915034381**	June 8, 2020	3:00 p.m. – 4:00 p.m.
Webinar **GoToMeeting:** https://attendee.gotowebinar.com/register/2727264232989173008	June 17, 2020	3:00 p.m. – 4:00 p.m.

SUBMITTING WRITTEN COMMENTS

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

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

Email: FLMedicaidWaivers@ahca.myflorida.com

WAIVER AND EXPENDITURE AUTHORITIES

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

The State is not proposing any alterations or amendments to the STCs in this MMA Waiver extension request. The State is requesting that the current waiver and expenditure authorities, granted by the CMS on March 26, 2019 (and as specified in the STCs) be continued during the waiver extension.

The current approved STCs are located on the Agency's website at the below link:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Technical_Edit_STCs_07201902.pdf

ATTACHMENT I: BENEFIT PACKAGES

MMA Standard Benefit Package	
Advanced practice registered nurse services	Mental health services
Ambulatory surgical treatment center services	Medical supplies, equipment, prostheses, and orthoses
Birthing center services	Nursing
Chiropractic services	Laboratory and imaging services
Birth Center and Licensed Midwife Services	Optometrist services
Early and periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy services
Emergency services	Physician services, including physician assistant services
Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate	Podiatric services
Healthy Start services, except as provided in s. 409.975(4).	Prescription drugs
Optical services and supplies	Renal dialysis service
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services

Expanded Benefits Offered by Health Plans	
General Expanded Benefits *Available for children and/or adults*	Adult Expanded Benefits (cont.)
Cellular Services (minutes and/or data)	Mental Health Targeted Case Management
Circumcision (newborns only)	Nutritional Counseling
CVS Discount Program (20% discount off certain items)	Occupational Therapy
Doula Services (birth coach who helps pregnant women)	Outpatient Hospital Services
Home Delivered Meals	Pet Therapy
Housing Assistance (rent, utilities, and/or grocery assistance)	Physical Therapy
Meal Stipend (available for long distance medical appointment day-trips)	Prenatal Services
Over-the-Counter Benefit	Primary Care Services
Swimming Lessons (children only)	Respiratory Therapy
Transportation Services to Non-Medical Appointments/Activities	Speech Therapy
Adult Expanded Benefits *These services are only available for adults because they are already covered for children on Medicaid when medically necessary*	Substance Abuse Treatment or Detoxification Services (Outpatient)
Acupuncture Services	Therapeutic Behavioral On-Site Services
Art Therapy	Vaccine – Influenza
Behavioral Health Assessment/Evaluation Services	Vaccine – Pneumonia
Behavioral Health Day Services/Day Treatment	Vaccine – Shingles
Behavioral Health Intensive Outpatient Treatment	Vaccine – TdaP
Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)	Vision Services
Behavioral Health Psychosocial Rehabilitation	Waived Copayments

Adult Expanded Benefits (cont.)	Long-Term Care Services *these services are only available for LTC enrollees*
Behavioral Health Screening Services	Assisted Living Facility/Adult Family Care Home - Bed Hold Days
Chiropractic Services	Individual Therapy Sessions for Caregivers
Computerized Cognitive Behavioral Therapy	Nursing Facility to Community Setting Transition Assistance Adult Expanded Benefits (cont.)
Durable Medical Equipment/Supplies	Child Welfare Specialty Plan Services *these services are only available for enrollees in a specialty plan*
	Nursing Facility to Community Setting Transition Assistance
Equine Therapy	Care Grant Child Welfare Specialty Plan Services - *these services are only available for enrollees in a specialty plan*
Group Therapy (Behavioral Health)	Life Skills Development Care Grant
Hearing Services	Transition Assistance - Youth Aging Out of Foster Care Life Skills Development
Home Health Nursing/Aide Services	HIV/AIDS Specialty Plan Services *these services are only available for enrollees in a specialty plan* Transition Assistance
	Youth Aging Out of Foster Care
Homemaker Services (e.g., hypoallergenic carpet cleanings)	Home and Community-Based Services HIV/AIDS Specialty Plan Services – *these services are only available for enrollees in a specialty plan*
Home Visit by a Social Worker	Vaccine - Hepatitis B Home and Community-Based Services
Individual/Family Therapy	Vaccine - Human Papilloma Virus Vaccine - Hepatitis B
Massage Therapy	Vaccine – Meningococcal Vaccine - Human Papilloma Virus
Medication Assisted Treatment Services	Vaccine – Meningococcal

