FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 1, 2011

Mr. Richard Jensen, Director
Division of State Demonstrations & Waivers
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Jensen:

Enclosed for your review is a request to amend Florida's Medicaid Reform 1115 demonstration (Project # 11-W-00206/4) to implement a recently enacted provision in Florida law related to cost sharing. The following provision requires the Agency to request federal approval to require Medicaid recipients to pay a $100 copayment for nonemergency services and care furnished in a hospital emergency department.

- Section 409.9081(1)(c), F.S., directs the Agency to "seek federal approval to require Medicaid recipients to pay a $100 copayment for nonemergency services and care furnished in a hospital emergency department. Upon waiver approval, a Medicaid recipient who requests such services and care must pay a $100 copayment to the hospital for the nonemergency services and care provided in the hospital emergency department."

The Florida Legislature developed certain principles to guide the process of reforming the Florida Medicaid Program. Similar to other state Medicaid programs and health insurers, Florida Medicaid seeks to implement substantial copayment that will result in a decrease in utilization of emergency room services for nonemergency services. The legislature found that the $15 copayment that is authorized in Florida law for use of a hospital emergency department for nonemergency services was not sufficient to encourage recipients to use more efficient ways of receiving care and was not consistent with copayments found in other health insurance. The legislature intended that a $100 copayment be imposed to encourage more appropriate health care utilization.

This requirement is part of a comprehensive set of programmatic changes by the Florida Legislature enacted for Florida's Medicaid Program and designed to provide needed care in a more effective manner through managed care for many recipients in need of primary and acute medical care. The copayment requirement will require individuals using emergency rooms for nonemergency services and care to participate in the cost of care since these individuals can obtain services in a less costly setting. Attachment I is the State's amendment request. Attachment II is provided to summarize compliance with the amendment requirements specified in STC #7 of the waiver, and Attachment III is the required budget neutrality.

In submitting the request, the Agency appreciates your willingness to discuss how to best accomplish this goal while providing beneficiary safeguards. We appreciate your consideration of this request and your efforts in working with our staff on the 1115 Florida Medicaid Reform Waiver. Should you have any questions, please contact me at (850) 412-4007. We look forward to continuing to work with you.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosures
cc: Mark Pahl, CMS-CO
Jackie L. Glaze, CMS-RO
Etta Hawkins, CMS-RO

Summary of Attachments

Attachment I	**Amendment Request #3 Overview**
Attachment II	**Compliance with Special Term and Condition #7**
Attachment III	**Budget Neutrality**

Attachment I
Amendment Request #3
Overview

Attachment I
Amendment Request #3

2011 Legislation – Related to Copayments

The Agency for Health Care Administration (the Agency) is designated as the single state agency responsible for the administration of the Florida Medicaid program. The Agency delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Elder Affairs and the Agency for Persons with Disabilities. The Florida Medicaid program currently serves more than 3 million Medicaid recipients and has a total appropriation for state fiscal year 2011-12 of $21.2 billion.

During the 2011 Florida legislative session, the Florida Legislature passed and Governor Scott signed legislation to expand managed care in the Florida Medicaid program. This legislation included CS/HB 7109 (Chapter 2011-135, Laws of Florida). CS/HB 7109, in part, amends the section of Florida law that provides for nominal copayments for certain Medicaid services. The provision in CS/HB 7109 requires the Agency to seek federal approval to require Medicaid recipients to pay $100 copayment for nonemergency services and care furnished in a hospital emergency department.

The following is the provision that requires the Agency to request federal approval to require Medicaid recipients to pay a $100 copayment for nonemergency services and care furnished in a hospital emergency department.

- Section 409.9081(1)(c), F.S., directs the Agency to "seek federal approval to require Medicaid recipients to pay $100 copayment for nonemergency services and care furnished in a hospital emergency department. Upon waiver approval, a Medicaid recipient who requests such services and care must pay a $100 copayment to the hospital for the nonemergency services and care provided in the hospital emergency department."

It is our intent that the $100 copayment would only be imposed when alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid recipients in a timely manner.

The legislation to implement the statewide Medicaid managed care program will include a comprehensive set of programmatic changes by the Florida Legislature to provide primary and acute medical care in a more efficient manner. Key provisions include: care coordination and establishment of Medical Homes.

As part of the programmatic design, the State is seeking authority to impose a $100 copayment when individuals use emergency room services for nonemergency purposes. The State seeks to demonstrate whether imposition of a substantial copayment will result in a decrease in the amount of nonemergency services being provided in emergency departments.

Current Copayment Provisions – Florida Law

Section 409.9081, Florida Statutes, Copayments.

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(a) Hospital outpatient services: up to $3 for each hospital outpatient visit.

(b) Physician services: up to $2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463.

(c) Hospital emergency department visits for nonemergency care: 5 percent of up to the first $300 of the Medicaid payment for emergency room services, not to exceed $15.

(d) Prescription drugs: a coinsurance equal to 2.5 percent of the Medicaid cost of the prescription drug at the time of purchase. The maximum coinsurance shall be $7.50 per prescription drug purchased.

