Florida Managed Medical Assistance Program
1115 Research and Demonstration Waiver

Public Notice Document
Waiver Extension Request
Released October 1, 2013

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(http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA)

Florida Agency for Health Care Administration

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A. Statement of Purpose

The state is seeking federal authority to extend Florida's Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2014 to June 30, 2017. The waiver is designed to implement a new statewide managed care delivery system without increasing costs and to continue the Low Income Pool program. The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers, as well as higher standards and more significant accountability measures for plans.

The MMA program will provide primary and acute medical care for certain populations through competitively selected high quality managed care organizations (MCOs). The program will:

- Provide incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting;
- Provide individuals a meaningful choice of plans and benefits; and
- Reduce fraud, abuse and waste through managed utilization of health care services.

The state seeks to use the current authorities granted by the Centers for Medicare and Medicaid Services (Federal CMS) in June 2013 to continue the waiver.

B. Goals and Objectives

1. Goals and Objectives: The goals of the MMA program are to improve coordination and patient care while fostering fiscal responsibility. The state's role has changed so that it is largely a purchaser of care, providing oversight focused on improving access and increasing quality of care. This program emphasizes personal responsibility and rewarding healthy behaviors. The overall program objectives are:

a. Improved program performance by expanding key components of the Medicaid managed care program statewide, while strengthening accountability for improved patient outcomes and preserving meaningful choices for participants. A key objective of improved program performance is to increase patient satisfaction.

b. Improved access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care). A key objective of improved access to coordinated care is to ensure access to services not previously covered and to improve access to specialists. This program includes requirements for MCOs to schedule appointments with a primary care physician within 30 days for new enrollees.

c. Enhanced fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems and shared savings model. Strict financial oversight requirements are established for MCOs to improve fiscal integrity.

d. Use of the expertise of MCOs, including health maintenance organizations (HMOs) and provider service networks (PSNs) to provide all coverage and services for medical assistance. A key objective of the program is to provide a choice of high quality,

competitively selected managed care plans throughout the state.

e. Stabilize plan participation and enhanced continuity of care by competitively procuring plans on a regional basis, extending plan contract period to five years and imposing substantial penalties for plan withdrawals.

f. Phased implementation of the MMA program, allowing for adequate development of Medicaid managed care across the State of Florida.

These goals and objectives will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government. Specific program objectives can be found in Section IV of this document.

2. Fundamental Elements of the Program: The MMA program permits Florida Medicaid to move from a fee-for-service system for acute care services to an integrated delivery system. The fundamental elements of the program are:

a. Risk-Adjusted Premiums that are developed for Medicaid recipients in managed care plans. The risk-adjusted premium will minimize the phenomenon of "adverse selection" and provide an incentive for plans to take all necessary steps to identify Medicaid recipients who have undiagnosed chronic conditions. Once a Medicaid recipient has chosen a plan, the plan may receive a higher premium only if the recipients has been diagnosed with a condition that merits the additional premium. Once a plan has identified someone with a chronic condition, it is then to the plan's financial benefit to properly manage the enrollee's condition so as to avoid higher cost services typical of untreated chronic conditions.

b. Healthy Behaviors will be provided through the managed care plans. The procurement process requires managed care plans to establish a program to encourage and reward healthy behaviors. The state will monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan.

c. Low-Income Pool will be maintained by the state to provide direct payment and distributions to safety net providers in the State of Florida for the purpose of providing coverage to Medicaid, the uninsured and underinsured populations. Funds will be distributed to safety net providers that meet certain state and federal requirements.

In addition, the program provides for specific requirements to enhance program integrity such as: the selection criteria used for the competitive procurement of managed care plans which requires documentation of policies and procedures for preventing fraud and abuse. Contractors face strict requirements to disclose business relationships to guard against conflicts of interest or prior involvement in health care fraud. The program also includes accountability provisions that address provider credentialing and monitoring, effective pre-payment and post-payment review processes, enhanced plan financial and data reporting and a mandatory compliance plan designed to prevent fraud and abuse.

3. Consumer Protections: The MMA program will increase consumer protections as well as quality of care and access for Floridians in many ways including:

a. Increasing recipient participation on Florida's Medical Care Advisory Committee (MCAC) and convening smaller advisory committees to focus on key special needs populations;

b. Ensuring the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan (no more than 60 calendar days after the effective date of enrollment);

c. Ensuring immediate review of recipient complaints, grievances and appeals for resolution as part of the rapid cycle response system;

d. Establishing Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requiring plans offer a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan;

e. Requiring Florida's External Quality Assurance Organization (EQRO) to validate each plan's encounter data every three years;

f. Enhancing consumer report cards to ensure recipients have access to understandable summaries of quality, access and timeliness regarding the performance of each participating managed care plan;

g. Enhancing the plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health and reducing per capita Medicaid expenditures;

h. Enhancing metrics on plan quality and access to care to improve plan accountability; and

i. Creating a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

The program introduces more individual choice, increases access and improves quality, efficiency and fiscal integrity while stabilizing cost. In addition, the program provides flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are sufficient and actuarially equivalent to meet the needs of the population.

C. Current Program

1. Managed Care: The state currently operates Medicaid managed care under two federal waivers: 1115 MMA Waiver and the 1915(b) Medicaid Managed Care Waiver. The following is a brief summary description of the current Medicaid managed care programs operating in the state. For a comprehensive description of the MMA program, please see Section III of this document.

a. 1115 MMA Waiver: The MMA Waiver (previously entitled Medicaid Reform) is authorized as a section 1115 Research and Demonstration Waiver for the period December 16, 2011 through June 30, 2014. The current program, Medicaid Reform, operates in Broward, Duval, Baker, Clay and Nassau Counties until implementation of the MMA program by region in 2014.

   Under Medicaid Reform, most Medicaid eligibles are required to enroll in a health plan (either a capitated health plan or a fee-for-service Provider Service Network plan) for their primary and acute care services as a condition for receiving Medicaid. Participation is mandatory for Temporary Assistance for Needy Families (TANF) related populations and the aged and disabled with some exceptions. The waiver allows Medicaid Reform plans to offer customized benefit packages and reduced cost-sharing, although each plan must cover all mandatory services and all state plan services for children and pregnant women including

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Medicaid Reform provides incentives for healthy behaviors by offering Enhanced Benefits Accounts and established a Low Income Pool (LIP) to ensure continued support for the provision of health care services to Medicaid, underinsured and uninsured populations.

b. 1915(b) Medicaid Managed Care Waiver: The original 1915(b) Medicaid Managed Care Waiver was approved in January 1990 which allowed for the implementation of the Medicaid Physician Access System (MediPass) that was designed as a managed care alternative for Medicaid recipients. The Medicaid Managed Care Waiver evolved over time into a variety of managed care options including MCOs, Primary Care Case Management Programs (PCCMs), Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). In general, the waiver offers a menu of managed care options from which a recipient may enroll (Health Maintenance Organizations, Frail Elderly program, MediPass program, Provider Service Networks, Prepaid Dental Health Plans, Children's Medical Services (CMS) Network, Healthy Start program and the Hemophilia Management program.) The waiver also established specialized programs for individuals enrolled in MediPass. These programs include the Prepaid Mental Health Plans and the Disease Management program.

c. MMA Implementation: With the implementation of the MMA program, recipients enrolled in the Medicaid Reform plans and the Medicaid Managed Care Waiver programs will transition to the MMA plans on a staggered basis. The only exception is the following programs will transition January 1, 2014 under the authority of the 1115 MMA Waiver as specified in Special Term and Condition (STC) #70 and #71 of the waiver. These programs, currently authorized under the Medicaid Managed Care Waiver, will continue to operate as they do today and will be available in all parts of the state.

- The Healthy Start Program;
- The Program for All Inclusive Care for Children (a component of the CMS Network); and
- The Comprehensive Hemophilia Program.

Implementation of the MMA program will be phased in by region. The implementation schedule along with the implementation plan will be posted on the Agency for Health Care Administration's (the Agency) Statewide Medicaid Managed Care (SMMC) website and submitted to Federal CMS on October 31, 2013. Section II of this document provides a description of the MMA program, and page 11 provides a summary of the approach to be used during the staggered implementation.

2. Low Income Pool: The LIP program provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. It consists of a capped annual allotment of $1 billion total computable for each year of the waiver. The LIP program is designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Programs include the quality-based LIP programs tracked through metric outcomes to ensure the access to quality care.

D. Federal and State Waiver Authority

The following is an historical description of the federal and state authority granted since authorization of the waiver was obtained in 2005.

1. Initial 5-Year Period (2006-2011): On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by Federal CMS. State authority to operate Medicaid Reform is located in section (s.) 409.91211, Florida Statutes (F.S.), which authorized a statewide pilot program. The program was implemented in Broward and Duval Counties July 1, 2006 and expanded to Baker, Clay and Nassau Counties July 1, 2007.

2. Three-Year Extension Period (2011-2014): On June 30, 2010, a three-year waiver extension request was submitted to Federal CMS to maintain and continue operations of Medicaid Reform for the period July 1, 2011 to June 30, 2014. State authority to seek the three-year waiver extension request is authorized in Part IV of Chapter 409, F.S. Federal CMS granted temporary extensions of the program until December 15, 2011, when final approval of the extension request was granted for the period December 16, 2011 to June 30, 2014.

3. MMA Waiver Amendment (June 14, 2013): On August 1, 2011, an amendment request was submitted to Federal CMS to implement the MMA program as authorized in Part IV of Chapter 409, F.S. The amendment can be viewed on the Agency's website at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA.

The Agency received a letter from Federal CMS stating an agreement in principle was reached regarding granting the amendment to implement the MMA program on February 20, 2013. The Agency received Federal CMS approval of the amendment as provided for in the newly amended STCs and waiver and expenditure authorities on June 14, 2013. The amendment approval documents along with an overview of the MMA program can be viewed on the Agency's website at the link provided above.

The existing Medicaid Reform program will be phased out as the MMA program is implemented in each region of the state no later than October 1, 2014 and as approved by Federal CMS. The state authority to sunset Medicaid Reform on October 1, 2014 can be found in s. 409.91211, F.S. The authority to sunset the 1915(b) Medicaid Managed Care programs on October 1, 2014 can be found in s. 409.912, F.S.

4. Authority to Seek Waiver Extension (2014-2017): During the 2011 Florida Legislative session, the Florida Legislature passed and Governor Scott signed legislation to expand managed care in the Florida Medicaid program with the creation of the MMA program. Part IV of Chapter 409, F.S., directs the Agency to submit any federal waiver or state plan amendment requests to Federal CMS as necessary to implement the MMA program no later than October 1, 2014. In accordance with this directive, the Agency is seeking approval to extend the waiver authorization period from July 1, 2014 until June 30, 2017.

E. Federal Waiver Extension Requirements

1. Public Notice Document: In accordance with 42 Code of Federal Regulation (CFR) 431.412 and STC #9 of the waiver, the Agency is posting this "Public Notice" document for public input 30 days prior to submission of the final waiver extension request to Federal CMS. This public notice document is required to include a comprehensive description of the waiver

extension request that contains sufficient level of detail to ensure meaningful input from the public, including:

a. The program description, goals and objectives to be extended under the waiver, including a description of the current or new recipients who will be impacted by the waiver. (See Section I of this document for program goals and overall objectives, Section IV for specific program objectives and Section II.A for a description of the current or new recipients impacted by the program.)

b. To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be impacted by the waiver and how such provisions vary from the state's current program features. (See Section II of this document)

c. An estimate of the expected increase or decrease in annual enrollment and annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the waiver requested by the state in its extension request. (See Section V of this document)

d. The hypothesis and evaluation parameters of the waiver. (See Section VII of this document)

e. The specific waiver and expenditure authorities that the state believes to be necessary to authorize the waiver. (See Section VIII of this document)

f. The locations and Internet address where copies of the waiver extension request are available for public review and comment. (See Section III of this document)

g. Postal and Internet e-mail addresses where written comments may be sent and reviewed by the public and a minimum 30-day time period in which comments will be accepted. (See Section III of this document)

h. The location, date and time of at least two public hearings convened by the state to seek public input on the waiver extension request. (See Section III of this document)

2. Final Waiver Extension Request: After the public input process has ended on October 30, 2013, the Agency will include the following information in the final waiver extension request in compliance with the transparency requirements 42 CFR 431.412, the public notice requirements provided in STC #16 and the extension requirements specified in STC #9 of the waiver:

a. Historical Narrative Summary of the Waiver: Provide a narrative summary of the waiver, reiterate the objectives set forth when the waiver was proposed and provide evidence of how the objectives have been met, along with the future goals of the program. If changes are requested, the Agency must provide a narrative of the proposed changes along with the objective of the change and desired outcomes.

b. Special Terms and Conditions: Provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information.

c. Waiver and Expenditure Authorities: Provide a list along with a programmatic description of the waivers and expenditure authorities being requested in the extension.

d. Quality: Provide summaries of EQRO reports, health plan state quality assurance monitoring and any other documentation of the quality of and access to care provided under the waiver including but not limited to: corrective action taken and the Federal CMS Form 416 EPSDT/CHIP report.

e. Financial Data: Provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the waiver. In addition, the state must provide up to date responses to the Federal CMS Financial Management standard questions. If Title XXI funding is used in the waiver, a CHIP allotment neutrality worksheet must be included. This would also include a financial analysis of changes to the waiver requested by the state.

f. Evaluation Report (interim evaluation): Provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date) and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available. If changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed changes.

g. Documentation of Public Notice (42 CFR 431.408): Provide documentation of compliance with public notice process requirements specified in federal regulations and the STCs of the waiver including the post-award public input process described in 42 CFR 431.420(c) with a summary of the issues raised by the public during the comment period and how the state considered the comments when developing the waiver extension request. The state must also provide evidence of solicitation of advice from Florida's Federal Recognized Tribes.

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II. Program Overview

The following provides a description of the MMA program, an integrated health care delivery system, by which eligible recipients will receive their primary and acute medical care services as specified in Florida law and as approved by Federal CMS.

A. Eligibility

1. Eligibility for Medicaid: The Florida Department of Children and Families (DCF) is the administering agency responsible for processing Medicaid applications and determining Medicaid eligibility. The state will continue to use the same application and eligibility processes for all individuals, including participants in the MMA program. Current income and asset limits will apply under the program, as will current residency and citizenship standards. There will be no limit on the number of individuals eligible for Medicaid as specified in the state plan. The state assures that all applications will be processed in a timely manner.

2. Eligibility for the MMA Program: Participation in the MMA program will be mandatory for the following eligibility groups currently covered by Florida Medicaid and as defined in STC #21 of the waiver:

The MMA program participants are individuals eligible under the approved state plan who reside in the MMA program regions and who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a capitated plan as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in an plan to receive Medicaid benefits.

a. Mandatory Participants - Individuals who reside in one of the 11 MMA regions, who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation are required to be MMA program participants.

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria
Infants under Age 1	Up to 150% of the FPL
Children under Age 1	With family income 186% - 200% of the FPL under Title XXI
Children 1-5	Up to 133% of the FPL
Children 6-18	Up to 100% of the FPL
Blind/Disabled Children	Children eligible under SSI
Foster Care	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL - Title IV-E)
TANF Pregnant Women	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000).
Pregnant Women with Incomes above the 1931 Poverty Level	Income greater than 1931 income level and not exceeding 150% of FPL.
Section 1931 Adults	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.)
Aged/Disabled Adults	Persons receiving SSI whose eligibility is determined by Social Security Act (SSA)

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria
Optional State Plan Groups	
Infants under Age 1 (Title XIX funded)	151% up to 200% of the FPL
Adoption Assistance under Age 18	Who receive an adoption subsidy
Pregnant Women with Incomes above the 1931 Poverty Level	Income greater than 150% of FPL and not exceeding 185% of FPL.
Individuals Eligible under a Hospice-Related Eligibility Group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.

b. Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid will be required to participate in the MMA program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-Medicaid recipients will be afforded the opportunity to choose a plan. However, to facilitate enrollment, if the individual does not elect a plan, then the individual will be assigned to a plan by the state using the criteria outlined in STC # 23 of the waiver.

d. Voluntary Participants – The following individuals are excluded from mandatory participation but may choose to be voluntary participants in MMA program:

   i. Individuals who have other creditable health care coverage, excluding Medicare;

   ii. Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

   iii. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); and

   iv. Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.

e. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from participation in the MMA program.

   i. Individuals eligible for emergency services only due to immigration status;

   ii. Family planning waiver eligibles;

   iii. Individuals eligible as women with breast or cervical cancer; and,

   iv. Children receiving services in a prescribed pediatric extended care facility.

B. Enrollment and Disenrollment

Upon implementation of the program, the Agency will use a staggered transition plan by region to transition individuals into the competitively procured managed care plans. The following describes the enrollment and disenrollment process in accordance with STCs #22 through #26.

1. New Enrollees: At the time of eligibility determination, individuals who are mandated to participate in the MMA program will receive information about plan choices in their region. New

enrollees will be informed of their options in selecting an authorized plan and will be provided the opportunity to talk with a choice counselor to obtain additional information in making a choice. New enrollees will be required to select a plan within 30 days of eligibility determination. If the individual does not select a plan within the 30-day period, the Agency may auto-assign the individual into a plan. Once an individual has made their choice, they will be able to contact the Agency or the Agency's designated choice counselor to register their plan selection. Once the plan selection is registered and takes effect, the plan will communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

2. Auto-Enrollment Criteria: Each enrollee will be given 30 days to select a plan in their region after being determined eligible for Medicaid. Within the 30-day period, the choice counselor will provide information to the individuals to encourage an active selection. Enrollees who fail to make an active selection within this timeframe will be auto-assigned to a plan. At a minimum, the Agency will use the criteria listed below when assigning an enrollee to a plan. When more than one plan meets the assignment criteria, the Agency will make enrollee assignments consecutively by family unit. The criteria include but are not limited to:

a. A plan has sufficient provider network capacity, including dental network capacity, to meet the needs of enrollees;

b. The plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers (PCPs) has previously provided health care to the enrollee;

c. The state has knowledge that the enrollee has previously expressed a preference for a particular plan as indicated by Medicaid fee-for-service (FFS) claims data, but has failed to make a choice; and,

d. The plan's PCPs are geographically accessible to the recipient's residence.

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

In addition, the Agency will use the following parameters when assigning a recipient to a plan.

a. To promote alignment between Medicaid and Medicare, each recipient who is enrolled with a Medicare Advantage Organization, will first be assigned to any plan in the recipient's region that is operated by the same parent organization as the recipient's Medicare Advantage Organization. If there is no match of parent organization or appropriate plan within the organization, then the recipient will be assigned as in auto-enrollment criteria under paragraph numbered 2 of Section II.B of this document.

b. If an applicable specialty plan is available, the recipient should be assigned to the specialty plan.

c. If, in the first year of the first contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.

d. Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

e. Children in foster care children will be assigned/re-assigned to the same plan/PCP to which the child was most recently assigned in the last 12 months, if applicable.

4. Lock-In/Disenrollment: Once a mandatory enrollee has selected or been assigned a plan, the enrollee will be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a plan the individual has 90 days to voluntarily disenroll from that plan without cause and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's treating provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of PCPs, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between PCPs within the same plan. Voluntary enrollees may disenroll from the plan at any time.

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

5. Re-enrollment: In instances of a temporary loss of Medicaid eligibility, which the state is defines as six months or less, the Agency will re-enroll a recipient in the same plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended.

6. Stagger Transition: The Agency will use a staggered transition plan for enrollment in the program. The Agency has carefully planned the transition of the affected recipients into the program to preserve continuity of care. The Agency will follow a multi-layered approach when transitioning recipients into the MMA program by:

a. Coordinating with the contracted plans and the Agency's designated contractor to create a staggered transition to ensure that the volume of recipients being transitioned occurs in an organized manner.
b. Planning, organizing and implementing a thorough desk and onsite review of all plans to ensure processes and systems are in place before recipients are enrolled, including assessing the capacity of the contracted plans' provider networks.
c. Coordinating with the contracted plans to identify primary care providers to ensure continuity of care and minimize disruption to the recipients.
d. Monitoring provider network participation to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new plan.
e. Coordinating with the new contracted plans, the Agency's designated contractor, local area staff and advocacy groups to ensure appropriate and timely notice to enrollees, including outreach and education to locations and providers frequented by impacted enrollees to help recipients understand the changes that are occurring.

Please note the Agency will submit the implementation plan to Federal CMS and post it on the Agency's website October 31, 2013. The Agency's estimated enrollment projection in the MMA program during the first year of operation will be a total of 3,071,171 recipients. This projection is based upon the proportion of the total Medicaid population eligible for the MMA program, applied to the Long Range Office of Economic and Demographic Research forecast for Medicaid caseloads in state fiscal year 2014-15.

C. Information and Choice

1. Enrollee Choice: Potential enrollees in the MMA regions will initially have the choice of enrolling in a plan. Potential enrollees will have a choice of two or more plans in each region.

The Agency assures Federal CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two options will be available in all MMA regions.

2. Enrollee Information: The Agency's designated contractor will ensure that enrollees are provided with full and complete information about their plan options. The Agency's designated contractor will provide information regarding an individual's choice to select a plan.

Through the designated contractor, the Agency will develop enrollee education so individuals will fully understand their choices and will be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly. Specifically, the Agency's designated contractor will provide information on selecting a plan.

As it does now, the Agency's designated contractor will provide information about each plan's coverage in accordance with federal requirements. Additional plan information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, provider network information, prescription drug formulary, contact information, performance measures, results of consumer satisfaction reviews and data on access to preventive services. Individuals will be assured of equal value among plans since all plans' benefit packages will be actuarially equivalent. In addition, the Agency will supplement coverage information by posting performance information on each plan. Information provided may include enrollee satisfaction surveys and performance data.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5% of the region speaks a language other than English. The Agency's designee will also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the Agency's designated contractor to obtain additional information. The Agency's designated contractor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

The state assures Federal CMS that it will provide information in accordance with Section 1932(a)(5) of SSA and 42 CFR 438.10, Information Requirements.

The Agency or the Agency's designated contractor will retain responsibility for all enrollment and disenrollment activities into the plans.

D. Benefits

1. Customized Benefit Packages: Capitated plans will have the flexibility to provide customized benefit packages for enrollees as long as the benefit package meets certain minimum standards described in STC #27 of the waiver, and actuarial benefit equivalency requirements and benefit sufficiency requirements described in STCs #28 through #32 of the waiver. The customized benefit packages must include all state plan services otherwise available under the state plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the state plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population and plans can offer additional services and benefits not available under the state plan. The plans contracted with the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women and emergency services. The state may capitate all state plan services for MMA enrollees.

Policies for determining medical necessity for children covered under the EPSDT benefit must be consistent with Federal statute at section 1905(r) of the SSA in authorizing vision, dental, and hearing services and other necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) of the SSA to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered in the state plan.

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

3. Plan Evaluation Tool: The Agency will utilize a Plan Evaluation Tool (PET) to determine if a plan that has been awarded a plan contract meets state requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, it 1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current state plan package for the average member of the population and 2) ensures that the overall level (sufficiency) of certain benefits is adequate to cover the vast majority of enrollees. The Agency will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

a. PET Actuarial Equivalency: Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid state plan services. This process ensures that the expected claim cost levels of all plans are equal (using a common benchmark reimbursement structure) to the level of the historic FFS plan for the target population and its historic levels of utilization. The Agency uses this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the state. In assessing actuarial equivalency, the PET considers the following components of the benefit package: services covered; cost sharing; and additional benefits offered, if any. Additional services

offered by the plan will be considered a component of the plan's customized benefits.

b. PET Sufficiency: In addition to meeting the actuarial equivalence test, each plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent for benefits identified as sufficiency tested benefits. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target population's historic use of the applicable Medicaid state plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the state as sufficiency tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to cover the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

4. Evaluation of Plan Benefits: The Agency will review and update the PET for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the MMA region. At a minimum, the Agency will conduct the review and update on an annual basis.

E. Cost Sharing

1. Premiums and Co-Payments. The Agency will pre-approve all cost sharing allowed by the plans. Cost-sharing must be consistent with the state plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan. Current cost-sharing, including co-payments and co-insurances, are:

Services	Co-payment / Co-insurance
Birthing Center	$2 per day per provider
Chiropractic	$1 per day per provider
Community Mental Health	$2 per day per provider
Dental – Adult	5% co-insurance per procedure
Federally Qualified Health Centers	$3 per day per provider
Home Health Agency	$2 per day per provider
Hospital Inpatient	$3 per admission
Hospital Outpatient	$3 per visit
Independent Laboratory	$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner	$2 per day per provider
Optometrist	$2 per day per provider
Pharmacy	2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant	$2 per day per provider
Podiatrist	$2 per day per provider
Portable X-Ray	$1 per day per provider
Rural Health Clinic	$3 per day per provider
Transportation	$1 per trip

All individuals not exempt by federal regulation will be responsible for cost-sharing for services. The Agency will review and approve cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing will not be required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by Federal CMS. The Agency will also encourage plans to reduce or waive cost-sharing requirements for preventive services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, vaccinations, pap smears and certain prescribed medication. The Agency believes that, due to the transparency of outcomes built into the MMA program – particularly with each plan's ability to maximize the number of people who receive preventive services - plans will be incentivized to remove all barriers to preventive services, including waiving cost sharing for those services. When a co-payment or co-insurance is required as part of the plan benefit structure, the provider will be responsible for collecting payments from individuals.

2. Healthy Behaviors: As part of the plan procurement process, each selected plan is required to establish a program to encourage and reward healthy behaviors. The Agency will monitor the plans' programs. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse program. These programs maybe modified by the Legislature.

F. Health Care Delivery System

1. Managed Medical Assistance Program: The MMA program is designed to operate statewide and will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. Mandatory recipients will be required to participate in the MMA program to receive their health care services.

The program will maintain individual choice, increase access, improve quality, efficiency and fiscal integrity while stabilizing cost. The program is an integrated model that will manage all care and increase the enrollment of recipients in plans that are capable of managing all of an individual's care. In addition, the Agency will allow flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are sufficient and actuarially equivalent to meet the needs of the population. For the first year of operation of the MMA program, the plans will be required to use the state's preferred drug list.

2. Regions: Florida law established 11 regions within the State of Florida for the MMA program, and outlines the number of plans authorized to provide services in each region. Table 1 provides a list of the counties by the 11 regions.

Table 1
Regions for the MMA Program

Region	Counties
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
Region 5:	Pasco and Pinellas
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk

Table 1 Regions for the MMA Program	
Region	**Counties**
Region 7:	Brevard, Orange, Osceola and Seminole
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10:	Broward
Region 11:	Miami-Dade and Monroe

3. Procurement Method: The Agency is competitively procuring the plans to provide primary and acute medical care services to all eligible Medicaid recipients. The Agency initiated separate but simultaneous procurements in each of the 11 regions of the state.

The law establishes criteria for preference in reviewing Invitation to Negotiate (ITN) respondents, including:

a. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body;

b. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations;

c. Availability and accessibility of primary care and specialty physicians in the provider network;

d. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services;

e. Commitment to quality improvement;

f. Provision of additional benefits, particularly dental care and disease management and other initiatives that improve health outcomes; and

g. Documentation of policies for preventing fraud and abuse.

4. Number of Plans per Region: Florida law specifies a minimum and maximum number of plans, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid.

Issuance of the procurement provides for a choice of plans, as well as, market stability as the Agency will enter into five year contracts. As noted in Table 2, there is a minimum of two plan choices in each of the 11 regions. To the extent that there are fewer than two plan choices in an area, the Agency will issue a procurement to obtain a second plan and will meet the federal requirements regarding choice until two plans are available.

Table 2 MMA Plans Per Region			
	Min # of Plans	**Max # of Plans**	**Min # of PSNs**
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1

Table 2 MMA Plans Per Region			
	Min # of Plans	**Max # of Plans**	**Min # of PSNs**
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1

Participation by the CMS Network shall be pursuant to a single, statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits but will be subject to all health plan contract requirements.

5. Plan Selection Criteria: As part of the ITN process, the Agency established preference criteria for reviewing respondents as previously described. Selection criteria includes, but is not limited to, the Agency's evaluation of whether plans: have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied and will be promptly paid under state law; are organizations that are based in and perform operational functions in the state of Florida, in-house or through contractual arrangements, by staff located in this state; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

Please note the state initiated the procurement of the MMA plans on December 28, 2012 and the Notice of Intent of Award was published the Florida Department of Management Services' Vendor Bid System on September 23, 2013. A listing of the plans selected for each region and relevant information about the procurement can be found via the Department of Management Services' Vendor Bid System at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu. Appendix A provides a summary chart of the plans selected in each region.

6. Types of Contracted Plans: The types of plans the Agency has selected to contract with include: HMOs and PSNs, and the state's CMS Network operated by the Florida Department of Health (DOH). The Agency will reimburse most contracted plans on a capitated basis as authorized in state law and as approved by Federal CMS.

7. Reimbursement: Capitation rates for the capitated plans will be developed in accordance with 42 CFR 438.6. The Agency will develop actuarially sound, risk-adjusted premiums. The premiums will be based on historical Medicaid expenditures including the use of encounter data, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures. The CMS Network will be reimbursed as approved by the Agency and Federal CMS.

Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. The purpose of health-based risk adjustment is to provide a risk score for each individual to reflect predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan.

The Agency assures Federal CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary.

Federal CMS Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

G. Accountability and Monitoring

The Agency is following standard Agency contracting procedures to enter into clear and comprehensive managed care contracts developed that are consistent with all state and federal requirements. The Agency specified monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted plans to enrollees. The overarching goal is to promote the health and well-being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes, promoting quality and cost-effective delivery of services. Other tenets of the MMA program are as follows:

- Comprehensive transition requirements for implementing the program;
- Increased stability among health plans;
- Comprehensive transition requirements when plan changes are necessary;
- Limits on the number of participating plans in the eleven regions;
- Plan selection criteria;
- Provider network adequacy;
- Plan solvency;
- Penalties for not completing a contract term; and
- Penalties for failure to comply with encounter data reporting requirements.

1. Contracting Assurances - Provider Network Requirements: The Agency is requiring all MMA plans ensure availability of services consistent with section 1932(c)(1)(A)(i) of the SSA and 42 CFR 438.206, that is, plans are required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected utilization of service.

In evaluating adequacy of networks for plans, the Agency considered the demographics of a community and availability of services locally. In geographic areas where there are a large number of Medicaid recipients, the Agency requires contracted plans to demonstrate access to an adequate network of health care providers serving that community.

In order to ensure access to necessary Medicaid services, the Agency established specific standards for the number, type and regional distribution of providers in plan networks. The Agency will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the 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. The plans are required to have providers available within reasonable travel and distance standards comparable to standards established by the Agency. See Table 8

located on pages 39 and 40 of this document for the provider network standards developed for the MMA program. Plans are also required to maintain a provider network sufficient to serve a percentage of recipients in the region, as established by the Agency, such that, if any one plan leaves a region, the remaining plans have immediate capacity in their provider network (primary care and specialist) to serve all recipients in that region.

In addition, plans are required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators and such other information as the state deems necessary. The provider database must be available online to both the Agency and the public and allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

The plans may limit the providers in their networks, if network adequacy standards are met, but must also include providers classified in Florida law as "statewide essential provider," which shall include:

a) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine, Florida State University College of Medicine and Florida International University College of Medicine;
b) Regional perinatal intensive care centers (RPICCs) as defined in s. 383.16(2), F.S., including All Children's Hospital, Arnold Palmer Hospital, Bayfront Medical Center, Broward General Medical Center, Jackson Memorial Hospital, Lee Memorial Hospital at HealthPark, Memorial Regional Hospital, Sacred Heart Hospital, Shands – Jacksonville, Shands Teaching Hospital, St. Mary's Hospital and Tampa General Hospital;
c) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28), F.S., including All Children's Hospital, Miami Children's Hospital, Nemours, and Shriners Hospitals for Children; and
d) Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment and Prescribed Pediatric Extended Care.

The plans are required to negotiate in good faith with statewide essential providers for one year. The plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid plan. In addition to the statewide essential providers, plans are required to offer a network contract to each home medical equipment and supplies provider who is currently participating in the Florida Medicaid program and meets quality and fraud and abuse prevention and detection standards established by the plan.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as a pharmacy option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency evaluates each plan's pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

2. Plan Accountability and Performance Standards: The Agency has enhanced the monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of formulary or preferred drug list on the plan's website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures with results published on each plan website; accreditation within one year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification of the Agency of the impending birth of a child to an enrollee. The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

3. Grievance and Appeals: The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for, services as required by section 1932(b)(4) of the SSA and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.
- Maintains a State-level panel to hear appeals of grievances not resolved at the plan level.
- Preserves the Medicaid fair hearing process that requires each Medicaid plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:
    - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the state takes action without the advance notice and as required in accordance with state policy consistent with Fair Hearings. The state must also inform enrollees of the procedures by which benefits can be continued or reinstated, and
    - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

4. Program Integrity: The state assures that the Medicaid program integrity system will require each Medicaid MCO to comply with Section 1932(d)(1) of the SSA and 42 CFR 438.610

Prohibited Affiliations with Individuals Barred by Federal Agencies. The state will prohibit any of the Medicaid MCOs from knowingly having a relationship with:

a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
b. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

a. A director, officer, or partner of the Medicaid MCO,
b. A person with beneficial ownership of 5% or more of the Medicaid MCO's equity,
c. A person with an employment, consulting or other arrangement with Medicaid MCO for the provision of items and services that are significant and material to the Medicaid MCO's obligations under its contract with the state.