The dental plans also offer a wide array of expanded benefits to their enrollees. The following expanded benefits options are provided by the dental plans if recipients are 21 or older with prior approval from the plan:

Dental Plan Expanded Benefits
Additional dental exams
Additional dental X-rays
Additional extractions
Dental Screenings
Fillings (silver and white)
Fluoride
Oral Health Instructions
Sealants
Teeth Cleanings (basic and deep)

ATTACHMENT II: ADDITIONAL PROGRAMS

HEALTHY START PROGRAM

The Healthy Start program is available statewide for eligible Medicaid recipients. The Healthy Start program is comprised of the following two components:

1. MomCare

MomCare includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is mandatory for these women as long as they are eligible for Medicaid and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening, and WIC services. Recipients may dis-enroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, and Medicaid coverage for the infant and the need to select a primary care physician.

2. Healthy Start Coordinated System of Care

The Healthy Start Coordinated System of Care includes outreach and case management services for eligible pregnant women and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children, up to the age of three, who are identified to be at risk for a poor birth outcome, poor health, and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling.

PROGRAM FOR ALL INCLUSIVE CARE FOR CHILDREN (PACC)

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

- Support Counseling
  Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.
- Expressive Therapies
  Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.
- Respite Support

Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by registered nurse, licensed practical nurse, or home health aide with pediatric experience. This service is limited to 168 hours per year.

- Hospice Nursing Services

  Assessment, pain, and symptom management along with in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.

- Personal Care

  This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.

- Pain and Symptom Management

  Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

- Bereavement and volunteer services

  Bereavement and volunteer services are provided but are not reimbursable services.

COMPREHENSIVE HEMOPHILIA DISEASE MANAGEMENT PROGRAM

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service. The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs, via one of the specialized contracted vendors, from the therapeutic MOF Factor IX, and MOE- Anti-Hemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand.

The program provides the following services, at no additional cost to the State, in addition to product distribution:

- Pharmacy benefit management
- Direct beneficiary contact
- Personalized education
- Enhanced monitoring
- Direct support of beneficiaries in the event of hospitalization
- 24-hour, 7-day a week access to registered nurses and licensed pharmacists

Enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products, other than those related to factor replacement therapy, via the usual and customary networks without restriction. Medicaid-Medicare eligible individuals may voluntarily enroll in this program.

ATTACHMENT III: PERFORMANCE MEASURES AND RESULTS

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

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

Calendar Years (CY) 2017 and 2018 Florida Medicaid Managed Care Performance Measures				
	CY 2017		CY 2018	
Measure	CY 2017 Weighted Mean	CY 2017 Comparison to National Mean[1,4]	CY 2018 Weighted Mean	CY 2018 Comparison to National Mean[2,4]
Adolescent Well-Care Visits	57%	Higher	60%	Higher
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years	68%	Lower	70%	Lower
Adults' Access to Preventive/Ambulatory Health Services - 45-64 years	86%	Higher	86%	Higher
Adults' Access to Preventive/Ambulatory Health Services - 65+ years	90%	Higher	90%	Higher
Adults' Access to Preventive/Ambulatory Health Services - Total	75%	Lower	77%	Lower
Adult BMI Assessment	90%	Higher	89%	Higher
Annual Dental Visit - Total[3]	51%	Lower	50%	Lower
Annual Monitoring for Patients on Persistent Medications - ACEs/ARBs	93%	Higher	93%	Higher
Annual Monitoring for Patients on Persistent Medications - Diuretics	93%	Higher	93%	Higher
Annual Monitoring for Patients on Persistent Medications - Total	93%	Higher	93%	Higher
Antidepressant Medication Management - Acute Phase	53%	At the mean	53%	Lower
Antidepressant Medication Management - Continuation Phase	37%	Lower	37%	Lower
Asthma Medication Ratio- Total	N/A	N/A	72%	Higher
Breast Cancer Screening	58%	Lower	60%	Higher
Cervical Cancer Screening	60%	Higher	60%	Higher