(2) The agency shall, subject to federal regulations and any directions or limitations provided for in the General Appropriations Act, require copayments for the following additional services: hospital inpatient, laboratory and X-ray services, transportation services, home health care services, community mental health services, rural health services, federally qualified health clinic services, and nurse practitioner services. The agency may only establish copayments for prescribed drugs or for any other federally authorized service if such copayment is specifically provided for in the General Appropriations Act or other law.

(3) In accordance with federal regulations, the agency shall not require copayments of the following Medicaid recipients:

(a) Children under age 21.

(b) Pregnant women when the services relate to the pregnancy or to any other medical condition which may complicate the pregnancy up to 6 weeks after delivery.

(c) Any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all but a minimal amount of her or his income required for personal needs for medical care costs.

(d) Any individual who requires emergency services after the sudden onset of a medical condition which, left untreated, would place the individual's health in serious jeopardy.

(e) Any individual when the services or supplies relate to family planning.

(f) Any individual who is enrolled in a Medicaid prepaid health plan or health maintenance organization.

(4) No provider shall impose more than one copayment for any encounter upon a Medicaid recipient.

(5) The agency shall develop a mechanism by which participating providers are able to identify those Medicaid recipients from whom they shall not collect copayments.

[1](6) This section does not require a provider to bill or collect a copayment required or authorized under this section from the Medicaid recipient. If the provider chooses not to bill or collect a copayment from a Medicaid recipient, the agency must still deduct the amount of the copayment from the Medicaid reimbursement made to the provider.

History.—s. 48, ch. 93-129; s. 6, ch. 95-393; s. 5, ch. 96-280; s. 5, ch. 96-387; s. 1022, ch. 97-103; s. 12, ch. 2003-405; s. 14, ch. 2006-28.

[1]Note.—As created by s. 5, ch. 96-280. This version is published as the last expression of legislative will. Subsection (6) was also created by s. 5, ch. 96-387, and that version reads:

(6) This section does not require a provider to bill or collect from the Medicaid recipient any copayment authorized by subsection (1). Regardless of whether the provider bills or collects the copayment, the agency shall deduct the amount of the copayment from the Medicaid reimbursement to the provider.

Attachment I
Amendment Request #3

Waiver Authority Requested

To implement the legislatively mandated copayment of $100 for nonemergency services and care furnished in a hospital emergency department, the Agency is seeking a waiver of the following federal statutory provision.

1. 1902(a)(14) of the Social Security Act — Copayment

To enable the state to operate the demonstration and impose a copayment of $100 for nonemergency services and care furnished in a hospital emergency department.

Impact on Budget Neutrality

Since this provision would offset the cost of the program and support more efficient and appropriate utilization of care, the Agency believes the amendment request does not require a change to the budget neutrality of the waiver. There are substantial savings in the current waiver and the State has not sought to use those savings under cost not otherwise matchable.

Attachment II
Compliance with Special Term and Condition #7

Attachment II
Compliance with Special Term and Condition #7

For reference purposes, find below Special Term and Condition (STC) #7 that outlines the process for requesting amendments to the waiver.

STC # 7. Amendment Process**.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

a) An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates by Eligibility Group the impact of the amendment; this paragraph will not apply to an amendment request for a geographic expansion since budget neutrality is statewide.

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

d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

The Agency is submitting this amendment request 120 days prior to the date of implementation of mandating the specified populations to managed care. The Agency understands approval from the Centers for Medicare and Medicaid Services must be granted before the amendment can be implemented. Find below the requirements specified in STC #7 and a description of how the state has complied with each requirement.

(a) An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment:

Public Process: The Agency provided public notice[1] in the Florida Administrative Weekly on June 3, 2011, regarding a series of 3 hour public workshops to be held across the state regarding the new legislation. The 3 hour public workshops were held in the 11 Medicaid regions (see below) beginning on June 10 and ending June 17, 2011. The workshops occurred as outlined in Table A on the following page:

[1] Link to public notice: https://www.flrules.org/gateway/View_Notice.asp?id=9980444

Attachment II
Compliance with Special Term and Condition #7

Table A		
Region	**Counties**	**Date, Time, Location**
Region 1	Escambia, Okaloosa, Santa Rosa, Walton	June 13, 2011 1-4 p.m. Pensacola
Region 2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	June 10, 2011 1-4 p.m. Tallahassee
Region 3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union	June 14, 2011 2:30-5:30 p.m. Alachua
Region 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	June 14, 2011 9 a.m.-noon Jacksonville
Region 5	Pasco, Pinellas	June 15, 2011 9 a.m.-noon Largo
Region 6	Hardee, Highlands, Hillsborough, Manatee, Polk	June 16, 2011 9 a.m.-noon Tampa
Region 7	Brevard, Orange, Osceola, Seminole	June 16, 2011 2-5 p.m. Orlando
Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	June 17, 2011 2-5 p.m. Fort Myers
Region 9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	June 14, 2011 9 a.m.-noon West Palm Beach
Region 10	Broward	June 16, 2011 9 a.m.-noon Ft. Lauderdale
Region 11	Miami-Dade, Monroe	June 16, 2011 2-5 p.m. Miami Gardens