The Agency's Medicaid program integrity system will oversee the activities of Medicaid MCO enrollees, health care providers, MCO networks, and their representatives in order to prevent fraud or abuse, over-utilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of enrollees and to recover overpayments as appropriate. The Agency will refer incidents of suspected fraud, abuse, over utilization and duplicative utilization and underutilization or inappropriate denial of services to the appropriate regulatory agency, including the licensing agency and the Medicaid Fraud Control Unit of the Attorney General's office.

The program integrity system will require each Medicaid MCO to comply with section 1932(d)(1) of the SSA and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable.

The payments to each Medicaid MCO will be based on data submitted by the MCO and will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

H. Penalties and Sanctions

To ensure stability, the Agency will impose new penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to three month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, plans must pay a penalty of 25% of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 day notice to the Agency before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the agency is required to terminate all contracts with that plan in other regions.

If a plan that is awarded an "additional contract" to ensure plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

If the Agency terminates a contract with a plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medication needs, and existing provider or care relationships.

The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes, the Agency will assess a daily fine for each day of non-compliance beginning on the 31st day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

I. Quality Initiatives

Improved quality and performance has been a key component of the state's managed care strategy, and will continue to be a primary focus of the MMA program.

Quality and performance measurement were a primary role in selecting the plans during the procurement process. Accreditation by a nationally recognized accrediting body, the organization's record in achieving specific quality standards and the organization's documented commitment to quality improvement will be among the criteria for selection.

Plan quality oversight will exist on two levels at the Agency and at individual plans. The Agency has a written strategy for assessing and improving the quality and appropriateness of care delivered by all plans to their enrollees. This strategy targets overall system improvement and specifies the steps the Agency will take to hold plans accountable for on-going quality:

- Coverage and authorization of services
- Systems performance
- Clinical outcome measures
- Enrollee satisfaction
- Provider satisfaction
- Provider access and timeliness of care
- Network adequacy
- Performance improvement projects
- Quality improvement indicators
- Care coordination and continuity of care
- Timeliness of handling complaints and grievances
- External quality review
- Evaluation of disease management programs

Reporting requirements by the contracted plans as a component of the quality strategy include, but are not limited to:

- Enrollment and disenrollment
- Enrollee information
- Provider network
- Encounter data
- Grievances and appeals
- Financial reporting
- Child health check-up (a.k.a., EPSDT)

The Agency assures Federal CMS that it complies with section 1932(c) of the SSA and 42 CFR 438.200, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions. In accordance with STC #118d, the Agency will submit the required draft Comprehensive Quality Strategy by October 11, 2013.

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III. Public Process

This section of the document provides a summary of public notice and input process used by the Agency in compliance with 42 CFR 431.412 and STC #16 of the waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the SSA as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Public Process Strategy

On August 29, 2013, the Agency provided to Federal CMS the state's public process strategy (see Appendix B.1 of this document) in preparation for a call held on September 12, 2013, to discuss the three-year waiver extension including the public process strategy. The public process strategy was developed to solicit stakeholder input on the waiver extension request, as authorized in Florida law and in accordance with federal regulations.

Prior to the submission of the public process strategy, there were numerous Legislative hearings and public meetings held at which the MMA program as a component of the SMMC was discussed and an opportunity for public input was provided. Appendix B.2 of this document provides a detailed list documenting the legislative, public workshops and education sessions held during 2011, 2012 and 2013 along with links to the workshop presentation materials. In addition to the legislative hearings, the Agency will host three geographically separate public input meetings (one will be accessible telephonically) and two advisory group meetings (one will be accessible telephonically) to ensure individuals have an opportunity for input. During the public meetings, the Agency will clarify the following:

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

A summary description of the public notice process and the public meetings are provided on pages 25 through 27 of this document.

B. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[1] located in Florida through written correspondence and conference calls, to solicit input on the waiver extension request and post award forum. Appendix B.3 of this document provides the correspondence sent on September 19, 2013, to the Seminole Tribe and Miccosukee Tribe requesting input on the waiver extension request. The Agency held conference calls[2] with representatives from the Seminole Tribe and Miccosukee Tribe to solicit input on the waiver extension request and post award forum. The Seminole Tribe representative and the Miccosukee representative, each stated during the conference calls that enrolled members of their tribes are not eligible for Medicaid due to income limits and thanked us for explaining the changes to the Medicaid program being implemented through the waiver.

[1] The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Organizations.
[2] Call held with Seminole Tribe on September 20, 2013; and call held with Miccosukee Tribe on September 19, 2013

C. Public Notice Process

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

- Publish public notices for the three public meetings and two advisory meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, F.S.
- Email the meeting information to individuals and organizations from the interested parties list that was created during the development of the initial waiver application and has been updated regularly thereafter.
- Mail letters to members of the Florida Legislature announcing the meetings.
- Release Agency Media Alerts announcing the meetings.
- Post on the Agency's home webpage a prominent link to the webpage where the following information can be found: the public meeting schedule including dates, times and locations as well as this public notice document for the waiver extension request. The meeting materials and the public notice document can be viewed by clicking on the following link:

  http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA
- Submit the public notice of meetings for posting on community bulletin boards.

D. Florida Medicaid Advisory Meetings

The Agency is requesting input on the extension request from the members of the two key Medicaid advisory groups listed below. The public meeting notices for the advisory groups were published in FAR. During the meetings, the Agency will provide an overview of the MMA program amendment approved June 14, 2013, a description of the extension request and will seek to obtain input on the waiver extension request. The agenda and presentation materials are posted on the Agency's website provided above.

- Medicaid Medical Care Advisory Committee meeting will be held October 15, 2013.
- LIP Council meeting was held August 8, 2013.

The following is a brief description of the Medicaid advisory groups.

1. Florida Medicaid's Medical Care Advisory Committee

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

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

2. Low Income Pool Council

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

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

The LIP Council was created to advise the Agency and Florida Legislature on the financing and distributions of the LIP and related funds. The LIP Council is statutorily directed to:

- Make recommendations on the financing of the LIP and the disproportionate share hospital program and the distribution of their funds.
- Advise the Agency on the development of the low-income pool plan required by the Federal CMS pursuant to the waiver.
- Advise the Agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

E. Public Meetings

The Agency will publish a public meeting notice in the FAR on October 1, 2013, inviting all interested parties to the three public meetings listed in the table located on the following page, which provides the dates, times and locations. Individuals who will be unable to attend the meeting in person can participate via conference call by using the toll free number provided in the FAR notice. During the meetings, the Agency will provide an overview of the provisions in Part IV of Chapter 409, F.S., related to the MMA program, an overview of the existing waiver including the June 14, 2013 federally approved waiver amendment, a description of the extension request and time for public comments. A video recording of the public meeting to be held in Tallahassee on October 11, 2013, will be posted on the Agency's website following the meeting.

Schedule of Public Meetings		
Location	**Date**	**Time**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00 p.m. – 3:30 p.m.
Miami Florida International University Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00 p.m. – 3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00 p.m. – 3:30 p.m.

F. Public Notice Document Made Available to the Public

The Agency will post on its website (link provided on page 25) beginning October 1, 2013 through October 30, 2013, this public notice document, the approved waiver documents (STCs of the waiver and the waiver and expenditure authorities document) and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program.

G. Submission of Written Comments

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

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

You may also e-mail your comments and suggestions to:

FLMedicaidWaivers@ahca.myflorida.com

IV. Program Objectives of the Waiver

This section of the document provides a description the program objectives of the waiver.

A. Program Objectives

As required by 42 CFR 431.412 and STC #16 of the waiver, the Agency is required to address the historical and programmatic objectives of the waiver including how the objectives were met. A description of the current program is outlined in Section I.C of this document. The five key design elements tracked by the Agency to evaluate progress towards achieving its goals are listed below along with a description of how each objective was met.

Objective 1: To ensure there is an increase in the number of plans from which an individual may choose; an increase in the different type of plans[3]; increased patient satisfaction.

Since the beginning of the waiver, the Agency has received 29 health plan applications [20 HMOs and nine FFS PSNs], of which 27 applicants sought and received approval to provide services to both the TANF and the SSI populations. Two applications were withdrawn by the applicants.

As illustrated by the Tables 3 through 5 located on page 29 of this document, the number and types of Reform health plans have increased in each geographical pilot area since the implementation of the waiver. Since the Reform health plans have the ability to create customized benefit packages to meet the needs of specific populations, Florida Medicaid recipients have a greater number of health plans from which to choose along with a greater variety of benefits. This flexibility empowers the recipients to choose the plan that best meets their needs. An exciting aspect of the waiver is the development of specialty plans. Florida Medicaid now has, as a result of the waiver, a health plan that specializes in serving children with chronic conditions and a health plan that specializes in serving individuals living with HIV or AIDS. As each specialty plan was developed, the Agency worked closely with medical professionals and national experts to ensure the model contracts encompass the unique needs of each population.

Tables 3 through 5 show the number of Reform health plans by plan type before implementation of the waiver on July 1, 2006 and the number of health plans as of August 1, 2013. Prior to the waiver, there were no specialty plans. Now there are three specialty plans in Broward County and one in Duval County. Similarly, there was one PSN in Broward County and none in Duval County prior to the waiver. Now there are two PSNs in Broward and one in Duval. The waiver has brought managed care to Baker, Clay and Nassau Counties. There are now three HMOs and one PSN serving these counties.

Broward County has seen a net increase of five health plans since implementation of the waiver, as has Baker, Clay and Nassau Counties. Duval County has seen a net increase of three health plans. Baker, Clay and Nassau, where there were no health plans prior to the waiver, have seen a net increase of four health plans. There are now significantly more health plan choices in the waiver (Reform) areas, including three specialty plans.

[3] Please note this part of objective will sunset when Medicaid Reform ends on or before October 1, 2014.

Table 3 Comparison of Number and Type of Health Plans in Broward County (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	8	9
PSN	1	2
Specialty Plan	0	3
Total	**9**	**14**

Table 4 Comparison of Number and Type of Health Plans in Duval County (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	2	3
PSN	0	1
Specialty Plan	0	1
Total	**2**	**5**

Table 5 Comparison of Number and Type of Plans in Baker, Clay and Nassau Counties (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	0	3
PSN	0	1
Specialty Plan	0	0
Total	**0**	**4**

A summary of the number and type of plans available prior to the waiver (Reform) is provided in Appendix C of this document.

Please note Section VI.C of this document provides the key findings of the recipient satisfaction surveys conducted in the Reform counties.

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

a. Access to Services Not Previously Covered

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

- Over-the-Counter Drug Benefit – The benefit has ranged from $10 - $25 per household, per month. Approved items can vary but usually include non-prescription drugs, first aid materials and other health-related items.
- Adult Preventative Dental Services – Benefits offered in this category have varied some but usually included coverage of select restorative dental procedures as well as preventative dental services for adults age 21 and over. Often there has been no cost for annual exams, x-rays, fluoride treatment (every six months), amalgams, or simple surgical extractions.
- Circumcisions for Male Newborns – Some health plans have extended circumcision coverage from six weeks after birth to one year.
- Acupuncture – Acupuncture has been offered to recipients specifically to aid with pain management and smoking cessation.
- Adult Vision Services – Vision services that have been offered to recipients age 21 and over include unlimited exams and eyeglasses when medically necessary (in some cases, this was limited to one pair per year). In addition to state plan covered adult vision services, some plans offered an extra $125 beyond the standard Medicaid vision benefit, which has been applied to upgrades to scratch-proof or tinted lenses, better frames, or additional pairs of glasses.
- Hearing Aid Services – recipients were offered one complete visit and received one hearing aid per year. This included an upgrade from a standard hearing aid to a digital canal hearing aid.
- Nutrition Therapy – Home-delivered meals have been offered to recipients recovering from surgery as well as to families of newborns.
- Respite Care – Recipients have received an initial home visit by a Registered Nurse as well as eight follow-up visits of four hours in length. There have been various packages including a maximum of 16 hours allowed per month and 32 hours allowed per year.
- Adult Hospital Outpatient – One health plan has offered an additional $3,500 per year for adult hospital outpatient services for their TANF and SSI populations above the $1,500 standard limit.
- Copayment Reduction or Elimination – Copayments for services rendered to non-pregnant adults have been significantly reduced over the course of the waiver and in many cases have been eliminated completely.

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

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

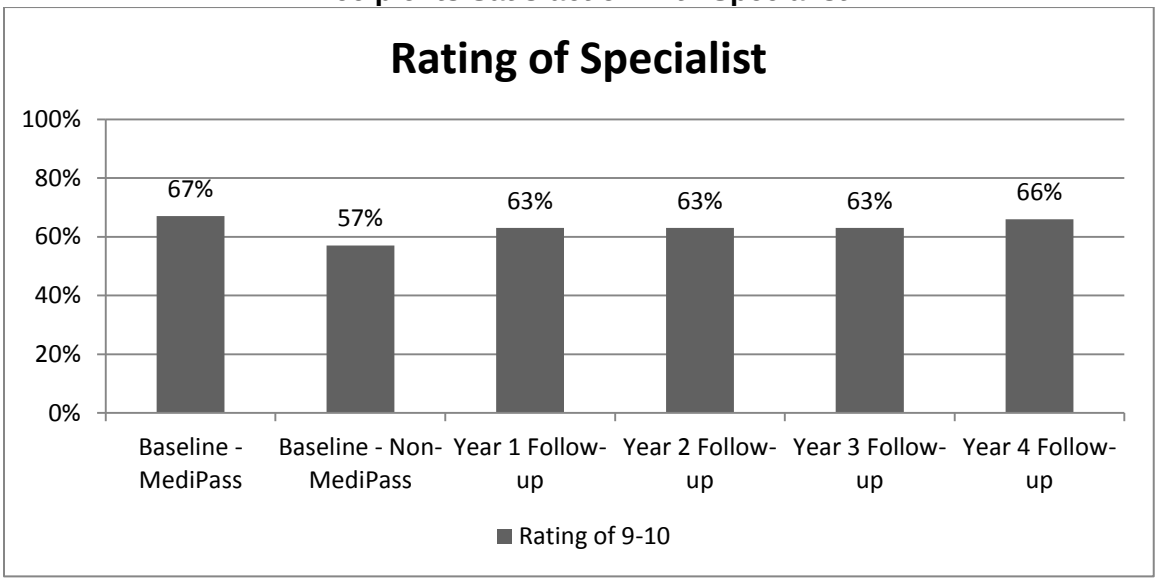
2. Improved Access to Specialists

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

- The Agency assessed recipients' experiences with specialists through items in the CAHPS Survey. The item regarding ease in seeing a specialist changed from the Baseline to the Year 1 through Year 4 follow-up surveys as did the response categories. In the Baseline survey, which used the CAHPS 3.0 survey, the question was "In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?" and the possible responses were "Big Problem," "Small Problem," or "Not a Problem." In the baseline CAHPS survey, 56% of MediPass enrollees and 54% of Non-MediPass enrollees reported that it was not a problem to see a specialist. In the Year 1 through Year 4 follow-up surveys, the CAHPS 4.0 survey was used and the question was "In the last 6 months, how often was it easy to get appointments with specialists?" The possible responses were "Never," "Sometimes," "Usually," or "Always." In the Year 1 through Year 4 follow-up surveys, the percentage of waiver enrollees reporting that it was always or usually easy to get appointments with specialists ranged from 63% to 67%.

- Additionally, the percentage of waiver enrollees rating their satisfaction with their specialists at the highest level (9 or 10 on a scale from 1 to 10) increased from the baseline (when 67% of MediPass enrollees and 57% of Non-MediPass enrollees gave this rating) to the follow-up years, when 63% to 66% of enrollees gave their specialists this rating.

Chart A
Recipients Satisfaction with Specialist



- The Agency tracks and trends issues and complaints received from recipients, providers and other stakeholders. All issues and complaints including complaints related to access to specialist are research and resolved in a timely manner. In each case, Agency staff contacted the health plan immediately and plan staff worked with the member to ensure that they received the needed appointment and/or care. The health plan contract requires plans to ensure the availability of at least 26 specialty provider types and 19 different behavioral health specialties to ensure access to contract covered services. The volume of complaints received in general is low compared to the number of recipients served and demonstrates recipients are able to access specialist.

  - A total of 244 issues/complaints from approximately 390,000 enrollees were received between July 2010 – June 2011, less than seven issues per 10,000 enrollees.
  - A total of 260 issues/complaints from approximately 410,000 enrollees were received between July 2011 – June 2012, less than seven issues per 10,000 enrollees.
  - A total of 139 issues/complaints from approximately 430,000 enrollees were received between July 2012 – June 2013, less than four issues per 10,000 enrollees.

  Service issues/complaints (which include access, authorization and denials) are one of the types tracked and discussed internally each quarter within the Agency to determine any concerning trends. To date, the overall volume or percentage of complaints received related to service has not been significantly different. In addition, health plan contract managers review complaints/issues received on a monthly basis to ensure there are no issues of concern with a particular health plan.

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

- In addition to monitoring plan reported complaints, grievances and appeals, the Agency also monitors the number of Medicaid Fair Hearings requested by recipients or providers on behalf of recipients. Medicaid Fair Hearings are conducted by the Florida Department of Children and Families with Agency staff in attendance. For the period September 2006 to June 2013, there were 241 requests for Medicaid Fair Hearings. Of the Hearings requested, 84 Hearings were held and the remaining requests were either withdrawn, abandoned, or resolved prior to the hearing. Of the hearings held, eight were decided in favor of the plan. The health plans are notified when a Fair Hearing is requested and continue to work with the recipient and provider to resolve the issue. The low number of Fair Hearings held demonstrates issues are being resolved at the plan level.

  The Agency continues to monitor the Fair Hearings on a quarterly basis to identify issues or trends of concern. Table 6 located on the following page identifies the number of Medicaid Fair Hearing Requests and the number of Fair Hearings held.

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Table 6 Medicaid Fair Hearing Requests and Medicaid Fair Hearings Held Demonstration Years 1 through 7			
Demonstration Period		**Medicaid Fair Hearing Held**	**Medicaid Fair Hearing Requests**
Year One	July 2006 – August 2006	No Plan Enrollment	
	September 2006 – December 2006	1	1
	Quarter 3 Jan 2007-Mar 2007	0	0
	Quarter 4 April 2007-June 2007	0	0
Year Two	Quarter 1 July 2007-Sept 2007	1	4
	Quarter 2 Oct 2007-Dec 2007	0	0
	Quarter 3 Jan 2008-Mar 2008	1	3
	Quarter 4 April 2008-June 2008	1	3
Year Three	Quarter 1 July 2008-Sept 2008	0	5
	Quarter 2 Oct 2009-Dec 2009	1	5
	Quarter 3 Jan 2009-Mar 2009	0	2
	Quarter 4 April 2010-June 2010	2	6
Year Four	Quarter 1 July 2009-Sept 2009	2	7
	Quarter 2 Oct 2009- Dec 2009	0	2
	Quarter 3 Jan 2010-Mar 2010	4	7
	Quarter 4 April 2011-June 2011	7	14
Year Five	Quarter 1 July 2010-Sept 2010	6	11
	Quarter 2 Oct 2010-Dec 2010	9	15
	Quarter 3 Jan 2011-Mar 2011	2	14
	Quarter 4 April 2011-June 2011	1	8
Year Six	Quarter 1 July 2011-Sept 2011	7	12
	Quarter 2 Oct 2011-Dec 2011	3	8
	Quarter 3 Jan 2012-Mar 2012	4	16
	Quarter 4 April 2012-June 2012	2	7
Year Seven	Quarter 1 July 2012-Sept 2012	2	22
	Quarter 2 Oct 2012-Dec 2012	10	27
	Quarter 3 Jan 2013-Mar 2013	5	24
	Quarter 4 April 2013-June 2013	13	20
Total		**84**	**241**

- From March 2008 through March 2009, the Agency headquarters staff and field office staff conducted 11 monthly plan Provider Network Validation surveys. These surveys assessed the percentage of health plan providers in the network files that are in fact contracted with the health plans. In the last six monthly surveys (September 2008 thru March 2009), the accuracy rates were consistently 99% or 100%, so the survey process was moved to a quarterly basis beginning in July 2009. Table 7 located on the following page provides the survey results for the period March 2008 through March 2009.

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

**The follow-up process for the March and April 2008 survey results was different than for the May 2008 surveys onward.*

- Quarterly Provider Network Validation Surveys were conducted in July and October 2009 and January 2010. With the switch from monthly to quarterly surveys, the sample size doubled (i.e., 30 providers were sampled from each health plan rather than 15) and the survey is at the statewide level, rather than focusing on a geographic Medicaid Area each time as well. Follow up on the July 2009 through May 2010 surveys found that 95% to 98.4% of providers sampled had current contracts with the health plans for which they were surveyed.

- In SFY 2010-11, the Agency conducted two semi-annual surveys, and found that 96% and 91% of the providers sampled had current contracts with the health plans for which they were surveyed.

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

- The Agency reviews the plan provider networks on an annual basis and at any time that the Agency receives notice of termination from a provider that appears to have a material impact on the health plan's provider network. The Agency reviews the plans' monthly submission of plan provider network files to ensure that the files are as accurate and complete as possible. Agency staff also review the provider networks displayed on the health plans' websites to ensure that the website directories are as up to date and accurate as possible.

- In Demonstration Year 6 and 7, the Agency began developing additional ways to analyze health plan encounter data in order to assess health care access. The most recent analyses focused on three types of specialty care: orthopedics, neurology and dermatology. These analyses use encounter data to target the number of recipients receiving these specialty services in waiver counties (measured as recipient utilization per 1,000 eligible recipients).

- Initiated in Demonstration Year 6, the Agency reviewed and refined methodologies for analyzing access to care in order to establish baselines and for identifying opportunities for health plans performance improvements. Encounter data improvements intended to enhance these analyses are ongoing, but recent improvements can be attributed to two factors: (1) Increase in volume of encounter data in the database; and (2) Improvement in filtering and stratifying data to target Reform health plan enrollees. Charts B and G located on pages 35-38 of this document demonstrate improving accessibility to neurology, dermatology and orthopedic services for Medicaid recipients statewide and in the waiver counties over time, for SFY 2009-10, SFY 2010-11 and SFY 2011-12.

- Specialty care access measurements have been communicated to the plans in their monthly Compliance Reports since March 2013. The Agency has reached out to the health plans to identify specific errors in their provider identification on encounter transactions and encouraged to educate and retrain providers. The accurate completion of specialty fields pertaining to these providers will provide necessary detail and enhance the ongoing analyses.

Chart B
Specialty Care – Reform Counties SFY 2009-10

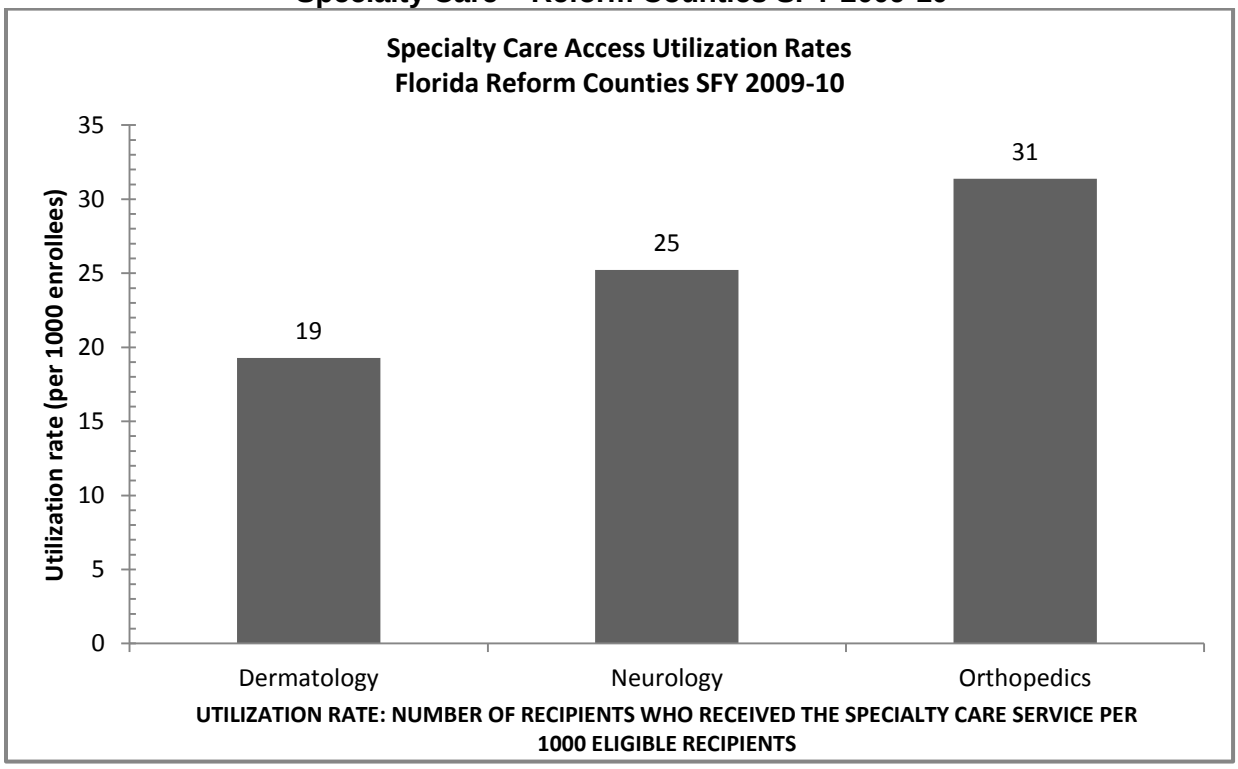

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Chart C
Specialty Care – Reform Counties SFY 2009-10