	CY 2017		CY 2018	
Measure	**CY 2017 Weighted Mean**	**CY 2017 Comparison to National Mean[1,4]**	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[2,4]**
Controlling High Blood Pressure	55%	Lower	64%	Higher
Childhood Immunization Status - Combination 2	78%	Higher	78%	Higher
Childhood Immunization Status - Combination 3	74%	Higher	73%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95%	At the mean	95%	At the mean
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	88%	Higher	89%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	88%	Lower	89%	Lower
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	84%	Lower	86%	Lower
Chlamydia Screening in Women - 16-20 years	62%	Higher	64%	Higher
Chlamydia Screening in Women - 21-24 years	70%	Higher	71%	Higher
Chlamydia Screening in Women - Total	64%	Higher	65%	Higher
Comprehensive Diabetes Care - HbA1c Testing	86%	Lower	86%	Lower
Comprehensive Diabetes Care - HbA1c Poor Control (INVERSE)	41%	Lower (Better)	42%	Lower (Better)
Comprehensive Diabetes Care - HbA1c Good Control	49%	Higher	48%	Lower
Comprehensive Diabetes Care - Eye Exam	55%	At the mean	56%	Lower
Comprehensive Diabetes Care - Nephropathy	93%	Higher	92%	Higher
Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years	11%	Lower	12%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years	6%	Lower	5%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - Total	7%	Lower	7%	Lower

	CY 2017		CY 2018	
Measure	**CY 2017 Weighted Mean**	**CY 2017 Comparison to National Mean[1,4]**	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[2,4]**
Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase	48%	Higher	41%	Lower
Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	64%	Higher	55%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years	43%	At the mean	42%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 18+ years	42%	Higher	42%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - Total	42%	Higher	41%	Lower
Immunizations for Adolescents - Combination 1	72%	Lower	74%	Lower
Lead Screening in Children	67%	Lower	71%	Higher
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	39%	Higher	40%	Higher
Timeliness of Prenatal Care	82%	Higher	83%	Higher
Postpartum Care	65%	Higher	63%	Lower
Use of Multiple Concurrent Antipsychotics in Children and Adolescents- Total	2%	At the mean	2%	At the mean
Use of First- Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	62%	Higher	62%	Higher
Well-Child Visits in the First 15 Months of Life - 0 Visits (INVERSE)	2%	Lower (Better)	2%	At the mean
Well-Child Visits in the First 15 Months of Life - 6+ Visits	69%	Higher	70%	Higher
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78%	Higher	78%	Higher

ATTACHMENT IV: CURRENTLY APPROVED WAIVER AND EXPENDITURE AUTHORITIES

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance

AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement—and not expressly waived in the title XIX waivers list below—shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act "the Act") to enable the state to continue its Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled "Medicaid Reform") consistent with the approved Special Terms and Conditions (STC). The state has acknowledged that it has not asked for, nor has it received, a waiver of Section 1902(a)(2).

These waivers are effective beginning the date of the amendment approval through June 30, 2022, unless otherwise specified.

Title XIX Waivers

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

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

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits.

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

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

4. Retroactive Eligibility **Section 1902(a)(34)**

Effective February 1, 2019, to enable Florida to only provide medical assistance beginning the month in which a beneficiary's Medicaid application is filed, for adult beneficiaries who are not pregnant or within the 60-day period after the last day of the pregnancy, and are aged 21 and older. The waiver of retroactive eligibility does not apply to pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or

individuals under age 21. The state currently has state legislative authority for this waiver through June 30, 2019. The state must submit a letter to CMS by May 17, 2019, if it receives state legislative authority to continue the waiver past June 30, 2019. In the event the state does not receive legislative authority to continue this waiver past June 30, 2019 and timely submit a letter to CMS to this effect, this waiver authority ends June 30, 2019.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from the date of the amendment approval through June 30, 2022, be regarded as expenditures under the state's title XIX plan, unless otherwise specified.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration.