The public workshops included an overview of the new legislation and included information on:

- What happens before implementation
- Medicaid vs. Medicare
- Evolution of Florida Medicaid delivery systems
- Key points of 2011 legislation
- Why changes are needed
- What statewide Medicaid managed care does not include
- When changes will happen
- Where the program will be implemented
- Who will participate
- Who may volunteer to participate
- Who will not participate
- What kinds of health plans can participate
- What to expect
- Timeline of recipient plan choice
- Public input and program improvements
- How to get more information
- How to submit comment

Supplemental information was also made available during the workshops on:

- The federal Medicaid program
- The Florida Medicaid program
- Mandatory services
- Optional services
- Medicaid waivers
- Florida Medicaid enrollment
- Statewide managed care:
  - Timelines
  - Procurement process
  - Plans per area
  - Eligibility, benefits
- Other program components

Summary of Comments

The following is a summary of the public comments received regarding the new legislation. A total of 1,785 attended the workshops and total of 348 provided verbal comments during the workshops. The opportunity for public comment will continue past the initial submission deadline of July 17, 2011. Table B below provides an overview of the number of attendees at each meeting and the number of attendees that provided public comments.

Table B
Final Number of Attendees and Speakers

Location	# of attendees	# of speakers
Tallahassee	178	28
Largo	154	28
Gainesville	80	19
West Palm Beach	170	29
Jacksonville	127	24
Pensacola	148	40
Broward	155	30
Tampa	180	39
Miami	266	37
Orlando	186	43
Ft Myers	141	31
Total Workshops	**1,785**	**348**

The Agency has received a total of 586 written comments as of July 29, 2011. This includes comments given at the public workshops described above, e-mails received through the Statewide Medicaid Managed Care program website, comments mailed directly to the Agency, and comments forwarded to the Agency from the Centers for Medicare and Medicaid Services.

Attachment II
Compliance with Special Term and Condition #7

Below is a summary of verbal and written comments provided during the public workshops. The comments are grouped by topic.

Summary of Issues Raised

- Health Plan Quality: Several comments expressed concern regarding quality of care under health plans participating in the program. Comments included concerns regarding access to specialty services and providers and prescription drugs, particularly for recipients with disabilities, chronic conditions or special health care needs. CS/HB 7107 outlines plan contract requirements relating to plan accountability and performance standards. These requirements include:

  - Posting of formulary or preferred drug list on plan website and ensuring the list is updated within 24 hours of any change;
  - Acceptance of electronic prior authorization requests;
  - Establishments of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers;
  - Requirement that all plans establish a primary care initiative to encourage enrollees to establish a relationship with the primary care provider and requiring enrollees see their primary care provider within 30 days of plan enrollment;
  - Collection and reporting of Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan website;
  - Accreditation during the first 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;
  - Establishment of enhanced fraud and abuse or program integrity requirements; and
  - Establishment of Agency approved internal process for reviewing and responding to grievances from enrollees. Plans are required to report on a quarterly basis regarding the number, description, and outcome of grievances filed by enrollees.

Requirements for compliance with the quality of care and other requirements listed above will be integral in the procurement documents, evaluation of procurement responses, contracting and monitoring of contract compliance.

- Confusion regarding participation: Several comments have indicated that individuals are unclear whether or not they will participate once the plans become available. In general, all individuals eligible for Medicaid will receive coverage through a plan once fully implemented. Comments made by specific groups are as follows:

  - Developmental disabilities population has expressed concerns about changes to their program, specifically the requirement that a sliding scale premium be imposed on families of children enrolled in the DD waivers. Those enrolled in the developmental disabilities waivers are not required to enroll in managed care, although they have the option to do so voluntarily.

- Dual eligibles: Comments expressed concerns regarding the program requirement that dual eligibles, as a unique population with extensive needs, enroll in managed care plans. Pursuant to HB 7107, duals are required to enroll in either a Managed Medical Assistance plan or a Long Term Care managed care plan.

As program implementation moves forward, additional information regarding enrollment requirements will be made available through the Agency's website and other publications. Once the Agency has selected plans and they are ready to provide services, then the Agency will send individuals information regarding changes and their plan choices.

- Network Adequacy- Several comments were provided regarding concerns and recommendations regarding network requirements. Comments included concerns regarding access to specialty or community providers, and a desire that health plans be required to enroll "any willing provider". Specific comments have been provided as follows:

  - The community pharmacy population has expressed concerns relating to potential shift to mail order or out of state pharmacy under managed care expansion. This concern is likely combined with general concerns about the Medicaid program implementing statutory language authorizing expanded mail order provision of pharmacy products. It should be noted that under the Statewide Medicaid Managed Care program, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards.

  - The Advanced Registered Nurse Practitioner community has expressed concern that they will not be included as eligible Primary Care Providers (in plan networks) under the Statewide Medicaid Managed Care program. However, the current managed care contract definition includes advanced registered nurse practitioners (ARNPs) as primary care providers (PCP) – and the language outlining the Statewide Medicaid Managed Care program does not preclude the use of ARNPs as primary care providers.