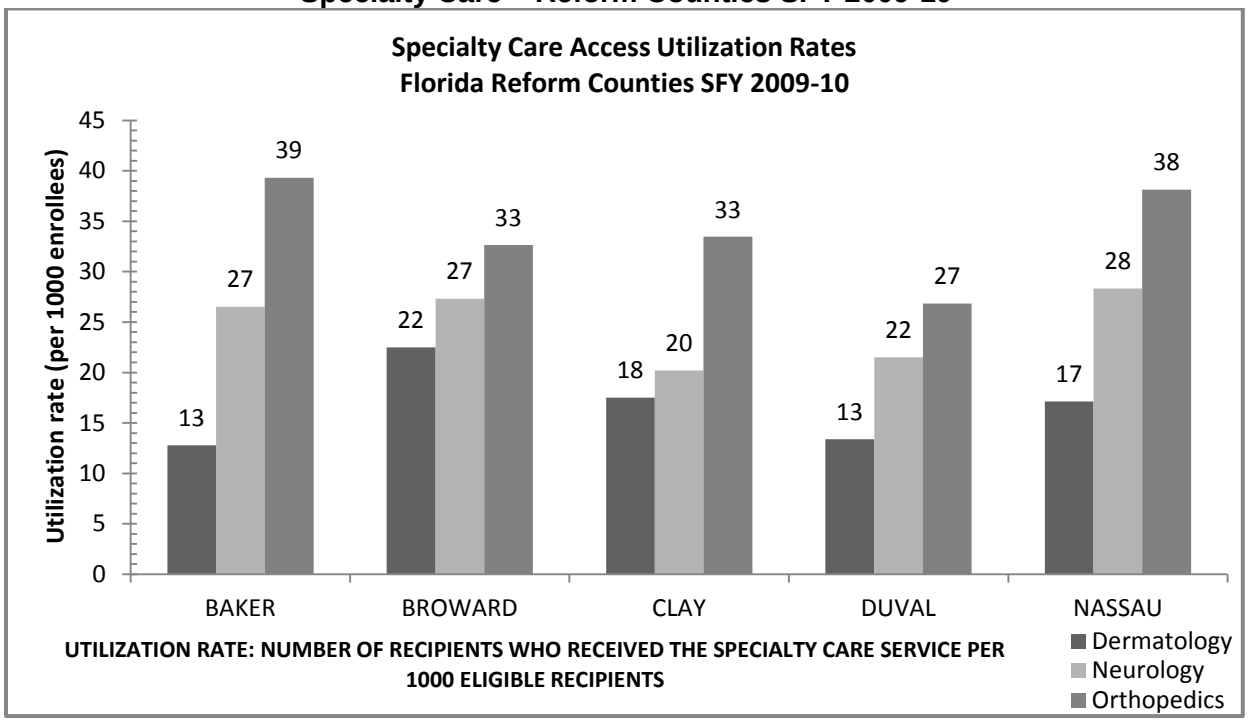


Chart D
Specialty Care – Reform Counties SFY 2010-11

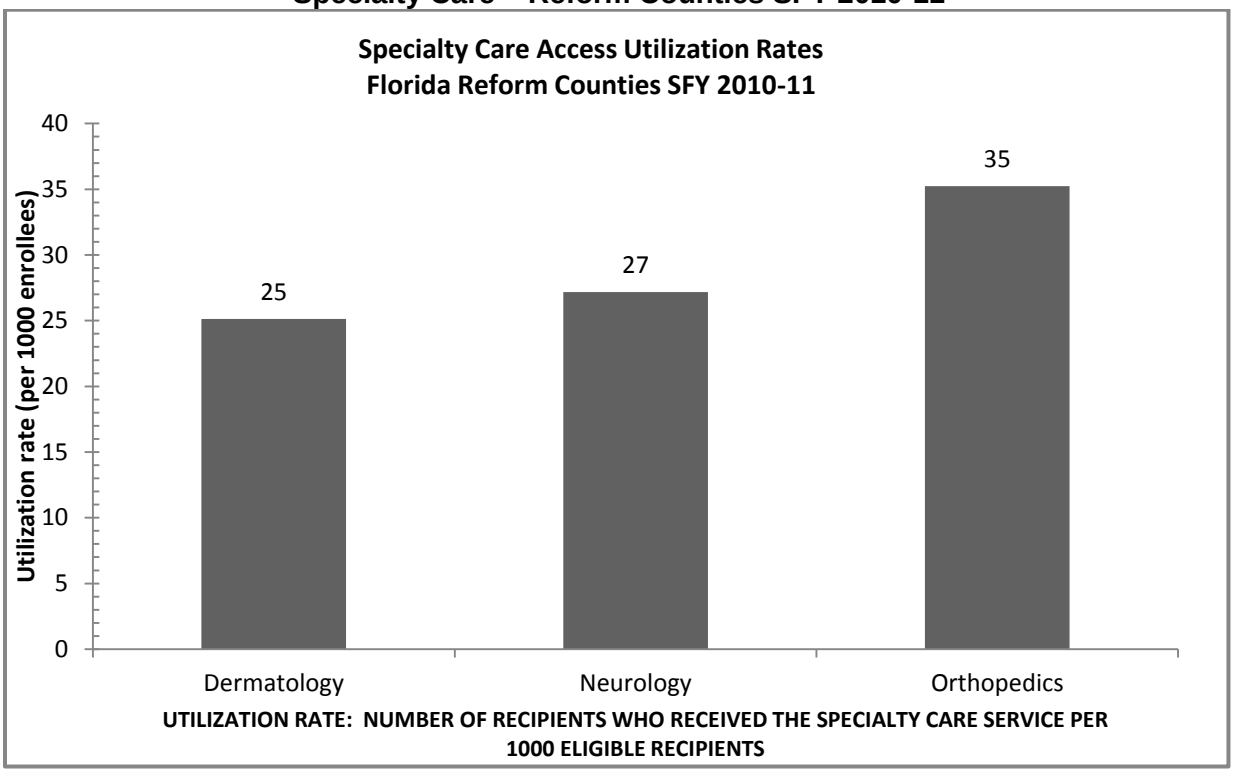


Chart E
Specialty Care – Reform Counties SFY 2010-11

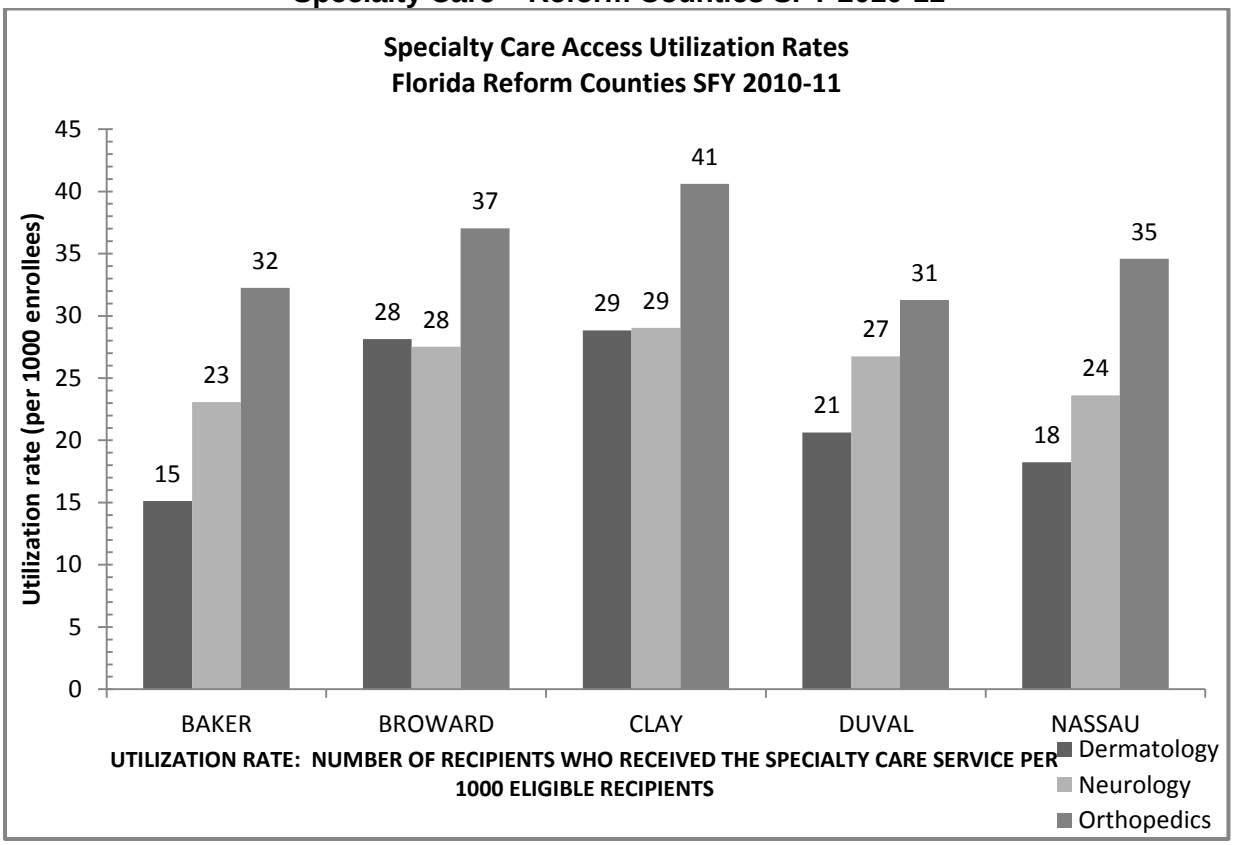


Chart F
Specialty Care – Reform Counties SFY 2011-12

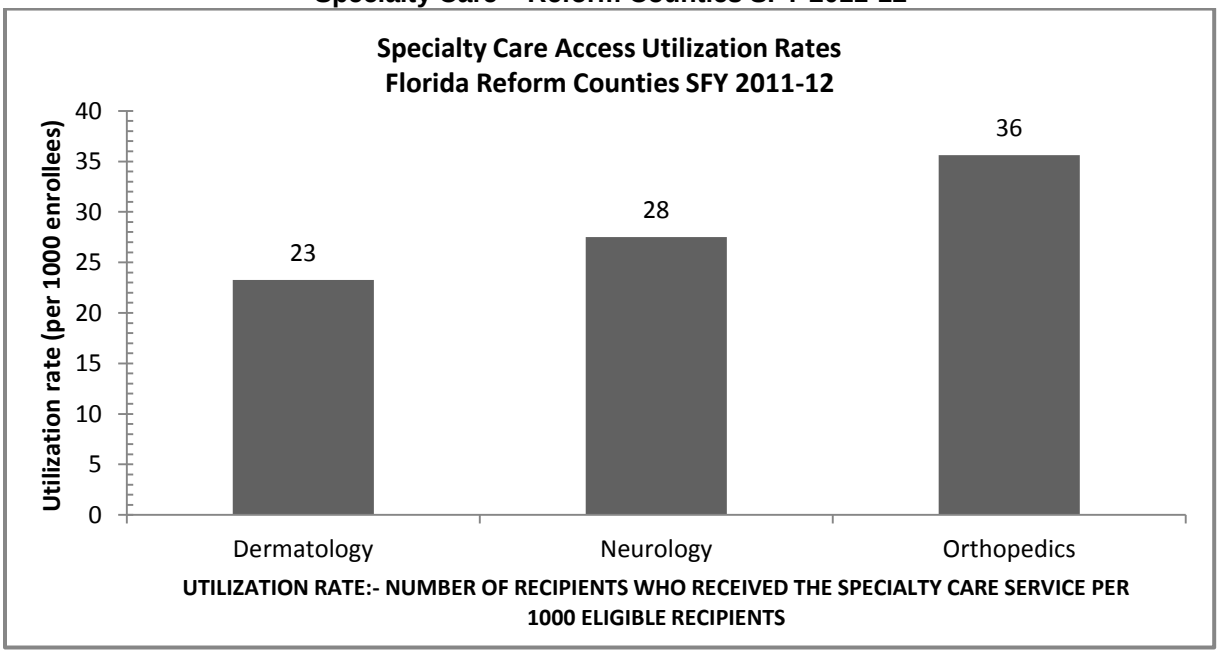
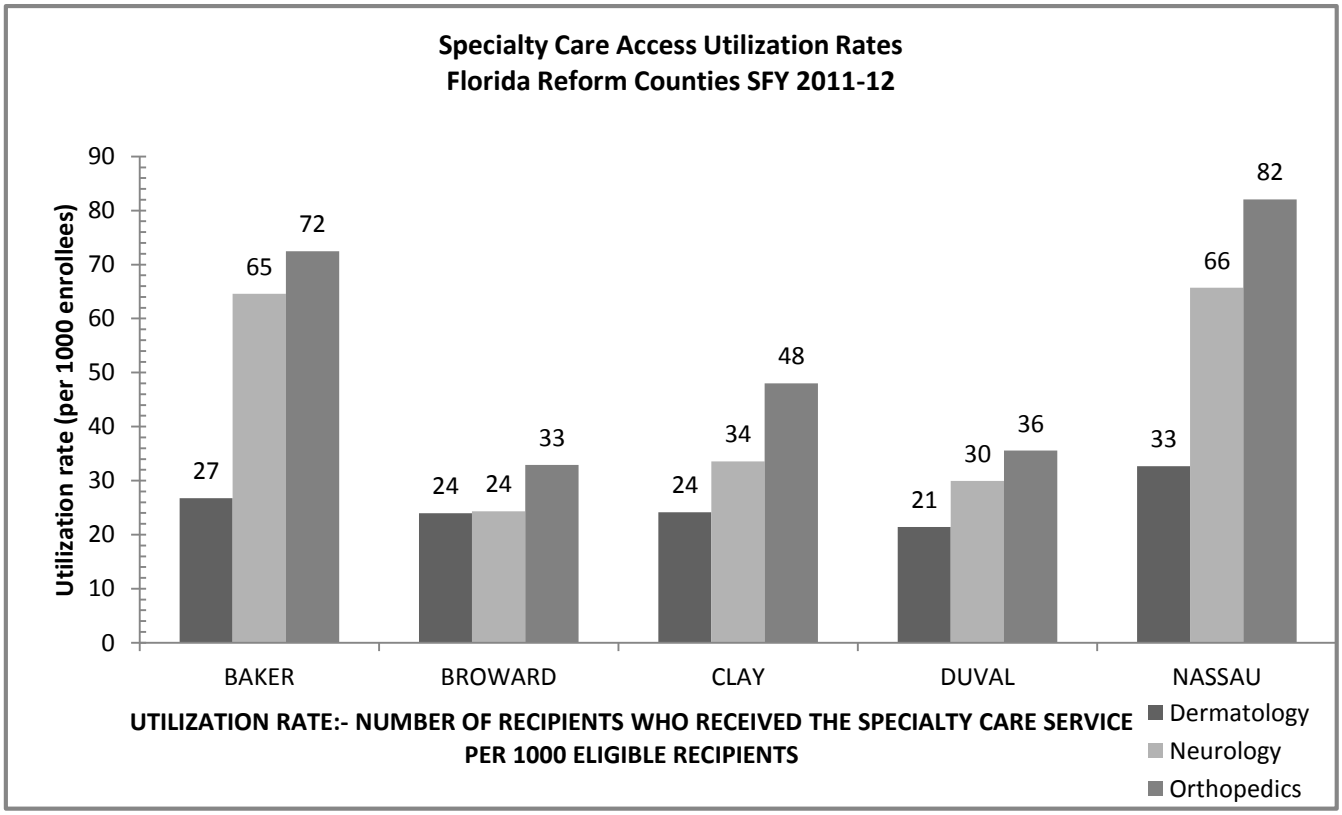


Chart G
Specialty Care – Reform Counties SFY 2011-12



2. Future Efforts

In addition to the ongoing monitoring and assessment of the health plan networks, the Agency will implement new MMA provider network standards that are more thorough than anything Florida Medicaid has required previously, as provided in Table 8 located on pages 39 and 40 of this document. The Agency drew these standards from Medicare with input from providers statewide including pediatric providers particularly Miami Children's Hospital and All Children's Hospital. Under the MMA program, the Agency intends to validate and verify these networks through a provider network verification process that the plans will be required to update weekly so that potential enrollees have the most up-to-date network information available when selecting a plan. The Agency, will continue its monitoring efforts to ensure providers listed as network providers actually participate in the plans network.

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Table 8 Managed Medical Assistance Provider Network Standards					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Providers	30	20	30	20	1:1,500 enrollees
Specialists					
Adolescent Medicine	100	75	110	90	1:31,200 enrollees
Allergy	80	60	90	75	1:20,000 enrollees
Anesthesiology	n/a	n/a	n/a	n/a	1:1,500 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (Pediatrics)	100	75	110	90	1:16,667 enrollees
Cardiovascular Surgery	100	75	110	90	1:10,000 enrollees
Chiropractic	80	60	90	75	1:10,000 enrollees
Dermatology	60	45	75	60	1:7,900 enrollees
Endocrinology	100	75	110	90	1:25,000 enrollees
Endocrinology (Pediatrics)	100	75	110	90	1:20,000 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees
General Dentist	50	35	75	60	1:1,500 enrollees
General Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Midwife	100	75	110	90	1:33,400 enrollees
Nephrology	80	60	90	75	1:11,100 enrollees
Nephrology (Pediatrics)	100	75	110	90	1:39,600 enrollees
Neurology	60	45	75	60	1:8,300 enrollees
Neurology (Pediatrics)	100	75	110	90	1:22,800 enrollees
Neurosurgery	100	75	110	90	1:10,000 enrollees
Obstetrics/Gynecology	50	35	75	60	1:1,500 enrollees
Oncology	80	60	90	75	1:5,200 enrollees
Ophthalmology	50	35	75	60	1:4,100 enrollees
Optometry	50	35	75	60	1:1,700 enrollees
Oral Surgery	100	75	110	90	1:20,600 enrollees
Orthodontist	100	75	110	90	1:38,500 enrollees
Orthopedic Surgery	50	35	75	60	1:5,000 enrollees
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pathology	n/a	n/a	n/a	n/a	1:3,700 enrollees
Pediatrics	50	35	75	60	1:1,500 enrollees

Table 8 Managed Medical Assistance Provider Network Standards					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Pharmacy	30	20	60	45	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services	30	20	30	20	2: County
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Adult Family Care Home	n/a	n/a	n/a	n/a	2: County
Assisted Living Facility	n/a	n/a	n/a	n/a	2: County
Birthing Center	n/a	n/a	n/a	n/a	1: County
Hospice	n/a	n/a	n/a	n/a	2: County
Durable Medical Equipment/Home Medical Equipment	n/a	n/a	n/a	n/a	As required in s. 409.975(1)(d), F.S.
Behavioral Health					
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500 enrollees
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100 enrollees
Licensed Practitioners of the Healing Arts	30	20	60	45	1:1,500 enrollees
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: county
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital for capitated plans only	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital for capitated plans only	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees

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

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

Please see Section VI.A of this document for the key findings regarding health status of enrollees for selected health indicators.

(3)(b) Reduction in ambulatory sensitive hospitalizations.

The Agency uses the Agency for Healthcare Research and Quality (AHRQ) Ambulatory Care Sensitive Conditions (ACSC) model to measure health plan member hospital utilization using quality indicators. The model includes use of quality indicators to analyze preventable hospitalizations. Aggregation of utilization data across multiple fee-for-service and managed care delivery systems fosters comparisons by county or by plan. The reports include morbidity scoring (MedRx), utilization by per member per month normalized to report per 1000 recipients, and a distribution by category of the quality indicator's for statewide (FFS and Managed Care), Reform, non-Reform and per-MCO basis. The model has been updated to support the latest version (4.4) provided by AHRQ.

Reports can be generated for designated Florida counties possessing similar Standard Metropolitan Statistical Areas characteristics, classified as small rural, medium rural, medium urban and large urban. Reports are also generated for a plan to plan comparison.

The Agency uses the AHRQ model for measuring and reporting plan performance. The Agency has shared the report results with the state's health plan association, the Florida Association of Health Plans. Through this collaboration, the Agency has refined the model and is moving forward with the changes. Additionally, the process is being updated to comport with the May 2013 version of AHRQ's model.

Chart H on the following page presents hospitalizations during state fiscal year 2011-12, where the recipient was admitted for a diagnosis defined as an ambulatory care sensitive condition. Chart H demonstrates measurably lower hospitalization admission rates for HMOs (both Reform and non-Reform) than the overall state average which includes all HMOs and FFS claims.

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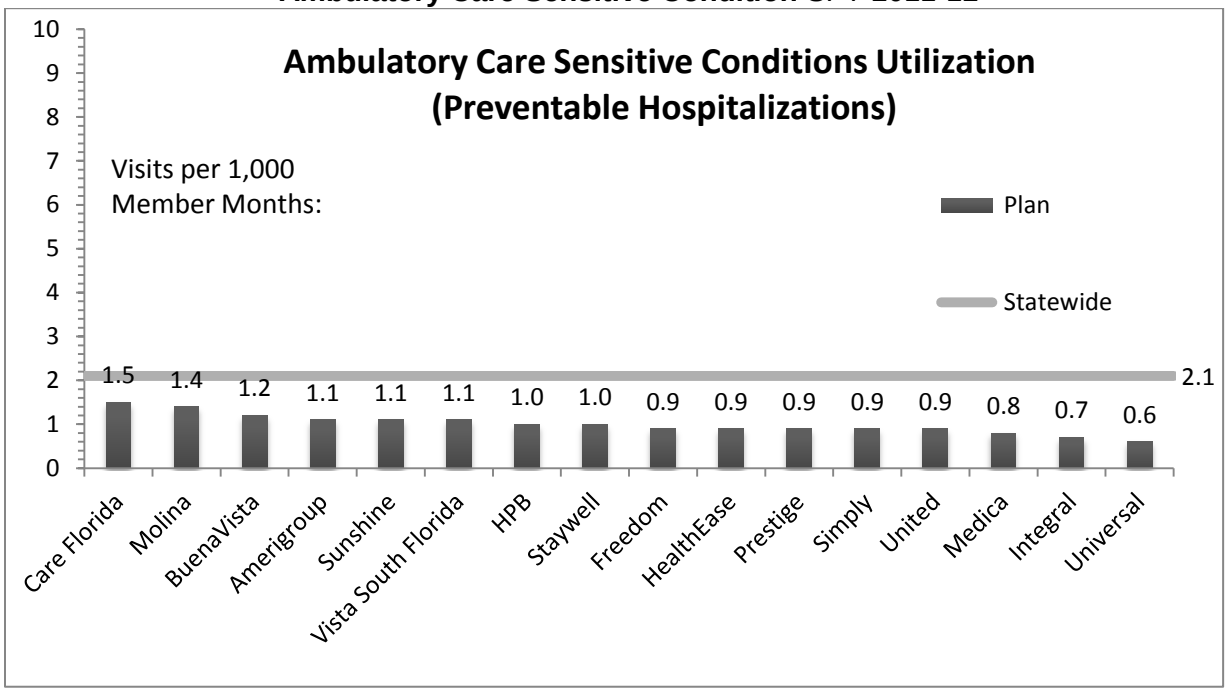
Chart H
Plan Performance Measures
Ambulatory Care Sensitive Condition SFY 2011-12



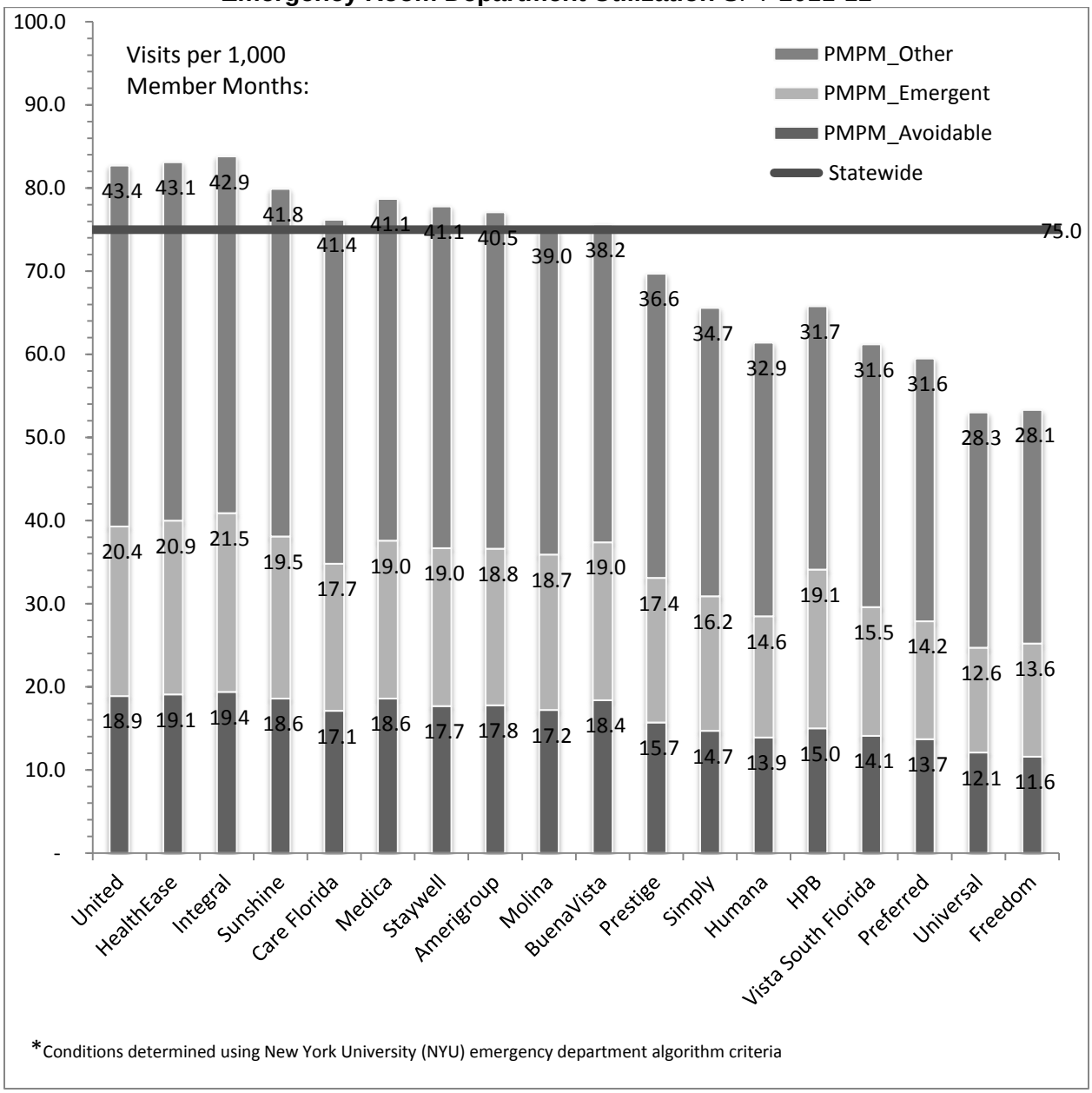
(3)(c) Decreased utilization of emergency room care.

The Agency uses a model to analyze the utilization of emergency departments (ED) based on the New York University ED algorithm. The model is set up to process data, generating comparable results across the fee for service recipients and managed care enrollees. The reports include a volumetric with morbidity scoring (MedRx), utilization per member per month per 1000, and distribution by reporting ED utilization category on a statewide (FFS and managed care), reform, non-Reform and per plan basis. Portions of the report are designed to produce a county comparison based on managed care eligible recipient utilization or report according to plan member utilization. The model is being updated to support the latest version 2.0 provided by New York University.

The algorithm developed by New York University is used to identify conditions for which an emergency department visit may have been avoided, either through earlier primary care intervention or through access to non-emergency department care settings.

The Agency uses this model as a tool for measuring plan performance. The Agency has shared the report results with the state's health plan association, the Florida Association of Health Plans. Through this collaboration, the Agency has refined the model and is moving forward with the changes. Chart I presents Emergency Department utilization during state fiscal year 2011-2012.

Chart I
Plan Performance Measures
Emergency Room Department Utilization SFY 2011-12



*Conditions determined using New York University (NYU) emergency department algorithm criteria

Objective 4: *To ensure that patient satisfaction increases.*

Section VI.C of this document provides the key findings of the recipient satisfaction surveys conducted in the waiver counties.

Objective 5: To evaluate the impact of the low-income pool on increased access for uninsured individuals.

Prior to the implementation of the waiver, Florida's Medicaid state plan included a hospital Upper Payment Limit program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The waiver created the LIP program, which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of these new Provider Access Systems allows for increased access to services for the Medicaid, underinsured and uninsured populations.

During Demonstration Year 1, the following Provider Access Systems received State appropriations for LIP distributions: Hospitals, County Health Departments, the St. John's River Rural Health Network and Federally Qualified Health Centers. During the first two quarters of Demonstration Year 1, the state approved a PAS distribution methodology and has worked with these PAS entities establishing agreements with the local governments or health care taxing districts.

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

The LIP Milestone data collected includes data for hospital PAS entities and non-hospital PAS entities. All PAS entities completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Demonstration Year 1). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. PAS entities with fiscal years different than July 1 – June 30 had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

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

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

- Primary Care Clinic Encounters
- Obstetric/GYN Encounters
- Disease Management Encounters
- Mental Health/Substance Abuse Encounters
- Dental Service Encounters

- Prescription Drug Encounters
- Laboratory Service Encounters
- Radiology Services
- Specialty Encounters
- Care Coordination Encounters

The PAS entities input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the University of Florida LIP Evaluation team. The evaluation team will use the data (along with data previously submitted such as pre-LIP payments, Intergovernmental Transfers, charge, cost and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports were used for the cost-effectiveness study. The evaluation team provided a "Plan for Evaluation of the Low Income Pool Program" to the Agency. The cost-effectiveness will be measured in the method described below.

> "In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost / Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in 'natural units' (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome."

During Demonstration Year 7, the Agency received and reviewed the LIP Milestone Statistics and Findings Report data results received from the LIP evaluation team. The Milestone data tracks the number of individuals and types of services provided through LIP. The following is some of the key data included in the results:

- A total of 146 PAS in Florida received LIP payments – 74 hospitals and 72 non-hospital providers.
- Total LIP funding was approximately $1 billion.
- For all providers, total LIP payments were approximately $995 million, a decrease of approximately $127 million from DY4: SFY 2009-10.
- Reporting hospitals receiving supplemental payments of rate enhancements served a total of approximately 3.7 million Medicaid, uninsured and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served a total of approximately 1.2 million Medicaid, uninsured and underinsured individuals.
- 126 hospitals that received supplemental payments of rate enhancements reported providing approximately 14.5 million service encounters to Medicaid, uninsured individuals across six service categories.
- For all categories of encounters, 63 reporting non-hospital providers receiving LIP payments provided a total of approximately 6.5 million encounters for specific services to Medicaid, uninsured and underinsured individuals.

One of the objectives of the Milestone Statistics and Findings Report is to determine the number of uninsured and underinsured recipients who receive services through LIP funding and determining what types of services are being provided in what setting. The following section summarizes and reports on the number of Medicaid, uninsured and underinsured individuals

served, the type of services provided and the setting in which the services were awarded by reporting providers receiving supplemental payments or rate enhancements.

a. Number of Uninsured and Underinsured Individuals Served

Hospital Providers

- Between Demonstration Year 1 and Demonstration Year 6, approximately 1.8 million uninsured and underinsured individuals were treated on an inpatient basis, and approximately 10.8 million uninsured and underinsured individuals were served on an outpatient basis by reporting hospital providers.
- Over six year period, the average number of uninsured and underinsured individuals served that received inpatient services was approximately 10,700 per reporting hospital. For outpatient services, the average number of uninsured and underinsured individuals served per reporting hospital was approximately 63,400.
- From Demonstration Year 1 to Demonstration Year 6, the number of reporting hospital providers decreased by 32 from 158 in Demonstration Year 1 to 126 in Demonstration Year 6. The number of Medicaid individuals served by hospital providers in inpatient and outpatient settings increased by 17,000 and 239,000 respectively. The number of uninsured and under insured individuals served on an inpatient basis and an outpatient basis by reporting hospital providers decreased.

Non-Hospital Providers

- Overall for non-hospital providers, between Demonstration Year 1 and Demonstration Year 6, there were 70 reporting non-hospital providers that furnished outpatient services to a total of approximately 2.1 million Medicaid and 3.4 million uninsured and underinsured individuals.
- The number of uninsured and underinsured individuals served increased by approximately 255,500, from 438,800 in Demonstration Year 1 to 694,300 in Demonstration Year 6 with a parallel increase in the number of reporting providers, 38 to 64.
- Overall, based on 70 reporting non-hospital providers, from Demonstration Year 1 to Demonstration Year 6, the average total number of uninsured and underinsured individuals served per reporting non-hospital providers was approximately 48,700. The average annual number of uninsured and underinsured individuals served per non-hospital provider decreased from 11,550 in Demonstration Year 1 to approximately 10,800 per reporting non-hospital provider in Demonstration Year 6. In Demonstration Year 3 and Demonstration Year 4, the average number of uninsured and underinsured individuals served per reporting non-hospital providers were approximately 11,500 and 14,500 respectively.

b. Summary

The LIP has provided hospital and non-hospital providers additional revenue that would not otherwise be available to serve the Medicaid, uninsured and underinsured populations. Reauthorization of the LIP funding at increased levels is a critical source of funding for care to the Medicaid, underinsured and uninsured populations in Florida. A reduction or static level of funding would undoubtedly result in reduction and access to care for the Medicaid, underinsured and uninsured populations.

B. Future Program Objectives

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

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

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

As Florida reviews the experiences during the seven years of the waiver and looks ahead to the three-year waiver extension period, the Agency plans to strengthen the evaluation of access to care under the MMA program by improving health plan performance on key child and adult core set measures, as well as other HEDIS® and Agency-defined performance measures.

With the implementation of the waiver in Florida, one major step forward in assessing the quality of care provided by the plans has been the increase in the number of plan performance measures reported to the Agency. Prior to the implementation of the waiver, the plans were required to report on 15 performance measures and currently the plans are required to report on 32 measures, including 13 of the Children's Core Set of Health Care Quality Measures and ten of the Initial Core Set of Health Care Quality Measures for Medicaid-eligible Adults. In the plan contract the Agency released with the Invitation to Negotiate to competitively procure the plans, an additional four measures from the Adult Initial Core Set are required to be reported.

In addition to increasing the number of performance measures that plans are required to report, the Agency has established a goal of the 75th percentile of the national benchmark for Medicaid health plans on the HEDIS® performance measures. For HEDIS® measures on which plans are performing below the 50th percentile, the plans have been required to do a Performance Measure Action Plan for each measure. With the 2012 performance measure submission (for calendar year 2011), plans were subject to sanctions for performing poorly in performance measure groupings, which is described in the Quality Improvement section. The 2012-2015 health plan contract includes liquidated damages as well as sanctions for poor performance on performance measures. It is the Agency's goal to move the health plans to achieving rates that are higher than 75 percent of the Medicaid plans across the nation.

V. Budget Neutrality

A. 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, 2014 to June 30, 2017) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the Federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver is budget neutral.

1. 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.

2. Budget Neutrality Results To Date

Table 9 located on the following page provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Capita Cost per Month (PCCM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through Demonstration Year 7, expenditures have been $15.8 billion less than the authorized budget neutrality limit. As a result, the state is in substantial compliance with budget neutrality and anticipates that by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

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Table 9 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 6	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	26,610,064	$6,922,217,820	$1,147,773,023	$8,069,990,843	$303.27
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,447,220,239)	
% Of WOW					70.07%
DY 7	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	28,179,336	$6,725,722,831	$1,256,222,251	$7,981,945,082	$283.26
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,807,277,232)	
% Of WOW					62.41%

3. Florida's 1115 Research and Demonstration Waiver

Appendix D of this document provides the required 1115 waiver templates supporting the waiver's compliance with the budget neutrality STCs. In addition, the projection of budget neutrality benchmarks for the requested three-year waiver extension (July 1, 2014-June 30, 2017) is included. The following are the basic concepts and assumptions used to project the three-years (DY09-DY11).

The Without Waiver (WOW) trend applied to the member month projections are based on the waiver's historic population trends experienced during DY01 to DY07. For the Statewide Medicaid Managed Care expansion population, the waiver was amended commencing with DY08, and a separate trend calculation was constructed for SFY08/09 to SFY12/13 (DY03-DY07). This is the same trend methodology utilized for the waiver amendment approved in March 2013 for DY08. This trend calculation has subsequently been updated to include the most current data available and includes both the expansion mandatory and voluntary populations. The same "president's trend" rates as defined in the March 2013 amendment were utilized for the WOW PCCM projections. For the historic waiver populations, the president's trend rates were applied to the DY08 PCCM as defined in STC #116b. For the expansion populations, the separate expansion trend calculations were utilized.

The With Waiver (WW) projections follow the same concept as the WOW calculations. There are no president's trends utilized in the WW projections. All the WW trend rates were derived from the historical population trends and the separate expansion trend calculations. The savings associated with the Hemophilia Management Program are factored into the per member per month calculation for the historic MEG 1 and 2 populations. This resulted in a $0.48 average reduction in the MEG 1 PMPM, and a $0.01 average reduction in the MEG 2 PMPM over the requested three waiver extension years.

The WOW and WW Months of Aging are defined as the 24 months from the mid-point of DY07 through the mid-point DY09. The one exception is for the WOW PMPM trend calculation for the historic populations. Since the STC #116b PCCM for DY08 was utilized, the months of aging were reduced to the 12 months from the mid-point of DY08 to the mid-point of DY09.

Regarding historic trend data for DY07, expenditures are complete through June 30, 2013. Since the demonstration years are defined as dates-of-service, there will be additional claim submissions still forthcoming for this year. Additional claim lapse time needs to occur before this year can be considered complete. DY07 may require an additional cost update.

With the above calculated PMPMs and member months, the total WOW expenditures for the three extension years are projected to be $63,736,924,665 compared to the WW expenditures of $36,698,548,780 for the same extension years. This would result in a savings over the three year period of $27,038,375,885. Separate calculations are identified for the two programs covered under the requested waiver extension period as Costs Not Otherwise Matchable (CNOM). These are the Healthy Start program and the Program of All Inclusive Care for Children. The cost for these programs for the three waiver extension years is anticipated to be $49,197,434. The budget neutrality net savings after adjusting for the CNOM costs are projected to be $26,989,178,451 for the requested waiver extension period.

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 facility and services as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the claims processing system but are lump sum payments made directly to the provider to offset the allowable uncompensated 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.

To provide for Florida's Medicaid, underinsured and uninsured populations, the Agency is likely to seek increased funding for the LIP ranging from $3 billion to $5 billion annually, for the upcoming waiver extension period of July 1, 2014 through June 30, 2017. The Agency is seeking to increase the number of Medicaid, underinsured and uninsured to be served through the LIP program. The demonstrated savings in the waiver may be available to use for this increased allocation. The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

B. Financial Management Standard Questions

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

   Response: Providers retain 100 percent of all payments made relating to Medicaid cost. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to Federal CMS.

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

with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

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

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

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

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

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

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

   For Florida State Fiscal Year 2013-14, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if

appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

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

This UPL analysis has been completed to accompany the SFY 2013-2014 inpatient reimbursement state plan amendment, which includes a move from per diem-based reimbursement to Diagnostic-Related Groups-based reimbursement.

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

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

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

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

VI. Quality Initiatives

This section provides summaries of EQRO reports, state quality assurance monitoring, and other documentation of the quality of and access to care provided under the waiver including but not limited to survey results from Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys and Choice Counseling Caller Satisfaction surveys. This information is provided in compliance with 42 CFR 431.412 and STC #9 of the waiver.

A. Plan Performance Measures and Improvement Strategies

1. The Waiver from Initiation through the Present

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

After a full review of the measures along with public input obtained through public meetings held in November 2006, the Agency identified a total of 33 proposed performance measures, including some Agency-defined measures. These measures were phased in over a three-year period (with the third year being reported July 1, 2010). For Year 1 of the waiver, the Agency collected 13 performance measures. The first set of performance measures was due to the Agency on July 1, 2008, for the measurement year beginning January 1, 2007 and ending December 31, 2007. The most recent set of performance measures was due to the Agency on July 1, 2013, for the measurement/calendar year 2012. The Agency has not completed its analysis of those measures, so the data are the most recent.