1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.
2. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured and/or underinsured.
3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.
4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 18, effective January 1, 2018.
5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 19, effective January 1, 2018.
6. Expenditures for behavioral health and supportive housing assistance services to individuals in MMA, as described in STC 55, effective as of the approval date of the amendment (March 26, 2019). The state will implement this pilot less than statewide and institute annual enrollment limits to 42,500 member months each demonstration year.

a. REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 6.

All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the behavioral health and supportive housing assistance services. In addition, the following Medicaid requirement is not applicable:

i. Statewide Operation Section 1902(a)(1)

To the extent necessary to enable the state to operate on less than a statewide basis for behavioral health and supportive housing assistance services.

ii. Amount, Duration and Scope Section 1902(a)(10)(B)

To the extent necessary to enable Florida to limit the amount, duration, and scope of behavioral health and supportive housing assistance pilot services to restrict this benefit to those individuals diagnosed with a serious mental illness (SMI), substance use

disorder (SUD), or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability, as described in the STC 55.

iii. Reasonable Promptness Section 1902(a)(8)

To the extent necessary to enable the state not to provide behavioral health and supportive housing assistance pilot services when the enrollment cap for this benefit is reached, as specified in the STCs.

ATTACHMENT V: SUMMARY OF COMMENTS

Subject	Comment	Actioned (Y/N)	Notes
[Subject]	• Comment Summary		

ATTACHMENT VI: LETTERS TO THE MICCOSUKEE AND SEMINOLE TRIBES

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

May 29, 2020

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

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from June 1, 2020 to June 30, 2020. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held:

- Webinar: June 8, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/5097900362915034381
- Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

If you have any questions about this amendment or would like to hold a call, please contact Karen Williams-Rockwell of my staff via email at Karen.Williams-Rockwell@ahca.myflorida.com.

Sincerely,

Beth Kidder

Beth Kidder
Deputy Secretary for Medicaid

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

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

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

May 29, 2020

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

Dear Dr. Isaacs:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from June 1, 2020 to June 30, 2020. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held:

- Webinar: June 8, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/5097900362915034381
- Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

If you have any questions about this amendment or would like to hold a call, please contact Karen Williams-Rockwell of my staff via email at Karen.Williams-Rockwell@ahca.myflorida.com.

Sincerely,

Beth Kidder

Beth Kidder
Deputy Secretary for Medicaid

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

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

ATTACHMENT VII: FAR NOTICE

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

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

DATES AND TIMES: June 8, 2020, 3:00 p.m. – 4:00 p.m.; June 17, 2020, 3:00 p.m. – 4:00 p.m.

PLACES: Webinar; June 8, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link: GoToMeeting https://attendee.gotowebinar.com/register/5097900362915034381

Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link: GoToMeeting https://attendee.gotowebinar.com/register/2727264232989173008

GENERAL SUBJECT MATTER TO BE CONSIDERED: Two-year extension request for Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver.

SUMMARY DESCRIPTION OF EXTENSION REQUEST: The State is seeking federal authority to extend Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 through June 30, 2024. The MMA program operates statewide and provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including higher quality of care and stronger protections for Florida Medicaid recipients.

A full description of the extension request and the public notice document will be published on the Agency's website at the following link:

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

PUBLIC NOTICE AND PUBLIC COMMENT PERIOD: The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The Agency will consider all public comments received regarding the proposed extension request. The 30-day public notice and public comment period is from June 1, 2020 through June 30, 2020. This public notice and public comment period is being held to solicit public input from recipients, providers, all stakeholders, and interested parties on the proposed extension request for Florida's 1115 MMA Waiver.

To submit comments by postal service or email please adhere to the following instructions. When providing comments regarding the extension request for the 1115 MMA Waiver, please put '1115 MMA Waiver Extension' in the subject line.

Mail comments and suggestions to: 1115 MMA Waiver Extension, Office of the Deputy Secretary for Medicaid, Agency for Health Care Administration, 2727 Mahan Drive, MS 8, Tallahassee, Florida 32308. Email your comments and suggestions to FLMedicaidWaivers@ahca.myflorida.com.