- CS/HB 7107 Provisions regarding Network Adequacy: In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks.

  - Plans are required to maintain a network of providers in sufficient numbers to meet the needs of the recipients.

  - 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 Agency deems necessary. The provider database must be available online to both the Agency and the public, allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

  - Plans may limit the providers in their networks but must include certain provider types and also certain specific providers that are classified by Agency as "essential."

  - 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.

As part of a competitive process, the Agency will establish plan participation criteria including network requirements. The Agency is currently evaluating enhancements to provider network monitoring activities.

- Appropriate Level of Care Long Term Care Managed Care Program: The Elder Law community has expressed concerns about "granny dumping" under the Long Term Care Managed Care program, and has specifically referenced concern with what they see as "bonus payments" for moving enrollees out of nursing homes.

  - Placement in facilities or home and community based settings will be closely monitored by the Agency to ensure that enrollees are receiving the appropriate level of care and "patient dumping" will not be tolerated.
  - The Statewide Medicaid Managed Care program includes incentives for plans to move enrollees from an institutional setting (such as a nursing home) to a home and community based setting as appropriate. Specifically, the Agency is directed to adjust the payment in order to provide an incentive for reducing institutional placements over time and increasing the utilization of home and community-based services.
  - The move to more home and community based setting is in line with recent nursing home transition and other efforts.

There appears to be a misunderstanding regarding components in CS/HB 7107 as the adjustment to payments will be applied at the plan level to encourage plans to serve more individuals in the community and most integrated setting over time. Granny dumping will not be tolerated. The Agency will continue to educate individuals about plan requirements regarding appropriate levels of care and transition to home and community based settings.

- Cost Sharing Requirements: Several comments were provided regarding concerns about the impact of the cost sharing requirements included in HB 7107 and HB 7109. Comments included concerns regarding cost sharing as a barrier to enrollment or to seeking needed medical care. Specifically:

  - Concern was expressed that the requirement of a monthly premium of $10 as a condition of eligibility will keep Floridians from enrolling or maintaining enrollment in the Medicaid program.
  - Concern was expressed that the requirement for a $100 co-payment for non-emergency treatment in an emergency room setting would create an access barrier to services.
  - As previously noted, concern was expressed regarding the requirement that a sliding scale premium be imposed on families of children enrolled in the DD waivers.

  The Agency will seek required federal authority to implement the provisions in law and will work with CMS to ensure appropriate safeguards while facilitating the objectives of more appropriate use of care and individual contribution.

Attachment II
Compliance with Special Term and Condition #7

- Timeline for Implementation: Many comments indicate that there is confusion regarding the timeline for implementation of the program. Comments indicated that many people believed implementation of program changes would be immediate. During the public workshops, the Agency provided the following detail regarding the timeline.

  - CS/HB 7107 requires that before seeking a waiver, the Agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application.
  - The Agency is required to hold one public meeting in each of the regions described in s. 409.966(2), F.S., and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.
  - The Agency is required to submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the Statewide Medicaid Managed Care program by August 1, 2011.
  - The Agency is directed to begin implementation of the Long Term Care Managed Care program by July 1, 2012, with full program implementation by October 13, 2013.
  - The Agency is required to begin implementation of the Managed Medical Assistance program by January 1, 2013, with full program implementation by October 1, 2014.

The Agency anticipates providing regular updates on the Agency's website. The Agency will also evaluate the best methods to provide ongoing information on updated timelines for recipients, providers, and stakeholders.

- Participation by Aging Networks: The Florida Association of Area Agencies on Aging, and other constituents, have expressed their desire to continue their role in assisting elderly Medicaid recipients with program choice, enrollment, etc. The Aging Resources Centers expressed support for their inclusion in the role outlined for them in CS/HB 7109.

- Concern about covered services: Several areas of concern regarding specific covered services were raised at numerous meetings. These included:

  - Concern relating to the impact of the Statewide Medicaid Managed Care Program on Behavioral Health Overlay Services, or BHOS. Providers have expressed concern that BHOS services will be included in managed care. However, BHOS is not listed as a covered service under the Statewide Medicaid Managed Care program.
  - Concern about the impact of the Statewide Medicaid Managed Care Program on non-emergency transportation (NET) services. Several expressed the desire to carve out this service and allow the Commission for the Transportation Disadvantaged continues to be the contracted provider for NET services to Florida Medicaid recipients.

- Support for Nursing Home Diversion Program: Many comments were received regarding gratitude for care received through the Nursing Home Diversion program. Comments included:

  - Appreciation for the care Nursing Home Diversion plans provided in regard to the quality and speed services were provided.

- Appreciation for the coordination of care and assistance provided by plan case managers was consistent throughout the comments received.