Over the course of the waiver, the Agency has made several changes to the list of performance measures that the health plans are required to report, due to modifications to HEDIS® by the National Committee for Quality Assurance (NCQA), and the release of the Initial Core Set of Children's Health Care Quality Measures and the corresponding Core Set of Quality Measures for Medicaid Eligible Adults by Federal CMS. The Agency has sought out standardized national measures as much as possible, but has retained several Agency-defined measures, keeping them as HEDIS®-like as possible. Several Agency-defined measures have been dropped due to the availability of similar standardized measures (e.g., Adult BMI Assessment, Use of Appropriate Medications for People with Asthma) and two HEDIS® measures (Follow-up after Hospitalization for Mental Illness and Frequency of Ongoing Prenatal Care) have been adapted by the Agency to better reflect care parameters within the State of Florida.

Performance measure data and specifications for the Agency-defined measures may be viewed on the Agency's Quality in Managed Care website:
http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Table 10 provides the list of performance measures the health plans were required to report to the Agency on July 1, 2013, for calendar year 2012.

Table 10 Plan Performance Measures for Calendar Year 2012		
HEDIS		**Children's and/or Adult Core Set Measure**
1	Adolescent Well Care Visits (AWC)	Yes
2	Adults' Access to Preventive /Ambulatory Health Services (AAP)	
3	Ambulatory Care (AMB)	Yes
4	Annual Dental Visits (ADV)	
5	Antidepressant Medication Management (AMM)	Yes
6	BMI Assessment (ABA)	Yes
7	Breast Cancer Screening (BCS)	Yes
8	Call Answer Timeliness (CAT)	
9	Cervical Cancer Screening (CCS)	Yes
10	Childhood Immunization Status (CIS) – Combo 2 and 3	Yes
11	Children and Adolescents' Access to Primary Care (CAP)	Yes
12	Chlamydia Screening for Women (CHL)	Yes
13	Comprehensive Diabetes Care (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy	Yes
14	Controlling High Blood Pressure (CBP)	Yes
15	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Yes
16	Immunizations for Adolescents (IMA)	Yes
17	Lead Screening in Children (LSC)	
18	Prenatal and Postpartum Care – (PPC)	Yes
19	Pharyngitis – Appropriate Testing related to Antibiotic Dispensing (CWP)	Yes
20	Use of Appropriate Medications for People With Asthma (ASM)	
21	Well-Child Visits in the First 15 Months of Life (W15)	Yes
22	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Yes
Agency-defined Performance Measures		
23	Call Abandonment [previously HEDIS] (CAB)	
24	Follow-Up after Hospitalization for Mental Illness (FHM)	Yes
25	Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)	
26	Highly Active Anti-Retroviral Treatment (HAART)	
27	HIV-Related Medical Visits (HIVV)	
28	Lipid Profile Annually (LPA)	
29	Mental Health Readmission Rate (RER)	
30	Prenatal Care Frequency (PCF)	Yes
31	Transportation Timeliness (TRT)	
32	Transportation Availability (TRA)	
33	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy (ACE)	

*AMB is a utilization measure and has not been compared against a national benchmark.
**Through the 2013 reporting year, CAP, CHL and CWP have been report only and not compared against national benchmarks.

In early 2009, the Agency hired a national consulting firm to assist with the development of a plan for performance improvement. A comprehensive performance improvement strategy was created and disseminated to all health plans that required health plans to complete corrective action plans for all performance measures that fell below the 50th percentile as calculated in the HEDIS® 2007 National Means and Percentiles, published by the National Committee for Quality Assurance. The corrective action plans must be designed to drive performance toward the 75th percentile, which the Agency selected as its goal for all contracted HEDIS® performance measures. It should be noted that this improvement strategy applies to both Reform and non-Reform health plans as the Agency has committed to improving quality throughout our managed care system.

To impart to the health plans the importance of the performance measures and the Agency's commitment to improvement, the Secretary for the Agency for Health Care Administration met with health plans individually to discuss their performance. Agency quality staff also held workshops with each health plan to discuss and improve their corrective action plans, culminating in the submission of final corrective action plans in late March and early April 2009. Health plans were required to report on the progress they made toward the goals in their corrective action plans quarterly. The Agency developed and distributed a quarterly reporting template, and the first reports were submitted to the Agency on August 17, 2009. Plans have continued to conduct Performance Measure Action Plans (PMAPs) each year for measures where the plans are performing below the 50th national percentile.

Table 11 lists the statewide average results for measures that were submitted from 2008 through 2012, and provides the 2012 National Mean as published by NCQA for the Medicaid product line as a comparison.

Table 11
Florida Medicaid Reform Plan Performance
HEDIS® Measures 2008-2012

Measure	2008	2009	2010	2011	2012	2012 National Mean
Annual Dental Visit	15.2%	28.5%	33.4%	34.0%	35.3%	45.8%
Adolescent Well-Care	44.2%	46.5%	46.3%	46.2%	47.6%	49.7%
Controlling Blood Pressure	46.3%	55.9%	53.4%	46.3%	52.9%	56.8%
Cervical Cancer Screening	48.2%	52.2%	50.8%	53.2%	56.8%	66.6%
Diabetes – HbA1c Testing	78.9%	80.1%	82.8%	81.9%	82.2%	82.4%
Diabetes - HbA1c Poor Control (INVERSE)	48.3%	46.8%	44.9%	48.6%	43.6%	43.2%
Diabetes – HbA1c Good Control (<8)	32.2%	48.0%	47.5%	43.7%	47.9%	48.0%
Diabetes - Eye Exam	35.7%	44.0%	45.4%	49.3%	50.2%	53.2%
Diabetes - LDL Screening	80.0%	80.2%	83.5%	81.8%	81.9%	74.9%
Diabetes - LDL Control	29.3%	35.5%	36.1%	36.9%	37.8%	35.2%
Diabetes – Nephropathy	79.2%	80.3%	81.9%	83.1%	82.3%	77.8%
Follow-Up after Mental Health Hospital – 7 day	20.6%	29.3%	25.4%	23.1%	22.7%	46.5%
Follow-Up after Mental Health Hospital – 30 day	35.5%	46.6%	41.3%	44.3%	41.2%	65.0%
Prenatal Care	66.6%	67.4%	75.2%	68.4%	72.1%	82.7%
Postpartum Care	53.0%	51.5%	52.1%	49.3%	52.9%	64.1%
Well-Child First 15 Months – Zero Visits (INVERSE)	4.9%	1.6%	6.0%	3.0%	2.1%	2.0%
Well-Child First 15 Months – Six Visits	44.4%	49.3%	35.4%	46.5%	58.4%	61.7%
Well-Child 3-6 years	71.3%	75.7%	72.7%	75.0%	75.5%	71.9%

Table 11 Florida Medicaid Reform Plan Performance HEDIS® Measures 2008-2012						
Measure	2008	2009	2010	2011	2012	2012 National Mean
Adults' Access to Preventive Care – total	n/a	77.2%	77.6%	77.0%	75.0%	81.8%
Antidepressant Medication Mgmt – Acute	n/a	52.0%	56.3%	56.3%	57.4%	51.1%
Antidepressant Medication Mgmt – Continuation	n/a	29.8%	43.8%	44.0%	43.1%	34.4%
Appropriate Medications for Asthma	n/a	83.6%	87.6%	86.0%	81.1%	85.0%
Breast Cancer Screening	n/a	51.4%	56.9%	59.2%	52.3%	50.4%
Childhood Immunization Combo 2	n/a	63.6%	70.0%	74.0%	74.8%	74.5%
Childhood Immunization Combo 3	n/a	53.8%	62.7%	66.9%	69.2%	70.7%
Frequency of Prenatal Care	n/a	52.6%	46.9%	44.0%	54.4%	60.9%
Lead Screening in Children	n/a	54.8%	52.0%	54.1%	59.6%	67.7%
Adult BMI Assessment	n/a	n/a	41.9%	52.7%	47.9%	52.6%
Follow-up Care for Children Prescribed ADHD Medication – Initiation	n/a	n/a	43.6%	44.5%	44.4%	38.8%
Immunizations for Adolescents – Combo 1	n/a	n/a	44.1%	43.6%	47.3%	60.4%

Of the 30 HEDIS® measure rates presented in Table 10, the statewide average results for the Reform plans improved by at least one percentage point for 14 of the measures, compared to the previous year. Non-Reform plans' rates for 11 of the measures stayed about the same, while their performance on seven of the measures dropped.

Performance measures with notable improvement include:

- Well-Child Visits in the First 15 Months – 6 or more: the statewide weighted average for Reform plans increased from 46.5% in 2011 (representing measurement year 2010) to 58.4% in 2012 (representing measurement year 2011).
- Controlling Blood Pressure: the statewide weighted average for Reform plans increased from 46.3% in 2011 to 52.9% in 2012.
- Diabetes – HbA1c Poor Control: the statewide weighted average for Reform plans dropped from 48.6% in 2011 to 43.6% in 2012. This is an inverse measure, meaning that a lower rate is more desirable.
- Frequency of Prenatal Care – 81% or more of expected visits: the statewide weighted average for Reform plans increased from 44% in 2011 to 54.4% in 2012.
- Lead Screening in Children: the statewide weighted average for Reform plans increased from 54.1% in 2011 to 59.6% in 2012.

On average, the Reform plans performed better than the national mean for a number of measures.

- For three of the Comprehensive Diabetes Care measure components, the statewide weighted average for Reform plans was higher than the national mean.
  - LDL Screening: the national mean was 74.9% while the weighted average for Reform plans was 81.9%.
  - LDL Control: the national mean was 35.2% while the weighted average for the Reform plans was 37.8%.

- Medical Attention for Nephropathy: the national mean was 77.8% while the weighted average for Reform plans was 82.3%.

- For the measure Well Child Visits in the 3rd-6th years of life, the weighted average for Reform plans was 75.5%, which exceeds the national mean of 71.9%.
- For both of the Antidepressant Medication Management rates (acute and continuation), the Reform plans' weighted averages (57.4% and 43.1%, respectively) exceeded the national means of 51.1% and 34.4%, respectively.
- For the Breast Cancer Screening measure, the Reform plans' weighted average was 52.3%, while the national mean was 50.4%.
- For the Follow-up Care for Children Prescribed ADHD Medication – Initiation measure, the Reform plans' weighted average was 44.4% while the national mean was 38.8%.

Through the 2012 submission of performance measures, there has been a steady upward trend for many of the performance measures, though additional progress will be needed to reach the 75th national percentile on all measures. There are several measures where the statewide average results for the Reform plans are very close to or surpass the 75th percentile. For the LDL Screening and Medical Attention for Nephropathy components of the Comprehensive Diabetes Care (CDC) measure, the Reform plans are above and just shy of the 75th percentile, respectively. The Reform plans are also within a few percentage points of the 75th percentile for the LDL Control component of the CDC measure. For Well Child Visits in the 3rd, 4th, 5th and 6th years of life, the Reform plans are within four percentage points of the 75th percentile. On average, Reform plans are above the 75th percentile for Antidepressant Medication Management (acute) and are above the 90th percentile for the continuation rate for this measure. For Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase), Reform plans are just shy of the 75th percentile.

Health plans are also required to submit performance measure data for their populations outside of the waiver. Table 12 compares the Reform and non-Reform plans' statewide average performance on HEDIS® measures reported in 2012. Again using statewide average data, the Reform health plans outperformed non-Reform health plans in 19 of 30 measure rates.

Table 12
2012 Reform Measures Compared to Non-Reform Measures

Plan Performance Measures	2012 Non-Reform	2012 Reform	Difference
Adolescent Well-Care	48.2%	47.6%	*
Annual Dental Visit	17.6%	35.3%	17.7%
Controlling Blood Pressure	51.5%	52.9%	1.4%
Cervical Cancer Screening	55.0%	56.8%	1.8%
Diabetes – HbA1c Testing	77.3%	82.2%	4.9%
Diabetes - HbA1c Poor Control (INVERSE)	46.6%	43.6%	3.0%
Diabetes – HbA1c Good Control (<8)	45.5%	47.9%	2.4%
Diabetes - Eye Exam	45.2%	50.2%	5.0%
Diabetes - LDL Screening	77.4%	81.9%	4.5%
Diabetes - LDL Control	34.2%	37.8%	3.6%
Diabetes – Nephropathy	77.7%	82.3%	4.6%
Follow-Up after Mental Health Hospital – 7 day	37.5%	22.7%	*
Follow-Up after Mental Health Hospital – 30 day	56.5%	41.2%	*
Prenatal Care	73.1%	72.1%	*
Postpartum Care	51.8%	52.9%	1.1%

Table 12 2012 Reform Measures Compared to Non-Reform Measures			
Plan Performance Measures	**2012 Non-Reform**	**2012 Reform**	**Difference**
Well-Child First 15 Months – Zero Visits (INVERSE)	3.2%	2.1%	1.1%
Well-Child First 15 Months – Six Visits	56.2%	58.4%	2.2%
Well-Child 3-6 years	75.6%	75.5%	*
Adults' Access to Preventive Care – total	69.9%	75.0%	5.1%
Antidepressant Medication Mgmt – Acute	50.4%	57.4%	7.0%
Antidepressant Medication Mgmt -- Continuation	33.6%	43.1%	9.5%
Appropriate Medications for Asthma	82.1%	81.1%	*
Breast Cancer Screening	50.1%	52.3%	2.2%
Childhood Immunization Combo 2	79.1%	74.8%	*
Childhood Immunization Combo 3	72.8%	69.2%	*
Frequency of Prenatal Care	60.2%	54.4%	*
Lead Screening in Children	59.5%	59.6%	0.1%
Adult BMI Assessment	58.6%	47.9%	*
Follow-up Care for Children Prescribed ADHD Medication – Initiation	40.8%	44.4%	3.6%
Immunizations for Adolescents – Combo 1	56.1%	47.3%	*

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

The Agency completed the final phase of the current Performance Improvement Strategy by finalizing sanctions language for the health plan contracts. The 2009-2012 HMO and PSN contracts included a performance measure sanction strategy, which levies monetary sanctions after health plans have had an opportunity to conduct a PMAP for a measure. The health plans were given an opportunity for input prior to finalizing the contract language, and a staggered implementation schedule was included in response to their comments. The first sanctions were applied to the health plans' performance measure submissions for calendar year 2011 measures. The key provisions of the sanction strategy are as follows:

- Each performance measure (PM) is assessed a score based upon its ranking relative to the national percentiles. A seven point scoring system is used (0-6).
- The PMs will be placed into PM groups comprised of similar PMs. The PM groups will receive an average PM group score. The PM groups are: Mental Health and Substance Abuse; Well-Child; Prenatal/Postpartum; Chronic Care; Diabetes; and Other Preventive Care.
- Plans are required to develop and submit PMAPs for any HEDIS® measures where the plan's score falls below the 50th national percentile. PMs will only be included in determinations of sanctions after the health plan has developed and implemented a PMAP.
- For the 2012 performance measure submission, PM group sanctions were assessed for PM group scores that fell below the equivalent of the 40th national percentile (calculated as a midpoint between the 25th and 50th national percentiles). For the 2013 performance measure submission, PM group sanctions will be assessed for PM group scores that fall below the equivalent of the 50th national percentile. A health plan may be sanctioned up to $10,000 per PM group score that falls below the threshold national percentile.
- Individual measure sanctions for measures in the Mental Health and Substance Abuse, Chronic Care and Diabetes groups may be applied if the health plan's rate falls below the equivalent of the 10th national percentile.

In addition to these sanctions, the 2012-2015 HMO and PSN contracts include liquidated damages for poor performance on HEDIS® performance measures.

Based on the 2012 performance measure submissions, the following PM group sanctions were given:

- Mental Health and Substance Abuse: four non-Reform plans and two Reform plans received sanctions.
- Well-Child: three non-Reform plans and two Reform plans received sanctions.
- Prenatal/Postpartum: 12 non-Reform plans and four Reform plans received sanctions.
- Chronic Care: seven non-Reform plans and two Reform plans received sanctions.
- Diabetes: three non-Reform plans and one Reform plan received sanctions.
- Other Preventive Care: eight non-Reform plans and four Reform plans received sanctions.

2. Looking Forward to Implementation of the MMA Program

Quality will continue to be a primary focus of the MMA program. As noted above, the Agency has used performance measures to identify areas in need of improvement throughout the Florida Medicaid program. These performance measures include HEDIS® measures, Children's Core Set measures, Medicaid Adult Core Set measures and state-defined measures. Because the Medicaid program in Florida has an outsized role in the birth process (paying for more than half of all deliveries), and due to the room for improvement in this area, prenatal/postpartum care and well-child visits within the first 15 months of life will be a primary area in which the state will focus improvement efforts by its plans. Child dental visits will also be a focus area. Under the MMA program, the plans will be required to conduct Performance Improvement Projects in both of these areas. In addition to performance measures currently reported by plans, the state has added several of the Federal CMS Medicaid Adult Core Set measures to the reporting requirements for the plans, including Annual Monitoring for Patients on Persistent Medications, Plan All-Cause Readmissions, Antenatal Steroids and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. Plans that perform highly on HEDIS® performance measures compared to the NCQA National Means and Percentiles will have the opportunity to earn financial incentives through an Achieved Savings Rebate.

On an annual basis, the state will continue to review the performance measures reported by the plans, considering whether any measures should be removed and whether there are additional measures from the Child and Adult Core Sets that should be added to reporting requirements. As national, standardized measures are developed that can replace state-defined measures in particular areas (e.g., a Mental Health Readmission Rate measure), the state will adopt those measures in order to collect data that are more comparable to other states and national benchmarks. As measures are added and removed from the Child and Adult Core Sets, and as technical specifications for these measures become available, the state will work on including these measures in required reporting.

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B. Summary of EQRO Reports

1. External Quality Review Activities

The Agency has contracted with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO) vendor since 2006. The state's EQRO, in compliance with section 1932(c)(2) of the SSA and 42 CFR 438 Subpart E, conducts an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO and prepaid inpatient health plans (PIHP) contract in Florida.

During State Fiscal Year 2012-13, the EQRO was responsible for the following six categories of annual activities:

- Validation of Performance Improvement Projects (PIPs);
- Validation of performance measures;
- Review of compliance with access, structural and operations standards;
- Focused Study and Report;
- Technical assistance (upon request) related to validation of PIPs, development of performance measures, compliance reviews and related activities and network adequacy and capacity standards; and
- Dissemination of reports and education.

In 2013, the Agency again selected HSAG as its EQRO vendor, through a competitive procurement process, for a new contract that began on July 1, 2013 and continues through June 30, 2018. The new contract includes the following eight categories of activities:

- Validation of Performance Improvement Projects;
- Validation of Performance Measures;
- Review of Compliance with Access, Structural and Operational Standards;
- Validation of Encounter Data;
- Focused Studies;
- Dissemination and Education;
- Annual Technical Report; and
- Technical Assistance and Other Activities

The new EQRO contract also includes the Prepaid Dental Health Plans in external quality review activities, beginning July 1, 2013.

Appendix E of this document lists the External Quality Review Reports by demonstration year.

2. Validation of Quality Initiatives

a. Validation of Performance Improvement Projects

MCOs and PIHPs are contractually required to develop and implement Performance Improvement Projects (PIPs) to improve the quality of health care in targeted areas. The plans are required to submit their PIPs to Agency staff and to the EQRO each year. The EQRO reviews PIPs using the Federal CMS validation protocol and evaluates the technical structure of PIPs to ensure that the MCOs and PIHPs have designed, conducted and reported PIPs in a methodologically sound manner, meeting all state and federal requirements. The EQRO also

evaluates the implementation of the PIP to determine how well the plan has improved its rates through effective processes.

HMOs and PSNs are currently required to perform at least four state-approved PIPs, while the other managed care plan types are required to perform at least two state-approved PIPs. With the transition to SMMC, the Managed Medical Assistance plans will still be required to perform at least four state-approved PIPs, while the Long-term Care plans will be required to perform at least two state-approved PIPs.

Health Maintenance Organizations
The EQRO reviewed PIPs to evaluate the services provided by the Health Maintenance Organizations (HMOs) to enrolled members based on quality, access and timeliness. The EQRO validated one collaborative and one non-collaborative PIP as required by the EQRO contract with the state. During SFY 2012-13, 58 PIPs were assessed for both Reform and non-Reform HMOs. The EQRO determined that 88 percent of the collaborative PIPs and 66 percent of the non-collaborative PIPs received a Met validation status.

Provider Service Networks
During SFY 2012-13, the EQRO assessed 11 PIPs for both Reform and non-Reform PSNs. Of the total PIPs assessed, 100 percent of the collaborative PIPs received a Met validation status and 75 percent of the non-collaborative PIPs received a Met validation status.

Table 13 provides summary information on the percentage of HMO and PSN collaborative and non-collaborative PIPs met for SFY 2012-13.

Table 13
Performance Improvement Project Validation Results
SFY 2012-2013

HMOs (Reform and Non-Reform)	**Percentage**
Percentage of Collaborative PIPs Met	88%
Percentage of Non-Collaborative PIPs Met	66%
Total Number of HMO PIPs Validated	58
PSNs (Reform and Non-Reform)	
Percentage of Collaborative PIPs Met	100%
Percentage of Non-Collaborative PIPs Met	75%
Total Number of PSN PIPs Validated	11

b. Validation of Performance Measures

All Reform and non-Reform HMOs and PSNs are required to report a selected set of HEDIS performance measures as well as Agency-defined measures on an annual basis. The EQRO reviewed and validated the audit findings from each plan's final audit report produced by the licensed auditing organization. The EQRO determined that the data collected and reported for the measures selected by the Agency followed NCQA HEDIS® methodology. Therefore, any rates and audit designations were determined to be valid, reliable and accurate.

c. Strategic HEDIS® Analysis Report

In March 2012, the EQRO published the *Florida Medicaid HEDIS 2011 Results Statewide Aggregate Report*. The data presented in this report was derived from the HMOs' and PSNs' reporting year 2011 data, which reflected calendar year 2010 as the measurement period. The Agency's contract with the EQRO has not included a specific HEDIS® validation deliverable after the March 2012 report.

A more detailed description of the past Strategic HEDIS® Annual Report may be found in Appendix F of this document.

Focused Study Quality Initiative: Emergency Department Collaborative

Beginning in 2011 and continuing through 2012, the EQRO facilitated an Emergency Department collaborative project. The project operated in Duval and Broward counties and was a voluntary collaborative project based on a modification of a model developed by the Institute for Healthcare Improvement. The Agency, in conjunction with HMOs, PSNs, hospitals, community providers, patient advocacy organizations, and Medicaid consumers, conducted an 18 month initiative to study effective ways to reduce the number of avoidable emergency department visits for Florida's Medicaid population. Over the 18 month period, the two area steering committees developed and implemented community-specific patient-centered interventions. The interventions addressed specific health conditions that had high emergency department utilization rates, including Asthma, Substance Abuse, Chronic Pain and Mental Illness. The two steering committees joined forces to launch a broader effort to educate Medicaid recipients using the emergency room to treat their child's asthma about more appropriate management strategies. This initiative educated Medicaid recipients about the importance of establishing a relationship with a primary care provider for their child's health care needs.

Some of the accomplishments of the Emergency Department Collaborative included:

- Increasing communication between providers and plans to facilitate shared patient information and effective management for high-needs patients with high emergency department use, resulting in improved coordination of care, increased patient participation and better health outcomes and health care utilization behaviors.
- The creation of patient-tested asthma educational materials that Medicaid recipients found easy to understand and useful in better managing their child's asthma.
- The implementation of a multidisciplinary care team involving emergency department staff, plan case managers, and other health providers to coordinate care for high utilizers.
- Establishment of a process to provide an emergency department daily census that will improve the plan's ability to manage and coordinate care for high-needs recipients.
- Successful co-location model of embedding a plan case manager in the emergency department for real-time patient follow-up and care coordination.

C. Enrollee Satisfaction Surveys and Choice Counseling Caller Satisfaction Survey

The following are summaries of the results from any recipient surveys performed during the period of the waiver, along with the results of any baseline surveys performed prior to implementation. The following recipient satisfaction survey results are provided to address this requirement.

1. Consumer Assessment of Health Care Providers and Systems

The Consumer Assessment of Health Care Providers and Systems (CAHPS) satisfaction survey was conducted to track enrollees' experiences and levels of satisfaction with their health plan and health care. To date, six rounds of the CAHPS survey have been completed in the waiver (Reform) counties:

- The Baseline survey was conducted in state fiscal year (SFY) 2006-07 and included MediPass and Non-MediPass enrollees (which includes FFS, HMO and PSN enrollees).
- A Year 1 follow-up survey was conducted in SFY 2007-08 (Survey Year 2) for enrollees in the Reform health plans.
- A Year 2 follow-up survey was conducted in SFY 2008-09 (Survey Year 3) for enrollees in the Reform health plans.
- A Year 3 follow-up survey was conducted in SFY 2010-11 (Survey Year 4) for enrollees in the Reform health plans.
- A Year 4 follow-up survey was conducted in SFY 2011-12 (Survey Year 5). Comparable methodologies were used for surveying enrollees in the Reform and non-Reform health plans.
- A Year 5 follow-up survey was conducted in SFY 2012-13 (Survey Year 6), including enrollees in the Reform and non-Reform health plans. These survey results are not yet available for reporting.

A detailed methodology of the survey is available on the Agency's website.

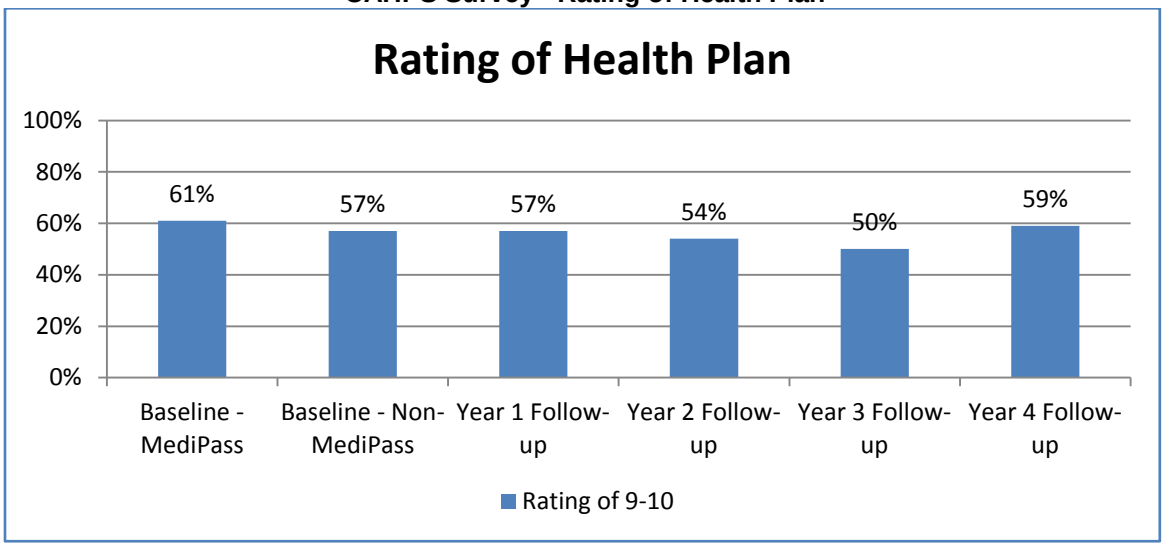
The multiple rounds of survey findings provide interesting and not entirely consistent trends. For example, while ratings of health plan satisfaction decreased in the first three follow-up years compared to Baseline, health plan satisfaction increased in the fourth follow-up survey, to approximately the levels observed at Baseline. Ratings of satisfaction with personal doctors and specialists improved slightly and remained relatively consistent over time. There were improvements in frequency of getting urgent care as soon as the enrollee wanted, while frequency of getting non-urgent care as soon as the enrollee wanted fluctuated a bit but remained about the same over time. In the follow-up surveys, higher percentages of Reform plan enrollees reported having a personal doctor than at Baseline. While the above are important and positive indicators, this was in contrast to a downward change observed in some ratings, specifically the indicator of overall health care satisfaction, although ratings for this indicator did improve in the Year 4 follow-up survey.

Key findings from the CAHPS surveys from the baseline survey through the Year 4 follow-up survey are presented in Charts J through M located on pages 65 – 67 of this document.

a. Ratings of Health Plan, Health Care, Personal Doctor and Specialist

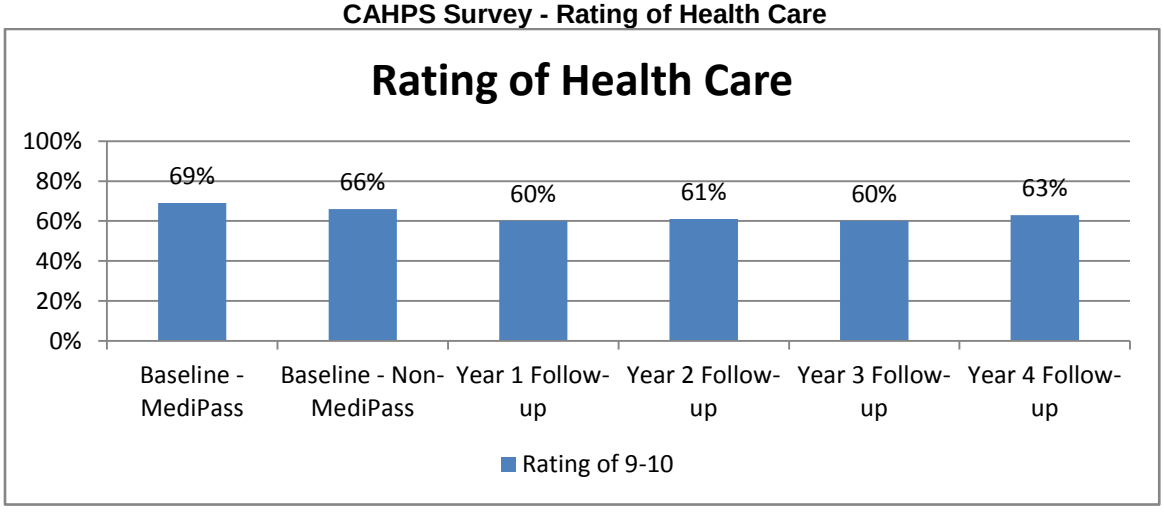
The CAHPS survey asks enrollees to rate their health plan on a scale from 0 to 10, with 0 being the worst plan possible and 10 being the best plan possible. At baseline, 61% of MediPass enrollees and 57% of Non-MediPass enrollees rated their health plan a 9 or a 10. The percentage of Reform plan enrollees rating their plan a 9 or a 10 dropped in the Year 1 through Year 4 follow-up surveys, but jumped back up to 59%, approximately its Baseline level, in the Year 4 follow-up survey.

Chart J
CAHPS Survey - Rating of Health Plan



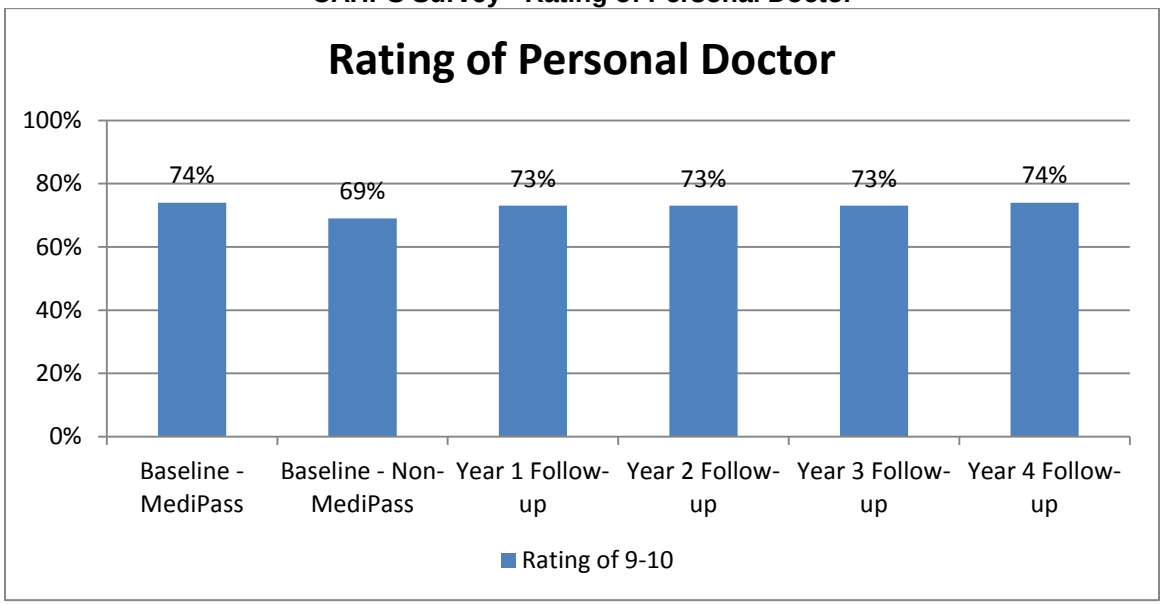
CAHPS survey respondents are asked to rate their health care on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best health care possible. At Baseline, 69% of MediPass enrollees and 66% of Non-MediPass enrollees rated their health care a 9 or 10. The percentage of Reform plan enrollees rating their health care a 9 or 10 dropped in the follow-up surveys, but increased from 60% in the Year 3 follow-up survey to 63% in the Year 4 follow-up survey.