A copy of the agenda may be obtained by contacting Karen Williams-Rockwell by email at Karen.Williams-Rockwell@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 seven days before the workshop/meeting by contacting: Karen Williams-Rockwell by email at Karen.Williams-Rockwell@ahca.myflorida.com. If you are hearing or speech impaired, please contact the Agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

ATTACHMENT VIII: PROVIDER ALERT

The Agency for Health Care Administration (Agency) is announcing the start of a 30-day public notice and comment period. The State is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver with no amendments, in order to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

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

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

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

Webinar
Monday, June 8, 2020 from 3:00 p.m. – 4:00 p.m.
GoToMeeting: https://attendee.gotowebinar.com/register/5097900362915034381

Webinar
Wednesday, June 17, 2020 from 3:00 p.m. – 4:00 p.m.
GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the Agency at least seven days before the workshop/meeting by contacting Karen Williams-Rockwell via email at Karen.Williams-Rockwell@ahca.myflorida.com

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

In addition to providing comment at the afore mentioned public meetings, comments can be submitted via mail or email per the instructions below. The Agency will conduct the 30-day public notice and comment period from June 1, 2020 to June 30, 2020, prior to the submission of the Demonstration Extension Application to Centers for Medicare and Medicaid Services (CMS). The public notice and public comment period is being held to solicit public input from recipients, providers, and all stakeholders and interested parties. The Agency will consider all public comments received during the public notice and comment period regarding the proposed MMA Waiver Extension Application.

Comments will be accepted from June 1, 2020 through June 30, 2020.

Mail comments and suggestions to:

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

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver Extension Request" referenced in the subject line.
Additional information about the SMMC program can be accessed by visiting www.ahca.myflorida.com/SMMC

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 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

ATTACHMENT IX: BUDGET NEUTRALITY

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

BUDGET NEUTRALITY COMPLIANCE

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested waiver extension period (July 1, 2020 to June 30, 2024) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the CMS financial management standard questions, see **Attachment X**. The following tables address the budget neutrality items specified above and documents the waiver's budget neutrality.

GENERAL BUDGET NEUTRALITY REQUIREMENTS

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

The established STCs of the waiver, as agreed upon by the state and 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 Research and Demonstration Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

BUDGET NEUTRALITY RESULTS TO DATE

The table located on the following page provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Member per Month (PMPM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PMPM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through Demonstration Year 13, expenditures have been $20.5 billion less than the authorized budget neutrality limit. However, during last approved extension Florida saving were rebased, and the new cumulative variance through Year 13 is $10.5 billion. As a result, the State remains in compliance with budget neutrality and anticipates that, by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

MEG 1 and 2 Cumulative Statistics DY1 – DY8					
DY 01	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
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**	**PMPM**
MEG 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					**89.15%**
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					**83.07%**
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					**76.94%**
DY 05	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					**71.73%**
DY 6	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					**70.14%**
DY 7	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	28,179,336	$7,224,274,901	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% Of WOW					**67.49%**
DY 08	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	28,867,69	$7,198,209,036	$1,579,606,142	$8,777,815,179	$304.07
WOW	28,867,69			$13,874,528,641	$480.62
Difference				$(5,096,713,462)	
% Of WOW					**63.27%**

MEG 1 and 2 Cumulative Statistics			
DY 09	**Actual CM**	**Total**	**PMPM**
Meg 1 & 2	29,099,424	$10,347,831,844	$355.60
WOW	29,099,424	$11,249,933,407	$386.60
Difference		$(902,120,063)	
% Of WOW			91.98%
DY 10	**Actual CM**	**Total**	**PMPM**
Meg 1 & 2	34,305,923	$12,559,757,972	$366.11
WOW	34,305,923	$13,717,298,419	$399.85
Difference		$(1,157,540,447)	
% Of WOW			91.56%
DY 11	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	38,019,658	$12,624,224,928	$332.04
WOW	38,019,658	$15,635,114,920	$409.88
Difference		$(3,010,889,992)	
% Of WOW			81.01%
DY 12	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	35,058,163	$13,842,405,018	$394.84
WOW	35,058,163	$13,398,987,974	$382.19
Difference		$443,417,044	
% Of WOW			103.31%
DY 13	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	33,473,543	$14,107,683,047	$421.46
WOW	33,473,543	$13,476,710,645	$402.61
Difference		$630,972,402	
% Of WOW			104.68%