- Hospital Systems: In addition, several hospital systems have submitted letters which urge the state to consider elements included in the April 28, 2011 letter from CMS, regarding the state's 1115 Medicaid Reform waiver, when developing the Statewide Medicaid Managed Care program waiver and amendment requests. Key elements mentioned include:

  - Medical Loss Ratio
  - Financial Reporting by Plans
  - Encounter Data
  - Low Income Pool Funding
  - Recipients ability to participate in cost sharing

  Other issues included in comments received through the mail or email include:

  - Request that Hillsborough be considered its own Region under the Statewide Medicaid Managed Care program.
  - Request for limits on flexibility of benefits packages.
  - Request for clarification on choice counseling/ enrollment broker services under Statewide Medicaid Managed Care program.
  - Consideration of Medical Home concept with drafting waiver/ amendment submissions.

The Agency has established a dedicated email box to receive comments regarding the program and is receiving comments via that mailbox and regular mail. Comments received as of July 29, 2011, fall into the groupings discussed above.

Consultation with Federally Recognized Tribes: The Agency consulted with the Indian Health Programs[2] located in Florida through written correspondence, to solicit input on the new legislation creating the Statewide Medicaid Managed Care program. The correspondence was sent to the Seminole Tribe and Miccosukee Tribe requesting input on the new Statewide Medicaid Managed Care program on June 1, 2011. The Seminole Tribe and Miccosukee Tribe did not provide input on the new legislation. A copy of the State's written notification to the Florida Federally Recognized Tribes and the State's reassurances of compliance with the American Recovery and Reinvestment Act (ARRA) requirements are provided on pages 10-12 of this Attachment.

(b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current Budget Neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates by Eligibility Group the impact of the amendment**.**

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

A data analysis and Budget Neutrality: The Agency believes this amendment request does not impact the budget neutrality as the voluntary populations are included budget neutrality. Attachment III is the Budget Neutrality provided to the Centers for Medicare and Medicaid Services updated in June 2011 as part of the renewal package.

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

Impact on Beneficiaries: See Attachment I for a summary description of this amendment request.

(d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions

Evaluation Design: Approval of this amendment request will not require the Agency to modify to the evaluation design.

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Attachment II
Compliance with Special Term and Condition #7

Written Notification to the Seminole Tribe of Florida

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

June 1, 2011

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

Dear Ms. Whidden:

The State of Florida, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Visit AHCA online at
AHCA.MyFlorida.com

Attachment I
Notice of Public Meetings

The notice of public meeting/workshop/hearing was submitted to the Florida Administrative Weekly (FAW) and will be published in the FAW's June 3rd publication related to the public meetings to be held on the Statewide Medicaid Managed Care Program. This information will also be posted on the Agency for Health Care Administration (Agency) website www.ahca.myflorida.com.

The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

Notice of Meeting/Workshop/Hearing

The Agency announces a series of public meetings to which all persons are invited.

DATE AND TIME: June 10, 2011 from 1:00pm - 4:00pm
PLACE: Agency for Health Care Administration, Building 3, Conference Room A, 2727 Mahan Drive, Tallahassee, FL, 32308

DATE AND TIME: June 13, 2011 from 1:00pm - 4:00pmCT
PLACE: City Hall, Hagler/Mason Auditorium 2nd floor, 222 W. Main St., Pensacola, FL 32502

DATE AND TIME: June 14, 2011 from 9:00am – 12:00pm
PLACE: Department of Children and Families, 5920 Arlington Expressway, Jacksonville, FL 32211, Main Auditorium

DATE AND TIME: June 14, 2011 from 9:00am -12:00pm
PLACE: Hilton Palm Beach Airport, 150 Australian Avenue, West Palm Beach, FL 33406

DATE AND TIME: June 14, 2011 from 2:30pm – 5:30pm
PLACE: Alachua Regional Service Center, 14107 US Highway 441, Conf Rm 190-A, Alachua, FL 32615

DATE AND TIME: June 15, 2011 from 9:00am -12:00pm
PLACE: Mary Grizzle Building, Rooms 136 & 137, 11351 Ulmerton Road, Largo, FL 33778-1629

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Florida Department of Transportation, Auditorium, 11201 N. McKinley Dr., Tampa, FL 33612

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: El Palacio, 21485 NW – 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D – 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm – 5:00pm
PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

Attachment II
Compliance with Special Term and Condition #7

Written Notification to the Miccosukee Tribe of Florida

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

June 1, 2011

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, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Miccosukee Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Visit AHCA online at
AHCA.MyFlorida.com

Attachment I
Notice of Public Meetings

The notice of public meeting/workshop/hearing was submitted to the Florida Administrative Weekly (FAW) and will be published in the FAW's June 3rd publication related to the public meetings to be held on the Statewide Medicaid Managed Care Program. This information will also be posted on the Agency for Health Care Administration (Agency) website www.ahca.myflorida.com.

The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

Notice of Meeting/Workshop/Hearing

The Agency announces a series of public meetings to which all persons are invited.