Chart K
CAHPS Survey - Rating of Health Care



Reform plan enrollees are asked to rate their personal doctor on a scale of 0 to 10, with 0 being the worst and 10 being the best possible personal doctor. At Baseline, 74% of MediPass enrollees and 69% of Non-MediPass enrollees rated their personal doctor a 9 or a 10. The percentage of Reform plan enrollees rating their personal doctor a 9 or a 10 remained high, at 73% and 74% in the Year 1 through Year 4 follow-up surveys.

Chart L
CAHPS Survey - Rating of Personal Doctor



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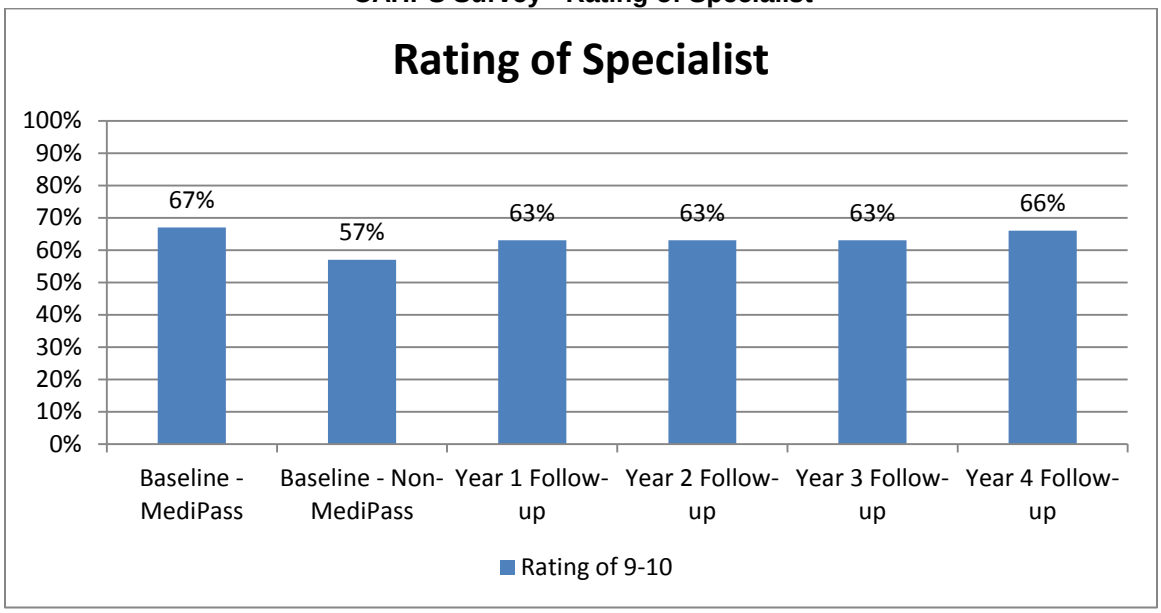
The CAHPS survey also has enrollees who have seen a specialist rate their specialist on a scale from 0 to 10, with 0 being the worst possible specialist and 10 being the best possible specialist. At Baseline, 67% of MediPass enrollees and 57% of Non-MediPass enrollees rated their specialist a 9 or 10. In the Year 1, 2 and 3 follow-up surveys, 63% of Reform plan enrollees rated their specialist a 9 or 10. In the Year 4 follow-up survey, 66% of Reform plan enrollees rated their specialist a 9 or 10.

Chart M
CAHPS Survey - Rating of Specialist



b. Ease of Getting Care: Specialists and Care, Tests, or Treatment

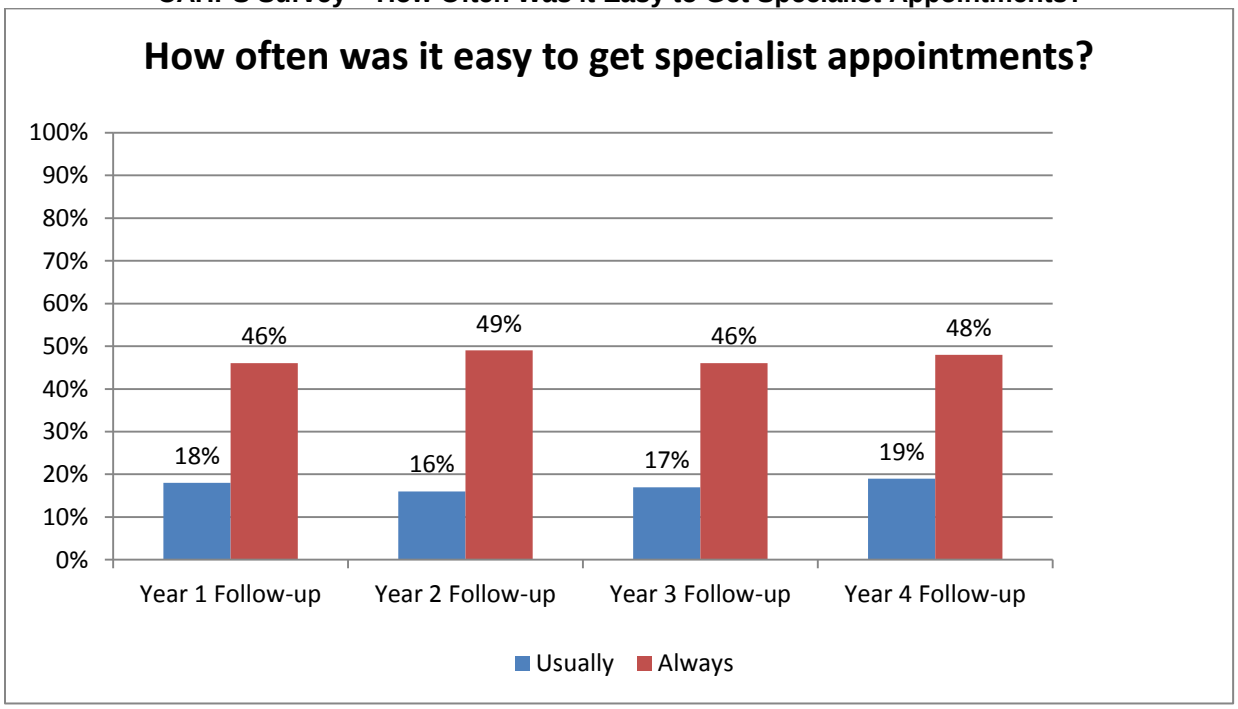
In the Baseline and Year 1 through 4 follow-up surveys, enrollees were asked about ease of getting specialist appointments and getting care, tests, or treatment needed through the respondent's health plan. The wording and orientation of these survey items changed from the Baseline to the follow-up surveys, as the Agency for Healthcare Research and Quality (AHRQ) changed from the CAHPS 3.0 version to CAHPS 4.0. In the 3.0 survey, the question was "In the last 6 months, how much of a problem, if any, was it to see a specialist that you needed to see?" There were only three answer categories: "a big problem," "a small problem," and "not a problem." The 3.0 survey question regarding care, tests and treatment asked "In the last 6 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?" This question had the same three answer categories as the question regarding specialists.

In the CAHPS 4.0 survey, the wording of these two items changed to "In the last 6 months, how often was it easy to get appointments with specialists?" and "In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you (your child) needed through your health plan?" Instead of three answer categories, the 4.0 survey included four answer categories: "Never," "Sometimes," "Usually," and "Always."

Due to the change in response categories between the Baseline survey and follow-up surveys, a comparison of the Baseline and follow-up survey results is given in the text, while Charts N through R located on pages 68 through 72 shows the percentage of respondents answering "Always" or "Usually" in the Year 1 through Year 4 follow-up surveys.

At Baseline, 56% of MediPass enrollees and 54% of Non-MediPass enrollees stated it was "not a problem" to see a specialist they needed to see. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting it was "always" easy to get appointments with specialists ranged from 46% to 49%, while 16% to 19% of enrollees reported it was "usually" easy to get appointments with specialists. Chart N provides the results the following question – How often was it easy to get specialist appointments.

Chart N
CAHPS Survey – How Often Was it Easy to Get Specialist Appointments?



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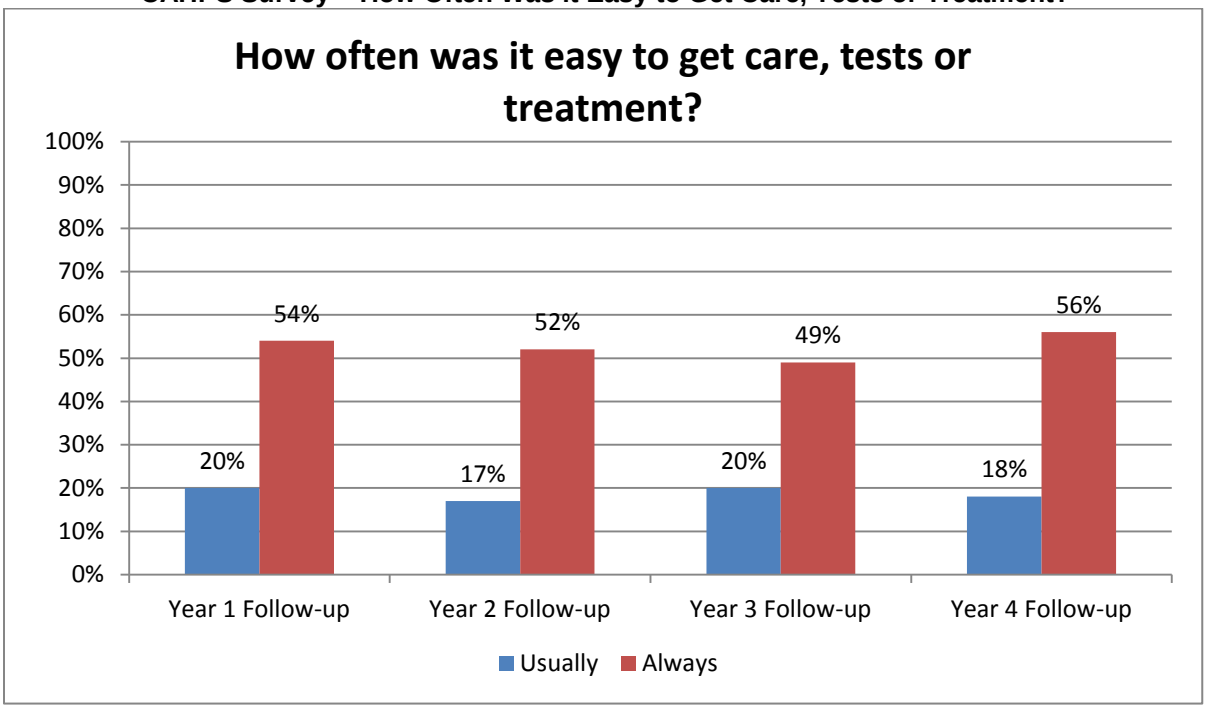
At Baseline, 72% of MediPass enrollees and 69% of Non-MediPass enrollees said it was “not a problem” to get the care, tests or treatment they or a doctor believed necessary. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting it was “always” easy to get the care, tests, or treatment they thought they needed ranged from 49% to 56%, while 17% to 20% of Reform plan enrollees reported it was “usually” easy to get the care, tests or treatment they needed. Chart O provides the results the following question – How often was it easy to get care, tests, or treatment?

Chart O
CAHPS Survey – How Often Was it Easy to Get Care, Tests or Treatment?



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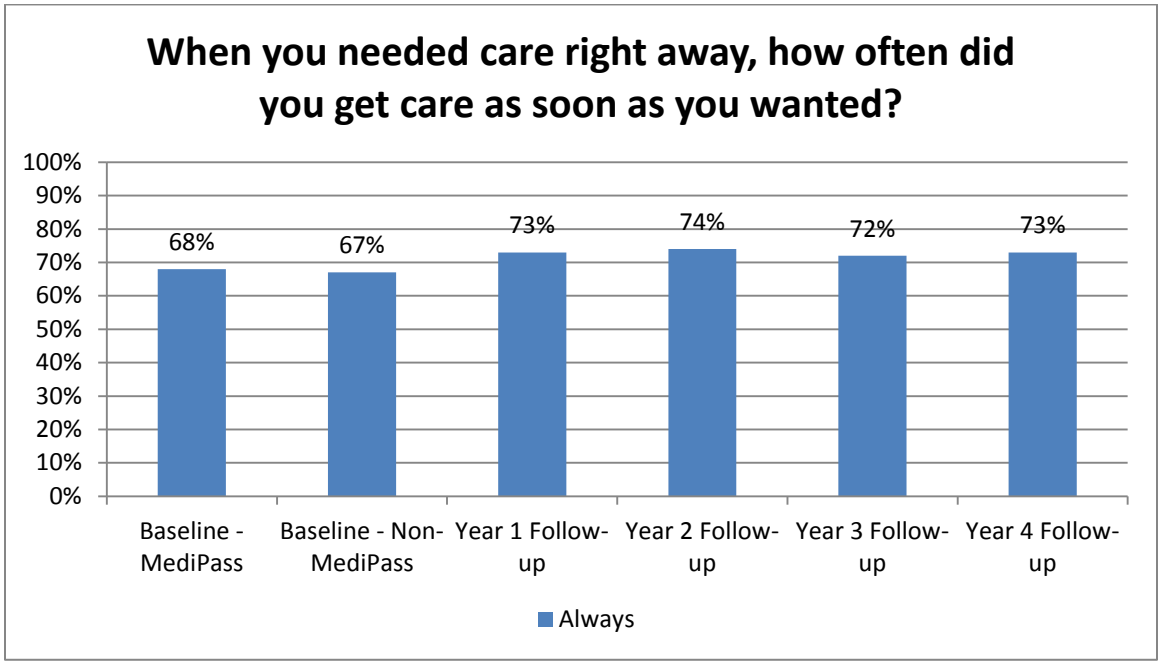
c. Getting Care when Needed: Urgent Care and Non-Urgent Care

Survey respondents were asked how often they got care as soon as they wanted when they needed care right away for an illness, injury, or condition. At the Baseline, 68% of MediPass and 67% of Non-MediPass respondents reported that they "always" got care as soon as they wanted when they needed care right away. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting that they "always" got care as soon as they wanted it ranged from 72% to 74%. Chart P provides the results the following question – When you needed care right away, how often did you get care as soon as you wanted?

Chart P
CAHPS Survey – When You Needed Care Right Away, How Often Did You Get Care as soon as You Wanted?



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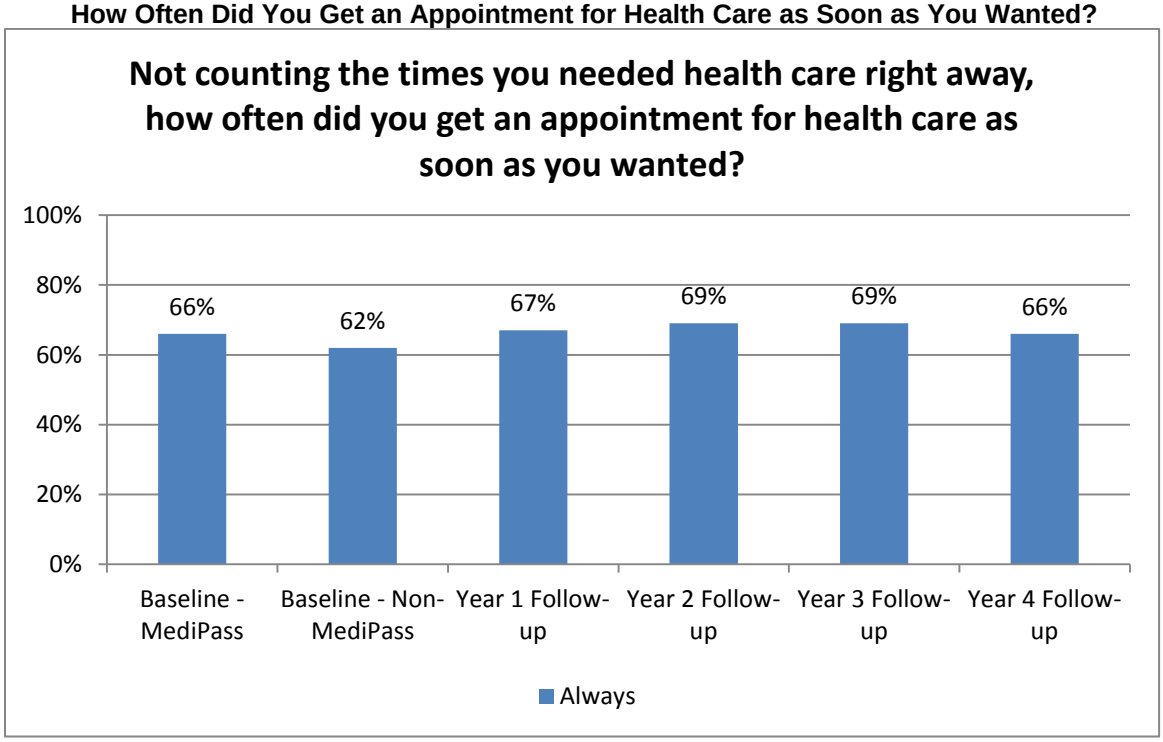
Survey respondents were also asked how often they got appointments for health care as soon as they wanted, not counting the times they needed health care right away. At Baseline, 66% of MediPass enrollees and 62% of Non-MediPass enrollees reported that they "always" got an appointment as soon as they wanted. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting that they "always" got an appointment as soon as they wanted ranged from 66% to 69%. Chart Q provides the results the following question – Not counting the times you needed health care right away, how often did you get an appointment for health care as soon as you wanted?

Chart Q
CAHPS Survey – Not Counting the Times You Needed Health Care Right Away, How Often Did You Get an Appointment for Health Care as Soon as You Wanted?



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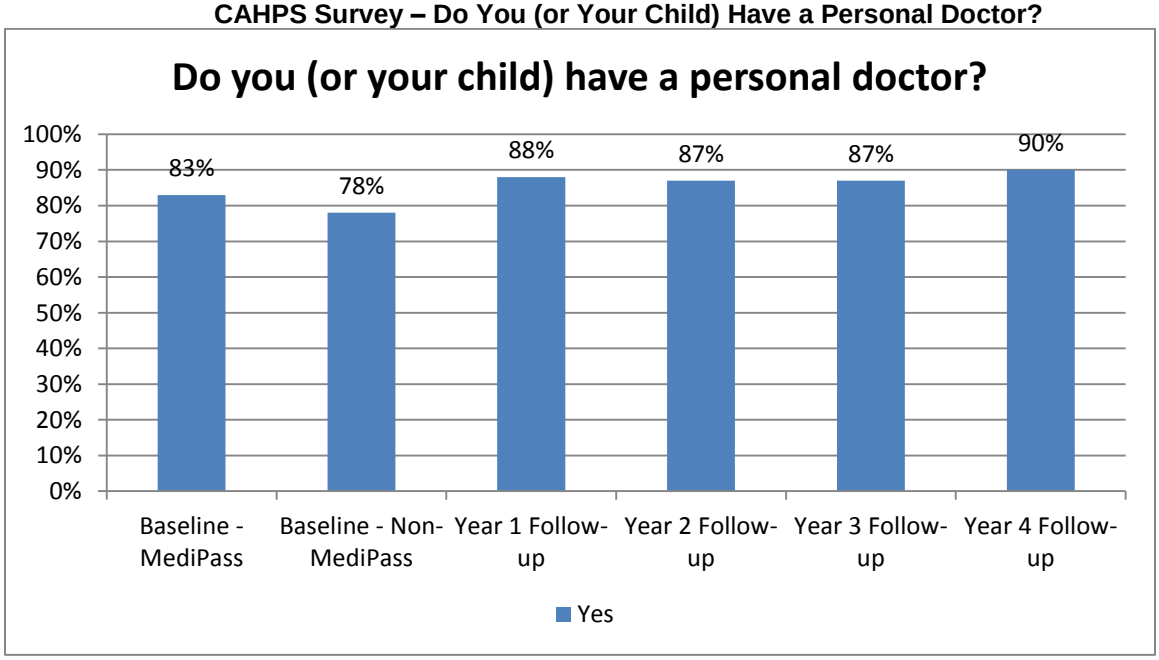
d. Having a Personal Doctor

The CAHPS survey asks respondents whether they have a personal doctor, which is described as the doctor that someone would see if he or she needed a checkup, wanted advice about a health problem, or got sick or hurt. At Baseline, 83% of MediPass enrollees and 78% of Non-MediPass enrollees reported having a personal doctor. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting that they have a personal doctor ranged from 87% to 90%. Chart R provides the results the following question – Do you (or your child) have a personal doctor?

Chart R
CAHPS Survey – Do You (or Your Child) Have a Personal Doctor?



2. Future CAHPS Survey Activities

A Year 6 follow-up CAHPS survey is being conducted in SFY 2013-14, allowing for further data collection and continued observation of enrollees' satisfaction and experiences with care in the demonstration. Measuring enrollee satisfaction will continue to be an important quality initiative under the MMA program. Plans under the MMA program will be contractually required to contract with an NCQA-certified CAHPS Survey Vendor to conduct the CAHPS Health Plan Survey each year and report their certified survey results to the Agency on an annual basis. The results of these surveys will be used to assess quality of and experiences with care provided by the plans, as well as being made publicly available so that Medicaid recipients may use the survey results to compare plans when making enrollment decisions.

3. Choice Counseling Caller Satisfaction Surveys

Every recipient whot calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. Between December 15, 2012 and August 31, 2013, callers have completed 3,341 surveys. Overall caller satisfaction with Choice Counseling averages 96%.

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

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

The average satisfaction of the seven categories measured from December 15, 2012 through August 31, 2013 was 96%.

The Agency is currently evaluating the survey process and questions to determine if enhancements or changes can be made to the caller survey and the process for the requested waiver extension period.

D. State Quality Assurance Monitoring

1. On-Site Surveys

Prior to contract execution and each operational year thereafter, the Agency performs an on-site survey of each health plan to gauge compliance with contract standards. This survey encompasses the various areas of compliance authorized by Title CFR 42, Title SSA 1915(c), Chapters 641 and 409 F.S., and 52 Federal Register and Balanced Budget Act of 1997. The survey process is consistent across health plan types (HMO and PSN). Each survey team consists of a team leader and at least two team members. Each survey lasted an average of two days. Since implementation of the waiver, the results of these on-site surveys show that all health plans are in good standing with the state and no related sanctions have been imposed.

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

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

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

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

The state conducts annual on-site reviews of the MCO contractor for assessment of compliance with contract requirements. The state, working with its EQRO, has developed a comprehensive data base monitoring tool that integrates inspection of records, papers, documents, facilities and services and extensive staff interviews, which are relevant to the contract. The contractor provides reports, which are used to monitor the performance of the contractual services. The comprehensive review is a focus on the main provisions of the contract including: Grievance System, Member Services, Provider Services, Quality Improvement, Utilization Management, Selected Example of Medical Records, Case Management, Credentialing of Providers, Staffing Requirements. Based on recommendation from the state's EQRO the state has divided the monitoring process into three sections and will review one section comprehensively per year, completing a monitoring of all contract sections within the three year contract period. The on-site monitoring for the year 2012 included Eligibility, Enrollment, Disenrollment, Enrollee Services, Enrollee Rights and Community Outreach.

The following components were reviewed as part of the 2012 Comprehensive Survey:

- Eligibility, Enrollment, Disenrollment, Enrollee Services, Enrollee Rights and Community Outreach Policies and Procedures.
- Member Identification Card
- Member Handbook
- Member Enrollment Processes
- Member Disenrollment Processes
- New Member Enrollment Processes
- New Member Enrollment Materials
- PCP Selection and Change
- Provider Directories
- Member Toll-Free Help Lines
- Member Translation Services
- Member Incentive Programs
- Community Outreach
- Grievance Files
- Appeal Files
- Prior Authorizations Denials Files
- Unborn Activation Processes
- Hysterectomies, Sterilizations and Abortions Files
- Complaint Log
- Medical Records: Pregnancy, Newborn, Case Management, Child Health Check-Up

Under the 2012 compliance survey, six HMOs and two PSNs were given a required Action for the following contract requirement: Section IV, A, 11. g, of the Health Plan Contract, the Health

Plan shall have an automated system available between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This automated system must provide callers with clear instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for caller to leave messages. The Health Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Health Plan representative shall respond to all messages on the next business day.

All Health Plans have submitted corrective actions which were reviewed and approved. All Health Plans are now in compliance.

2. Ongoing Desk Reviews

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

- Provider Network Adequacy, Notification of New and Terminating Providers
- Medical and Behavioral Health Policies and Procedures
- Cultural Competency Plans
- Member Materials (Handbooks, Directories, Letters, Website, Call Center Scripts, etc)
- Provider Materials (Handbooks, Letters, Website, etc)
- Outreach Requests
- Reporting (Monthly, Quarterly, Annual, Per Incident)

The monitoring tools developed in conjunction with the EQRO are now also being used in some desk reviews.

3. Annual Document Review

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

For example, health plans must submit a Quality Improvement Plan within 30 days of their initial contract execution and annually by April 1 of each contract year. The health plan's Quality Improvement Plans are reviewed against the required components in the contract, both medical and behavioral health. The Agency reviews the Quality Improvement Plans within 30 days of receipt, providing technical assistance as necessary to ensure each Quality Improvement Plan meets the contract requirements. The annual Quality Improvement Plan submissions are reviewed for action items such as problem identification and interventions developed as a result. In Demonstration Year 4, all Quality Improvement Plans were submitted timely and all approval letters were sent out within 45 days. Each health plan's Quality Improvement Program and Quality Improvement Plan are reviewed again during the annual on-site survey visit. The on-site survey team evaluates policies and procedures, reviews member and provider records, and interviews health plan staff.

Disease management is also reviewed. Each health plan is required by contract to offer disease management programs for at least five conditions: HIV/AIDS, asthma, diabetes, congestive heart failure and hypertension. The specialty plan for recipients living with HIV/AIDS must also offer disease management for tuberculosis and hepatitis B and C. All initial health plan applicants complied with these requirements in 2006, and submitted their programs as a part of their initial reviews. All plans have been submitting them annually by April 1. The health plans

have taken varied methods to comply with these requirements. Some plans have in-house disease managers and very structured programs for each of the referenced diseases. Other plans have chosen to have an over-arching disease management algorithm that narrows the focus for the individual member as the evaluation is done. The health plan disease managers monitor their plan's disease management programs through the individualized treatment plans that are tailored to meet the needs of the recipient. Still other health plans have chosen to outsource to disease management companies. When the programs are outsourced, the Agency evaluates the health plan's incorporation of oversight into their Quality Improvement Program. The only exception is the specialty plan for children with chronic conditions. This specialty plan's entire program is geared toward disease management of children and is very individualized. Members are not eligible for this program unless they meet pre-determined clinical screening criteria. Once a child is enrolled, he or she is assigned to a nurse care coordinator who works with him or her throughout his or her enrollment to ensure individualized and highly specialized disease and case management.

4. Readiness Review Preparation for MMA Program

As the Agency prepares to contract with the MMA plans, focus areas will be incorporated into the readiness review. This will consist of desk review and on-site review for each health plan. The desk review will include Key managed care plan policies and procedures, member and provider materials, internal staffing plans and organizational charts, provider network plan, claims management system, prior authorization system, etc. Agency staff will use the desk review findings as well as focus areas listed below to develop the on-site survey agenda and questions for each plan.

Agency staff will review the plan's documentation and the plan's staff understanding of transition and continuity of care when enrollees change plans, when enrollees are under case management, have complex medication needs and strive to maintain case relationships. Agency staff will also review the plan's documentation for provider terminations effect on recipient continuity and coordination of care and requests by enrollees for out of network care. Regarding EPSDT services for children under the age of 21, Agency staff will review plan documentation and determine plan staff understand the benefit and their implementation is compliant with Section 1905 9(r) of the SSA to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, regardless of state plan coverage.

The following items will be reviewed during the readiness review and monitored to report on quarterly:

- Provider network adequacy by region, including dental;
- Provider network access, by travel time and distance;
- Provider availability for routine, urgent and emergent appointments;
- Provider availability that is appropriate for region population;
- Referral and coordination of services outside the provider network;
- Coordination and access to care for enrollees with special health care needs; and
- Cultural considerations.

E. Additional Quality Activities

1. Continuous Improvement Activities

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

The Agency has made many improvements in the Reform program and applied those to the entire state so that all Medicaid recipients and providers can benefit from these accomplishments. Table 14 provides a detailed list of the more notable quality improvement activities that the Agency has been involved with that stems from the waiver and lessons learned through public input, workshops, team efforts and forums.

Table 14
Continuous Quality Improvement Activities

Health Plan Communication Activities

- Technical and operational calls with all Medicaid health plans on a regular basis, at least monthly.
- Technical assistance calls with fee-for-service provider service networks and their third party administrators regarding Medicaid fiscal agent processes, including claims, file submission and reports, at least monthly.
- Quarterly technical assistance meetings with health plans related to fraud and abuse initiatives.
- Technical assistance webinars with health plans related to fraud and abuse training.
- Technical assistance calls and meetings with health plans related to implementation of Diagnosis-Related Group coding initiative.
- Technical assistance calls and meetings with health plans related to implementation of Affordable Care Act requirements including 2013 and 2014 physician fee increase to Medicare rates for certain primary care physicians and procedures and coverage restrictions for provider preventable conditions.
- Technical assistance calls with new health plans to assist in implementation of the contract, recipient enrollment and to ensure communication to all affected parties regarding the new plan.
- Focus group with plan applicants and new contractors to request input on what worked and was cumbersome in the health plan application process in order to streamline the application process and better serve potential contractor needs.
- Technical assistance calls with health plans and plan applicants to collect input on revisions to the model health plan contract for 2012-2015 contract period.
- Technical assistance calls with health plans and applicants to collect input on the development and implementation of the electronic Report Guide companion to the model health plan contract for 2012-2015 contract period.
- Continuous improvement meetings with the health plans to collect input into various processes related to implementation of the waiver, including outreach, systems, claims processing, etc.
- Technical assistance and review calls with health plans regarding their provider network accuracy.
- Technical assistance calls with affected health plans when plans leave a county or transition populations due to acquisition or assignment.
- Technical assistance calls with health plans related to collection of Medicaid encounter data.
- Technical assistance calls and meetings with health plans and the EQRO vendor relative to performance improvement plans, at least quarterly.

Table 14
Continuous Quality Improvement Activities

- Technical assistance calls with health plans regarding the development of and implementation of performance measures, required performance measure objectives, related corrective action process, sanctions and incentives.
- Technical assistance calls relative to enhanced benefits program.
- Technical assistance calls relative to enhancements to the choice counseling program.
- Technical assistance calls relative to data used for capitation rate development.
- Included affected providers on technical and operational calls with the health plans to discuss implementation issues. Such providers included prescribed pediatric extended care providers and the Department of Health.
- Written communications regarding contract policy and procedures to ensure contract compliance.
- Written communications regarding phase-out of the enhanced benefits program with the implementation of the Healthy Behaviors programs to be operated by the plans under the MMA program.

Health Plan Application and Contract Revisions

- Streamlined the health plan contract to eliminate duplicative contract requirements and reporting and incorporating an electronic Report Guide that provides health plans with the detailed information necessary to develop and submit contract required reports.
- Added the imposition of liquidated damages in the event of a health plan's breach of contract requirements.
- Added requirements to ensure implementation of the Affordable Care Act 2013 and 2014 physician fee increases to Medicare rates for certain primary care physicians and procedures and to ensure coverage restrictions for provider preventable conditions.
- Added additional plan performance measure reporting, implementing performance measure objectives, corrective action plan and sanction requirements and incentives for high performance.
- Added additional critical incident reporting requirements.
- Added claims processing, submission, provider notification and reporting requirements for fee-for-service provider service networks.
- Added the ability, upon Agency approval, to provide certain services through telemedicine.
- Added Medicaid encounter data submission and accuracy requirements and sanctions for poor performance.
- Added requirements to ensure a seamless transition from ICD-9 codes to the new ICD-10 codes and to reflect the coding changes brought about by the transition.
- Added the following specialties to the required provider list, including required availability of both adult and pediatric participating providers:
  - Adolescent Medicine,
  - Cardiovascular and Orthopedic Surgery,
  - Rheumatology and
  - Speech Therapy.
- Revised behavioral health reporting requirements to streamline audits for ongoing health plans in good status.
- Added requirements relative to fraud and abuse detection, reporting and policies and procedures in order to ensure appropriate plan activities and oversight.
- Added marketing and community outreach requirements.
- Added an optional ability for health plans to notice enrollees on upcoming Medicaid eligibility redetermination dates.
- Enhanced requirements regarding the provision of information to enrollees about how to update mailing and/or residence address information with the health plan and through Florida Department of

Table 14 Continuous Quality Improvement Activities
Children and Families and/or the Social Security Administration. • Added requirements for 120-day notice and enrollee transition plan requirements when a health plan leaves a county. • Added additional Agency monitoring relative to health plan websites, provider networks and directories, fraud and abuse and quality initiatives, such as performance measures. • Contracted with EQRO for development of an automated on-site health plan survey tool to ensure consistency of reviews and standardized scoring. • Implemented quarterly contract oversight review meetings between various Agency bureaus responsible for oversight of some aspect of the health plan contract, including changes in plan management, on-site and desk reviews regarding provider networks, general medical health care behavioral health, fraud and abuse and reporting.
Consolidated Web-based Complaint Reporting and Tracking System • Conducted workgroup meetings and conference calls with Agency headquarters and local agency staff relative to development of a web-based system for health plan complaint reporting and tracking. • Implemented a consolidated complaint database for the collection of complaints received about health plans by the Agency either at a headquarters location or local area office location and automated referrals to the appropriate Agency office responsible for resolution. • Developed a standard complaint definition, reporting process and training manual for staff to handle, disseminate, resolve and track complaints received about health plans using the consumer issues report system. • Developed quarterly trend reports and conducted meetings to review such trends to ensure attention to any atypical results.
Legislatively Mandated Advisory Panels • Low Income Pool (LIP) Council – LIP Council meetings, several per year, to advise the Agency, the Governor and the Florida Legislature on financing and distributions of the LIP. • Technical Advisory Panel – Technical Advisory Panel meetings, at least quarterly, to advise the Agency on various aspects of the waiver, including choice counseling, enhanced benefit program, risk-adjusted capitation rates and encounter data. • Medical Care Advisory Committee – The MCAC meets at least three times a year and provides advice on various aspects of the waiver.