FLORIDA'S 1115 RESEARCH AND DEMONSTRATION WAIVER

The 1115 waiver templates supporting the waiver's compliance with the budget neutrality STCs will be included as required by CFR upon submission to CMS. Additionally, the projection of budget neutrality benchmarks for the requested two-year waiver extension (July 1, 2022 - June 30, 2024) is included. The following are the basic concepts and assumptions used to project the two years (DY17-DY18).

The Without Waiver (WOW) trend applied to the member month projections are based on the waiver's historic population and voluntary Fee-For-Service population trends experienced during DY09 to DY13 for Aged and Disabled population (MEG1), and DY09 to DY13 for TANF and related group (MEG2). During this amendment the trend methodology was updated to combine historical and churning population since 85% of Florida Medicaid population is now in MMA. The actual PMPM for DY13 is being utilized as a jump to trend forward through DY18. The same "president's trend' rates as defined in the latest amendment are being used for the WOW PMPM projections.

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

WOW and WW Months of Aging are defined as the 24 months for MEG1 and 36 months for MEG2 from the mid-point of DY12 through the mid-point DY15. Regarding historic trend data for DY13, expenditures are included through December 31, 2019. Since the demonstration years are defined as dates-of-service, there will be additional claim submissions still forthcoming for this year.

During last amendment two new hypothetical populations were introduced, MEDS-AD and Housing Assistance. WOW and WW include them as new hypothetical groups. Total spending allowed for MEDS-AD and Behavioral Health and Supportive Housing Assistance Pilot are found in STC 95, and STC 96 respectively.

With the above calculated PMPMs and member months, the total WOW expenditures including the two renewal years are projected to be $72,109,060,502 compared to the WW expenditures of $69,303,905,919 for period. This would result in a savings of $2,805,154,583. Separate calculations are identified for the two programs covered under this waiver renewal as Costs Not Otherwise Matchable (CNOM). These are HIV/AIDS beneficiaries, Healthy Start program, and the Program of All Inclusive Care for Children.

MEG 3 was established in the initial waiver application as approved by Federal CMS. The MEG is also referred to as the LIP and is not directly linked to Medicaid eligibility. Expenditures for the LIP program are authorized to provide services to the uninsured and underinsured.

Distributions to qualifying providers under the LIP program are determined by the type of provider 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 claims processing system but are lump sum payments made directly to the provider to offset the allowable charity care services.

The limit for the LIP program is established in the budget neutrality and is reported in accordance with the requirements of the STCs of the waiver specific to budget neutrality. However, the program requirements and monitoring are subject to STCs of the waiver established for the LIP program.

The Agency is seeking to continue funding for the LIP at $1,508,385,773 annually, for the waiver extension period of July 1, 2022 through June 30, 2024.

The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

ATTACHMENT X: STANDARD FINANCIAL QUESTIONS

The following questions were asked and the Agency's responses provided in relation to all payments made to all providers under the section 1115 demonstration under review.

a. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

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

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

   B. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

      State response: If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS on the CMS 64 report.

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

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

      State Response: The state share of payments for these programs are appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, Tobacco Settlement Trust Fund, Grants and Donations Trust Fund, and the Public Medical Assistance Trust Fund.

   B. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide the NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please also indicate if any managed care organizations, prepaid

inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.

State Response: The non-federal share for the Low Income Pool is provided through Intergovernmental Transfers.

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

State Response: The state share of payments for these programs are appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, Tobacco Settlement Trust Fund, Grants and Donations Trust Fund, and the Public Medical Assistance Trust Fund.

D. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

State Response: The state and the intergovernmental transfer provider enter into a Letter of Agreement annually, signed by the provider by October 1. The Agency invoices the provider based on the pledged amounts in the letter of agreement on an annual basis or based on an alternative plan if specifically approved by the Agency. The Agency begins invoicing after the Low Income Pool model is approved by the Legislature through the Budget Amendment process.

E. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds is in accordance with 42 CFR 433.51(b).

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

F. For any payment funded by CPEs or IGTs, please provide the following:

i. A complete list of the names of entities transferring or certifying funds;

ii. The operational nature of the entity (state, county, city, other);

iii. The total amounts transferred or certified by each entity;

iv. Clarify whether the certifying or transferring entity has general taxing authority; and

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

State Response: Please see the SFY 2018-19 Summary of LIP IGTs that immediately follows the conclusion of these questions. No entities received appropriations for this purpose.

c. 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.

State Response: Please see the SFY 2018-19 LIP Payment and Charity Care listing, available at http://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/docs/SFY2018-19_LIP_Payments_Charity_Care.pdf.

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

State Response: The methodology for the Low Income Pool is outlined in the Special Terms and Conditions and the Reimbursement and Funding Methodology documents.

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

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

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

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

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

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

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

requirements that direct the managed care plans on how to pay providers, or direct payments from the State to providers such as DSH hospitals, academic medical centers, or FQHCs.)

State Response: Yes, Florida Medicaid pays DSH hospitals, certain hospitals for Graduate Medicaid Education (GME), Medical School Faculty payments, and wrap payments to FQHCs. There are payment arrangements subject to 42 CR 438.6(c) for Medical School Faculty Physicians, Florida Cancer Hospitals, and Public Emergency Medical Transportation.

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

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

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

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

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

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

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

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

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

Summary of Low Income Pool Funded by Local and State Government	
SFY 2018-19	
Local Government	**Intergovernmental Transfers**
City of Jacksonville	$21,911,460
City of Orlando	$55,600,336
City of Pensacola	$14,462,331
Florida Board of Governors/DOE	$2,025,000
Halifax Hospital Medical Center Taxing District	$10,979,107
Health Care District of Palm Beach County	$2,424,718
Hillsborough County	$32,901,917
Lee Health	$21,331,313
Manatee County	$629,825
North Brevard County Hospital District	$1,308,672
North Broward Hospital District	$16,350,660
North Lake County Hospital District	$834,401
Public Health Trust of Miami Dade County	$50,183,181
Sarasota County Public Hospital Board	$6,322,197
South Broward Hospital District	$22,188,519
Southeast Volusia Hospital Taxing District	$104,195
UF Board of Trustees	$17,587,791
Total Group 1 - Hospitals	**$277,145,623**
Florida International University	$839,866
Public Health Trust of Miami Dade County	$14,502,573
UF Board of Trustees	$22,656,632
USF Board of Trustees	$1,640,498
Total Group 2 - Medical School Physician Practices	**$39,639,569**

Local Government	Intergovernmental Transfers
Brevard County Board of County Commissioners	$868,598
City of Jacksonville	$398,279
Collier County Board of County Commissioners	$605,978
Escambia County Board of County Commissioners	$351,284
Florida Department of Health	$462,750
Health Care District of Palm Beach County	$1,900,485
Hernando County Board of County Commissioners	$150,000
Hillsborough County	$2,258,157
Indian River Taxing District	$214,614
Lee Health	$102,139
Leon County	$339,580
Manatee County Board of County Commissioners	$1,419,268
Marion County	$251,096
Marion County Hospital District	$186,896
Orange County	$1,928,785
Osceola County Board of County Commissioners	$261,019
Pinellas County	$818,851
Polk County	$539,113
Seminole County	$221,608
The Children's Trust	$2,587,312
Total Group 3 - Federally Qualified Health Centers	**$15,865,812**

Hillsborough County	$191,677
Leon County	$258,362
Manatee County	$258,038
North Lake Hospital Taxing District	$554,117
Orange County Board of County Commissioners	$1,343,497
Osceola County Board of County Commissioners	$193,183
West Volusia Hospital Authority	$135,388
Total Group 4 - Behavioral Health Providers	**$2,934,262**

Grand Total	**$335,585,266**