DATE AND TIME: June 10, 2011 from 1:00pm - 4:00pm
PLACE: Agency for Health Care Administration, Building 3, Conference Room A, 2727 Mahan Drive, Tallahassee, FL, 32308

DATE AND TIME: June 13, 2011 from 1:00pm - 4:00pmCT
PLACE: City Hall, Hagler/Mason Auditorium 2nd floor, 222 W. Main St., Pensacola, FL 32502

DATE AND TIME: June 14, 2011 from 9:00am – 12:00pm
PLACE: Department of Children and Families, 5920 Arlington Expressway, Jacksonville, FL 32211, Main Auditorium

DATE AND TIME: June 14, 2011 from 9:00am -12:00pm
PLACE: Hilton Palm Beach Airport, 150 Australian Avenue, West Palm Beach, FL 33406

DATE AND TIME: June 14, 2011 from 2:30pm – 5:30pm
PLACE: Alachua Regional Service Center, 14107 US Highway 441, Conf Rm 190-A, Alachua, FL 32615

DATE AND TIME: June 15, 2011 from 9:00am -12:00pm
PLACE: Mary Grizzle Building, Rooms 136 & 137, 11351 Ulmerton Road, Largo, FL 33778-1629

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Florida Department of Transportation, Auditorium, 11201 N. McKinley Dr., Tampa, FL 33612

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm
PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: El Palacio, 21485 NW – 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm
PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D – 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm – 5:00pm
PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

Attachment II
Compliance with Special Term and Condition #7

State's Reassurances of Compliance with the ARRA

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

MEMORANDUM

TO: Mary Kay Justis, Acting Associate Regional Administrator
Centers for Medicare and Medicaid Services

FROM: Roberta K. Bradford, Deputy Secretary for Medicaid

DATE: January 6, 2010

RE: American Recovery and Reinvestment Act (ARRA)
Stimulus Funding Compliance Reassurances – Standard Responses

The state provides the following reassurances of compliance with the ARRA requirements on all State Plan amendments, waivers and waiver amendments, contract and contract amendments as specified below:

1. Maintenance of Effort - The Florida Legislature continued funding for the following programs to meet the Maintenance of Effort requirements: MEDS-AD Waiver and the Medically Needy program.

2. Local Match – The Florida Legislature did not impose any additional local funding requirements for the state share of the Florida Medicaid program.

3. Prompt Pay – Mechanisms are in place to assure Florida Medicaid's conformity with prompt pay requirements, and we do not anticipate any issues meeting these requirements.

4. Rainy Day Funds – ARRA funds as appropriated by the Florida Legislature allowed for decreased demand for state revenue. Those "freed up" state funds were then used to fund other priority items in the state budget as approved by the Florida Legislature and Governor. None of the ARRA funds were used as rainy day funds or other reserve funds.

5. Eligible Expenditures (e.g. no DSH or other enhanced match payments) – Via Finance and Accounting systems, only eligible expenditures are being captured for ARRA funding purposes, and non-eligible expenditures are specifically excluded from ARRA expenditures as part of this Finance and Accounting process.

2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

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http://ahca.myflorida.com

Attachment III
Budget Neutrality

Attachment III
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F
1						
2	**States would enter information in the shaded cells. The rest of the sheet will be calculated.**					
3	HISTORIC DATA: SFY 0910 and 7 PRIOR YEARS FOR MANDATORY POPULATIONS					
4	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:**					
5	**Pre-Demonstration Waiver Periods**	**SFY 02-03**	**SFY 03-04**	**SFY 04-05**	**SFY 05-06**	**WOW AVERAGES**
6	**TOTAL EXPENDITURES**					**AHCA:** Trends not used in June 2011 updated WOW projection - President's trend used instead.
7	MEG 1 - SSI RELATED	$ 2,047,157,566	$ 2,203,085,933	$ 2,413,865,641	$ 2,514,883,881	
8	**ELIGIBLE MEMBER MONTHS**	2,890,214	2,925,038	2,992,401	2,941,374	
9	**COST PER ELIGIBLE**	$ 708.31	$ 753.18	$ 806.67	$ 855.00	
10						
11	**TREND RATES**		**ANNUAL CHANGE**			**3-YEAR AVERAGE**
12	TOTAL EXPENDITURE		7.62%	9.57%	4.18%	5.90%
13	ELIGIBLE MEMBER MONTHS		1.20%	2.30%	-1.71%	0.59%
14	COST PER ELIGIBLE		6.34%	7.10%	5.99%	***6.48%***
15						
16	**TOTAL EXPENDITURES**					**AHCA:** Trends not used in June 2011 updated WOW projection - President's trend used instead.
17	MEG 2 - CHILD & FAM	$ 2,204,501,439	$ 2,473,745,468	$ 2,955,249,433	$ 2,908,107,720	
18	**ELIGIBLE MEMBER MONTHS**	14,908,204	15,621,916	18,153,023	16,836,229	
19	**COST PER ELIGIBLE**	$ 147.87	$ 158.35	$ 162.80	$ 172.73	
20						
21	**TREND RATES**		**ANNUAL CHANGE**			**2-YEAR AVERAGE**
22	TOTAL EXPENDITURE		12.21%	19.46%	-1.60%	5.31%
23	ELIGIBLE MEMBER MONTHS		4.79%	16.20%	-7.25%	4.14%
24	COST PER ELIGIBLE		7.09%	2.81%	6.10%	***6.59%***
25	NOTE: Children between 150-185% FPL are included in above MEGS. Although this is technically an optional category, the					
26	nature of this waiver allows for their inclusion in the mandatory MEGS. No other optional eligibility groups are included.					
27						