2. Florida Medicaid Encounter Data

The Agency has collected fee-for-service (FFS) claims data for more than 30 years. Encounter data, an alternative claims data source reported by health plans, was initially processed for inpatient quality measures by the State Center of Data Operations through 2008, after which encounter data were collected and validated on a much larger scale (for all medical and pharmacy services) by the Florida Medicaid Management Information System (FMMIS). During the past five years the Agency has collected approximately 250 million encounter claim lines. This achievement emphasizes the Agency's ability to effectively coordinate responsibilities internally (i.e., multiple bureaus) and externally (i.e., health plans, fiscal agents, third party contractors and other state agencies).

With the movement from a FFS provider reimbursement system to statewide managed care delivery system, about 87 percent of the Florida Medicaid population will be enrolled in managed care, which will significantly increase the volume of encounter claims to be collected

and validated in the foreseeable future. Continuous improvement activities foster the refinement of the fiscal agent operations and transaction processing. Agency's efforts to provide continuing support and to work with the health plans to make their encounter data submissions more successful include:

- Participation in monthly Agency-coordinated 'Technical and Operations' calls with the health plans, when communications related to policy changes are reviewed, technical issues are discussed, and questions are answered.

- Periodic assistance provided to health plans regarding updates to the X12 standard transaction Companion Guides and pharmacy encounter payer specifications documents on the Agency's fiscal agent website.

- Periodic technical assistance provided to health plans regarding data submission and related issues. Workshops held for all health plans in Tallahassee, March 15, 2013 and April 16, 2013, focused on provider enrollment operations and resubmission of encounter transactions. Periodic emails and Dear Health Plan Letters are distributed by the Agency to review and clarify encounter guidelines and/or to address issues common to the majority of the health plans.

- Data assessment activities to support "front end" encounter data collection and processing through the FMMIS. These activities include validation of submissions to comport with certification of data received from the health plans for X12 and pharmacy encounter transactions.

- Development and refinement of system edits and error crosswalks to aid health plans with review of encounter transaction response files.

- Monthly reporting to each health plan via a Compliance Report that assesses the timeliness, accuracy and completeness of the health plan's medical, dental, institutional and pharmacy encounter submissions. These Compliance Reports are used by the Agency and the health plans to monitor the volume and quality of encounter submissions and to isolate specific challenges associated with the transactions.

- Weekly meetings among Agency bureaus to discuss developments and improvements for the encounter data collection, validation, processing and reporting processes.

As the Agency transitions to the MMA program, encounter data validation and analysis will become increasingly essential. These analytics will help determine the data's reliability by pinpointing gaps and other variances that should be examined and corrected in a timely manner. As a result, these analytics will instill confidence in the encounter data's ability to describe accurately the services provided by the health plans. The Compliance Reports being produced monthly and distributed to the health plans prompt both the plans and the Agency to evaluate the encounter data and to discuss corrective action strategies, when applicable, to promote more complete and reliable encounter data.

Encounter Data is used to evaluate health plans' performance measures. In the last two fiscal years, reports were presented to the legislature, legislative staff and the health plan association demonstrating four specific examples of measures being conducted through analysis of the data. These specific analyses measured Emergency Department Utilization, Ambulatory Care

Sensitive Conditions (ACSC), PCP Utilization and History and Physical 180 (H&P 180). The Agency is refining the performance measure reports to include additional information, such as risk adjusted data. Results are used to communicate deficiencies to the health plans and to identify issues initiating focused analyses by compliance, fraud or program integrity units.

In addition to the Agency's own validation and analysis of its encounter data, the Agency's EQRO was contracted as of July 2013 to validate encounter data. The EQRO and the Agency communicate at least weekly to finalize plans for encounter data validation studies. Meetings with the health plans began in mid-September to kick-off the encounter data validation project which will include intensive medical records, systems, and encounter transaction reviews.

Through this continuing process, the Agency will validate all encounter data to ensure that it remains sufficiently reliable to reflect and evaluate utilization, to assess the quality and appropriateness of the health care services provided, to be used as a component in the core data used for setting capitated rates for the health plans and to assist the Agency to assure quality and manage health care costs for Florida.

3. Low-Income Pool Quality Initiatives

The STCs of the waiver as approved on December 15, 2011, established LIP milestones that apply to the state and the 15 hospitals (LIP milestone hospitals) that are allocated the largest annual amounts of LIP funding. STC #62 requires that these hospitals participate in initiatives that broadly drive from the three overarching goals of Federal CMS' Three-Part Aim, which are part of the Department of Health and Human Services' National Strategy for Quality Improvement in Health Care. The three goals are:

- Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency and equity;
- Better health for populations by addressing areas such as poor nutrition, physical inactivity and substance abuse; and
- Reducing per-capita costs.

STC #62 specifies that the initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding.

Fourteen of the 15 top LIP funded hospitals proposed and are conducting three initiatives each, while one of the hospitals is conducting two initiatives. Examples of the initiatives are:

- Reductions of Surgical Site Infections and Other Surgical Complications
- Reductions of Readmissions (in general and for specific conditions/illnesses)
- Primary Care Expansions and Enhancements
- Sickle Cell Day Treatment Program
- Post-discharge Support Services
- Acute Care at Home
- Emergency Department Diversion
- Reducing No-shows for Physician Appointments

- Enhancement of Patient Centered Medical Homes at Community Health Centers
- Improving Emergency Department Turn-around Time
- Reducing Inpatient Falls
- Improving Birth Outcomes
- Developing and Providing Access to Electronic Health Record Systems
- Improving the Monitoring of Patients with Chronic Conditions through Mobile Technology
- Decreasing Average Length of Stay for Patients with Particular Conditions
- Disease Management Programs and Coordination, for physical and behavioral health
- Reducing the Number of Mislabeled Specimens

In SFY 2012-13, the 15 hospitals submitted progress reports on their initiatives to the Agency. The next progress report is due to the Agency by September 30, 2013, and the Agency will be assessing whether the hospitals have met the implementation and improvement measure targets identified in their milestone proposals.

4. Florida Medical Schools Quality Network

Part IV of Chapter 409, F.S., requires the Agency to contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in plans. To be eligible to participate in the quality network, a medical school must contract with each plan in its region.

The Agency has been working with this group, which is headed by the deans of the state's medical schools, to define projects that could help improve quality of care for Medicaid recipients. Ideas being explored include: providing support and guidance for performance improvement in the areas of perinatal care, preventive dental care and other areas; reviewing and validating state-defined performance measures; and developing a standardized core survey to assess provider satisfaction with plans.

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VII. Evaluation Status and Findings

A. Overview of Independent Evaluation

1. Evaluation of the Initial Waiver Period (2006-2011)

In November 2005, the Agency contracted with a health services research team at the University of Florida to conduct an independent evaluation of Florida's Section 1115 Medicaid Reform Research and Demonstration Waiver. The University of Florida research team examined the evolution of the waiver, including the earliest expressions of interest, the initial legislation, the waiver application process, the subsequent legislation, the program design, the initial implementation in Broward and Duval Counties, the subsequent expansion in Baker, Clay and Nassau Counties, and ongoing operations through June 30, 2011.

During the initial waiver period, the University of Florida research team conducted its analysis through inquiry in five major project areas:

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

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

While reports on the specific project areas were produced over the course of the evaluation, the evaluation of the initial waiver period culminated in a final evaluation report that was submitted to Federal CMS on December 15, 2011. Key findings described in the final evaluation report include:

- Consumers found that the Reform pilot improved access. The independent research team found statistically significant improvements from the Baseline year (pre-demonstration) to the Demonstration Years regarding ratings of "always" getting care right away, in terms of both urgent and routine care.
- Consumers found it easy to find a personal doctor. The independent researchers found significant increases between the year prior to the demonstration and Demonstration Year 1 in the percentage of enrollees reporting that they have a personal doctor and that they did not have a problem finding a personal doctor with whom they were happy. The level achieved in Demonstration Year 1 was maintained in Years 2 and 3.
- Consumers' satisfaction with their personal doctor went up significantly. The independent research team found a significant increase over time in the percentage of Reform plan enrollees reporting satisfaction with their personal doctor at the highest level.

- Consumers reported improved communication with their personal doctor. The independent research team found statistically significant improvements between the year prior to the Demonstration and Demonstration Years 1, 2 and 3 in enrollees' ratings of communication with their personal doctor.
- The waiver allowed for consumer choice. The independent researchers found a clear majority of enrollees self-selected their health plans through the Choice Counseling program during the Demonstration.
- Reform health plans scored higher on quality measures, and improved their quality scores more rapidly. The independent research team found that health plans in the waiver areas achieved higher levels of performance than plans in non-Reform areas for a number of HEDIS performance measures. From 2008 to 2009, Reform plans also showed greater improvement in performance measures than non-Reform plans.
- The Demonstration rewarded Medicaid recipients for engaging in healthy behaviors. The independent research team found enrollees' awareness of and participation in the Enhanced Benefits Reward$ program increased from Demonstration Year 1 to Demonstration Year 2.

The final evaluation report and previous evaluation reports for the initial waiver period may be found on the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/index.shtml

2. Evaluation of the Extension

a. Current Waiver Extension Period (2011-2014)

On December 15, 2011, Federal CMS approved the Agency's request to extend the Research and Demonstration Waiver through June 30, 2014. The Agency submitted the draft evaluation design for the extension period to Federal CMS on April 12, 2012 as specified in STC #80 and, following discussion with Federal CMS was submitted a revised draft which was approved October 31, 2012.

The evaluation requirements in STC #80 included nine Domains of Focus:

i. The effect of managed care on access to care, quality and efficiency of care and the cost of care;
ii. The effect of customized benefit plans on recipients' choice of plans, access to care or quality of care;
iii. Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
iv. The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;
v. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
vi. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
vii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency and equity);
viii. The impact of Tier-One and Tier-Two milestone initiatives on population health; and,
ix. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured and underinsured populations) and the cost-effectiveness of care.

After receiving approval of the evaluation design, the Agency executed contracts with two state universities to conduct different parts of the evaluation. In late October 2012, the Agency contracted with a research team at the University of Florida to conduct the evaluation of domains i-iii and v-ix. In February 2013, the Agency contracted with a research team at Florida International University to evaluate domain iv.

b. Federally Approved MMA Amendment (June 2013)

With Federal CMS approval of the MMA Amendment on June 14, 2013, the Agency is required to submit a revised evaluation design update by October 11, 2013. The draft evaluation design update is required to build and improve upon the previous evaluation design. At a minimum, the draft design is required to include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on recipients, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in STC #112 of the waiver and is subject to Federal CMS approval. The updated design will accommodate and reflect the staggered implementation of the MMA program to produce more reliable estimates of program impacts.

B. Research Questions and Findings

This section provides the research questions for the evaluation of the waiver extension period by domain of focus. It also includes the data sources and describes the analyses that are being used to study the domains. Due to the approval of the evaluation design being at the end of October 2012, and the contracts with the evaluators being executed subsequent to that approval, only a few evaluation reports regarding the waiver extension period have been completed to date, so there are few new findings to report at this point.

1. Research Questions by Domain of Focus, i through ix

Domain i) The effect of managed care on access to care, quality and efficiency of care and the cost of care:

- Are services accessible to enrollees? Have there been changes in the accessibility of services to enrollees over the course of the demonstration? Has the demonstration resulted in more appropriate use of services by enrollees?
- Has the quality of care that enrollees receive improved during the demonstration? What have managed care plans done to improve quality of care?
- How has the demonstration increased timeliness of services?
- How has the demonstration affected the growth of Medicaid costs?

Domain ii) The effect of customized benefit plans on recipients' choice of plans, access to care, or quality of care:

- To what extent do health plans offer customized benefits? How much variation is there between plans' benefit packages? Are there plans whose customized benefits are geared to particular populations?
- When presented the opportunity, do plans provide additional services not previously covered by Medicaid? If so, what types of services? To what extent do enrollees use these additional services?
- Are there differences in enrollees' satisfaction with and experiences with care between plans with different benefit packages? Between plans that offer additional benefits vs. those that do not?
- Does access to and quality of care vary between plans with different benefit packages? Between plans that offer additional benefits vs. those that do not?

Domain iii) Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status:

- To what extent do enrollees earn Enhanced Benefits? To what extent to they spend their rewards?
- Is the Enhanced Benefits program associated with increased use of preventive services by enrollees?
- Is there a difference in services used by enrollees participating in the Enhanced Benefits Account Program vs. enrollees who do not in demonstration and non-demonstration counties?
- Is there variation in the likelihood of participation in certain health care behaviors between enrollees in demonstration and non-demonstration counties?
- To what extent does participation in the Enhanced Benefits Account Program vary by characteristics of enrollees (e.g., race/ethnicity, chronic illness and plan type)?
- Is there a difference in rates of avoidable hospitalizations and emergency department use among the Enhanced Benefits Account Program users (high, medium, low) and non-users?

Domain iv) The impact of the demonstration as a deterrent against Medicaid fraud and abuse:

- What are the program integrity-related measures employed by the health plans in the demonstration related to: deterring fraud and abuse by network and non-network providers; deterring fraud and abuse by recipients; detecting fraud and abuse by network and non-network providers; and detecting fraud and abuse by recipients?
- How often do health plan compliance officers/teams interact with providers in the health plan networks? What types of contact and interactions do the compliance officers/teams have with providers? How do plans document and track their efforts to deter fraud and abuse?
- How does health plan compliance officers/teams measure the effectiveness of the health plan policies and procedures related to program integrity?

Domain v) The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance:

- How has LIP funding improved access to care for uninsured/underinsured recipients? That is, how many uninsured and underinsured recipients receive services through LIP funding? What types of services are being provided and in what settings?

Domain vi) The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups:

- How does LIP funding impact access to and use of services by different population groups? Does it increase access to services in particular areas?
- How many programs funded by LIP, including Tier-One and Tier-Two initiatives, are focused on reducing disparities in the provision of health care services or health outcomes? What are these programs doing to reduce disparities and how successful are they?

Domain vii) The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency and equity):

- What are the goals of the Tier-One Milestone programs? What interventions/activities are they using to enhance quality of care and the health of low-income populations? Are they successful? Do hospitals participating in Tier-One initiatives have higher quality measure rates than other hospitals?
- What are the goals of the Tier-Two Milestone initiatives? How many of the initiatives are focused on access to care and quality of care? How are the top 15 hospitals working to meet their goals? Are they successful?

Domain viii) The impact of Tier-One and Tier-Two milestone initiatives on population health:

- How are the Tier-One Milestone initiatives proposing to affect population health? Are they targeting particular groups of recipients or health conditions? Are they successful in achieving their objectives?
- How are the Tier-Two Milestone initiatives proposing to affect population health? Are they targeting particular groups of recipients or health conditions? What interventions/activities are they engaging in to impact population health? Are they successful?

Domain ix) The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured and underinsured populations) and the cost-effectiveness of care:

- How do expenditures for services funded through the Tier-One Milestone initiatives differ from other LIP expenditures? How do the services provided under Tier-One milestone initiatives differ from those provided under other LIP funding? That is, do Tier-One Milestone expenditures result in more preventive and outpatient care than emergency department and inpatient visits? Do Tier-One milestone initiatives, including hospital quality initiatives, result in lower expenditures for recipients who are served by them?
- Do the Tier-Two Milestone initiatives impact expenditures for care for the uninsured/underinsured? How are expenditures affected? That is, what initiatives are successful in helping recipients to access the appropriate level of care and prevent the need for emergency or inpatient care?

2. Data Sources and Analyses for Evaluating the Domains of Focus

Domains 1 and 2**:** Studying the effect of managed care and customized benefit plans on recipients' choice of plans, access to care, quality of care and cost of care

Hypotheses: It is expected that the demonstration will result in improved access to and quality of care, and that the utilization of preventive services and engagement in healthy activities will increase. It is expected that the demonstration will result in significant cost containment. That is, it is hypothesized that the per-enrollee cost by eligibility group in the demonstration will be less than the non-demonstration program's projected growth.

Data Sources: To answer the research questions related to domains 1 and 2, the following data sources will be used:

a. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data: Surveys of a sample of each plan's enrollees will be fielded on a rolling basis. To answer questions related to access, quality, and efficiency of care, overall ratings variables related to health care, health plan, personal doctor, and satisfaction with specialists will be analyzed. Analyses of survey results related to getting needed care, ease in getting care, getting care quickly, and length of time with the same personal doctor will be conducted as well.

b. HEDIS and Agency-defined performance measures: HMOs and PSNs are required to submit performance measures to the Agency annually. Plans are required to certify, through independent audit, that the data have been "fairly and accurately reported" and plans must attest to the accuracy of their performance measure data. The Agency has four years of performance measure data (calendar years 2007-2010) that will be analyzed for changes over time and that will be compared to the performance measures submitted for calendar years 2011, 2012 and 2013 moving forward. To answer questions related to access and quality of care, measures related to use of preventive services and management of chronic conditions will be analyzed.

c. Performance Measure Action Plans (PMAPs) and Performance Improvement Projects (PIPs): HMOs and PSNs are contractually required to conduct a set number of PIPs and are required to have two of them validated by the state's EQRO each year. Plans must report on their PIPs according to Federal CMS protocols, and the EQRO provides technical assistance to the plans as well as preparing an annual report on the status of the health plans' PIPs. In addition to PIPs, the Agency requires HMOs and PSNs to develop PMAPs for any HEDIS measures where the plan's performance falls below the 50th percentile, according to the National Medicaid Means and Percentiles issued by the National Committee for Quality Assurance (NCQA). Health plan PMAP and PIP submissions will be analyzed to look at what measures the health plans have taken to improve quality of care for enrollees during the demonstration. EQRO reports on the status of health plan PIPs may be analyzed as well.

d. Medicaid claims, eligibility, enrollment and encounter data: these data will be used to look at service utilization and expenditures during the demonstration. Data for demonstration and non-demonstration counties will be included.

e. Health plan contracts and Agency quarterly and annual reports to Federal CMS: these data sources will be used to identify customized benefit plans and any expanded/additional services they cover.

Analyses will include:

- Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, looking at the demonstration as a whole as well as comparing plans and plan types (e.g., by varying benefit packages);
- Comparison of demonstration and non-demonstration means to Medicaid National Means and Percentiles for HEDIS measures;
- Examination of trends in individual health plan performance on HEDIS and Agency-defined measures;
- Descriptions of Performance Measure Action Plans and Performance Improvement Projects, including their objectives, interventions and outcomes;
- Descriptive statistics of plan benefits over time, including the number of expanded or optional benefits offered per plan as part of customized benefit packages, as well as the average number of expanded benefits offered across plans; and,
- Difference-in-difference statistical analysis with both bivariate and multivariate controls to assess utilization and expenditures before and after and compared to non-demonstration counties. Control counties will be identified for each Reform county and differences between the Reform and control counties will be described. Trends in utilization and expenditures over time will also be examined. Multivariate controls will include age, gender and race/ethnicity.

Domain 3: Studying participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status

Hypotheses**:** It is expected that the availability of the Enhanced Benefits Account Program will be associated with an increase in the utilization of select preventive services and healthy activities. It is anticipated that participants in the Enhanced Benefits Account Program may have lower rates of emergency department visits and inpatient hospitalizations.

Data Sources: To answer the research questions related to Domain 3, the following data sources will be used:

a. Enhanced Benefits Information System (EBIS): This database includes information on the healthy behavior activities in which enrollees have participated (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees and the items purchased using credits.

b. Medicaid claims, eligibility and encounter data: these data will be used to look at service utilization during the demonstration. Data for demonstration and non-demonstration counties will be included.

c. Agency quarterly and annual reports to Federal CMS: these reports will be used to look at the Agency's quarterly updates on Enhanced Benefits Account Program-related activities.

Analyses: This study will compare changes in enrollee participation in the Enhanced Benefits Account Program and utilization of services over time within the demonstration. Service utilization of non-demonstration enrollees will be analyzed for comparison. An analytic dataset will be formed by combining EBIS data, claims, eligibility and encounter data. Bivariate and multivariate analyses that control for age, gender, eligibility category, race/ethnicity, length of time in Medicaid, plan type and demonstration vs. non-demonstration counties will be conducted. Specifically, general descriptive statistics and active participation rates (e.g.,

comparison of dollar amounts of credits earned and purchases within a month) will be assessed using EBIS data. Claims, eligibility and encounter data will be used to compare the likelihood of receipt of certain preventive services between demonstration enrollees and non-demonstration enrollees. Preventive services are those that allow enrollees to earn Enhanced Benefits Account Program credits (e.g., office visits, adult/childhood preventive care visits, dental preventive services, vision exams, pap smears, mammograms and colorectal screenings). Claims, eligibility, and EBIS data will be used to compare demographic and health status characteristics of high, medium, and low credit earners to individuals who do not earn credits. These data will be linked to encounter data to compare the likelihood of avoidable hospitalizations for ambulatory sensitive conditions (using Prevention Quality Indicators) for high, medium, and low credit earners vs. individuals who do not earn credits.

Domain 4: Studying the impact of the demonstration as a deterrent against Medicaid fraud and abuse

Hypotheses: It is expected that managed care plans in the demonstration will use a variety of strategies to prevent Medicaid fraud and abuse and to detect fraud and abuse by providers and recipients.

Data Sources: To answer the research questions related to Domain 4, the following data sources will be used:

a. Health plan policies and procedures (including manuals) related to compliance and to fraud and abuse.

b. Interviews of health plan executive leadership and compliance/fraud and abuse directors at health plans.

Analyses: This study will review the program integrity-related measures health plans in the demonstration take to deter and detect fraud and abuse, by both providers and recipients. Analyses will include comparisons of those efforts over time in the demonstration counties and comparison entities that may include non-demonstration health plans and the Medicaid fee-for-service environment. Descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors will be used to assess the impact of the demonstration as a deterrent against Medicaid fraud and abuse. The Agency's efforts to assist the health plans in their program integrity-related activities will be reviewed as well.

Domains 5-9: Studying the effect of LIP funding on the provision of health care services to the uninsured and the impact of Tier-One and Tier-Two Milestone initiatives on (a) access to and quality of care, (b) population health and (c) per capita costs and the cost-effectiveness of care.

Hypotheses: It is expected that LIP funds to hospital and non-hospital providers will increase access to care for uninsured individuals. Tier-One Milestone programs and Tier-Two Milestone initiatives are expected to increase access to and quality of care, improve population health and impact per capita costs.

Data Sources: To answer the research questions related to Domains 5-9, the following data sources will be used:

a. Annual Milestone Statistics and Findings Report: This report includes information on the numbers and types of services that are provided by hospital and non-hospital providers, the number of recipients served and encounters.

b. Information on innovative programs funded under Tier-One Milestones (STC #61a): This information will include descriptions, goals, and progress reports of programs that are established (and funded through the $50 million allocation) to meaningfully enhance the quality of care and the health of low income populations.

c. Hospital quality measure scores, for which hospitals are eligible to receive additional LIP distributions based on performing well.

d. Primary Care and Alternative Delivery System Report: This report includes descriptions of primary care and alternative delivery systems operating with LIP funds. The report will include descriptions of each program, including the services provided, the populations served, goals of the program, expenditures and results of the program.

e. Tier-Two Milestone Initiative proposals and quarterly progress reports: These documents will contain the descriptions and goals of each of the three initiatives adopted by the 15 hospitals receiving the largest annual allocations of LIP funds. The proposals and quarterly reports will contain information on expected outcomes and targets of the initiatives, specific process and improvement measures related to infrastructure development, innovation, redesign and population-focused improvement.

Analyses: The analytic strategy of this study will be a review of the innovative programs and services funded by the LIP. Analyses will include examinations of those efforts over time among LIP recipients in the demonstration counties and the non-demonstration counties. Descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained and any changes over time will be conducted. Analyses of the Tier-One and Tier-Two initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative and whether those strategies result in the intended outcomes. The entities conducting Tier-One and/or Tier-Two initiatives will be reviewed individually, though if there are several entities conducting similar initiatives, differences and similarities between those projects and their levels of success may be analyzed. The final evaluation report will include a summary of lessons learned through the LIP projects.

3. Reports and Findings to Date

Low Income Pool Milestone Statistics and Findings Report for DY6: SFY 2011-12

This report was submitted to Federal CMS on April 1, 2013. This report provides a summary of LIP payments received by hospital and non-hospital providers, the number and types of services provided, the number of recipients served and the number of service encounters. While this report is not technically an evaluation report, it does summarize the data to be used for answering the Domain v research questions, regarding how many uninsured and underinsured recipients receive services through LIP funding, what types of services are provided and in what settings.

The DY6 accomplishments that were identified include the following:

- The LIP program included the following types of providers: safety-net hospitals; hospitals that operate poison control centers; specialty pediatric hospitals; rural hospitals; hospitals with designated trauma centers; primary care hospitals; hospital Provider Access Systems, LIP-other (which includes designated premium assistance programs, emergency room diversion projects, primary care projects, and Federally Qualified Health Centers); County Health Initiatives as performed by County Health Departments; and Rural Health Networks.
- A total of 146 PAS in Florida received LIP payments – 74 hospitals and 72 non-hospital providers.
- Total LIP funding was approximately $1 billion.
- Reporting hospitals receiving supplemental payments or rate enhancements served a total of approximately 3.7 million Medicaid, uninsured and underinsured individuals.
- Reporting non-hospital providers receiving LIP payments served a total of approximately 1.2 million Medicaid, uninsured and underinsured individuals.
- 126 hospitals that received supplemental payments or rate enhancements reported providing approximately 14.5 million service encounters to Medicaid, uninsured, and underinsured individuals across six service categories (discharges, inpatient days, emergency room encounters, outpatient encounters, affiliated encounters and prescriptions filled).
- For all categories of encounters, 63 reporting non-hospital providers receiving LIP payments provided a total of approximately 6.5 million encounters for specific services to Medicaid, uninsured, and underinsured individuals. The specific services/encounters include: primary care, OB/GYN, disease management, mental health/substance abuse, dental, prescriptions filled, lab services, radiology, specialty encounters and care coordination.

4. Final Report of Domains v-ix: through DY 6

The Evaluation Report of Domains v-ix, completed in the summer of 2013, provides a preliminary look at the effect of LIP funding on the provision of health care services to the uninsured and the impact of Tier-One and Tier-Two Milestone initiatives on: access to and quality of care; population health; and per capita costs and the cost-effectiveness of care. Tier-One and Tier-Two Milestone initiatives are described in STCs #61 and #62, respectively.

- STC #61.a Tier-One Milestone requires Florida to allocate $50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. These initiatives are required to be driven from the overarching goals of Federal CMS' Three-Part Aim: better care for individuals; better health for populations; and reducing per-capita costs.
- STC #62 Tier-Two Milestones, requires that the 15 hospitals that are allocated the largest annual amounts of LIP funding develop and conduct initiatives that are driven by the Three-Part Aim and focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. The participating facilities are required to implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations).

This report focuses on DY 6 and the beginning of DY 7 activities related to the Tier-One and Tier-Two Milestone quality initiatives. This timeframe included planning, development, and

implementation of the initiatives, so outcomes and the successes/challenges of the initiatives could not yet be assessed. General findings of this report for Domains v-ix include:

- Overall, the number of uninsured, underinsured and Medicaid individuals served and the types and number of outpatient services furnished by non-hospital providers has increased. For hospital providers, the number of individuals with Medicaid served has increased but the number of uninsured and underinsured individuals served has decreased. The types of services provided by reporting hospital providers have not changed.
- In general, the Tier-One and Tier-Two initiatives intend to reduce healthcare disparities for similar demographic, socioeconomic and condition-specific populations. Examples of targeted populations include: individuals with chronic obstructive pulmonary disease (COPD), behavioral health disorders, the homeless, pregnant women and other groups.
- Regarding access to care and quality of care, the various Tier-One and Tier-Two initiatives are focused on :
  - Providing better care coordination;
  - Reducing inpatient readmissions and avoidable ER visits;
  - Expanding infrastructure to increase access to primary care services;
  - Providing integrated, comprehensive care to uninsured and underinsured individuals; and
  - Improving the health of vulnerable populations.
- Regarding population health, Tier-One and Tier-Two initiatives are aimed at affecting population health by:
  - Increasing access to primary care services;
  - Targeting chronic conditions such as diabetes, hypertension and cardiovascular disease; and
  - Focusing on specific population groups including, but not limited to, women, children and the homeless.

  The activities being conducted to achieve these goals include readmission reduction and ER diversion programs, expanding primary care residency programs, and the addition of mental health care and dental services in rural outpatient clinics.
- Tier-One initiatives aimed at lowering per-capita costs and improving the cost-effectiveness of care include focusing on providing comprehensive and coordinated acute, chronic and preventive primary care services (including medical, dental and behavioral health) with the goal of reducing the number of avoidable ER and inpatient visits.
- Tier-Two initiatives aimed at lowering per-capita costs include implementing ER diversion and readmission reduction programs, establishing condition-specific outpatient clinics and testing the use of mobile health technology to monitor heart failure patients at home.

5. Preliminary Analysis and Final Report for 2012-13, Evaluation of the Florida Medicaid Reform Demonstration's Impact on Deterring Fraud and Abuse

A Preliminary Analysis Report and a Final Report regarding the demonstration's impact as a deterrent against Medicaid fraud and abuse were completed by Florida International University in May and June of 2013. In these first reports regarding Domain iv, the Florida International University research team describes the results of their preliminary content analysis of four Medicaid managed care plans' anti-fraud plans. The researchers' review of the plans' anti-fraud

plans identified five major themes, although they note that the level of detail regarding each of these themes varies by plan. These five major themes reflect statutory requirements regarding anti-fraud plans and are::

a. Detection tools, including descriptions of: plan staff and their qualifications and responsibilities; strategies and various tools used to identify areas of risk for fraud and abuse (e.g., utilization review, data mining/analysis, auditing and monitoring); hotlines for reporting suspected fraud or abuse; and notifications to plan members.
b. Education and training, including descriptions of: activities geared toward plan employees, members, providers, vendors/suppliers and contractors; health care fraud and abuse training and business ethics training; and trainings specific to particular risk areas.
c. Internal and external reporting, including descriptions of: methods to handle reports of fraud and abuse through internal committees and higher plan administration; procedures for reporting suspected or confirmed fraud and abuse to the appropriate regulatory or law enforcement agencies; and the Annual and Quarterly Fraud and Abuse Activity Reports that are required to be submitted to the Agency.
d. Internal and external investigations, including descriptions of: the staff responsible for conducting investigations; the steps involved in internal investigations; and the possible use of outside vendors for external investigations, as well as if and when external entities will be notified as a result of internal investigative actions.
e. Corrective actions, including descriptions of: disciplinary steps or termination of employees and/or providers in confirmed cases of fraud and abuse; recovery of losses through repayments; termination or amendment of contracts; and claims suspension or denial.

6. Pending and Upcoming Evaluation Reports

The Agency has reviewed preliminary reports by the University of Florida regarding Domains i and ii and Domain iii, and is anticipating receiving the final reports for these domains later this fall.

A LIP Milestone Statistics and Findings Report for DY 7 and a Primary Care and Alternative Delivery Systems Expenditure Report for DY 7 will be completed and submitted to Federal CMS during SFY 2013-14 as well. A second report on the evaluation of the LIP quality initiatives will be done in the spring of 2014.

The research team at Florida International University is preparing to conduct interviews with compliance staff for five plans, and will be conducting content analysis of those plans anti-fraud plans and fraud and abuse activity reports. These reports on the evaluation of Domain iv will be completed in the spring of 2014.

C. Proposed Evaluation Activities

On June 14, 2013, Federal CMS approved MMA amendment with revised STCs of the waiver. As previously noted in this document and pursuant to new STC #110, the Agency is required to submit a Draft Evaluation Design Update, which includes an adjustment to domain iii and adds domains x through xiii. The amended and new domains are:

iii. Participation in the Enhanced Benefits Account Program and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status;

x. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014;

xi. The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014;

xii. The effect of transitioning the Enhanced Benefits Account Program program from direct state operation to the MMA plans' Healthy Behaviors programs; and,

xiii. The impact of efforts to align with Medicare and improving recipient experiences and outcomes for dual-eligible individuals.