Attachment III
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F
28	**Pre-Demonstration Waiver Periods**	**SFY 02-03**	**SFY 03-04**	**SFY 04-05**	**SFY 05-06**	
29	**TOTAL EXPENDITURES**					
30	COMBINED ALL MEGS		$ 4,676,831,402	$ 5,369,115,075	$ 5,422,991,601	
31	**ELIGIBLE MEMBER MONTHS**		18,546,954	21,145,425	19,777,604	
32	**COST PER ELIGIBLE**		$ 252.16	$ 253.91	$ 274.20	
33						
34	**TREND RATES**					
35	TOTAL EXPENDITURE		10.00%	14.80%	1.00%	
36	ELIGIBLE MEMBER MONTHS		4.21%	14.01%	-6.47%	
37	COST PER ELIGIBLE		5.56%	0.69%	7.99%	
38						
39						
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50						

Attachment III
Revised Budget Neutrality - 6/10/2011

Demonstration Waiver Periods	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10 *	DY5 SFY 10-11	WW 4-YEARS
TOTAL EXPENDITURES						
MEG 1 - SSI RELATED	$ 2,895,417,932	$ 3,101,151,925	$ 3,437,614,582	$ 3,596,647,161	$ 3,912,500,869	**$ 13,030,831,601**
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,352,695	3,409,260	
COST PER ELIGIBLE	$ 972.13	$ 1,022.14	$ 1,057.81	$ 1,072.76	$ 1,147.61	
TREND RATES		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
TOTAL EXPENDITURE		7.11%	10.85%	4.63%	8.78%	7.50%
ELIGIBLE MEMBER MONTHS		1.87%	7.11%	3.17%	1.69%	4.02%
COST PER ELIGIBLE		5.14%	3.49%	1.41%	6.98%	3.34%
TOTAL EXPENDITURES						
MEG 2 - CHILD & FAM	$ 2,429,520,901	$ 2,518,857,614	$ 2,853,852,002	$ 3,325,471,871	$ 4,321,206,430	**$ 11,127,702,388**
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	19,964,506	22,460,415	
COST PER ELIGIBLE	$ 160.23	$ 169.85	$ 166.94	$ 166.57	$ 192.39	
TREND RATES		**ANNUAL CHANGE**				**3-YEAR PMPM AVERAGE**
TOTAL EXPENDITURE		3.68%	13.30%	16.53%	29.94%	11.03%
ELIGIBLE MEMBER MONTHS		-2.20%	15.27%	16.79%	12.50%	9.60%
COST PER ELIGIBLE		6.00%	-1.71%	-0.22%	15.50%	2.07%

Attachment III
Revised Budget Neutrality - 6/10/2011

	H	I	J	K	L	M	N
28	**Demonstration Waiver Periods**	**DY1 SFY 06-07**	**DY2 SFY 07-08**	**DY3 SFY 08-09**	**DY4 SFY 09-10**	**DY5 SFY 10-11 ***	**WW 5-YEARS**
29	**LIP Allocated**	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 5,000,000,000
30	**LIP Actual Expenditures ***	$ 998,806,049	$ 999,632,926	$ 877,493,058	$ 1,122,122,816	$ 463,462,276	$ 4,461,517,125
31	**ELIGIBLE MEMBER MONTHS**	N/A	N/A	N/A	N/A	N/A	N/A
32	**COST PER ELIGIBLE**	N/A	N/A	N/A	N/A	N/A	N/A
33							
34	**TREND RATES**		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
35			0.08%	-12.22%	27.88%	-58.70%	3.96%
36		N/A	N/A	N/A	N/A	N/A	N/A
37		N/A	N/A	N/A	N/A	N/A	N/A
38							
39							
40	**TOTAL EXPENDITURES**	**DY1 SFY 06-07**	**DY2 SFY 07-08**	**DY3 SFY 08-09**	**DY4 SFY 09-10 ***	**DY5 SFY 10-11**	
41	COMBINED ALL MEGS ***WITHOUT*** LOW INCOME SUBSIDY POOL	$ 5,324,938,833	$ 5,620,009,540	$ 6,291,466,584	$ 6,922,119,032	$ 8,233,707,298	$ 24,158,533,989
42	**ELIGIBLE MEMBER MONTHS**	18,141,234	17,863,960	20,344,582	23,317,201	25,869,675	
43	**COST PER ELIGIBLE**	$ 293.53	$ 314.60	$ 309.25	$ 296.87	$ 318.28	
44							
45	**TREND RATES**		**ANNUAL CHANGE**				**4-YEAR AVERAGE**
46	TOTAL EXPENDITURE		5.54%	11.95%	10.02%	18.95%	9.14%
47	ELIGIBLE MEMBER MONTHS		-1.53%	13.89%	14.61%	10.95%	8.73%
48	COST PER ELIGIBLE		7.18%	-1.70%	-4.00%	7.21%	0.38%
49							
50	*Actual Demonstration Values as of December 31, 2010 payments. SFY 10-11 are partial year payments for LIP; the full allotment is anticipated to be spent.						

Attachment III
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F	G
1							
2	**EXTENSION OF REFORM 1115 DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**						
3							
4	**MANDATORY POPULATIONS**						
5	**ELIGIBILITY**	**DEMONSTRATION**	**MONTHS**	**RENEWAL DEMONSTRATION YEARS (DY)**			**TOTAL**
6	**GROUP**	**TREND RATE**	**OF AGING**	**DY6 (SFY 11-12)**	**DY7 (SFY 12-13)**	**DY8 (SFY 13-14)**	**WOW**
7	**MEG 1 - SSI RELATED**						
8	Eligible Member Months	N/A	12	3,627,670	3,773,502	3,925,197	
9	Total Cost Per Eligible	5.10%	12	$ 1,357	$ 1,426	$ 1,548	
10	Total Expenditure			$ 4,921,484,792	$ 5,380,414,233	$ 6,076,249,521	$ 16,378,148,547
11							
12	**MEG 2 - CHILD & FAM**						
13	Eligible Member Months	N/A	12	23,981,684	26,283,926	28,807,183	
14	Total Cost Per Eligible	5.30%	12	$ 286	$ 301	$ 327	
15	Total Expenditure			$ 6,853,333,861	$ 7,909,350,369	$ 9,429,313,198	$ 24,191,997,427
16							
17	**TOTAL EXPENDITURES WOW D6-D8**						
18	**COMBINED MEGS 1 and 2**			$ 11,774,818,653	$ 13,289,764,602	$ 15,505,562,719	$ 40,570,145,974
19	**ELIGIBLE MEMBER MONTHS**			27,609,354	30,057,428	32,732,379	
20	**COST PER ELIGIBLE**			$ 426.48	$ 442.15	$ 473.71	
21							
22	**TREND RATES**						**3-YEAR**
23						**ANNUAL CHANGE**	**AVERAGE**
24	TOTAL EXPENDITURE				12.87%	16.67%	14.75%
25	ELIGIBLE MEMBER MONTHS				8.87%	8.90%	8.88%
26	COST PER ELIGIBLE				3.67%	7.14%	5.39%

AHCA: President's trend.

AHCA: President's trend.

AHCA: 12 months represents inflation from DY5 PCCM (per STC) to midpoint of DY6.

Attachment III
Revised Budget Neutrality - 6/10/2011

	A	B	C	D	E	F	G
1							
2	**EXTENSION OF REFORM 1115 DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**						
3					n		
4	**MANDATORY POPULATIONS**						
5	**ELIGIBILITY**	**DEMONSTRATION**	**MONTHS**	**RENEWAL DEMONSTRATION YEARS (DY)**			**TOTAL**
6	**GROUP**	**TREND RATE**	**OF AGING**	**DY6 (SFY 11-12)**	**DY7 (SFY 12-13)**	**DY8 (SFY 13-14)**	**WW**
7	**MEG 1 - SSI RELATED**						
8	Eligible Member Months	4.02%	24	3,627,670	3,773,502	3,925,197	
9	Total Cost Per Eligible	3.34%	24	$ 1,145.62	$ 1,183.88	$ 1,263.80	
10	Total Expenditure			$ 4,155,932,144	$ 4,467,388,837	$ 4,960,659,098	$ 13,583,980,079
11							
12	**MEG 2 - CHILD & FAM**						
13	Eligible Member Months	9.60%	24	23,981,684	26,283,926	28,807,183	
14	Total Cost Per Eligible	2.07%	24	$ 173.54	$ 177.13	$ 186.76	
15	Total Expenditure			$ 4,161,698,524	$ 4,655,638,869	$ 5,380,074,330	$ 14,197,411,722
16							
17	**LOW INCOME SUBSIDY POOL**						
18	Eligible Member Months			N/A	N/A	N/A	
19	Total Cost Per Eligible			N/A	N/A	N/A	
20	Total Expenditure			$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 3,000,000,000
21							
22	**TOTAL EXPENDITURES WW D6-D8**						
23	**COMBINED MEGS 1 and 2**			$ 8,317,630,668	$ 9,123,027,706	$ 10,340,733,427	$ 27,781,391,801
24	**ELIGIBLE MEMBER MONTHS**			27,609,354	30,057,428	32,732,379	
25	**COST PER ELIGIBLE**			$ 301.26	$ 303.52	$ 315.92	
26							
27	**TREND RATES**						**3-YEAR**
28						**ANNUAL CHANGE**	**AVERAGE**
29	TOTAL EXPENDITURE				9.68%	13.35%	11.50%
30	ELIGIBLE MEMBER MONTHS				8.87%	8.90%	8.88%
31	COST PER ELIGIBLE				0.75%	4.08%	2.40%
32							
33	(WOW-WW)						
34	$ 12,788,754,173						

AHCA:
24 months represents inflation from midpoint of 0910 (last base year) to midpoint of DY6.