The Draft Evaluation Design Update will address the new evaluation Domains of Focus and the new evaluation requirements in STC #110. The Agency intends that the updated evaluation for the waiver extension period will continue to follow the research questions for Domains i-ix, but will add data sources related to the Healthy Behaviors programs in order to measure enrollee participation and the impact of the programs on participant behavior or health status. Preliminary research questions are being developed for Domains x – xiii, and potential data sources for measuring these domains are being identified. For Domains x and xi, first steps will include identifying how many enrollees are receiving acute care and long term care services through separate plans and how many enrollees are receiving these services through comprehensive plans. For Domain xiii, first steps will include measuring the extent to which the state has worked to align the MMA program with Medicare.

In the near future, the Agency will be soliciting proposals for conducting the evaluations of the MMA program.

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VIII. Waiver and Expenditure Authorities

To effectively maintain the program, the state is seeking a three-year extension of Florida's section 1115 Research and Demonstration waiver in order to waive statutory provisions under Section 1902 of the SSA and obtain expenditure authority that permits the state to provide maximum flexibility in administering Florida's Medicaid program. Specifically, the state requests waivers of statutory provisions to provide for:

- Approval and federal financial participation for MMA program benefits with cost-sharing for all Medicaid eligibility categories participating in the waiver.
- Approval and federal financial participation for the Healthy Behaviors Plan to enable managed care plans to administer programs to encourage and reward healthy behaviors.
- Approval and federal financial participation for costs not otherwise matchable for Program for All Inclusive Care for Children services and the Healthy Start program.
- Approval and federal financial participation for funds disbursed through the Low-Income Pool to eligible providers.

In accordance with STC #9 of the waiver, the federal waiver and expenditure authorities requested for the program remain consistent with the current authorities granted by Federal CMS June 14, 2014. (Refer to Appendix G Waiver and Expenditure Authorities)

As previously noted, the Florida law directs the Agency to seek any federal authorities necessary to implement the MMA program on or before October 1, 2014.

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Appendices A-G

Appendix A
Plans Selected for the Managed Medical Assistance Program

	REGION											
RESPONDENT NAME	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total Number of Awards**
General, Non-specialty Plans												
Amerigroup Florida, Inc.					X	X						2
Better Health, LLC - PSN	X					X				X		3
First Coast Advantage, LLC - PSN				X								1
Humana Medical Plan, Inc.	X					X			X	X	X	5
Integral Health Plan, Inc. d/b/a Integral Quality Care - PSN						X		X				2
Preferred Medical Plan, Inc.											X	1
Prestige Health Choice - PSN		X	X		X	X	X		X		X	7
Sunshine State Health Plan, Inc.			X	X	X	X	X	X	X	X	X	9
UnitedHealthcare of Florida, Inc.				X							X	2
Wellcare of Florida, Inc. d/b/a Staywell Health Plan of Florida		X	X		X	X	X	X			X	7
General, Non-specialty Plans Awarded	2	2	3	3	4	7	3	3	3	3	6	39
Specialty Plans												
AHF MCO of Florida, Inc. d/b/a Positive Healthcare Florida HIV/AIDS Specialty Plan										X	X	2
Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan		X		X	X	X	X		X	X	X	8
Freedom Health, Inc. Cardiovascular Disease (CVD) Specialty Plan			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Chronic Obstructive Pulmonary Disease (COPD) Specialty Plan			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Congestive Heart Failure (CHF) Specialty Plan			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Diabetes Specialty Plan			X		X	X	X	X	X	X	X	8
Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance HIV/AIDS Specialty Plan	X	X	X		X	X	X	X	X	X	X	10
Sunshine State Health Plan, Inc. Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
Specialty Plans Awarded	2	3	6	2	7	7	7	6	7	8	8	63

Appendix B.1
Public Process Strategy

Florida's Agency for Health Care Administration (the Agency) will provide stakeholders the opportunity to provide input on the three-year extension request for the 1115 Managed Medical Assistance (MMA) Waiver, as authorized in Part IV of Chapter 409, Florida Statutes. The waiver extension period to be requested is July 1, 2014-June 30, 2017. The Agency will conduct the following public process activities:

- **Record the legislative activities and public meetings** held prior to and during the 2011, 2012 and 2013 Florida Legislative session at which time the MMA program and federal authority to implement the program was discussed and, to the extent provided, the opportunity for public input.
- **Consult with the Indian Health Programs** through written correspondence and conference calls to solicit input on the future of the demonstration and the waiver extension request.
- **Publish a public meeting notice on October 1, 2013**, in the Florida Administrative Register, to announce a series of three public meetings. The public meeting notice will include a summary description of the demonstration, the location and times of the public meetings, and an active link to the MMA Waiver Extension Request Document to be posted on the Agency's website in compliance with 42 CFR 431.408(a)(2)(ii).
- **Post Waiver Public Notice Document** – The document will be posted for public comment on the Agency's website October 1- 30, 2013 and provide a complete description of the demonstration in accordance with 42 CFR 431.408(a)(1).
- **Hold Three Public Meetings** – The meetings will be held from October 8-11, 2013 in separate accessible geographic locations (Miami, Tampa and Tallahassee) where the demonstration will operate upon implementation of the MMA program. During the public meetings, a description of the MMA Waiver Extension Request will be provided and time will be allocated to receive public input in accordance with 42 CFR 431.408(a)(3).
- **Hold at Least Two Advisory Committee Meetings** – The committee meetings will be open to the public, noticed in the Florida Administrative Register at least seven days prior to holding each meeting, posted on the Agency's website, and will be held during the period August 8, 2013 through October 15, 2013. The advisory committees are the Low Income Pool Council and the Medical Care Advisory Committee.
    - The Low Income Pool Council meeting was held August 8, 2013.
    - The Medical Care Advisory Committee meeting will be held October 15, 2013. In addition to discussing the wavier extension request, a description of the MMA Waiver Amendment will be provided ("Post Award Forum") as required by Special Term and Condition #18 of the waiver.
- **Post Legislative Authority** – The legislation authorizing the request for federal waiver authority was posted on the Agency's website on August 1, 2011, and the approved MMA Waiver Amendment documents were posted on the Agency's website on June 14, 2013**.**
- **Provide Public Ways to Submit Written Comments** – The ways for the public to provide written comments will be posted on the Agency's website, emailed to the interested parties list and provided during the public meetings as well as the advisory committee meetings. The Agency will post public comments directly on the website to allow for public review of comments by others in accordance with 42 CFR 431.408(a)(1)(iii).

Appendix B.2
Legislative Activities and Public Workshops

The Agency held a series of three-hour workshops across the state regarding the Statewide Medicaid Managed Care (SMMC) and the MMA program between June 10, 2011 and June 17, 2011. The workshops were held in all 11 Medicaid regions to collect public comment about SMMC including MMA program.

Since the initial SMMC workshops held 2011, the Agency has held over 500 workshops, presentations, face-to-face meetings, staff trainings, health fairs, conference calls and education sessions (webinars). The following is a list of the Legislative meetings and workshops held between June 2011 and September 2013 related to SMMC and the MMA program.

Legislative Activities and Public Workshops[4] 1115 Waiver Extension Request June 10, 2011 – September 30, 2013			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
6/10/11	***SMMC Public Meeting:** Medicaid Region 2	Tallahassee	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_2.pdf
6/13/11	***SMMC Public Meeting:** Medicaid Region 1	Pensacola	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_1.pdf
6/14/11	***SMMC Public Meeting:** Medicaid Region 3	Alachua	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_3.pdf
6/14/11	***SMMC Public Meeting:** Medicaid Region 4	Jacksonville	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_4.pdf
6/14/11	***SMMC Public Meeting:** Medicaid Region 9	West Palm Beach	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_9.pdf
6/15/11	***SMMC Public Meeting:** Medicaid Region 5	Largo	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_5.pdf
6/16/11	***SMMC Public Meeting:** Medicaid Region 6	Tampa	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_6.pdf
6/16/11	***SMMC Public Meeting:** Medicaid Region 7	Orlando	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_7.pdf
6/16/11	***SMMC Public Meeting:** Medicaid Region 10	Fort Lauderdale	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_10.pdf
6/16/11	***SMMC Public Meeting:** Medicaid Region 11	Miami Gardens	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_11.pdf
6/17/11	***SMMC Public Meeting:** Medicaid Region 8	Fort Meyers	http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/public_meetings/SMMCP_Public_Meeting_Agenda_Region_8.pdf

[4] * The asterisk denotes the workshops that were publicly noticed in the Florida Administrative Register. Please note the Legislative committee meetings are open to the public and publicly noticed through the Florida Legislature's website.

Legislative Activities and Public Workshops[4] 1115 Waiver Extension Request June 10, 2011 – September 30, 2013			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
8/17/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
9/12/11	***SMMC Update** Public Meeting Region 11	Marathon	http://ahca.myflorida.com/medicaid/statewide_mc/pubinfomeetings.shtml
9/13/11	***SMMC Update** Public Meeting Region 11	Coral Gables	http://ahca.myflorida.com/medicaid/statewide_mc/pubinfomeetings.shtml
9/14/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
9/20/11	**Status of SMMC Program Submission** Presented to The Health Regulation Committee	Tallahassee	Presentation available upon request
9/21/2011	**Status of SMMC Program Submission** Presented to Health and Human Services Policy Committee	Tallahassee	Presentation available upon request
9/21/11	**Brief Update on Waiver Negotiations (Reform extension and SMMC)** Presented to Health and Human Services Appropriations Committee	Tallahassee	Presentation available upon request
9/27/11	**Florida Medicaid Program Overview** Presented to Greater Miami Chamber of Commerce	Miami	Presentation available upon request
10/3/11	***Medicaid Reform Technical Advisory Panel**	Teleconference	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/2011.shtml
10/4/11	**Presentation to the House Health Care Appropriations Committee at the Florida House of Representatives**	Tallahassee	Presentation available upon request
10/25/11	***Medical Care Advisory Committee**	Tallahassee	http://ahca.myflorida.com/Medicaid/mcac/Archive/2011.shtml
10/26/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
11/18/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
11/29/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
12/2/11	**SMMC Update** Presented to KidCare Coordinating Council	Tallahassee	Presentation available upon request

Legislative Activities and Public Workshops[4] 1115 Waiver Extension Request June 10, 2011 – September 30, 2013			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
12/7/11	**SMMC Implementation** Presented to Florida House of Representative: Health & Human Services Committee	Tallahassee	Presentation available upon request
12/9/11	***Medicaid Reform Technical Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/2011.shtml
12/13/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
1/5/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2012.shtml
1/11/12	**Low Income Pool Council Recommendations for SFY 2012-13** Presented to the House Health Care Appropriations Committee	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/index.shtml
2/3/12	**SMMC Update** Presented to Florida Commission for the Transportation Disadvantaged	Tallahassee	Presentation available upon request
3/2/12	***Enhanced Benefits Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/previous_meetings.shtml
3/13/12	***Medical Care Advisory Committee**	Tallahassee	http://ahca.myflorida.com/medicaid/mcac/Archive/2012.shtml
3/19/12	***Medicaid Reform Technical Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/2012.shtml
7/31/12	***Medical Care Advisory Committee**	Tallahassee	http://ahca.myflorida.com/medicaid/mcac/Archive/2012.shtml
8/17/12	**Florida Medicaid Update** Presented to KidCare Coordinating Council	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/index.shtml
8/30/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2012.shtml
9/6/12	**Medicaid Managed Care: Long Term Care Overview** Presented to Florida Health Care Association: Managed Care Forum	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/index.shtml
9/19/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2012.shtml

Legislative Activities and Public Workshops[4] 1115 Waiver Extension Request June 10, 2011 – September 30, 2013			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
9/27/12	**Florida Medicaid Update** Presented to Florida Alliance for Home Care Services	Orlando	Presentation available upon request
10/2/12	**Florida Medicaid Update** Presented to Catholic Health Services Planning Conference	Ft. Lauderdale	Presentation available upon request
10/12/12	**Florida Medicaid Update** Presented to American Association of Healthcare Administrative Management, the Greater Florida Buccaneer Chapter	Tampa	Presentation available upon request
10/23/12	***Medical Care Advisory Committee**	Tallahassee	http://ahca.myflorida.com/medicaid/statewide_mc/pubinfomeetings.shtml
10/26/12	**National Association of Medicaid Directors**	Washington D.C.	Presentation available upon request
11/14/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2012.shtml
11/19/12	***SMMC MMA Data Book Technical Session**	Tallahassee	http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#databook
11/19/12	***Medicaid Reform Technical Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/2012.shtml
12/4/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
12/5/12	**Florida Medicaid: An Overview** Presented to House and Human Services Committee	Tallahassee	Presentation available upon request
12/7/12	**Statewide Medicaid Managed Care** Presented to KidCare Coordinating Council	Tallahassee	Presentation available upon request
12/20/12	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/9/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/15/13	**Florida Medicaid: An Overview** Presented to House Health Care Appropriation Subcommittee	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/SMMC_Overview_House_HHS_Approps.pdf

Legislative Activities and Public Workshops[4] 1115 Waiver Extension Request June 10, 2011 – September 30, 2013			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
1/16/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/22/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/23/13	**Florida Medicaid: An Overview** Presented to Senate Health Policy Committee	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/SMMC_Status_Report_Senate_Health_Policy.pdf
1/28/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/30/13	***Medicaid Reform Technical Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/meetings.shtml
1/31/13	***Enhanced Benefits Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/meetings.shtml

Appendix B.3
Letters to the Miccosukee Tribe and the Seminole Tribe

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 19, 2013

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

Dear Ms. Whidden:

The State of Florida anticipates submitting to the Centers for Medicare and Medicaid Services (Federal CMS) a three-year extension request for Florida's 1115 Research and Demonstration Waiver (Managed Medical Assistance) by the end of November 2013. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the waiver extension request.

The 1115 Research and Demonstration Waiver was originally authorized by Federal CMS for the period July 1, 2006 to June 30, 2011, and in 2011 was extended for the period December 16, 2011 to June 30, 2014. The waiver is currently operational in Broward, Duval, Baker, Clay and Nassau Counties and will be expanded statewide as the Managed Medical Assistance program by October 1, 2014.

The 1115 waiver authority enables the state to mandatorily enroll the majority of Medicaid recipients into approved managed care health plans. Managed care eligible recipients choose from the available approved managed care plans. Unless found to be ineligible for enrollment in the demonstration waiver, newly eligible Medicaid recipients receive information to assist them in choosing one of the approved managed care plans. The information includes materials about the available managed care plan options, the timetable for making a choice, and a telephone number for choice counseling and enrollment. If a Medicaid eligible recipient does not select a managed care plan within the given timeframe, the recipient will be assigned appropriately to a managed care plan.

The Agency will be holding a public meeting in Tampa (October 8), Miami (October 9) and Tallahassee (October 11) to solicit public input on the waiver extension request. Please refer to Attachment I of this letter for details regarding the dates, times and location of the meetings.
In addition, the Agency will publish a public notice document on the Agency's website that provides a comprehensive description of the waiver from October 1 to October 30, 2013. The public notice document when published can be accessed at the following link under "Request for Extension of 1115 Managed Medical Assistance Waiver and Public Input."

http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA

Medicaid recipients who are members of federally-recognized Indian tribes are allowed to enroll in managed care programs if they are determined to be managed care eligible. However, they are not automatically enrolled or locked in to any managed care program and are permitted to change managed care plans and/or primary care providers at any time.

If you would like additional information or have any questions about the Florida's 1115 Research and Demonstration Waiver or the three-year waiver extension request, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam

Attachment I

The following table provides the dates, times and locations of the three public meetings to be held in October to solicit public input on the 3-year extension request for Florida's 1115 Managed Medical Assistance Waiver.

Schedule of Public Meetings		
Location	**Date**	**Time**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00 p.m. – 3:30 p.m.
Miami Florida International University Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00 p.m. – 3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00 p.m. – 3:30 p.m.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 19, 2013

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

Dear Ms. Osceola:

The State of Florida anticipates submitting to the Centers for Medicare and Medicaid Services (Federal CMS) a three-year extension request for Florida's 1115 Research and Demonstration Waiver (Managed Medical Assistance) by the end of November 2013. This letter is being sent to solicit comments from the Miccosukee Tribe of Florida on the waiver extension request.

The 1115 Research and Demonstration Waiver was originally authorized by Federal CMS for the period July 1, 2006 to June 30, 2011, and in 2011 was extended for the period December 16, 2011 to June 30, 2014. The waiver is currently operational in Broward, Duval, Baker, Clay and Nassau Counties and will be expanded statewide as the Managed Medical Assistance program by October 1, 2014.

The 1115 waiver authority enables the state to mandatorily enroll the majority of Medicaid recipients into approved managed care health plans. Managed care eligible recipients choose from the available approved managed care plans. Unless found to be ineligible for enrollment in the demonstration waiver, newly eligible Medicaid recipients receive information to assist them in choosing one of the approved managed care plans. The information includes materials about the available managed care plan options, the timetable for making a choice, and a telephone number for choice counseling and enrollment. If a Medicaid eligible recipient does not select a managed care plan within the given timeframe, the recipient will be assigned appropriately to a managed care plan.

The Agency is conducting public meetings in Tampa on October 8, Miami on October 9 and Tallahassee on October 11 to solicit public input on the waiver extension request. Please refer to Attachment I of this letter for details regarding the dates, times and location of the meetings.
In addition, the Agency will publish a public notice document on the Agency's website that provides a comprehensive description of the waiver from October 1 to October 30, 2013. The public notice document, when published, can be accessed at the following link under "Request for Extension of 1115 Managed Medical Assistance Waiver and Public Input."

http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308

Medicaid recipients who are members of federally-recognized Indian tribes are allowed to enroll in managed care programs if they are determined to be managed care eligible. However, they are not automatically enrolled or locked in to any managed care program and are permitted to change managed care plans and/or primary care providers at any time.

If you would like additional information or have any questions about the Florida's 1115 Research and Demonstration Waiver or the three-year waiver extension request, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam

Attachment I

The following table provides the dates, times and locations of the three public meetings to be held in October to solicit public input on the 3-year extension request for Florida's 1115 Managed Medical Assistance Waiver.

Schedule of Public Meetings		
Location	**Date**	**Time**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00 p.m. – 3:30 p.m.
Miami Florida International University Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00 p.m. – 3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00 p.m. – 3:30 p.m.

Appendix C
Number & Type of Plans Available Prior to Waiver

Prior to the implementation of the waiver, the Agency contracted with various managed care programs including: 8 health maintenance organizations (HMOs), 1 provider service network (PSN), 1 Pediatric Emergency Room Diversion Program, and 2 Minority Physician Networks (MPNs), for a total of 12 managed care programs in Broward County; and 2 HMOs and 1 MPN, for a total of 3 managed care programs in Duval County. The Pediatric Emergency Room Diversion Program and MPNs that operated in Broward and Duval Counties prior to implementation of the waiver operated as prepaid ambulatory health plans offering enhanced medical case management services to recipients enrolled in MediPass, Florida's primary care case management (PCCM) program. There were no health plans serving Baker, Clay, and Nassau populations prior to implementation of waiver; there was one MPN serving those counties. There were no specialty plans serving children with chronic conditions or individuals living with HIV or AIDS prior to the waiver.

Florida implemented Medicaid managed care in 1982, when the Palm Beach County Public Health Unit began operating Florida's first Medicaid managed care plan. In 1984, Florida was selected as one of five states to receive a grant from what is now the Centers for Medicare and Medicaid Services, formerly named the Health Care Financing Administration, to implement a demonstration program. Between 1984 and 1990, eligible Medicaid recipients were provided the opportunity to enroll in Medicaid HMOs. Since Medicaid HMOs were not available statewide, many areas of the state were initially left uncovered. In response, Florida developed a PCCM program known as MediPass as an alternative strategy to expand managed care throughout the state and to provide Medicaid recipients with another managed care option.

After the implementation of MediPass in 1990, Medicaid managed care evolved into a variety of programs, including managed care organizations (MCO), PCCMs, prepaid inpatient health plans (PIHP) and prepaid ambulatory health plans (PAHP). The chart below lists the programs by delivery system.

Delivery System	Program Name
MCO	Health Maintenance Organization
	Frail / Elderly Program
	Exclusive Provider Organization
PCCM	MediPass
	Children's Medical Services Network
PIHP	Provider Service Network
	Prepaid Mental Health Plan
PAHP	Prepaid Dental Health Plan
	Minority Physicians Network
	Pediatric Emergency Room Diversion Program

Prior to implementation of the waiver, of the 2.2 million individuals eligible for Medicaid, 1.5 million were enrolled in one of the managed care programs. Of this number, over 700,000 individuals were enrolled in PCCMs paid on a fee-for-service basis. In an effort to better manage their care, individuals enrolled in MediPass may also be enrolled in other managed care programs. For example, an individual in MediPass may also be enrolled in the prepaid mental health program. One goal of the waiver was to eliminate the fragmented system of carve outs by requiring all comprehensive health plans to cover all state plan services.

Appendix D Budget Neutrality Templates

HISTORICAL TREND CALCULATIONS

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED: **As of June 30, 2013**

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	
TOTAL EXPENDITURES								
MEG 1 - SSI RELATED	$2,895,417,932	$3,101,151,925	$3,437,772,158	$3,616,664,546	$3,837,794,411	$4,032,172,248	$3,892,200,514	
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,357,141	3,499,758	3,653,867	3,830,936	
COST PER ELIGIBLE	$972.13	$1,022.14	$1,057.86	$1,077.30	$1,096.59	$1,103.54	$1,015.99	
TREND RATES								DY2-DY7 6-YEAR AVERAGE
			ANNUAL CHANGE					
TOTAL EXPENDITURE		7.11%	10.85%	5.20%	6.11%	5.06%	-3.47%	4.65%
ELIGIBLE MEMBER MONTHS		1.87%	7.11%	3.30%	4.25%	4.40%	4.85%	4.78%
COST PER ELIGIBLE		5.14%	3.49%	1.84%	1.79%	0.63%	-7.93%	-0.12%
TOTAL EXPENDITURES								
MEG 2 - CHILD & FAM	$2,429,520,901	$2,518,857,614	$2,854,235,134	$3,343,861,760	$3,623,958,323	$4,037,818,595	$4,089,744,568	
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	20,033,842	21,686,199	22,956,197	24,348,400	
COST PER ELIGIBLE	$160.23	$169.85	$166.96	$166.91	$167.11	$175.89	$167.97	
TREND RATES								DY2-DY7 6-YEAR AVERAGE
			ANNUAL CHANGE					
TOTAL EXPENDITURE		3.68%	13.31%	17.15%	8.38%	11.42%	1.29%	10.18%
ELIGIBLE MEMBER MONTHS		-2.20%	15.27%	17.19%	8.25%	5.86%	6.06%	10.42%
COST PER ELIGIBLE		6.00%	-1.70%	-0.03%	0.12%	5.26%	-4.51%	-0.22%

As of June 30, 2013

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13
TOTAL EXPENDITURES	$1,000,000,000	$1,000,000,000	$1,000,000,000	$1,000,000,000	$1,000,000,000	$1,000,000,000	$1,000,000,000
LOW INCOME SUBSIDY POOL (LIP)	$998,806,049	$999,632,926	$877,493,058	$1,122,122,816	$997,694,341	$807,232,567	$1,019,291,544
ELIGIBLE MEMBER MONTHS	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COST PER ELIGIBLE	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TREND RATES							
			ANNUAL CHANGE				
TOTAL EXPENDITURE		0.08%	-12.22%	27.88%	-11.09%	-19.09%	26.27%
ELIGIBLE MEMBER MONTHS		N/A	N/A	N/A	N/A	N/A	N/A
COST PER ELIGIBLE		N/A	N/A	N/A	N/A	N/A	N/A
TOTAL EXPENDITURES COMBINED ALL MEGS ***WITHOUT*** LOW INCOME SUBSIDY POOL	$5,324,938,833	$5,620,009,540	$6,292,007,292	$6,960,526,306	$7,461,752,734	$8,069,990,843	$7,981,945,082
ELIGIBLE MEMBER MONTHS	18,141,234	17,863,960	20,344,582	23,390,983	25,185,957	26,610,064	28,179,336
COST PER ELIGIBLE	$293.53	$314.60	$309.27	$297.57	$296.27	$303.27	$283.26
TREND RATES							
			ANNUAL CHANGE				
TOTAL EXPENDITURE		5.54%	11.96%	10.62%	7.20%	8.15%	-1.09%
ELIGIBLE MEMBER MONTHS		-1.53%	13.89%	14.97%	7.67%	5.65%	5.90%
COST PER ELIGIBLE		7.18%	-1.69%	-3.78%	-0.44%	2.36%	-6.60%

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13
TOTAL WOW EXPENDITURES							
MEG 1 - SSI RELATED	$2,825,890,368	$3,108,877,695	$3,596,391,979	$4,012,454,923	$4,517,557,622	$4,957,018,666	$5,462,301,786
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,357,141	3,499,758	3,653,867	3,830,936
COST PER ELIGIBLE	$948.79	$1,024.69	$1,106.67	$ 1,195.20	$1,290.82	$1,356.65	$1,425.84
TREND RATES							
			ANNUAL CHANGE				
TOTAL WOW EXPENDITURES							
MEG 2 - CHILD & FAM	$ 3,024,679,134	$3,194,973,261	$3,977,627,371	$5,034,304,156	$5,885,417,547	$6,560,192,417	$7,326,920,528
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	20,033,842	21,686,199	22,956,197	24,348,400
COST PER ELIGIBLE	$199.48	$215.44	$232.68	$251.29	$271.39	$285.77	$300.92
Total WOW	$5,850,569,502	$6,303,850,956	$7,574,019,350	$9,046,759,079	$10,402,975,168	$11,517,211,082	$12,789,222,314
Variance - BN Surplus	$525,630,669	$683,841,416	$1,282,012,059	$2,086,232,774	$2,941,222,434	$3,447,220,239	$4,807,277,232
Cumulative Variance	$525,630,669	$1,209,472,085	$2,491,484,143	$4,577,716,917	$7,518,939,351	$10,966,159,591	$15,773,436,823

MMA Expansion Population (Mandatory and Voluntary)

* Data thru July 2013

		SFY 08-09	SFY 09-10	SFY 10-11	SFY 11-12	SFY 12-13*	TREND RATE
MEG 1	TOTAL EXPENDITURES **	$728,335,050	$967,513,065	$1,120,195,159	$1,051,506,954	$928,333,815	
	ELIGIBLE MEMBER MONTHS	4,110,160	4,360,767	4,419,051	4,421,151	4,475,744	2.15%
	COST PER ELIGIBLE	$ 177.20	$ 221.87	$ 253.49	$ 237.84	$ 207.41	4.01%
MEG 2	TOTAL EXPENDITURES **	$861,835,170	$1,007,412,153	$1,192,774,859	$974,407,072	$954,665,063	
	ELIGIBLE MEMBER MONTHS	1,615,921	1,816,671	2,229,256	1,755,535	1,867,034	3.68%
	COST PER ELIGIBLE	$ 533.34	$ 554.54	$ 535.06	$ 555.05	$ 511.33	-1.05%

** LTC costs have been excluded.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DEMO TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY9 (SFY 14-15)	DY10 (SFY 15-16)	DY11 (SFY 16-17)	TOTAL WW
MEG 1: SSI RELATED						
Eligible Member Months	4.78%	24	4,205,927	4,406,970	4,617,623	13,230,519
PMPM Cost *	-0.12%	24	$1,013.11	$1,011.42	$1,009.70	
Total Expenditure			$4,261,071,697	$4,457,303,590	$4,662,419,130	$13,380,794,417
MEG 2: CHILD & FAMILY						
Eligible Member Months	10.42%	24	29,686,973	32,780,355	36,196,068.30	98,663,396
PMPM Cost *	-0.22%	24	$167.22	$166.84	$166.46	
Total Expenditure			$4,964,155,510	$5,468,949,715	$6,025,083,535	$16,458,188,760
MEG 1: Expansion						
Eligible Member Months	2.15%	24	4,670,270	4,770,681	4,873,250	$14,314,201
PMPM Cost	4.01%	24	$224.38	$233.38	$242.74	
Total Expenditure			$1,047,927,181	$1,113,382,965	$1,182,927,259	$3,344,237,405
MEG 2: Expansion						
Eligible Member Months	3.68%	24	2,006,976	2,080,833	2,157,407	6,245,216
PMPM Cost	-1.05%	24	$500.65	$495.39	$490.19	
Total Expenditure			$1,004,783,751	$1,030,821,316	$1,057,533,607	$3,093,138,674

* PMPM is adjusted for the savings associated with the Hemophilia Management Program.

MMA AMENDMENT WITHOUT WAIVER (WOW) PROJECTION

ELIGIBILITY GROUP	HISTORIC TREND RATE	MONTHS OF AGING	DY9 (SFY 14-15)	DY10 (SFY 15-16)	DY11 (SFY 16-17)	TOTAL WOW
MEG 1 - SSI RELATED						
Eligible Member Months	4.78%	24	4,205,927	4,406,970	4,617,623.01	13,230,519
Total Cost Per Eligible President's Trend	5.10%	12	$1,574.99	$1,655.31	$1,739.73	
Total Expenditure			$6,624,277,800	$7,294,905,111	$8,033,425,256	$ 21,952,608,168
MEG 2 - CHILD & FAMILY						
Eligible Member Months	10.42%	24	29,686,973	32,780,355.28	36,196,068.30	98,663,396
Total Cost Per Eligible President's Trend	5.30%	12	$333.66	$351.35	$369.97	
Total Expenditure			$9,905,477,332	$11,517,322,357	$13,391,450,997	$ 34,814,250,686
MEG 1 - SSI RELATED EXPANSION						
Eligible Member Months	2.15%	24	4,670,270	4,770,681	4,873,250	14,314,201
Total Cost Per Eligible President's Trend	3.20%	24	$220.90	$227.97	$235.27	
Total Expenditure			$1,031,668,824	$1,087,572,894	$1,146,506,294	$3,265,748,013

MEG 2 - CHILD & FAMILY EXPANSION						
Eligible Member Months	3.68%	24	2,006,976	2,080,832.84	2,157,407.48	6,245,216
Total Cost Per Eligible President's Trend	0.91%	24	$520.68	$525.41	$530.19	
Total Expenditure			$1,044,983,465	$1,093,298,150	$1,143,846,659	$3,282,128,274

TOTAL EXPENDITURES WOW D8-D11				
COMBINED MEGS 1 and 2 & EXPANSION	$18,606,407,421	$20,993,098,513	$23,715,229,206	$ 63,314,735,140
ELIGIBLE MEMBER MONTHS	40,570,145	44,038,839	47,844,349	132,453,333
COST PER ELIGIBLE	$458.62	$476.70	$495.67	

STC #116 b. PCCM WOW initial waiver	**PCCM MEG 1**	**MEG 2**
FY1314 DY8	$1,498.56	$316.87

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DY9 (SFY 14-15)	DY10 (SFY 15-16)	DY11 (SFY 16-17)	TOTAL
Current Populations				
MEG 1	$6,624,277,800	$7,294,905,111	$8,033,425,256	$21,952,608,168
MEG 2	$9,905,477,332	$11,517,322,357	$13,391,450,997	$34,814,250,686
Expansion Populations				
MEG 1 Expansion	$1,031,668,824	$1,087,572,894	$1,146,506,294	$ 3,265,748,013
MEG 2 Expansion	$1,044,983,465	$1,093,298,150	$1,143,846,659	$ 3,282,128,274
CHIP Transition Population *				
Member Months	872,400	903,924	939,852	
PMPM	$151.52	$155.31	$159.19	
Total Expenditures	$132,186,048	$140,388,436	$149,615,040	$ 422,189,524
TOTAL	$18,738,593,469	$21,133,486,950	$23,864,844,246	$63,736,924,665

With-Waiver Total Expenditures

	DY9 (SFY 14-15)	DY10 (SFY 15-16)	DY11 (SFY 16-17)	TOTAL
Current Populations				
MEG 1	$4,261,071,697	$4,457,303,590	$4,662,419,130	$13,380,794,417
MEG 2	$4,964,155,510	$5,468,949,715	$6,025,083,535	$16,458,188,760
Expansion Populations				
MEG 1 Expansion	$1,047,927,181	$1,113,382,965	$1,182,927,259	$ 3,344,237,405
MEG 2 Expansion	$1,004,783,751	$1,030,821,316	$1,057,533,607	$ 3,093,138,674
CHIP Transition Population *				
Member Months	872,400	903,924	939,852	
PMPM	$151.52	$155.31	$159.19	
Total Expenditures	$132,186,048	$140,388,436	$149,615,040	$ 422,189,524

TOTAL	$11,410,124,186	$12,210,846,022	$13,077,578,572	$36,698,548,780

VARIANCE	$7,328,469,283	$8,922,640,928	$10,787,265,674	$27,038,375,885

CNOM HEALTHY START DY9-DY11:	$ 14,404,219	$ 14,277,850	$ 14,152,691	$42,834,759
CNOM PACC DY9-DY11:	$1,605,033	$2,072,317	$2,685,326	$ 6,362,675
				$49,197,434
VARIANCE LESS CNOM COSTS:	$7,312,460,032	$8,906,290,762	$10,770,427,658	$26,989,178,451

Cumulative Variance from Prior Years (DY1-DY7)	$15,773,436,823
Total Cumulative Variance	$42,762,615,274
Amendment (1=yes, 0=no) 1	

*** Source: Florida Kid Care Program (Social Services Estimating Conference, June 27, 2013, Final Report)**

Appendix E
External Quality Review Reports

External Quality Review Reports Submitted by the waiver demonstration year

Demonstration Year 1 – July 1, 2006 through June 30, 2007

External Quality Review Organization (EQRO) Introduction, May 10, 2006
Annual EQR Communication Plan
Annual Performance Improvement Projects (PIP) Technical Assistance Plan
*Annual PIP Validation Summary Report (Statewide Aggregate)
*Annual PIP Managed Care Organization (MCO) Specific Validation Reports
*Annual PIP Strategic Report
*Annual Statewide Collaborative Methodology Report for PIPs
*Quarterly PIP Technical Assistance Reports
*Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
*MCO-Specific Strategic HEDIS Analysis Reports

*Since twelve continuous months of data are required to validate these activities, the EQRO reviewed the data-collecting capabilities of the plans and offered technical assistance in preparation for validation activities to begin in Demonstration Year 2.

†Annual Validation of Performance Measures Statewide Report
†Annual Validation of Performance Measures MCO-Specific Reports

†Validation activities began in Demonstration Year Three using Calendar Year 2007 data. The EQRO reviewed plan processes and offered technical assistance in preparation for validation activities to begin in Demonstration Year 3.

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures

Review of Compliance with Access, Structural, and Operations Standards Report,
HMO Consumer Satisfaction Surveys (CAHPS) Alternate Scoring Methods Report with Recommendations to Improve HMO Scoring Algorithm, FY 2006-2007

Approaches for Improving CAHPS and other MCO Consumer Satisfaction Surveys, 2006-2007

Technical Assistance Report on Enrollee Race/Ethnicity and Primary Household Language
Report on Value-Based Purchasing Methodologies (Approaches for Defining and Evaluating Superior Performance), FY 2006-2007

Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided
Annual Report on Evaluation of AHCA's Quality Strategies
Statewide Focused Study Report on Identification of Individuals with Special Health Care Needs, FY 2006-2007

Statewide Focused Study Report on Adolescent Well-Care, FY 2006-2007
Managed Care Organization Specific Reports on Adolescent Well-Care Focused Study, FY 2006-2007

The EQRO Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activities)

Annual Florida Medicaid Managed Care External Quality Review Technical Report

Demonstration Year 2 – July 1, 2007 through June 30, 2008

Annual EQR Communication Plan
Annual Performance Improvement Projects (PIP) Technical Assistance Plan
Annual PIP Validation Summary Report (Statewide Aggregate)
Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs
Annual PIP Strategic Report
Annual Statewide Collaborative Methodology Report for PIPs
Annual PIP Strategic and Collaboration Methodology Report
Quarterly PIP Technical Assistance Reports
†Annual Validation of Performance Measures Statewide Report
†Annual Validation of Performance Measures MCO-Specific Reports

†Validation activities began in Demonstration Year Three using Calendar Year 2007 data. The EQRO reviewed plan processes and offered technical assistance in preparation for validation activities to begin in Demonstration Year Three.

Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures
Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
MCO-Specific Strategic HEDIS Analysis Reports, FY 2006-2007
Review of Compliance with Access, Structural, and Operations Standards Report,
Report of Technical Assistance Provided for Improving Consumer Satisfaction Surveys,
Technical Assistance Report on Enrollee Race/Ethnicity and Primary Household Language
Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided
Annual Report on Evaluation of AHCA's Quality Strategies
The EQRO Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activities)
Annual Florida Medicaid Managed Care External Quality Review Technical Report

Demonstration Year 3 – July 1, 2008 through June 30, 2009

- Annual EQR Communication Plan
- Annual Performance Improvement Projects (PIP) Technical Assistance Plan
- Annual PIP Validation Summary Report (Statewide Aggregate)
- Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs
- Annual PIP Strategic Report
- Annual Statewide Collaborative Methodology Report for PIPs
- Annual PIP Strategic and Collaboration Methodology Report
- Quarterly PIP Technical Assistance Reports
- Annual Validation of Performance Measures Statewide Report
- Annual Validation of Performance Measures MCO-Specific Reports
- Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures
- Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
- Review of Compliance with Access, Structural, and Operations Standards Report,
- Report of Technical Assistance Provided for Improving Consumer Satisfaction Surveys,
- Value-Based Purchasing Methodologies Report Describing Technical Assistance Provided
- Technical Assistance Provided on AHCA's Quality Strategies

- The EQRO Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activities)
- Annual Florida Medicaid Managed Care External Quality Review Technical Report
- Technical Assistance on Network Adequacy, FY 2008-2009

Demonstration Year 4 – July 1, 2009 through June 30, 2010

- Annual EQR Communication Plan
- Annual Performance Improvement Projects (PIP) Technical Assistance Plan
- Annual PIP Managed Care Organization (MCO) Specific Validation Reports – HMOs/PSNs
- Quarterly PIP Technical Assistance Reports
- Annual Validation of Performance Measures Statewide Report
- Annual Validation of Performance Measures MCO-Specific Reports
- Annual Methodology Report for Addressing Bias Identified in Validation of Performance Measures
- Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
- HMO Consumer Satisfaction Surveys (CAHPS) Alternate Scoring Methods Report with Recommendations to Improve HMO Scoring Algorithm, FY 2006-2007, June 2007
- The EQRO Monthly EQRO Activity Reports, (received 10th of each month for the previous month's activities)
- Development and Onsite Testing of Standards Compliance Monitoring Tools for HMOs and PSNs
- Review of Compliance with Access, Structural, and Operations Standards Report

Demonstration Year 5 – July 1, 2010 through June 30, 2011

- Annual EQR Communication Plan
- Annual Technical Assistance for Other EQR Activities Report
- Annual Performance Improvement Projects Strategic Report
- Annual Performance Improvement Projects MCO-Specific Validation Reports
- Quarterly PIP Technical Assistance Reports
- Annual Validation of Performance Measures Statewide Report
- Annual Validation of Performance Measures MCO-Specific Reports
- Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
- Review of Compliance with Access, Structural, and Operations Standards Report
- Annual Florida Medicaid Managed Care External Quality Review Technical Report
- The EQRO Monthly EQRO Activity Reports (received 10th of each month for the previous month's activity)

Demonstration Year 6 – July 1, 2011 through June 30, 2012

- Annual EQR Communication Plan
- Technical Assistance Plan for Performance Improvement Projects
- Annual Performance Improvement Projects Strategic Report
- Annual Performance Improvement Projects MCO-Specific Validation Reports
- Annual Validation of Performance Measures Statewide Report
- Annual Validation of Performance Measures MCO-Specific Reports
- Annual Florida Medicaid HEDIS® Results Statewide Aggregate Report
- Review of Compliance with Access, Structural, and Operations Standards Report
- Annual Florida Medicaid Managed Care External Quality Review Technical Report
- The EQRO Monthly EQRO Activity Reports (received 10th of each month for the previous month's activity)

Demonstration Year 7 – July 1, 2012 through June 30, 2013

- Annual Performance Improvement Projects Strategic Report
- Annual Performance Improvement Projects MCO-Specific Validation Reports
- Annual Validation of Performance Measures Statewide Report
- Annual Validation of Performance Measures MCO-Specific Reports
- Florida Emergency Department Collaborative Report
- Florida Emergency Department Collaborative Report Tool Kit
- Review of Compliance with Access, Structural, and Operations Standards Report
- Annual Florida Medicaid Managed Care External Quality Review Technical Report
- The EQRO Monthly EQRO Activity Reports (received 10th of each month for the previous month's activities)

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Appendix F
Strategic HEDIS Analysis Report

Strategic HEDIS® Analysis Reports

Strategic HEDIS® Analysis Reports – HEDIS® is a standard tool used to measure performance on important dimensions of care and service. This makes it possible to compare the performance of health plans. The plans also use HEDIS® results themselves to see where they need to focus their improvement efforts, such as PIPs. HEDIS® Compliance Audits indicate whether managed care organization s have adequate and sound capabilities for processing medical, member and provider information as a foundation for accurate and automated performance measurement.

July 1, 2007 through June 30, 2008

An examination of plan HEDIS® results was not performed in Demonstration Year 2 because twelve consecutive months of member data are required to validate performance measures and the Federal CMS protocol specifies the measurement period to be a calendar year. Thus, the first measurement period was Calendar Year 2007. The first validation of HEDIS® results occurred during Demonstration Year 3 (SFY 2008-2009).

July 1, 2008 through June 30, 2009

The EQRO established performance levels for all of the reported HEDIS® measures. The performance levels were set at specific, attainable rates and were based on NCQA national means and percentiles. This standardization allowed for comparison to the performance levels. HMOs meeting the high performance level (HPL) exhibited rates among the top in the nation and performed at or above the national HEDIS® Medicaid 90th percentile. The low performance level (LPL) was set to identify HMOs/PSNs in the greatest need for improvement. The LPL represents rates at or below the national HEDIS® Medicaid 25th percentile.

The EQRO has examined the measures along four different dimensions of care: (1) Pediatric Care, (2) Women's Care, (3) Living With Illness and (4) Use of Services. This approach to the analysis was designed to encourage consideration of the key measures as a whole rather than in isolation and to think about the strategic and tactical changes required to improve overall performance. The data presented in this report (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2008 HEDIS® data, which was collected by the HMO/PSN in calendar year 2007, but reported in 2008.

The EQRO analyzed the Florida Medicaid HEDIS results in three ways:

- A weighted average comparison presents the Florida Medicaid 2009 results relative to the 2008 Florida Medicaid weighted averages and the national HEDIS® 2008 Medicaid 50th percentiles.
- A performance profile analysis discusses the overall Florida Medicaid 2009 results and presents a summary of HMO and PSN performance relative to the Florida Medicaid performance levels.
- An HMO/PSN ranking analysis for each dimension of care (Sections 3 to 7) provides a more detailed comparison, presenting results relative to the Florida Medicaid performance levels and the national HEDIS® 2008 Medicaid percentiles.

Of the 18 weighted averages calculated for 1115 Waiver health plans that were comparable to national standards, three (or 16.7 percent) fell below the national Medicaid 10th percentile (namely *Annual Dental Visits*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*), seven (or 38.9 percent) fell between the national Medicaid 10th and 25th percentiles, three (or 16.7 percent) fell between the 25th and 50th percentiles, four (or 22.2 percent) fell between the 50th and 75th percentiles, and one (or 5.6 percent) fell between the 75th and 90th percentiles. The weighted average that exceeded the 75th percentile was for the *Comprehensive Diabetes Care—LDL-C Screening* measure.

Pediatric Care

Performance for 1115 Waiver HMOs and PSNs within the Pediatric Care dimension ranged from below average to average, except for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, which had one health plan that performed above the HPL.

For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measures, 7 of the 16 Waiver plans were not able to report rates due to insufficient sample sizes (with a denominator of less than 30). Six of the remaining 9 plans that reported rates ranked below the LPL for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure, and 4 health plans reported rates below the LPL for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure.

For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures, 1 of the 16 1115 Waiver plans was not able to report a rate because the denominators were less than 30. Most plans performed above the national HEDIS 2007 Medicaid 50th percentile and 1 of those plans exceeded the HPL.

For the *Annual Dental Visits* measure, two 1115 Waiver health plans had an audit designation of *Not Report* (NR) because the rates were materially biased. The remaining plans all reported rates below the LPL.

Women's Care

Overall performance for the Women's Care dimension for the 1115 Waiver HMOs and PSNs ranged from below average to average. One HMO was unable to report a rate for the *Cervical Cancer Screening* measure, and six health plans were unable to report rates for the *Timeliness of Prenatal Care* and *Postpartum Care* measures due to insufficient sample sizes (with denominators of less than 30).

All of the 1115 Waiver HMOs and PSNs with reported rates performed below the LPL for *Cervical Cancer Screening*. All 10 Waiver health plans with rates other than NA performed below the LPL for *Timeliness of Prenatal Care*. Six out of 10 health plans with rates other than NA performed below the LPL for *Postpartum Care*.

Living With Illness

Performance for measures in the Living With Illness dimension ranged from below average to above average. All of the measures had at least one 1115 Waiver HMO or PSN that was unable to report rates due to insufficient sample sizes (with denominators of less than 30), designated as NA in the tables.

Performance on the *Comprehensive Diabetes Care* measures ranged from below average to above average. For the *Comprehensive Diabetes Care—HbA1c Testing*, four of the 1115 Waiver plans performed below the LPL. The *Comprehensive Diabetes Care—Poor HbA1c Control* and *Comprehensive Diabetes Care—Good HbA1c Control* measures had only one and two health plans performing below the LPL, respectively, indicating that for those members who had HbA1c testing, the rate of members who had their HbA1c under control ranged between the LPL and the HPL. For the *Comprehensive Diabetes Care—LDL-C Screening* measure, six of the HMOs and PSNs performed above the HPL and six performed between the LPL the HPL. The *Comprehensive Diabetes Care—LDL-C Level <100* measure for all of the 1115 Waiver plans with reported rates ranked between the LPL and HPL, indicating that for those members who had an LDL-C screening, the percentage of members with an LDL-C level <100 mm/dL was average. Performance for the *Comprehensive Diabetes Care—Eye Exam* indicator ranged from below average to average, with eight plans ranking below the LPL. The majority of the health plans ranked between the LPL and HPL for the *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* measure, with one health plan ranking below the LPL.

For *Controlling High Blood Pressure*, three of the 1115 Waiver HMOs and PSNs reported an NA due to an insufficient sample, five health plans had rates below the LPL, six health plans had rates between the LPL and HPL, and one health plan had a rate above the HPL. One PSN was not required to report the *Controlling High Blood Pressure* measure since the population it served did not meet eligibility requirements.

Performance on the *Follow-Up After Hospitalization for a Mental Illness* measures ranged from below average to average. Five of the 1115 Waiver plans reported an NA due to an insufficient sample size. The majority of plans ranked below the LPL for both the *30 Day and 7 Day* measures.

Use of Services

The HMOs and PSNs began collecting and reporting Use of Services data in FY 2008. All plans reported valid rates for the *Ambulatory Care* measure. Use of Services data are descriptive in nature and are used to monitor patterns of utilization over time. Because the measures do not lend themselves to measuring the quality of care, the EQRO did not compare plan performance on these measures.

July 1, 2009 through June 30, 2010

Eleven HMOs and six PSNs were reviewed. The data presented (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2008 HEDIS data, which was collected by the HMO/PSN in calendar year 2008, but reported in 2009.

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

Pediatric Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to above average for the Pediatric Care dimension measures. For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measures, 6 Waiver plans performed between the LPL and HPL, while 1 plan performed above the HPL. Five plans reported that the rates for the measures were NA because of small sample sizes. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, 10 plans reported rates between the LPL and HPL, while 3 plans reported rates that exceeded the HPL. For the *Adolescent Well-Care Visits* measure, 12 plans reported rates between the LPL and HPL, while 1 plan reported a rate higher than the HPL. Four plans reported that rates for both of these measures were NA because of small sample sizes.

While all of the 1115 Waiver plans offered dental benefits, only two reported rates between the LPL and HPL. Thirteen plans reported rates lower than the LPL, while two of the plans had sample sizes too small to report rates.

Of all the *Childhood Immunization Status* measures, diphtheria, tetanus, and acellular pertussis (DTaP) and HiB were the only measures that had two and three plans, respectively, that performed higher than the HPL. The inactivated polio vaccine (IPV) and pneumococcal conjugate vaccine (PCV) measures both had nine 1115 waiver plans that performed below the LPL and five plans that performed between the LPL and HPL. For the measles, mumps, and rubella (MMR), HiB, and varicella zoster virus (VZV) measures, three plans performed below the LPL. Eleven plans performed between the LPL and HPL for the MMR and VZV measures, while eight plans performed between the LPL and HPL for the HiB measure. For the Hepatitis B measure, eight plans performed below the LPL, while six plans performed between the LPL and HPL. Seven plans performed below the LPL and seven other plans performed between the LPL and HPL for the Combination 3 measure, while six plans performed below the LPL and eight plans performed between the LPL and HPL for the Combination 2 measure. For all of the *Childhood Immunization Status* measures, three plans reported that the rates were NA.

Four of the 1115 Waiver plans performed below the LPL for the *Lead Screening in Children* measure, while 10 plans performed between the LPL and HPL. Three plans reported that rates for the measures were NA.

Women's Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to average for the Women's Care dimension measures. Two plans were not required to report rates for the *Cervical Cancer* and *Breast Cancer Screening* measures because they serve a younger population and would not have eligible populations for these measures. For the *Cervical Cancer Screening* measure, 10 plans performed below average, while 2 plans performed between the LPL and HPL for the measure. Three plans reported that their rate was NA because of a small sample size.

For the *Breast Cancer Screening* measure, two 1115 Waiver plans performed below average, while eight plans performed between the 25th and 90th percentiles, or between the LPL and HPL. Five plans reported that the rate was NA. Almost all of the plans that could report the *Timeliness of Prenatal Care* measure performed below average. One plan performed between the LPL and HPL, while seven plans reported that the rate was NA. For *Postpartum Care*, five

plans performed below average, while five plans performed between the LPL and HPL. Seven plans reported that the rate was NA.

Living With Illness

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to above average for the Living With Illness dimension measures. For the *Comprehensive Diabetes Care* measure, there was mixed performance. Five plans reported that all of their *Comprehensive Diabetes Care* measure rates were NA because of small sample sizes. The plans performed best on the *Good HbA1c Control* measure. Eight plans performed above the HPL, two plans performed between the LPL and HPL, and only one plan performed below the LPL. Another measure with good performance was *LDL-C Screening*. Four plans performed above the HPL, and the remaining seven plans performed between the LPL and HPL. The plans also performed nearly as well on the *Nephropathy* and *LDL-C Screening < 100* measures. For both measures, three plans performed better than the HPL, seven plans performed between the LPL and HPL, and one plan performed below the LPL. For the remaining *Comprehensive Diabetes Care* measures—*HbA1c Testing*, *Poor HbA1c Control*, and *Eye Exam*—none of the plans performed above average. For the *HbA1c Testing* measure, all of the plans performed between the LPL and HPL. For the *Poor HbA1c Control* measure, eight plans performed average, while three plans performed below average. For the *Eye Exam* measure, six plans performed average, while five plans performed below average.

For the *Controlling High Blood Pressure* measure, 10 of the 1115 Waiver plans performed between the 25th and 90th percentiles, or between the LPL and HPL, and one plan performed above average. Four plans reported the measure's rate as NA.

For both of the *Antidepressant Medication Management* measures, 10 plans reported that the rate was NA. Four plans performed above the HPL for the *Effective Acute Phase Treatment* measure, while two plans reported above the HPL for the *Effective Continuation Phase Treatment* measure. For the *Effective Acute Phase Treatment* measure, one plan performed between the LPL and HPL. For the *Effective Continuation Phase Treatment* measure, three plans performed between the LPL and HPL. For both measures, only one plan performed below average.

For both of the *Follow-Up After Hospitalization for Mental Illness* measures, five plans reported that the rates were NA. For the *30-Day* measure, six plans performed below average and six plans performed between the LPL and HPL. For the *Seven-Day* measure, three plans performed below average and nine plans performed between the LPL and HPL. None of the plans performed above average for either of the measures.

None of the 1115 Waiver plans performed above average for any of the *Use of Appropriate Medications for People With Asthma* measures. For the *5–9* age group, 5 plans performed below average, 2 plans performed between the LPL and HPL, and the remaining 10 plans reported that the rate was NA. For the *10–17* age group, 5 plans also performed below average, 1 plan performed between the LPL and HPL, and the remaining 11 plans reported that the rate was NA. For the *18–56* age group, 3 plans performed below average, 3 plans performed between the LPL and HPL, and 11 plans reported that the rate was NA. For the *Total* age group, 7 plans performed below average, 4 plans performed between the LPL and HPL, and the remaining 6 plans reported that the rate was NA.

Access to Care

Overall performance for the 1115 Waiver HMOs and PSN ranged from below average to average for the Access to Care dimension measures. PAR did not report the Access to Care dimension measures because they were not appropriate for the populations PAR serves. Eight of the plans performed below average, while 5 plans performed between the LPL and HPL for the *Adults' Access to Preventive Ambulatory Health Services for 20–44 Years*. Three plans reported that the measure was NA. For the same measure for *45–64 Years*, only 1 plan performed below average, 10 plans performed between the LPL and HPL, and 5 plans reported that the rate was NA. For *65+ Years*, 1 plan performed below average, 9 plans performed between the LPL and HPL, and 6 plans reported that the rate was NA. For the *Total* measure, data were not presented because there were no Medicaid benchmarks for that measure.

July 1, 2010 through June 30, 2011

Nine HMOs and four PSNs were reviewed. The data presented (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2009 HEDIS data, which was collected by the HMO/PSN in calendar year 2009, but reported in 2010.

Of the 34 weighted averages calculated for the 1115 Waiver plans that were comparable to national standards, 27 had performance targets at the 75th percentile, two were inverse measures that had performance targets at the 25th percentile, and five did not have AHCA performance targets. Of the 27 with performance targets at the 75th percentile, 16 (or 59 percent) fell below the national Medicaid 75th percentile, and 11 (or 41 percent) were at or above the national Medicaid 75th percentile. Both of the two inverse measures were above the national Medicaid 25th percentile.

The EQRO examined five different dimensions of care for Florida Medicaid members: Pediatric Care, Women's Care, Living With Illness, Use of Services, and Access to Care. This approach to the analysis was designed to encourage the HMOs/PSNs to consider the measures as a whole rather than in isolation and to think about the strategic and tactical changes required to improve overall performance.

Pediatric Care

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to above average for the Pediatric Care dimension measures. For *Well-Child Visits in the First 15 Months of Life—Zero Visits*, none of the Waiver plans reached the State's performance target. For the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure, one plan exceeded the performance target. Four plans reported that the rates for these two measures were NA because of small sample sizes. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, four plans reported rates that exceeded the State's performance target and of the 14 plans that reported rates, 10 demonstrated an improvement in performance. For the *Adolescent Well-Care Visits* measure, three plans reported rates above the State's performance target. Of the six plans that reported rates for this measure, five showed an improvement in performance.

All seven of the 1115 Waiver plans' reported rates were at least 10 percentage points below the AHCA performance target for *Annual Dental Visit, Total*. Five plans reported NA for this due to small sample sizes.

Two of the nine plans who reported rates for *Childhood Immunization Status— Combination 2* reported rates that exceeded the State's performance target. Of the eight plans that reported rates for HEDIS 2009, six showed improvement for the *Childhood Immunization Status—Combination 3* measure. For both of these *Childhood Immunization Status* measures, three plans reported that the rates were NA due to sample size.
Three of the six 1115 Waiver plans who reported rates for the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* measure exceeded the AHCA performance target, with the lowest rate being 2.5 percentage points below the target.

Women's Care

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to average for the Women's Care dimension measures. One plan was not required to report rates for the *Cervical Cancer* and *Breast Cancer Screening* measures because they serve a younger population and would not have eligible populations for these measures. For the *Cervical Cancer Screening* measure, all seven of the plans who reported rates performed below the performance target, and three of those plans showed improvement from HEDIS 2009 to 2010. Four plans reported that their rate was NA because of a small sample size.

For the *Breast Cancer Screening* measure, two 1115 Waiver plans reported rates that were above the AHCA performance target. Six plans reported that the rate was NA. All of the plans that could report the *Timeliness of Prenatal Care* measure performed below the AHCA performance target, but four of the plans showed an increase of more than 10 percentage points from HEDIS 2009 to 2010. For *Postpartum Care*, all of the 1115 Waiver plans reported rates below the performance target, while four of the six plans who reported rates for both HEDIS 2009 and 2010 showed improvement.

Living With Illness

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to above average for the Living With Illness dimension measures. For the *Comprehensive Diabetes Care* measures, there was mixed performance. Five plans reported that all of their *Comprehensive Diabetes Care* measure rates were NA because of small sample sizes. The plans performed best on the *HbA1c Testing* and *LDL-C Control* measures. For both measures, three plans performed above the AHCA performance targets. Two plans reported rates that were higher than the performance target for the *LDL-C Screening* and *CDC-Nephropathy* measures. *HbA1c Poor Control* had one plan that reported a rate that exceeded the performance target, while none of the 1115 Waiver plans reached the target for the *Eye Exam* measure.
For the *HbA1c Good Control* measure, no AHCA performance target was available.

For the *Controlling High Blood Pressure* measure, one of the 1115 Waiver plans reported rates that were above the AHCA performance target. Four plans reported the measure's rate as NA. One plan was not required to report a rate for this measure because they serve a younger population and would not have eligible population.

The age groups for *Use of Appropriate Medications for People With Asthma* measures were changed from HEDIS 2009 to 2010, therefore, a comparison with the AHCA performance target was only available for the *Total* measure. For that measure, one of the five plans that reported rates exceeded the performance target, and six plans reported NA due to sample size

For both of the *Antidepressant Medication Management* measures, nine plans reported that the rate was NA due to sample size. For the *Effective Acute Phase Treatment* measure, two plans reported rates that were higher than the AHCA performance target. For the *Effective Continuation Phase Treatment* measure, all three of the plans who reported rates exceeded the performance target.

For the *Adult BMI Assessment* measure, three 1115 Waiver plans reported rates that exceeded the State's performance target, while four plans reported NA due to sample size.

Use of Services

The HMOs and PSNs began collecting and reporting Use of Services data in FY 2008. All plans offering ambulatory care or mental health benefits reported valid rates for the *Ambulatory Care* and *Mental Health Utilization* measures. Use of Services data are descriptive in nature and are used to monitor patterns of utilization over time. Because these measures do not lend themselves to measuring the quality of care, the EQRO did not compare performance on these measures.

Access to Care

Overall performance for the 1115 Waiver HMOs and PSN was below average for the Access to Care dimension measures. For *Adults' Access to Preventive Ambulatory Health Services for 20–44 Years*, *45–64 Years* and *65+ Years,* one plan reported a rate that exceeded the AHCA performance target. For the *Total* measure, no AHCA performance target was available.

July 1, 2011 through June 30, 2012

Fifteen HMOs and five PSNs were reviewed. The data presented (including the Florida Medicaid weighted averages) are derived from HMO's/PSN's reporting year 2010 HEDIS data, which was collected by the HMO/PSN in calendar year 2010, but reported in 2011.

Of the 37 weighted averages calculated for the 1115 Waiver plans that were comparable to national standards, 26 had performance targets at the 75th percentile, two were inverse measures that had performance targets at the 25th percentile, and 9 did not have AHCA performance targets. Of the 26 with performance targets at the 75th percentile, 16 (or 62 percent) fell below the national Medicaid 75th percentile, and 10 (or 38 percent) were at or above the national Medicaid 75th percentile. Both of the two inverse measures were above the national Medicaid 25th percentile.

The EQRO examined five different dimensions of care for Florida Medicaid members: Pediatric Care, Women's Care, Living With Illness, Use of Services, and Access to Care. This approach to the analysis was designed to encourage the HMOs/PSNs to consider the measures as a whole rather than in isolation and to think about the strategic and tactical changes required to improve overall performance.

Pediatric Care

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to above average for the Pediatric Care dimension measures. For *Well-Child Visits in the First 15 Months of Life—Zero Visits*, two of the Waiver plans exceeded AHCA's performance target. For the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure, none of the nine

plans who reported rates reached the performance target. Two plans reported that the rates for these two measures were NA because of small sample sizes. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, four plans reported rates that exceeded the State's performance target and all of the seven plans that reported rates for HEDIS 2010 demonstrated improved performance. For the *Adolescent Well-Care Visits* measure, three plans reported rates above the State's performance target. Again, all of the seven plans that reported rates for this measure showed an improvement in performance.

All eleven of the 1115 Waiver plans' reported rates were at least 7 percentage points below the AHCA performance target for *Annual Dental Visit, Total*. Four of the seven plans who also reported rates for HEDIS 2010 demonstrated improvement for this measure.

None of the eight plans who reported rates for *Childhood Immunization Status— Combination 2* and *Combination 3* reported rates that exceeded the State's performance targets. Two plans reported NA due to sample size for both measures.

Four of the six 1115 Waiver plans who reported rates for the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* measure exceeded the AHCA performance target, with the lowest rate being 9 percentage points below the target.

Women's Care

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to above average for the Women's Care dimension measures. One plan was not required to report rates for the *Cervical Cancer* and *Breast Cancer Screening* measures because they serve a younger population and would not have eligible populations for these measures. For the *Cervical Cancer Screening* measure, all ten of the plans who reported rates performed below the performance target, and five of six plans who reported rates for HEDIS 2010 and 2011 showed improvement.

For the *Breast Cancer Screening* measure, four 1115 Waiver plans reported rates that were above the AHCA performance target. Three plans reported that the rate was NA. All of the plans that could report the *Timeliness of Prenatal Care* measure performed below the AHCA performance target, and only one plan showed improvement from HEDIS 2010 to 2011 for this measure. For *Postpartum Care*, all of the 1115 Waiver plans reported rates below the performance target, while four of the five plans who reported rates for both HEDIS 2010 and 2011 demonstrated improvement.

The *Chlamydia Screening in Women* measure was recently added to the Medicaid reporting set. Since it was not included in the prior year's reporting set, trending data and AHCA performance targets were not available.

Living With Illness

Overall performance for the 1115 Waiver HMOs and PSNs ranged from below average to above average for the Living With Illness dimension measures. For the *Comprehensive Diabetes Care* measures, there was mixed performance. Two plans reported that all of their *Comprehensive Diabetes Care* measure rates were NA because of small sample sizes. The plans performed best on the *LDL-C Screening* measure, where seven out of nine plans performed above the AHCA performance targets. Four plans reported rates that were higher than the performance target for the *LDL-C Control* and *Nephropathy* measures. *HbA1c Testing* and *HbA1c Poor*

Control measures had two plans that reported rates that exceeded the performance target, while one of the 1115 Waiver plans reached the target for the *Eye Exam* measure. For the *HbA1c Good Control* measure, no AHCA performance target was available.

For the *Controlling High Blood Pressure* measure, none of the 1115 Waiver plans reported rates that were above the AHCA performance target. One plan was not required to report a rate for this measure because they serve a younger population and would not have eligible population.

AHCA performance targets for the *Use of Appropriate Medications for People With Asthma* age group measures were not available. For the *Total* measure, none of the 1115 Waiver plans met or exceeded the performance target. 6 of the plans reported NA due to sample size.

For both of the *Antidepressant Medication Management* measures, three of the five plans who reported rates exceeded the AHCA performance target. For the *Effective Acute Phase Treatment* measure, the weighted average was nine percentage points higher than the performance target. For the *Effective Continuation Phase Treatment* measure, the weighted average was 12.7 percentage points higher than the target.

For the *Adult BMI Assessment* measure, three 1115 Waiver plans reported rates that exceeded the State's performance target, while three plans reported NA due to sample size.

Use of Services

The HMOs and PSNs began collecting and reporting Use of Services data in FY 2008. All plans offering ambulatory care or mental health benefits reported valid rates for the *Ambulatory Care* and *Mental Health Utilization* measures. Use of Services data are descriptive in nature and are used to monitor patterns of utilization over time. Because these measures do not lend themselves to measuring the quality of care, the EQRO did not compare performance on these measures.

Access to Care

Overall performance for the 1115 Waiver HMOs and PSN was below average for the Access to Care dimension measures. For *Adults' Access to Preventive Ambulatory Health Services for 20–44 Years*, one plan reported a rate that exceeded the AHCA performance target. For the *45–64 Years* age group, two plans exceeded the performance target. For the *65+ Years* age group, three plans reported rates that exceeded the target. For the *Total* measure, no AHCA performance target was available.

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Appendix G
Waiver and Expenditure Authorities

WAIVERS AND AUTHORITIES FOR FLORIDA'S MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: **11-W-00206/4**
TITLE: **Managed Medical Assistance Program**
AWARDEE: **Agency for Health Care Administration**

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

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the state to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning December 16, 2011, through June 30, 2014.

Title XIX Waivers

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

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

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

   To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, 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. Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group.

3. **Income and Resource Test** **Section 1902(a)(10)(C)(i)**

   To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under state and federal law for purposes of determining Medicaid eligibility.

4. 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.

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 December 16, 2011, through June 30, 2014, be regarded as expenditures under the state's Title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration (formerly titled Medicaid Reform).

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration.

2. 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.

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

4. Expenditures for benefits under the enhanced benefits account program.

5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 71 and 72.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the expenditure authorities:

1. Provision of Medical Assistance Section 1902(a)(10)(A)

To enable Florida to limit the medical assistance for demonstration Population A to health care related costs not to exceed the amount of the individual's enhanced benefit account.

2. Amount, Duration, Scope and Comparability of Benefits Section 1902(a)(10)(B)

To enable Florida to vary the amount, duration, and scope of benefits offered to demonstration Population A from that offered to other beneficiaries under the plan, and to enable benefits for Population A to be non-comparable to those offered to the categorically needy group.

3. Provider Agreements Section 1902(a)(27)

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits under the enhanced benefits account program.

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